EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 4th June 2019, commencing at 09:30 in St Mary's Boardroom, EDGH

	AGENDA		Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Monthly award winner(s)		Chair	0930 - 1030
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 2nd April 2019	A		
4.	Matters arising	B		
5.	Freedom to Speak Up Guardian	C	Ruth Agg	
6.	ReSPECT	D	DDN	
7.	Board Committee Chair's Feedback		Committee Chairs	
8.	Board Assurance Framework	E	DCA	
9.	Chief Executive's Report	F	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
10.	Integrated Performance Report Month 1 (April) 1. Quality and Safety 2. Access, Delivery & Activity 3. Leadership and Culture 4. Finance	Assurance	G	DDN MD COO HRD DF	1030 - 1125
11.	Learning From Deaths (Quarter 3)	Assurance	H	Imelda Donnellan	

BREAK

STRATEGY

					Time:
12.	East Sussex Health and Care Initiatives	Assurance	I	DS	1140 - 1155
13.	Clinical Strategy Development	Assurance		DS	

GOVERNANCE AND ASSURANCE

					Time:
14.	Staff Survey Action Plan	Assurance	J	HRD	1155 - 1230
15.	Workforce Disability Equality Standard (WDES)	Assurance	K	DCA	
16.	Organ Donation Annual Report	Assurance	L	Judith Highgate	
17.	Quality Walks	Assurance	M	Chair	
18.	Delegation of approval of Quality Account 2018/19	Assurance		DCA	
19.	Board Sub Committee Minutes	Assurance	N		

ITEMS FOR INFORMATION

				Time:
20.	Use of Trust Seal	O	Chair	1230 - 1245
21.	Questions from members of the public (15 minutes maximum)		Chair	
22.	Date of Next Meeting: Tuesday 6th August, Hastings Centre, Hastings		Chair	

Steve Phoenix

Chairman

3rd May 2019

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DS	Director of Strategy
DF	Director of Finance
DDN	Deputy 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, 2nd April 2019 at 09:30 in the Manor Barn, Bexhill.

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

In attendance:
Mr Mark Friedman, Recovery Director
Mr Pete Palmer, Assistant Company Secretary (minutes)

020/2019 **Welcome**

1. Chair's Opening Remarks
Mr Phoenix welcomed everyone to the meeting of the Trust Board held in public.

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

Mr Barry Nealon, Vice Chairman
Miss Jan Humber, Joint Staff Committee Chairman
Mrs Angela Ambler, NHSI Next NED Programme

3. Monthly Award Winners
Mr Phoenix reported that the monthly award winner for January had been Darren Cumber, an Infrastructure Engineer with the Digital Team. February's winner had been Karen Carter, Senior Secretary to the Gastroenterology Consultants at EDGH.

021/2019 **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.

022/2019 **Minutes**
The minutes of the Trust Board meeting held on 5th February 2019 were considered. Two amendments were noted and they were otherwise agreed as

an accurate account of the discussions held. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

023/2019 **Matters Arising**

Two matters arising were noted:

010/2019 – Month 9 IPR

Mrs Chadwick-Bell reported that the IPR had been updated to clarify admission data.

012/2019 - STP Population Health Check

Mrs Chadwick-Bell reported that she had been unable to identify the author of the report. She would continue to pursue the matter.

024/2019 **Quality Walks**

Mrs Manson reported that 52 quality walks had taken place during the previous four months. Staff reported that they were very appreciative of the walks, giving them the opportunity to highlight their successes and to raise their concerns. Common themes emerging from the walks were improving relationships both within teams and with senior management, and the desire of staff to have their voices heard during organisational changes.

Staff also voiced concerns about their capacity to meet the increasing demand on services, and services were being redesigning to both improve them for patients and to meet capacity challenges. She noted that the podiatry team had recently launched a multidisciplinary clinic to help prevent diabetic amputations; a checklist developed for use in the clinic was being rolled out nationwide. The team were understandably very proud of their achievements.

Feedback received from patients during Quality Walks had been largely positive.

025/2019 **Board Committees' Feedback**

1. Audit Committee

Mrs Webber reported that the Audit Committee had met on 28th March. The Committee had received a presentation of the Estates and Facilities risk register. A decision about whether an application for substantial funding for fire compartmentalisation works at EDGH was awaited. The Committee had sought assurance that capital plans for 2019/20 reflected the key risks to the organisation.

Internal audit had presented an audit report of Delayed Transfers of Care which had given no assurance. The Trust had asked auditors to carry out the inspection as they were concerned about the accuracy of data and work was being undertaken to address the issues raised in the report. Draft reports on three other areas had been completed, all giving reasonable assurance.

External audit had begun preliminary work for the end of year audit of the Trust. The draft Annual Governance Statement had been approved by the Committee. A report had been received from the Emergency Preparedness, Resilience & Response (EPRR) team who had made fantastic progress during the previous 18 months and were commended. The Trust was substantially compliant with core EPRR standards.

2. Finance and Investment Committee

Mr Phoenix reported that the Finance and Investment (F&I) Committee had met on 27th March. Mr Reid reported that the Committee had discussed progress against meeting 2018/19 targets and the assumptions included within the 2019/20.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had met on 21st March. The national NHS long term workforce implementation plan had been discussed. The recently published Topol review concerning preparing the workforce for the digital future had also been discussed.

The results of the 2018/19 staff survey had been presented and the Committee was pleased to see an increased response rate of 53%, up from 49% the previous year. Dr Walker had presented new initiatives for medical engagement, and a recent survey of medical engagement in the organisation had shown that the Trust was in the top 10% in the country, having previously been in the bottom 10%.

The Trust's gender pay gap was reported on an annual basis; during 2018/19 female pay remained lower than male pay, but the gap had narrowed in comparison to the previous year. Mrs Kavanagh noted that the Trust's workforce plan would be presented to the Board in July.

4. Quality and Safety Committee

Mrs Manson reported that the Quality and Safety (Q&S) Committee had met on 21st March with an altered focus to its agenda; a number of the reports presented had already been discussed in other meetings, and spending less time on these allowed for more detailed conversations about strategy, governance and risk. The Committee had reviewed preparation and action plans for anticipated CQC inspections. A verbal update on medical engagement, focussing on junior doctors and Guardians of Safe Working Hours, had been received. The challenges that existed in recruiting consultants to a number of specialties were discussed, as well as medical appraisals, the Topol report, the Excellence in Care programme and workforce implementation plans.

The Board noted the Committee Reports.

026/2019 **Board Assurance Framework**

Mrs Wells presented the Board Assurance Framework (BAF) proposing the removal of the gap in control concerning an effective process to manage follow up appointments particularly in the acute setting. The issue had been resolved and assurance received that a new software system and processes were robust and embedded.

Mrs Wells asked whether the red rating for the gap in control relating to the Trust's financial position should be amended to amber. She noted that a red rating implied that the Trust had no effective controls in place; the Trust was expected to meet its target for 2018/19 and had introduced greatly improved financial controls. Mr Phoenix proposed that the rating should be moved subject to the 2018/19 target had been achieved and a control total agreed for 2019/20. The gap in control would be redrafted to reflect the 2019/20 position. Mrs Webber reported that the Audit Committee had discussed the potential of splitting the gap in assurance concerning the Trust's financial position into two

separate risks. They could more accurately reflect that the Trust had improving financial controls, but remained concerned about the delivery of future financial performance.

Mrs Kavanagh asked whether the rating for 62 day cancer targets should remain red as plans had been introduced resulting in improved performance. Mrs Chadwick-Bell explained that while a recovery plan had been introduced, she felt that it would be premature to change the rating. Once plans had been robustly tested then consideration could be given to amending the rating. It was agreed that the Board would review this rating in June.

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 removal of gap in control 2.1.3 concerning effective controls for the monitoring of follow up appointments and the revision to the gap in control in respect of the Trust's financial performance.

27/2019 **Chief Executive's Report**

Dr Bull reported that the Trust was anticipating meeting its financial target for 2018/19. The organisation generated £13m of capital each year to improve the organisation. The MRI scanner building at the Conquest Hospital had been delivered and was being constructed. The £5m cost of this had had to be absorbed into the 18/19 budget since the original plan to borrow the money from the County Council had not received the expected approvals. The work on the Urology Investigation Suite at EDGH continued and work had begun on the Ambulatory Care Unit at the Conquest. There remained a significant capital backlog.

The Trust's apprenticeship programme continued to be effective, with staff keen to get their courses registered in order to develop their own staff.

The Trust's A&E performance was the second best in the country on one day at the end of March, and was regularly above 90% which was a credit to the hard work of staff. Performance against 62 day cancer targets was still behind targets, but plans and a trajectory for improvement had been introduced.

Dr Bull reported that the Trust's Clinical Research Programme had been awarded funding of around £350k for 2019/20. All trusts were obliged to make research programmes available to patients, with recruitment targets linked to funding. Two members of the research team had recently received awards from a local network, and Liz Still had been highly commended in the Involving Patients in Research Programme.

Mr Phoenix asked for an update on February's flu outbreak. Mrs Carruth reported that the Trust had seen a considerable number of flu cases, more at EDGH than the Conquest. A number of patients had required admission to critical care, and sadly there had been six deaths. Root Cause Analyses were being undertaken for the patients who had died, and the Infection Control Committee had reviewed the patients' notes and discussed the cases.

It was thought that three of the six patients who had died had probably acquired flu while in Trust's care. Investigations would try to identify if any lapses in care had contributed to the deaths, and Mrs Carruth noted that the patients that died all had complex underlying problems. Mrs Chadwick-Bell noted that February had been incredibly busy and the Trust had struggled to move patients

identified with flu into side rooms, as these were already occupied. This had had a significant impact on patient flow through the organisation and the Trust would look to learn lessons from this for the following year.

028/2019 **QUALITY, SAFETY AND PERFORMANCE**

Integrated Performance Report Month 11 (February)

1. Quality & Safety

Mr Phoenix asked for an update on clostridium difficile (c.diff) infections in the organisation, noting that the Trust had breached its annual limit for infections in 2018/19. Ms Carruth reported that Trust was assigned limit of 40 cases, but had unfortunately seen 49 c.diff infections during 2018/19 so far. A Post Infection Review was undertaken for each case, in conjunction with the CCG. Of the 49 cases, two had been identified as being potentially due to lapses of care contributing to the infection. In both cases an initial appropriate prescription of antibiotics was made, but regimes could have been altered or stopped sooner.

The Trust was not alone in breaching its c. diff targets and it was suspected that programmes of work to swiftly treat sepsis through the use of broad spectrum antibiotics could be responsible for the rise in cases. The Trust had a significant action plan in place to address the issue, which had been discussed with Public Health England (PHE) who had not raised any significant concerns about the rise in infections. Mrs Carruth noted the fantastic work that the infection control team did within the Trust.

Dr Walker explained that the Trust had worked hard to realise a 38% reduction in deaths from sepsis; patients were given antibiotic treatment for sepsis within the first hour of their admission. The need for swift prescription meant that doctors could not always be sure of the type of infection they were treating without access to testing/results and therefore broad spectrum antibiotics were given. While this treatment has dramatically improved the treatment of sepsis, it also increases the risk of getting c.diff, so the Trust was working to balance these factors. Doctors will be reviewing patients and downgrading antibiotics when additional information about infections became available to them and a new electronic prescribing system, which would be introduced over the next two years, will aid this process.

Mr Phoenix asked how progress would be monitored by the organisation. Mrs Carruth explained that the Infection Control Committee (which PHE attended) would report regularly on progress to the Q&S Committee. Mr Phoenix asked that a progress report be presented to the Board in October. **PP**

Mrs Kavanagh asked whether there was a process of education and training for medics about how to better manage reviews of prescriptions. Dr Walker explained that reviews would be undertaken during ward rounds, and with pharmacists on wards. The electronic prescribing system would help to free up pharmacists to provide education and training for junior doctors on wards.

Mrs Webber asked what learning had been taken from the reviews of the infections. Mrs Carruth explained that the Trust reviewed and learnt from each of the cases whether a lapse in care was identified or not. She anticipated that increased numbers of infections would be reported by organisations across the region in 2019/20 and work was being undertaken by the STP to minimise the unintended consequences of the effective treatment of sepsis.

Mrs Carruth reported that rising trends in falls and pressure ulcers had been discussed by the Q&S Committee. The recent busy period had seen some 70 additional beds regularly open, which had contributed to the pressures and increases. Metrics were being closely monitored to ensure that they reduce as the Trust becomes less busy.

Mrs Churchward –Cardiff raised concerns about increasing falls in the Trust. She noted that a new assessment tool had been introduced, but explained that she wasn't assured that this was working appropriately. Mrs Carruth reported that staff had fedback that the new tool was too complex and that it had been simplified as a result but that this was not solely due to the risk assessment/tool. She hoped that better analysis of data across a number of years would help identify trends that could address any issues. A deep dive would be presented to the Q&S Committee.

Mrs Webber asked about the level of detail of analysis of falls and whether correlations, and possible reasons for increases in falls could be identified. Mrs Carruth explained that a full Root Cause Analysis (RCA) was undertaken where patients fell and suffered harm. Mini RCAs were also undertaken on patients who suffered more than one fall and issues were identified and addressed. She explained that not all falls were avoidable and some patients, who have capacity to do so, choose not to follow advice that they are given.

2. <u>Access and Responsiveness</u>

Mr Phoenix explained that he had been very pleased with the progress made against cancer targets and the trajectory until July. He noted the importance of maintaining this performance beyond July.

Mrs Chadwick-Bell reported that the Trust had achieved all cancer targets in January apart from those for 62 days performance and 62 day screening. 62 day performance had remained the main area of focus and had improved to 72.9%, 7.4% better than the previous year. February's performance would improve further to around 80%. The Trust was now focussing on reducing the number of patients over 62 days who were still being tracked on a cancer pathway.

Two major changes that would help to sustain performance were changes to the lower GI/colorectal pathway, where FIT testing had been introduced to facilitate quicker diagnosis. The completion of the Urology Investigation Suite at EDGH would speed up the Urology pathway for patients, and a 28 day pathway would be introduced in June. Recovery plans would be reviewed with divisions and the CCG later in the week by the COO.

Mrs Chadwick-Bell explained that the number of long waiting patients was reducing. There was a 15% tolerance to allow for patients with medical exceptions and patient choice, but even with this factored in the Trust would not have achieved 85% performance in January. She anticipated that the Trust would perform at 85% in July, but only if no significant changes in demand were seen. Other factors that might affect achievement of the target included patient choice, clinical exception and patients moving from other providers after day 38 in the pathway. Meeting targets would continue to be challenging during summer months and in December when patients and doctors due to reduced capacity at peak holiday times. She explained that an expert in cancer recovery had been recruited in order to provide support for, and test the

robustness of, the recovery plan.

Mrs Churchward-Cardiff noted that cancer activity had grown by about 30% during 2018/19. Mrs Chadwick-Bell explained that plans would need to be revised if activity continued to grow at that rate, but that services had been asked to plan at 18/19 levels of demand. She noted that national standards were likely to change, so the Trust was focussing on 28 day and 62 day standards.

Mrs Chadwick-Bell reported that February had been a challenging month for urgent care which was reflected in performance of 83.84% against the four hour target. Attendances had increased by 17.2% in comparison to the previous year, and the reasons for this increase were being investigated. The Trust had performed well in comparison to peer organisations.

The outbreak of flu had had a significant impact; impacting wait times for beds to become available, due to increased patient moves which are required to isolate patients and establish cohort areas, leading to delays in patient flow from A&E. Improved performance was being seen at EDGH A&E thanks to back to basics interventions and performance in the Trust in March had improved to 93.1% despite increased attendances, an 8% improvement on the previous year.

Mrs Chadwick-Bell reported that the Trust was ensuring that measures introduced to improve performance in 2018 were still working as planned. The Trust was aiming to discharge 40% of appropriate patients by noon each day and would be establishing a transformation programme to support this and the introduction of a live bed state after Easter would help to manage capacity and flow. Ambulatory services were being extended to seven days a week, and the Trust would be working with social care on an integrated set of actions to streamline discharges.

Mrs Chadwick-Bell reported that the Trust had seen a slight increase in super-stranded patients, those with a length of stay of 21 days or longer, in February. She reported that at EDGH the longest medically fit waiter was 78 days, a delay in discharge of 4 days and at Conquest the longest medically fit waiter was 40 days. The average length of stay for inpatients was reducing, but elective lengths of stay has increased and the reasons for this were being investigated.

Mrs Chadwick-Bell noted an error in the CEO's report where performance against the eighteen week RTT should have read 91.1%, not 91.9%. In comparison to peer organisations the Trust was performing well, and she noted the continued aim of meeting the 92% standard. The Trust had only failed to meet diagnostic targets in one of the previous five months.

3. <u>Leadership and Culture</u>

Miss Green reported that in February the Trust had used 351 wte below budget, but that expenditure had been slightly above budget due to the use of clinical agency staff. Most of the Trust's workforce was substantive, with 9% being bank staff and 3.2% agency staff. The busy period in February had led to continued use of agency staff.

The overall vacancy rate for the organisation had reduced, although medical vacancies were at 11%. A lot of positive recruitment was taking place, including in radiology and haematology, areas where it had been difficult to recruit in the past. A new intake of nurses were due to join the organisation.

Staff turnover had reduced to 10.9%, and sickness had reduced slightly in February to its lowest level in two years, with staff supported by an active wellbeing agenda. The annual staff survey results showed slight improvements in many categories, in particular where staff had praised the quality of appraisals and the identification of their developmental needs.

Mrs Churchward-Cardiff asked why short-term sickness had increased. Miss Green explained that work was being undertaken to address long-term sickness in the organisation, but that staff had been affected in the short-term by seasonal illnesses. She noted that Trust policies were being followed in the management of these staff, and emphasised the importance of return to work interviews. Dr Bull noted that the proportion of long term sickness in the organisation had reduced, leading to a concomitant increase in the proportion of short term sickness.

4. Finance

Mr Reid reported that the Trust was forecasting full delivery of the 2018/19 plan, with a deficit of £44.89m and £3.9m of reserves. The annual accounts were due to be finalised and submitted to auditors on 24th April. The Trust's capital programme remained tight, but was well controlled. He explained that the financial plan for 2019/20 would be discussed in detail by the Board that afternoon in the Private Board meeting.

The Board noted the IPR Report for Month 11.

029/2019 **Learning from Deaths (Quarter 2)**

Dr Walker reported that the Trust continued to increase the proportion of deaths that were being reviewed. Only one death in the previous quarter had been identified as avoidable. Deaths of patients with learning disabilities were required to be sent away for external review; these deaths were also being internally reviewed, to ensure that any learning could be swiftly understood.

030/2019 **Seven Day Working**

Dr Walker reported that NHSI had requested Board assurance about the Trust's progress in meeting key standards for seven day working. He noted that the Trust was already meeting many of the standards. He highlighted key clinical standards:

- Clinical Standard 2: For patients to be reviewed by a consultant within 14 hours of admission. The Trust was meeting this standard but was not assured that it could do so at all times of the weekend, particularly in smaller sub-specialities.

- Clinical Standard 8: For ongoing consultant review of patients. This was being achieved during the week throughout the Trust and during weekends in critical care. The Trust was working hard to meet this standard, but doing so would require alteration of consultant job plans.

- Clinical Standards 5 and 6: For access to consultant led diagnostics, and interventions. Dr Walker anticipated that these standards would be met by the end of April.

The Trust would be focussing on meeting Clinical Standard 1, for patient experience, and Clinical Standard 8.

Dr Walker reported that continual audit against the seven day service standards took place via the Excellence in Care programme, and that the Trust had found that its performance was better than anticipated. Dr Bull noted that the Trust's progress in meeting the standards compared to peer organisations was excellent.

031/2019 **East Sussex Integrated System Governance**

Dr Bull presented an update on governance structure that was being implemented for the East Sussex Integrated System. A system of joint governance was being put in place which would include the CCGs, Hospital Trusts and County Council.

A health and social care executive group had been established, with membership from all partner organisations and conversations about the evolution of federations into primary care networks were taking place. Three key programme boards had been set up, for urgent care, planned care and community health and social care.

He reported that monthly regulatory meetings continued to take place with NHSE and NHSI. Christopher Langley was no longer leading this work, with Bob Alexander taking the role of Executive Chair for the system.

Mrs Manson asked what arrangements were being made for stakeholder engagement in the integrated system. Dr Bull explained that a standing stakeholder body had not been created. There is an increased governance role for the Health and Wellbeing Board. A variety of opportunities would be offered to ensure continued stakeholder engagement and a programme of work was being developed by the communications leads of the various organisations involved.

The Board endorsed the integrated system governance structure

032/2019 **2019/20 Plans Update**

Ms Ashton presented an update of the Trust's plans for 2019/20. She reported that the plans of divisional teams were aligned with the Trust contract agreed with CCGs. This would ensure that the Trust could meet its control total and CIP targets. She reported that all the divisional corporate budgets had been signed off, with the exception of those for Medicine and Estates which were expected to finalised by the end of the week. Ongoing cost pressures would be incorporated into plans as they were identified.

033/2019 **Quality Improvement Priorities**

Mrs Carruth reported that the paper had been presented and discussed at the Q&S Committee. She explained that reporting on the Trust's 2018/19 priorities was due to be finalised shortly, and presented the proposed priorities for 2019/20. These would be:

- Continuing to improve the management of the deteriorating patient;
- Improve compliance against the seven day working standard for ongoing consultant-directed review;
- Continued implementation and development of the Excellence in Care Programme;
- Improve communication so that patients feel better informed about their care and treatment.

Mrs Churchward-Cardiff noted the importance of setting a baseline for priorities

and then having measurable outcomes to ensure that improvements could be accurately assessed.

034/2019 **Delivering Same Sex Accommodation Annual Declaration of Compliance**
Mrs Carruth presented the annual declaration which would be published on the Trust's website. It reaffirmed the organisation's commitment to minimising same sex accommodation breaches. She noted that with increasing pressures on capacity it was not possible to eliminate them entirely, and any breaches, whether justified or not were reported. This information was shared publically and with the CCG. There were still no nationally agreed guidelines for reporting with some differences in place. The Trust had seen a rise in breaches during the recent busy period and continued to try to find the best possible balance between avoiding breaches and swiftly treating patients, which may lead them to being treated in the "wrong" sex bed on occasions when rapid treatment was required. Staff were briefed to ensure that they knew when it was appropriate to treat patients in the "wrong" bed in these instances.

Mrs Churchward-Cardiff noted that the Trust's estate did not enable the correct bed to be offered all the time. Dr Bull explained that it wasn't realistic to keep capacity open just to avoid breaches.

035/2019 **Delegation of Approval of Annual Report and Accounts 2018/19**
Mrs Wells sought the approval of the Board for delegated authority to the Audit Committee for the approval of the 2018/19 Annual Report and Accounts at its meeting on 24th May. She noted that the Trust Board would not be meeting again before this date and that the accounts would formally be received by the Board at the Trust's AGM on 6th August.

The Board approved delegation to authorise the 2018/19 Annual Report and Accounts to the Audit Committee.

036/2019 **Annual Self-Certification**
Mrs Wells explained that it was a regulatory requirement for the Board to self-certify that they could meet the obligations set out in the NHS provider license and that they had complied with governance requirements at end of each financial year. She noted that the Board was fully compliant for 2018/19. The certificates would be put onto the Trust's website once approved by the Board.

The Board approved the annual self-certification.

037/2019 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- Audit Committee 28.11.19
- POD Committee 24.01.19

The Minutes were received by the Board

038/2019 **Questions from Members of the Public**

Mrs Walke commended the Board on the openness of discussions that had taken place during the meeting, noting that issues were raised and discussed in public in a way that had not happened under former Trust leaders. Mr Phoenix

explained that the Board appreciated the comments, and noted that the credit for this change in approach lay with the previous Chairman, Mr Clayton-Smith.

Mrs Walke noted that the faded map outside EDGH had not yet been replaced. Dr Bull reported that a wayfinding project was being undertaken to improve signage throughout the organisation and that the map would be replaced as part of this project.

Mrs Walke asked if any update was available on the proposed ENT reconfiguration in the Trust. She asked if concerns had been raised about the plans by consultants in Hastings. Dr Bull explained that all of the Trust's ENT consultants worked on a cross-site basis. The Trust would continue to ensure that patients with post-operative complications or emergency situations could attend A&Es and, if necessary, be attended to by a senior ENT surgeon at both main sites. It had been agreed that two operating lists a month would be undertaken at the Conquest Hospital in order to maintain competences. When there were sufficient patients then a third list would be utilised. The Trust remained committed to providing ENT consultant support in both A&E department.

Mr Hardwick asked for more information about podiatry one stop clinics and Dr Bull explained that the team had worked in collaboration with a vascular surgeon in Brighton concerning complications with the foot that could lead to amputation. A new approach has been introduced with very early identification of complications. This was an Trust-wide initiative, undertaken in an multidisciplinary team fashion, which, while difficult to do, had been adopted very effectively by staff.

Mr Hardwick asked whether there were any financial penalties for being over the target for c.diff infections. Dr Bull reported that the Trust had reached an agreement with NHSE and NHSI that it wouldn't be subject to fines and penalties during the year as long as financial targets were met. If the Trust agreed a control total for 2019/20 then financial penalties would continue to be waived.

039/2019 **Date of Next Meeting**
Tuesday 4th June, St Mary's Boardroom, EDGH

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 4th April 2019 Trust Board Meeting

Agenda item	Action	Lead	Progress
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**	Unable to confirm with the author of the document, but through discussion with the STP we believe this refers to a number of conditions which could be managed in the community as opposed to attendance at ED. These are likely to include UTI, Blocked Catheters, Flu/Pneumonia, non-injury falls, cellulitis. The East Sussex system has already identified this as an area of focus and established five new pathways and this is being managed through the system urgent care board.
026/2019 – Board Assurance Framework	The Board agreed to review the rating on the BAF for risk 2.1.1 concerning 62 day cancer targets.	**LW**	To be discussed under item 8 of the agenda.
028/2019 I – IPR – Quality & Safety	An update on progress in reducing c.diff infections within the organisation to be presented to the Board in October.	**VC**	Added to agenda for October's meeting.

Freedom to Speak Up Guardian's Report

Meeting information:			
Date of Meeting:	4th June 2019	Agenda Item:	xx
Meeting:	Trust Board	Reporting Officer:	Ruth Agg

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☐ *(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 National Freedom to Speak Up review by Sir Robert Francis, following the Mid-Staffordshire enquiry, provided independent advice on creating a more open and honest reporting culture in the NHS with the aim of making it a better place to work and a safer place for patients. The report concluded that there was a culture within many parts of the NHS which deterred staff from raising concerns, as there were often negative consequences for those who raise them. The experiences of patients and workers in Mid-Staffordshire and recently in Gosport highlight the potential consequences of getting this wrong.

The review recommended the appointment of a Freedom to Speak up Guardian in all Trusts, advising that they should be independent and impartial; have the authority to speak to anyone within or outside the organisation; be an expert in all aspects of raising and handling concerns and have the tenacity to ensure safety issues are addressed. It is now a requirement that all NHS Trusts have a Freedom to Speak up Guardian and it forms part of the NHS contract. The Freedom to Speak up Guardian complements other avenues available to staff to receive advice and support including via direct line management, through the Trust's HR department, directly to the Chief Executive and by contacting the Senior Independent Director. ESHT appointed a Freedom to Speak up Guardian in December 2016.

Monthly contacts with the Freedom to Speak up Guardian remained consistent from 2017/18 to 2018/19 at around 24 a month. When the Freedom to Speak up Guardian was appointed, the Trust initially saw a much larger number of contacts from staff than other NHS organisations. Recent national figures have shown a large increase in contacts in many other organisations; this upward trend is not repeated at ESHT, indicating that the Trust's culture of being open has been embedded and working effectively for some time.

The two areas which have led to the largest numbers of contacts with the Freedom to Speak up Guardian have been behavioural/relationship issues and system/process issues. These impact on staff wellbeing and attendance at work and include actions to address these issues include ensuring that policies are applied in a fair and even manner to all staff.

Following focussed work by the Trust, the number of contacts relating to bullying and harassment has reduced from 73 in 2017/18 to 45 in 2018/19, an improvement reflected in the Trust's Staff Survey results.

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

None.

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

The Board is asked to continue to support the promotion of speaking up as everyday business and to ensure that staff will not face detriment for raising genuine concerns. The Board is asked to support any staff who cite reprisal or detriment.

The Board is asked to receive assurance that effective speaking up arrangements are in place to ensure learning and continual improvement which will protect patients and improve the experiences of NHS workers.

FREEDOM TO SPEAK UP GUARDIAN'S REPORT MAY 2019

Background to Freedom to Speak Up

Sir Robert Francis, in his Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013), described the experiences of nurses and doctors who raised whistleblowing concerns about the poor care of some patients at Stafford Hospital. As a result, he was asked to conduct a further review into whistleblowing in the NHS. 'Freedom to Speak Up – an independent review into creating an open and honest reporting culture in the NHS' was published in 2015. The report identified a need for culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups, and extending the legal protection. Sir Robert Francis identified 20 principles that addressed these themes. In particular, he recommended that all trusts should have a Freedom to Speak Up Guardian to 'act in a genuinely independent capacity' and support staff to raise concerns.

In 2016-17 it became a contractual requirement for all NHS provider trusts to have a Freedom to Speak Up Guardian. By the end of the financial year, all trusts in England had made appointments although not all Guardians were in post. Trusts were also expected to adopt a model NHS whistleblowing/raising concerns policy.

The Role of the Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian is not part of the management structure of the Trust and is able to act independently in response to the concerns being raised with her. The Freedom to Speak Up Guardian reports directly to the Chief Executive, and this gives her access to the executive directors of the Trust. The role of the Freedom to Speak Up Guardian is to:

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

Staff should not suffer any detriment for raising genuine concerns

Designated Freedom to Speak Up Leads

Ruth Agg is the Freedom to Speak Up Guardian and has been in post since December 2016. She acts as a point of contact for staff wishing to raise a concern who feel unable to raise concerns with their line manager or who feel a concern has not been addressed at the local level. She ensures that concerns are dealt with appropriately and confidentially, with regular communication and feedback to staff. She seeks feedback to ensure staff do not face any reprisal or detriment. The Guardian reports to Dr Adrian Bull and regularly meets with members of the executive team.

Dr Adrian Bull is the Executive Lead for Freedom to Speak Up, supported by the Senior Independent Director. He regularly meets with the Freedom to Speak Up Guardian to oversee and review internal processes for raising concerns, ensuring staff feel empowered to raise concerns.

Barry Nealon is the Senior Independent Director, a designated Non-Executive Directors who is an independent voice and champion for those who raise concerns. He acts as a conduit through which information is shared with the Board and provides challenge to the executive team on areas specific to raising concerns and the culture in the organisation.

Freedom to Speak Up contacts 2018/19

Category	Q1	Q2	Q3	Q4	2018/19 Totals	2017/18 Totals
Behavioural / Relationship	22	20	21	19	**82**	**81**
Bullying / Harassment	12	17	12	4	**45**	**73**
Cultural	0	0	0	1	**1**	**8**
Leadership	0	2	1	1	**4**	**13**
Not Known	0	2	5	8	**15**	**1**
Patient Safety / Quality	6	7	6	7	**26**	**29**
Racial discrimination	1	0	4	0	**5**	**0**
Sexual Discrimination	1	0	0	0	**1**	**0**
Staff Safety	2	0	2	1	**5**	**9**
System / Process	23	27	20	10	**80**	**68**
Quarter Totals	**67**	**75**	**71**	**51**	**264**	**297***

	Q1	Q2	Q3	Q4	2018/19 Totals	2017/18
Reprisals	2	3	2	0	**7**	**1**

	Q1	Q2	Q3	Q4	2018/19 Totals	2017/18
Anonymous contacts	1	0	3	0	**4**	**10**

*2017/18 figure includes contacts about infrastructure/environment (4), middle management (8), reprisal (1) and senior management (2).

- During 2017-2018 there was a total of 297 contacts with the Freedom to Speak Up Guardian – an average of 24.75 a month. The Freedom to Speak Up Guardian was away for one month during 2018/19; the year saw a total of 264 contacts at an average of 24 a month.

- The highest scoring categories for contacts have remained the same, but there has been a significant decrease in contacts concerning bullying and harassment from 73 in 2017/18 to 45 in 2018/19. This reduction was reflected in the recent staff survey results:

	2017/18	2018/19
Q13b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from Managers	13.6%	12.6%

- The staff survey also demonstrates the improving culture in the organisation of confidence amongst staff to raise concerns:

	2017/18	2018/19
Q18a b I would feel secure raising concerns about unsafe clinical practice	65.3%	67.5%

Recording of detriment

Detriment can be described as any treatment which is disadvantageous and/or demeaning and may include being ostracised, given unfavourable shifts, being overlooked for promotion, moved from a team, etc.

The Freedom to Speak Up Guardian is required to record the number of cases where an individual feels they have suffered detriment as a result of speaking up. In addition, should details of a case reveal elements of detriment as described, these should also be recorded even if the individual bringing the case does not identify detriment.

During 2018/19, seven members of staff raised concerns that they faced detriment. These matters were escalated and reassurance was sought to ensure the staff were fully supported. Examples of detriment included:

- Feeling ignored following the raising of a concern;
- Being told "you should not have gone to the Speak up Guardian";
- A staff member who was advised that a complaint had been received regarding their behaviour. This was responded to by the Senior Manager and reviewed with discussion and understanding of the detriment concern raised.

Freedom to Speak Up Guardian activity in 2018/19

- A meeting charter has been developed and put into all meeting rooms in the organisation , and on the intranet, to provide a visible reminder of the Trust values for all staff;
- Managers are offered support and advice about how to respond to concerns in a timely and supportive way;
- Advice is given about how to apply Trust policies in a pragmatic and compassionate manner;
- Datix is utilised to monitor investigations, ensure that appropriate actions are taken, learning is shared and that feedback is given to staff;
- Partnership working with HR is undertaken to review cases and ensure that staff are reassured by the feedback they receive;
- Partnership working with Staff Engagement has taken place to train managers on how to support staff who feel bullied and how to respond to poor behaviour;
- Concerns are escalated to Senior Colleagues and HR for formal investigation where necessary;
- Staff are supported in carrying out and attending exit interviews to enable the organisation to learn from the experiences of staff;
- Continued work to promote the Freedom to Speak Up Guardian has been undertaken, evidenced by the range of staff groups who have made contact;
- The Freedom to Speak Up Guardian attends induction events for new staff, including medical and nursing colleagues;
- Training is delivered to junior doctors in conjunction with the GMC;
- Regular meetings with the Chief Executive take place, with open access as required. Regular meetings also take place with Trust Executives;
- The launch of the new Trust intranet has led to improved information being available to staff about the Freedom to Speak Up Guardian.
- The Freedom to Speak Up Guardian attends the South East network. Local networks are due to be merged to form regional networks, with regional leads being appointed.
- The Freedom to Speak Up Guardian continues to network with local Trusts and has supported new Guardians in post on induction

National Guardian's Office Updates

The National Guardian's Office (NGO) is an independent, non-statutory body with a remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC, NHS England and NHS Improvement.

The NGO published their 2017/2018 Annual report in November 2018 highlighting some of the positive difference Freedom to Speak Up Guardians make. The report highlighted some national themes and specific data about the Trust:

- Over 7,000 cases were raised nationally through Freedom to Speak Up Guardians in 2017/18, and there are now over 800 guardians and champions in trusts, independent sector organisations and some arm's-length bodies. Nearly a third of the cases raised to guardians in trusts had an element of patient safety, ranging from a patient incorrectly put on an end of life care pathway, to the uncovering of a human trafficking and modern slavery ring.
- Nearly half of the cases had an element of bullying and harassment. The NHS annual staff survey 2017 showed nearly a quarter of all staff describing being bullied or harassed.
- The themes of contacts seen at ESHT are similar to those of seen by other Trusts, with behavioral and relationship issues prevalent. The Trust is working to address these issues by offering support and intervention from HR, continuing support for managers and staff when bullying concerns are raised and additional training for managers.
- In August 2018 the "Independent investigation into the management of the Trusts disciplinary process resulting in the dismissal of Mr Amin Abdullah was published by Verita for Imperial College Healthcare NHS Trust. The report highlighted many failings into the handling of the investigation on the lead up to his tragic death. The recommendations support investigation processes and how they are managed.

In June 2017, the NGO launched a 12 month trial of its case review process. The trial reviewed the handling of concerns, the treatment of people who had spoken up and evidence where good practice had not been followed. The purpose of a case review is to identify any areas where the handling of NHS workers' concerns does not meet the standards of accepted good practice in supporting speaking up in NHS trusts. The emphasis of a case review will be on learning, not blaming and where a review finds that good practice was not followed the National Guardian will make recommendations about how this can be improved.

Case reviews will also identify where NHS trusts have demonstrated good practice in supporting their workers to raise concerns, to help develop a positive culture of speaking up. An example of a case review is included as an appendix to the Board papers.

Feedback and Measuring Success

- The Trust's internal auditor, TIAA, undertook an audit of Freedom to Speak Up within the Trust, giving an outcome of substantial assurance;
- 100% compliance with data returns to the Freedom to Speak Up National Office;
- Staff survey data is triangulated to ensure that improvements are reflected;
- A reduction in monthly contacts with the Freedom to Speak Up Guardian reflects staff confidence that they can share concerns through the leadership route when appropriate;
- Plaudits and complaints about the Freedom to Speak Up Guardian are reviewed;
- The National Guardian request feedback is sought and it is reported quarterly.
- Any cases where staff say that they have faced detriment are reviewed.
- Survey monkey feedback is requested from staff making contact with the Freedom to Speak Up Guardian on an anonymous basis. Staff are asked 'Given your experience, would you speak up again?'; only one negative response has been received.

Feedback	Q1	Q2	Q3	Q4	Feedback Totals
Don't know	0	1	0	0	**1**
No	1	0	0	0	**1**
Not specified	31	31	15	0	**77**
Yes	32	33	27	8	**100**
					179

Next Steps

- NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.
- This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve. This is due to be presented to the People and Organisational Development Committee in July.
- Once the self-review has been completed an improvement action plan will be undertaken. This has been developed to help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.
- Further review and engagement to support the Trust's Freedom to Speak up strategy implementation
- Training and Education to support a further reduction in unwanted behaviours, bullying and harassment.
- Continuing to ensure speaking up is part of everyday business

Ruth Agg
Freedom to Speak Up Guardian
16th May 2019

RESPECT

Trust Board

Dr David Barclay, Consultant in Palliative Medicine and Clinical Lead for Palliative Care
Hazel Tonge, Deputy Director of Nursing

Ref: NB Content of some slides taken from ReSPECT National Toolkit

Contents

1. What conversations have you had ?
2. What do people want at the end of their life
3. What is ReSPECT ?
4. Who developed ReSPECT ?
5. Background
6. National guidance on CPR decisions
7. The ReSPECT form and aims
8. Who is it for?
9. ESHT Timeline
10. Other local ReSPECT initiatives

What conversations have you had ?

Advance Care Planning

- ✓ Who has already had conversations themselves?
- ✓ If you were facing a life limiting illness, what would be most important to you?

What people want at the end of life

- ✓ 78%: to be free from pain and discomfort
- ✓ 71%: to be surrounded by loved ones
- ✓ 53%: to have privacy and dignity
- ✓ 45%: to be in familiar, calm environment

[Ref: Time and a place: Sue Ryder Report complied by DEMOS, July 2013].

Yet

- ✓ 87% feel it is important for HCPs to know of their wishes for future interventions
- ✓ Less than 1 in 10 currently record end of life wishes
- ✓ Only 10% wanted a doctor to make final treatment decisions
- ✓ Only 7% have a LPA for Health & Welfare

(YouGov Survey 2018)

[Ref:https://richmondgroupofcharities.org.uk/news/how-can-we-ensure-people-can-make-their-own-decisions-right-end-life}

What is RESPECT ?

- ReSPECT – an alternative process for discussing, making and recording recommendations about future emergency care and treatment, including CPR
- ReSPECT – developed by many stakeholders, including patients, doctors, nurses and ambulance clinicians, to try to achieve a process that will be adopted nationally
- ReSPECT focuses on treatments to be considered as well as those that are not wanted or would not work
- ReSPECT encourages people to plan ahead for their care and treatment in a future emergency in which they are unable to make decisions

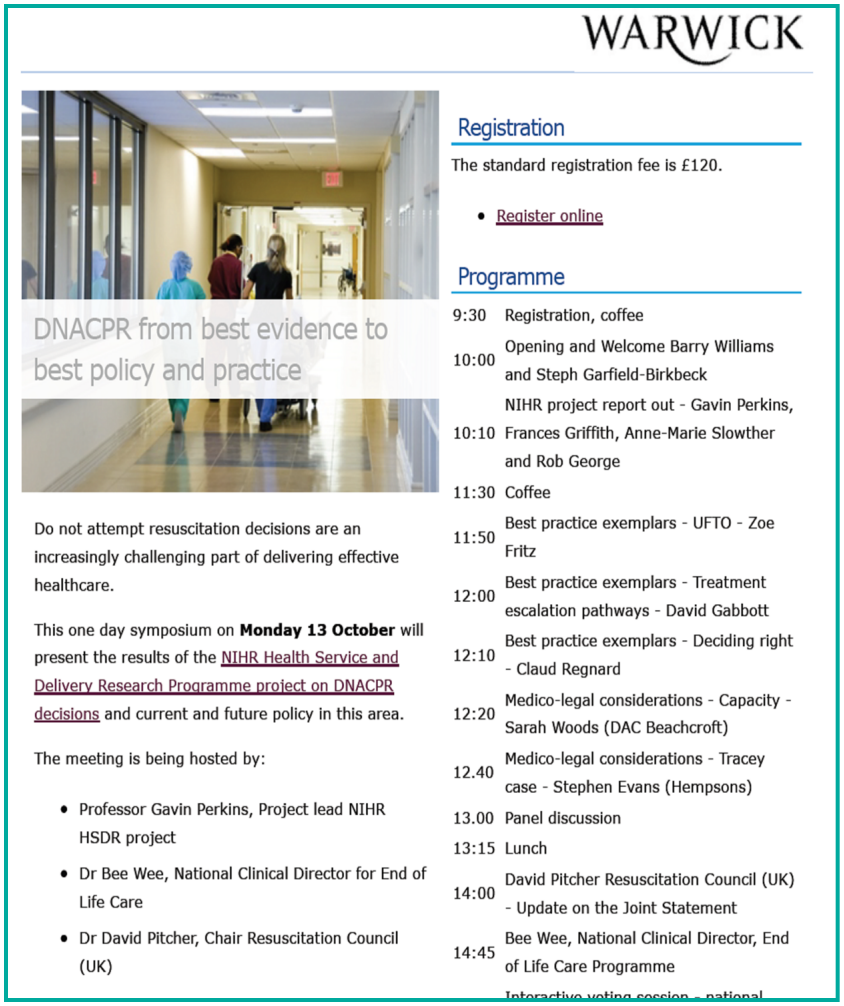
Who developed RESPECT ?

The ReSPECT Working Group

Wide stakeholder representation including:

- Patient and public representatives
- Royal Colleges including the Royal College of Nursing
- Ambulance service representatives
- Resuscitation Council (UK)
- General Medical Council
- Care Quality Commission
- Leaders of successful local and regional initiatives

Background – the evidence



WARWICK

DNACPR from best evidence to best policy and practice

Do not attempt resuscitation decisions are an increasingly challenging part of delivering effective healthcare.

This one day symposium on **Monday 13 October** will present the results of the NIHR Health Service and Delivery Research Programme project on DNACPR decisions and current and future policy in this area.

The meeting is being hosted by:

- Professor Gavin Perkins, Project lead NIHR HSDR project
- Dr Bee Wee, National Clinical Director for End of Life Care
- Dr David Pitcher, Chair Resuscitation Council (UK)

Registration

The standard registration fee is £120.

- Register online

Programme

9:30	Registration, coffee
10:00	Opening and Welcome Barry Williams and Steph Garfield-Birkbeck
10:10	NIHR project report out - Gavin Perkins, Frances Griffith, Anne-Marie Slowther and Rob George
11:30	Coffee
11:50	Best practice exemplars - UFTO - Zoe Fritz
12:00	Best practice exemplars - Treatment escalation pathways - David Gabbott
12:10	Best practice exemplars - Deciding right - Claud Regnard
12:20	Medico-legal considerations - Capacity - Sarah Woods (DAC Beachcroft)
12.40	Medico-legal considerations - Tracey case - Stephen Evans (Hempsons)
13.00	Panel discussion
13:15	Lunch
14:00	David Pitcher Resuscitation Council (UK) - Update on the Joint Statement
14:45	Bee Wee, National Clinical Director, End of Life Care Programme

Interactive voting session - national

October 2014

DNACPR

from

best evidence

to

best policy and practice

https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr04110#/abstract

Background

DNACPR decisions and discussions have led to:

- Negative patient/public and clinician perceptions
- Complaints and litigation
- Negative media reports

Common Themes:

- Poor or absent communication, poor decision-making, poor or absent documentation
- This was also seen locally in CQC visit and our own internal audits

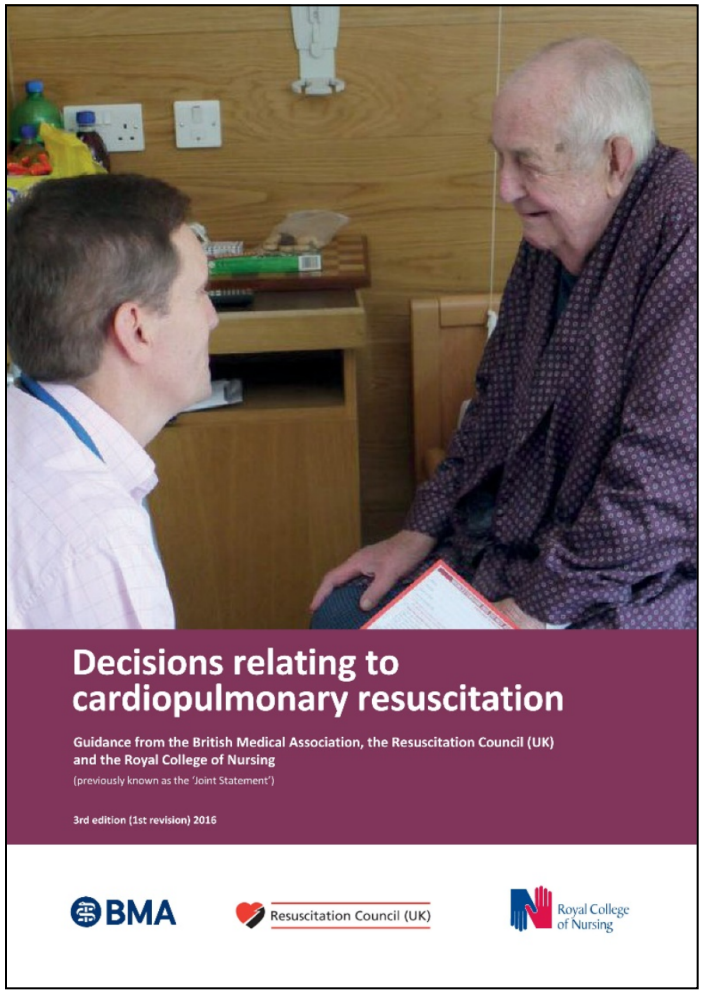
High profile court Case

Court of Appeal 2014

Tracey vs. Cambridge University Hospitals NHS Foundation Trust

"…presumption in favour of patient involvement"

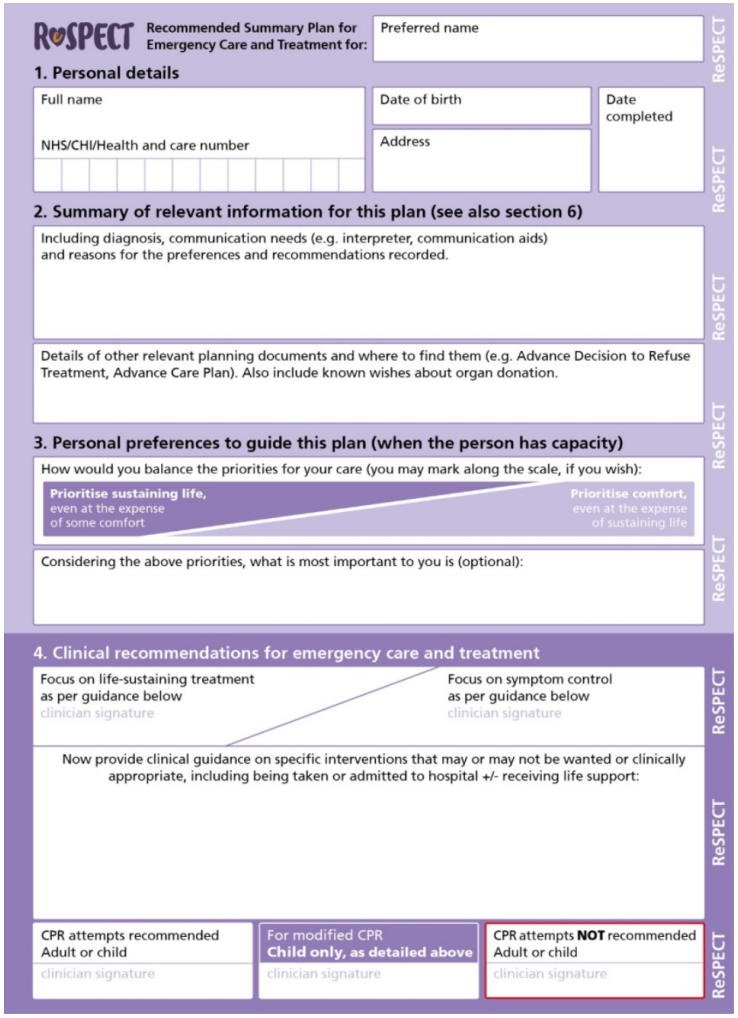
National guidance on CPR decisions



"Where no explicit decision…
…there should be an initial presumption in favour of CPR."

"…there are clear benefits in having (CPR) decisions recorded on standard forms that are…recognised across geographical and organisational boundaries within the UK."

The ReSPECT form and aims



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for: Preferred name

1. Personal details

Full name
NHS/CHI/Health and care number
Date of birth
Address
Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
clinician signature

Focus on symptom control as per guidance below
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended Adult or child
clinician signature

For modified CPR **Child only, as detailed above**
clinician signature

CPR attempts **NOT** recommended Adult or child
clinician signature

ReSPECT

- More conversations between people and clinicians
- More planning in advance
- Good communication
- Good decision-making
- Shared decision-making (whenever possible)
- Good documentation
- Better care

Who is it for

Everyone – with increasing relevance for those:

- ✓ with particular healthcare needs nearing the end of their lives

  or

- ✓ at risk of cardiac arrest who want to record their preferences for any reason

A ReSPECT form is best completed when a person is relatively well, so that their preferences and agreed clinical recommendations are known if a crisis occurs.

If an emergency occurs in someone with no ReSPECT form the healthcare team can consider discussing and completing it as soon as possible (before or after hospital admission)

ESHT timeline

- Meeting of key stakeholders within ESBT September 2017
- Original proposed date of launch August 2018
- Staff awareness training started early Spring 2018 through Basic Life Support Training
- Dedicated project manager appointed and focused on ESHT May 2018
- Pilot sites – both ITU, Newington ward in Conquest.
- Launch on 1st April 2019: all DNACPR pads removed from all acute in patient areas and replaced with ReSPECT forms
- Training has been available for relevant clinical staff in all settings

Other local ReSPECT initiatives

- ReSPECT collaboration group set up across all Sussex, now hosted within Kent, Surrey and Sussex Academic Health Science Network. Been in place since Feb 2018
- Sussex Community NHS Trust – implementation stage, and have employed full time educator
- HWLH CCG – steering group overseeing its introduction
- ESH / H&R – embedding into frail and vulnerable patient scheme this year (presenting to learning event May 2019) – pilot sites using new process, all surgeries informed of new forms arriving for their patients.
- Hospices – St Wilfrid's established; St Michael's Hospice aware
- South East Coast Ambulance NHS Trust – all staff trained, dedicated e-mail receiving copies

Summary

- East Sussex Healthcare NHS Trust were the first to introduce this nationally driven initiative locally in the South East
- Governance processes in place internally
  - Audit
  - Feedback 'It's hard to imagine how we managed before without it'- Dr Nahas, New Consultant in Frailty
- Roll out being monitored for reassurance
- Support for non medical decision makers

Board Assurance Framework

Meeting information:			
Date of Meeting:	4th June 2019	Agenda Item:	8
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Summary:

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

Attached is the updated Board Assurance Framework (BAF). Revisions to the BAF are shown in red.

It is proposed that a new gap in control, 2.1.3, should be added to the BAF regarding follow up appointments.

It is also proposed to remove the gap in assurance, 5.2.1, in respect of culture and the staff survey.

There remain two areas rated red

- 2.1.1 in respect of delivery of the 62 day cancer metrics
- 4.2.1 in relation to capital constraints.

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

Senior Leaders Forum 9 May 2019
Quality and Safety Committee 23 May 2019

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

The Trust Board is asked to review and note the revised Board Assurance Framework and consider whether the main inherent/residual risks have been identified and that actions are appropriate to manage the risks.

The Trust Board is asked to agree the addition of the gap in control 2.1.3 regarding follow up appointments and remove the gap in assurance 5.2.1 regarding culture and the staff survey.

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 Governance accountability agreed and known eg HN, ward matrons, clinical leads. 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 IPR 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 Deep dives into QIP areas such as staff engagement, cancer Trust CQC rating moved from 'Inadequate' to 'Requires Improvement' a number of areas rated Good in March inspection. "Safer" ward rounds in place Mortality metrics below national average

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.	**May-19** Mock inspections taking place this month across acute and community to provide assurance against actions and key lines of enquiry - inspection team include Trust staff, Healthwatch and NHSI. **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.	end Dec-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 Cancer PTL formats revised, capacity and demand analysis undertaken as well as re-design of patient pathways.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls required to support the delivery of cancer metrics and ability to respond to demand and patient choice.	**May-19** Positive signs of progress are being demonstrated in the Trusts 62 day Cancer performance position. Although the 85% target is still to be achieved (target July 2019), the Trusts performance over the past 4 months has been in line with the agreed recovery trajectory or at times even higher. Patients waiting longer than 104 Days has reduced by 65% since December 18 and the number of patients waiting over 62 days (Backlog) has reduced 50%. Patient choice and patient fitness remain a challenge but the Trust is proactively working to address this and is working closely with CCG colleagues and the Cancer Alliance. The continued focus and drive to improvement the patient's treatment times remains in place and is monitored through the Trust Cancer Recovery Plan. Shadow monitoring of the 28 Day Faster Diagnosis target was implemented in May with result being available in June 19 ahead of go-live in 2020. This monitoring period will allow the Trust to understand the challenges of implementing this new standard. **Mar-19** Comprehensive update provided to March Board seminar. Achievement of 62 day standard remains challenging, recovery plan being progressed and further analysis undertaken.	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.	**May-19** Limited progress, continued liaison with SPFT **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.	end Jul-19	◄►	COO	SLF Q&S
2.1.3	C	Following the implementation of the follow up appointment database a number of risks have been highlighted due to insufficient clinical capacity and limitation in the functionality of the database. Effective controls are required to ensure that treatment is not delayed as a result of overdue follow up appointments	**May-19** Follow up database is reviewed/discussed at each specialty PTL and PAS supplier contacted to review configuration. Every time a follow up patient is booked from the database checks are made to ensure this is a valid action/entry. Ophthalmology follow ups circa 3,550 have been subject to admin & clinical review. Additional training and guidance provided to booking and reception teams.	end Dec-19	New May-19 ◄►	COO	SLF Q&S

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
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	**May-19** Draft Accountability and Governance framework scoped and presented to POD and SLF in May 19. Action plan developed to support implementation. **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 Aligned plan developed with wider health economy

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. Revise to: Assurance is required that there will be continued delivery of the system-wide aligned plan	**May-19** A final submission of the integrated plan was submitted to NHSI/E at the beginning of April. Work is ongoing on implementing the plan and progress is monitored through an integrated governance structure which reports to the East Sussex Health and Social Care Executive. **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	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.	**May-19** 7DS progress reported and discussed with CCGs at CQRG. CCGs currently considering our arrangements to mitigate the effect of gaps in ENT consultant workforce (use of senior non-consultant permanent staff). - Standard 2 Routine Monitoring of via "Excellence in Care" programme weekly audits indicates sustained compliance overall , at more than 91% since November 2018. Preparations to separate audit of weekend and weekday admissions underway. Anticipated to come on line in June. - Standard 5/6 both now compliant overall, having started full 24/7 GI bleeding service on 15.4.19. - Standard 8 Board rounds in place. Documentation of delegated review remains incomplete. Rollout of Nerve Centre proceeding over next 6 months to support and document review and delegation processes. **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.	end Jul-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. Revise to: Controls for financial delivery are robust, but the level of CIP challenge and proposed scheme for 2019/20 need continual monitoring and support.	**May-19** A detailed review of the financial assurance arrangements for CIP will be completed in Q1 by the DoF. Internal audit are currently reviewing the CIP arrangements at the Trust. 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.	Commenced and on-going review and monitoring to end Mar-20	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 2017/18

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.	**May-19** Agreed capital plan for 2019/20, following a robust prioritisation process, aligned with the Capital Resource Limit of £13.6m. The Capital Plan is monitored on a monthly basis by the CRG, which has the ability to vary the capital plans as clinical and operational priorities emerge, and includes clinical representation to ensure that the quality impact of capital decisions is included. The Trust has a five year capital plan, which will be refreshed in Q1+Q2 2019/20, and has submitted emergency capital bids to NHSI for infrastructure works (£13m) and medical equipment (£2m = £1.4m). Mar-19 NHSI 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.	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	**May-19** Outcome of application for funding awaited. **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	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.	**May-19** Presentation and **o**verview provided to Board seminar Apr-19. Technical solutions in place and on-going regular staff awareness training is considered the best defence against cyber/phishing attacks. Agreed to pursue ISO27001 certification in 2019 and engaging with national funded resources to assess and report on our current position against the Cyber Essential Plus framework Mar-19 Information Security Strategy drafted, critical 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.	end Dec-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	**May-19** Medacs continue to successfully source consultant/middle grade posts with 7 candidates offered Following the recent visit to India for Band 5 nurses 89 IELTs (International English Language Test) ready candidates sourced. On going skype interviews for both Nurse and Medical posts. Ongoing social media activity to promote Trust Brand. **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.	end Dec-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 in place Leadership Conversations in place National Leadership programmes Surveys conducted eg CQC Staff Survey and GMC and show sustained improvement 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.	**May-19** Staff Survey and other workforce data used to focus efforts where staff do not feel as engaged. Identified specific areas which require improvement and these areas are being supported with focused pieces of work. The continued development of our Leaders and the importance of staff engagement remains a priority . Last Staff Family and Friends Test(Jan-March 2019) results demonstrated that 62.9% of respondents would recommend the trust as a place to work . This is a ^5 increase on the previous quarter **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 Piloting "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.	end Dec-19	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:			
Date of Meeting:	4th June 2019	Agenda Item:	9
Meeting:	Trust Board	Reporting Officer:	Dr Adrian Bull

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

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

Summary:

Introduction

The Trust closed the year with a strong performance on quality and safety, particularly in regard to Sepsis, patient satisfaction, standardised mortality, and prevention of harm, a strong performance operationally although with continued challenge on the cancer 62 day target, improved results from staff satisfaction surveys, and meeting its financial targets. The Trust also delivered a tight and challenging capital programme, although the incorporation of the build for the new MRI scanners has displaced or deferred a number of projects.

The financial plan for 19/20 has been set, the activity levels agreed with our CCGs, and the contract for the year has been signed.

1. Quality and Safety

Infection Prevention and Control

Mandatory reporting of Infections

The reporting algorithm has significantly changed this year. As part of Public Health England's mandatory healthcare associated infection surveillance the trust is required to report blood stream infections caused by MRSA, MSSA, E.coli, Klebsiella and Pseudomonas. We must also report Clostridium difficile toxin infections (CDIs).

For the first time, cases diagnosed within 48hrs of admission (community onset infections) will now be attributed to the acute trust and classed as community onset healthcare associated (COHA), if the patient has been an inpatient in the previous 4 weeks. This change is to take account of the patient's

prior healthcare exposure. It will increase the numbers of all reportable infections for acute trusts and the work required for post infection reviews will also increase.

Clostridium difficile Infection

There is an additional change for CDIs, as cases will be considered hospital onset after 48hrs of admission and not 72hrs as in previous years. ESHT reported 51 cases against a limit of 40 for 2018/19. For 2019/20, the limit for ESHT has increased to 68, to take into account this change and the patients with prior healthcare exposure (COHA). PHE has published data for 2018/19 using the new criteria and this shows that ESHT would have had 70 cases. Therefore, the limit for 2019/20 equates to 2 cases less than last year. In April, under the new criteria, we reported 4 cases against a limit of 5.

Seasonal Influenza

National influenza reports indicate that the impact on hospital admissions was high. 445 influenza cases were diagnosed at ESHT this year, the highest number ever. A serious investigation is underway relating to 30 patients who appear to have acquired the infection at EDGH in February, during a period of high local and national influenza prevalence.

Friends and Family Test

A total of 3737 responses for all areas were received in April.

The Trust maintains a high FFT response rate for inpatient areas with 48.67% for March 2019 (which is the highest percentage to date). There was a slight drop in April to 47.89% but the rate remains higher than the national response rate of 24.6%. Also our recommendation score in April was 97.3% compared to 96% nationally.

Mortality

The latest SHMI (January 18 to Dec 18) has fallen to 0.97, the lowest level the Trust has achieved since the index was implemented. RAMI from March 2018 to February 2019 (rolling 12 months) is 72 compared with a peer value of 85. Crude mortality (i.e. unadjusted for co-morbidities etc.) from March 2018 to February 2019 is 1.51% compared to 1.75% for the same period last year (a 14% relative reduction in one year). These all indicate a significant improvement in the quality of care we offer to our patients.

2. People, Leadership and Culture

Recruitment

The substantive staff fill rate is 90.2% as at the end of April 2019. There are now 670.6fte permanent vacancies across the Trust. Key actions being undertaken include:

- International recruitment is continuing in the Philippines and Indian sub-continent for Band 5 Nurses.
- 11 International nurses are due to join the Trust by July 2019, Following a visit to India in April this year, candidates have been recruited and it is expected they will join the Trust from October onwards.
- Targeted recruitment campaigns to support radiology and urgent care departments.
- Social media activity to promote the Trust continues with the number of ‘interactions’ increasing month on month, focused activity in Histopathology, Emergency Department, and Optometry.

- Relationship with Medacs now fully established. To date 7 candidates in post and a further 1 offer of appointment in the pipeline.

Pay Review

- Work is being undertaken with union representatives and managers on the implementation of the pay reforms. A Choices Exercise was undertaken on the closure of Band 1. 73% of staff will have transferred to Band 2 with effect from 1st May. The remaining staff are anticipated to transfer by 1st June. A process has been put in place for any remaining staff to review the position on an annual basis.

Staff Engagement

- 24 staff have volunteered to act as Ambassadors for the Trust and have come together to co-design how the role can further support embedding the Trusts Values.
- Work is currently underway on developing a robust action plan for the 4 corporate priorities linked to the feedback for the Staff survey.
- The Q4 Staff Family and Friends Test had a response rate of 21%. 82.2% of respondents would recommend the Trust for care or treatment, which is better than the national average which was 81%. 62.9% of respondents would recommend the Trust for a place to work which has considerably improved and is closer to the national average of 64%.

Leadership and Culture

- The Leading Community Together programme has come to an end with very positive feedback.
- A New Consultants orientation programme will launch in July.

3. Communication and engagement

In April we began distributing the new ESHT 'Bedside Booklet' which is a practical guide for those coming into hospital, advising about what to bring, what to expect, what facilities are on offer, and how we are working to get them home. These new booklets will be given out at pre-assessments as well as on the wards. We are working on a similar booklet for Bexhill Irvine Rehabilitation Unit. Alongside this, in May all members of staff received the new ESHT staff handbook which offers advice and information about all aspects of our work. These booklets will also be given out as part of new staff induction.

Our maternity service has received a great deal of very positive coverage over the last few months. Our local papers and Meridian TV reported on the increase in births at Eastbourne Midwifery Unit. BBC South East also filmed at Conquest Obstetric Unit talking to two mothers who had given birth in Sussex on the same day as the Duke and Duchess of Sussex's baby was born. We received positive coverage about the first baby born as part of the new community continuity of carer teams and the launch of the Happy Baby club. The local media also reported on the start of the build of the new MRI scanners, Eastbourne's Pets As Therapy dog winning an award at Crufts and our progress towards seven-day working. Ninety four percent of the coverage we received over this period was positive or neutral.

Public engagement work continues and as part of the development of the Quality Account we talked to members of the local GP Patient Participation Groups and East Sussex Senior Forum. We also worked as part of the local Sustainability and Transformation Partnership to get feedback from local people about their priorities, to feed into the NHS Long Term Plan. The Long Term Plan also featured as a story in the latest (Spring/Summer) edition of ESHTNews. 5000 copies of the newspaper that promotes the work of the Trust will be delivered throughout our hospitals and community sites over the next few months.

Our social media profile continues to grow and we average between 70k and 87k impressions on Twitter (our reach) a month. Our most popular tweets were about the reduction in length of stay at Bexhill and Rye and the donation of money from Eastbourne FC to Pevensey ward. Our most popular posts on Facebook related to the new MRI scanner and the launch of the Happy Baby Club.

4. Finance

In Month 1, we delivered our financial plan. We have agreed a reduced deficit target for this year of £34m compared to £44.5m last year. As we deliver this on a month by month basis, we are awarded additional national transformation funding. In month 1, we delivered a deficit of £3.45m and we 'earned' extra national funding of £1m in the month. By the end of the year, our aim is to reduce our underlying monthly deficit to £2m, using GIRFT and CIP to deliver transformational change. This is a great start to the year, given the operational pressures and the continued strong delivery of national targets. We were also on plan for our cash balance and our capital expenditure.

In May, we signed the final contract with our CCG colleagues. This is a new type of aligned incentive contract, and we are working together in partnership to manage the system financial position. We have agreed a new monitoring and management approach, where we work together to address the system financial challenge. We were also asked by our regulators to refresh our aligned financial plan, and risk mitigations, for this year by June, so that they can start considering whether as a system we are ready to exit Financial Special Measures and 'Directions.' Work is underway on this plan.

5. Strategic Development and Sustainability

Quality Improvement

The Improvement Hub opened in mid-April on the EDGH site; a dedicated space for the Improvement Team to deliver our quality improvement and service redesign programme (QISR) for all ESHT Staff. During the opening week the hub hosted a number of training sessions, health and wellbeing events and pop up QI sessions. We also welcomed the Kent Surrey and Sussex Academic Health Science Network who ran an open session on the many programmes of innovation that they are supporting across the patch.

Sussex Acute Collaborative Network

Chief Executives and Medical Directors from the Acute Providers in Sussex met together to consider how we can work collaboratively to ensure sustainable services models for our local populations and specialist care in centres of excellence. A Programme Board will be established to lead this work, and updates will be provided to the Trust Board in due course.

6. Performance

Urgent Care

The Trust admitted or discharged 90.6% of patients who arrived at the Emergency departments within 4 hours and saw 10,314 patients. The clinical and operational teams across the Trust and local system worked well together to plan and deliver and responsive service over the Easter period. This is often a challenging time due to increased demand, however the trust achieved 94.1% over the Easter Weekend seeing 1577 patients over 4 days.

East Sussex Healthcare NHS
NHS Trust

MONTH 1 (APR 2019)

TRUST INTEGRATED PERFORMANCE REPORT

East Sussex Healthcare NHS Trust

Contents

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

QUALITY AND SAFETY

DIRECTOR OF NURSING & MEDICAL DIRECTOR

Indicators

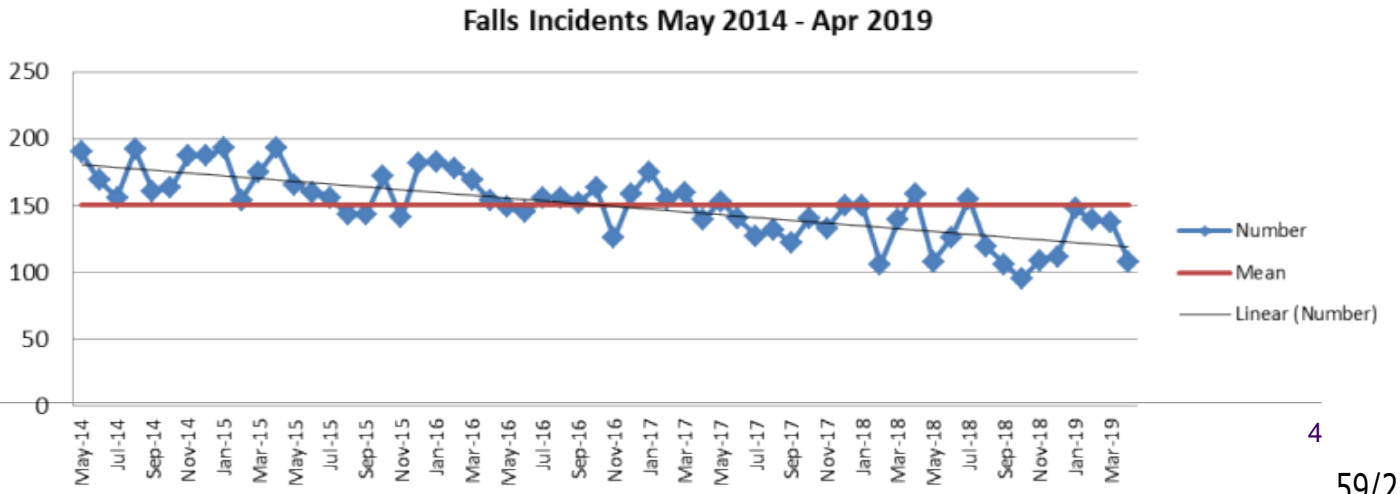
East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-18	Apr-19	Var	2018/19	2019/20	Var		
Total falls	M	158	108	-31.6%	158	108	-31.6%	122	
Number of no-harm falls	M	123	85	-30.9%	123	85	-30.9%	89	
Number of minor/moderate falls	M	35	21	-40.0%	35	21	-40.0%	31	
Number of major/catastrophic falls	0	0	2	2	0	2	2	1	
All patient falls per 1000 Beddays	5.5	6.7	5.1	-1.6	6.7	5.1	-1.61	5.4	
All patient falls with harm per 1000 Beddays		1.5	1.1	-0.4	1.5	1.1	-0.40	1.4	
Falls assessment compliance	M	94.7%	90.2%	-4.5%	94.7%	90.2%	-4.5%	91.6%	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	1.7	2.3	36.4%	1.7	2.3	36.4%	2.2	
Number of grade 2 pressure ulcers	M	40	49	22.5%	40	49	22.5%	48	
Number of grade 3 to 4 pressure ulcers	M	0	0	0	0	0	0	1	
Pressure ulcer assessment compliance	M	75.0%	83.3%	8.3%	75.0%	83.3%	8.3%	82.9%	
VTE Assessment compliance	95.0%	95.5%	95.7%	0.3%	95.5%	95.7%	0.3%	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.

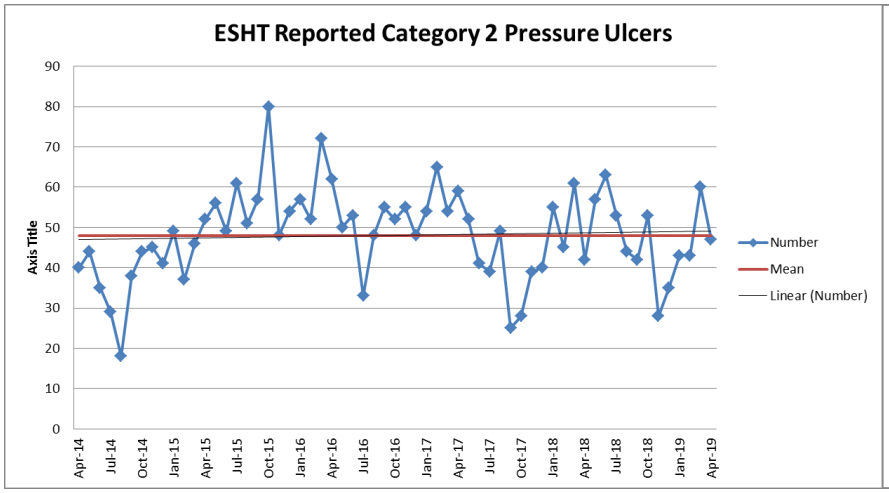
- The percentage of no harm/near miss patient safety incidents for March is 78% (national figure 73%).
- The 2 incidents reported as major/catastrophic falls are being investigated. One was a possible collapse and the other an out of hospital fall.

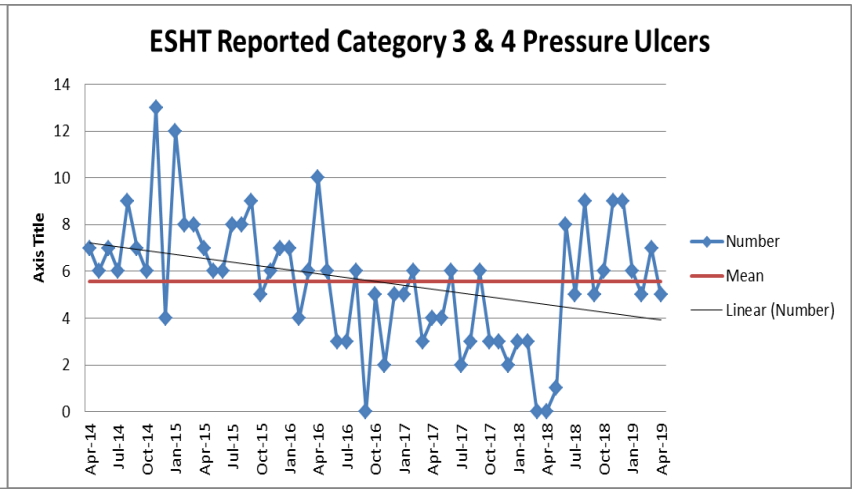
There has been an overall reduction in falls incidents over 5 years.
In April there was 108 falls with 1 x severity 4. The rate per 1000 bed days has decreased to 5.1

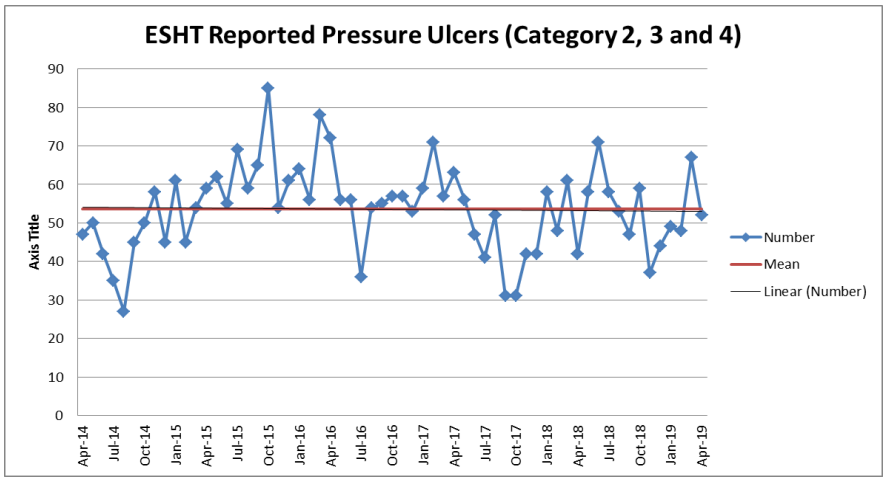


Pressure Ulcer Incidents

East Sussex Healthcare NHS
NHS Trust







In the last 5 years there has been an overall reduction in category 3 and 4 pressure ulcers with a static trend in category 2 and overall pressure ulcer incidents.

There has been a reduction in numbers of pressure ulcers reported by ESHT in the last month (March to April) from 67 to 52.

A replacement programme from static foam mattresses to hybrid mattresses is planned for June.

The focus for 2019/2020 will be on seating to decrease numbers of category 2 pressure ulcers from shear whilst maintaining the significant reduction of 76% in category 3 & 4 pressure ulcers.

Infection Control

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-18	Apr-19	Var	2018/19	2019/20	Var		
Number of MRSA Cases	0	0	1	1	0	1	1	0	
Number of C diff cases	4	4	4	0	4	4	0	4	
Number of MSSA cases	M	1	3	2	1	3	2	2	

MRSA bacteraemias – One case in April. PIR identified peripheral cannula as likely source. Additional training underway.

C. Difficile – The limit for 2019/20 is 68 cases, to include patients with prior healthcare exposure within 4 weeks of a positive sample.

4 cases in April against a monthly limit of 5. All cases were hospital onset healthcare associated (HOHA). PIRs have taken place, outcome pending.

MSSA bacteraemias - 3 cases in April. 1 avoidable related to a peripheral cannula. Additional staff training undertaken.

Gram negative bacteraemia

Organism	Total	UTI source	CAUTI source	Biliary source	GI source	Other source	Unknown source
E. coli	2	2	1	0	0	0	0
Klebsiella sp.	1	0	0	0	1	0	0
Pseudomonas	1	1	0	0	0	0	0
Total (%)	4	3	1	0	0	0	0

No avoidable Gram negative bacteraemias. Report algorithms have changed for 2019/20 to take account of prior healthcare exposure.

Influenza

450 patients diagnosed at ESHT, 30 cases probably hospital acquired relating to an outbreak at EDGH, a serious incident investigation has been undertaken

Serious Incidents (SI) reported in April

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-18	Apr-19	Var	2018/19	2019/20	Var		
Number of Serious Incidents	M	4	3	-1	4	3	-1	4	
Number of Never Events	0	0	0	0	0	0	0	0	

There were 3 **serious incidents** reported during April :

- 1 x Failure to reappoint an Ophthalmology patient in a timely manner resulting in deterioration of eye condition
- 1 x Inappropriate referral to non-ESHT organisation for urgent treatment instead of to ESHT for potential cancer
- 1 x Fall to fracture

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 21 Serious Incidents open in the system all within the correct timescales (2 of which are with the CCG for review). The Amber incident backlog is at 32. 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. Good and steady progress is being maintained.
Duty of Candour compliance for all moderate and above harm incidents is at 99% informed verbally, 98% followed up in writing and 95% findings shared with patient or family upon completed investigation.

Patient Experience

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-18	Apr-19	Var	2018/19	2019/20	Var		
Inpatient FFT response rate	45.0%	38.6%	47.4%	8.7%	38.6%	47.4%	8.7%	44.8%	
Inpatient FFT score	96.0%	97.8%	97.3%	-0.6%	97.8%	97.3%	-0.6%	97.5%	
A&E FFT response rate	22.0%	4.8%	10.6%	5.7%	4.8%	10.6%	5.7%	5.8%	
A&E FFT score	88.0%	94.9%	93.7%	-1.2%	94.9%	93.7%	-1.2%	92.5%	
Outpatient FFT Score	M	97.1%	98.2%	1.1%	97.1%	98.2%	1.1%	97.6%	
Maternity FFT response rate	45.0%	0.4%	27.3%	27.0%	0.4%	27.3%	27.0%	16.8%	
Maternity FFT score	96.0%	100.0%	98.5%	-1.5%	100.0%	98.5%	-1.5%	97.3%	

FFT and Patient questionnaire

Indicator	Response rate %	National % (March)	Recommend Score %	National % (March)	No of surveys
Inpatient	47.4	24.6	97.3	96	2731
A&E	10.6	12.3	93.7	86	969
Maternity	27.3	21.6	98.5	97	125

Examples of questionnaire comments in April:

Positive comments

- *"I would like to thank all of the staff in the team for showing me that I can actually manage to help myself by doing exercises"*
- *"Wonderful team spirit cannot thank you enough"*
- *"Thank you for taking your time with me and making sure that I had everything I needed and lots of help when needed"*

Negative comments

- "Discharge procedure could be better"
- "Possibly a bit quieter at night"
- "Insufficient staffing levels for the demand, staff did keep smiling"

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

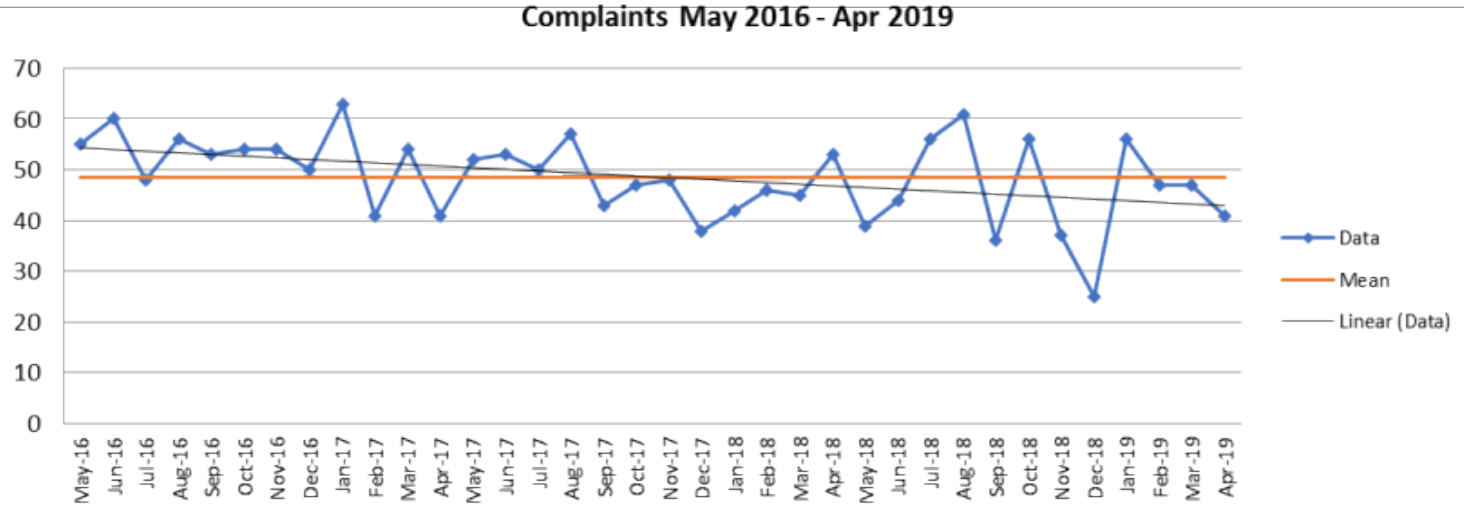
- Were you bothered by noise at night?
- Were you informed as to why you had to repeat clinical information when asked by a nurse or doctor?
- Did you receive written information about your condition (patient information leaflet and discharge letter)

• **NHS Choices - Overall rating of 4.5 stars for EDGH and for Conquest Hospital**

Work is underway to look at better digital solutions to collecting and sharing the information from surveys and FFT.

Complaints

East Sussex Healthcare NHS
NHS Trust



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

- Medicine – 0.8 per 1000 bed days (10 complaints)
- DAS – 3.5 per 1000 bed days (17 complaints)
- Women, Children and Sexual Health – 2.5 per 1000 bed days (4 complaints)
- Urgent Care - 5 complaints
- Out of Hospital – 2 complaints

There were no Parliamentary and Health Service Ombudsman (PHSO) contacts or outcomes in April

More detailed discussion and analysis is at the Patient Safety and Quality Group and the Quality and Safety Committee.

Mixed Sex Accommodation

East Sussex Healthcare NHS
NHS Trust

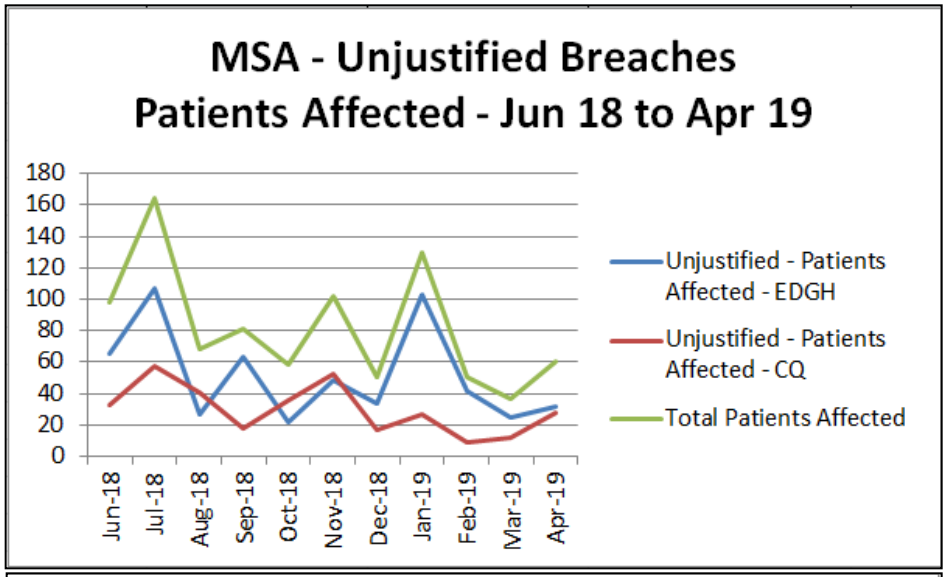
In April the total number of validated and reportable unjustified incidents for the Trust was 25, affecting 60 patients.

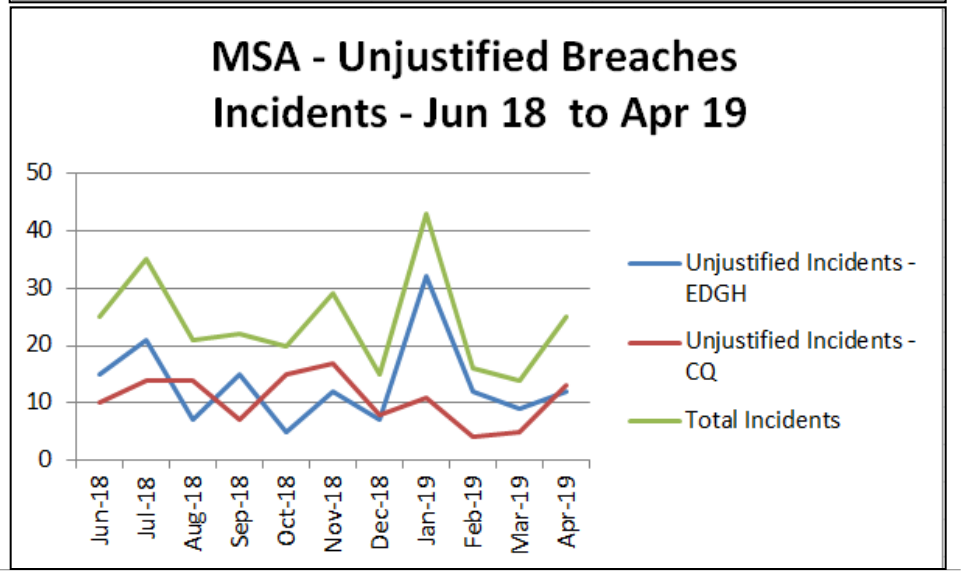
Breaches continue to be associated with the following areas:
Conquest – Critical Care
Eastbourne – Coronary Care/Coronary Step Down Unit/Critical Care

4 breaches affecting 13 patients were at a time when the Trust was in 'Black' status.

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 April.





East Sussex Healthcare NHS
NHS Trust

Safer Staffing and Workforce

Fill Rate and CHPPD by Site - Apr-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	87.1%	107.6%	93.7%	100.8%	6.56
EASTBOURNE DISTRICT GENERAL HOSPITAL	90.8%	101.1%	91.4%	110.4%	8.62
CONQUEST HOSPITAL	88.9%	102.8%	85.9%	109.6%	9.29
Totals	89.7%	102.3%	88.4%	109.4%	8.81

Fill Rate and CHPPD by Division - Apr-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	88.0%	106.7%	92.4%	118.9%	8.05
Out-of-Hospital	90.4%	104.4%	94.7%	102.6%	6.50
Surgery Anaesthetics & Diagnostics	88.7%	94.4%	86.5%	93.5%	9.79
Women Children & Sexual Health	97.4%	88.5%	80.4%	94.1%	15.18
Totals	89.7%	102.3%	88.4%	109.4%	8.81

- 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 supported by the site team and divisional senior nursing teams.
- Trust CHPPD has increased slightly to 8.81 in April. The latest national median CHPPD (December 2018) was 8.0.
- Divisionally, WSCH CHPPD has reduced this month from 18.07 to 15.18. An internal review into last month's exceptionally high report for this division identified some reporting errors (not all maternity in patient beds had been included, a delay in patient data being uploaded and over reporting of staffing in paediatrics) . These have now been rectified in this month's report.
- 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.
- More detailed discussion and analysis will take place in revised reporting at the People and Organisational Development Committee.

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 nursing & midwifery establishment review for staffing of in patient wards is almost complete; the data collection and professional judgement elements have been completed. An initial report was presented to Execs in April. A full report with recommendations & impact is being prepared with divisional and finance colleagues.

- The establishment review also aims to plan ahead for expected number of wards and beds for next winter and associated staffing plans to meet this period of highest demand.

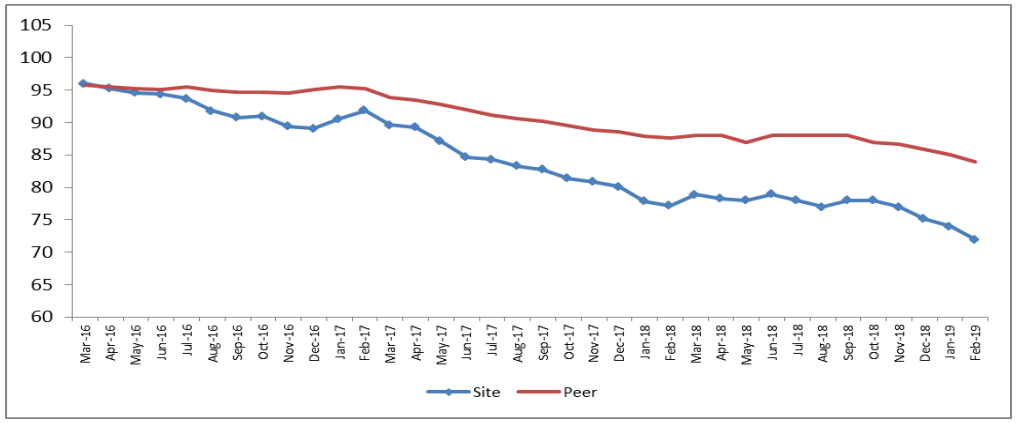
- A team of 4 trust staff visited India in early April to interview over 150 Registered Nurses wishing to work at ESHT. The event was reported as being very successful, details of offers and timelines for appointments mapped to current vacancies will be available soon.

- Previously the Director of Nursing voiced concerns regarding an increase in harms, being in some part related to the significant additional capacity open and an increased reliance on temporary staff and/or staffing gaps. There are still planned escalation beds that remain open beyond the expected closure date of 31 March 2019. This is being closely monitored with staffing/additional capacity remaining a concern and a challenge.

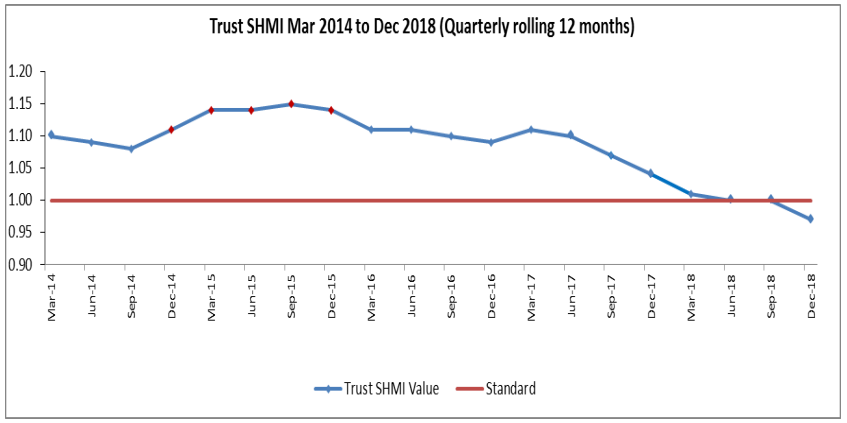
Mortality Metrics

East Sussex Healthcare NHS Trust

RAMI 17 (Rolling 12 months)



SHMI (Rolling 12 months)



SHMI for the period January 2018 to December 2018 is **0.97**. The Trust remains within the EXPECTED range.

RAMI 17 - March 2018 to February 2019 (rolling 12 months) is **72** compared to 77 for the same period last year (March 2017 to February 2018). February 2018 to January 2019 was 74.

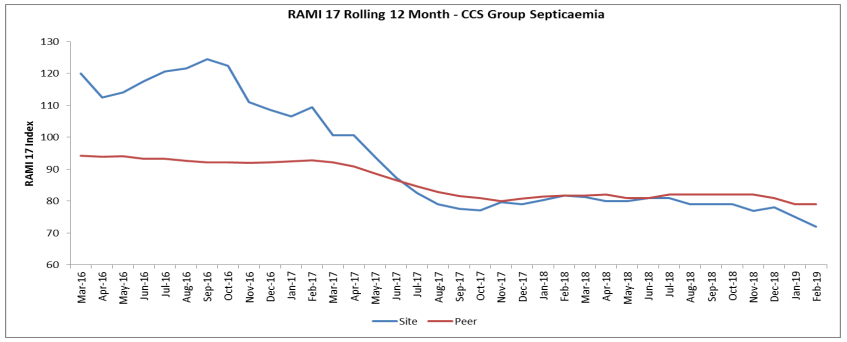
RAMI 17 shows a February position of 72. The peer value for February is 94. The January position was 79 against a peer value of 90.

Crude mortality shows March 2018 to February 2019 at 1.51% compared to 1.75% for the same period last year.

The percentage of deaths reviewed within 3 months was 80% in January 2019, December 2018 was 78%.

SHMI (NHS Digital) Top 5 diagnostic groups by Volume Jan 18 to Dec 18	Observed deaths	Expected deaths	SHMI
Septicaemia (except in labour), Shock.	495	514	0.96
Pneumonia (except that caused by tuberculo	357	380	0.94
Acute cerebrovascular disease.	146	148	0.94
Congestive heart failure; nonhypertensive.	95	93	0.99
Urinary tract infections	72	76	0.95

Main causes of death during April 2019 (Mortality Database)	
Pneumonia	27
Cancer	19
Sepsis/Septicaemia	16
Chronic Obstructive Pulmonary Disease (COPD)	6
Myocardial Infarction	5
Heart Failure	5



Access & Delivery

ACCESS AND DELIVERY

East Sussex Healthcare NHS Trust

URGENT CARE

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-18	Apr-19	Var	2018/19	2019/20	Var		
Four hour standard	95.0%	89.5%	90.6%	1.1%	89.5%	90.6%	1.1%	91.0%	
A&E Minor Performance	98.0%	95.6%	98.1%	2.6%	95.6%	98.1%	2.6%	96.9%	
Four hour standard (Local System)	95.0%	92.2%	92.8%	0.6%		92.8%			
12 Hour DTAs	0	0	0	0	0	0	0	0	
Unplanned re-attendance to Emergency Department	5.0%	3.5%	3.8%	0.3%	3.5%	3.8%	0.3%	3.5%	
% Patients waiting less than 15 minutes for assessment in ED	M	85.7%	83.5%	-2.2%	85.7%	83.5%	-2.2%	85.7%	
% Patients waiting less than 60 minutes for treatment in ED	M	49.7%	42.5%	-7.2%	49.7%	42.5%	-7.2%	47.0%	
% Patients waiting less than 120 minutes for treatment in ED	M	80.9%	73.0%	-7.9%	80.9%	73.0%	-7.9%	79.1%	
% Patients that left without being seen in ED	M	2.5%	1.9%	-0.6%	2.5%	1.9%	-0.6%	2.1%	
% Patients admitted from ED (Conversion rate)	M	30.0%	31.0%	1.0%	30.0%	31.0%	1.0%	30.2%	
Emergency Department attendances	M	10154	11381	12.1%	10154	11381	12.1%	10884	
Ambulance conveyances	M	3118	3392	8.8%	3118	3392	8.8%	3227	

The April Trust 4 Hour standard performance was 90.6% against a national performance of 85.1%. This ranked the Trust 23rd out of 129 reporting organisations.
Although performance was lower than March (93.2%), the Trust expected to see this reduction due to the Easter holiday period and had reflected this in its performance trajectory (90.5%).

The system 'Walk-In' centres and the Acute Trusts combined performance for April was 92.8%.

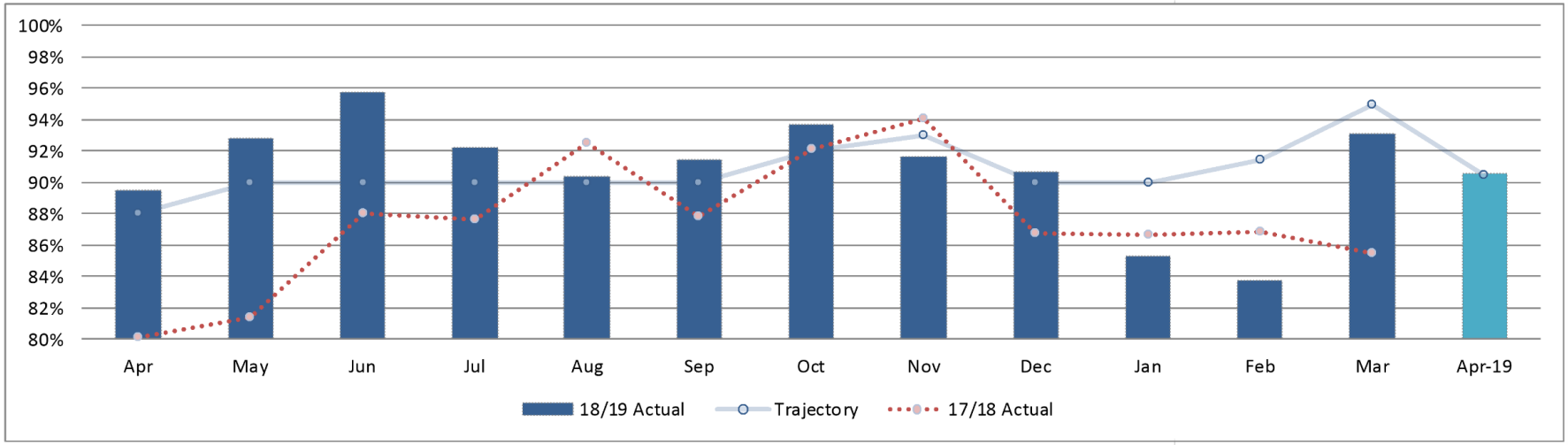
Activity continues to be higher than previous years, A&E attendances are up 12.1% year to date and the longer term trend is consistently up over the last 24 months. Full year 18/19 growth against 17/18 was 8.9%.
Non-elective spells are up 8.9% year to date and full year 18/19 v 17/18 was 9.7% increase, so 8.9% year on year increase in April is not unexpected.

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 Trust

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-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%	90.5%
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%	93.1%	90.6%
17/18 Actual	80.1%	81.4%	88.0%	87.7%	92.5%	87.8%	92.1%	94.1%	86.7%	86.7%	86.8%	85.5%	

The Trusts' 4 hour performance for April 2019 was 90.6% (Conquest 94.68% and EDGH 86.55%).

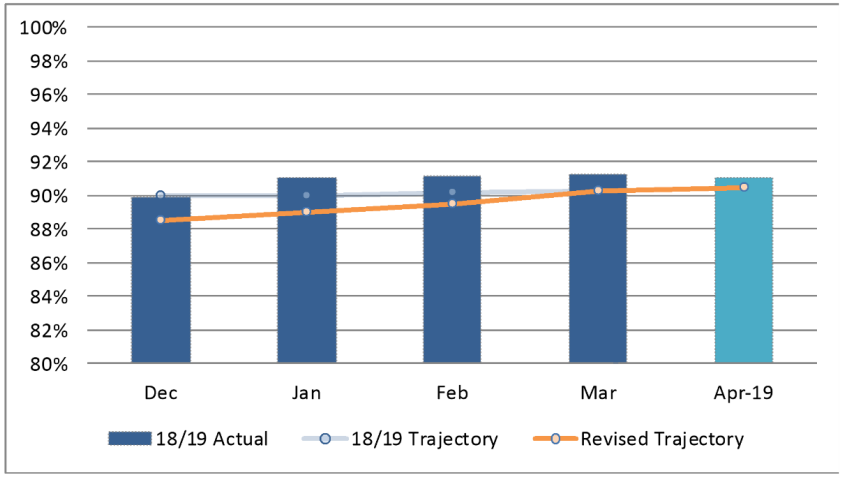
- Minors performance for April decreased to 98.1%.
- Attendances in April were up 12.1% against the corresponding month last year.
- Ambulance conveyances have increased by 8.8% financial year to date although conveyances were down by 0.7% in 18/19 compared to previous year.

RTT

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-18	Apr-19	Var	2018/19	2019/20	Var		
RTT Incomplete standard	92.0%	90.0%	91.1%	1.2%	90.0%	91.1%	1.2%	90.0%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	2886	2470	-416	2886	2470	-416	2803	
RTT Total Waiting List Size	28221	28853	27904	-949	28853	27904	-949	28103	
RTT 52 week waiters	0	0	0	0	0	0	0	0	
RTT 35 week waiters	M	186	154	-17.2%	186	154	-17.2%	178	

RTT (Referral to Treatment 18 Weeks)



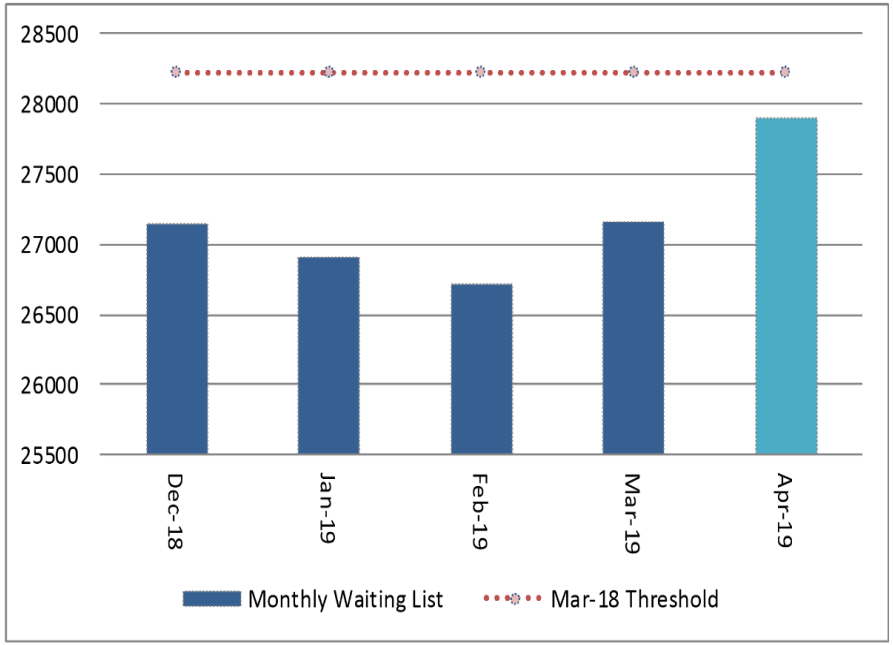
	Dec	Jan	Feb	Mar	Apr-19
18/19 Trajectory	90.0%	90.0%	90.2%	90.3%	
Revised Trajectory	88.5%	89.0%	89.5%	90.3%	90.5%
18/19 Actual	89.9%	91.1%	91.1%	91.2%	91.1%

- The Trust performance for April 2019 was 91.15% against a trajectory of 90.5%.
- In order to meet a 92% aggregate position in 19/20 ,the Trust will need to achieve an additional (circa) 300 clock stops per month.
- T&O delivery of 92% is achievable but reliant on iMSK patients moving through the system efficiently.
- Ophthalmology has the opportunity to generate more clock stops if capacity can be flexed between day case / theatre.
- Gynaecology will continue to find it challenging achieve a 90% position without investment but 85% is achievable by August if the service can deliver the extra capacity required. To achieve 85%, the service will need to find an additional 125 clock stops between now and August on top of their current activity and performance rate.

RTT Waiting list

East Sussex Healthcare NHS
NHS Trust

RTT Waiting List



	Dec	Jan	Feb	Mar	Apr-19
18/19 Actual	27150	26904	26721	27157	27904

Surgery: Performance is slightly lower in April at just under 90%. This is mainly due to capacity and patient availability over the Easter holiday period.

- T&O is3% down on the previous month predominantly due to limited theatre capacity which is restricting recovery progress.
- The Ophthalmology service is currently working on plans to increase its theatre / day case capacity in order to reduce the long waits.
- General Surgery: The service has concerns for the future delivery of 92% due to current consultant gaps which has resulted in a loss of 8 OP clinics and 2 All Day Theatre lists per week .

Medicine: Steady state remains. Collectively achieving over 96%.

- All specialties have achieved over 92%

Women & Children: The division has seen an improvement of 1% compared to the previous month.

- Paediatrics continues to deliver over 95%
- Gynaecology has improved slightly from previous month. Additional OP clinics have been and continue to be provided but the benefits of which are yet to be realised and impact on RTT position.

East Sussex Healthcare NHS Trust

CANCELLATIONS AND DTC

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-18	Apr-19	Var	2018/19	2019/20	Var		
Super Stranded (Census on last day of month)	M	151	112	-39	76	56	-20	103	
Avg Daily Super Stranded Beddays (single month metric)	142	176	128	-48	176	128	-48	151	
Avg Daily Super Stranded Beddays (rolling 3 month avg NHSI metric)	142	183	147	-36	183	147	-36	156	
Delayed transfer of care national standard	3.5%	1.5%	3.9%	2.4%	1.5%	3.9%	2.4%	3.3%	
Cancellations									
Urgent operations cancelled for a second time	0	2	0	-2	2	0	-2	0	

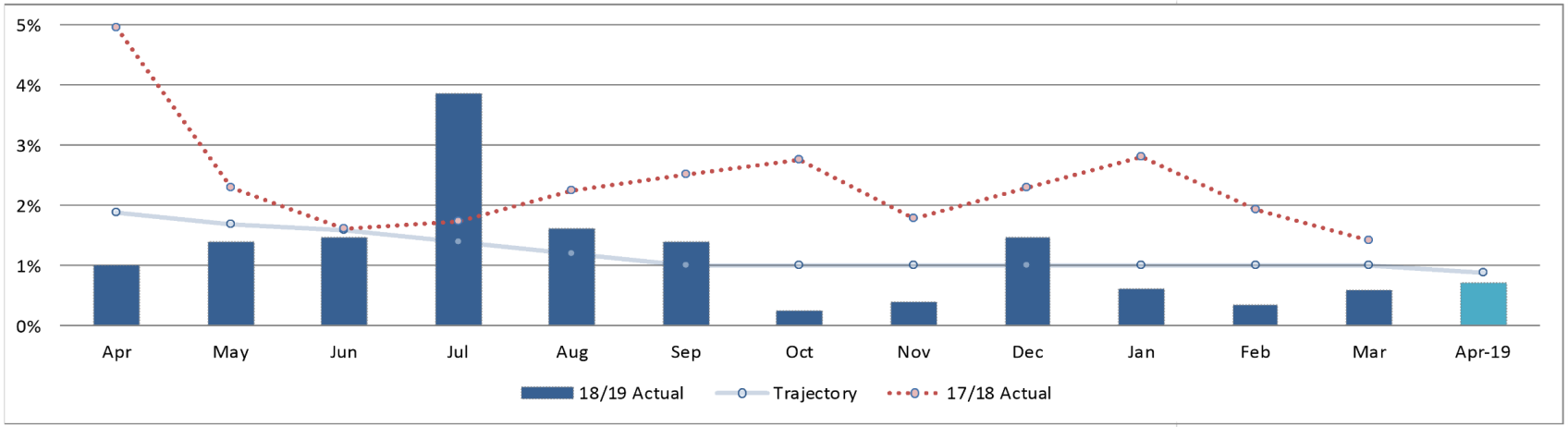
- DTC performance for April has shown rectification by reducing from 4.7% to 3.9%
- Target in 18/19 to reduce super stranded by 27% to 142. This was achieved by September and maintained until Winter pressures in February. The Trust has reduced its long stays over March and April and are close to 18/19 target at 25% reduction.
- An improvement plan and trajectories are in development with the aim of meeting the NHSI standards of increasing to a 40% reduction in the super stranded patients in 19/20 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
		Apr-18	Apr-19	Var	2018/19	2019/20	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	1.0%	0.7%	-0.3%	1.0%	0.7%	-0.3%	1.2%	

Diagnostic waiting times (over 6 weeks)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-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%	0.9%
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%	0.6%	0.7%

- The Trust achieved April's 6 week diagnostic target with a final position of 0.72% which is the fourth month of achievement in a row.
- A total of 36 DM01 breaches occurred in April 2019: Computed Tomography (2), Audiology (2), Respiratory physiology - sleep studies (10), Urodynamics – pressures and flows (1), Colonoscopy (3), Flexi sigmoidoscopy (2), Cystoscopy (13) and Gastroscopy (3).
- The Radiology service continues to see an increase in demand for its services especially with the focus on Cancer performance recovery. The Trust will continue to monitor any potential impact this might have on the DM01 performance.

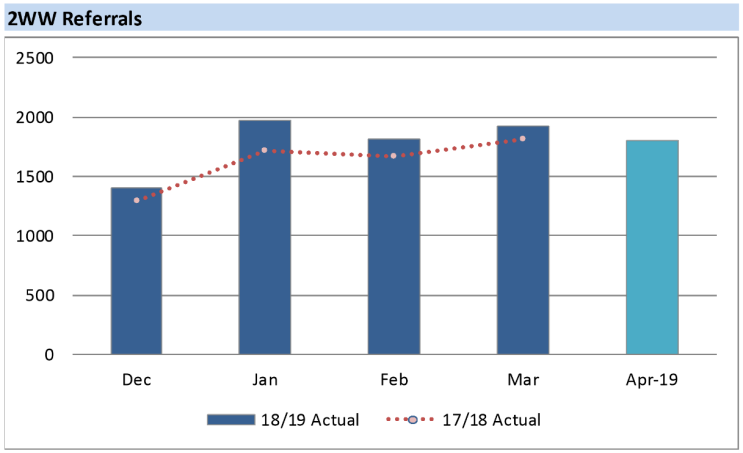
East Sussex Healthcare NHS
NHS Trust

CANCER STANDARDS

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-18	Mar-19	Var	2017/18	2018/19	Var		
Cancer 2WW Standard	93.0%	95.2%	96.4%	1.2%	96.0%	94.2%	-1.7%	94.2%	
Cancer 62 day urgent referral standard	85.0%	78.0%	75.5%	-2.4%	75.9%	72.7%	-3.2%	72.7%	
Cancer 2WW Standard (breast symptoms)	93.0%	94.9%	97.1%	2.1%	95.8%	96.0%	0.2%	96.0%	
Cancer 31 day standard	96.0%	96.1%	96.1%	0.0%	97.1%	94.8%	-2.3%	94.8%	
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%	88.1%	-10.4%	88.1%	
Cancer 62 day screening standard	90.0%	47.6%	100.0%	52.4%	66.9%	69.4%	2.4%	69.4%	

- Cancer 62 Day performance was to 75.5% for March compared to an national aggregate of 79.7% which is down on Februarys performance of 80.3%.
- This was just below the Trust recovery trajectory by 0.48% and due to services focusing on reducing the number of patients waiting over 104 days.
- This placed the Trust 95th out of 131 reporting providers.
- Activity numbers (62 day treatments) for March decreased slightly in comparison to the total treatments reported in February however, the total number of treatments continues to be high.
- Gynaecology, Haematology, Head and Neck, and Breast are the highest breaching specialities this month (March) of the 62 Day Standard.
- An analysis of all of the 62 day breaches (by the Cancer Services Team) showed that 13 of the 35.5 breaches were deemed as potentially avoidable breaches e.g. within ESHT's control.
- The Trust continues to reduce the number of patients waiting over 104 days.
- The Trust reported 9 treatments on or over 104 days, 5 of these were shared treatments with other Trusts (Brighton, GSTT and Kings) and there were 18 individual patients in total.

Cancer 2 Week Wait Referrals



	Dec	Jan	Feb	Mar	Apr-19
18/19 Actual	1404	1966	1810	1926	1805

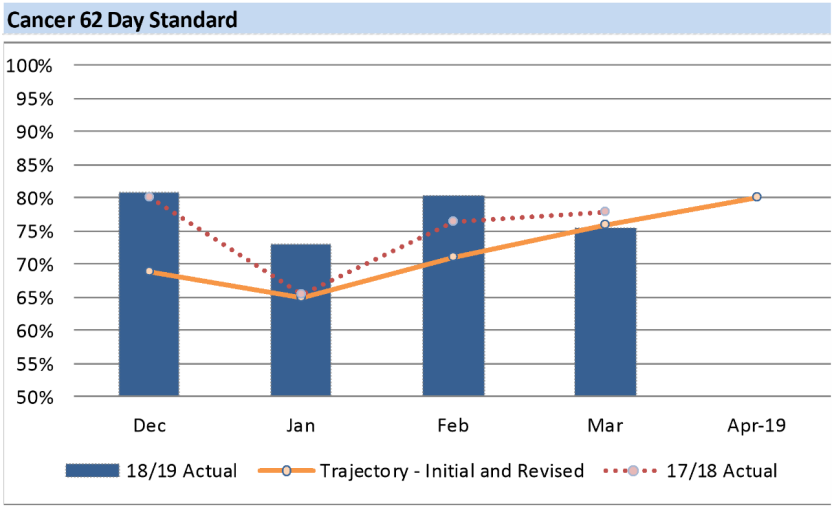
2WW referrals in April 2019 were up 4.0% (69 referrals) on April 2018. This increase has resulted in significant pressure on the system.

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

Suspected Cancer Site	Apr-18	Apr-19	% Variance
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	171	143	-16.4%
Other suspected cancers	1	0	-100.0%
Suspected brain/central nervous system tumours	1	10	900.0%
Suspected breast cancer	237	253	6.8%
Suspected childrens cancer	1	0	-100.0%
Suspected gynaecological cancers	136	150	10.3%
Suspected haematological malignancies (excluding acute leukaemia)	13	24	84.6%
Suspected head & neck cancers	164	178	8.5%
Suspected lower gastrointestinal cancers	332	358	7.8%
Suspected lung cancer	50	57	14.0%
Suspected sarcomas	0	0	
Suspected skin cancers	277	322	16.2%
Suspected testicular cancers	14	14	0.0%
Suspected upper gastrointestinal cancers	122	129	5.7%
Suspected urological cancers (excluding testicular)	217	167	-23.0%
Grand Total	**1,736**	**1,805**	**4.0%**

Cancer 62 Days

East Sussex Healthcare NHS Trust



	Dec	Jan	Feb	Mar	Apr-19
Trajectory - Initial and Revised	*69.0%*	*65.0%*	*71.0%*	*76.0%*	*80.0%*
18/19 Actual	80.7%	72.9%	80.3%	75.5%	

- The Cancer recovery plan is a working document which continues to be developed throughout the recovery phase. The Trust has contracted additional support for the next 4 months in order to drive forward the actions and initiatives within the plan.
- Key actions from the recovery plan include:
  - Shadow monitoring of the 28 Day FDS started on 1st April 2019 (first report due in June 19).
  - Implementation of FIT test (lower GI) February 2019 to support 'Straight to Test'. Requires primary care compliance with referral pathways.
  - UIS build to be completed by the end of May 19, moving to 28 day pathways from 3 June.
  - Implementation of Histology reporting SLA for any outsourcing activity.
  - Revised PTL process in place.
  - New cancer dashboard in place with further monitoring tools being implement to support recovery.
  - Implementation of a twice weekly 104 day PTL supported by a weekly NHSI assurance call.
- Following the release of the guidance for the Cancer 28 Day Faster Diagnosis Standard and version 10 of the Cancer Waiting Time Guidance, the Trust has drafted a new Cancer Access policy . It is expected that this will be ratified by the end of June.

Cancer Summary

ESHT Cancer Waiting Times Report for March 2019 – Published on 02/05/2019					
March 2019 Summary					
Standard	Total Seen /Treated	On Target	Breaches	Compliance	Target
Cancer Two Week Wait	1,771.0	1,707.0	64.0	96.4%	93%
Breast Symptom Two Week Wait	136.0	132.0	4.0	97.1%	93%
31 Day First Treatment (Tumour)	181.0	174.0	7.0	96.1%	96%
31 Day Subsequent Surgery	16.0	16.0	0.0	100.0%	94%
31 Day Subsequent Drug Treatments	10.0	10.0	0.0	100.0%	98%
Cancer 62 Day Standard (Tumour)	145.0	109.5	35.5	75.5%	85%
62 Day Screening Standard (Tumour)	2.5	2.5	0.0	100.0%	90%
62 Day Upgrade Standard (Tumour)	12.0	8.5	3.5	70.8%	N/A

East Sussex Healthcare NHS
NHS Trust

Cancer Standards – Cancer 62 Days

March 2019 2WW Referral to First Treatment 62 Days

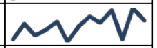
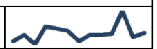
Tumour Site	Total treated	Treated within 62 days	Breaches	% meeting standard
Brain	1.0	1.0	0.0	**100.0%**
Sarcoma	1.0	1.0	0.0	**100.0%**
Skin	23.0	22.5	0.5	**97.8%**
Upper GI	10.0	8.5	1.5	**85.0%**
Lung	9.5	7.5	2.0	**78.9%**
Urology	41.0	32.0	9.0	**78.0%**
Breast	24.0	17.0	7.0	**70.8%**
Colorectal	16.5	11.0	5.5	**66.7%**
Head & Neck	3.5	2.0	1.5	**57.1%**
Haematology	10.5	5.5	5.0	**52.4%**
Gynaecology	5.0	1.5	3.5	**30.0%**
Totals:	**145.0**	**109.5**	**35.5**	**75.5%**

Activity

ACTIVITY

Acute Activity

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-18	Apr-19	Var	2018/19	2019/20	Var		
Emergency Department attendances	M	10154	11381	12.1%	10154	11381	12.1%	10884	
Ambulance conveyances	M	3118	3392	8.8%	3118	3392	8.8%	3227	
Elective spells	M	498	505	1.4%	498	505	1.4%	553	
Day Cases	M	3771	3930	4.2%	3771	3930	4.2%	3960	
Elective Beddays	M	1384	1544	11.6%	1384	1544	11.6%	1697	
Total Non-Elective Spells	M	4393	4785	8.9%	4393	4785	8.9%	4703	
Number of Emergency spells	M	3825	4213	10.1%	3825	4213	10.1%	4114	
Number of Maternity spells (ante and post partem)	M	305	316	3.6%	305	316	3.6%	313	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	263	256	-2.7%	263	256	-2.7%	277	
Non-Elective beddays	M	21924	19610	-10.6%	21924	19610	-10.6%	20088	
LOS									
Elective Average Length of Stay	M	2.8	3.1	0.3	2.8	3.1	0.3	3.1	
Non-Elective Average Length of Stay	M	4.8	4.0	-0.8	4.8	4.0	-0.8	4.3	
Inpatient Average Length of Stay at intermediate care units	M	30.4	22.8	-7.6	30.4	22.8	-7.6	24.7	

East Sussex Healthcare NHS
NHS Trust

ESHT WORKFORCE REPORT

- MONTH 1 (APR 2019)

HR DIRECTORATE
Apr 2019
Version v0.2

East Sussex Healthcare NHS
NHS Trust

CONTENT

TARGET AREA	CONTENT	PAGE
Trust Overview	Key Metrics	Page 3
Executive Summary	Headlines	Page 4
Workforce Expenditure	Substantive, Bank, Agency split by fte	Page 5
Trending FTE Usage	FTE Usage by month split into Substantive, Bank & Agency	Page 6
NHSI KPIs Planned v Actual	Workforce Indicators Actual v Forecast	Page 7/8
Turnover Trend by Staff Group	Turnover % by Staff Group	Page 9
Leavers & Stability by Staff Group	Leavers & Stability measure by Staff Group	Page 10
Trending Net Vacancies	Trending Net Vacancies by staff Group	Page 11
Absence Mgt – Sickness Rates	Annual & Monthly	Page 12
Absence Mgt – Sickness Reasons	Sickness Reasons Top 6 annual and Top 10 by % Jan 2018	Page 13
Wellbeing & Engagement	Latest update from Wellbeing & Engagement	Page 14
Training & Appraisal by Division	Training & Appraisal Compliance by Division by end of month	Page 15
APPENDIX	Supporting Documents	Page 16

East Sussex Healthcare NHS
NHS Trust

TRUST OVERVIEW

TRUST														
WORKFORCE CAPACITY	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend line
Budgeted fte	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	7,033.8	7,054.8	
Total fte usage	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	6,841.9	6,754.9	
Variance	-149.5	-299.5	-286.0	-275.7	-274.3	-235.0	-293.3	-177.8	-250.6	-456.7	-351.2	-191.9	-299.9	
Substantive vacancies	644.6	605.2	651.3	663.5	641.2	611.9	576.4	556.6	595.9	693.2	659.1	641.4	670.6	
Fill rate	90.5%	91.0%	90.4%	90.3%	90.5%	90.9%	91.4%	91.7%	91.1%	89.8%	90.3%	90.6%	90.2%	
Bank fte usage (as % total fte usage)	10.1%	7.3%	8.1%	8.3%	7.8%	8.1%	6.8%	7.9%	7.6%	7.7%	7.1%	8.9%	8.0%	
Agency fte usage (as % total fte usage)	1.6%	1.9%	1.8%	1.7%	1.6%	1.4%	1.2%	1.4%	1.2%	1.2%	1.5%	1.5%	1.3%	
Turnover rate	10.9%	11.0%	10.9%	11.1%	11.0%	10.8%	10.7%	11.0%	11.1%	11.1%	10.9%	10.9%	11.0%	
Stability rate	92.1%	91.9%	89.5%	92.0%	92.0%	91.8%	91.4%	91.0%	90.9%	89.8%	91.1%	91.3%	91.5%	
SICKNESS ABSENCE														
Annual sickness rate	4.5%	4.5%	4.5%	4.4%	4.4%	4.4%	4.4%	4.4%	4.3%	4.2%	4.3%	4.2%	4.2%	
Monthly sickness rate (%)	3.6%	3.7%	3.5%	3.8%	3.9%	4.2%	4.4%	4.6%	4.4%	4.7%	4.6%	4.0%	4.1%	
Short term sickness (<28 days)	45.9%	42.8%	46.0%	41.2%	45.0%	42.6%	50.1%	55.1%	51.3%	60.7%	59.1%	52.0%	54.4%	
Monthly long term sickness (28 days+)	54.1%	57.2%	54.0%	58.8%	55.0%	57.4%	49.9%	44.9%	48.7%	39.3%	40.9%	48.0%	45.6%	
MANDATORY TRAINING & APPRAISALS														
Appraisal rate	79.5%	79.2%	78.1%	78.2%	79.7%	80.1%	79.5%	80.6%	81.3%	80.9%	79.8%	79.5%	78.7%	
Fire	86.2%	87.4%	87.1%	86.6%	87.6%	87.2%	88.2%	87.9%	87.2%	87.5%	87.2%	87.3%	87.5%	
Moving & Handling	89.4%	89.9%	89.8%	88.7%	89.2%	89.2%	90.2%	90.4%	90.3%	91.1%	91.2%	91.9%	92.4%	
Induction	94.4%	95.0%	94.3%	94.8%	96.2%	95.5%	91.3%	90.8%	91.1%	92.0%	92.1%	92.2%	94.1%	
Infec Control	89.9%	90.5%	90.1%	89.6%	90.0%	89.7%	90.9%	91.0%	91.0%	90.7%	90.6%	91.4%	91.7%	
Info Gov	85.8%	85.1%	83.8%	84.7%	84.0%	82.5%	82.0%	80.5%	79.3%	79.1%	76.2%	77.4%	79.8%	
Health & Safety	88.8%	89.1%	88.6%	89.4%	88.7%	88.2%	88.3%	87.6%	88.2%	87.6%	88.0%	88.3%	88.8%	
MCA	95.8%	96.1%	96.1%	96.5%	96.5%	95.7%	95.7%	95.1%	95.6%	95.6%	95.5%	95.6%	74.9%	
DoLs	96.4%	96.8%	96.9%	97.2%	96.7%	94.9%	94.9%	93.9%	94.4%	95.0%	95.0%	95.4%	72.3%	
Safeguarding Vulnerable Adults	84.2%	85.8%	86.0%	86.7%	86.6%	86.3%	87.2%	86.8%	87.2%	87.6%	87.5%	87.7%	88.4%	
Safeguarding Children Level 2	84.7%	86.4%	87.4%	87.6%	87.8%	87.5%	88.2%	88.0%	88.4%	88.5%	87.3%	88.3%	89.2%	

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

MONTHLY HEADLINES

- Trust total workforce utilisation for April is 6,754.9 fte which is 299.9 fte below the budgeted establishment. Actual expenditure of £25,653k is below budget of £23,858k by £205k. Budget and expenditure are higher this month due to the annual pay award which included the one off unconsolidated annual payment.

- Substantive expenditure of £22,570k, accounts for 88% of total expenditure & temporary expenditure of £3,083k equates to 12% of total as follows:

  - Bank £2,270k (8.8%) decrease due to end of winter pressures,
  - Agency £611k (2.4%) decrease due to end of winter pressures
  - Overtime £62k (0.2%) slight increase due to some offset of bank & agency reduction
  - Waiting List payments £140k (0.5%) decrease due to reduction in demand.

- The Trust vacancy rate has increased by 0.4% to 9.8%. This is due to increases in the budgeted fte establishment as part of budget setting for 2019/20. Current vacancies equate to 670.6 fte (an increase of 29.2 fte vacancies whilst the substantive budgeted establishment has increased by 30.3 ftes). Net changes are:-

  - Medical establishment (+20.7 fte),
  - Nursing Registered Nurses (-25.5 fte) & Healthcare Assistants (+29.5 fte),
  - Scientific & Technical staff (+0.6 fte)
  - Administrative staff (+3.9 fte)
  - Ancillary staff (+1.0 fte)

- Annual turnover has slightly increased by 0.1% to 11.0% reflecting 643.9 fte leavers in the rolling 12 months.

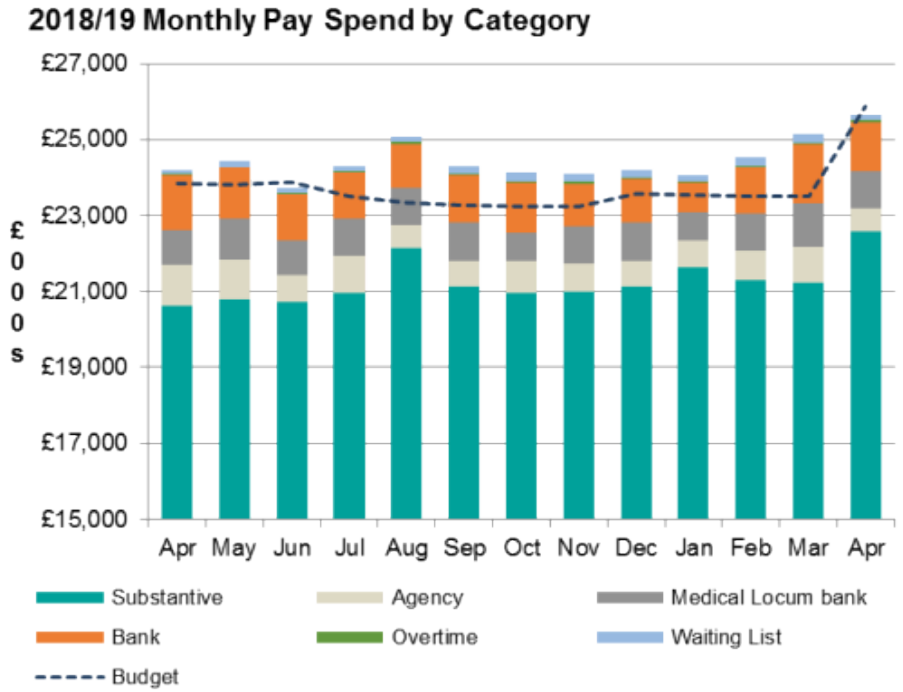
- Monthly sickness increased by 0.1% against March to 4.1%, whilst the overall annual sickness rate remained unchanged at 4.2%.

- Mandatory Training rate has reduced by 2.2% to 86.3% but this is due to the introduction of a 3 year renewal period for Mental Capacity Act & Deprivation of Liberties training. Compliance rates have increased for all other mandatory training courses.

- Appraisal compliance has reduced by 0.8% to 78.7%.

WORKFORCE EXPENDITURE

Actuals in Month (£000s)														
Category	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Trend line
Budget	£23,830	£23,824	£23,875	£23,490	£23,321	£23,282	£23,228	£23,231	£23,578	£23,528	£23,520	£23,520	£25,858	
Substantive	**£20,634**	**£20,783**	**£20,727**	**£20,972**	**£22,152**	**£21,117**	**£20,966**	**£21,001**	**£21,109**	**£21,618**	**£21,287**	**£21,225**	**£22,570**	
Agency	£1,053	£1,037	£697	£954	£604	£667	£833	£732	£687	£727	£772	£952	£611	
Medical Locum bank	£911	£1,086	£923	£977	£960	£1,037	£738	£979	£1,017	£731	£1,003	£1,137	£982	
Bank	£1,451	£1,343	£1,210	£1,229	£1,172	£1,244	£1,309	£1,131	£1,144	£799	£1,209	£1,557	£1,288	
Overtime	£46	£28	£30	£43	£41	£42	£51	£43	£49	£28	£36	£50	£62	
Waiting List	£110	£151	£128	£136	£156	£183	£225	£196	£180	£161	£224	£233	£140	
Total Temp Expenditure	**£3,571**	**£3,645**	**£2,988**	**£3,339**	**£2,933**	**£3,173**	**£3,156**	**£3,081**	**£3,077**	**£2,446**	**£3,244**	**£3,929**	**£3,083**	
Total Spend	**£24,205**	**£24,428**	**£23,715**	**£24,311**	**£25,085**	**£24,290**	**£24,122**	**£24,082**	**£24,186**	**£24,064**	**£24,531**	**£25,154**	**£25,653**	

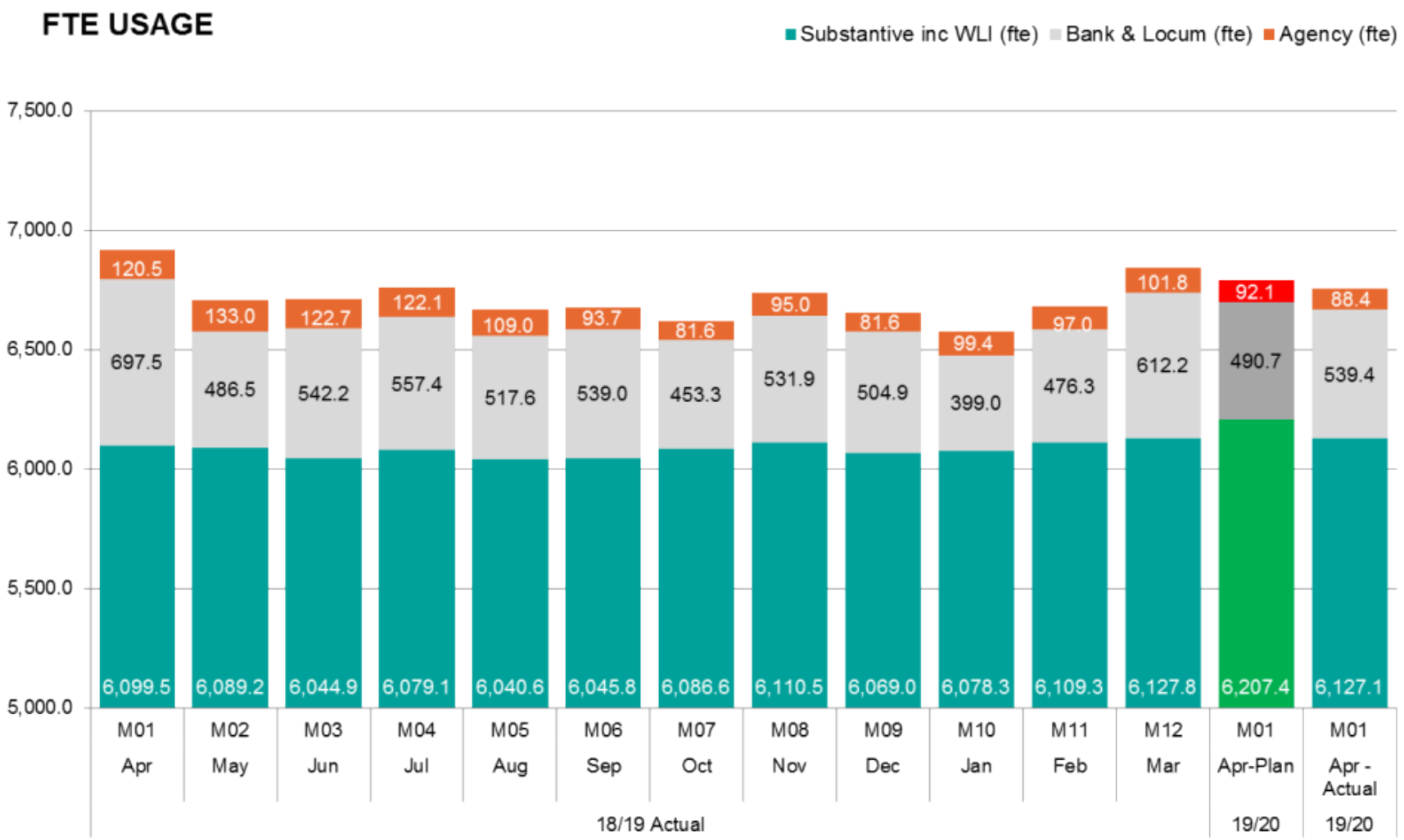


- **BUDGETED ESTABLISHMENT** – FTE Establishment for the new financial year has increased by 30.3 ftes with increases in A&E, Ambulatory Care and for additional beds on De Cham, Benson and Stroke Unit
- **SUBSTANTIVE** – Expenditure increased by £1,345 due to the annual pay award, including £846k in respect of the one off unconsolidated annual payment
- **BANK/LOCUM** - Expenditure reduced by £424k overall this month largely due to end of winter pressures, grip & control measures in place on Elderly Care wards plus arrears paid in March, reducing to normal this month
- **AGENCY** - Expenditure reduced by £341k reflecting the end of winter pressures, and adjustments in A&E in respect of booked shifts in March not worked.
- **OVERTIME** – Expenditure increased by £12k this month
- **WLI** - Payments have decreased by £93k with reductions in Ophthalmology

***Source data**: Finance Ledger*

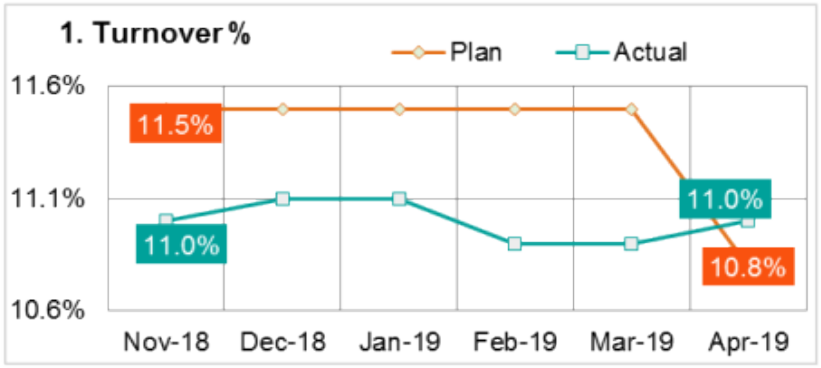
East Sussex Healthcare NHS
NHS Trust

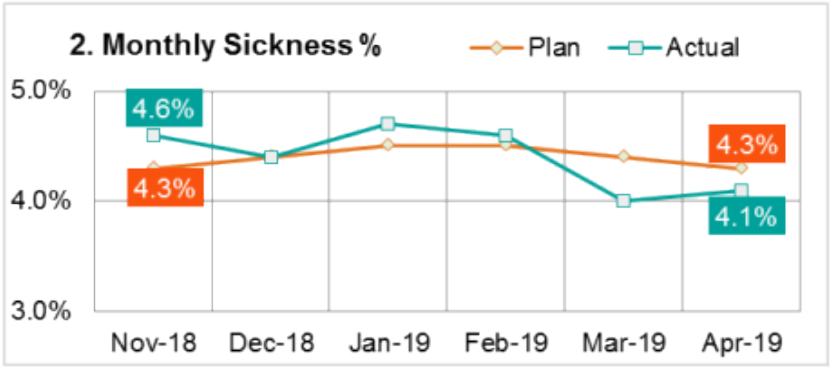
TRENDING FTE USAGE BY MONTH

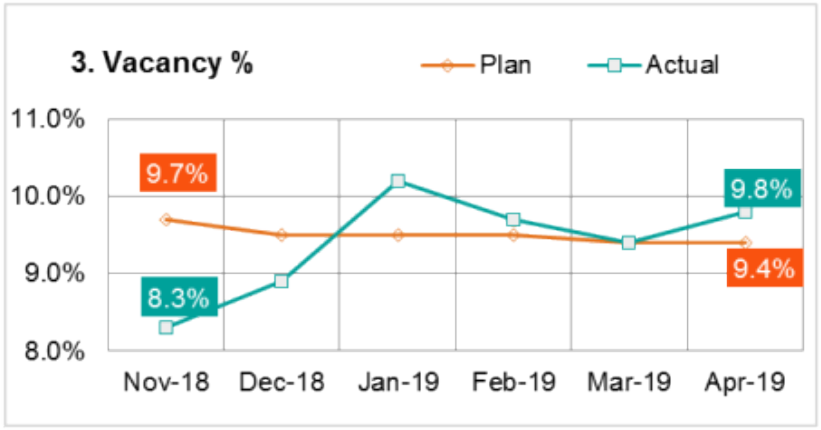


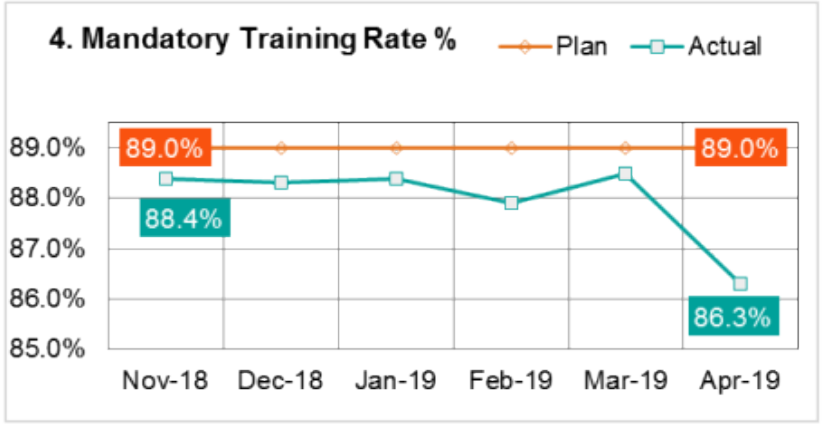
NHSI KPI'S - PLANNED v ACTUAL

Category	Plan/Actual	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Annual Turnover %	Plan	11.5%	11.5%	11.5%	11.5%	11.5%	10.8%
	Actual	11.0%	11.1%	11.1%	10.9%	10.9%	11.0%
Monthly Sickness %	Plan	4.3%	4.4%	4.5%	4.5%	4.4%	4.3%
	Actual	4.6%	4.4%	4.7%	4.6%	4.0%	4.1%
Vacancy Rate %	Plan	9.7%	9.5%	9.5%	9.5%	9.4%	9.4%
	Actual	8.3%	8.9%	10.2%	9.7%	9.4%	9.8%
Mandatory Training rate	Plan	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%
	Actual	88.4%	88.3%	88.4%	87.9%	88.5%	86.3%







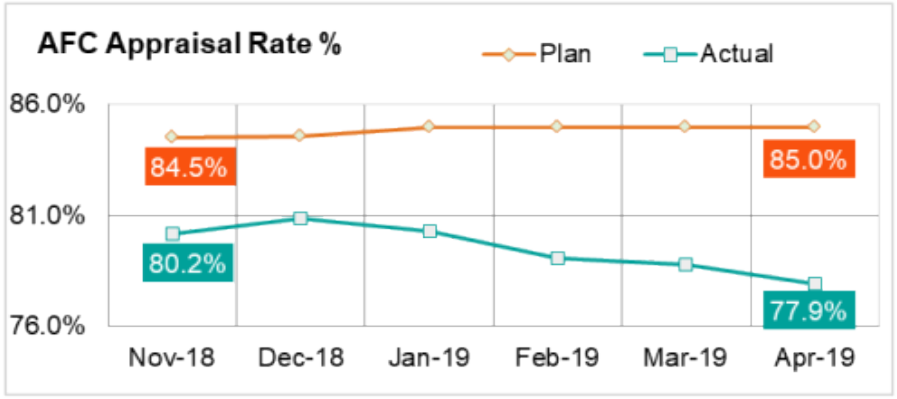


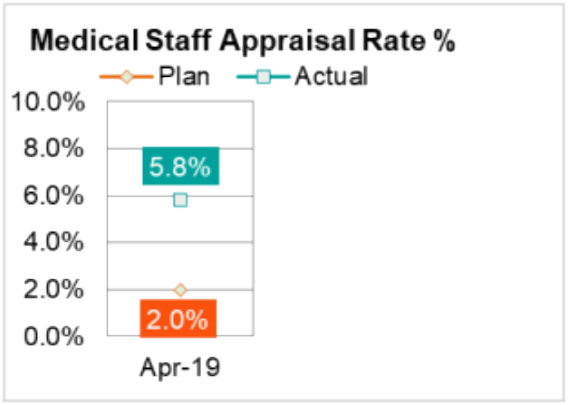
***Source data**: ESR & Finance Ledger*

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 starts again for 2019/20 from zero.

Category	Plan/Actual	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
AfC Appraisal Rate (rolling year)	Plan	84.5%	84.6%	85.0%	85.0%	85.0%	85.0%
	Actual	80.2%	80.9%	80.3%	79.1%	78.8%	77.9%
Medical Staff Appraisal Rate (Yr to date)	Plan	70.2%	87.1%	92.0%	96.0%	98.0%	2.0%
	Actual	83.4%	91.8%	96.5%	98.5%	100.0%	5.8%





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

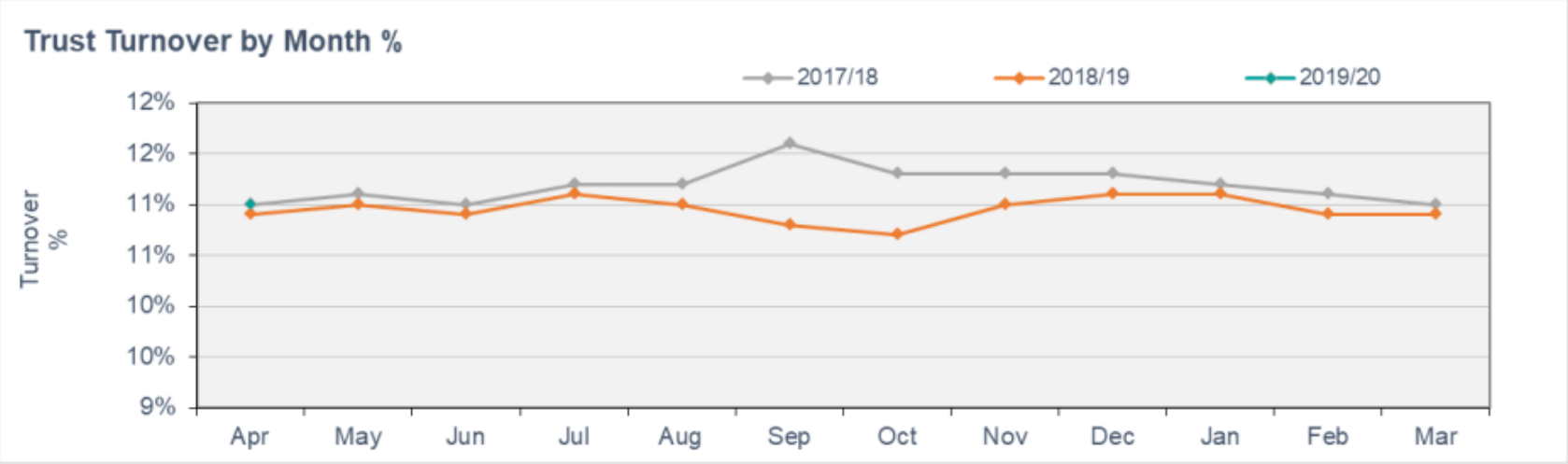
East Sussex Healthcare NHS
NHS Trust

TURNOVER TREND – STAFF GROUP

- Turnover rate does not include junior doctors rotation.
- Turnover rate has slightly increased by 0.1% to 11.0% in April which equates to 643.9 fte leavers.
- 49.7 fte staff left the Trust in April '19, including 0.8 fte Medical & Dental staff and 23.3 fte Registered Nurses.
- Our peer Trusts in the Model Hospital benchmarking tool had turnover rates in the range 10.5% to 16.9% in Jan 19 (ESHT 10.9%)

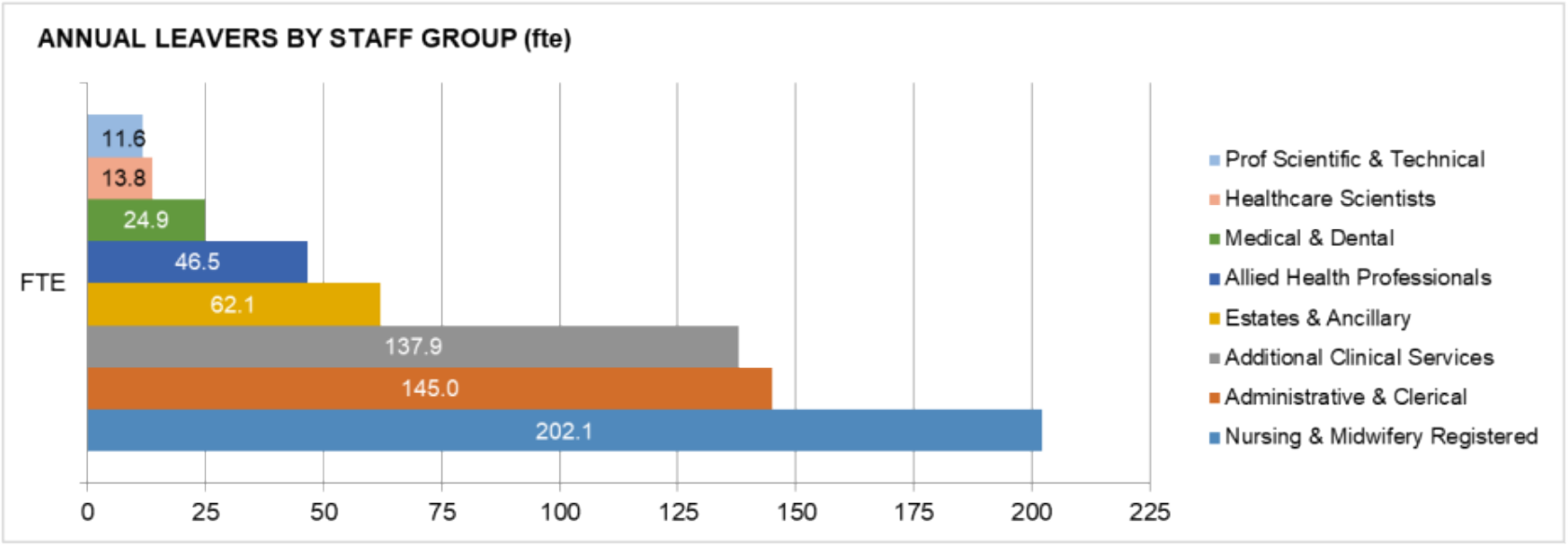
TRUST TURNOVER BY STAFF GROUP (%)

Year on Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Trend line
Additional Clinical Services	13.4%	13.5%	13.4%	14.0%	13.5%	12.9%	12.3%	12.1%	12.0%	11.5%	11.2%	11.7%	11.6%	
Administrative and Clerical	11.7%	12.5%	11.7%	11.8%	11.6%	11.6%	12.0%	12.5%	12.8%	12.8%	12.9%	11.7%	11.3%	
Allied Health Professionals	12.1%	10.6%	10.0%	9.6%	9.6%	9.7%	10.5%	10.6%	10.9%	11.0%	12.4%	12.1%	11.7%	
Estates and Ancillary	8.9%	8.6%	9.1%	9.9%	9.1%	8.8%	8.2%	9.1%	9.1%	9.2%	8.8%	9.6%	10.4%	
Healthcare Scientists	11.8%	10.8%	12.3%	12.5%	12.1%	10.2%	10.1%	9.9%	12.0%	12.6%	10.9%	9.4%	10.0%	
Medical & Dental	10.4%	11.1%	11.7%	11.8%	11.5%	10.7%	10.4%	10.2%	10.1%	10.4%	9.4%	8.9%	8.3%	
Nursing & Midwifery Registered	9.2%	9.4%	9.3%	9.5%	9.9%	10.2%	10.1%	10.4%	10.7%	10.8%	10.4%	10.8%	11.1%	
Prof Scientific and Tech	8.7%	8.6%	8.7%	9.3%	9.1%	8.9%	8.2%	8.2%	6.9%	8.5%	7.4%	7.8%	8.5%	
TOTAL TRUST TURNOVER	**10.9%**	**11.0%**	**10.9%**	**11.1%**	**11.0%**	**10.8%**	**10.7%**	**11.0%**	**11.1%**	**11.1%**	**10.9%**	**10.9%**	**11.0%**	



***Source data**: ESR*

LEAVERS & STABILITY – STAFF GROUP



STAFF GROUPS	STABILITY > 1YR
Medical & Dental	94.4%
Prof Scientific & Technical	83.6%
Administrative & Clerical	92.4%
Nursing & Midwifery Registered	92.3%
Estates & Ancillary	91.6%
Additional Clinical Services	90.1%
Healthcare Scientists	95.4%
Allied Health Professionals	89.2%
TRUST	**91.5%**

Overview

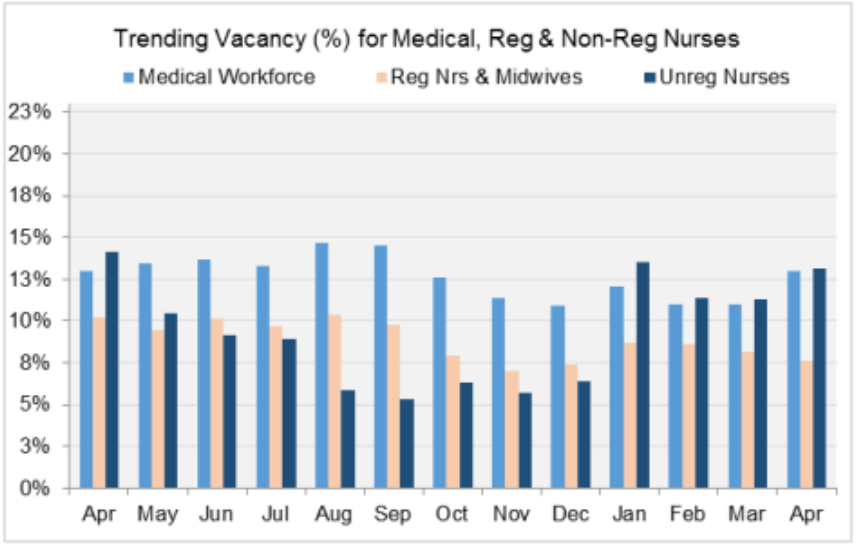
- The Stability Rate measures the number of current staff who have more than 1 year's service with ESHT
- The Stability rate has increased by 0.2% this month
- Professional Scientific & Technical staff (i.e. Pharmacy staff, ODPs, Optometrists and other technical staff) and Allied Health Professionals have stability rates below 90%.

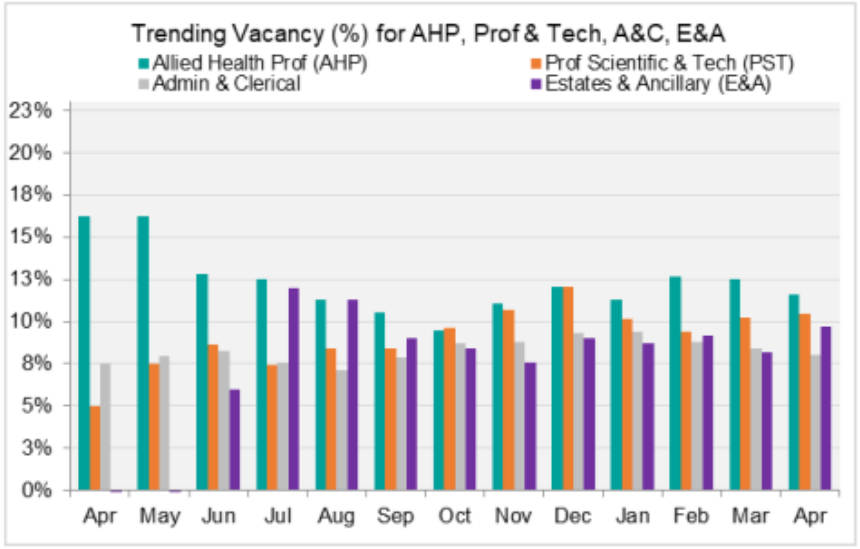
***Source data**: ESR February 2019*

RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- Trust vacancy rate has increased by 0.4% to 9.8% (670.6 fte), an increase of 29.2 ftes. This is due to a net increase in the budgeted establishment of 30.3 ftes.
- International recruitment is continuing in the Philippines and Indian sub-continent for Band 5 Nurses. 11 International nurses due to join the Trust by July. Candidates from India recruitment visit in April to start arriving from October 19.
- Relationship with Medacs now fully established. To date 7 candidates in post and a further 1 offer of appointment in the pipeline.

APR 2018 TO APR 2019	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Trend line
Medical Workforce	13.0%	13.5%	13.7%	13.3%	14.7%	14.5%	12.6%	11.4%	11.0%	12.1%	11.0%	11.0%	13.0%	
Reg Nrs & Midwives	10.2%	9.5%	10.1%	9.7%	10.4%	9.8%	7.9%	7.0%	7.4%	8.7%	8.6%	8.2%	7.6%	
Unreg Nurses	14.1%	10.5%	9.2%	8.9%	5.9%	5.3%	6.3%	5.7%	6.4%	13.5%	11.4%	11.3%	13.1%	
Allied Health Prof (AHP)	16.2%	16.2%	12.8%	12.5%	11.3%	10.5%	9.5%	11.1%	12.1%	11.3%	12.7%	12.5%	11.6%	
Prof Scientific & Tech (PST)	5.0%	7.5%	8.6%	7.4%	8.4%	8.4%	9.6%	10.7%	12.1%	10.2%	9.4%	10.2%	10.5%	
Admin & Clerical	7.5%	8.0%	8.2%	7.6%	7.1%	7.9%	8.7%	8.8%	9.3%	9.4%	8.8%	8.4%	8.0%	
Estates & Ancillary (E&A)	-1.5%	-2.7%	6.0%	12.0%	11.3%	9.0%	8.4%	7.6%	9.0%	8.7%	9.2%	8.2%	9.7%	
TRUST	**9.5%**	**9.0%**	**9.6%**	**9.7%**	**9.5%**	**9.1%**	**8.6%**	**8.3%**	**8.9%**	**10.2%**	**9.7%**	**9.4%**	**9.8%**	





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

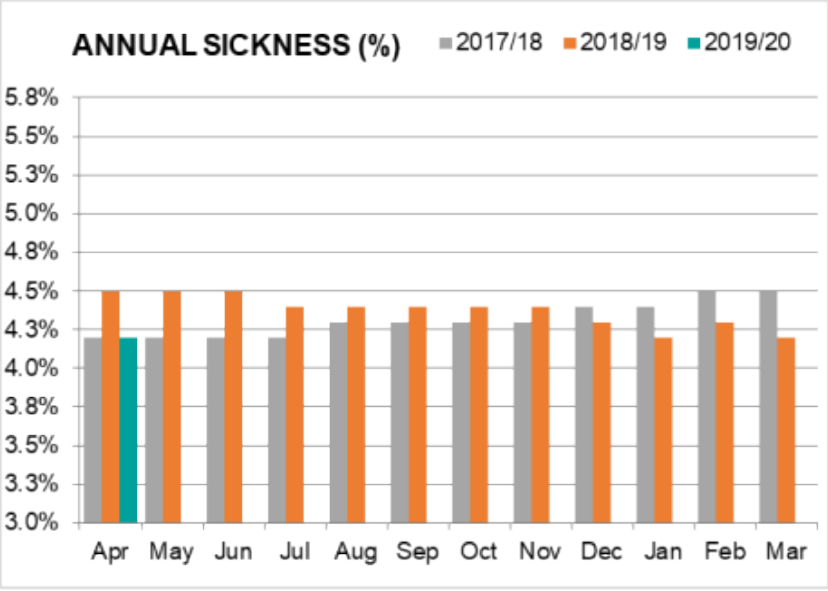
East Sussex Healthcare NHS
NHS Trust

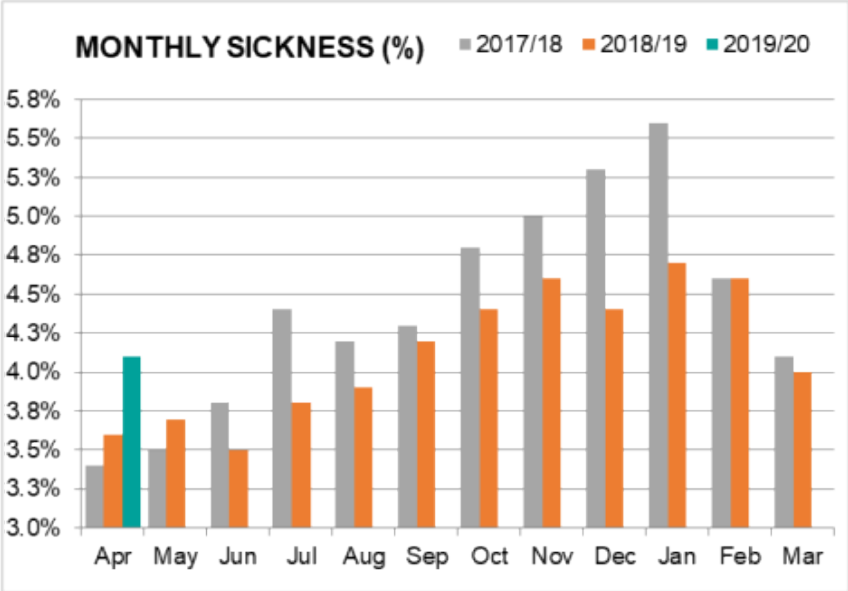
ABSENCE MANAGEMENT – SICKNESS RATES

- Monthly sickness has slightly increased by 0.1% to 4.1%. The annual sickness rate remains unchanged at 4.2%.
- In Dec'18 the national NHS monthly sickness rate was 4.5% (ESHT 4.4%). Our peer Trusts in Model Hospital had monthly sickness in the range 3.7% - 5.7%. Nationally, the staff group with the highest sickness rate was Additional Clinical Services (mostly unregistered nurses & therapy helpers) at 6.9% (ESHT 5.8%, Dec 18; 5.4% Apr 19).

ANNUAL (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%	4.2%
2019/20	4.2%											

MONTHLY (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%	4.0%
2019/20	4.1%											



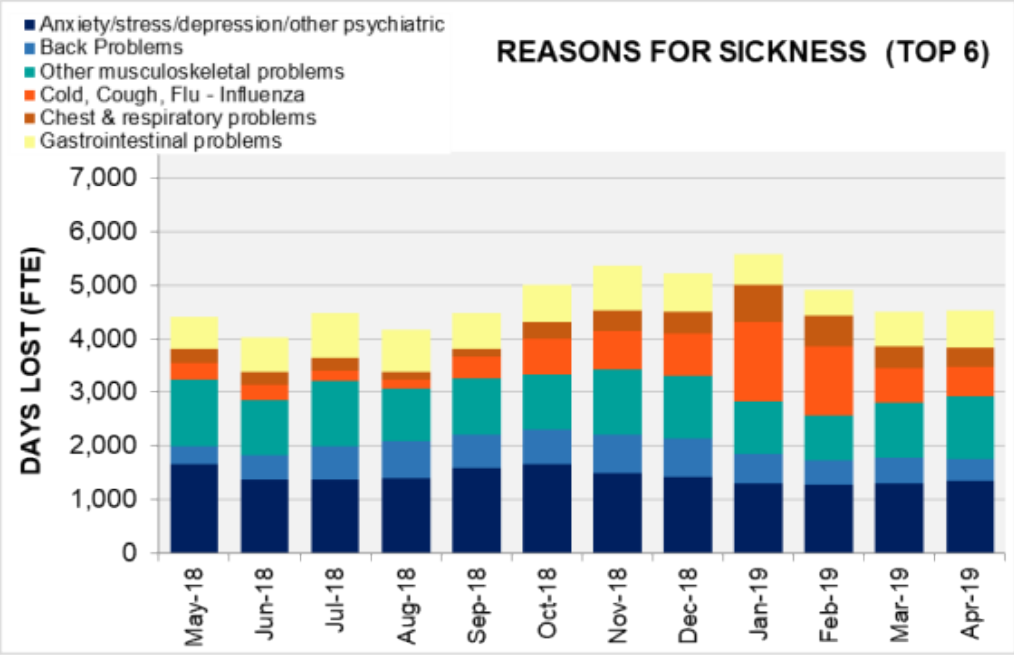


***Source data**: ESR*

ABSENCE MANAGEMENT – SICKNESS REASONS

- Seasonal illnesses continue to decline month with cold, cough, flu reducing by a further 125 fte days lost (41%) and chest & respiratory problems by a further 21 fte days .
- Other musculoskeletal problems have continued to increase by a further 51 fte days lost.

TOP 6	Fte Days Lost by Month												
Reason for sickness	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend line
Anxiety/stress/depression/other psychiatric	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	1,309.0	1,341.0	
Back Problems	346.1	462.9	629.8	691.8	617.0	641.4	708.0	718.3	557.1	455.6	461.2	409.3	
Other musculoskeletal problems	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	1,030.6	1,181.4	
Cold, Cough, Flu - Influenza	313.0	275.3	189.2	185.8	410.6	682.5	730.2	788.3	1,474.1	1,300.1	662.3	537.0	
Chest & respiratory problems	264.0	235.8	244.2	132.8	142.1	291.9	371.3	393.2	705.9	568.4	384.5	363.2	
Gastrointestinal problems	604.9	657.3	825.8	782.7	657.3	698.0	829.0	724.7	566.9	485.4	656.8	704.8	



Apr 2019 - Top 10 in descending order (%)		%
1	Anxiety/stress/depression/other psychiatric illnesses	17.6%
2	Other musculoskeletal problems	15.5%
3	Other known causes - not elsewhere classified	11.5%
4	Gastrointestinal problems	9.2%
5	Cold,Cough,Flu - Influenza	7.0%
6	Unknown causes / Not specified	6.2%
7	Back Problems	5.4%
8	Genitourinary & gynaecological disorders	4.8%
9	Chest & respiratory problems	4.8%
10	Benign and malignant tumours, cancers	3.2%
	TOP 10 REASONS	**85.2%**

***Source data**: ESR*

WELLBEING & ENGAGEMENT

Staff Engagement

- Staff Family & Friends feedback showing improvements in staff recommending Trust for treatment and as a place of work
- Staff survey results reported to Trust Board. 4 Corporate priorities identified and action plans being developed as key focus for 2019/20
- Divisional meetings for Staff Survey actions arranged for Staff Survey action planning

Health & Wellbeing

- Launched Employee Assistance Programme with Care First for staff to access support on emotional and practical issues and for managers to receive guidance on how best to support their staff
- Trust has commenced embedded service with REMPLOY, offering practical advice and support for staff experiencing mental health symptoms to stay in and/or return to work.
- Work is progressing on the Stress and Mental Wellbeing policy which incorporates a new approach to undertaking team stress risk assessments

Retention

- Updated total rewards information on employee support health & wellbeing and occupational health services will go live at the end of May which will increase awareness of the benefits offered to staff members
- Continue to support members of staff with flexible working requests so that they will remain working for the Trust

East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISAL COMPLIANCE BY DIVISION

MANDATORY TRAINING

- Overall mandatory training compliance has reduced by 2.2% to 86.3% but this is due to the resetting of the renewal requirement for Mental Capacity Act and Deprivation of Liberties training to 3 years (previously no set renewal period). This has reduced compliance for these subjects by 21% and 23 % respectively,
- Overall compliance for the other mandatory subjects have all increased this month

APPRAISAL OVERVIEW

- The overall appraisal rate for the Trust has reduced again by 0.8% to 78.7%. This is the fourth consecutive monthly fall since a high of 81.3% compliance in Dec 18.
- There are another 409 appraisals which are currently compliant but due for renewal in May.

DIVISION	APPRAISAL COMPLIANCE	
	12 mth	16 mth
Urgent Care	77.4%	87.4%
Medicine	78.1%	88.1%
Out of Hospital	74.1%	86.4%
Diag/Anaes/Surg	81.5%	91.6%
Womens, Child, S/Health	80.0%	87.5%
Estates & Facilities	74.7%	89.0%
Corporate	82.1%	87.9%
TRUST	**78.7%**	**88.6%**

										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	85.7%	90.0%	91.1%	86.4%	79.2%	89.2%	80.7%	80.3%	29.4%	89.9%	91.2%	88.3%
Medicine	84.5%	89.7%	92.6%	89.1%	74.8%	85.0%	75.3%	67.5%	53.3%	87.9%	87.1%	60.0%
Out of Hospital	89.2%	93.6%	99.2%	94.9%	81.4%	89.1%	72.1%	71.2%	40.3%	89.0%	88.3%	75.9%
Diag/Anaes/Surg	87.4%	91.2%	88.6%	89.8%	77.8%	87.2%	74.4%	69.0%	43.5%	88.4%	89.4%	43.3%
Womens, Child, S/Health	88.0%	93.6%	96.8%	92.2%	81.6%	89.3%	77.6%	77.0%	5.2%	88.2%	93.6%	89.6%
Estates & Facilities	80.7%	91.2%	96.5%	90.5%	70.2%	89.2%	n/a	n/a	n/a	n/a	n/a	n/a
Corporate	95.2%	100.0%	100.0%	100.0%	95.2%	100.0%	70.3%	72.5%	17.9%	24.7%	84.8%	100.0%
TRUST	**87.5%**	**92.4%**	**94.1%**	**91.7%**	**79.8%**	**88.8%**	**74.9%**	**72.3%**	**41.5%**	**88.4%**	**89.2%**	**80.0%**

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

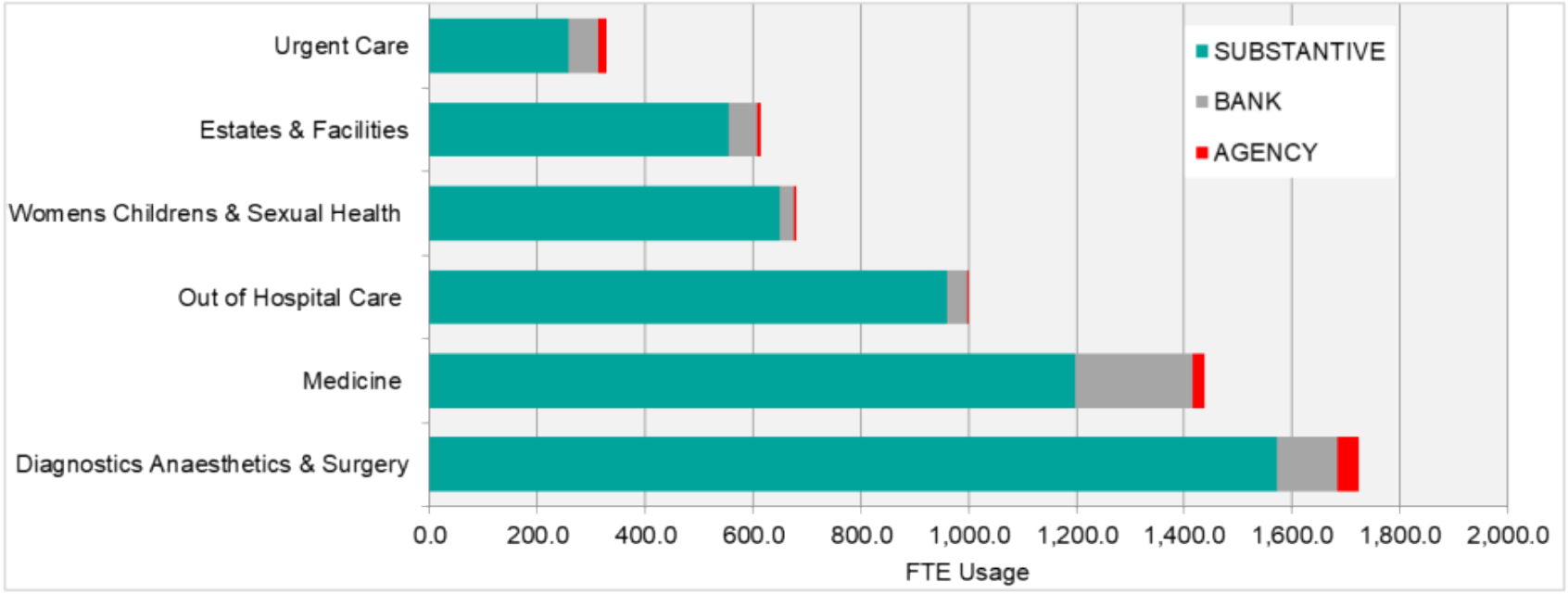
***Source data**: ESR*

APPENDIX

- Supporting documents

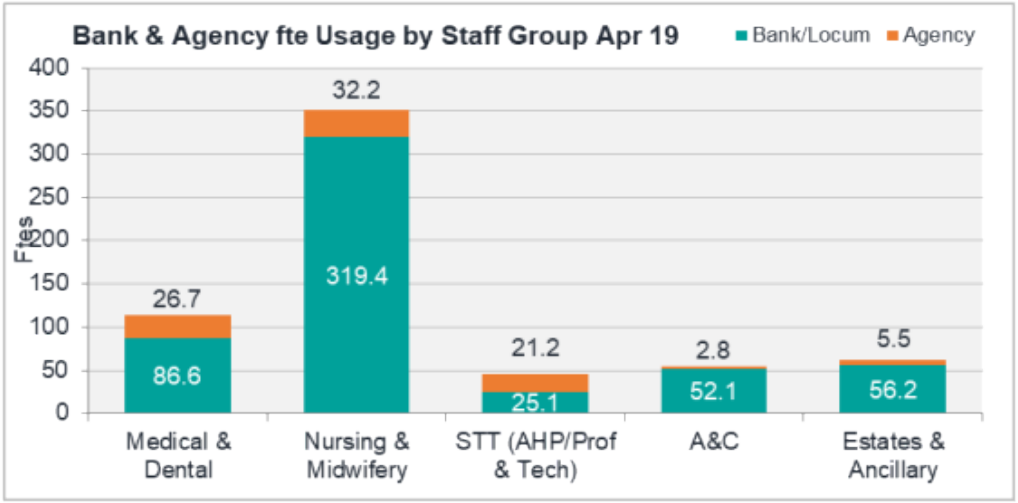
WORKFORCE UTILISATION BY DIVISION (FTE USAGE) – APR '19

DIVISION	BUDGET	SUBSTANTIVE		BANK		AGENCY		TOTAL
	FTE	FTE	%	FTE	%	FTE	%	FTE
Diagnostics Anaesthetics & Surgery	1,817.8	1,572.3	91.3%	112.8	6.5%	37.7	2.2%	1,722.8
Medicine	1,481.1	1,197.2	83.2%	219.4	15.3%	21.8	1.5%	1,438.4
Out of Hospital Care	1,053.7	960.9	96.2%	36.4	3.6%	1.7	0.2%	999.0
Womens Childrens & Sexual Health	704.6	649.3	95.5%	27.2	4.0%	3.2	0.5%	679.7
Estates & Facilities	637.7	553.8	90.2%	54.8	8.9%	5.5	0.9%	614.1
Urgent Care	344.3	258.1	78.8%	53.8	16.4%	15.8	4.8%	327.7
Corporate	1,015.6	935.5	96.1%	35.0	3.6%	2.7	0.3%	973.2
TRUST	**7,054.8**	**6,127.1**	**90.7%**	**539.4**	**8.0%**	**88.4**	**1.3%**	**6,754.9**



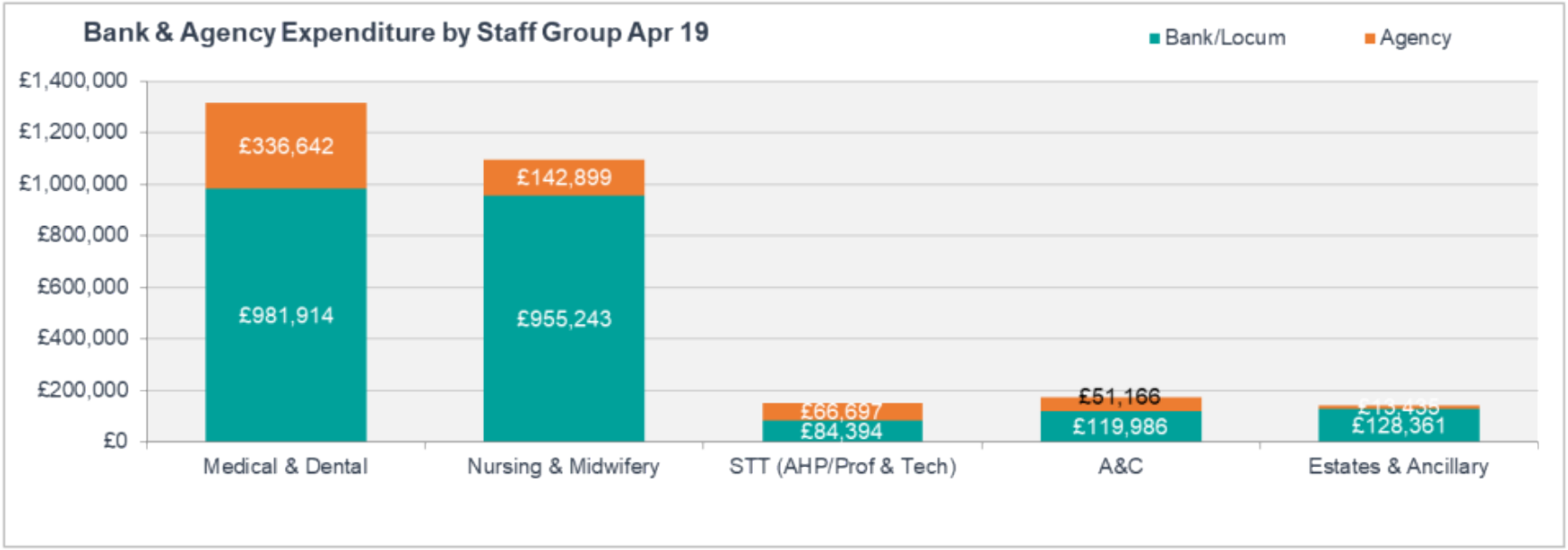
***Source data**: Finance Ledger*

FLEXIBLE LABOUR – FTE & EXPENDITURE FOR APRIL '19



- Total temporary workforce expenditure reduced in Apr '19 against Mar '19 by £846K:
  - Bank costs reduced by £269K
  - Locum costs reduced by £155K
  - Agency costs reduced by £341K
  - Overtime costs increased by £12K
  - Waiting list costs reduced by £93K

(Source data: Finance Ledger M1)



***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 1

	Plan YTD	Actual YTD	Plan FOT	Forecast FOT
Capital service cover	4	4	4	4
Liquidity	1	1	1	1
I&E margin	4	4	4	4
Variance From Control Total	1	1	1	1
Agency	1	1	1	1
Rating With Overrides	4	4	4	4

Operational Deficit

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(4,950)	(3,450)	(3,446)	4
Year End Forecast	(44,782)	(10,125)	(10,125)	0

The Trust is £4k ahead of plan in month and is therefore eligible for PSF (£0.4m) and FRF (£0.7m) funding, which are included within the position. The YTD value of the Aligned Incentive contract with the ESBT CCGs is included in the financial position. Overspends are primarily in medical pay, (WLIs and locum payments) and offset by underspends in nursing pay. CIP is £2k ahead of plan YTD. YTD non-pay overspends in tariff excluded drugs are offset in non-pay and underspends in clinical supplies offset income underperformance due to reduced theatre activity in month.

Agency Usage

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(1,053)	(861)	(611)	250
Year End Forecast	(9,716)	(8,743)	(8,743)	0

Agency spend is £250k below plan YTD. The largest underspends are in the Prof, Scientific & Tech and Administrative and Management staff groups. All agency usage is reviewed by the T3 Pay Panel. There is a continued requirement for agency to be used in difficult to recruit medical and AHP posts. Overall agency costs remain within the NHSI ceiling for 2019/20. YTD agency spend is a reduction of £442k (42%) compared to the same period 2018/19.

Income

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	32,413	35,286	34,791	(495)
Year End Forecast	408,783	441,780	441,780	0

Underperformance on elective and day case activity (£0.4m) and underperformance of non-elective activity (£0.8m) is partially mitigated by the YTD value of the Aligned Incentive Contract with the ESBT CCGs which is included in the financial position. A&E activity was above plan in month, a continuation of the trend from 2018/19. PSF (£0.4m), FRF (£0.7m) and MRET (£0.1m) is included in the position. COIN income underperformance (£0.2m) is offset by underspends in non-pay and private patient underperformance (£0.1m) is partially offset by underspends in pay.

Operating Costs

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(36,742)	(38,171)	(37,762)	409
Year End Forecast	(445,874)	(444,666)	(444,666)	0

Overall operating costs are reporting £0.4m underspend against plan. Overspends include medical pay costs including agency (£0.1m) and drugs overspend (£0.2m, of which £0.4m is offset within income). Non-pay underspends in clinical supplies (£0.3m) are due to below plan activity levels in Theatres. The AfC lump sum payment was made in M1 to all staff at the top of band (£0.9m). Underspends in non-pay expenditure in relation to COIN (£0.2m) are offset in income.

Cost Improvement Programme

	Plan £k	Actual £k	Variance £k
Year to Date	1,430	1,432	2
Year End Forecast	20,603	20,603	0

The Trust has delivered its £1.43m plan for M1, with an over delivery of £2k. The main favourable variance is in Ambulatory Care recruitment slippage (£135k) and an adverse variance in bed modelling (£48k). The forecast is to reach the £20.6m 2019/20 CIP target, with £10.7m currently identified as process green.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	12,915	10,815
Year End Forecast	2,100	2,100	2,100	0

Cash balance above minimum balance at month end, due to the equal phasing of the Trust's monthly income received from the CCG's. Income is received on 15th of each month. At year end, the minimum cash balance of £2.1m is achieved.

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	1,050	1,065	(15)
Year End Forecast	12,598	12,598	0

The indicative CRL for 2019/20 was £13.148m. Following finalisation of the 2018/19 capital outturn and a review of the depreciaiton charge in M1, the CRL has been revised to £12.598m.

The 2019/20 capital programme has been reprioritised and will be monitored on a monthly basis by the Capital Resource Group.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	85.89%	93.73%	85.89%	93.73%
NHS Invoices	91.40%	99.63%	91.40%	99.63%

86% of trade invoices were paid within 28 days which equates to 94% of the total value paid in month.

91% 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	1,817.75	1,722.83	94.92	(322)	(1,107)	(785)	(322)	(1,107)	(785)	5,862	5,862	0
Medicine	1,481.06	1,438.42	42.64	3,450	2,560	(890)	3,450	2,560	(890)	51,143	51,143	0
Urgent Care	344.29	327.73	16.56	751	946	196	751	946	196	10,977	10,977	0
Out of Hospital Care	1,053.66	998.99	54.67	(844)	(562)	282	(844)	(562)	282	(5,645)	(5,645)	0
Women's, Children's & Sexual Health	704.56	679.74	24.82	691	965	274	691	965	274	12,135	12,135	0
Estates & Facilities	637.72	614.13	23.59	(2,243)	(2,195)	48	(2,243)	(2,195)	48	(24,977)	(24,977)	0
Corporate	1,015.72	973.07	42.65	(4,662)	(4,235)	427	(4,662)	(4,235)	427	(52,677)	(52,677)	0
Central	0.00	0.00	0.00	(270)	182	452	(270)	182	452	(6,943)	(6,943)	0
Total	**7,054.76**	**6,754.91**	**299.85**	**(3,450)**	**(3,446)**	**4**	**(3,450)**	**(3,446)**	**4**	**(10,125)**	**(10,125)**	**0**

Key Risks

Key Risk 1	Medical pay costs increased by 6% compared to M1 2018/19 (£0.1m overspend YTD)
Key Risk 2	Inpatient activity (elective, day case and non-elective) £1.2m below plan YTD
Key Risk 3	Delivery of CIP plan

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. An enhanced T3 pay process is being introduced to strengthen the controls framework around premium pay.
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. PIDs in process of being worked up at divisional level to achieve plans.

Income & Expenditure Summary - Month 1

	In Month				Year to Date				Forecast Outturn		
	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	19/20 Plan (£m)	19/20 FOT (£m)	Variance (£m)
NHS Patient Income	26.4	28.7	27.9	(0.8)	26.4	28.7	27.9	(0.8)	347.9	347.9	0.0
Tariff-Excluded Drugs & Devices	2.6	2.7	3.0	0.3	2.6	2.7	3.0	0.3	38.3	38.3	0.0
Private Patient / ICR	0.3	0.3	0.1	(0.1)	0.3	0.3	(0.2)	(0.5)	3.4	3.4	0.0
Other Non-Clinical Income	3.1	2.3	2.4	0.1	3.1	2.3	2.8	0.5	28.3	28.3	0.0
Total Income	**32.4**	**34.0**	**33.5**	**(0.5)**	**32.4**	**34.0**	**33.5**	**(0.5)**	**417.9**	**417.9**	**0.0**
Pay - Substantive	(20.8)	(22.6)	(22.8)	(0.2)	(20.8)	(22.6)	(22.8)	(0.2)	(262.5)	(262.5)	0.0
Pay - Bank	(2.4)	(2.4)	(2.3)	0.2	(2.4)	(2.4)	(2.3)	0.2	(22.8)	(22.8)	0.0
Pay - Agency	(1.1)	(0.9)	(0.6)	0.3	(1.1)	(0.9)	(0.6)	0.3	(8.7)	(8.7)	0.0
Total Pay	**(24.2)**	**(25.9)**	**(25.7)**	**0.2**	**(24.2)**	**(25.9)**	**(25.7)**	**0.2**	**(294.0)**	**(294.0)**	**0.0**
Drugs	(3.5)	(3.5)	(3.7)	(0.2)	(3.5)	(3.5)	(3.7)	(0.2)	(44.6)	(44.6)	0.0
Supplies & Services - Clinical	(2.6)	(2.5)	(2.2)	0.3	(2.6)	(2.5)	(2.2)	0.3	(32.2)	(32.2)	0.0
Supplies & Services - General	(0.4)	(0.3)	(0.3)	0.0	(0.4)	(0.3)	(0.3)	0.0	(4.0)	(4.0)	0.0
Purchase of Healthcare (non-NHS)	(0.4)	(0.5)	(0.5)	(0.0)	(0.4)	(0.5)	(0.5)	(0.0)	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(0.6)	(0.6)	(0.4)	0.2	(0.6)	(0.6)	(0.4)	0.2	(7.1)	(7.1)	0.0
Consultancy	(0.3)	(0.0)	(0.0)	(0.0)	(0.3)	(0.0)	(0.0)	(0.0)	(0.4)	(0.4)	0.0
Clinical Negligence	(0.9)	(0.8)	(0.8)	(0.0)	(0.9)	(0.8)	(0.8)	(0.0)	(8.9)	(8.9)	0.0
Premises	(1.2)	(1.3)	(1.3)	(0.0)	(1.2)	(1.3)	(1.3)	(0.0)	(15.0)	(15.0)	0.0
Depreciation	(1.0)	(1.1)	(1.1)	0.0	(1.0)	(1.1)	(1.1)	0.0	(13.0)	(13.0)	0.0
Other	(1.6)	(1.7)	(1.8)	(0.1)	(1.6)	(1.7)	(1.8)	(0.1)	(19.6)	(19.6)	0.0
Total Non-Pay	**(12.5)**	**(12.3)**	**(12.1)**	**0.2**	**(12.5)**	**(12.3)**	**(12.1)**	**0.2**	**(150.7)**	**(150.7)**	**0.0**
Total Operating Costs	**(36.7)**	**(38.1)**	**(37.8)**	**0.4**	**(36.7)**	**(38.1)**	**(37.8)**	**0.4**	**(444.7)**	**(444.7)**	**0.0**
Net Surplus/(Deficit) from Operations	**(4.3)**	**(4.1)**	**(4.2)**	**(0.1)**	**(4.3)**	**(4.1)**	**(4.2)**	**(0.1)**	**(26.8)**	**(26.8)**	**0.0**
Financing Costs	(0.7)	(0.6)	(0.6)	0.0	(0.7)	(0.6)	(0.6)	0.0	(7.2)	(7.2)	0.0
Total Non-Operating Costs	**(0.7)**	**(0.6)**	**(0.6)**	**0.0**	**(0.7)**	**(0.6)**	**(0.6)**	**0.0**	**(7.2)**	**(7.2)**	**0.0**
Total Costs	**(37.4)**	**(38.7)**	**(38.3)**	**0.4**	**(37.4)**	**(38.7)**	**(38.3)**	**0.4**	**(451.9)**	**(451.9)**	**0.0**
Net Surplus/(Deficit)	**(5.0)**	**(4.7)**	**(4.8)**	**(0.1)**	**(5.0)**	**(4.7)**	**(4.8)**	**(0.1)**	**(34.0)**	**(34.0)**	**0.0**
Donated Asset/Impairment Adjustment	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.1	0.0	0.0	0.0
Operational Surplus/(Deficit)	**(4.9)**	**(4.7)**	**(4.7)**	**0.0**	**(4.9)**	**(4.7)**	**(4.7)**	**0.0**	**(34.0)**	**(34.0)**	**0.0**
Provider Sustainability Fund	0.0	0.4	0.4	0.0	0.0	0.4	0.4	0.0	7.6	7.6	0.0
Financial Recovery Fund	0.0	0.7	0.7	0.0	0.0	0.7	0.7	0.0	14.8	14.8	0.0
Marginal Rate Emergency Tariff (MRET)	0.0	0.1	0.1	0.0	0.0	0.1	0.1	0.0	1.5	1.5	0.0
Net Surplus/(Deficit)	**(4.9)**	**(3.5)**	**(3.4)**	**0.0**	**(4.9)**	**(3.5)**	**(3.4)**	**0.0**	**(10.1)**	**(10.1)**	**0.0**

Summary & Next Steps

The Trust's YTD performance at M1 is £4k ahead of plan with a CIP over performance of £2k. Income underperformed in month by £0.5m, £0.2m is due to COIN income underdelivery which was offset by underspends in non-pay. Elective activity is £0.4m below plan in month. The YTD effect of the Aligned Incentive Contract with the ESBT CCGs has been recognised in the position, the Trust has also recognised £1.2m of PSF, FRF and MRET. The overspend in drugs is attributable to Tariff Excluded Drugs and is fully offset within income. Medical pay contonues to overspend (£0.1m), largely due to temporary workforce and WLI payments.

Income & Expenditure Summary - Month 1

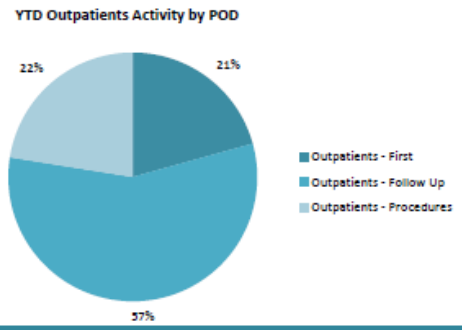
	In Month				Year to Date				Forecast Outturn		
	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	19/20 Plan (£m)	19/20 FOT (£m)	Variance (£m)
NHS Patient Income	26.4	28.7	27.9	(0.8)	26.4	28.7	27.9	(0.8)	347.9	347.9	0.0
Tariff-Excluded Drugs & Devices	2.6	2.7	3.0	0.3	2.6	2.7	3.0	0.3	38.3	38.3	0.0
Private Patient / ICR	0.3	0.3	0.1	(0.1)	0.3	0.3	(0.2)	(0.5)	3.4	3.4	0.0
Other Non-Clinical Income	3.1	2.3	2.4	0.1	3.1	2.3	2.8	0.5	28.3	28.3	0.0
Total Income	**32.4**	**34.0**	**33.5**	**(0.5)**	**32.4**	**34.0**	**33.5**	**(0.5)**	**417.9**	**417.9**	**0.0**
Pay - Substantive	(20.8)	(22.6)	(22.8)	(0.2)	(20.8)	(22.6)	(22.8)	(0.2)	(262.5)	(262.5)	0.0
Pay - Bank	(2.4)	(2.4)	(2.3)	0.2	(2.4)	(2.4)	(2.3)	0.2	(22.8)	(22.8)	0.0
Pay - Agency	(1.1)	(0.9)	(0.6)	0.3	(1.1)	(0.9)	(0.6)	0.3	(8.7)	(8.7)	0.0
Total Pay	**(24.2)**	**(25.9)**	**(25.7)**	**0.2**	**(24.2)**	**(25.9)**	**(25.7)**	**0.2**	**(294.0)**	**(294.0)**	**0.0**
Drugs	(3.5)	(3.5)	(3.7)	(0.2)	(3.5)	(3.5)	(3.7)	(0.2)	(44.6)	(44.6)	0.0
Supplies & Services - Clinical	(2.6)	(2.5)	(2.2)	0.3	(2.6)	(2.5)	(2.2)	0.3	(32.2)	(32.2)	0.0
Supplies & Services - General	(0.4)	(0.3)	(0.3)	0.0	(0.4)	(0.3)	(0.3)	0.0	(4.0)	(4.0)	0.0
Purchase of Healthcare (non-NHS)	(0.4)	(0.5)	(0.5)	(0.0)	(0.4)	(0.5)	(0.5)	(0.0)	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(0.6)	(0.6)	(0.4)	0.2	(0.6)	(0.6)	(0.4)	0.2	(7.1)	(7.1)	0.0
Consultancy	(0.3)	(0.0)	(0.0)	(0.0)	(0.3)	(0.0)	(0.0)	(0.0)	(0.4)	(0.4)	0.0
Clinical Negligence	(0.9)	(0.8)	(0.8)	(0.0)	(0.9)	(0.8)	(0.8)	(0.0)	(8.9)	(8.9)	0.0
Premises	(1.2)	(1.3)	(1.3)	(0.0)	(1.2)	(1.3)	(1.3)	(0.0)	(15.0)	(15.0)	0.0
Depreciation	(1.0)	(1.1)	(1.1)	0.0	(1.0)	(1.1)	(1.1)	0.0	(13.0)	(13.0)	0.0
Other	(1.6)	(1.7)	(1.8)	(0.1)	(1.6)	(1.7)	(1.8)	(0.1)	(19.6)	(19.6)	0.0
Total Non-Pay	**(12.5)**	**(12.3)**	**(12.1)**	**0.2**	**(12.5)**	**(12.3)**	**(12.1)**	**0.2**	**(150.7)**	**(150.7)**	**0.0**
Total Operating Costs	**(36.7)**	**(38.1)**	**(37.8)**	**0.4**	**(36.7)**	**(38.1)**	**(37.8)**	**0.4**	**(444.7)**	**(444.7)**	**0.0**
Net Surplus/(Deficit) from Operations	**(4.3)**	**(4.1)**	**(4.2)**	**(0.1)**	**(4.3)**	**(4.1)**	**(4.2)**	**(0.1)**	**(26.8)**	**(26.8)**	**0.0**
Financing Costs	(0.7)	(0.6)	(0.6)	0.0	(0.7)	(0.6)	(0.6)	0.0	(7.2)	(7.2)	0.0
Total Non-Operating Costs	**(0.7)**	**(0.6)**	**(0.6)**	**0.0**	**(0.7)**	**(0.6)**	**(0.6)**	**0.0**	**(7.2)**	**(7.2)**	**0.0**
Total Costs	**(37.4)**	**(38.7)**	**(38.3)**	**0.4**	**(37.4)**	**(38.7)**	**(38.3)**	**0.4**	**(451.9)**	**(451.9)**	**0.0**
Net Surplus/(Deficit)	**(5.0)**	**(4.7)**	**(4.8)**	**(0.1)**	**(5.0)**	**(4.7)**	**(4.8)**	**(0.1)**	**(34.0)**	**(34.0)**	**0.0**
Donated Asset/Impairment Adjustment	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.1	0.0	0.0	0.0
Operational Surplus/(Deficit)	**(4.9)**	**(4.7)**	**(4.7)**	**0.0**	**(4.9)**	**(4.7)**	**(4.7)**	**0.0**	**(34.0)**	**(34.0)**	**0.0**
Provider Sustainability Fund	0.0	0.4	0.4	0.0	0.0	0.4	0.4	0.0	7.6	7.6	0.0
Financial Recovery Fund	0.0	0.7	0.7	0.0	0.0	0.7	0.7	0.0	14.8	14.8	0.0
Marginal Rate Emergency Tariff (MRET)	0.0	0.1	0.1	0.0	0.0	0.1	0.1	0.0	1.5	1.5	0.0
Net Surplus/(Deficit)	**(4.9)**	**(3.5)**	**(3.4)**	**0.0**	**(4.9)**	**(3.5)**	**(3.4)**	**0.0**	**(10.1)**	**(10.1)**	**0.0**

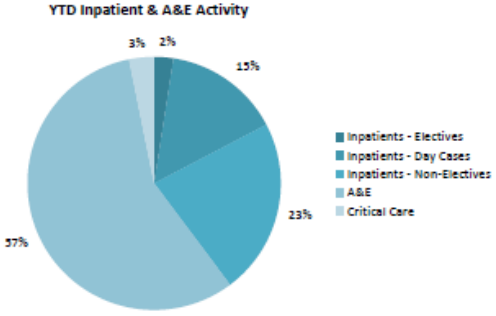
Summary & Next Steps

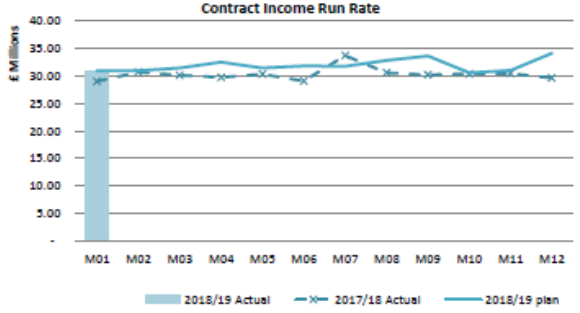
The Trust's YTD performance at M1 is £4k ahead of plan with a CIP over performance of £2k. Income underperformed in month by £0.5m, £0.2m is due to COIN income underdelivery which was offset by underspends in non-pay. Elective activity is £0.4m below plan in month. The YTD effect of the Aligned Incentive Contract with the ESBT CCGs has been recognised in the position, the Trust has also recognised £1.2m of PSF, FRF and MRET. The overspend in drugs is attributable to Tariff Excluded Drugs and is fully offset within income. Medical pay contonues to overspend (£0.1m), largely due to temporary workforce and WLI payments.

Income & Activity Summary - Month 1

	In Month								Year to Date								Forecast Outturn		
	18/19 Activity Actual	19/20 Activity Plan	19/20 Activity Actual	Activity Variance	18/19 Actual (£k)	19/20 Plan (£k)	19/20 Actual (£k)	Variance (£k)	18/19 Activity Actual	19/20 Activity Plan	19/20 Activity Actual	Activity Variance	18/19 Actual (£k)	19/20 Plan (£k)	19/20 Actual (£k)	Variance (£k)	19/20 Plan (£k)	19/20 FOT (£k)	Variance (£k)
Contract Income																			
Inpatients - Electives	497	543	487	(56)	1,490	1,825	1,517	(308)	497	543	487	(56)	1,490	1,825	1,517	(308)	22,979	22,979	0
Inpatients - Day Cases	3,202	3,133	2,962	(171)	2,261	2,342	2,267	(75)	3,202	3,133	2,962	(171)	2,261	2,342	2,267	(75)	29,491	29,491	0
Inpatients - Non-Electives	4,080	4,610	4,473	(137)	8,665	10,302	9,782	(520)	4,080	4,610	4,473	(137)	8,665	10,302	9,782	(520)	121,483	121,483	0
Outpatients	32,323	33,245	32,604	(641)	3,760	4,100	3,836	(265)	32,323	33,245	32,604	(641)	3,760	4,100	3,836	(265)	51,643	51,643	0
A&E	10,190	11,055	11,361	306	1,407	1,695	1,721	26	10,190	11,055	11,361	306	1,407	1,695	1,721	26	21,111	21,111	0
CQUIN	0	0	0	0	0	308	302	(5)	0	0	0	0	0	308	302	(5)	3,695	3,695	0
Critical Care	735	693	634	(59)	825	846	701	(145)	735	693	634	(59)	825	846	701	(145)	9,973	9,973	0
Direct Access	8,237	7,831	9,931	2,100	324	335	356	20	8,237	7,831	9,931	2,100	324	335	356	20	4,285	4,285	0
ESBT	0	0	0	0	588	694	611	(83)	0	0	0	0	588	694	611	(83)	8,379	8,379	0
Excess Bed Days	1,062	828	686	(142)	251	273	181	(92)	1,062	828	686	(142)	251	273	181	(92)	3,250	3,250	0
Exclusions	0	0	0	0	2,874	2,718	3,043	325	0	0	0	0	2,874	2,718	3,043	325	38,294	38,294	0
IMSK	0	0	0	0	118	123	123	0	0	0	0	0	118	123	123	0	1,472	1,472	0
Maternity Pathway	573	529	456	(73)	626	565	552	(13)	573	529	456	(73)	626	565	552	(13)	7,268	7,268	0
Unallocated QIPP	0	0	0	0	0	(919)	0	919	0	0	0	0	0	(919)	0	919	(11,029)	(11,029)	0
AIC	0	0	0	0	0	0	355	355	0	0	0	0	0	0	355	355	0	0	0
Other	308,415	285,307	306,769	21,462	5,723	5,793	5,625	(167)	308,415	285,307	306,769	21,462	5,723	5,793	5,625	(167)	71,288	71,288	0
Contract Income Total	369,314	347,776	370,363	22,587	28,912	30,999	30,971	(27)	369,314	347,776	370,363	22,587	28,912	30,999	30,971	(27)	383,582	383,582	0
Divisional Income					3,369	4,287	3,820	(467)					3,369	4,287	3,820	(467)	58,198	58,198	0
Total Income	**369,314**	**347,776**	**370,363**	**22,587**	**32,281**	**35,286**	**34,791**	**(495)**	**369,314**	**347,776**	**370,363**	**22,587**	**32,281**	**35,286**	**34,791**	**(495)**	**441,780**	**441,780**	**0**







Summary & Next steps

Inpatients - Electives & Day Cases (YTD) **£0.38m behind plan** **-9.2%**

Trauma & Orthopaedics have under performed by (£0.27m) YTD

Urology (£0.13m) has under performed against plan.

Despite having more working days compared to April 2018, elective activity is lower than at the same month last year.

Inpatients - Non-Electives (YTD) **£0.52m behind plan** **-5.0%**

Early indications that there is continued growth in non-elective activity. The Trust discharged 4,473 patients in month, compared to 4,083 in the previous April. The April plan was set slightly ahead of this, on the assumption that more patients would be discharged over the Easter period. This under performance is expected to reverse in month 2.

Under performance in month in General Medicine (£0.42m), Gastroenterology (£0.225m) and Trauma & Orthopaedics (£0.23m) are offset by over performance in Stroke Medicine (£0.31m).

Outpatients (YTD) **£0.3m behind plan** **-6.5%**

Ophthalmology (£0.128m) and Cardiology (£0.06m) have underperformed YTD against plan.

A&E (YTD) **£0m on plan** **1.5%**

As witth NEL, A&E activity is experiencing continued growth; attendances in April where 8% higher than April 2018

QIPP adjustment (YTD) **£0.9m above plan**

The AIC contract includes £11m of QIPP, which has not yet been split by POD. This is currently shown as a one-line adjustment in the Trust income plan, giving a £0.92m over performance in month

AIC Adjustment (YTD) **£0.4m above plan**

AIC adjustment in month (£0.35m). This is driven by a down turn in Elective and Non-Elective activity with a particular focus on EHS.

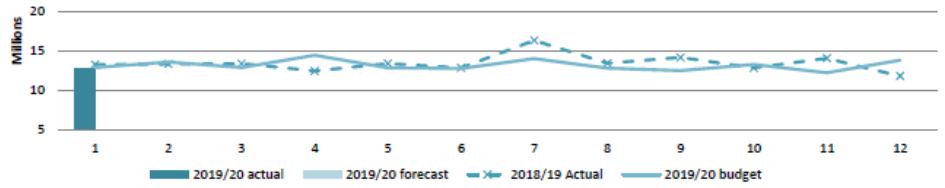
Other (YTD) **£0.2m above plan** **-2.9%**

Under performance in month in Audiology tests (£0.047m), Cardiology tests (£0.01m) and Clinical Oncology and Haematology test (£0.02m)

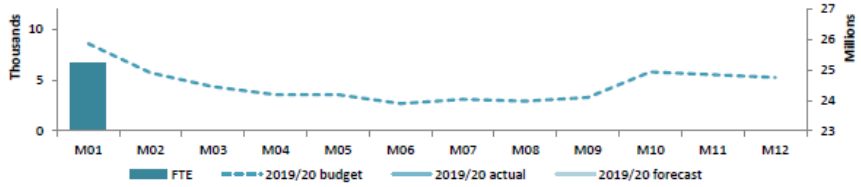
Operating Expenditure & Workforce Summary - Month 1

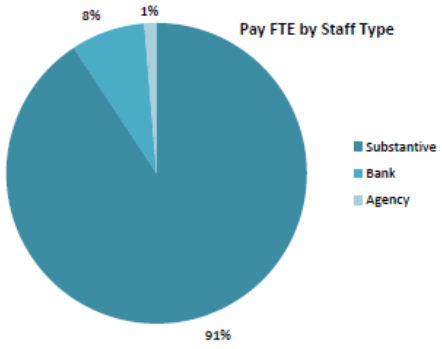
Cost Element	In Month								Year to Date								Forecast Outturn			
	18/19 WTE Actual	19/20 WTE Plan	19/20 WTE Actual		WTE Variance	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	19/20 Expenditure Variance (£k)	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)		19/20 Expenditure Variance (£k)	19/20 Plan (£k)	19/20 FOT (£k)		Variance (£k)
Administrative & Management	1340	1393	1316		77	3,661	4,069	3,901	169	3,661	4,069	3,901		169	46,878	46,878		0
Ancillary	714	698	668		30	1,409	1,594	1,555	39	1,409	1,594	1,555		39	18,475	18,475		0
Medical	672	743	718		25	5,816	6,004	6,148	(144)	5,816	6,004	6,148		(144)	72,069	72,069		0
Nursing & Midwifery	3220	3157	3075		82	9,738	10,550	10,418	132	9,738	10,550	10,418		132	122,074	122,074		0
Prof, Scientific & Tech	522	537	507		30	1,723	1,938	1,770	169	1,723	1,938	1,770		169	22,243	22,243		0
Professions Allied to Medicine	450	527	471		56	1,512	1,875	1,724	151	1,512	1,875	1,724		151	22,138	22,138		0
Other	0	0	0		0	345	(173)	138	(310)	345	(173)	138		(310)	(9,744)	(9,744)		0
Total Pay	**6917**	**7055**	**6755**		**300**	**24,205**	**25,858**	**25,653**	**205**	**24,205**	**25,858**	**25,653**		**205**	**294,133**	**294,133**		**0**
Services from Other NHS Bodies						619	541	428	113	619	541	428		113	6,497	6,497		0
Clinical Negligence Premium						877	806	806	0	877	806	806		0	9,667	9,667		0
Consultancy						275	36	44	(8)	275	36	44		(8)	435	435		0
Drugs						1,130	1,066	794	271	1,130	1,066	794		271	9,957	9,957		0
Drugs - Tariff Excluded						2,322	2,443	2,868	(425)	2,322	2,443	2,868		(425)	34,770	34,770		0
Education and Training						74	166	23	142	74	166	23		142	1,992	1,992		0
Establishment Expenses						944	700	532	168	944	700	532		168	8,409	8,409		0
Premises						1,248	1,298	1,275	23	1,248	1,298	1,275		23	15,587	15,587		0
Purchase of Healthcare from Non NHS Bodies						397	506	490	15	397	506	490		15	6,077	6,077		0
Supplies and Services - Clinical						2,634	2,599	2,238	360	2,634	2,599	2,238		360	32,683	32,683		0
Supplies and Services - General						362	347	310	37	362	347	310		37	4,165	4,165		0
Other Non-Pay						1,655	1,769	2,301	(532)	1,655	1,769	2,301		(532)	20,294	20,294		0
Total Non-Pay						**12,537**	**12,276**	**12,110**	**166**	**12,537**	**12,276**	**12,110**		**166**	**150,533**	**150,533**		**0**
Total Expenditure	**6917**	**7055**	**6755**		**300**	**36,742**	**38,134**	**37,762**	**372**	**36,742**	**38,134**	**37,762**		**372**	**444,666**	**444,666**		**0**

Non-Pay Monthly Run rate



Pay Monthly Run Rate vs FTE





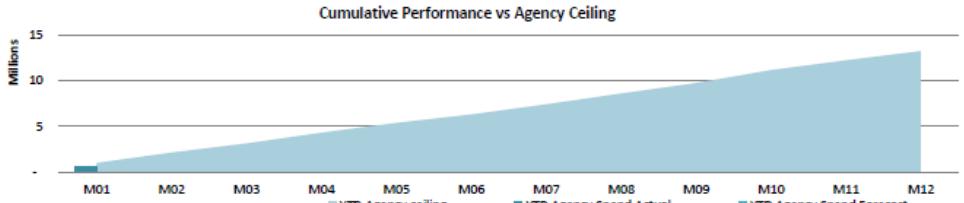
Summary & Next Steps

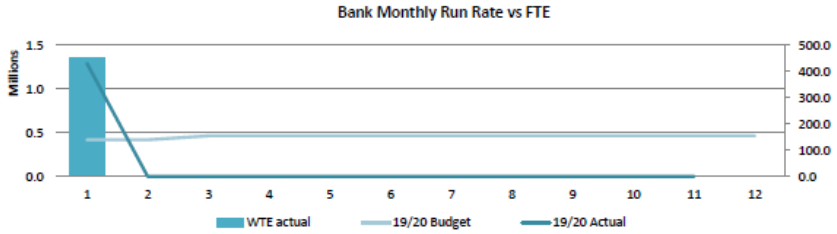
The non consolidated lump sum payment was made to AfC staff at the top of band in Month 1. Medical pay is £0.1m overspent YTD (which includes waiting list premium payments and agency covering vacancies), despite holding 25WTE Vacancies. Variances in Other Pay is attributable to vacancy factors applied various specialties with historically high levels of clinical vacancies, spend is due to apprenticeship levy payments.

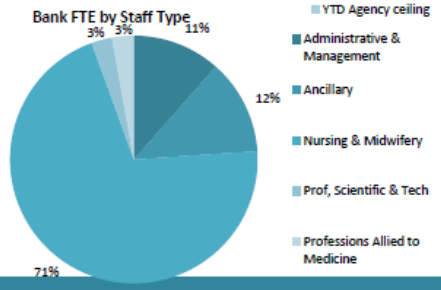
Tariff Excluded Drugs spend is showing £425k overspent, which is offset wihtin Income. Supplies & services - Clinical underspends are in line with lower than anticipated Theatre activity in month, and partially offset underperformance in inpatient spells.

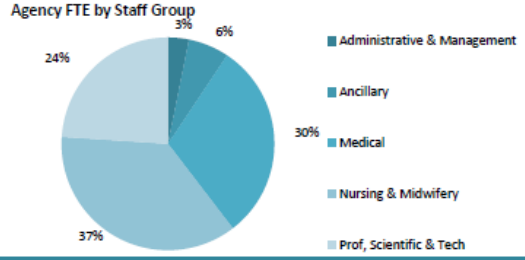
Temporary Workforce Summary - Month 1

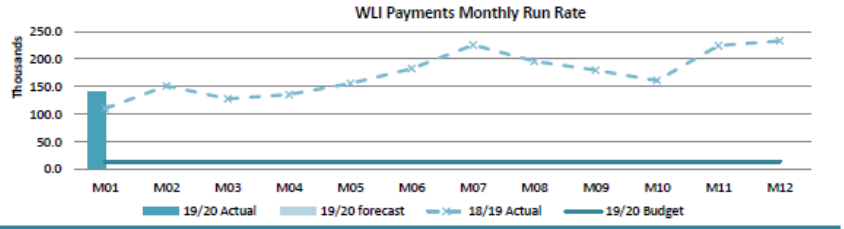
Cost Element	In Month								Year to Date				Forecast Outturn			
	18/19 WTE Actual	19/20 WTE Plan	19/20 WTE Actual	WTE Variance	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	Expenditure Variance (£k)	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	Expenditure Variance (£k)	19/20 Plan (£k)	19/20 FOT (£k)	Variance (£k)	
Agency																
Administrative & Management	11	2	3	-1	172	56	51	5	172	56	51	5	601	601	0	
Ancillary	32	0	5	-5	47	56	13	43	47	56	13	43	601	601	0	
Medical	19	12	27	-15	425	320	337	(17)	425	320	337	(17)	3,336	3,336	0	
Nursing & Midwifery	33	0	32	-32	219	207	143	64	219	207	143	64	1,761	1,761	0	
Prof, Scientific & Tech	26	0	21	-21	190	222	67	155	190	222	67	155	2,444	2,444	0	
Total Agency	**120**	**14**	**88**	**-75**	**1,053**	**861**	**611**	**250**	**1,053**	**861**	**611**	**250**	**8,743**	**8,743**	**0**	
Bank																
Administrative & Management	69	5	52	-47	134	139	120	19	134	139	120	19	1,414	1,414	0	
Ancillary	83	22	56	-34	141	139	128	11	141	139	128	11	1,414	1,414	0	
Nursing & Midwifery	451	101	319	-218	1,101	985	955	30	1,101	985	955	30	8,302	8,302	0	
Prof, Scientific & Tech	14	0	12	-12	38	49	39	10	38	49	39	10	534	534	0	
Professions Allied to Medicine	12	0	13	-13	38	35	45	(10)	38	35	45	(10)	211	211	0	
Total Bank	**628**	**128**	**453**	**-325**	**1,451**	**1,347**	**1,288**	**59**	**1,451**	**1,347**	**1,288**	**59**	**11,874**	**11,874**	**0**	
Total Locum	**70**	**21**	**87**	**-66**	**911**	**832**	**982**	**(150)**	**911**	**1,080**	**982**	**98**	**10,895**	**10,895**	**0**	
Total Waiting List Initiative	**10**	**0**	**17**	**-17**	**110**	**14**	**140**	**(126)**	**110**	**14**	**140**	**(126)**	**165**	**165**	**0**	
Total Temporary Workforce	**828**	**162**	**645**	**-483**	**3,525**	**3,054**	**3,021**	**33**	**3,525**	**3,302**	**3,021**	**281**	**31,677**	**31,677**	**0**	











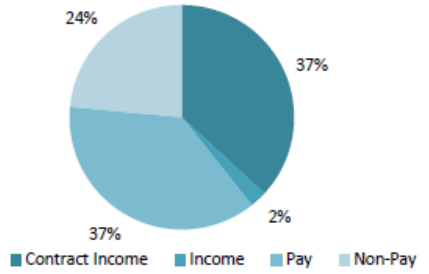
Summary & Next steps

Overall agency is £250k below plan. Medical specialties which are heavily reliant on agency are neurology, rheumatology, pathology, general surgery, radiology and A&E. Agency spend in M1 has reduced by 42% 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 70% compared to M1 in 18/19. Total temporary staffing costs have fallen by 14% compared to the previous year (£0.5m lower). The T3 pay process is being enhanced to strengthen the controls framework on premium pay.

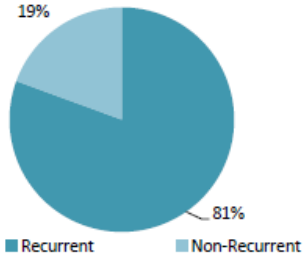
Cost Improvement Programme Summary - Month 1

Category	In Month			Year to Date			Forecast Outturn			YTD Rec (£k)	YTD Non-Rec (£k)
	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)		
Contract Income	532	528	-4	532	528	-4	5,408	5,346	-62	528	0
Income	89	35	-54	89	35	-54	546	317	-229	34	0
Pay	354	533	180	354	533	180	1,896	1,948	52	314	219
Non-Pay	283	337	53	283	337	53	2,868	2,561	-307	278	59
Total 'Green' schemes	**1,257**	**1,432**	**175**	**1,257**	**1,432**	**175**	**10,718**	**10,172**	**-546**	**1,154**	**278**
Pipeline/Unidentified	173	0	-173	173	0	-173	9,885	10,431	546	81%	19%
Total	**1,430**	**1,432**	**2**	**1,430**	**1,432**	**2**	**20,603**	**20,603**	**0**		

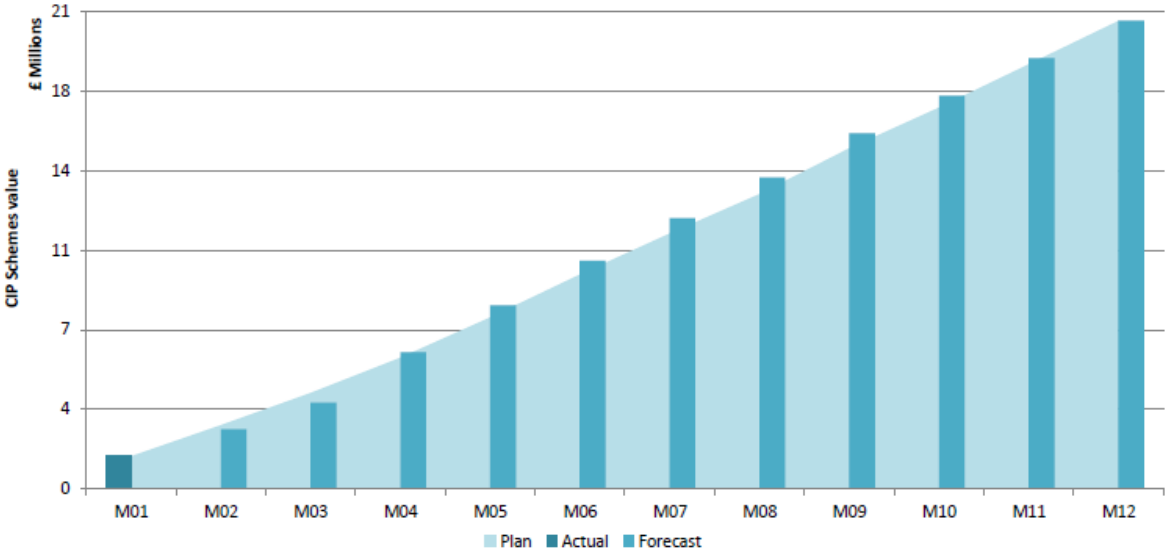
YTD CIP green schemes by category



YTD CIP green schemes recurrent/non-recurrent



CIP Performance



Summary & Next Steps

In Month and YTD: The Trust has delivered £1.432m against a total Plan of £1.430m, showing a £2k overperformance in the month. Against the 'Green' scheme Plan of £1.257m, the Trust has overperformed by £175k in month. The main schemes contributing to this overperformance are Ambulatory Care Recruitment Slippage (£135k), Emergency Care Reduction in Nurse Spend from Vacancies (£32k) and Urology Development (£30k). These are mainly offset by adverse variances in Bed Modelling (£48k) and Radiology Outsourcing (£35k).

By Category: Overperformance in month is shown in Pay (£180k), which is mainly made up of Ambulatory Care (£135k) and Emergency Care Reduction in Nurse Spend from Vacancies (£32k), and Non Pay (£53k), which is mainly made up of Urology Development (£30k). Underperformance is seen in Other Income (£54k) and Contract Income (£4k). For full year forecast, Pay shows a favourable variance (£52k), with adverse variances in Non Pay (£307k), mainly due to Radiology Outsourcing (£313k), Other Income (£229k) and Contract Income (£62k).

Forecast: Against the £10.7m 'Green' scheme Plan the Trust is forecasting £10.2m, an adverse outturn of £0.5m. This is mainly made up of adverse variances in Radiology Outsourcing (£313k) and Bed Modelling (£180k), with the main favourable variance in Ambulatory Care Recruitment Slippage (£135k).

Finance Report Divisional Summaries - Month 1

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				9,304	8,347	(956)	9,304	8,347	(956)	115,204	115,204	0				YTD contract income underperformance is the key driver of YTD underperformance, largely in T&O and Urology. Pay has underspent in month, due to part implementation of Urology Investigation Suite. Theatres non-pay costs are significantly underspent in the month due to activity below plan in Theatres.
Divisional Income				425	335	(90)	425	335	(90)	5,095	5,095	0				
Pay	1,817.75	1,722.83	94.92	(7,581)	(7,488)	93	(7,581)	(7,488)	93	(84,787)	(84,787)	0				
Non-Pay				(2,469)	(2,301)	168	(2,469)	(2,301)	168	(29,651)	(29,651)	0				
Overall	**1,817.75**	**1,722.83**	**94.92**	**(322)**	**(1,107)**	**(785)**	**(322)**	**(1,107)**	**(785)**	**5,862**	**5,862**	**0**				
Medicine																
Contract Income				9,515	8,770	(745)	9,515	8,770	(745)	114,879	114,879	0				Key drivers of divisional underperformance are contract income (£0.8m), particularly in elective and day case. Medical pay is overspent (£110k) in Respiratory, Gastro, elderly Care & Cardiology. Non Pay underspend of £37k forms part of professional fees CIP currently in development.
Divisional Income				134	80	(54)	134	80	(54)	1,612	1,612	0				
Pay	1,481.06	1,438.42	42.64	(5,470)	(5,598)	(127)	(5,470)	(5,598)	(127)	(57,268)	(57,268)	0				
Non-Pay				(729)	(692)	37	(729)	(692)	37	(8,080)	(8,080)	0				
Overall	**1,481.06**	**1,438.42**	**42.64**	**3,450**	**2,560**	**(890)**	**3,450**	**2,560**	**(890)**	**51,143**	**51,143**	**0**				
Urgent Care																
Contract Income				2,503	2,506	3	2,503	2,506	3	30,662	30,662	0				A&E activity is on plan in month. Pay is underspent by £173k, of which £97k of the underspend is in Medical pay and £84k is in Nursing.
Divisional Income				33	32	(1)	33	32	(1)	394	394	0				
Pay	344.29	327.73	16.56	(1,699)	(1,526)	173	(1,699)	(1,526)	173	(19,067)	(19,067)	0				
Non-Pay				(86)	(66)	21	(86)	(66)	21	(1,012)	(1,012)	0				
Overall	**344.29**	**327.73**	**16.56**	**751**	**946**	**196**	**751**	**946**	**196**	**10,977**	**10,977**	**0**				
Out of Hospital Care																
Contract Income				3,348	3,534	187	3,348	3,534	187	42,396	42,396	0				ContractIncome is significantly above plan in the month, this is due to phasing of the block contract in the month and will be rectified in Month 2. Pay underspends are in Therapies, ESBT and MSK where investment has been received but posts have not yet been recruited to.
Divisional Income				311	317	6	311	317	6	3,730	3,730	0				
Pay	1,053.66	998.99	54.67	(3,410)	(3,297)	113	(3,410)	(3,297)	113	(38,739)	(38,739)	0				
Non-Pay				(1,092)	(1,117)	(24)	(1,092)	(1,117)	(24)	(13,031)	(13,031)	0				
Overall	**1,053.66**	**998.99**	**54.67**	**(844)**	**(562)**	**282**	**(844)**	**(562)**	**282**	**(5,645)**	**(5,645)**	**0**				
Women's, Children's & Sexual Health																
Contract Income				3,785	3,961	176	3,785	3,961	176	47,023	47,023	0				Contract income under delivery of Health Visiting contract YTD is offset by, activity in Paediatrics (non-elective) and Gynaecology (day case/elective). Continued vacancies in Health Visiting and reduction in agency usage in Paediatircs and Gynaecology in month are leading to the pay underspend.
Divisional Income				49	87	38	49	87	38	587	587	0				
Pay	704.56	679.74	24.82	(2,847)	(2,843)	4	(2,847)	(2,843)	4	(32,425)	(32,425)	0				
Non-Pay				(296)	(240)	56	(296)	(240)	56	(3,050)	(3,050)	0				
Overall	**704.56**	**679.74**	**24.82**	**691**	**965**	**274**	**691**	**965**	**274**	**12,135**	**12,135**	**0**				
Estates & Facilities																
Divisional Income				676	677	2	676	677	2	8,225	8,225	0				Vacancies in Hotel Services, Ops & Maintenance and Laundry have led to the pay uderspend in month, slightly overperformacne in month was due to activity based income stream, e.g. car parking. Non Pay overspends are alrgely due to Laundry services.
Pay	637.72	614.13	23.59	(1,577)	(1,525)	53	(1,577)	(1,525)	53	(17,750)	(17,750)	0				
Non-Pay				(1,341)	(1,348)	(7)	(1,341)	(1,348)	(7)	(15,452)	(15,452)	0				
Overall	**637.72**	**614.13**	**23.59**	**(2,243)**	**(2,195)**	**48**	**(2,243)**	**(2,195)**	**48**	**(24,977)**	**(24,977)**	**0**				
Corporate																
Divisional Income				1,139	979	(159)	1,139	979	(159)	13,843	13,843	0				COIN Income is below plan, offset but underspends in Non Pay. Pay underspends are driven by vacancies in HR, Finance, Clinical admin and Medical Education. Training and Education spend in non pay is also udnerspent against plan in the month.
Pay	1,015.72	973.07	42.65	(3,534)	(3,363)	172	(3,534)	(3,363)	172	(39,871)	(39,871)	0				
Non-Pay				(2,267)	(1,852)	415	(2,267)	(1,852)	415	(26,649)	(26,649)	0				
Overall	**1,015.72**	**973.07**	**42.65**	**(4,662)**	**(4,235)**	**427**	**(4,662)**	**(4,235)**	**427**	**(52,677)**	**(52,677)**	**0**				
Central																
Contract Income				2,545	3,853	1,308	2,545	3,853	1,308	33,419	33,419	0				Tariff Exclusions income is above plan YTD to contra £0.4m overspend on non-pay costs. 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				1,521	1,312	(209)	1,521	1,312	(209)	24,712	24,712	0				
Pay	0.00	0.00	0.00	262	(13)	(274)	262	(13)	(274)	(4,226)	(4,226)	0				
Non-Pay				(4,598)	(5,053)	(455)	(4,598)	(5,053)	(455)	(60,847)	(60,847)	0				
Overall	**0.00**	**0.00**	**0.00**	**(270)**	**100**	**370**	**(270)**	**100**	**370**	**(6,943)**	**(6,943)**	**0**				
Donated assets adjustment				**0**	**83**	**83**	**0**	**83**	**83**							
Total	**7,054.76**	**6,754.91**	**299.85**	**(3,450)**	**(3,446)**	**4**	**(3,450)**	**(3,446)**	**4**	**(10,125)**	**(10,125)**	**0**				

Statement of Financial Position - Month 1

	Year to date				Forecast Outturn			
	18/19 Actual (£k)	19/20 Plan (£k)	19/20 Actual (£k)	Variance (£k)	19/20 Plan (£k)	19/20 Outturn (£k)		Variance (£k)
Property, Plant and Equipment	223.6	229.4	222.0	229.4	229.4	229.4		0.0
Intangible Assets	1.9	1.9	1.9	1.9	1.9	1.9		0.0
Other Assets	1.8	1.8	1.8	1.8	1.8	1.8		0.0
Non Current Assets	**227.3**	**233.1**	**225.7**	**233.1**	**233.1**	**233.1**		**0.0**
Inventories	6.8	6.7	5.6	6.7	6.7	6.7		0.0
Trade and Other Receivables	19.4	29.6	24.0	29.6	29.6	29.6		0.0
Cash and Cash Equivalents	2.1	2.1	12.9	2.1	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	**28.4**	**38.5**	**42.5**	**38.5**	**38.5**	**38.5**		**0.0**
Trade and Other Payables	(23.0)	(7.3)	(34.7)	(7.3)	(7.3)	(7.3)		0.0
Borrowings	(59.2)	(1.1)	(59.2)	(1.1)	(1.1)	(1.1)		0.0
Other Financial Liabilities	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Provisions	(0.5)	(0.4)	(0.5)	(0.4)	(0.4)	(0.4)		0.0
Other Liabilities	(1.3)	(2.2)	(1.5)	(2.2)	(2.2)	(2.2)		0.0
Current Liabilities	**(84.0)**	**(11.1)**	**(96.0)**	**(11.1)**	**(11.1)**	**(11.1)**		**0.0**
Borrowings	(143.6)	(242.4)	(147.7)	(242.4)	(242.4)	(242.4)		0.0
Trade and Other Payables	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Provisions	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)		0.0
Public Dividend Capital	159	163	159	163	163	163.2		0
Income & Expenditure Reserve	(231)	(242)	(234)	(242)	(242)	(241.8)		0
Revaluation Reserve	98	94	98	94	94	94.5		0
Total Tax Payers Equity	**25.9**	**15.9**	**22.4**	**15.9**	**15.9**	**22.4**		**0.0**

Summary & Next Steps

1. Minimum cash balance of £2.1m achieved at year end and at month end.
2. High percentage of the Trust's monthly income is received on 15th of each month (SLA income). As a rule this cash is spread equally across the weeks until the next SLA income is received. This process together with faster reporting can potentially lead to higher cash balances at the close of the reporting period.
3. MRET funding received in month.

Cashflow & Borrowing Summary - Month 1

Short Term (13 week) Cashflow Forecast

	Actual (£k)				Forecast (£k)								
Week Ending (Friday)	05-Apr	12-Apr	19-Apr	26-Apr	03-May	10-May	17-May	24-May	31-May	07-Jun	14-Jun	21-Jun	28-Jun
Balance Brought Forward	2,100	2,597	3,371	26,308	12,782	10,015	4,561	24,948	10,623	7,758	4,751	34,014	24,031
Receipts													
WGA Income	363	98	27,373	3,340	436	100	30,522	160	160	160	30,522	160	160
Other Income	713	2,119	1,262	122	709	100	1,221	2,875	335	498	1,249	198	668
External Financing	0	0	4,095	0	0	0	4,603	0	0	0	0	3,321	0
Total Receipts	1,076	2,217	32,730	3,463	1,145	200	36,346	3,035	495	658	31,771	3,679	828
Payments													
Pay	(238)	(228)	(6,073)	(13,958)	(228)	(270)	(11,832)	(14,046)	(270)	(270)	(270)	(10,170)	(13,585)
Non-Pay	(331)	(1,208)	(3,512)	(2,620)	(3,683)	(5,384)	(4,127)	(3,090)	(3,090)	(3,395)	(2,238)	(3,090)	(3,090)
Capital Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend	0	0	0	0	0	0	0	0	0	0	0	0	0
Other payments	(11)	(7)	(208)	(410)	(1)	0	0	(224)	0	0	0	(402)	0
Total Payments	(580)	(1,443)	(9,793)	(16,989)	(3,912)	(5,654)	(15,959)	(17,361)	(3,360)	(3,665)	(2,508)	(13,662)	(16,675)
Net Cash Movement	497	774	22,937	(13,526)	(2,767)	(5,454)	20,387	(14,326)	(2,865)	(3,007)	29,263	(9,983)	(15,847)
Balance Carried Forward	2,597	3,371	26,308	12,782	10,015	4,561	24,948	10,623	7,758	4,751	34,014	24,031	8,184

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

1. The Trusts Capital Resource Limit (CRL) of £17.4m has been met in year. 2. Several major schemes dominated the	Draw Value £k	Date Drawn	Term	Interest Rate	Value £k	Annual Interest £k
Prior Years						
Capital Loan 2 - Endoscopy Developmer	2,000	Dec 09	20	4.00%	1,167	41
Capital Loan 3 - Endoscopy Developmer	2,000	Jun 10	20	3.90%	1,200	42
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	12
Revolving Working Capital	31,300		5	3.50%	31,300	1,099
Interim Loan Agreement	35,218		3	1.50%	35,218	528
2016/17 Loans	23,144	Dec 16 - Mar 17	3	6.00%	22,619	1,361
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	1,768
2018/19 Loans	45,001	Apr 19 - Mar 19	3	3.50%	45,001	1,587
Prior Years Total	204,480				202,062	7,273
Current Year						
Loan April 2019	4,095	Apr 19	3	3.50%	4,095	73
Current Year Total	4,095				4,095	73
Total Loans	208,575				206,157	7,346

Summary & Next steps

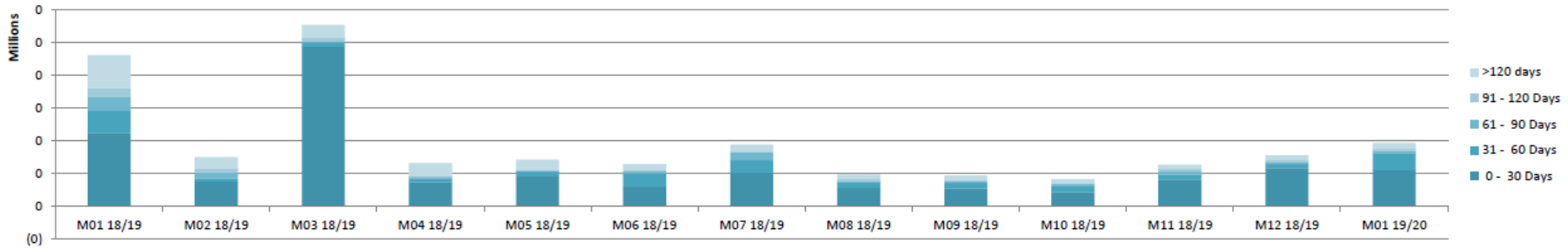
1. Opening balance was £2.1m.

2. All existing loans are listed in the table on the left.

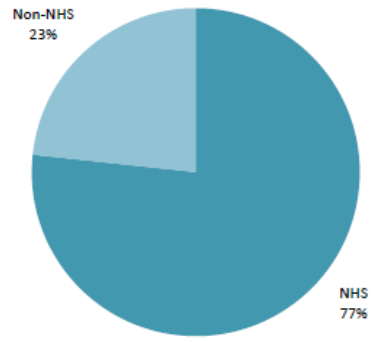
Receivables Summary - Month 1

Receivables Aging Run rate (£k)

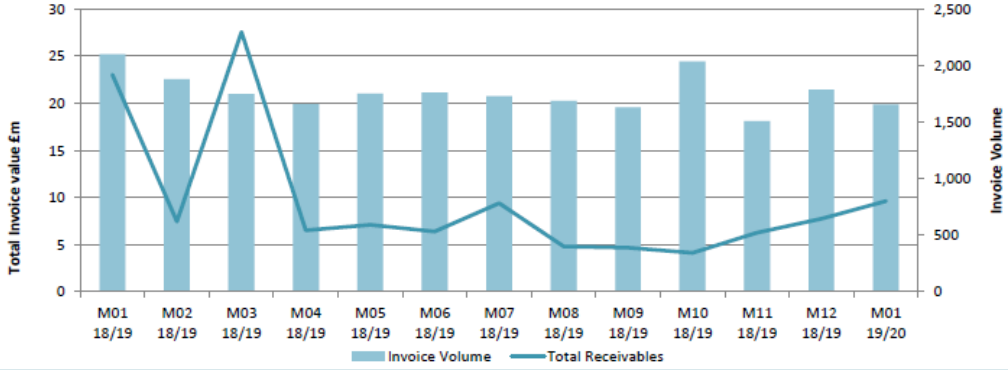
Aging Profile	M01 18/19	M02 18/19	M03 18/19	M04 18/19	M05 18/19	M06 18/19	M07 18/19	M08 18/19	M09 18/19	M10 18/19	M11 18/19	M12 18/19	M01 19/20
0 - 30 Days	11,164	3,753	24,337	3,630	4,559	2,924	5,070	2,765	2,639	2,093	4,038	5,807	5,525
31 - 60 Days	3,335	448	696	566	685	2,033	1,918	894	910	896	786	600	2,602
61 - 90 Days	2,189	968	(44)	273	161	369	1,248	147	238	406	464	307	305
91 - 120 Days	1,316	518	618	(71)	100	95	131	321	101	101	352	251	270
>120 days	5,048	1,775	1,963	2,111	1,586	988	1,021	698	783	620	632	774	938
Total Receivables	**23,053**	**7,461**	**27,572**	**6,508**	**7,091**	**6,408**	**9,389**	**4,825**	**4,670**	**4,116**	**6,272**	**7,739**	**9,639**
Invoice Volume	**2,100**	**1,880**	**1,749**	**1,660**	**1,752**	**1,761**	**1,732**	**1,688**	**1,632**	**2,037**	**1,508**	**1,788**	**1,655**



Current Month % NHS vs Non-NHS by Value



Receivables Invoice Value vs Volume Run Rate

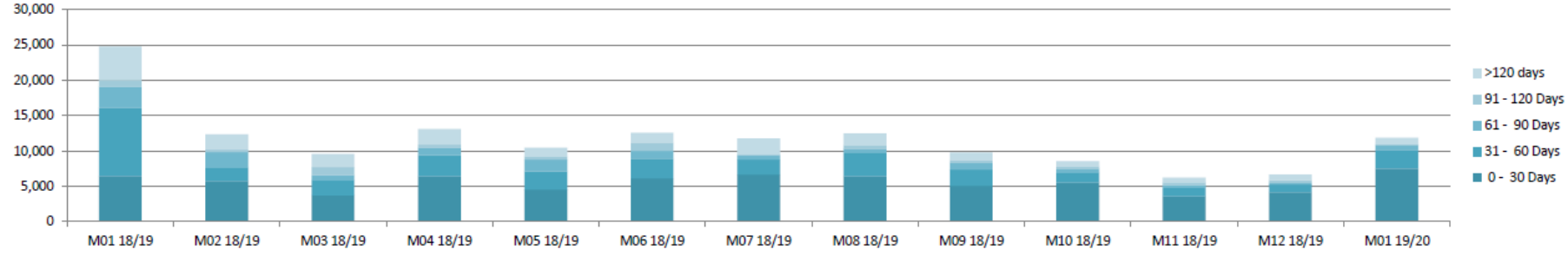


1. Slippage in aged debt levels in April expected due to the focus on producing the annual accounts.
2. Aged debt adverse movement of £2.2m in month from £1.9m in March to £4.1m in April.
3. Consequently Increase in over 90 day debt of £184k in month.
4. Debtor days 23 days in April (19 days in March)
5. 1,655 invoices on the sales ledger system at the end of the month (a decrease of 133 in month).

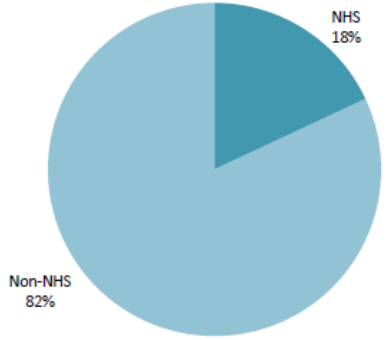
Payables Summary - Month 1

Payables Aging Run rate (£k)

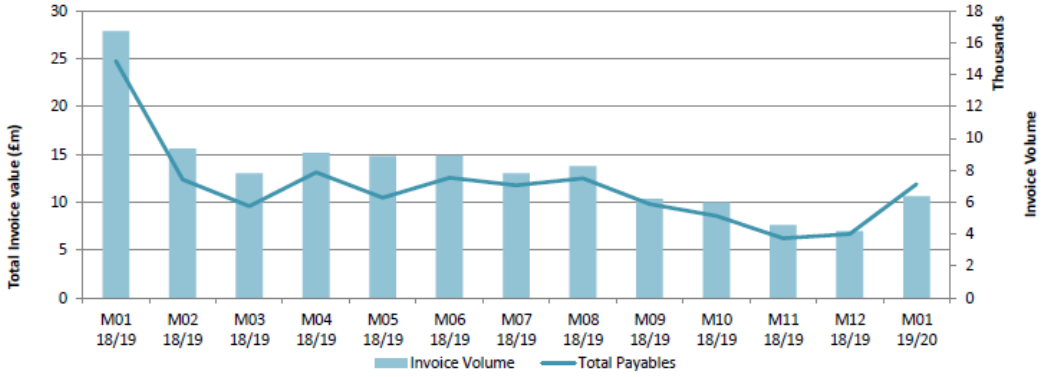
Aging Profile	M01 18/19	M02 18/19	M03 18/19	M04 18/19	M05 18/19	M06 18/19	M07 18/19	M08 18/19	M09 18/19	M10 18/19	M11 18/19	M12 18/19	M01 19/20
0 - 30 Days	6,423	5,752	3,711	6,387	4,552	6,153	6,708	6,410	5,109	5,530	3,611	4,151	7,517
31 - 60 Days	9,679	1,843	2,117	3,002	2,547	2,774	2,102	3,301	2,245	1,338	1,135	1,093	2,612
61 - 90 Days	2,969	2,267	766	1,039	1,703	1,099	599	600	986	629	442	253	735
91 - 120 Days	932	367	1,148	452	366	1,078	124	459	301	258	386	378	108
>120 days	4,762	2,135	1,854	2,249	1,315	1,464	2,233	1,725	1,169	806	675	801	909
Total Payables	**24,765**	**12,363**	**9,596**	**13,129**	**10,484**	**12,568**	**11,765**	**12,494**	**9,810**	**8,561**	**6,249**	**6,675**	**11,881**
Invoice Volume	**16,715**	**9,382**	**7,829**	**9,092**	**8,889**	**8,947**	**7,830**	**8,266**	**6,209**	**5,975**	**4,580**	**4,204**	**6,373**



Current Month % NHS vs Non-NHS by Value



Payables Invoice Value vs Volume Run Rate



1. Creditors at the highest level since M08 of 2018/19.
2. Creditor days at 88 days in month (59 days in March)
3. Internal KPIs to target elimination of registered > 120 days and creditor days < 60.
4. 6,373 invoices on the purchase ledger system at the close of the month (increase of 2,169 on March)

Capital Programme Summary - Month 1

YTD Capital Programme Performance	ORIGINAL PLAN £000	REVISED PLAN £000	CRG COMMITTED £000	ACTUAL EXPENDITURE £000	FORECAST EXPENDITURE £000
Brought Forward	6,715	6,370	0	839	6,370
Backlog Maintenance	1,050	995	0	0	995
Central/Divisions	290	290	0	0	290
Digital	1,701	1,813	0	6	1,813
Estates	202	202	0	0	202
Medical Equipment	1,351	766	0	0	766
Finance	1,500	1,500	0	125	1,500
Unplanned urgents	339	339	0	0	339
Brought Forward - other	0	323	0	95	323
Total Owned	13,148	12,598	0	1,065	12,598
Donated	1,000	1,000	0	52	1,000
Less donated Income	(1,000)	(1,000)	0	(52)	(1,000)
Less disposals				0	0
Total	13,148	12,598	0	1,065	12,598

Capital Resource Limit	Source	£k
Opening Capital Resource Limit (CRL)		12,598
Forecast Capital Outturn		12,598
Closing Capital Resource Limit (CRL)		12,598
Variance		0

Summary & Next steps

1. The Trust's indicative Capital Resource Limit (CRL) for 2019/20 was £13.1m but following finalisation of the 2018/19 outturn and subsequent review of the 2019/20 depreciation charge, the CRL has been revised to £12.5m and the capital programme has been re-prioritised to meet the revised CRL.
2. The Capital Resource Group (CRG) will meet on a monthly basis to monitor levels of capital expenditure and review progress against the CRL.


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

East Sussex Healthcare NHS Trust

Mortality Report – Learning from Deaths (01.04.17 to 31.12.18)

Meeting information:			
Date of Meeting:	4th June 2019	Agenda Item:	
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 – December 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.

Required national changes for the reviewing of deaths are still to be put in place by all Trusts and Medical Examiner posts will be recruited to at both ESHT sites. The new review process is now likely to commence by April 2020.

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 extremely 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 2017-18 to December 2018-19

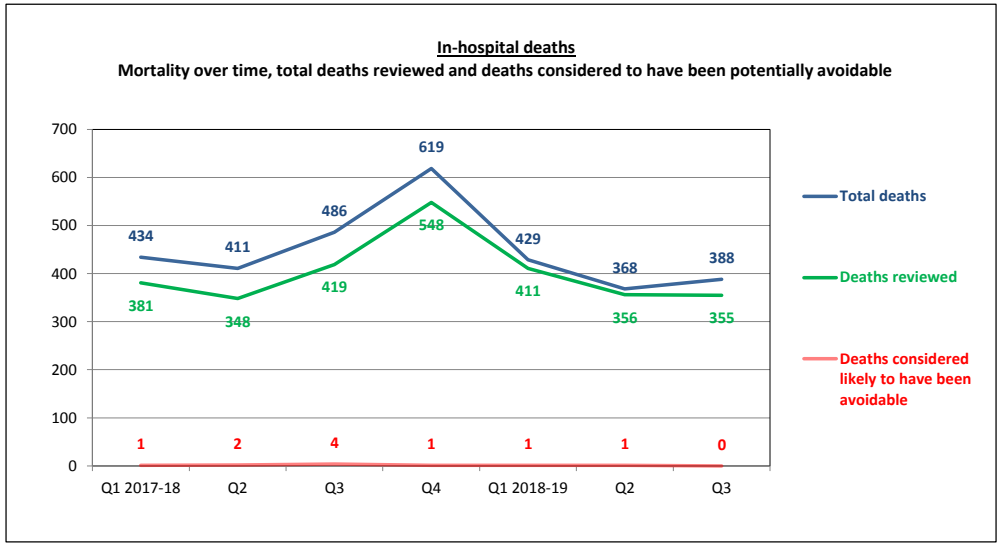
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 17/05/2019)

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	Q3

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
129	130	111	119	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
388	368	355	356	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1185	1950	1122	1696	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)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	2	22.2%	This Year (YTD)	0	0.0%	This Year (YTD)	1	11.1%	This Year (YTD)	3	33.3%	This Year (YTD)	3	33.3%

Data above is as at 17/05/2019 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 3 2018/19 deaths, none of which were subsequently raised as a complaint.
Complaints - Of the complaints received relating to 'bereavement' which were partially or fully upheld during Quarter 3 2018/19, none have overall care ratings of 'poor care' on the mortality database.
Serious incidents - There was no severity 5 incidents reported in Quarter 3 2018/19 relating to in-hospital deaths.
As at 17/05/2019 there are 317 April 2017 - December 2018 deaths still outstanding for review on the Mortality database.

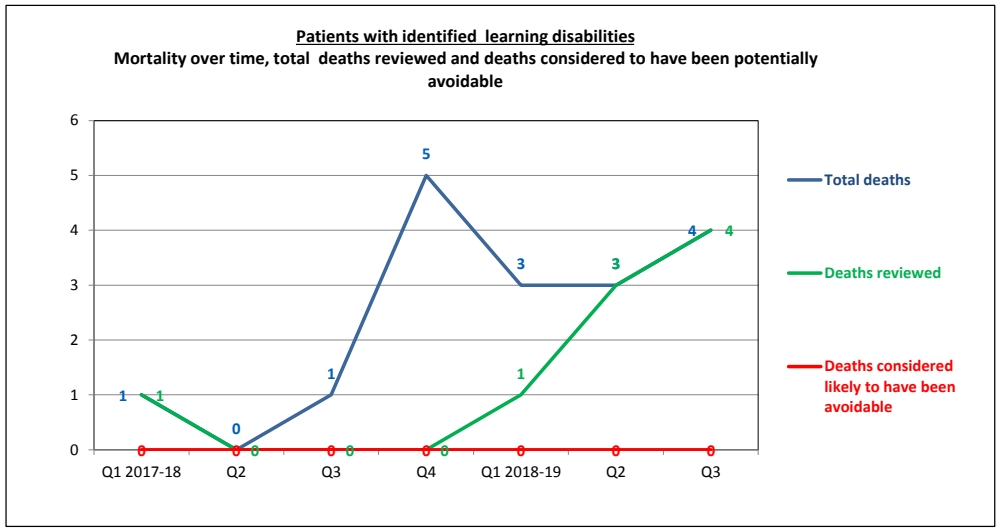
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 17/05/2019)

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	Q3

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	3	4	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
10	7	8	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 entered 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.

East Sussex Healthcare NHS Trust

East Sussex Health and Social Care Alliance Work Programmes update

Meeting information:			
Date of Meeting:	4th June 2019	Agenda Item:	12
Meeting:	Trust Board	Reporting Officer:	Catherine Ashton

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

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

Summary:

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

Update on the key work programmes being progressed by the East Sussex Health and Social Care Alliance

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

East Sussex Health and Care Executive. April 2019

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

For information and assurance on progress of integrated work

Introduction

As previously reported, there are three integrated work programmes which are being led by SROs from the East Sussex Health and Care Alliance. This report provides a summary of the current programmes and projects and an update on progress.

Community Oversight Board.
SRO **Mark Stainton (ESCC)**
Programmes and Projects
▸ Home First Project ▸ Locality working pilot ▸ OT and JCR Joint working ▸ Rapid Response, Integrated Hospital avoidance and discharge ▸ A&E 5 pathways (admission avoidance)
Update for April 2019 ▸ Home Care Pathway 1 (Home First Project) Findings and Recommendations Report being drafted and will be reviewed by Community Oversight Board in May ▸ Community Nursing and Social Care staff co-located into shared office accommodation in St Marys House, Eastbourne; this was the first phase of the Locality working pilot. ▸ Finalised objectives and Lead KPIs and started to monitor with System PMO ▸ Finalised current benefits ▸ Clinical lead Milan Radia invited to future board meetings ▸ System PMO provided focussed support to address issues to rolling out A&E 5 pathways. Support continues and benefits expected to begin to be realised in June at the latest

Planned Care Oversight Board
SRO **Niki Cartwright (CCG)**
Programmes and Projects
▸ Low priority procedures ▸ MSK ▸ Diabetes pathway redesign ▸ GP referral variation / optimising GP referrals ▸ Cardiology (Community, unwarranted clinical variation, Acute model) ▸ Pathology Direct Access ▸ Outpatient productivity and optimisation

Update for April

- Project Analytics – project analytics development continues through the PMO with the aim of creating a detailed clear process for creating high quality analytics
- Agreed way forward of MSK Hip/Knee CEC policy adherence for iMSK mitigating T&O Sustainability risk
- Finalised definition of optimising outpatients objective and Lead KPIs and started to monitor with System PMO
- Commenced Direct Access US - NOUS project
- Realignment of teams to provide dedicated programme and project management support of Planned Care Plan
- Interim Programme Manager, Adrian Lambert
- Head of Planned Care Transformation, Nazma Jabbar
- Oversight Board governance and reporting now in line with other Oversight boards
- Project Workbooks standardised and in development supported by CCG PMO

Integrated A&E delivery and Urgent Care Oversight Board
SRO: **Joe Chadwick Bell (ESHT)**
Programmes and Projects
• High Intensity Users • NHS 111 Integrated care and Directory of Services • Re admissions • Frailty • GP extended access • Urgent Treatment Centre • Streaming and Clinical pathways • Ambulatory Emergency Care • Mental Health at the Front Door • Specialty Hot Clinics • SAFER • Dementia/MH as secondary diagnosis • Discharge to assess (ASC and CHC) • Let's Get You Home Policy • Trusted Assessor • Acute Bed Modelling
Update for April 2019: • Refreshed Programme Structure • Substantive Head of Urgent Care and Programme Lead for Transformation in place; Head of System Resilience due to start 29thApril • Lead KPIs and priority objectives finalised and will start to be reported from May 2019 • Defined programme's current benefits and current investment profile • Initial Business Case for Care Homes Education Training and currently under review • Funding agreed to deliver 7-day ambulatory care across two acute sites (implementation plan in development)

- Initial ideas for “pipeline” projects identified
- **High Intensity User Services:**
  - Addressed issues preventing increase in referrals for the service and now on track to deliver benefits
  - Data from 14 patients (27 recruited now), Dec-Feb (post-intervention) to Sept-Nov (pre-intervention)
  - 29% reduction in A&Es (31 attendances)
  - 36% reduction in NELs (12 admissions)
  - 10% reduction in Outpatient Appointments
- **Urgent Treatment Centres**
  - Draft Outline Business Case presented to Governing Bodies w/c. 22ndApril 2019
  - Timelines for governance and approval finalised
  - Draft clinical model developed
- **Extended Ambulatory Care**
  - Rockwood scored on Nerve Centre on track to be implemented by the end of May

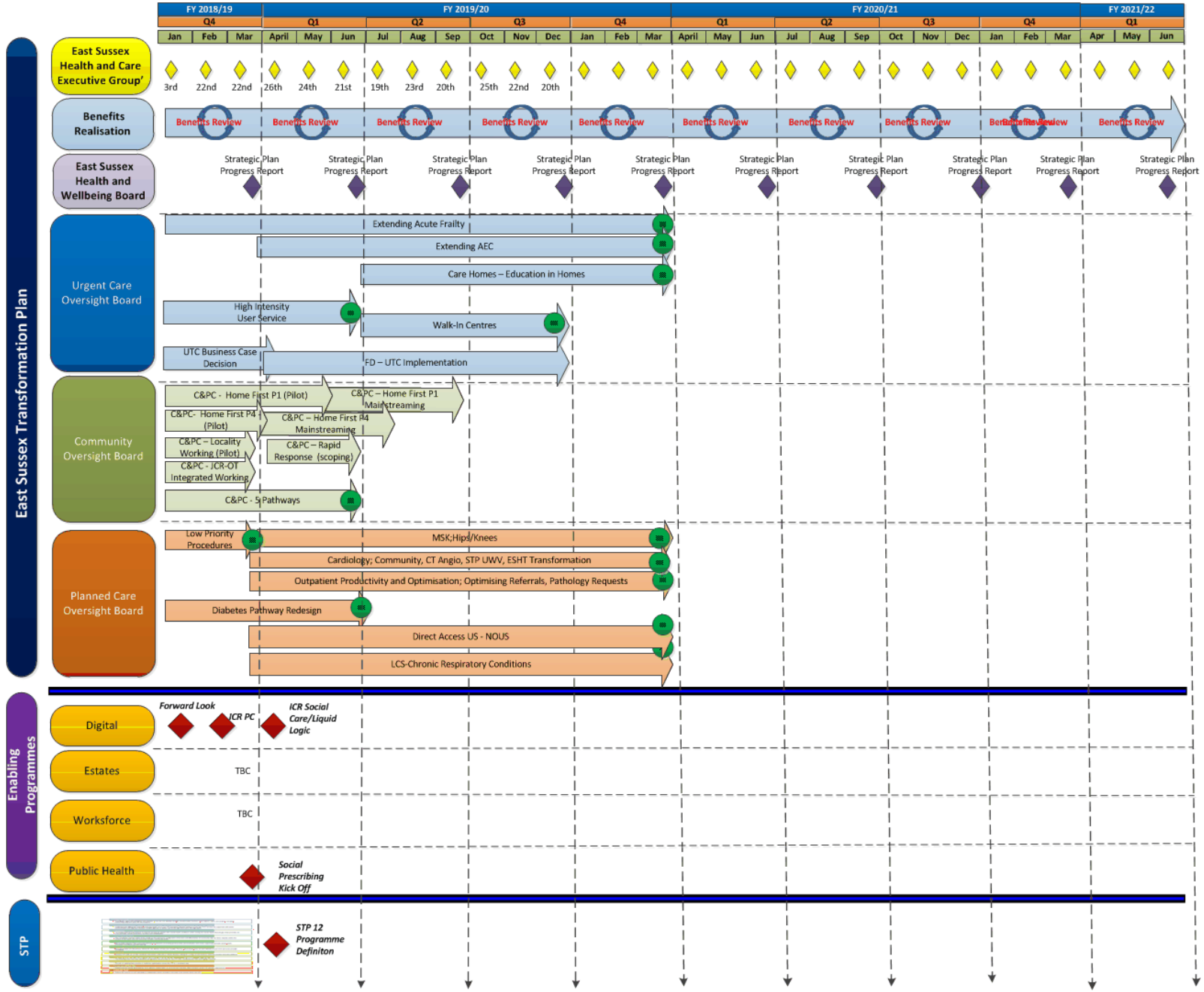
Strategic Drivers

- Carnell and Farrar Community Investment Review – complete
- Review of Ambulatory Care
- PwC Community Baseline
- PwC CCG QiPP and Legal Directive Recommendations – Complete
- Drivers of A&E Demand – Mark Angus - complete
- PwC ESHT Drivers of the Deficit - complete
- 3+2 Aligned Plan – due Dec 2018
- NHS Delivery Unit Drivers of the Deficit – complete
- NHS Deliver Unit Financial Quantification – complete
- ESCC Health and Social Care Profile of Older People – complete
- GIRFT – In Progress
- East Sussex Financial Recovery ESHT CIP/CCG QiPP/ESCC RPPR – in progress
- Five Year Forward View
- Social care Green Paper – due Mar 2019
- Efficiency of Community Services – PA Consulting
- **NHS 10 Year Plan – Jan 2019**

KEY:

Expected cost reduction/ financial saving to the system

Key Milestone not delivered by this plan but may impact plan deliverables timing/ positive/raise issues or risks



Staff Survey Action Plan

Meeting information:	
Date of Meeting: 4th June 2019	Agenda Item: 14 - Staff Survey Action Plan
Meeting: Trust Board	Reporting Officer: Monica Green

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
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 2018 National Staff Survey results were published at the end of February 2019. The results have been shared widely through the People and Organisational Development committee (POD), Divisional structure, Senior Leaders Forum and the Joint Staff Committee. (JSC)

The response rate to the survey at ESHT was 53% which is statistically significant and compares favourably to the national response rate of 41%

A presentation of the results was given at Trust Board by Quality Health, the independent company working with the NHS to carry out the survey in April. The presentation included a summary of the Trusts Staff Survey results for the past three years and demonstrated a significant improvement in areas where there had been focused effort.

The report also included a number of recommendations for further improvement:

- Seek to understand why some staff feel that patient care may not be the trust priority
- To understand why some members of staff may feel that they have been discriminated against
- To continue to prioritise issues of stress at work
- To continue to ensure that immediate managers inform and involve staff in decisions that affect them
- To continue to maintain the quality of appraisals
- Investigate any incidences of harassment and bullying within the organisation
- Take action to review incidences of physical violence experienced by staff from patients or the public
- Ensure that staff are aware of the policy for raising concerns and are provided with assurance around how concerns are dealt with.

The recommendations have been considered in relation to other information/feedback such as Datix incidents, themes from Speak Up Guardian, feedback through the JSC and other staff groups we have in the trust and identified 4 corporate to focus on improvement for 2019.

We have explored those recommendations in relation to other information/feedback such as Datix incidents, themes from Speak-Up Guardian, feedback through the JSC and other staff groups we have in the trust and identified 4 corporate to focus on improvement for 2019.

These are:

- To ensure all staff are involved in decisions that impact them by introducing and implement a robust engagement process/framework when we implement change
- To understand why some of our staff do not feel that they are treated fairly in terms of career progression and to take appropriate action
- To understand particular hotspots linked to violence, bullying and aggression within divisions and develop a range of interventions to improve reporting
- To continue to support staff wellbeing with specific focus on improving physical and mental wellbeing.

Based on these priorities a draft Action plan has been developed which will include corporate and divisional actions and key measures. The draft action plan is enclosed (Appendix 1) and will be a document that continues to be reviewed and refreshed .The plan currently does not include the divisional feedback. The divisions and directorates are currently exploring the priorities and any other relevant feedback more widely with their staff and identifying areas for improvement.

The action plan also includes those recommendations that have not been identified as a corporate priority for 2019 to assure the POD Committee as there is ongoing work in these areas.

Divisional actions linked to the staff survey will be reviewed at IPRs and an update on progress will be presented to POD on a quarterly basis.

2. REVIEW BY OTHER COMMITTEES

N/A

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

To agree the draft action plan and receive regular updates on progress.

APPENDIX 1 - STAFF SURVEY ACTION PLAN 2019

Objective	Activity	Time Scale	Indicators to measure success	Lead	Updates	RAG
Corporate Priorities						
To ensure all staff are involved in decisions that affect them by introducing and implementing a robust engagement process /framework for when changes are made.	To develop an engagement process which can be implemented across the Trust. To test out the process and make appropriate changes. To ensure the process is embedded into business as usual through line management training and communications. Evaluation process of successful implementation of a change to include staff views on their engagement	Jun-19	**Staff Survey Improvement in :** Q4C I am involved in deciding on changes introduced that affect my work area / team / department. 4d.I am able to make improvements happen in my area of work.	Assistant HR Director-OD & Staff Engagement Associate Director of Planning and Business Development	Draft staff engagement process developed. First meeting held with OD, Strategy, and Communications Teams to discuss process, further work ongoing.	
To understand better why some of our staff do not feel that they are treated fairly in relation to career progression and to take the appropriate action	To review the more detailed survey information. To work with HR and all staff networks to gain a clear understanding of specific issues. To develop listening conversations for various staff groups to identify specific actions that will bring out improvement. Develop, implement and monitor an action plan	Sep-19	**Staff Survey Improvement in**: Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	Staff Engagement and Wellbeing Manager Divisional & Service Leads	Reviewed staff survey data in detail and also shared with Divisional teams to identify specific hotspots. Initial planning of listening conversations	
To understand any particular hotspots within each division linked to violence, bullying and aggression and develop a range of interventions to improve staff experiences	To request further detailed information re incidents To share data with all Divisional and service leads to use to help identify areas of concern. Discuss further with the Head of Security /Complaints Manager and HR to identify specific themes/hotspots. Review training provided to support staff to manage situations linked to bullying, harrassment and violence. Review awareness of support available to staff and raise awareness where appropriate	Oct-19	**Staff Survey Improvements in** : Q13C Experienced harassment, bullying or abuse at work from other colleagues in the last 12 months. Q12A In the last 12 months have you Experienced discrimination at work from patients / service users, their relatives or other members of the Public	Assistant HR Director- OD & Staff Engagement	Workforce planning team provided drill down data on Corporate priorities which has been shared across all divisions and services to support action planning	

APPENDIX 1 - STAFF SURVEY ACTION PLAN 2019

Objective	Activity	Time Scale	Indicators to measure success	Lead	Updates	RAG
To continue to support staff wellbeing with specific focus on improving both physical and mental health.	To implement ESHT Health and Wellbeing Strategy and ensure robust action planning is in place To ensure a range of wellbeing programmes are developed to support staff physical and mental wellbeing	Oct-19	**Staff survey Improvements in:** Q11a. Does your organisation take positive action on health and well-being?	Staff Engagement and Wellbeing Manager	Health & Wellbeing Strategy launched Action Plan developed Wellbeing Programme in Progress	
Other Recommendations						
To review decline in reporting violent incidents.	Work with Governance teams and staff groups to identify the reasons for the decline. To raise awareness of the importance of reporting incidents, discuss further with Estates and Facilities further actions required	Oct-19	**Staff survey improvements in**:12 d.The last time you experienced physical violence at work, did you or a colleague report it?	Datix team	Discussed regularly at HSSG. Planning listening conversations	
To maintain and continue to improve the quality of appraisals – in particular focus on ensuring staff feel valued and are given clear objectives.	Identify areas of low compliance and work with managers to ensure appraisals and reviews are completed. Review current appraisal process to include a great emphasis on talent conversations. Explore the option of an electronic appraisal system	Oct-19	**Staff survey Improvements in** : 19a. In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	Assistant Director HR-Education	Regular feedback and support offered to those areas of low compliance. Initial conversation taken place on how to include talent management conversations in appraisal processes. Currently reviewing the use of ESR for electronic appraisal	
To use patient feedback to inform continuous improvement and decision making	Review process with Director of Strategy for seeking patient feedback. Agree how that is used in Business planning process and transformation plans	Oct-19	**Staff survey improvements in** : 21b. My organisation acts on concerns raised by patients/service users	Director of Strategy	Initial conversation re process	
Ensure that staff are aware of the organisations policy and process for raising concerns about unsafe clinical practice and are provided with reassurance about how these would be handled	Continue to raise awareness of the policy for raising concerns. To continue to raise awareness of the role of the Speak Up Guardian. Continue to review at Quality & Standards Committee	Oct-19	**Staff survey Improvements in:** 18b. I would feel secure in raising concerns about unsafe clinical practice	DON Governance team	Speak Up Guardian newsletter. New Ambassador role will be signposting the role of the Speak Up Guardian. Regularly reviewed at Quality & Standards Committee	
To examine reasons behind a high number of staff reporting they do not have adequate materials and supplies to do their job.	To seek feedback from divisions on specific areas that feel they do not have adequate materials to do their job.	Jul-19	**Staff survey Improvements in :** Q4f. I have adequate materials, supplies and equipment to do my work	Deputy Chief Executive	Divisonal leads to look at own services to identify specific needs around equipment.	

The Workforce Disability Equality Standard (WDES)

Meeting information:			
Date of Meeting:	4th June 2019	Agenda Item:	15
Meeting:	Trust Board	Reporting Officer:	Lynette Wells

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

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

Summary:

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

The Workforce Disability Equality Standard (WDES) is a new national standard mandated in the NHS Standard Contract. It reports key relevant responses on the National Staff Survey and reports disability related workforce data. The metrics indicate that staff with a disability report feeling less engaged, less satisfied and more likely to report harassment, bullying or abuse. They are also less likely to be appointed from shortlisting to vacant posts and more likely to enter formal capability procedures. The indicators suggest that the overall experience of membership for disabled staff is less likely to be a positive one compared to non-disabled staff.

Robust data is a key element in identifying gaps in equality and the outcomes to the WDES. Indicators have highlighted where data relating to disability is unreliable or does not currently exist.

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

ESHT Staff Disability Network May 2019
POD May 2019

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

The Board is asked to note the report and the overarching action plan. The Board should be assured that a detailed action plan is currently being developed with the Trust Staff Disability Network. The network will explore ways of improving processes on data collection, analysis and reporting of disabled staff.

The Board is further asked to recommend/provide executive level leadership to the Staff Disability Network to ensure the WDES action plan is supported at Board level.

East Sussex Healthcare NHS
NHS Trust

The Workforce Disability Equality Standard (WDES)

2018/19

Author: Kim Novis
Equality & Human Rights Lead

Contents	Page
Introduction	2
Data Collection and Monitoring	2
Highlights	3
Workforce Disability Equality Standard Metrics 2018/19	5
Findings from the WDES Data	8
Conclusion	8
References	9
Actions for 2019/20	10

The Workforce Disability Equality Standard

1. Introduction

The Workforce Disability Equality Standard (WDES) is a set of ten specific, evidence based measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used to develop an action plan, and enable the Trust to demonstrate progress against the indicators of disability equality.

The WDES has been commissioned by the Equality and Diversity Council (EDC) and developed through a pilot and extensive engagement with Trusts and key stakeholders. It is mandated through the NHS Standard Contract and is restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.

East Sussex Healthcare NHS Trust (ESHT) has welcomed the new standard which has provided the opportunity to review disability workforce data in detail for the first time, enabling us to identify areas of practices where disability equality is lagging.

The metrics will be used as a tool to help identify and close gaps between disabled and non-disabled staff within the organisation. The report will be used to support us in improving recruitment practices and the experience of disabled staff across the organisation.

The WDES will be used along with the refreshed Equality Delivery System (EDS2), to assist the Trust in ensuring our workforce can be confident that the we are giving due regard to using the indicators (below) contained in the WDES to help ensure inequalities are identified and addressed.

The regulators, the Care Quality Commission (CQC) and NHS Improvement (NHSi) will monitor the WDES and EDS2 to help assess whether East Sussex Healthcare NHS Trust is inclusive and well-led.

To demonstrate our commitment to advancing equality of opportunity as an equal opportunities employer, we will use the outcomes of the ten metrics to improve representation and disability equality for staff. This will support us in becoming an inclusive organisation whilst fulfilling its legal duties to comply with the Public Sector Equality Duty.

2. Data Collection and Monitoring

Electronic Staff Records (ESR) is the system used to hold employee information. As of 31st March 2019, 233 (3.3%) members of our staff were recorded as having a disability. 56% of staff were recorded as not having a disability and 40% were recorded as undisclosed. The National NHS Staff Survey 2018 results showed 18.6% of respondents reported having a physical or mental health condition, disability or illness that had or, they expected to last for 12 months or more. NHS Employers report a similar data gap across most NHS Trusts. Previous years ESR data and ESHT National NHS Staff Survey results have produced a similar data gap.

The data produced by the WDES metrics will be used by the Staff Disability Network to identify further area's that require improvement including starting with exploring ways of encouraging staff with a disability to update their employee records held on ESR.

The 2011 Census is still the most up to date information available to identify disability in the local areas. 'East Sussex in Figures' provides actual figures of the total local populations in 2017, along with 'projections' of the number of people living with a disability from 2016 – 2031. This report has used the 2017 figures below to provide an estimate of the local population and the percentage of local people living with a disability. This can provide the

Trust with insight of how representative or under-representative the Trust is at particular levels within the organisation.

The UN also estimate that 15% of the population worldwide live with one or more disabling conditions with more than 46%of older persons (aged 60 years and over) having disabilities. As life expectancy increases, persons with disabilities who survive into old age are likely to contribute to the increases in the population affected by disability. As of the 31st March 2019 the Trust had no employees over the age of 80 years. This may contribute slightly towards ESHT low disability employment rate figures. Therefore considering much of the data is estimated, caution must be taken when forming judgements using the data and should consider the following:

- Number of people living with a disability is a projected figure from the 2011 Census.
- The projection is for the year 2017 and workforce data is as of 31st March 2019.
- The estimated East Sussex data does not take into account working age population.
- There are currently no employees over the age of 80 years.
- The Trust does not employ people under the age of 18 years.

Area	Total population, 2017	Projected number of people with a disability, 2017	Number of people in receipt Disability related benefits (Nov 2017)	Percentage of population with a Disability
East Sussex	552,259	93,127	30,306	16.86%
Eastbourne	103,251	18,218	6,548	17.64%
Hastings	92,813	16,876	7,303	18.18%
Lewes	102,257	16,563	5,164	16.20%
Rother	94,997	17,646	5,197	18.58%
Wealden	158,941	23,825	6,094	14.99%

Using the above projected figures along with the local population figure, the estimated percentage of all people living with a disability in East Sussex as of 2017 is 16.9%. ESHT employee data reports 3.3% (233) of staff employed by the Trust have a disability. 53% (3639) of staff completed the National Staff Survey with 538 (18%) reported living with a physical disability or mental health illness.

There are several suggestions that may contribute to the data gap. These include staff developing disabilities after commencing employment and have not informed Human Resources (HR). We also recognise that some people may choose to keep their disability private but will disclose this on an anonymised survey. Others may feel that they will be unfairly disadvantaged by disclosing their disability and choose to keep it private. Some further reasons may include:

- Staff/Applicant does not feel employer needs to know (personal preference)
- Staff/Applicant does not want employer to know (personal preference)
- Staff/Applicant does not feel able to tell employer (perceived prejudice or stigma)
- Staff/Applicant is not aware of any reason to inform HR (lack of awareness)
- Staff/Applicant may feel disclosure may alter people's perception of them (perceived assumptions)
- Staff/Applicant does not recognise their condition as a disability (lack of awareness or personal preference).

This list is not exhaustive and further exploration is needed to understand and begin closing the data gap; this is considered in the action plan.

3. Highlights of 2018/19

The East Sussex Healthcare NHS Trust (ESHT) Disability Staff Network was developed during 2017/18. It is jointly chaired by the Associate Director of Estates and Facilities and the Equality Lead. The Network is well supported by Human Resource Managers, Leadership Managers, Staff Health & Wellbeing Leads and Staff Engagement Leads. The Network aims to provide a safe place for staff with a range of Disabilities to raise concerns, support one another and identify best practice. The Network also aims to identify training and development opportunities for staff. There are currently over 20 members of staff who regularly participate and/or contribute to the Network.

Through listening to the concerns raised by members of the Staff Disability Network during 2018/19, a common theme was delays to receiving adjustments in the workplace. By reviewing the processes with managers, the Equality Lead and a dedicated Human Resource Manager identified confusion regarding who and/or where reasonable adjustment requests were sent. The Equality Lead and a dedicated Human Resource Manager commenced improving the way reasonable adjustments are requested and actioned. By developing a simple process map to guide managers where to obtain advice and support, including equipment requests, it is anticipated that unnecessary delays can be avoided. Measuring the improvement will be obtained through evaluating feedback from staff requesting reasonable adjustments and the reduction of formal grievances raised.

Highlights from the Health & Wellbeing Team

The Trust implemented the Health & Wellbeing Plan 2018-2020 which aims to work with staff to integrate health & wellbeing into day to day activities to create a positive and healthy working environment.

The Trust host Project Search which provide young adults with learning difficulties /disabilities the opportunity to undertake work experience opportunities across a range of services within the Trust. This is jointly supported by East Sussex College. The interns are mentored and supported during their placements with the objective being to support them to be work ready with the Trust and other local employers. Project Search is now in its 6th year of supporting a total of 52 interns to graduate through the scheme. The Trust has employed 17 young men and women from Project Search as part of the on-going programme. Of the 17 employed interns, 13 remain employed by the Trust with 11 of the interns from the first two cohorts. 12 have been employed locally, 6 are currently volunteering and 6 are no longer in Education Training or Employment. 11 interns from the 2018/19 cohort are graduating this summer.

A representative from Project Search team attends the ESHT Staff Disability Network meetings and is able to contribute to changes and bring issues on behalf of the Project Search interns.

Project Search interns regularly meet various teams across the organisation including senior leaders/directors to discuss their experience of working at ESHT and where improvements and opportunities can be enhanced.

Health & Wellbeing Team Plans going forward to facilitate the voices of Disabled staff

- The Staff Engagement and Wellbeing manager will work with Employee Support Managers and the Equality team to design, plan and host a range of "Listening Conversations" in order to facilitate the voices of disabled staff. (Linked to feedback from the 2018 staff survey by August 2019.)
- To use Local Pulse surveys to test the experience of disabled staff and use feedback to make improvements.

- To use all existing communication channels to promote engagement with disabled staff across the organisation

Workforce Disability Equality Standard Metrics 2018/19

Workforce Disability Equality Standard Metrics 2017/18/19		
Metric 1		
Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff. Percentage of staff on ESR recorded with a disability.		
Percentage of all Staff within Cluster		
Cluster	Clinical	Non-clinical
1: AfC Band 1, 2, 3 and 4	2.72%	3.50%
2: AfC Band 5, 6 and 7	3.47%	5.11%
3: AfC Band 8a and 8b	3.45%	7.53%
4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)	0%	2.38%
5: Medical and Dental staff, Consultants	0.41%	NA
6: Medical and Dental staff, Non-consultant career grade	2.75%	NA
7: Medical and Dental staff, including Doctors in training.	1.79%	NA

Metric 1 – 233 (3.3%) members of staff are recorded as having a disability as of 31st March 2019. Data suggests that disability is significantly under-representative at all levels of the Trust. When reviewing local population data, ESHT National NHS Staff Survey results and data held on ESR it is evident that there are significant gaps in the data. It is important to recognise that whilst ESR data may indicate staff have not disclosed a disability, staff may disclose this locally to their line managers and colleagues which has not been recorded on ESR. Previous years ESR data and staff survey results have produced a similar data gap.

Metric 2			
Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.			
	With a Disability	Without a Disability	Relative likelihood
Shortlisted	811	11,177	**0.75** (1.34)
Appointed	46	847	
% Appointed from shortlisting	5.7%	7.6%	

Metric 2 – The Relative likelihood of Disabled applicants compared to non-disabled a.30pplicants being appointed from shortlisting across all posts suggests that an applicant is 1.34 times more likely to be appointed if they do not have/disclose a disability. The Trust operates a 'guaranteed interview scheme' that offers disabled applicants an interview if they meet the minimum requirement for that post.

Metric 3		
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note: This data is a two-year rolling average of the current year and the previous year.		
Year	Percentage of Staff with a Disability as a Percentage of All Staff Entering the formal Capability Process	Likelihood of Staff with a Disability Compared to staff without a Disability Entering the formal Capability Process
2017 - 2018	0.00%	**7.4**
2018 - 2019	33.00%	
2 year total	**25.00%**	

Metric 3 – The total number of staff entering the formal capability process (using a two-year rolling average) is below 5 and therefore caution must be taken when forming judgments using the data. Data suggests that staff with a disability are 7.4 times more likely to enter the formal capability process than non-disabled staff. This data will be reviewed by HR Managers.

National NHS Staff Survey Metrics			
Metric 4 (Staff Survey Q13)			
For each of the following four Staff Survey Metrics, compare the responses for both disabled and non-disabled staff.			
a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	National average Dis/ Non-Dis	Staff with Disability	Staff without a Disability
i. Patients/service users, their relatives or other members of the public	34.1%/ 27%	33%	26%
ii. Managers	19.6%/ 11.6%	21%	11%
iii. Other colleagues	26.6/ 17.3%	29%	18%
b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	47.6%/ 47%	50%	50%

Metric 4 – Staff Survey respondents that have reported having a disability are more likely to experience harassment, bullying or abuse from patients/service users, their relatives or other members of the public, Managers and other colleagues compared to non-disabled staff. Disabled staff are equally likely to report such incidents as non-disabled staff.

Metric 5 (Staff Survey Q14)			
Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	77.7%/ 84.9%	77%	86%

Metric 5 - Disabled staff are less likely to report believing that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff;

Metric 6 (Staff Survey Q11)			
Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	32.4%/ 22.5%	30%	20%

Metric 6 - Disabled staff are more likely to report feeling pressure from their manager to come to work, despite not feeling well enough to perform their duties when compared to non-disabled staff; Both disabled and non-disabled staff at ESHT are less likely to feel this compared to other organisations.

Metric 7 (Staff Survey Q5)			
Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	36.9%/ 48.2	37%	49%

Metric 7 - Disabled staff report feeling less satisfied with the extent to which their organisation values their work compared to non-disabled staff; This is in line with the national average.

Metric 8 (Staff Survey Q28b) Only includes the responses of Disabled staff		
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. Has your employer made adequate adjustment(s) to enable you to carry out your work?	73%	71%

Metric 8 - 71% of Disabled respondents reported that the Trust had made adequate adjustments to enable them to carry out their work. This is 2% lower than the national average.

Metric 9 NHS Staff Survey and the engagement of Disabled Staff		
9a Engagement scores for Disabled, non-disabled staff	6.5	7
Trust's overall engagement score	6.9	
9b Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (At least one practical example of current action being taken)	Yes	

The Trust has developed a Disability Staff Network which is jointly chaired by the Associate Director of Estates & Facilities and The Equality & Human Rights Lead. Managers from the Staff Engagement & Wellbeing team also support the network. The Network aims to ensure the voices of disabled staff considered in decision making processes. The group meets bi-monthly.

Metric 9 – Disabled staff report a lower Trust engagement score compared to no-disabled staff.

Metric 10 Board Representation Metric		
The difference for disabled and non-disabled staff.		
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:	With a disability	Without a disability
By voting membership of the Board.	0%	5
By Executive membership of the Board.	0%	8
Percentage Difference	**-3.3%**	

Metric 10 – Trust Boards are expected to be representative of the workforce and communities they serve. ESR records show there are currently no Board members with a disability.

4. The WDES Data

The 10 indicators highlight that there is difference in experience of approximately 10% across the metrics between disabled and non-disabled staff. When comparing ESHT scores nationally, the Trust is close to average on all metrics. Whilst the data is disappointing, the WDES is designed to improve workplace experience and career opportunities for disabled people working, or seeking employment in the NHS (WEDS Technical Guidance 2019). The WDES will provide the Trust with the opportunity to use the indicators to develop an action plan, enable positive change and measure improvements.

5. Conclusion

The WDES and Staff Survey metrics indicate that staff with a disability report feeling less engaged, less satisfied and more likely to report harassment, bullying or abuse. They are also less likely to be appointed from shortlisting to vacant posts and more likely to enter formal capability procedures. The indicators suggest that the overall experience of membership for disabled staff is less likely to be a positive one compared to non-disabled staff.

Robust data is a key element in identifying gaps in equality and the outcomes to the WDES indicators has highlighted where data relating to disability is unreliable or does not currently exist. There is a need to improve processes on data collection, analysis and reporting of disabled staff.

To support the Trust in meeting our legal obligations we are currently developing a 4 yearly Public Sector Equality Duty, Equality Objectives. When considering the objectives we will have due regard to the outcomes of this report. The Trust Equality Objectives are developed using all available data including (but not limited to) the EDS2 and the WDES indicators. The Equality Objectives can be accessed on the Trust website at the end of summer 2019.

We are committed to being an inclusive employer as well as an inclusive healthcare provider and therefore encourages all employees to disclose a disability.

We recognise that data currently held on the electronic staff records (ESR) does not accord that of the National Staff Survey (15% difference) and therefore will seek to improve the reliability and quality of data available for 2019/20 reporting. Declaration of a disability to an employer is entirely optional and may be a personal preference not to disclose. There is no legal requirement for a person to declare whether they have a disability or not.

It is accepted that the Trust should do all it can to improve the quality of data and encourage and ensure staff feel safe to disclose their disability. It is also equally important that staff do not feel pressured and that their choice not to disclose a disability is respected. However to enable an employer to make reasonable adjustments, or to hold an employer to account for failure to make reasonable adjustments, the employer must be reasonably aware of the employees disability. Non-disclosure does not absolve an employer from making reasonable adjustments.

We have taken positive steps to engage disabled staff through a Disability Staff Network. Membership uptake for the Trust Disability Staff Network has been a slow start which is in contrast to the Staff BME Network. In order to achieve the level of membership to truly hear the voices of our staff with disabilities wider engagement, promotion, senior leadership and sponsorship are required. Securing Board level support for the network, it is anticipated that network membership will increase and strengthen the voices of staff with disabilities.

There is always more that can be done and starting with the actions below which will be taken forward with the Staff Disability Network, the Trust will continue to identify opportunities to improve the working environment for all staff with a disability and to ensure equality is embedded into everyday practices as an employer and in the healthcare we deliver.

6. References

NHS Workforce Disability Equality Standard Technical Guidance, April 2019

East Sussex in Figures - http://www.eastsussexinfigures.org.uk/webview/index.jsp?catalog=http%3A%2F%2Fwww.eastsussexinfigures.org.uk%3A80%2Fobj%2FfCatalog%2FCatalog6&submode=catalog&mode=documentation&top=yes (accessed on 4th May 2019)

United Nations - Ageing and disability https://www.un.org/development/desa/disabilities/disability-and-ageing.html (accessed: 4th May 2019)

Sources of information

NHS Employers Disability Summit 2019 (May 2019)

HiAP 2019 - Delivering Health Equity Tackling Inequalities (May 2019)

NHS Employers WDES Workshop (April 2019)

National NHS Staff Survey 2017 and 2018

ESHT Staff Disability Network minutes 2018-2019

East Sussex Healthcare NHS Trust Electronic Staff Records

Overarching Action Plan 2019/20

The Equality Act 2010 and the Public Sector Equality Duties.

The Trust must have due regard to the 3 aims of the Equality Duty. The 3 aims of the equality duty are to have due regard to the need to:

1. Eliminate unlawful discrimination, harassment, and victimisation and any other conduct that is prohibited by the Act.

2. Advance equality of opportunity between people who share a protected characteristic and those who do not.

3. Foster good relations between people who share a protected characteristic and those who do not:

In order to demonstrate the Trusts' due regard to the NHS Workforce Disability Equality Standard, the following overarching actions for 2019/20 have been agreed by the ESHT Disability Network and the People and Organisational Development (POD) Committee.

Eliminate unlawful discrimination, harassment, and victimisation and any other conduct that is prohibited by the Act.

- Incidents reported on Datix involving disability discrimination, will be reviewed monthly by the Trust Speak up Guardian, the Director of Human Resource and the Chief Executive.
- Incidents of disability discrimination will be addressed under the relevant HR policy.
- Data, trends and themes relating to disability discrimination will be reviewed by the Staff Disability Network annually.
- Before disabled staff enter into the formal capability process, a review to ensure that all reasonable adjustment options have been explored will be carried out.

Advance equality of opportunity between people who share a protected characteristic and those who do not.

- Ensure disability equality is embedded in recruitment practices. Including encouraging disclosing disabilities.
- Ensure robust processes are in place to support staff requesting reasonable adjustments in their workplace.
- Ensure reasonable adjustments are made within a reasonable time and where delays are unavoidable, the member of staff is kept informed and supported.
- Review the 'Guaranteed Interview Scheme' to ensure it is accessible to internal and external applicants that would be entitled to the scheme.

Foster good relations between people who share a protected characteristic and those who do not:

- Identify and understand why gaps exist in disability data through pulse surveys and Staff FFT.
- Improve understanding of the benefits to declaring disability on employment records.
- Promote the benefits of joining the staff disability network.
- Promote the benefits of disclosing disabilities.
- Ensure managers have the necessary skills to identify and tackle discrimination and foster good relations amongst their teams through bespoke disability awareness training for managers.

This Report is available in alternative formats upon request. Alternative formats include (but not limited to) Large Print, Braille, Audio, Alternative Community Languages. Please contact the Equality, Diversity & Human Rights Team by emailing esh-tr.accessibleinformation@nhs.net or Telephone 01424 755255.

Organ Donation Annual Report

Meeting information:	
Date of Meeting: 4th June 2019	Agenda Item: Organ Donation Annual Report
Meeting: Trust Board	Reporting Officer: Dr Judith Highgate – Clinical Lead for Organ Donation

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

Key Discussion Points:

Actual & Potential Donors: Within ESHT, between April 18 & March 19, there were 6 solid organ donors leading to 12 patients receiving transplants. Areas of good practice include the referral of patients following neurological death and ESHT has been rated as exceptional in the involvement of specialist nurses for organ donation in all family approaches. Areas identified for improvement include referral of patients following circulatory death, neurological testing of patients with potential brainstem death and improved consent rates.

Changes to donation consent: A change in the law to deemed consent for organ and tissue donation in England has now received Royal Assent. The new consent process is expected to roll out in April 2020. The change in the consent process will require publicity to increase staff and public awareness of changes. Hospital policy due for update in January 2020.

Staffing: From July 2019 there will be no Specialist nurse for Organ donation (SN-OD) allocated to the trust. Local SN-OD to be shared with Maidstone & Tunbridge Wells NHS Trust with support from Brighton & Sussex University NHS Trust nurses.

Benefits of Implementation: Raised awareness of organ donation within ESHT and East Sussex.

Improved End of Life Care that respects the wishes of patients and their families.

Improved transplantation rates across the UK - improving the health of patients awaiting transplants & reducing deaths of patients while on transplant list.

Risk & Implications:

Missed referrals - potential for end of life care that does not respect patient's wishes surrounding organ donation.

No SNOD for the trust – lack of SNOD input for activity except during patient referral leading to a reduced capacity for training and potentially reduced staff awareness for organ donation.

Potential for Reduced Income: changes introduced in 2018 to the way Donor Recognition funding is calculated mean that financial provision for local Organ Donation committees is based on the number of proceeding donors.

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

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

Recruitment:	Local advert during next round of Specialist Nurse for Organ Donation recruitment to raise awareness of the role and encourage a local candidate to apply.
Public awareness:	It would be beneficial to have a communications representative on the organ donation committee to support and assist where needed for events including during organ donation week in September and during the national campaign to raise awareness of changes to organ donation consent.
Hospital Volunteers:	A link to and engagement with ESHT volunteers to assist with local publicity events within the trust – such as organ donation week. This would increase local public awareness.
Executive on ODC:	It would be advantageous operationally to have a trust executive representative on the organ donation committee. This would help to support initiatives such as organ donation week, volunteer engagement and recruitment to the specialist nurse position.
Discrete Budget:	Organ donation finances have previously been reported in the theatre management report. This has made it difficult to track & utilise funds for improving organ donation in the trust. Having a separate budget would enable these funds to benefit patients and their relatives by improving the tracking of income & expenditure.
Training:	Roll out of national training on the implications of the deemed consent system for staff members initially focused on key areas including Emergency Departments, Acute Medical Units & Intensive Care.
Wi-Fi access:	Reports have been received from transplant teams and organ donation staff regarding lack of telephone signal and Wi-Fi in theatres especially at Eastbourne and the potential impact that this has on the donation process. Access to a trust Wi-Fi enabled device for the use by organ donation & transplant staff while on site would prevent further issues.

Organ Donation ESHT

1. Introduction

1.1. Recognition of a patient's wishes regarding organ donation and discussion with nominated representatives was highlighted as part of End of Life Care Pathways in the Department of Health End of Life Care Strategy, published in 2008.

1.2. The ESHT organ donation committee oversees policy, education and publicity to educate and support organ donation within ESHT and East Sussex.

2. Background

2.1. On the 31st March 2019 there were 6083 people on the active transplant list in the UK. Over the last year 403 patients in the UK have died whilst waiting for a transplant.

2.2. In 2008 the Organ Donation Taskforce published 'Organs for Transplants' which set recommendations with the target of increasing deceased donor rates by 50% by 2013. Recommendations included the introduction of organ donation committees and donation champions – clinical lead for organ donation (CL-OD) and national notification criteria & reporting.

2.3. By 2013 donation rates had increased by 50% with a 30.5% increase in transplants.

2.4. In 2013 The 'Taking Organ Transplantation to 2020 UK Strategy' was published. This built on the changes initiated in 2008. The aim of the strategy was to 'pursue consistently excellent practice in the care of every potential donor and maximise the use of every available organ'. The strategy focused on 4 outcomes:

- Outcome 1: Action by society and individuals: to raise awareness of donation, ensure it is easy to pledge support for organ donation and encourage discussion with family members regarding wishes. Aim to increase consent rates to above 80%.
- Outcome 2: Action by NHS hospitals and staff: every person should have donation considered as part of their end of life care, to increase in the number of people who are able to donate following circulatory death and support training of hospital staff to ensure optimal donor care.
- Outcome 3: Action by NHS hospitals and staff: increase the number of organs retrieved by providing information and guidance on organ suitability and compatibility. Aim to transplant 5% more of the organs offered from consented donors.
- Outcome 4: Action by NHS Blood & Transplant (NHSBT) and Commissioners: support regional collaboratives to lead on local improvements to donation practices, improve workforce and IT systems and build a sustainable training and development programme.

2.5. In England 80% of people support donation but only 41% have registered their wishes. Following public consultation, the Organ Donation (Deemed Consent) Bill received Royal Assent on the 15th March 2019. This means that all competent adults in England will be considered as potential donors unless they specifically chose to opt out. Under the law donation will still be discussed with families to ensure individual wishes are respected.

3. Main content

3.1. NHS Blood & Transplant Report April 2018 to March 2019:

During the report period, East Sussex Healthcare NHS Trust had 6 deceased solid organ donors resulting in 12 patients receiving a transplant. In addition there were 2 additional consented donors that did not proceed to donation – 1 as they did not meet criteria for Donation after Circulatory Death (DCD) and 1 where the organs were declined by the transplant centres.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2018 - 31 March 2019

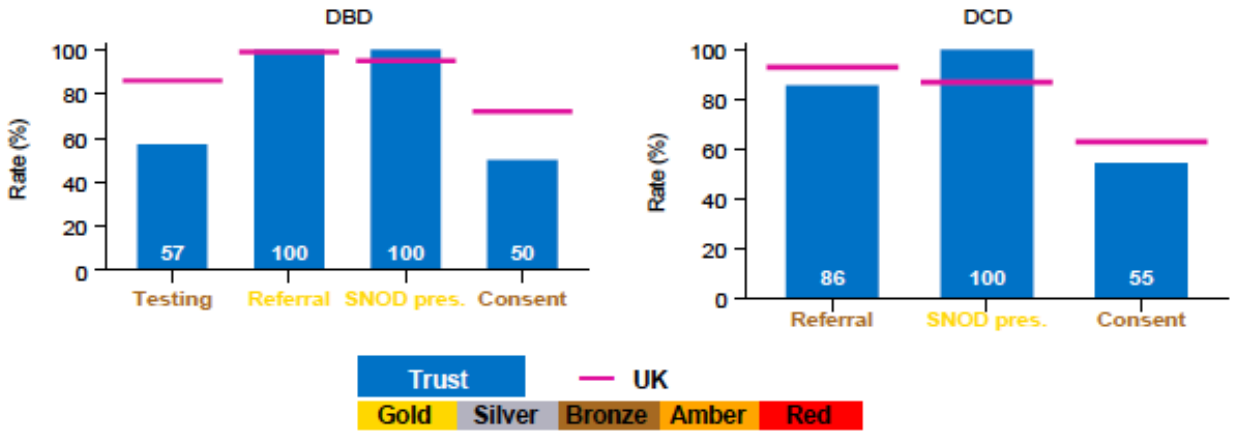
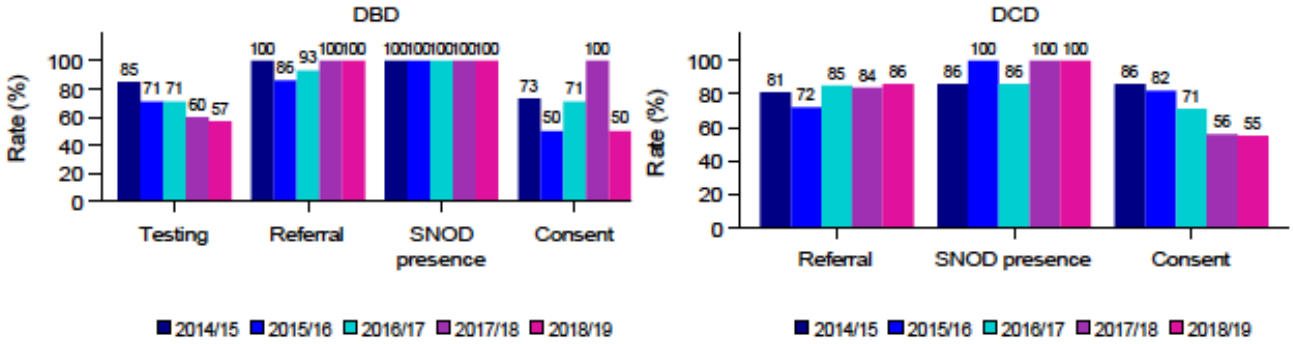


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2014 - 31 March 2019



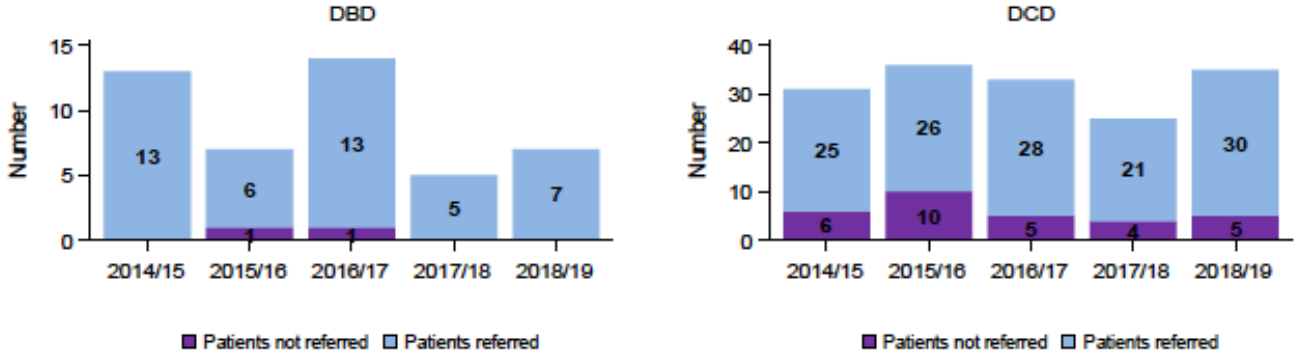
3.2. Referrals & Missed Opportunities:

3.2.1. Referrals:

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135 and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors.

Of 7 potential Donation After Brainstem Death (DBD) donors, all patients were referred to the Specialist Nurse for Organ Donation (SN-OD). 1 patient proceeded to donation. Of 35 potential DCD donors, 30 patients were referred to the SN-OD and 5 patients proceeded to donation.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2014 - 31 March 2019



Funnel plot of deceased donor referral rate, 1 April 2018 - 31 March 2019

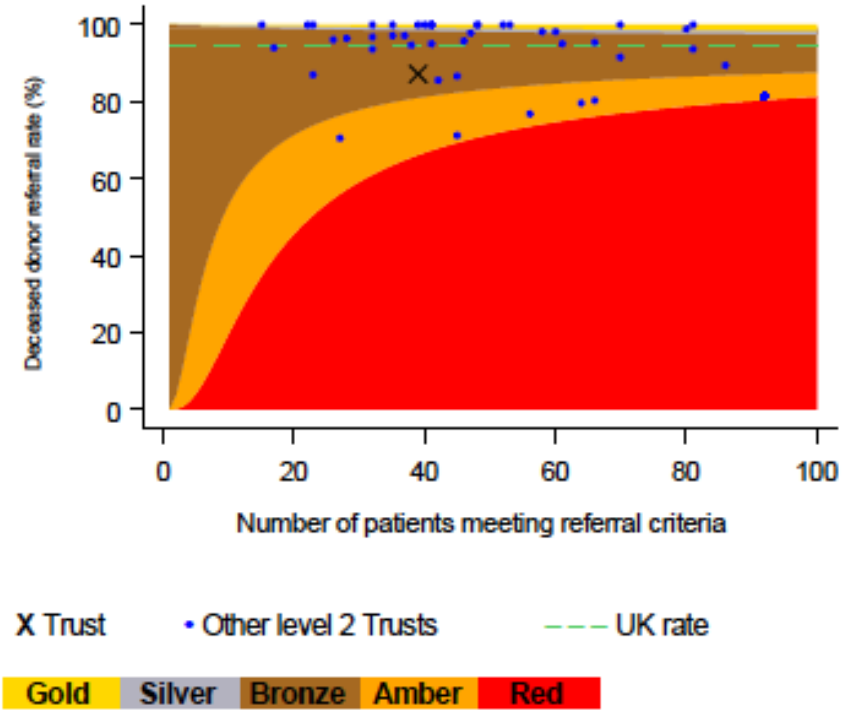


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	4
Coroner/Procurator Fiscal Reason	-	1	-	2
Family declined donation following decision to withdraw treatment	-	2	-	15
Family declined donation prior to neurological testing	-	2	-	2
Medical contraindications	-	-	-	56
Not identified as a potential donor/organ donation not considered	-	11	3	215
Other	-	4	2	56
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	-	-	2
Thought to be medically unsuitable	-	2	-	78
Thought to be outside age criteria	-	-	-	2
Total	-	**22**	**5**	**435**

If 'other', please contact your local SNOD or CLOD for more information, if required.

Reasons for not referring patients have been explored with the clinicians involved. 2 patients were not referred as it was felt inappropriate to delay end of life care due to family wishes and 3 patients were considered to have medical contraindications to referral by the clinical involved.

As offering the potential for donation is considered a part of standard end of life care, it has been agreed that nursing staff can approach the SN-OD for information regarding the patient's wishes on organ donation and any potential contraindications for donation. The aim of this change is to reduce any potential delays for families when a withdrawal of life sustaining treatment decision has been made and the patient is moved to end of life care. Consideration of End of Life Care & SN-OD referral is also included in the daily ICU staff safety huddle process.

3.2.2.Neurological Testing:
Goal: Neurological death tests are performed wherever possible.

Of 7 potential patients with suspected neurological death and potential for Donation after Brainstem Death, 3 patients did not have neurological death tests performed. 1 patient was haemodynamically unstable, which precludes testing, 1 did not initially meet prerequisites to testing and subsequently testing did not occur at family request and 1 was identified as having medical contraindications to donation.

Funnel plot of neurological death testing rate, 1 April 2018 - 31 March 2019

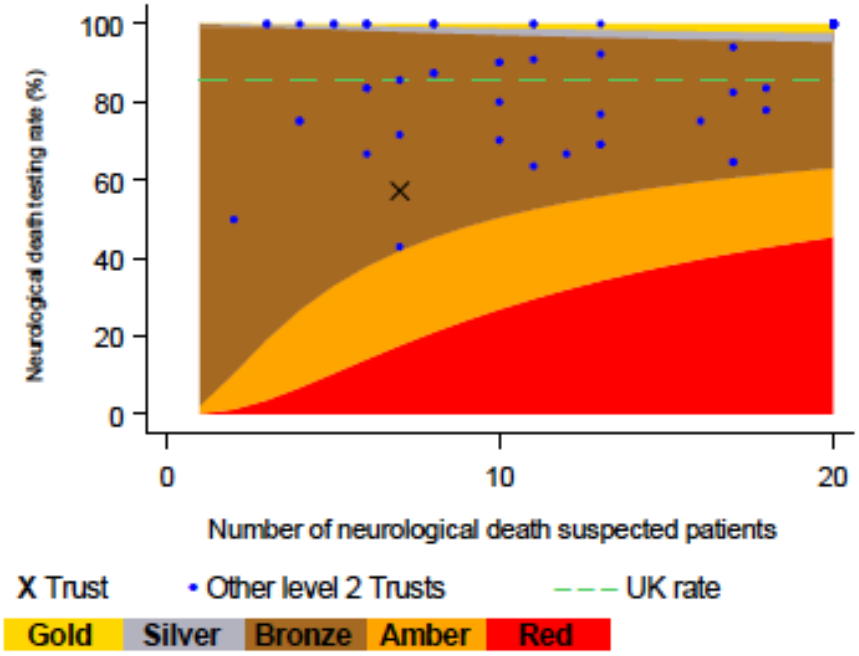


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2018 - 31 March 2019

	Trust	UK
Biochemical/endocrine abnormality	-	20
Clinical reason/Clinicians decision	1	48
Continuing effects of sedatives	-	14
Family declined donation	-	22
Family pressure not to test	-	35
Inability to test all reflexes	-	13
Medical contraindication to donation	-	10
Other	-	18
Patient had previously expressed a wish not to donate	-	5
Patient haemodynamically unstable	1	80
Pressure on ICU beds	-	1
SN-OD advised that donor not suitable	1	7
Treatment withdrawn	-	11
Unknown	-	5
Total	**3**	**289**

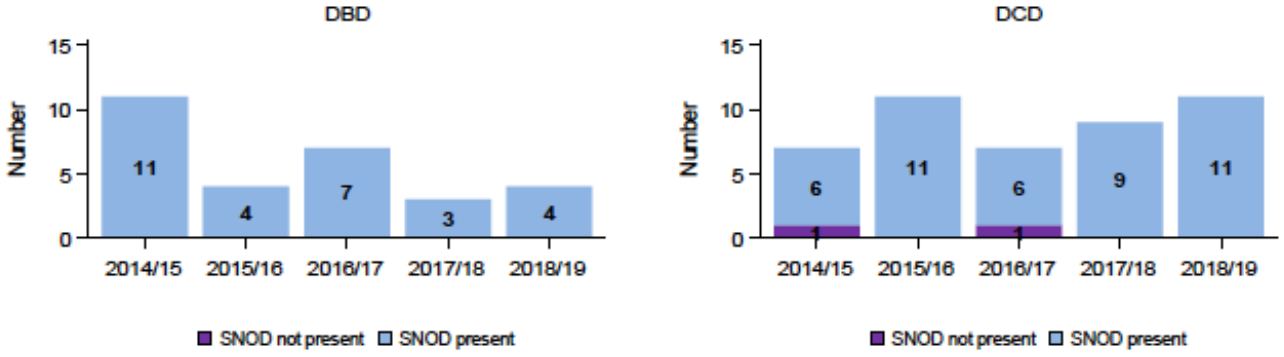
If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3. Specialist Nurse For Organ Donation presence:

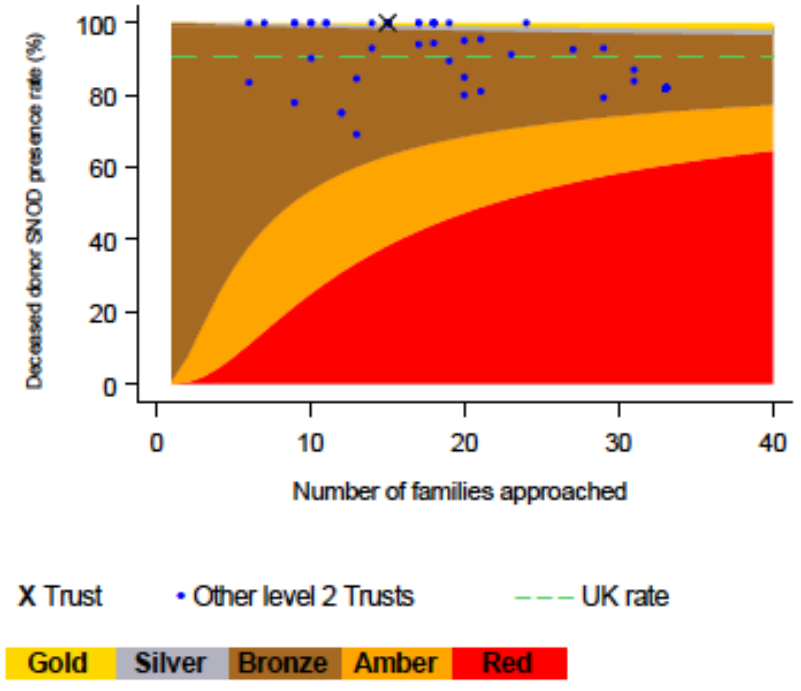
Goal: A SNOD should be present during the formal family approach as per NICE CG135 and NHSBT Best Practice Guidance.

East Sussex Healthcare Trust had 100% SNOD presence during formal family approaches to discuss donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2014 - 31 March 2019



Funnel plot of SNOD presence rate, 1 April 2018 - 31 March 2019

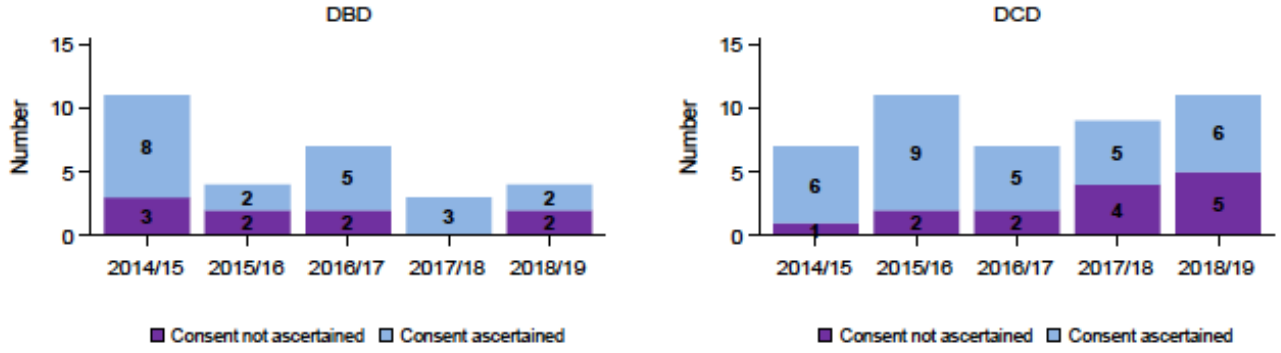


3.4. Consent:

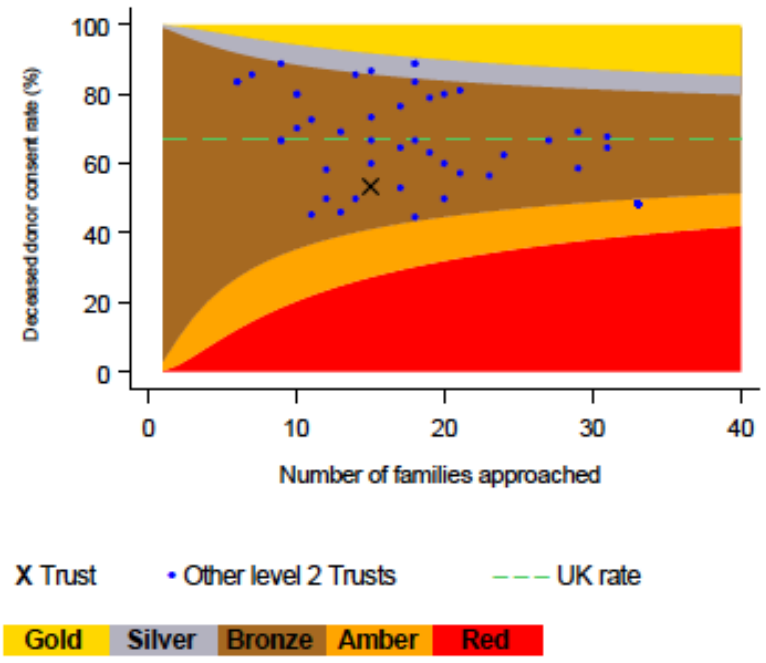
Goal: Agreed 2018-19 national targets for DBD & DCD consent rates are 78% & 72% respectively.

The DCD consent rate in ESHT was 55% with 6 families consenting to donation out of 11 approached. The DB0D consent rate was 50% with 2 families consenting out of 4 approached. The highest reason for families to decline donation was the family being unsure if their relative would have agreed to donation.

Figure 3.4 Number of families approached, 1 April 2014 - 31 March 2019



Funnel plot of consent rate, 1 April 2018 - 31 March 2019

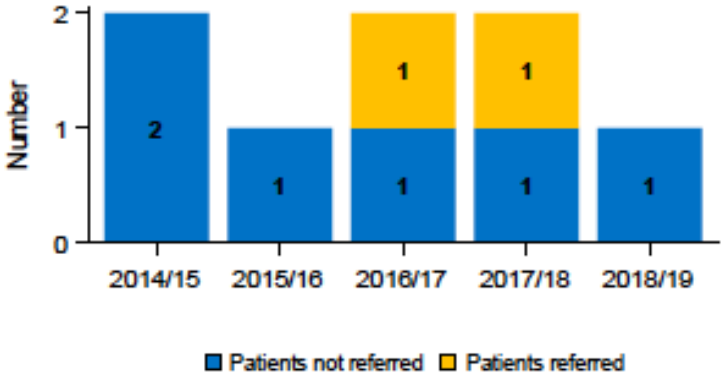


3.5. Emergency Department:

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.

In 2018-19 there was 1 patient identified as having died in the emergency department who would have met referral criteria for organ donation.

Number of patients meeting referral criteria that died in the ED, 1 April 2014 - 31 March 2019



We have established links to the emergency departments across the trust. Dr Vidler, ED Consultant, has agreed to act as consultant liaison and we have senior nurse representation on the Organ Donation Committee. The aim is to increase awareness of staff through training over the coming year.

3.6. Training:

This has been limited by the lack of local Specialist Nurses for Organ Donation & a Clinical Lead for Organ Donation (CL-OD). Following the appointment of a new CL-OD and with the changes in consent occurring over the next year, this is now a major focus of the clinical lead and dates have been arranged for training Foundation Year 1 & 2 doctors and provisionally the anaesthetic department.

3.7. Finances:

NHSBT pays the trust 1PA for the Clinical Lead who is appointed following a joint interview process between the trust & NHSBT representatives and appraised annually by the regional CL-OD. The SN-OD position is also appointed by NHSBT. For each donation consent the trust receives funding from NHSBT to cover the costs of donation and residual funds can be used to improve the donor families experience, assist with education & publicity.

Previously, organ donation finances have been included as a single reported line of income and expenditure as part of the Theatres Management Report. This has historically made it difficult to track the income and use of the funds allocated to organ donation activity. Having an individual budget report would lead to improved accountability of these funds and aid appropriate use of these funds for improvement in local organ donation processes. This is especially important as changes made in 2018 to the formula used to calculate Donor Recognition funding mean that NHS Blood & Transplant funding for Organ Donation Committees is now based on the number of proceeding donors from each trust.

3.8. Publicity:

NHSBT have a national publicity campaign planned to raise public awareness of the change in consent rates. Locally the committee has publicity campaigns arranged for Eastbourne 999 show, Eastbourne Airbourne & National Organ Donation week in September. Communications team representation on the Organ Donation Committee and engagement of hospital volunteers to assist with locally planned events would assist in the organisation of these events and increase staff & public awareness.

4. Conclusions & Recommendations

4.1. ESHT has been categorised as a level 2 trust by NHS Blood & Transplant (NHSBT). This is based on the average number of donors proceeding each year.

4.2. ESHT continues to have 100% SN-OD presence during the formal approach to families – deemed exceptional by NHSBT.

4.3. ESHT will not have a dedicated specialist nurse for organ donation from July 2019. It would be beneficial to organ donation activity at the trust to support local recruitment by advertising the role during the next round of national NHSBT recruitment.

4.4. There is scope for improved referral rates amongst patients who have potential to become donors after circulatory death. The aim is to improve awareness through training amongst all staff and increase nursing involvement in the process of gathering information on each patient's wishes as part of end of life care planning. Additionally, increased consultant liaison to establish barriers to referral and improve communication between ESHT clinical staff & organ donation staff.

4.5. There is potential for improvement in consent rates. It is worth considering that numbers within this review period were low and therefore any declined consent by families has a significant impact on the % consent rates quoted by NHSBT. All approaches have been made with SN-OD presence in accordance with national guidance. Following the publicity campaigns in Wales that preceded their change of consent law, the experience has been increased consent rates. It is possible that this trend will be seen locally following NHSBT publicity in the next year.

4.6. The appointment of both a trust executive and communications representative to the organ donation committee would assist in the operational role of the committee by:

- Supporting local recruitment for a dedicated SN-OD for the trust,
- Introduction of a separate organ donation cost centre,
- Improved communications for visiting organ donation & transplant staff during the donation process – potentially by the introduction of a trust Wi-Fi enabled device,
- Help to link to & engage hospital volunteers for publicity events,
- Improved publicity for organ donation week and to raise awareness of changes to consent occurring in the next 12 months.

4.7. While there are areas for improvement, Organ Donation remains well supported amongst staff who are proactively involved in changes that can improve referral and consent rates. Engagement of departments such as the emergency department and theatres remains key and the ODC will support all staff by improving access to education and by supporting local publicity.

5. References:

5.1. End of life care strategy (2008) Department of Health

5.2. Organs for Transplant – a report from the Organ Donation Taskforce (2008) Department of Health.

5.3. Taking Organ Transplantation to 2020. A UK strategy (2013) NHS Blood & Transplant & Department of Health.

5.4. NICE Clinical Guidelines CG135, 2011

East Sussex Healthcare NHS Trust

Quality Walks March – April 2019

Meeting information:			
Date of Meeting:	4th June 2019	Agenda Item:	17
Meeting:	Trust Board	Reporting Officer:	Chair

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

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

Summary:

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

29 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st March and 30th April 2019. In addition to the formal programme the Chief Executive has also visited 19 wards or departments and staff groups. Details of the visits made are listed in the attached.

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 MARCH - APRIL 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.

The following services or departments were visited as part of the Quality Walk programme by the Executive Team or by the Chief Executive between 1st March and 30th April 2019.

Date	Service/Ward/Department	Site	Visit by
March			
1.3.19	Health Visitors & Children's Centre Services	Hailsham	Adrian Bull
1.3.19	Junior Doctors Forum	Eastbourne	Adrian Bull
4.3.19	Coronary Care Unit	Eastbourne	Jonathan Reid
7.3.19	District Nursing Team	Westfield (Rural Team)	Karen Manson
12.3.19	Community Podiatry	Seaford/Newhaven/ Eastbourne/Hastings	Karen Manson
13.3.19	Health Visitors	Heathfield, Uckfield and Crowborough	Nikki Webber
14.3.19	Pharmacy	Conquest	Adrian Bull
14.3.19	Acute Admissions Unit and Ambulatory Care	Conquest	Jackie Churchward-Cardiff
14.3.19	Crisis Response Team	Conquest	Monica Green
15.3.19	Health Visiting Team	Eastbourne	Adrian Bull
15.3.19	Cancer Services	Eastbourne	Adrian Bull
18.3.19	EME Department	Conquest	David Walker
19.3.19	Health Records Department	Hailsham	Nicky Webber
19.3.19	Dietetics Team	Eastbourne	Nicky Webber
19.3.19	Diabetes and Endocrinology	Eastbourne	Catherine Ashton
19.03.19	MSK	Bexhill	Karen Manson
20.3.19	Emergency Department Team Meeting	Eastbourne	Adrian Bull
20.3.19	Physiotherapy/MSK	Uckfield Hospital	Miranda Kavanagh
25.03.19	Orthotics & Fracture Liaison	Conquest	Lynette Wells
26.3.19	Women's & Children's	Conquest	Adrian Bull
28.3.19	Seaford 4	Eastbourne	Monica Green

28.03.19	Procurement	Eastbourne	David Walker
29.3.19	Dietetics Team Meeting	Bexhill	Adrian Bull
29.3.19	Cancer Services	Conquest	Adrian Bull
April			
01.4.19	Volunteers	Eastbourne	Adrian Bull
01.4.19	Theatres	Eastbourne	Adrian Bull
1.4.19	Cardiology Admin Team	Eastbourne	Jonathan Reid
4.4.19	Dental Service	Uckfield Hospital	Miranda Kavanagh
4.4.19	Physiotherapy	Conquest	Monica Green
4.4.19	Day Surgery Unit	Uckfield Hospital	Miranda Kavanagh
5.4.18	Occupational Health	Eastbourne	Adrian Bull
8.4.19	Seaford 2/Medical Assessment Unit/Ambulatory Care	Eastbourne	Vikki Carruth
9.4.19	Ophthalmology	Eastbourne	Monica Green
9.4.19	Rural Rother Health Visiting Team	Battle	Adrian Bull
9.4.19	Theatre Matrons	Conquest	Adrian Bull
11.4.19	Jubilee Eye Suite	Eastbourne	Adrian Bull
12.4.19	Occupational Health	Bexhill	Adrian Bull
15.4.19	Rainbow Nursery	Eastbourne	Adrian Bull
16.4.19	Clinical Coding	Conquest	Adrian Bull
17.4.19	Clinical Coding	Eastbourne	Adrian Bull
17.4.19	Orthotics & Fracture Liaison	Eastbourne	Lynette Wells
18.4.19	Rainbow Creche	Eastbourne	David Walker
18.4.19	Ophthalmology Admin Team	Eastbourne	Jackie Churchward-Cardiff
23.4.19	Human Resources Department	Eastbourne	Nicky Webber
23.4.19	Occupational Health	Eastbourne	Jonathan Reid
29.4.19	Vascular Access service	Eastbourne	Catherine Ashton
29.4.19	Health Visiting Team	Battle, Rye & Ticehurst	Lynette Wells
30.4.19	McCartney Unit	Conquest	Jackie Churchward-Cardiff

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Thursday 31st January 2019 at 1300 in the Committee Room, 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
Ms Liului Chen, Audit Executive, Grant Thornton
Mr Chris Lovegrove, Counterfraud Manager, TIAA
Mrs Debbie Lennard, Assistant Director of Nursing, Out of Hospital Division (for item 005/19 only)
Mr Adrian Mills, Audit Manager, TIAA
Mrs Emma Moore, Clinical Effectiveness Lead
Mr Damian Paton, Head of Digital Services
Ms Saba Sadiq Deputy Director of Finance
Mr Mike Townsend, TIAA
Mr Darren Wells, Engagement Lead, Grant Thornton
Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

001/19 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
Mr Stephen Hoaen, Head of Financial Services
Ms Vikki Carruth, Director of Nursing
Dr David Walker, Medical Director

002/19 Minutes of the meeting held on 28th November 2018

The minutes of the meeting held on 28th November 2018 were reviewed and agreed as an accurate record. Mr Lovegrove noted that he was not in attendance at the meeting.

003/19 Matters Arising

060/18 – Medicine Division Clinical Audit and Risk Register Review

Mrs Moore explained that an issue existed with audit action plans not being closed. An action plan had been introduced, and actions were discussed with divisions with the highest risk actions escalated to the Trust Board. Mrs Moore's team were ensuring that agreed actions were smart and realistic, and were discussed at divisional governance meetings. A cleanse of historical actions that were no longer relevant had taken place.

Mr Reid suggested that outstanding recommendations could be discussed at IPRs. Mrs Moore confirmed that numbers of outstanding reports were already discussed during IPRs, but not the details of the actions. Mrs Wells suggested that divisions could be called in turn to the Clinical Audit Effectiveness Group, chaired by Dr James Wilkinson. Dr Wilkinson would

be asked to produce a plan to address the issue, to be presented to a future Audit Committee. **JW**

066/18 – Emergency Preparedness, Resilience & Response (EPRR) Policy
Mrs Wells explained that a Non-Executive link for EPRR was a requirement for the Trust. The outgoing Chair had been undertaking this role, and she would ask Mr Phoenix, the incoming Chair, if he would take on this role.

004/19 Board Assurance Framework and High Level Risk Register
Mrs Wells presented the risk register, and thanked Rae Joel for her work on improving the way information was presented. 43 risks on register were rated above 15 with seven rated at 20. None were rated above 20.

Three risks had been added to the register, concerning data storage at end of life and at capacity, intensive care consultant capacity to deliver seven day working and risks around taking clinical images on personal mobile phones. Mrs Wells noted that the risk concerning clinical images had been discussed in detail at the recent Quality and Safety Committee meeting.

Two risks had the ratings downgraded. The risk concerning diabetic foot risk had been reduced due to compliance with NICE guidance, and the maternity risk around interpreting CTGs had been reduced following a program of training for staff.

One addition was proposed for the Board Assurance Framework (BAF), in light of the Deloitte recommendations related to developing an explicit accountability framework which set out expectations regarding roles, responsibilities and accountabilities.

Mrs Webber asked why the three additions had not been added to the Risk Register earlier, as they could have been forecast. Mr Reid explained that they had become risks due to capital constraints on the organisation. He anticipated that they would be removed from the register once capital was available in the following financial year.

Mrs Webber asked for assurance that there were no further risks that Mr Reid was aware of that should be added to the Risk Register. Mr Reid confirmed that there were no other risks that he was aware of, explaining that a dynamic process was in place for assessing risk, with weekly conversations held about what should be added to the register.

Mr Nealon asked whether the Trust was assured that all appropriate measures had been taken to ensure the continuity of drugs after Brexit. Mr Reid explained that a paper on Brexit preparation would be presented to the Board the following week. A Trust working group had been formed to undertake a full review of the potential risks to the organisation. Mrs Wells noted that national guidance for continuity of drugs was do nothing, and that the Trust would be advised what to do when necessary. The risk was being looked at to ensure that it was fully understood, and would be added to the BAF if appropriate.

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.

005/19 Out Of Hospital Division Clinical Audit and Risk Register Review

i. Risk Register

Mrs Lennard presented a report on the Out of Hospital division's risk register, explaining that there were 25 risks on register. All risks were reviewed by the division during monthly integrated governance meetings, and appropriate controls were in place. The highest rated risk concerned an aseptic cytotoxic labelling issue in pharmacy, which was rated at 16. Mrs Lennard reported that some division was awaiting an update from IT about the risk, and Mr Paton agreed to follow this up and provide feedback to Mrs Lennard.

Mrs Lennard noted that the risk register contained two corporate risks relating to pharmacy which affected all divisions. These concerned inconsistent training records for patient group directives, and issues with clinical screening for a third party homecare pharmacy provider. Six risks relating to the Integrated Musculoskeletal service were also impacting on the division's but sat on the Risk registers of other divisions.

Mrs Webber asked whether Mrs Lennard was comfortable that existing systems revealed all risks in the Trust that were relevant to the division. Mrs Lennard explained that it could be challenging when there were disagreements between divisions about what constituted a risk. Mr Reid explained that divisional issues around risk were discussed in IPRs. Mrs Webber encouraged divisions to continue to liaise closely to resolve risks as they arose.

Mr Reid asked whether the division felt that adequate arrangements were in place to support lone working in community teams, asking what additional digital support was required. Mrs Lennard reported that a review had been undertake to look at compliance with the Trust's lone worker policy. This had shown that there was inconsistency across teams and therefore work was being undertaken to improve practices. She noted that Trust staff and colleagues in adult social care had different capabilities and systems which was proving problematic. Dynamic scheduling software, which would support lone working by providing live tracking of visits, was being procured and should help to more easily identify potential risks.

Clinical Audit

Mrs Lennard explained that the division was currently 99% compliant with NICE guidelines. The two outstanding guidelines were being reviewed and would be completed shortly. The division had no outstanding NICE action plans and no NCEPOD actions.

The division had completed the national fracture liaison service database report and actions that had arisen from this were being reviewed. 24 national audits were being undertaken by the division, all of which were on track with no concerns. Mandated national audits were also being carried out with no concerns.

Mrs Lennard noted that there had been issues with collecting data following a change from the Meridian system to the Allocate e-rostering system which had impacted on assurance levels from quality audits. Mrs Moore

reported that this issue had effected a number of areas in the organisation and was expected to be resolved in February. A meeting had been scheduled the following week to ensure that all remaining issues were appropriately addressed.

Mrs Webber thanked Mrs Lennard for the reports that had been submitted, noting that they had made it clear that the Out of Hospital division took both risk and audit seriously.

ii. Digital Risk Register Review

Mr Paton explained that there were 22 risks on the Digital division's risk register. Two risks, one concerning data storage at end of life and one concerning cybersecurity were rated over 15.

Mrs Webber asked what checks and balances would be introduced in order to avoid a repeat of a recent incident concerning migration from old systems to new following outsourcing of the process to an external NHS partner. Mr Paton explained that the incident had only become apparent once the migration had taken place. He explained that the underlying interface code had been updated, with checks introduced, and hoped that this would mean that the issue was not repeated in the future.

Mrs Webber suggested that real world checks should be undertaken to ensure that systems were working properly in the future, and Mr Paton agreed to take this suggestion back to the division. Mr Reid noted that the incident had been treated as a Serious Incident (SI) by the Trust. He explained that the investigation would ensure that recommendations would be made to avoid repetition of the incident in the future.

Mr Nealon asked about technology issues being seen by members of community teams, and asked for assurance about the level of support offered to Out of Hospital staff. Mr Paton assured the Committee that support was offered to Out of Hospital colleagues, accepting that they would prefer greater levels of support in the future.

Mrs Webber asked for assurance that the highest rated digital risks in the organisation were being addressed. Mr Parton explained that the risks were being addressed within divisional plans for future capital, which enabled a full picture of digital risk in the organisation to be compiled. Mr Reid explained that these risks would be reflected in the Trust's five year capital plan.

Mrs Webber asked if there were any areas of particular concern for Mr Paton, who explained that capital constraints were making some issues hard to address in a timely manner, leading to increased levels of risk for the organisation.

Mrs Webber asked whether Mr Reid was confident that requests for capital clearly articulated associated risks and interdependencies. Mr Reid explained that while this process had been improved there was still scope for further improvement.

Mr Paton explained that planning for disaster recovery in the organisation had been difficult, as it required engagement and ownership of issues by clinicians across the Trust. He hoped that chiefs of service would support

the process to increase engagement. He suggested that formally tracking progress via the Emergency Preparedness would help provide impetus. Mrs Wells noted that the Information Governance (IG) Steering Group already tracked progress, as this information formed part of the Data Security and Protection Toolkit (DSPT). She asked that Mr Paton present a paper to the IG steering group setting out the specific issues that needed addressing.

Mr Townsend noted that the number of risks on the Division's risk register seemed very high in comparison to other organisations. He noted that there were plans to address most of the risks, but that some had quite long timescales. Mr Paton explained that his preference was for risks to be recorded on the register at an early stage, so that they could be addressed. He explained that some of the included risks were very complex and would take time to resolve. Mrs Webber noted the importance of the Trust's capital programme addressing as many of the risks as possible moving forward.

006/19 Clinical Audit Update

Mrs Moore reported that there had been a recent improvement in responses to the Royal College of Emergency Medicine audit, alongside an extended deadline for submission. She was confident that submission requirements at the Conquest Hospital would be met by mid-February. The amount of time required by clinicians to complete the audit remained problematic.

Mrs Webber asked why the paper presented to the Audit Committee in November had not mentioned the issues with the audit. Mrs Moore explained that clinicians carrying out the audit had not reported any issues with completion before November. Mrs Webber asked how the audit team could ensure that this situation didn't recur in the future. Mrs Moore explained that responses could be checked, but only by logging into the audit website and counting responses. Mrs Moore noted that the issue had been escalated to Dr Walker, who had helped to elicit an increase in responses. Mrs Webber noted that regular progress checks on mandated audits would be helpful in identifying issues at an early stage.

Mr Nealon asked about the process for escalating audit issues. Mrs Moore explained that it was Trust policy for audit leads to present any issues with completion of mandated national audits to the Audit Committee in advance of the deadline for completion. Mrs Webber suggested that a process could be introduced for all national audits that provided assurance at a halfway point that everything was on track. If issues were identified at this point then these could be escalated.

Mr Reid suggested that the issue should be escalated to Chair of the Clinical Effectiveness Group Mrs Webber asked that Clinical Effectiveness Group be added to the agenda for the next Audit Committee, to enable discussion with either Dr Walker of Dr Wilkinson about the issues. **PP**

Mrs Moore reported that six low priority audits had been flagged as red as no responses to enquiries were being received. The issue had been raised at the Divisional Governance Meetings and at the Clinical Effectiveness Group but updates were not being received from either divisions or identified audit leads. Mrs Wells agreed to discuss the issues raised by the **LW**

Committee with Dr Walker. Mrs Webber noted that she was not assured that the Groups that sat below the Audit Committee were providing appropriate assistance in helping to resolve issues.

Mrs Moore reported that the Trust had seen a large reduction in abandoned audits in comparison to the previous year. The Trust's Annual Clinical Audit Awards would be held on 20th June 2019. She reported that the audit plan for 2019/20 was being developed, and that the Trust had received the mandated national audits for the year which were being discussed with divisions.

She reported that an issue had arisen at the last meeting of the Clinical Effectiveness Group where her team had chased the medicine division to complete a report for the medicine consent audit for almost a year. The issue had been escalated to the Trust's consent lead, and would be raised again during the medicine division's governance meetings.

Mrs Wells explained that clinical audit had improved greatly in recent years within the Trust. The process of escalation of issues as they arose was not working correctly. Mrs Webber asked that issues of accountability and escalation should also be discussed at the next Audit Committee meeting.

007/19 Internal Audit

i) Progress Report

Mr Mills reported that three final audit reports had been finalised since the previous meeting. One of these had given reasonable assurance, one Limited assurance and one was a status report without opinion.

He reported that a draft audit report had been issued concerning the delayed transfer of care (DTOC) process which gave no assurance. The reporting process for DTOCs had been flawed leading to underreporting. Meetings had taken place to discuss the issue, with rapid improvement in the identification of DTOCs expected. Mr Reid explained that the Trust had become concerned when reports of DTOCs had dropped during 2018, and as a result both the performance team and internal audit had been asked to review the issue. An issue was identified with a proprietary Trust system, which was leading to incidents being inadvertently deleted.

Mr Mills reported that prior to September the Trust had been reporting outstanding performance with DTOCs, but that once the error had been discovered and rectified, the rate increased to 3.5% from 1.3%. He noted that auditors currently had no confidence that the revised figure was accurate, explaining that there was a high risk that the rate could be greater. He explained that the Trust had been following out of date rules for recording DTOCs, leading to the discrepancy. He was satisfied with the actions being taken to resolve the issue, and Mr Reid confirmed that an action plan would be taken to the Executive team for approval.

Mrs Webber asked if there were consequences for getting the data wrong, and Mr Reid explained that the error would undermine confidence in the accuracy of other data produced by the Trust. He noted that there was also a small financial risk, as the Trust was paid for DTOCs, and that income could have been missed as a result.

Mrs Wells noted that concerns about the accuracy of data had been raised with the Trust Board on a number of occasions. Mr Mills reported that internal audit would be undertaking a review of data quality in the Trust in the future. A data quality framework was being developed, and one aspect of this would be confidence in the data being presented.

Mr Mills reported that there were no concerns about progress against internal audit's annual plan. Mr Reid reported that audit recommendations would be regularly reviewed by the Executive team in the future.

Mrs Webber thanked the internal audit team for their support, noting that the work that they undertook was very valuable.

008/19 Local Counter Fraud Service Progress Report

Mr Lovegrove reported that three new referrals had been received by the counter fraud service. One involved an overpayment of salary as a result of human error. Ms Sadiq explained that self-service HR was being introduced by the Trust in order to address errors of this type in the future. Mr Lovegrove commended the volume of referrals seen by the service.

Consultant job planning would be the next thematic review to be carried out, and a report would be presented to the Audit Committee in the future.

Mr Lovegrove reported that the counterfraud authority was due to be restructured and anticipated that more information would be requested from Trust's in the future, with more detailed reviews undertaken.

Mrs Webber asked how recommendations were shared and actioned within the Trust. Mr Reid explained that he received recommendations, and would pass them on to the relevant member of staff for action. He conceded that better documentation of this process should be kept, and asked Mr Lovegrove to send him a table of alerts and actions to allow this to take place. **CL**

009/19 External Audit

Mr Wells presented the external audit report, explaining that it set out the anticipated risks to financial statements that would require focus prior to audit and identified risks to the financial control total. Risks associated with Brexit would be considered as the emerged.

Mrs Webber asked whether Executives were comfortable that staff would have the time and capacity to manage a full audit following the end of the year Ms Sadiq accepted that there was an operational risk to the organisation, as Steve Hoaen would be leaving, but provided assurance that the audit would be supported.

Mr Nealon asked whether long term plans and integrated care systems would be tested by auditors. Mr Wells explained that this wouldn't happen for the audit in 2019, but recognised that this would be an issue moving forwards. The effectiveness of system working would likely form a key test for auditors in the future.

Mrs Webber thanked Mr Wells for the concise and clear report.

010/19 Information Governance

Mrs Wells reported that the second stage of the DSPT submission would take place in February. Mr Reid was supporting requests for outstanding data.

Mrs Wells reported that inappropriate access of patient data was reviewed by carrying out random audits. Eight incidents had been reported to the Information Governance (IG) team, and after investigation six were found to have been breaches by members of staff. Mrs Webber suggested that sample sizes of audits, and their frequency, could be increased to understand if there was an issue in the organisation, and Mr Reid agreed to discuss this with the IG lead. The lead would also be asked to include information about referrals to the IG team in subsequent reports to the Audit Committee.

Mrs Wells explained that no serious IG incidents had been reported to the Information Commissioner's Office (ICO) since August 2018. Mrs Webber asked whether the Trust benchmarked itself against other organisations for IG queries received. Mrs Wells explained that a log of queries was kept, but was unsure if the data was benchmarked. Mr Mills noted that the IG lead was very thorough, and agreed to investigate whether comparative data was available. **AM**

011/19 Cybersecurity Update

Mr Paton explained that a cybersecurity report would be presented to the Audit Committee on a quarterly basis. A model of compliance, linked with regulatory requirements, had been developed to allow any issues identified to be assessed on an ongoing basis. The cybersecurity threat level to the Trust had been assessed as being high, with concerns about timeliness of patching PCs and servers.

Mrs Webber asked whether the external threat to the organisation was high, or whether the Trust's vulnerability was high. Mr Paton explained that both were high, and Mrs Wells explained that the issue was included on the BAF and had recently had its rating reduced from red to amber. Mr Reid explained that the model of compliance had been developed to allow the Trust to assess progress with cybersecurity. The Trust felt that there were adequate cybersecurity measures in place, and was not flagged as being a high risk in comparison to other organisations. Mrs Wells explained that the amber rating reflected the improvements that had been realised, but did not signify that the issues had been resolved. Mr Paton noted that the Trust would never achieve a green rating, as risks would always exist.

Mr Wells queries why the report stated that the cybersecurity risk was high, while it was rated as amber on the BAF. Mrs Wells explained that the specific risk on the BAF was about no cybersecurity controls being in place, an issue which had been and would continue to be addressed.

Mr Paton asked the Committee whether they were supportive of the spending plans outlined in his paper. Mrs Webber explained that the Committee was supportive of the model being proposed, but that capital spend would have to be balanced against capital demands from throughout the organisation. Mr Reid confirmed that the Executive team was also fully supportive of the proposed model.

012/19 Tenders and Waivers

Mrs Webber thanked Ms Sadiq for incorporating the Committees requests into the updated report. She explained that she had a number of queries, but that she would send these to Mr Reid outside the meeting.

Mr Mills noted that it would be helpful to specify the period for which each waiver was granted, and to include the reasons for the waiver being issued.

Mrs Webber asked whether there was a process and plan in place to reduce the number of waivers being issued. Mr Reid explained that an updated process to reduce waivers had been introduced. He agreed to speak to Mr Freeman and ask him to produce a report setting out the plan and trajectory for reducing waivers for July's Audit Committee. **JR**

Ms Sadiq noted that the Trust's waiver form had been updated following feedback from Grant Thornton around best practice.

013/19 Review of Losses and Special Payments

Ms Sadiq explained that the report format had been updated following feedback from the Audit Committee. She explained that there were no areas of concern and that losses and special payments were in line with previous years.

014/19 Audit Fees for 2019/20.

Ms Sadiq reported that the fee for provision of external audit services by Grant Thornton for 2019/20 would be £71,300. This fee was set for three years, and benchmarking against other organisations had shown it to be good value.

015/19 Update on Procurement of Internal Audit

Ms Sadiq explained that provision of internal audit was currently undergoing procurement processes. Bids had been received and were being reviewed and processed.

016/19 Date of Next Meeting

The next meeting of the Audit Committee would be held on:
Thursday, 28th March 2019, 1300-1500, St Mary's Boardroom, EDGH

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Thursday 28th March 2019 at 1330 in the Small Meeting Room, Centenary House, The Avenue, Eastbourne, East Sussex, BN21 3XY

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

In attendance:
Mr Jonathan Reid, Director of Finance
Mrs Lynette Wells, Director of Corporate Affairs
Mr Kevin Claxton, Head of EPRR (for item 029/19 only)
Mr Andy Conlan, Engagement Manager, Grant Thornton (for all items except 033/19)
Mr Chris Lovegrove, Counterfraud Manager, TiAA (for all items except 033/19)
Mr Mark Paice, General Manager, Estates (for item 020/19 only)
Mr Mike Townsend, TiAA (for all items except 033/19)
Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

017/19 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
Mr Barry Nealon, Non-Executive Director
Ms Vikki Carruth, Director of Nursing
Dr David Walker, Medical Director
Dr James Wilkinson, Deputy Medical Director
Dr Paul Cornelius, Clinical Lead, Emergency Division
Mr Adrian Mills, Audit Manager, TIAA
Mrs Emma Moore, Clinical Effectiveness Lead
Mr Darren Wells, Engagement Lead, Grant Thornton
Ms Saba Sadiq, Deputy Director of Finance

018/19 Minutes of the meeting held on 31st January 2019

The minutes of the meeting held on 31st January 2019 were reviewed. One error was corrected, but they were otherwise agreed as an accurate record.

019/19 Matters Arising

060/18 – Medicine Division Clinical Audit and Risk Register Review

Dr Wilkinson had been scheduled to attend the Audit Committee, but was unable to attend the rescheduled date. He would attend August's Committee meeting to discuss Clinical Effectiveness.

008/19 Local Counter Fraud Service Progress Report

Mr Lovegrove reported that he had produced a table of recommendations and sent this to Mr Reid.

010/19 – Information Governance
Mr Mills confirmed that he had circulated the Information Governance Benchmarking report 2016/17 to the Committee. This was the most up to date IG benchmarking information available.

012/19 – Tenders and Waivers
A plan and trajectory for reducing the number of waivers being issued by the Trust was due to be presented to the Committee in August.

020/19 Estates and Facilities Risk Register Review

Mr Paice reported that the Estates and Facilities Division had 51 risks on their Risk Register rated at 12 and above, with two rated at 20. An independent review of the risks was undertaken every six months to ensure that ratings were accurate, and this was due to be undertaken again in May 2019. The risks regularly underwent internal review in a number of different forums.

Mrs Webber noted concern about the number of risks on the register. Mr Paice explained that he was very hopeful that a bid to NHSI for £13m to manage fire issues at EDGH would be successful; this would address a number of risks on the register. The new energy performance contract would deal with a number of other issues.

Mrs Webber asked which issue, apart from fire, kept Mr Paice awake at night. Mr Paice reported that the biggest issue concerned the boiler house at EDGH; this was situated on a roof with a lot of critical plant underneath and potential failure would affect heating and power in the hospital. Mr Paice noted that a survey of the repairs that were needed was due to be undertaken Mr Reid explained that £370k to resolve the issue was included within capital plans for 2019/20. Mrs Webber asked that progress on the works be presented to the Audit Committee. **MP/PP**

Mr Paice noted that there were roofing issues at the Conquest hospital as the lifespan of underfelt had ended. A system to manage this had been introduced, but the hospital's roof would need to be replaced in around ten years.

Mrs Wells noted that the Division's Risk Register was much better managed than had been the case a few years previously. The register was comprehensive, accurately capturing the existing risks in the organisation.

Mrs Webber thanked Mr Paice for attending the Committee, and for his helpful presentation.

021/19 Clinical Audit Update

Mrs Moore was unable to attend the rescheduled meeting.

022/19 Board Assurance Framework and High Level Risk Register

Mrs Wells presented the Trust's Risk Register. She reported that there were 45 risks on the register, eight of which were rated above 15 and eight rated at 20. None were rated above 20.

A new risk had been added concerning the boiler ingress at EDGH as discussed above. She reported that the risk register was reviewed on a line-by-line basis quarterly at Senior Leader's Forums.

Mrs Wells presented the Board Assurance Framework (BAF), noting that it had already been presented to the Quality and Safety Committee. She proposed the removal of the gap in control concerning an effective process to manage follow up appointments particularly in the acute setting. The issue had been resolved and assurance received that a new software system and processes were robust and embedded.

Mrs Wells asked whether the red rating for the gap in control relating to the Trust's financial position should be amended to amber. She noted that a red rating implied that the Trust had no effective controls in place; the Trust was expected to meet its target for 2018/19 and had introduced greatly improved financial controls. Mrs Webber suggested that the gap in control could potentially be split into two separate risks. These could more accurately reflect that the Trust had improving financial controls, but remained concerned about the delivery of future financial performance.

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.

023/19 Internal Audit

Mr Townsend reported that one audit, concerning Delayed Transfers of Care (DTOCs), had been finalised since last meeting and had been given a rating of no assurance. The matter had been discussed in detail at the previous Audit Committee. The Trust executive had commissioned the audit as they welcomed an external view DTOCs and the response to the report had been positive.

He reported a draft report into End of Life Care (EOLC) at the Trust gave limited assurance. He noted that EOLC in the Trust's demonstrated an improving trajectory, emphasising the importance of being able to provide evidence of this improving care. A follow-up audit in 2018/19 was being considered, once The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) had become embedded within the organisation.

Mr Townsend reported that an audit of the Data Protection and Security Toolkit (DPST) had given reasonable assurance. Mr Reid noted that this was the first year that the DPST toolkit had been used, and thanked the audit team for their help with managing this process. Mr Townsend reported that substantial assurance had been given following an audit of Critical Financial Assurance – Financial & Non-Pay.

Mrs Webber asked whether a Trust response had been received by auditors following audits of Waiting List Initiatives and Performance Data Quality VTE in January. Mr Reid explained that the actions from these audits had been received by the Trust, and agreed to ensure that responses were sent to auditors. **JR**

Mr Townsend reported that 12 audits recommendations were being recommended for closure, 12 for follow up and 22 that were either due or overdue a response. Mrs Wells reported that Executives had recently scrutinised the outstanding audit actions; she was unsure that the results of

this exercise had been fedback to auditors, She explained that Executives regularly reviewed audit recommendations to ensure that they were appropriate and that action was being taken to address them. Mr Reid noted that some of the recommendations were no longer applicable and agreed to speak to TiAA about this. **JR**

An updated list of audit recommendations would be presented to the Committee in August.

024/19 Local Counter Fraud Service Progress Report

Mr Lovegrove reported that one new referral had been received by Local Counter Fraud Services (LCFS) since the papers had been circulated. He provided updates on two existing cases.

Mrs Webber asked about LCFS' threshold for prosecution. Mr Lovegrove explained that this would depend on the level of the abuse, and whether the prosecution was in the public interest. He was assured that the Trust took a zero tolerance approach to fraud.

Mr Lovegrove reported that LCFS continued to promote fraud awareness at team meetings. Support had been offered to the Overseas Management team where issues had been identified. Mr Reid explained that a member of staff was employed by the Trust to manage overseas patients, ensuring that the Trust remained compliant with legislation. He praised the work that they did in recouping fees for the treatment of overseas patients.

Mr Reid noted that the recommendations contained within the report had been submitted to him, and explained that he would provide responses to these at a future meeting. **JR**

Mr Lovegrove reported that a national exercise reviewing counterfraud measures in NHS procurement was planned, and Mr Reid noted that the Trust was very keen to participate.

025/19 External Audit

Mr Conlan reported that interim field work and testing of finances had been undertaken by external auditors in advance of the financial year end. Minor issues had been identified and were being addressed, resulting in no adjustment to the auditor's view of risk assessment and materiality. Mr Reid reported that the finance team had been very happy with the engagement that they had had with auditors. He noted that a new head of financial services was being sought by the Trust.

Mrs Wells asked whether a decision had been made about which quality account indicators would be audited. Mr Conlan reported that indicators for Venous Thromboembolism and Clostridium Difficile would be audited.

026/19 Going Concern

Mr Reid presented a paper setting out the testing that had been used to provide assurance that the Trust's accounts had been prepared on a Going Concern basis, and the draft Going Concern statement that would be included within the Annual Report and Accounts support this. He noted that the statement was less aspirational than it had been in previous years as the Trust was delivering its financial plans.

Mrs Webber noted that she was concerned about the wording of the statement, and Mr Conlan explained that he had discussed this with the Trust. It had been agreed that the statement would be amended to clarify that the Trust was a Going Concern, but with material uncertainty.

The Committee agree to the statement on condition that the amendment was made.

027/19 **Information Governance**

Mrs Wells reported that the Trust had made a fully compliant DSPT submission earlier in the week. Other matters brought to the Committee's attention included:

- Information Governance (IG) training for staff was now carried out electronically.
- Four possible IG breaches had been passed to HR for investigation.
- The IG team was closely involved in the Trust's Brexit preparations, with no potential IG issues having been identified.

Mrs Webber asked if the report could be updated to reflect data since the last meeting, rather than data for the whole year. Mrs Wells suggested that reporting could be done on a quarterly basis to the Committee and agreed to discuss the format of the report with the IG team. **LW**

028/19 **Draft Annual Governance Statement for 2018/19**

Mrs Wells presented the draft Annual Governance Statement for 2018/19, noting that would form part of the Annual Report and Accounts. She explained that guidance on the format of the report was published each year, and that the statement was fully compliant with the latest guidance. Mrs Wells noted that the statement would be updated when full year data was available.

029/19 **Emergency Preparedness, Resilience & Response Update**

Mr Claxton presented an update on Emergency Preparedness, Resilience & Response (EPRR) in the Trust. Two years previously the Trust had been partially compliant with EPRR standards and requirements; in 2018 that had increased to substantially compliant, largely due to the employment of two EPRR practitioners by the organisation. He hoped that full compliance would be achieved in 2019 and noted that Mrs Webber had taken on the role of EPRR NED lead for the organisation.

Mrs Webber praised the progress that had been made by the Trust, noting that many similar organisations were reporting reduced compliance. Mr Reid explained that EPRR had been transformed since Mr Claxton and Luke Blackwell had joined the organisation, noting that the work they were doing was fantastic.

Mr Claxton explained that the EPRR team was working with the Learning and Development to plan EPRR training required by staff and the best way to deliver this. Mrs Webber thanked Mr Claxton for the fantastic job that he was doing in improving EPRR in the organisation.

030/19 **Tenders and Waivers**

Mr Reid explained that the report had been refreshed following feedback from the Committee.

Mrs Webber noted that the report continued to include waivers that should not have been issued, noting that timing was not an excuse for issuing a waiver. Mr Reid explained that the estates team employed a number of key specialists when necessary at short notice, and that their procurement needed to be managed in a more controlled manner. Intra-trust waivers continued to be included on the report and a detailed plan for addressing these issues would be presented to the Committee in August. **JR**

031/19 Review of Losses and Special Payments

Mr Reid reported that he would be meeting with the head of pharmacy to understand the write offs of medicine that were reported each month, and would update the Committee in the report in August. **JR**

Mrs Webber asked for dates of major individual write offs to be included within the report.

032/19 Accounting Standards and Policies.

Mr Reid reported that a number of changes to international accounting standards had taken place. He explained that the Trust would meet all mandated accounting standards for 2018/19.

033/19 Procurement of Internal Audit and LCFS Update

Mr Reid provided an update on the procurement of internal audit and LCFS to the Committee. He explained that a procurement exercise had been undertaken and asked the Committee to agree to appoint TiAA as the Trust's Internal Audit and Local Counter Fraud service with effect from 1 April 2019 for a 3 year period.

The Committee asked that a review of the 2019/20 audit plan be undertaken to test whether all audits that had been proposed were required.

The Committee approved the appointment of TiAA **from 1st April 2019, subject to review of proposed 19/20 internal audit plan.**

034/19 Date of Next Meeting

The next meeting of the Audit Committee would be held on:
Friday 24th May 2019, 0900 - 1100, St Mary's Boardroom, EDGH

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee

Thursday 21 March 2019
10:00 – 12:00
St Mary's Boardroom, EDGH vc Room 7, Education Centre, Conquest

Present:
Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Dr Adrian Bull, Chief Executive (AB)
Ms Monica Green, Director of HR (MG)
Mrs Joe Chadwick-Bell Chief Operating Officer (JCB)
Mrs Vikki Carruth, Director of Nursing (VC)
Ms Karen Manson, Non-Executive Director (KM)
Dr David Walker, Medical Director (DW)
Mrs Kim Novis, Equality & Human Rights Lead (KN)
Mrs Lesley Houston, Deputy GM – Medicine (LH)
Mrs Lorraine Mason, Assistant Director of HR - OD (LM)
Mrs Dawn Urquhart, Assistant Director HR, Education (DU)
Mrs Lynette Wells, Director of Corporate Affairs (LW)
Mr Pravin Sangle, Associate Specialist (PS)
Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)

In Attendance:
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 (JR) Mr Salim Shubber, Director of Medical Education (SS) Mrs Jan Humber, Staff Side Chair (JH) Mrs Brenda Lynes O'Meara, Associate Director of Operations (BLO) Mrs Moira Tenney, Deputy Director of HR (MT) Ms Penny Wright, Head of Workforce Planning (PW) Ms Emma Chambers, Interim Assistant Director of Nursing (EC) Mrs Michelle Elphick, Associate Director of Operations (ME) Ms Anne-Marie Newsholme, Lead Healthcare Scientist (AMN)	

2	**Minutes and Matters Arising** **2.1 Minutes of the previous meeting held on 24 January 2019** 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 An accountability and governance review was being undertaken, which would be shared at the next meeting. Developing Workforce Safeguards (DWS) To be discussed within the Agenda. **Action: Closed**	**LW**
3	**National Update** 3.1 NHS Long Term Plan: Workforce Implementation Plan MG provided a verbal overview of the Workforce Implementation Plan. Baroness Dido Harding, chair of NHSI, was asked by the Secretary of State to take forward the development of this plan. An interim plan would be delivered by the end of April of this year with a full plan within 2 months of the final 2019/20 spending review. The Trust Workforce Implementation Group would be looking at both longer and shorter term aspects of the Long Term Plan. Five groups had been set up nationally to cover all expectations: • Future Medical and Dental Workforce • Future Clinical Workforce • Making the NHS the best place to work • Leadership Talent Management and Development • Technical Skills and Enablement Each group would provide regular updates on the progress of their work and when the interim report is published in April, it would be shared with the Committee for discussion around local implications and actions. KM queried the process in feeding back into the plan and how much of a voice the Trust actually has. MG explained that the groups listed above provide updates on a weekly basis and as part of that there is an electronic feedback mechanism. There have also been a couple of national meetings to which HR Directors have been invited to attend and provide feedback. MG assured the Committee that she was confident that the voice of the employers and local people were being heard and taken into account within those groups and that they have varied and extensive membership. 3.2 The Topol Review: Preparing the healthcare workforce to deliver the digital future MG provided a verbal overview of The Topol Review, which is a report on preparing the workforce of the NHS to have the digital skills and new technology to aid patient care/journey; working with various education providers. There will be a need to link closely with what is happening nationally and updates will be provided regularly.	

	MK asked if local voices would be heard. MG stated that, in her view, this was not necessarily the case at the moment as this was in the early stages but there would be some opportunity for the Trust to get involved in the workforce implications of some of the digital transformation agenda. KM asked if there was a timeline for the Trust to develop its own plan. MG explained that the Trust IT lead was developing a strategy to meet the digital future and would ensure that there was a learning agenda linked into that. AB confirmed that there was a dedicated digital training scheme available but there was a need for future training on the use of apps for healthcare. KM asked how the Trust would change the mind set of employees for a new way of working and highlighted that there would be a challenge, from a systems point of view, to ensure that everybody was in agreement and working in similar ways. AB referred to Patients Know Best portal and said that we would ensure that this would be led by patients, working through what patients require then both clinical and administration colleagues would follow.	
4	**Workforce Engagement** 4.1 Staff Survey Presentation MG provided a verbal overview of the Staff Survey Presentation The staff survey was conducted between October and November 2018 with a range of paper and online responses; response rate 53% (previous year 49%). The Staff Survey would be shared with the divisions for the development of action plans. MG highlighted the importance of this survey which monitors how the staff within the Trust are feeling, how they are involved, engaged and the culture. The key findings had been replaced with ten themes, which were be scored on a 0-10pt scale: • Equality, diversity and inclusion • Health & wellbeing • Immediate managers • Morale • Quality of appraisals • Quality of care • Safe environment – Bullying and harassment • Safe environment – Violence • Safety culture • Staff engagement The Trust had progressed; improving year on year; examples of positive areas were highlighted and those needing action. AB referred to the Women & Children IPR staff survey results that had been summarised. The question: *"In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers or colleagues"* which were recorded as high – in the 80%s. AB asked LM if she was aware of this. LM stated that information would be picked up via drilling down data and that she would provide a response to this particular finding at the next meeting. **Post Note 23.05.19**: LM highlighted that the statistics shared at this meeting relating to bullying and harassment within the women and children's division were in fact incorrect, therefore no issues to be concerned about.	**LM**

	AB stated there was a need to identify any questions on which there was a wide spectrum of response across the divisions and corporate areas. KM stated that she supported the idea of looking at divisions rather than the aggregate; looking at areas of concern to make a difference to staff. A discussion took place regarding the percentages and the statistical relevance of them and the way the data had been shared within the presentation; it was agreed that this requires more explanation and that raw data and trend information will be shared with the Divisions. MK referred to the question "*Care of patients/service users is my organisation's top priority"* under the Staff Engagement Advocacy section and highlighted that the score was under the sector score at 73%. JCB explained that the organisation was spending a lot of time focussing on finances and staff would be more likely to say that the purpose is to deliver excellent healthcare but the focus is on finance. Quality should remain the top priority in context of sustainability. LW reported that the aggregate information is really important for the CQC and explained that the CQC insight report tool is used to target areas when the CQC visit to inspect the organisation. As a Trust we need to be mindful that benchmarking and national figures are looked at. AB highlighted that individual results within each division would be discussed and fed back via the IPR process. LM reported that this presentation was the start of the conversation with divisions and a divisional data pack had been sent out. LM highlighted the importance of involving staff in decision making and for them to be aware that this survey is taken seriously with ongoing discussions taking place around priority areas. PS referred to the health and wellbeing response at 30% and queried the other 70% of staff. PS stated that that it could be about the different experiences of staff lacking equipment etc. rather than actual stress and that the low score would not always relate to medical health. PS suggested that every 6 months each division have a snapshot audit picking up staff responses prior to uploading nationally. LM stated that pulse surveys are undertaken, which are linked to corporate and divisions, although have a slightly lower response rate but this is something that could be looked at. KM queried whether key actions would be fed back to this committee. LM confirmed that regular feedback is discussed at this committee. MG stated that information would be presented to the Board and the Senior Leaders Forum sharing best areas of practice and areas that need to be targeted.	
5	**Workforce Development** <u>5.1 High Potential Scheme</u> LM provided a verbal update of the High Potential Scheme and explained that this was part of the approach to talent management and linked with the workforce implications in the Long Term Plan about being an employer of choice.	

	Two schemes available: 1. Aimed at staff 8b and above or equivalent grades (open to medical staff too) who demonstrate the performance and potential to be either a Deputy or Director within the next 2 years. This is on the basis of recognising that there is a national shortage of high calibre Executive Directors. Also aware that people could be brought in from outside of the organisation as the scheme is intended for people to compete at interview and have the opportunity to apply for a Deputy or Director position. There will be 10-15 positions available on this programme. 2. Aimed at Band 6 and 7s who have high performance and high potential leaders (scored a 1 in their appraisal) and want to develop to the next level within 2 years. The scheme is intended to prepare people in advance to apply and compete for roles and have the skills required. There will be 2 cohorts available on this programme with 20 positions each. Work currently underway regarding the selection procedure. A model is being developed on how to measure potential, which will include their motivation, energy, focus, approach, emotional potential regarding their insight about themselves and others and how flexible they are with their thinking and can adapt to situations. Firstly there would be an initial conversation with the applicant and the line manager, there will then be an application process and for the aspiring Directors and Deputies there will be a mini-assessment centre. The scheme is to be launched in May 2019 with the programme commencing in September 2019. KM stated that is was a good incentive for the retention of staff. MG replied that there is a need to be clear on the criteria and the outlays of this need to be costed out. KM suggested doing this prior to the launch in May 2019. AB and JCB expressed the importance of having honest conversations with unsuccessful applicants explaining why the programme is not suitable but highlight other pathways open to them.	
6	**Medical Engagement Update** DW provided a verbal update on medical engagement. <u>Junior Doctor Forums</u> Positive work had been undertaken to engage with junior doctors whereby a wide range of issues were discussed with good attendance at these meetings in order to raise any issues. <u>Guardian of Safe Working Meetings</u> It was noted that the Guardian of Safe Working meetings were less well attended and the BMA have been encouraging the organisation to try to promote these meetings to increase attendance. <u>Training Meetings</u> Training meetings are led by the education department, which are for junior doctors' issues around training, which are discussed separately from the Guardian of Safe Working meetings.	

	Hospital at Night Committee Good junior doctor representation. Local Negotiating Committee (LNC) Good junior doctor representation. SAS Doctors The Trust has made a particular effort in recognising the skills and abilities of SAS Doctors to improve care within the organisation and have reintroduced associate specialist grade; currently working on promotions within divisions. There is current SAS representation on POD and LNC. Significant improvement made with SAS Doctors. PS highlighted the change within the last 2 years in the way that the meetings were managed, the SAS Doctors feel recognised, their morale had improved and positive feedback had been received. Consultants A Medical Engagement Scale had not been undertaken this year; due to financial implications. Lots of opportunities for consultants to get involved in the work of the organisation and regular meetings take place within each division. Good consultant attendance at the Maternity Board, LNC, Deteriorating Patient Group, Hospital at Night. One area for non-attendance is on the Patient, Safety and Quality Group and the Clinical Outcomes Group is variable. Overall in terms of trying to involve consultants in all aspects good progress has been made. MK asked how the outcomes were being measured. DW replied that the only outcome was the Medical Engagement Scale, which had previously been at the bottom 10% and then moved to the top 10% when it was re-done last year. It was suggested to undertake this measure every 5 years. LH highlighted the engagement in working in effectiveness and quality of consultants and junior doctors within the medicine division. MK reminded DW that at a previous meeting the Chief Executive had requested that a joined up strategic approach to the Trust Engagement Strategy with medical staff should be brought to a future meeting. MK therefore requested that this be put on the agenda for the May meeting. DW highlighted that there is a real improvement in the quality and depth of discussion that is taking place around clinical governance across the Trust. 6.1 Developing Workforce Safeguards VC provided a verbal overview of the Developing Workforce Safeguards, which is oversight and assurance that the organisation has systems and assurance in place. Key highlights: • Compliance and triangulated approach • Tools and systems in place • Ensuring the organisation has the right forum and people to discuss new posts/roles • Workforce challenges • Quality outcome and excellence in care is progressing	**DW**

	A discussion took place regarding workforce challenges and it was highlighted that there were different ratios of staff on the wards. DW stated that if Health Roster was fully implemented for medical staff it would give a much better way of looking at ward cover. It was noted that there would be possible challenges in junior doctors covering shifts, there are no strict national guidelines as in nursing and in terms of standards it is a speciality specific issue. MK asked what the consequences or implications were of declaring partial compliance. VC stated that targeted support would be provided by NHSI. MG stated that we were not different to any other Trust nationally. AB referred to the Rota Supervisory Group that had been established to look at Guardian of Safe Working hours, rota issues and cover for junior doctors. The group had asked divisions to consider where there are shortages, what use can be made of supplementary roles to support that; a number of things that have been done. AB highlighted the need for a more concerted set of actions to bring the doctors up to the same level as nursing. KM asked about the inclusion of community care where safety issues had been raised i.e. lone working and facilities. VC stated that community have very little tools nationally and lots of conversations were taking place regarding challenges, vacancies and looking at different ways of working. Management decisions were currently being taken regarding the structure of the Out of Hospitals division.	
7	**Gender Pay Gap** MG provided a verbal overview of the Gender Pay Gap and stated that it was the duty of the Trust to provide a report around gender pay gap annually for organisations that have more than 250 employees. MG stated that it was important to note the differences between staff on Agenda for Change pay scales and Medical and Dental pay scales because for the latter the award of CEAs alters the data. Key points: **Average gender pay gap as a mean average** - female mean pay is lower than male pay by 21.5% **Average gender pay gap as a median average** female median pay is lower than male pay by 2.8% Both these indicators have improved on last year. -Agenda for Change staff male mean pay is lower than female by 3.8% -Medical staff female mean pay is lower than male by 18.8% Only medical and dental staff are eligible for bonus payments through the Clinical Excellence Awards scheme. **Average bonus gender pay gap as a mean average**, Female mean bonus payments are lower than male by 33.2% showing an increase of 1.9% **Average bonus gender pay gap as a median average**, Female median bonus payments lower than male by 29% showing a reduction in the gap by 18.6% **Average bonus gender pay gap as a median average**, Lower % of female staff receiving bonus payments (of those receiving a bonus male 78.6%: female 21.4%). Consistent with previous year.	

	MK asked if the lower mean pay was because of part time working. MG said this is taken into account in the calculations Historically more of the CEAs were awarded to male consultants as the numbers of male consultants were greater. More women were coming forward and applying for awards. MG reported that under new arrangements for CEAs the Trust has a requirement to provide a detailed report around the breakdown of people eligible to apply by all protected characteristics, those who do apply and those who are successful.	
8 **8.1** **8.2** **8.3**	**Items for Information:** <u>Nursing Report</u> MK queried why the vacancies for HCAs/unregistered nurses had doubled. JCB explained that in January an establishment had been allocated for the winter ward so the establishment had increased. The plan for next year would be to look into the recruitment of those posts. VC reported that she would meet with divisional colleagues, finance and recruitment to try to understand the implications around these vacancies. VC to feedback progress to the committee. <u>Workforce Report</u> MK queried the large variance on Agenda for Change appraisals within the rolling year. MG explained that the plan was to reach 85%; the figure actually reached was 79% which was thought to be due to pressures on the wards. MB highlighted that discussions were taking place within divisions through the IPR meetings and stated that divisions receive a breakdown of individual appraisal levels, which are reviewed on a monthly basis. **Minutes from sub-groups**: <u>Organisational Development & Engagement Group</u> Item noted. <u>Education Steering Group</u> Item noted. <u>Workforce Resourcing Group</u> Group had not met. <u>HR Quality & Standards Group</u> Item noted.	**VC**
9	**Any other business** <u>Medical Appraisals</u> DW highlighted an imminent crisis regarding medical appraisals. DW explained that historically appraisals were completed on time. Appraisers are currently responsible for undertaking the appraisals of bank staff, which has resulted in over a 100 extra staff requiring appraisals. There are currently 90 doctors for whom we are unable to allocate an appraiser for this year. JCB queried if appraisals were being undertaken for every doctor on the bank. DW stated that not all as some are registered with agencies and have commitments elsewhere. Where the Trust is their primary work base then we are obliged to appraise them.	

	MK asked how long it would take to complete the outstanding appraisals. DW stated that they will not get done in a timely manner so external appraisers at a cost may be an option. DW to feedback progress to the Committee. <u>Workforce Plan</u> MK reported that there had been a number of comments at some recent meetings that she had attended, which displayed that people were not aware of all the work that has been done on the workforce plan. MK suggested sharing at the Board Seminar in July 2019.	**DW**
10	**The next meeting of the Committee will take place on:** **Thursday 23 May 2019** **10:00 – 12:00** **Committee Room, Conquest vc John Cook Room, EDGH**	

Dates of 2019 Meetings:

Date	Time	Venue	Call for Papers Date	Submission Deadline
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

Use of Trust Seal

Meeting information:			
Date of Meeting:	4th June 2019	Agenda Item:	20
Meeting:	Trust Board	Reporting Officer:	Lynette Wells

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

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

Summary:

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

The purpose of this paper is to provide an overview of the use of the Trust Seal since the last Board meeting.

28th March 2019 – Contract with Booker and Best Ltd for work carried out on the Urology Investigation Suite at Eastbourne Hospital.

3rd April 2019 – Agreement with British Telecommunications plc for charges relating to the use of the Health and Social Care Network (HSCN) for 54 months.

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

Not applicable.

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

The Board is asked to note the use of the Trust Seal since the last Board meeting.

East Sussex Healthcare NHS Trust

Raising Concerns:
Freedom to Speak Up and Datix

May 2019

During quarters 3 and 4 (Oct - Mar), 122 concerns were raised by staff through the Freedom to Speak Up Guardian (FtSUG). This compares with 162 concerns during the same time last year, with a significant decrease in Q4 following a period of absence from the Speak Up Guardian. The key themes in concerns raised are behaviour and relationships at work, bullying and harassment and systems and processes. There has, however, been a reduction in concerns relating to behaviours/relationships and bullying/harassment in the last six months, which was also reflected in the annual staff survey results (see page 4 for more information).

Category	Concern raised to FtSUG	
	Q3	Q4
Behavioural / Relationship	19	13
Bullying / Harassment	12	3
Patient Safety / Quality	6	7
Racial discrimination	4	0
Sexual discrimination	0	0
Staff Safety	2	1
System / Process	20	8
Leadership	1	1
Cultural	0	1
Not known	7	17
Totals	**71**	**51**

Category	Incident recorded on Datix	
	Q3	Q4
Verbal abuse from employee	19	16
Sexual harassment	1	3
Aggression - intentional physical assault by member of staff	0	2
Aggression - harassment relevant to race/racial motivation	1	1
Totals	**21**	**22**

Trust's Meeting Charter launched

The Trust's Meeting Charter has now been launched, setting out the expected behaviour of all colleagues in all meetings. The Charter (see right) will be displayed in all meeting rooms - further detail is available on the extranet.

All meetings will be run by the Chair in line with Trust values. Any behaviour that does not meet this will be addressed in a supportive way but with clear understanding of how staff should conduct themselves in meetings.

Freedom to Speak Up Guardian—Ruth Agg

Mobile: 07920 087059 Email: ruthagg@nhs.net

You said…

"I approached a member of the public to offer support while he was waiting for an appointment. He became aggressive, shouting and threatening that he would be waiting for me after work. I was very distressed and had to ask my husband to meet me from work as I was so scared."

We did…

The member of staff was reassured and support was provided. The leadership team of the service was contacted to advise of the distress caused and to remind of the support available for colleagues who have been involved in an incident, as set out in the Policy for Supporting Staff involved in Incidents, Complaints or Claims. The Trust has a zero tolerance approach to violence and aggression, as set out in the Violence and Aggression Policy (which is currently being updated) and members of staff must be supported to address behaviour in line with the policy. If any member of staff feels threatened, they should call for assistance from security.

For any member of staff involved in a traumatic or stressful incident, complaint or claim, their line manager is the first line of support. The manager should offer immediate and on-going support and re-assurance to the employee as follows:

- Work through the staff support checklist (Appendix B of the Policy) with the member of staff, offering support and assistance as required
- Provide the support and advice required by staff directly and/or take action to refer to the Occupational Health Department (as appropriate and necessary)
- Ensure that any recommendations from the Occupational Health Department are considered and followed through in relation to individuals and their workplace environment
- Ensure regular communication with the member of staff and continue to assess them to ensure that the most appropriate support is provided to them
- Arrange for the de-briefing of staff following trauma.

You said…

"I sent a confidential email to raise concerns and it was forwarded to other colleagues, causing me great distress."

We did…

The member of staff has been supported to share their concern that the email was shared without their consent. A meeting has been held between the employee and their manager where an apology was given and agreement reached on how to move forward.

You said…

"I have faced racial discrimination from patients and been asked not to touch them."

"I have had comments about my colour and ethnicity which have caused great distress."

We did…

Cases of racial discrimination are taken very seriously and must be reported. Managers can use the Violence and Aggression Policy and seek advice from Human Resources (HR) on how to manage this. Any racial discrimination should be reported on Datix, these are reviewed by HR and clinical divisions to ensure staff are supported and actions have been taken.

Freedom to Speak Up Guardian—Ruth Agg

Mobile: 07920 087059 Email: ruthagg@nhs.net

You said…

"My manager has said all concerns must be raised with the Speak Up Guardian."

The Freedom to Speak Up Guardian has seen an increased number of colleagues who have been sent by their managers.

We did…

As set out in the flowchart below, any concerns should first be raised with the line manager, tutor or colleague. However, it has been recognised that some managers do not feel confident to support staff raising concerns and so meetings with Human Resources and Staff Engagement have been held to look at including training regarding raising and addressing concerns and providing feedback in leadership courses. If members of staff feel unable to raise concerns directly with their line manager, they can escalate to a more senior manager.

STEP 1
Raise concern with line manager, tutor or colleague.

STEP 2
If not reassured, escalate to senior manager.

STEP 3
If unable to raise concern through leadership team, make contact with the Freedom to Speak Up Guardian.

STEP 4
Where possible, the aim is for local resolution. Serious concerns may need to be addressed through the formal HR route.

STEP 5
Particularly serious concerns involving patient safety or risk to the organisation will be escalated to the Chief Executive, through senior management colleagues.

STEP 6
If all internal routes have been exhausted, concerns can be raised with specific external organisations - see the extranet for more details.

Top tips for managers

Listen carefully to any worker raising a concern

- Commit to taking the matter seriously
- Thank the person for raising the concern (even if you think they may be mistaken)
- Acknowledge how they may be feeling, that it may be a difficult or stressful situation, and offer reassurance
- Respect the worker's belief that they are raising a genuine concern
- Avoid prejudging if this is correct or valid until an appropriate investigation has taken place.

Respond positively and clearly

- Reassure the person that the concern will be looked into promptly and (where appropriate) investigated thoroughly and fairly as soon as possible.
- Manage expectations of the individual - discuss next steps, reasonable timeframes, and arrangements for feedback on the outcome
- Respect a worker's request for confidentiality and any concerns about their job or career, but explain any circumstances where there may be limits on confidentiality
- Offer advice about the type of support available to them
- Be clear on what the worker should do and where they should go if they experience any reprisals or unacceptable behaviour, e.g. bullying, harassment or victimisation, from managers or colleagues.

NHS Staff Survey results 2018

The results of the 2018 Annual Staff Survey showed continued improvements in the way we work with each other at ESHT and the cultural environment that we create. Progress on addressing bullying and harassment has been made and more colleagues feel able to raise issues or concerns with confidence that they will be addressed. The results also show areas where further improvements need to be made, for example, supporting the safety of staff working directly with patients and encouraging everyone to demonstrate behaviours that reflect our Trust values.

Responses and progress at ESHT since 2015 for key questions which have been identified as markers for speaking up are given below.

I would feel secure raising concerns about unsafe clinical practice

67.5% of staff agreed or strongly agreed

11.9% improvement since 2015

I am confident that my organisation would address my concern

55.1% of staff agreed or strongly agreed

16.6% improvement since 2015

My organisation acts on concerns raised by patients/service users

69.3% of staff agreed or strongly agreed

18.1% improvement since 2015

In the last 12 months, have you personally experienced physical violence at work from patients/service users, their relatives or other members of the public?

12.9% of staff had experienced at least one incident of violence

0.6% improvement since 2015

In the last 12 months, have you personally experienced physical violence at work from managers?

0.6% of staff had experienced at least one incident of violence

0.1% improvement since 2015

In the last 12 months, have you personally experienced physical violence at work from other colleagues?

1.7% of staff had experienced at least one incident of violence

0.3% increase since 2015

The message to all members of staff from Chief Executive Adrian Bull about our staff survey results is available on the extranet, and includes the link to the full results report.

Freedom to Speak Up Guardian—Ruth Agg

Mobile: 07920 087059 Email: ruthagg@nhs.net

You said…

"I was undermined and shouted at in front of others by a senior colleague."

"I was physically pushed by a colleague."

"I was called a fat b***h by a colleague."

"Nursing staff were unhelpful and laughed at me."

We did…

Colleagues have received apologies where appropriate and members of staff have been spoken to regarding their behaviours, which are unacceptable. Persistent concerns regarding poor behaviour have been referred to Human Resources to enable a more formal approach through investigation and, where appropriate, disciplinary action. Some members of staff have recognised that their inappropriate behaviour is linked to work-related stress or problems with their work-life balance, and support has been put in place to help them with this.

Behaviours such as shouting, aggression, undermining and unprofessionalism are frequently raised on Datix and to the Freedom to Speak Up Guardian. Poor behaviour is not acceptable and everyone in the Trust must behave in line with our values, which have recently been refreshed (see right).

- Staff are encouraged, where possible, to address unacceptable behaviour at the time and consider local resolution and an apology, if appropriate. It is recognised that this is difficult for some staff groups, so support is available from line managers, clinical leads and tutors.
- Persistent poor behaviour should be reported on Datix to enable investigation and support for all involved and to ensure there is learning moving forward.
- Persistent poor behaviour should be addressed through a more formal route if there is no evidence of improvement following support.

You said…

"I requested compassionate leave following the death of a close relative and was told to take annual leave."

"Other members of staff have been given compassionate leave to attend a colleague's funerals, there does not appear to be equity in application of the policy."

"I requested time off for a relative's funeral and was told I couldn't attend despite offering to take leave."

We did…

The Work-Life Balance and Special Leave Policy has been amended and should be applied in line with our Trust values. Bereavement leave has been increased to five days for immediate family plus one day to attend the funeral. Employees may be able to take paid time off to attend the funeral of a work colleague, subject to the needs of the service. Anyone who requires support following the death of a family member or friend should discuss this with their line manager, who should consider how time off should be taken. All members of staff should feel supported in a kind and compassionate way.

Freedom to Speak Up Guardian—Ruth Agg

Mobile: 07920 087059 Email: ruthagg@nhs.net

Speaking Up terminology

What do these terms mean to you?

Raising concerns

Speaking Up

Whistleblowing

Raising concerns, speaking up and whistleblowing are all essentially the same thing.

The impact of the word and differences in interpretation can cause confusion, hence the preference for the term "speaking up". Speaking up is about patient safety and culture and is about learning and improving.

If a concern is raised confidentially, the person raising it is happy to share their identity with the person they are raising the concern with, but does not want it shared with anyone else without their consent.

Confidential

If a concern is raised anonymously, the person raising it does not want to share their identity with anyone. This can make it more difficult to investigate/take action.

Anonymous

Feedback on the Freedom to Speak Up Guardian (FtSUG)

All colleagues who contact the FtSUG are sent a survey to get their feedback on the service and their suggestions for improvements. 33 colleagues completed the survey during quarters 3 and 4:

100% of respondents said they received a timely response from the FtSUG
100% of respondents felt their concerns were completely listened to
100% of respondents said they felt supported either completely or to some extent
100% of respondents are very likely or likely to recommend the FtSUG
97% of respondents would speak up again
70% felt that their concerns had been resolved completely or to some extent. For those where concerns were yet to be resolved, reasons given included line managers not yet taking action, investigations still underway and changes to culture taking place slowly.

"Ruth gave me the confidence that I'm not alone and made me more determined to do the right thing."

"I shall be eternally grateful to Ruth for holding out a hand of support to me."

"Ruth has a calm demeanour and puts across alternative solutions extremely well."

"Knowledgeable, understanding and sympathetic, Ruth gave me essential support in a difficult time at work, which made an enormous difference to my wellbeing."

"It gave me the confidence to address my concerns knowing there would be no reprisals for doing so if I followed the correct procedure."

Freedom to Speak Up Guardian—Ruth Agg

Mobile: 07920 087059 Email: ruthagg@nhs.net

National Guardian
Freedom to Speak Up

NHS
Improvement

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

May 2018

Contents

Introduction 2
About this guide 3
Our expectations 4
Individual responsibilities 8
FTSU Guardian reports 11
Resources 13

Introduction

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led trust.

This guide sets out our expectations of boards in relation to Freedom to Speak Up (FTSU). Meeting the expectations set out in this guide will help a board to create a culture responsive to feedback and focused on learning and continual improvement.

This guide is accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust's speaking up culture is.

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office and represents current good practice.

We want boards to treat this guide as a benchmark; review where they are against it and reflect on what they need to do to improve. We expect that the board, and in particular the executive and non-executive leads for FTSU, will complete the review with proportionate support from the trust's FTSU Guardian.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better performance.

The attitude of senior leaders to the review process, the connections they make between speaking up and improved patient safety and staff experience, and their judgements about what needs to be done to continually improve, are much more important.

Key terms used in this guide

- **The board**: we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean executive and non-executive directors.
- **Workers**: we use this term to mean everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

We will review this guide in a year. In the meantime, please provide any feedback to enquiries@improvement.nhs.uk

Our expectations

Leaders are knowledgeable about FTSU

Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.

Leaders have a structured approach to FTSU

There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian). It aligns with existing guidance from the National Guardian. Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.

Leaders actively shape the speaking up culture

All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. Senior leaders model speaking up by acknowledging mistakes and making improvements. The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.

Leaders are clear about their role and responsibilities

The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. Other senior leaders support the FTSU Guardian as required. For more information see page 8 below.

Leaders are confident that wider concerns are identified and managed

Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.

Leaders receive assurance in a variety of forms

The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.

In addition the board receives a report, at least every six months, from the FTSU Guardian. For more information see page 11 below. Boards should consider inviting workers who speak up to present their experience in person.

Leaders engage with all relevant stakeholders

A diverse range of workers' views are sought, heard and acted on to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.

The organisation is open and transparent about speaking up internally and externally. Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. Reviews and audits are shared externally to support improvement elsewhere.

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture. Likewise, senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians. Senior leaders request external improvement support when required.

Leaders are focused on learning and continual improvement

Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.

The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

The FTSU policy and process are reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. A sample of cases is audited to ensure that:

- the investigation process is of high quality; outcomes and recommendations are reasonable and the impact of change is being measured
- workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome
- investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored.

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. This is demonstrated in organisational data and audit.

Individual responsibilities

Chief executive and chair

The chief executive is responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair are responsible for ensuring the annual report contains information about FTSU and that the trust is engaged with both the regional Guardian network and the National Guardian's Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

Executive lead for FTSU

The executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring that the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence.
- ensuring that a sample of speaking up cases have been quality assured
- conducting an annual review of the strategy, policy and process
- operationalising the learning derived from speaking up issues
- ensuring allegations of detriment are promptly and fairly investigated and acted on
- providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.

Non-executive lead for FTSU

The non-executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement
- role-modelling high standards of conduct around FTSU
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up concerns regarding board members – see below.

We appreciate the challenges associated with investigating issues raised about board members, particularly around confidentiality and objectivity. This is why the role of the designated non-executive director is so important. In these circumstances, we would expect the non-executive director to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
- if so, whether an investigation is proportionate and what the terms of reference should be.

Depending on the circumstances, it may be appropriate for the non-executive director to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive director does take the lead, they should inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive director should inform NHS Improvement and CQC that they are overseeing an investigation into a board member. NHS Improvement and CQC can then provide them with support and advice. The trust would need to think about how to enable a non-executive director to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the

confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for:

- ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up
- ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust
- ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.

Medical director and director of nursing

The medical director and director of nursing are responsible for:

- ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues
- ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- ensuring learning is operationalised within the teams and departments they oversee.

FTSU Guardian reports

Reports are submitted frequently enough to enable the board to maintain a good oversight of FTSU matters and issues, and no less than every six months. Reports are presented by the FTSU Guardian or a member of the trust's local Guardian network in person.

Reports include both quantitative and qualitative information and case studies or other information that will enable the board to fully engage with FTSU in their organisation and to understand the issues being identified, areas for improvement, and take informed decisions about action.

Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.

Board reports on FTSU could include:

Assessment of issues

- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

Potential patient safety or workers experience issues

- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built

Action taken to improve FTSU culture

- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

Learning and improvement

- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

Recommendations

- suggestions of any priority action needed.

Resources

Care Quality Commission (2017): Driving Improvement Accessed at: www.cqc.org.uk/sites/default/files/20170614_drivingimprovement.pdf

National Guardian Office (2017): Example job description Accessed at: http://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

National Guardian Office (2017): Annual report Accessed at www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf

NHS Improvement (2014) Strategy development toolkit Accessed at https://improvement.nhs.uk/resources/strategy-development-toolkit/

NHS Improvement (2016) Freedom to speak up: whistleblowing policy for the NHS Accessed at https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/

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NHS Improvement
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

@NHSImprovement

National Guardian's Office
151 Buckingham Palace Road
London
SW1W 9SZ

0300 067 9000
enquiries@nationalguardianoffice.org.uk
cqc.org.uk/national-guardians-office/content/national-guardians-office

@NatGuardianFTSU

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National Guardian
Freedom to Speak Up

A review by the National Guardian of speaking up in an NHS trust

December 2018

Contents

Executive summary 3
Introduction 5
Our findings 10
Annex – summary of recommendations 33

Executive summary

The National Guardian's Office has conducted a review of the speaking up processes, policies and culture at Royal Cornwall Hospitals NHS Trust, in response to information the office received that the trust's response to the concerns raised by its workers was not in accordance with good practice.

The purpose of the review was to look at the trust's speaking up policies and procedures, as well as how it had handled individual speaking up cases raised by its workers, to identify any learning to improve the trust's speaking up culture.

We also wanted to highlight any good examples of speaking up practice in the trust so that these may be followed by other trusts in England.

The trust supported the review through arranging interviews and meetings with many of its workers and leaders.

The review found evidence that the trust did not always respond to instances of its workers speaking up in accordance with its policies and procedures, or with good practice. Such responses contributed to a belief among some of the workers who spoke to our review that there was not a positive speaking up culture in the trust and that the issues that they raised were either poorly handled, or ignored by management.

Our review also identified areas where the trust could do more to support the speaking up culture. While the trust commissioned speaking up training for its workers, the training did not refer to national guidance on good speaking up practice issued by either the National Guardian's Office, or NHS Improvement.

In addition, there was evidence that settlement agreements between the trust and workers were difficult to understand and gave workers the impression that they were not free to speak up.

More positively, it was clear that the leadership of the trust understood well the need to improve the speaking up culture, and were beginning to take steps to do this. These included providing workers with a variety of means of raising issues through a network of speaking up champions across the trust, who supported the work of the trust Freedom to Speak Up Guardian.

The trust leadership also expressed a commitment to make the settlement agreements it reached with its workers more supportive of speaking up.

Our findings can be summarised as follows:

There were areas where the trust leadership needed to do more to improve the speaking up culture for its workers:

- Evidence that senior staff did not always respond to workers who spoke up in a manner that was consistent with the trust's speaking up policy, or in accordance with general principles of good speaking up practice
- Staff who spoke up did not always receive feedback on the outcome of concerns raised
- Evidence that staff in some parts of the trust feared they would receive 'retaliation' for speaking up
- Evidence that relations between staff in several parts of the trust was poor and were characterised by a grievance culture, often arising from historic issues between workers that had not been resolved
- Although the trust had commissioned speaking up training for its Freedom to Speak Up Champions to help ensure they properly handled issues raised by workers this training did not make appropriate reference to guidance on speaking up good practice issued by the National Guardian's Office or NHS Improvement
- Evidence that settlement agreements between the trust and workers who had left their posts presented a barrier to speaking up and potentially to staff receiving support
- The trust did not have a conflicts of interest policy. This was not in accordance with national guidance from NHS England.

There were also examples of where the trust was taking active steps to support speaking up. These included:

- Ring-fenced time for the trust Guardian to ensure their availability to support workers
- Appointing a network of speaking up champions to support the work of the trust Freedom to Speak Up Guardian and to help ensure that staff working across a geographically wide area had access to support to raise issues
- Gap analysis undertaken by the trust in relation to learning identified in other case review reports from the National Guardian's Office to determine how the trust could apply that learning to improve its own speaking up arrangements

Acknowledgements and thanks

The completion of our review has been made possible only because of the support and contributions from the following individuals and organisations:

- Trust workers who have told us about their experiences of speaking up
- The leaders of the trust
- The trust's Freedom to Speak Up Guardian and champions
- NHS Improvement
- Care Quality Commission
- The Department of Health and Social Care
- NHS Employers

Introduction

The National Guardian's Office

The National Guardian's Office (NGO) provides leadership, support and guidance on speaking up in the NHS, and was set up in response to recommendations made in Sir Robert Francis' 'Freedom to Speak Up' review, published in 2015[1].

The review set out 20 principles and actions to enable NHS workers to speak up freely at work, without fear of detriment, and to ensure that their concerns are responded to appropriately. These principles are designed to create a safer and more effective service for everyone.

The office began its work in April 2016. This principally involves support, training and guidance for a network of Freedom to Speak Up Guardians across the NHS, whose function is to provide independent support for workers to raise issues in the workplace. The office also undertakes reviews of the speaking up arrangements in NHS trusts, including how individual cases have been handled, where it receives evidence that workers have not been appropriately supported to speak up.

The NGO is an operationally independent body funded by NHS Improvement, NHS England and the Care Quality Commission.

More information about the work of the National Guardian's Office is available here.

Case reviews by the NGO

As part of its work the NGO reviews how a NHS trust has supported its workers to speak up, where it receives evidence that this support may not have met with good practice.

The standards of good practice against which the NGO assess the actions of trusts are found in a variety of sources, including the Francis Freedom to Speak Up review and the speaking up guidance for trust boards, published jointly by NHS Improvement and the National Guardian's Office in May 2018 [2].

The dual roles of case reviews are to listen to individuals and to identify learning about how speaking up practices may be improved, not just in the trust where the review takes place, but across the whole NHS, including bodies responsible for supporting the system.

In addition to recommending improvements, the reviews also seek to identify examples of good speaking up practice.
To promote this shared learning, the guidance for boards described above includes a recommendation that all trusts adopt, where appropriate, the recommendations for improvement identified in each speaking up review.

[1] http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf
[2] https://improvement.nhs.uk/documents/2468/Freedom_to_speak_up_guidance_May2018.pdf

The NGO works with the trust in question to identify relevant information and to feedback learning as it arises.

The NGO operates independently. It works closely with the regulators that fund it and shares the findings of its case reviews with them to help ensure NHS trusts receive all appropriate support to improve their speaking up culture, processes and policies.

Care Quality Commission inspectors review evidence relating to speaking up cultures and arrangements as part of their assessment of how well a trust is led.

Why we conducted a case review at Royal Cornwall Hospitals NHS Trust

The NGO initially received information that the response of the trust to a speaking up issue raised by one of its workers was not in accordance with good practice. Because the information indicated that significant learning could be obtained from reviewing the case the office decided to review how the trust had handled the case.

As well as considering the information received in the original referral, the NGO looked at other available data about the trust, including its 2017 NHS staff survey, to determine whether learning could be obtained from reviewing the speaking up culture, across the whole trust.

As this information indicated this was the case, the office decided to undertake a broad review of the speaking arrangements at the trust, as well as a review of the case first referred to it.

Following the announcement of our review, we received information relating to further examples of potential poor handling of individual speaking up cases, which we then also reviewed and have commented upon in this report.

How we conducted our review

In May 2018 we visited the three principal sites in the trust, namely Royal Cornwall Hospital in Truro, St. Michael's Hospital in Hayle and West Cornwall in Penzance.

Across those three locations we met with a total of 34 members of staff, including clinicians, managers and ancillary staff, as well as the trust chief executive officer, board members and the Freedom to Speak Up Guardian and champions.

We held a total of four staff forums across all sites to encourage as many workers as possible to tell us about their experiences of speaking up in the trust, to gain an insight into the culture, to identify examples of good practice and where we could support the trust to improve. These forums were actively promoted by the trust to enable workers to share their experiences.

As well as meeting with staff, we reviewed a range of documents relating to speaking up in the trust, including trust policies, procedures and strategies, as well as staff surveys.

In addition to forums and one to one meetings, trust workers were also able to contact NGO staff directly.

In addition, we asked other bodies to share what they knew about the trust's support for speaking up, including the Care Quality Commission and NHS Improvement.

Where we found issues we immediately raised them with the trust to allow them to address them as quickly as possible.

We worked jointly with the trust to undertake the review, including collaborating on joint communications. We want to thank the trust for its positive and supportive response to the review process at every stage.

Recommendations and actions

In response to the learning we identified, we have made 13 recommendations for the trust relating to the actions they need to take to improve their support for their workers to speak up.

We have also made two recommendations for ourselves; to provide national guidelines concerning the content of speaking up training provided by NHS trusts for their workers and on settlement agreements.

Each of our recommendations carries a time frame by which we expect them to be implemented. NHS Improvement, which is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care, will ask trust leaders to provide them with a plan summarising these actions within 28 days of the publication of this report. The NGO will also provide NHS Improvement with an action plan to address the training recommendation it has made for itself.

These actions will in all cases include measures to determine their effectiveness.

Representatives from NHS Improvement will meet with the trust and the NGO at regular intervals to review the implementation of their respective action plans.

The good practice we found – based on the principles from the 2018 Freedom to Speak Up Guardian Survey

We identified examples of good speaking up practice in the trust as a whole, based on the principles of good practice that we set out in our survey of Freedom to Speak Up Guardians in 2018.

A link to this survey can be found here.

- **Fairness** - The Freedom to Speak Up Guardian was appointed through an open recruitment process
- **Reach** - The appointment of a Freedom to Speak Up Guardian with ring-fenced time and 10 Freedom to Speak Up champions to help enable workers to receive support to speak up across the wide geography of the trust and its multiple locations and services
- **Leadership** - Staff working as part of the trust's freedom to speak up arrangements demonstrated a commitment to supporting workers to speak up and a willingness to improve the trust's speaking up culture
- **Openness** - The Freedom to Speak Up Guardian presented regular reports to the trust board in person that summarised their work in supporting workers to speak up, including data summaries, analysis and recommendations for action
- **Feedback** – The Guardian regularly sought feedback from the workers they had supported to speak up to help identify how they could continually develop and improve their performance
- **Time** – Ring-fenced time for the Guardian helped ensure that their time to support workers was protected

The structure of this report

26 workers approached our review team during our visits to the trust to describe their experiences of speaking up and gave their consent for us to look into how their cases had been handled. Because there were common themes relating to how their cases were handled we have grouped those cases under those themes. The learning we have identified is set out beneath each theme.

As with all our case reviews, we take all reasonable steps to ensure that we do not reveal individual workers' identities, regardless of their position in the trust. This is because the focus of our reviews is on learning, not blaming.

The only individual we identify in this report is the trust Freedom to Speak up Guardian. This is because it would not be possible to describe accurately the speaking up arrangements in the trust without making reference to them.

We have discussed the learning we have identified regarding those services with the trust's leaders. Wherever they have committed to take action to address that learning we have reported this.

Where we have quoted individuals or organisations we have indicated this through the use of inverted commas and speech marks.

About the trust

The trust website states[3] 'The Royal Cornwall Hospitals NHS Trust is the main provider of acute and specialist care services in Cornwall and the Isles of Scilly. It serves a population of around 430,000 people, a figure that can increase significantly with visitors during the busiest times of the year. The Trust employs approximately 5,000 staff and has a budget of approximately £380 million.'

[3] https://www.royalcornwall.nhs.uk/our-organisation/about/

Published information about speaking up in the trust

NHS England annual Staff Survey[4]

All NHS trusts are required to participate in the NHS England staff survey. Its purpose is to collect staff views about working in their NHS organisation to help trusts improve working conditions for staff and patient care.

We looked at relevant results from the trust survey from 2017 and compared these results with those from the 2016 trust survey. (The results from the 2018 NHS Staff Survey are published early in 2019.)

2860 staff took part in the survey, which represented a response rate of 56%. The full results of the survey can be found here.

Three key findings in the survey particularly relate to staff responses regarding a trust's speaking up culture. The first of these relates to whether staff thought the trust's procedures for reporting near misses, errors and incidents were 'fair and effective'. When compared with NHS trusts providing similar services to Royal Cornwall trust the result was in the bottom 20% of all like trusts for that key finding. This result was also the same for that key finding in the trust's 2016 survey.

The second key finding in respect of speaking up related to whether staff felt 'confidence and security' when reporting unsafe clinical practice. Again, when compared to like NHS trusts the result placed Royal Cornwall in the bottom 20% of all like trusts for that key finding.

The third key finding related to what workers said about whether they had experienced harassment, bullying or abuse from other staff in the past 12 months. The findings showed that the trust was worse than other like trusts, although the number of Royal Cornwall staff reporting such experiences was fewer than in the 2016 staff survey.

Care Quality Commission (CQC) Inspection

Inspectors from the CQC last undertook a comprehensive inspection of the services in the trust in September 2018. Overall, they rated the trust as 'requires improvement.' This compared with an overall rating of 'Inadequate' when the CQC previously conducted a comprehensive inspection in the trust in July 2017.

As part of their evaluation of how well a trust is led, inspectors looked at the trust's culture, including its processes to support speaking up. Inspectors gave a rating of 'inadequate' for how well led the trust was.

The full CQC inspection report can be found here.

[4] http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2018/

Our findings

To reach our findings, we met with 34 trust workers, either in one to one interviews or in staff forums, to learn about their experiences of speaking up. We also looked at a range of documents relating to the trust's speaking up arrangements, including its speaking up policy.

From those workers we spoke to 18 workers who believed they had faced obstacles to speaking up gave their consent for us to discuss their experiences of doing so with trust leaders.

Following our review of the trust's speaking up arrangements and of individual cases, we have summarised our findings below.

The speaking up issues the trust workers told us about took place over a four year period dating back from the time of our review.

Firstly, we have set out our findings in relation to workers' individual experiences of speaking up, under sub-headings that reflect obstacles to speaking up that were common to those individual cases. In all the cases described, the workers concerned gave their consent for us to discuss their cases with trust leaders, so that we could obtain a balanced view of what had occurred.

We have taken every reasonable step to protect the identity of individuals.

Secondly, we set out our findings relating to the speaking up arrangements across the whole trust.

Under each sub-heading we provide a recommendation on how support for workers to speak up can be improved. Most recommendations are for actions to be taken by the trust. There are also two recommendations for the National Guardian's Office.

As per NHS Improvement's board guidance, we expect all NHS trusts and foundation trusts to examine the recommendations we make in our case review reports and apply the learning from them where appropriate to their own organisation.

A. Findings from themes arising from workers' experiences

1. Poor staff relationships

Of the 34 workers we spoke to, many from across all three main trust locations described a working environment characterised by relationships between staff members that had broken down, often over a long period of time.

The causes of the common breakdown of working relationships were not clear from the information we gathered during our review, although the symptom of such difficulties was evident in how often staff told us that they had brought grievances about the conduct of their colleagues.

We discuss the use of a grievance process within a speaking up culture further below.

The reasons staff gave for the existence of poor working relationships often referred to the working culture in the trust, including the speaking up culture, which we describe below.

Several also cited what they regarded as inappropriate recruitment practices as a cause of poor staff relations, describing their belief that individuals were appointed and promoted based on their close relationships with trust colleagues, rather than as a result of an open and fair recruitment process. The trust acknowledged that in certain circumstances in the past this had occurred but that they are taking steps to address this.

The National Guardian's Office has recently highlighted[5] the need for trusts to support open and honest working cultures by ensuring that personal relationships between staff, especially those with responsibility for decision making, are openly declared, in accordance guidance for trusts relating to conflicts of interest published by NHS England.[6]

However, the trust had no policy to address conflicts of interest, save for in relation to board members, nor were trust leaders aware of the national guidance.

Workers also highlighted the geographical location of the trust as a factor in poor staff relations, stating that because of the trust's relative isolation staff often stayed in their roles for many years and where they remained so did the poor relations between them. One senior leader commented "Many [staff] have a long length of service, they don't go elsewhere. Their views become entrenched."

Nevertheless, what was not clear from our review was why the poor staff relationships that were often so evident were not resolved. When we asked trust leaders about this they could not give a clear explanation, but said that they planned to use mediation more frequently in the trust as a method for resolving issues between workers.

They were also receptive to our suggestion of considering mediation between groups of staff to resolve historic disputes, where there was support and consent from the workers concerned to do this.

We therefore recommend that the trust takes steps to address the problem of poor relationships as described to us by many of the workers who spoke to us across many of its services, firstly by seeking to identify their cause, and then taking appropriate action to address those causes.

We also recommend that the trust takes steps to implement the guidance on managing conflicts of interest from NHS England.

[5] https://www.cqc.org.uk/sites/default/files/201801107-Nottinghamshire%20Healthcare%20NHS%20Foundation%20Trust%20A%20review%20of%20the%20handling%20of%20speaking%20up%20cases.pdf

[6] https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/

Recommendation 1

Within 12 months the trust takes appropriate measures to identify the causes of poor working relationships across the whole organisation and implements effective actions to remedy those causes, including steps to measure the effectiveness of those actions.

Recommendation 2

Within 12 months the trust takes steps to implement national guidance from NHS England relating to the managing of conflicts of interest.

2. Speaking up culture

As described above, the results for the trust in the 2017 NHS England staff survey were in the bottom 20% percent relating to whether workers felt procedures for reporting near misses, errors and incidents were 'fair and effective' and whether they had 'confidence and security' when reporting unsafe clinical practice.

We asked the workers that we met, at all levels in the organisation across the three main locations of the trust, their view of the speaking up culture in the organisation. Almost all the answers we recorded were negative.

Workers described a culture that was highly unsupportive, where staff did not feel free to speak up, who were ignored when raising matters, told not to speak up at all, or whose issues were not handled in accordance with trust policy, procedures or good practice.

One worker told us that staff where they worked 'got into trouble' for raising concerns. Another, working in a different service said, 'if you do speak up middle management will block you'. Two workers from one service commented 'nobody has acknowledged our difficulty or concerns, and we won't speak up again'.

These experiences go against the principles established in the Francis Freedom to Speak Up review that workers should be thanked and listened to, that their concerns should be investigated and that they should not be victimised because of speaking up.[7]

Several staff from different services also commented that there was a culture of managers telling workers not to raise and record issues using the trust electronic incident reporting system. These staff members said they believed this culture created risks to patient safety. We reported these concerns to both trust leaders and regulators.

Staff comments often referred to a historic poor speaking up culture across the trust. One senior leader told us 'There's a long and dark history to this trust, and to Cornwall generally. Getting through to people is labour intensive. Getting through to them to believe that they will really be listened to and taken seriously has been the most difficult of anywhere I have seen.'

[7] http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

As described above, there was also evidence that a common response to workers who raised issues was the suggestion that they use the grievance process to resolve the matter. This included when the matter raised was not reasonably a grievance, suggesting that the managers were not taking ownership of the issues.

The frequency with which grievance cases were brought was commented upon by one senior trust leader, who told us "I have never been in a trust where grievances are used as much, even referrals to professional bodies."

As commented upon in a previous case review from the National Guardian's Office[8], there are alternatives to grievance processes, which may better support workers' needs due to the often-adversarial nature of the grievance process.

In one example of the use of the process a worker told us that, having raised a series of issues via a grievance, the trust then investigated their concerns, found in their favour, before then offering them the opportunity to bring a further grievance as a remedy to those issues.

Inappropriate use of the grievance process to respond to workers who raise issues neither supports their needs, nor a positive speaking up culture.

Trusts should therefore ensure that workers are aware of all possible routes available to them to speak up and we expect all trusts, including Royal Cornwall to implement the recommendation we made in the case review referred to above.

The positive comments regarding the speaking up culture came in relation to the role of the trust's Freedom to Speak Up Guardian, described below. One worker who received support from the Guardian told us 'I felt for the first time that someone was actually listening.'

We discussed the trust's speaking up culture with its senior leaders, who acknowledged that it needed significant improvement.

At the time of our review the trust did not yet have a planned response to this issue. We therefore recommend that it undertakes its own work to assess the culture that operates across its workforce, to gain insight into the steps it needs to take to improve that culture. It should then take steps to address the issues it identifies.

As with our comments relating to staff relationships above, we recommend the trust works closely with NHS Improvement in addressing the cultural issues it faces.

[8] https://www.cqc.org.uk/sites/default/files/20180620_ngo_derbyshirecommunityhealthservices_nhsft-case_review_speaking_up_processes_policies_culture.pdf

Recommendation 3

Within 12 months trust leaders develop and begin the implementation of a strategy to improve the speaking up culture across its workforce. The plan should contain measures to identify the main issues the trust should address, clear actions to address those issues and steps to measure the effectiveness of those actions.

Recommendation 4

Within 6 months the trust should review incident reporting rates and identify any areas which appear to be under-reporting and take action to address this.

3. Issues raised by workers not handled with suitable independence

We asked for the trust's comments on each of the case studies set out below on how they had responded to workers' speaking up. The trust were able to provide some information in this regard, however, this information was not available in all cases. Where it was provided this is reflected in the case studies.

The case studies set out below describe events that have occurred over a four year time period dating back from the time of our review.

Background

The trust speaking up policy states that matters raised by workers will be investigated 'using someone suitably independent (usually from a different part of the organisation)'. The first two case studies below describe experiences of speaking up shared with our review where the workers who spoke up believe this did not happen.

Case study 1

A worker told us that they believed their colleague had neglected patients. The worker told us that they reported this using the trust's electronic incident reporting system. The electronic reporting system was not set up to provide feedback automatically.

The worker received written feedback several weeks after raising the incident. This did not meet their expectations. We have not received a response from the trust as to whether this was within accepted timescales.

The feedback said that the matter had been looked into, and it was concluded that the alleged neglect did not happen. The feedback they received did not say who had carried out the investigation.

The worker approached their manager to discuss this feedback. The worker was shocked to find out that their manager had passed their initial electronic report to the colleague they had alleged neglected patients to investigate their own conduct.

The worker was not aware of any other investigation into the concerns they had raised.

This is an example of practice which is against the principle of fair independent investigations as described by the Francis report.

Case study 2

A worker told us that they were worried about speaking up about a colleague who had allegedly sexually assaulted[9] them because this colleague was in a relationship with the worker's manager.

The worker said that despite their concern about retaliation, they spoke up about this issue and other issues including patient safety matters. The worker said that following this their manager became verbally hostile towards them. The worker said that subsequently they themselves faced what they regarded as 'trumped up' allegations.

The worker said that their manager initially tasked their self with investigating these allegations, even though, the worker argued, the manager was conflicted because of their relationship with the colleague who the worker claimed had sexually assaulted them.

The worker said that with the support of their union, they made a case against the manager's role in this investigation. The worker said that their manager eventually put someone else in charge of investigating the case.

Independence and timeliness of investigations are key recommendations from the Francis Freedom to Speak Up review.

Learning and recommendations

On the basis of the information provided by the workers in the first two cases, the trust was in breach of its own policy. Individuals alleged to have acted improperly, or who are closely related to those against who such allegations are made, should clearly not investigate those matters, themselves or other matters where potential conflicts of loyalty exist.

The need to ensure suitably independent investigations in response to workers who speak up has been previously highlighted by a NGO case review.[10]

The failure to appoint suitably independent and trained investigators to respond to matters raised by staff not only creates the risk that necessary learning will not be identified, but also that workers

[9] The incident was the subject of a police investigation.

[10] https://www.cqc.org.uk/sites/default/files/20180620_ngo_derbyshirecommunityhealthservices_nhsft-case_review_speaking_up_processes_policies_culture.pdf

will feel unsupported, believe the trust is not taking their concerns seriously and so undermine the whole speaking up culture in the organisation and the public trust in the NHS.

Recommendation 5

Within 3 months the trust should take appropriate steps to ensure that its response to workers speaking up, including the investigations of those issues and the implementation of learning resulting from them, is undertaken by suitably independent trained investigators.

4. Breach of confidentiality

Background

It is an important aspect of good speaking up practice that the confidentiality of those who raise issues should be protected, where they indicate they wish this to happen. The trust speaking up policy clearly demonstrated a commitment to support this.

The case study below describes a worker's experience where they believed this did not happen.

Case study 3

A worker told us that they spoke up to a manager after witnessing a colleague handling medication in breach of the trust's relevant policies and procedures. The worker said that the manager assured them that they would escalate the concern and that it would be dealt with confidentially.

The worker explained they found out shortly after that the same manager had discussed the concern they had raised with the colleague they had spoken up about without maintaining their confidentiality. Later, the worker also became aware that other staff members had been told that they had spoken up about the medicines issue.

The worker was then informed by their manager that although their colleague admitted the allegation, they also regarded the worker speaking up about them as malicious.

No other action was taken to investigate the concern the worker had raised.

We asked the trust about how they had responded to the worker's speaking up in this case. A trust representative explained that a senior trust leader had been in touch with the worker to thank them for speaking up and reassure them that they had done the right thing by raising this issue. The worker told us that they were nonetheless disappointed with the outcome of the case because the senior leader had told them that they were satisfied with the response to the worker's speaking up.

Recommendation 6

Within 3 months the trust should take appropriate steps to ensure that the confidentiality of workers who speak up is appropriately supported, in accordance with trust policy and procedure and good practice.

5. Failure to respond to speaking up

Case study 4

A worker told us that they and their colleagues spoke up about bullying and harassment in their department. The worker explained that in response to this a staff survey was undertaken which found several issues in the department, including a management style which could be interpreted as bullying. The worker explained that an action plan was produced to respond to the survey findings.

However, the worker told us that a senior colleague who it was alleged was partly responsible for the issues highlighted in the survey was tasked with implementing the action plan. The worker said this individual had not acknowledged that they had personally ever bullied staff, or showed any insight into these issues and therefore were not suitable to implement the plan. The worker explained that ultimately nothing came of the action plan.

Case study 5

A worker told our review they had experienced prolonged bullying and harassment by senior colleagues in their department. They said they had spoken up about this issue on several occasions, but nothing was done about it. The worker said that this caused them great stress, which eventually led to them resigning from the organisation.

Case study 6

A worker told us of concerns they raised relating to standards of care and patient safety. The worker explained that, in response, their senior colleagues became 'defensive' and blamed the worker for causing the issues that the worker had spoken up about.

The worker said they were also criticised by their colleagues for speaking up about 'too many' issues. Because of this criticism the worker said they sometimes chose not to report issues.

Case study 7

A worker who had subsequently left the trust told us that they had spoken up many times throughout the organisation regarding patient safety and other concerns. The worker said that they were 'shouted at and threatened' by their manager for speaking up. As a result, the member of staff explained that they resigned.

The worker explained that they insisted on an exit interview so that they had an opportunity to explain why they had resigned. However, the worker said that the manager carrying out the interview was not interested in what they had to say.

Case study 8

Workers told us that they were concerned about breaches of the trust's recruitment and secondment policies. They told us that over a long period of time individuals were regularly being appointed to roles without a competitive recruitment process.

Workers told us that attempts to speak up about this within their department were not treated seriously or were met with denial. The workers told us that they escalated their concerns to senior leaders in the trust. However, the first time they did this they were ignored and the practices continued.

The workers said that they then put in an informal grievance with another senior leader detailing their concerns about recruitment practices in their department. However, the workers said that their confidentiality was breached because their manager was informed about the grievance. The workers added that the senior leader assigned to look into their grievance failed to reply to their concerns.

After several weeks, the workers escalated the matters again to a more senior leader who investigated their concerns and ultimately upheld all their grievances. In all, the grievance took nearly seven months to be dealt with by the trust which the workers described as very stressful.

Learning and recommendations

The experiences of workers in these case studies, as well as what we heard from other workers during our review, showed that there was a real perception among some workers in the trust that there is often a failure to act when workers speak up in the trust.

This belief that speaking up is futile because it will not result in improvement was so entrenched among some workers that we heard of workers who questioned the point of talking about their experiences to the NGO.

In case studies 5 and 7, this poor response to workers speaking up resulted in the workers resigning. In case study 6, the failure to respond appropriately to concerns and even to confront the worker speaking up for raising 'too many' issues resulted in the worker deciding not to speak up in the future.

The failure to act to address the issues raised in the instances of speaking up described in these case studies was in breach of the trust's speaking up policy that states that the trust is committed to *'listening to our staff, learning lessons and improving patient care'.*

Failing to act also potentially represents a failure of insight and a loss of opportunity to learn. Workers are the eyes and ears of an organisation and are often first to identify actual or latent issues that could impact on an organisation's ability to deliver its objectives. A positive speaking up culture recognises the contribution that workers can make to improving the quality of care it delivers.

The cases described above highlight the need for the trust to ensure that it responds appropriately to its workers who speak up, in full accordance with its policies and procedures. Its speaking up policy states: **'**In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.'

Recommendation 7

Within 3 months the trust should ensure that it responds to the issues raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice.

6. Detriment caused to staff who speak up

Background

Ensuring that workers who speak up are protected from detriment for doing so is a key element in a positive speaking up culture and a key recommendation from the Francis Freedom to Speak Up Review.

Case study 9

A worker told us that after raising issues about patient safety including low staffing levels they were bullied by their senior colleagues as well as their manager who had verbally assaulted them.

The worker perceived that disciplinary proceedings were then brought against them based on false allegations, which led to their dismissal. The worker believed that these actions were motivated by the fact that they had been speaking up about standards of care and patient safety.

Following their dismissal, the worker was referred to their professional body, which launched its own investigation into the worker's conduct. The worker perceived that this was a malicious referral.

We asked the trust to comment on how they had responded to the worker's speaking up, but they did not provide specific information on this point.

Case study 10

A worker told us that they had concerns regarding the speaking up culture in their team. They explained that the team manager would respond defensively when colleagues spoke up about patient safety and other issues. Those who spoke up would subsequently face 'concocted' allegations and the threat of disciplinary action. The worker explained that this created a 'culture of fear' in the team and resulted in colleagues leaving the trust.

The worker explained that frequent and prolonged attempts to escalate concerns above local management eventually resulted in a review of the team. This review made a number of recommendations to improve the functioning of the team, including workshops.

The worker explained that the team manager whose behaviour caused concern for many colleagues was either leading or attending these workshops. The worker said that this meant that many colleagues were reluctant to speak openly at these events. The worker said that according to their perception this manager did not display insight and their behaviour had not changed.

The worker claimed that, over a year after the review, the speaking up culture in their team had not improved. The worker said that they approached this manager to express their concern about the lack of improvement in their team. However, the worker added that the manager was frustrated by their speaking up and threatened to put in a grievance against the worker. Fearing that they would face retaliatory allegations, the worker resigned and left the trust.

We asked the trust to comment on how they had responded to the worker's speaking up but they did not provide specific information on this point. However, a trust representative told us that they have taken active steps to improve the speaking up policies and practices in the service where the worker was employed. In particular, the trust representative told us that staff engagement has improved.

Learning and recommendations

The trust's speaking up policy seeks to assure trust workers that retaliation for speaking up is against the trust's values and that it will not be tolerated. It states:

> *'If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action'*

We note the assurances provided by the trust's policy on this matter. However, Case Studies 9 and 10, as well as other accounts we heard from trust workers, show that there is a perception among some of them that speaking up could and sometimes does result in retaliatory action in the trust.

The consequences of such alleged retaliation for the individual who has spoken up is apparent. We have heard from several individuals who claimed that they were either dismissed or felt they had no option but to resign because they had spoken up. Many trust workers also told us about the devastating impact that speaking up had on their relationships, career and health.

However, it is not just those individuals who claim to have been victimised when speaking up who suffer. This can also harm the services they work for when their employment ends because of these issues.

Similarly, if workers feel unable to speak up because they fear the consequences, this also puts patient safety at risk.

The speaking up data submitted by the trust shows that 43 cases were brought to the Freedom to Speak Up Guardian over a 12-month period between April 2017 and March 2018 and that in 2 cases the workers (4.6%) perceived that they had received detriment for having spoken up.

This compares with an average of 43 cases per trust per year and an average of 5% workers perceiving detriment.

The trust needs to listen to the perceptions of its workers and to ensure that their policy offers the protection that it describes.

We refer to recommendation 7 (p. 19) to address our findings in this regard.

7. Settlement agreements

Background information

A settlement agreement is a legally binding document that sets out the agreed terms and conditions between an employer and a worker to resolve a dispute between them, or to terminate the worker's contract of employment.

Settlement agreements can have common features, including an agreed financial payment to be made to the worker, as well as an agreement from the worker to waive their right to bring claims under their contract of employment, for example at an employment tribunal.

They can also contain confidentiality clauses, where the parties agree not to reveal specific aspects of the agreement, including the existence of the agreement itself.

The use of confidentiality clauses in settlement agreements in the public sector, particularly where they prevent the parties from disclosing the existence of the agreement itself, has been the subject of criticism. This has included House of Commons Public Accounts Committee, which expressed the concern in 2013 that such clauses where used inappropriately "may deter former employees from speaking out about serious and systematic failures within the public sector, for example, in patient care or child safety."[11]

[11] https://publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/477/477.pdf

Legally, any provision in a settlement agreement that seeks to prevent an employee from making a protected disclosure[12] under the Public Interest Disclosure Act is void.[13]

A protected disclosure is determined to have occured when an employment tribunal rules that a worker has disclosed certain information in specific, legally defined circumstances. Circumstances where such rulings are made include where an employer and a worker disagree whether a concern raised qualifies for protection.

Tribunals may award compensation to workers who have made protected disclosures where it is shown that they suffered detriment for having done so.

The Secretary of State for Health in 2013[14] stated that the Government "would not approve any [settlement agreements] with a confidentiality clause that prevents people speaking out about patient safety or patient care". In the same year the minister also wrote to all NHS trust chairs to ask them to check that their trusts' use of settlement agreements supported 'an open NHS culture'.[15]

Guidance for NHS organisations on the use of settlement agreements was published by NHS Employers in 2013.[16] This guidance reminds NHS organisations that settlement agreements must legally contain a provision relating to a worker's right to make a protected disclosure, as well as patient safety issues in accordance with their professional and ethical obligations and provides a recommended form of words for such clauses.

It is also a provision of NHS organisations' standard contract with NHS England that they will not 'prevent or inhibit' their workers, or sub-contractors, from making a protected disclosure.[17]

Why we looked at settlement agreements in this case review

We looked at the issue of settlement agreements because a former worker, who had previously signed a settlement agreement with the trust, told us that they believed that the trust had unlawfully used that agreement to prevent them from speaking up.

The agreement had been drawn up in accordance with the above guidance from NHS Employers and included provisions stating that although the worker could not raise any complaint or grievance relating to their employment this did not include those that amounted to protected disclosures under the Public Interest Disclosure Act or in line with professional duties.

The former worker said the trust acted unlawfully in its use of the settlement agreement because it refused to investigate issues the individual raised about their employment. The former worker said

[12] https://www.legislation.gov.uk/ukpga/1996/18/part/IVA
[13] https://www.legislation.gov.uk/ukpga/1996/18/section/43J
[14] https://www.dailymail.co.uk/news/article-2293000/Victory-NHS-whistleblowers-After-Daily-Mail-campaign-Health-Secretary-bans-gagging-orders-NHS-staff.html
[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/217036/open-culture-letter.pdf
[16] http://www.nhsemployers.org/~/media/Employers/Publications/settlement-agreements.pdf
[17] https://www.england.nhs.uk/wp-content/uploads/2018/01/3-nhs-standard-contract-1718-1819-general-conditions-full-length-v2.pdf

that they had raised these issues multiple times in accordance with the trust's speaking up policies and procedures. The trust reused to investigate the issues on the grounds the settlement agreement prevented the worker from speaking up about such matters. By contrast, the former worker asserted they were, in fact, making protected disclosures, and therefore the trust had a duty to investigate them.

It is not within the remit of the National Guardian's Office to pass any comment on whether any organisation has acted lawfully or not. However, as we describe below, the form and content of settlement agreements are highly relevant to speaking up cultures in the NHS. For this reason, the NGO is currently working with its partners, including the Department of Health and Social Care and NHS Employers to improve clarity about the nature, scope and use of settlement agreements in the NHS, with the intention of preventing misuse and barriers to speaking up.

Therefore, we describe below the potential issues relating to settlement agreements that we have observed and on which we are working with our partners to resolve.

Potential issues with settlement agreements

Making agreements easier to understand for workers

We saw the settlement agreement used in relation to the trust worker described above. The document was not easy to understand. Many of the clauses were long and complex and contained legalistic language.

With our partners we will look at the use of plain English, to help assist workers to understand their rights and obligations.

Supporting learning and patient care and safety

It is common for settlement agreements to contain clauses stating that the worker agrees not to raise any complaints or grievances with the employer about their former role. Such a provision was included in the agreement we saw during our review.

The rationale for the inclusion of such clauses is understood, as the purpose of many settlements is not only to agree the terms on which a worker's employment will end, but also to agree an end to any disputes relating to that employment.

However, a settlement agreement that prevents the worker raising matters about their former employment arguably prevents, at the same time, the employer from investigating such issues and therefore from also discovering any potentially important learning from those issues.

As set out above, settlement agreements may not preclude workers from raising issues that are protected under the Public Interest Disclosure Act. The guidance from NHS Employers referred to above also says that settlement agreements should not prevent workers from speaking up about patient safety, in accordance with their professional and ethical obligations.

The National Guardian's Office and its partners will consider whether these provisions go far enough in supporting workers to speak up about patient safety matters, or whether they need to be stated more clearly.

Confidentiality clauses

As described above, confidentiality clauses are often used in settlement agreements and are terms where the parties agree not to reveal specified aspects of the agreement, including sometimes the existence of the agreement itself.

Such clauses may have an unintended detrimental impact upon the worker. For example, a worker seeking support to deal with the stresses relating to the ending of their employment, for example from a clinician or counsellor, may be prevented by a confidentiality clause from discussing the details of the very issues that are the source of their distress.

Another unintended negative impact of clauses that prevent workers from disclosing their existence may be in relation to the whistleblower employment support scheme[18]. The scheme was launched by NHS Improvement in 2017 to help NHS workers in secondary care who have suffered detriment because of speaking up to find alternative employment within the NHS.

The scheme offers support to those who are having difficulties finding employment in the NHS where they previously experienced detriment for speaking up in a former NHS role. However, where a worker has signed an agreement containing a confidentiality clause preventing them disclosing the agreement's existence, it is possible they may be deterred from accessing the scheme, in the belief that they will have to reveal their settlement agreement in order to apply for it.[19]

A similar scheme for whislteblowers in primary care was also launched by NHS England in 2017. The National Guardian's Office and its partners will therefore consider the impact of confidentiality clauses on the wellbeing of workers, as well their possible impact on the openness of NHS culture.

Inspection of settlement agreements

To help ensure that future settlement agreements support the needs of individual workers and the NHS as a whole, the NGO and its partners will consider the role regulators can play in reviewing their use, including whether they are in accordance with national guidance.

Updating national guidance

The NGO will work with its partners to ensure that national guidance for the use of settlement agreements better supports a positive speaking up culture in the NHS and reflects agreed best practice.

[18] https://improvement.nhs.uk/events/whistleblowers-support-scheme-launch/

[19] NHS Improvement wrote in 2018 to trusts asking them not to enforce confidentiality clauses against workers seeking to access the Whistleblower Support Scheme. At the time of writing of this report NHS Improvement had not received any expressions of concern from trusts relating to this request.

Our recommendation

The National Guardian Guardian's Office therefore makes a recommendation for itself and its partners in relation to the review of the use of settlement agreements in the NHS.

Recommendation 8

Within 3 months the National Guardian's Office and its partners involved in reviewing settlement agreements in the NHS, including the Department of Health and Social Care, NHS Employers and NHS Improvement, should complete this review and take all appropriate steps to implement its findings.

B. Findings regarding the trust's speaking up arrangements

1. The trust's speaking up policy

At the time of our review the trust was in the process of updating its speaking up policy ('Freedom To Speak Up: Raising Concerns Policy') to ensure that it was in accordance with the national, integrated speaking up policy for the NHS, published by NHS Improvement.

We asked NHS Improvement to provide feedback on the trust's updated policy for the purposes of this review report, which was as follows:

Overall

The policy is good. It incorporates a significant proportion of the national policy, has trust specific details and contact details for relevant individuals, and really helpful flowchart at the start, which is brilliant.'

Main areas for improvement

The policy describes supporting workers to speak up who have *"a reasonable belief"* that something has, or may have gone wrong. NHS Improvement comment that this language is not helpful as it is taken from the Public Interest Disclosure Act, which only provides support to workers in limited circumstances.

The trust's policy also makes further references to the Act in relation to *"protected disclosures".* NHS Improvement comments that the reference 'does not appear to reflect current legal requirements', nor the national speaking up policy for the NHS, which 'seeks to move beyond quoting the legislation'.

The scope of the policy is unnecessarily repeated

The feedback regarding necessary improvements reflects comments the National Guardian's Office has previously made repeatedly in its published case reviews[20], particularly in relation to unnecessary references in speaking up policies to the Public Interest Disclosure Act.

We remind all trusts that we expect them to implement our recommendations, where appropriate and that assessment of this aspect of governance forms part of the Care Quality Commission inspectors' evaluation of how well led trusts are.

We therefore recommend that the trust amends its policy to take account of the feedback from NHS Improvement and takes steps to communicate the revised policy to all its workers.

At the time of writing this review we understand that NHS Improvement are planning to update its national speaking up policy. We therefore also suggest that the trust updates its policy relating to the feedback above once these changes are known.

Recommendation 9

Within 3 months the trust should revise its new speaking up policy, to ensure it is in line with the NHS Improvement national speaking up policy.

Recommendation 10

Within 6 months the trust should take steps to ensure all existing and new workers are aware of the contents and meaning of its revised freedom to speak up policy.

2. Measuring the effectiveness of speaking up

We asked senior trust leaders how they intended to measure the effectiveness of speaking up policies and processes to ensure that they were meeting the needs of trust workers and promoting a positive speaking up culture.

The importance of monitoring the effectiveness of speaking up arrangements was highlighted in our case review report for Southport and Ormskirk NHS trust, published in November 2017. [21]

At the time of our review, trust leaders agreed that it was important to monitor the effectiveness of the organisation's speaking up arrangements, with several observing that the trust annual NHS staff survey provided important information in this regard. One trust leader also said that the organisation was planning to develop their trust's use of the exit interview for staff ending their employment so that feedback could be obtained about their view of the speaking up culture.

While we commend the use of the exit interview process for this purpose, it was clear that the trust did not have a dedicated or strategic approach as to how to measure the effectiveness of its speaking up arrangements, either in terms of what information it would, or how it would use it.

[20] https://www.cqc.org.uk/national-guardians-office/content/case-reviews
[21] https://www.cqc.org.uk/sites/default/files/20171115_ngo_southportormskirk.pdf

As well as appointing Freedom to Speak Up Guardians and implementing appropriate policies trust leaders must take steps to assure themselves that the culture and processes of their organisation meets workers' needs. This important role for trust leaders is highlighted in the speaking up guidance for trust boards, published in May 2018:

> *"All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty."*

We therefore recommend that the trust takes appropriate steps to address this.

Recommendation 11

Within 6 months the trust should put effective systems in place to monitor the development of a positive speaking up culture.

3. Speaking up training

At the time of our review the trust told us that they had recently commissioned training for its newly appointed freedom to speak up champions. This training was given by an external provider.

We recognise that freedom to speak up has made significant progress over the previous two years and during that time the NGO and NHS Improvement have issued guidance and training materials. In light of this, training organisations may have found it difficult to keep pace with these developments.

We make these observations based on the training slides we saw during our review:

- The National Guardian's Office advocates a consistent use of the term 'speaking up' to describe any matter that gets in the way of delivering great care. This embraces not only early alerts to potential problems, but also encourages suggestions for change and improvement. The use of the word 'whistleblowing', as seen in the slides, is often used to define more narrow issues such as very serious matters including the Public Interest Disclosure Act[22], or both.
- The training distinguished between 'grievances' and 'concerns' which risks implying that these may not all be speaking up matters. The NGO believes that all issues a worker may want to raise should fall under the description of 'speaking up'. This allows workers raising any issue to receive support and for a holistic approach to speaking up matters to be taken so that potential patient safety issues are not missed.
- The training materials suggest that freedom to speak up champions should consider which issues to record. The National Guardian's Office guidance to guardians is that all cases raised

[22] q.v. Public Interest Disclosure Act - https://www.legislation.gov.uk/ukpga/1998/23/contents

through their own network should be recorded. The NGO first issued guidance on recording in February 2017.[23]

- The training contained several references to the Public Interest Disclosure Act. As the NGO has observed in all its previous case review reports, it is unhelpful to focus on this legislation, whether in speaking up policies or training, as it may act as a barrier to workers thinking about speaking up.
- The training did not appear to reference previously published developments in speaking up, including recommendations and guidance from the National Guardian's Office and NHS Improvement's national speaking up policy.

Our observations lead us to conclude that, in this fast-moving landscape, it would be helpful for the National Guardian's Office to create national guidelines to assist training providers and trusts to meet our expectations.

Therefore, in addition to making a recommendation for trusts about the speaking up training they provide, we also make a recommendation for our own office to provide national guidelines regarding the content of such training.

Recommendation 12

Within 6 months the National Guardian's Office should draw up national guidelines for the NHS relating to the content of speaking up training for workers.

Recommendation 13

Within 12 months the trust should ensure that the content of any speaking up training it provides for its workers is consistent with guidance issued by the National Guardian's Office and NHS Improvement, including findings and recommendations from NGO case reviews and the Freedom to Speak Up Survey 2018 and board guidance from NHSI

4. Freedom to Speak Up Guardian

In accordance with obligations under the NHS England standard contract the trust had appointed a Freedom to Speak Up Guardian. The purpose and expectations of the role, as set out by the NGO[24] are as follows:

[23] https://www.cqc.org.uk/sites/default/files/20180719%20Guidance%20on%20Recording_0.pdf
[24] https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

Purpose

Freedom to Speak Up Guardians help:

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

Expectations

- Guardians operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team
- Seek guidance and support from and, where appropriate escalate matters to bodies outside their organisation
- Support, and contribute to, the national Freedom to Speak Up Guardian network, comply with National Guardian Office guidance, and support each other by providing peer-to-peer support and sharing learning
- Should be supported with the resources they need, including ring-fenced time, to ensure that they meet the needs of workers in their organisation. Their views on the impact of activities and decisions on Freedom to Speak Up should be actively sought

The Guardian in the trust was appointed in June 2017, using an open and fair process. This was in accordance with guidance issued by the National Guardian's Office on the implementation of the role.[25]

The Guardian was employed two days a week and was supported by a network of 10 champions, who undertook the role on a voluntary basis, to help workers to speak up across the widely dispersed geography of the trust.

[25] https://www.cqc.org.uk/sites/default/files/20170915_Freedom_to_Speak_Up_Guardian_Survey_2017.pdf

The Guardian reported regularly to the trust board on updates to the trust's speaking up arrangements. Guidance for trust boards on speaking up from NHS Improvement[26] identifies what such reports can contain:

Assessment of issues

- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issue are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

Potential patient safety or workers experience issues

- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built

Action taken to improve FTSU culture

- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

[26] https://improvement.nhs.uk/documents/2468/Freedom_to_speak_up_guidance_May2018.pdf

Learning and improvement

- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- suggestions of any priority action needed
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

Recommendations

We saw three of these reports, which showed that the level of detail improved over time. The most recent of which showed a commendable level of detail, including many of the areas described in the above guidance.

Earlier reports were less detailed. We therefore recommend that the level of content of the most recent trust report continues.

The role of the Guardian was advertised across the trust via a variety of methods, including posters and through the trust internal communications system. Most workers we spoke to were aware of the role and many knew the identity of the staff member who undertook the role.

We asked trust leaders about the amount of ring-fenced time they had allocated for the Guardian role, given the number of concerns expressed by many workers to our review regarding the poor speaking up culture in the trust. In response, a senior leader told us that the trust planned to provide resources for the role to be undertaken full-time, to meet the needs of workers, although they did not state when this would specifically happen.

Given the clear need to improve the speaking up culture across the trust we endorse the trust's commitment to providing appropriate resources for the Guardian role and recommend that the trust implements this plan without undue delay.

Recommendation 14

Within 3 months the trust should take appropriate steps to identify the necessary resources required to ensure the Guardian role meets the needs of workers and then provide those resources.

Recommendation 15

Within 3 months the trust should ensure that reports for board members regarding the trust's speaking up arrangements continue to contain appropriate levels of detail, in accordance with the joint guidance from NHS Improvement and the National Guardian's Office.

What will happen next

An action plan from the trust to implement our recommendations

Following publication of this report, NHS Improvement, which is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care, will ask the trust to produce an action plan to implement our recommendations, within the timescales we have set.

It is the NGO's expectation that NHS Improvement will ask trusts to publish their action plans.

Once the trust puts their plan into effect NHS Improvement will monitor the trust's implementation of that action plan and will provide the NGO with updates regarding its progress.

Where there is evidence that the trust has not taken effective actions to implement our recommendations we will expect NHS Improvement, as well as Care Quality Commission inspectors, to take appropriate steps to address this.

The National Guardian's Office will also publish an update on the work it is undertaking with its partners to develop guidance relating to settlement agreements. In addition, it will produce national guidance within the required timescales on speaking up training.

Our response to individual contributors to our review

The National Guardian's Office will contact those individuals who have spoken up to our review, thanking them and providing feedback to them on how their experiences have been reflected in this report. We will also ask them for feedback on their experience of how we have conducted this review.

In addition, we will contact staff who spoke to us individually during the review to confirm whether they have subsequently experienced any detriment for speaking up. Where they tell us this has taken place we will refer any such cases to the trust and, if necessary, regulators to take appropriate action.

Other NHS trusts' responsibilities to implement our recommendations

We expect all other NHS trust boards in England, in accordance with the guidance we have produced in collaboration with NHS Improvement, to implement this report's recommendations in their own services, where it is appropriate to do so.

Feedback to help improve our case review process

To help us improve our process we welcome feedback from all readers of this report. Please send your comments to: casereviews@nationalguardianoffice.org.uk

Annex – summary of recommendations

The recommendations arising from the case review are listed below.

They are grouped according to when we recommend the work is completed by the body in question to implement each recommendation.

We also list below those recommendations for improvement that we have not made in previous reviews, to assist trusts to undertake gap analysis of this report relating to their own speaking up arrangements and culture.

Recommendations to be completed within three months

Recommendation 5

Within 3 months the trust should take appropriate steps to ensure that its response to workers speaking up, including the investigations of those issues and the implementation of learning resulting from them, is undertaken by suitably independent trained investigators.

Recommendation 6

Within 3 months the trust should take appropriate steps to ensure that the confidentiality of workers who speak up is appropriately supported, in accordance with trust policy and procedure and good practice.

Recommendation 7

Within 3 months the trust should ensure that it responds to the issues raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice.

Recommendation 8

Within 3 months the National Guardian's Office and its partners involved in reviewing settlement agreements in the NHS, including the Department of Health and Social care, NHS Employers and NHS Improvement, should complete this review and take all appropriate steps to implement its findings.

Recommendation 9

Within 3 months the trust should revise its new speaking up policy, to ensure it is in line with the NHS Improvement national speaking up policy.

Recommendation 14

Within 3 months the trust should take appropriate steps to identify the necessary resources required to ensure the Guardian role meets the needs of workers and then provide those resources.

Recommendation 15

Within 3 months the trust should ensure that reports for board members regarding the trust's speaking up arrangements continue to contain appropriate levels of detail, in accordance with joint guidance from NHS Improvement and the National Guardian's Office.

Recommendations to be completed within six months

Recommendation 4

Within 6 months the trust should review incident reporting rates and identify any areas which appear to be under-reporting and take action to address this.

Recommendation 10

Within 6 months the trust should take steps to ensure all existing and new workers are aware of the contents and meaning of its revised freedom to speak up policy.

Recommendation 11

Within 6 months the trust should put effective systems in place to monitor the development of a positive speaking up culture.

Recommendation 12

Within 6 months the National Guardian's Office should draw up national guidelines for the NHS relating to the content of speaking up training for workers.

Recommendations to be completed within twelve months

Recommendation 1

Within 12 months the trust takes appropriate measures to identify the causes of poor working relationships across the whole organisation and implements effective actions to remedy those causes, including steps to measure the effectiveness of those actions.

Recommendation 2

Within 12 months the trust takes steps to implement national guidance from NHS England relating to the managing of conflicts of interest.

Recommendation 3

Within 12 months trust leaders develop and begin the implementation of a strategy to improve the speaking up culture across its workforce. The plan should contain measures to identify the main issues the trust should address, clear actions to address those issues and steps to measure the effectiveness of those actions.

Recommendation 13

Within 12 months the trust should ensure that the content of any speaking up training it provides for its workers is consistent with guidance issued by the National Guardian's Office and NHS Improvement, including findings and recommendations from NGO case reviews and the Freedom to Speak Up Survey 2017 and board guidance from NHSI.

Recommendations in this report that we are making for the first time in a case review report

- Recommendation 1
- Recommendation 8
- Recommendation 12
- Recommendation 13