EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 6th August 2019, commencing at 09:30 in Oak Room, Hastings Centre

AGENDA			Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Monthly award winners	A	Chair	0930 - 1005
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 4th June 2019	B		
4.	Matters arising	C		
5.	Board Committee Chair's Feedback • Presentation of Committee Annual Reports	D	Committee Chairs	
6.	Board Assurance Framework	E	DCA	
7.	Chief Executive's Report	F	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
8.	Integrated Performance Report Month 3 (June) 1. Quality and Safety 2. Access, Delivery & Activity 3. Leadership and Culture 4. Finance	Assurance	G	DDN MD COO HRD DF	1005 - 1050

BREAK

STRATEGY

					Time:
9.	STP and ICP Update	Assurance	H	CEO	1105 - 1115

GOVERNANCE AND ASSURANCE

					Time:
10.	CNST Board Report	Assurance	I	DN	1115 - 1200
11.	Annual Reports: 11.1 Workforce Race Equality Standard 11.2 Complaints 11.3 Revalidation	Assurance	J	Various	
12.	Quality Walks	Assurance	K	Chair	
13.	Board Sub Committee Minutes	Assurance	L		

ITEMS FOR INFORMATION

				Time:
14.	Use of Trust Seal	M	Chair	1200 - 1215
15.	Questions from members of the public (15 minutes maximum)		Chair	
16.	Date of Next Meeting: Tuesday 1st October, St Peter's Community Centre, Church Street, Bexhill-on-Sea TN40 2HE		Chair	

Steve Phoenix

Chair man

3rd July 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

Monthly Award Winners

Meeting information:			
Date of Meeting:	6th August 2019	Agenda Item:	1.3
Meeting:	Trust Board	Reporting Officer:	Steve Phoenix

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:

MAY

Mortuary Manager, Lydia Judge-Kronis won the Employee of the Month Award for May for her compassion and thoughtfulness when dealing with a family who had special wishes after the death of a loved one.

Jenny Douthwaite, Clinical Nurse Specialist who nominated Lydia said: “The reason I am nominating Lydia for this award is because she has shown compassion and thoughtfulness for a patient we were both recently involved with. The time she spent with us and the family supporting them in how the patient will be looked after once they had died, was exceptional. As a palliative care clinical nurse specialist I have learnt a lot about the different processes available and I know the patient’s wife was very appreciative of the time the team spent with her, making her experience at a very difficult time much easier”.

In another of Lydia’s nominations Jo Thorpe, Clinical Nurse Specialist said: “Recently we were involved with a patient and family who had specific wishes following his death. Lydia was so compassionate and instrumental in ensuring these wishes were met. She came to the ward to meet the family and spent time ensuring everything was in place to meet these wishes prior to the patient’s death. The support she gave to the family and us as a team was exceptional, and greatly appreciated enabling person-centred care. As a supportive and palliative care team this has been an excellent experience of cohesive working and we have all learnt so much more about how care after death can be individualised. Thank you Lydia for making this possible”.

JUNE

June's winner was Erwin Castro, Diabetes Specialist Nurse at the Conquest Hospital.

He was nominated by Dr Umesh Dashora who explained that "Erwin is an inspirational person and specialist diabetes nurse. He works very hard to keep all his patients safe and happy giving them free access to his personal time. He is an exceptionally gifted teacher and spends huge amounts of time and energy organising an educational programme for medical students, ward nurses, health care assistants and junior doctors. He is highly organised and updates a large number of Trust guidelines in relation to diabetes. He is always more than happy to cover any staffing or service gaps and is probably one of the most popular people in the hospital amongst patients as well as staff."

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 4th June 2019 at 09:30 in the St Mary's Boardroom, EDGH.

Present: Mr Steve Phoenix, Chairman
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mrs Miranda Kavanagh, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Dr Adrian Bull, Chief Executive
Mrs Joe Chadwick-Bell, Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mr Jonathan Reid, Director of Finance
Mrs Hazel Tonge, Deputy Director of Nursing
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Mr Mark Friedman, Recovery Director
Miss Imelda Donnellan, Chief of Service, DAS
Mrs Tracey Rose, Deputy Director of Strategy, Innovation & Planning
Mrs Hazel Tonge, Deputy Director of Nursing
Ms Ruth Agg, Freedom to Speak Up Guardian (item 044/2019 only)
Dr David Barclay, Medical Director, St Wilfrid's Hospice, Eastbourne (item 044/2019 only)
Mrs Vicky Saddle, Specialist Nurse for Organ Donation (for item 055/2019 only)
Miss Kelly Porter, Executive Assistant to Chief Executive & Chairman (minutes)

040/2019 **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
Mrs Nicola Webber, Non-Executive Director
Ms Vikki Carruth, Director of Nursing
Dr David Walker, Medical Director
Mrs Catherine Ashton, Director of Strategy, Improvement & Planning
Miss Janice Humber, Staff Side

3. Monthly Award Winners
Mr Phoenix reported that the monthly award winners for March had been Sue Elliot, Amanda Selby, Soraya Shah and Julie Sheppard from Conquest Hospital and Donna Jessup from Eastbourne Hospital, all of whom are members of the Outpatients reception team. The winner for April was Janice Saunders, an HCA on DeCham Ward, Conquest Hospital

041/2019 **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.

042/2019 **Minutes**

The minutes of the Trust Board meeting held on 2nd April 2019 were considered and agreed as an accurate record. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

043/2019 **Matters Arising**

Three matters arising were noted:

012/2019 - STP Population Health Check

Mrs Chadwick-Bell reported that she had been unable to confirm with the author of the document, but through discussion with the STP believed it referred to a number of conditions which could be managed in the community as opposed to attendance at the Emergency Departments. These were likely to include UTI, Blocked Catheters, Flu/Pneumonia, non-injury falls, cellulitis.

The East Sussex system had already identified this as an area of focus and established five new pathways and this was being managed through the system urgent care board.

026/2019 – Board Assurance Framework

To be discussed under item 8 of the agenda.

028/2019 I – IPR – Quality & Safety

An update on the progress in reducing *clostridium difficile* infections would be presented to the Board in October.

044/2019 **Freedom to Speak Up Guardian**

Mrs Ruth Agg presented the Freedom to Speak Up Guardian's update to the Board. She confirmed that the figures collected within the Trust provide assurance that staff were speaking up and that in her role as Speak Up Guardian she provided support to these members of staff when they raised concerns. In addition, there had been a reduction in the numbers of staff reporting bullying and harassment following significant work with staff engagement which helped to reduce this. Recent national figures indicated a large increase in contacts in many other organisations but this upward trend was not evident in the Trust.

Mrs Agg explained that the two areas which resulted in the largest number of contacts with the Speak Up Guardian were behavioural/relationship issues and system/process issues but confirmed that there was ongoing work being undertaken with leadership within teams. Significant work had also been undertaken with Human Recourses to update key Trust policies.

Mrs Agg highlighted that one of the key questions asked nationally was "Would you speak up again, if not why not", explaining that the Trust encouraged feedback following referrals to the Speak Up Guardian and the majority of staff confirmed that they would speak up again. A staff survey monkey questionnaire had been developed which included a question on what prevented a member of staff from raising their concerns.

Mrs Agg also explained that behaviours at meetings was a key issue raised and a meeting charter has been developed with staff and this was and this was displayed in meeting rooms across the Trust.

Significant support from the leadership team resulted in swift resolution of issues and led to behavioural change and staff working together in partnership. Mrs Agg attended staff induction sessions and a Freedom to Speak up newsletter had been created and distributed via communications. A self-review tool was also being developed and would be presented to both the People and Organisational Development Committee (POD) and Trust Board at future meetings.

Dr Bull confirmed that Mrs Agg ensured that the leadership team are involved with the resolution of issues and that the newsletter had received positive feedback. Additional training was being provided for middle grade managers and this would be supplemented by training on how to deal with difficult conversations.

Mrs Mason asked why there was a high number of contacts under the "Not Known" category. Mrs Agg explained that she had to record every contact made and that this category included staff who were offered assistance but subsequently decided not to respond or meet which resulted in the case being closed.

Ms Green highlighted that Trust Values were in place and that a piece of work around this had been completed outlining behaviours and what is expected of staff; this was currently being rolled out in the Trust.

Mrs Kavanagh asked whether staff felt that they could raise concerns without the fear of reprisal. Mrs Agg explained that it could be difficult for some staff to raise concerns however feedback indicated that staff were feeling more confident in raising concerns.

The Chairman thanked Mrs Agg for the hard work she carried out as Speak Up Guardian on behalf of the Trust.

045/2019 **ReSPECT**

Dr David Barclay joined the meeting and presented an update on the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). He advised that ReSPECT was an alternative process for discussing, making and recording recommendations about future emergency care, which built on the do not attempt CRP (DNCPR) form. The new form focused on what treatment a patient wanted, rather than what treatment they did not want. This was a national initiative and followed a large study held across the country which identified poor experience of the DNCPR.

Dr Barclay advised that a lot of work was being undertaken by staff at the Trust with support from the Resuscitation and project planning teams. The new ReSPECT form was rolled out in the Trust in April 2019 and non-medical decision makers were being trained on how to complete it with patients. Currently the Trust was focussing on ensuring that patients with special medical needs completed the ReSPECT form; but noted that this should be completed when patient the patient was well and in the community rather than when admitted to hospital. Audits of ReSPECT forms would be carried out to ensure that high standards were maintained.

Collaboration was key to the successful implementation of this new form and CCGs had been involved; the form had also been established at St Wilfrid's Hospice and St Michaels Hospice were looking at providing training for their staff to implement it. The Ambulance Service (SeCAMB) had trained staff and the form would be available on their IBIS system; to ensure that they were aware of the wishes of patients.

Mrs Churchward-Cardiff asked whether the ReSPECT form had legal standing. Dr Barclay explained that the form provided a way of communicating between clinicians; it was not a legal document unlike the ADRT (advanced decision to refuse treatment) or the lasting power of attorney form.

Mrs Churchward-Cardiff noted that the frailty team worked hard on developing Peace Plans and asked whether this was incorporated into the ReSPECT document. Dr Barclay confirmed that staff would now complete a ReSPECT form, but that a patient may have a separate Peace Plan and there was a section in the ReSPECT document that refers to Peace Plans and ADRT forms.

Dr Bull advised that when looking at the interconnectivity between primary and acute care; ReSPECT forms would become part of the patients electronic records and all GPs have access to eSearcher and the Trust has access to the Summary Care Records; therefore it is important that the ReSPECT form should be included in this by GPs to ensure that the Trust can view them.

Mrs Manson highlighted that it was important to build awareness of the forms, asking whether there was an opportunity to have sample forms in waiting rooms. Mrs Tonge explained that Newington Ward at the Conquest had created a "ReSPECT Shrine" for patients, but more was still to be done in the acute and community areas, starting with out-patients.

The Chairman thanked Dr Barclay for presenting the overview and for his leadership and commitment to the project.

046/2019 **Board Committees' Feedback**

1. <u>Audit Committee</u>

Mr Reid reported that the Audit Committee had met on 24th May. This was a single issue meeting which reviewed the financial statements and draft annual report. Internal audit colleagues attended and provided their opinion on the system of internal control for the year, on which they had concluded reasonable assurance. Mr Reid also confirmed that external audit had issued their final report, and had issued an unqualified opinion on the financial statements and a qualified opinion on value for money.

The auditors reported on the Quality Account, noting that testing on some indicators was taking place and the deadline for publishing the Account was the end of June

2. <u>Finance and Investment Committee</u>

The Chairman reported that the Finance and Investment (F&I) Committee had met on 30th May. The meeting reviewed Month 1 figures along with reviewing the remainder of the first quarter, spending time discussing the practicalities of grip and control.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had met on 23rd May. The meeting discussed the Schwartz Round which was greatly valued by staff, noting that the organisers would like to see more front line staff and members of Trust Board in attendance. Additional pop up rounds were going to be created for front line staff.

Mrs Kavanagh also confirmed that the under-reporting of exception reports was highlighted from the Junior Doctors survey. The issue regarding Junior Doctors cover for Michelham ward had been resolved. Concerns regarding IT issues were also raised with a request for wider communication to be published.

Mrs Kavanagh noted that the Committee had reviewed the draft Accountability Framework and suggested that the definition of accountability and responsibility be refined to ensure it was understood by all staff.

Additional items highlighted from POD were the pay review; staff survey action plans and Friends and Family Test; it was noted that the employee relations report was going in the right direction and that polices were in place to support staff. Medical & Nursing revalidation was maintaining its strong position however, there was an urgent need to find more staff to act as revalidators.

4. Quality and Safety Committee

Mrs Churchward-Cardiff reported that the Quality and Safety (Q&S) Committee had met on 23rd May. The agenda covered a patient story, strategic focus on the quality account and on GIRFT. The Committee considered reports on governance, compliance and risk followed by a performance review for Cancer. The key points from these items were that consideration had to be given to End of Life Care and where the patient was placed on the ward. Quality account priority leads would be asked to write up the progress in future reports. GIRFT themes had been identified and were being led by the appropriate divisions and executive. Assurance was given that governance and compliance issues were being managed with sustained improvements seen across a number of areas. Cancer performance was being managed and the risk could reduce to Amber.

The Board noted the Committee Reports.

047/2019 **Board Assurance Framework**

Mrs Wells presented the Board Assurance Framework (BAF).

Mrs Wells explained that in relation to the delivery of the 62 cancer metrics, 2.1.1, a discussion was held at Quality & Safety committee in which it was agreed to recommend moving this from red to amber. Therefore Mrs Wells asked the Board to agree this proposal.

Mrs Churchward-Cardiff highlighted concerns over the limited progress made on Mental Health support for young people being admitted to acute medical wards, 2.1.2, questioning whether there were any further processes that could be put in place to assist with this. Dr Bull explained that following a recent discussion at the East Sussex Health and Social Care Executive Group meeting, it was confirmed that additional funding was being released nationally to support this issue. The Interim Director of Commissioning for the CCG was reviewing how best to use these funds to address the issues. This was recognised across the STP and not just a Trust issue, noting that there could and should be a faster resolution.

The Board confirmed that the main inherent/residual risks and gaps in assurance or controls had been identified in the Board Assurance Framework and actions were appropriate to manage the risks.

The Board approved:
The addition of a new gap in control, 2.1.3, to the BAF regarding follow up appointments.

The removal of the gap in assurance, 5.2.1, in respect of culture and the staff survey

Revision of the RAG rating for 2.1.1 regarding achievement of the 62 day cancer metric from Red to Amber.

048/2019 **Chief Executive's Report**

Dr Bull presented the paper highlighting the main points for the Board's attention.

Dr Bull explained that the Trust ended the 2018/2019 financial year with strong performances in quality and safety, operational performance and capital; although outlining that the Trust had to absorb the cost of the MRI build which resulted in the Trust having to defer some schemes and maintenance backlog items.

In relation to Quality and Safety there had been some changes in the categorisation of HCAIs; productive discussions were held in relation to CDI (*Clostridium difficile* infections) and this remained well-managed for the Trust.

The Trust continued to see a high number of A&E attendances.

Dr Bull reported that 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 was better than the national average of 81%. 62.9% of respondents would recommend the Trust as a place to work which had considerably improved and was closer to the national average of 64%.

The latest SHMI (January 18 to Dec 18) had fallen to 0.97, the lowest level the Trust had achieved since the index was implemented.

In relation to Communications & Engagement the "Bedside Booklet" was launched in April, this provided patients with practical guidance and an overview of what to expect when coming into hospital.

There was continued growth in the number of babies born at the Eastbourne Midwifery Unit.

Dr Bull confirmed that the Trust had achieved the year-end budgeted financial position. An aligned incentive contract for 2019/20 had been signed with the Clinical Commissioning Groups (CCGs).

In terms of Quality Improvement & Strategy, all of the divisions had their business plans in place which had been incorporated into the wider Trust plan. The Trust was developing a quality improvement and service redesign programme for all Trust staff, with a number of staff already trained. The new Improvement Hub had also opened.

Mrs Kavanagh asked whether the Trust should be concerned over the number of CDI numbers last year. Dr Bull explained that this was reviewed and that there was a good understanding of the drivers behind these numbers; for example due to the broad spectrum of antibiotics being used to treat Sepsis, but that this was being addressed. Mrs Churchward-Cardiff confirmed that this was discussed at Quality & Safety committee, noting that this was a consequence of providing excellent care where Sepsis was suspected.

049/2019 **QUALITY, SAFETY AND PERFORMANCE**

Integrated Performance Report Month 1 (April)

1. Quality & Safety

Mrs Tonge reported that the trust had made significant improvement in quality and safety over the last few years. To demonstrate this, the format of the report had been revised and included charts showing improvements over the last 5 years. Mrs Tonge highlighted the following areas:

The number of falls showed a downward trend and substantial improvement over the last five years. The number of falls in April was 108 which was a decrease from 137 in march and the number of falls per bed days had fallen to 5.19 in April, from 6.34 in March. There was one serious incident in April with a fall to fracture which occurred while the patient was walking to the bathroom. There was a further severity 4 fall reported on datix which would be formally reported in May's data.

Mrs Tonge confirmed that in the last five years there had been a dramatic reduction in grade 3 and 4 pressure ulcers, however grade 2 remained static. A mattress replacement programme was being undertaken and there was also a focus on seating to prevent shearing.

Mrs Tonge reported that there was one case of MRSA bacteraemia and identified the peripheral line as the likely cause. The patient had recovered from the infection and a meeting was scheduled to review training and supporting staff at gateway areas with the management of peripheral cannulas. In terms of *Clostridium difficile*, the limit for 18/19 was 40 and this was exceeded at 51 positives (from 48 patients), which was mainly apportioned to the use of wide spectrum antibiotics to treat sepsis.

There was a high incidence of influenza locally and nationally which resulted in 450 cases diagnosed by the trust and the most serious cases had been reviewed.

Mrs Tonge reported that in terms of Patient Experience the total number returns for in patients was 2731 with an improvement in the A&E response rate compared to last year 10.6 comparted to 4.8.

The Trust had interviewed 150 registered nurses during a visit to India and timelines and final numbers for this recruitment drive would be available soon.

Mrs Churchward-Cardiff asked whether a record was maintained of how long internationally recruited nurses remained in employment with the organisation. Ms Green confirmed that this was recorded; adding that nurses from the Philippines and India tend to remain with the Trust longer, than those from Europe.

Mrs Kavanagh noted that mixed sex accommodation was not included in the report. Mrs Chadwick-Bell advised that the majority of patients being transferred to mixed sex accommodation were in the areas of stroke and CCU and this was where breaches occurred. Mrs Tonge added the Trust had not received any complaints from patients in the last two years about mixed sex accommodation and adhered to guidelines in classifying breeches.

2. Access and Responsiveness

Mrs Chadwick-Bell reported that, despite Easter being exceptionally busy with attendances increased by 12.1% against April 2018, 90.6% had been achieved for the 4 hour standard. Non elective admissions were up 10%, but non-elective bed days down by 10%. The Ambulatory Unit at Eastbourne DGH would be extending its service to seven days as well as in the evenings. The dedicated unit at the Conquest hospital was being built and due to open in Autumn 2019.

A piece of work examining the drivers of demand was being undertaken including reviewing patient behaviours and funding was being sought from the STP in relation to this.

Mrs Chadwick-Bell reported that medical teams were working on the Frailty model with a new pathway and business case to be presented to relevant committees in due course.

RTT continued at above 91% and a plan was in place to achieve 92%; the waiting list had reduced and the Trust continued to perform well against peers.

Mrs Chadwick-Bell confirmed that in relation to diagnostics, six out of the last seven months had been below 1%, which was the standard.

The Trust met all of the Cancer standards in March, with the exception of the 62 day metric but this was in line with the recovery trajectory. Mrs Chadwick-Bell confirmed that in terms of cancer standards, 28 days would be the new trajectory coming into effect from next year. Mrs Chadwick-Bell reported that the new Urology Investigation Suite at Eastbourne DGH had opened. This would reduce the waiting time for those patients referred via their GP.

Mrs Churchward-Cardiff queried whether the Trust was seeing a trend in relation to delayed transfers of care. Mrs Chadwick-Bell explained that whilst there was an improvement, reporting was getting better and the Trust had increased its controls around reporting and that a new medically fit app was now in place.

Mrs Churchward-Cardiff asked whether the Trust was trying to reduce the number of patient attending A&E. Mrs Chadwick-Bell advised there was a need to understand the patient behaviours around attendances and consider the most effective model of treatment pathways; these conversations were being held at STP level. Dr Bull added that the Trust had streaming in place and was seeing an increase in the patients being treated via primary care streaming but there was also an increase in patient's requiring emergency treatment.

The Chairman commented that over the last decade the NHS had tried many different streaming and systems without achieving the desired effect and asked when this strategic piece of work would be completed. Mrs Chadwick-Bell advised it should be complete over the next six weeks and if so an update

would be available at the next Trust board.

3. Leadership and Culture

Ms Green reported that total workforce was 6754.9 full time equivalents, 299.9 below the budgeted establishment. However, both budget and expenditure were higher due to the annual pay award.

Ms Green explained that substantive expenditure of £22,750K accounted for 80% of total expenditure and temporary expenditure of £3.083K equated to 12% of the budget. There was also a reduction in use of agency staff due to the end of winter pressures.

Ms Green confirmed that there had been positive recruitment campaigns for both medical and nursing staff. Turnover and sickness remained stable and the New Employee Assistance Plan had been launched which was proving to be successful with good feedback from staff.

4. Finance

Mr Reid reported that headlines for month 1 confirmed that the Trust had delivered the plan and CIP target. The Trust would use quarter one to bed down the CIPs of which a target of £13m had been identified.

As the Trust had delivered the month 1 plan, transformational funding of £1m had been received. Mr Reid reported that there was some risk, as when the CIP target was set this was based on an assumption of a certain investment level; however this investment level was now anticipated to be £1m lower than expected and that discussions will be held at the next F&IC.

There was still significant pressure on the capital budget.

Mrs Churchward-Cardiff asked whether the proportion of overtime in the total pay spend was reviewed. Ms Green confirmed that this information is tracked.

The Board noted the IPR Report for Month 1.

050/2019 **Learning from Deaths (Quarter 3)**

Miss Donnellan advised that the report covered learning from deaths for the period April 2017 to December 2018. Deaths were reviewed by the individual looking after the patient, along with a peer group and any concerns were documented. This was then triangulated against any other concerns flagged on Datix or through complaints. The number of deaths reviewed in a timely fashion was over 90%. Miss Donnellan confirmed that there were no potentially avoidable deaths recorded during the period.

Learning Disability Deaths were reviewed separately via the external LeDeR (learning disability mortality review) programme although the Trust still undertook an initial review to ensure there was no immediate learning or change in practice required.

Miss Donnellan also confirmed that as part of the required national changes for the reviewing of deaths, Medical Examiner posts would be recruited to at both ESHT sites and this new process was anticipated to commence by April 2020.

051/2019 **Clinical Strategy Development**

Dr Bull presented the paper noting the East Sussex Alliance would now incorporate High Weald Lewes and Havens CCG. There were three key

programme boards led by SROs from the East Sussex Health and Care Alliance; Urgent Care, Planned Care and Primary and Community Health Board.

The Alliance Project Management Office was supporting specific initiatives for the programme boards; these were linked to transformation in the system which in turn would help to health economy wide improvements. However, there were some issues which needed to be resolved including delays in data passing through to report on KPIs and ensuring that there was a cost benefit to deliver QIPPs as this was currently showing a shortfall.

The Chairman asked whether the Urgent Care programme was incorporated into these schemes. Mrs Chadwick-Bell confirmed that they are.

Mrs Churchward-Cardiff asked about the education training for care homes and whether this would still happen. Mrs Chadwick-Bell advised this was currently on hold but alternatives were being reviewed with consideration to outcomes and cost benefit of providing this.

Mrs Churchward-Cardiff asked whether the Urgent Care business case had been approved. Mrs Chadwick-Bell advised that it had been drafted but was waiting for financial information before it could be finalised.

Mrs Manson noted that there were lots of plans in the report and asked whether the Trust was working on all of these. Mrs Chadwick-Bell explained that the main plans were the Urgent Treatment Centre, the extension of Ambulatory Care and Frailty.

Mr Reid highlighted the risks as the programmes aimed to deliver an £11.1m reduction in the system finances; there was a core £4million risk to the Trust and the residual risk remained with commissioners.

052/2019 **Clinical Strategy Development**

As Ms Ashton was not in attendance, this item was deferred to a future meeting.

053/2019 **Staff Survey Action Plan**

Ms Green advised that since last presented to the Board, a lot of work had been undertaken with each of the divisions producing their own action plans; which were monitored via the divisional integrated performance meetings. In addition to this there were four corporate priorities for which work was also being undertaken.

The Chairman noted that the detailed assurance has been provided via the People and Organisational Development Committee (POD). Ms Green confirmed that this was being presented at Trust Board to ensure that all members had sight of the plan. Mrs Kavanagh noted that Ms Green was providing a comprehensive support but that the divisions must ensure that they owned their action plans.

Dr Bull explained that it was highlighted to him by a senior member of staff, that they felt we lose sight of our working conditions compared to working conditions in other trusts and also against the private sector. We also lose sight of the positive responses received via the staff survey and that we must ensure that this is put this into context.

Ms Green confirmed that a new initiative on The Best Place to Work was being rolled out.

054/2019 **Workforce Disability Equality Standard**

Mrs Wells presented the paper confirming that the Workforce Disability Equality Standard (WDES) was launched on 1st April and was a national, mandated requirement. The aim was to ensure Trusts were more inclusive and the ten metric. She explained that WDES was a set of ten specific measures (metrics) that enabled NHS Trusts to compare the experiences of Disabled and non-disabled staff. This information would then be used to develop a local action plan, which would enable the organisation to demonstrate progress against the indicators of disability equality.

The main issues highlighted related to data quality, staff may have never been asked to disclose their disability, may choose not to disclose it or may not recognise that they have a disability. WDES is about education and encouraging staff to declare their disability in order to capture this. Mrs Wells confirmed that a disability steering group had been created and work was ongoing to increase staff involvement.

Mrs Churchward-Cardiff commented that the board was not very diverse and whether future recruitment could target applicants with a disability. The Chairman advised that the criteria for the current recruitment had already been set and the post advertised. However, the recruitment pack did highlight that we welcomed applicants applications from women, people from the local black and minority ethnic communities, and disabled people who we know are under-represented in non-executive roles

The Chairman noted that the report suggests that an Executive Director should be nominated as lead for this. Mrs Wells confirmed that she was the Executive Sponsor as equality and diversity was within her portfolio but also confirmed that Mr Chris Hodgson, Associate Director of Estates & Facilities chaired the network with the Head of Equality and Diversity.

Mrs Wells confirmed that compliance would be monitored through the People and Organisational Development Committee (POD).

055/2019 **Organ Donation Annual Report**

Mrs Churchward-Cardiff introduced Mrs Saddle who presented the Annual Organ Donation report.

Mrs Saddle explained that the report covered Organ Donations carried out during the period April 2018 and March 2019; The Trust has been categorised as a level 2 trust by NHS Blood & Transplant (NHSBT) which was based on the average number of donors proceeding each year.

The number of donation referrals were slightly down on last year's numbers. However, this was is improving as there was an increase in patients who were suitable for organ donation. Mrs Churchward-Cardiff noted that it was very important not to miss the referrals. Mrs Saddle confirmed that only four referrals were missed over the last year.

Mrs Saddle highlighted concerns over the replacement for the Specialist Nurse for Organ Donation (SNOD) due to the currently SNOD leaving in July. The remaining team were a junior team but would receive support from Dr Trimmings, whilst the clinical lead for Organ Donation was on maternity leave.

Mrs Churchward-Cardiff echoed the concerns highlighting the training and education that is required; confirming that there were currently two vacancies for SNODs.

In order to raise awareness of organ donation, Mrs Saddle requested that a communications representative attends the organ donation committee to help promote the scheme. Training was also required to support the key areas, including A&E. Mrs Wells advised that the communications team would support where they could but had limited capacity to attend additional committees.

Mrs Saddle explained that the transplant teams and organ donation staff had highlighted the lack of a telephone signal and Wi-Fi in theatres, especially at Eastbourne DGH and the impact that this has on the process. Dr Bull advised that the new telephone system this would allow for a dedicated direct dial number for the organ donation team, which could be diverted to a mobile phone.

Dr Bull confirmed that he would discuss with Dr David Walker the options of an Executive lead for the programme.

Mrs Churchward-Cardiff expressed her thanks to Mrs Saddler for her hard work and dedication, as she had gone above and beyond.

056/2019 **Quality Walks**

The Board noted the quality walks that had been undertaken between March and April 2019. The model of quality walks was under review. Mrs Chadwick-Bell explained that many of the Executive Directors carry out additional visits which were not necessarily included in this report.

057/2019 **Delegation of Approval of Quality Account 2018/19**

As submission was due to be made on 30 June, Mrs Wells sought the approval of the Board for delegated authority to Dr Adrian Bull and Ms Vikki Carruth for the approval of the 2018/19 Quality Account. She noted that the Trust Board would formally receive the Quality Account at its AGM on 6th August.

The Board approved delegation to authorise the 2018/19 Quality Account to Dr Adrian Bull & Ms V Carruth.

058/2019 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- Audit Committee 31st January 2019 and 28th March 2019
- POD Committee 21st March 2019

The Minutes were received by the Board

059/2019 **Use of Trust Seal**

Two uses of the Trust Seal since the previous meeting were noted:

- 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

060/2019 **Questions from Members of the Public**

Mr Hardwick raised concerns over the pricing of the catering at the café at the front entrance of Eastbourne DGH, highlighting that the sandwiches were more expensive than Costa Coffee. Mr Hardwick also asked what rent the Trust receives from the company.

Mrs Wells advised that she can only provide a ball-park figure in relation to the rental income due to this being commercially sensitive information. Mrs Wells confirmed that the company had been contacted in relation to their pricing and they had advised that they would look to provide a less expensive range of food. Dr Bull added that the Trust was not able to control the prices that the company charged.

Mr Hardwick asked whether the board anticipated any increased activity following the closure of the Esperance and what effect this would have on Michelham Ward. Mrs Chadwick-Bell confirmed that the Trust had contacted the consultants involved, who have expressed an interest in bringing their private activity through the Trust and a further meeting was being held to review this. There are seventeen beds on Michelham and a number of these were used by the Trust's own orthopaedic consultants. Mrs Chadwick-Bell confirmed that the Esperance did not solely provide private healthcare. Ms Green confirmed that the recruitment team have been invited to the Esperance to assist where they could.

Mr Hardwick asked whether those attending the Public Board meetings could ask questions directly to those presenting the papers who were not Trust Board members and leave before the end of the meeting. The Chairman confirmed that this would not be possible as the meeting was a Board meeting in public and not a public meeting. Dr Bull added that all items presented to the Board had an Executive sponsor who would be able to answer any questions from the public at the end of the meeting.

Mrs Hardwick complimented the Trust following her appointment with Dr Youseff, noting how very impressed she was with her experience today. The Chairman acknowledged this, thanking Mrs Hardwick for her comments.

Mrs Walke asked for clarification over the out of hours paediatric services, as concerns had been raised by members of the public who had contacted her.

Dr Bull confirmed that when the changes were made in 2013/2014 the Short Stay Paediatric Unit (SSPAU) was established; there was no overnight service at Eastbourne and patients were transferred to the Conquest if the need arose.

For a short period of time, the Trust retained an on-site overnight registrar at Eastbourne but this did not form part of the Emergency Department service. This post was generally filled by locums and it was not also possible to fulfil the requirement. It would be discontinued but there was no other change to the service being provided; although the SSPAU would remain open until 9.30pm on weekdays, patients would not be admitted after 6pm and 90% of patients were discharged home within that time. Dr Bull explained that this would be communicated to GPs, the 111 assessment unit were aware of this and that our other service partners are also aware. Mrs Chadwick-Bell confirmed that there were no pathway changes. Children presenting to A&E would be treated or treated and transferred according to their medical requirements.

Mrs Walke highlighted the need to repair the hospital signs outside of Eastbourne DGH prior to the CQC inspection.

Dr Bull explained that there was a major change in the signage used in the system, of which these signs are part of and would be replaced. Dr Bull confirmed that he would be in contact with the Associate Director of Estates and Facilities to highlight these concerns.

Mrs Walke mentioned that she had heard patients often miss notifications of appointments due to being on holiday. She also passed on feedback from two patients who had contacted her to compliment the Trust relating to their appointments at Eastbourne DGH, noting that they had been seen by their consultant and left without the car parking charges coming into effect.

Mr Campbell asked whether any of the Quality Walks take place between midnight and 6am. Mrs Wells confirmed that some Quality Walks are undertaken out of hours by the Executive Team; however, they are not carried out as often as during the day time.

Mr Campbell asked Mr Reid regarding the variable income, noting that this is 73% of total income. Mr Reid explained that this is on a fixed term aligned incentive contract and equated to 80% of NHS patient income.

Mr Campbell asked for clarification in relation to the Financial Plan figures regarding the agency whole time equivalent figures as nothing is noted against this in the column. Mr Reid explained that figures relating to agency whole time equivalent are estimated based on agency rate conversions into whole time equivalents, but advised that this would be reviewed.

061/2019 **Date of Next Meeting and AGM**
Tuesday 6th August, Oak Room, Hastings Centre

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

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

There were no matters arising from the Board meeting in public on 4th June 2019.

East Sussex Health Care NHS Trust

Audit Committee Annual Report 2018/19

1. Introduction

The purpose of this report is to formally appraise the Board of the work of the Audit Committee during the period 1st April 2018 to 31st March 2019 and to set out how it has met its terms of reference [attached as Appendix A] and priorities.

2. Meetings of the Committee

The Committee is chaired by a non-executive director with a financial background and membership comprised two other non-executive directors until one retried in August 2018. The Trust is currently recruiting for an associate non-executive director who will join the Committee. This reflects and meets the need for independence and objectivity. The Committee convened on five occasions throughout the financial year and four of the meetings were quorate. No decisions were taken by the Committee at the meeting on 28th March which was not quorate.. Meetings were also held with auditors in private session.

The Audit Committee was chaired by Mike Stevens until 10th September 2018. The Committee was then chaired by Nicola Webber from 24th September 2018. Sue Bernhauser left the Trust on 31st August 2018.

Attendance at meetings was as follows:

Mike Stevens, Audit Chair (to 10.09.18)	2/2
Nicola Webber, Audit Chair (from 24.09.18)	3/3
Sue Bernhauser, Non-executive director (to 31.08.18)	1/2
Barry Nealon, Non-executive director	4/5

Mr Nealon chairs the Finance and Investment Committee.

3. Governance, risk management and internal control

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

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

Progress against achieving compliance with the Data Security and Protection Toolkit (DSPT) was monitored throughout the year. The Trust achieved full compliance with the DSPT in March 2019.

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

4. Internal audit

The internal audit service was provided by TIAA Limited. The Committee approved the detailed internal audit programme of work and received a report from the internal auditor at each of its committee meetings which summarised the audit reports issued since the previous meeting. TIAA carried out 14 assurance reviews during the year, which were designed to ascertain the extent to which the internal controls in the system were adequate to ensure that activities and procedures were operating to achieve the Trust's objectives. Two audits gave 'substantial assurance', eight audits gave 'reasonable assurance', three gave 'limited assurance' and one gave 'no assurance'.

The report where a 'no assurance' opinion was given concerned Delayed Transfer of Care (DToC) processes. This was included in the internal audit programme as a result of concerns raised by Senior Management and a desire to analyse and improve processes underpinning the Trust's reporting of DToC. Agreed actions are being implemented to improve discharge efficiency and reporting, including the 'Medically Fit for Discharge' App, which should result in reduced DToCs which are accurately reported.

Throughout the year, the Committee worked effectively with internal audit to strengthen the Trust's internal control processes and ensured there is an improved process for tracking audit actions. The overall annual opinion from TIAA was Reasonable Assurance on the adequacy of the Trust's risk management, control and governance processes.

5. External audit

The external audit service was provided by Grant Thornton UK LLP.

The Committee approved the External Audit Plan at the start of the financial year and received regular updates on the progress of work. At each meeting the Committee received reports and briefings from the external auditors in accordance with the national requirements. These included: the annual audit letter; final accounts memorandum; a report on the audit of financial statements; and briefings on specific issues.

6. Counter Fraud Services

Counter fraud services were provided by TIAA Limited and the service continued to enhance the Trust's overall anti-fraud arrangements through a range of agreed activities, managed and monitored against an approved counter fraud work plan for 2018/19. A counter fraud representative attended each meeting and updated on actions being taken in respect of reactive work and progress of investigations. Proactive work included:

- Dissemination of fraud alerts/intelligence bulleting
- Cyber awareness on-line training module
- Reviewed matches from the 2018/19 National Fraud Initiative
- Fraud awareness presentations at inductions for new staff and to departmental meetings
- A benchmark review of Consultant Job Planning in the Trust

Fraud awareness training was promoted throughout the Trust and counter fraud education was included in induction training.

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

7. Clinical Audit

At each meeting, the Committee received a report on progress in implementing the Clinical Audit Forward Plan 2018/19, ensuring that the system in place allowed lessons learnt from clinical audit activity to be shared effectively, and recommendations for improvement to be implemented in a timely manner.

A new two-tier clinical audit approval process endorsed by the Committee was introduced in April 2018: all applications are initially sent for approval to the divisional senior management team, allowing for full divisional oversight, engagement and commitment to the audit before it begins. If approval is granted, the application is then sent to the Clinical Effectiveness Lead for final sign off. The two-tier system will work to ensure that each audit is meaningful, robust and fully aligned to core Trust objectives. Any audits conducted without official approval will not be supported by the Clinical Effectiveness team or recognised by the Trust.

The Committee was pleased to note a reduction in the number of 'abandoned' local audits in 2018-19. During the year, a new process was introduced whereby if a decision is taken to abandon an audit, details are sent to the relevant supervisor for review at the auditor's next appraisal. This process has helped to ensure a greater number of audits are fully completed as per the requirements set out in the Trust's Audit Policy.

8. Management

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

The Committee worked closely with the executive directors to ensure that the assurance mechanisms within the Trust were fully effective and that a robust process was in place to ensure that actions falling out of external reviews were implemented and monitored by the Committee.

9. Financial reporting

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

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

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

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

There were no areas identified that required improvement although committee membership needs to be addressed.

The Committee undertakes a review of its Terms of Reference on an annual basis.

11. Audit Committee Chairman's Comments

The Audit Committee has supported the Board by critically reviewing the governance and assurance process on which the Board places reliance. The Committee has sought and found assurance that internal controls (clinical and non-clinical) are reliable, robust, appropriately applied, and support the Trust's objectives, and has sought reports and assurances from officers as appropriate.

The Committee has ensured that there are effective internal and external audit and counter-fraud functions which provide appropriate independent assurance to the Committee, the Chief Executive and the Board, and has monitored the integrity of the Trust's financial systems, and systems of control, and found these to be effective.

The Committee has appropriately reported issues to the Board on an exception basis, and there are no matters of which the Committee is aware that have not been appropriately disclosed.

Nicola Webber
Audit Committee Chair

May 2019

Appendix A

Audit Committee Terms of Reference

East Sussex Healthcare NHS Trust

Audit Committee - Terms of Reference

1. Constitution

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

2. Purpose

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

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

3. Membership

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

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

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

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

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

4. Attendance

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

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

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

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

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

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

5. Quorum

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

6. Frequency

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

7. Authority

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

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

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

8. Duties

8.1 Governance, Risk Management and Internal control

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

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

- the board assurance framework, risk management system, Annual Governance Statement together with an accompanying Head of Internal Audit Statement, external

audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible

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

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

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

8.2 Internal Audit

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

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

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

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

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

- An annual review of the effectiveness of internal audit.

8.3 External audit

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

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

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

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

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

8.4 Counter Fraud

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

8.5 Other assurance functions

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

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

- Department of Health
- Care Quality Commission
- NHS Litigation Authority
- Other regulators and inspectors

- Professional bodies with responsibility for performance of staff or functions including Royal Colleges and accreditation bodies
- The Trust's internal assurance function

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

8.6 Hosted arrangements

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

8.8 Management

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

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

8.9 Financial reporting

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

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

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

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

9. Reporting arrangements

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

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and compliance with CQC registration standards.

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

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

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

East Sussex Healthcare NHS Trust

Finance and Investment Committee - Annual Review 2017/18

1. Introduction

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

2. Authority and Duties

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

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

3. Membership

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

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

4. Annual review of terms of reference and work plan

The Committee's Terms of Reference (TORs) were considered as part of the self-effectiveness review and it was agreed they remain fit for purpose. *[Drafting Note: The Terms of Reference are attached for review]*

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

Matters considered in 2018/19 included:

- Oversight of Financial Special Measures Requirements including a review of governance arrangements, and the drivers of the Trust Deficit
- Reviewing monthly operational and financial performance against the Trust's Financial Recovery Plan, to provide assurance to the Trust Board;
- Divisional assurance updates on a monthly basis across all areas of the Trust, aimed at testing the robustness of reporting and providing assurance to the Trust Board on the financial position;
- Review of 2018/19 forecast outturn on a quarterly basis, analysis of key variances, challenge to the Executive Team and Director of Finance, aimed at providing assurance to the Board on the forecast financial position;
- Review of the Long Term Financial Model (3+2) and its assumptions, including testing the key model inputs and evaluating the likely impact on the financial and operational plans for the Trust;
- Oversight of the financial and business planning process on behalf of the Trust Board, including budget setting for 2019/20
- The annual capital programme and regular updates against plan
- Reviews of all Business Cases over £250k in value, either for approval or for recommendation for further review at the Trust Board – including both capital and revenue business cases as appropriate;
- Approval of the annual reference cost collection process, and updates on the Costing Transformation Programme (CTP);
- Quarterly reviews of EBITDA (Earnings before interest, taxes, depreciation, and amortisation) and a programme of regular rolling reviews of specialties with negative EBITDA;

- Estates and energy planning
- Regular review of the cash flow including aged debtors
- Tenders and Service developments
- Updates on Operational Productivity Programme (Lord Carter) bed modelling and Clinical Services Strategy
- Progress on Sussex and East Surrey STP and East Sussex Better Together

5. Annual Self Assessment of Effectiveness

In June 2018 the Committee undertook an annual self assessment of its effectiveness. The key messages from this feedback are summarised below and [were] discussed in the Committee meeting.

Members agreed that the number of Committee meetings held had been sufficient in the past year and the majority of members agreed that the financial position of the Trust means there is little opportunity to reduce the frequency at this stage. A small number of members considered that continued strong financial performance would enable a reduction in the number of meetings over time.

Most members agreed that the agenda for the Committee is appropriately structured. However, it was noted whilst that the agenda and reports have significantly improved from previous years, these remain too long and focused on operational matters which can affect the Committee's ability to discharge its responsibilities effectively. A number of Committee members noted that the 'core papers' could be more focused, with supplementary papers provided for reading/background information. Two members suggested that business cases were often constrained for discussion time, and that the agenda could be reshaped to move this up to the start of the meeting.

A number of members noted that the Committee could significantly increase the focus onto financial planning and service strategy development, suggesting that the 3+2 review process had been helpful, but had not clearly made the link to strategy development and delivery. These members felt that the focus on operational financial delivery had been broadly appropriate, but this, coupled with longer papers, was not allowing sufficient time to develop a more refined financial and investment model, aligned with the strategy, and therefore did not allow the Committee time to review business case, financial plans and proposed investments in a way which is fully aligned with the broader financial and strategic plan. There is a clear link between the desire for less and clearer information, and more strategic analysis, in these responses – which will be carefully reviewed by the Committee moving forward.

A number of Committee members noted that, despite the broad agenda and range of issues considered, the Committee was not always reviewing all items within the terms of reference (e.g. risk appetite) and members noted the terms of reference could be reviewed to include greater reference to the assurance role for the Trust Board (e.g. in providing assurance on the Integrated Plan for the year). Some Committee members would welcome greater work with the Committee on the formulation of strategy and the link to the financial and workforce planning.

The substantial majority of members agreed matters considered and decisions made by the Committee were taken on an informed basis based on the information presented and where appropriate additional details were requested and provided. These members agreed that decisions were understood, owned and properly recorded and would bear scrutiny. Subsequent implementation of decisions and progress had been reported back to the Committee although a number of members suggested that follow through and tracking of previous decisions could be strengthened in the future.

An effective feedback mechanism from the F&I to the Board is in place, with the minutes being received and matters highlighted by the Committee Chair at each Board meeting. A small number of members suggested increasing the level of financial reporting to the Board alongside the feedback from the Finance and Investment Committee, although a number of members noted that the feedback process was adequate. An alternative suggestion was that the Chair could feedback the key decisions for the Trust Board – e.g. on investments.

Finally, some Committee members noted that greater examples of best practice could be made available to the Committee.

6. F&I Chair's Overview

The Trust continued to be in Financial Special Measures during the financial year. There was close scrutiny of our financial recovery plans both by the Committee and NHS Improvement, who attended many of the meetings in the year. The Trust fully delivered its financial plan in 2018/19, and has set an ambitious but deliverable plan for 2019/20 – and is delivering in Q1. The Trust also now has a robust medium-term financial plan, and an agreed financial plan with the wider East Sussex CCGs. All of this marks good progress in the past year, and the Trust is seeking to exit FSM in Quarter 1.

The F&I Committee have remained clear clear in its position that all cost improvement and efficiency plans should have no adverse impact on quality or safety. The Committee received assurance throughout that an effective quality impact assessment process was in place, and the current quality metrics reviewed at the Trust Board support this assurance.

During 2018/19 the Trust continued with its involvement in East Sussex Better Together and the STP. In the coming year the wider health economy will continue to work closely in developing the East Sussex plan, and supporting the development of the ICS plan at the STP. The Committee will continue to take an interest in these developments and ensure potential financial risks to the Trust arising from these discussions are mitigated as much as possible.

On behalf of the Committee, I would like to place on record our thanks to the Executive Assistants in the Finance Department, both of whom so ably provide administrative support.

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

Barry Nealon
Finance & Investment Committee Chairman
27 June 2019

East Sussex Healthcare NHS Trust

Finance and Investment Committee - Terms of Reference

1. Constitution

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

2. Purpose

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

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

3. Membership and attendance

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

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

4. Quorum

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

5. Frequency

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

6. Duties

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

In particular its duties include:

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

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

- Do not compromise the Standing Orders and Standing Financial Instructions
- Do not adversely affect the strategic risk facing the Trust

- Do not adversely affect the organisation's ability to deliver its operational plans

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

7. Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the PA to the Finance Director and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive actions.

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

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

June 2018

Annual Review of Effectiveness

Meeting information:	
Date of Meeting: 25 July 2019	Agenda Item: 8
Meeting: POD Committee	Reporting Officer: Miranda Kavanagh, Committee Chair

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

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

Summary:

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

It is best practice for every Committee of the Trust to conduct an annual self-assessment review of its effectiveness and to produce an Annual Report for the Board. The attached report provides an overview of the activities of the Committee and confirms how it has complied with its Terms of Reference. It sets out the outcome of the effectiveness review which was conducted via a questionnaire to all Committee members in July 2019.

The Terms of Reference remain fit for purpose with one revision; Health & Safety Steering Group to report jointly to the People & Organisational Development Committee and Quality & Safety Committee.

2. REVIEW BY OTHER COMMITTEES

Report will be presented to Trust Board.

3. RECOMMENDATIONS

The Committee is requested to review and endorse the attached report.

East Sussex Healthcare NHS Trust

People and Organisational Development Committee Annual Review

1. Introduction

The purpose of this paper is to provide assurance to the Trust Board that the People and Organisational Development Committee (POD) has carried out its objectives in accordance with its Terms of Reference set by the Trust Board.

2. Authority and Duties

POD is a sub-committee of the Board and was established in March 2016. The Committee's Terms of Reference were last reviewed and updated in July 2019. POD has responsibility for strategic oversight of workforce development, planning, performance and culture. It provides assurance to the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting the Trust objectives and organisational success.

The Committee meets bi-monthly and is chaired by a Non-Executive Director of the Trust and includes a broad membership including, HR and OD staff, senior managers, staff-side and equality and diversity representatives.

3. Annual review of terms of reference and work plan

The Annual Work Programme was set at the start of the year as a standing agenda item and matters considered over the past year have included:

Updates on national workforce agenda

- Employee Relations trends and good practice
- Medical Engagement
- Guardian of Safe Working Hours
- Workforce planning and metrics
- Staff and doctor surveys and action plans
- Equality and diversity and Workforce Race Equality Standards
- CQC Well Led Framework
- Nursing and Medical Revalidation
- Appraisal Rates
- Retention Strategy
- Integrated Education to include funding issues, apprenticeships and training needs analysis
- National updates
- Leadership development
- Staff health and Well being

4. Annual Self-Assessment of Effectiveness

In July 2019 the Committee undertook an annual self-assessment of its effectiveness, completed by 8 members. It was agreed that the number of Committee meetings held had been sufficient and attendance was good but attendance by divisional representatives needed to be improved.

Members concurred that matters considered and decisions made by the Committee were taken on an informed basis and that these decisions were understood, owned and properly recorded and would bear scrutiny; subsequent implementation of decisions and progress had been reported back to the Committee. Members suggested implementing a decision log for highlighting specific decisions made.

An effective feedback mechanism from POD to the Board was in place, with the minutes being received and matters highlighted by the Committee Chair at each Board meeting, although it was suggested that feedback from the Board would be beneficial.

A number of Committee members felt that agendas were appropriately well-structured but that sufficient time and attention should be given for key programmes of work. It was suggested that members should be asked to provide their updates for assurance and information and should not expect POD to make operational decisions as the Committee's remit was strategic and assurance. The Committee will act upon this feedback.

The Committee's Terms of Reference were considered as part of the self-effectiveness review and it was agreed they remain fit for purpose with one revision; Health & Safety Steering Group to report jointly to the People & Organisational Development Committee and Quality & Safety Committee.

Miranda Kavanagh
People and Organisational Development Committee
Chairman
25 July 2019

Board Assurance Framework

Meeting information:			
Date of Meeting:	6th August 2019	Agenda Item:	6
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

Following the Trust Board Seminar in July 2019, the Board agreed that the format of the Board Assurance Framework (BAF) should be revised. Attached is the updated BAF, which has been reviewed by the Quality and Safety and Audit Committees. Further information will be added moving forward, including dates when the gap in control or assurance was added to the BAF.

There are no additions or items proposed for removal from the BAF.

There remains one area rated red

- 4.2.1 in relation to capital constraints.

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

Quality and Safety Committee 25th July 2019
Audit Committee 1st August 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.

Assurance Framework - Key

RAG RATING:
Effective controls in place and Board satisfied that adequate assurances is available.
Effective controls in place but additional actions may be required to provide further assurance
Effective controls may not be in place and/or sufficient assurances are not available to the Board.

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

Risk Tolerance **Low**	As little as reasonably possible. Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Risk Tolerance **Moderate**	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Risk Tolerance **High**	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM).
Risk Tolerance **Significant**	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

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

Strategic Objectives:
Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.

All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

We will work closely with commissioners, local 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.

We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.

We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.

Risks:
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.
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.
There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.
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.
We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.
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
We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.
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
We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan
We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.
We are unable to effectively recruit our workforce and to positively engage with staff at all levels.
If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

Board Assurance Framework - July 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Timescale	Lead and Monitoring Committee
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									
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	1.1 Quality improvement programme required to ensure compliance with CQC fundamental standards and for Trust to improve "Requires Improvement" rating	Low	Framework in place to support ambition of "Outstanding and always improving" Health Assure being utilised as depository for CQC evidence Audits and reviews taking place	Significant number of services rated Good by CQC in March 18 inspection. Positive feedback from Trust internal reviews		Review and plan for "Use of Resources" review	Aug-19	DoCA/DN Q&S
Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.									
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.	2.1.1 Effective controls required to support the delivery of 62 day cancer metric and ability to respond to demand and patient choice.	Low	Cancer recovery plan and trajectory in place and progress monitored	Positive signs of progress in 62 day Cancer performance - position over past 4 months in line with agreed recovery trajectory - 81.6% in May. CCG attends monthly assurance meeting.		Full capacity and demand review to be undertaken in recognition that referrals continue to increase; baseline capacity to be reset with analysis of potential requirement for additional substantive clinicians	COO Dec 19	COO Q&S

Board Assurance Framework - July 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Timescale	Lead and Monitoring Committee
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.	2.1.2 Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards, with mental health and deliberate self harm diagnoses, are assessed and treated appropriately.	Low	CAMHS transformation plan in place. Assessment delays tracked and logged as incidents - escalated for COO/ COO discussion. Paeds record and escalate inappropriate ward admissions. Reviewing previous 12 months risks for trends/themes.	Independent review taking place pan Sussex into mental health provision		Greater pace required and being followed up through STP meetings. Escalation process from ED/Paeds to COO being refined.	Dec-19 Aug-19	COO Q&S
		<u>Added May-19</u> 2.1.3 Following implementation of follow- up appointment database, risks have been highlighted due to insufficient clinical capacity and limitation in the functionality of the database. Effective controls required to ensure treatment is not delayed as a result of overdue follow up appointments	Low	Follow up database is reviewed/ discussed at each specialty PTL Additional training, competency assessment and guidance provided to booking and reception teams.	Audit of 600 patients on the FU database has given a high level of confidence regarding data accuracy. Ophthalmology follow ups have been subject to admin & clinical review.		Digital team exploring an alternative approach to allow 'time critical' follow up patients to be highlighted.	Sep-19	COO Q&S

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Timescale	Lead and Monitoring Committee
2.2	There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.	Added January 2019 2.2.1 A more explicit accountability framework is required to set out expectations regarding roles, responsibilities and accountabilities; including leadership model at all levels and the Trust operating structure to ward level	Moderate	Accountability and Governance framework drafted. Action plan developed to support implementation.	Framework developed following liaison with senior managers and reviewed by People and Organisational Development Committee, Senior Leaders Forum and Trust Board.		Trust wide communications to be developed and shared Implementation and completion of action plan.	Aug-19 Dec-19	DCA POD
3.1 3.2	*We are unable to:* maintain collaborative relationships with partner organisations based on shared aims objectives and timescales resulting in an impact on our ability to operate efficiently and effectively within the local health economy. define our strategic intentions, service plans/configuration in an Integrated Business Plan to ensure sustainable services and future viability.	Revised May 2019 3.1.1 Assurance is required that there will be continued delivery of the system-wide aligned plan	Moderate	Aligned plan developed with wider health economy. Final submission of the integrated plan was submitted to NHSI/E at the beginning of April. Three integrated transformation programmes in place - Urgent Care, Planned Care and Community, each have an identified SRO who report progress to the East Sussex Health and Social Care Executive.	Trust fully engaged with STP and Alliance programmes At Month 2, the system has a high likelihood of delivering the 2019/20 system financial plan		Implementation of the East Sussex system wide integrated plan is in progress. . Work is underway to establish the governance structures to commence the development of the integrated East Sussex Place.	Dec-19	DS East Sussex Health and Social Care Executive/ Trust Board

Strategic Objective 3: We will work closely with local 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									
Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Timescale	Lead and Monitoring Committee
3.1	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.	3.1.2 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.	Moderate	7 Day Service Steering Group established. PMO project support with dedicated project lead assigned. PID in place with monitoring of progress. Rollout of Nerve Centre will support documentation of consultant-led review and delegation processes for inpatients. Increased the number of Acute Medicine consultants to provide better support on AMU/AAU, particularly at weekends.	Self-Assessment submitted to NHS Improvement and 7DS progress reported and discussed with CCGs at CQRG. Standard 2 Routine Monitoring of via “Excellence in Care” programme weekly audits indicates sustained compliance overall , at more than 91% since November 2018. Standard 5/6 both now compliant overall. Standard 2/8 partially compliant - not fully met at weekends.		Standard 2 - In some surgical subspecialties the formalised arrangement for consultant cover has provided insufficient cover to deliver review within 14 hours, in particular ENT and Urology. Preparations to separate audit of weekend and weekday admissions underway Not fully compliant with Standard 8 at weekends in a number of specialities where the formalised arrangement for consultant cover at weekends does not include a consultant-led ward round.	Dec-19	MD Q&S

Board Assurance Framework - July 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Timescale	Lead and Monitoring Committee
Strategic Objective 4: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.									
4.1	We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.	Revised May-19: 4.1.1 Controls for financial delivery are robust, but the level of CIP challenge and proposed scheme for 2019/20 need continual monitoring and support.	Moderate	Risk adjusted CIP programme in place and PID produced for each scheme. Confirm and Challenge arrangements remain in place for teams who have not identified the full value of the CIP, or where delivery is adverse to plan.	Activity and delivery of CIPs regularly managed and monitored through accountability reviews, FISC and F&I. At Q1, CIP has been fully delivered, and the Trust is delivering on the Q1 financial plan		CIP delivery in Q1 has a number of non-recurrent elements and full year programme has not yet been fully approved. A full review of the financial assurance arrangements for CIP has been undertaken by the DoF, building on the results of the internal audit review, with a paper to the Executive Team and the FIC (July) on the arrangements for Q2.	On-going review and monitoring to end of Mar 20	DoF F&I

Board Assurance Framework - July 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Timescale	Lead and Monitoring Committee
4.2 4.3	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 We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.	4.2.1 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.	Moderate	Capital plan for 2019/20 in place, following a robust prioritisation process, aligned with the Capital Resource Limit of £13.6m. Essential work prioritised with estates, IT and medical equipment	Regular review by F&I and FISC committees		Delivering against the agreed capital plan remains challenging within a robust control framework. The Department of Health have asked for all Trusts to reduce their capital plans by 20%, and for the STP to mediate this process of capital reduction. Trust is working with STP partners and the Capital Review Group will review any completed proposals before presentation to the F&I Committee. There are also operational pressures (at £360k) against the capital budget, and CRG are working hard to maintain spend within the current budget.	On-going review and monitoring to end Mar-20	DoF F&I

Board Assurance Framework - July 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Timescale	Lead and Monitoring Committee
4.3	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	4.3.1 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	Low	Initial works completed as planned and meeting to update ESFRS on progress to date	Regular communication with ESFRS		Additional work 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 further refined in Mar 18. Outcome of application for funding awaited.	end Nov-19	COO F&I
4.4	We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.	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.	Low	Anti-virus and Anti-malware software Client and server patching NHS Digital CareCert notifications Data Security and Protection Toolkit (DSPT) Technical solutions in place and on-going regular staff awareness training	SESCSG Sussex and East Surrey Cyber Security Group Cyber Essential Plus Framework		Establishment of the cyber security team being strengthened. Pursuing ISO27001 certification and engaging with national funded resources to assess and report on our current position against the Cyber Essential Plus framework.	end Dec-19	DF Audit Committee

Board Assurance Framework - July 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Timescale	Lead and Monitoring 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.									
5.1	We are unable to effectively recruit our workforce and to positively engage with staff at all levels.	5.1.1 Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties	High	Workforce strategy aligned with workforce plans, strategic direction and other delivery plans Ongoing monitoring of Recruitment and Retention Strategy Workforce metrics Quarterly CU Reviews to determine workforce planning requirements. Review of nursing establishment quarterly Medacs supporting recruitment In house Temporary Workforce Service Full participation in HEKSS Education commissioning process	Success with some hard to recruit areas e.g. Paeds and A&E Ongoing social media activity to promote the Trust has seen an rise of 30% in overall applications to the Trust.(April-June 2018 vs April-June 2019). Positive links with University of Brighton to assist recruitment of nursing workforce. Reduction in time to hire Reduction in labour turnover.		7 Candidates sourced and offered via Medacs. 7 Candidates in place sourced via Medacs, a further 3 posts at offer . First cohort of Band 5 Indian nurses arrive at Trust from July onwards, first of 89 IELTs (International English Language Test) ready candidates. Continued International sourcing of Medical candidates, including Radiographers and Sonographers.	ongoing to end Mar-20	DHR POD

Chief Executive's Report

Meeting information:			
Date of Meeting:	6th August 2019	Agenda Item:	7
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?	

Introduction

The Board will be pleased to note that the NHSI central committee decided that ESHT should be brought out of Financial Special Measures on Tuesday 9th July. The announcement was made on Thursday 11th.

HRH Princess Royal visited to open the new MRI suites on 17th July. There was very good attendance from donors and members of the appeal committee, along with other dignitaries including the Lord Lieutenant and Sheriff.

On Tuesday 9th and Wednesday 10th July the Trust had a HSE inspection which focussed on Moving and Handling and Violence and Aggression. There were six inspectors who visited areas across Conquest and Bexhill. The H&S team had put in considerable work in preparation for the visit. At the feedback the Trust was complimented on the reception that we had given the team, and the responsiveness that we had showed. The Moving and Handling team were complimented on the excellence of their service. We were, however, deemed to be in breach on violence and aggression. While it was acknowledged that we took serious incidents of violence and aggression seriously, and had done much to improve the culture of staff, it was felt that our approach to these issues did not sufficiently include low levels of violence and aggression from disturbed/demented patients, or those recovering from anaesthetics. We did not have a full training needs assessment for staff dealing with such patients. There was also perceived to be underreporting on incidents of this nature. We had not triangulated data from security teams and Datix reports in regard to A&E. We will receive a formal letter and will develop an action plan. A repeat inspection will not be required. We will be subject to charges for time and work done by the HSE inspectors.

Significant progress is being made in discussions about the development of the STP – which will now formally become the Sussex Health and Care Partnership. Plans are being drawn up for the development of the three 'places' (West Sussex, Brighton & Hove, East Sussex) to develop

Integrated Care Providers alongside a strategic commissioning function in each place, recognising that the ICPs will incorporate primary care and provider functions of local authorities.

The new digital telephony system continues to be implemented but teething problems continue which have caused difficulties for the switchboard team. Regular meetings and updates are being held.

The Staff Awards event was held on Thursday 11th July and feedback has been very positive.

1. Quality and Safety

Pressure Ulcer Prevention
Last year there was an overall reduction of 76% in category 3 and 4 pressure ulcers with a static trend in category 2 and overall pressure ulcer incidents. There were no category 3 or 4 pressure ulcers reported in June 2019. A mattress replacement programme from static foam to hybrid was successfully implemented in June 2019. The improvement focus for 2019/2020 will be on patient seating to decrease numbers of category 2 pressure ulcers resulting from shear, whilst maintaining the significant reduction in category 3 & 4 pressure ulcers. There is also a plan to present data over a longer time period to improve the identification of areas for improvement and learning.

Excellence in Care (EIC)
An Excellence in Care Intranet page is now available for staff to view and utilise. Progress against the plan is on trajectory. All ESHT Essential Standards, metrics, audit questions and data sources for Quality and Safety, Access and Delivery, Leadership and Culture and Finance have been developed and agreed. Walking roadshows by the Corporate Nursing Team are planned for July and August to communicate the Essential Standards to staff. Quality Improvement methodology training sessions are available to staff to support the improvement they want to make as identified by Excellence in Care. An End of Life Care audit has been incorporated which audits all deaths across the trust in order to improve the quality of care delivery. The Information Management team are now developing a user-friendly EIC interface.

Duty of Candour
It was noted in June 2019 that there had been an error in the way data was being retrieved from Datix for Duty of Candour (DoC) compliance resulting in over reporting of verbal DoC. A manual review of 18/19 incidents requiring DoC was completed. The verbal DoC was 75% and written has improved to 100%.

From June 2019, an improved reporting template has been implemented which will provide accurate data. For Q1 the verbal DoC is 63% and written has reduced to 55%. This is a significant reduction from the annual data. This has been escalated to Divisions and the Quality and Safety Committee.
The Patient Safety Team will continue to provide focussed support to divisions to improve DoC.

Friends and Family Test
A total of 3448 surveys/responses were received for inpatients, emergency departments and maternity in June. The Trust continues to have one of the highest inpatient response rates and satisfaction scores nationally.

In June the response rate for inpatient areas with 48.9% which is the highest percentage to date.

Infection Prevention and Control
Clostridium difficile infection
The limit for 2019/20 is 68 cases for ESHT, to include patients with prior healthcare exposure within 4 weeks of a positive sample. 13 cases were reported for quarter 1 against a limit of 17.

4 cases of Hospital Onset Healthcare Associated and 2 cases Community Onset Healthcare Associated infection in June against a monthly limit of 6. PIRs have taken place, outcome pending. There is no evidence of cross infection.

Outbreaks and Serious Incidents
Transmission of MRSA on SCBU at Conquest

IPC have investigated three babies who were identified as MRSA positive on special care baby unit during June 2019. PHE have been informed. The babies did not receive decolonisation due to prematurity. All babies were discharged and did not require treatment for MRSA. IPC team are supporting the ward. Enhanced cleaning has taken place. There has been no further MRSA positive babies since 19/06/19.

Access and Delivery

The Trust continues to be busy with non-elective attendances and admissions well above predicted levels, although this is in line with other provider experience both locally and nationally. The Integrated Performance Report provides more detail, but the activity is impacting on the 4 hour performance as well as the increased need for beds and increasing pressure on our staff.

The Trust has a number of key programmes in place to manage the demand, as well as increasing clinicians both in the emergency department, acute medicine and frailty, all with the aim of avoiding overnight stays for patients who can be best supported at home or alternative facilities and further reducing hospital stay.

The wider Health and Social care system are undertaking a diagnostic to better understand the drivers of demand. We are also due to complete an engagement exercise in July with patients attending the emergency department. This will better help us to develop services to meet the patient's needs.

2. People, Leadership and Culture

Recruitment

There are now 700.6 fte permanent vacancies across the Trust, with the vacancy rate at 10.3%. Currently 83 Medical, 23 AHP and 165 Nurse vacancies.

Key actions being undertaken include:

- Following a visit to India in April this year 89 candidates have been sourced with 17 International nurses due to join the Trust by August 2019
- Targeted recruitment campaigns to support radiology and urgent care departments. Medacs agency engaged to assist with Radiology department vacancies.
- 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 continues to strengthen. To date 7 medical staff in post and a further 3 offer of appointment in the pipeline
- Recruitment campaign discussed with Estates and Facilities to address their current vacancies.

Pay Review

- Band 1 closure Choices Exercise completed and that part of the pay review closed. Local policies developed to implement the new Shared Parental Leave and Child Bereavement

Leave which are currently going through the policy ratification process. The next phase is the implementation of Pay Progression and working groups are in place to address this.

Health and Wellbeing

- Flu: we are preparing for another flu season, promoting the flu peer vaccinators. The target for this year is 80% of patient facing staff
- The Occupational Health, Moving and Handling and HR teams will be working together to identify themes linked to areas of high sickness linked to MSK and developing a coordinated approach to reducing the risk of these injuries.

Leadership and Culture

- We are developing an approach to further improve the development of our Leadership behaviours
- We have hosted two masterclasses with a focus on improving patient outcomes through enhanced staff experience. 70 leaders and managers attended. There was a positive evaluations Creation and one outcome has been the facilitation of a 'Courageous Conversations' Training Design Group

Retention

- 33 staff attended the Maternity Supports Groups with a focus on coming back to work using on site nurseries and flexible working
- We have promoted carers Week – providing support for those staff with additional caring responsibilities and in particular highlighting flexible working

3. Communication and engagement

During NHS Values Week in July, we launched our refreshed values material, which included new posters, cards and leaflets that show how our values are demonstrated day-to-day. During Values Week members of staff were also encouraged to attend sessions being run across the Trust, to help bring our values to life.

In this quarter, we received a great deal of positive media coverage about different capital investments that the Trust has made, for example the opening of the Urology Investigation Suite at Eastbourne, the start of the build of the Ambulatory Care Unit at Conquest Hospital and the recent visit of The Princess Royal to open new MRI Suite at Conquest Hospital. The installation of new signage at Eastbourne was also positively reported by local media. The signage, which splits the hospital into coloured zones, was developed with members of staff, members of the public and representative from local disability groups. BBC South East also reported on the Trust's Critical Care Clinical Psychologist who is the first in the South of England to have been employed to provide psychological care for patients on the Unit and after their stay. And local media reported on the Trust's exit from special measures.

Our social media profile continues to grow and we have nearly 11,000 twitter followers and average between 70k and 87k impressions (our reach) a month. Our most popular tweets this month focussed on the Trust's annual awards #PrideofESHT

4. Finance

The Trust came out of Financial Special Measures in July 2019, reflecting the results of hard work by staff across the organisation over the past three years. Delivering the 2018/19 financial plan, agreeing a new five year plan, and meeting out quarter one financial targets have all been key to demonstrating that the Trust is ready to move out of this regime. On the same day, the two local Clinical Commissioning Groups also came out of legal directions, and the whole East Sussex System is one of the most financial improved in England for 2018/19. There is more to do, and the finances

will remain challenging, but the benefits of partnership working across East Sussex have been significant.

At Month 3, the Trust remains on financial plan. Urgent care activity levels are considerably higher than planned (and the Chief Operating Officer has commissioned a review across the system of drivers of demand), which requires a higher operating bed base for the Trust, and in turn increased costs. However, this is being managed by the Trust within available resources – although as the year continues, the Trust will work with the local Commissioners to ensure that appropriate funding arrangements are in place. Planned and elective care activity is less than we planned at the start of the financial year, and this remains an area of review with Clinical Unit teams across the Trust. The East Sussex CCGs also met their financial plans at Quarter 1 (Month 3), and the whole system remains on track to deliver the 2019/20 financial plan.

Capital budgets remain a challenge, locally and nationally. At a national level, all NHS Trusts, working within the STP partnership arrangements, have been asked to seek a 20% reduction or deferral in capital plans. The Trust is working closely with local stakeholders, and through the Trust Capital Review Group, to ensure that it can deliver the assets required within the Trust within the resources available. The Trust has two significant emergency capital loans in process with the Department of Health/ NHSI&E – for fire compartmentalisation works, and for medical equipment – and is continuing to work closely with key partners to ensure that these are fit for purpose. Despite the challenges, and with the help of our Friends, the Trust is continuing to develop several key significant programmes of work, including the ambulatory care unit on the Conquest Hospital site.

5. Strategic Development and Sustainability

Quality Improvement

The first cohort of QSIR (Quality and Service Improvement) Practitioners started our training programme in June. This is a national training programme supported by NHSI which we have adopted as our formal approach to embedding improvement methodology in the Trust. 18 corporate, service and nursing managers are enrolled in the first cohort and we are planning the second cohort for commencement later in the year.

Transformation programmes

The Acute Cardiology Transformation programme is entering a phase of wider stakeholder engagement. We will be working closely with CCG colleagues to ensure that patients and public are made aware of our proposals and have the opportunity to shape and comment on our plans to improve Acute Cardiology services for the people of East Sussex.

East Sussex Healthcare NHS
NHS Trust

MONTH 3 (JUNE 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

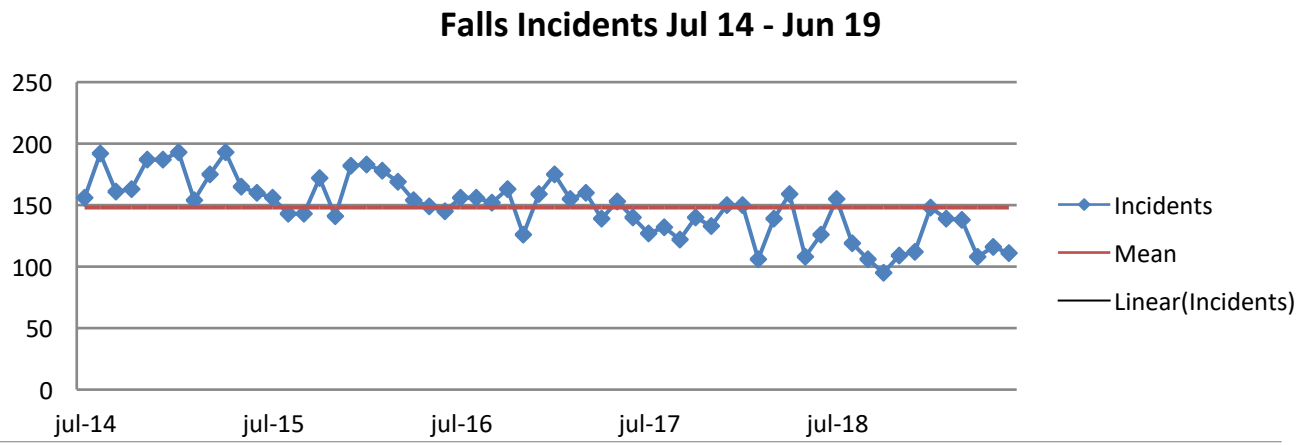
East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-18	Jun-19	Var	2018/19	2019/20	Var		
Total falls	M	126	111	-11.9%	392	335	-14.5%	121	
Number of no-harm falls	M	75	73	-2.7%	280	250	-10.7%	90	
Number of minor/moderate falls	M	51	37	-27.5%	111	80	-27.9%	30	
Number of major/catastrophic falls (severe harm or death)	0	0	1	1	1	5	4	1	
All patient falls per 1000 Beddays	5.5	6.2	5.1	-1.1	5.9	5.2	-0.73	5.4	
All patient falls with harm per 1000 Beddays	M	2.5	1.8	-0.8	1.7	1.3	-0.38	1.4	
Falls assessment compliance	M	94.5%			92.7%	90.1%	-2.6%	91.5%	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	1.1	2.1	88.0%	1.8	2.1	18.2%	2.3	
Number of grade 2 pressure ulcers	M	23	46	100.0%	117	133	13.7%	48	
Number of grade 3 to 4 pressure ulcers	M	0	0	0	1	3	2	1	
Pressure ulcer assessment compliance	M	77.8%	100.0%	22.2%	82.8%	83.9%	1.1%	82.9%	
VTE Assessment compliance	95.0%	96.2%	95.5%	-0.7%	96.1%	95.9%	-0.2%	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 77% (national figure 73%).

In June there was 111 falls with 1 x severity 4. The rate per 1000 bed days has decreased slightly from 5.39 in May to 5.1. in June.



Indicators

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-18	Jun-19	Var	2018/19	2019/20	Var		
Number of Serious Incidents	M	1	3	2	8	13	5	4	
Number of Never Events	0	0	1	1	0	1	1	0	

There were 3 **serious incidents** reported during June 2019:

- 1 x Fall to fracture
- 1 x Failure to appropriately treat (previously reported and investigated as severity 3)
- 1 x **Never Event – wrong site surgery**
- 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

At the end of June 2019 there were 23 Serious Incidents open in the system; 13 under investigation, within timescales, 4 returned by CCG for further information and have 3 with the CCG for closure and 3 incidents are with the HSIB. 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 the longest.

From June 2019, an improved reporting template has been implemented which will provide accurate data. For Q1 the verbal DoC is 63% and written has reduced to 55%. This is a significant reduction from the annual data as the length of time taken to complete written DoC usually exceeds the internal target of 10 working days.

The Patient Safety Team are continually checking if the DoC has been completed, but compliance remains low. Escalated to Quality & Safety Committee. Action plan required.

Mixed Sex Accommodation

East Sussex Healthcare NHS
NHS Trust

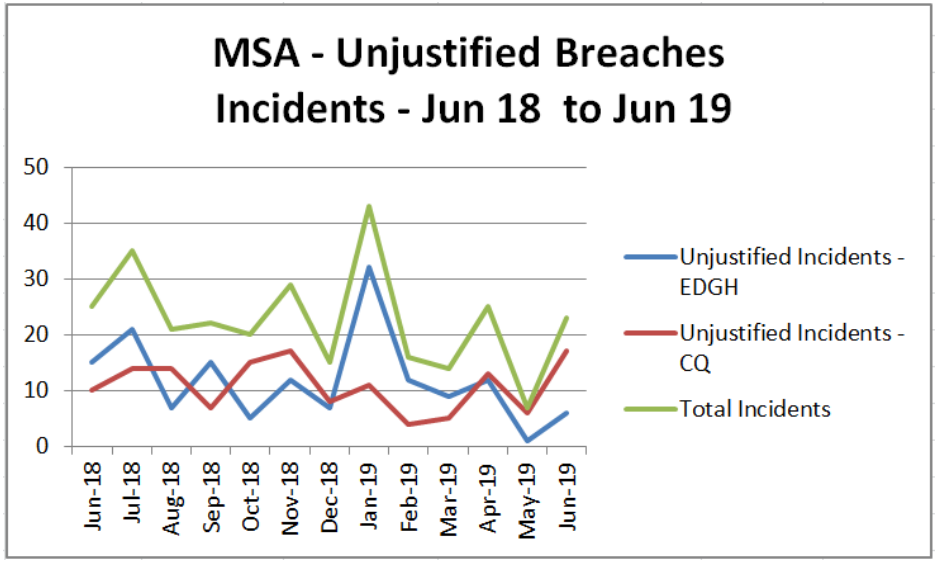
In June the total number of validated and reportable unjustified incidents for the Trust was 23, affecting 82 patients. It should be noted that due to a change in process and personnel there may be some over-reporting. This is being actioned with the Site Team.

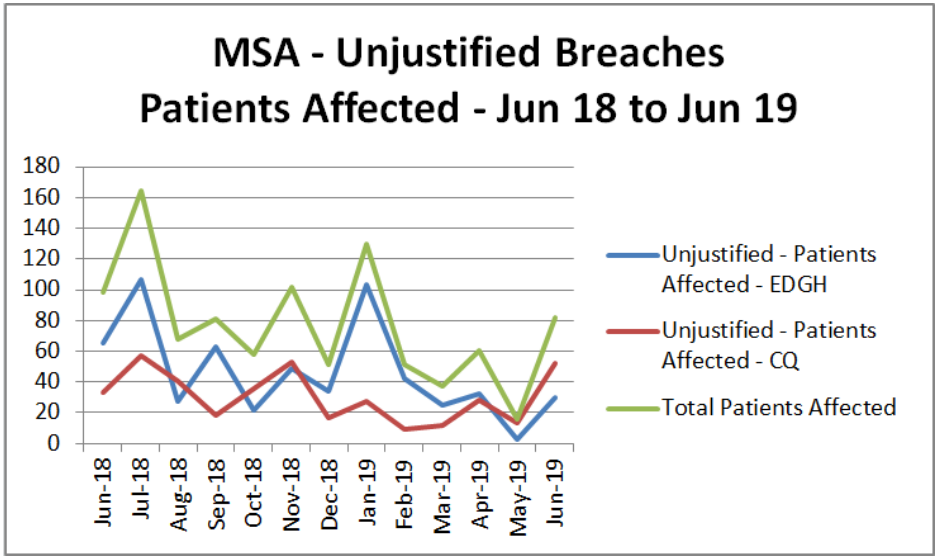
Breaches continue to be associated with the following areas:
Conquest – Critical Care,
Eastbourne – Critical Care, AMU and Coronary Care

1 breach affecting 5 patients at Conquest and 2 incidents affecting 8 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 June.





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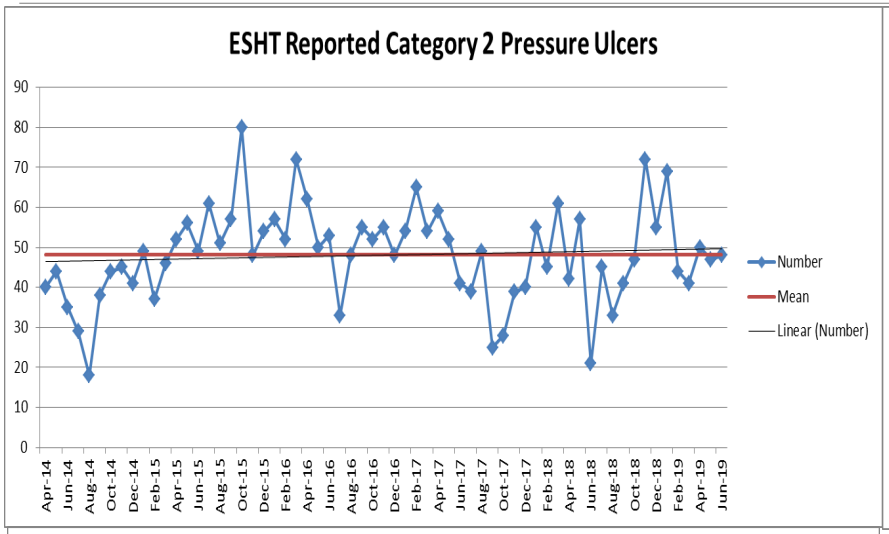
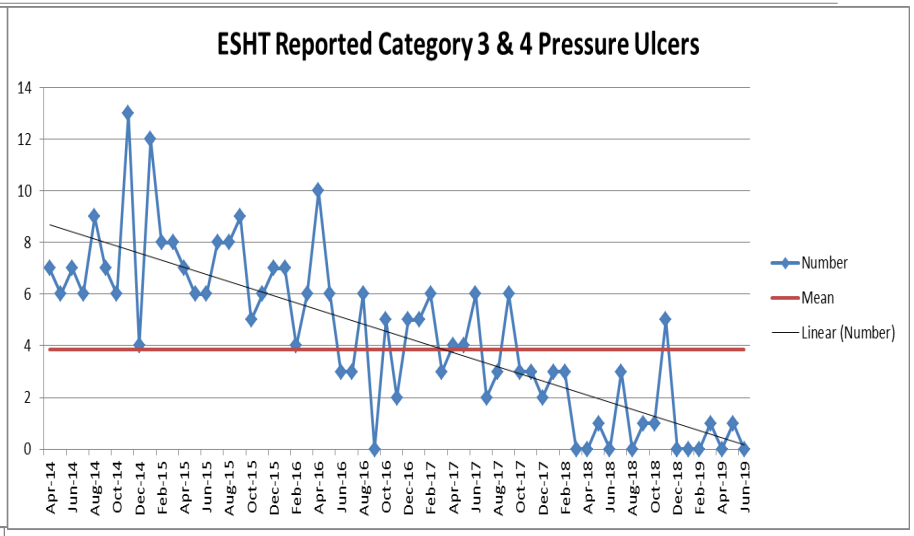
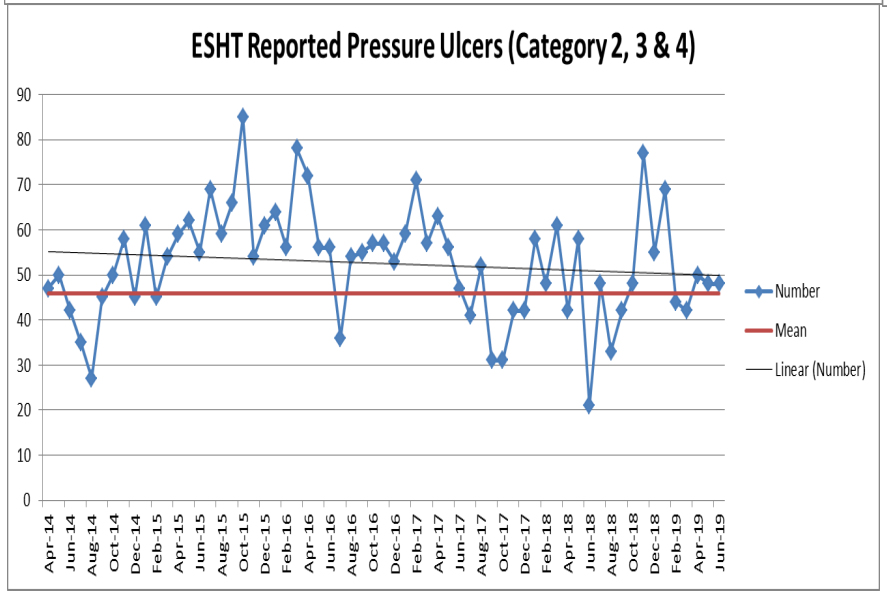
NHS Trust

Pressure Ulcer Incidents







In the last 5 years there has been an overall reduction of 76% in category 3 and 4 pressure ulcers with a static trend in category 2 and overall pressure ulcer incidents.

0 category 3 & 4 pressure ulcers were reported in June 2019.

A mattress replacement programme from static foam to hybrid was successfully implemented in June 2019.

The focus for 2019/2020 will be on seating to decrease numbers of category 2 pressure ulcers resulting from shear, whilst maintaining the significant reduction in category 3 & 4 pressure ulcers. Data will also be presented using new charts to help identify specific issues.

Infection Control

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-18	Jun-19	Var	2018/19	2019/20	Var		
Number of MRSA Cases	0	0	0	0	0	1	1	0	
Number of Cdiff cases	6	1	6	5	12	13	1	4	
Number of MSSA cases	M	0	0	0	2	4	2	2	

MRSA bacteraemias – None to report for June.

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 of Hospital Onset Healthcare Associated and 2 cases Community Onset Healthcare Associated in June against a monthly limit of 6. Post Infection Reviews (PIRs) have taken place, outcome pending. No evidence of cross infection.

MSSA bacteraemia - No ESHT cases in June.

Gram negative bacteraemia

Organism	Total	UTI source	CAUTI source	Biliary source	GI source	Vascular access	Other source	Unknown source
E. coli	4	1	(1)	1	1	0	0	1
Klebsiella sp.	1	1	(1)	0	0	0	0	0
Pseudomonas	0	0	0	0	0	0	0	0
Total (%)	5	2	(2)	1	1	0	0	1

Outcome of catheter-associated urinary tract infection (CAUTI) RCAs:

Klebsiella CAUTI RCA assessed as possibly avoidable. There was insufficient documentation of catheter care on the IT system, actioned by ward matron.
E. Coli CAUTI RCA assessed as unavoidable.

Patient Experience

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-18	Jun-19	Var	2018/19	2019/20	Var		
Inpatient FFT response rate	45.0%	45.7%	48.2%	2.5%	41.7%	47.1%	5.4%	45.4%	
Inpatient FFT score	96.0%	97.9%	97.8%	-0.1%	97.9%	97.6%	-0.3%	97.4%	
A&E FFT response rate	22.0%	3.9%	5.9%	2.0%	4.4%	7.5%	3.1%	6.1%	
A&E FFT score	88.0%	91.5%	92.3%	0.8%	94.1%	93.5%	-0.6%	92.6%	
Outpatient FFT Score	M	98.9%	98.2%	-0.7%	97.6%	98.0%	0.4%	97.6%	
Maternity FFT response rate	45.0%	13.6%	34.0%	20.4%	5.2%	36.2%	30.9%	22.3%	
Maternity FFT score	96.0%	100.0%	96.6%	-3.4%	100.0%	97.8%	-2.2%	97.3%	

FFT and Patient questionnaire - June

Indicator	Response rate %	National % (March)	Recommend Score %	National % (March)	No of surveys
Inpatient	45.7	24.0	97.7	96	2713
A&E	6.1	11.5	94.3	85	597
Maternity	46.4	20.5	98.4	96	123

Examples of questionnaire comments in June:

Positive comments

- "It's a terrific team effort and everyone deserves a medal."
- "Very good care and communication and some nursing; staff excellent caring and efficient"
- "No words could cover the family's gratitude."

Negative comments

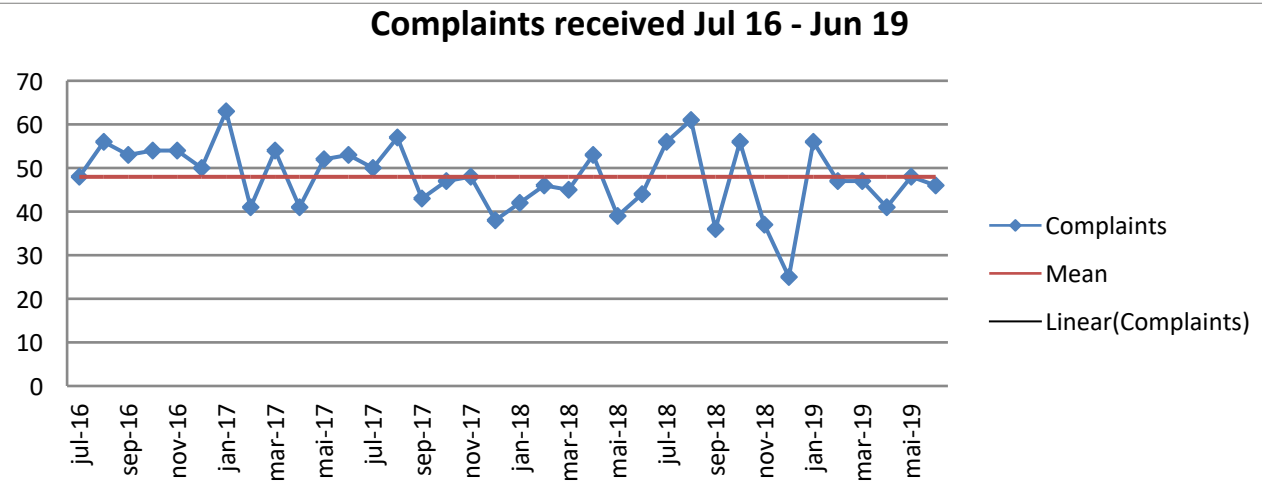
- "Make more effort to separate awkward noisy patients"
- "Turn off the bleeps quicker - especially at night - they're like some form of mental torture after 30 minutes."
- "Provide free or cheaper TV. Most people would use if cheaper"

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

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

Complaints

East Sussex Healthcare NHS Trust



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

- Medicine – 1.0 per 1000 bed days (14 complaints)
- DAS – 2.2 per 1000 bed days (111 complaints)
- Women, Children and Sexual Health – 4.3 per 1000 bed days (7 complaints)
- Urgent Care - 9 complaints
- Out of Hospital – 3 complaints

There was one outcome from the Parliamentary and Health Service Ombudsman (PHSO) in June. The PHSO did not find any evidence of delay in diagnosis but felt there was a service failure on a readmission in January 2018. The service failure related to a delay in antibiotic provision for treatment of severe sepsis, which they feel denied the patient the best possible chance of recovery.

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

East Sussex Healthcare NHS
NHS Trust

Safer Staffing and Workforce

Fill Rate and CHPPD by Site Jun-19	Day		Night		
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	CHPPD
BEXHILL HOSPITAL	83.20%	105.80%	91.00%	107.40%	5.79
EASTBOURNE DISTRICT GENERAL HOSPITAL	82.60%	99.10%	82.60%	108.20%	8.27
CONQUEST HOSPITAL	85.80%	104.40%	84.90%	110.10%	9.49
RYE HOSPITAL	98.30%	102.00%	93.30%	143.30%	5.31
Totals	84.50%	102.00%	84.20%	109.40%	8.57

Fill Rate and CHPPD by Division Jun-19	Day		Night		
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	CHPPD
Medicine	83.80%	104.10%	86.20%	113.20%	8
Out-of-Hospital	87.50%	105.00%	91.80%	112.60%	5.66
Surgery Anaesthetics & Diagnostics	81.20%	97.90%	79.80%	104.60%	9.21
Women Children & Sexual Health	93.80%	93.80%	85.30%	92.00%	15.91
Totals	84.50%	102.00%	84.20%	109.40%	8.57

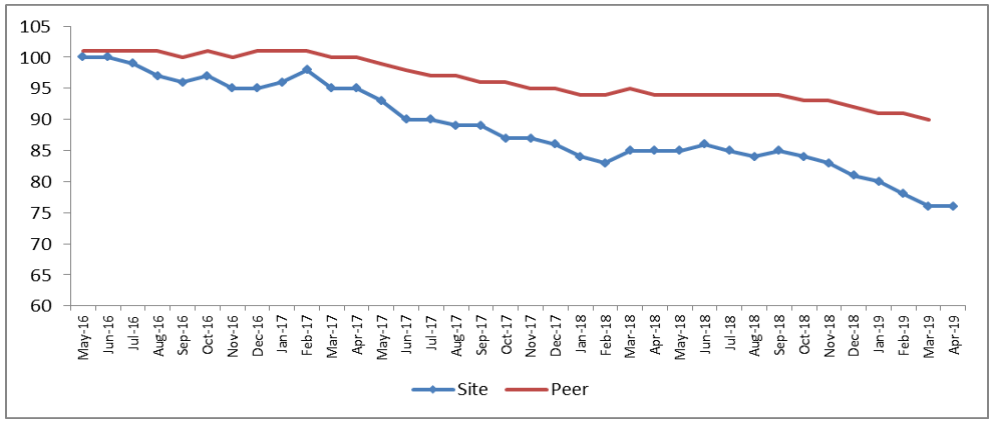
- Exceptions to the 100% fill rate continue to be driven by additional duties for escalation beds, risk assessed and authorised enhanced care for individual patients, and HCA usage to support some RN gaps.
- The twice daily site staffing meetings review all staffing by ward, including skill mix, and agree redeployments of staff to mitigate any risks supported by the site team and divisional senior nursing teams.
- Trust overall CHPPD has reduced marginally to 8.57. The latest national median CHPPD (April 2019) was 8.0 with a recommendation of 8.4 compared to our peers.
- The CHPPD in W&Cs Division is affected significantly by new ways of working with the introduction of Better Births
- The fill rate of staffing by ward (planned vs actual) is reviewed in the monthly safer staffing meetings for action at divisional level where required or for narrative regarding reasoning to be agreed where there is a variance of 25% or more.

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

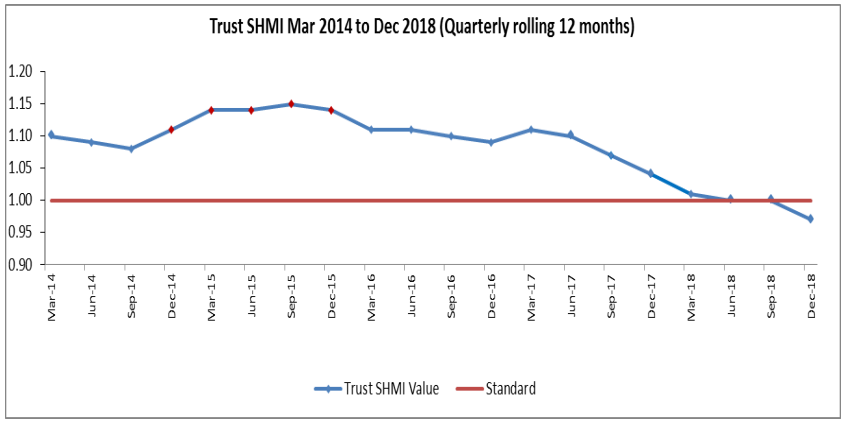
Mortality Metrics

East Sussex Healthcare NHS Trust

RAMI 18 (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 18 - May 2018 to April 2019 (rolling 12 months) is **76** compared to 85 for the same period last year (May 2017 to April 2018). April 2018 to March 2019 was also 76.

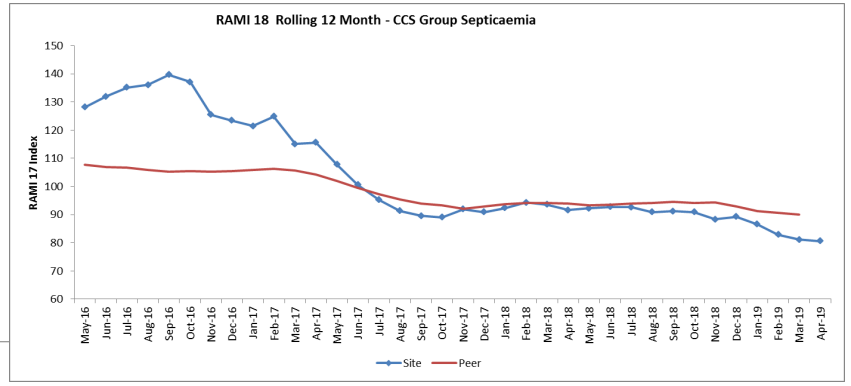
RAMI 18 shows an April position of 77. The peer value for April is not yet available. The March position was 82 against a peer value of 90.

Crude mortality shows May 2018 to April 2019 at 1.44% compared to 1.78% for the same period last year.

The percentage of deaths reviewed within 3 months was 82% in March 2019, February 2019 was also 82%.

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 June 2019 (Mortality Database)	
Pneumonia	21
Cancer	17
Cerebro-vascular incident	10
Sepsis/Septicaemia	8
Heart Failure	7
Myocardial Infarction	7



Access & Delivery

ACCESS AND DELIVERY

East Sussex Healthcare NHS
NHS Trust

Access and Delivery Summary

Non-elective activity continues to increase compared to the previous year (YTD 8.4% admissions, 9.1% attendances) and against the plan agreed with the CCGs (6%), the increasing demand is affecting the ability for the Trust to respond in a timely way and has resulted in escalation beds remaining open. Additional resource and service redesign is underway, although with a system diagnostic to better understand the drivers of demand and agree appropriate interventions.

Trust efficiencies continue to improve, with reductions in length of stay through our acute and community beds, increases in patients being managed through 'same day emergency care' pathways and a reduction in patients in hospital over 7 and 21 days. In line with national priorities we are focusing on:

- Achieving 30% Same Day Emergency care
- Increasing discharges before noon (home for lunch)
- Increasing weekend discharges
- Streaming patients to primary care clinicians in ED

Cancer 62 days remains a challenge, in part due to increasing demand and the challenge to increase capacity at the same rate. Service teams have recovery plans in place with a specific focus on redesigning and improving pathways. They are undertaking a review of capacity and demand in order to quantify the gaps and proposed workforce solutions.

East Sussex Healthcare NHS
NHS Trust

URGENT CARE

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-18	Jun-19	Var	2018/19	2019/20	Var		
Four hour standard	95.0%	95.7%	89.5%	-6.3%	92.8%	90.0%	-2.7%	90.3%	
A&E Minor Performance	98.0%	98.3%	97.9%	-0.4%	97.0%	98.0%	1.1%	96.9%	
Four hour standard (Local System)	95.0%	96.7%	91.8%	-5.0%		92.3%			
12 Hour DTAs	0	0	0	0	0	0	0	0	
Unplanned re-attendance to Emergency Department	5.0%	3.1%	3.7%	0.6%	3.3%	3.8%	0.5%	3.6%	
% Patients waiting less than 15 minutes for assessment in ED	M	86.8%	83.0%	-3.8%	86.5%	84.5%	-2.0%	85.4%	
% Patients waiting less than 60 minutes for treatment in ED	M	52.1%	41.7%	-10.3%	51.3%	42.0%	-9.3%	45.3%	
% Patients waiting less than 120 minutes for treatment in ED	M	85.6%	73.6%	-12.0%	82.8%	73.1%	-9.8%	77.2%	
% Patients that left without being seen in ED	M	1.7%	2.1%	0.3%	2.1%	2.4%	0.3%	2.2%	
% Patients admitted from ED (Conversion rate)	M	29.0%	31.0%	1.9%	29.2%	30.6%	1.4%	30.5%	
Emergency Department attendances	M	10773	11600	7.7%	32023	34942	9.1%	11025	
Ambulance conveyances	M	2961	3238	9.4%	9233	10020	8.5%	3270	

The Trust 4 Hour performance standard in June was 89.5% against a national performance of 86.4%. This ranked the Trust 26th out of 121 reporting organisations. The system 'Walk-In' centres and the Acute Trusts combined performance for June was 91.8%. Activity continues to be higher than previous years, A&E attendances are up 7.7%, ambulance conveyances 9.4% and emergency admissions 8.7% , compared to June 2018. 57% of the increase in demand (17/18 vs 18/19) can be seen in working age adults. A number of IT interruptions has impacted the ability to utilise the electronic ED tracking and performance systems, relying on manual methods.

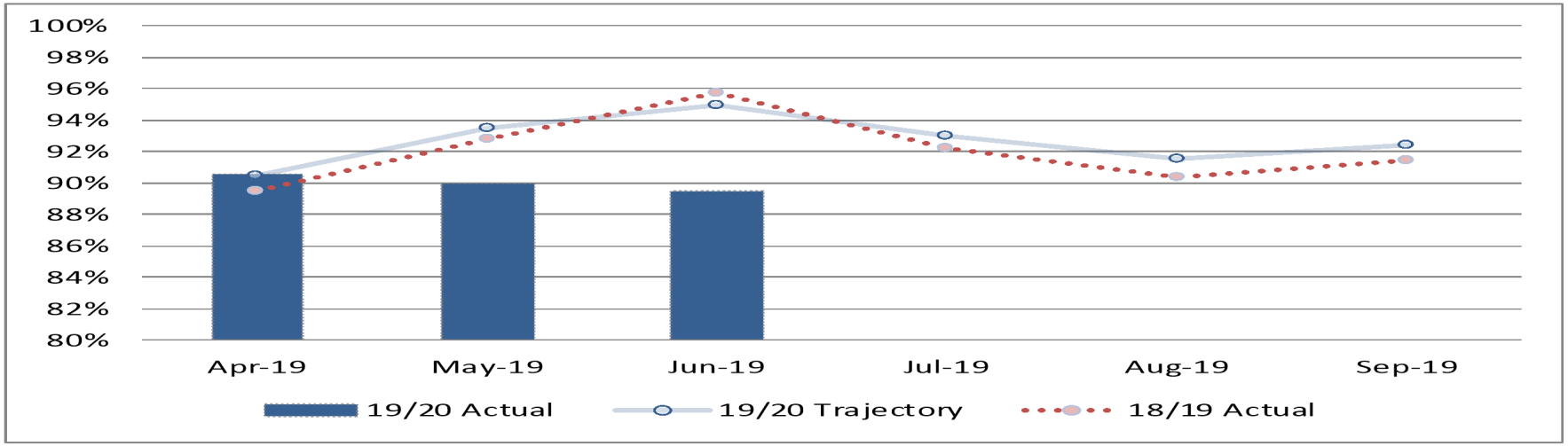
Recovery and Transformation:

- System transformation plan in place
  - Acute medicine and ambulatory service extension
  - Acute Frailty
  - High Intensity User Service
  - Admission avoidance pathways and alternative ambulance conveyances
  - Enhanced care home model
  - Development of Urgent Treatment Centres and Integrated Urgent Care
- System diagnostic, drivers of demand analysis and patient interviews
- Additional medical workforce deployed with refresh capacity and demand in the emergency departments

A&E Trajectory

East Sussex Healthcare NHS Trust

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



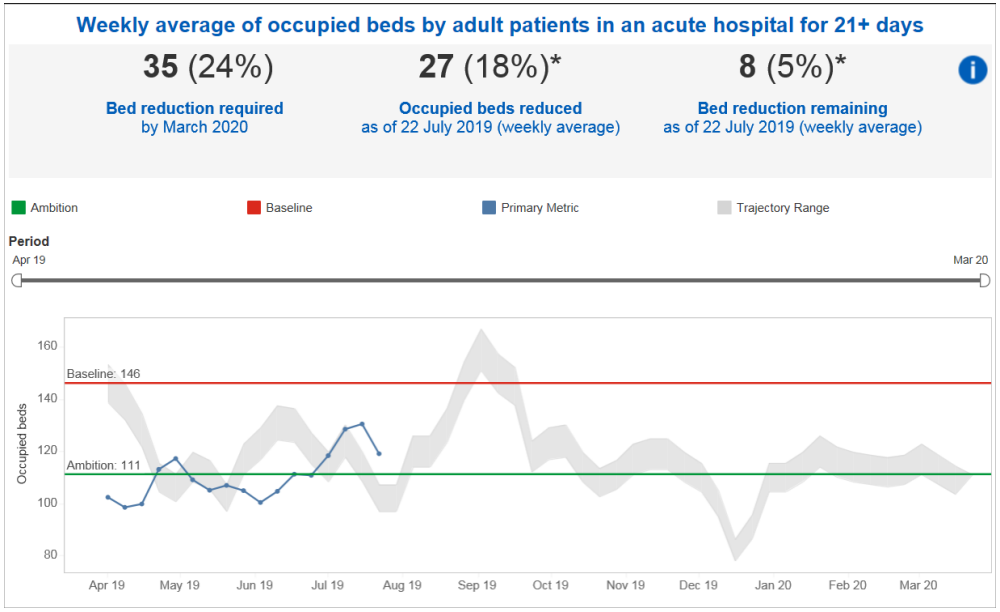
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
19/20 Trajectory	90.5%	93.5%	95.0%	93.0%	91.5%	92.4%
19/20 Actual	90.6%	90.0%	89.5%			
18/19 Actual	*89.5%*	*92.8%*	*95.7%*	*92.2%*	*90.4%*	*91.4%*

- The Trusts' 4 hour performance for June 2019 was 89.46% (Conquest 91.42% and EDGH 87.56%).
- Minors performance for June was in line with May at 97.9%, whilst Majors performance reduced by 1.2% to 82.9%.
- Ambulance conveyances have increased by 8.5% year to date and June was up 9.4% on June 2018.

Patient Flow Metrics

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-18	Jun-19	Var	2018/19	2019/20	Var		
Super Stranded (Census on last day of month)	M	89	104	15	58	52	-6	103	
Avg Daily Super Stranded Beddays (single month metric)	142	154	138	-17	183	130	-54	142	
Avg Daily Super Stranded Beddays (rolling 3 month avg NHSI metric)	142	183	130	-53	188	136	-52	146	
Delayed transfer of care national standard	3.5%	1.4%	2.8%	1.4%	1.6%	3.3%	1.7%	3.6%	
Cancellations									
Urgent operations cancelled for a second time	0	0	0	0	2	0	-2	0	



- The Trust, in line with NHSI priorities is moving to a revised set of patient flow metrics:
- Deputy COO will be leading a refresh of the patient flow programme
- - reduction in long length of stay (21+ patients) by 40%
- - increase pre noon discharges to 40%
- - increase weekend discharges by 50% on Saturdays and 25% on Sundays
- Say day emergency care 33%
- Development of integrated discharge team (Trust and social care)
- Specialty specific length of stay reductions

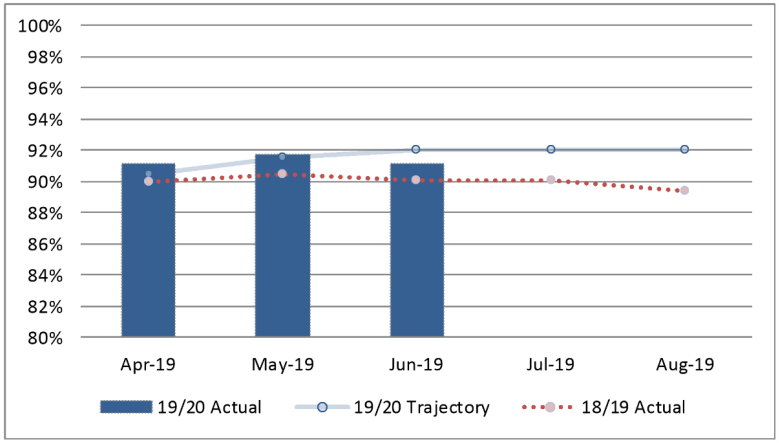
The Trust has delivered the 40% reduction in patients with a length of stay 21 days and over, although this has increased through July. The new patient flow programme aims to improve on the national ambition to prepare for winter.

RTT

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-18	Jun-19	Var	2018/19	2019/20	Var		
RTT Incomplete standard	92.0%	90.1%	91.2%	1.1%	90.2%	91.4%	1.2%	90.2%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	2921	2518	-403	2921	2518	-403	2736	
RTT Total Waiting List Size	28221	29426	28550	-876	29426	28550	-876	27968	
RTT 52 week waiters	0	0	0	0	0	0	0	0	
RTT 35 week waiters	M	211	214	1.4%	211	214	1.4%	175	

RTT (Referral to Treatment 18 Weeks)



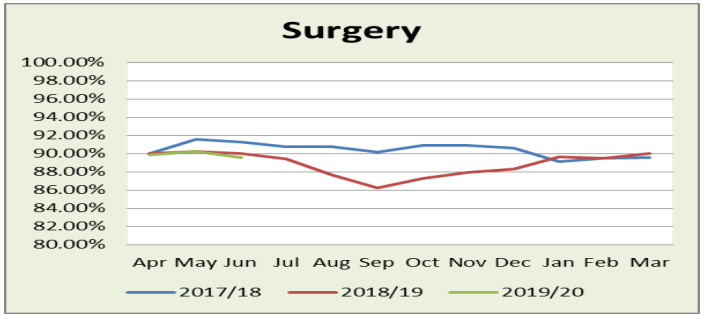
	Apr-19	May-19	Jun-19	Jul-19	Aug-19
19/20 Trajectory	90.5%	91.5%	92.0%	92.0%	92.0%
19/20 Actual	91.1%	91.8%	91.2%		
18/19 Actual	*90.0%*	*90.5%*	*90.1%*	*90.1%*	*89.4%*

All Incomplete Pathways Main Specialty Report

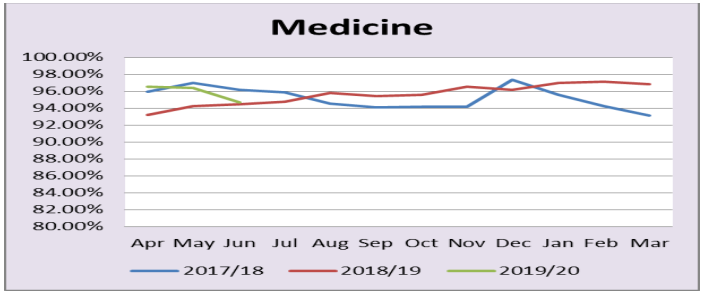
Specialty	Breaches	NonBreaches	Total Cases	Performance	
General Surgery	396	4564	4960	92.02%	✓
Urology	146	1886	2032	92.81%	✓
Trauma & Orthopaedics	191	1115	1306	85.38%	✗
Ear, Nose & Throat (ENT)	444	2780	3224	86.23%	✗
Ophthalmology	366	3145	3511	89.58%	✗
Oral Surgery	167	1817	1984	91.58%	✗
Gastroenterology	166	1908	2074	92.00%	✗
Cardiology	6	1880	1886	99.68%	✓
Dermatology	8	939	947	99.16%	✓
Respiratory Medicine	8	783	791	98.99%	✓
Neurology	72	1029	1101	93.46%	✓
Rheumatology	10	199	209	95.22%	✓
Geriatric Medicine	4	240	244	98.36%	✓
Gynaecology	440	2011	2451	82.05%	✗
Other	94	1736	1830	94.86%	✓
Totals	**2518**	**26032**	**28550**		

RTT performance for June has declined marginally from previous month. Closing at 91.2% against a trajectory of 92%
The waiting list has increased to 28,550 in June which is higher then the opening threshold however the waiting list historically increases in May and June before reducing for the remainder of the year.

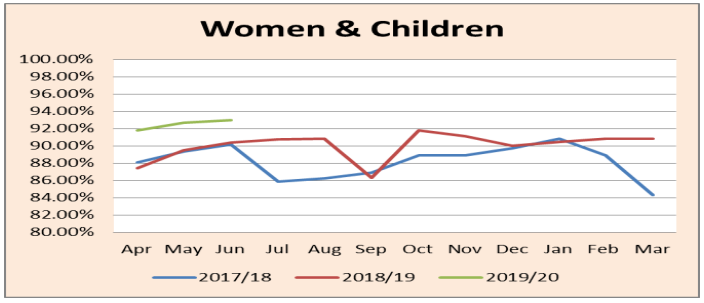
Due to the impact on pensions and tax, nationally and locally consultants are reducing the additional sessions undertaken to balance the demand and capacity gap. This is a risk to RTT performance and is being closely monitored. Divisions will re-asses[18] capacity and demand and build in substantive capacity to 19/20 business planning.



- The Surgical Division showed a decline in June. Moving down 1% to 89.60%.
- ENT has dropped by over 2% which was as a result of increasing waits for 1st appointment in the specialty. A loss of consultant and revision of templates have directly impacted on waits. Plans are in place to recover this position along with the follow-up backlog
- General Surgery did achieve with 92%. This is a reduction of nearly 2% from previous month. As this is one of the services with the highest volume of patients, this drop has impacted on overall performance.
- Ophthalmology continues to show positive improvements.
- T&O has challenges specifically with Hip & Knee modalities and additional laminar flow theatre capacity is needed to address this.



- Medicine specialties with the exception of Diabetes (90.20%) achieved 92% or higher for June. Although collectively, a drop of almost 2%
- Neurology, although still currently achieving, has seen a decline in performance .
- Rheumatology has also dropped by over 3% with capacity concerns for future delivery
- Gastro did achieve 92% however, pathway redesign work is underway to improve capacity and flow through the specialty in order to improve performance.



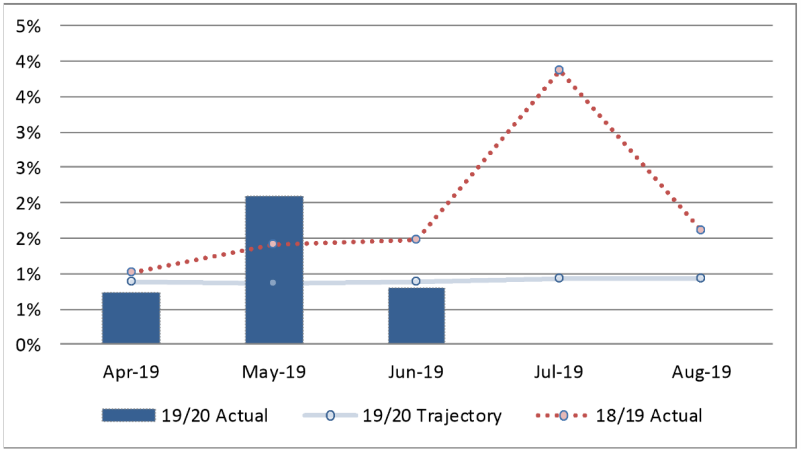
- The Women & Children division continues to show a month on month, steady improvement since December 18, with a final position of 92.97% in June.
- The divisional performance is propped by Paediatrics as the Gynaecology speciality continues to face challenges in achieving the 92 % standard.
- Gynaecology whilst continuing to improve and now up to almost 83% still has an admitted issue with a high volume of long waits for theatre and day case over 18 weeks. Outpatient wait times are slowly reducing. The specialty are working to address both issues with Waiting List Initiatives and recruitment of clinicians in order to reduce the backlog.

Diagnostics

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-18	Jun-19	Var	2018/19	2019/20	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	1.5%	0.8%	-0.7%	1.3%	1.2%	-0.1%	1.2%	

Diagnostic waiting times (over 6 weeks)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19
19/20 Trajectory	0.9%	0.9%	0.9%	0.9%	0.9%
19/20 Actual	0.7%	2.1%	0.8%		
18/19 Actual	*1.0%*	*1.4%*	*1.5%*	*3.9%*	*1.6%*

- The Trust was able to recover and achieved the 6 week diagnostic target in June with a final performance position of 0.8% against a target of < 1%.
- A total of 42 DM01 breaches occurred in June 2019:
  - Magnetic Resonance Imaging (5)
  - Computed Tomography (1)
  - Non-obstetric Ultrasound (25)
  - Audiology (3)
  - Colonoscopy (3)
  - Cystoscopy (4)
  - Gastroscopy (1)

East Sussex Healthcare NHS
NHS Trust

CANCER STANDARDS

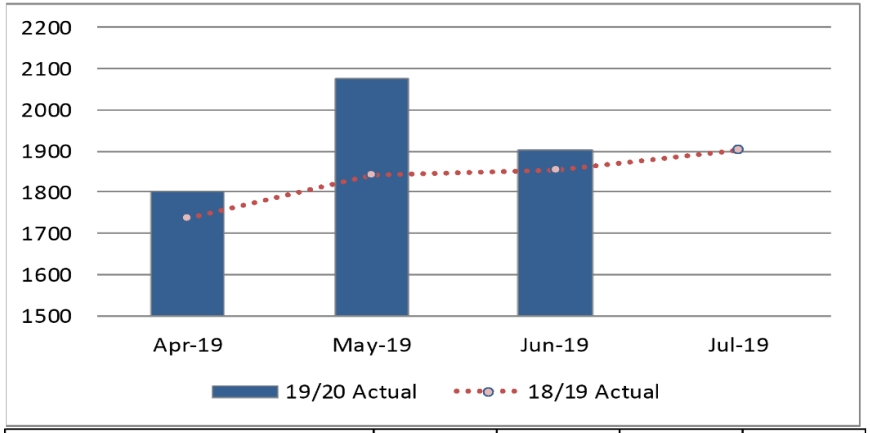
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		May-18	May-19	Var	2018/19	2019/20	Var		
Cancer 2WW Standard	93.0%	95.1%	94.9%	-0.2%	94.6%	95.6%	1.0%	94.4%	
Cancer 62 day urgent referral standard	85.0%	81.9%	77.1%	-4.8%	74.9%	79.4%	4.4%	73.3%	
Cancer 2WW Standard (breast symptoms)	93.0%	95.9%	93.5%	-2.4%	94.9%	93.5%	-1.4%	95.8%	
Cancer 31 day standard	96.0%	95.5%	96.7%	1.2%	95.8%	96.4%	0.6%	94.9%	
Cancer 31 day subsequent drug treatment	98.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	94.0%	92.3%	100.0%	7.7%	95.3%	100.0%	4.7%	86.9%	
Cancer 62 day screening standard	90.0%	31.3%	92.3%	61.1%	46.2%	91.3%	45.2%	81.3%	

- All standards were met with the exception of 62 Day performance was 77.1% for May compared to an national aggregate of 77.5%, this was higher than the Trust recovery trajectory of 74.5%% by 2.6%
- There were 30.5 breaches of the 62 day target out of 133 treatments in May and 2075 cancer pathway referrals. Referrals continue to increase, with particular challenges in gynae, lower GI and skin.
- As of April, the new Day 38 Inter-Provider Transfer (IPT) rules are in place which increased the Trusts performance by 0.8%
- The Trust reported 8 treatments on or over 104 days, 1 of these were shared treatments with other Trusts (Brighton) and there were 9 individual patients in total.
- The Trust action plan is jointly reviewed by the COO and CCG monthly, key priorities: timed pathways, refresh of capacity and demand with specific focus on the diagnostic stage of the pathway.
- NHSE/I have undertaken a review of the Trusts compliance with high impact changes with positive informal feedback. Key areas to focus: timed pathways and MDT reform.

East Sussex Healthcare NHS
NHS Trust

Cancer 2 Week Wait Referrals (June)

2WW Referrals



	Apr-19	May-19	Jun-19	Jul-19
19/20 Actual	1803	2075	1903	
18/19 Actual	*1736*	*1842*	*1855*	*1903*

2WW referrals in June 2019 were up 2.6% on June 2018 and up 6% Year to Date.

There were 88 breaches out of 1,710 2WW patients first seen.

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	Jul 17-Jun 18	Jul 18-Jun 19	% Variance
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	1,780	1,727	-3.0%
Other suspected cancers	36	25	-30.6%
Suspected brain/central nervous system tumours	60	99	65.0%
Suspected breast cancer	2,596	3,126	20.4%
Suspected childrens cancer	20	12	-40.0%
Suspected gynaecological cancers	1,588	1,805	13.7%
Suspected haematological malignancies (excluding acute leukaemia)	184	220	19.6%
Suspected head & neck cancers	2,073	2,194	5.8%
Suspected lower gastrointestinal cancers	3,502	4,150	18.5%
Suspected lung cancer	717	640	-10.7%
Suspected sarcomas	1	1	0.0%
Suspected skin cancers	3,804	4,034	6.0%
Suspected testicular cancers	159	258	62.3%
Suspected upper gastrointestinal cancers	1,763	1,643	-6.8%
Suspected urological cancers (excluding testicular)	2,167	2,231	3.0%
Grand Total	**20,450**	**22,165**	**8.4%**

Activity

ACTIVITY

Acute Activity

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-18	Jun-19	Var	2018/19	2019/20	Var		
Emergency Department attendances	M	10773	11600	7.7%	32023	34942	9.1%	11025	
Ambulance conveyances	M	2961	3238	9.4%	9233	10020	8.5%	3270	
Elective spells	M	597	529	-11.4%	1685	1613	-4.3%	547	
Day Cases	M	3891	3959	1.7%	11533	11877	3.0%	3976	
Elective Beddays	M	1591	1524	-4.2%	4744	4567	-3.7%	1669	
Total Non-Elective Spells	M	4475	4874	8.9%	13589	14737	8.4%	4766	
Number of Emergency spells	M	3918	4258	8.7%	11866	12917	8.9%	4169	
Number of Maternity spells (ante and post partem)	M	295	336	13.9%	914	988	8.1%	318	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	262	280	6.9%	809	832	2.8%	279	
Non-Elective beddays	M	18589	19882	7.0%	61199	59795	-2.3%	20164	
LOS									
Elective Average Length of Stay	M	2.7	2.9	0.2	2.8	2.8	0.0	3.1	
Non-Elective Average Length of Stay	M	4.4	3.9	-0.4	4.7	4.0	-0.7	4.2	
Inpatient Average Length of Stay at intermediate care units	M	23.8	23.6	-0.2	29.3	24.0	-5.3	23.9	

East Sussex Healthcare NHS Trust

YTD Exception Reporting: Top 10 Outliers

First OP

SpecialtyName	Activity	Plan	Var (%)	Var
Trauma & Orthopaedics	3613	3832	-5.7%	-219
General Surgery	1670	1875	-10.9%	-205
ENT	2105	2250	-6.5%	-146
Urology	1513	1613	-6.2%	-101
Orthodontics	5	81	-93.8%	-76
Breast Surgery	1314	1201	9.4%	113
Dermatology	1272	1157	9.9%	114
Obstetrics	807	675	19.7%	133
Gynaecology	2029	1747	16.1%	282
Ophthalmology	4215	3869	8.9%	346
Total	**28801**	**28599**	**0.7%**	**202**

Follow-Up OP

SpecialtyName	Activity	Plan	Var (%)	Var
General Surgery	1924	2590	-25.7%	-666
ENT	2266	2874	-21.2%	-609
Urology	3826	4371	-12.5%	-545
Paediatrics	1418	1951	-27.3%	-534
Ophthalmology	16974	17429	-2.6%	-455
Anaesthetics	130	6	2119.9%	125
Gynaecology	2414	2285	5.6%	128
Clinical Oncology	2348	2152	9.1%	196
Maxillo-Facial Surgery	2983	2768	7.8%	216
Cardiology	8421	8132	3.5%	288
Total	**70587**	**74199**	**-4.9%**	**-3612**

Day Case

SpecialtyName	Activity	Plan	Var (%)	Var
Maxillo-Facial Surgery	403	476	-15.4%	-73
Cardiology	541	587	-7.8%	-46
Endocrinology	92	115	-20.5%	-24
General Medicine	25	32	-21.8%	-7
Gynaecology	176	183	-3.7%	-7
Rheumatology	530	480	10.3%	49
General Surgery	1702	1642	3.7%	60
Gastroenterology	2340	2266	3.3%	74
Haematology	1591	1472	8.1%	119
Clinical Oncology	1851	1569	17.9%	282
Total	**11942**	**11351**	**5.2%**	**590**

Elective

SpecialtyName	Activity	Plan	Var (%)	Var
Cardiology	45	73	-38.0%	-28
Urology	318	337	-5.7%	-19
General Surgery	157	175	-10.1%	-18
Respiratory Physiology	95	106	-10.1%	-11
Gynaecology	131	140	-6.1%	-9
General Medicine	28	19	43.9%	9
Breast Surgery	71	61	16.8%	10
Thoracic Medicine	33	22	48.1%	11
ENT	90	68	32.9%	22
Haematology	92	58	58.6%	34
Total	**1631**	**1623**	**0.5%**	**8**

Top five Specialties above and below plan by point of delivery shown for the first three months of 2019/20. Uncashed activity included using Specialty specific attendance rates to determine realisable activity. Gross total for each point of delivery shown
This is an estimated level of activity that will eventually be recorded if all outstanding clinics are cashed up - we estimate the proportion that have attended based on average proportion.

East Sussex Healthcare NHS
NHS Trust

ESHT WORKFORCE REPORT

- MONTH 3 (JUN 2019)

HR DIRECTORATE
Jun 2019
Version v2.0

East Sussex Healthcare NHS
NHS Trust

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TRUST OVERVIEW

TRUST														
WORKFORCE CAPACITY	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Trend line
Budgeted fte	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	7,026.4	7,031.9	
Total fte usage	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	6,650.6	6,659.1	
Variance	-286.0	-275.7	-274.3	-235.0	-293.3	-177.8	-250.6	-456.7	-351.2	-191.9	-299.9	-375.8	-372.9	
Substantive vacancies	651.3	663.5	641.2	611.9	576.4	556.6	595.9	693.2	659.1	641.4	670.6	700.6	677.8	
Fill rate	90.4%	90.3%	90.5%	90.9%	91.4%	91.7%	91.1%	89.8%	90.3%	90.6%	90.2%	89.7%	90.1%	
Bank fte usage (as % total fte usage)	8.1%	8.3%	7.8%	8.1%	6.8%	7.9%	7.6%	7.7%	7.1%	8.9%	8.0%	7.1%	7.0%	
Agency fte usage (as % total fte usage)	1.8%	1.7%	1.6%	1.4%	1.2%	1.4%	1.2%	1.2%	1.5%	1.5%	1.3%	1.4%	1.2%	
Turnover rate	10.9%	11.1%	11.0%	10.8%	10.7%	11.0%	11.1%	11.1%	10.9%	10.9%	11.0%	10.8%	10.7%	
Stability rate	89.5%	92.0%	92.0%	91.8%	91.4%	91.0%	90.9%	89.8%	91.1%	91.3%	91.5%	89.1%	91.3%	
SICKNESS ABSENCE														
Annual sickness rate	4.5%	4.4%	4.4%	4.4%	4.4%	4.4%	4.3%	4.2%	4.3%	4.2%	4.2%	4.3%	4.3%	
Monthly sickness rate (%)	3.5%	3.8%	3.9%	4.2%	4.4%	4.6%	4.4%	4.7%	4.6%	4.0%	4.1%	3.9%	4.1%	
Short term sickness (<28 days)	46.0%	41.2%	45.0%	42.6%	50.1%	55.1%	51.3%	60.7%	59.1%	52.0%	54.4%	46.4%	44.8%	
Monthly long term sickness (28 days+)	54.0%	58.8%	55.0%	57.4%	49.9%	44.9%	48.7%	39.3%	40.9%	48.0%	45.6%	53.6%	55.2%	
MANDATORY TRAINING & APPRAISALS														
Appraisal rate	78.1%	78.2%	79.7%	80.1%	79.5%	80.6%	81.3%	80.9%	79.8%	79.5%	78.7%	78.1%	77.0%	
Fire	87.1%	86.6%	87.6%	87.2%	88.2%	87.9%	87.2%	87.5%	87.2%	87.3%	87.5%	87.9%	88.0%	
Moving & Handling	89.8%	88.7%	89.2%	89.2%	90.2%	90.4%	90.3%	91.1%	91.2%	91.9%	92.4%	92.6%	92.5%	
Induction	94.3%	94.8%	96.2%	95.5%	91.3%	90.8%	91.1%	92.0%	92.1%	92.2%	94.1%	98.2%	92.6%	
Infec Control	90.1%	89.6%	90.0%	89.7%	90.9%	91.0%	91.0%	90.7%	90.6%	91.4%	91.7%	91.8%	91.9%	
Info Gov	83.8%	84.7%	84.0%	82.5%	82.0%	80.5%	79.3%	79.1%	76.2%	77.4%	79.8%	80.5%	81.6%	
Health & Safety	88.6%	89.4%	88.7%	88.2%	88.3%	87.6%	88.2%	87.6%	88.0%	88.3%	88.8%	90.2%	90.8%	
MCA	96.1%	96.5%	96.5%	95.7%	95.7%	95.1%	95.6%	95.6%	95.5%	95.6%	74.9%	73.6%	73.9%	
DoLs	96.9%	97.2%	96.7%	94.9%	94.9%	93.9%	94.4%	95.0%	95.0%	95.4%	72.3%	71.0%	72.1%	
Safeguarding Vulnerable Adults	86.0%	86.7%	86.6%	86.3%	87.2%	86.8%	87.2%	87.6%	87.5%	87.7%	88.4%	87.5%	88.2%	
Safeguarding Children Level 2	87.4%	87.6%	87.8%	87.5%	88.2%	88.0%	88.4%	88.5%	87.3%	88.3%	89.2%	87.6%	88.9%	

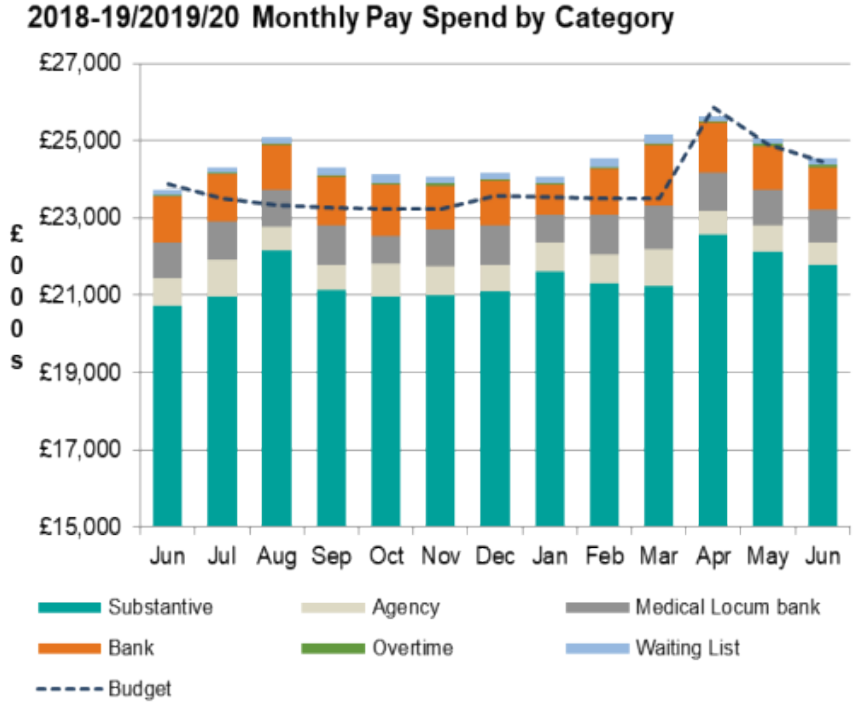
***Source data**: ESR & Finance Ledger*

MONTHLY HEADLINES

- Trust total workforce utilisation for June 2019 is 6,659.1 fte which is 372.9 fte below the budgeted establishment. Actual expenditure of £24,539k is above budget of £24,447k by £92k, however, temporary expenditure of £2,751k represents a reduction £201K since last month and is on a reducing trajectory.
- Substantive expenditure of £21,788k, accounts for 89% of total expenditure & temporary expenditure of £2,751k equates to 11% of total as follows:
  - Bank £1,964k (8.0%)
  - Agency £558k (2.3%)
  - Overtime £55k (0.2%)
  - Waiting List payments £174k (0.7%)
- The Trust vacancy rate has reduced by 0.4% to 9.9%. Current vacancies equate to 677.86 fte (a reduction of 22.8 fte vacancies).
- Annual turnover has decreased by 0.1% to 10.7% reflecting 631.9 fte leavers in the rolling 12 months.
- Monthly sickness increased by 0.2% against May to 4.1% (7650. 5 fte day lost to sickness), however, the overall annual sickness rate is unchanged at 4.3% (across the year, the average fte days lost to sickness is 15.8 per fte member of staff).
- The Mandatory Training compliance rate has increased by 0.3% to 86.7%. Compliance rates for all mandatory training courses have increased, with the exception of Trust Induction and Moving & Handling, which have reduced.
- Appraisal compliance has reduced by 1.1% to 77.0%.

WORKFORCE EXPENDITURE

Actuals in Month (£000s)														
Category	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Trend line
Budget	£23,875	£23,490	£23,321	£23,282	£23,228	£23,231	£23,578	£23,528	£23,520	£23,520	£25,858	£24,908	£24,447	
Substantive	**£20,727**	**£20,972**	**£22,152**	**£21,117**	**£20,966**	**£21,001**	**£21,109**	**£21,618**	**£21,287**	**£21,225**	**£22,570**	**£22,108**	**£21,788**	
Agency	£697	£954	£604	£667	£833	£732	£687	£727	£772	£952	£611	£707	£558	
Medical Locum bank	£923	£977	£960	£1,037	£738	£979	£1,017	£731	£1,003	£1,137	£982	£914	£870	
Bank	£1,210	£1,229	£1,172	£1,244	£1,309	£1,131	£1,144	£799	£1,209	£1,557	£1,288	£1,133	£1,094	
Overtime	£30	£43	£41	£42	£51	£43	£49	£28	£36	£50	£62	£50	£55	
Waiting List	£128	£136	£156	£183	£225	£196	£180	£161	£224	£233	£140	£148	£174	
Total Temp Expenditure	**£2,988**	**£3,339**	**£2,933**	**£3,173**	**£3,156**	**£3,081**	**£3,077**	**£2,446**	**£3,244**	**£3,929**	**£3,083**	**£2,952**	**£2,751**	
Total Spend	**£23,715**	**£24,311**	**£25,085**	**£24,290**	**£24,122**	**£24,082**	**£24,186**	**£24,064**	**£24,531**	**£25,154**	**£25,653**	**£25,060**	**£24,539**	

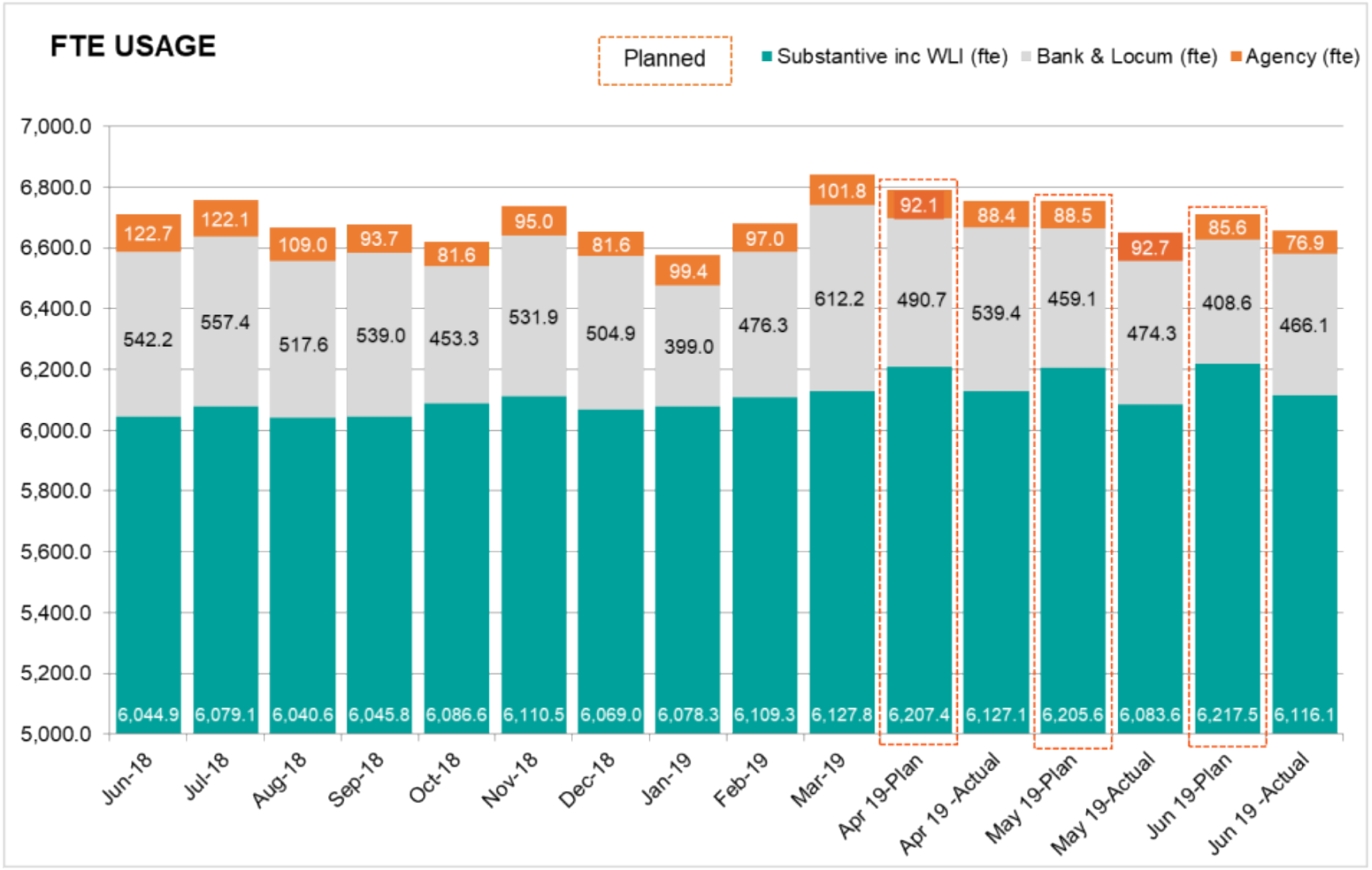


- **BUDGET** - A reduction of £461K in the budgeted establishment this month due to the removal of non recurrent CIPs identified in the first quarter.
- **SUBSTANTIVE** – Expenditure reduced by £320k, following a year to date accrual for the medical pay award in May which has reduced to normal levels this month. Vacancies have also increased in Out of Hospitals, Integrated Community Services and MSK Services.
- **BANK/LOCUM** - Expenditure reduced by £83K overall this month due to a reduction of locum usage in Paediatrics, where activity is down, and locums in EDGH A&E. Reduction in unregistered nursing usage.
- **AGENCY** - Expenditure reduced by £149K this month with reductions in medical agency at Conquest A&E & General Surgery. EDGH Theatre nurse vacancies filled and some agency covered by overtime for Conquest Theatre Nurses .
- **OVERTIME** – Expenditure increased by £5k this month partly due to unavailability of Radiology locums and vacancy cover in Pharmacy.
- **WLI** - Payments have increased by £26k this month with increase in Ophthalmology sessions.

***Source data**: Finance Ledger*

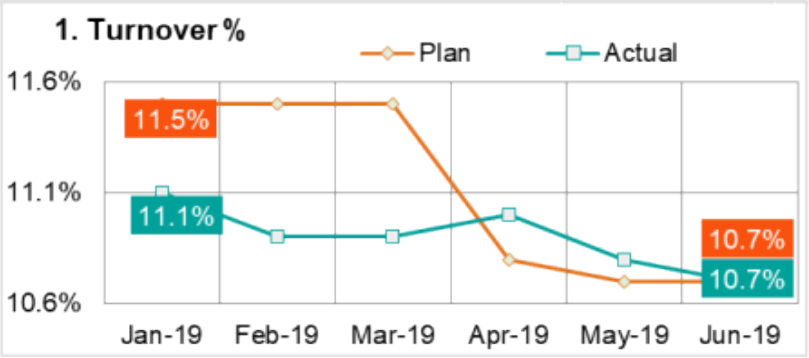
East Sussex Healthcare NHS
NHS Trust

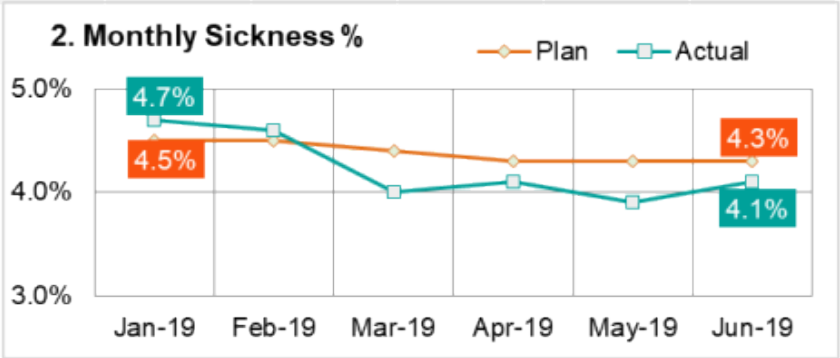
TRENDING FTE USAGE BY MONTH

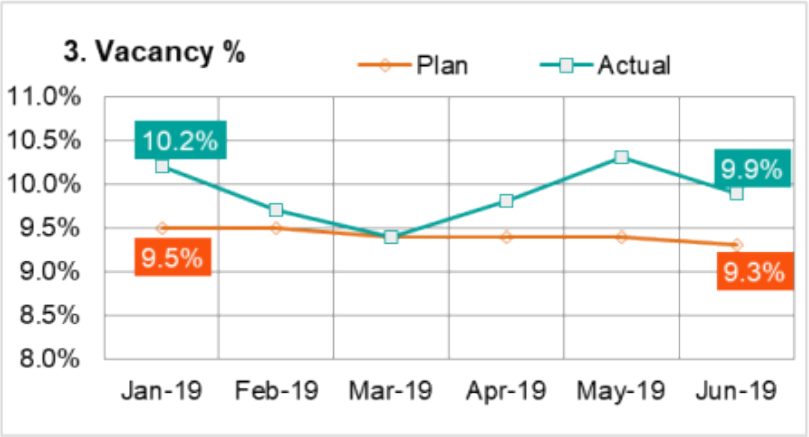


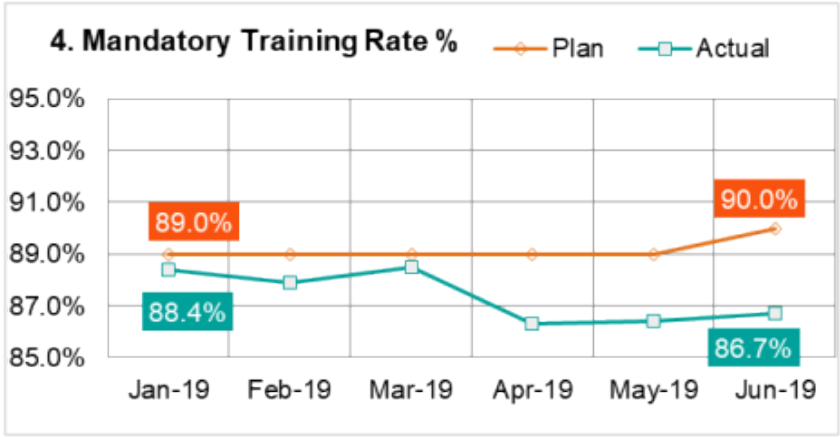
NHSI KPI'S - PLANNED v ACTUAL

Category	Plan/Actual	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Annual Turnover %	Plan	11.5%	11.5%	11.5%	10.8%	10.7%	10.7%
	Actual	11.1%	10.9%	10.9%	11.0%	10.8%	10.7%
Monthly Sickness %	Plan	4.5%	4.5%	4.4%	4.3%	4.3%	4.3%
	Actual	4.7%	4.6%	4.0%	4.1%	3.9%	4.1%
Vacancy Rate %	Plan	9.5%	9.5%	9.4%	9.4%	9.4%	9.3%
	Actual	10.2%	9.7%	9.4%	9.8%	10.3%	9.9%
Mandatory Training rate	Plan	89.0%	89.0%	89.0%	89.0%	89.0%	90.0%
	Actual	88.4%	87.9%	88.5%	86.3%	86.4%	86.7%







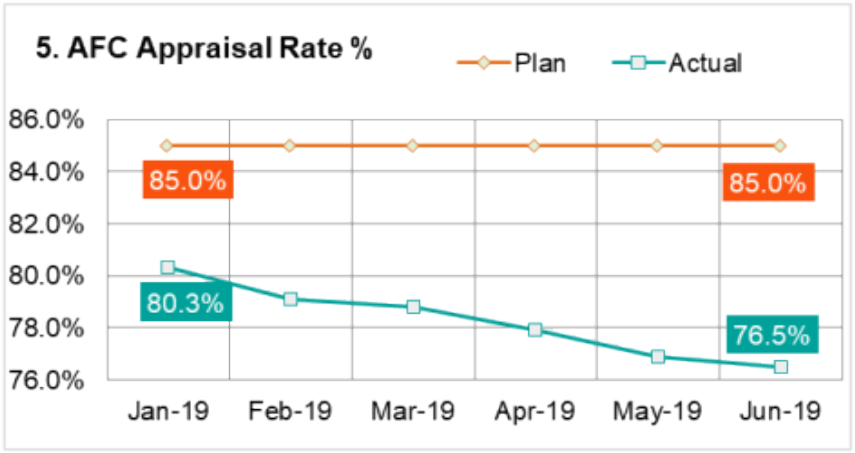


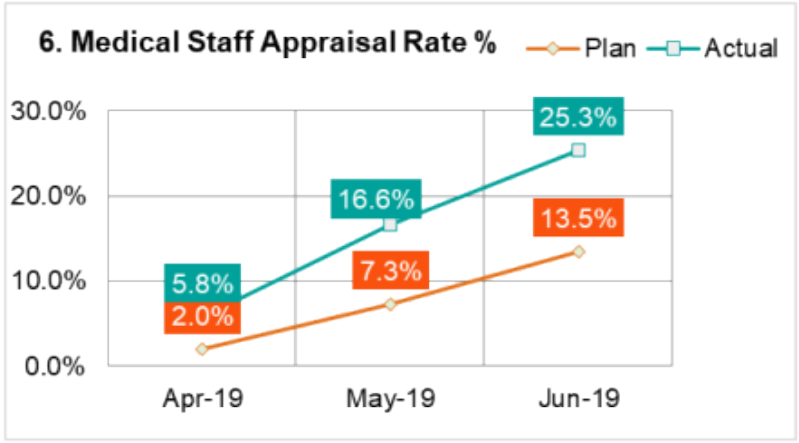
***Source data**: ESR & Finance Ledger*

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	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
AfC Appraisal Rate (rolling year)	Plan	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
	Actual	80.3%	79.1%	78.8%	77.9%	76.9%	76.5%
Medical Staff Appraisal Rate (Yr to date)	Plan	92.0%	96.0%	98.0%	2.0%	7.3%	13.5%
	Actual	96.5%	98.5%	100.0%	5.8%	16.6%	25.3%





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

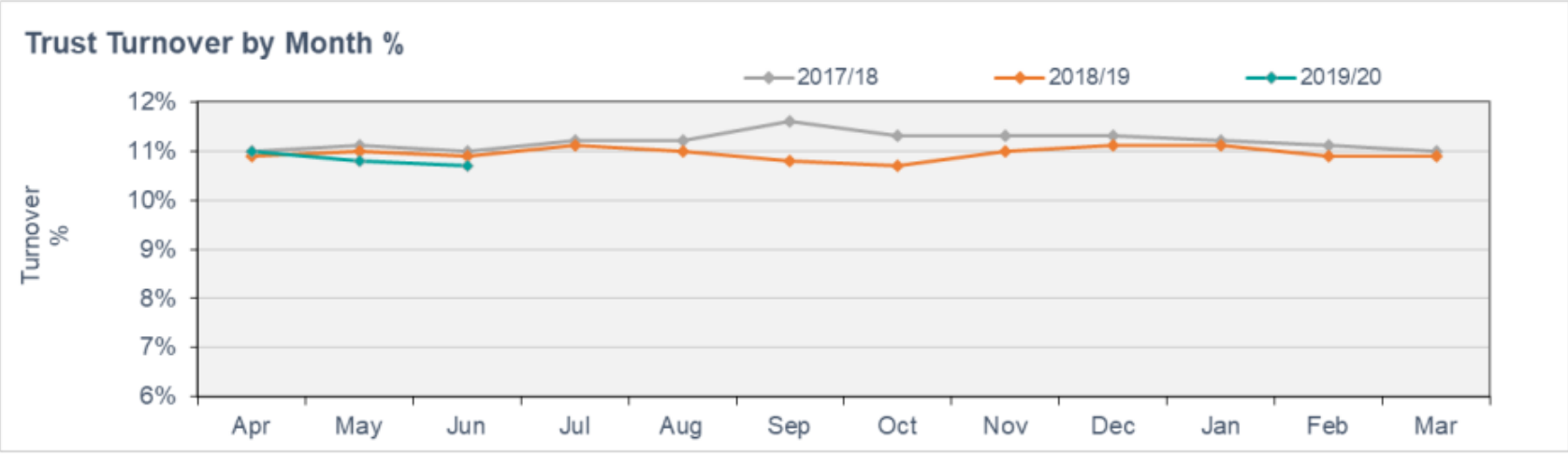
East Sussex Healthcare NHS
NHS Trust

TURNOVER TREND – STAFF GROUP

- Turnover rate has reduced by 0.1% to 10.7% in June which equates to 631.9 fte leavers in the last 12 months.
- 39.6 fte staff left the Trust in June '19, including 3.0 fte Medical & Dental staff and 11.2 fte Registered Nurses & Midwives
- Trust turnover rate is at lowest rate since March 2017.
- AHP turnover is highest amongst Occupational Therapists (17.8%) and Radiographers (17.2%)

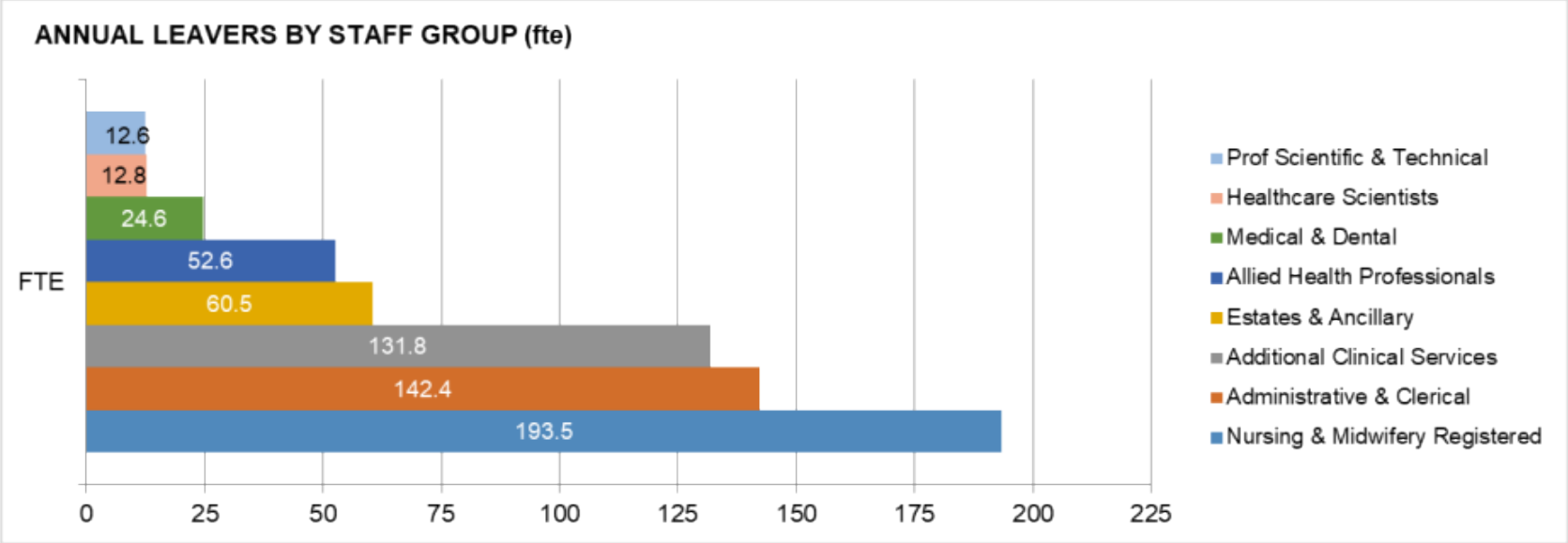
TRUST TURNOVER BY STAFF GROUP (%)

Year on Year	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Trend line
Additional Clinical Services	13.4%	14.0%	13.5%	12.9%	12.3%	12.1%	12.0%	11.5%	11.2%	11.7%	11.6%	11.2%	11.1%	
Administrative and Clerical	11.7%	11.8%	11.6%	11.6%	12.0%	12.5%	12.8%	12.8%	12.9%	11.7%	11.3%	11.1%	11.1%	
Allied Health Professionals	10.0%	9.6%	9.6%	9.7%	10.5%	10.6%	10.9%	11.0%	12.4%	12.1%	11.7%	13.4%	13.3%	
Estates and Ancillary	9.1%	9.9%	9.1%	8.8%	8.2%	9.1%	9.1%	9.2%	8.8%	9.6%	10.4%	10.1%	10.1%	
Healthcare Scientists	12.3%	12.5%	12.1%	10.2%	10.1%	9.9%	12.0%	12.6%	10.9%	9.4%	10.0%	11.4%	9.3%	
Medical & Dental	11.7%	11.8%	11.5%	10.7%	10.4%	10.2%	10.1%	10.4%	9.4%	8.9%	8.3%	7.9%	8.3%	
Nursing & Midwifery Registered	9.3%	9.5%	9.9%	10.2%	10.1%	10.4%	10.7%	10.8%	10.4%	10.8%	11.1%	10.8%	10.6%	
Prof Scientific and Tech	8.7%	9.3%	9.1%	8.9%	8.2%	8.2%	6.9%	8.5%	7.4%	7.8%	8.5%	8.3%	9.1%	
TOTAL TRUST TURNOVER	**10.9%**	**11.1%**	**11.0%**	**10.8%**	**10.7%**	**11.0%**	**11.1%**	**11.1%**	**10.9%**	**10.9%**	**11.0%**	**10.8%**	**10.7%**	



***Source data**: ESR*

LEAVERS & STABILITY – STAFF GROUP



STAFF GROUPS	STABILITY > 1YR
Medical & Dental	94.4%
Prof Scientific & Technical	87.6%
Administrative & Clerical	91.5%
Nursing & Midwifery Registered	91.5%
Estates & Ancillary	92.7%
Additional Clinical Services	90.1%
Healthcare Scientists	96.5%
Allied Health Professionals	88.1%
TRUST	**91.3%**

Overview

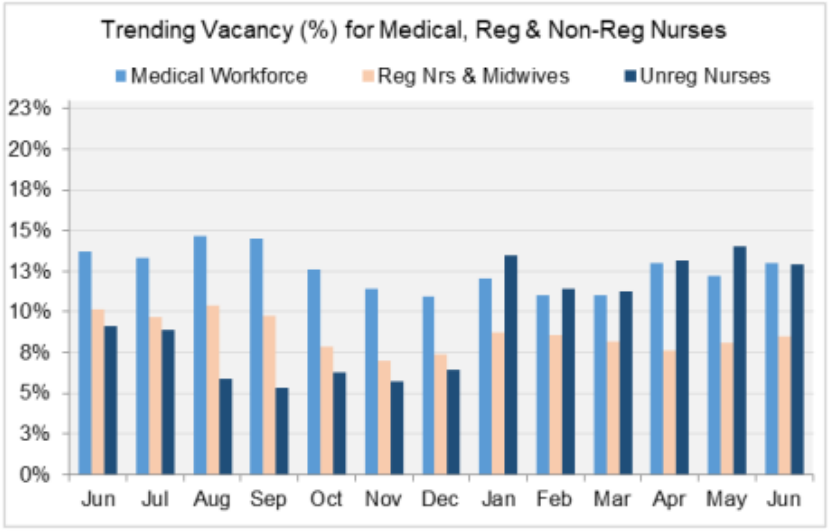
- The Stability Rate measures the number of current staff who have more than 1 year's service with ESHT
- The Stability rate has increased by 2.2% this month
- Professional Scientific & Technical staff (i.e. Pharmacy staff, ODPs, Optometrists and other technical staff) and Allied Health Professionals have stability rates below 90%.

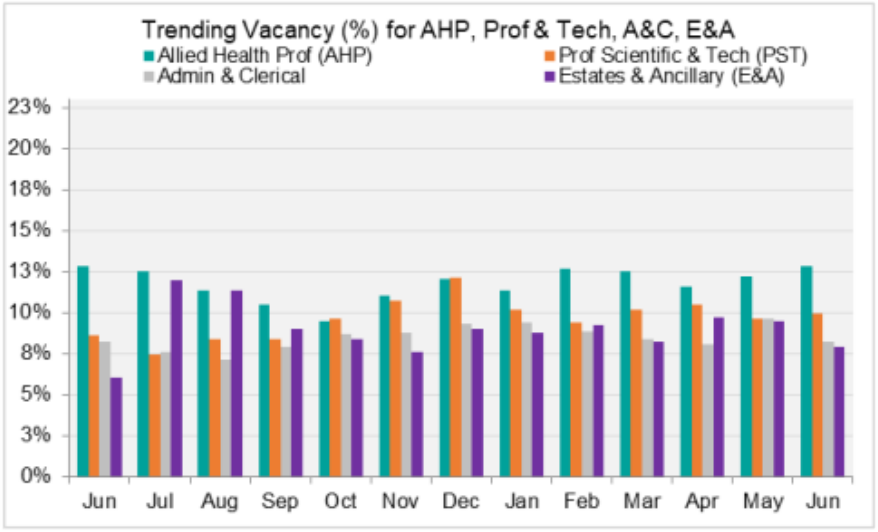
***Source data**: ESR*

RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- The Trust vacancy rate has decreased by 0.4% to 9.9% (677.8 fte), a reduction of 22.8 ftes.
- Following a visit to India in April this year 89 candidates have been sourced with 4 nurses arriving in the July cohort. An additional 13 International nurses are due to join the Trust by August 2019
- Working with Medacs agency. To date 7 medical staff in post and a further 3 offer of appointment in the pipeline

JUN 2018 TO JUN 2019	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Trend line
Medical Workforce	13.7%	13.3%	14.7%	14.5%	12.6%	11.4%	11.0%	12.1%	11.0%	11.0%	13.0%	12.2%	13.0%	
Reg Nrs & Midwives	10.1%	9.7%	10.4%	9.8%	7.9%	7.0%	7.4%	8.7%	8.6%	8.2%	7.6%	8.1%	8.5%	
Unreg Nurses	9.2%	8.9%	5.9%	5.3%	6.3%	5.7%	6.4%	13.5%	11.4%	11.3%	13.1%	14.0%	12.9%	
Allied Health Prof (AHP)	12.8%	12.5%	11.3%	10.5%	9.5%	11.1%	12.1%	11.3%	12.7%	12.5%	11.6%	12.2%	12.8%	
Prof Scientific & Tech (PST)	8.6%	7.4%	8.4%	8.4%	9.6%	10.7%	12.1%	10.2%	9.4%	10.2%	10.5%	9.6%	9.9%	
Admin & Clerical	8.2%	7.6%	7.1%	7.9%	8.7%	8.8%	9.3%	9.4%	8.8%	8.4%	8.0%	9.6%	8.2%	
Estates & Ancillary (E&A)	6.0%	12.0%	11.3%	9.0%	8.4%	7.6%	9.0%	8.7%	9.2%	8.2%	9.7%	9.5%	7.9%	
TRUST	**9.6%**	**9.7%**	**9.5%**	**9.1%**	**8.6%**	**8.3%**	**8.9%**	**10.2%**	**9.7%**	**9.4%**	**9.8%**	**10.3%**	**9.9%**	





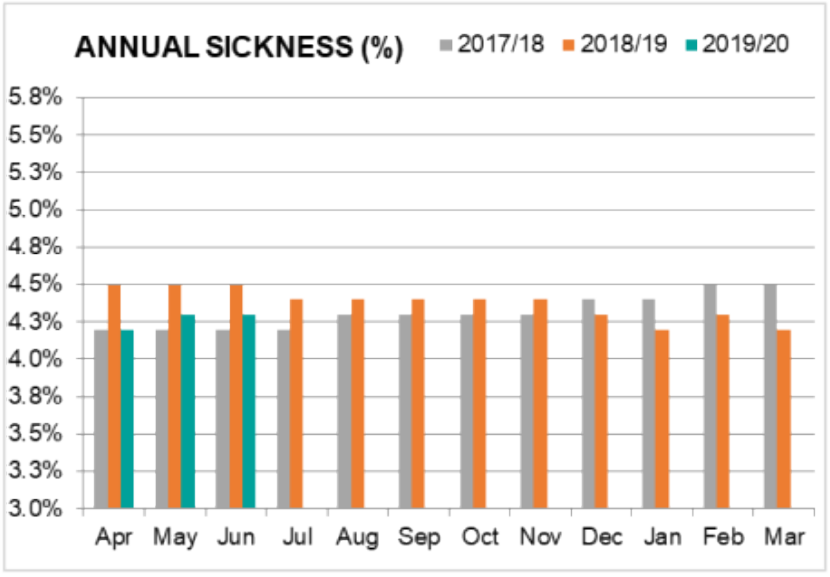
***Source data**: ESR & Finance Ledger*

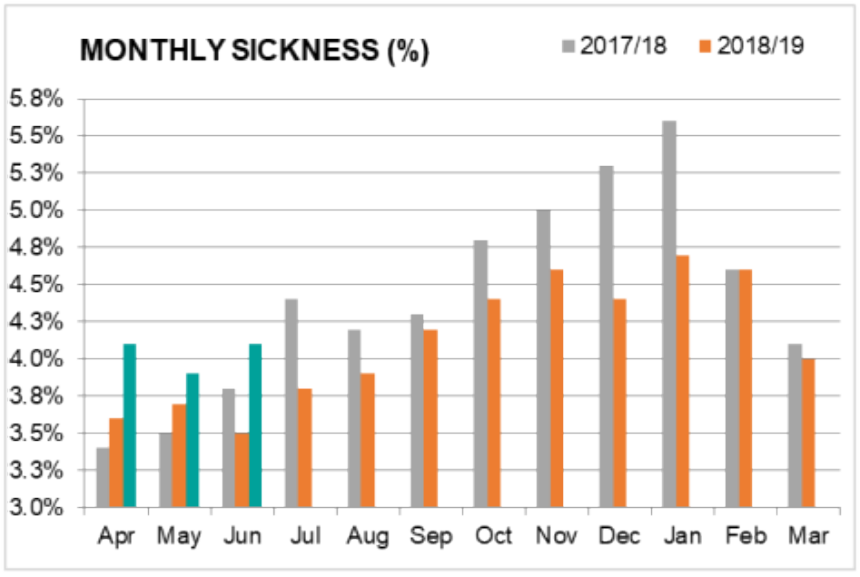
ABSENCE MANAGEMENT – SICKNESS RATES

- Monthly sickness has increased by 0.2% to 3.9%. Although this rate is higher than the June rates for the last two years, the annual sickness rate has remained unchanged at 4.3%.
- The staff group with the highest monthly sickness rate was Additional Clinical Services (mostly unregistered nurses & therapy helpers) at 5.1% followed by Estates & Ancillary staff at 4.9% and Registered Nurses & Midwives at 4.5%.
- Peer Trusts in the Model Hospital had monthly sickness in the range 4.2% - 4.3% in Mar '19.

ANNUAL (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
2017/18	4.2%	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.3%	4.4%	4.4%	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%
2019/20	4.2%	4.3%	4.3%								

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%	3.9%	4.1%									





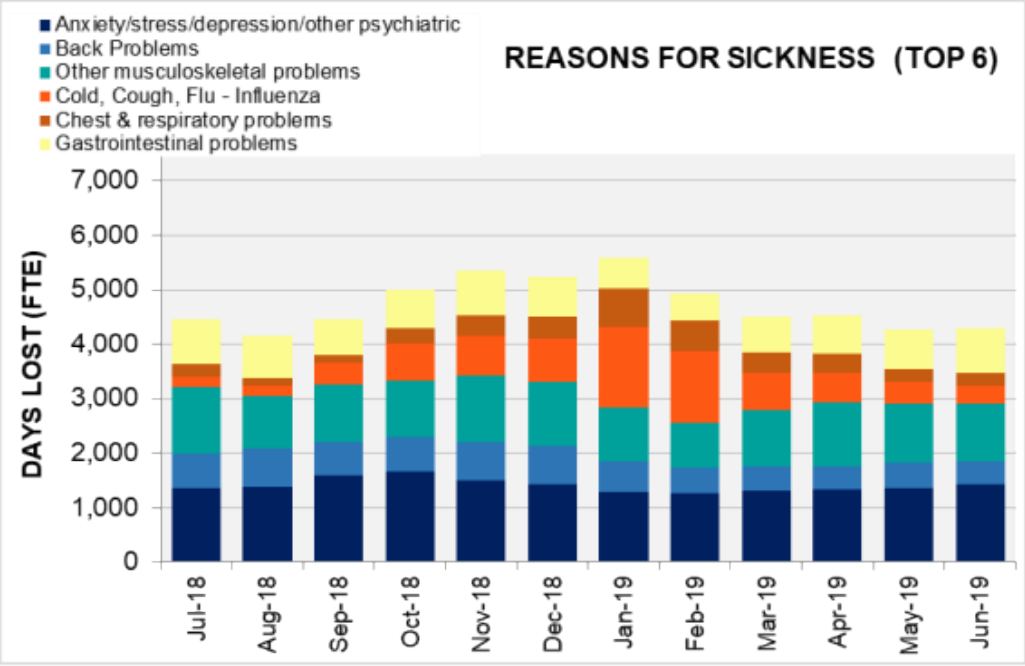
***Source data**: ESR*

East Sussex Healthcare NHS
NHS Trust

ABSENCE MANAGEMENT – SICKNESS REASONS

- Anxiety/depression/other psychiatric illnesses have increased by 64 fte days lost this month to the highest level since December ’18
- Other musculoskeletal and back problems have reduced by a combined 72 fte days since last month.

TOP 6	Fte Days Lost by Month												
Reason for sickness	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Trend line
Anxiety/stress/depression/other psychiatric	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	1,357.4	1,421.3	
Back Problems	629.8	691.8	617.0	641.4	708.0	718.3	557.1	455.6	461.2	409.3	460.8	427.0	
Other musculoskeletal problems	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	1,102.1	1,063.5	
Cold, Cough, Flu - Influenza	189.2	185.8	410.6	682.5	730.2	788.3	1,474.1	1,300.1	662.3	537.0	397.7	324.2	
Chest & respiratory problems	244.2	132.8	142.1	291.9	371.3	393.2	705.9	568.4	384.5	363.2	216.0	242.6	
Gastrointestinal problems	825.8	782.7	657.3	698.0	829.0	724.7	566.9	485.4	656.8	704.8	731.2	809.5	



Jun 2019 - Top 10 in descending order (%)		%
1	Anxiety/stress/depression/other psychiatric illnesses	18.5%
2	Other musculoskeletal problems	13.8%
3	Gastrointestinal problems	10.5%
4	Other known causes - not elsewhere classified	8.4%
5	Unknown causes / Not specified	6.9%
6	Back Problems	5.5%
7	Genitourinary & gynaecological disorders	4.4%
8	Injury, fracture	4.3%
9	Cold, Cough, Flu	4.2%
10	Heart, Cardiac & circulatory problems	3.4%
	TOP 10 REASONS	**79.9%**

***Source data**: ESR*

WELLBEING & ENGAGEMENT

Health and Wellbeing

- Schwartz rounds continue to support staff emotional wellbeing. Positive evaluations received.
- Focused work to identify high areas of sickness linked to musculoskeletal problems (MSK) and take a coordinated approach to improvement
- Menopause cafés well attended. Themes include focus on MSK and self-care

Engagement

- Hosted 2 Masterclasses with focus on improving patient outcomes through enhanced staff experience. 70 managers attended ,
- Working with all divisions to support action planning linked to staff survey.
- Continue to provide tailored support through specific engagement sessions.
- Project Search, 12 interns graduated.

Retention

- 33 staff attended the Maternity Support Groups. Focus on coming back to work, on site nurseries and flexible working
- Carers Week. Support for those staff with additional caring responsibilities, highlighting flexible working

East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISAL COMPLIANCE BY DIVISION

MANDATORY TRAINING

- Overall mandatory training compliance has increased by 0.3% to 86.7%.
- Information Governance is continuing to increase slowly and Divisions are being asked to focus on this together with the Mental Capacity Act & Deprivation of Liberties training which have changed to a 3 yearly update.
- Induction has seen a significant drop in compliance this month and this will be investigated to identify why some staff are not being automatically booked onto Induction as part of the recruitment process. Staff who have failed to attend Induction will also be supported to attend

APPRAISAL OVERVIEW

- The overall appraisal rate for the Trust for the last 12 months continues to fall, down by 1.1% to 77.0%. This is the 6th consecutive monthly fall since a high of 81.3% compliance in Dec 18.

DIVISION	APPRAISAL COMPLIANCE	
	12 mth	16 mth
Urgent Care	75.8%	89.4%
Medicine	75.0%	89.2%
Out of Hospital	74.1%	84.7%
Diag/Anaes/Surg	80.8%	91.4%
Womens, Child, S/Health	78.1%	87.0%
Estates & Facilities	74.8%	87.9%
Corporate	78.1%	87.5%
TRUST	**77.0%**	**88.3%**

										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	88.3%	91.9%	90.5%	90.5%	82.7%	92.6%	82.6%	82.4%	33.6%	92.5%	93.4%	93.4%
Medicine	84.7%	88.9%	91.5%	88.7%	73.6%	86.9%	73.1%	64.6%	61.3%	86.7%	85.3%	100.0%
Out of Hospital	88.1%	93.3%	95.0%	94.7%	81.2%	91.1%	70.5%	70.6%	43.4%	88.4%	88.5%	79.5%
Diag/Anaes/Surg	87.3%	91.5%	86.9%	89.8%	82.6%	89.8%	73.5%	70.5%	52.5%	87.6%	88.4%	33.8%
Womens, Child, S/Health	89.3%	92.8%	94.5%	92.2%	82.9%	90.4%	76.9%	75.7%	7.9%	89.6%	94.0%	89.7%
Estates & Facilities	85.7%	93.8%	97.3%	92.6%	78.2%	92.6%	N/A	N/A	N/A	N/A	N/A	N/A
Corporate	93.8%	96.9%	98.3%	96.0%	92.0%	95.5%	71.3%	73.2%	20.9%	90.3%	87.0%	100.0%
TRUST	**88.0%**	**92.5%**	**92.6%**	**91.9%**	**81.6%**	**90.8%**	**73.9%**	**72.1%**	**47.7%**	**88.2%**	**88.9%**	**80.1%**

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

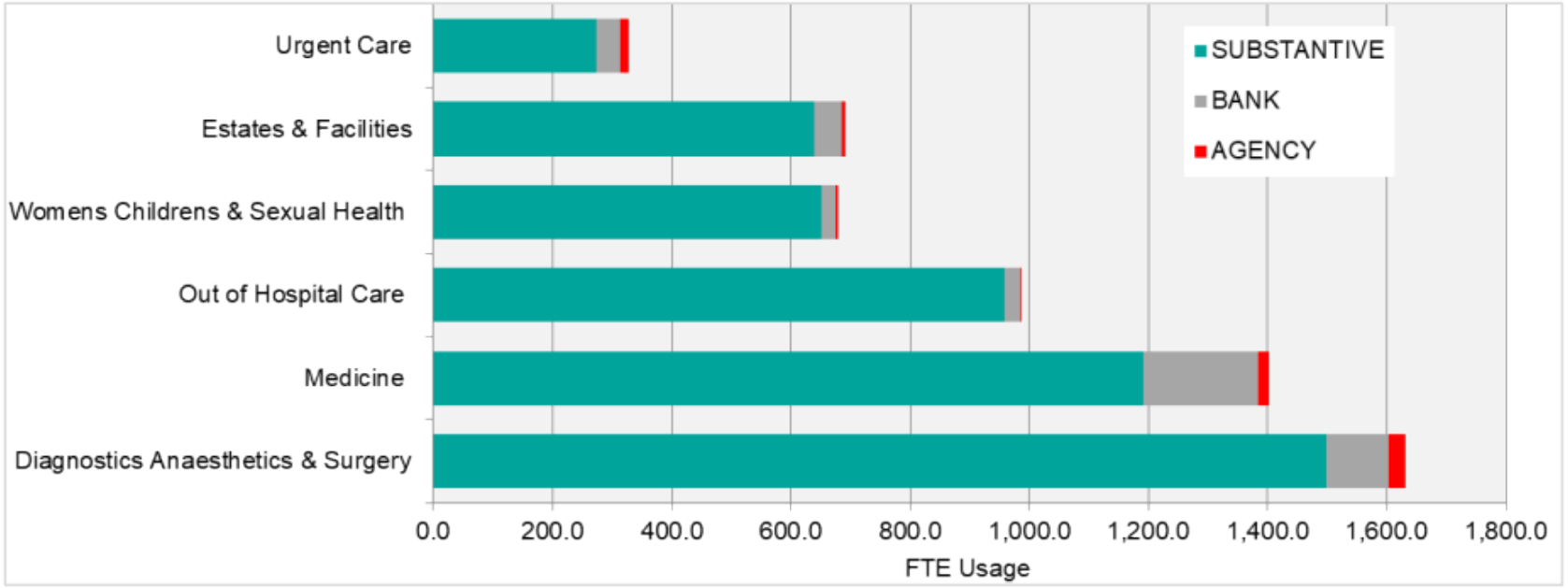
***Source data**: ESR*

APPENDIX

- Supporting documents

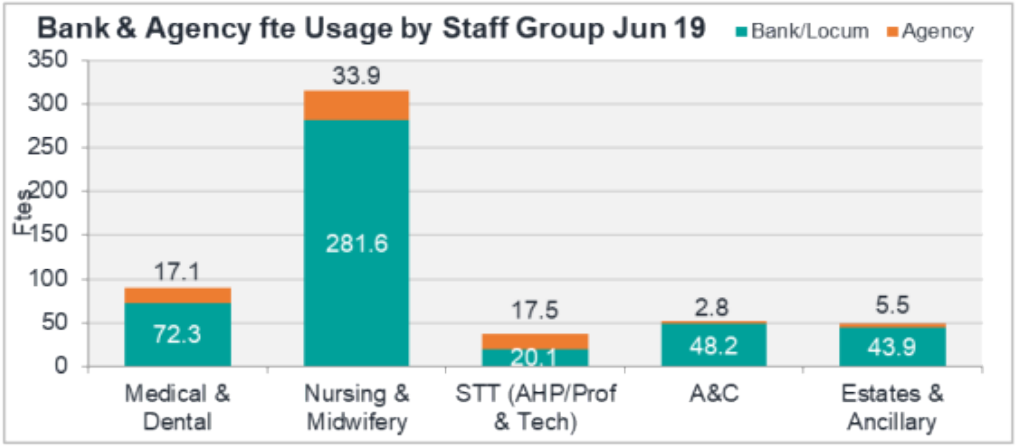
WORKFORCE UTILISATION BY DIVISION (FTE USAGE) – JUN '19

RESOURCE RATIO - MONTHLY					
DIVISION	**BUDGET FTE**	**SUBSTANTIVE**	**BANK**	**AGENCY**	**TOTAL**
Diagnostics Anaesthetics & Surgery	1,741.6	1,497.8	105.3	27.4	1,630.5
Medicine	1,468.5	1,192.0	191.7	18.6	1,402.3
Out of Hospital Care	1,072.3	959.2	24.4	2.4	986.0
Womens Childrens & Sexual Health	708.9	650.8	23.9	4.9	679.6
Estates & Facilities	724.8	639.4	45.8	5.5	690.7
Urgent Care	362.1	273.6	39.7	15.1	328.4
Corporate	953.7	820.6	35.3	2.6	858.5
TRUST	**7,031.9**	**6,116.1**	**466.1**	**76.9**	**6,659.1**



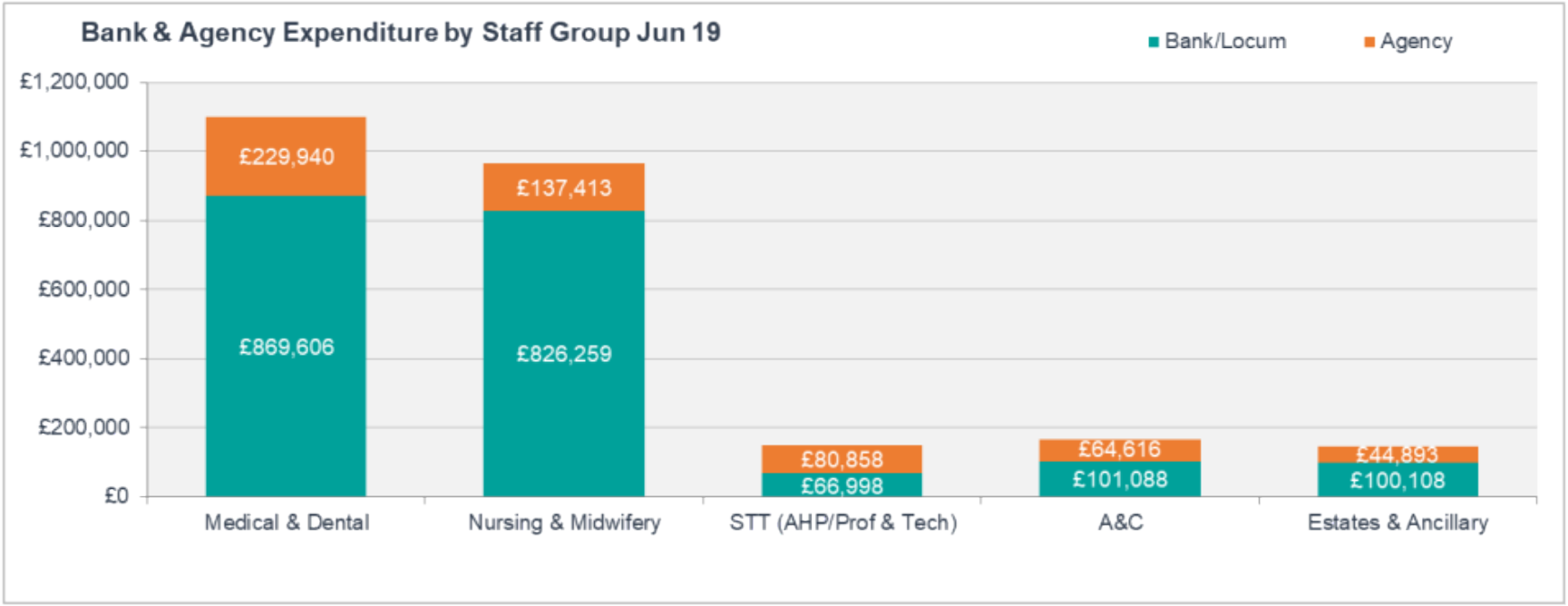
***Source data**: Finance Ledger*

FLEXIBLE LABOUR – FTE & EXPENDITURE FOR JUN '19



- Total temporary workforce expenditure reduced in Jun '19 against May '19 by £201K:
  - Bank costs reduced by £39K
  - Locum costs reduced by £44K
  - Agency costs reduced by £149K
  - Overtime costs increased by £5K
  - Waiting list costs increased by £26K

(Source data: Finance Ledger M3)



***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 3

	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	(13,298)	(8,653)	(8,628)	25
Year End Forecast	(44,782)	(10,125)	(10,125)	0

The Trust is £25k ahead of plan YTD and eligible for PSF (£1.1m) and FRF (£2.2m) funding, which is included in the financial position. The YTD value of the Aligned Incentive Contract with the ESBT CCGs is included in the financial position. Overspends are primarily in nursing and medical pay, (WLIs and locum payments) and are offset by underspends in A&C and AHP pay. CIP is £26k ahead of plan YTD. YTD non-pay overspends in tariff excluded drugs are offset in contract income.

Agency Usage

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(2,787)	(2,517)	(1,876)	641
Year End Forecast	(9,716)	(8,743)	(8,743)	0

Agency spend is £641k 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 £911k (33%) compared to the same period 2018/19.

Income

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	98,893	105,865	107,311	1,446
Year End Forecast	408,783	441,780	441,780	0

Underperformance on elective and day case activity (£0.6m) offset by overperformance of non-elective activity (£0.7m) and 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 (£1.1m), FRF (£2.2m) and MRET (£0.4m) are 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	(110,312)	(112,759)	(112,644)	115
Year End Forecast	(445,874)	(444,666)	(444,666)	0

Overall operating costs are reporting £115k underspent against plan. Overspends include medical pay costs including agency, WLI and Locum (£0.7m) and clinical supplies (£0.5m), in line with an increased in non-elective activity. 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	3,650	3,675	26
Year End Forecast	20,602	20,602	0

The Trust has over delivered by £26k against its £3.6m YTD plan. Despite this there is underperformance on private patients (£24k) and radiology outsourcing (£104k) schemes which have been offset by non-recurrent savings on pay arising from vacancies and non-pay savings. The forecast is to achieve the £20.6m 2019/20 CIP target, with £14.3m currently identified as process green.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	11,502	9,402
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.

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	3,150	3,503	(354)
Year End Forecast	12,598	12,598	0

The CRL was revised in M1 to £12.5m. YTD the capital programme is reporting a small overplanning margin and is slightly ahead of schedule in terms of actual expenditure compared to plan. The capital position is monitored on a monthly basis by the Capital Resource Group and the current overspend will be managed within the capital programme to achieve the CRL at year end.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	94.25%	95.01%	90.37%	94.17%
NHS Invoices	88.46%	99.66%	89.55%	98.79%

94% of trade invoices were paid within 28 days which equates to 95% of the total value paid in month.

88% of NHS invoices were paid within contract or within 28 days of receipt which was 100% of the total NHS invoices paid.

Divisional Performance

Division	In the Month						Year to Date			Forecast Outturn		
	Plan FTE	Actual FTE	Variance FTE	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Diagnostics, Anaesthetics & Surgery	1,741.62	1,630.48	111.14	479	368	(111)	109	(1,157)	(1,266)	5,593	5,593	0
Medicine	1,468.52	1,402.27	66.25	3,374	3,724	349	10,119	9,829	(291)	46,743	46,743	0
Urgent Care	362.06	328.43	33.63	1,111	1,107	(3)	2,814	3,028	214	10,352	10,352	0
Out of Hospital Care	1,072.34	986.01	86.33	(635)	(464)	172	(2,174)	(1,589)	585	(6,594)	(6,594)	0
Women's, Children's & Sexual Health	708.90	679.60	29.30	850	838	(13)	2,238	2,771	533	11,724	11,724	0
Estates & Facilities	724.79	690.73	34.06	(2,295)	(2,156)	139	(6,923)	(6,532)	391	(26,225)	(26,225)	0
Corporate	953.69	933.87	19.82	(3,954)	(4,005)	(51)	(12,444)	(11,577)	866	(49,629)	(49,629)	0
Central	0.00	7.68	(7.68)	(1,129)	(1,605)	(476)	(2,393)	(3,401)	(1,008)	(2,089)	(2,089)	0
Total	**7,031.92**	**6,659.07**	**372.85**	**(2,199)**	**(2,194)**	**5**	**(8,653)**	**(8,628)**	**25**	**(10,125)**	**(10,125)**	**0**

Key Risks

Key Risk 1	Medical pay costs, including WLI and locum increased (£0.7m overspend YTD)
Key Risk 2	Inpatient elective activity (elective, day case) £0.6m 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 include agency and locums. A detailed review of locum and agency overspends is being undertaken by Finance to further reduce agency spend by working with clinical units. An improved WLI approvals process is being launched in line with recent internal audit recommendations.
Mitigation 2	Ongoing review of all areas of activity underperformance at specialty level to understand correlation with costs, waiting list and referral trends.
Mitigation 3	Divisions being held to account via Confirm & Challenge sessions, detailed reviews and IPRs. Grip and control has been strengthened across the Trust. PIDs are being worked up at divisional level to achieve the CIP plan.

Income & Expenditure Summary - Month 3

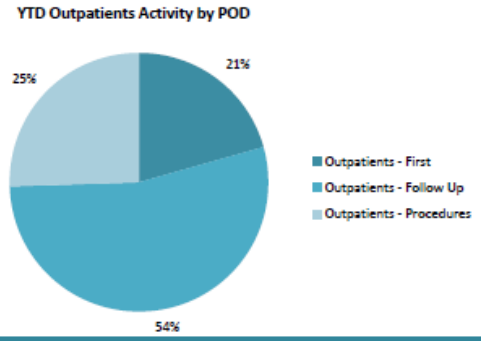
	In Month				Year to Date				Forecast Outturn		
	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	19/20 Plan (£m)	19/20 FOT (£m)	Variance (£m)
NHS Patient Income	26.9	27.8	27.8	(0.0)	81.0	85.0	83.9	(1.1)	347.9	347.9	0.0
Tariff-Excluded Drugs & Devices	3.3	3.4	3.3	(0.2)	8.9	9.2	9.1	(0.1)	38.3	38.3	0.0
Private Patient / ICR	0.2	0.3	0.2	(0.0)	0.8	0.8	(0.5)	(1.4)	3.4	3.4	0.0
Other Non-Clinical Income	2.6	2.3	2.5	0.2	8.2	7.1	11.0	4.0	28.3	28.3	0.0
Total Income	**32.9**	**33.9**	**33.8**	**(0.1)**	**98.9**	**102.1**	**103.6**	**1.4**	**417.9**	**417.9**	**0.0**
Pay - Substantive	(20.9)	(21.6)	(22.0)	(0.4)	(62.6)	(66.0)	(67.1)	(1.1)	(262.6)	(262.6)	0.0
Pay - Bank	(2.1)	(2.0)	(2.0)	0.1	(6.9)	(6.7)	(6.3)	0.5	(22.8)	(22.8)	0.0
Pay - Agency	(0.7)	(0.8)	(0.6)	0.3	(2.8)	(2.5)	(1.9)	0.6	(8.7)	(8.7)	0.0
Total Pay	**(23.7)**	**(24.4)**	**(24.5)**	**(0.1)**	**(72.3)**	**(75.2)**	**(75.3)**	**(0.0)**	**(294.1)**	**(294.1)**	**0.0**
Drugs	(3.7)	(3.5)	(3.7)	(0.2)	(10.9)	(10.9)	(11.1)	(0.2)	(44.6)	(44.6)	0.0
Supplies & Services - Clinical	(3.2)	(2.6)	(2.7)	(0.2)	(9.1)	(7.7)	(8.1)	(0.4)	(32.2)	(32.2)	0.0
Supplies & Services - General	(0.4)	(0.3)	(0.3)	0.0	(1.2)	(1.0)	(0.9)	0.2	(4.0)	(4.0)	0.0
Purchase of Healthcare (non-NHS)	(0.5)	(0.5)	(0.5)	0.0	(1.4)	(1.6)	(1.5)	0.1	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(0.6)	(0.6)	(0.6)	(0.0)	(1.7)	(1.8)	(1.7)	0.2	(7.1)	(7.1)	0.0
Consultancy	(0.2)	(0.0)	(0.0)	(0.0)	(0.5)	(0.1)	(0.2)	(0.0)	(0.4)	(0.4)	0.0
Clinical Negligence	(0.9)	(0.8)	(0.8)	(0.0)	(2.6)	(2.3)	(2.4)	(0.1)	(8.9)	(8.9)	0.0
Premises	(1.2)	(1.3)	(1.2)	0.1	(3.6)	(3.9)	(3.7)	0.2	(15.0)	(15.0)	0.0
Depreciation	(1.0)	(1.1)	(1.1)	0.0	(3.1)	(3.3)	(3.2)	0.1	(13.0)	(13.0)	0.0
Other	(1.1)	(1.5)	(1.1)	0.4	(3.7)	(4.8)	(4.7)	0.2	(19.5)	(19.5)	0.0
Total Non-Pay	**(12.8)**	**(12.3)**	**(12.1)**	**0.1**	**(38.0)**	**(37.5)**	**(37.4)**	**0.1**	**(150.5)**	**(150.5)**	**0.0**
Total Operating Costs	**(36.5)**	**(36.7)**	**(36.7)**	**0.0**	**(110.3)**	**(112.7)**	**(112.6)**	**0.1**	**(444.7)**	**(444.7)**	**0.0**
Net Surplus/(Deficit) from Operations	**(3.6)**	**(2.8)**	**(2.9)**	**(0.1)**	**(11.4)**	**(10.6)**	**(9.1)**	**1.5**	**(26.8)**	**(26.8)**	**0.0**
Financing Costs	(0.5)	(0.6)	(0.6)	0.0	(1.9)	(1.8)	(1.7)	0.1	(7.2)	(7.2)	0.0
Total Non-Operating Costs	**(0.5)**	**(0.6)**	**(0.6)**	**0.0**	**(1.9)**	**(1.8)**	**(1.7)**	**0.1**	**(7.2)**	**(7.2)**	**0.0**
Total Costs	**(37.1)**	**(37.3)**	**(37.2)**	**0.1**	**(112.2)**	**(114.5)**	**(114.4)**	**0.1**	**(451.9)**	**(451.9)**	**0.0**
Net Surplus/(Deficit)	**(4.2)**	**(3.4)**	**(3.5)**	**(0.0)**	**(13.4)**	**(12.4)**	**(10.8)**	**1.6**	**(34.0)**	**(34.0)**	**0.0**
Donated Asset/Impairment Adjustment	(0.0)	0.0	0.0	0.0	0.1	0.0	(1.6)	(1.6)	0.0	0.0	0.0
Operational Surplus/(Deficit)	**(4.2)**	**(3.4)**	**(3.4)**	**0.0**	**(13.3)**	**(12.4)**	**(12.4)**	**0.0**	**(34.0)**	**(34.0)**	**0.0**
Provider Sustainability Fund	0.0	0.4	0.4	0.0	0.0	1.1	1.1	0.0	7.6	7.6	0.0
Financial Recovery Fund	0.0	0.7	0.7	0.0	0.0	2.2	2.2	0.0	14.8	14.8	0.0
Marginal Rate Emergency Tariff (MRET)	0.0	0.1	0.1	0.0	0.0	0.4	0.4	0.0	1.5	1.5	0.0
Net Surplus/(Deficit)	**(4.2)**	**(2.2)**	**(2.2)**	**0.0**	**(13.3)**	**(8.7)**	**(8.6)**	**0.0**	**(10.1)**	**(10.1)**	**0.0**

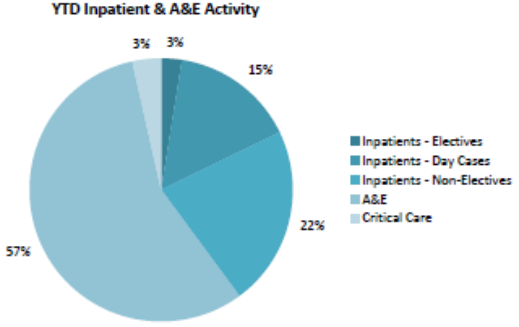
Summary & Next Steps

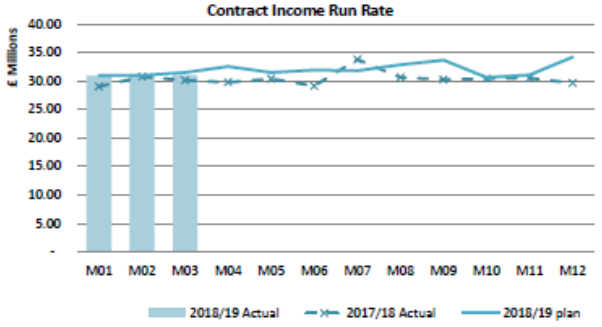
The Trust's YTD performance at M3 is £25k ahead of plan with a CIP over performance of £26k. Income underformed in month by £0.1m, £0.2m of which relates to tariff excluded drugs & devices, which are offset by non pay underspends. Elective activity is £0.4m below plan in month. The YTD impact of the Aligned Incentive Contract with the ESBT CCGs has been recognised in the financial position as has £3.7m of PSF, FRF and MRET YTD. Medical pay continues to overspend (£0.7m) YTD, mainly due to locum and WLI payments.

Income & Activity Summary - Month 3

	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	594	543	463	(80)	1,851	1,825	1,383	(442)	1,675	1,657	1,563	(94)	5,156	5,563	5,064	(499)	22,979	22,979	0
Inpatients - Day Cases	3,298	3,133	2,862	(271)	2,459	2,342	2,363	22	9,822	9,553	9,408	(145)	7,124	7,140	7,061	(79)	29,491	29,491	0
Inpatients - Non-Electives	4,148	4,371	4,411	40	8,716	9,754	9,549	(205)	12,628	13,227	13,638	411	26,625	29,515	30,174	659	121,311	121,311	0
Outpatients	34,619	33,245	34,667	1,422	4,011	4,125	3,674	(452)	102,828	101,369	100,670	(699)	12,024	12,578	11,776	(802)	51,950	51,950	0
A&E	10,826	11,537	11,547	10	1,492	1,769	1,743	(26)	32,172	34,336	34,901	565	4,440	5,265	5,331	66	21,111	21,111	0
CQUIN	0	0	0	0	0	308	356	48	0	0	0	0	0	924	1,016	92	3,695	3,695	0
Critical Care	654	746	700	(46)	674	802	789	(13)	2,182	2,162	2,172	10	2,399	2,426	2,441	15	9,973	9,973	0
Direct Access	8,323	8,432	9,787	1,355	309	358	342	(16)	25,479	24,440	40,223	15,783	973	1,042	1,164	122	4,285	4,285	0
ESBT	0	0	0	0	588	694	611	(83)	0	0	0	0	1,764	2,086	1,832	(254)	8,379	8,379	0
Excess Bed Days	848	791	721	(71)	206	262	182	(80)	2,901	2,397	2,008	(389)	705	794	531	(262)	3,266	3,266	0
Exclusions	0	0	209	209	3,044	3,445	3,303	(143)	0	0	229	229	8,897	9,230	9,258	28	38,294	38,294	0
iMSK	0	0	0	0	118	123	123	0	0	0	0	0	355	368	369	1	1,472	1,472	0
Maternity Pathway	563	570	493	(77)	591	608	559	(49)	1,720	1,652	1,615	(37)	1,828	1,763	1,824	62	7,268	7,268	0
Unallocated QIPP	0	0	0	0	0	(919)	0	919	0	0	0	0	0	(2,757)	0	2,757	(11,029)	(11,029)	0
AIC	0	0	0	0	0	0	(1,363)	(1,363)	0	0	0	0	0	0	(1,751)	(1,751)	0	0	0
Other	306,546	307,211	322,222	15,011	5,739	6,008	6,085	77	925,649	890,392	947,839	57,447	17,178	17,541	16,992	(549)	71,137	71,137	0
Contract Income Total	370,419	370,581	388,082	17,501	29,797	31,504	29,700	(1,804)	1,117,056	1,081,185	1,154,265	73,080	89,469	93,478	93,084	(395)	383,582	383,582	0
Divisional Income					2,772	3,599	3,993	394					8,953	12,387	14,227	1,840	58,198	58,198	0
Total Income	370,419	370,581	388,082	17,501	32,569	35,103	33,693	(1,410)	1,117,056	1,081,185	1,154,265	73,080	98,422	105,865	107,311	1,446	441,780	441,780	0







Summary & Next steps

Inpatients - Electives & Day Cases (YTD) £0.6m behind plan -4.6%

Activity and income are behind plan at M3

The main areas of underperformance are Cardiology (£187k) T&O (£192k) and Urology (£325k). There is focused work with the divisions to understand the drivers for this and develop action plans.

Inpatients - Non-Electives (YTD) £0.7m above plan 2.2%

Non-elective activity is above plan YTD. Activity continues to increase compared to previous levels - QIPP reductions anticipated in the local health economy plan have yet to have an impact.

Gastroenterology and Cardiology reported lower levels of activity for M3.

Outpatients (YTD) £0.8m behind plan -6.4%

Outpatient activity is behind plan for M3 and mainly relates to Ophthalmology, ENT and Urology. This is due to delays in completing the cashing up of clinics. Divisions have been reminded of the need to cash up clinics promptly.

A&E (YTD) £0.1m on plan 1.3%

A&E activity is continuing to grow with attendances in June 2019 being 7% higher than June 2018.

QIPP adjustment (YTD) £2.8m 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 £2.8m YTD over performance.

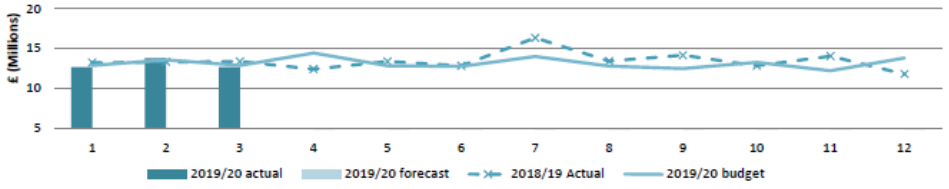
AIC Adjustment (YTD) £1.8m

The value of activity is currently £1.8m more than the AIC for Sussex CCGs.

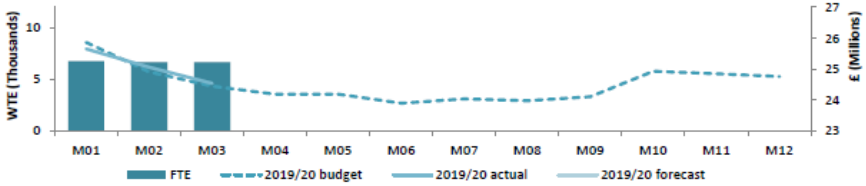
Expenditure & Workforce Summary - Month 3

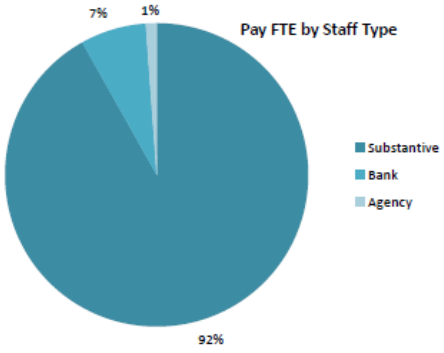
Cost Element	In Month								Year to Date				Forecast Outturn		
	18/19 WTE Actual	19/20 WTE Plan	19/20 WTE Actual	WTE Variance	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	19/20 Expenditure Variance (£k)	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	19/20 Expenditure Variance (£k)	19/20 Plan (£k)	19/20 FOT (£k)	Variance (£k)
Administrative & Management	1323	1381	1300	81	3,501	3,843	3,690	153	10,799	11,743	11,255	488	46,889	46,889	0
Ancillary	685	698	669	30	1,432	1,579	1,570	9	4,272	4,710	4,617	93	18,526	18,526	0
Medical	669	744	702	42	5,778	5,689	5,974	(285)	17,635	17,527	18,225	(698)	71,647	71,647	0
Nursing & Midwifery	3067	3140	3026	114	9,500	9,772	9,904	(132)	28,890	30,224	30,268	(44)	121,162	121,162	0
Prof, Scientific & Tech	523	528	501	27	1,662	1,830	1,693	137	5,201	5,575	5,189	385	22,157	22,157	0
Professions Allied to Medicine	445	541	463	78	1,501	1,886	1,633	253	4,512	5,604	5,011	593	22,466	22,466	0
Other	0	0	0	0	342	(153)	75	(228)	1,039	(168)	687	(855)	(8,714)	(8,714)	0
Total Pay	**6711**	**7032**	**6659**	**373**	**23,715**	**24,447**	**24,539**	**(92)**	**72,348**	**75,213**	**75,251**	**(38)**	**294,133**	**294,133**	**0**
Services from Other NHS Bodies					613	592	614	(22)	1,741	1,682	1,682	(0)	6,604	6,604	0
Clinical Negligence Premium					877	806	806	0	2,632	2,417	2,417	0	9,667	9,667	0
Consultancy					160	36	40	(4)	505	108	150	(42)	337	337	0
Drugs					647	335	589	(253)	2,740	2,557	2,432	126	9,950	9,950	0
Drugs - Tariff Excluded					3,078	3,171	3,119	51	8,140	8,374	8,685	(311)	34,770	34,770	0
Education and Training					46	190	59	132	238	583	120	464	2,426	2,426	0
Establishment Expenses					535	692	391	301	1,860	2,109	1,755	354	8,532	8,532	0
Premises					1,173	1,206	1,202	4	3,622	3,919	3,665	254	16,080	16,080	0
Purchase of Healthcare from Non NHS Bodies					505	506	508	(2)	1,393	1,518	1,541	(22)	6,077	6,077	0
Supplies and Services - Clinical					3,182	2,540	2,745	(205)	9,087	7,645	8,108	(463)	30,990	30,990	0
Supplies and Services - General					444	341	329	13	1,235	1,037	855	182	4,130	4,130	0
Other Non-Pay					1,556	1,838	1,715	123	4,771	5,551	5,985	(435)	20,971	20,971	0
Total Non-Pay					**12,816**	**12,253**	**12,116**	**137**	**37,965**	**37,499**	**37,393**	**106**	**150,533**	**150,533**	**0**
Total Expenditure	**6711**	**7032**	**6659**	**373**	**36,531**	**36,700**	**36,655**	**45**	**110,312**	**112,712**	**112,644**	**68**	**444,666**	**444,666**	**0**

Non-Pay Monthly Run rate



Pay Monthly Run Rate vs FTE





Summary & Next Steps

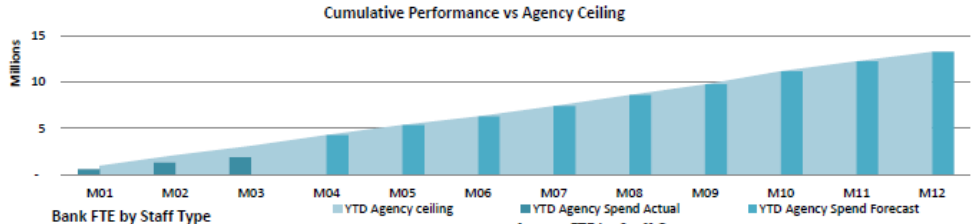
Medical pay is £0.7m overspent YTD (which includes waiting list initiative payments and agency covering vacancies), despite holding 42WTE vacancies. Variances in Other Pay is attributable to vacancy factors applied to various specialties with historically high levels of clinical vacancies, spend is due largely to apprenticeship levy payments. Nursing & midwifery is overspent by £44k YTD, largely due to nurse specialing being overspent by £169k YTD, this is partially offset by nursing & midewifery vacancies.

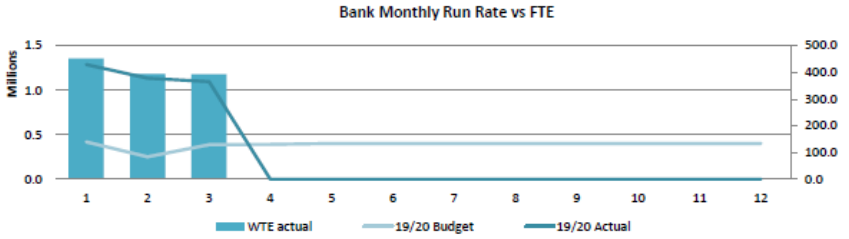
The non consolidated lump sum payment was made to AfC staff at the top of band in Month 1.

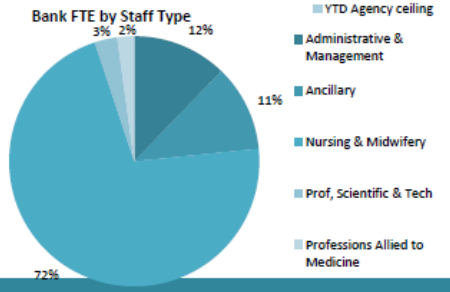
Tariff Excluded Drugs spend is showing £311k overspent, which is offset within Income. Supplies & services - Clinical is overspent in the month in line with non-elective activity overperformance.Drugs is £253k overspent in the month, £115k of this relates to biosimilars costs which are offset within contract income.

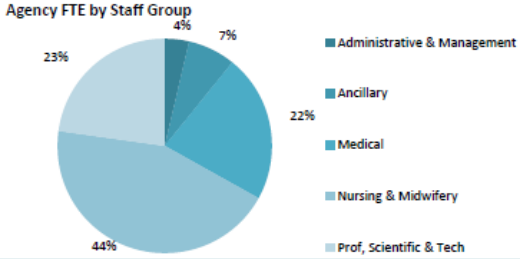
Temporary Workforce Summary - Month 3

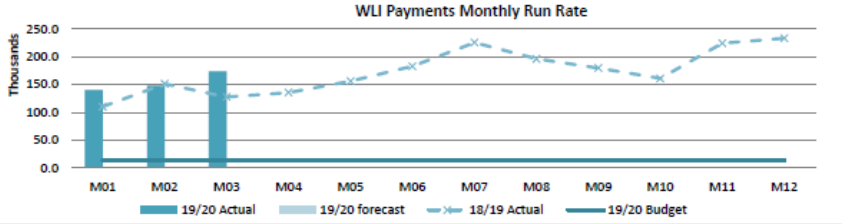
Cost Element	In Month								Year to Date				Forecast Outturn			
	18/19 WTE Actual	19/20 WTE Plan	19/20 WTE Actual	WTE Variance	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	Expenditure Variance (£k)	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	Expenditure Variance (£k)	19/20 Plan (£k)	19/20 FOT (£k)	Variance (£k)	
Agency																
Administrative & Management	5	3	3	0	(7)	54	65	(11)	314	164	185	(21)	601	601	0	
Ancillary	24	0	6	-6	72	54	45	9	185	164	99	65	601	601	0	
Medical	19	12	17	-5	269	308	230	78	1,028	942	875	67	3,336	3,336	0	
Nursing & Midwifery	41	0	34	-34	176	192	137	55	610	597	476	121	1,761	1,761	0	
Prof, Scientific & Tech	34	0	18	-17	187	212	81	131	650	650	239	411	2,444	2,444	0	
Total Agency	123	15	77	-62	697	819	558	261	2,787	2,517	1,876	641	8,743	8,743	0	
Bank																
Administrative & Management	63	5	48	-43	131	117	101	15	410	386	324	61	1,414	1,414	0	
Ancillary	62	22	44	-22	126	117	100	16	402	386	323	62	1,414	1,414	0	
Nursing & Midwifery	323	83	282	-198	887	819	826	(7)	2,976	2,726	2,644	82	8,302	8,302	0	
Prof, Scientific & Tech	14	0	11	-11	40	42	42	(0)	123	137	121	16	534	534	0	
Professions Allied to Medicine	8	12	9	3	25	27	25	2	94	94	103	(9)	211	211	0	
Total Bank	469	122	394	-272	1,210	1,121	1,094	27	4,003	3,728	3,515	213	11,874	11,874	0	
Total Locum	73	21	72	-52	923	832	870	(38)	2,920	3,011	2,766	245	10,895	10,895	0	
Total Waiting List Initiative	7	0	18	-18	128	14	174	(160)	389	41	463	(421)	165	165	0	
Total Temporary Workforce	672	157	561	-404	2,957	2,786	2,696	90	10,099	9,297	8,619	678	31,677	31,677	0	









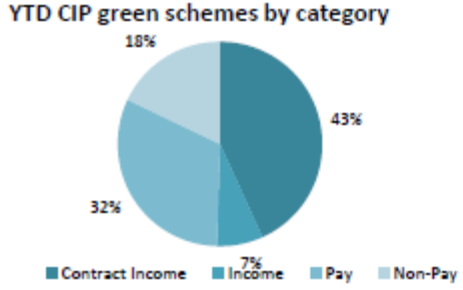


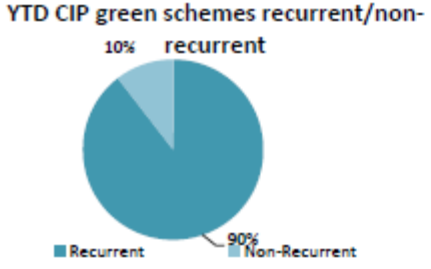
Summary & Next steps

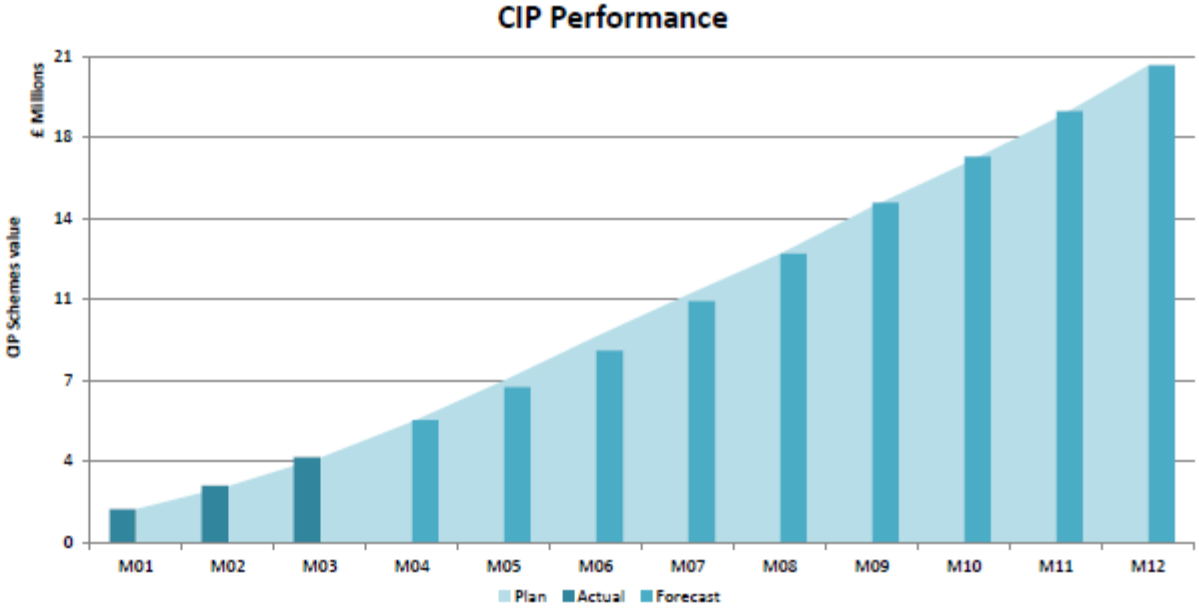
Overall agency is £641k below plan, this is due to a significant reduction in agency Allied Health Professionals compared to plan. Medical specialties which are heavily reliant on agency are neurology, rheumatology, pathology, general surgery, radiology and A&E. Agency spend in M3 has reduced by 33% compared to the previous financial year due to the shift towards using 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 are looking at alternative staffing models. YTD administrative and clerical agency has reduced by 41% compared to the same period in 18/19, some high cost agency staff remain on time limited contracts in corporate areas; HR, Clinical Admin and IT. Total temporary staffing costs have fallen by 15% compared to the previous year (£1.5m lower). The T3 pay process has been enhanced to strengthen the controls framework on premium pay. WLI pay continues to overspend and have deteriorated by £160k in the month, largely in nursing and medical, a new process for WLI approval has been developed in line with audit recommendations.

Cost Improvement Programme Summary - Month 3

Category	In Month			Year to Date			Forecast Outturn			YTD Rec (£k)	YTD Non-Rec (£k)
	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)		
Contract Income	555	530	-25	1,664	1,588	-76	5,594	5,526	-68	1,588	0
Income	84	147	63	251	268	17	965	788	-177	267	1
Pay	364	371	8	1,037	1,162	125	3,149	3,785	636	889	273
Non-Pay	224	187	-37	697	657	-40	4,555	3,899	-656	547	111
Total Identified Schemes	**1,226**	**1,235**	**9**	**3,650**	**3,675**	**26**	**14,264**	**13,997**	**-266**	**3,290**	**385**
Pipeline/Unidentified	0	0	0	0	0	0	6,338	6,605	266	90%	10%
Total	**1,226**	**1,235**	**9**	**3,650**	**3,675**	**26**	**20,602**	**20,602**	**0**		







Summary & Next Steps

In Month: The Trust has over delivered by £9k in month against a total plan of £1,227k.

YTD: The Trust has over delivered by £26k against a plan of £3,650k. The main underperforming schemes are Private Patents (£24k) an improvement since last month, Radiology Outsourcing (£104k), this is offset by non-recurrent savings on pay from vacancies and non-pay.

Forecast: The Trust is forecasting to achieve the £20.6m plan. Against the £14.3m identified 'Green' scheme plan the Trust is forecasting £14m, an adverse outturn of £0.3m. This adverse variance is mainly due to Radiology Outsourcing (£313k).

Finance Report Divisional Summaries - Month 3

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				9,268	9,318	50	27,975	26,621	(1,354)	115,348	115,348	0	YTD contract income underperformance is the key driver of YTD underperformance, largely in T&O and Urology EL and OP. Pay has underspent YTD, due to part implementation of Urology Investigation Suite in Months 1&2. One off year to date adjustments, due to CIP identifiaction and capitalisation of minor works, have caused the deterioration in non pay in the month.
Divisional Income				377	465	88	1,116	1,152	37	4,463	4,463	0	
Pay	1,741.62	1,630.48	111.14	(7,002)	(7,089)	(87)	(21,669)	(21,582)	86	(84,356)	(84,356)	0	
Non-Pay				(2,164)	(2,326)	(162)	(7,313)	(7,348)	(35)	(29,862)	(29,862)	0	
Overall	**1,741.62**	**1,630.48**	**111.14**	**479**	**368**	**(111)**	**109**	**(1,157)**	**(1,266)**	**5,593**	**5,593**	**0**	
Medicine													
Contract Income				9,223	9,857	633	27,908	28,278	371	114,902	114,902	0	Contract income is above plan due to increased NEL activity (£379k). Medical pay is overspent (£264k) due to overspends in Respiratory, Gastroenterology, Elderly Care & Cardiology. Special observations is £111k overspent. The cost of open escalation wards continue to deteriorate pay and non pay positions (£305k YTD).
Divisional Income				122	71	(51)	337	313	(24)	1,554	1,554	0	
Pay	1,468.52	1,402.27	66.25	(5,324)	(5,436)	(112)	(16,033)	(16,435)	(403)	(61,169)	(61,169)	0	
Non-Pay				(647)	(768)	(121)	(2,093)	(2,327)	(235)	(8,544)	(8,544)	0	
Overall	**1,468.52**	**1,402.27**	**66.25**	**3,374**	**3,724**	**349**	**10,119**	**9,829**	**(291)**	**46,743**	**46,743**	**0**	
Urgent Care													
Contract Income				2,541	2,589	49	7,597	7,736	139	30,662	30,662	0	A&E activity and income are above plan YTD. Pay is underspent by £81k YTD, of which £112k is in Nursing offset by overspends in Medical (£12k) and Admin and Ancilliary pay (£22k).
Divisional Income				33	35	2	99	99	0	394	394	0	
Pay	362.06	328.43	33.63	(1,415)	(1,477)	(62)	(4,670)	(4,589)	81	(19,792)	(19,792)	0	
Non-Pay				(48)	(40)	8	(211)	(217)	(6)	(911)	(911)	0	
Overall	**362.06**	**328.43**	**33.63**	**1,111**	**1,107**	**(3)**	**2,814**	**3,028**	**214**	**10,352**	**10,352**	**0**	
Out of Hospital Care													
Contract Income				3,545	3,622	78	10,364	10,519	155	42,456	42,456	0	Contract income is above plan YTD and includes £115k for biosimilars, which is offset by an overspend in non pay. Pay underspends are in Therapies, ESBT and MSK where investment has been received but posts have not yet been recruited to, a recruitment plan is in place to address vacancies.
Divisional Income				377	331	(46)	998	1,034	36	3,993	3,993	0	
Pay	1,072.34	986.01	86.33	(3,491)	(3,162)	329	(10,282)	(9,705)	577	(40,031)	(40,031)	0	
Non-Pay				(1,065)	(1,255)	(189)	(3,255)	(3,438)	(183)	(13,012)	(13,012)	0	
Overall	**1,072.34**	**986.01**	**86.33**	**(635)**	**(464)**	**172**	**(2,174)**	**(1,589)**	**585**	**(6,594)**	**(6,594)**	**0**	
Women's, Children's & Sexual Health													
Contract Income				3,850	3,719	(131)	11,413	11,703	289	47,023	47,023	0	Contract income over delivery of Health Visiting contract YTD is and activity in Paediatrics (non-elective) and Gynaecology (day case/elective). Divisional Income overperformance is attributable to secondments, which are ofset in Pay. Non pay overspends are due to continence products and glucose monitors, which are offset within income.
Divisional Income				60	79	19	158	276	118	680	680	0	
Pay	708.90	679.60	29.30	(2,809)	(2,752)	57	(8,492)	(8,441)	51	(32,968)	(32,968)	0	
Non-Pay				(250)	(209)	41	(841)	(767)	74	(3,011)	(3,011)	0	
Overall	**708.90**	**679.60**	**29.30**	**850**	**838**	**(13)**	**2,238**	**2,771**	**533**	**11,724**	**11,724**	**0**	
Estates & Facilities													
Divisional Income				754	813	59	2,255	2,425	170	9,067	9,067	0	Vacancies in Hotel Services, Ops & Maintenance and Laundry have led to the pay uderspend YTD, overperformance in income YTD is due to activity based income streams, e.g. car parking. Non pay underspends are largely due to laundry services.
Pay	724.79	690.73	34.06	(1,749)	(1,705)	44	(5,254)	(5,063)	191	(20,147)	(20,147)	0	
Non-Pay				(1,300)	(1,264)	36	(3,924)	(3,894)	30	(15,145)	(15,145)	0	
Overall	**724.79**	**690.73**	**34.06**	**(2,295)**	**(2,156)**	**139**	**(6,923)**	**(6,532)**	**391**	**(26,225)**	**(26,225)**	**0**	
Corporate													
Divisional Income				1,164	808	(356)	3,474	3,158	(317)	14,123	14,123	0	COIN income is below plan (£0.2m), 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 underspent against plan in the month.
Pay	953.69	933.87	19.82	(3,011)	(2,972)	39	(9,403)	(9,044)	360	(36,594)	(36,594)	0	
Non-Pay				(2,107)	(1,842)	265	(6,515)	(5,691)	823	(27,157)	(27,157)	0	
Overall	**953.69**	**933.87**	**19.82**	**(3,954)**	**(4,005)**	**(51)**	**(12,444)**	**(11,577)**	**866**	**(49,629)**	**(49,629)**	**0**	
Central													
Contract Income				3,077	1,904	(1,173)	8,221	8,227	6	33,193	33,193	0	Tariff exclusions income underperformance is offset entirely by non-pay underspends costs. The YTD adverse variance is due to identification of CIP in operational divisions requiring central phasing adjustments between Income, Pay and Non-Pay in order to ensure alignment to NHSI plan (this will net off in M12). This division also contains the value of the YTD AIC adjustment, which is the value of the difference between activity priced on PBR and the value of the AIC.
Divisional Income				713	1,391	678	3,950	5,770	1,819	23,925	23,925	0	
Pay	0.00	7.68	(7.68)	354	54	(301)	589	(392)	(981)	923	923	0	
Non-Pay				(5,274)	(4,966)	307	(15,154)	(15,444)	(290)	(60,130)	(60,130)	0	
Overall	**0.00**	**7.68**	**(7.68)**	**(1,129)**	**(1,618)**	**(489)**	**(2,393)**	**(1,839)**	**554**	**(2,089)**	**(2,089)**	**0**	
Donated assets adjustment				**0**	**13**	**13**	**0**	**(1,562)**	**(1,562)**				
Total	**7,031.92**	**6,659.07**	**372.85**	**(2,199)**	**(2,194)**	**5**	**(8,653)**	**(8,628)**	**25**	**(10,125)**	**(10,125)**	**0**	

Statement of Financial Position - Month 3

	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	225.6	229.4	229.4	229.4		0.0
Intangible Assets	1.9	1.9	1.8	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**	**229.2**	**233.1**	**233.1**	**233.1**		**0.0**
Inventories	6.8	6.7	6.7	6.7	6.7	6.7		0.0
Trade and Other Receivables	19.7	29.6	24.8	29.6	29.6	29.6		0.0
Cash and Cash Equivalents	2.1	2.1	11.5	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	**28.6**	**38.5**	**43.1**	**38.5**	**38.5**	**38.5**		**0.0**
Trade and Other Payables	(23.2)	(7.3)	(33.9)	(7.3)	(7.3)	(7.3)		0.0
Borrowings	(59.2)	(1.1)	(60.2)	(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)	(1.2)	(2.2)	(2.2)	(2.2)		0.0
Current Liabilities	**(84.3)**	**(11.1)**	**(95.7)**	**(11.1)**	**(11.1)**	**(11.1)**		**0.0**
Borrowings	(143.6)	(242.4)	(155.6)	(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)	(238)	(242)	(242)	(241.8)		0
Revaluation Reserve	98	94	98	94	94	94.5		0
Total Tax Payers Equity	**25.9**	**15.9**	**18.9**	**15.9**	**15.9**	**18.9**		**0.0**

Summary & Next Steps

1. Minimum cash balance of £2.1m achieved 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 3

Short Term (13 week) Cashflow Forecast

	Actual (£k)				Forecast (£k)								
Week Ending (Friday)	07-Jun	14-Jun	21-Jun	28-Jun	05-Jul	12-Jul	19-Jul	26-Jul	02-Aug	09-Aug	16-Aug	23-Aug	30-Aug
Balance Brought Forward	**10,885**	**10,188**	**35,970**	**26,926**	**11,674**	**8,909**	**5,704**	**25,667**	**10,677**	**6,391**	**3,673**	**34,650**	**9,665**
Receipts													
WGA Income	939	29,005	1,704	412	566	989	31,493	152	122	122	30,525	122	122
Other Income	1,405	289	183	260	513	214	1,814	1,533	168	168	1,721	468	1,187
External Financing	0	0	3,321	0	0	0	2,549	0	0	0	2,673	0	0
Total Receipts	**2,343**	**29,295**	**5,207**	**673**	**1,079**	**1,203**	**35,856**	**1,685**	**290**	**290**	**34,919**	**590**	**1,309**
Payments													
Pay	(258)	(239)	(10,229)	(13,424)	(358)	(270)	(10,170)	(13,585)	(270)	(270)	(270)	(23,485)	(270)
Non-Pay	(2,782)	(3,269)	(3,618)	(2,500)	(3,486)	(4,138)	(5,080)	(3,090)	(4,306)	(2,738)	(3,094)	(2,090)	(2,090)
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	(1)	(4)	(405)	(0)	0	0	(643)	0	0	0	(577)	0	0
Total Payments	**(3,041)**	**(3,512)**	**(14,252)**	**(15,925)**	**(3,843)**	**(4,408)**	**(15,893)**	**(16,675)**	**(4,576)**	**(3,008)**	**(3,942)**	**(25,575)**	**(2,360)**
Net Cash Movement	**(697)**	**25,782**	**(9,045)**	**(15,252)**	**(2,764)**	**(3,205)**	**19,963**	**(14,990)**	**(4,286)**	**(2,718)**	**30,977**	**(24,985)**	**(1,051)**
Balance Carried Forward	**10,188**	**35,970**	**26,926**	**11,674**	**8,909**	**5,704**	**25,667**	**10,677**	**6,391**	**3,673**	**34,650**	**9,665**	**8,614**

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 Developmen	2,000	Dec 09	20	4.00%	1,167	41
Capital Loan 3 - Endoscopy Developmen	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
Loan May 2019	4,603	May 19	3	3.50%	4,603	83
Loan June 2019	3,321	Jun 19	3	3.50%	3,321	56
Current Year Total	**12,019**				**12,019**	**212**
Total Loans	**216,499**				**214,081**	**7,485**

Summary & Next steps

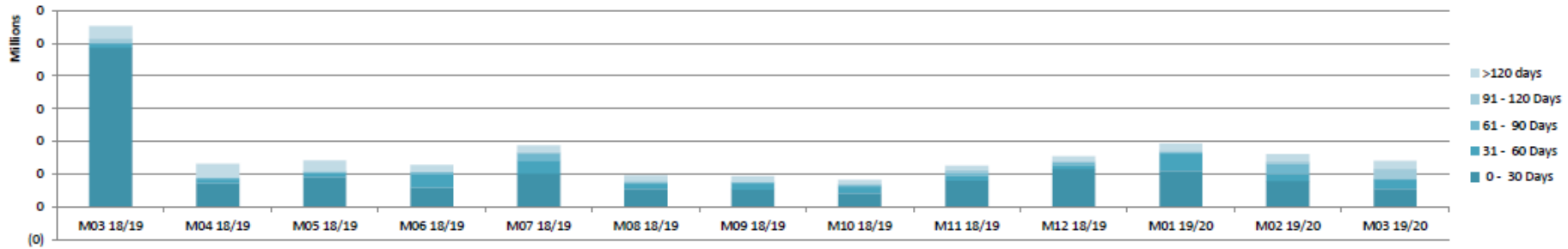
1. All existing loans are listed in the table on the left.

2. Trust is part of a NHSI pilot on restructuring historic debt. This work is progressing and is currently focusing on 6% loans and obtaining emergency capital funding via a PDC route.

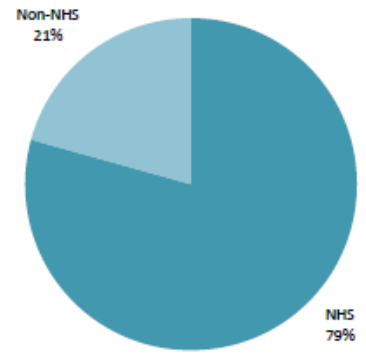
Receivables Summary - Month 3

Receivables Aging Run rate (£k)

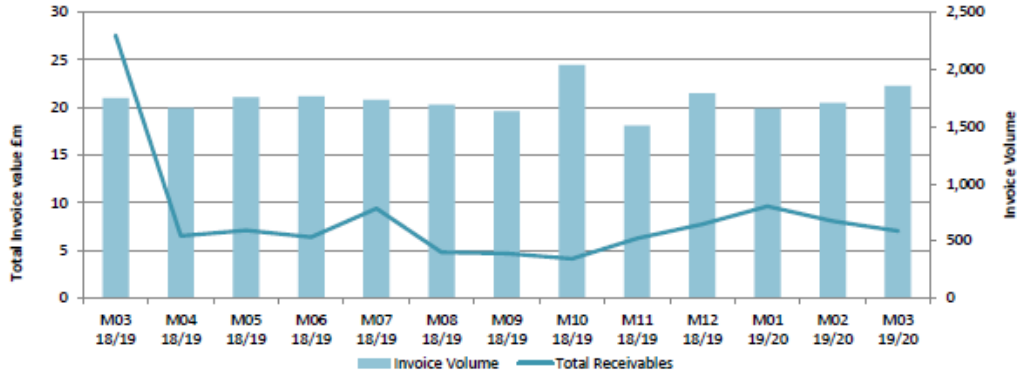
Aging Profile	M03 18/19	M04 18/19	M05 18/19	M06 18/19	M07 18/19	M08 18/19	M09 18/19	M10 18/19	M11 18/19	M12 18/19	M01 19/20	M02 19/20	M03 19/20
0 - 30 Days	24,337	3,630	4,559	2,924	5,070	2,765	2,639	2,093	4,038	5,807	5,525	3,972	2,765
31 - 60 Days	696	566	685	2,033	1,918	894	910	896	786	600	2,602	1,005	1,418
61 - 90 Days	(44)	273	161	369	1,248	147	238	406	464	307	305	1,674	182
91 - 120 Days	618	(71)	100	95	131	321	101	101	352	251	270	279	1,402
>120 days	1,963	2,111	1,586	988	1,021	698	783	620	632	774	938	1,153	1,286
Total Receivables	**27,572**	**6,508**	**7,091**	**6,408**	**9,389**	**4,825**	**4,670**	**4,116**	**6,272**	**7,739**	**9,639**	**8,083**	**7,052**
Invoice Volume	**1,749**	**1,660**	**1,752**	**1,761**	**1,732**	**1,688**	**1,632**	**2,037**	**1,508**	**1,788**	**1,655**	**1,705**	**1,852**



Current Month % NHS vs Non-NHS by Value



Receivables Invoice Value vs Volume Run Rate

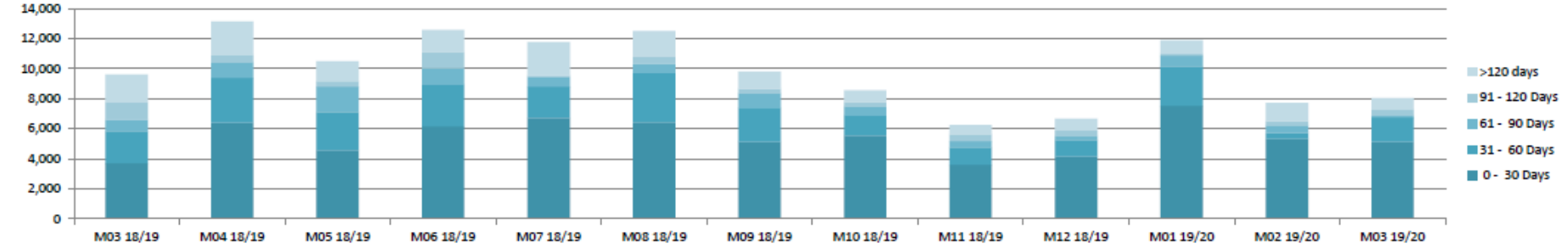


1. Overall debt reduced from May to June by £1.0m.
2. A movement in total aged debt (> 31 days) by £0.2m in month.
3. Adverse movement in over 90 day debt of £1.3m in month.
4. Improvement in debtor days in month, 23 days in June (24 days in May).
5. 1,852 invoices on the sales ledger system at the end of the month (an increase of 147 in month).

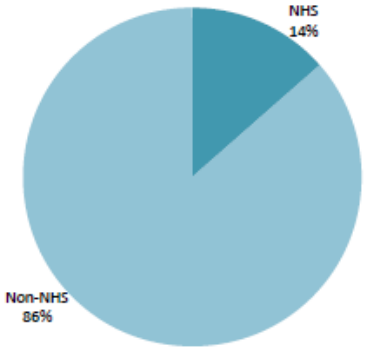
Payables Summary - Month 3

Payables Aging Run rate (£k)

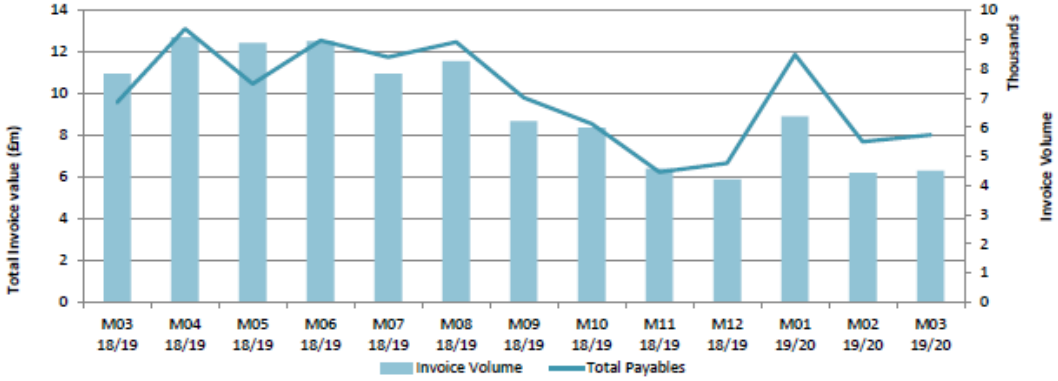
Aging Profile	M03 18/19	M04 18/19	M05 18/19	M06 18/19	M07 18/19	M08 18/19	M09 18/19	M10 18/19	M11 18/19	M12 18/19	M01 19/20	M02 19/20	M03 19/20
0 - 30 Days	3,711	6,387	4,552	6,153	6,708	6,410	5,109	5,530	3,611	4,151	7,517	5,324	5,133
31 - 60 Days	2,117	3,002	2,547	2,774	2,102	3,301	2,245	1,338	1,135	1,093	2,612	396	1,603
61 - 90 Days	766	1,039	1,703	1,099	599	600	986	629	442	253	735	494	133
91 - 120 Days	1,148	452	366	1,078	124	459	301	258	386	378	108	277	380
>120 days	1,854	2,249	1,315	1,464	2,233	1,725	1,169	806	675	801	909	1,217	788
Total Payables	**9,596**	**13,129**	**10,484**	**12,568**	**11,765**	**12,494**	**9,810**	**8,561**	**6,249**	**6,675**	**11,881**	**7,710**	**8,037**
Invoice Volume	**7,829**	**9,092**	**8,889**	**8,947**	**7,830**	**8,266**	**6,209**	**5,975**	**4,580**	**4,204**	**6,373**	**4,425**	**4,512**



Current Month % NHS vs Non-NHS by Value



Payables Invoice Value vs Volume Run Rate



1. Slight adverse movement in total creditors in month of £0.3m. Movement increases creditors to £8.037m in June.
2. Creditor days remains constant at 83 days in month (83 days in May).
3. Internal KPIs to target elimination of registered > 120 days and creditor days < 60. Balances that are aged and not ready for payment reflect high levels of invoices that are received without a valid purchase order number.
4. 4,512 invoices on the purchase ledger system at the close of the month (slight increase of 87 on May).

Capital Programme Summary - Month 3

YTD Capital Programme Performance	ORIGINAL PLAN £000	REVISED PLAN £000	YTD PLAN £000	CRG COMMITTED £000	ACTUAL EXPENDITURE £000	VARIANCE TO PLAN £000
Brought Forward	**6,715**	**6,401**	**1,600**	**5,543**	**2,138**	**538**
Backlog Maintenance	1,050	1,073	268	411	49	(219)
Central/Divisions	290	290	73	0	0	(73)
Digital	1,701	1,690	423	1,444	328	(95)
Estates	202	256	64	178	0	(64)
Medical Equipment	1,351	832	208	824	282	74
Finance	1,500	1,500	375	1,500	546	171
Unplanned urgents	339	396	99	68	0	(99)
Brought Forward - other	0	160	40	160	160	120
Total Owned	**13,148**	**12,598**	**3,150**	**10,128**	**3,503**	**354**
Donated	1,000	1,000	250	1,809	1,809	1,559
Less donated Income	(1,000)	(1,000)	(250)	(1,809)	(1,809)	(1,559)
Less disposals					0	0
Total	**13,148**	**12,598**	**3,150**	**10,128**	**3,503**	**354**
Year End Forecast					**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 Capital Resource Limit (CRL) for 2019/20 is now £12.5m.
2. The Capital Resource Group (CRG) meets on a monthly basis to monitor levels of capital expenditure and review progress against the CRL.
3. After the first quarter, the capital programme has an overplanning margin that will be managed by the CRG.


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

System Reform and Integrated Partnerships

Meeting information:			
Date of Meeting:	6th August 2019	Agenda Item:	9H
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?	No

Summary:

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

Significant progress is being made in discussions about the development of the STP – which will now formally become the Sussex Health and Care Partnership. Plans are being drawn up for the development of the three 'places' - West Sussex, Brighton & Hove, East Sussex - to develop Integrated Care Providers alongside a strategic commissioning function in each place, recognising that the ICPs will incorporate primary care and provider functions of local authorities.

The attached presentation provides an overview of ICPs and quarter two plans for each 'place'

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

Executive Team

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

The Board are asked to review and note the progress.

System Reform

Problem Statement

"The pace of delivering the transformation required to address the needs of a growing and ageing population has slowed."

- Shortage of staff in key areas
- Absence of real terms funding increases
- CCG/LA relationships not strong enough
- Patients still experience fragmented care
- Gradual deterioration in outcomes
- Significant health inequalities

System Reform Principles

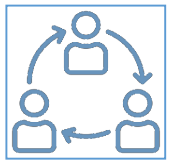
Co-produce solutions alongside citizens, communities, & staff, with unrelenting focus on health, well-being & prevention as means of improving outcomes & driving sustainability.

Design new ways of working with local authorities to commission for population health & care outcomes, which address the wider determinants of health.

Empower providers to plan & deliver health & care that is aligned to needs of local population, allowing localities to progress according to local need and readiness.

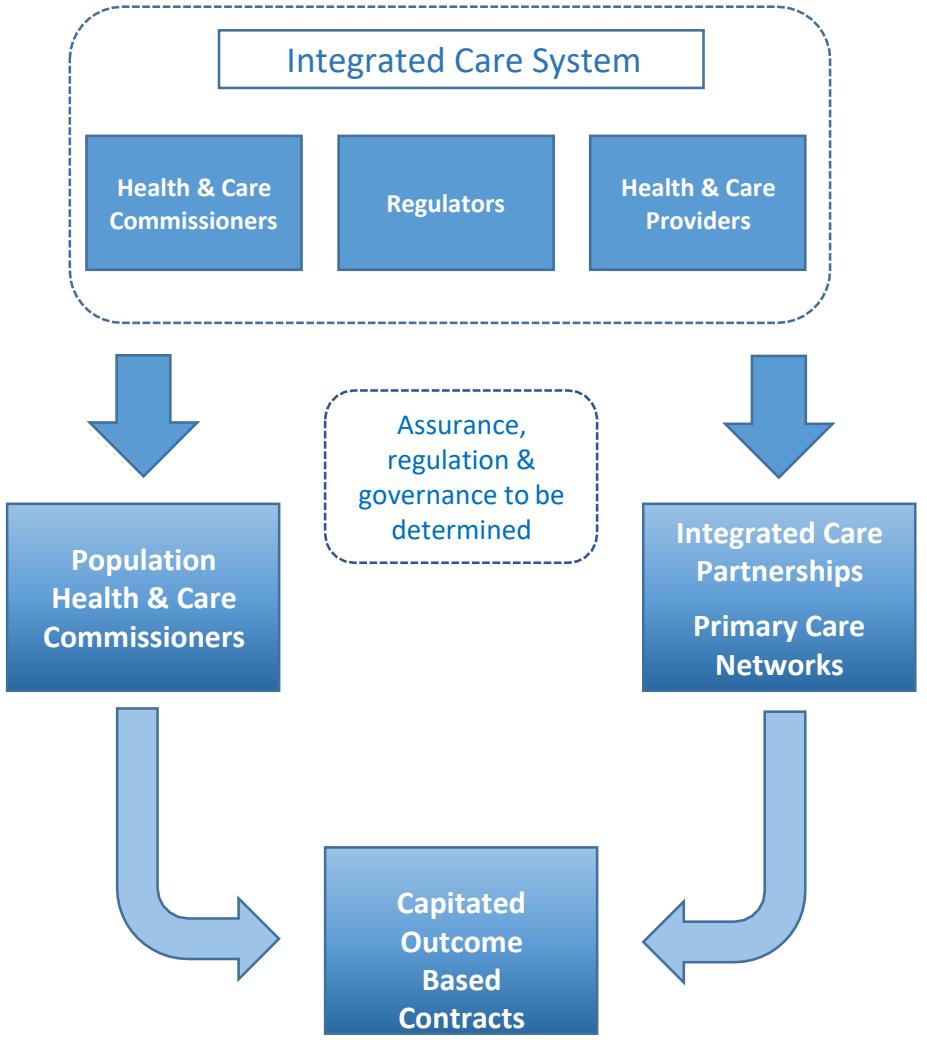
Harness the great work that is already under way & use experience and evidence as a means of driving successful change across Sussex and East Surrey.

Incorporate a robust and transparent process, sharing data and information where this does not represent commercial conflict.



Through collaboration, clear roles and responsibilities for delivery, hold each other to account for the delivery of system reform.

Conceptual System Reform Model



Population Health Commissioning

Contributors to Health Outcomes

Health Behaviours 30%
Smoking 10%
Diet/Exercise 10%
Alcohol use 5%
Poor sexual health 5%

Socioeconomic 40%
Education 10%
Employment 10%
Income 10%
Family/Social Support 5%
Community Safety 5%

Clinical Care 20%
Quality of Care 10%
Access to Care 10%

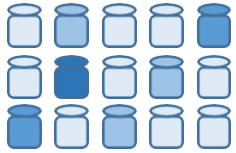
Built Environment 10%
Environmental quality 5%
Built environment 5%

Population Health Management

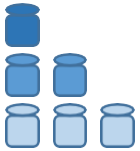
Dynamic & in depth understanding of population need, required to identify & address health inequalities, and to stratify and segment populations to prioritise support which can improve outcomes for individuals, communities & whole populations.

Define
Population Identification

Assess
Health Assessment



Stratify
Risk stratification/Segmentation



Engagement
Working with populations, communities & individuals to collaborate on needs assessment, co-design outcomes and co-produce solutions alongside ICPs.

Partnership Working
Communities & partner agencies working together with health & care around PCNs to address wider determinants of health (i.e. income, housing, environment, transport, education, work and nutrition).

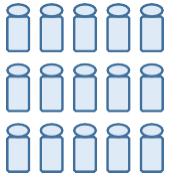
Outcomes Based Commissioning
Focus on collation, selection, & commercialisation of metrics which are able to measure health & care inequalities, the well-being of the population, experience of care, quality, & per capita cost.

Capitated Payment Systems
Risk adjusted lump sum payment per patient made to ICPs to cover the majority (or all) of the care provided to a specified population across different care settings.

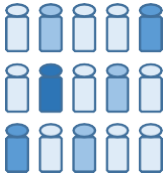
Contracting
Longer term contracts to support the setting of outcomes, that may take some years to show improvements and an evolution of contracts management to focus on population health & assurance for delegated functions to ICPs.

SES Outline Population Health Model

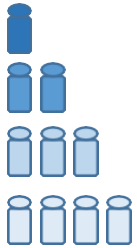
Define
Population Identification



Assess
Health Assessment



Stratify
Risk stratification/Segmentation



Engage individuals & communities

Outcomes Development

Design & Collation
Process of local engagement & literature review to identify what service users value and how health and care services can help them achieve their ambitions and goals.

Indicator Selection Mapping long-list of indicators to outcome statements, covering whole pathway of care, combining existing and new measures and reflecting different population groups or segments.

Commercialisation
Prioritising & weighting indicators, confirming baseline performance & considering performance trajectories for the duration of a contract.

Risk-adjusted, capitated budget

Long term value based contract

Payment model aligned to outcomes

Population Focus

Organisations working together to improve outcomes across a whole population as well as targeting specific interventions on the most deprived populations.

- Population-level data to understand need across populations & track outcomes
- Population-based budgets (either real or virtual) to align financial incentives with improving population health
- Community involvement in managing their health and designing local services

Segmented Care

Different strategies for different segments of the population, depending on need and level of health risk.

- Segmentation and risk stratification to identify the needs of different groups within the population
- Targeted strategies for improving the health of different population segments
- Developing 'systems within systems' with relevant organisations, services and stakeholdersto focus on different aspects of population health.

Individual Health

Aimed at improving health of individuals with emphasis on prevention & self management.

- Integrated health records to co-ordinate people's care services
- Scaled-up primary care systems that provide access to a wide range of services and co-ordinate effectively with other services
- Close working across organisations and systems to offer a wide range of interventionsto improve people's health
- Close working with individuals to understand the outcomes and services that matter to them, as well as supporting and empowering individuals to manage their own health.

Population Health & Care Commissioner → **Integrated Care Partnership**

Defining an ICP

What is an ICP?

Alliance of "Sovereign" Providers
Including local authorities, acute hospital trusts, community providers, PCNs & mental health providers.

Contracted to Deliver End to End Health & Care
Making resource allocation decisions for the registered population.

Deploys PCNs as Basis of New Models of Care
Hosting integrated care teams across system with LA & voluntary sector engagement, supported by easy access to secondary care expertise.

A Focus on Addressing Health Inequalities
Through effective integrated care & embedding citizens in decision making & delivery to improve outcomes for the population.

Using Population Health Management Tools
Will have whole population stratification in place & will be able to anticipate health & care needs ahead of time, to help prevent need for medical treatment where possible.

Commissioned to Deliver Outcomes
With contract of at least 10 years in length & accountable for sub-contracting services within ICP but not directly provided by partner organisations.

What will an ICP do?

Integrate Provision & Address Health Inequalities
Co-ordination of self care activity, care planning & management, integration of care records, public & patient navigation, population education & partnerships to address wider determinants of health.

Model Care Delivery
Develop operational plans & joint programmes of work, manage & plan demand & capacity, optimise whole system pathways, & allocate resources against delivery of contracted outcomes.

Manage & Evaluate Quality & Performance
Managing regulatory compliance of partners & services, safeguarding, system wide quality surveillance, and ensuring delivery of constitutional standards.

Provide a Range of System Wide Functions & Services
Best delivered on an ICP footprint, such as medicines optimisation, clinical training & education, & emergency planning.

What will an ICP deliver?

1. Improved personal wellbeing
2. Increased confidence of people to take responsibility for their own health, and greater public confidence in the urgent care service
3. Increased proportion of people having a positive experience of care; more people experiencing services as being 'joined up'
4. Improved mental and physical health outcomes

5. More care delivered at home or in the community, resulting in reduced hospital utilisation and reduced rate of permanent admissions to residential/nursing care homes
6. Stabilised general practices
7. Reduced demand on primary care through prevention and social prescribing, and a sustainable model of primary care, with more time for GPs to spend with people with chronic conditions.
8. Seamless pathways across primary and secondary care

9. Reduced annual costs per head of population
10. Simplified planning, prioritisation and decision making, with reduced transaction costs

11. Greater staff satisfaction, staff confidence and teamwork

Shaping the ICP at Place

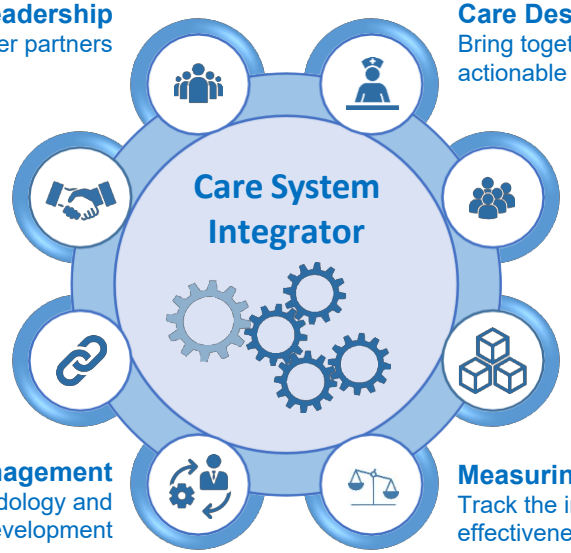
Population Health & Care Commissioner
Long term, Capitated, Outcomes Based Contract

Partnership Agreement

Integrated Care Partnership

Primary Care Networks | NHS Acute Provider(s) | NHS Community Services Provider(s) | NHS Mental Health Services Provider(s) | Local Authority Provision

Integrated Care Partnership Board



Leadership
Provide system leadership to bring together provider partners

Care Design
Bring together local providers around the specific priorities for actionable & tangible population health improvements

Partnership Development
Ensure the partnership is truly cross sector and maximises the opportunity for provider partners to contribute and feel valued in the partnership

Resource Deployment
Identify & deploy shared resources to invest in the supporting structures and capabilities needed to enable transformation

Governance & Support
Establish and maintain the governance and support service networks that will be essential to the range of services in scope as they grow and integrate

Building Blocks
Building the infrastructure for integration to achieve local population health improvement goals, including data, estate etc

Programme Management
Putting in place a change management methodology and infrastructure underpinning service development

Measuring Success
Track the impact of the incremental change in delivery, adjust to improve effectiveness, and augment as resources and local confidence permit

ICP Associates: Ambulance | Districts & Boroughs | Education | Police & Criminal Justice | Vol. Sector

Sub contracted Services: Ind. Sector | Patient Transport | Other NHS Providers | I.T. & Estates | CSU

Shaping the Footprints for ICPs

Population Size
Projected population meets recommended levels at 250k to 500k

Patient Flow
Volume of patients receiving treatment with specific secondary care provider(s)

Partner Alignment
Alignment of potential partners to community or population

Existing Partnerships
Pre-existing formal or informal arrangements for joint working

Shared Values & Ambition
Alignment of strategic intent & purpose between organisations

Communities Alignment
Alignment of communities to specific geography and/or each other

Demographic Alignment
Alignment of health & care needs and/or population characteristics

Resilience & Resource
Capacity of groups of organisations to support resource required for effective partnership working

Emerging ICP Footprints

	Coastal West Sussex	East Sussex	South
Primary Care	**Primary Care Networks*** 46 practices 10 PCNs 520k population	**Primary Care Networks*** 55 practices 10 PCNs 495k population	**Primary Care Networks*** 53 practices 12 PCNs 502k population
Acute	**Western Sussex Hospitals**	**East Sussex Healthcare**	**Brighton and Sussex University Hospitals**
Community	**Sussex Community**	**Sussex Community** **East Sussex Healthcare**	**Sussex Community**
Mental Health	**Sussex Partnership**	**Sussex Partnership**	**Sussex Partnership**
Social Care	**West Sussex CC**	**East Sussex CC**	**Brighton & Hove CC** **East Sussex CC** **West Sussex CC**

* estimated numbers of practices, PCNs and population size. To be confirmed at place.

Key Partnership Enablers

1

Finance & Contracting

Develop a finance & contracting framework which provides clear incentives for providers to design and develop partnerships locally & outcomes against which each place can set meaningful plans for change

2

CCG Future Operating Model

Ensure alignment of the CCG Future Operating Model to the distribution of resources locally to support the development of partnership working and, ultimately, the establishment of ICPs

3

Leadership

Secure local leadership and a partnership agreement around delivery of the 19/20 Business Plan, the ambition for ICP development, and governance of programmes to support integrated care and population health

4

Local Authority Partnerships

Strengthen engagement with LA partners for integration of care and population health & care commissioning

5

Building Blocks for Integration

STP wide framework for delivery of shared clinical record, population data, risk stratification in support of PCNs & ICPs

6

Communicate

Develop a framework to ensure ongoing engagement with communities, staff and other stakeholders with regard to the impact of integration on care & supporting a co-design approach to the development of services.

Quarter 2 Priorities - the STP ask for each place

1 Delivering 19/20

Delivery plan for 19/20 focused on the key themes for transformation; ensuring management of place-based control total; & establishing provider guided risk share approach

2 Leadership

Constitute interim ICP Board; appoint SRO & programme management team; & establish clinical/professional leadership group to drive design & delivery of integrated care model

3 A Plan

A plan for establishing partnership working against an agreed maturity index, with clear timescales for delivery and a framework for engagement with communities, staff and primary care

4 Partnership Agreement

Develop proposal for each place which sets out the commitment of boards & governing bodies for all participating organisations to establish new ways of working & deliver better outcomes for populations

Clinical Negligence Scheme for Trusts (CNST)

Meeting information:			
Date of Meeting:	6th August 2019	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Brenda Lynes-O'Meara/ Emma Chambers

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

NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year one, the scheme incentivises ten maternity safety actions (as described in this report). Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten out of ten threshold will not recover their contribution to the CNST incentive fund, but may be eligible for a small discretionary payment from the scheme to help make progress against actions they have not achieved.

This report provides confirmation that ESHT (Women, Children and Sexual Health Division) have met the criteria for all ten safety actions in line with guidance provided by NHS Resolution. Each safety action with criteria is set out within this report; further evidence is stored within a secure database, available for review upon request.

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

Reviewed by:

- Governance and Accountability Meeting 14 June 2019
- Internal Performance Review 19 June 2019
- Quality and Safety Committee 25 July 2019.

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

The Board is asked to approve the submission of the Trust's compliance with the ten safety actions set out within the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme.

INTRODUCTION
ESHT have reviewed its compliance against the CNST and confirm compliance against all Safety actions currently as listed within this report.

Safety action 1
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

ESHT confirm that we achieve the required Safety action;
We have embedded the NPMRT tool into their Governance arrangements; this process has been in place since January 2018.

In line with the required standard:

ESHT confirm that a review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) have occurred from Wednesday 12 December 2018 and have been started within four months of each death.

That at least 95% of all deaths of babies who were born and died within ESHT (including any home births where the baby died) from Wednesday 12 December 2018 have been reviewed, by ESHT's multidisciplinary review team (professional review), that each review completed generated a draft report, within four months of each death.

In 95% of all deaths of babies who were born and died within ESHT (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought in line with ESHT Duty of Candour. Quarterly reports have been submitted to the trust Board this includes details of the deaths, this data is added to the Women and Children's Governance report on a quarterly basis.

Safety action 2
Are you submitting data to the Maternity Services Data Set to the required standard?

These Safety action requirements are set out below. 1-3 of the mandated categories must be met and 14 of 19 optional categories must be met by trusts.

ESHT can confirm we have met the mandated standards 1, 2 and 3. ESHT meet 17 of the 19 optional criteria as set out below, we do not currently meet criteria 6 or 8. MSDSv2 must be submitted by the end of June, ESHT confirm submission of this data.

Assessment to cover January 2019 data submitted for the deadlines of March 2019, one criteria relates to data between October 2018 and March 2019, submitted to deadlines December 2018 - May 2019, and one around MSDSv2 data for April 2019 being submitted to the deadline of June 2019.

Mandatory categories 1-3 must be met to pass Safety action 2

1. January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood)
2. MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales
3. Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019

14 of the 19 optional categories 4-22 must be met to pass Safety action 2

4. Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019
5. January 2019 data contained valid smoking at booking for at least 80% of bookings
6. January 2019 data contained valid smoking at delivery for at least 80% of births
7. January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank)
8. January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511

(unless justifiably blank)

9. January 2019 data contained method of delivery for at least 80% of births
10. January 2019 data contained valid baby's first feed for at least 80% of births
11. January 2019 data contained valid in days gestational age for at least 80% of births
12. January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded
13. January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded
14. January 2019 data contained valid place type actual delivery for at least 80% of births
15. January 2019 data contained valid site code for at least 80% of births
16. January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births
17. January 2019 data contained valid Apgar score at five minutes for at least 80% of births
18. January 2019 data contained valid Apgar score at five minutes for at least 80% of births
19. January 2019 data contained valid birth weight for at least 80% of births
20. January 2019 data contained valid figure for previous live births for at least 80% of bookings
21. MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance
22. January 2019 data contained valid (including "Not Stated") ethnic category (Mother) for at least 80% of bookings.

Safety action 3
Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

ESHT confirm that we achieve the required Safety action;
Pathways of care for admission into and out of transitional care have been jointly approved by both maternity and neonatal teams with neonatal involvement in the decision making and the planning care for all babies in transitional care. Babies receive care on the postnatal ward through a dedicated transitional care team, who are part of the SCBU team.

A data recording process for transitional care is fully established within ESHT through our Badgernet system, enabling us to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.
ESHT have an action plan which has been discussed and agreed at Board level (IPR) and with our Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.
d) Progress with the agreed action plans has been shared at both Maternity Board and the Women and Children's Internal Performance Meeting and our LMS & ODN.

ESHT continue to asses our transitional care provision, in line with ATAIN, a brief overview below identifies current activity;

- Work with the South East Coast Neonatal Operational Delivery Network who provide graphs, data and statistics for our Trust. These are discussed at the ATAIN meetings (see below).
- All term admissions to the Neonatal unit are put onto "Datix" (incident reporting system) and investigated jointly by maternity and neonatal staff to establish if the admission was avoidable/unavoidable. This is discussed at the daily Risk meeting held by Maternity with Neonatal attendance.
- ATAIN (Avoiding Term Admissions into Neonatal Units) leads have been identified- Consultant Obstetrician, Paediatrician and Midwife and Neonatal Nurse.
- Regular ATAIN meetings are held. TOR's available
- When babies are reviewed at ATAIN, included is a discussion about whether the baby could have been cared for as T/C as opposed to a full SCBU admission.

- Regular presentations and display of information updating staff with ESHT's results
- ATAIN e-learning package available to all neonatal and midwifery staff
- There is a new guideline for Hypoglycaemia and related teaching
- There is a new flowchart for hypothermia and related teaching for the prevention of hypothermia.
- Enhanced training to midwives regarding babies with jaundice in order to care for these babies on the post-natal ward.
- Review of the induction pathway with identified improvements now in place.
- Designated midwife for caesarean sections to ensure these are always undertaken appropriately.
- "Bobble Hat Care Package" which aims to identify babies at risk.

Safety action 4
Can you demonstrate an effective system of medical workforce planning to the required standard?

ESHT confirm that we achieve the required Safety action;
ESHT hold a formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question:
'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, the Obstetrics and Gynaecology department produced a plan to address lost educational opportunities due to rota gaps. The main issue was a shortage of middle grades which has now improved; the most recent survey is showing significant improvement (data available).

The proportion of trainees are recorded at Board level (led by the Medical Director) the action plan to address lost educational opportunities is signed off by the medical director at Board level and a copy submitted to the Royal College of Obstetricians and Gynaecologists.

ESHT confirm they meet the criteria below:
Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff

2.6.5.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident
2.6.5.2 A separate anaesthetist is allocated for elective obstetric work
2.6.5.3 Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies
2.6.5.4 Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)
2.6.5.5 There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit)
2.6.5.6 The duty anaesthetist for obstetrics attends hand over meeting daily

Safety action 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

ESHT confirm that we achieve the required Safety action;
A systematic, evidence-based process is used to calculate midwifery staffing establishment this was last completed in April 2018 using Birthrate+.

The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) this enables oversight of all birth activity in the service.
Women cared for within ESHT's delivery suite receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on).

ESHT provide a Bi-annual report that covers staffing/safety issues is submitted to the Trust Board (Maternity Board and IPR), this includes planned versus actual midwifery staffing levels, with an action plan to address findings.

Safety action 6
Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

ESHT confirm that we achieve the required safety standard;
The division provide board minutes (Maternity Board) demonstrating that the Saving babies Lives (SBL) bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place (Board minutes available). Most elements are fully met.

In reference to element 2 of the Saving Babies' Lives care bundle, compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. The Women and Children's division uses the SBL recognised risk assessment pathway.

The Women and Children's division can confirm that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians who are trained in their use. All staff are assessed and competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated.

Safety action 7
Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

ESHT confirm that we achieve the required Safety action;

ESHT has strong feedback mechanisms ranging from online platforms to user forums to allow for the continuous improvement of maternity services and to enhance the experience of its patients.
One mechanism used is the (Maternity Voices Partnership) MVP which includes staff and service users, and managed by the CCG. The forum is active at both the EDGH and the Conquest Hospital.

Meetings are held quarterly and chaired by a lay co-chair. There is a formal agenda, a programme and minutes are circulated after each meeting (available on request). The discussions in these meetings involve initiatives and improvements currently being undertaken at ESHT. User representative group members provide periodic feedback from women and their families direct from their postnatal groups. This is shared and actioned at the Midwifery Senior Group (MSG) which includes a mix of senior management, clinical and specialist midwives. Members from the MSG attend the MVP to provide a feedback loop about any improvements that are being made.

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

The Friends and Family Test is another mechanism that has been embedded into the service to drive improvement. The results are shared amongst all staff through team meetings by the Matrons as a regular

agenda item. Any issues are discussed and an atmosphere of learning has been developed to allow for fast action and mitigation of risk.

Service users also have the ability to feed back through the Trust's website.
The CQC published its annual Maternity Survey results on 29th January 2019. The purpose of the survey is to benchmark against national findings (each year each survey is analysed against a 'new' average across England).

The responses were from women who gave birth in February 2018. There were 111 responses from women cared for by ESHT, this was a 37.63% response rate (the national response rate was 37%, 17,600 women) The response rate from the previous year was 41% (121 women). All scores are out of 10 with 10 being the highest/best score. For comparison the results received for the 2017 survey are in **green.** The survey has a total of 48 questions under six categories.
The overall findings were that we performed "about the same" as other Trusts nationally. There is no national league table of results.

Maternity strategy – The Trust's maternity services strategy was been developed with the multidisciplinary team and MVP feedback.

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

ESHT confirm that we achieve the required Safety action (by 15 August 2019 as the mandated time frame), evidence is included below;
The division uses PROMPT Training, this includes fetal monitoring in labour; using integrated team-working, relevant simulated emergencies and/or hands-on workshops.

The Training syllabus is based on current evidence, national guidelines and national and local recommendations, relevant local audit findings, risk issues and case review feedback are used to plan the sessions, this includes the use of local charts, emergency boxes, algorithms and pro-formas. The Board has sight of training numbers annually.
Local feedback on local maternal and neonatal outcomes is included.

ESHT can confirm we comply with the requirements as set out below;

- Maternity staff attendees should be 90% of each of the following groups is confirmed: Obstetric consultants
- All other obstetric doctors (including staff grade doctors, obstetric trainees)
- Obstetric anaesthetic consultants contributing to the obstetric rota
- Midwives (including midwifery managers and matrons, community midwives; birth centre midwives
- Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)
- Board sight of a staff training database on a monthly basis (through IPR).

Safety action 9
Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

ESHT confirm that we achieve the required Safety action
Executive sponsor engagement in quality improvement led by our trust nominated Improvement Lead. This includes MNHSC as well as other quality improvement activity for trusts in waves one and three.

The Trust Board have been sighted on the local improvement plan and updated on progress, impact and outcomes through the Maternity Board

- South Region Maternity Safety Event attended by HOM and Deputy Chief Nurse (Board level maternity

safety champion)

- . LMS meetings are attended by the Chief Executive and HOM

The Maternity dashboard is published to staff and the Trust Board monthly. Staff concerns are discussed at the Midwifery Senior Group (MSG), MSG reports to Maternity Board. Action plans from the Staff Survey will be tracked through MSG.

- ESHT have set up Bi-Monthly meetings in line with Standard nine compliance between the ADN/HOM and Board Safety Champion
- Board Safety Champion – Vikki Carruth (Director of Nursing)
- Trust Safety Champion – Dexter Pascal (Clinical Lead for Maternity)

Documented Evidence includes:

1. Women, Children & Sexual Health Division Integrated Performance Review (minutes)
2. Maternity Board meetings (minutes)
3. Weekly Patient Safety Summit (log)

Safety action 10
Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?

The Trust Board have sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.

ESHT can confirm that we have a Governance process in place which includes reporting all qualifying incidents to NHS Resolution under the early Notification scheme reporting criteria through Legal Services.

The Workforce Race Equality Standard (WRES)

Meeting information:			
Date of Meeting:	6th August 2019	Agenda Item:	11.1
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 WRES is a national initiative and a contractual requirement. It has 9 metrics which are used as a tool to help identify and close gaps between Black & Minority Ethnic (BME) and White British, White Irish and White Other (White) staff within the organisation.

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

The BME Staff Network is Chaired by Dr Adrian Bull (CEO) and attended by the Equality Lead, Human Resource Managers, Leadership Managers, Staff Health & Wellbeing Leads and Staff Engagement Leads. The network reviews and monitors the WRES metrics bi-monthly through a rolling action log. The action log is updated annually following publication of WRES. The network continued to strengthen in 2018/19, aiming to provide a safe place for BME staff to raise concerns, support one another and identify best practice, It aims to identify learning and development opportunities for staff and has hosted outside speakers to support career development and inclusive practices within the organisation.

WRES data indicates that BME representation has declined in senior, non-clinical positions. Further exploration is currently being carried out to identify reasons for this. Towards the end of 2019, staff payslips will be available online. During this change staff will be encouraged and supported to update their equality information on ESR.

During 2019/20, the Trust intends to:

- Identify the gaps in treatment and experiences between white and BME staff
- Make comparisons with similar organisations on progress over time
- Take remedial action on causes of ethnic disparities in indicator outcomes.
- Enhance the experience of BME staff, eliminate unfair treatment and support staff when raising concerns.

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

People & Organisational Development Committee 25th July 2019

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

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

East Sussex Healthcare NHS Trust

The Workforce Race Equality Standard (WRES)

2018/19

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The Workforce Race Equality Standard

1. Introduction

The Workforce Race Equality Standard (WRES) was introduced by NHS England to all NHS organisations from April 2015. WRES consists of nine metrics that can be used to help NHS organisations identify and address race inequality. East Sussex Healthcare NHS Trust (ESHT) welcomed the new standard which has provided the opportunity to demonstrate our commitment to advancing equality of opportunity for the diverse workforce it employs.

The metrics are used as a tool to help identify and close gaps between Black & Minority Ethnic (BME) and White British, White Irish and White Other (White) staff within the organisation. The standard will continue to support the Trust in becoming an inclusive organisation and meeting its legal obligations as an equal opportunities employer. It will also assist in ensuring the Trust is fulfilling its legal duties to comply with the Public Sector Equality Duty.

Along with the Refreshed Equality Delivery System (EDS2), WRES continues to assist the Trust in ensuring its workforce can be confident that the Trust is giving due regard to using the indicators (below) contained in the WRES to help ensure inequalities are identified and addressed.

The regulators, the Care Quality Commission (CQC) and NHS Improvement (NHSi) will monitor the WRES and EDS2 to help assess whether NHS organisations are inclusive and well-led.

2. Data Collection and Monitoring

The first WRES report (2014/15) highlighted the importance of having processes for collecting robust data. Through the use of the WRES metrics the Trust has identified ways to improve the way data is collected and reported. Data collection methods of staff attending non-mandatory training has continued to prove challenging. However the way in which the data has been reported has remained consistent. Managers continue to be reminded of the importance of ensuring accurate and detailed recording of staff attending non-mandatory training; however caution must still be used when forming judgements on the outcomes. The Trust will continue to include reminders for managers using Trust communication methods and will continue to explore further options to improve this data.

Each year data is produced for the WRES metrics which are then used by the Staff BME Network to identify area's that require improvement and develop an action plan. Each metric is considered at the Staff BME Network. Leads for the action are identified accordingly. Through engagement with managers, the BME Staff Network and the wider staff, each action is addressed over the year.

The 2011 Census continues to remain the most up to date information we have available to identify Ethnicity in the local areas. As highlighted in previous reports, using East Sussex in Figures, East Sussex "…is less ethnically diverse than the South East region or nationally" (ESiF 2012). The local black and minority ethnic (BME) populations are around 10.5% which is lower than the South East (14%) and England (17%). Eastbourne and Hastings have the highest percentage of BME groups at 13%. BME groups include: White Irish, Other White in addition to Mixed, Asian, Black, Chinese and Other groups. ESHT calculations are formulated according to the WRES technical guidance where White Irish and White Other are not included in BME calculations.

Figures produced by East Sussex County Council Equality and Diversity Profile for Hastings and Rother Clinical Commissioning Group in February 2017, highlight East Sussex BME populations (excluding White Irish and White other) to be 8.3%. Organisations are expected to be representative of the populations they serve and whilst ESHT remains overall representative, there are areas within the Trust that are not. These are highlighted in the graph below. These underrepresented bands are further separated by Clinical and non-clinical positions in metric 1. The most underrepresented bands continue to be addressed through recruitment processes.

3. Highlights of 2018/19

The East Sussex Healthcare NHS Trust (ESHT) BME Staff Network continues to strengthen and grow in members. The network continues to be Chaired by Dr Adrian Bull (CEO) and attended by the Equality Lead, union representatives, Human Resource Managers, Leadership Managers, Staff Health & Wellbeing and Engagement Leads. The Network aims to provide a safe place for BME staff to raise concerns, support one another and identify best practice. The Network also aims to identify training and development opportunities for staff as well as hosting speakers such as Dionne Daniel, Senior Nurse at Barts Health NHS Trust, Banji Adewumi, Associate Director for Inclusion at Barts Health NHS Trust and Dame E Nneka Anionwu to support career development and promote inclusive practices.

ESHT BME network supported the formation of a representative recruitment group, developed to support interview panels recruiting to AfC positions band 8A and above.

The Trust participated in various initiatives to promote Equality week and Black History Month during 2018/19. The national Director for WRES Implementation, Yvonne Goghill attended a meeting with the Trust Board and delivered a presentation on evidence based strategies for improvement. The team also delivered a workshop for ESHT staff focusing on WRES and the importance of networks. The Equality team focused Equality week on Staff Networks along with career development workshops.

BME good news stories were included in NHS 70th year anniversary communications and added induction packs.

To support the Trust in meeting its legal obligations the Trust has 4 Equality Objectives which will be redeveloped during 2019. Currently the objectives include ensuring senior BME recruitment remains fair and support the Trust to continue to be representative of the population it serves. The Trust Equality Objectives will be developed using the equality reports including EDS2 and the WRES indicators. The current full document and progress reports can be accessed on the Trust website with the new objectives available later in the year.

4. Workforce Data

2018/19 has seen a slight percentage decrease in BME staff in band 4 clinical posts from 4% to 2%. Other slight variations in clinical bands are not considered statistically significant and would be considered normal variation. Non-clinical posts band 5 decreased 3.6% and band 6 also saw a decrease in representation from 2.5% to 0%. A 1.7% increase in BME representation at band 7, may suggest progression of some BME staff.

BME representation at Clinical band 7 which has declined just over 1% and non-clinical band 8a which has reduced just under 2%. The level of BME representation at these bands falls just below the representation of the local population.

Data suggests non-clinical bands 8b, 8c, 8d and band 9 have no BME representation. Many senior staff are members of the BME Staff Network identify as BME in Bands 8b to band 9 but have not identified on the electronic staff records (ESR). These bands also have higher percentages of undefined ethnicity.

Data suggests all non-clinical posts, with the exception of band 1, are not representative of the local BME population. Clinical bands are 1, 4, 7, and 9 are also not representative of the local BME population or the workforce overall.

9% of ESHT workforce has undefined ethnicity and it is likely that some of these with recorded undefined ethnicity are from a BME backgrounds. Further work is planned to increase reporting.

Recruitment staff continue to have due regard to the promotion of equal opportunities in the Trust.

Ethnicity Undisclosed/Not stated

Awareness of the benefits to declaring ethnicity formed part of the 2017/18 action plan. Data suggests that declaration rates within some AfC bands has improved. There was a 12% improvement from 2017/18 in medical trainees declaring their ethnicity in 2018/19. Slight decreases in undefined were also reported in bands 2 & 3. Most senior positions increased in undefined ethnicity.

Percentage of staff Undefined Ethnicity			
AfC Pay Band	**2018/19**	**2017/18**	**Change**
Band 1	7.69%	7.32%	-
Band 2	7.85%	9.73%	↓
Band 3	6.85%	8.48%	↓
Band 4	7.51%	6.88%	-
Band 5	12.01%	13.54%	↓
Band 6	6.51%	6.42%	-
Band 7	3.81%	4.09%	-
Band 8a	8.20%	8.05%	-
Band 8b	3.64%	11.32%	↓
Band 8c	11.11%	7.14%	↑
Band 8d	20.00%	26.67%	↓
Band 9	42.86%	40.00%	↑
Exec	25.00%	6.87%	↑
VSM	100.00%	44.44%	↑
Other	100.00%	0%	↑
Consultant	6.94%	6.87	-
Medical Trainee	31.18%	42.96%	↓
NCCG	19.27%	15.22%	↑
Grand Total	**8.97%**	**10.22%**	↓

Data suggests 100% of 'Other' and 'Very Senior Management' (VSM) did not disclose their ethnicity. Caution must be taken when forming judgements on these figures as the number of staff in those bands are below the reporting number.

55.21% of all medical trainees currently identify as BME (2.71% increase from 2017/18). 31% Previous discussions with BME staff, who had not declared their ethnicity felt declaring ethnicity was seen as irrelevant to their job.

During 2017/18 ESHT recruitment team reviewed the way equalities information was collected during the recruitment process of new junior and career grade doctors. It was identified that equalities information was collected on more than one form. Some of these doctors only completed one form which lead to some ESHT workforce IT systems not receiving the data. Identifying this administration challenge has supported the decrease number of undefined reporting in this group. Plans to reduce the number of staff not declaring their ethnicity continues in the 2018/19 action plan.

5. Workforce Race Equality Standard Metrics 2018/19

Workforce metrics
For each of these four workforce indicators, the Standard compares the metrics for white and BME staff.

1. **Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**

Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff

- **77.7% of all staff identified as White British or White Other**
- **13.4% of all staff identified as BME**
- **9% of staff's ethnicity was unknown and are excluded from calculations.**

Clinical & Non-clinical

- 17.79% of all clinical staff identified as BME
- 82.21% of all clinical staff identified as White British, White Irish or White Other

- 5.14% of all non-clinical staff identified as BME
- 94.86% of all non-clinical staff identified as White British, White Irish or White Other

Percentage of BME and White staff in each clinical and non-clinical pay band
Key: White B/I/O = White British/Irish/Other. **BME:** Black & Minority Ethnic

	Clinical			Non-Clinical		
Pay Band	White B/I/O (%)	BME 2018/19 (%)	BME 2017/18 (%)	White B/I/O (%)	BME 2018/19 (%)	BME 2017/18 (%)
Band 1	100.00	0.00%	0.00	87.57%	12.43	12.57
Band 2	78.58	21.42	23.53	94.94%	5.06	5.92
Band 3	87.96	12.04	12.79	96.70%	3.30	3.73
Band 4	97.16	2.84	4.14	98.03%	1.97	2.54
Band 5	78.03	21.97	23.42	96.69%	3.31	6.98
Band 6	88.44	11.56	9.78	100.00%	0.00	2.53
Band 7	93.06	6.94	8.01	95.45%	4.55	2.82
Band 8a	89.52	10.48	14.00	93.65%	6.35	8.33
Band 8b	94.12	5.88	0.00	100.00%	0.00	0.00
Band 8c	92.86	7.14	7.69	100.00%	0.00	0.00
Band 8d	N/A	N/A	0.00	100.00%	0.00	10.00
Band 9	100	0	0.00	100.00%	0	0.00
Consultant	68.42	31.58	31.80	-	-	-
Med.Trainee	44.79	55.21	52.53	-	-	-
NCCG	40.91	59.09	61.54	-	-	-
Other	100	0	0		-	-
Senior Manager/Exec	100	0	0	100		0
Grand Total	**82.21**	**17.79**	**18.05**	**94.86**	**5.14**	**5.99**

2.	**Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.**
	2018/19 The relative likelihood of white staff being appointed from shortlisting compared to BME staff was 1.28 times greater. **2017/18** The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 0.91 times greater.
3.	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*** ***Note: this indicator will be based on data from a two year rolling average of the current year and the previous year**
	2017/18 – 2018/19 Staff identified as BME were 1.81 times more likely to enter the formal disciplinary process compared to staff identified as White British, White Irish or White other.
4.	**Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff**
	Available figures demonstrate White staff were **1.33** times more likely to access non-mandatory training compared to BME staff. This is a negative move from 2017/18 which was 1.11 times. Note: Managers are reminded to inform Learning & Development, and staff are encouraged to advise their managers of completed non-mandatory training attended; Caution must be taken when forming judgments on data due to how these data are captured. Previously line managers have block book places on conferences and university workshops, the booking forms require a line manager's name plus the number of attendees and not necessarily individual names. Identifying members of staff who had attended these non-mandatory training events proved challenging. Where staff have been identified this has been reported. Improvements to how these data are collected remains under review.
National NHS Staff Survey findings For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for white and BME staff	
5.	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**
	2018/19 results ❖ 26.3% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 26.3%. ❖ 32.3% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 26.5% **2017/18 results** ❖ 27.86% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 26%. ❖ 30.85% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 27%.

6.	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**
	2018/19 results ❖ 25% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 23.6%. ❖ 29.3% of BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 29.2%. **2017/18 results** ❖ 26.7% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 23%. ❖ 28.61% of BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 29%.
7.	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**
	2018/19 results ❖ 86.2% of White respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 87.2%. ❖ 74.5% of BME respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 74.2%. **2017/18 results** ❖ 88.63% of White respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 88%. ❖ 80.22% of BME respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 83%.
8.	**Q 17b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**
	2018/19 results ❖ 6% of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. National Average was 5.6%. ❖ 17.1% of BME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. National Average was 15.4%. **2017/18 results** ❖ 7.11% of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. National Average was 6%. ❖ 15.92% of BME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. National Average was 15%.
Boards Does the Board meet the requirement on Board membership in 9?	
9.	**Percentage difference between the organisations' Board voting membership and its overall workforce**
	All voting members of ESHT Trust Board identify as White British or White other. Vacancies for Trust Board positions are widely advertised and communicated to the NHS BME Network. In 2018/19 the Percentage difference between the organisations' Board voting membership and its overall workforce was -12.8%. In 2016/17 the Percentage was -12.3%

6. National NHS Staff Survey findings

The Key Findings (KF) 25, 26, 21 and Q17 are questions specific for helping identify race inequality in the NHS workforce.

KF 25 – The percentage gap between white and BME respondents experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months, has increased from 3% in 2017/18 to 6% in 2018/19. White staff reported a slight decrease remaining the same as the national average whilst BME staff report a slight increase from 27.86% in 2017/18 to 32.3% in 2018/19. This is 5.8% higher than the national average.

KF 26 – The percentage gap between white and BME respondents increased from 2% in 2017/18 to 4% in 2018/19 in experiencing harassment, bullying or abuse from staff in last 12 months. Findings reported a slight decrease for White staff and a slight increase for BME Staff. White staff reported a slight decrease resulting in 1.5% higher than the national average. BME staff report a less than 1% increase from 28.61% in 2017/18 to 29.3% in 2018/19. This is the same as the national average.

KF 21 – 2018/19 survey suggested 74.5% of BME staff reported believing they were provided with equal opportunities for career progression or promotion. This is the same as the BME national average but 6% lower compared to 2017/18. White respondents reported 86.2% which is 1% below the national average for white staff.

Q 17b – 17% of BME respondents reported experiencing discrimination at work from their manager or team leader on the grounds of Ethnic background. This is a 1% increase from 2017/18 survey. The National Average was 15.4%.

The findings of the survey have been considered during the development of the action plan to enhance career progression and eliminating unlawful discrimination. Trust wide initiatives are in place to reduce bullying and harassment and are also included in the 'ESHT BME Staff Network Terms or Reference'.

7. Plans for 2019/20

Data indicates that BME representation has declined in senior, non-clinical positions. Further exploration is currently being carried out to identify reasons for this. Towards the end of 2019, staff payslips will be available online. During this change staff will be encouraged and supported to update their equality information on ESR.

The recent WRES data will be used to create a series of conversations designed to promote a safe and inclusive platform for staff to express and explore views, and for the organisation to gain a deeper understanding of the lived experiences of BME staff in the Trust. Staff feedback will be used to positively influence and shape organisational actions to improve the experiences of our current and future BME staff as measured by the annual NHS Staff Survey and Workplace Race Equality Standard Data.

The data from the Listening conversations will enable the organisation to:

- Identify the gaps in treatment and experiences between white and BME staff
- Make comparisons with similar organisations on progress over time
- Take remedial action on causes of ethnic disparities in indicator outcomes.

8. Conclusion

There continues to be good progress in many areas of the race equality agenda across the organisation. Many steps have been taken to promote the positive contribution BME staff make through the network and beyond. Further action is planned to enhance the experience of BME staff, eliminate unfair treatment and support staff when raising concerns.

Action Plan 2018/19 – 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 Race Equality Standard, the following actions for 2018/19 have been agreed by the ESHT BME Network and the Trust Board.

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

- Incidents reported on Datix involving racial discrimination, harassment or victimisation continued to be reviewed monthly by the Trust Speak up Guardian, the Director of Human Resource and the Chief Executive.
- Incidents of racial discrimination continue to be closely monitored and actioned accordingly using Trust policies.

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

- Ensure equality is embedded in recruitment of non-clinical positions band 8 and above.
- Ensure robust processes are in place to record and monitor CPD and non-mandatory.

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

- Improve understanding of the benefits to declaring ethnicity on employment records.
- Promote the benefits of joining staff networks.
- Ensure managers have the necessary skills to identify and tackle discrimination and foster good relations amongst their teams.

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

Complaints and PALS Annual Report

Meeting information:			
Date of Meeting:	6th August 2019	Agenda Item:	11.2
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

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

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

Summary:

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

The Complaints and Patient Advice and Liaison Service (PALS) annual report details the activity at ESHT for the year 2018/19. All the data provide has been extracted for the Datix system which is used to record complaint and PALS contacts. The report shows a reduction in complaints received as well as improvement is how they are managed. PALS have also seen a reduction in contacts.

Key points:

- Trust received 558 complaints in 2018/19 – this is 9 less than the previous year
- The Trust acknowledged 100% of complaints within 3 working days
- The trust's response rate compliance for non-complex complaints was 100% and for complex 92% - both figures are an improvement on 2017/18
- There were 80 complaints re-opened which is a sustained reduction on 2017/18. There were no key themes identified on reviewing the re-opened cases
- There were no overdue complaints and the end of 2018/19 and only 1 occasion within the year where a response was overdue for a couple of days.
- There has been a decrease in the number of PALS contacts compared to previous years
- The PHSO only fully upheld 2 complaints and partially upheld 7 complaints out of the 20 contacts received.

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

Patient Safety and Quality Group 27th June 2019
Quality and Safety Committee 25th July 2019

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

To acknowledge the Complaints and PALS annual report

East Sussex Healthcare NHS Trust

Annual Report

Complaints & Patient Advice and Liaison Service (PALS) 2018/19

Executive Sponsor:	Vikki Carruth, Director of Nursing
Main Report Author:	Darren Langridge-Kemp, Complaints, PALS and Patient Experience Manager
Date:	June 2019

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1. Executive Summary for 2018/19

This report details the activity of the Complaints Team and Patient Advice and Liaison Service (PALS) at East Sussex Healthcare NHS Trust for the year 2018/19, together with comparative data for 2016/17 and 2017/18. All data provided has been extracted from Datix, which is the risk management database the Trust used for recording complaints and contacts with PALS.

- The Trust received 558 new complaints across all services during 2018/19; this represents a reduction of nine complaints compared to the number of complaints received in 2017/18 (567).

- The Trust acknowledged 100% of complaints within three working days.

- The Trust's compliance with the response rate for non-complex complaints (30 working days) at the end of 2018/19 rose to 100%, whilst compliance with the response rate for complex complaints (45 working days) was 92%. This has sustained and further built on the improvements made to compliance with response rates for 2017/18 (83% and 71% respectively).

- There were seven complaint actions open at the end of 2018/19, down from 120 at the end of 2017/18

- There were 80 complaints re-opened in 2018/19; this represents a sustained reduction in numbers of 12 compared to 2017/18.

- There were no complaints overdue at the end of 2018/19 which has been sustained from the year end position in 2017/18.

- There was a further decrease in PALS contacts for 2018/19 compared to the two previous years; 6,805 in 2018/19 compared to 7,139 contacts in 2017/18 and 7,325 recorded in 2016/17, marking a reduction in activity of 7.1%.

- The Trust received 20 contacts from the Parliamentary and Health Service Ombudsman (PHSO) during 2018/19, and received 19 case outcomes (please note some of the outcomes relate to cases the PHSO opened in 2017/18). In summary, the PHSO decided not to investigate six cases, four cases investigated were not upheld, seven cases investigated were partially upheld and two cases investigated were fully upheld. Of the contacts made in respect of investigations, four were to provide decisions/outcomes (one case upheld, two cases partially upheld and one case not upheld).

The objectives for the Complaints Team in 2019/20 are:

1. To sustain a satisfactory rate of compliance with the internal response rates for all complaints; and
2. To support clinical divisions in completing actions and learning arising from complaints, and ensuring they are evidenced and closed in Datix.

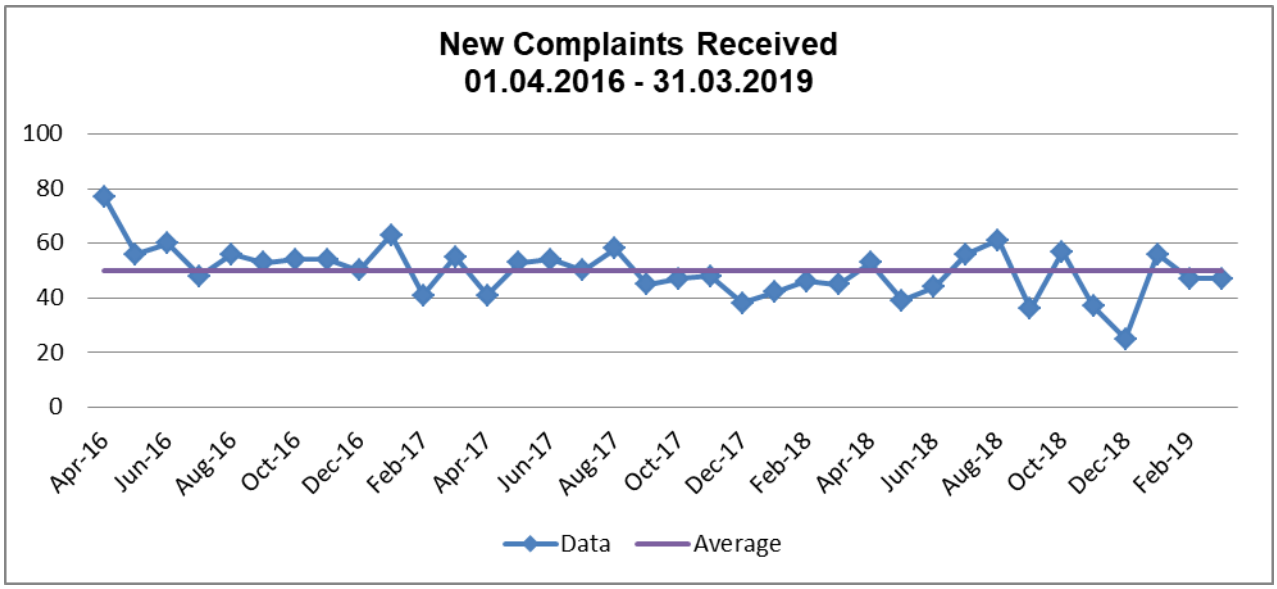
2. Complaints

The Trust considers complaints to be an important source of feedback, providing opportunities for reflection and improvement on the care and treatment provided to patients and their relatives. All complaints received are investigated in accordance with the Trust's "Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (The 4C's Model)", which itself is underpinned by the principles of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the NHS Constitution.

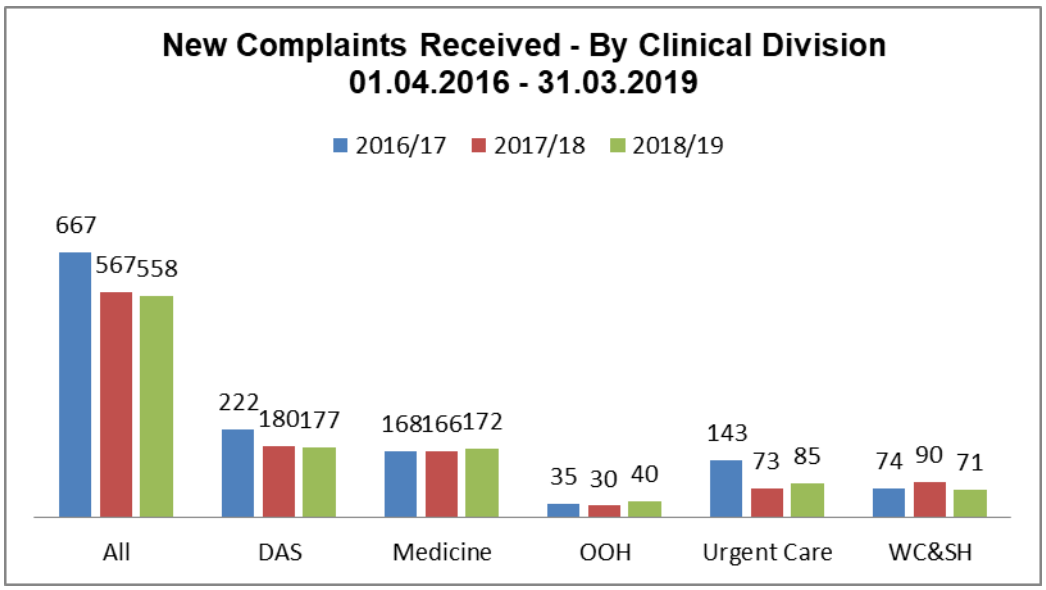
The Trust makes every effort to resolve each complaint locally as far as it is possible to through comprehensive investigations and high quality responses and, where appropriate, Local Resolution Meetings. The Trust continues to work collaboratively with the local Advocacy Service to ensure complainants can access independent support with their complaint; our local Advocacy Service is provided by an organisation called Support Empower Advocate Promote (seAp).

2.1 Complaints Received

The following chart represents all complaints received between 01.04.2016 and 31.03.2019 measured against the average mean.



Once a new complaint has been assessed and triaged, it is assigned to a clinical division – this is usually the main clinical division involved in the events relating to the complaint, or where the most serious matters have arisen if several clinical divisions are involved (please note complaints about non-clinical matters, for example, parking, facilities etc are assigned to the appropriate non-clinical division). In terms of distribution of new complaints, the following chart represents complaint assignment to each clinical division on an annual basis.



As part of the assessment and triage process, new complaints are also assigned a primary subject to allow for trend analysis when reporting. The following table sets out the top three primary subjects assigned to complaints for the reporting period; these, and their ranking, have not changed over the last three years.

2016/17		2017/18		2018/19	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
Standard of Care	221	Standard of Care	194	Standard of Care	226
Communication	143	Communication	137	Communication	83
Patient Pathway	127	Patient Pathway	94	Patient Pathway	82

Each primary subject can then be broken down by a range of sub-subjects to facilitate more specific coding of complaint issues. The following tables provide a breakdown of the top sub-subjects under each of the top three primary subjects assigned to complaints.

Standard of Care

"Standard of Care" has consistently remained the primary subject being assigned the largest number of complaints. The top sub-subjects under this primary subject are set out in the table below.

	2016/17	2017/18	2018/19
Standard of Care	**221**	**194**	**226**
Overall Care	125	67	
Lack of Confidence in Delivery of Care	39	18	84
Pain Control	20		12
Missed Diagnosis	14	29	29
Incorrect Diagnosis		20	12
Problems/Complications Following Surgery/Procedure		15	25
Medication Error	11		
Lack of Diagnosis			8
Delay in Medical Review			8

Please note that in September 2017, the Complaints Team reviewed and updated all primary and sub-subjects for complaints; the implementation and use of the revised and

expanded range of subjects subsequently facilitated improved reporting for greater analysis, and explains why complaints coded to the less specific sub-subject of "overall care" had dropped to just one by 2018/19.

Communication
"Communication" has consistently remained the primary subject being assigned the second largest number of complaints. The top sub-subjects under this primary subject are set out in the table below.

	2016/17	2017/18	2018/19
Communication	**143**	**137**	**83**
Lack of Communication/Information	46	36	24
Written Information for Patients	21	18	7
Verbal Information for Patients*	18	18	*
Listening and Respecting Patient Choice	11	15	11
Confidentiality Issues	11	9	7
Verbal Information for Relatives	8	9	
Inappropriate Communications			7
Delayed Communications/Information			6
Breaking Bad News			5
Conflicting Information			5

*__NB__: this sub-subject only had two complaints assigned to it in 2018/19

As set out above, the review of primary and sub-subjects in September 2017 has facilitated more specific reporting of the issues attached to why complaints were assigned to the primary subject of "Communication".

Patient Pathway
"Patient Pathway" has consistently remained the primary subject being assigned the third largest number of complaints. The top sub-subjects under this primary subject are set out in the table below.

	2016/17	2017/18	2018/19
Patient Pathway	**127**	**94**	**82**
Delays in Access to Service/Treatment - Outpatient	70	47	28
Appointment Issues	39	13	13
Referral Delays	9		4
Delays in Access to Service/Treatment - Inpatient		12	22
Lack of Follow Up/Monitoring		7	13
Admission Issues	6	6	2
Transfer Between Wards/Hospitals	3		

2.2 Complaints by Specialty
As part of the assessment and triage process, new complaints are additionally assigned to the specific specialties to which the complaint relates to allow for trend analysis when reporting. The following table sets out the top specialties assigned to complaints.

Top Specialty	2016/17	2017/18	2018/19
Emergency Department	126	71	84
General Medicine	51	47	45
General Surgery	45	39	35

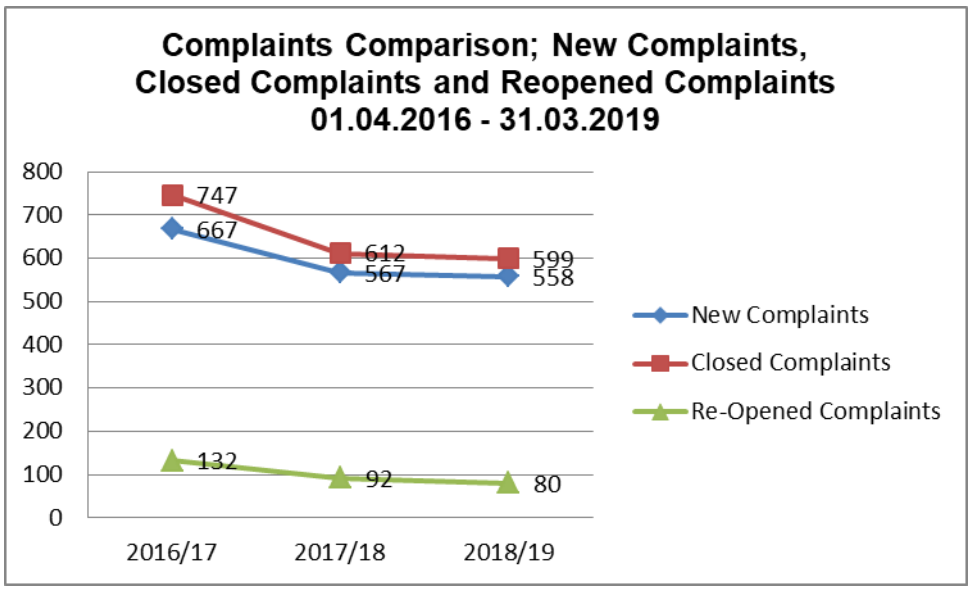
Urology	43	21	25
Trauma and Orthopaedics	36	38	35
Gastroenterology	26	19	25
Paediatrics	25	28	28
Gynaecology	24	32	21
Radiology	23	16	16
Appointments	20	9	
Cardiology	19	20	15
Ear, Nose and Throat	13	19	10
Obstetrics	13	22	15
Ophthalmology – EDGH	13		8
Ophthalmology – CQ	12	8	10
Stroke Team	11	8	
Frailty	10	12	
Maxillo Facial	8	7	7
General Administration	7		
Neurology	7		11
Geriatric and Services for the Elderly		14	18
Endocrinology and Diabetes		11	11
Respiratory Medicine		8	8
Endoscopy			8

2.3 Closed Complaints and Reopened Complaints

In line with the reduction in new complaints being received during the reporting period, there has been a correlating reduction in the number of complaints being closed for the same period. However, there were no complaints overdue at the end of 2018/19 for the second consecutive year.

In addition to no complaints overdue at the end of 2018/19, compliance with response rates in time once again improved on the figures reported for 2017/18. The response rate for non-complex complaints (30 working days) reached 100% at the end of 2018/19, up from 83% in 2017/18 and 54% in 2016/17. The response rate for complex complaints (45 working days) increased to 92% at the end of 2018/19, up from 71% in 2017/18 and 53% in 2016/17. This underlines the commitment of the Complaints Team to handle a high volume of complaints in a timely manner to meet the expectations of complainants and treat their complaints with respect.

The following table compares complaints by the number of new complaints received, closed and reopened by year for the reporting period.



The rate of reopened complaints has steadily decreased over the reporting period; this may be the result of several factors, including more robust statements of response from staff in clinical divisions, increased robustness from the Complaints Team to challenge poor quality or incomplete statements of response from clinical divisions, and further improvements in the quality of complaint responses prepared for the Chief Executive to sign off.

It will not always be possible to resolve a complaint to the satisfaction of the complainant and where the Trust feels a local resolution meeting maybe beneficial, this will be offered. Alternatively, the Trust will work with the complainant to identify issues that could be further investigated and responded to in writing in an effort to address the complaint as far as it is possible to.

Whilst mindful of the clinical and operational pressures experienced in the Trust during 2018/19, the Complaints Team continues to experience difficulties and delays in the timely receipt of satisfactory complaint investigations. In a number of cases, the delays experienced have led to complaint responses breaching their response date in-month, or resulted in the case having to be reopened because the Complaints Team could not secure the robust response they wanted. The clinical divisions have been regularly offered meetings with the Complaints, PALS and Patient Experience Manager and/or Deputy Complaints Manager to support staff with investigations but in the main, these offers have not been taken up.

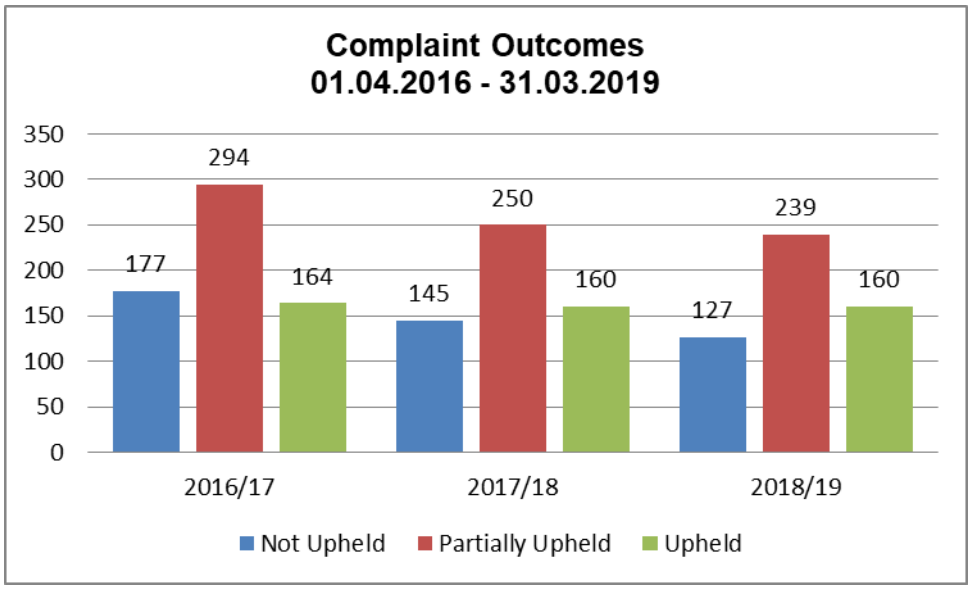
2.4 Complaints by Outcome

During 2018/19, the decision was taken to rebrand the outcome codes used for complaints (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 state at Regulation 17, Section (b), that all responsible bodies must record a subject matter and outcome for each complaint); prior to this the Trust had used outcome codes that mirrored those used by the PHSO (not upheld, partially upheld, upheld). The new outcome codes being used are:

Old Outcome Code	New Outcome Code
Not Upheld	Investigation Complete; No Actions/Learning Identified
Partially Upheld	Investigation Complete; Apologies Required But No Actions/Learning Identified

Upheld	Investigation Complete; Apologies Required And Actions/Learning Identified

The following chart sets out the outcome codes assigned to complaints for the reporting period; please note that as two thirds of data used the previous outcome codes, these have been referenced in the chart for ease of analysis.



2.5 Learning from Complaints

As part of robust complaint handling, the Trust is committed to implementation of actions or learning arising from complaint investigations to prevent, as far as it is possible to, any recurrence of the source of complaints being raised. The following are examples of learning embedded during 2018/19:

Complaint 13052

Complaint was around the assessment made by staff using the Continuing Healthcare Checklist (CHC) as they felt this was not completed correctly. As a result of the complaint, from January 2019, it was agreed that all CHC checklists which fail to meet the criteria for a full assessment will now be verified by a second member of the team, to ensure that a 'fresh eyes approach' has been taken, and the forms have been completed fairly.

Complaint 11489

Complaint was around the level of care provided to the complainant's late wife in 2015. One of the issues was around when patient attended an appointment with the Respiratory Technician and was clearly unwell and unable to complete the lung function texts, but despite this she was not admitted to hospital, which resulted in an emergency admission to hospital the following day. Whilst it was considered that the actions taken by the Respiratory Technician were correct, there was no clear guidance for staff to follow in a similar situation. As a result of the discussions surrounding this episode of care, it was agreed that a formal guidance would be devised for Pulmonary/Respiratory Technicians to follow if a patient presents who is too unwell to undergo the lung function test giving a range of responses, such as referring to the Emergency Department or the Medical Assessment Unit (MAU). This has been acted upon in June 2018 and guidance has been issued for each main hospital site.

Complaint 13282
Complaint concerning delay in diagnosis by the Surgical Assessment Unit (SAU), as tumour was subsequently found, appropriateness of discharge with a drain in-situ and lack of continuity and ownership of care, as seen by different Consultants each day. It was agreed that there would be a review of the General Surgery 'Drains' Policy for patients who are discharged home with a drain, as the management plan for these patient was not always clear. This policy was reviewed and ratified at the General Surgery Governance Meeting in September 2018 and drain guidelines are now in place on SAU and Gardner Ward.

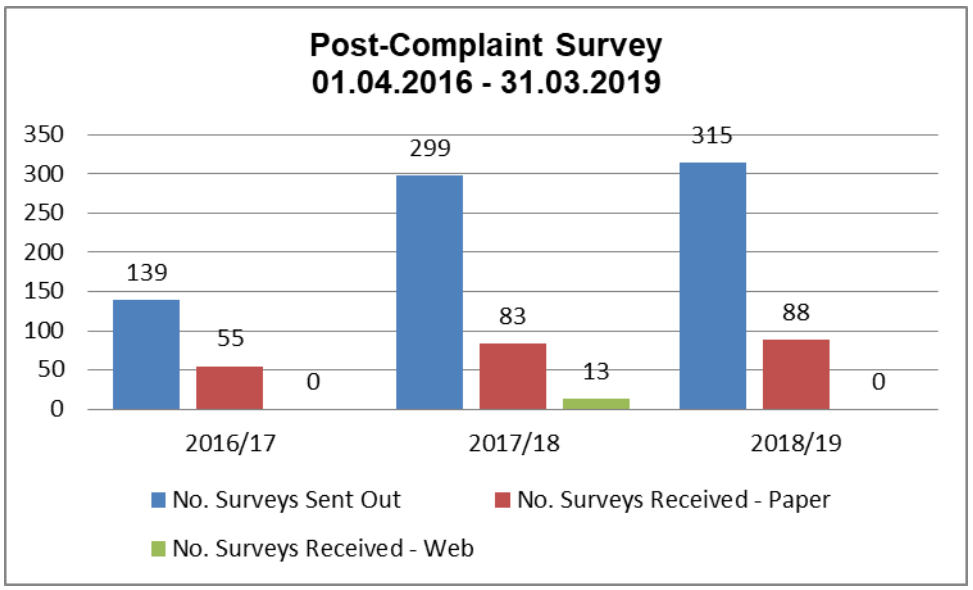
Complaint 13331
Patient attended Fertility Clinic and was asked to complete paperwork entitled 'male partner details', but she is in a same sex marriage. As a result of this complaint, the form was changed and now reads 'partner's details'.

Complaint 13035
Complaint related to End of Life Care in terms of breaking of bad news, discharge arrangements regarding medication and lack of Macmillan nursing support. Action was implemented around discharge palliative care medications, as for injectable controlled drugs, the Trust is looking to now place this type of medication, together with all injectable medication, into a separate coloured bag from the standard green medication bags used. The aim is that this will help patients and carers to be able to easily differentiate standard drugs, as opposed to injectable drugs, when discharged home. New pink medication bags have been purchased and in place since May 2018.

2.6 Complaint Actions
During 2018/19, a key focus was to ensure that actions and learning arising from complaints were closed with supporting evidence. This piece of work resulted in the number of open actions and learning being reduced from 120 at the end of 2017/18, to just seven at the end of 2018/19. In 2019/20, the focus will be to guide and support clinical divisions to identify meaningful and achievable actions and learning so that the Trust can confidently demonstrate it will learn from what complaints investigations have raised.

2.7 Post-Complaint Survey
Although there are no local or national requirements to do so, since September 2016 the Trust has collected anonymous feedback from complainants on their experience of using the complaints process. The feedback is collected by way of a 12 question survey which is sent approximately four weeks after the complaint has been closed; this is to give complainants an opportunity to contact the Trust with any queries, questions or expressions of dissatisfaction they may have with the complaint response provided. The exception to this is cases of complaints where bereavement is a source or reason for the complaint; it would not be appropriate to contact these complainants for feedback as they are very likely to be grieving following the death of a loved one.

Cumulatively for the reporting period 01.04.2016 to 31.03.2019, the Trust has sent out 753 post-complaint surveys; from this, 239 post-complaint surveys have been returned, giving a three year return rate of 31.7%. The following chart sets out the details for each of the years in the reporting period.



In terms of the three survey questions scoring the highest positive feedback (by combining all responses scoring questions with Strongly Agree or Agree), these were exactly the same as 2017/18:

1.	I was able to communicate my concerns in the way I wanted	67.0%
2.	It was easy to find out how to make a complaint	64.8%
3.	I was able to understand the response as everything was clearly explained, including names and terminology	58.0%

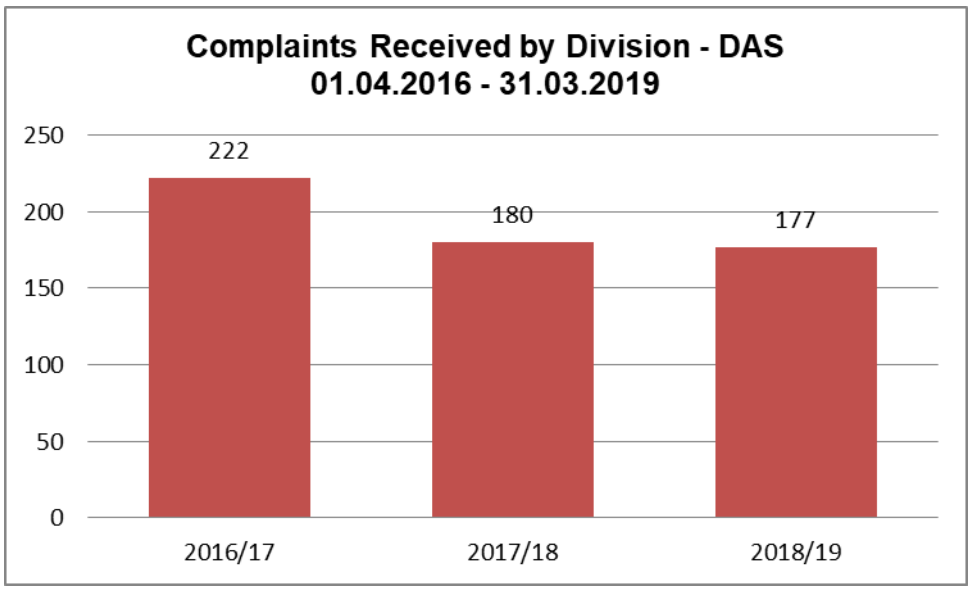
Conversely, the three questions scoring the highest negative feedback (by combining all responses scoring questions with Disagree or Strongly Disagree) were also the same, but with one additional question tying in second place:

1.	I felt the response answered all of the concerns I had raised	56.8%
2.	I felt assured that the Trust would learn from my experience	47.7%
	I was satisfied with how quickly the Trust provided me with a response to my complaint	
3.	I felt the Trust understood my concerns and what I wanted from raising a complaint	39.8%

The return rate for the post-complaint survey has declined year on year for the reporting period, and a significant proportion of the surveys returned in 2018/19 were used to express more general dissatisfaction with the Trust. In order for this survey to help facilitate change the Complaints, PALS and Patient Experience Manager and the Deputy Complaints Manager will be reviewing the questions to enhance the feedback being provided.

2.7 Complaints by Clinical Division

Diagnostics, Anaesthetics and Surgery (DAS)
The following chart represents complaints received over the last three years.



DAS is one of the largest clinical divisions in the Trust, and incorporates a comprehensive range of specialties in both inpatient and outpatient modalities; it therefore consistently incurs a higher number of complaints (with the exception of Medicine) than other clinical divisions. Following a dip in complaints received between 2016/17 and 2017/18, the number of complaints received in 2018/19 is on par with the previous year. The following tables set out the top three primary subjects and top locations for complaints in DAS.

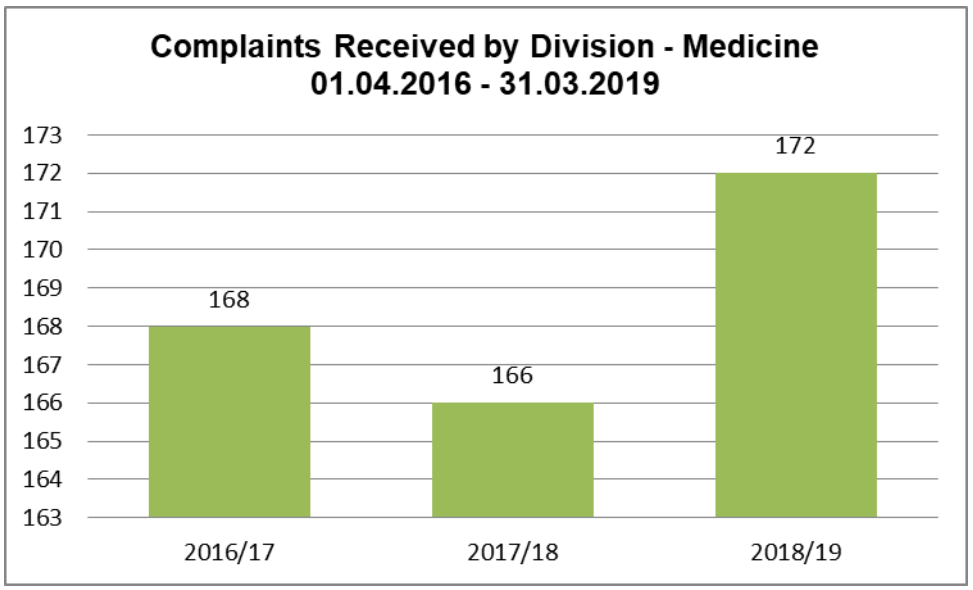
Top 3 Primary Subjects for Complaints

2016/17		2017/18		2018/19	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
Standard of Care	116	Standard of Care	97	Standard of Care	74
Communication	103	Communication	93	Patient Pathway	27
Patient Pathway	82	Patient Pathway	82	Attitude	22
				Communication	22

Top Locations for Complaints

2016/17		2017/18		2018/19	
Location	**No.**	**Location**	**No.**	**Location**	**No.**
Outpatients – EDGH	38	Outpatients – EDGH	32	Outpatients – EDGH	24
Outpatients – CQ	27	Outpatients – CQ	27	Outpatients – CQ	13
Hailsham 4 Urology Ward	20	Richard Ticehurst SAU	14	Richard Ticehurst SAU	12
De Cham Ward	12	Egerton Trauma Ward	11	Hailsham 4 Urology Ward	11
Richard Ticehurst SAU	9	Hailsham 4 Urology Ward	8	Ophthalmology Outpatients - CQ	10

Medicine
The following chart represents complaints received over the last three years.



Medicine, as with DAS, is also one of the largest clinical divisions in the Trust, and incorporates a comprehensive range of specialties in both inpatient and outpatient modalities; it therefore consistently incurs a higher number of complaints as does DAS than other clinical divisions. The number of complaints received in Medicine has remained relatively consistent over the last three years with only minimal changes year on year. The following tables set out the top three primary subjects and top locations for complaints in Medicine.

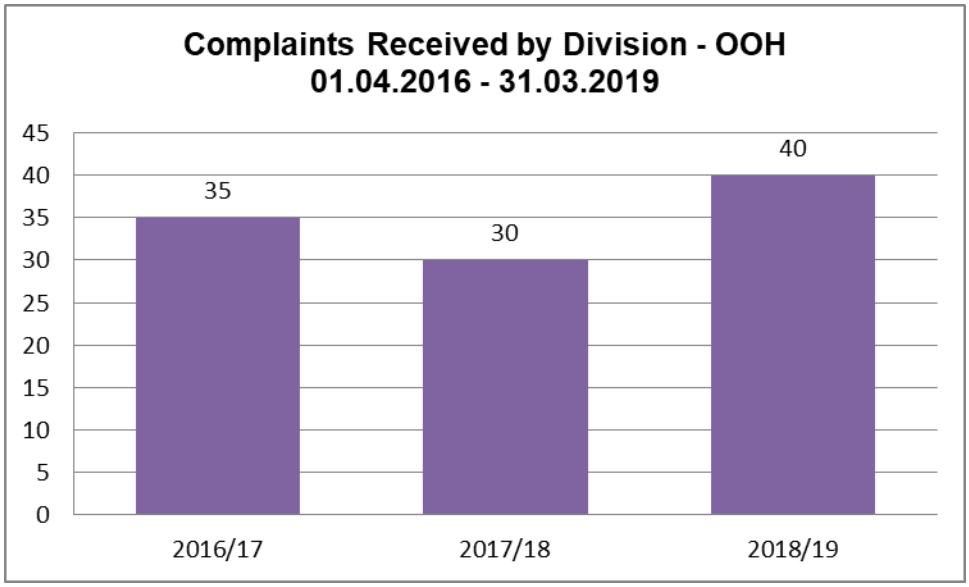
Top 3 Primary Subjects for Complaints

2016/17		2017/18		2018/19	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
Communication	92	Standard of Care	100	Standard of Care	66
Standard of Care	90	Communication	99	Communication	33
Patient Pathway	62	Patient Pathway	49	Patient Pathway	25

Top Locations for Complaints

2016/17		2017/18		2018/19	
Location	**No.**	**Location**	**No.**	**Location**	**No.**
Outpatients – EDGH	18	Outpatients – EDGH	31	Outpatients – EDGH	32
Administration	15	Acute Medical Unit – EDGH	17	Outpatients – CQ	14
Outpatients – CQ	15	Outpatients – CQ	11	Acute Assessment Unit	10
Acute Medical Unit – EDGH	11	Cuckmere Ward	8	Acute Medical Unit – EDGH	10
Berwick Ward	8	Tressell Ward	8	Cuckmere Ward	9
Wellington Ward	8	Berwick Ward	7	Jevington Ward	7
		Seaford 4 Ward	7	Newington Ward	7

Out of Hospital (OOH)
The following chart represents complaints received over the last three years.



The number of complaints received by OOH has remained relatively low compared to other clinical divisions, with minimal change year on year. Although the increase in complaints received between 2017/18 and 2018/19 is just 10, it represents an increase of 33.3%. This increase is likely to be, in the main, due to contractual changes to the provision of incontinence products in the Adult Bladder and Bowel Service. The following tables set out the top three primary subjects and top locations for complaints in OOH.

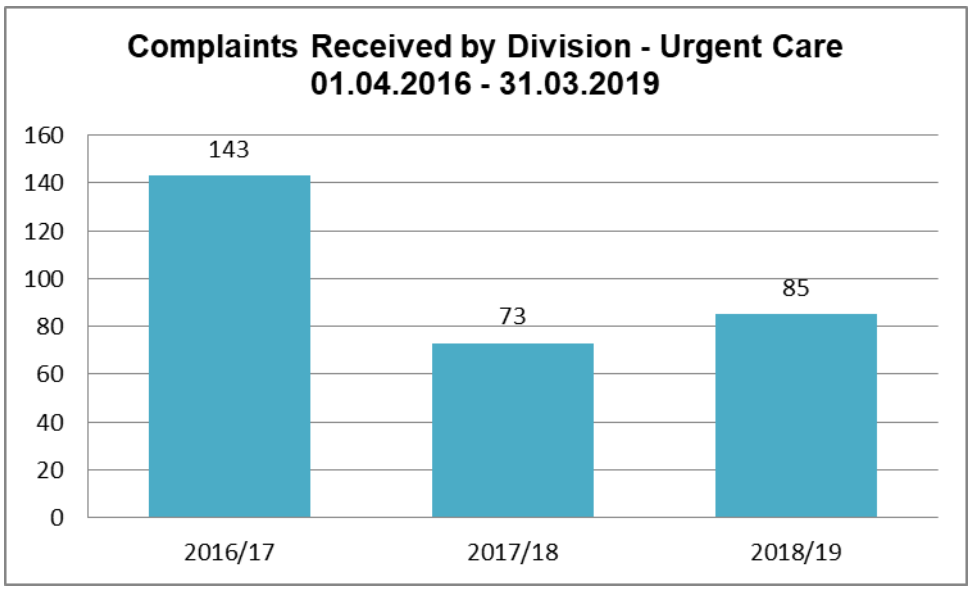
Top 3 Primary Subjects for Complaints

2016/17		2017/18		2018/19	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
Patient Pathway	20	Communication	17	Standard of Care	12
Communication	16	Standard of Care	14	Patient Pathway	9
Standard of Care	9	Patient Pathway	9	Provision of Services	6

Top Locations for Complaints

2016/17		2017/18		2018/19	
Location	**No.**	**Location**	**No.**	**Location**	**No.**
Patients Home	16	Patients Home	13	Patients Home	15
Outpatients – CQ	4	Irvine Unit – Bexhill	6	Outpatients – EDGH	4
Outpatients - EDGH	3	Outpatients - EDGH	3	Outpatients - CQ	3

Urgent Care
The following chart represents complaints received over the last three years.



Following a significant drop in the number of complaints received between 2016/17 and 2017/18, there was small increase in the number of complaints received during 2018/19 but with no discernible rationale. The following tables set out the top three primary subjects and top locations for complaints in Urgent Care.

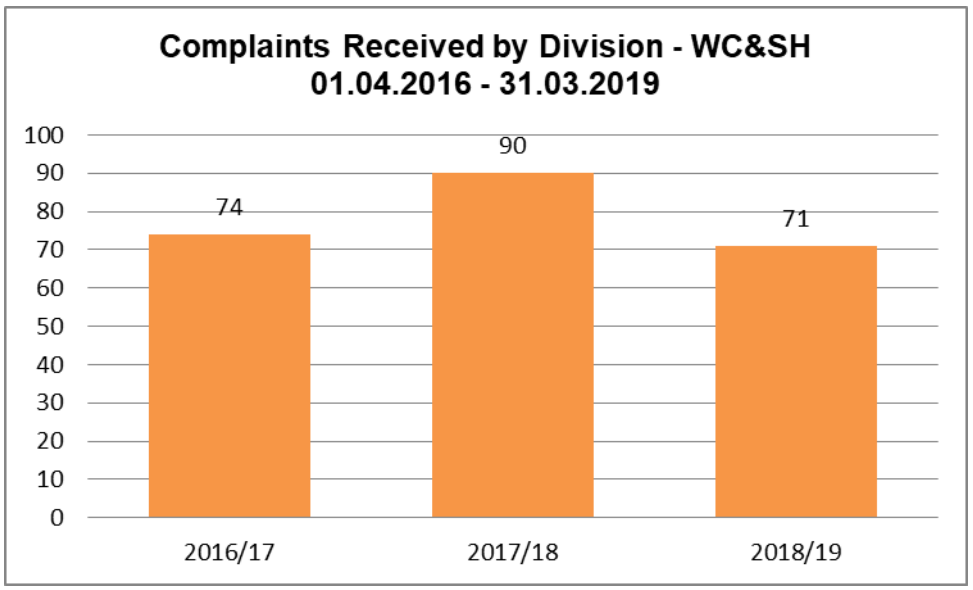
Top 3 Primary Subjects for Complaints

2016/17		2017/18		2018/19	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
Standard of Care	88	Standard of Care	31	Standard of Care	51
Patient Pathway	52	Communication	15	Attitude	9
Communication	51	Attitude	10	Patient Pathway	8

Top Locations for Complaints

2016/17		2017/18		2018/19	
Location	**No.**	**Location**	**No.**	**Location**	**No.**
Emergency Unit – EDGH	69	Emergency Unit – CQ	32	Emergency Unit – EDGH	42
Emergency Unit - CQ	50	Emergency Unit – EDGH	30	Emergency Unit - CQ	27

Women, Children and Sexual Health (WC&SH)
The following chart represents complaints received over the last three years.



After being the only clinical division to see an increase in complaints received in 2017/18 compared to the previous year, WC&SH saw a return to figures on par with 2016/17. Although there was a contractual change to the provision of incontinence products in Paediatrics which did not have any noticeable impact on the overall complaint rates for 2018/18, it will largely explain the increase in complaints assigned to the primary subject of "Provision of Services" and complaint location of "Patients Home". The following tables set out the top three primary subjects and top three locations for complaints in WC&SH.

Top 3 Primary Subjects for Complaints

2016/17		2017/18		2018/19	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
Standard of Care	38	Communication	55	Standard of Care	22
Communication	34	Standard of Care	48	Provision of Services	16
Patient Pathway	31	Patient Pathway	31	Communication	12

Top Locations for Complaints

2016/17		2017/18		2018/19	
Location	**No.**	**Location**	**No.**	**Location**	**No.**
Outpatients – EDGH	18	Outpatients – EDGH	15	Patients Home	16
Kipling Ward	10	Frank Shaw Ward	10	Frank Shaw Ward	9
Patients Home	6	Mirrlees Ward	10	Mirrlees Ward	7
		Patients Home	9		

3. Parliamentary and Health Service Ombudsman (PHSO)

If a complainant is unhappy with the Trust's response(s) to their complaint, they have the right to take the matter to the PHSO if all local avenues of resolution have been exhausted. The PHSO are an independent body who will consider all referrals made to them; the PHSO may request copies of the Trust's complaint file and the patient's medical records to help them decide if they wish to undertake a further review or investigation of

the matter. The Trust fully complies with all requests made by the PHSO, and appropriately acts upon decisions and direction give in any case.

In 2018/19, the Trust received 20 contacts from the PHSO and 19 case outcomes (please note some of the outcomes relate to cases the PHSO opened in 2017/18). In summary, the PHSO decided not to investigate six cases, they did not uphold four cases investigated, they partially upheld seven cases investigated and fully upheld two cases investigated. Given our contact rate from the PHSO is dictated by their own processes, it is difficult to meaningfully use comparative data.

The following provides a summary of the cases partially and fully upheld (in the favour of the complainant), together with details of the PHSO decisions.

Partially Upheld

1. The initial complaint was around the care complainant's father received from August 2016, as whilst an inpatient the Trust sent correspondence to his home address to organise a Colonoscopy and did not inform him to stop taking Clopidogrel seven days before the procedure. This led to a delay and prolonged hospital stay, during which time the patient's property was also lost. The PHSO found that the Trust failed to communicate appropriately when organising the patient's colonoscopy, causing him and his family unnecessary stress and frustration, which they felt the Trust had already acknowledged, apologised for and taken appropriate action. However, the PHSO found that the Trust did not take appropriate action with regards to the property and recommended that the Trust write to the complainant to apologise for the unnecessary frustration caused to the patient by failing to follow the Patient Monies and Property Procedure and provide copy of the communication document the Endoscopy Unit implemented as a result of his complaint.

2. Patient complained that the Trust failed to investigate and missed opportunities to diagnose his cancer, instead treating him for prostatitis. He felt this led to a six month delay in his prostate cancer being diagnosed reducing his chance of survival. The PHSO partly upheld the case as they identified some failings in the actions of the Trust which caused a delay in the patient's prostate cancer being diagnosed. They found this did not impact on treatment options available to the patient or whether his cancer was curable, but it is likely to have had a small impact on his prognosis. The PHSO were satisfied that the Trust appropriately identified that the time taken between the MRI report being available and the result being shared was excessive and that we had apologised and put an action plan in place to address this. The PHSO recommended that i) the Trust provide the patient with an update regarding the action plan, ii) acknowledge that delaying PSA testing in the absence of a proven infection is not in line with NICE guidance and apologise for the impact this had and produce an action plan within 12 weeks explaining what action will be taken to prevent similar failings from occurring in the future and iii) pay patient £1,350.00 in recognition of the impact the failings had on him.

3. Concerns were raised by the patient’s wife around the nursing care provided to her husband during his admission to hospital in November 2016. This was around cause and treatment of red marks on skin, administering and recording of pain relief, communication between staff and patient and his wife and standard of personal care provided. The PHSO partially upheld the complaint as they found failure in record keeping surrounding the decision to use urine bottles rather than a

catheter and asked the Trust to apologise for this and provide evidence within six weeks of what steps have been taken to remind staff of the importance of accurate record keeping.

4. Patient raised concern that whilst her initial diagnosis was a shoulder dislocation, she was also told there was a fracture; however, the discharge summary did not reflect this. When she subsequently attended the Fracture Clinic she was informed that her shoulder was broken and she is unhappy that she was initially discharged in August 2017 with a broken shoulder – she feels that if it was treated appropriately at the outset she may have received appropriate care sooner and avoided pain, suffering and financial impact which followed. Whilst the PHSO found that the Trust failed to update the discharge summary correctly, and as a consequence left the patient unsure of her diagnosis at discharge, they cannot see that it can be linked to the injustice claimed. They also felt that the Trust's remedial actions taken at the time of the complaints process were proportionate in addressing and remedying the failure that occurred. In view of this, the PHSO did not propose any recommendations to be taken. It was suggested that the discharge summary can be amended to show the patient's shoulder was fractured and not just dislocated if patient wished.

5. Complainant raised concern about how staff treated her mother at Conquest Hospital in November 2015. This was in terms of delays in treatment and a cardiology consultant attending, lack of increase in frequency of monitoring when her mother's health deteriorated, failure to record allergy to Morphine and about how the Trust investigated the circumstances that led to her mother's death. Complainant was unhappy that the same person who completed this was also allowed to respond to the complaint. The PHSO did not find any significant failings in the care and treatment that hospital staff gave to the patient and they did not find that her death was avoidable. However, the PHSO partly upheld the case as they found failings with the Trust's investigation and complaints handling. The PHSO recommended that the Trust should i) apologise within one month for the failings identified, and ii) develop an action plan within two months to ensure serious untoward incidents are investigated in line with relevant guidelines and how it intends to improve complaints handling.

6. A patient initially complained that the Orthotic Department incorrectly raised his left shoe by 25mm and then to 31mm and he is also unhappy about the waiting time for an appointment. The patient states that as a result of the incorrect shoe raise, he experienced pain, discomfort and prolonged healing. The PHSO partially upheld the complaint as they found the Trust failed to properly assess the patient during his orthotic appointments on 20 April 2017 and 6 July 2017. In view of this, he was supplied with a shoe raise that was too high. They asked the Trust to i) apologise for this within one month, ii) pay the patient £500.00 in recognition that the failing contributed to his pain and discomfort and iii) provide an action plan within three months to ensure the failings do not happen again.

7. Complainant raised concerns about how staff at Eastbourne District General Hospital treated her late daughter between 16 October to 8 December 2016, and the lack of communication from doctors. Complainant believes her daughter might not have developed pressure ulcers, sepsis or pneumonia if treatment had been appropriate. The PHSO partly upheld the case, as they found failing in the end of life care and treatment doctors provided to the patient. Although they did not see

evidence that this had any significant impact on her health or that they contributed to her death, an opportunity to provide palliative care was missed which would have made her death more dignified and less distressing for her family. The PHSO recommended that within two months the Trust i) acknowledge failings in end of life care and apologise to the complainant for impact they had, and ii) explain what action it has taken (or proposes to take) to address the failings identified.

Fully Upheld

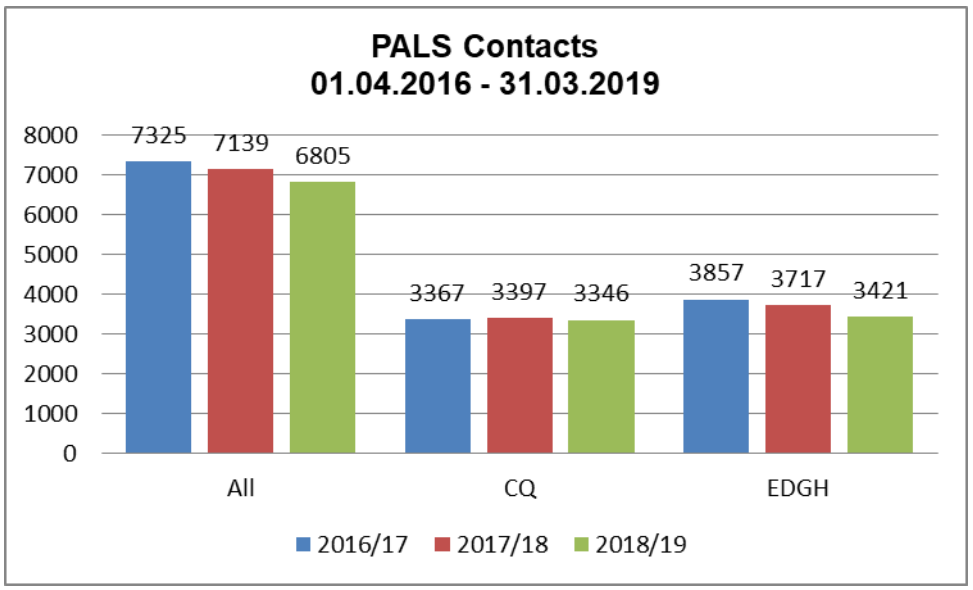
1. The PHSO provided an outcome on a case whereby the patient stated that because she was not admitted as an inpatient to surgically manage a miscarriage (SMM) on 16 February 2018, despite being told by a member of staff that this was possible two days earlier, she suffered the miscarriage at home, which caused her and her family significant distress. The PHSO upheld the case, as they found there was a failing in communication, in that the date for SMM was not documented properly or communicated to other staff. The PHSO recommended that the Trust pay the patient £500.00 and provide a formal written apology in recognition of the injustice suffered.

2. The Local Governance Ombudsman (LGO) provided an outcome on a complaint concerning the Trust, East Sussex County Council and the Royal Free London NHS Foundation Trust, whereby complainant raised concerns in terms of poor communication and arrangements between all organisations when her father was discharged from London. The complainant stated that this led to a delay (as CSRT declined initial referral) to assess her father and provide therapy at home, which impacted on his wellbeing. The LGO upheld the complaint as they found poor communication and conflicting information between all three organisations, which led to a two month delay in the patient receiving community rehabilitation. The LGO recommended that within six weeks ESCC and the Trust i) review the improvements made to the referral process for CSRT, JCR reablement and HSCC to ensure the outcome decision of a referral is properly recorded and the referring officer/organisation is formally notified ii) jointly apologise for the adverse impact the delay had on the patient's wellbeing and iii) jointly pay £250.00 to acknowledge the impact the faults had on the complainant and her father and for the time and trouble in pursuing the complaint.

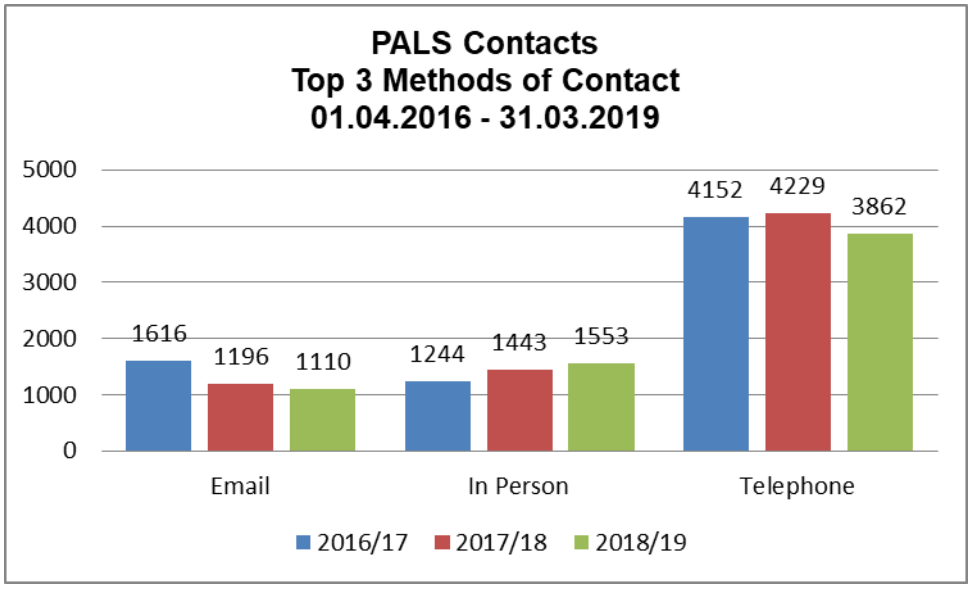
4. Patient Advice and Liaison Service (PALS)

PALS provide a vital role for the Trust in supporting patients, their relatives and members of the public with general advice, questions, and concerns that can be handled quickly and locally without the need for a formal resolution approach. There is a PALS office based in, or very close to, the main reception areas at both Conquest Hospital and Eastbourne District General Hospital (DGH). These small teams are a regular source of advice to everyone accessing them, and often prevent concerns from needing to become a formal complaint by working with clinical divisions to deliver the best outcome as close as possible to the source.

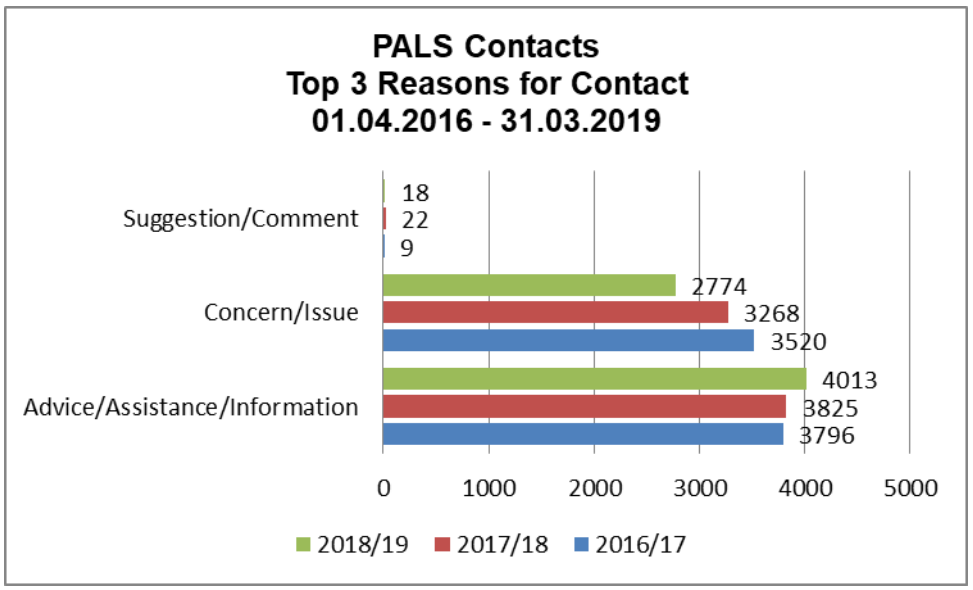
The following chart represents all PALS contacts received over the last three years.



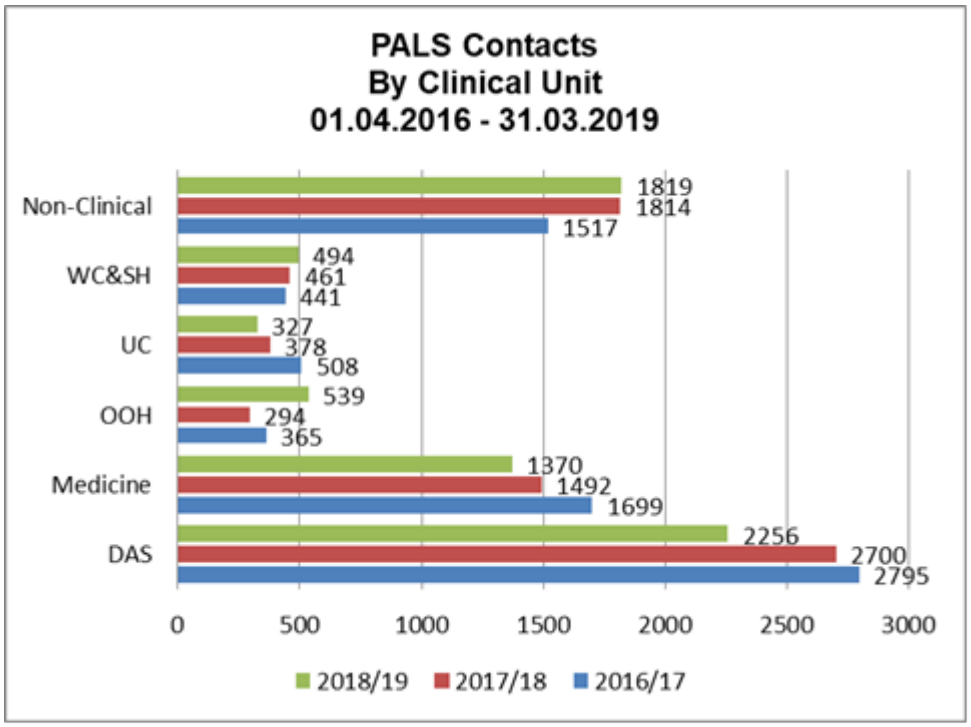
PALS record their activity to cover a wide range of data reporting functions, and the following charts represent PALS activity for key data points.



During the reporting period it is interesting to note that given the technological age we now live in, the area in which contacts increased was the face-to-face office visits. This demonstrates the value of the friendly and helpful service PALS provides to those visiting their offices, and how much face-to-face contact means to our patients and their relatives.



During the reporting period, there has been a stepped reduction in the number of contacts made to raise a concern or issue without a correlating increase in new complaints. This is encouraging to see as it may suggest improvements at clinical level that has reduced the need for patients and relatives to raise a concern or issue with care and treatment.



During the reporting period the most significant change in contacts with PALS on the basis of the clinical division the matter related to was with OOH. This, and the increase in contacts with WC&SH in 2018/19, were due to the contractual changes to the provision of incontinence products. Additionally, contact with PALS relating to non-clinical matters remained the second highest category. In many cases, these contacts related to issues with appointments, particularly short notice cancellations, patients experiencing multiple cancellations and non-receipt of information advising of cancellation.

In terms of contacts raised as a concern or issue, the following table sets out the top 10 sub-subjects recorded against this contact reason.

2016/17		2017/18		2018/19	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
Unable to Contact Department	913	Unable to Contact Department	720	Unable to Contact Department	373
Appointment Issues	448	Appointment Issues	359	Appointment Issues	270
Clinical Service/Treatment Not Available/Delays	203	Clinical Service/Treatment Not Available/Delays	235	Clinical Service/Treatment Not Available/Delays	188
Unhappy With Attitude	195	Unhappy With Attitude	203	Unhappy With Attitude	172
Admission Issues	138	Lack of Confidence in Delivery of Care	134	Lack of Confidence in Delivery of Care	132
Lack of Confidence in Delivery of Care	127	Lack of Information/Communication	118	Lack of Notification of Cancellation	100
Lack of Information/Communication	112	Overall Care	90	Multiple Cancellations	97
Overall Care	106	Lack of/Delay in Referral	84	Lack of Information/Communication	88
Delayed Communication/Information	84	Delayed Communication/Information	80	Delays in Access to Service/Treatment – Outpatient	77
Lack of/Delay in Referral	66	Multiple Cancellations	79	Written Information for Patients	69

As referenced earlier, contacts for non-clinical matters are the second highest category and this table demonstrates that concerns and issues with appointments are a key element of this. Whilst the sub-subject of “Unable to Contact Department” has been the top sub-subject for the last three years, it is encouraging to see contacts about this significantly dropping, and this is likely to be as a result of new measures being introduced such as patients having the ability to cancel or rebook appointments online, and a rolling programme of improvements to the Trust’s telephone systems.

The following table sets out the top five primary subjects for PALS contacts.

2016/17		2017/18		2018/19	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
Communication	1275	Communication	1121	Communication	752
Patient Pathway	830	Patient Pathway	690	Patient Pathway	625
Standard of Care	330	Provision of Services	326	Provision of Services	482

Provision of Services	206	Standard of Care	310	Standard of Care	313
Attitude of Staff	203	Attitude of Staff	213	Attitude of Staff	190

The top five primary subjects have remained the same over the last three years, with only a change in the ranking in 2017/18 that went unchanged in 2018/19. Although there has been a reduction in overall contact rates with PALS, it is encouraging to note the significant drop in contacts relating to communication.

The contacts made with PALS relate to a vast number of locations across the area covered by the Trust. The following table sets out the top 15 locations.

2016/17		**2017/18**		**2018/19**	
Primary Subject	**No.**	**Primary Subject**	**No.**	**Primary Subject**	**No.**
Administration	1751	Administration	1291	Outpatients – EDGH	1212
Outpatients – EDGH	1329	Outpatients – EDGH	1248	Administration	1161
Outpatients – CQ	815	Outpatients – CQ	660	Outpatients – CQ	565
Booked Admissions Department	236	Booked Admissions Department	233	Patients Home	466
Emergency Unit – EDGH	188	Patients Home	214	Booked Admissions Department	205
Radiology Department – CQ	149	Emergency Unit – EDGH	179	Emergency Unit – EDGH	157
Emergency Unit – CQ	128	Cashiers	140	Emergency Unit – CQ	136
Patients Home	121	Audiology Department	130	Orthopaedics Outpatients – CQ	105
Radiology Department – EDGH	118	Emergency Unit – CQ	130	Cashiers	100
Cashiers	78	Fracture Clinic	124	Radiology Department – CQ	97
Community or Public Areas	77	Radiology Department – CQ	112	Fracture Clinic	82
Orthopaedics Outpatients – CQ	73	Orthopaedics Outpatients – CQ	110	Acute Assessment Unit	81
Health Records Library – EDGH	71	Radiology Department – EDGH	100	Audiology Department	61
Fracture Clinic	70	Endoscopy U nit – EDGH	72	Physiotherapy – CQ	61
Richard Ticehurst SAU	65	Orthopaedics Outpatients - EDGH	71	Radiology Department – EDGH	61

Although PALS record contacts for over 200 different locations each year, it is interesting to note there are no significant changes in the top 15 locations year on year. Given the

number of contacts about appointments it is understandable why Administration, Outpatients for both sites and Booked Admissions are consistently in the top five locations.

The major change in the location of PALS contacts during 2018/19 relates to that of “Patient Home” as a result of contacts regarding contractual changes to the provision of incontinence products.

Finally, “Cashiers” regularly appears as a location for PALS contacts; however, this is not due to concerns or issues. This is because PALS handle patient travel reimbursements when the Cashiers Department is closed, or when patients are too unwell to make their way to the Cashiers Department given its location in relation to the main hospital; it also further demonstrates how PALS supports staff and patients.

5. Conclusion

It has once again been busy and challenging year for both the Complaints Team and for PALS. However, these teams have been consistent in their commitment and sustained high levels of activity and productivity despite a Trust landscape of high service demand, service changes and regular episodes of operational and clinical pressures. Of particular success, the Complaints Team have been able to maintain a consistent approach to minimising complaints becoming overdue and built on the success of 2018/19 through increased compliance with published response rates, whilst PALS responded to 87.2% of all contacts (6,805) in three working days.

Receiving, investigating and learning from concerns and complaints is crucial to the Trust as part of its improvement journey and goal to be outstanding by 2020. The ability and capacity for clinical divisions to learn and act on the findings will be a focus of attention for 2019/20, as they are best placed to identify actions and learning that are within their resource and financial control.

Medical Revalidation and Nursing & Midwifery Revalidation Annual Reports 2018 - 2019

Meeting information:			
Date of Meeting:	6th August 2019	Agenda Item:	11.3
Meeting:	Trust Board	Reporting Officer:	Medical Director & Director of Nursing

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

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

Summary:

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

Medical Revalidation

1. ESHT has achieved 100% compliance for doctors who were expected to undergo a medical appraisal in 2018 – 2019 for the third consecutive year.

2. Although medical revalidation takes place over a five year cycle, revalidation was initially implemented by the GMC in 2012 in a phased approach over a three year period. In the first year of implementation (2012 – 2013), 20% of all doctors were put forward for a revalidation recommendation, followed by 40% for each of the following two years (2013 – 2015). This means that the medical revalidation workload is increasing exponentially over the next few years as the full five year cycle is completed again and is heaviest in the years 2019 – 2020 and 2020 – 2021 with 109 and 118 recommendations expected to be made respectively.

3. A plan is in place to accommodate the increased workload and ESHT but the success of revalidation compliance also depends on the number of medical appraisers required to assist with offering high quality appraisals. The key risk to the Trust and to the medical appraisal process is insufficient medical appraisers as three have relinquished their role this year.

4. In March 2019 we had 35 medical appraisers. We have a trajectory of 428 appraisals to be undertaken, and we are expected to make 109 revalidation recommendations, over the coming year 2019 – 2020.

5. This risk has been added to the Trust Risk Register. To mitigate the risk, a recruitment drive for medical appraisers is being held regularly and training is offered on a frequent basis to both new and experienced appraisers to support them in their role.

Nursing Revalidation

1. ESHT has achieved a 100% compliance with completed nursing revalidation submissions in its third year 2018 – 2019.

2. The Nursing Revalidation Policy has been revised to clarify the consequences of not re-registering with the NMC in a timely manner.

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

- Medical Revalidation – Medical Revalidation Advisory Panel 20.5.19; People & Organisation Development Group 23.5.19

- Nursing Revalidation – Professional Advisory Group 24.5.19; People & Organisation Development Group 23.5.19

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

1. The Trust Board is asked to approve both annual reports.

2. The Chief Executive and Chair are asked to sign the Statement of Compliance for medical revalidation. This is submitted to the Secretary of State for Health.

East Sussex Healthcare NHS
NHS Trust

MEDICAL REVALIDATION ANNUAL REPORT 2018-2019

1. Executive Summary

NHS England requires all Responsible Officers to present information and data to their Trust Board annually. This report and its appendix provide all prescribed information about medical appraisal and revalidation in ESHT over the year 2018-2019, highlighting key issues and actions being taken to respond to them.

The key achievement for 2018 - 2019 is 100% compliance with the requirements of the Trust's Medical Revalidation and Appraisal Policy by all doctors who have a prescribed connection to the Responsible Officer.

The key risk for medical revalidation is the lack of trained medical appraisers. This report describes the probable reasons for this and how the risk is being addressed. The prescribed data pertaining to appraisal and revalidation is included in the appendix.

2. Background

The Trust has, for the sixth year running, achieved a very high medical appraisal compliance status; in 2018-2019, 100% of all Trust doctors, who were expected to have their medical appraisal within the required timescales, have done so.

On 31st March 2018 there were 415 doctors in the Trust (an increase of 31 on the previous year) claiming a prescribed connection to the Responsible Officer, the Medical Director. Of the 415 doctors with a prescribed connection at 31/3/19, 58 were not due to undertake an appraisal at ESHT until 2019-20. This is because these doctors had an authorised deferral until the next year's appraisal cycle as they have either been in the Trust for less than eight months or have been on long-term sickness or maternity leave.

It should be noted that, because doctors join and leave during the year, the actual number of appraisals undertaken by our appraisers differs from the revalidation data relating to the 415 doctors discussed in this report and totals 383 appraisals in total undertaken. There were eight further appraisals undertaken for doctors who work for the local hospices. Some doctors have joined the Trust as Locum Appointed for Service (LAS) or engaged via the Trust Bank, of whom some have not required an appraisal within the Trust during this reporting period as they will have had their annual appraisal elsewhere or are not yet due to have an appraisal.

Through a Service Level Agreement, ESHT's Responsible Officer also offers all doctors who are employed at either St. Wilfrid's Hospice or St. Michael's Hospice a prescribed connection to ESHT as a Designated Body in support of their revalidation and appraisal. On 31st March 2018, there were seven hospice doctors with a prescribed connection.

Both hospices have achieved 100% compliance for the year 2018–2019. For the purpose of this report, however, the data refers exclusively to the medical staff in ESHT.

3. Lack of Medical Appraisers

The Medical Profession (Responsible Officers) Regulations 2010 (section 19) requires that each Designated Body must provide its Responsible Officer with the resources necessary to enable them to discharge their duties. This includes having sufficient trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection.

ESHT aims to have sufficient trained medical appraisers available so that each appraiser has an average of 8 – 10 appraisals to conduct annually. ESHT currently has 35 appointed medical appraisers and requires a minimum of 44 appraisers to cover the doctors with a prescribed connection and the new starters waiting for their prescribed connection to be established. This has been recorded on the risk register.

The reasons behind the lack of medical appraisers this year is multifactorial.

Firstly, the compliance rate has been exceptional over the past few years for medical appraisals but this has placed our medical appraisers under pressure to complete a large number of appraisals, often over the allocated 8-10 each year.

Whilst many of our appraisers already work to a high standard, some appraisers have been required to improve further the quality of the outputs of their appraisals. A robust quality assurance process has been introduced which identifies where appraisers need further support and training. This has, of course, been provided to them, with the offer of templates and other methods of streamlining their work whilst not sacrificing quality.

However, many appraisers still feel that they have insufficient time away from their clinical duties and responsibilities to conduct appraisals to the standards now required and imposed by NHS England. This has had the unfortunate consequence of them either stepping down from the appraiser role or not wishing to apply for the role.

The need for medical appraisers is also affected by the increase in the number of doctors working on the bank who can claim a prescribed connection to the Responsible Officer and the increased number of revalidation recommendations to the GMC. A ‘revalidation ready’ appraisal, that is the one before a revalidation recommendation, often takes longer as the review of five years of supporting evidence is needed.

Although medical revalidation takes place over a five-year cycle, revalidation was initially implemented by the GMC in 2012 in a phased approach over a three-year period. In the first year of implementation (2012 – 2013), 20% of all doctors were put forward for a revalidation recommendation, followed by 40% for each of the following two years (2013 – 2015). Of course, revalidation is now in its second cycle and the number of revalidation recommendations is therefore exponentially increasing. For 2018 – 2019, the number of revalidation recommendations was 94, an increase of 74 on the previous year. There are 109 recommendations due in the coming year, 115 in the following year. This can put a strain on our medical appraisers.

To mitigate against this risk, which has been added to the Trust Risk Register, the SPA time granted for appraisals was recently increased from 0.25 to 0.3 SP to undertake 10 appraisals per annum. Nonetheless, our appraisers are still advising this does not allow enough time to undertake a quality appraisal so negotiations continue. The Responsible Officer is investigating how the Trust might retain the skills of our retired appraisers who offer good quality appraisals and outputs. There is no centralised budget for appraisals and requests have been made to the Divisions to share out the responsibility and cost of appraisals equitably.

Finally, a recruitment campaign for new appraisers is ongoing and at 31st March 2019 there were six applicants waiting to be interviewed; new appraiser training will take place on the 6th June 2019.

4. Recommendations

1. The Trust Board is asked to approve this annual report, noting it will be shared, along with the annual organisational audit, with the higher level Responsible Officer at NHS England.
2. The Trust Board is also asked to approve the 'statement of compliance' confirming that the organisation, as a designated body, is compliant with all the regulations with the exception of regulation 3 (which relates to the Trust having sufficient number of trained appraisers as, at present, ESHT has too few medical appraisers to carry out an annual medical appraisal for all licensed medical practitioners with a prescribed connection).

   The CEO and/or Chair of the Trust Board are asked to sign the statement.

Dr David Walker
Medical Director & Responsible Officer 1.5.19

APPENDIX A - Additional background information

1. History of revalidation

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that the Trust Board of ESHT will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2. Trust values

Every medical appraiser is expected to abide by a professional code of conduct which is explicitly included within the medical revalidation policy. This code of conduct reinforces the Trust's set of values and behaviours of: respect & compassion; engagement & involvement; improvement & development; and working together.

Every doctor being appraised is also invited to provide feedback on their appraisal and the Trust values can be evaluated as part of this process. Doctors are provided with an annual appraisal governance report, which includes information on any complaints or incidents in which they may have been involved, and this helps them to reflect on their behaviours and learning from these.

At least once per revalidation cycle doctors are required to undergo colleague and patient feedback which reports, for example, how effectively they work with colleagues, how polite they are to patients and colleagues and how they have involved patients in decisions about their treatment. Each doctor is also expected to provide information on how they learn from this feedback to improve and enhance their clinical practice. Another facet of the medical appraisal is the requirement to demonstrate involvement in quality improvement initiatives to promote the quality of patient care.

3. Governance and Quality Assurance

NHS England provides a Framework of Quality Assurance for Responsible Officers (FQA) and this has been published by the Department of Health. The framework details the combined approaches to achieving quality assurance so that the Responsible Officer has confidence that the doctors working in ESHT are up to date and fit to practise. It comprises of the following elements:

<u>Monthly and Quarterly information:</u>

There is a quarterly report sent from the ESHT Responsible Officer to the 2nd Tier (higher level) Responsible Officer, to whom they are linked, which informs NHS England of ESHT's appraisal compliance data. A monthly performance report/dashboard with narrative is also provided by the revalidation team to the Trust Board so that assurance is given that the medical appraisal compliance status is steadily increasing during the year.

[1] 'The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

Annual Organisational Audit (AOA):

The AOA is a mandatory audit that all Responsible Officers are required to complete. This is a standardised return to the higher level Responsible Officer and ultimately to Ministers and the public on the status of the implementation of revalidation across England. This information forms the benchmark across the NHS region. ESHT has consistently improved its medical appraisal rates, achieving the highest compliance in the region for an acute hospital trust over the previous four years.

In the 2018–2019 Annual Organisational Audit (AOA), submitted in April 2019, it is reported that 415 doctors held a prescribed connection to the Responsible Officer in ESHT at 31st March 2019, of whom 415 had completed the entire medical appraisal process within the last year. This figure includes doctors to be appraised, 50 new starters in the Trust who received authorisation to defer their appraisals to the 2019-20 cycle and eight doctors who received authorised deferrals to the following year (i.e. 2019–2020) as they had mitigating circumstances.

There are no doctors, with a prescribed connection to the Responsible Officer in the Trust, who should have had their appraisal and did not, or deferred their appraisal, without formal authorisation in 2018 – 2019.

This means that 100% of all Trust doctors with a prescribed connection to the Trust's Responsible Officer are compliant with the Trust's Medical Revalidation Policy.

Trust Board Annual Report:

Trust Boards are responsible for monitoring the organisation's progress in implementing the Responsible Officer regulations. The Trust Board annual report is one method of informing the Board of the achievements, challenges and compliance status in ESHT with regard to medical appraisals and medical revalidation

Statement of Compliance:

The Responsible Officer Regulations include the requirement of Designated Bodies such as ESHT to provide adequate support to the Responsible Officer. The Chair of the Trust Board or the Chief Executive is asked to sign a statement of the organisation's compliance (or lack thereof) with the RO Regulations. This is submitted to the higher level Responsible Officer. The statement of compliance accompanies this Trust Board annual report for signed approval and submission to the Secretary of State for Health.

Independent Verification:

All Designated Bodies undergo a process to validate their systems and processes at least once in each five-year revalidation cycle. ESHT is due to receive an Independent Verification visit in the current revalidation cycle.

Consistency of the quality of medical appraisals

The quality and consistency of appraisal is supported by regular medical appraiser training which is mandated at least twice per year and contributes to the medical appraiser's own Professional Development Plan. Medical appraisers are encouraged to undertake professional calibration of their medical appraisal judgements during this training.

ESHT has a process of undertaking regular quality assurance checks for the first three appraisal outputs of new appraisers with constructive feedback provided. Regular quality assurance audits of medical appraisal outputs are undertaken using a template provided by NHS England called the Appraisal Summary and Personal Development Plan Audit Tool (ASPAT). Feedback is then provided to the individual medical appraiser and further training and support provided if the need is identified.

All medical appraisals are anonymously evaluated by the doctors being appraised their appraisal; reports on the evaluations for each medical appraiser are provided to them on an annual basis.

4. The 'Pearson' report

Pearson Report recommendations for acute Trusts:

In January 2017 and at the GMC's request, 'Taking Revalidation Forward: improving the process of relicensing for doctors', a report by Sir Keith Pearson, was published. The report reviewed the progress of medical revalidation over the first five years of revalidation and made some recommendations.

These recommendations were included within the medical revalidation annual report for 2016 – 2017 and identified actions that have either since been addressed or where progress was being made. One item to bring to the Trust Board's attention is the recommendation: work with patient groups to publicise and promote processes for ensuring that doctors are up to date and fit to practise.

During 2018 – 2019 ESHT has been fortunate in gaining two lay representatives, the Chair of the Board of Trustees of St Wilfrid's Hospice and a retired GP who is on the Board at St Michael's Hospice. Having this support further strengthens the bond between the Trust and St Wilfrid's and St Michael's Hospice. These representatives joined the Medical Revalidation Advisory Panel in May 2018. An integral element of this role will be to work with the Trust to progress the work on promoting medical revalidation and appraisals to the public.

5. Policy and Guidance

The current Medical Revalidation & Medical Appraisal Policy has been revised to reflect all the recent changes in GMC and NHS England guidance and has been ratified.

APPENDIX B - Statistical data for appraisals and revalidation at ESHT 2018-2019

1. Medical Revalidation and Medical Appraisals

1.1 Revalidation Recommendations in ESHT between 1 April 2018 – 31 March 2019

ESHT has never missed any of the deadlines for recommendation for revalidation.

Table 1. Revalidation Recommendations in ESHT 1 April 2018 – 31 March 2019

Positive recommendations	83
Non engagement notifications	0
Recommendations completed on time	93
Recommendations completed not on time	1
Deferrals requests	11
Reasons for only late recommendation A doctor left a training post and transferred to a locum post at ESHT and then went on maternity leave but did not change her prescribed connection from the Deanery to ESHT. It is a doctor's responsibility to ensure they are linked to the correct designated body; however, her revalidation recommendation deadline date was missed by the Deanery. As the doctor's prescribed connection is now at ESHT, the Responsible Officer made a recommendation to defer revalidation to the GMC to allow the doctor to undertake a revalidation–ready appraisal six months after she returns from maternity leave. The GMC's system shows this as a recommendation not completed on time.	

Table 2. Reasons for medical revalidation deferrals 1 April 2018 – 31 March 2019

Reason for a deferral recommendation	**Number of doctors**
Defer- Insufficient Evidence	11
Defer- Subject to an Ongoing Process	0

1.2 Medical Appraisals

Table 3. Medical Appraisals completed in ESHT between 1 April 2018 – 31 March 2019

On 31st March 2019 there were 415 doctors in the Trust claiming a prescribed connection to the Responsible Officer, the Medical Director.

The Trust can again report an excellent medical appraisal compliance status for 2018 – 2019 with 100% of all doctors with a prescribed connection abiding by the Trust's medical appraisal compliance criteria.

Mar-19	**Total**	**Green**	**%**	**Amber**	**%**	**Red**	**%**
Consultants	**233**	**233**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**
SAS	**100**	**100**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**
LAS/Trust Grade	**49**	**49**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**
Bank	**33**	**33**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**
Totals	**415**	**415**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**

Total (n) Doctor Appraisal status	Total (%) Doctor Appraisal status							
415	100.0%	Doctors who HAVE forwarded evidence of an appraisal since April this year OR have an authorised deferral until the next year's appraisal cycle as they have either been in the Trust for less than eight months OR have been on long-term sickness/maternity leave						
0	0.0%	Doctors who have NOT had an appraisal since 1st April this appraisal year but are expected to have an appraisal before the end of the appraisal cycle in March if still with the Trust at that date						
0	0.0%	Doctors who do NOT have an authorised postponement and have missed their appraisal						
100%	**100%**							

1.3 Methods of reporting appraisal compliance

There are two methods of reporting appraisal compliance and these are outlined below.

1.3.1 NHS England/GMC method of reporting:

NHS England has changed the way they measure appraisal compliance this year. From April 2019, new starters who are not due to undertake an appraisal until the following appraisal cycle in April must now be recorded as an authorised deferred appraisal. In previous years, they were recorded as compliant. The Board should be aware that this will show against our compliance for future NHS England's reports and the Trust's annual report.

The method of reporting medical appraisal compliance is prescribed by NHS England/GMC as follows:

Measure 1:
A completed annual medical appraisal is one where either:
a) All of the following three standards are met:

i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*,
ii. the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting,
iii. the entire process occurred between 1 April and 31 March.

or

b) the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the three standards in a) has been missed. However, the judgement of the responsible officer is that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

Measure 2:
Approved incomplete or missed appraisal:
An approved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of a Category 1 completed annual medical appraisal, but the responsible officer has given approval to the postponement or cancellation of the appraisal.

Measure 3:
Unapproved incomplete or missed appraisal:
An Unapproved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of a Category 1 completed annual medical appraisal, and the responsible officer has not given approval to the postponement or cancellation of the appraisal.

Summary

This now results in doctors who have been in the Trust for less than eight months to be recorded by NHSE as an unauthorised or deferred appraisal. The consequence is that the Trust will be unlikely to gain 100% compliance in the future with the new NHS England's reporting system.

1.3.2 ESHT method of reporting:

In ESHT, the medical appraisal cycle runs from April to December each year. If it is agreed by the Responsible Officer that, due to exceptional circumstances, an appraisal may take place between January and March, an additional appraisal must be undertaken by the end of December in the same year. Every doctor should have an appraisal in the anniversary month, or before, of their previous appraisal. Doctors who conform to this and/or have their appraisal within 365 days of their last appraisal are reported as being compliant.

ESHT's medical revalidation team contacts all doctors joining the Trust and provides them with supporting information including the expected month of appraisal; this is particularly significant in situations where their previous appraisal took place between January and March or if they have not had an appraisal within the twelve months before joining ESHT.

If doctors have had a medical appraisal within the last 12 months, and it was not conducted between January and March, the doctor will be expected to inform the Revalidation team, who will then make every effort to provide a medical appraisal no later than their annual appraisal anniversary month. Therefore, doctors are currently reported as being compliant until they have been in the Trust for eight months. After this time, if the doctor has not had an appraisal, they are reported as being non-compliant.

1.4 Appraisals completed between 1 April 2018 and 31 March 2019 by Division

Table 4. Appraisals completed between 1 April 2018 and 31 March 2019 by Division

includes leavers

Division	Total Number of doctors (excluding hospice)	Number of completed appraisals (excluding hospice)	Number of doctors who missed their 2018-19 appraisal (unauthorised)	Number of doctors with an authorised deferred appraisal for mitigating circumstances	Number of new starters not due an appraisal until next year's cycle (excluding hospice)
Diagnostics, Anaesthetics & Surgery	224	182	0	3	12
Medicine	157	105	0	5	21
WCSH	75	59	0	0	9
Urgent Care	67	37	0	0	8
Totals	**523**	**383**	**0**	**8**	**50**

1.5 Audit of appraisals undertaken outside the 12 month appraisal anniversary

It is felt that one of the contributing factors in the high medical appraisal compliance status in ESHT is that doctors are reminded of their annual appraisal on at least two occasions. However, some doctors do miss their appraisals and an audit is conducted for all missed appraisals, whether approved or otherwise, and the reasons for these are provided here in Table 5.

A 'postponed' appraisal is defined as one that does not take place within the anniversary month but is authorised by the RO to take place in a later month and it does take place within the same Trust/GMC appraisal year.

A 'deferred' appraisal is defined as one that does not take place within the Trust/GMC appraisal year but it is authorised by the RO.

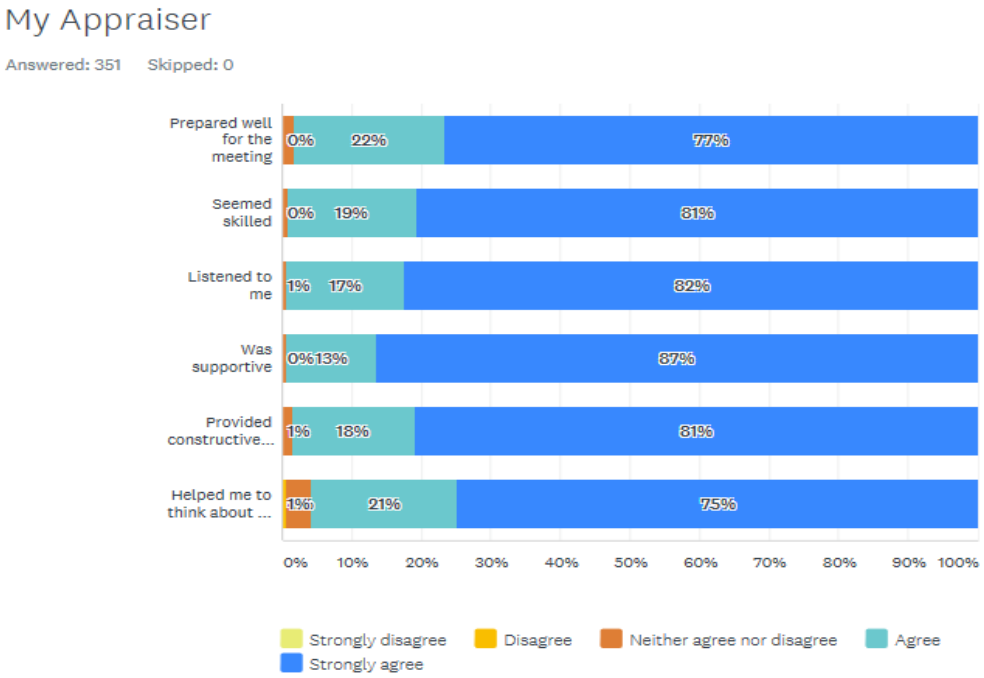
A 'missed' appraisal is defined as one that has not taken place within twelve months from the date of the last appraisal or one where the appraisal outputs are not signed off within 28 days from the date of the appraisal and has not been approved by the Responsible Officer.

Table 5. Reasons for postponed, deferred or missed appraisals 1st April 2018 – 31th March 2019

Doctor factors (total)	**Number**
Maternity leave (deferred authorised)	5
Sickness absence (deferred authorised)	3
Sickness absence (postponed in same year)	4
Prolonged Leave	3
New starter not due to have appraisal in current year but due within eight months of joining (authorised)	50
Postponed due to incomplete portfolio/insufficient supporting information (authorised)	6
Lack of time of doctor	5
Lack of engagement of doctor (Unauthorised) • Both doctors subsequently completed their appraisal	2
Compassionate	
Other doctor factors (describe) • Exam preparation • Personal laptop containing MAG and appraisal history was stolen • Appraisal moved closer to Revalidation date	3
Appraiser factors	
Unplanned absence of appraiser	1
Lack of time of appraiser	3
Organisational factors	
Other organisational factors • Appraiser stepped down unexpectedly.	1
Difficulty in arranging a mutually convenient time due to opposing timetable/clinical commitments/annual leave	36

1.6 Feedback on medical appraiser and revalidation team performance

Table 6. Feedback on medical appraiser performance by ESHT doctors 2018-19

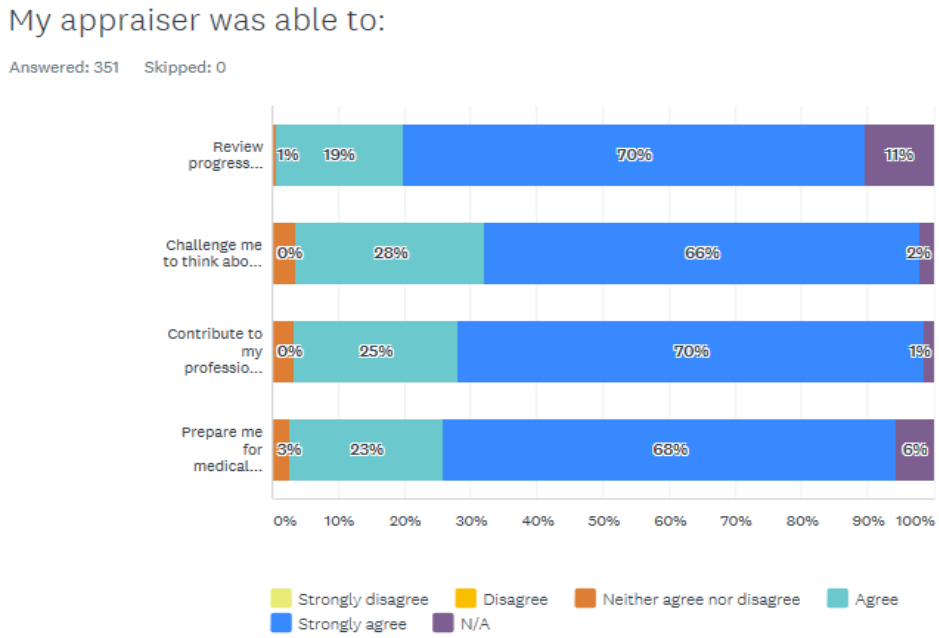


My appraiser was well prepared, skilfully manged the whole process, I didn't notice 2:30hrs was over in minutes. He is a good listener; communication was 2 ways, taking on board and reflecting back my presentation, experience, opinions and expectation .Supportive; secondary to my background as foreign trained doctor, and working as a locum.

Excellent and enjoyable appraisal. Really valuable and informative. The appraiser gave me excellent guidance and advice and I really enjoyed the process and have come away with lots of positives and goals for next year / next 5 years

My Appraiser was very well prepared or the appraisal meeting. He was very supportive and gave me lots of time in spite of his busy schedule. He not only provided very useful feedback but also encouraged me to think about various ways I can increase my knowledge and clinical skills.

Table 7. Feedback on medical appraiser performance by ESHT doctors 2018-19



Medical appraisers receive regular training on their appraisal skills but also of any GMC updates and ESHT processes. This leads appraisers to become excellent sources of knowledge and champions for medical appraisals, one of the many reasons that the appraisal compliance in

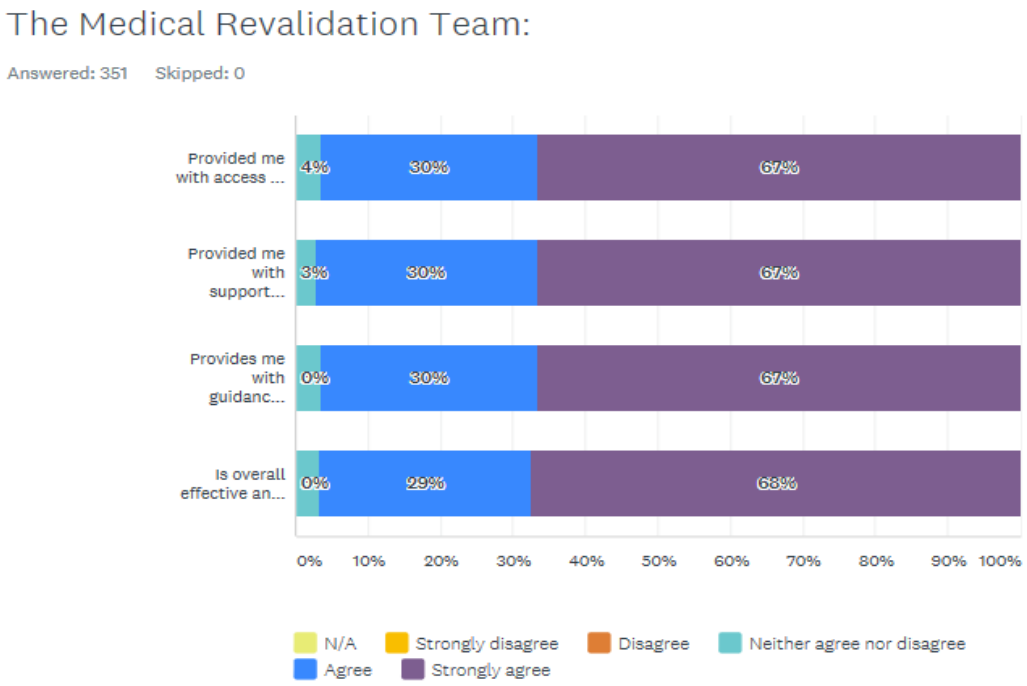
ESHT is so high, particularly compared with other Trusts. Our medical appraisers are highly valued.

He took time to gather the data, inspecting the subject properly. I am very happy and grateful with his good advice.

There was good rapport and listening. Constructive comments and an opportunity to feedback on issues. Good environment created.

We briefly went through my past experience abroad and concentrated on my experience in the UK for the past 9 months. We discussed about my aspirations and difficulties I was facing in reflecting as something I was not used to put into writing, after my appraisal I feel I can document my reflection better

Table 8. Feedback on medical revalidation team performance by doctors



I attended course for appraisal and revalidation, it was very helpful, I've got all necessary information that I needed to complete my appraisal without having any problems. I wish the other hospitals had the same system

The Revalidation team was very helpful and patient with me. This being my first revalidation in UK, they guided me through this processes very professionally and It was really good experience with the team

Very efficient system. I use the reminder emails rather than the extranet as I find the extranet clunky. I save all the emails in a file as they arrive. They might be irritating at the time but are vital when you sit down to do the appraisal process! Thank you.

1.7 Current trajectory for revalidation recommendations until 2024

Table 9. Current trajectory for revalidation recommendations until 2024

	Year					
Month	19/2020	20/2021	21/2022	22/2023	23/2024	Total
Apr	8	5	2	1	5	21
May	13	15	3	1	8	40
Jun	4	8	1	3	6	22
Jul	19	3	4	3	15	44
Aug	2	18	6	12	5	43
Sep	13	14	3	3	6	39
Oct	12	12	2	4	16	46
Nov	6	13	4	5	10	38
Dec	10	10	2	4	9	35
Jan	8	11	0	4	16	39
Feb	4	4	0	4	4	16
Mar	10	2	4	4	17	37
Total	109	115	31	48	117	420

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The board of East Sussex Healthcare NHS Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

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

   Yes

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

   Comments: Yes

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

   Comments: No

   The Medical Profession (Responsible Officers) Regulations 2010 (section 19) requires that each Designated Body must provide its Responsible Officer with the resources necessary to enable them to discharge their duties. This includes having sufficient trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection.

   ESHT aims to have sufficient trained medical appraisers available so that each appraiser has an average of 8-10 appraisals to conduct annually. ESHT currently has 35 appointed medical appraisers and requires a minimum of 44 appraisers to cover the doctors with a prescribed connection and the new starters waiting for their prescribed connection to be established. This has been recorded on the risk register.

   The reasons behind the lack of medical appraisers this year is multifactorial.

   Firstly, the compliance rate has been exceptional over the past few years for medical appraisals but this has placed our medical appraisers under pressure to complete a large number of appraisals, often over the allocated 8-10 each year.

   Whilst many of our appraisers already work to a high standard, some appraisers have been required to improve further the quality of the outputs of their appraisals. A robust quality assurance process has been introduced which identifies where appraisers need further support and training. This has, of course, been provided to them, with the offer of templates and other methods of streamlining their work whilst not sacrificing quality.

   However, many appraisers still feel that they have insufficient time away from their clinical duties and responsibilities to conduct appraisals to the standard now required and imposed by NHS England. This has had the unfortunate consequence of them either stepping down from the appraiser role or not wishing to apply for the role.

   The need for medical appraisers is also affected by the increase in the number of doctors working on the bank who can claim a prescribed connection to the Responsible officer and the increased number of revalidation recommendations to the GMC. A 'revalidation ready' appraisal, that is the one before a

revalidation recommendation, often takes longer as the review of five years of supporting evidence is needed.

Although medical revalidation takes place over a five-year cycle, revalidation was initially implemented by the GMC in 2012 in a phased approach over a three-year period. In the first year of implementation (2012-2013), 20% of all doctors were put forward for a revalidation recommendation, followed by 40% for each of the following two years (2013-2015). Of course, revalidation is now in its second cycle and the number of revalidation recommendations is therefore exponentially increasing. For 2018-19, the number of revalidation recommendations was 93, an increase of 73 on the previous year. There are 109 recommendations due in the coming year, 115 in the following year. This can put a strain on our medical appraisers.

To mitigate against this risk, which has been added to the Trust Risk Register, the SPA time granted for appraisals was recently increased from 0.25 to 0.3 SP to undertake 10 appraisals per annum. Nonetheless, our appraisers are still advising this does not allow enough time to undertake a quality appraisal so negotiations continue. The Responsible Officer is investigating how the Trust might retain the skills of our retired appraisers who offer good quality appraisals and outputs. There is no centralised budget for appraisals and requests have been made to the Divisions to share out the responsibility and cost of appraisals equitably.

Finally, a recruitment campaign for new appraisers is ongoing and at the 31st March 2019, there were six applicants waiting to be interviewed; new appraiser training will take place on the 6th June 2019.

Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

Comments: Yes

4. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Comments: Yes

5. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

Comments: Yes

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

Comments: Yes

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

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

7. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

   Comments: Yes

8. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

   Comments: Yes

9. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

   Comments: Yes

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: East Sussex Healthcare NHS Trust

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

Role: _ _ _ _ _ _ _ _ _ _ _ _

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

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Quality Walks May – June 2019

Meeting information:			
Date of Meeting:	6th August 2019	Agenda Item:	12
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

38 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st May and 30th June 2019. In addition to the formal programme the Chief Executive has also visited 16 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 MAY- JUNE 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 May and 30th June 2019.

Date	Service/Ward/Department	Site	Visit by
May			
2.5.19	Scott Paediatric Unit	Eastbourne	Nicky Webber
3.5.19	General Outpatients Department	Eastbourne	Adrian Bull
7.5.19	Pathology Department	Eastbourne	Catherine Ashton
7.5.19	Sexual Health Clinic	Avenue House Eastbourne	Jonathan Reid
9.5.19	Physiotherapy Department	Eastbourne	Jackie Churchward-Cardiff
9.5.19	Newington Ward	Conquest	Catherine Ashton
13.5.19	Sterilisation and Decontamination Unit	Conquest	Jonathan Reid
14.5.19	Frailty Practitioner service	Eastbourne	Jackie Churchward-Cardiff
15.5.19	Mortuary	Eastbourne	Adrian Bull
16.5.19	Emergency Department	Conquest	Monica Green
17.5.19	Junior Doctors Forum	Conquest	Adrian Bull
17.5.19	Critical Care Unit	Conquest	Adrian Bull
17.5.19	Community Dental Service	Ian Gow Memorial Health Centre	Monica Green
20.5.19	Sexual Health Clinic	Station Plaza	Karen Manson
20.5.19	Sexual Health Clinic	Bexhill Health Centre	Karen Manson
21.5.19	Speech and Language Clinics	Centenary House	Karen Manson
21.5.19	Audiology Administration	Centenary House	Karen Manson
21.5.19	Volunteers Services	Eastbourne	Vikki Carruth
24.5.19	Physiotherapy Department	Eastbourne	Adrian Bull
24.5.19	Sterilisation Decontamination Unit	Eastbourne	Adrian Bull
28.5.19	Radiology Department	Conquest	Lynette Wells
28.5.19	Jevington Ward	Eastbourne	Catherine Ashton
29.5.19	District Nursing	Arthur Blackman Clinic	Karen Manson
29.5.19	Community Dental Service	Arthur Blackman Clinic	Karen Manson
29.5.19	Community Dental Service	Seaford Health Centre	Jonathan Reid
30.5.19	IT/Data Quality Department	St Anne's House	Karen Manson
30.5.19	Finance Department	St Anne's House	Karen Manson
June			
3.6.19	Wellington Ward	Conquest	Karen Manson
4.6.19	Infusion Unit	Eastbourne	Jackie Churchward-Cardiff
6.6.19	Joint Community Rehabilitation Team	Lewes	Catherine Ashton
6.6.19	Volunteers Long Service Awards	Bexhill	Adrian Bull
7.6.19	Rainbow Nursery	Conquest	Adrian Bull
7.6.19	Surgical Wards	Conquest	Adrian Bull
10.6.19	Critical Care	Conquest	Karen Manson
11.6.19	James Ward, CCU & Cath Lab	Conquest	Karen Manson
11.6.19	Occupational Therapy Department	Eastbourne	Adrian Bull
11.6.19	Surgical Wards	Eastbourne	Adrian Bull

13.6.19	Michelham Unit	Eastbourne	Catherine Ashton
13.6.19	Discharge lounge	Eastbourne	Jackie Churchward-Cardiff
13.6.19	Intermediate Care Unit	Rye	Karen Manson
13.6.19	Booked Admissions team	Eastbourne	Steve Phoenix
13.6.19	Joint Community Rehabilitation Team	Firwood House	Adrian Bull
14.6.19	Occupational Therapy Department	Conquest	Adrian Bull
17.6.19	Occupational Health Department	Conquest	David Walker
19.6.19	Outpatients and '2 week wait' teams	Conquest	David Walker
19.6.19	Tissue Viability Service	Conquest	Lynette Wells
20.6.19	Respiratory Team	Conquest	Jonathan Reid
20.6.19	Medical Photography Department	Conquest	Steve Phoenix
20.6.19	Complaints and Patient Advice Liaison Service (PALS)	Conquest	Adrian Bull
20.6.19	IT Department	Eastbourne	Jackie Churchward-Cardiff
21.6.19	End of Life Care Team	Eastbourne	Vikki Carruth
25.6.19	Sleep Studies Department	Conquest	Adrian Bull
25.6.19	Special Care Baby Unit	Conquest	Vikki Carruth
27.6.19	Critical Care Unit	Eastbourne	Adrian Bull

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee

Thursday 23 May 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 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 Moira Tenney, Deputy Director of HR (MT)
Ms Emma Chambers, Interim Assistant Director of Nursing (EC)
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 Jamal Zaidi, Associate Medical Director – Workforce (JZ)

In Attendance:
Ms Jilly Alexander, Interim Strategy Project Manager (JA)
Ms Claire Parnell, Senior HR Manager (CP)
Mr Farida Malik, Palliative Care Consultant (FM)
Ms Kim Boorman, Staff Wellbeing (KB)
Mr Waleed Yousef, Obstetrics & Gynaecology Consultant (WY)
Ms Nadia Muhi-Iddin, Guardian of Safe Working (NMI)
Ms Polly Moore-Weekes, Revalidation Team Leader (PM-W)
Mrs Jeanette Williams, Staff Engagement & Wellbeing Manager (JW)
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) Ms Penny Wright, Head of Workforce Planning (PW) Mrs Michelle Elphick, Associate Director of Operations (ME) Ms Anne-Marie Newsholme, Lead Healthcare Scientist (AMN) Mrs Joe Chadwick-Bell Chief Operating Officer (JCB) Mr Pravin Sangle, Associate Specialist (PS) Mrs Tina Lloyd, Assistant Director of Nursing (TL)	

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 To be discussed under agenda item 6. Nursing Report **Update to be provided by VC.** Medical Appraisals To be discussed under agenda item 12. Staff Survey LM highlighted that the statistics shared at the previous meeting relating to bullying and harassment within the women and children division were in fact incorrect, therefore no issues to be concerned about. Trust Engagement Strategy with medical staff **Update to be provided by DW.**	
3	**Schwartz Rounds** FM provided a verbal overview of the Schwartz Rounds at ESHT, which included data on numbers and groups of staff attendance as well as themes collated from attendee feedback. Key highlights: • Schwartz rounds had been in place at ESHT since May 2015 offered at EDGH and Conquest with an increase in community settings. • Ongoing study had indicated that staff in attendance had seen an improvement in their psychological health. • Participation voluntary; 1 hour of CPD accreditation for attendance. • Positive feedback from staff. • Aim for more frontline staff attendance by introducing “pop-up” rounds and visits to wards. MG stated that this was an excellent initiative valued by staff members. MG suggested linking in with the Staff Engagement team to measure the impact on staff, looking at indicators/data from the staff survey. KM referred to the employees that work in the community and asked if they were encouraged to attend by their managers. KB replied that the aim was to provide more sessions within the community and that they were currently in the process of recruiting a facilitator. JW highlighted that managers were informed of the impact that Schwartz rounds had on staff relating to staff and patient outcomes. AB suggested a future theme involving the BME network. MK stated that she would be very happy to attend a Schwartz round and asked for a list of dates to be sent to the Trust Board.	**JW**

4	**Guardian of Safe Working (GOSW) Quarterly Report (Jan/Feb/Mar)** NMI provided a verbal overview of the GOSW covering the quarter January to March 2019; a joint report for EDGH and Conquest. Key highlights: • A small decrease in exception reports (ERs) (14%) for the same period last year. • Promoting exception reporting and engaging with clinical supervisors. • Educational/explanatory videos on exception reporting to be uploaded on to the Intranet in the near future to support new and existing supervisors. • Face to face discussions with staff. • Exception report under-reporting was a national issue. • £60k had been allocated nationally to support junior doctors in their learning environment. <u>Risks and concerns</u> <u>*Private Patient Policy*</u> Junior doctors were being asked to be responsible for private patients on the Michelham Unit, EDGH. DW reported that the policy had initially been written by the surgical division and that this had been amended and it had been agreed that junior doctors were no longer responsible for any routine work with private patients. DW reported that the only occasion that junior doctors would be required to work with private patients at ESHT would be if there had been a cardiac or peri-arrest. <u>*IT*</u> WY highlighted the issue of junior doctors accessing computers AB replied that the IT department were undertaking work for the whole Trust as there was a general issue with access to computers: • Additional computers would be installed on every ward (1 or 2) capacity to increase. • Speed of machines; Trust to update all computers to windows 10. • Over the next 3 to 5 years every computer to be replaced within the Trust. • Clinical areas where multiple systems in use would be considered a priority. • Continued development of software and interfaces. MK asked if the IT improvements had been communicated with staff. AB replied that it had been discussed at the junior doctors' forum along with the medical education team. KM referred to page 2 of the report "juniors to be encouraged to submit ERs without any reprisal to their future careers" and asked if this was speculation or evidenced. NMI stated that this is being addressed as there was no evidence within the Trust but reported nationally through Freedom of Information requests. DW referred to medical staff on wards and what constitutes safe and reported that work was being undertaken looking at appropriate staffing levels.	
5	**Accountability Framework** JA provided a verbal overview of the Accountability Framework, which consisted of 2 reports, the first explaining the current position and the second with recommendations for going forwards. <u>Case for Change (where we are now)</u> A description of the current way in which ESHT holds individuals to account for the delivery of the Trust objectives.	

	Action Plan (where we want to be) A summary of performance required measured against the 5 strategic domains and a change in the way that the operational and clinically led triumvirate way of reporting. JA referred to the cancer multi-disciplinary teams and stated that they would feed into the cancer clinical board followed by the clinical outcomes group. The service managers within the divisions would have responsibility for cancer targets. JA referred to centralised outpatient service, which would provide a service to all the divisions. Activity to be reported via the Integrated Performance Review meetings (IPRs). KM commended the work undertaken by JA and stated that it would make a big difference to the Trust overall. KM referred to the definition of accountability and queried whether every employee within the Trust would understand the difference between accountability and responsibility. KM suggested choosing a clear and concise definition which could be understood by every employee at every level. JA stated that she would look further into the definition of accountability.	**JA**
6	**Review of Well Led CQC** LW provided a verbal update of Well-Led for the Trust and confirmed that mock inspections were currently taking place; inspections had already taken place at EDGH, Bexhill and Rye. LW confirmed that informal feedback had been positive. Key highlights: • 22 actions, with one "must do" (hours in emergency department) had been addressed • CQC visit thought to be autumn (to provide 3 months' notice) • Focus groups in place with staff; an opportunity for them to share/showcase any positive work.	
7	**Pay Review update** MT provided a verbal overview of the pay review update, which was a continued implementation of the national pay review implemented in July 2018 and to be completed in March 2021. Key highlights: • Restructure of pay bands; year 2 of annual pay review implemented with effect 1st April 2019. • Closure of band 1 was closed to new entrants with effect 1st December 2018; impacted on 404 members of staff. A "Choices Exercise" had been undertaken with all affected staff. • Pay progression is a significant feature of the new pay deal and links closely with the new governance framework. • Pay progression policy to be written. • Appraisal policy to be reviewed. • Parental Leave policy amended; effective 1st April 2019 all employees will have the right to take up to 52 weeks of maternity and/or adoption leave or up to 52 weeks of shared parental leave. • Child bereavement leave – all bereaved parents will be eligible for a minimum of two weeks leave with no requirement for the child to be under the age of 18. • Buying and selling of annual leave is being reviewed by a National group; expected to be implemented April 2020.	

8	**Staff Survey:** **Corporate priorities and Action plans** **Update on progress** LM reported that the staff survey results had been presented at the previous POD meeting and further data was requested; this data had been produced in a slightly different format covering the previous 3 years. Work was being undertaken on "drill down" data at divisional level with a view to discussing the key focus of improvement within their areas and four corporate priorities had been set based on staff survey feedback, staff groups and workforce data to help focus on improvement. MK referred to the previous discussion on the accountability framework and queried that the plan described the lead but not the accountability. AB replied that every division's area had a further breakdown and that each division were devising their own local specific action plans; reporting into monthly IPR meetings.	
9	**Staff Family and Friends** LM provided a verbal overview of the Staff Family and Friends Test report, which is completed every quarter consisting of two standard questions: 1. If a friend or relative needed treatment would you be happy with the standard of care provided by the organisation? *Positive response rate 82.2% (national average 81%)* 2. Would you recommend your organisation as a place to work? *Positive response rate 62.9% (national average 64%)* Further work to be carried out with the divisions to develop retention plans, share learnings across divisions, continue to focus on Wellbeing programmes and the role of the line manager to improve staff satisfaction.	
10	**Employee Relation Report** MT provided a verbal overview of the Employee Relation report, which provides information relating to the number of formal staff complaints and conduct issues, Employment Tribunal claims, terminations and absences. Key highlights: • 12 cases had been carried over from quarter 2; all of these cases had been closed. • 37 formal incidents reported between 1st October 2018 and 30th March 2019 compared to 28 during the same reporting period last year. • 12 disciplinary hearings were heard resulting in 5 written warnings, 4 final written wards and 3 dismissals. • 13 appeal hearings; 2 in response to disciplinary dismissal sanction, 2 performance related, 1 fixed term contract, 1 sickness, 2 flexible working requests, 5 grievances; decision to dismiss was upheld in all cases. • 4 dismissals on the grounds of ending a fixed term contract. • 1 suspension in relation to a safeguarding/police matter. • No formal whistleblowing cases. • Average length of time on 27 case investigations was 12 weeks. • 2 Tribunal claims against the Trust ongoing. MT assured the committee that the numbers of cases were dealt with by type and confirmed that there were no patterns or concerns.	

	AB highlighted the good work that has been undertaken on training staff to support conflict with members of staff. AB reiterated that management need to take on the responsibility and competence, not just HR staff. Managers and team leaders should feel confident in dealing with HR issues. MT would be leaving the Trust in July 2019. MK commended MT for her outstanding contribution to the work of the POD committee and wished her well for the future.	
11	**Workforce Disability Equality Standard (WDES)** KN provided a verbal overview of the WDES report, which is a set of 10 specific, evidence based measures that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. ESHT Disability Staff Network was developed during 2017/18 joint chaired by the Associate Director Estates and Facilities and the Equality Lead. KN highlighted that there is an estimate that 15% of the population worldwide live with 1 or more disabling condition with more than 46% of older persons (over the age of 60 years) having disabilities. 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. KN reported that the group are developing a 4 yearly Public Sector Equality Duty, Equality Objectives using available data. These objectives would be available on the Trust website at the end of summer 2019. MG suggested sharing the progress of the action plan with a future POD Committee. JZ queried recognition of the autistic spectrum and asked if the action plan would be able to address disabilities like this or provide additional support. KN replied that this was potentially a small group at the moment but with more staff involved there would be the potential of looking at different areas including mental health and developing action plans relating to each area. KM suggested a positive communication regarding WDES to be shared with staff as some staff do not feel comfortable disclosing their disability.	
12	**Nursing & Medical Revalidation Annual Reports** PM-W provided a verbal overview of the nursing and medical revalidation reports and reported that ESHT had achieved 100% compliance for doctors and nurses in 2018/19 for the third consecutive year. PM-W raised the issue of the lack of medical appraisers. Many of the appraisers felt that there was insufficient time to appraise due to clinic pressures. In the last 18 months there had been an increase of bank and locum doctors joining the Trust. DW highlighted that if the doctor had a preferred connection to the Trust then it would be the Trust's responsibility to provide them with appraisal support. The situation had been added to the Trust Risk Register and work was ongoing on resolving the issue. A recruitment campaign had been undertaken and 6 applicants would be interviewed in June 2019. DW reported that the Trust were looking at the legal situation regarding the responsibility of appraisals as declarations were required for NHS England and an option appraisal was being drawn up.	

13 **13.1** **13.2**	**Items for Information:** Workforce Report Item noted. **Minutes from sub-groups**: Organisational Development & Engagement Group Item noted. Education Steering Group Item noted. Workforce Resourcing Group Group had not met. HR Quality & Standards Group Item noted. Workforce Equality meeting Item noted.	
9	**Any other business** There was no other business.	
10	**The next meeting of the Committee will take place on:** **Thursday 25 July 2019** **10:00 – 12:00** **St Mary's Boardroom, EDGH vc Room 1, Ed Centre, Conquest**	

Dates of 2019 Meetings:

Date	Time	Venue	Call for Papers Date	Submission Deadline
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:	6th August 2019	Agenda Item:	14
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

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

4th June 2019 – Project Agreement with Imtech Low Carbon Solutions.

4th June 2019 – Direct Agreement with Intech Low Carbon Solutions and Credit Suisse.

4th June 2019 – Deed of Guarantee with ESSCI Limited.

23rd July 2019 – Agreement with Canon (UK) Ltd for provision of multifunctional printing devices for a 60 month period.

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.