EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 1st October 2019, commencing at 09:30 in St Peters Community Church Hall, Bexhill Old Town, Bexhill TN40 2HE

AGENDA			Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Monthly award winners	A	Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 6th August 2019	B		
4.	Matters Arising	C		
5.	Board Committee Chair's Feedback	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 5 (August) 1. Quality and Safety 2. Access, Delivery & Activity 3. Leadership and Culture 4. Finance	Assurance	G	DDN MD COO HRD DF	1015 - 1115
9.	Learning From Deaths, Quarter 4	Assurance	H	MD	
10.	7 day Working Self-Assessment	Assurance	I	MD	

BREAK

STRATEGY

					Time:
11.	STP Independent Chair Monthly Report	Assurance	J	Chair	1135 - 1140

GOVERNANCE AND ASSURANCE

					Time:
12.	Nursing Establishment Review	Assurance	K	DN	1140 - 1215
13.	Winter Planning 2019/20	Assurance	L	COO	
14.	Annual Reports: 14.1 Health & Safety 14.2 Infection Control 14.3 Safeguarding 14.4 Fire 14.5 Guardian of Safe Working Hours	Assurance	N	Various	
15.	Quality Walks	Assurance	O	Chair	
16.	Board Sub Committee Minutes	Assurance	P	Chair	

ITEMS FOR INFORMATION

				Time:
17.	Questions from members of the public (15 minutes maximum)		Chair	1215 - 1230
18.	Date of Next Meeting: Tuesday 3rd December, St Mary's Boardroom, EDGH		Chair	

Steve Phoenix

Chair man

29th Augus t 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:	1st October 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:

JULY

There were two winners in July, both from Rye Memorial Hospital.

Samantha Teare, Therapy Assistant. Her nomination read:

“Samantha has taken the work currently being done by the Rehab Consultant around increasing patient engagement, motivation and rehab dosage and really run with it. She has taken the initiative to set up various physiotherapy and occupational therapy groups which encourage patients to not spend all day sat by their bed, but instead to get up and be active, engaging with other people currently requiring rehabilitation, and to socialise and keep their mental wellbeing.

She has engaged other members of staff in setting up timely activities, including a recent Wimbledon Day which was a roaring success, including afternoon cream tea, tennis on the WiiFit and general exercise and enjoyment.

Feedback from patients included:

"Thank you so much Samantha, I had a lovely afternoon"

"Thoroughly enjoyed myself, it was different"

"Lovely afternoon"

Being in inpatient rehabilitation can be a stressful and often lonely time for people. Rye being a rural setting, often patients aren't near their family and friends which makes it hard for them to visit. Samantha's groups have turned around patient's experience keeping their mood positive, enjoying the company of others even if their own loved ones can't visit, and therefore engaging more with their functional rehabilitation. The groups happen in a communal area so all patients have to try to mobilise there which increases their confidence and often gets them home sooner.”

Jane Ferguson, Clinical Ward Orderly. Her nomination read:

"Jane deserves this. She goes above and beyond her clinical ward orderly role and deserves the recognition for it. This month Jane was made aware of the new mattresses being distributed throughout the Trust with the exception of Rye Hospital. Jane contacted Conquest to find out what was happening to the static mattresses no longer in use from the wards.

As a result Jane was able to secure 14 new static and 4 quatro airloss mattresses from the equipment library, that were due to be removed from the Trust, having been serviced and passed quality control checks.
Jane then went about sourcing the transportation of the mattresses from the Conquest and the disposal of our ancient ones.

On the day of arrival at Rye, Jane liaised with the nursing staff, removed our old pink foam mattresses from the patient's beds and placed the new ones in position, securing the help of the driver (the mattress technician). Jane's excitement in being able to secure the new items for patients' comfort was palpable.

I have nominated Jane for the Trust Unsung Hero Awards for two consecutive years due to her commitment to her role and going above and beyond.

I am nominating her through this medium now as her commitment deserves recognition from the Trust."

AUGUST

Dr Rannie Nahas, Consultant on the Frailty Unit at Eastbourne. His nomination read:

"Dr Nahas always makes time to liaise with the Supportive and Palliative care team. His communication is clear and concise and often provides excellent feedback to the team regarding patients, enhancing patient care and experience.

Whilst working alongside Dr Nahas he is always friendly, listening to support and advise given, questioning as appropriate and teaching/developing the team along the way, respecting everyone's input."

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 6th August 2019 at 09:30am in the Oak Room, Hastings Centre.

Present:
Mr Steve Phoenix, Chairman
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mrs Miranda Kavanagh, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Mr Pravin Patel, Associate Non-Executive Director
Ms Carys Williams, Associate Non-Executive Director
Dr Adrian Bull, Chief Executive
Mrs Joe Chadwick-Bell, Deputy Chief Executive
Mrs Catherine Ashton, Director of Strategy, Improvement & Planning
Ms Vikki Carruth, Director of Nursing
Ms Monica Green, Director of Human Resources
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Mrs Angela Ambler, Next NED Program
Mr Mark Friedman, Recovery Director
Miss Janice Humber, Staff Side Chair
Dr James Wilkinson, Deputy Medical Director
Mr Peter Palmer, Assistant Company Secretary (minutes)

042/2019 **Welcome**

1. Chair's Opening Remarks
Mr Phoenix welcomed everyone to the meeting of the Trust Board held in public. He welcomed Mr Patel and Ms Williams to their first meeting of the Trust Board since their appointments as Associate Non-Executive Directors.

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
Mr Jonathan Reid, Director of Finance
Dr David Walker, Medical Director

3. Monthly Award Winners
Mr Phoenix reported that the monthly award winner for May had been Mortuary Manager, Lydia Judge-Kronis. June's winner had been Erwin Castro, Diabetes Specialist Nurse at the Conquest Hospital.

063/2019 **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.

064/2019 **Minutes**

The minutes of the Trust Board meeting held on 4th June 2019 were considered and two minor amendments were noted. They were otherwise agreed as an accurate record. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

065/2019 **Matters Arising**

No matters arising were noted.

066/2019 **Board Committees' Feedback**

1. Audit Committee

Mrs Wells reported that the Audit Committee had met on 1st August. The Diagnostics, Anaesthetics and Surgery division had attended the meeting and provided an overview of clinical audit within their division and of their divisional risk register, providing assurance around the controls they had in place. Two issues with completion of national audits had been highlighted; the national diabetes audit was of particular concern, due to software issues, and a plan to address the issues would be presented at the next Committee meeting.

The Committee approved the 2019/20 internal audit plan. External auditors presented the results of their audit of the 2019/20 Quality Account, along with the 2019/20 Annual Audit Letter with no concerns raised about either. The Information Governance and Research and Development annual reports had been received and approved by the Committee.

A review of the Audit Committee's work program and Terms of Reference would be undertaken. It was planned to return to basics to ensure that the focus of the Committee was appropriate and that divisions weren't unnecessarily repeating work. The Committee presented their Annual Report to the Board.

2. Finance and Investment Committee

Mr Phoenix reported that the Finance and Investment (F&I) Committee had met on 1st August, their first meeting since the Trust had been taken out of financial special measures. He thanked the Trust's staff for their hard work in achieving the Trust's financial targets and the Committee for its oversight.

He explained that the Committee had reviewed the Trust's in-year financial performance with good progress being made during the first four months of the year. Detailed reports on the Cost Improvement Programme (CIP) and on grip and delivery within the organisation had been received. The Medicine division had attended to discuss their financial progress, a report that had been well received by the Committee.

The Committee had discussed whether it should meet on a bi-monthly basis if the Trust continued to meet financial targets, in order to create space for a strategic committee to be formed. The Committee presented their Annual Report to the Board.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had met on 25th July. The implications for the Trust of the NHS Interim People Plan had been discussed and the Committee had no concerns about the Trust's response. A six monthly update on disciplinary procedures within the organisation had been received, along with a report on health and wellbeing within the Trust. The annual WRES report had been presented and was included on the Board agenda. A report on workforce safeguarding and an update from the recent Health and Safety Executive (HSE) visit had also been received.

The Committee presented their Annual Report to the Board. Mrs Kavanagh felt that the Committee was now working well and striking the correct balance between strategic conversations and receiving assurance from detailed information provided by the organisation.

4. Quality and Safety Committee

Mrs Churchward-Cardiff reported that the Quality and Safety (Q&S) Committee had met on 25th July. The Committee's agenda had been recently revised and the Committee now received significantly more assurance about governance and safety in the organisation than it had done previously. An issue with ensuring that outstanding actions following incidents were appropriately closed continued to require oversight and divisions were working hard to address this. Dr Bull explained that outstanding actions were reviewed with divisions during monthly IPRs and the number of outstanding actions had recently been significantly reduced.

Mrs Churchward-Cardiff reported that a patient story had been discussed by the Committee, with learning shared with the Committee and through divisions. The Committee had been increasingly assured about cancer performance within the Trust and the actions implemented to improve 62 day performance; although issues of capacity and demand remained. The Committee's Terms of Reference and Agenda had been reviewed and would be updated to include the formal review of Trust documents such as Quality Improvement Plans.

Mrs Churchward-Cardiff noted the impressive work that had been undertaken by the maternity team to ensure continued compliance with the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. A report was being presented to the Board having been reviewed by the Q&S Committee.

The Board noted the Committee Reports.

067/2019 **Board Assurance Framework**

Mrs Wells presented the Board Assurance Framework (BAF). She explained that following discussions at a recent Board Seminar, and feedback from internal auditors, the BAF had been revised. The new format had been reviewed and approved by the Audit and Q&S Committees, where members had found it easy to follow with actions aligned to gaps in control and assurance. Work would be undertaken to strengthen the assurance provided by the revised BAF. She noted that the only area rated red related to capital and explained that good progress was being made in other areas with controls of assurance being managed effectively.

Mrs Kavanagh noted that she found the new format to be much clearer but was concerned that it would be hard to track actions over time. Mrs Wells explained

that once an action was completed it would be moved to the assurance column, along with evidence of completion.

Mr Phoenix noted the importance of ensuring that the clarity of the document wasn't lost by making it overly complicated. The Board agreed to trial the revised format for 6 months and then review its effectiveness.

068/2019 **Chief Executive's Report**

Dr Bull reported that the Trust had recently been removed from Financial Special Measures by regulators, a key step forward for the Board and for the organisation. Members of staff had spoken to Dr Bull about their pride in the improved performance of the organisation and this good news had a positive impact throughout the organisation.

HRH Princess Anne had visited the Conquest Hospital in July to open the new MRI suite. The new facility was now operational and alongside the improvements to the CT scanner at Eastbourne had enabled the Trust to significantly improve its high grade diagnostic capabilities. The MRI building had been the Trust's single largest capital investment in the last ten years and the Trust was extremely grateful for the support of its local communities and the Friends of the Hospitals in purchasing the machines.

The Trust had recently been inspected by HSE who were undertaking a program of visits around the NHS to look at moving and handling and violence and aggression. Positive feedback had been received from inspectors about the reception they had received from staff throughout the organisation. Inspectors also commended the moving and handling team as one of the best they had seen.

Feedback about violence and aggression had shown that the Trust was complying with legislation, supported by very clear organisational policies. Inspectors noted that some areas where the Trust had not considered violence and aggression, such as children coming round from anaesthetic, should be included within policies due to the potential for unintentional violence and aggression. They also raised concerns about training needs assessments and the recording of low level violence in A&E and had issued a material breach to the Trust as a result. The Trust agreed with the feedback from inspectors, and would address the concerns raised by the HSE. Once the issues had been addressed then the material breach would be lifted.

The annual staff awards had been held in Bexhill in July, with one in five members of staff within the organisation nominated for an award. Mr Phoenix noted that this had been the first awards that he had attended, and thanked organisers for their hard work in arranging the event and explained that he had felt very privileged to be able to hand over prizes to winners.

Dr Bull highlighted that significant improvements in pressure ulcer performance had been seen, with no grade 2 or 3 ulcers reported in June. The purchase of new mattresses by the Trust had contributed to this success. The Excellence in Care Programme, now including End of Life Care data, was being used by divisions on a consistent basis, and contributing to their reporting in IPRs. Questions asked in Friends and Family tests were due to amended in the near future; the Trust continued to see some of the highest response rates in the country for inpatients, with levels of satisfaction at around 95%. However, response rates in A&E and maternity remained challenging.

Dr Bull reported that the Trust's vacancy and turnover rates remained at around 10%. 20 new members of staff had joined the Trust following international recruitment in India, with 80 more due to join. The recent radiology recruitment programme was showing good results and two consultant haematologists had been successfully recruited.

The Trust's flu vaccination team had vaccinated around 70% of front line staff in 2018, one of the highest rates in the country; the flu team was hoping to improve on this in 2019. Work to increase the resilience of staff continued and a resilience programme and stress assessment was being undertaken with A&E staff at the Conquest which had recently been very busy. Other areas which might require assistance were being monitored.

Dr Bull reported that development of Quality Improvement within the organisation continued, with a significant number of staff receiving training. The Trust was looking to replicate the success of the Improvement Hub at EDGH throughout the organisation. front line

It was noted that a strategic review of cardiology services was being undertaken and work was being undertaken with the CCG to ensure that cardiology services remained sustainable for the people of East Sussex. Any proposal would be subject to a full consultation and review by HOSC.

Mrs Kavanagh asked what actions were being taken by the Trust to address recent issues of taxation of doctors' pensions. Dr Bull explained that clinical colleagues were concerned that earning money in addition to their basic salary might make them liable for significant tax bills. The issue was being reviewed on a national level, but in the meantime the Trust had sought legal advice about how the issue could be mitigated in compliance with tax legislation. A letter would be sent to all consultants explaining the options that were available to them. Dr Wilkinson noted that there was a large degree of disquiet amongst consultants about the issue, with many unwilling to undertake additional work due to the financial risk.

069/2019 **QUALITY, SAFETY AND PERFORMANCE**

Integrated Performance Report Month 3 (June)

1. Quality & Safety

Mrs Carruth advised that issues raised within the report had been discussed in detail by the Q&S Committee. She reported that the one fall, resulting in a fracture, had been reported in the Trust during month 3. A deep dive into the incident had been undertaken and the Trust would continue work to minimise falls.

Ms Ashton asked if there was a way of identifying those patients who might be prone to falling in order to better protect them when they attended hospital. Mrs Carruth explained that the Trust's patients were often elderly and frail and likely to have co-morbidities. Work was being undertaken across the system to identify patients who might be prone to falling and put in place preventative measures. Mrs Churchward-Cardiff noted that the Trust's newly introduced falls assessment had been revised following its introduction. The fall resulting in a fracture occurred for a patient who had no risk factors and who slipped as they left the hospital.

Mrs Carruth reported that one Never Event had occurred during June, during maxillofacial surgery. Dr Walker was executive lead for the incident and would ensure that learning from the incident was shared across the organisation. Dr Bull explained that the incident had concerned potential tooth extraction on the wrong side and advised that Standard Operating Procedures had been reviewed to ensure that it would not be repeated.

An issue with the accuracy of data for Duty of Candour had been identified by the patient safety team. Data had been validated to ensure that it was correct for 2019/20 and had shown that the Trust was 55% compliant with verbal Duty of Candour but 100% for written. The main issue concerned the formal documentation of verbal discussions; reviews of notes had shown that the conversations were taking place, but this was not being correctly recorded on Datix. There was work in place to address this.

The Trust had seen a significant improvement in the number of reported pressure ulcers since a recent focus on grade 2 ulcers. New mattresses had been introduced, reducing moving and handling requirements for patients. The Trust was below the limit for reported c.diff infections. One catheter associated community acquired infection had been reported in June that may have been avoidable. Over 3,400 patient surveys were completed during the month; the Trust received over 3,000 plaudits and 46 new complaints.

Mrs Carruth reported that nursing vacancies in some areas were likely to impact on record keeping and audit compliance. Staff continued to work hard to prioritise the safety of patients and teams were being supported by HCAs. Analysis of alternate ways of working was being undertaken and an establishment review had been discussed at the last meeting of the F&I Committee, and would be presented to the Board in the future.

Dr Wilkinson reported that the Trust continued to see encouraging progress with mortality. The Risk Adjusted Mortality Index (RAMI) in the Trust had steadily improved over the previous 3-4 years; in April 2019 the Trust's figure was 76, much better than the national average of 90. The Summary Hospital-level Mortality Indicator (SHMI) had reduced to 0.97, putting the Trust in top half of the country. These improvements had been realised without effecting emergency readmissions, leading to patients getting home quicker with no impact on their safety. The Trust's focus on treating patients with suspected sepsis had led to a substantial improvement in mortality associated with septicaemia during previous three years.

Mrs Kavanagh asked whether the year to date increase in Serious Incidents (SIs) from eight in 2018 to 13 in 2019 was of concern. Mrs Carruth responded that she was not concerned and explained that a strong reporting culture within an organisation led to a larger number of incidents being reported. She explained that it was crucial that staff were confident that when incidents and near misses were reported there would be candour, no blame and that lessons were learnt. If this wasn't the case then reports would not happen. Reports were closely monitored and trends and themes identified and investigated. The number of SIs that the Trust reported was in line with other organisations. Dr Wilkinson confirmed that the Trust had robust systems in place for investigating reports and ensuring that learning was shared throughout the organisation. Dr Bull confirmed that a report on SIs would continue to be presented to the Board in private in order to provide additional assurance.

2. Access and Delivery

Mrs Chadwick-Bell reported that the Trust's performance against the four hour A&E standard in June had been 89.5%, whilst not at 95% the Trust was still in the top quartile of performers nationally. A significant increase in activity was being seen and on busy days 60 more patients were attending on each site than at the same time in 2018. A 9% increase in patients brought to hospital by ambulance was also being seen.

The Trust had seen the average length of stay (LOS) for patients reduce from 6.7 days in 2017 to 3.9 days in 2019. There was focus on providing same day emergency care and the new ambulatory care unit at the Conquest was due to be completed by Christmas 2019. Work was being undertaken to increase the number of patients discharged by noon, and to introduce weekend discharges and streaming of primary care patients to GPs within the emergency department. An integrated discharge team was looking at true integration between different organisations, with a single point of leadership for the discharge team, therapists and social workers in order to improve the flow of patients into bedded and non-bedded care in the community. Investment in frailty services would help patients to get home as soon as possible, as this was the best place for them to be cared for and would reduce unnecessary hospitalisation.

Mrs Manson reported that she had recently shadowed discharge teams and found issues existed around arranging for patients to return home with appropriate levels of social care. She asked whether integrated discharge teams were being prioritised by the system. Mrs Chadwick-Bell explained that an Assistant Director of Adult Social Care managed the integrated discharge team, which was a single service for both the Trust and social services. The system was fully committed to this joined up approach.

Mrs Manson reported that she had received verbal feedback from nursing staff that discharge rates were limited by capacity. Mrs Chadwick-Bell explained that every patient with a length of stay over seven days was closely monitored to ensure that the reason for this was fully understood. The top reason for patients remaining in hospital was that patients were not fit for discharge. The second highest reason was due to delays between handing patients over from the Trust to social services, and social service staff would be included on ward rounds in the future to improve this.

Mr Phoenix noted that it would be easy for the Trust to be content with doing better than other organisations, and not aiming to continue to improve. He was very pleased that this was not the case and looked forward to seeing the results of initiatives that had been introduced within the organisation.

Mrs Chadwick-Bell reported that during the last year the Trust had seen a 9% increase in attendances and a 10% increase in admissions, against a national average of 5%. These changes were not in line with population growth and work was being undertaken to understand the drivers of the increased demand. Patients attending A&E from care homes were reducing and the largest proportionate increase was in same day emergency care.

Mrs Churchward-Cardiff noted that the Trust's long term plan had been to reduce the number of beds, and asked if this was still feasible given the increase in attendances. Mrs Chadwick-Bell explained that a review of bed numbers would be presented to both F&I and the Board, looking at the impact of the increase in activity and work within the Trust to reduce length of stay.

This review was undertaken on an annual basis. She explained that it was likely that an increase in both the number of beds and the nursing establishment would be needed to meet rising demand. Dr Bull reported that a capacity and demand assessment of the Trust's consultant body was also being undertaken. He noted that the National Long Term NHS plan accepted that previous assumptions about reducing inpatient beds were no longer tenable.

Mrs Chadwick-Bell reported that the Trust's Referral to Treatment (RTT) performance in June had been 91.2%. This level of performance had been maintained for a number of months. Work continued to reach the 92% target, but increased numbers of patients and the recent loss of a local private healthcare provider were impacting capacity within the Trust. The Trust's waiting list had seen an anticipated increase as a result of Easter and recent bank holidays and this was expected to reduce again over the next couple of months. Performance against the diagnostic standard had improved to below 1% and the Trust continued to recruit in order to improve diagnostic capacity.

The Trust's performance against the 62 day cancer target had declined from 81.7% in April to 77.1% in May, just below the national median of 77.5%. The Trust's cancer action plan continued to be closely monitored and areas where improvements could be made identified. Significant improvements in the urology pathway had recently been realised. Cancer referrals had risen by 9.1%, and cancer treatments had increased by 24% in comparison to the previous year.

Around 250 additional referrals were being received each month and challenges existed around patient choice and compliance, alongside a local population who had a greater likelihood of getting cancer than the national average. The Trust's greatest challenge was diagnostic capacity and methods of increasing this as quickly as possible were being identified.

Mr Phoenix noted that previous predictions had forecast that the Trust's performance against the 62 day standard would be around 85% by July and asked whether this would be achieved. Mrs Chadwick-Bell anticipated that performance would be in the mid-70s, explaining that the Trust had been on track to meet the forecast until a considerable increase in referrals had been seen in May. A revised recovery plan based on existing capacity was being developed.

Mrs Churchward-Cardiff asked whether information was available about the percentage of patients being referred to the Trust who were diagnosed with cancer. Mrs Chadwick-Bell explained that the conversion rate for patients was not decreasing, so the increase being seen was not due to inappropriate referrals. The Trust was looking to grow available capacity, identifying the resources that would be required if the number of patients being seen continued to increase.

Mrs Manson asked whether comparable trusts were seeing similar surges in demand and Mrs Chadwick-Bell explained that ESHT was not an outlier in this regard. Mrs Kavanagh asked whether additional funding would be made available to trusts as this was a national issue. Mrs Chadwick-Bell explained that the Trust was bidding for around £300k of transformation funding which would support the redesign of services, but that this would not help to increase capacity. She did not anticipate that additional funding would be made available, but noted that the Trust would receive additional income from its contract with the CCG as a result of seeing more patients.

3. Leadership and Culture

Miss Green reported that during June the Trust's total workforce utilisation had been below its budgeted establishment. Expenditure had been £92k above budget for the month due to temporary staff usage. 7% of the total workforce used during the month had been bank staff and 1% had been agency staff, equating to 11% of expenditure. The Trust's overall vacancy rate continued to reduce and was below the national average at 9.9%. Turnover had reduced slightly in June. Work continued on recruiting new staff to the Trust, with a focus on new roles and on how tasks could be undertaken differently in the future. Stay interviews were being held with staff to help improve retention, and training was being offered to staff to enable them to develop new skills in order to improve their career pathways.

A slight increase in sickness had been seen in June, although the annual rate remained unchanged. Stress remained the highest reason for sickness, and an employee assistance package had been introduced, including a helpline for staff. The largest causes of stress for staff were out of work factors.

Statutory training and mandatory training had seen slight reductions, reflecting recent pressures on the organisation. Ongoing action plans to address issues raised by the recent staff survey were in place, with divisions focussed on good outcomes.

4. Finance

Dr Bull reported that the Trust was slightly ahead of its financial plan for the year to date, and remained eligible for additional income as a result. If the Trust remained on plan throughout 2019/20 then it would achieve a £10m deficit for year. Greater financial challenges were anticipated during the second half of the year and work on the development of CIPs continued. The Trust's had started a T3 pay panel, providing scrutiny for all aspects of pay within the organisation.

Mr Phoenix noted that this would be Mr Friedman's final Board meeting in public and thanked him for his help in getting the organisation to its current financial position.

Mrs Churchward-Cardiff asked for an update on the two bids, for fire improvements and equipment that had been submitted to the STP. Dr Bull reported that an amendment to the fire compartmentalisation business case had been requested and it was anticipated that this would be supported. The second bid for equipment would be considered once the fire bid had been resolved.

The Board noted the IPR Report for Month 3.

070/2019 **STP and ICP update**

Dr Bull presented a set of slides that had been developed by the STP. He reported the STP would be developed into the Sussex Health and Care Partnership, an Integrated Care System (ICS). This would be made up of three Integrated Care Partnerships (ICP), based on geographical areas of West Sussex, Brighton & Hove and East Sussex. The CCGs within the region would be reorganised to match these geographical areas. It was expected that an application to become an ICS would take place within the next 12 months.

A Health and Social Care Executive for the local system had been established which would continue under the ICS. The work of the ICS would include a

prevention agenda, with public health playing a large role in the process. The current priority was the development of a delivery plan for 2019/20 looking at key themes for transformation. An interim ICP board for East Sussex would be formed, and programme management team established. A plan for establishing partnerships and the timescale of delivery would be agreed.

Mr Phoenix explained that while conversations about partnership working had taken place in the past, he felt that there was now a clear intent to go beyond collaborative joint working into more substantial arrangements. Issues of accountability and responsibility for sovereign organisations would need to be resolved, and it was vital that overly bureaucratic organisational structures did not distance the Trust from the local population. Understanding the system's capacity and capability to deliver care would be crucial to the success of the ICP and Non-Executive oversight of plans would be important.

Mrs Manson asked when the first ICSs were likely to be approved. Dr Bull reported that the first ICSs were expected to be announced in April 2020 and were likely to be the current vanguard systems. It was expected that an application to form a pan-Sussex ICS would take place in the second half of 2020, dependant on the three ICPs having well developed plans. Mr Phoenix noted the importance of regular Board discussions about the plans, and the need for the Board to ensure that it had sufficient time to consider strategic issues.

Mrs Kavanagh explained that she had previous experience of integration and that ensuring that details, such as governance and accountability, were correct would be crucial to the success of the plans. She asked whether there was any help available to ensure that arrangements were correct and Dr Bull explained that support had not yet been put in place. He noted that conversations about functions of particular organisations within the partnership had taken place in the past, and felt that the local ICP planning would learn from the experiences of the first wave of ICSs. Ms Ashton reported that some of the testing of cross organisational issues had already been undertaken when the integrated 3+2 plan had been developed.

071/2019 **Clinical Negligence Scheme for Trusts**

Mr Phoenix noted that the paper had been discussed and was recommended for approval by the Q&S Committee following the meeting on 25th July.

Mrs Carruth explained that the only issue noted by Q&S had been about the length of time it took for investigations into perinatal deaths to be completed. Mrs Chadwick-Bell thanked the maternity team for the huge amount of work that had been undertaken in meeting the criteria for CNST.

The Board approved the report.

072/2019 **Annual Reports**

Mr Phoenix noted that the annual reports being presented to the Board had previously been discussed and endorsed by the Committees of the Board.

Workforce Race Equality Standard 2018/19

Mrs Wells reported that the Workforce Race Equality Standard (WRES) had been discussed in detail at the POD Committee. The Trust had a very engaged BME network, but the data from WRES demonstrated that there were some issues within the organisation that needed to be addressed. Work would be undertaken to understand why the issues existed and to address them. Mr

Phoenix explained that he would be taking a close interest in the resolution of the issues raised by the report, noting that it was vital that they were addressed.

The report was endorsed by the Board.

Complaints and PALS Annual Report 2018/19

Mrs Carruth explained that the annual report had been discussed by the Q&S Committee. She noted that future versions of the report would present information differently, in order to better represent the improvements that had been made within the complaints and PALS departments.

Mrs Churchward-Cardiff explained that the Committee had asked for additional information about the number of complaints being seen in the outpatient departments, as they were consistently within the top bands of complaints being seen within the organisation.

The report was endorsed by the Board.

Medical Revalidation and Nursing & Midwifery Revalidation Annual Reports 2018 – 2019

Dr Wilkinson reported that the revalidation annual reports had been reviewed by the POD Committee. Good progress was being made with both nursing and medical revalidation. A major challenge to medical revalidation concerned the reducing number of appraisers available within the organisation, and six additional appraisers were being recruited to address this issue.

The report was endorsed by the Board.

073/2019 **Quality Walks**

The Board noted the quality walks that had been undertaken between May and June 2019. Mr Phoenix reported that work was being undertaken to change the format of quality walks.

074/2019 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- POD Committee 23rd May 2019

The Minutes were received by the Board

075/2019 **Use of Trust Seal**

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

- **4th June 2019** – Project Agreement with Imtech Low Carbon Solutions.
- **4th June 2019** – Direct Agreement with Imtech 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.

076/2019 **Questions from Members of the Public**

STP

Mr Campbell asked whether, given the consolidation process taking place within the local area, there was any likelihood that contracts for local providers would be amalgamated and not made available to individual healthcare providers. Dr Bull explained that when providers came together, they would either take collective or individual responsibility for budgets. They would then sub-contract to other services, but this should not lead to fragmentation of services. The Trust already operated under a capitated contract through CCGs, so the proposed changes as an integrated provider would not alter capitated funding. Potential issues with new arrangements would be tested and explored as they were identified.

Divisional Expenditure

Mr Campbell asked whether the current over-expenditure seen in some divisions would be recovered before the end of the current financial year. Dr Bull explained that over-expenditure would be addressed by reviewing CIPs. The Trust continued to look to reduce over-expenditure and also to increase income as a result of the increased activity that was being seen by the organisation. Mrs Chadwick-Bell explained that over-performance in some divisions was matched by under-performance in other areas.

Mr Phoenix noted that if the Trust continued to meet financial targets during the year then non-recurrent support payments would be received which would reduce over-expenditure. Dr Bull noted that there were two funds available which provided additional funding when financial targets were met. There was an expectation that the funds would be amalgamated into tariffs in the future, leading to a position where the Trust expected to reach a break-even positon in 2020/21. The national expectation was that the additional funding would be phased out over the coming three years.

Sign Posting

Mrs Walke thanked the Trust for the introduction of new signs at EDGH. She said that she had found them to be excellent and had made a big difference.

Maternity

Mrs Walke explained that a decision had recently been reached about a maternity unit at West Cumberland Hospital, where consultant led services had been maintained despite only having 1,200 births a year by having a combined obstetrics and gynaecology rota. She asked whether the decision taken by the Trust in 2013 could be revisited in light of this.

Mrs Chadwick-Bell explained that some of the Trust's consultants were specialists only undertaking either obstetric or gynaecology duties. Where consultants practised both obstetrics and gynaecology, a dual rota was already maintained. Dr Bull noted that national guidance was that 2,200 annual births were required to maintain a sustainable service. He explained that he had not yet seen a report on the decision at West Cumberland Hospital, but would review this when it was available. He explained that he could not make a commitment that a strategic review of obstetrics would be undertaken, as the Trust had a number of other areas that required review as a higher priority.

Maternity Compensation

Mrs Walke asked about recent compensation of £26m that had taken place as a result of an incident in maternity at the Conquest Hospital prior to the decision being taken about maternity services in 2013. She noted that the Conquest had been considered as the safer site during the decision making process, and asked which metrics had been considered when making that decision.

Mr Phoenix asked Mrs Walke to liaise with Mrs Wells following the meeting in order that a full response to the question could be given. Mrs Wells noted that a full framework of evidence had been considered by the Board when the decision regarding maternity services had been taken.

077/2019 **Date of Next Public Meeting**

Tuesday 1st October, St Peter's Community Centre, Bexhill

Signed ……

Position ……..

Date ……

C.Campbell, 01/08/19

East Sussex Healthcare NHS Trust
Board Meeting on Tuesday 6th August 2019
Question from Mr C Campbell
Responses from ESHT in italics

1. Does Internal Audit cover the identification, billing and payment for services received by those not eligible for NHS care without payment?

   Internal audit does not review cases of this nature unless it is required to by the Trust after a risk assessment. During 2018/19, we identified the need for dedicated resource within the finance team to ensure full compliance with the overseas patients' regulations. We have now recruited an individual in the finance department who supports the identification and collection of appropriate payments for services received by those not eligible for free NHS care.

2. Have there been any sums written off in the financial year 2018/19 in respect of billed but unpaid healthcare charges for non-eligible individuals?

   It is not uncommon for charges to overseas visitors to be written off, across the health service, given the potential costs of recovery in other countries where the patient may have returned.

   During 2018/19, the Trust appointed a new and experienced Overseas Visitors lead to ensure full compliance with legislation and recovery of all appropriate costs. The Trust has a robust identification and credit-control process in place, and works closely with the appropriate regulators to seek redress and has, where appropriate, written off sums for unpaid bills. These are reported as appropriate to the Trust Audit Committee.

   This has been subject to a recent FOI and there was actually nothing written off over £10,000 in 2018/19

3. Can you provide an update on cost and progress of the BT Communications contract for which ESHT was providing the lead? Has it been successfully completed, was it within cost and have the anticipated benefits been realised?

   The Trust is the host for the Sussex COIN network (effectively the NHS wide area network for Sussex), which contains a contract for services with BT. During 2017/18 and 2018/19, the NHS bodies across Sussex agreed a new joint contract with BT for five years with a revised cost, following the expiry of the previous contract. This service was tested for value for money by each of the leads within the consortium of NHS bodies. The contract delivers significant benefits and is an essential element of the local and national service infrastructure. The project is on plan to complete Phase 1 in August and will have migrated 410 sites to the new service, providing both financial saving and improved connectivity services. The second phase will be to move the whole network to the Health and Social Care Network (HSCN) in October which will deliver further financial savings.

4. Under Strategic Objective 1 where the risk stated is “Unable to demonstrate continuous and sustained improvement in patient safety and quality of care” is this ever possible in an adequately staffed situation and if so how would it be measured?

   It would be measured through our own internal metrics eg excellence in care and also through external inspection by the CQC or HSE.

5. Strategic Objective 2, should there be an internal Trust measure available for review as well?

   Sorry not sure what you mean by this. Objective 2 is “We will operate efficiently and effectively, diagnosing and treating patients in a timely fashion to optimise their health.”

6. Risk 2.2, “lack of leadership capability and capacity to lead on-going performance improvement”, how was this risk identified and assessed?

   It was a risk that comes from a number of sources e.g. risk register, surveys and external reviews, compliance with access standards etc.

7. What is an “accountability framework” and can it be measured?

   The accountability framework supports the delivery of key organisational strategies, objectives and targets. Outlining accountability and responsibility and how this flows from ward/service to Board. The framework is about ensuring job roles are clear and that accountability is translated in to individual objectives and reviewed/discussed at appraisals.

8. Risk4.1, what exactly is meant by “We are unable to adapt our capacity in response to commissioning intentions”? If Commissioners require capacity then should they not provide funding to ensure delivery?

   This could for example that we are no longer commissioned for a service – it is not always easy to quickly adapt our staffing or reduce our overheads as individuals often work across teams especially with integrated care and we cannot downsize our estate easily. If a new service is commissioned it is not always easy to recruit staff, particularly if it a role where there are national shortages.

9. Is there any form of Resource Gap exercise undertaken on a rolling basis to support the Capital Programme i.e. start with the Wish-list then input reality?

   This is a good description of the process that we follow. The Trust has a formal Capital Review Group in place, which meets monthly. During the planning process, all services across the Trust are asked to submit requests (i.e. the wish list) for capital, and then the capital group prioritises these to ensure that scarce capital is allocated only to those projects which meet the needs for the organisation. For 2019/20, the CRG held four well-attended workshops which supported the finalisation of the

2019/20 capital plan. Each month, the CRG also reviews the 'reserve list' and may make adjustments to the plan as new risks or challenges emerge.

10. Is there ever an exercise undertaken to compare A&E Attendance volumes with A&E staffing levels to measure how many attendees are treated per head of staff?

    We undertake an annual review of nursing levels in light of demand and last year made a considerable investment £1.5million into Emergency Department nursing. We reviewed medical workforce against demand earlier in the year and are reviewing the figures in light of recent increases in activity. This will reflect a greater skill mix. We have over the past 2 years increased consultant input to 16 hours a day and have a GP on site to manage primary care presentations 12 hours a day. We have agreed a further middle grade shift per day whilst we are reviewing our workforce model, although this is not always filled due to lack of available staff.

11. How are the "Super Stranded" patients defined, whose problem are they and is there a set metric e.g. timeframe in which a resolution should be obtained?

    Super stranded is a national measure now referred to as long length of stay. This refers to patients who have been in hospital for 21 days and over. Clinically the Trust is responsible for these patients although it is seen as a system measure. We submit a weekly list (anonymised) to NHS England and are able to identify why each patient remains in hospital. The highest reason for the LLOS is that the patient still requires care which requires a hospital admission. There are systems in place with partners to review actions to facilitate inward care and discharge.

12. Why were non-recurring CIP's included in the budget?

    During 2018/19, the Trust delivered the CIP target in full. However, some £2.8m of these CIPS were identified as 'non-recurrent.' This is for a range of reasons, including CIPs which arise from delays in investments. So, for example, we may have set aside funding for new services at £2m in the plan, but due to recruitment ramp-up, we may only be going to spend £1.5m in year – allowing us a £0.5m non-recurrent CIP in year. During the planning process for 2019/20, the finance team then works with budget-holders to identify whether these CIPS can safely be made recurrent or whether the overall CIP programme needs to be increased in value.

    Ideally the trust would also focus on recurrent opportunities, but as the year progresses there are rolling reviews against budgets and often there are some underspends that can be utilised in year. However, the trust will not commit to making this recurrent if it is anticipated that this cost will be incurred in the following months or year. These are one time benefits but do not detract from the focus on delivering recurrent savings to meet the plan. The Trust aspires to deliver 90-95% recurrent savings in year.

13. Is there an identified underlying cause that is driving the increase in the anxiety, etc. classification of absence?

    No, not in particular: we have just introduced an externally delivered extensive Employee Assistance Programme to support staff with problems and issues both at work and outside of work. The first report we have received from this company indicates that many of the problems and stress that staff are facing are non-worked based and are due to personal factors.

    We have an extensive Health and Well Being programme in place for staff which includes regular stress assessments and advice and support sessions. This was recently commended by the Health and Safety Executive.

14. Why is the actual cash balance out of sync with the plan?

    Our cash balance is ahead of plan for three reasons. First, we have strengthened our credit control and debt recovery processes, and our cash collection cycle has reduced. Second, we are being paid a full 1/12 of the agreed contract value with CCGs, and we are delivering on plan in Q1 – meaning that we have a health underlying cash balance. Third, our capital cash expenditure is slower than our accrued capital expenditure – leading to an increase in the cash balance. We are not anticipating ending the year with a significantly greater cash balance than planned, although we will be reviewing whether our monthly planned cash balance at the month end is too low (as this impacts on some of the NHS financial performance metrics, which were not relevant when we were in FSM).

15. How will it be possible to recover the over expenditure to date shown in the Divisional performance page (46/58 or 101/200) over the remainder of the financial year and thus achieve the plan outturn?

    Each Division is supported by the Finance Director and the Recovery Director to develop and deliver an action plan to ensure that the plan is achieved. However, for both the Medicine and Surgery Clinical Units, the financial plan is a challenging one, and there are early indications that the plan will not be fully achieved in year, despite the hard work of the teams. This will be managed in three ways – supporting the Divisions to deliver their best performance against plan, supporting other Divisions to over-deliver against plan, and working across the Trust and the wider East Sussex system to deliver appropriate mitigations to the growth in demand levels emerging in 2019/20.

16. Why is the Total Waiting List Initiative cost to date so out of step with the YTD budget and how can forecast outturn be achieved?

    It is important to contextualised the WLI spend – the Trust is delivering on its plan overall, with WLI spend higher than planned, but substantive pay below plan. In other words, the WLI spend is in areas where we are experiencing demand above available staffing levels. The Trust has a rigorous approvals process in place in respect of each

WLI session undertaken, and is working with each Clinical Unit to ensure that there is a plan in place for the remainder of the financial year.

17. How can it be possible to achieve improvements in Income under a Cost Improvement Programme?

    We use the CIP term to describe the overall programme of financial improvement for the year, with the main focus being cost, but where income can be appropriately recovered, this is also included within the CIP plan. The Trust is working within a semi-fixed contract envelope with our local Clinical Commissioners, and therefore would not seek to secure additional income in this area. However, there are a range of other areas for potential over-recovery of income. This includes areas where the Trust is below national or benchmarked standards, such as private patient income, or overseas visitors income recovery. In addition, the baseline CIP plan, agreed with our local CCGs, included income corrections relating to historical undercoding of income, and these have been reflected within the CIP programme.

18. On the Balance Sheet why are Trade and Other Payables and Borrowings so out of step with Plan? Similarly with Cash & Cash Equivalents.

    There is a link between the two variables with the Trust having a higher level of cash and cash equivalents than planned at the start of the year. The drivers for the improved cash position are described above.

19. On the Cash Flow and Borrowing Summary can we have the calendar or period month end value shown so that it ties into the Balance Sheet figure?

    This is a helpful suggestion and we will review presentation for future months. The month end value is shown in the Board paper, but we will review the cash and borrowing summary to see if this can be further developed.

    Questions 20 – 22 and 24 - 26. Dr Bull will be presenting a paper on Integrated Care at the Board (notwithstanding all the work that has currently taken place in developing integrating teams and has previously been reported to the Board); this is all currently being discussed so a plan and governance framework can be developed.

20. When will the public be given sight of an Integrated Care Design document to review and assess its impact on the Trust?

21. Should the Integrated Care Strategy be being developed based on current and forecast targeted health conditions with their associated costs and, thereafter, given the on-going scarcity of resources across the NHS, be prioritised for prevention before treatment.

22. Within the Integrated Care Partnerships will there be clear statements as to who will own the care pathway, what their roles and responsibilities will be, who will ensure

that accountability exists and how the patient will be kept informed of their treatment at every stage?

23. Is the Integrated Care Partnership strategy a proven successful strategy or as yet untested?
    It has been successful in the joint projects we have undertaken to date eg joint community rehabilitation team. Nationally it is being piloted for example in Manchester.

24. Will the Integrated Care Partnership be backed by patient based service level operational performance criteria that must be met?

25. What impact if any will the creation of multiple Primary Care Networks and their Clinical Directors have on the Trust compared with the current Primary Care interface?

26. Will the ICP's be classified as statutory bodies and therefore accessible to the public? At the moment public visibility of the decision making process and the possibility of interaction with the various SES STP Programme Boards is non-existent?

27. Is there a set time to wait before the umbilical cord is cut after birth?

    This would be dependent on circumstances at the time and there are likely to be varying opinions about it.

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 6th August 2019 Trust Board Meeting

There were no matters arising from the Board meeting in public on 6th August 2019.

19th September 2019 Quality and Safety Committee Summary

The Quality and Safety (Q&S) Committee met on the 19th September.

The patient story presented concerned positive feedback regarding a young lady's trauma surgery. The admission involved cross division and site care and involved a variety of staff. Throughout the admission the young lady felt safe and cared for and wanted to thank all the staff involved in her care.

The strategic focused concerned the MSK pathways and future plans for the service. The positive impact of the service has been demonstrated but the front end of the pathway will require additional resource to counter long waits for assessment. The redesign of MSK will increase input at the Primary Care level to reach people at an early stage.

Key points from the agenda:

- We received positive assurance on our preparations for the CQC visit.
- Our capacity to meet the 62 day cancer target remains challenged. The committee was assured that the pathways were being well managed and working efficiently. However capacity gaps at consultant level and in radiology remained, and would need to be resolved for progress to be sustained.
- Under the Health and Safety Annual Report it was agreed that Lone Working would be included in the 2019/20 objectives.
- The Committee received assurance from the Night Moves Audit that this issue was being addressed and late moves could be further reduced if moves occurred between 6-8pm in anticipation of the need for beds in the gateway areas.
- The Infection Control Annual Report demonstrated continued good practice and a plan to increase community engagement in 2019/20 to further reduce and manage bacteraemia.
- The Safeguarding Annual Report gave strong assurance that ESHT was meeting its obligations and was well placed and engaged in system responses.
- The Governance Report noted the improvement in DAS in closing out actions and recommendations from incident reports. The other divisions have adopted the DAS approach and were also seeing reductions in outstanding actions. The increase in falls to fracture was discussed and assurance given that the nursing executive were focussed on this issue.

The committee was informed of further Never Events making 4 in recent months. The executive team have responded to these and actions are in place. There seemed to be no common reasons for the Never Events, but this is being further investigated. The Committee will be kept informed and will receive the action plan and update at the next meeting.

Jackie Churchward-Cardiff
Chair of Quality and Safety Committee

20th September 2019

Board Assurance Framework

Meeting information:			
Date of Meeting:	1st October 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. The BAF continues to be improved following review by the Board, the Quality and Safety Committee and the Audit Committee.

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 19th September 2019
Audit Committee 29th September 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 - September 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Time-scale	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 Progress reported to Q&S and action plan reviewed. Positive feedback from mock reviews undertaken of acute and community services involving external as well as Trust staff.		Submitted CQC information request 28 August 2019. Preparing for CQC inspection and use of resources review.	Nov-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 in place and progress monitored. Number of controls in place: - Patient Pathway Coordinators track every 62 day pathway patient. Route-cause analysis of each 62 day breach - Weekly Patient Tracking List (PTL) meetings - Shared PTL's with Tertiary centres - Monthly Cancer meeting with Divisional managers chaired by COO - Daily review of PTL by Cancer Management team - Weekly monitoring/ reporting of 104 day patients on the PTL - Tumour Site Recovery Action Plans- reduction of median waits for first appointments to 7 days, optimal timed pathways, reduction of histology reporting times.	There were positive signs of progress in 62 day Cancer performance - position over past 4 months in line with agreed recovery trajectory - 81.6% in May. However, decline in 62 day performance across a number of the tumour sites in June - 73.1% Overview reported presented to Q&S Sept-19 CCG attends monthly assurance meeting.		Increase in the referral trend for suspected cancers and cancer treatments impacting performance. 9.1% increase (an extra 1,367) in referrals in 2018/19 compared to 2017/18 (July-March) and a 6.41% increase year to date. 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

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Time-scale	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 Paeds record inappropriate ward admissions. Assessment delays tracked and logged as incidents - escalated for COO/ COO discussion. Reviewing previous 12 months risks for trends/themes for escalation to CAMHS	Independent review taking place pan Sussex into mental health provision. New model of care being introduced from next year that will make the provision of CAMHS beds more flexible and support young people requiring NG feed tubes.		Greater pace required and being followed up through STP meetings. Working party, including CAMHS and ESHT, being established to review existing services and processes to develop a revised operational policy to include roles, responsibilities and escalation processes.	Dec-19 Dec-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. Continued extensive validation and local procedures for patient on cancer pathways & urgent Ophthalmology follow up appointment	Audit of 600 patients on the FU database has given a high level of confidence regarding data accuracy.		Digital team exploring an alternative approach to allow 'time critical' follow up patients to be highlighted. However, options available to date are not functional. Ongoing work on validation. Capacity remains a challenge although backlogs have been reduced in some specialties	Sep-19	COO Q&S

Board Assurance Framework - September 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Time-scale	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. Action plan reviewed at Board Seminar Sept-19		Trust wide communications to be developed and shared Implementation and completion of action plan.	Aug-19 Dec-19	DCA POD
3.1	*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.	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 and submited to NHS/E 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. Establishing governance structures to commence development of the integrated East Sussex Place.	Trust fully engaged with STP and Alliance programmes At month 5 the system remains on plan for delivery of 19/20 financial plan. Implementation of the East Sussex system wide integrated plan is in progress.		Ongoing work on the development of the East Sussex plan (response to the national LTP) through clinical and strategic forums. Creation of an East Sussex health and care system partnership Board which includes Executive representatives from health and social care commissioners and providers	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	Time-scale	Lead and Monitoring Committee
3.3	We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners.	3.3.1 Effective controls are required to ensure the Trust achieves compliance with the four core 7 day service standards by 2020.	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. Educational work has been undertaken across all specialities to improve documentation of daily review and review delegation.	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 audits indicates sustained compliance overall. Can now evidence >90% of patients seen by consultants within 14 hours of admission both on weekdays and at weekends In last quarter standard 2/5/6 both now compliant overall. Standard 8 partially compliant - not fully met at weekends.		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. Number of actions in place - recruitment, audit and improvement of Board Rounds Use of nerve centre to document consultant led review (anticipated October)	Dec-19	MD Q&S

Board Assurance Framework - September 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Time-scale	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. Trust is on plan at Month 5, but delivering CIP non-recurrently. A Programme Director for Financial Efficiency has joined the Trust and is developing a refreshed pipeline. Confirm and Challenge are being refreshed to ensure that these are fit for purpose and will support full delivery of the CIP target. Workstream leads have been asked for a resources review to ensure delivery. Full Divisional forecasts are complete and being reviewed for Month 5.	Activity and delivery of CIPs regularly managed and monitored through accountability reviews, FISC and F&I. At Month 5, CIP has been fully delivered, and the Trust is delivering on the M5 financial plan – this includes set aside of planned contingency to mitigate non-delivery of CIP.		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 (September) on the arrangements post FSM, with new leadership for the programme.	On-going review and monitoring to end of Mar 20	DoF F&I

Board Assurance Framework - September 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Time-scale	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 A £13.8m fire costs bid has been approved by DHSC in September 2019, and will support delivery of key infrastructure investment and repairs over the next three years – but this represents only a component of the £95m estimated backlog maintenance cost.	Regular review by F&I and FISC committees		Delivering against the agreed capital plan remains challenging within a robust control framework. There are also operational pressures (at £1,000k) against the capital budget, and CRG are working hard to maintain spend within the current budget. This requires monthly review of spend and forecast and careful prioritisation of the programme. The FIC have requested a 10 year capital programme covering key areas of pressure and investment, aimed at supporting the Trust in delivery of the strategic plan. This is anticipated for the October 2019 FIC.	On-going review and monitoring to end Mar-20	DoF F&I

Board Assurance Framework - September 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 including remedial works to existing compartment walls completed in Seaford and Hailsham Wards at DGH. Fire Safety Team in place and Trust has a Fire Strategy, Policy and Fire Risk Assessments undertaken. Fire Training and evacuation drills in place Fire Warden's in place and undertake Weekly Checks. Maintenance of active fire precautions eg automatic fire detection. emergency lighting and fire fighting equipment.	Regular communication and meeting with ESFRS Simulated patient safety exercise underaken on Seaford ward in June 2019 - will support refinement of evacuation plans		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. Confirmation of funding received Sept 19 - programme of works to be developed.	end Nov-1	COO F&I

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Time-scale	Lead and Monitoring Committee
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 Threat Protection (ATP) solution implemented ATP Vulnerability scanning NHS Digital CareCert notifications Data Security and Protection Toolkit (DSPT) Technical solutions in place and on-going regular staff awareness training	Information sharing and development with SESCSG Sussex and East Surrey Cyber Security Group Assessment against Cyber Essential Plus Framework Regular quarterly security status report to IG Steering Group and Audit Committee Trust was resilient to WannaCry ransomware attack (May 2017)		Establishment of the cyber security team being strengthened. Funding approved for x2 additional security roles. Pursuing ISO27001 certification and engaging with national funded resources to assess and report on our current position against the Cyber Essential Plus framework. Need further investment in monitoring solutions and to increase compliance with server patching. Trust cyber security awareness campaign to start in Oct 2019	end Nov-19 end Jun-20 end Oct-19	DF Audit Committee

Board Assurance Framework - September 2019

Ref	Risk	Gap	Risk Tolerance	Controls	Assurance	Current Progress RAG	Update/Further action required to reduce level of risk	Time-scale	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 Continued Brand awareness through social media activity to promote the Trust has seen an increase of 30% in overall applications to the Trust.(April-August 2019). Reduction in time to hire (76 to 72 days inc advertising/notice period) and in labour turnover (10.4% July 19 vs 11.1% July 18)		Medical recruitment -7 candidates in place sourced via Medacs, a further 4 posts at offer . First cohort of 12 Band 5 Indian nurses arrived at Trust,with a further 17 due to arrive in September. Remainder to arrive at Trust over next 3 months. Continued International sourcing of Medical candidates, including Radiographers and Sonographers. A further 4 Radiographers due to start with Trust in September.	ongoing to end Mar-20	DHR POD

Chief Executive Report

Meeting information:			
Date of Meeting:	1st October 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?	

Summary:

1. ***Quality and Safety***

Never Events:
Over the past four months, there have been four 'never events' at the Trust. Three involved wrong-side procedures. One involved administration of drugs through a line inserted into an artery instead of a vein. No persisting harm was caused to patients in any of the incidents. Each individual incident is subject to a full RCA investigation and response in the usual way. However, the executive team have concluded that this cluster of events requires a systemic response. We will continue to put great emphasis on the importance of an open, collaborative, and reporting culture, based on our values, as a key driver of safe care. In addition we will commission a senior, clinician-led group to review our culture and practice on the implementation and compliance with standard protocols – including both LOCSSIPS (local safety standards for interventional procedures) and WHO guidelines for theatres. A communication will be sent to all relevant clinical staff highlighting the importance of this issue.

Pressure Ulcers:
In the last five 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.

There has been an increase in category 2 ESHT acquired pressure ulcers from 48 in July to 56 in August. The areas where the highest numbers have occurred are receiving additional support from the Tissue Viability Nurse team.

No category 3 & 4 pressure ulcers have been reported in June, July and August 2019.

The focus for 2019/2020 is on seating to reduce the 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.

Excellence in Care
All in-patient areas are now auditing against the new Essential Standards and revised metrics to identify areas for improvement. Other areas such as Paediatrics and Critical Care are now creating their own bespoke standards and their EIC data will be integrated into the main EIC dashboard throughout 2019/2020.

Health and Safety Executive Inspection – Update on progress of action plan
Following the planned HSE inspection that took place on the 9th and 10th July, the final report has been received. The focus of the inspection was on the management of musculoskeletal disorders and violence and aggression. The HSE confirmed by letter that contraventions of health and safety law had been identified in relation to the management of risks from violence and aggression across the Trust. The key points which need to be addressed are:

- Not all potential sources of violence and aggression considered
- Dealing with violence and aggression risks – insufficient consideration given to designing out risk
- Training for violence and aggression – does not adequately address all potential sources of violence and aggression towards staff
- Reporting of violence and aggression incidents across the Trust is incomplete.

The Trust will need to provide a time tabled action plan confirming that we have acted on each of these matters by the 30th October 2019. The Trust is also liable to pay a fee due to the material breaches of £154.00 per hour.

A task and finish group has been established and is being led by the Director of Nursing (Executive Lead for Health and Safety) and the Head of Governance. An action plan has been drafted. The task and finish group will have a communications strategy to keep staff informed and to seek their views. It will report directly to the Health and Safety Steering Group.

CQC Inspection
We anticipate that the Care Quality Commission (CQC) will be inspecting the Trust in the Autumn. This is multi-faceted, encompassing a review of information and data, site inspections, focus groups and a well-led review. For the first time we will also have a Use of Resources Inspection, undertaken by NHS Improvement, on the 2nd October and this review will feed into the CQC process.

Overdue Amber Incident reports
There has been concern about the number of overdue amber incident (severity 3 – moderate harm) investigations reports. Any delay by Divisions in completing these reports has an impact on the learning that can be identified and taken forward as well as the impact on the Duty of Candour feedback to patients for family. In February there were 62 overdue reports but at the end of August this had reduced to 56 with a reduction in the number of reports overdue by more than 100 days.

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. Up to this point the Trust had been reporting compliance in excess of 95%. 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 and provided more accurate data. At the end of June the verbal DoC was 63% and written was 55%. In August, the rolling 12 month results demonstrated further improvement with verbal DoC reaching 70% and written increasing to 90%.

Access and Delivery

The Trust has remained busy over the summer with high levels of demand continuing for urgent and emergency care services. The teams have work hard to ensure patients are seen and treated in a timely way and we continue to see performance in the top quartile of systems nationally. The local system has undertaken a drivers of demand analysis and patients have been surveyed so that we understand why patients come to A&E and their understanding of how they access urgent care and what barriers they encounter. This information is helping us to understand how we might shape services and future communication with patients.

The Trust manages 40% of admissions on a same day basis, avoiding unnecessary overnight admissions and we are expanding the workforce and facilities to support this further. This is facilitated by the ambulatory (same day unit) at Eastbourne; the new unit at Conquest is underway with an anticipated completion before Christmas. We have agreed additional funding for both units and recruitment is underway to extend the hours into the evening and weekends. In addition recruitment has started for the extension of the frailty services across both sites with initial changes due in the autumn.

The Integrated discharge team (therapies, social care and discharge support nurses/assistants) is due to start in October with a soft launch on 17 September. The aim is to reduce duplication in assessment and actions between professionals with the objective of supporting patients who are medically stable to return home or to the next step in their care journey sooner.

The Trust and its system partners have been working on the winter plans over the past few months, building on existing plans, service developments and ensuring we have enough capacity to meet the anticipated demand. A separate paper is attached within the agenda.

2. <u>People, Leadership and Culture</u>

Recruitment

The Trust had its highest number of starters ever in a month in September with 89 new starters joining in a range of roles and areas.

The vacancy rate has now reduced to 10.5% and we are noticing an increase in the numbers of applications for all roles.

Key and on-going actions also being undertaken include:

- Following a visit to India in April this year 89 candidates have been sourced with 16 International nurses already started with the Trust and a further 17 due to start shortly.
- Targeted recruitment campaigns to support radiology and urgent care departments. Medacs agency engaged to assist with these vacancies.
- Social media activity to promote the Trust continues with the number of ‘interactions’ increasing month on month.
- Relationship with Medacs continues to strengthen. To date 8 medical staff in post and a further 3 offers of appointment in the pipeline.
- On-going campaign with Out of Hospital, with a further recruitment drive for candidates for bank HCA commencing in October.

Education

- A revised Education Strategy is being developed and will be presented to the Education Steering Group meeting in October.
- Mandatory Training compliance continues to gradually improve with additional resources provided to some services including the loan of portable laptops. Further review of processes and access to

ESR undertaken with result that all staff will be bulk uploaded onto ESR over September and October. Staff will no longer need to register onto ESR and emails will be automatically generated to remind individuals that their training is due for renewal

- Appraisal Compliance data is improving. Pilot in progress across OOH, DAS and HR to implement supervisor access to ESR that will enable managers to input data directly onto ESR. Appraisal Policy under review linked to revised pay progression scheme.
- A meeting has been held with key stakeholders to discuss and agree action plans following the GMC Survey of Junior Doctors (2018).

Workforce Systems, Analytics & Planning

- The Healthroster configuration for Junior Doctors has been completed with 100% of new intake receiving rosters 6 weeks prior to contract start date. 100% of Registrar rosters were updated for the October rotations

- Rostering Compliance sessions have been held for Maternity & DAS Division to maximise planning functionality, adherence to policy and regulate unavailability. Focus remains on patient safety and quality whilst continuing to driving financial sustainability by reducing the use of temporary workforce.

Staff Engagement

Health & Wellbeing

- Focussed work with emergency departments and community teams in addressing absence related to stress. Healthy weights programme - NHSI project in progress, with thirty staff currently on the programme.

Leadership & Culture

- The High Potential Programme for senior leaders has been launched with an assessment centre planned.
- A Listening Conversation initiative has been designed and delivered to capture BME staff experiences linked to the NHS People Plan.

Retention

- Welcome events and keeping in touch days have been developed for the significant number of overseas recruits.
- The Trust website has been refreshed to include positive examples of what it is like to work at ESHT.
- The information available to staff on their Total Reward Statements which outlines the benefits of working for the Trust have been refreshed.

3. Communication and engagement

In August we saw eighty people join us at our Annual General Meeting where we launched our 'Review of 2018/19' publication. Fifteen teams from across the organisation highlighted their work, shared improvements and offered health information as part of our 'Market Place'. A panel of ESHT experts talked about improvements that we have made around the detection and treatment of Sepsis, continuity of carer for mothers and our new frailty pathway. Attendees were also given an opportunity to ask questions of the board.

Thirty members of the public also took part in a tour of our cardiology unit at Eastbourne. Visitors found out more about how we diagnose, assess and treat patients with heart problems as they visited

labs and saw where we perform procedures. A range of consultants and staff were on hand giving talks, answering questions and demonstrating the cardiac equipment. Feedback from the event was excellent and we hope to run a similar event in Conquest later this year. Cardiology open days for members of staff also took place at Conquest and Eastbourne.

Over this period we saw a number of high profile stories promoted in the news. Whilst the vast majority of our coverage was positive or neutral (97%), we did have a number of challenging stories reported. Amongst our positive coverage were reports of new equipment and technology, recruitment of new members of staff and praise for individual members of staff.

We continue to see high numbers of people visiting our website and extranet. Nearly half a million pages were viewed on our website in July and August. Our extranet had over 1.3m page views over the same time. Our social media platforms continue to grow and in July and August we saw nearly 200,000 impressions on Twitter and 28,300 impressions on Facebook.

4. Finance

At Month 5, the Trust continued to deliver its financial plan for the year. If we deliver our full year deficit plan of £34m, compared to £45m last year, then transformation funding of £24m will be made available to us – leaving the Trust with a £10m deficit at the end of this year. To achieve this, we plan to reduce our monthly deficit from £3m to £2m by the end of the financial year – and our operational run rate is slightly better than we planned (£2.790m) at month 5. Because of this, we received transformation funding of £1.60m taking our reported in-month deficit down to £1.1m. Our cash position remains stable, given the aligned incentive contract with Sussex CCGs, and our continued delivery of plan.

Our Cost Improvement Programme also continues to deliver as planned at Month 5 – with teams across the Trust having achieved £7m of savings in the year to date. Having supported us to move out of Financial Special Measures and to strengthen financial discipline across the Trust, our Recovery Director has now moved to a new role in another organisation. This provides an opportunity to refresh the operating arrangements for financial efficiency across the Trust. The focus of the programme will continue to be on operational productivity, with a stronger link to the outcomes of our Getting it Right First Time Programme, and our Model Hospital Programme – both of which are led by our Medical Director, Dr David Walker. Dr Simon Dowse is supporting the reshaping of the programme, and is working with our Director of Finance and broader leadership team to ensure the continued delivery of efficiencies across the Trust.

Urgent care activity levels remain considerably higher than system plans at the start of the year, which requires a higher operating bed base for the Trust, and in turn causes increased costs – but more importantly, extra demand for services creates operational pressure for teams across the organisation. The Trust will continue to work with local Commissioners to develop an appropriate response as well as ensuring 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 Month 5, and the whole system remains on track to deliver the 2019/20 financial plan.

Capital budgets remain a challenge, locally and nationally. The Trust capital budget is constrained, at £13m across all of our services and sites, and there are significant pressures on this budget, which is carefully managed by our multi-disciplinary Capital Review Group. The Trust continues to work closely with NHS England and Improvement on our applications for emergency capital funding, for significant infrastructure, equipment and maintenance.

5. ***Strategic Development and Sustainability***

No Deal EU Exit Planning

The EU Exit Operational Readiness Guidance, developed and agreed with NHS England and Improvement, lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU without a ratified deal – a 'no deal' exit.

The Trust continues to work closely with commissioners and providers regionally and nationally to ensure that we are prepared for, and can manage, the risks that an exit from the EU on the 31st October with no deal in place may present.

The Director of Strategy Innovation and Planning is the Trusts Senior Responsible Officer (SRO) and chairs the Trust;s 'no deal' planning group .The Trust has been advised to undertake local EU Exit readiness planning, local risk assessments and plan for wider potential impacts.

We have focussed our contingency planning on 7 key areas:

- Supply of medicines and vaccines;
- Supply of medical devices and clinical consumables;
- Supply of non-clinical consumables, goods and services;
- Workforce;
- Reciprocal healthcare;
- Research and clinical trials; and
- Data sharing, processing and access.

An internal risk assessment has been undertaken and this is reviewed regularly by both the Trust's no deal planning group and the Executive Directors. The risk is currently rated as a 16 (4x4).

Integrated Performance Report – Month 5 - August 2019

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	8
Meeting:	Trust Board	Reporting Officer:	Trust Executives

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 Executive Summary provides key highlights from the Trust Board IPR.

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

Performance is discussed at divisional IPRs.

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

The Trust Board are asked to note the report and the key points raised.

EXECUTIVE SUMMARY

The Board are asked to note the key issues highlighted below and complements the IPR, provided as an appendices to this summary. The report covers the period August 2019 (Month 5).

The executive summary aims to provide answers to the following two questions:

1. What are the key issues that should be drawn to the Board's attention?
2. Is the action being taken/planned sufficient to address the issues identified. If not, what further action should be taken?

Highlights

Quality and Safety

- **Falls** – overall reduction noted compared to previous year.
- **Pressure ulcers (grade 2 – 4)** – overall increase compared to previous year.
    - ***Action:*** Quarterly deep dives continue with snap shot audits of category 2 damage, unstageable damage and Deep Tissue Injuries presented at the Quality and Safety Committee to review any lapses in care and share/embed learning.
- **Serious Incidents** – overall slight increase compared to previous year.
    - ***Action:*** All details are scrutinised at the Weekly Patient Safety Summit and the Patient Safety & Quality Group.
- **Infection Control** – MRSA – no increase compared to previous year but action plan in place. C.Diff – although a reduction compared to previous year, there are outbreak actions taken, requesting further sub-typing. MRSA – only 1 identified, compared to 3 same time previous year. This has been identified as Sepsis of 'unknown origin' and no lapse has been identified.
- **Friends and Family Test** – overall response rate slightly down compared to previous year, with Maternity Services and A&E being the lowest. However, of the response rates, scores are overall higher than the previous year.
- **Complaints** – The Trust received 51 new complaints in August. .
    - ***Action:*** Detailed discussions, analysis *A*ction planning takes place at the Patient Safety and Quality Group and Quality and Safety Committee.
- **Care Hours Per Patient Day (CHPPD)** – overall there has been a reduction in August, taking the average closer to the national median.
    - ***Action:*** Ongoing monitoring and actions via the twice daily site meetings, which review all staffing by ward, including skill mix and agree deployment of staff to mitigate risks.

Access and Delivery

Urgent Care – Constitutional Standard 95%. The Trust achieved 88.6% in August, slightly down on the same time previous year. However, the national performance level is 86.3%, making the Trust's performance above average. This ranked the Trust 32nd out of 121 Trusts reporting performance. Of note, A&E attendances continue to rise, 10.8% compared to same last previous year. Ambulance conveyances are also up at 6.2%.

- ***Action:*** System transformation plans are in place.

Referral to Treatment – Constitutional Standard 92%. The Trust achieved 89.2%, a fraction down from July. An increase in the number of patients being referred on a cancer pathway coupled with service redesign in multiple specialties and a reduction in workforce capacity has contributed to the current performance position.

- ***Action***: A review of recovery plans, complete with timelines on actions has been encouraged to heighten focus on improving performance in the coming months.

Diagnostics (DMO1) – Constitutional Standard <1%. The Trust delivered performance of 1.61% in August. Key reasons contributing the performance includes an increase in two week wait cancer referrals is impacting on available diagnostic capacity as well as a total of 91 breaches in August 2019.

Cancer – there are a range of Constitutional Standards to deliver as follows:

- Two week wait referral – 93%
- 62 day urgent referral – 85%
- Two week wait – breast symptoms – 93%
- 31 day - 96%
- 31 day subsequent drug treatment – 98%
- 31 day subsequent surgery - 94%
- 62 day screening – 90%

With the exception of the 62 day urgent referral standard, the Trust is achieving all the Constitutional Standards. There were 124 treatments during August of which 28 patients breached the 62 day pathway.

- **Action:** The Trust action plan is jointly reviewed by the COO and CCG monthly. Key priorities are: timed pathways, a refresh of capacity and demand with specific focus on the diagnostic stage of the pathway. NHSE/I have undertaken a review of the Trust's compliance with high impact changes with positive feedback. Key areas to focus: timed pathways and MDT reform.

Workforce

NHS Improvement's key performance indicators show the August Trust position as follows:

- Annual staff turnover 10.3% (0.2% under plan)
- Monthly staff sickness 4.5% (0.2% over plan)
- Vacancy rate 10% (0.7% over plan)
- Mandatory training rate 87.5% (2.5% under plan)
- Non-Medical Staff appraisal rate – rolling year - 78% (7% under plan)
- Medical Staff appraisal rate – year to date – 41.4% (14.6% over plan)

Finance

- The operational deficit is £33,000 ahead of plan (year to date). This has made the Trust eligible for the Provider Sustainability Fund and will receive £2.2m. In addition the Trust will receive £4.2m as part of the Financial Recovery Fund. These two additional funding elements have been included in the Trust's financial position.
- The Trust's spend on Agency fees is £491,000 below plan (year to date).
- Underperformance on elective and day case activity (1.3m) is offset in the main by over performance of non-elective activity (£1m).
- Overall operating costs are reporting £176k overspent against plan. These are mainly due to medical pay costs, including agency, waiting list initiatives, Locums and clinical supplies.
- The Trust has over delivered by £37,000 against the Cost Improvement Programme (year to date).

East Sussex Healthcare NHS
NHS Trust

MONTH 5 (AUGUST 2019)

TRUST INTEGRATED PERFORMANCE REPORT

East Sussex Healthcare NHS Trust

Contents

QUALITY AND SAFETY

DIRECTOR OF NURSING & MEDICAL DIRECTOR

Indicators

East Sussex Healthcare NHS Trust

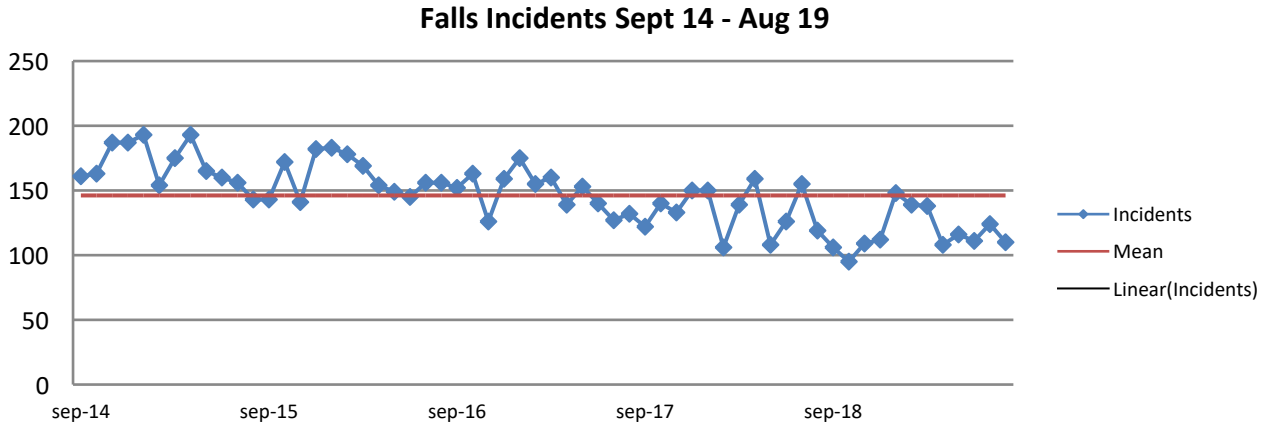
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-18	Aug-19	Var	2018/19	2019/20	Var		
Total falls	M	119	110	-7.6%	666	569	-14.6%	118	
Number of no-harm falls	M	86	74	-14.0%	471	410	-13.0%	87	
Number of minor/moderate falls	M	32	34	6.3%	193	149	-22.8%	29	
Number of major falls	0	1	2	1	2	10	8	1	
Number of catastrophic falls	0	0	0	0	0	0	0	0	
All patient falls per 1000 Beddays	5.5	5.4	5.1	-0.3	6.0	5.3	-0.78	5.3	
All patient falls with harm per 1000 Beddays	M	1.5	1.7	0.2	1.8	1.5	-0.30	1.4	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	1.6	2.4	49.3%	1.8	2.1	15.1%	2.3	
Number of grade 2 pressure ulcers	M	35	51	45.7%	198	222	12.1%	49	
Number of grade 3 to 4 pressure ulcers	M	0	0	0	3	5	2	1	
Pressure ulcer assessment compliance	M	82.9%	100.0%	17.1%	82.7%	85.3%	2.5%	83.3%	
VTE Assessment compliance	95.0%	94.5%	95.3%	0.7%	95.1%	95.8%	0.7%	96.0%	

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

- The percentage of no harm/near miss patient safety incidents for August is 79% (national figure 73%).

In August there were 110 falls with 3 x severity 4 (1 was reported on dashboard in July).

The rate per 1000 bed days has decreased slightly from 5.7 in July to 5.1. in August.



Indicators

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-18	Aug-19	Var	2018/19	2019/20	Var		
Number of Serious Incidents	M	5	6	1	15	27	12	5	
Number of Never Events	0	0	0	0	0	1	1	0	

There were 6 **serious incidents** reported on STEIS during August 2019:

- 1 x Child death in alleged suspicious circumstances (further information has since been obtained and resulted in a request to the CCG for a downgrade to an internal amber investigation)
- 3 x Fall to Fracture (one appeared on dashboard in July as incident reported on 31st July but reported on SteiS on 1st August)
- 1 x Treatment delay following readmission after missed spinal fractures in ED
- 1 x sub-optimal care following the inappropriate change of anticoagulant therapy for a mechanical heart valve resulting in a thrombosis on heart valve

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

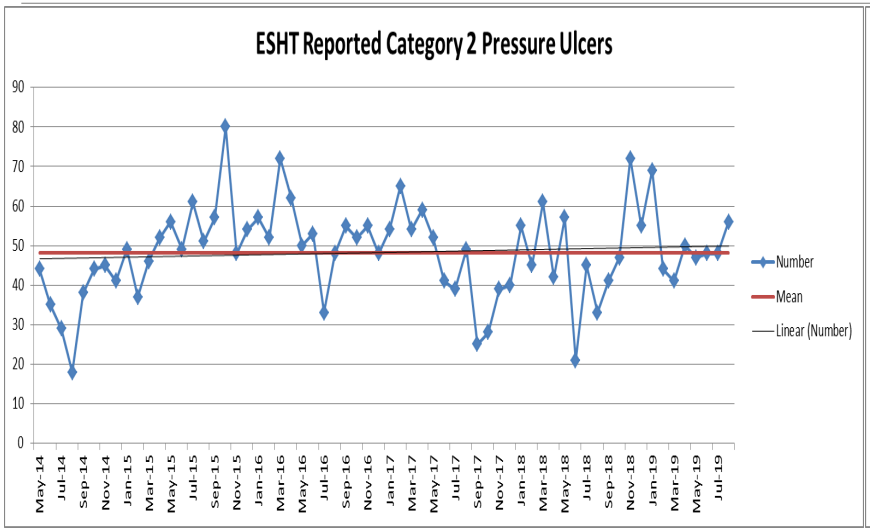
At the end of August 2019 there were 31 Serious Incidents open in the system; 17 under investigation and within timescales, 9 are with the CCG for closure and 3 incidents are with the HSIB. ESHT has requested a downgrade for one SI relating to a child death, to an internal amber incident following receipt of further information. The remainder are in process of internal approval.

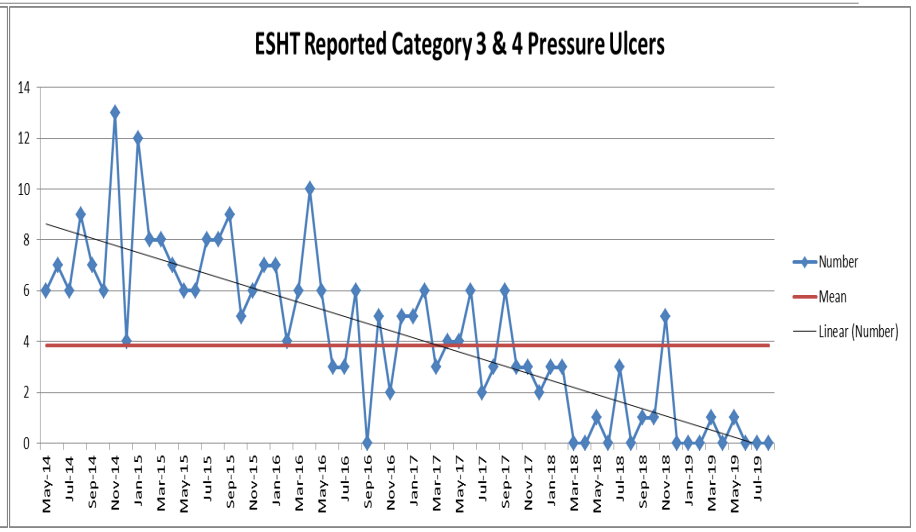
A full breakdown of Amber incidents which are overdue by number of days is presented to the Patient Safety and Quality Group on a monthly basis with updates from ADoN colleagues for those open the longest.

For August 2019, the verbal DoC was 70% and written DoC was 90%. This is a rolling 12 month figure which has been affected by the recent issue with the DoC reporting template. This is an improvement compared to July but a risk register entry has been raised until there is confidence in the DoC process.

The Patient Safety Team are continually monitoring the compliance with DoC.

Pressure Ulcer Incidents





A more detailed report is sent to the Patient Safety and Quality Group (PSQG) by the Pressure Ulcer review Group (PURG) and there are plans to review reporting going forward as it is complex. This is because the numbers reported/declared in month may change over time as the ulcers do, i.e. an unstagable ulcer after debridement or treatment may improve or deteriorate. Also damage may occur or even deteriorate despite all appropriate treatment due to clinical condition or comorbidities for example and on occasions patient may decline treatment suggested/offered.

In Aug there were 29 category 2 ulcers declared in the acute hospitals, 24 in the community and 3 in our community hospitals, which was a slight increase from July.

There were zero category 3 & 4 pressure ulcers reported in August 2019 with none in June or July so a very positive trend so far.

Quarterly deep dives continue with snap shot audits of category 2 damage, unstageable damage and Deep Tissue Injuries presented at the Quality and Safety Committee to review any lapses in care and share/embed learning.

East Sussex Healthcare NHS Trust

Infection Control

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-18	Aug-19	Var	2018/19	2019/20	Var		
Number of MRSA Cases	0	1	1	0	1	2	1	0	
Number of Cdiff cases	4	5	4	-1	23	24	1	4	
Number of MSSA cases	M	3	1	-2	8	6	-2	1	

MRSA bacteraemias – One MRSA bacteraemia on Seaford ward, reported as avoidable. PIR has taken place, identifies source as sacral wound or peripheral cannula. Improvements required with Low NSC, hand hygiene compliance and documentation of cannula. Datix raised and action plan agreed.

C. Difficile – Within limit for 2019/20. 5 cases reported for August against a monthly limit of 5, (4 Hospital Onset Healthcare Associated (HOHA) – as shown, and 1 case Community Onset Healthcare Associated (COHA) infection). Two cases on Newington ward have been assessed as the same ribotype of 002, outbreak actions have been taken and further subtyping has been requested.

MSSA bacteraemia - 1 ESHT case in Aug. Sepsis of unknown origin. No lapse identified

Gram negative bacteraemia

Organism	Total	UTI source	CAUTI source	Biliary source	GI source	Other source	Unknown source
E. coli	3	0	0	2	0	1	0
Klebsiella sp.	2	1	0	0	0	1	0
Pseudomonas	1	0	0	0	0	1	0
Total (%)	6	1	0	2	0	3	0

There were no avoidable gram negative bacteraemias in August.

Serious incidents/outbreaks – Outbreak of CDI on Newington ward as above.

Patient Experience

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-18	Aug-19	Var	2018/19	2019/20	Var		
Inpatient FFT response rate	45.0%	42.9%	42.3%	-0.6%	42.6%	45.5%	2.9%	45.3%	
Inpatient FFT score	96.0%	97.8%	97.3%	-0.5%	97.8%	97.5%	-0.3%	97.4%	
A&E FFT response rate	22.0%	3.5%	4.5%	1.0%	4.1%	6.5%	2.4%	6.3%	
A&E FFT score	88.0%	92.8%	92.9%	0.1%	93.0%	92.9%	-0.1%	92.6%	
Outpatient FFT Score	M	97.7%	97.1%	-0.6%	97.6%	97.7%	0.2%	97.6%	
Maternity FFT response rate	45.0%	26.5%	19.3%	-7.2%	11.7%	29.8%	18.1%	22.2%	
Maternity FFT score	96.0%	95.7%	97.8%	2.2%	96.7%	97.2%	0.4%	97.3%	

FFT and Patient questionnaire - August

Indicator	Response Rate %	Latest National % (June 19)	Recommend Score %	Latest National % (June 19)	No of Surveys
Inpatient	42.3	24.6	97.3	96	2368
A&E	4.5	12.1	93	86	451
Maternity	19.3	20.5	80.77	97	64

Examples of questionnaire comments in August:

Positive comments

Positive comments;

- "A first class regime carried out to the letter and care day and night – nothing was too much trouble."
- "I hear about complaints about the NHS but have not found a bad service and have been in EDGH and Conquest, Hastings and have had great treatment."
- "Made me laugh when I felt alone and scared, did not hesitate to help me at all times."

Negative comments

- "Doctors to explain things better, didn't understand my options, felt like I was pushed"
- "Conflicting info from different staff"
- "When it comes to discharging patients, please get on with it as patients have lives to be getting on with"

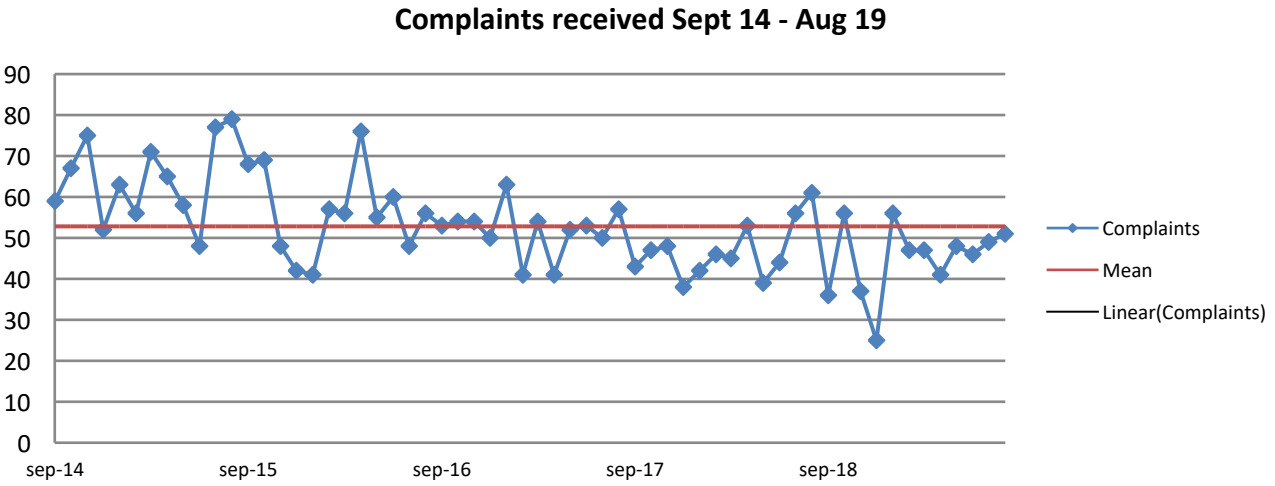
The lowest scoring questions from the inpatient experience questionnaire (part of FFT data) are as follows:

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

•*Error on Maternity FFT data discovered as duplicate survey found, on FSW device now deleted but dropped the reccommend score.

Complaints

East Sussex Healthcare NHS Trust



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

- Medicine – 1.3 per 1000 bed days (18 complaints)
- DAS – 3.6 per 1000 bed days (18 complaints)
- Women, Children and Sexual Health – 1.2 per 1000 bed days (2 complaints)
- Urgent Care - 5 complaints
- Out of Hospital – 6 complaints

There were 3 re-opened complaints in August, lower than in July. No themes identified.

In August, there was only one contact from the PHSO to make an enquiry about a case they are considering for investigation. This relates to a missed diagnosis of a stroke resulting in a delay in treatment

More detailed discussion and analysis takes place 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 Aug-19	Day				Night				
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average Fill Rate Registered Nursing Assocs	Average Fill Rate Non-Registered Nursing Assocs	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average Fill Rate Registered Nursing Assocs	Average Fill Rate Non-Registered Nursing Assocs	CHPPD
BEXHILL HOSPITAL	81.50%	99.20%			93.30%	97.80%			6.21
EASTBOURNE DISTRICT GENERAL HOSPITAL	82.90%	95.50%		100.00%	85.20%	105.70%		100.00%	8.26
CONQUEST HOSPITAL	83.00%	100.60%		100.00%	82.70%	110.10%			8.88
RYE HOSPITAL	94.80%	99.80%			96.80%	106.50%			6.25
Totals	83.10%	98.30%		100.00%	84.20%	107.40%		100.00%	8.4

Fill Rate and CHPPD by Division Aug-19	Day				Night				
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average Fill Rate Registered Nursing Assocs	Average Fill Rate Non-Registered Nursing Assocs	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average Fill Rate Registered Nursing Assocs	Average Fill Rate Non-Registered Nursing Assocs	CHPPD
Medicine	83.00%	101.00%		100.00%	85.90%	115.20%		100.00%	7.85
Out-of-Hospital	85.30%	99.30%			94.40%	99.10%			6.22
Surgery Anaesthetics & Diagnostics	81.30%	94.30%		100.00%	83.70%	93.70%			9.22
Women Children & Sexual Health	87.20%	85.80%			78.20%	96.40%			13.84
Totals	83.10%	98.30%			84.20%	107.40%			8.4

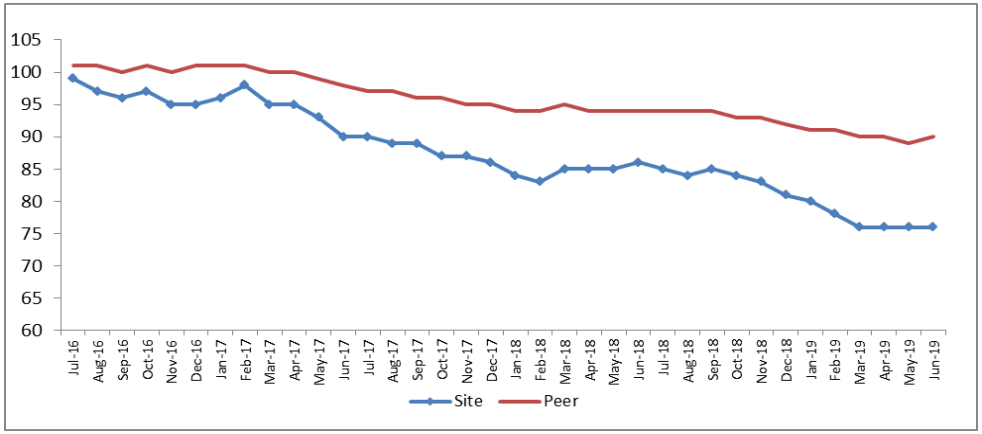
- Trust overall CHPPD has reduced from 8.82 in July to 8.4 in August. The latest national median CHPPD (May 2019) was 8.1 with a recommendation of 8.2 compared to our peers.
- New national CHPPD guidance & reporting came into effect on 1st Aug 2019; Nursing Associates (registered and non – registered trainees are now reported separately to care staff).
- The CHPPD in W&Cs Division is significantly affected 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 or for discussion and escalation if required where there is a variance of 25% or more.
- 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.

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

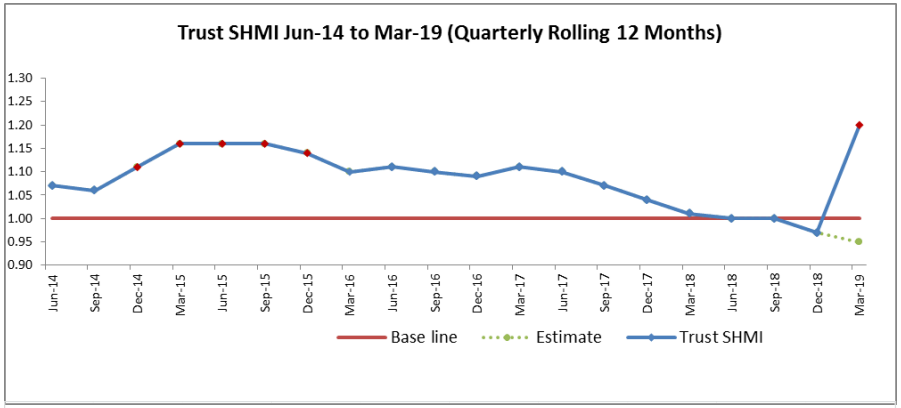
Mortality Metrics

East Sussex Healthcare NHS Trust

RAMI 18 (Rolling 12 months)



SHMI



Data published for the period Apr 18 to Mar 19 should be viewed with caution due to a technical error with the submission

SHMI for the period April 2018 to March 2019 has been published and is showing an index of 1.20. Unfortunately, there was a technical issue with the data submission and as a result diagnostic and procedural data was omitted from the calculation. It is estimated the true Trust position should be around 0.95. The National data will be updated when the issue has been resolved by NHS Digital.

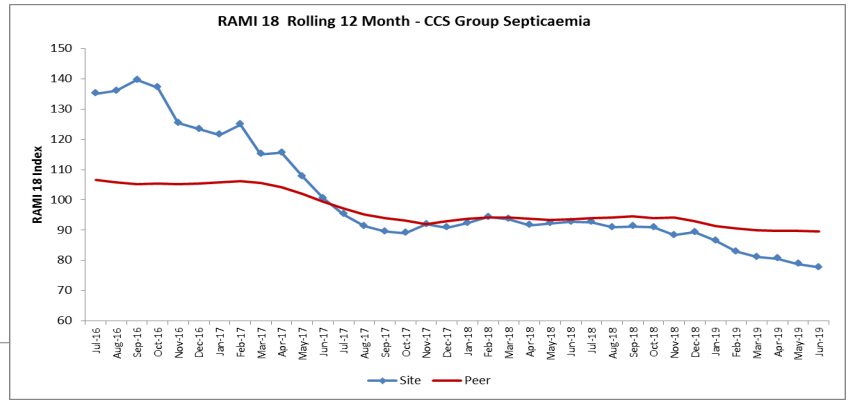
RAMI 18 - July 2018 to June 2019 (rolling 12 months) is **76** compared to 86 for the same period last year (July 2017 to June 2018). June 2018 to May 2019 was also 76.

RAMI 18 shows a June position of 75. The peer value for June is 90. The May position was also 75 against a peer value of 84.

Crude mortality shows July 2018 to June 2019 at 1.44% compared to 1.75% for the same period last year.

The percentage of deaths reviewed within 3 months was 78% in May 2019, April 2019 was 86%.

Main causes of death during August 2019 (Mortality Database)	
Pneumonia	24
Sepsis/Septicaemia	15
Cancer	14
Heart Failure	5
Liver Disease	4



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 8.2% admissions, 8.9% 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
		Aug-18	Aug-19	Var	2018/19	2019/20	Var		
Four hour standard	95.0%	90.4%	88.6%	-1.8%	92.2%	89.2%	-3.0%	89.7%	
A&E Minor Performance	98.0%	95.8%	98.3%	2.5%	96.6%	98.0%	1.3%	97.2%	
Four hour standard (Local System)	95.0%	92.7%	91.3%	-1.4%	94.0%	91.7%	-2.4%	92.0%	
12 Hour DTAs	0	0	0	0	0	0	0	0	
Unplanned re-attendance to Emergency Department	5.0%	3.9%	3.6%	-0.3%	3.5%	3.7%	0.2%	3.6%	
% Patients waiting less than 15 minutes for assessment in ED	M	81.9%	83.4%	1.6%	85.7%	84.0%	-1.7%	85.1%	
% Patients waiting less than 60 minutes for treatment in ED	M	47.4%	39.5%	-7.9%	49.7%	40.6%	-9.1%	43.7%	
% Patients waiting less than 120 minutes for treatment in ED	M	77.4%	70.0%	-7.4%	80.7%	71.6%	-9.1%	75.8%	
% Patients that left without being seen in ED	M	2.7%	3.1%	0.4%	2.3%	2.6%	0.3%	2.2%	
% Patients admitted from ED (Conversion rate)	M	29.3%	28.7%	-0.6%	28.8%	29.6%	0.8%	30.5%	
Emergency Department attendances	M	11105	12307	10.8%	54681	59782	9.3%	11207	
Ambulance conveyances	M	3249	3451	6.2%	15540	16939	9.0%	3321	

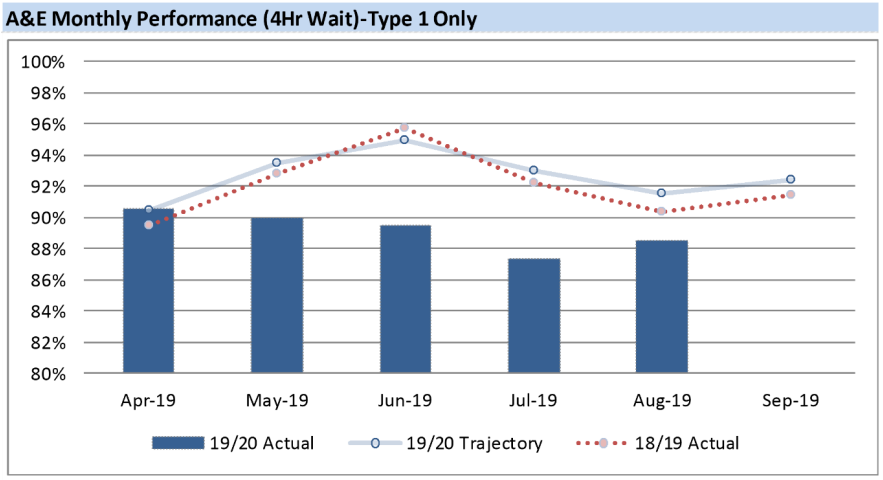
The Trust 4 Hour performance standard in August was 88.6% against a national performance of 86.3%. This ranked the Trust 32nd out of 121 reporting organisations. The system 'Walk-In' centres and the Acute Trusts combined performance for August was 91.3%. Activity continues to be higher than previous years, A&E attendances are up 10.8% and ambulance conveyances are up 6.2% compared to August 2018.

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

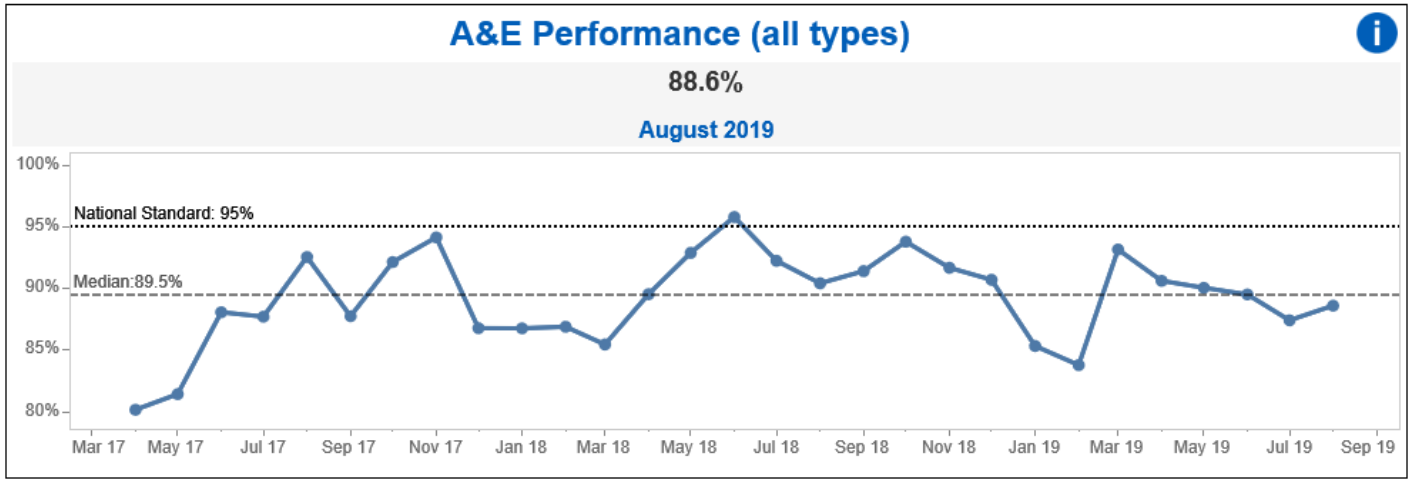
A&E Trajectory

East Sussex Healthcare NHS Trust



	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%	87.4%	88.6%	
18/19 Actual	*89.5%*	*92.8%*	*95.7%*	*92.2%*	*90.4%*	*91.4%*

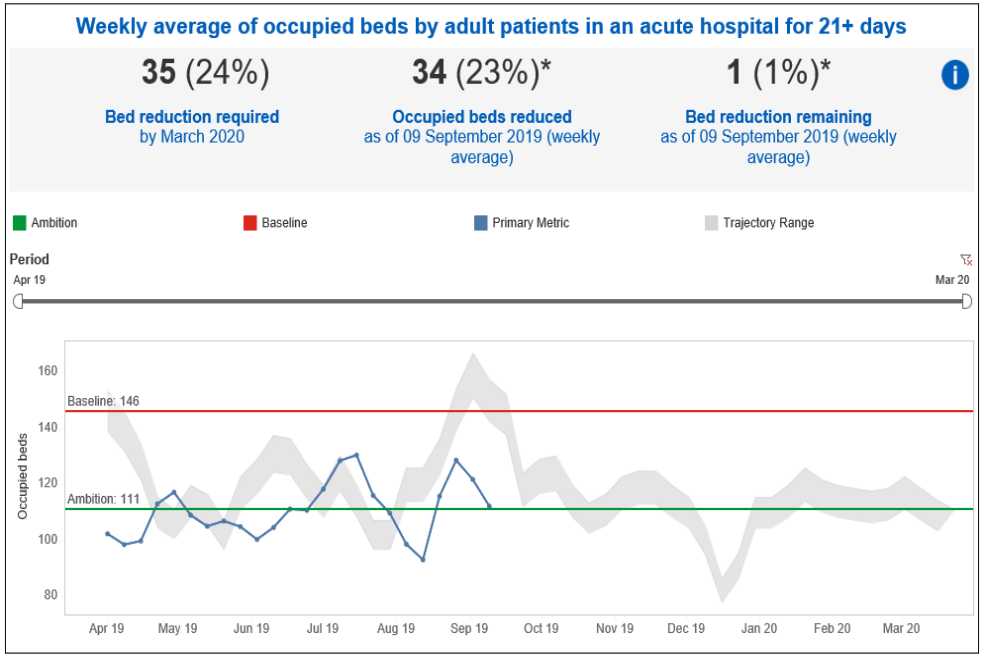
- The Trusts' 4 hour performance for August 2019 was 88.55% (CONQ 88.28% and EDGH 88.82%).
- Minors performance for August was in line with July at 98.3%, whilst Majors performance improved by 1.1% to 81.7%.
- Ambulance conveyances have increased by 9.0% year to date and August was up 6.2% on August 2018.



East Sussex Healthcare NHS Trust

Patient Flow Metrics

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-18	Aug-19	Var	2018/19	2019/20	Var		
Super Stranded (Census on last day of month)	M	98	116	18	55	54	0	106	
Avg Daily adult patients in acute hospital for 21+ days (NHSI metric)	111	119	107	-12	125	109	-16	111	
Delayed transfer of care national standard	3.5%	3.9%	3.2%	-0.6%	2.2%	3.2%	1.0%	3.5%	
Cancellations									
Urgent operations cancelled for a second time	0	1	0	-1	4	0	-4	0	



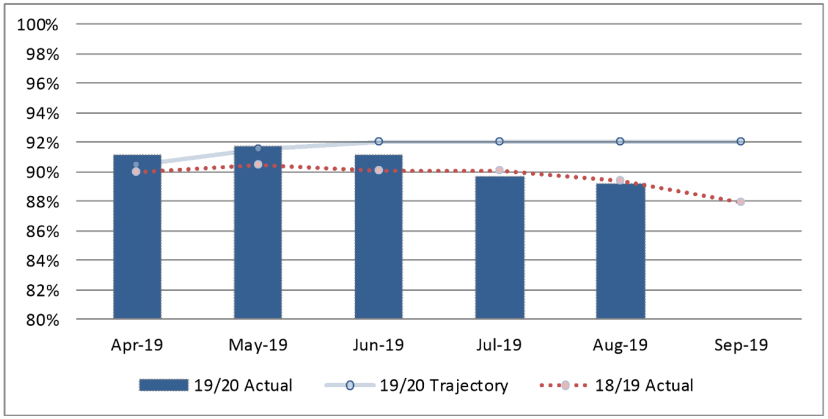
- The Trust, in line with NHSI priorities is moving to a revised set of patient flow metrics:
- Deputy COO will be leading a refresh of the patient flow programme
- - reduction in long length of stay (21+ patients) by 40%
- - increase pre noon discharges to 40%
- - increase weekend discharges by 50% 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

RTT

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-18	Aug-19	Var	2018/19	2019/20	Var		
RTT Incomplete standard	92.0%	89.4%	89.2%	-0.2%	90.0%	90.6%	0.6%	90.2%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	3062	3079	17	3062	3079	17	2749	
RTT Total Waiting List Size	28221	28818	28567	-251	28818	28567	-251	27829	
RTT 52 week waiters	0	0	0	0	0	0	0	0	
RTT 35 week waiters	M	194	267	37.6%	194	267	37.6%	185	

RTT (Referral to Treatment 18 Weeks)



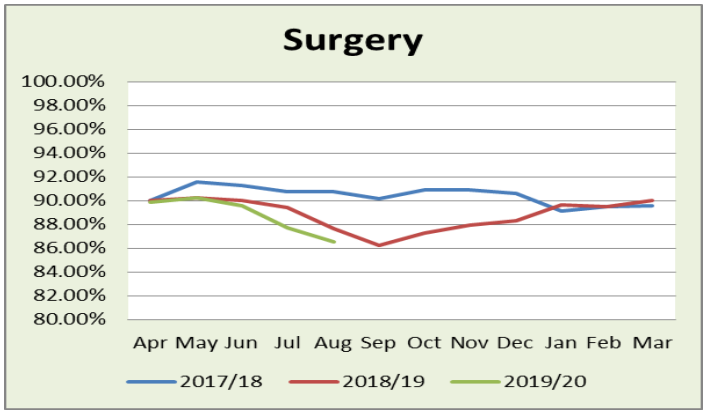
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
19/20 Trajectory	90.5%	91.5%	92.0%	92.0%	92.0%	92.0%
19/20 Actual	91.1%	91.8%	91.2%	89.7%	89.2%	
18/19 Actual	*90.0%*	*90.5%*	*90.1%*	*90.1%*	*89.4%*	*87.9%*

All Incomplete Pathways Main Specialty Report

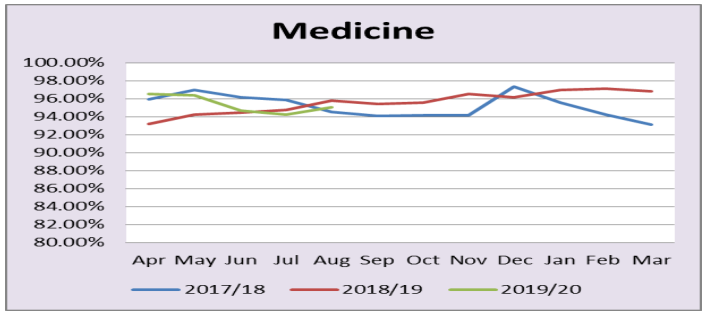
Specialty	Breaches	NonBreaches	Total Cases	Performance	
General Surgery	452	4578	5030	91.01%	✗
Urology	339	1587	1926	82.40%	✗
Trauma & Orthopaedics	189	1074	1263	85.04%	✗
Ear, Nose & Throat (ENT)	518	2614	3132	83.46%	✗
Ophthalmology	452	3062	3514	87.14%	✗
Oral Surgery	170	1558	1728	90.16%	✗
General Medicine	0	5	5	100.00%	✓
Gastroenterology	236	1980	2216	89.35%	✗
Cardiology	10	1649	1659	99.40%	✓
Dermatology	8	1063	1071	99.25%	✓
Respiratory Medicine	13	734	747	98.26%	✓
Neurology	71	1333	1404	94.94%	✓
Rheumatology	9	246	255	96.47%	✓
Geriatric Medicine	6	227	233	97.42%	✓
Gynaecology	490	2003	2493	80.34%	✗
Other	116	1775	1891	93.87%	✓
Totals	**3079**	**25488**	**28567**		

An increase in the number of patients being referred on a cancer pathway coupled with service redesign in multiple specialties and a shortage of clinicians (various reasons, including vacancies, annual leave and sickness) has seen the RTT performance reduced further. Although to be expected in some areas, a review of recovery plans, complete with timelines on actions has been encouraged to heighten focus on improving performance in the coming months.

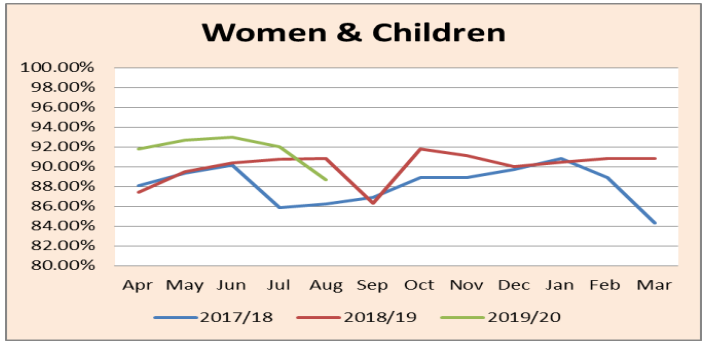
RTT



- Urology saw a significant drop in performance. Principally due to the Urology Investigation Suite (UIS) redesign at EDGH but compounded by a range of workforce issues, which led to reduction in capacity. The service is expecting the RTT position to improve following the opening of the UIS and newly agreed clinical pathways. Action plan in place to ensure recovery.
- General Surgery has also reduced, with workforce issues contributing in part and an increase in cancer referrals. Work is underway to focus on the middle section of the patient pathway, which is expected to contribute to an improvement in performance and waiting times.
- ENT remains at the 83/84% mark and although recovery plans are in place, this has yet to impact positively on performance.
- T&O continues to have a capacity gap specifically in the hip & knee modality. Waiting times in other modalities have reduced which is helping overall position but more capacity required within hip & knee to bring specialty up to 92% or above.



- Medicine has collectively improved its overall RTT position.
- Gastro remains the challenging specialty. With cancer and diagnostics (DM01) being the priority over RTT. New clinical pathway design and continued work on improving the service aims to help to recover the RTT position in the coming months.



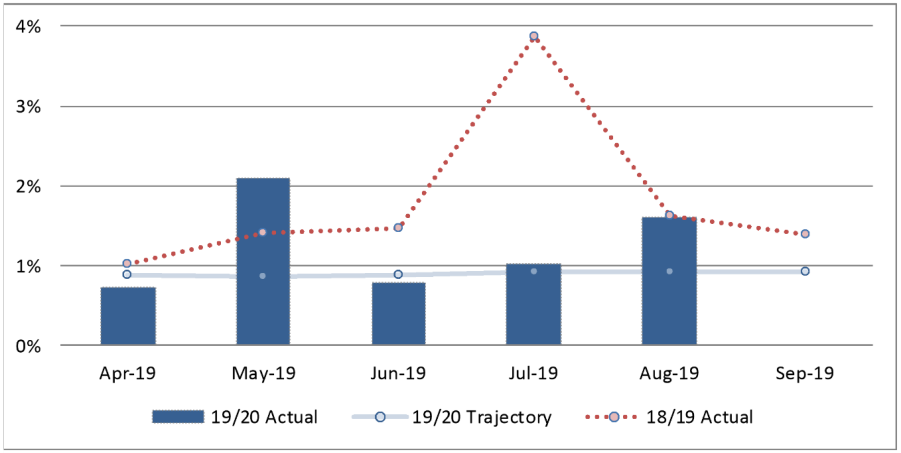
- Paediatric Surgery just missed out on 92% but plans in place and is expected to recover for next month.
- Gynae has remained at around 80% but with the waiting time for out-patient first appointment (OPFA) continuously reducing and the recovery plans set to improve performance, we would envisage seeing a rise to 85% or above in the coming 4 months. The admitted element of the Gynae pathway remains a focus for improvement.

Diagnostics

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-18	Aug-19	Var	2018/19	2019/20	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	1.6%	1.6%	0.0%	1.8%	1.3%	-0.6%	1.0%	

Diagnostic waiting times (over 6 weeks)



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

- The Trust was unable to achieve the 6 week diagnostic target for a second consecutive month, with a final performance position of 1.61% for August against a target of < 1%.
- The increase in Two Week Wait cancer referrals is impacting on available diagnostic capacity.
- A total of 91 breaches occurred in August 2019:
  - Computerised Tomography (9)
  - Non-obstetric Ultrasound (63)
  - Audiology (5)
  - Colonoscopy (5)
  - Cystoscopy (3)
  - Gastroscopy (6)

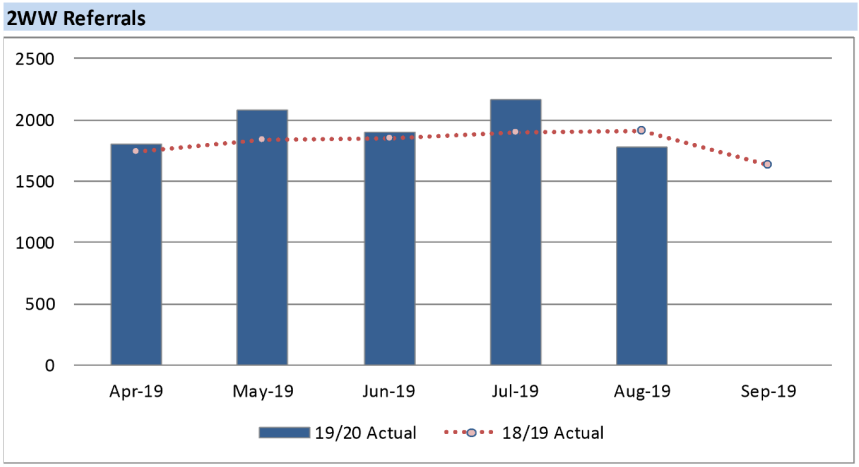
East Sussex Healthcare NHS
NHS Trust

CANCER STANDARDS

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-18	Jul-19	Var	2018/19	2019/20	Var		
Cancer 2WW Standard	93.0%	96.0%	94.6%	-1.4%	94.2%	95.1%	0.9%	94.6%	
Cancer 62 day urgent referral standard	85.0%	73.1%	77.4%	4.3%	73.3%	77.3%	4.0%	74.0%	
Cancer 2WW Standard (breast symptoms)	93.0%	97.5%	93.0%	-4.5%	95.5%	93.2%	-2.3%	95.1%	
Cancer 31 day standard	96.0%	95.9%	97.4%	1.6%	94.7%	96.0%	1.3%	95.3%	
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%	90.0%	100.0%	10.0%	90.0%	100.0%	10.0%	89.3%	
Cancer 62 day screening standard	90.0%	76.5%	100.0%	23.5%	56.6%	73.3%	16.7%	78.5%	

- For July the Trust achieved all of the Cancer Standards apart from the 62 Day standard.
- 62 Day performance was 77.4% for July compared to a national aggregate of 77.6% and a recovery trajectory of 85.2%. Unfortunately the Trust has been unable to meet its 62 Day recovery trajectory for the second consecutive month.
- Of the 124 treatments provided in July, there were 28 breaches.
- 1978 patients were seen under the two week wait referral pathway.
- Referrals continue to increase, especially in Breast, Head & Neck, Lower GI and Skin.
- As of April, the new Day 38 Inter-Provider Transfer (IPT) rules came into place which increased the Trust's performance by **2.2%**
- The Trust reported 7 treatments on or over 104 days, 3 of these were shared treatments with other Trusts (Brighton, Maidstone and The Royal Brompton) and there were 10 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 Trust's compliance with high impact changes with positive feedback. Key areas to focus: timed pathways and MDT reform.

Cancer 2 Week Wait Referrals (July / August)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
19/20 Actual	1804	2076	1900	2171	1781	
18/19 Actual	*1736*	*1842*	*1855*	*1903*	*1912*	*1631*

There were 106 breaches out of 1,978 2WW patients first seen for **July 2019**.

2WW referrals in **August 2019** were down 6.9% on August 2018. However, the latest rolling twelve month referral numbers continue to be above those received in the previous twelve months. 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.

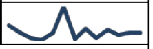
Suspected Cancer Site	Sep 17-Aug 18	Sep 18-Aug 19	% Variance
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	1,722	1,783	3.5%
Other suspected cancers	29	22	-24.1%
Suspected brain/central nervous system tumours	64	109	70.3%
Suspected breast cancer	2,744	3,097	12.9%
Suspected childrens cancer	24	3	-87.5%
Suspected gynaecological cancers	1,615	1,810	12.1%
Suspected haematological malignancies (excluding acute leukaemia)	187	218	16.6%
Suspected head & neck cancers	2,048	2,255	10.1%
Suspected lower gastrointestinal cancers	3,666	4,259	16.2%
Suspected lung cancer	694	622	-10.4%
Suspected sarcomas	0	3	
Suspected skin cancers	3,822	4,050	6.0%
Suspected testicular cancers	177	247	39.5%
Suspected upper gastrointestinal cancers	1,740	1,640	-5.7%
Suspected urological cancers (excluding testicular)	2,225	2,185	-1.8%
Grand Total	**20,757**	**22,303**	**7.4%**

Activity

ACTIVITY

Acute Activity

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-18	Aug-19	Var	2018/19	2019/20	Var		
Emergency Department attendances	M	11105	12307	10.8%	54681	59782	9.3%	11207	
Ambulance conveyances	M	3249	3451	6.2%	15540	16939	9.0%	3321	
Elective spells	M	516	494	-4.3%	2713	2632	-3.0%	546	
Day Cases	M	3841	3707	-3.5%	19378	19922	2.8%	3992	
Elective Beddays	M	1663	1735	4.3%	8095	7996	-1.2%	1676	
Total Non-Elective Spells	M	4771	4880	2.3%	22944	24537	6.9%	4803	
Number of Emergency spells	M	4172	4278	2.5%	20045	21469	7.1%	4200	
Number of Maternity spells (ante and post partem)	M	318	321	0.9%	1537	1639	6.6%	321	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	281	281	0.0%	1362	1429	4.9%	283	
Non-Elective beddays	M	20662	20063	-2.9%	102104	99894	-2.2%	20097	
LOS									
Elective Average Length of Stay	M	3.2	3.5	0.3	3.0	3.0	0.1	3.1	
Non-Elective Average Length of Stay	M	4.4	4.0	-0.4	4.6	4.0	-0.5	4.2	
Inpatient Average Length of Stay at intermediate care units	M	25.5	28.0	2.5	27.5	25.1	-2.4	24.2	

East Sussex Healthcare NHS
NHS Trust

YTD Exception Reporting: Top 10 Outliers

First OP

SpecialtyName	Activity	Plan	Var (%)	Variance
Trauma & Orthopaedics	5992	6483	-7.6%	-491
General Surgery	2821	3172	-11.1%	-351
Urology	2485	2729	-9.0%	-244
ENT	3614	3807	-5.1%	-193
Cardiology	2626	2797	-6.1%	-171
Obstetrics	1333	1141	16.8%	192
Thoracic Medicine	1483	1252	18.4%	231
Dermatology	2278	1958	16.3%	320
Gynaecology	3309	2956	11.9%	353
Ophthalmology	6957	6546	6.3%	410
Total	**48689**	**48383**	**0.6%**	**306**

Follow-Up OP

SpecialtyName	Activity	Plan	Var (%)	Variance
Ophthalmology	27739	29486	-5.9%	-1747
General Surgery	2945	4382	-32.8%	-1437
Trauma & Orthopaedics	10974	12097	-9.3%	-1123
Urology	6324	7394	-14.5%	-1070
ENT	3840	4863	-21.0%	-1023
Stroke Medicine	287	207	38.3%	80
Obstetrics	1877	1796	4.5%	81
Anaesthetics	215	10	2062.2%	205
Cardiology	14091	13758	2.4%	333
Clinical Oncology	4015	3641	10.3%	374
Total	**117217**	**125529**	**-6.6%**	**-8312**

Day Case

SpecialtyName	Activity	Plan	Var (%)	Variance
Maxillo-Facial Surgery	703	806	-12.7%	-103
Trauma & Orthopaedics	948	1035	-8.4%	-87
Cardiology	910	992	-8.3%	-82
Ophthalmology	1735	1787	-2.9%	-52
Endocrinology	180	195	-7.4%	-15
General Surgery	2831	2777	1.9%	54
Rheumatology	907	813	11.5%	94
Haematology	2657	2490	6.7%	167
Gastroenterology	4052	3833	5.7%	219
Clinical Oncology	3083	2655	16.1%	428
Total	**20032**	**19204**	**4.3%**	**828**

Elective

SpecialtyName	Activity	Plan	Var (%)	Variance
Urology	520	570	-8.8%	-50
Cardiology	73	123	-40.5%	-50
General Surgery	249	296	-15.7%	-47
Trauma & Orthopaedics	657	682	-3.6%	-25
Respiratory Physiology	155	179	-13.4%	-24
Geriatric Medicine	10	4	173.6%	6
General Medicine	43	33	30.7%	10
ENT	135	115	17.9%	20
Thoracic Medicine	69	37	83.6%	31
Haematology	146	98	48.8%	48
Total	**2656**	**2745**	**-3.3%**	**-89**

Top five Specialties above and below plan by point of delivery shown for the first five 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.

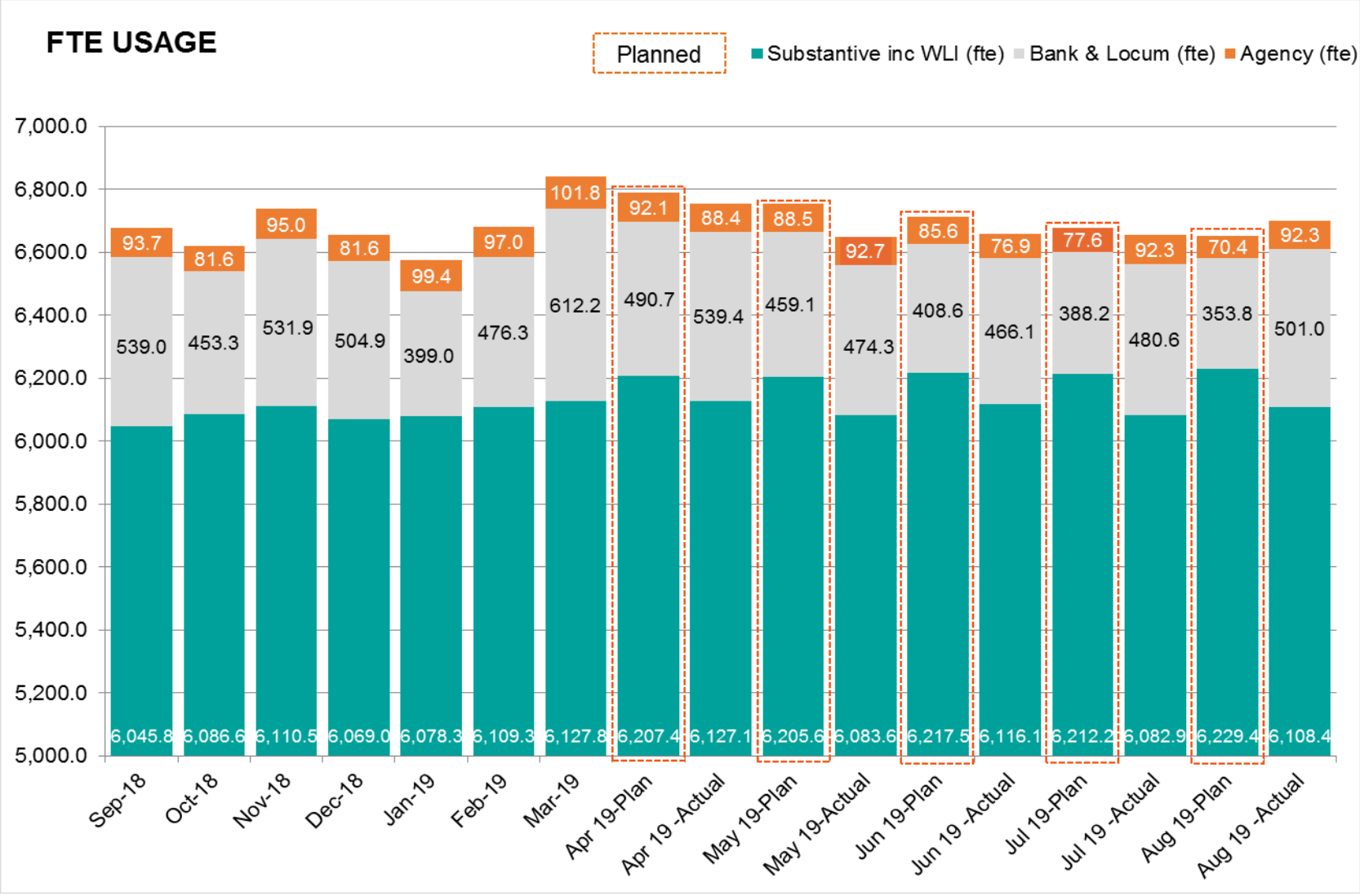
East Sussex Healthcare NHS
NHS Trust

ESHT WORKFORCE REPORT

- MONTH 5 (AUG 2019)

HR DIRECTORATE
Jul 2019
Version v2.0

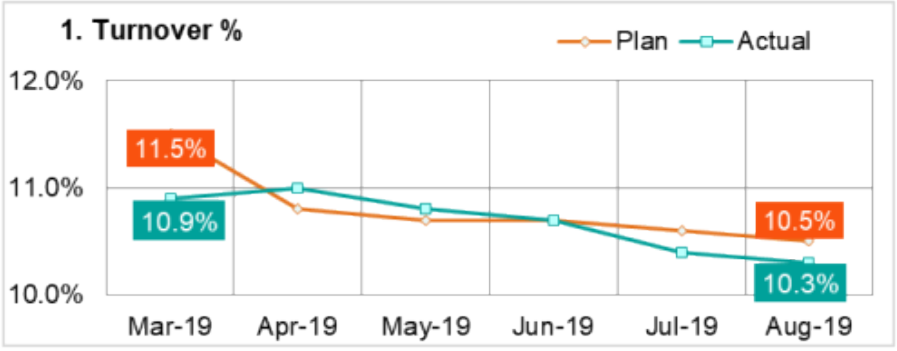
TRENDING FTE USAGE BY MONTH

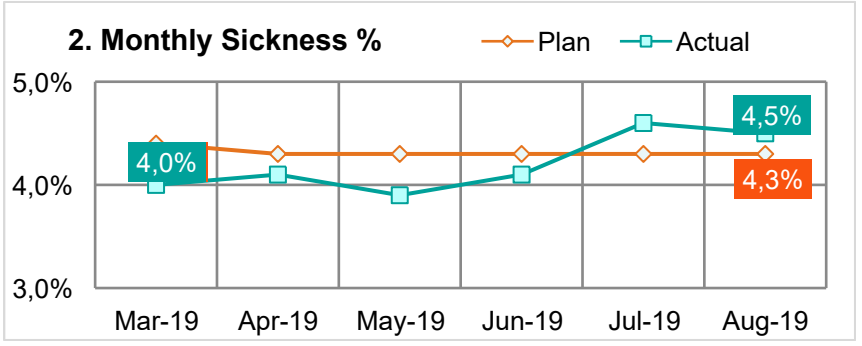


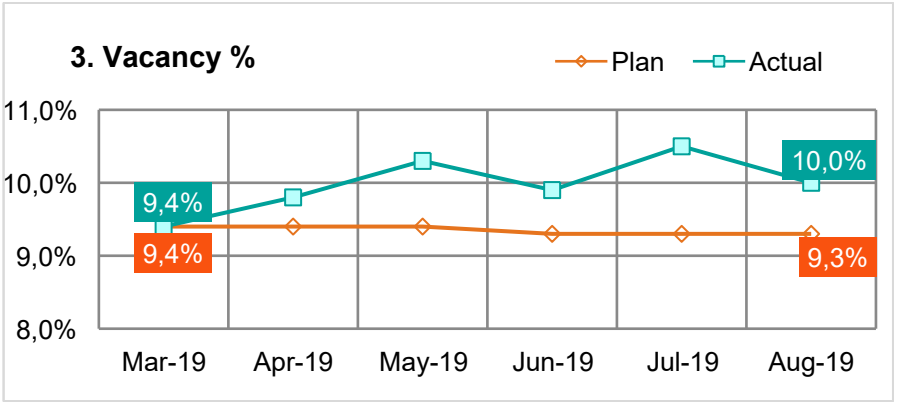
***Source data**: Finance Ledger*

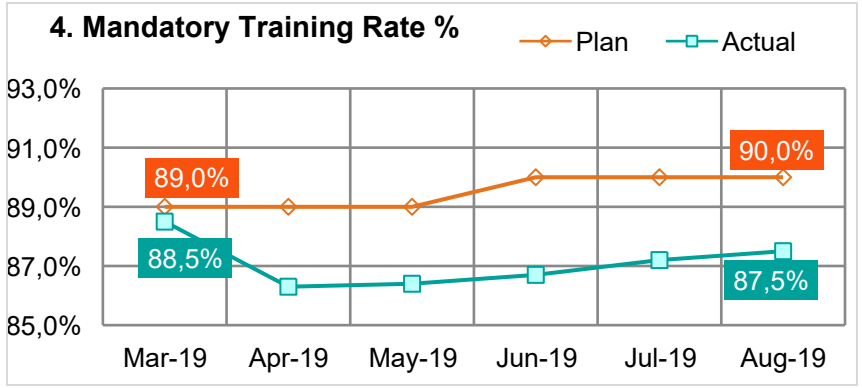
NHSI KPI'S - PLANNED v ACTUAL

Category	Plan/Actual	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Annual Turnover %	Plan	11.5%	10.8%	10.7%	10.7%	10.6%	10.5%
	Actual	10.9%	11.0%	10.8%	10.7%	10.4%	10.3%
Monthly Sickness %	Plan	4.4%	4.3%	4.3%	4.3%	4.3%	4.3%
	Actual	4.0%	4.1%	3.9%	4.1%	4.6%	4.5%
Vacancy Rate %	Plan	9.4%	9.4%	9.4%	9.3%	9.3%	9.3%
	Actual	9.4%	9.8%	10.3%	9.9%	10.5%	10.0%
Mandatory Training rate	Plan	89.0%	89.0%	89.0%	90.0%	90.0%	90.0%
	Actual	88.5%	86.3%	86.4%	86.7%	87.2%	87.5%







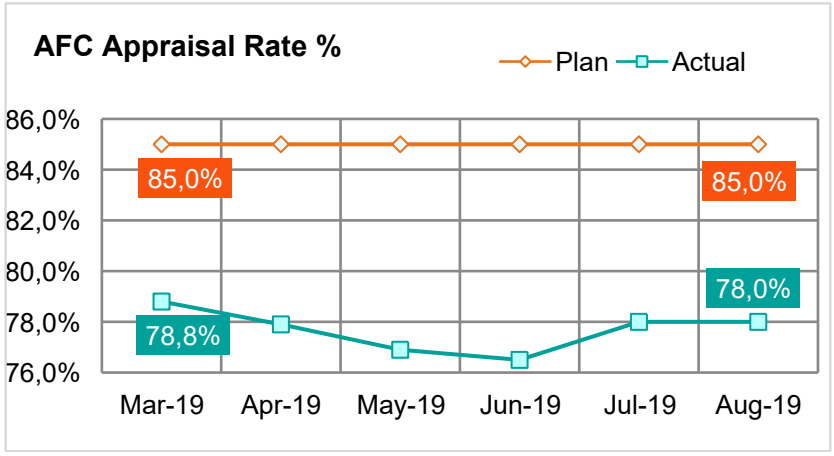


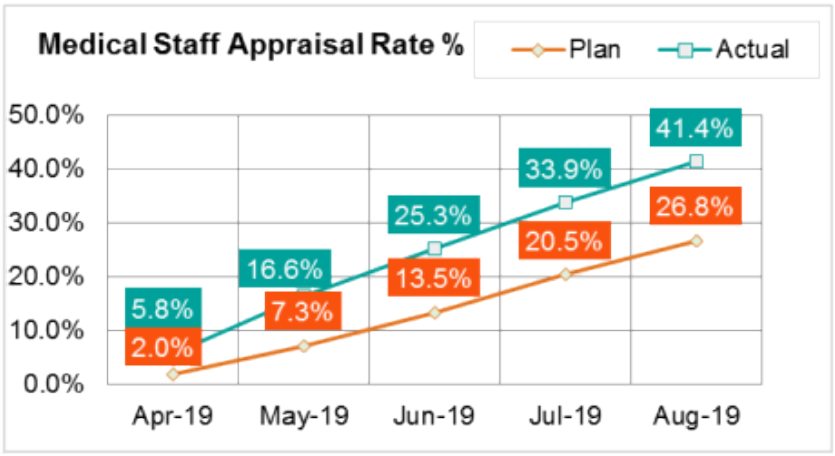
***Source data**: ESR & Finance Ledger*

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	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
AfC Appraisal Rate (rolling year)	Plan	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
	Actual	78.8%	77.9%	76.9%	76.5%	78.0%	78.0%
Medical Staff Appraisal Rate (Yr to date)	Plan	98.0%	2.0%	7.3%	13.5%	20.5%	26.8%
	Actual	100.0%	5.8%	16.6%	25.3%	33.9%	41.4%





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

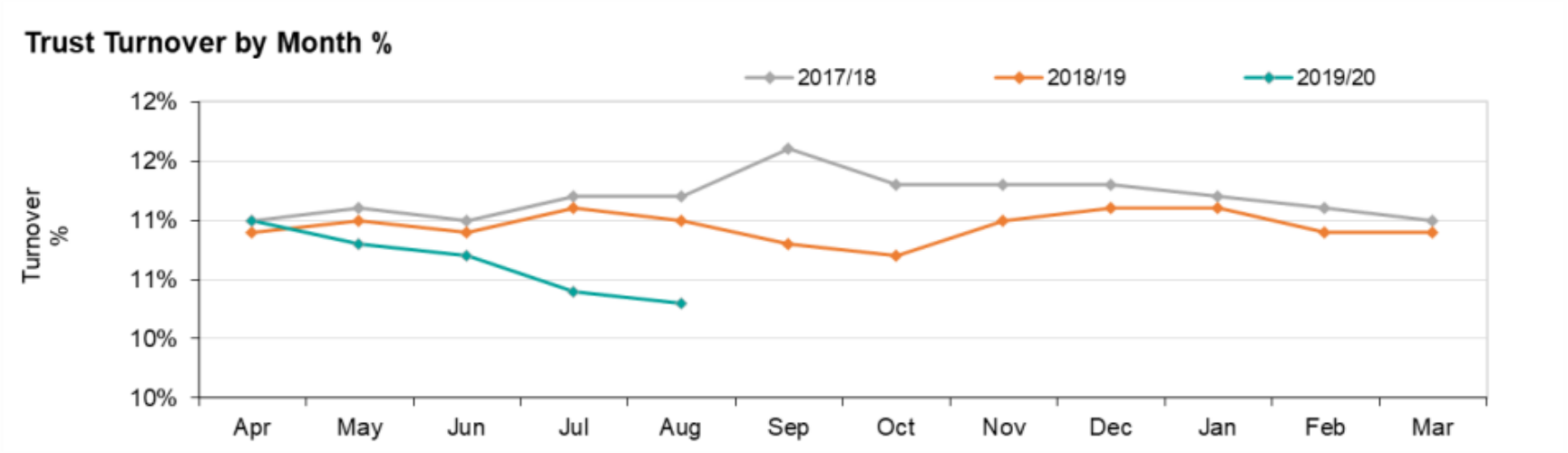
East Sussex Healthcare NHS
NHS Trust

TURNOVER TREND – STAFF GROUP

- Turnover rate for the Trust has reduced by a further 0.1% to 10.3% which equates to 610.7 fte leavers in the last 12 months.
- 10.3% Registered Nursing turnover equates to 186.7 fte leavers in year (averaging 15.6 fte per month). 12.1 ftes left in Aug
- 10.3% Additional Clinical Services turnover equates to 122.8 fte leavers in year, of which 75.0 ftes are unregistered nursing (average fte leavers 6.3 fte per month). 7.4 ftes left in Aug.

TRUST TURNOVER BY STAFF GROUP (%)

Year on Year	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Trend line
Additional Clinical Services	13.5%	12.9%	12.3%	12.1%	12.0%	11.5%	11.2%	11.7%	11.6%	11.2%	11.1%	10.3%	10.3%	
Administrative and Clerical	11.6%	11.6%	12.0%	12.5%	12.8%	12.8%	12.9%	11.7%	11.3%	11.1%	11.1%	11.2%	11.1%	
Allied Health Professionals	9.6%	9.7%	10.5%	10.6%	10.9%	11.0%	12.4%	12.1%	11.7%	13.4%	13.3%	13.3%	13.9%	
Estates and Ancillary	9.1%	8.8%	8.2%	9.1%	9.1%	9.2%	8.8%	9.6%	10.4%	10.1%	10.1%	8.8%	8.9%	
Healthcare Scientists	12.1%	10.2%	10.1%	9.9%	12.0%	12.6%	10.9%	9.4%	10.0%	11.4%	9.3%	8.4%	8.2%	
Medical & Dental	11.5%	10.7%	10.4%	10.2%	10.1%	10.4%	9.4%	8.9%	8.3%	7.9%	8.3%	7.9%	7.8%	
Nursing & Midwifery Reg	9.9%	10.2%	10.1%	10.4%	10.7%	10.8%	10.4%	10.8%	11.1%	10.8%	10.6%	10.6%	10.3%	
Prof Scientific and Tech	9.1%	8.9%	8.2%	8.2%	6.9%	8.5%	7.4%	7.8%	8.5%	8.3%	9.1%	8.4%	9.0%	
TOTAL TRUST TURNOVER	**11.0%**	**10.8%**	**10.7%**	**11.0%**	**11.1%**	**11.1%**	**10.9%**	**10.9%**	**11.0%**	**10.8%**	**10.7%**	**10.4%**	**10.3%**	



***Source data**: ESR*

East Sussex Healthcare NHS
NHS Trust

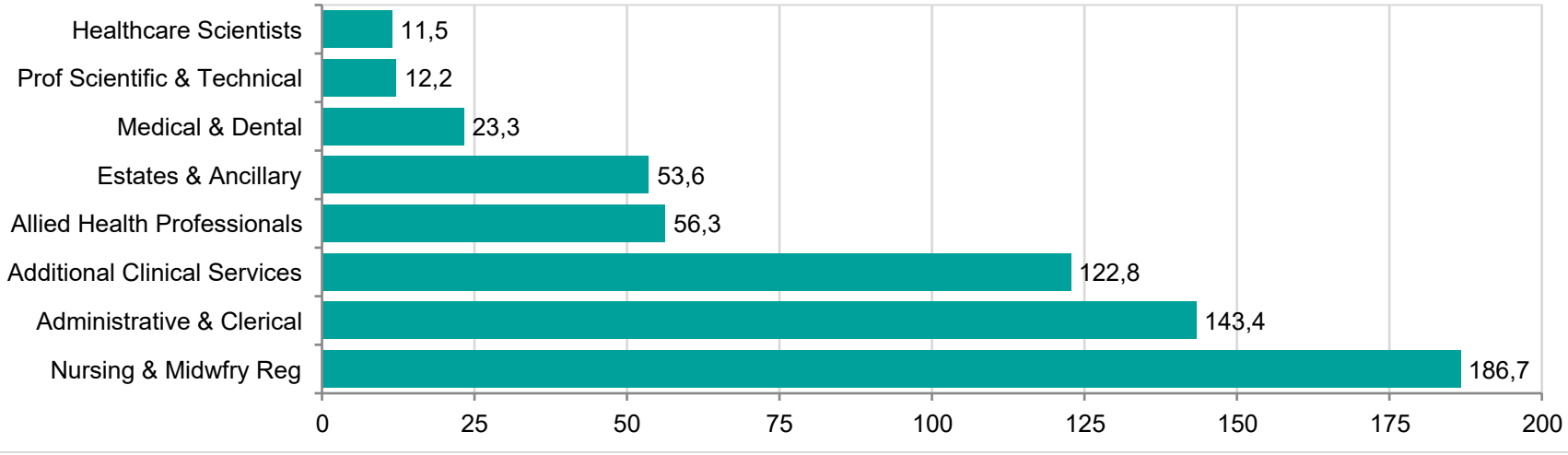
LEAVERS & STABILITY – STAFF GROUP

Overview

- The Stability Rate measures the number of current staff who have more than 1 year's service with ESHT
- The Stability rate has reduced by 0.2% this month
- Administrative and Clerical & Allied Health Professionals have stability rates below 90%.

STAFF GROUPS	STABILITY > 1YR
Add Prof Scientific and Technic	93.6%
Additional Clinical Services	90.5%
Administrative and Clerical	89.9%
Allied Health Professionals	88.0%
Estates and Ancillary	92.6%
Healthcare Scientists	97.7%
Medical and Dental	95.5%
Nursing and Midwifery Registered	91.0%
TRUST	**91.0%**

ANNUAL LEAVERS BY STAFF GROUP (fte)



***Source data**: ESR*

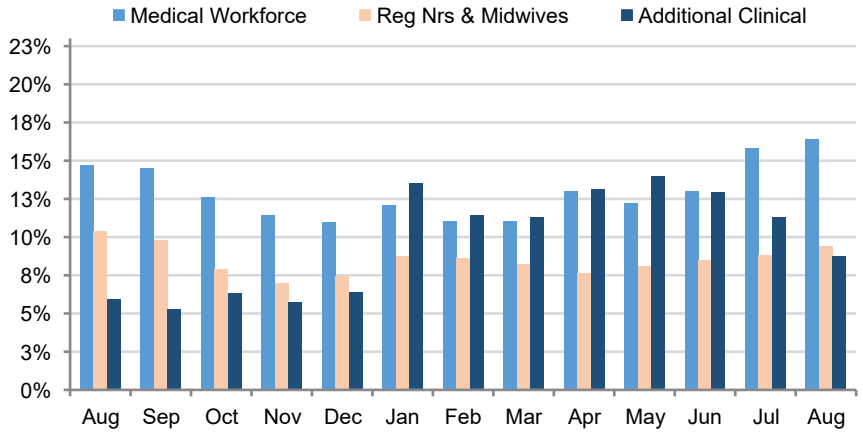
RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- Trust vacancy rate decreased by 0.5% to 10.0% (688.1 fte)
- International recruitment continues with 12 nurses and 3 Radiographers joining the Trust in Sept with a further 17 due to start in Oct.
- Medacs agency have supplied 7 medical staff with a further 4 at offer stage. Continued focus on difficult to recruit posts.
- Recruitment key focus for activity in September was Out of Hospital Division and the Emergency Department.

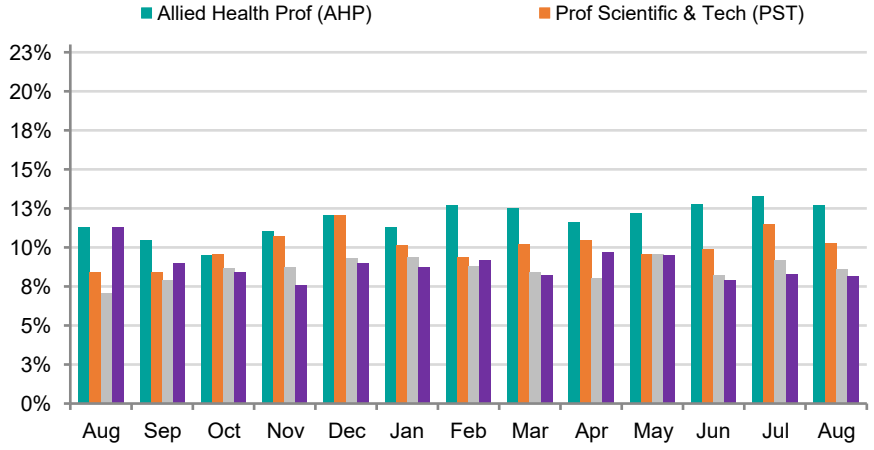
TRENDING VACANCY (%)

AUG 2018 TO AUG 2019	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Trend line
Medical Workforce	14.7%	14.5%	12.6%	11.4%	11.0%	12.1%	11.0%	11.0%	13.0%	12.2%	13.0%	15.8%	16.4%	
Reg Nrs & Midwives	10.4%	9.8%	7.9%	7.0%	7.4%	8.7%	8.6%	8.2%	7.6%	8.1%	8.5%	8.8%	9.4%	
Additional Clinical	5.9%	5.3%	6.3%	5.7%	6.4%	13.5%	11.4%	11.3%	13.1%	14.0%	12.9%	11.3%	8.7%	
Allied Health Prof (AHP)	11.3%	10.5%	9.5%	11.1%	12.1%	11.3%	12.7%	12.5%	11.6%	12.2%	12.8%	13.3%	12.7%	
Prof Scientific & Tech (PST)	8.4%	8.4%	9.6%	10.7%	12.1%	10.2%	9.4%	10.2%	10.5%	9.6%	9.9%	11.5%	10.3%	
Admin & Clerical	7.1%	7.9%	8.7%	8.8%	9.3%	9.4%	8.8%	8.4%	8.0%	9.6%	8.2%	9.2%	8.6%	
Estates & Ancillary (E&A)	11.3%	9.0%	8.4%	7.6%	9.0%	8.7%	9.2%	8.2%	9.7%	9.5%	7.9%	8.3%	8.2%	
TRUST	**9.5%**	**9.1%**	**8.6%**	**8.3%**	**8.9%**	**10.2%**	**9.7%**	**9.4%**	**9.8%**	**10.3%**	**9.9%**	**10.5%**	**10.0%**	

Trending Vacancy (%) for Medical, Reg & Non-Reg Nurses



Trending Vacancy (%) for AHP, Prof & Tech, A&C, E&A



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

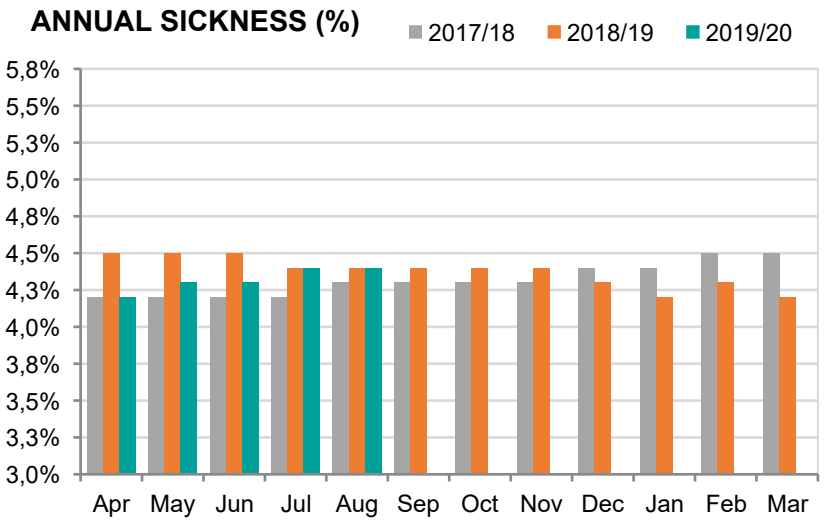
East Sussex Healthcare NHS
NHS Trust

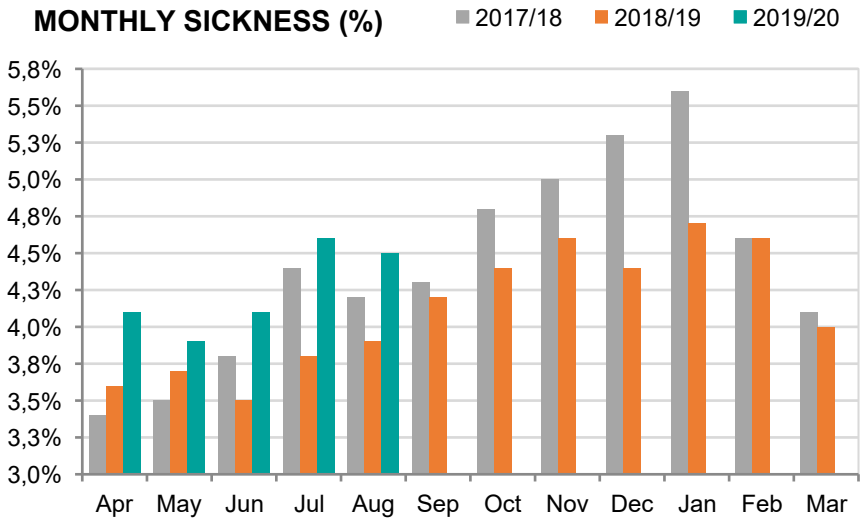
ABSENCE MANAGEMENT – SICKNESS RATES

- Monthly sickness has decreased by 0.1% to 4.5%. Although this rate is higher than the August rates for the last two years, the annual sickness rate has remained at 4.4%. This rate is in line with August 2019.
- The staff group with the highest monthly sickness rate was Additional Clinical Services at 6.4% followed by Estates & Ancillary staff at 6.2% and then Registered Nurses & Midwives at 4.7%.
- 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	Mar
2017/18	4.2%	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.3%	4.4%	4.4%	4.5%	4.5%
2018/19	4.5%	4.5%	4.5%	4.4%	4.4%	4.4%	4.4%	4.4%	4.3%	4.2%	4.3%	4.2%
2019/20	4.2%	4.3%	4.3%	4.4%	4.4%							

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%	4.6%	4.5%							



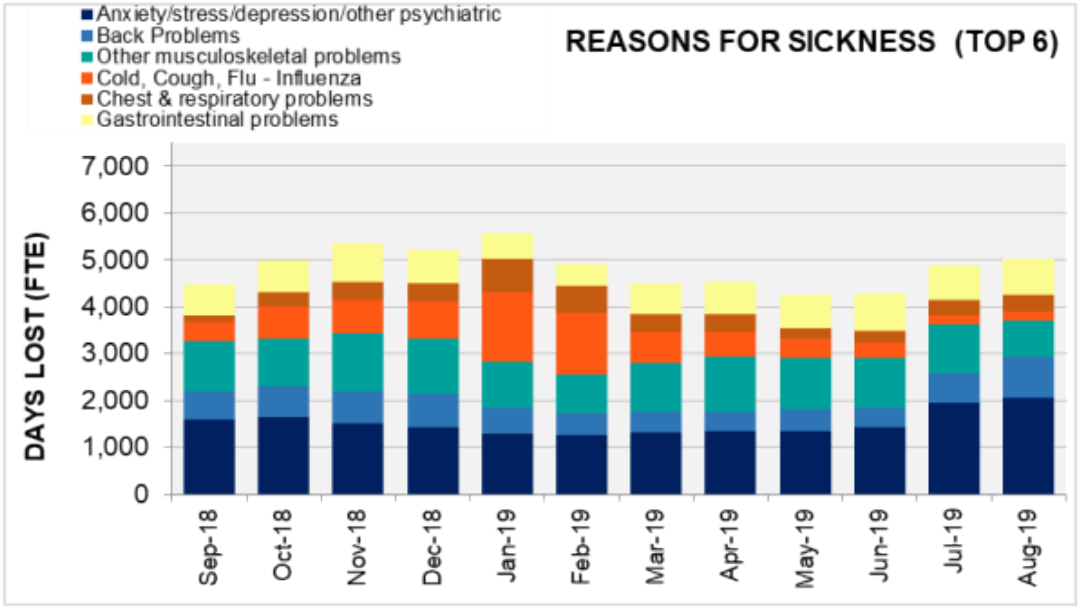


***Source data**: ESR*

ABSENCE MANAGEMENT – SICKNESS REASONS

- Anxiety/stress/depression illnesses have increased by 120.0 fte days lost this month to the highest level in the last 12 months.
- The staff groups accounting for the highest proportion of the fte days lost for anxiety/stress/depression are Additional Clinical Services accounting for 27.2% of the total, Registered Nursing & Midwifery Reg at 25.6%, Admin & Clerical at 21.9% and Estates & Ancillary at 17.9%.
- Wellbeing & Engagement actions outlined below (p.14)

TOP 6	Fte Days Lost by Month												
Reason for sickness	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Trend line
Anxiety/stress/depression/other psychiatric	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	1,945.4	2,065.4	
Back Problems	617.0	641.4	708.0	718.3	557.1	455.6	461.2	409.3	460.8	427.0	649.0	869.7	
Other musculoskeletal problems	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	1,024.3	780.8	
Cold, Cough, Flu - Influenza	410.6	682.5	730.2	788.3	1,474.1	1,300.1	662.3	537.0	397.7	324.2	206.9	190.2	
Chest & respiratory problems	142.1	291.9	371.3	393.2	705.9	568.4	384.5	363.2	216.0	242.6	317.7	358.3	
Gastrointestinal problems	657.3	698.0	829.0	724.7	566.9	485.4	656.8	704.8	731.2	809.5	730.8	762.5	



Top 10 in descending order (%)		%
1	Anxiety/stress/depression/other	23.8%
2	Other known cau- not elsewhere classified	11.2%
3	Back Problems	10.0%
4	Other musculoskeletal problems	9.0%
5	Gastrointestinal problems	8.8%
6	Unknown cau/ Not specified	5.9%
7	Genitourinary & gynaecological disorders	5.4%
8	Injury, fracture	4.7%
9	Chest & respiratory problems	4.1%
10	Benign and malignant tumours, cancers	3.8%
	TOP 10 REASONS	**86.6%**

***Source data**: ESR*

WELLBEING & ENGAGEMENT

Engagement

- Sharing best practice between the Divisions/Directorates on how they have improved staff engagement through “You Said We Did”
- Communication and Action Plan for this year’s national staff survey further developed

Health & Wellbeing

- Focussed work on stress within Emergency Department and Estates & Facilities. Supporting Community teams in addressing absence related to stress.
- Mental Health First Aiders. 12 staff trained by One You

Retention

- Working to ensure that the on boarding experience for new staff is positive and supporting staff with health issues to return to or remain in work or find mutually acceptable options.

Leadership & Culture

- Development of Courageous Conversations skills training programme
- Design and facilitation of BME Listening Conversation to examine and explore the experiences of BME colleagues and create ideas for inclusion in an improvement action plan.
- Continuing to transform the Occupational Health & Wellbeing service in response to Trust need & priorities - eg implementation of Employee Assistance Programme (EAP), recruitment of mental health nurse, increasing awareness of musculoskeletal issues & greater access to information on the Extranet.

East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISAL COMPLIANCE BY DIVISION

APPRAISAL OVERVIEW

- The overall appraisal rate for the Trust for the last 12 months remained at 78.6%.
- Pilot schemes are planned for 19th Aug with DAS and OOH uploading their appraisal data for one month with the expectation of rolling this out Trust wide

DIVISION	APPRAISAL COMPLIANCE	
	12 mth	16 mth
Urgent Care	74.3%	86.2%
Medicine	78.4%	88.3%
Out of Hospital	76.4%	85.0%
Diag/Anaes/Surg	80.1%	92.1%
Womens, Child, S/Health	79.0%	86.8%
Estates & Facilities	81.5%	90.9%
Corporate	77.4%	88.1%
TRUST	**78.6%**	**88.7%**

MANDATORY TRAINING

- Overall compliance with mandatory training improved again this month to 87.5% despite the holiday period and the hospital being in Black status.
- Significant improvements have been made in the rates for Induction, Fire and Information Governance. Additional eLearning support sessions have been arranged to assist staff with access to ESR modules and over the coming months changes will be made which will simplify the eLearning process for staff.
- Learning & Development will be meeting with Safeguarding Leads to look at how compliance with the Safeguarding/MCA training can be improved.

										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	87.8%	87.0%	75.0%	87.8%	83.3%	91.5%	83.8%	78.2%	41.5%	87.3%	90.8%	91.5%
Medicine	87.1%	89.2%	91.8%	90.2%	73.3%	87.9%	70.0%	62.0%	57.3%	85.4%	85.9%	100.0%
Out of Hospital	89.1%	93.3%	96.9%	94.3%	82.3%	91.7%	70.0%	72.1%	46.1%	87.6%	87.9%	80.8%
Diag/Anaes/Surg	89.3%	92.0%	85.7%	90.8%	85.8%	91.1%	76.0%	69.5%	57.3%	89.1%	88.7%	42.3%
Womens, Child, S/Health	91.3%	93.9%	93.5%	92.9%	82.7%	89.3%	81.3%	79.7%	23.0%	89.9%	93.0%	89.1%
Estates & Facilities	90.3%	94.2%	97.3%	95.6%	87.5%	94.5%	n/a	n/a	n/a	n/a	n/a	n/a
Corporate	94.4%	97.0%	95.8%	95.5%	92.3%	94.7%	76.8%	77.5%	57.1%	92.6%	83.7%	90.9%
TRUST	**89.9%**	**92.7%**	**91.8%**	**92.6%**	**83.6%**	**91.3%**	**76.8%**	**71.9%**	**49.6%**	**87.9%**	**88.6%**	**82.0%**

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

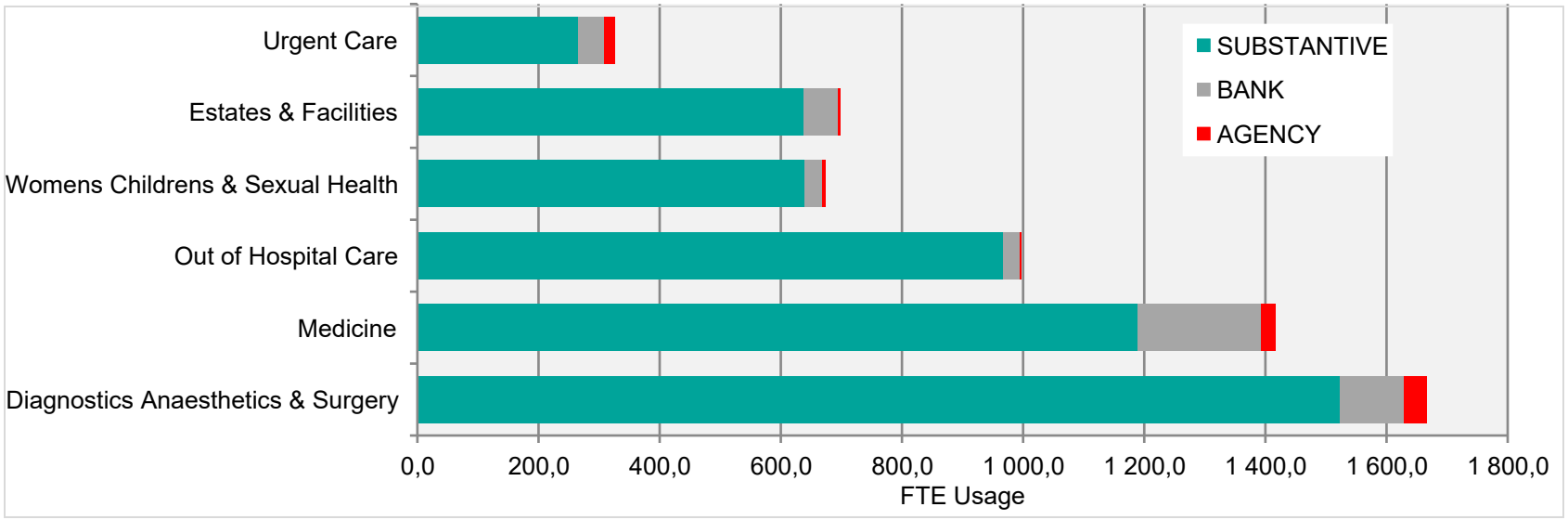
***Source data**: ESR*

APPENDIX

- Supporting documents

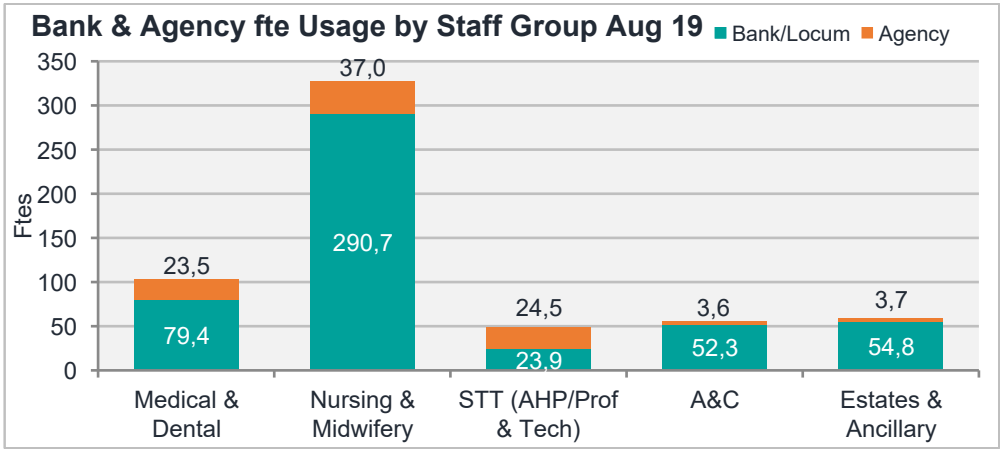
WORKFORCE UTILISATION BY DIVISION (FTE USAGE) – AUG '19

RESOURCE RATIO - MONTHLY					
DIVISION	**BUDGET FTE**	**SUBSTANTIVE**	**BANK**	**AGENCY**	**TOTAL**
Diagnostics Anaesthetics & Surgery	1,750.5	1,523.0	105.3	37.5	1,665.8
Medicine	1,471.4	1,189.7	203.9	23.3	1,416.9
Out of Hospital Care	1,084.8	966.4	28.3	1.8	996.5
Womens Childrens & Sexual Health	708.4	640.2	28.1	5.5	673.8
Estates & Facilities	724.8	638.4	56.2	3.7	698.3
Urgent Care	362.1	266.0	42.9	16.9	325.8
Corporate	963.2	819.6	36.3	2.6	858.5
TRUST	**7,065.2**	**6,108.4**	**501.0**	**92.3**	**6,701.7**



***Source data**: Finance Ledger*

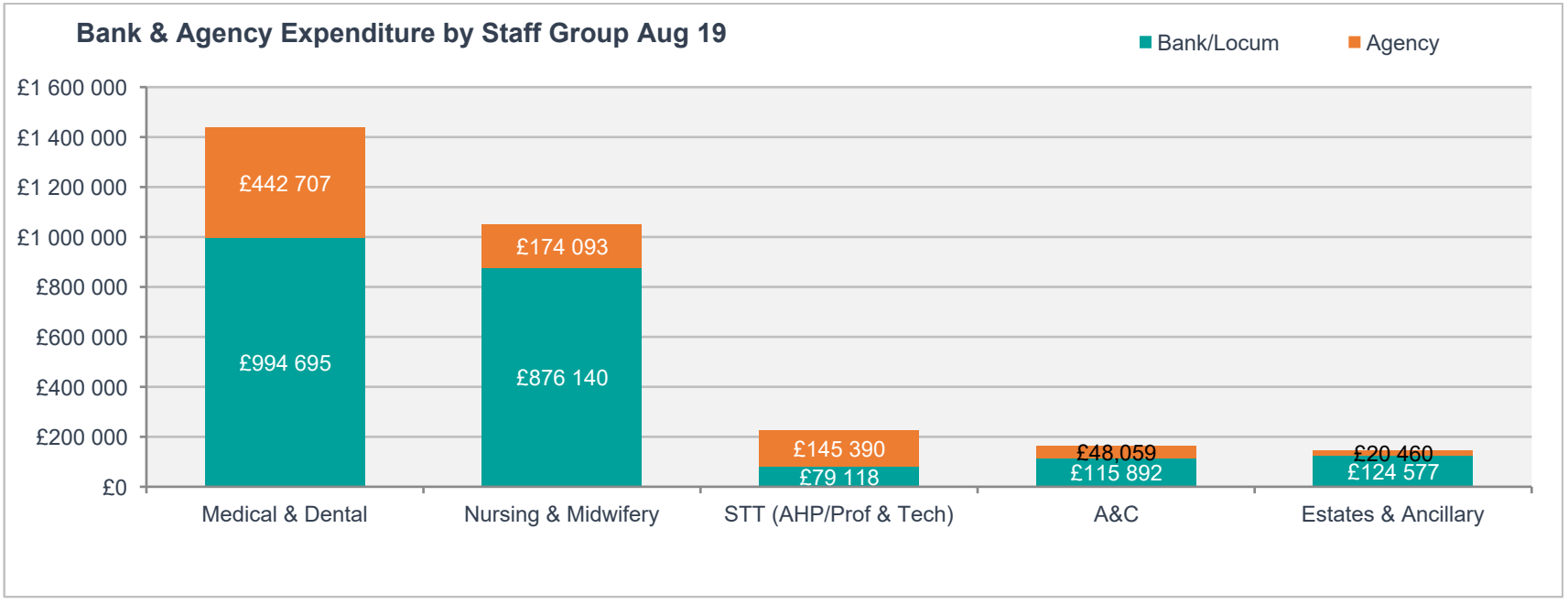
FLEXIBLE LABOUR – FTE & EXPENDITURE FOR AUG '19



Total temporary workforce expenditure increased in July '19 against Jun '19 by £535K:

- Bank costs ireduced by £17K
- Locum costs increased by £52K
- Agency costs reduced by £36K
- Overtime costs increased by £6K
- Waiting list costs ireduced by £27K

(Source data: Finance Ledger M5)



***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 perbd

Finance

FINANCE

Jonathan Reid, Director of Finance

Finance Report Summary - Month 5

	Plan YTD	Actual YTD	Plan FOT	Forecast FOT
Capital service cover	4	4	4	4
Liquidity	1	4	1	1
I&E margin	4	4	4	4
Variance From Control Total		1		1
Agency	1	1	1	1
Rating With Overrides		**3**		**3**

Operational Deficit

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(20,106)	(10,883)	(10,850)	33
Year End Forecast	(44,782)	(10,125)	(10,125)	0

The Trust is £33k ahead of plan YTD and eligible for PSF (£2.2m) and FRF (£4.2m) funding, which is included in the financial position. The YTD value of the Aligned Incentive Contract with the ESBT CCGs is also included in the financial position. Overspends are primarily in medical pay, (WLIs and locum payments) and are offset by underspends in A&C and AHP pay. CIP is £37k 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	(4,345)	(4,064)	(3,573)	491
Year End Forecast	(9,716)	(8,743)	(8,743)	0

Agency spend is £491k below plan YTD. The largest underspends are in the Prof, Scientific & Tech staff group. 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 £772k (18%) compared to the same period 2018/19.

Income

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	167,360	179,230	180,953	1,723
Year End Forecast	408,783	441,780	441,780	0

Underperformance on elective and day case activity (£1.3m) is offset,in the main, by overperformance of non-elective activity (£1.0m). The YTD value of the Aligned Incentive Contract with the ESBT CCGs is included in the financial position and is reducing income by £2.7m YTD. PSF (£2.2m), FRF (£4.2m) and MRET (£0.6m) are included in the position. COIN income underperformance (£0.2m) is offset by underspends in non-pay. The Trust has received £1.7m more donated asset income than planned YTD, primarily related to the MRI.

Operating Costs

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(184,207)	(187,102)	(187,278)	(176)
Year End Forecast	(445,874)	(444,666)	(444,666)	0

Overall operating costs are reporting £176k overspent against plan. Overspends are due to medical pay costs including agency, WLI and Locum (£1.0m) and clinical supplies (£0.4m), in line with an increase 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	6,990	7,027	37
Year End Forecast	20,603	20,603	0

The Trust has over delivered by £37k against its YTD plan. Despite this there is underperformance on private patients (£24k) and radiology outsourcing (£174k) schemes which have been offset by non-recurrent pay savings arising from vacancies and non-pay savings. The forecast is to achieve the £20.6m 2019/20 CIP target, with £15.7m currently identified as process green. The Divisions are increasing their reliance on non-recurrent savings with the proportion of M5 non-recurrent savings at 17% against 12% in M4.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	8,338	6,238
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.

ESHT is part of the NHSI pilot for historical debt restructuring which focuses on our 6% loans.

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	5,249	5,418	(169)
Year End Forecast	12,598	12,598	0

The CRL was revised in M1 to £12.5m. YTD the capital programme is £0.2m 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.

The capital programme includes an over planning margin of £1.0m. Both the overspend and over planning margin are being managed to ensure we remain with our CRL.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	83.60%	92.71%	88.90%	94.18%
NHS Invoices	93.25%	99.97%	91.33%	99.24%

84% of trade invoices were paid within 28 days which equates to 93% of the total value paid in month.

93% 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	1,750.49	1,665.77	84.72	300	(318)	(618)	947	(1,525)	(2,472)	4,444	4,444	0
Medicine	1,471.43	1,416.93	54.50	3,661	3,533	(127)	18,021	16,736	(1,285)	45,740	45,740	0
Urgent Care	362.06	325.75	36.31	948	1,129	182	4,765	5,295	530	10,304	10,304	0
Out of Hospital Care	1,084.76	996.45	88.31	(581)	(18)	563	(3,160)	(1,953)	1,207	(7,372)	(7,372)	0
Women's, Children's & Sexual Health	708.36	673.80	34.56	1,033	786	(247)	4,331	4,796	465	11,349	11,349	0
Estates & Facilities	724.79	698.30	26.49	(2,166)	(1,946)	220	(11,303)	(10,674)	629	(26,460)	(26,460)	0
Corporate	963.30	919.29	44.01	(4,069)	(3,888)	181	(20,694)	(19,148)	1,546	(49,764)	(49,764)	0
Central	0.00	6.17	(6.17)	(302)	(327)	(25)	(3,790)	(4,376)	(587)	1,634	1,634	0
Total	**7,065.19**	**6,702.46**	**362.73**	**(1,177)**	**(1,049)**	**128**	**(10,883)**	**(10,850)**	**33**	**(10,125)**	**(10,125)**	**0**

Key Risks

Key Risk 1	Medical pay costs, including WLI and locum increased (£1.0m overspend YTD)
Key Risk 2	Inpatient elective activity (elective, day case) £1.3m 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 plans.

Income & Expenditure Summary - Month 5

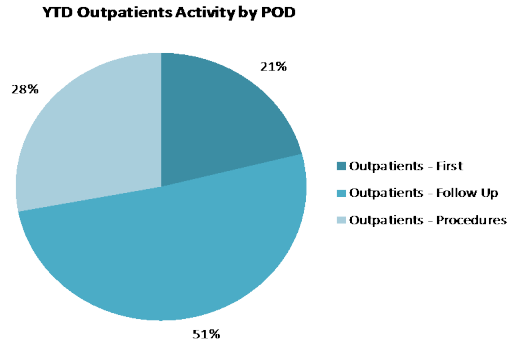
	In Month				Year to Date				Forecast Outturn		
	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	19/20 Plan (£m)	19/20 FOT (£m)	Variance (£m)
NHS Patient Income	27.4	28.2	27.9	(0.2)	135.2	143.5	141.7	(1.8)	347.9	347.9	0.0
Tariff-Excluded Drugs & Devices	2.9	3.4	3.2	(0.2)	14.9	15.6	15.1	(0.4)	38.3	38.3	0.0
Private Patient / ICR	0.2	0.3	0.3	0.1	1.0	1.4	(0.9)	(2.3)	3.4	3.4	0.0
Other Non-Clinical Income	4.6	2.4	3.0	0.6	16.2	11.8	18.1	6.3	28.3	28.3	0.0
Total Income	**35.2**	**34.2**	**34.5**	**0.3**	**167.4**	**172.3**	**174.0**	**1.7**	**417.9**	**417.9**	**0.0**
Pay - Substantive	(22.3)	(21.6)	(21.9)	(0.3)	(106.1)	(108.9)	(111.0)	(2.1)	(262.6)	(262.6)	0.0
Pay - Bank	(2.1)	(1.9)	(2.2)	(0.3)	(11.3)	(10.6)	(10.6)	(0.1)	(22.8)	(22.8)	0.0
Pay - Agency	(0.6)	(0.8)	(0.8)	(0.1)	(4.3)	(4.1)	(3.6)	0.5	(8.7)	(8.7)	0.0
Total Pay	**(25.1)**	**(24.2)**	**(24.9)**	**(0.7)**	**(121.7)**	**(123.6)**	**(125.2)**	**(1.6)**	**(294.1)**	**(294.1)**	**0.0**
Drugs	(3.4)	(3.7)	(3.6)	0.1	(18.0)	(18.7)	(18.7)	(0.0)	(44.6)	(44.6)	0.0
Supplies & Services - Clinical	(3.1)	(2.7)	(2.4)	0.3	(14.5)	(13.3)	(13.4)	(0.1)	(32.2)	(32.2)	0.0
Supplies & Services - General	(0.3)	(0.3)	(0.3)	0.1	(2.0)	(1.7)	(1.5)	0.2	(4.0)	(4.0)	0.0
Purchase of Healthcare (non-NHS)	(0.5)	(0.5)	(0.6)	(0.1)	(2.3)	(2.6)	(2.6)	(0.0)	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(0.6)	(0.6)	(0.2)	0.4	(3.1)	(3.0)	(2.4)	0.6	(7.1)	(7.1)	0.0
Consultancy	(0.1)	(0.0)	(0.0)	(0.0)	(0.5)	(0.2)	(0.2)	(0.1)	(0.4)	(0.4)	0.0
Clinical Negligence	(0.9)	(0.8)	(0.8)	(0.0)	(4.4)	(3.8)	(4.0)	(0.2)	(8.9)	(8.9)	0.0
Premises	(1.8)	(1.2)	(1.4)	(0.2)	(6.4)	(6.4)	(6.3)	0.1	(15.0)	(15.0)	0.0
Depreciation	(1.0)	(1.1)	(1.1)	0.0	(5.2)	(5.4)	(5.3)	0.1	(13.0)	(13.0)	0.0
Other	(1.1)	(1.3)	(1.4)	(0.1)	(6.2)	(8.5)	(7.5)	1.0	(19.5)	(19.5)	0.0
Total Non-Pay	**(12.7)**	**(12.2)**	**(11.7)**	**0.5**	**(62.5)**	**(63.5)**	**(62.1)**	**1.5**	**(150.5)**	**(150.5)**	**0.0**
Total Operating Costs	**(37.8)**	**(36.4)**	**(36.7)**	**(0.3)**	**(184.2)**	**(187.1)**	**(187.3)**	**(0.2)**	**(444.7)**	**(444.7)**	**0.0**
Net Surplus/(Deficit) from Operations	**(2.6)**	**(2.2)**	**(2.2)**	**0.0**	**(16.8)**	**(14.8)**	**(13.3)**	**1.5**	**(26.8)**	**(26.8)**	**0.0**
Financing Costs	(0.6)	(0.6)	(0.6)	0.0	(3.2)	(3.0)	(3.0)	0.0	(7.2)	(7.2)	0.0
Total Non-Operating Costs	**(0.6)**	**(0.6)**	**(0.6)**	**0.0**	**(3.2)**	**(3.0)**	**(3.0)**	**0.0**	**(7.2)**	**(7.2)**	**0.0**
Total Costs	**(38.5)**	**(37.0)**	**(37.3)**	**(0.3)**	**(187.4)**	**(190.1)**	**(190.3)**	**(0.1)**	**(451.9)**	**(451.9)**	**0.0**
Net Surplus/(Deficit)	**(3.2)**	**(2.8)**	**(2.8)**	**0.0**	**(20.1)**	**(17.9)**	**(16.3)**	**1.6**	**(34.0)**	**(34.0)**	**0.0**
Donated Asset/Impairment Adjustment	0.0	0.0	(0.0)	(0.0)	(0.0)	0.0	(1.6)	(1.6)	0.0	0.0	0.0
Operational Surplus/(Deficit)	**(3.2)**	**(2.8)**	**(2.8)**	**0.0**	**(20.1)**	**(17.9)**	**(17.8)**	**0.0**	**(34.0)**	**(34.0)**	**0.0**
Provider Sustainability Fund	0.0	0.5	0.5	0.0	0.0	2.2	2.2	0.0	7.6	7.6	0.0
Financial Recovery Fund	0.0	1.0	1.0	0.0	0.0	4.2	4.2	0.0	14.8	14.8	0.0
Marginal Rate Emergency Tariff (MRET)	0.0	0.1	0.1	0.0	0.0	0.6	0.6	0.0	1.5	1.5	0.0
Net Surplus/(Deficit)	**(3.2)**	**(1.2)**	**(1.2)**	**0.0**	**(20.1)**	**(10.9)**	**(10.8)**	**0.0**	**(10.1)**	**(10.1)**	**0.0**

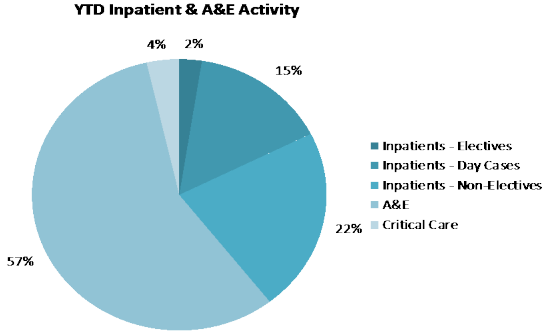
Summary & Next Steps

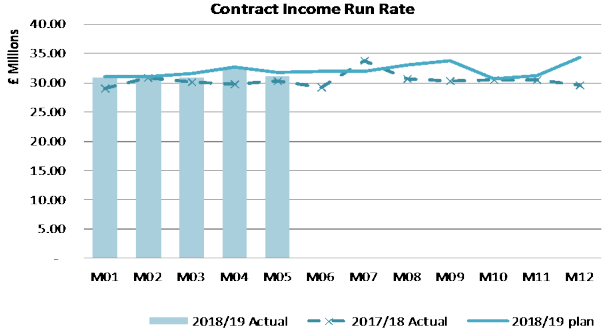
The Trust's YTD performance at M5 is £33k ahead of plan with a CIP over performance of £37k. Income was ahead of plan in the month and pay overspends continued in Medical, due to agency, locum and WLI payments. Elective activity is £0.7m below plan in month. The YTD impact of the Aligned Incentive Contract with the ESBT CCGs has been recognised in the financial position, as has £7.0m of PSF, FRF and MRET YTD. Medical pay continues to overspend (£1.0m) YTD, mainly due to locum and WLI payments.

Income & Activity Summary - Month 5

	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	517	543	437	(106)	1,709	1,825	1,402	(423)	2,704	2,825	2,587	(238)	8,420	9,486	8,602	(884)	22,979	22,979	0
Inpatients - Day Cases	3,248	3,133	3,041	(92)	2,436	2,342	2,051	(290)	16,421	16,289	15,857	(432)	12,108	12,174	11,734	(440)	29,491	29,491	0
Inpatients - Non-Electives	4,480	4,431	4,690	259	9,575	9,887	10,027	140	21,342	22,083	22,934	851	45,032	49,275	50,235	959	121,311	121,311	0
Outpatients	34,349	33,245	31,251	(1,994)	4,024	4,154	3,458	(696)	172,545	172,842	168,325	(4,517)	20,210	21,474	20,286	(1,188)	52,177	52,177	0
A&E	11,144	12,047	12,313	266	1,525	1,847	1,881	34	54,914	58,829	59,774	945	7,543	9,021	9,124	103	21,111	21,111	0
CQUIN	0	0	0	0	0	308	339	31	0	0	0	0	0	1,540	1,712	172	3,695	3,695	0
Critical Care	780	735	686	(49)	742	813	877	64	3,784	3,657	3,739	82	4,074	4,051	4,323	272	9,973	9,973	0
Direct Access	8,109	8,306	13,679	5,373	292	354	387	33	42,221	41,334	64,474	23,139	1,579	1,760	1,893	133	4,285	4,285	0
ESBT	0	0	0	0	588	694	611	(83)	0	0	0	0	2,939	3,487	3,054	(433)	8,379	8,379	0
Excess Bed Days	777	800	310	(490)	187	265	52	(213)	4,576	4,015	3,374	(641)	1,107	1,330	902	(428)	3,266	3,266	0
Exclusions	0	0	181	181	2,908	3,409	3,786	376	0	0	1,139	1,139	14,875	15,554	15,366	(188)	38,294	38,294	0
iMSK	0	0	0	0	118	123	123	0	0	0	0	0	592	613	615	2	1,472	1,472	0
Maternity Pathway	560	562	523	(39)	558	599	639	40	2,825	2,794	2,734	(60)	2,937	2,981	2,964	(17)	7,268	7,268	0
Unallocated QIPP	0	0	0	0	0	(919)	0	919	0	0	0	0	0	(4,595)	0	4,595	(11,029)	(11,029)	0
AIC	0	0	0	0	0	0	(735)	(735)	0	0	0	0	0	0	(2,677)	(2,677)	0	0	0
Other	300,219	302,605	305,745	3,140	5,809	5,977	6,499	522	1,530,603	1,505,894	1,588,132	82,238	28,742	29,758	28,705	(1,053)	71,939	71,939	0
Contract Income Total	364,183	366,407	372,856	6,449	30,472	31,676	31,142	(280)	1,851,935	1,830,562	1,933,069	102,507	150,159	157,908	156,839	(1,069)	384,611	384,611	0
Divisional Income					4,845	4,148	4,953	805					17,280	21,322	24,115	2,793	57,169	57,169	0
Total Income	**364,183**	**366,407**	**372,856**	**6,449**	**35,316**	**35,824**	**36,095**	**525**	**1,851,935**	**1,830,562**	**1,933,069**	**102,507**	**167,438**	**179,230**	**180,953**	**1,723**	**441,780**	**441,780**	**0**







Summary & Next steps

Inpatients - Electives & Day Cases (YTD) **£1.3m behind plan** **-6.1%**

Activity and income are behind plan at M5

The main areas of underperformance are Urology (£646k) Cardiology (£387k) and T&O (£322k). There is focused work with the divisions to understand the drivers for this and develop action plans.

Inpatients - Non-Electives (YTD) **£1m above plan** **1.9%**

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.

Outpatients (YTD) **£1.2m behind plan** **-5.5%**

Outpatient activity is behind plan for M5 and mainly relates to Ophthalmology (£395K), T&O (£437K) and Urology (£233K).

A&E (YTD) **£0.1m on plan** **1.1%**

A&E activity is continuing to grow with 12,313 attendances in August 2019 being 6% higher than August 2018.

QIPP adjustment (YTD) **£4.6m 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 £3.7m YTD over performance.

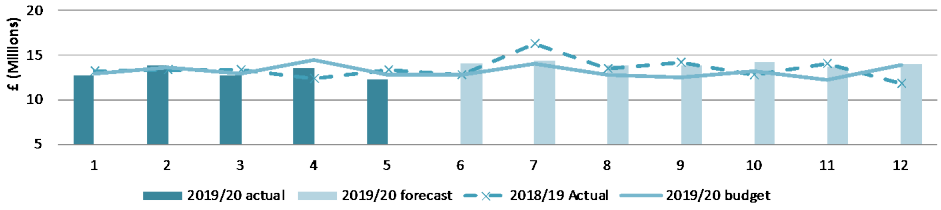
AIC Adjustment (YTD) **£2.7m**

The value of activity is currently £2.7m higher than the value of the AIC for Sussex CCGs.

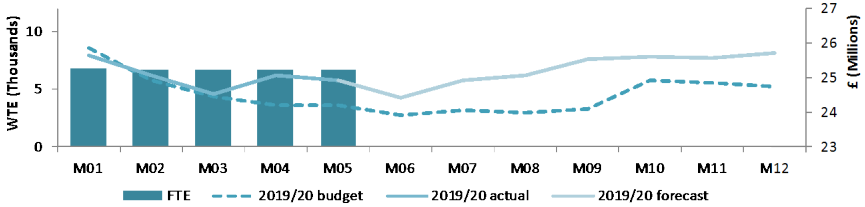
Expenditure & Workforce Summary - Month 5

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	1334	1396	1297	99	4,030	3,978	3,698	280	18,448	19,595	18,583	1,011	47,049	47,049	0
Ancillary	677	698	676	22	1,806	1,531	1,484	47	7,573	7,776	7,629	147	18,573	18,573	0
Medical	659	750	703	47	5,830	6,029	6,233	(204)	29,462	29,679	30,693	(1,013)	73,050	73,050	0
Nursing & Midwifery	3011	3146	3032	114	10,301	9,980	9,821	159	48,898	50,333	50,107	226	121,751	121,751	0
Prof, Scientific & Tech	526	531	522	9	1,902	1,845	1,810	35	8,861	9,273	8,753	520	22,196	22,196	0
Professions Allied to Medicine	460	544	471	73	1,707	1,882	1,654	228	7,785	9,393	8,315	1,078	22,567	22,567	0
Other	0	0	0	1	(493)	(1,057)	228	(1,285)	717	(2,465)	1,145	(3,610)	(11,052)	(11,052)	0
Total Pay	**6667**	**7065**	**6702**	**364**	**25,085**	**24,187**	**24,927**	**(740)**	**121,743**	**123,585**	**125,226**	**(1,641)**	**294,133**	**294,133**	**0**
Services from Other NHS Bodies					585	564	225	339	3,054	2,853	2,442	411	6,790	6,790	0
Clinical Negligence Premium					869	806	806	0	4,379	4,028	4,028	0	9,667	9,667	0
Consultancy					66	35	43	(8)	491	179	234	(55)	376	376	0
Drugs					684	594	658	(64)	4,330	4,594	4,515	80	10,279	10,279	0
Drugs - Tariff Excluded					2,707	3,117	2,911	205	13,696	14,088	14,175	(87)	34,770	34,770	0
Education and Training					81	204	58	146	372	1,012	217	795	2,430	2,430	0
Establishment Expenses					737	680	582	99	3,119	3,315	3,026	289	8,074	8,074	0
Premises					1,796	1,303	1,417	(113)	6,419	6,613	6,323	291	16,069	16,069	0
Purchase of Healthcare from Non NHS Bodies					495	450	584	(133)	2,326	2,517	2,620	(102)	6,125	6,125	0
Supplies and Services - Clinical					3,072	2,575	2,364	211	14,453	13,021	13,382	(362)	31,231	31,231	0
Supplies and Services - General					304	347	276	71	1,956	1,732	1,515	217	4,139	4,139	0
Other Non-Pay					13,048	1,538	1,822	(284)	7,870	9,565	9,576	(11)	20,584	20,584	0
Total Non-Pay					**24,443**	**12,212**	**11,744**	**468**	**62,463**	**63,518**	**62,052**	**1,466**	**150,533**	**150,533**	**0**
Total Expenditure	**6667**	**7065**	**6702**	**364**	**49,528**	**36,399**	**36,671**	**(272)**	**184,207**	**187,103**	**187,278**	**(175)**	**444,666**	**444,666**	**0**

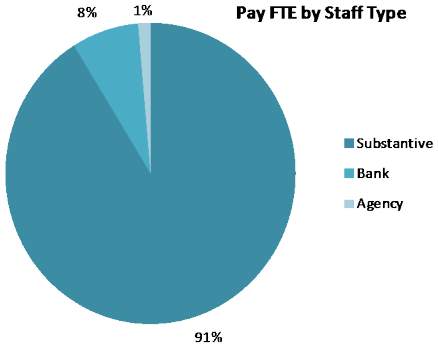
Non-Pay Monthly Run rate



Pay Monthly Run Rate vs FTE



Pay FTE by Staff Type



Summary & Next Steps

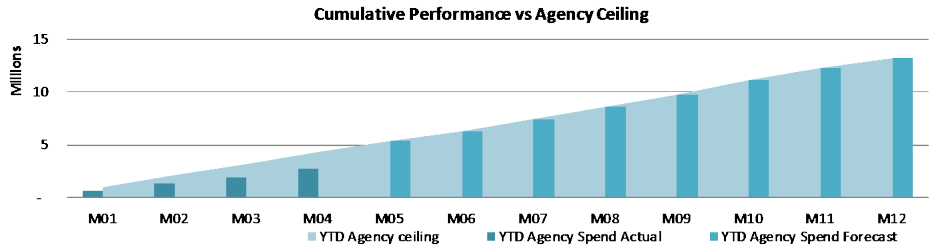
Medical pay is £1.0m overspent YTD (which includes waiting list initiative payments and agency covering vacancies), despite holding 47WTE vacancies. Variances in Other Pay is attributable to vacancy factors applied to various specialties with historically high levels of clinical vacancies and unidentified pay CIP, spend is due largely to apprenticeship levy payments. Nursing & midwifery is underspent by £226k YTD due to vacancies, however nursing specialing is overspent by £326k YTD.

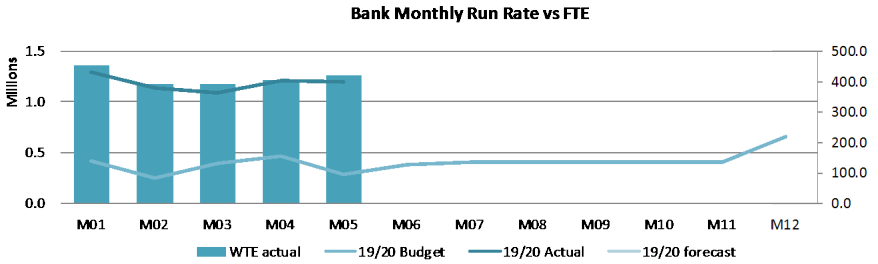
The non consolidated lump sum payment was made to AfC staff at the top of band in Month 1.

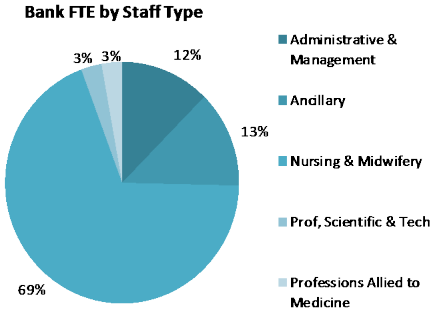
Tariff Excluded Drugs spend is showing £87k overspent, which is offset within Income, non-Tariff Excluded Drugs is £8k underspent YTD. Supplies & services - Clinical is overspent by £362k YTD due to non-elective activity overperformance, these costs have underspent by £211k in the month due to reduced theatres activity in August.

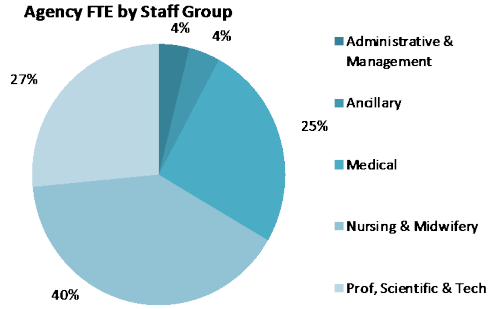
Temporary Workforce Summary - Month 5

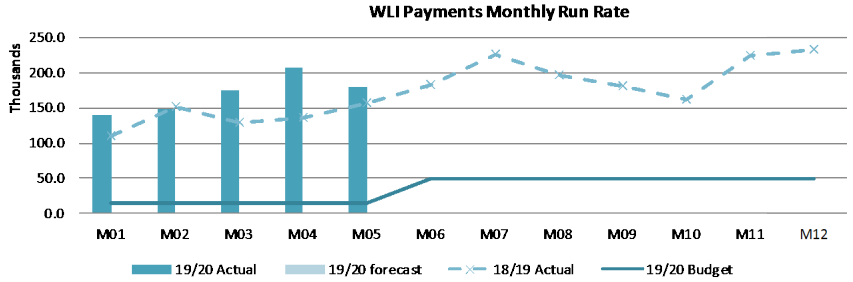
Cost Element	In Month								Year to Date				Forecast Outturn		
	18/19 WTE Actual	19/20 WTE Plan	19/20 WTE Actual	WTE Variance	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	Expenditure Variance (£k)	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	Expenditure Variance (£k)	19/20 Plan (£k)	19/20 FOT (£k)	Variance (£k)
Agency															
Administrative & Management	2	3	4	-1	29	52	48	3	315	270	302	(33)	601	601	0
Ancillary	17	0	4	-4	93	52	20	31	339	270	157	113	601	601	0
Medical	16	12	24	-12	100	286	443	(157)	1,572	1,531	1,749	(218)	3,336	3,336	0
Nursing & Midwifery	36	0	37	-37	167	153	174	(21)	1,018	919	860	59	1,761	1,761	0
Prof, Scientific & Tech	38	0	24	-24	215	209	145	64	1,101	1,075	505	570	2,444	2,444	0
Total Agency	**109**	**15**	**92**	**-77**	**604**	**751**	**831**	**(80)**	**4,345**	**4,064**	**3,573**	**491**	**8,743**	**8,743**	**0**
Bank															
Administrative & Management	67	6	52	-47	139	116	116	(0)	676	619	559	60	1,414	1,414	0
Ancillary	60	22	55	-33	129	116	125	(9)	661	619	565	54	1,414	1,414	0
Nursing & Midwifery	295	90	291	-201	826	695	876	(181)	4,702	4,192	4,417	(225)	8,302	8,302	0
Prof, Scientific & Tech	14	0	12	-12	47	43	42	1	210	223	208	15	534	534	0
Professions Allied to Medicine	8	12	12	0	31	19	37	(18)	156	136	177	(41)	211	211	0
Total Bank	**443**	**129**	**422**	**-292**	**1,172**	**988**	**1,196**	**(208)**	**6,404**	**5,789**	**5,924**	**(135)**	**11,874**	**11,874**	**0**
Total Locum	**74**	**21**	**79**	**-59**	**960**	**832**	**995**	**(163)**	**4,855**	**4,788**	**4,703**	**85**	**10,895**	**10,895**	**0**
Total Waiting List Initiative	**10**	**0**	**17**	**-17**	**156**	**14**	**180**	**(166)**	**681**	**69**	**849**	**(781)**	**415**	**415**	**0**
Total Temporary Workforce	**637**	**165**	**610**	**-445**	**2,892**	**2,585**	**3,201**	**(616)**	**16,286**	**14,710**	**15,051**	**(341)**	**31,927**	**31,927**	**0**











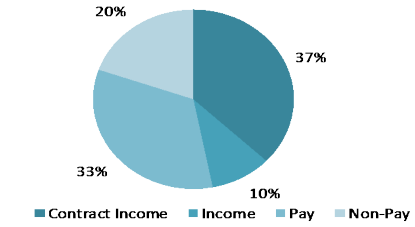
Summary & Next steps

Overall agency is £491k below plan YTD but £80k overspent in month. This is due to a significant reduction in agency Allied Health Professionals compared to plan, offset by an increase in Medical and Nursing agency usage in the month. Medical specialties which are heavily reliant on agency are neurology, rheumatology, pathology, general surgery, radiology and A&E. Progress is being made with medical recruitment through Medacs with a focus on hard to fill vacancies. YTD administrative and clerical agency has reduced by 4% compared to the same period in 18/19 despite some high cost agency staff in corporate areas who are on fixed term contracts: HR, Clinical Admin and COO. Total temporary staffing costs have fallen by 8% compared to the previous year (£1.2m lower). The T3 pay process is being enhanced to strengthen the controls framework on premium pay. WLI pay continues to overspend largely in Nursing and Medical, a new process for WLI approval has been developed in line with audit recommendations.

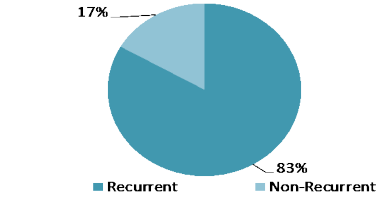
Cost Improvement Programme Summary - Month 5

Category	In Month			Year to Date			Forecast Outturn			YTD Rec (£k)	YTD Non-Rec (£k)
	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)		
Contract Income	523	505	-19	2,717	2,603	-114	5,594	5,517	-78	2,603	0
Income	73	276	202	399	694	295	1,648	1,630	-18	651	43
Pay	706	690	-17	2,444	2,350	-94	3,839	3,980	140	1,400	950
Non-Pay	477	314	-163	1,431	1,381	-50	4,568	4,155	-413	1,201	180
Total Identified Schemes	**1,780**	**1,785**	**4**	**6,990**	**7,027**	**37**	**15,650**	**15,282**	**-368**	**5,854**	**1,173**
Pipeline/Unidentified	0	0	0	0	0	0	4,953	5,321	368	83%	17%
Total	**1,780**	**1,785**	**4**	**6,990**	**7,027**	**37**	**20,603**	**20,603**	**0**		

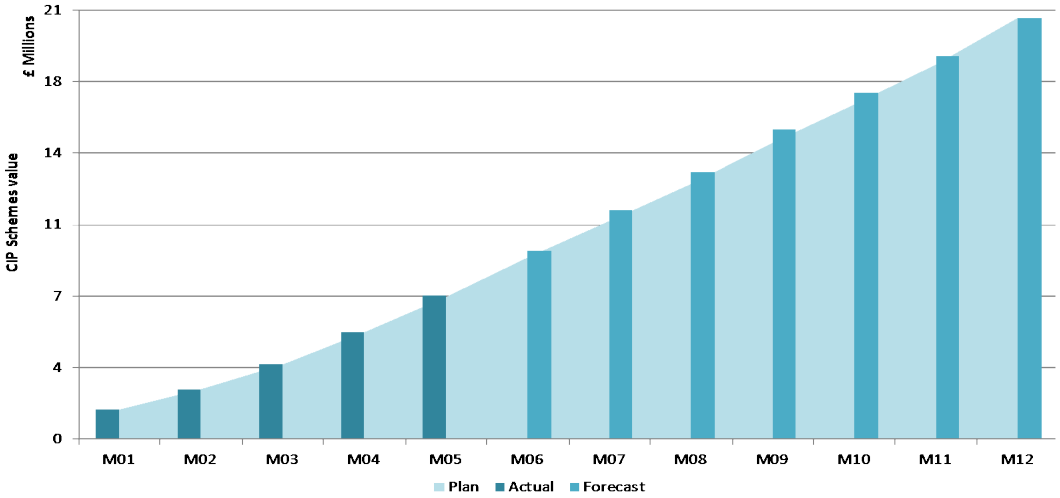
YTD CIP green schemes by category



YTD CIP green schemes recurrent/non-recurrent



CIP Performance



Summary & Next Steps

In Month: The Trust has delivered £1.785m against a total plan of £1.780m, showing a £4k overperformance in month.

YTD: The Trust has delivered £7.027m against a total plan of £6.990m, showing a £37k overperformance YTD. The main underperforming schemes are Private Patents (£24k), urology locum replacement with substantive (£38k), savings carried forward from 18/19 for bed modelling, where the beds remain open due to activity increases (£180k) Radiology Outsourcing (£174k), these are offset by non-recurrent savings on pay from vacancies, procurement rebates and non-recurrent non-pay savings.

Forecast: The Trust is forecasting to achieve our £20.6m plan. Against the £15.7m identified 'Green' scheme plan the Trust is forecasting £15.3m, an adverse outturn of £0.4m. This adverse variance is mainly due to Radiology Outsourcing (£313k), plus the bed modelling (£180k).

Recurrent/Non-recurrent split: The Divisions are becoming more reliant on non-recurrent schemes, the proportion of non-recurrent savings is 17% at M5 versus 12% at M4. This will increase the 2020/21 CIP challenge as the plan assumes all savings will be delivered recurrently.

Finance Report Divisional Summaries - Month 5

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				9,284	9,020	(264)	47,342	45,061	(2,281)	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 continues to overspend in the month due to unidentified CIP and agency usage in Theatres. Clinical supplies costs in Theatres have reduced significantly in month due to low levels of elective activity.
Divisional Income				458	406	(52)	1,964	2,006	42	4,672	4,672	0	
Pay	1,750.49	1,665.77	84.72	(6,975)	(7,247)	(272)	(35,762)	(36,130)	(367)	(85,100)	(85,100)	0	
Non-Pay				(2,467)	(2,498)	(30)	(12,596)	(12,463)	134	(30,476)	(30,476)	0	
Overall	**1,750.49**	**1,665.77**	**84.72**	**300**	**(318)**	**(618)**	**947**	**(1,525)**	**(2,472)**	**4,444**	**4,444**	**0**	
Medicine													
Contract Income				9,327	9,495	168	47,062	47,264	201	115,627	115,627	0	Contract income is above plan YTD due to increased NEL activity (£218k). Medical pay is overspent (£518k YTD) with to overspends in Oncology, Gastroenterology & Elderly Care due to sickness and vacancies. Special observations is £326k overspent. The cost of open escalation wards continue to deteriorate pay and non pay postions (£522k YTD).
Divisional Income				188	201	13	644	702	58	1,683	1,683	0	
Pay	1,471.43	1,416.93	54.50	(5,128)	(5,542)	(414)	(26,089)	(27,480)	(1,390)	(62,798)	(62,798)	0	
Non-Pay				(725)	(620)	105	(3,596)	(3,750)	(154)	(8,772)	(8,772)	0	
Overall	**1,471.43**	**1,416.93**	**54.50**	**3,661**	**3,533**	**(127)**	**18,021**	**16,736**	**(1,285)**	**45,740**	**45,740**	**0**	
Urgent Care													
Contract Income				2,628	2,701	74	12,913	13,156	243	30,662	30,662	0	A&E activity and income are above plan YTD. Pay is underspent by £335k YTD, of which £332k is in Nursing due offset by unidentified CIP (£104k).
Divisional Income				41	16	(26)	173	148	(24)	414	414	0	
Pay	362.06	325.75	36.31	(1,643)	(1,495)	149	(7,954)	(7,619)	335	(19,861)	(19,861)	0	
Non-Pay				(78)	(93)	(15)	(367)	(390)	(24)	(911)	(911)	0	
Overall	**362.06**	**325.75**	**36.31**	**948**	**1,129**	**182**	**4,765**	**5,295**	**530**	**10,304**	**10,304**	**0**	
Out of Hospital Care													
Contract Income				3,622	3,628	6	17,689	17,956	268	42,551	42,551	0	Contract income is above plan YTD and includes £115k for biosimilars, which is offset in non pay. Pay underspends are in Therapies, ESBT and MSK where investment has been received but posts have not yet been recruited to but a recruitment plan is in place to address vacancies.
Divisional Income				360	382	23	1,646	1,701	55	3,897	3,897	0	
Pay	1,084.76	996.45	88.31	(3,382)	(3,221)	161	(17,017)	(16,078)	939	(40,635)	(40,635)	0	
Non-Pay				(1,181)	(809)	372	(5,478)	(5,533)	(55)	(13,186)	(13,186)	0	
Overall	**1,084.76**	**996.45**	**88.31**	**(581)**	**(18)**	**563**	**(3,160)**	**(1,953)**	**1,207**	**(7,372)**	**(7,372)**	**0**	
Women's, Children's & Sexual Health													
Contract Income				3,839	3,703	(136)	19,238	19,664	426	47,023	47,023	0	Contract income over delivery YTD is due to Health Visiting, Paediatrics (non-elective) and Gynaecology (day case/elective). Divisional income overperformance is attributable to secondments, which are offset in Pay, many are due to end in the latter half of the year. Non pay overspends are due to Gynae OPD clinical supplies and glucose monitors, which are offset within income.
Divisional Income				46	81	35	241	460	218	646	646	0	
Pay	708.36	673.80	34.56	(2,644)	(2,763)	(119)	(13,861)	(14,008)	(147)	(33,380)	(33,380)	0	
Non-Pay				(208)	(235)	(27)	(1,287)	(1,320)	(33)	(2,939)	(2,939)	0	
Overall	**708.36**	**673.80**	**34.56**	**1,033**	**786**	**(247)**	**4,331**	**4,796**	**465**	**11,349**	**11,349**	**0**	
Estates & Facilities													
Divisional Income				755	835	80	3,779	4,088	309	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.
Pay	724.79	698.30	26.49	(1,659)	(1,628)	30	(8,583)	(8,353)	230	(20,193)	(20,193)	0	
Non-Pay				(1,262)	(1,152)	110	(6,499)	(6,409)	90	(15,334)	(15,334)	0	
Overall	**724.79**	**698.30**	**26.49**	**(2,166)**	**(1,946)**	**220**	**(11,303)**	**(10,674)**	**629**	**(26,460)**	**(26,460)**	**0**	
Corporate													
Divisional Income				1,162	1,094	(68)	5,699	5,557	(142)	13,792	13,792	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 YTD.
Pay	963.30	919.29	44.01	(3,087)	(2,885)	202	(15,580)	(14,848)	732	(36,838)	(36,838)	0	
Non-Pay				(2,144)	(2,097)	46	(10,813)	(9,857)	956	(26,718)	(26,718)	0	
Overall	**963.30**	**919.29**	**44.01**	**(4,069)**	**(3,888)**	**181**	**(20,694)**	**(19,148)**	**1,546**	**(49,764)**	**(49,764)**	**0**	
Central													
Contract Income				2,977	2,619	(358)	13,663	13,737	74	33,401	33,401	0	Tariff exclusions income underperformance is offset entirely by non-pay underspends costs. The YTD favourable 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 acitivity priced on PBR and the value of the AIC.
Divisional Income				1,138	1,938	800	7,177	9,453	2,276	22,997	22,997	0	
Pay	0.00	6.17	(6.17)	332	(146)	(478)	1,261	(712)	(1,973)	4,673	4,673	0	
Non-Pay				(4,749)	(4,837)	(88)	(25,891)	(25,302)	589	(59,437)	(59,437)	0	
Overall	**0.00**	**6.17**	**(6.17)**	**(302)**	**(426)**	**(124)**	**(3,790)**	**(2,824)**	**966**	**1,634**	**1,634**	**0**	
Donated assets adjustment				**0**	**(24)**	**(24)**	**0**	**(1,552)**	**(1,552)**				
Total	**7,065.19**	**6,702.46**	**362.73**	**(1,177)**	**(1,172)**	**5**	**(10,883)**	**(10,850)**	**33**	**(10,125)**	**(10,125)**	**0**	

Statement of Financial Position - Month 5

	Year to date				Forecast Outturn			
	18/19 Actual (£k)	19/20 Plan (£k)	19/20 Actual (£k)	Forecast (£k)	19/20 Plan (£k)	19/20 Outturn (£k)		Variance (£k)
Property, Plant and Equipment	223.6	229.4	224.7	229.4	229.4	229.4		0.0
Intangible Assets	1.9	1.9	2.0	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**	**228.6**	**233.1**	**233.1**	**233.1**		**0.0**
Inventories	6.8	6.7	6.5	6.7	6.7	6.7		0.0
Trade and Other Receivables	19.7	29.6	30.7	29.6	29.6	29.6		0.0
Cash and Cash Equivalents	2.1	2.1	8.3	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**	**45.5**	**38.5**	**38.5**	**38.5**		**0.0**
Trade and Other Payables	(23.2)	(7.3)	(30.7)	(7.3)	(7.3)	(7.3)		0.0
Borrowings	(59.2)	(1.1)	(59.9)	(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)	(0.4)	(0.4)	(0.4)	(0.4)		0.0
Other Liabilities	(1.3)	(2.2)	(3.5)	(2.2)	(2.2)	(2.2)		0.0
Current Liabilities	**(84.3)**	**(11.1)**	**(94.6)**	**(11.1)**	**(11.1)**	**(11.1)**		**0.0**
Borrowings	(143.6)	(242.4)	(160.8)	(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		0.0
Income & Expenditure Reserve	(231)	(242)	(240)	(242)	(242)	(241.8)		0.0
Revaluation Reserve	98	94	98	94	94	94.5		0.0
Total Tax Payers Equity	**25.9**	**15.9**	**16.6**	**15.9**	**15.9**	**16.6**		**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 5

Short Term (13 week) Cashflow Forecast

	Actual (£k)				Forecast (£k)								
Week Ending (Friday)	**02-Aug**	**09-Aug**	**16-Aug**	**23-Aug**	**30-Aug**	**06-Sep**	**13-Sep**	**20-Sep**	**27-Sep**	**04-Oct**	**11-Oct**	**18-Oct**	**25-Oct**
Balance Brought Forward	**13,116**	**10,751**	**9,806**	**32,088**	**12,772**	**8,257**	**5,313**	**35,468**	**23,552**	**7,582**	**4,299**	**2,184**	**25,588**
Receipts													
WGA Income	996	111	30,127	1,140	46	152	30,879	152	152	122	122	32,112	122
Other Income	426	1,806	316	264	110	559	1,747	520	553	171	171	1,786	1,490
External Financing	0	0	2,673	0	0	0	0	2,160	0	0	0	2,047	0
Total Receipts	**1,421**	**1,917**	**33,117**	**1,404**	**155**	**711**	**32,626**	**2,832**	**705**	**293**	**293**	**35,945**	**1,612**
Payments													
Pay	(254)	(259)	(6,359)	(17,355)	(228)	(270)	(270)	(10,170)	(13,585)	(270)	(270)	(10,170)	(13,585)
Non-Pay	(3,530)	(2,600)	(4,461)	(2,523)	(4,432)	(3,384)	(2,138)	(3,094)	(3,090)	(3,306)	(2,138)	(2,094)	(3,590)
Capital Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend	0	0	0	0	0	0	0	0	0	0	0	0	0
Other payments	(2)	(2)	(16)	(842)	(11)	0	(63)	(1,484)	0	0	0	(276)	0
Total Payments	**(3,786)**	**(2,861)**	**(10,835)**	**(20,720)**	**(4,671)**	**(3,654)**	**(2,471)**	**(14,748)**	**(16,675)**	**(3,576)**	**(2,408)**	**(12,540)**	**(17,175)**
Net Cash Movement	**(2,365)**	**(944)**	**22,282**	**(19,315)**	**(4,516)**	**(2,944)**	**30,155**	**(11,916)**	**(15,970)**	**(3,283)**	**(2,115)**	**23,405**	**(15,564)**
Balance Carried Forward	**10,751**	**9,806**	**32,088**	**12,772**	**8,257**	**5,313**	**35,468**	**23,552**	**7,582**	**4,299**	**2,184**	**25,588**	**10,025**

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

	Draw Value £k	Date Drawn	Term	Interest Rate	Value £k	Annual Interest £k
Prior Years						
Capital Loan 2 - Endoscopy Development	2,000	Dec 09	20	4.00%	1,167	41
Capital Loan 3 - Endoscopy Development	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 Year Total	**204,480**				**202,062**	**7,273**
Current Year						
Loan April 2019	4,095	Apr 19	3	3.50%	4,095	146
Loan May 2019	4,603	May 19	3	3.50%	4,603	163
Loan June 2019	3,321	Jun 19	3	3.50%	3,321	117
Loan July 2019	2,549	Jul 19	3	3.50%	2,549	90
Loan August 2019	2,673	Aug 19	3	3.50%	2,673	96
Current Year Total	**17,241**				**17,241**	**612**
Total Loans	**221,721**				**219,303**	**7,885**

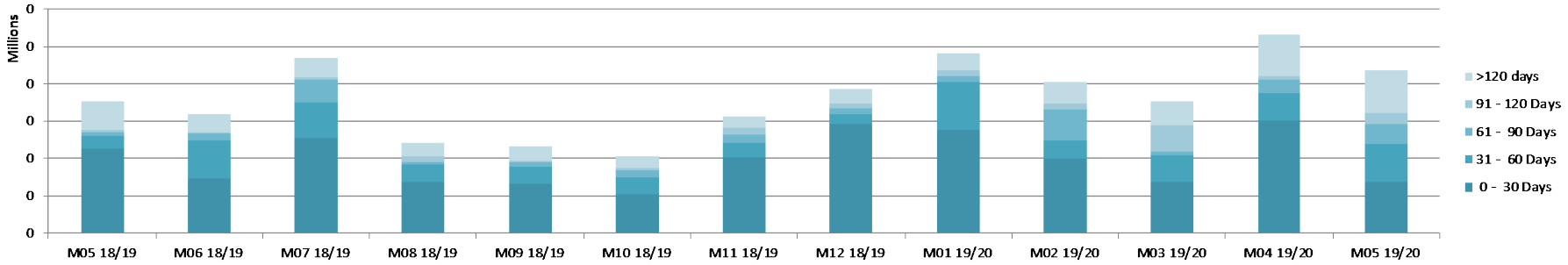
Summary & Next steps

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

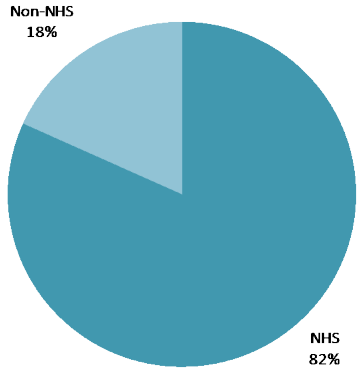
2. The Trust is part of a NHSI pilot on restructuring historic debt. This work is progressing and is currently focusing on 6% loans. In addition, we are working with NHSI to be able to access emergency capital funding via a PDC route.

Receivables Summary - Month 5

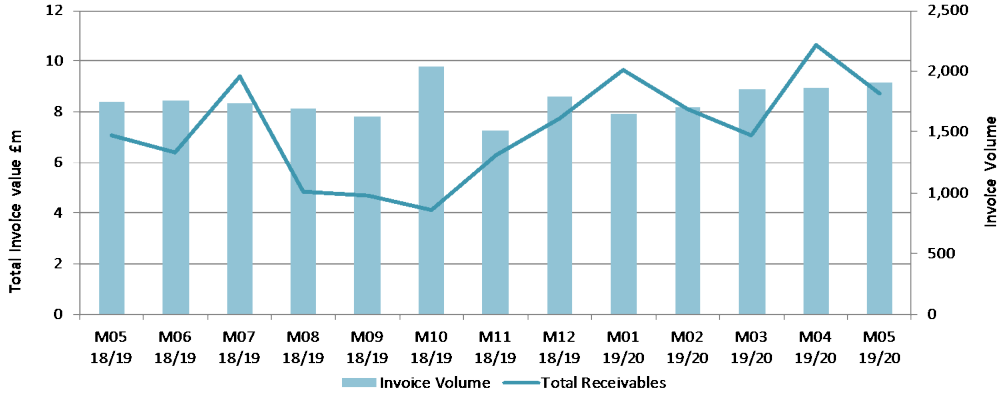
Receivables Aging Run rate (£k)													
Aging Profile	**M05 18/19**	**M06 18/19**	**M07 18/19**	**M08 18/19**	**M09 18/19**	**M10 18/19**	**M11 18/19**	**M12 18/19**	**M01 19/20**	**M02 19/20**	**M03 19/20**	**M04 19/20**	**M05 19/20**
0 - 30 Days	4,559	2,924	5,070	2,765	2,639	2,093	4,038	5,807	5,525	3,972	2,765	6,013	2,785
31 - 60 Days	685	2,033	1,918	894	910	896	786	600	2,602	1,005	1,418	1,501	2,027
61 - 90 Days	161	369	1,248	147	238	406	464	307	305	1,674	182	719	1,014
91 - 120 Days	100	95	131	321	101	101	352	251	270	279	1,402	211	637
>120 days	1,586	988	1,021	698	783	620	632	774	938	1,153	1,286	2,188	2,255
Total Receivables	**7,091**	**6,408**	**9,389**	**4,825**	**4,670**	**4,116**	**6,272**	**7,739**	**9,639**	**8,083**	**7,052**	**10,632**	**8,717**
Invoice Volume	**1,752**	**1,761**	**1,732**	**1,688**	**1,632**	**2,037**	**1,508**	**1,788**	**1,655**	**1,705**	**1,852**	**1,862**	**1,911**



Current Month % NHS vs Non-NHS by Value



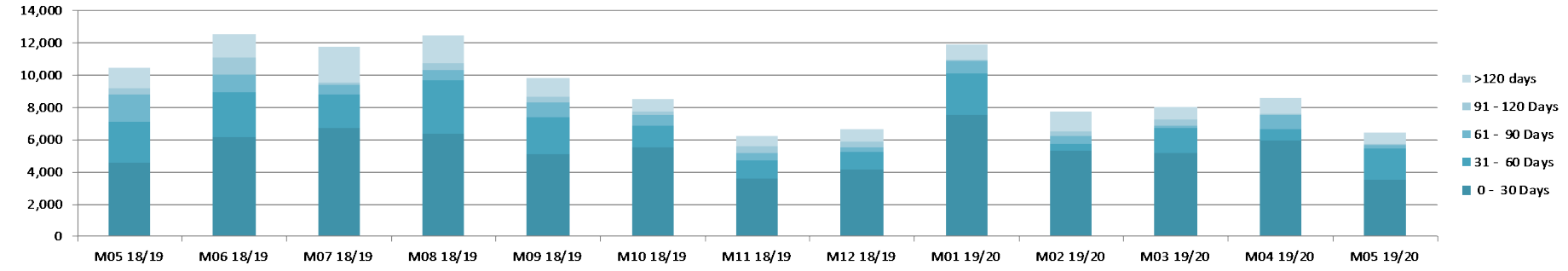
Receivables Invoice Value vs Volume Run Rate



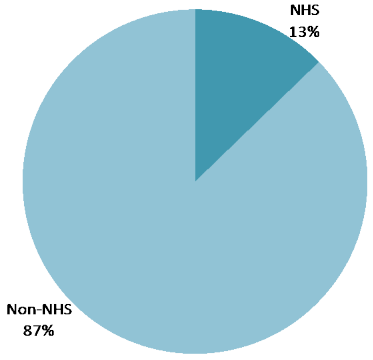
1. Overall debt decreased between July and August by £1.9m.
2. An adverse movement in total aged debt (>31 days) by £1.3m in month.
3. Adverse movement in over 90 day debt of £0.5m in month.
4. Increase in debtor days in month by 1 day, 28 days in August (27 days in July).
5. 1,911 invoices on the sales ledger system at the end of the month (an increase of 49 in month).

Payables Summary - Month 5

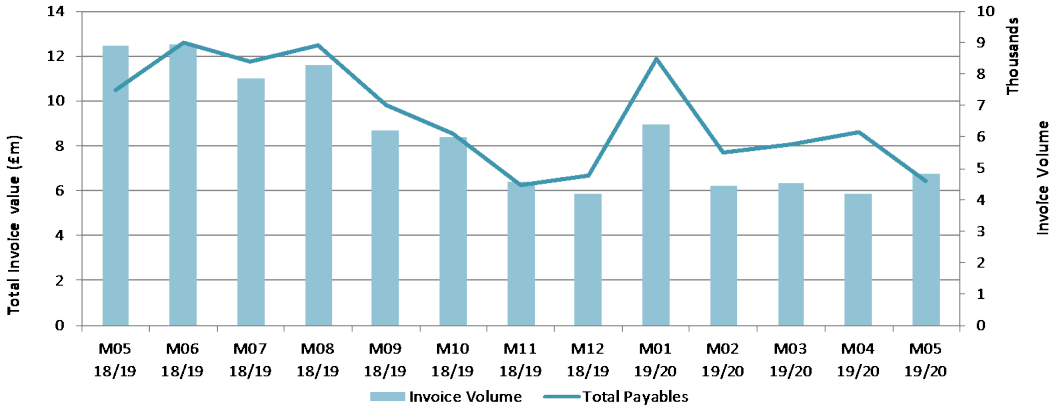
Payables Aging Run rate (£k)													
Aging Profile	M05 18/19	M06 18/19	M07 18/19	M08 18/19	M09 18/19	M10 18/19	M11 18/19	M12 18/19	M01 19/20	M02 19/20	M03 19/20	M04 19/20	M05 19/20
0 - 30 Days	4,552	6,153	6,708	6,410	5,109	5,530	3,611	4,151	7,517	5,324	5,133	5,927	3,476
31 - 60 Days	2,547	2,774	2,102	3,301	2,245	1,338	1,135	1,093	2,612	396	1,603	753	1,943
61 - 90 Days	1,703	1,099	599	600	986	629	442	253	735	494	133	842	241
91 - 120 Days	366	1,078	124	459	301	258	386	378	108	277	380	59	86
>120 days	1,315	1,464	2,233	1,725	1,169	806	675	801	909	1,217	788	1,020	681
Total Payables	**10,484**	**12,568**	**11,765**	**12,494**	**9,810**	**8,561**	**6,249**	**6,675**	**11,881**	**7,710**	**8,037**	**8,601**	**6,427**
Invoice Volume	**8,889**	**8,947**	**7,830**	**8,266**	**6,209**	**5,975**	**4,580**	**4,204**	**6,373**	**4,425**	**4,512**	**4,190**	**4,834**



Current Month % NHS vs Non-NHS by Value



Payables Invoice Value vs Volume Run Rate



1. Favourable movement in total creditors in month of £2.2m. Movement decreases total creditors to £6.4m in August.
2. Creditor days reduced by 2 days, to 75 days in month (77 days in July).
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. 4,834 invoices on the purchase ledger system at the close of the month (increase of 644 on July).

Capital Programme Summary - Month 5

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**	**2,667**	**4,920**	**2,874**	**207**
Backlog Maintenance	1,050	1,073	447	861	47	(400)
Central/Divisions	290	290	121	0	0	(121)
Digital	1,701	1,690	704	1,444	583	(121)
Estates	202	846	353	262	0	(353)
Medical Equipment	1,351	832	347	839	691	344
Finance	1,500	1,500	625	1,500	626	1
Unplanned urgents	339	396	165	177	77	(88)
Brought Forward - other	0	160	67	153	158	91
Total Owned	**13,148**	**13,188**	**5,495**	**10,156**	**5,056**	**(439)**
Donated	1,000	1,000	417	1,964	1,328	911
Less donated Income	(1,000)	(1,000)	(417)	(1,964)	(1,964)	(1,547)
Less disposal		361			361	361
Total	**13,148**	**13,549**	**5,495**	**10,156**	**4,781**	**(714)**
Overplanning Margin		**951**				
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 Trust has a capital over planning margin of £1.0m relating to the Conquest Front of House project (£0.6m) and the loss on disposal of the MRI scanner (£0.4m). The over planning margin is being managed to ensure we remain within our CRL.
3. The Capital Resource Group (CRG) meets on a monthly basis to monitor levels of capital expenditure and review progress against the CRL.


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

Learning from Deaths 1st April 2017 to 31st March 2019

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	9
Meeting:	Trust Board	Reporting Officer:	David Walker

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

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

Summary:

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

The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. The mortality database reflects the new review process and all plaudits and care concerns raised by family or carers of the deceased are recorded.

This report details the April 2017 – March 2019 deaths recorded and reviewed on the mortality database.

We continue to emphasise to clinical teams the importance of reviewing deaths within the 3 month timescale and as a result the backlog of deaths outstanding for review has decreased. The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability on a quarterly basis, to ensure accuracy in reporting however, remarkably in quarter 3 and quarter 4 no deaths were considered likely to have been avoidable.

The Chief Medical Examiner for England and Wales has now been appointed and we are waiting for our regional Medical Examiner to be appointed before completing the local recruitment. A job description has been prepared in close liaison with the coroner Mr Craze.

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

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

N/A

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

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

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard March 2018-19

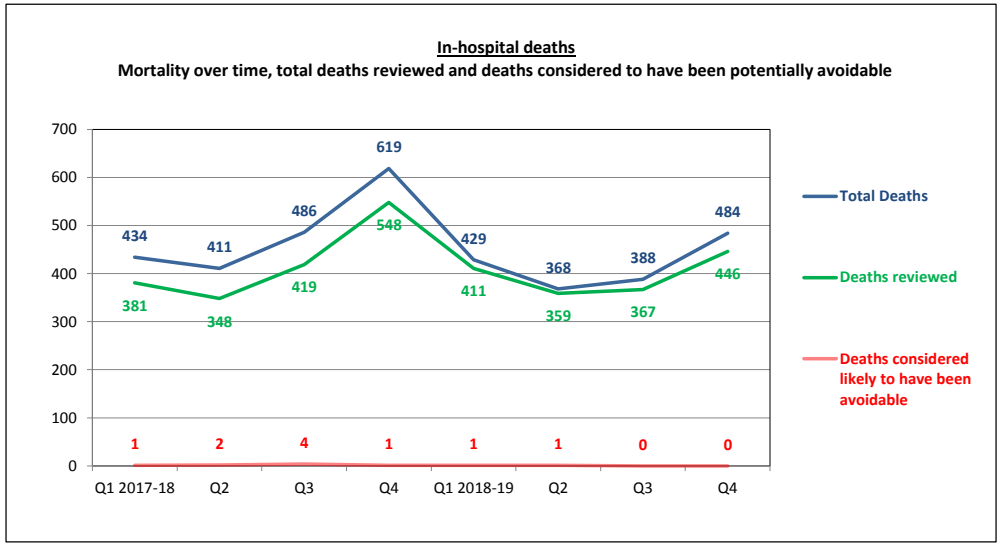
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 05/09/2019)

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

Time Series:	Start date	2017-18	Q1	End date	2018-19	Q4

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
152	148	139	137	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
484	388	446	367	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1669	1950	1583	1696	2	8



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	2	22.2%	This Year (YTD)	0	0.0%	This Year (YTD)	1	11.1%	This Year (YTD)	3	33.3%	This Year (YTD)	3	33.3%

Data above is as at 05/09/2019 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were 4 care concerns expressed to the Trust Bereavement team relating to Quarter 4 2018/19 deaths, none of which were subsequently raised as a complaint.
Complaints - Of the complaints received relating to 'bereavement' which were closed during Quarter 4 2018/19, none have overall care ratings of 'poor care' on the mortality database.
Serious incidents - There were no severity 5 incidents reported in Quarter 4 2018/19 relating to in-hospital deaths.
As at 05/09/2019 there are 340 April 2017 - March 2019 deaths still outstanding for review on the Mortality database.

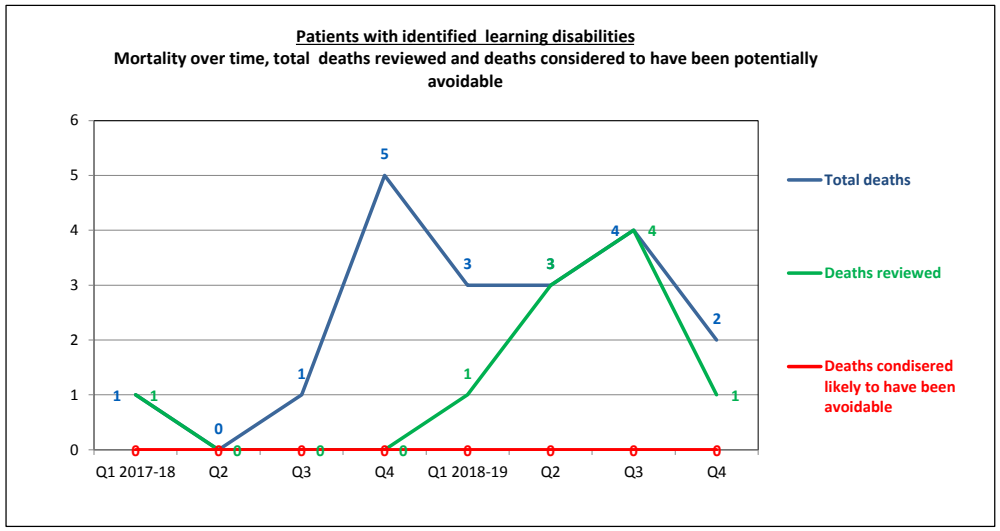
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 05/09/2019)

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

Time Series:	Start date	2017-18	Q1

End date	2018-19	Q4

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	4	1	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
12	7	9	1	0	0



The LeDeR (learning disability mortality review) programme is now in place and the learning disability deaths are being reviewed against the new criteria externally. Feedback from these external reviews will be received by the Trust in due course. Prior to the national requirement to review learning disability deaths using the national LeDeR methodology, the deaths were reviewed by the learning disability nurse and Head of nursing for safeguarding who entered their review findings on the mortality database.
As the feedback from the wider external LeDeR has not yet been received, the internal reviews are being continued in order to mitigate against any risk.

7 Day Hospital Services (7DS) Board Assurance Framework

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Dr David Walker

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Yes 1459, 1616, 1772	

Summary:

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

The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency. Overall there are 10 clinical standards for 7DS, of which four clinical standards were prioritised by NHS England (NHSE) and NHS Improvement (NHSI) for delivery by April 2020.

In November 2018, NHSE and NHSI introduced a Board Assurance Framework, replacing a series of 6 monthly audits. The BAF was implemented with a trial period followed by full implementation from March 2019. This is the Trust's second report using the new framework, the first having been submitted in March. It summarises the current self-assessment, to be submitted to NHSE/I by 28th November.

Standard 2 (initial consultant review within 14 hours of admission) - we are now achieving this throughout the week, with data from the Excellence in Care audits indicating that more than 94% of patients at weekends, and 90% of patients Monday-Friday, are seen within 4 hours in each of the last four months.

Standard 5 (access to key diagnostics) and **Standard 6** (access to key therapeutic services) – we are now compliant, since the provision of the 24/7 emergency GI endoscopy service in April this year.

Standard 8 (ongoing senior review) remains a challenge and is now the focus of work with the Divisions to achieve compliance over the next six months. The establishment of Nerve Centre will support this but there are also elements of behavioural change, particularly in documentation, to be achieved.

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

N/A

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

The Board is asked to note the self-assessment against the 7DS clinical standards and the progress that is being made to improve delivery of the priority 7DS clinical standards at ESHT.

7 Day Hospital Services (7DS) Board Assurance Framework

1. Introduction

- The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England.
- Overall there are 10 clinical standards for 7DS. Four of those clinical standards have been made priorities for delivery by April 2020, by NHSE and NHSI.
- To enable tracking of progress in achieving the four priority 7DS clinical standards, ESHT has submitted a self-assessment survey and audit to NHS England since 2016.
- In November 2018, NHS England and NHS Improvement introduced a new template for self-assessment, to ensure that providers can produce a single consistent report for national reporting, in conjunction with a board assurance framework for provider boards provide evidence-based assurance of delivery of 7DS. The new process requires provider organisation Boards to self-assess performance twice per year; in spring and autumn.
- This is the Trust's second report using this framework and provides an overview of the work undertaken at ESHT in relation to 7DS to enable the Trust board to confirm their assurance of the assessment of delivery.

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

- The four priority standards are aimed at ensuring that patients admitted in an emergency receive the same high quality care at any time of day, on any day of the week, by ensuring that patients have access to initial consultant assessment (clinical standard 2), access to diagnostics and interventions (clinical standards 5 and 6), and ongoing consultant-directed review (clinical standard 8).
- Achievement of each standard requires meeting the level of care for at least 90% of patients admitted in an emergency. Self-assessment of achievement must be supported by local evidence, and be formally assured by the Trust board.
- Published guidance on the 7DS board assurance framework requires the self-assessment to be evidenced by local data. An overview of the required sources of evidence for the priority clinical standards is provided below:

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

- The template enables providers to record an assessment of 7DS delivery in each of the four priority standards for both weekdays and weekends, by selecting from a list of pre-determined options that generate an automatic calculation of the overall score.

- The measurement template also captures detail on 7DS in urgent network specialist services and all of the other 7DS clinical standards.

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

- This section provides an overview of the self-assessment against achievement of the priority 7DS clinical standards. The completed self-assessment template can be found in Appendix1 and a summary has been provided below.

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

Clinical Standard	Diagnostic	Weekday	Weekend	Overall Score
Clinical Standard 5	Microbiology	Yes available on site	Yes available on site	**Standard Met**
	Computerised Tomography (CT)	Yes available on site	Yes available on site	
	Ultrasound	Yes available on site	Yes available on site	
	Echocardiography	Yes available on site	Yes available on site	
	Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
	Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical Standard	Intervention	Weekday	Weekend	Overall Score
Clinical Standard 6	Critical Care	Yes available on site	Yes available on site	**Standard Met**
	Interventional Radiology	Yes available on site	Yes available on site	
	Interventional Endoscopy	Yes available on site	Yes available on site	
	Emergency Surgery	Yes available on site	Yes available on site	
	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
	Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
	Stroke Thrombolysis	Yes available on site	Yes available on site	
	Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
	Cardiac Pacing	Yes available on site	Yes available on site	

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

- Consultant job plans are in place across medicine and general surgical specialities to deliver compliance with clinical standard 2.

- All medical specialties participating in the general medical acute rota have in place consultant or senior staff rotas to enable review of medical patients within 14 hours, using a combination of GIM consultant of the day and AMU consultants, with on-site cover provided from 0800 to 2000, though many consultants start earlier in the morning and are present till 9pm evening shift change or later

- General surgery has a consultant of the day on the Surgical Assessment Unit (SAU), available to see patients from 0800 to 2000 throughout the week.

- In some subspecialties the formalised arrangement for consultant cover has provided insufficient cover to deliver review within 14 hours, in particular ENT, Urology (Risk Register # 1459, 1616, 1772)

    - ENT is unable to staff a 7/7 consultant rota due to recruitment difficulties. This is currently being mitigated by employing an associate specialist and a locum and this arrangement is currently under consideration by the CCGs.
    - Urology operates a consultant of the day rota. The commitments of the daily consultant have been adjusted to support senior review within 14 hours 7 days per week.

- From November 2018, we have monitored the rate of review within 14 hour standard, by ward, on a monthly basis as part of the "Excellence in Care" programme. This audit samples between 400 and 460 inpatients each month. These audits indicate that overall compliance with Standard 2 has been consistently above the 90% standard since November 2018

- From May we have differentiated between weekday (Monday – Friday) and weekend (Saturday-Sunday) admissions. Weekend performance is slightly better than for weekdays.

- A separate audit of weekend admissions to the AMU at Eastbourne from 13/4/19 to 11/5/19 (covering 5 weekends) indicated 90.5% (182/201) of patients were seen within 14 hours; a level similar to the overall level at that stage.

Month	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Overall	91.7%	91.9%	90.5%	94.0%	96.7%	94.6%	93.4%	93.1%	93.1%	91.2%
Weekday	-	-	-	-	-	-	95.1%	92.8%	92.9%	90.3%
Weekend	-	-	-	-	-	-	90.3%	94.0%	94.0%	94.2%

- Introduction of the Nerve Centre (live bed state system) across the Trust will support tracking of patients and their review within 14 hours

Improvements made so far:

- We have increased the number of Acute Medicine consultants to provide better support on AMU/AAU, particularly at weekends.

- An Excel-based electronic record (the "Pink List") has been in use from December 2018 on our Acute Medical Unit (AMU) at EDGH to enable more reliable tracking of patients referred, the time of their admission clerking and the time of consultant review. This helps alert both junior and senior staff to patients approaching the 14 hour standard. A similar arrangement is in place at Conquest using the clinical portal eSearcher.

- The Trust has purchased "Nerve Centre"; a clinical management system used by many acute Trusts. Real time bed state is currently being introduced. Clinical management software modules, supporting tracking of patients and their review within 14 hours, handover and Hospital at Night functions, and enabling documentation of delegated review of inpatients, is scheduled to start later in the year. This should generate patient and task lists for medical staff, and provide a robust mechanism for monitoring performance against this clinical standard.

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

- The Trust has made progress since the last assessment in February, and now meets Standard 5 overall. Further details of the specific diagnostic services are in the Appendix.
- A cross-site 24/7 acute Upper GI bleeding rota has been fully operational since 15 April 2019, following which the Trust became fully compliant for this standard for all diagnostics.

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

- Likewise the Trust now meets Standard 6 overall. Compliance against clinical standard 6 is based on a combination of weekday and weekend assessments with equal weighting to availability at weekdays and weekends. To achieve compliance, the Trust must comply with 17 out of 18 instances.
- The lack of a fully functional 7 day GI bleeding rota enabling endoscopic intervention had prevented us achieving this standard. Since the implementation of the 24/7 GI Bleed service in April, we have become compliant with Standard 6.

3.4. Clinical Standard 8: Ongoing consultant-directed review

- ESHT does not currently meet Standard 8 overall.
- Twice daily review is standard practice in our intensive care and high dependency units on both sites which delivers compliance with this standard for patients with high dependency needs.
- Specialty teams at ESHT also conduct daily multidisciplinary consultant-led board rounds on our assessment units and on acute inpatient wards during weekdays. However ESHT is not compliant with standard 8 at weekends in a number of specialities where the formalised arrangement for consultant cover at weekends does not include a consultant-led ward round.
- Daily handover lists on eSearcher are used for patients requiring review overnight and over the weekend.
- Documentation of need for medical review and delegation of consultant review is variable across specialities and wards, and remains poor in some.
- However ESHT is not compliant with standard 8 at weekends in a number of specialities where the formalised arrangement for consultant cover at weekends does not include a consultant-led ward round.
- Documentation of need for medical review and delegation of consultant review is variable across specialities and wards, and remains poor in some.
- Daily board rounds have been in place on wards in the two acute hospitals but the attendance and function of these is currently variable; likewise documentation of board round decisions and delegation of review.
- Patient observations are recorded electronically on VitalPAC. This automatically calculates NEWS scores and alerts medical and/or ITU outreach staff to patients whose condition is deteriorating.

Actions

- We continue recruitment efforts to increase consultant numbers across a range of specialties including ENT, Urology, Stroke, Acute Medicine. This includes a recruitment arrangement with Medacs, to source suitably qualified staff from overseas.
- Variation in Board Round practice has been audited and support is being directed towards those clinical areas and specialities that are less compliant.

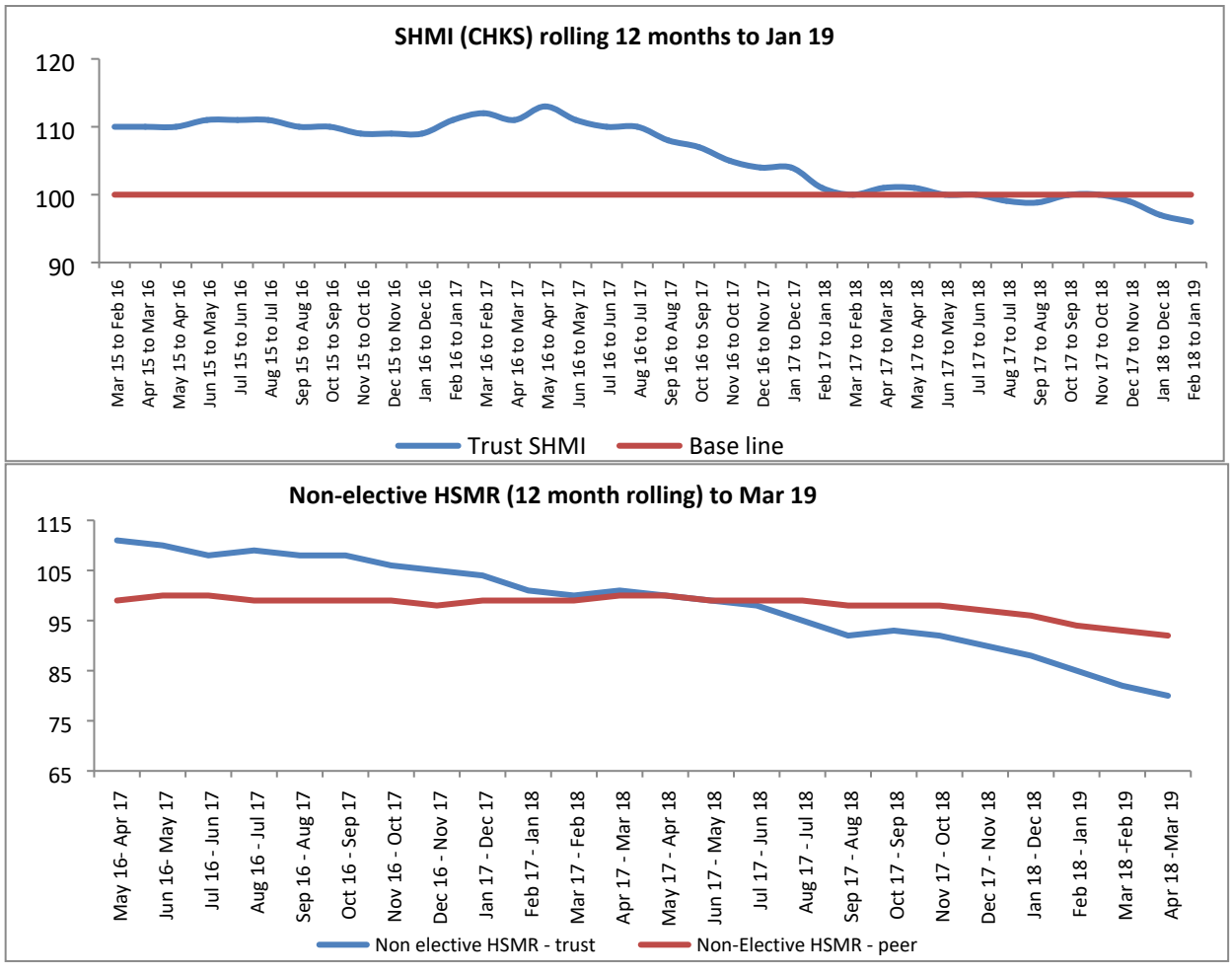
- Educational work is ongoing across all specialities to improve documentation of daily review and delegation of review.
- Both senior and non-consultant medical staff are advised on the importance of correct documentation of inpatient reviews (both consultant and delegated review).
- The Nerve Centre system, purchased late in December 2018, incorporates a more reliable mechanism to document when a consultant-led review has taken place, and provide a robust mechanism to document delegation and time of review of inpatients, generate specific review lists for clinical staff and ensure appropriate review, by consultants or juniors, particularly at weekends.
- The initial components of Nerve Centre are currently being installed. The roll-out was scheduled to start early in August but there has been some slippage in the timescale, due to other IT issues, and this is now anticipated to start in early November. This is being accompanied by educational and training programmes for all clinical staff.

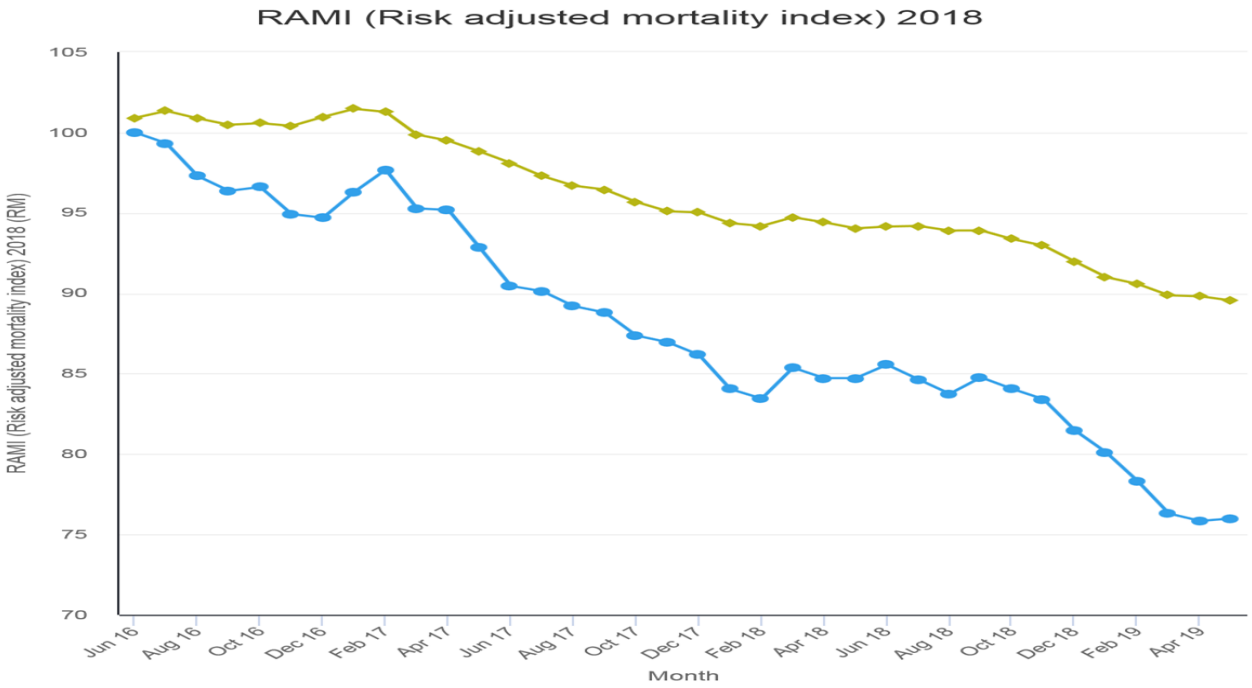
4. Effects on quality of care

The changes that the Trust has made in achieving progress in the four core standards, and in the other 7 Day Services standards, both internally and in partnership with other organisations in the local health and social care partners, have contributed to a sustained improvement in a number of objective parameters

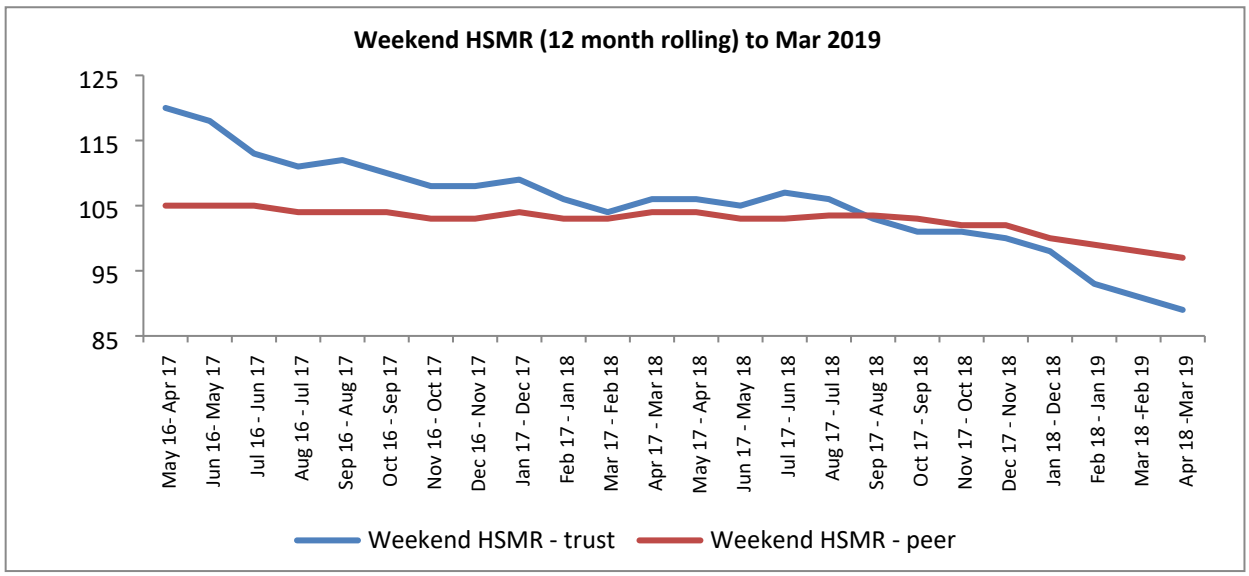
4.1 Mortality

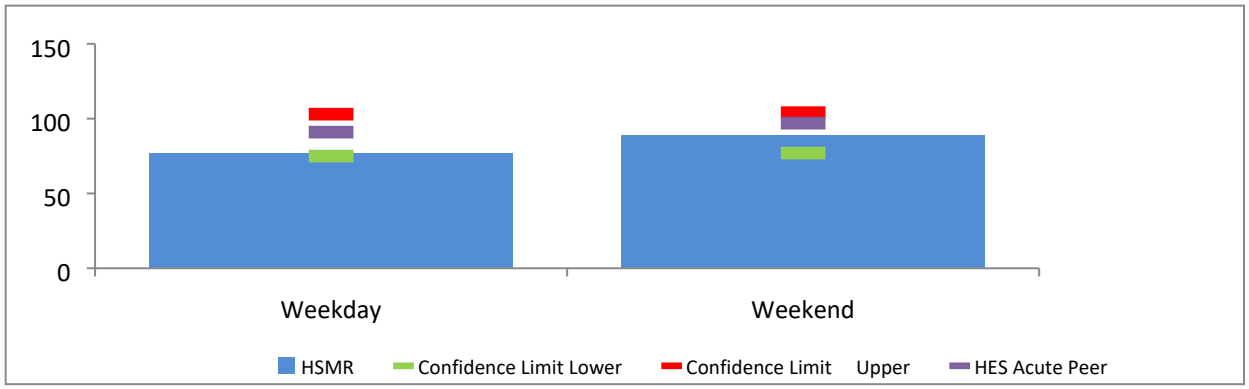
- We have seen a decrease in all the standard indices of mortality over the last 3 years.





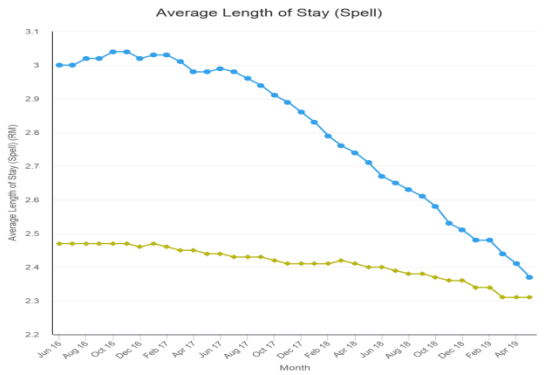
- Both weekend and weekday mortality have improved, with the Trust now lying at or below (better then) the national average

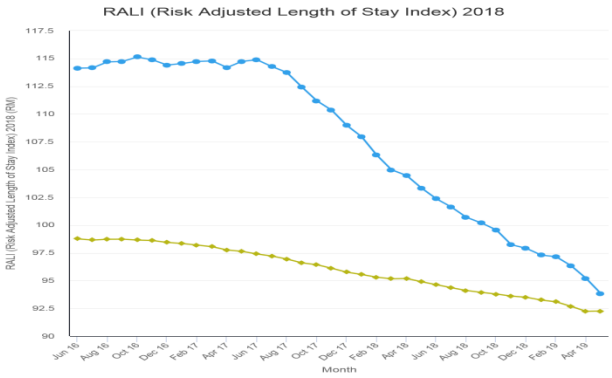




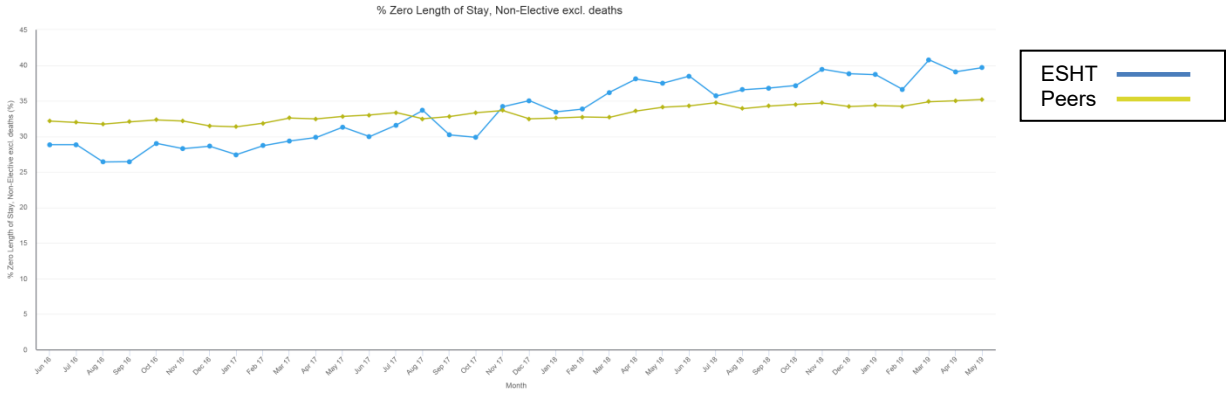
4.2 Length of stay

- Since November 2016 average length of stay has reduced from 3.04 to 2.29 days and risk-adjusted length of stay index has similarly improved.

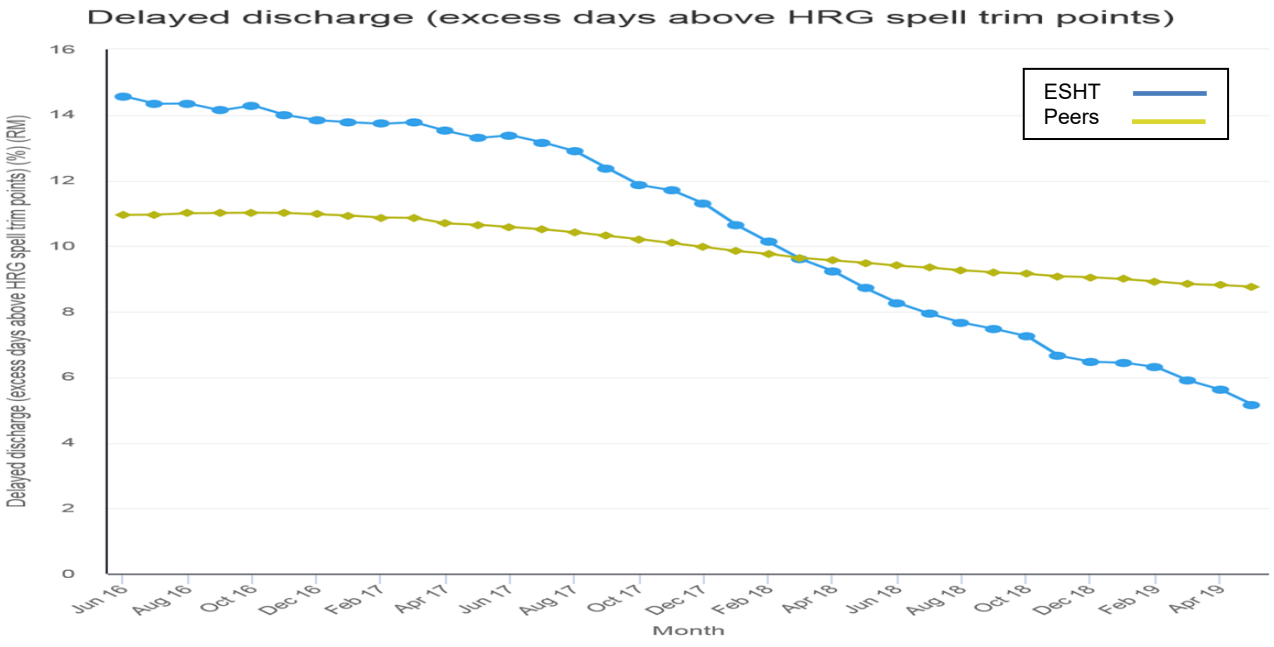




- The proportion of patients with zero length of stay ("same day discharge") has increased substantially from 26.4% to 39.7% (national 35.2%). This is due both to the increased consultant presence at entry points (eg AMU/AAU, SAU. PAU) and to the investment in the Ambulatory Emergency Care service.

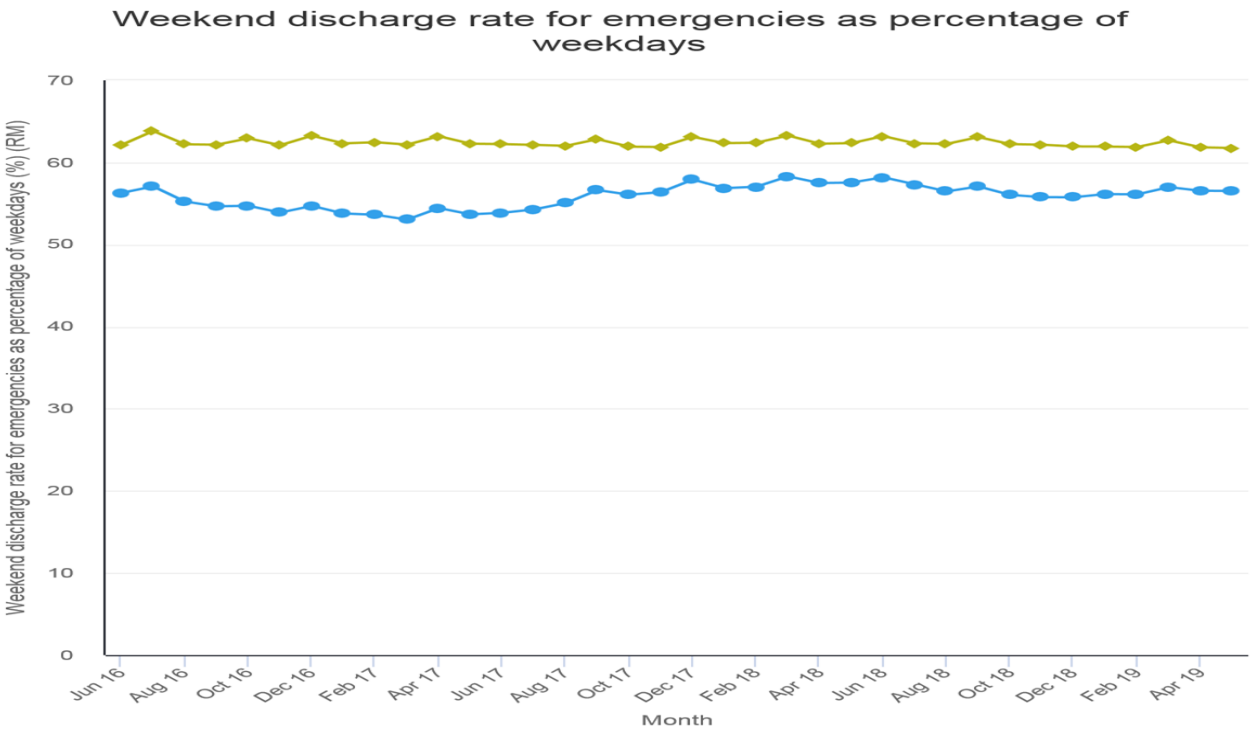


- There has been a major reduction in the number of delayed discharges over the last two years, the Trust now having substantially fewer than national average.



- Weekend discharges as a proportion of weekday discharges have improved gradually over the last two years from 53.7% in May 2017 (national 62.3%) to 56.5% in May 2019 (national 61.8%), but remain

below the national acute average. This may be a reflection of the local demographic, with high numbers of extreme elderly (>85 yrs).



Recommendations and next steps

The Trust board is asked to note the progress that is being made in delivering the priority 7DS clinical standards at ESHT, particularly the achievement of Standards 2, 5 and 6.

Although the current self-assessment indicates that the Trust does not yet meet standard 8 (ongoing consultant-directed review), particularly at weekends, this is now the main focus of ere are plans identified to improve delivery.

The Trust improvement plan for 7DS includes:

- Continuing to develop divisional improvement plans for delivering against the 7DS standards, particularly Standard 8.
- Continuing recruitment of additional consultants in specialties with vacancies.
- Recruitment of other scarce staff groups, including ultrasound and cardiac technicians.
- Using Nerve Centre as a reliable mechanism to support delivery of standards 2 and 8 by:
    - Providing patient and task lists for medical staff
    - Enabling documentation of Board Round decisions, acuity, delegation of review and completion of daily review.
- Pending the full implementation of Nerve Centre, strengthening of delegated review, board and ward round documentation and handover lists.

Dr James Wilkinson
Assistant Medical Director (Quality & Innovation)

Dr David Walker
Medical Director

NHS

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	ESHT has consultant job plans in place across medicine and general surgical specialities to deliver compliance with clinical standard 2. • All medical specialties participating in the general medical acute rota have in place consultant or senior staff rotas to enable review of medical patients within 14 hours, using a combination of GIM consultant of the day and AMU consultants, with on-site cover provided from 0800 to 2000, though many consultants start earlier in the morning and are present till 9pm evening shift change or later • General surgery has a consultant of the day on the Surgical Assessment Unit (SAU), available to see patients from 0800 to 2000. • The "Excellence in Care" audits indicate that overall compliance with Standard 2 has been consistently above the 90% standard since Nov-18 . • Since May, this audit has differentiated weekday and weekend admissions and confirms 94% weekend and 90.3-95.1% weekday compliance with standard 2 in May-August. A separate audit of weekend admissions to the AMU at Eastbourne from 13/4/19 to 11/5/19 indicated 90.5% (182/201 patients seen within 14 hours), supporting the validity of the of the EiC audits. Performance at weekends in some surgical subspecialties a number of specialties where the formalised arrangement for consultant cover provides insufficient cover in order to deliver review within 14 hours: • ENT is unable to staff a 7/7 consultant rota due to recruitment difficulties. This is currently being mitigated by employing an associate specialist and a locum. We have asked the CCGs • Urology operates a consultant of the day rota. The commitments of the daily consultant have been adjusted to ensure senior review within 14 hours 7 days per week. • An Excel based electronic record has been in use from December 2018 on our Acute Medical Unit (AMU) at EDGH	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	• Microbiology advice is available 24/7 from the microbiology consultant on call. Urgent lab investigations (eg CSF samples) are accessible 24/7 via the onsite medial scientists. • Ultrasound is provided by a combination of scheduled lists on weekdays and Saturdays. Emergency access is via the interventional radiology service 24/7 but also we have increasing numbers of senior staff in the Emergency and Acute Medicine departments trained in fast scanning to cover basic, essential ultrasound needs.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	• Critical Care (HDU/ITU) operates at both sites. • Interventional radiology is serviced by a24/7 acute cross-site consultant IR rota. • Acute Surgery is based at the Conquest site. Recognised or suspected surgical emergencies are taken to SAU at Conquest by SECAMB. An on-site surgical middle grade (out of hours), and middle grade or consultant surgeon (in office hours) is available at all times for surgical assessment of patients self-presenting or conveyed to Eastbourne DGH. • Acute ENT and Urology are based at Eastbourne. Similar arrangements are in place for patients in those specialties requiring specialist intervention. • Emergency renal replacement is available via haemofiltration ion ITY at both	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	• Twice daily review is standard in ITU/HDU at both sites and recorded on EPR. • Daily multidisciplinary consultant-led board rounds are in place on admission and assessment units and on acute inpatient wards, as the Trust is operating the SAFER approach to inpatient care. • Cardiology has a consultant of the day, covering CCU at each site, and an alternating site acute primary angioplasty rota provides 24/7 cover. At weekends, there is currently cardiology consultant cover at the acute site (receiving STEMIs) to provide ward rounds. • ESHT is not compliant with standard 8 at weekends in a number of specialties where the formalised arrangement for consultant cover does not include a consultant-led ward round. Delegation of review occurrs across the Trust but documentation of the need (or otherwise) for medical review and delegation of consultant review is variable across specialties and wards, and remains poor in some. Improvements to be implemented: • The clinical Divisions are reducing variation in Board Round practice. Thisi has been audited and education and support directed towards those clinical areas and specialties that are less developed. ESHT piloted a project to improve documentation of delegation in 2 specialties in 2018. Educational work has been undertaken across all specialties in improved documentation of daily review and review delegation and this continues. • The Nerve Centre clinical management system, which is currently in set-up phase, will incorporate a more reliable record of review and review delegation and provide patient and task lists for delegated medical staff. • Notwithstanding the above, the Trusts crude mortality has reduced and all indices of risk-adjusted mortality have improved substantially over the last 3 years: SHMI from 1.14 to 0.97, HSMR from 145 to 74, and RAMI from 126 to 75. • Weekend and weekday HSMR have both improved from above to below national average. Weekday HSMR is 77	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

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

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Cardiology has a consultant of the day, covering CCU at each site, and an alternating site acute primary angioplasty rota provides 24/7 cover. At weekends, there is cardiology consultant cover to provide CCU ward rounds at the "hot" site (the site admitting the STEMIs that week).

Template completion notes

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

STP Independent Chair's Update

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	11
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:

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

Bob Alexander, Independent Chair of the Sussex Health and Care Partnership produces a monthly update for the Chair's Oversight Committee. This provides an update on work that is being undertaken across the STP and is presented for the Board's information.

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

None

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

The Trust Board is asked to note the STP Independent Chair's update.

Independent Chair Update

Sussex Health and Care Partnership – August 2019

Leadership and Organisational Updates

To start my second update, I am delighted to announce that we have been recognised that we will be fast tracked to an ICS. We will be meeting the Regional Team in the next few weeks to understand what this means for us in the 15 week programme and I will feedback further updates in future reports.

The Sussex Health and Care Partnership team has been further strengthened with Glynn Dodd joining as Programme Director and Pennie Ford as Interim Director of Assurance. Glynn Dodd is leading the work required on a revised governance model.

Adam and I are also continuing our SRO and Independent Chair reviews and discussion of the priority work streams with the following programmes being reviewed over the coming weeks:

- Step Up Step Down Beds
- Local Maternity Services
- Medicines Optimisation
- Mental Health
- Acute Provider Collaborative
- Theatre Productivity

Development of the Sussex Health and Care Strategic Plan

As colleagues are aware, we are developing a Sussex wide Health and Care Strategy and clinical model that brings together our collective aims for improving the health of the population of Sussex, and will also provide the building block for our STP wide response to the NHS Long Term Plan (LTP) and subsequent Implementation Framework. System plans have freedom to respond to local need and to prioritise the pace of delivery for many commitments. However, there are a number of essential commitments, programme milestones and end goals that the Long Term Plan has set, and which must be incorporated into strategic planning.

Significant progress has been achieved over the last month. The Sussex Health and Care Partnership Clinical and Professional Cabinet have developed a draft Health and Care model which sets out how the Sussex Health and Care Partnership health and care system will be delivered and illustrates the benefits for our population as a whole. This has now been discussed at key system wide committees and circulated across stakeholder organisations with the expectation that cabinet members will ensure that it is widely socialised with clinical and professional colleagues and other staff within their respective organisations to ensure broad awareness and involvement with the development of the plan.

In addition, we are working with Clinical and Programme leads to agree the framework and

map out the level of detail for their contribution to the delivery of the NHS Long Term Plan requirements which will be incorporated into our system wide strategic plan. These will also reflect the differing responsibilities for actions and delivery that needs to be achieved across three levels, namely:

- Neighbourhoods – providing social, physical and mental health services closer to home
- Local area –multi-disciplinary community sector services taking responsibility for specific population, based around Local Authority boundaries
- Sussex Wide – complex services planned and managed collectively across Sussex serving the entirety of the population

As previously reported we are holding a workshop for a CCG Governing Bodies on Tuesday 13th August where colleagues will have the opportunity to influence and shape the Health and Care model and inform the sign off process given the challenging timescales we face. We have also included the development of our Sussex Health and Care Strategic Plan as a key agenda item for the series of CCG Governing Body Seminar's taking place throughout August and September to ensure further opportunities for colleagues to contribute to the ongoing development of this important document.

Assurance Update

Pennie Ford has started discussions with partners about how the system could develop a new assurance framework as it moves towards becoming an ICS from April. Key principles would include transparency and sharing of information, an integrated approach around commissioning and provision and a streamlined, non-duplicative approach, supported through positive system behaviours.

The emerging outline suggests an approach to assurance which is focused on improvement with routes for escalation, a line of sight at system and organisational level, taking joint action to address under delivery and learning from good practice. Our new arrangements will need to be able to cover integrated care, primary, community, acute and mental health services and to consider operational delivery & improvement against our plans, as well as the wider transformation & service reconfiguration.

ICP Development – Achievements

Excellent progress has been made to date on our development to an ICP with the main highlights being:

- A system wide Strategy Directors Group has been convened with the first meeting held in July.
- Aligned incentives contracts have been agreed with BSUH, ESHT and WSHFT.
- Outline programme plans have been established at place and aligned to key outputs and milestones for wider system reform programme.
- Establishment and/or re-establishment of partnership infrastructure at place to support ICP development of Sussex Health and Care Partnership business plan.
- Definition, primary functions and outcomes and high level model for ICPs at place established for Sussex Health and Care Partnership Executive against and outline population health model

- High level model established for place-based partnership infrastructure including roles and responsibilities for the SRO at place, the programme management infrastructure and the programme board.
- Framework for shaping footprints for ICPs provided at place supporting decision making at Sussex Health and Care Partnership Executive.

ICP Development – Next Steps

The next few months will see more great progress with the following key stages of ICP development due to be completed between August and October 2019:

- Chief Officer engagement to ensure consensus on ICP footprints and place-based plans for partnership working.
- Local Authority engagement to ensure consensus on ICP footprints, place-based plans for partnership working and commissioning development.
- Place-based engagement to suggested footprint model, proposed models for partnership infrastructure and timescales for developing plans, governance arrangements and partnership agreement.
- Agree revised maturity index for ICPs and report by place to Director of Strategy on progression for inclusion in response to NHS long term plan.
- Establish programme with partners to develop contracting infrastructure, including 3 year revenue agreement for aspirant ICPs and interim outcomes framework.
- Develop communication strategy in support of development of population health approach to underpin framework for establishing both ICPs and commissioning development.

Programme Update

Monthly highlight reports have now been collected from the priority programmes. The latest overview report shows the majority of programmes have made progress against their plans, and for those that had identified potential savings, the majority have made progress in this as well. Progress against milestones is also good, but there is some slippage within programmes. Overall, the assessment of likelihood of delivery is gradually improving.

All programmes are aligned to Long Term Plan priorities and interdependencies between programmes have been identified.

A risk log has been created. All risks have mitigating actions and are being monitored within programmes at Programme Boards.

The process for monitoring all programmes is being reviewed to be effective by end of August. The aim is to create a more robust monitoring process providing more scrutiny of progress and risks. Additional programmes will be included which were not included originally (such as Theatre Productivity and Cancer) and the overarching programmes of work (Strategy/LTP response, ICP development, Operating Model) will also be included.

Bob Alexander
Independent Chair
Sussex Health and Care Partnership

Nursing Establishment Review 2018/19 – inpatient wards

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	12
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth, Director of Nursing

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

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

Summary:

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

This paper provides the Board with the recommendations arising from the 2018/19 review of the nursing establishment in inpatient wards for approval and implementation in 2019/20.

The report details the methodology and tools used in line with the National Quality Board (NQB) and National Health Service Improvement (NHSI) guidance, a summary of the proposed changes by division and trust (see section 4.0) and a break down by ward including the rationale that informed the professional judgement decision (see section 5).

The financial implications of the proposal have been approved by the Finance and Investment Committee. The revised establishment, if approved, will have a £1.07m impact on revenue costs in a full year of operation. For 2019/20, the revised establishment will not be implemented until Q4, it is therefore anticipated that this will create a £0.25m pressure on the 2019/20 financial plan. This will initially be managed through in-year contingency, with the full £1m funding applied to the start budgets for 2020/21. However, it is also anticipated that a significant proportion of the revised establishment is already in current run-rates and identified overspends, and the 2019/20 impact on run-rate will be less than £0.25m. This will be reviewed at Q3, and reflected in the quarterly trust full year forecasts.

2. REVIEW BY OTHER COMMITTEES

A summary of this paper was reviewed and approved at the Executive Team Meeting on 26th June 2019 including a request for consideration of any other potential service changes that might affect the proposal.

The proposal was formally approved by the Finance and Investment Committee on 1st August 2019.

3. RECOMMENDATIONS

The Board is asked to:

- Approve the proposed changes to the nursing establishment for in-patient wards.
- Approve the planned timeline for implementation as follows:
    - 3 month recruitment period (Oct – Dec 2019)
    - Commence formal reporting against revised staffing templates on 1st Jan 2020.

Outcome of the 2018/19 Nursing Establishment Review (inpatient wards)

Proposed changes for 2019-2020

1.0 Background

National Quality Board's (NQB) guidance states that providers:

- **must** deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- **must** use an approach that reflects current legislation & guidance where it exists

In support of the NQBs expectations NHSI published 'Developing workforce safeguards' in October 2018 to support trusts manage their workforce, including new recommendations to ensure these principles are in place including that **Trusts must ensure the following 3 components are used in staffing processes:**

1. evidence based tools (where they exist)
2. professional judgement
3. outcomes

This will be checked in yearly assessment of trusts as part of the well led framework.

The 2018/19 nursing establishment review for inpatients wards was carried out between Jan & Mar 2019; an initial report of findings was presented to the Executive Team on 10th April 2019. A second report was presented on 26th June 2019 including further information that had been requested, in collaboration with Finance colleagues, to provide a summary of all of the proposed changes, including the financial impact to support a fully informed decision regarding approval.

2.0 Introduction

This paper provides the Board with details of the proposed changes in the nursing establishment review undertaken in 2018/19, including the financial investment required for consideration and formal approval.

3.0 Methodology

The Safer Nursing Care Tool (SNCT) is a nationally recognised and validated tool which enables the assessment of patient acuity and dependency, incorporating a staffing multiplier to ensure staffing establishments reflects patient needs. The trust processes the required licence to use the SNCTs, both the acute adult tool and the children's and young person's tool.

The tool was used in conjunction with nurse sensitive indicators (NSIs) which can be linked to staffing (patient falls, pressure ulcers and infections for example) and triangulation with other relevant local information to inform professional judgement. Royal College Guidance and nurse to bed/patient ratios were also considered.

The patient acuity, staffing and activity data was all collected at ward level and recorded and entered into an electronic tool created by Allocate on 'My Assurance' in line with SNCT guidance. The findings and outcome were presented and shared with divisional senior nurses along with the NSI to inform the professional judgement decision making which was presented to the Director of Nursing for challenge/discussion.

4.0 Summary of proposed changes by Division & Trust

Division	*FTE change in HCAs & APs	*FTE change in RNs	*Total change in FTEs	*Impact
Diagnostics, Anaesthetics & Surgery	+11.83	+1.86	+13.69	£ 404,992
Medicine	+15.82	+4.59	+ 20.41	£ 668,997
Urgent Care	nil	nil	nil	nil
Women's and Children's	nil	nil	nil	nil
Out of Hospital	nil	nil	nil	nil
TRUST	**+27.65**	**+6.45**	**+34.1**	**£1,073,988**

* Includes enhancements for out of hours working and 21% uplift/headroom for sickness/absence, and training.

5.0 Breakdown of proposed changes by division & ward with outcome & rationale

Division	Ward	Change	Proposed FTE change in HCAs	Proposed FTE change in RNs	Finance impact	Evidence based tool variance in FTE from current funded establishment (- suggests more required)	Professional judgement & outcomes
Diagnostics, Anaesthetics & Surgery (DAS)	Egerton (T&O)	+ 1 HCA TWILIGHT LN 7/7 (11.5hrs)	+2.60	-	£81,723	-2.60 (SNCT)	Change in acuity since bed reconfiguration – New pathway for Trauma – patients in early stages of pre and post op care inc. multiple underlying complex co morbidities, reduced mobility and ability to self-care. Highest level of harm from falls amongst wards in DAS. See DAS Governance information. Original request from DAS for increase in 1 HCA LD & LN – agreed compromise of twilight shift to cover the busiest periods of activity (exact shift times to be confirmed, assumed 12:00hrs – 00:30hrs)
	Benson (T&O)	+ 1 AP 8 – 4 Mon - Fri	+1.21	-	£32,486	-1.70 (SNCT)	Changed from mixed T&O to Ortho-geriatric speciality in the last 12 months for patients aged > 76 years New Specialist Band 4 Assistant Practitioner (AP) role proposed to focus on complex discharge planning and reducing length of stay for patients
	Gardner (General Surgery)	+ 1 RN LD Mon – Fri	-	+1.86	£60,279	-8.57 (SNCT)	Change in acuity & dependency in the last 12 months - Gardner has become the sole acute general surgical ward, which has resulted in the highest acuity surgical patients with the highest risk factors for harm being concentrated on this ward (eg risk of infection). The ward/ division are currently creating additional duties to safely care for patients on this ward to meet patients care needs in line with trust protocols
		+ 1 HCA LD + LN 7/7	+5.42	-	£155,833		

							(see minimum staffing return, MSR May 2019). **To meet known demand and current spend propose increase of 1 RN Mon – Fri to take charge of this highly acute ward & increase in 1 HCA day and night to meet patients acute care needs**.
	Surgical Assessment Unit (SAU)	+ 1 HCA LD & LN 7/7	+5.07	-	~~£150,121~~ **DEFERRED – Further evidence of activity requested**	No validated tool exists for this complex area which consists of inpatient beds, ward attenders, waiting area and rapid assessment	Change in use of this ward from solely SAU to SAU and elective surgery & elective medicine - The reduction of 28 surgical beds at Conquest in 2018 (De Cham ward converted to medicine) has led to an increase in surge into this ward when beds are required (for elective admissions) and acutely ill patients remaining in the unit longer than previously. **Propose increase in 1 HCA LD & LN to meet additional activity of elective surgical and medical care in this ward (pre and post procedures)**
	Critical Care Conquest	+1HCA LD	+2.6	-	£74,670	No validated tool exists for this area – speciality guidance exists for RN ratios	**An additional HCA is proposed LD** to support direct patient care of critically ill patients and to free up RN time by undertaking other tasks currently undertaken by nurses (eg. Specialist equipment cleaning and topping up of supplies) NB: Critical care does not have a clinical orderly role – it is felt this multi skilled individual would be more appropriate for this specialist unit with complex equipment
	Division Total		**+11.83**	**+1.86**	**£404,991**		
Medicine	Mac Donald	+ 1 HCA LD 7/7	+ 2.6	-	£74,670	-2.44 (SNCT)	Minimum staffing return for this frailty ward consistently demonstrates high level of additional duties are being requested and required to meet the complex needs of the patients on this ward (above existing template) coupled with a shortfall in SNCT **Propose additional HCA LD to provide enhanced care needs currently being provided by additional shifts/duties.**

	Newington	+ 1 HCA LD 7/7	+ 2.6	-	£74,670	- 2.98 (SNCT)	Minimum staffing return for this frailty ward consistently demonstrates high level of additional duties are being requested and approved to meet the complex needs of the patients on this ward (above existing template) coupled with a shortfall in SNCT **Propose additional HCA LD to provide enhanced care needs currently being provided by additional duties.**
	James (16 bedded ward and 6 bedded CCU & emergency treatment of patients out of hours in the cardiac catheter lab)	+ 1 HCA LN 7/7	+2.6	-	£81,355	No validated tool exists for this ward as it combines ward, CCU and out of hours Cath Lab activity	Currently only 1 HCA on staffing template for this 16 bedded ward at night 6 bedded intensive coronary care unit which also provides emergency care and treatment for patients following acute cardiac events out of hours (PCI and Additional) HCA LN
		+ 0.5 RN (band 5)		+0.61	£23,892		To enable the matron to be fully supervisory to adequately support ward and acute CCU
	Seaford 3	+ 1 HCA LD & LN 7/7	+5.42	-	£162,519	-4.89 (SNCT)	Minimum staffing return for this frailty ward consistently demonstrates high level of additional duties are being requested and approved to meet the complex needs of the patients on this ward (above existing template) coupled with a shortfall in SNCT **Propose additional HCA LD & LN to provide enhanced care needs currently being provided by additional duties.**
	Folkington	+ 1 HCA LN 7/7	+2.6	-	£81,355	-2.44 (SNCT)	Minimum staffing return for this frailty ward consistently demonstrates high level of additional duties are being requested and approved to meet the complex needs of the patients on this ward (above existing template) coupled with a shortfall in SNCT **Propose additional HCA LN to provide enhanced care needs currently being provided by additional duties.**

	CCU EDGH ward (11 bedded unit)	+ 1 RN LN 7/7 + 1RN LD weekends	- -	+2.6 +0.77	£110,239 £36,405	No validated tool exists for this area– speciality guidance exists for RN ratio for Level intensive care	Currently 4 RNs on LN and weekend LD compared to 5 RNs on LD weekdays. 1:2 ratio for Level 2 patients is not currently being met on nights or on weekend days. (This is usual and in place in most other units nationally) Acuity of patients in CCU is the same 24 hrs per day and area also has additional ward attenders and out of hours calls to assess and manage. **Propose uplift of 1 RN LN 7/7 and LD on weekends**
		+ 0.5 RN	-	+0.61	£23,892		To enable the matron to be fully supervisory of this intensive cardiac care unit in line with guidance for intensive care units
	Division Total		**+15.82**	**+4.59**	**£668,997**		
Urgent Care	No inpatient wards					No changes in service to suggest another detailed review on this occasion. Previously had significant investment.	
Women & Children's	**Paediatrics:** Kipling, Special Care Baby Unit (SCBU) **Gynaecology:** Mirlees **Obstetrics:** Frank Shaw, Delivery Suite, EMU, Murray					No change No change Excluded from this report: Maternity review undertaken separately with external support and approved with additional funding	
Out of Hospital	Rye & Bexhill Intermediate Care Units					No change	

6.0 Recommendations

The Trust Board is asked to:

- Approve the proposed changes to the nursing establishment for in- patient wards.
- Approve the planned timeline for implementation as follows:

  - 3 month recruitment period (Oct – Dec 2019)
  - Commence formal reporting against revised staffing templates on 1st Jan 2020.

NB: This proposal is related to substantive staff for bedded wards only and does not include staffing for the additional escalation beds and wards (Glynde, Seaford, Polegate, the Annexe, Irvine & Rye). It is important to note the reliance and pull on substantive staff to support these areas over and above the funded establishment to ensure patient safety.

Winter Planning 2019/20

Meeting information:			
Date of Meeting:	1 October 2019	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	Pauline Butterworth

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: East Sussex Health and Social Care Organisations			
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

The Trust and health and social care partners have jointly developed the winter plan, under taking detailed analysis of demand and capacity.

The system winter plan sets out the East Sussex local A&E Delivery Board's (LAEDB) plan to ensure that the system is able to manage effectively the capacity and demand pressures anticipated during the Winter period, which covers the period from 01st December 2019 to 31st March 2020.

The plan aims to ensure our local system remains resilient and is able to manage demand surge effectively, maintain patient safety and support delivery of the STP business plan objectives and locally agreed system improvements during the this period.

The East Sussex LAEDB has developed this plan, which is supported by the East Sussex System Surge and Escalation Plan. Together these plans have been developed with engagement of all local system partners and members of the LAEDB. The system surge and escalation plan describes the way in the LAEDB system will respond to the additional demands of Winter and peak pressures periods throughout the year. A copy of the plan can be found in Appendix 1 of this document.

The objectives of the LAEDB Winter plan are as follows:

- To maintain patient acute bed occupancy of no more than 85% by Monday 23rd December and to aim maintain bed occupancy below 95% throughout Winter.
- To make sure that community capacity is fully utilised.
- To avoid ambulance delays of over 30 minutes.
- To support delivery of the agreed local system performance trajectory in respect of A&E, RTT and Cancer.
- To deliver a 40% reduction in long length of stay patients by March 2020.
- To ensure system DTOCs are no greater than 3.5%.
- To increase weekend discharge rates from the current baseline by 50%.
- To proactively prevent and manage infection control issues such as influenza and norovirus.

- To maximise use of Same Day Emergency Care (SDEC).
- To increase Streaming patients from A&E and redirecting from primary care.

Capacity and Demand

The table below, outlines the demand and capacity planning. Assuming all beds are open across acute sites, there will be a shortfall of 6 beds at Eastbourne and 17 beds at Conquest. Assumptions are based on year to date actuals, with the growth split between those admitted for overnight stays of one or more nights and those managed on a same day emergency care basis.

		EDGH		CONQUEST
Demand assumptions	Medical Growth, of which:	13%	Medical Growth, of which:	10%
	0 days LoS Growth	29.2%	0 days LoS Growth	41%
	1+ days LoS Growth	7.5%	1+ days LoS Growth	1.8%
BASELINE SHORTFALL		**-28 beds**		**-31 beds**
Acute escalation areas	Shut 12 Seaford beds now and re-open for winter	-16 beds	Shut 8 beds at Decham now and re-open for winter	-8 beds
	Open 10 beds Glynde Escalation beds	-10 beds	Shut 6 beds at Benson Ward and re-open for winter	-6 beds
BEDS SHORTFALL		**-6 beds**		**-17 beds**
Key Actions	Reduce 1+ days admissions by 2 per day	-6	Reduce 1+ days admissions by 4 per day	-17

Key Actions to Reduce Risk and Delivery Reduction in Overnight Admissions

Below are excerpts from the full winter plan, with key system actions defined. Further slides detail the actions relating to 999, 111, mental health and GP out of hours.

Capacity & Demand Plan – Key Enabling Actions

Action	By when	Impact
Develop system-wide dashboard to monitor all available community capacity (intermediate care beds, D2A beds, interim beds, NWB pathway beds, Crisis Response and Crisis Response capacity)	October	• Daily monitoring of available capacity • Quicker identification of unmapped patients and capacity • Faster implementation of remedial actions • Flexibility in using available capacity
HIT Team – ESHT internal improvement programme	November	• Increased flow out of the gateway areas of patients. • Stopping patients who are on the Clinical Decision Units from entering ward beds and use of home first pathway.
GP Streaming – increase utilisation of GP Streaming at EDGH and CQ to a minimum of 3 patients per hour	September	• Contribution to fewer admissions and better management of A&E demand
Re-allocate Frailty resources to support Community Frailty and Crisis Response teams in admission avoidance – targeting patients who would have normally been admitted and instead send back home with appropriate support	November	• Expected 2 fewer admissions at both EDGH and CQ sites
Direct access referral pathways to gateway areas	TBC.	TBC.
Targeted LoS reduction at EDGH from 4.8 days to 4.1 through LLOS improvement programme	September	0.2 beds at EDGH site
Milton Grange – pathway review and targeted LoS reduction to 14 days average	December	
Enhanced Care in Care Homes – ward rounds – focusing in particular on Hastings and Rother and Bexhill areas	December	Expected 2 fewer admissions at CQ

Primary Care - Extended Access, UTCs, WICs, Care Home Support, Pharmacy

Target/Initiative	Delivery Dates	Risks if any	Mitigating Actions
GP Extended Hours DES is provided by the Primary Care Networks (PCN). This is available to the entire registered population within each PCN.	Providing appointments outside of core hours.	• No significant risks identified	• DES is being delivered as a Primary Care Network so workload could be absorbed by another practice.
Primary Care GP Extended Access (Improved Access)	7 days a week 365 days a year – providing appointments in the evenings and weekends.	• Workforce and rota fill • Utilisation	• Work to look at booking extended access appointments through A&E. • EHS provider seeking to introduce LIVI to provide additional capacity through video consultations.
Community pharmacy opening times and NUMSUS (Urgent medicines supply service) information to be sent out and added to DOS	November 2019	• No significant risks identified	• None
Walk-in centre services in Eastbourne and Hastings operating across 7-days, including bank holiday hours.	Ongoing	• Impact of the planned formal consultation on Eastbourne WIC may result in staff leaving and make it more difficult to cover shifts	• Weekly monitoring of rotas • Agency and locum staff • Support from ANPs
Urgent Treatment Centres at EDGH and Conquest Hospitals to go live from 01st December 2019	1st December 2019	• UTCs may drive additional demand to the "front door"	• CCG working closely with Acute Trust to support delivery and manage timelines. • Monitoring of activity and pathway development.
1st December digital roll out for improved access via NHS 111 to	1st December 2019	• Slippage in digital programme.	• Regular updates from digital programme team and early escalation of changes.
Flu Management – Care Homes – Improved provision of flu management to cover to care homes.	1st January 2020	• Higher demand on provision	• Additional slippage cost to be secured.

Acute Provider Plans

Target/Initiative	Delivery Dates	Risks if any	Mitigating Actions
Primary Care GP Streaming fully covered during– 12 hour per day across 7 days with expected productivity of 3 patients per hour	October 2019	• Inability to staff.	• Early rota planning and 1:1 re expectations
Additional 40 Acute Winter Beds – 28 at EDGH and 12 at Conquest Hospital	Open Jan 2020	• Inability to staff the areas • NEL admissions growth	• Block book bank/Agency • Work with system to reduce NEL admissions
Further development of EDGH Ambulatory and Acute Assessment Model extended to 7 days..	Nov 2019	• Inability to recruit staff • NEL Growth	• Acute Physician adverts going out • Middle grade medical registrar to work daily in EDGH ED/AEC • 7 day rota in place by Oct
AEC Conquest to open and deliver 7 days	Nov 2019	• Inability to staff. • Growth	• Acute Physician adverts going out • Middle grade medical registrar to work daily in /AEC • 7 day rota in place by
Targeted reduction in NEL LOS by 3 days for frailty patients across both sites	Jan 2020	• Delays in implementing IDT	• Baseline audit for demand currently being undertaken • IDT implementation October 2019
Detailed Acute Winter operational plan to be developed by October 2019	October 2019	• Slippage due to time scales	• Regular updates at AEDB
Enhanced Discharge Events to held across Acute bed base through out Winter Period	Nov 2019	None significant risk identified.	
Implementation of Live Bed state (Nerve Centre) to reinforce red/green and patient flow at board rounds	Summer 2019	• Slippage on implementation date.	
Targeted LoS reduction at EDGH from 4.8 days to 4.1 through LLOS improvement programme	September 2019	• This cannot be achieved. • LLOS increases	• Regular reviewed at the AEDB and Operational support group.

Community Provider Plans (Including planned additional capacity, Discharge to Assess, Step Up Step Down quick wins, Length of Stay, bed occupancy & system flow support improvements)

Target/Initiative	Delivery Dates	Risks if any	Mitigating Actions
Escalation beds in intermediate Care units by 12 beds in Bexhill Irvine Unit and 4 beds in Rye Memorial Care Centre	24th December to 31st March	• Staffing of both Units	• Temporary workforce
Enact service escalation plans to support prevention of admission and Home First	In response to surge	• Meeting capacity	• Re-align resources to highest risk clinical area
Twice weekly reviews of LOS of patients within the intermediate care units.	Ongoing pre winter and post.	• LOS increases and a bottleneck occurs.	• Regular compliance updates at IPR.
Twice weekly reviews of LOS of patients within the D2A beds.	Ongoing pre winter and post.	• LOS increases and a bottleneck occurs.	• Regular compliance updates from ASC at AEDB and Ops Group.
Sussex Community Foundation Trust - Additional community rehabilitation beds to support patient flow across the BSUH system (But also can be used for ESHT patients): • 4 beds at Crowborough Hospital • 2 beds at Uckfield Hospital	TBC	• Workforce required to open additional beds • Funding from CCG needs to be agreed in advance from Brighton and Hove CCG.	• Planning for opening additional beds in advance, subject to agreement from CCG to proceed

Adult Social Care Plans (1)

Target/Initiative	Delivery Dates	Risks if any	Mitigating Actions
ESx -0 DToCs attributable to assessment or funding	December 2019	• Staff availability	• Pilot Bank hours for staff. • Flue Jabs for staff • Planned Annual leave • Contingency planning for sickness
ESx – 20 Discharge to Assess beds and 22 Interim beds; Totalling 42 beds available across the system. Target 90% occupancy to support flow through the hospital for people requiring resettlement and awaiting packages of Care – Reduce LoS, Stranded & Super stranded patients, prevent delays	Ongoing	• Independent Sector Capacity • Ensuring flow through the beds	• Daily systems calls with Supply and Management Team to monitor Capacity and escalate accordingly. • Dedicated assessors aligned to beds
Esx - Additional ASC care managers to support 7 day working, assessment and discharge over the Winter period	December2019	• Staff availability	• Pilot Bank hours for staff • HSCC 24 hours back up cover • Ops & Heads of Service 24/7 Duty for Escalation, in place.24/7. • EDS Out of Hours service
ESx – Flexing criteria for Joint Community Rehab. service to accept delayed patients with agreed PoC start dates but no rehab. goal.	Ongoing	• JCR (care) capacity in HWLH	• Utilise back up services ie Crisis response. • Supply Management Team to continue to prioritise discharges. • Escalation to support flow through JCR
ESx – 104 hours per day Pre-Booked independent sector home care capacity for the 3 week Christmas/New Year period	December 2019	• Engagement of home care providers. • Low levels of referral and utilisation (previous experience)	• Supply and Management Team to facilitate negotiations with providers. • Promote the service across the Adult Social Care Hospital Teams.

Target/Initiative	Delivery Dates	Risks if any	Mitigating Actions
Target LOS reduction at Milton Grange Generic beds to 14 Days average	Ongoing	• Restricted admission criteria • Capacity to support discharge	• Matron @ MG to attend Enhanced Discharge Meetings to id suitable admissions • Assessor cover to support flow through the unit. • HoS to participate in Weekly IMC Call to monitor flow.
AD, Head of Service and Operations Manager to be available for escalation and ensure representation on daily system calls, enhanced discharge planning, Made events and site meetings	Ongoing	• Staff availability sickness	• Pre planned and agreed annual leave. • Ops and Heads of Service Duty providing back up cover.

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

The LAEDB have jointly developed than plan, which has been submitted for review to the STP and subsequently NHSE. Initial STP comments have been incorporated.

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

The paper is submitted for assurance.

Overarching Health and Safety Annual Report 2018/19

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	14.1
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 purpose of this annual report is to provide the Trust Board with a summary of activity and outcomes relating to the promotion and management of health and safety within East Sussex Healthcare NHS Trust.
The reporting period is 1st April 2018 to 31st March 2019.

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

The annual report has been reviewed by:
The Health and Safety Steering Group
The Quality and Safety Committee

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

To review the annual report and seek assurance around health and safety monitoring, compliance and the actions the Trust is taking.

EXECUTIVE SUMMARY

The aim of the programme of work that was delivered by the specialties (Health & Safety, Medical Devices, and Moving & Handling) within Health and Safety was to ensure that the Trust was compliant with Health & Safety legislation. These three core functions contribute to the overall management of health and safety within the organisation.

The key achievements for 2018/2019 were:

- The implementation of the Assure online Health and Safety risk and audit software has enabled a more efficient tracking of departmental risk assessment and audits, alerting when audits are due and also ensuring accountability of actions to be taken as a potential result of audit. The software also enables scrutiny of documentation for each department prior to audit.
- The Trust does not have a Trust wide inventory of hazardous substances; Health and Safety worked with Procurement to identify all purchasing routes and control the purchases of all substances. Ad hoc inventories were undertaken and a stringent control exerted with the aim of significant assurance for 2019/ 20. The Health & Safety Department has also included the compilation of a Trust wide inventory of hazardous substances in their work plan for 2019/20.
- Medical Devices - There were no major/moderate incidents reported for this year and the incidents reported were addressed with additional training for the staff involved. There is an effective and robust training programme in place, with daily monitoring of Datix incidents and timely responses to issues that are raised.
- The latter half of the year was a challenging period for the Medical Devices Educators due to staff shortages; however they maintained and achieved compliance with mandatory training.
- Moving & Handling incidents - Whilst there have been small increases in severity 1 and 2 incidents in the first 3 quarters of 2018, a significant decrease in severity 3 incidents is evident, with just 1 incident in Q4. M&H continue to encourage reporting, with the aim of identifying issues before harm occurs.
- Moving & Handling training – Achieved the proposed staff training compliance mean of 90.1%, with all directorates been compliant for Quarter 4. All training materials have been updated in line with the National Back Exchange recommendations and bespoke training is provided to balance the needs of the acute and community teams.
- The dedicated staff in all three areas provide accessible services; the Health and Safety department hold Trust wide surgeries where staff can book time to discuss health and safety issues and concerns; the Medical Devices team continues to work closely with the relevant services and groups and are responsive to the needs of the clinical teams; and the Moving and Handling Team have an open and collaborative working relationship with staff across the Trust and are developing and encouraging M&H link roles.

The Key Risks identified for 2018/19 by ESHT were included in the work plan and were monitored by the Health & Safety Steering Group:

- Work related musculoskeletal disorders – Actions identified including raising awareness, improving physical and emotional resilience and good working practices are included in the Health & Well Being Strategy.
- Work related stress – the Stress policy has been revised. A number of initiatives are being taken forward to raise awareness and provide proactive support to staff. It is anticipated that once the new Occupational Health & Wellbeing IT system is fully established triangulation of Workforce data will be possible.
- Security, violence and aggression
- Needle stick and clinical sharps
- Purchasing and management of COSHH substances
- There were fourteen staff claims related to health and safety issues closed during 2018/19

Progress with security, violence and aggression; needle stick and clinical sharps; and the management of COSHH substances are outlined in the Health &Safety Department section of the report.

Overall 2018/19 was a challenging year with the re-configuration of the governance teams having a significant impact on service delivery. The teams continued to provide support, guidance, completion of audits and training to the organisation, and there is assurance that the Trust is compliant with all mandatory of health and safety requirements. However it is acknowledged that improvement is required with the Trust's internal monitoring systems e.g. completion of health and safety audits.

At the time of writing the report during July 2019 the organisation had undergone a two day inspection by the HSE with a focus on the management of violence and aggression and musculoskeletal disorders. The inspectors made special mention of the management of manual handling with positive feedback stating that the team had a good approach, were engaged and involved with the staff and had a consistent 90% compliance rate with training. However, the inspectors felt that the Trust did not have a full understanding of the extent and issues concerning violence and aggression therefore the organisation would be subject to a material breach. This has now been confirmed and actions arising from the report are being addressed under the leadership of the Executive Lead.

The work plans for 2019/2020 will deliver clarity on the compliance within the Trust to core requirements on health and safety risk assessments, control of substances hazardous to health, lone working and the assessments required for the management of violence and aggression. In addition the divisions and directorates will be supported to ensure and be assured that any gaps identified in the safe use and management of medical devices and moving and handling equipment have been identified and plans put into place to address them.

Training for health and safety, medical devices and moving and handling will continue to be provided by the three specialties as outlined in the Trust training programme and compliance will be monitored by the divisional and directorate governance groups, the Health & Safety Steering Group, the Clinical Procurement Group and the Education Steering Group.

The team will also support the Violence and Aggression Task and Finish Group in the development and implementation of the action plan to address the concerns raised during the Health & Safety Executive inspection in July 2019.

Infection Prevention & Control Annual Report 2018/19

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	14.2
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

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2018/19.

Arrangements made by ESHT allow the early identification of patients with infections; the measures taken to reduce the spread of infections to others, achievements and challenges are presented.

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

Trust Infection Prevention and Control Group (TICPG) 28/08/19. Patient Quality and Safety Group, 29/08/19

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

Approval.

EXECUTIVE SUMMARY

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

Key points during 2018/19 are:

The number of MRSA bacteraemia cases reported was 2 unavoidable infections.

- *Clostridium difficile* infections (CDI) limit was exceeded. The trust reported 51 cases from 48 patients, against a limit of 40. There were 4 cases assessed as lapses in care which contributed to the development of CDI. 2 lapse due to antimicrobial prescribing and 2 related to cross infection. A recovery plan was produced in August 2018 to strengthen antimicrobial stewardship and IPC at clinical level. The incidence of CDI improved in quarter 3 and 4.

- There is a requirement to reduce E. coli blood stream infection by 10% each year. This year ESHT achieved a 7% reduction on the baseline. This year ESHT has participated in a new national improvement collaborative focusing on reducing E.coli bacteraemia associated with urinary tract infection. This work will continue into 2019/20 and requires a system wide approach as most of the infections occur initially in the community.

- The Trust is showing as a high outlier for orthopaedic surgical site infections on the national PHE report. The data relates to the period 2017/18 when an SI was completed in relation to increased cases. Current data indicates that the incidence of infection with orthopaedic hip and knee surgery has returned within national limits this year and this data will be reported in 2019.

- The Trust signed up to two national projects to improve orthopaedic surgical site infection rates and reduce urinary tract infection related Gram negative bloodstream infections. We have held a study day on reducing gram negative infections for over 100 delegates and invited national experts to present to trust staff.

- ESHT experienced our busiest ever influenza season, with 450 patients diagnosed with the infection. There was an outbreak of influenza at EDGH involving 30 patients and a serious incident investigation has been submitted to the CCG for sign off. The outbreaks reflected delays in diagnosing index cases on wards which enabled the infection to spread to others. The outbreak occurred during high national prevalence and operational escalation when bed occupancy was 100%.

- Compliance with screening patients for Carbapenemase producing Enterobacteriaceae (CPE) has improved.

- Norovirus outbreaks occurred on individual wards and were managed in line with local and national policy without significant consequence.

- Hand hygiene compliance remains above 98%. The number of audits undertaken was reduced in the first half of the year as the reporting system was changed and required ICLFs to be trained on the new system. As the year progressed, initial problems with the new system were addressed.

- Auditing of environmental and equipment cleanliness shows the trust is overall compliant with national specification of cleanliness (NSC). Staffing shortages within the NSC team led to a reduced number of audits being undertaken and this has been addressed following recruitment.

- Antimicrobial stewardship has been strengthened by the introduction of ward rounds in areas of high use. The overall use of antimicrobials in the trust remains higher than the national average but has reduced by 5% on the previous year. The trust has been advised that it will receive full payment for the CQUIN this year.

- Pseudomonas was isolated from an outlet in Special Care Baby Unit and this required considerable work by Estates and Facilities. The problem has resolved. There were no related infections on the unit. Water Safety continues to be well managed.

- Priorities for 2019/20: To prevent avoidable infections. Adjusting processes to take account of the new algorithm for CDI. Focusing on improvements in urinary tract infections and CAUTI, assessing compliance with revised NICE guidance for prevention of surgical site infection. Implementing lessons learnt from the influenza outbreak, working with occupational health and wellbeing to strengthen our processes for contact tracing following exposure to infection, revising our visitor and patient information and strengthening ANTT training provision.

Lisa Redmond, Head of Infection Prevention and Control

Safeguarding Annual Report 2018/19

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	14.3
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth, Director of Nursing

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

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

Summary:

1. EXECUTIVE SUMMARY

The Annual Safeguarding Report provides retrospective information around the key points that arise from national and local safeguarding guidance and incidence. The report provides an update of progress of these key points and Safeguarding responsiveness. The report includes the annual work plan for 2018-19 to provide assurance that actions are in place to address statutory reporting as well as being responsive to risks. There are some risks that have been identified:

- The Safeguarding Team were the winners of the Trusts Working in Partnership Award 2018.
- Safeguarding actively participated in the Domestic Abuse Awareness Event.
- Proactively undertaken a review of the safeguarding service that we provided for young people between 16–18 years from a safeguarding perspective, piloting a Safeguarding Transition Specialist Nurse role to oversee patients placed on adult wards and out-patient specialism such as diabetes.
- Re-designed the Mental Capacity Act and Deprivation of Liberty training and support to staff, moving to e-solutions, following a review of training and staff knowledge. Our staff now has access to the NHS Safeguarding app and Media Training
- Head of Safeguarding has revised the collaborative working arrangements with Sussex Partnership NHS Foundation Trust to ensure interventions where patients are sectioned are recorded, compliance with training and improved practice with the Mental Health Act (2007) where detained patients are admitted to our inpatient beds.
- Delivered training to key professionals using a risk based approach, to key teams in ESHT to ensure the rights of patients detained under the Mental Health Act are safeguarded.
- Secured external funding for an Independent Domestic Violence Advisor (IDVA) working with the emergency departments, maternity services and Special Care Baby Unit to improve practice, documentation of risk and support affected persons. In March 2019 ESHT were informed by the CCG that funding stopped and service would cease in May 2019.
- Successfully raised the PREVENT profile, attending the Regional Prevent Board, and sharing information across the Trust through awareness and targeted WRAP training.
- Implemented the mandatory Female Genital Mutilation Information System (FGM-IS) in maternity.

- Maternity Safeguarding Midwives raised the profile of domestic abuse within maternity. Working with Maternity staff with strategies to enable them to discuss the issue of domestic abuse with all pregnant women antenatal and postnatal.
- Worked closely with Women's and Children's Division and Urgent Care to address concerns regarding the experiences of Mental Health patients, specifically through audit, review of the Risks upon the Trust Risk Register and development of a more robust process of monitoring the patients that are referred to Child and Adolescent Mental Health and Children's Social Care database (GDPR compliant) .
- Undertaken a GDPR review of information sharing from a Safeguarding perspective.
- Refined safeguarding governance systems and processes delivering increased collaborative working with the divisions and visible assurance information for the Board.
- Implemented the mandatory Child Protection Information System (CP-IS) in the emergency departments to ensure clinicians are supported to safeguard children achieving the goal of 100 % compliance in March 2019.
- Increased the delivery of Safeguarding Supervision in Adult and Child Specialist areas, specifically the community which has managed self-neglect and complex caseloads.
- Contributed to LSCB Quality Assurance Subgroup in monitoring and evaluating the effectiveness of the work carried out by board partners by contributing to 4 multiagency audits (frequent attenders case file, elective home educated children and young persons, domestic abuse and fabricated or induced illness).
- Multi-agency Child Exploitation (MACE) alerts have been added to e-searcher to identify young people at risk of being missing or sexually exploited.

Throughout 2018–2019 ESHT is changing practice as a result of the learning from Safeguarding Case Reviews, including;

- A domestic abuse training package has been developed to improve staff knowledge and help staff support patients. Specialist domestic abuse workshops have been commenced for acute staff in areas where we know patients are likely to attend.
- Developing a programme to support staff who are working with patients who self-neglect (ESHT participated in the Adult A - Safeguarding Adult Review in 2018 but have continued to share learning)
- Safeguarding learning will inform the work underway regarding discharge planning especially when someone is known to be vulnerable (Adult C - Safeguarding Adult Review)
- An unpublished Child Serious Case Review (Child T) - has highlighted the vulnerability of children who transition from Child to adult health and social care services. An innovative multiagency project is now being piloted were high end safeguarding complex cases with chronic medical needs are now jointly supervised by both ESHT and LA safeguarding team
- Maternity services are improving their practice in relation the return of mother and baby hand held notes postnatal
- National Case reviews have as a consequence led Maternity Services to work hard to identify women and children who are at risk of FGM by implementing Child Protection Information systems specifically aimed at alerting cases of high risk.

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

PAG - Chaired by the Director of Nursing
Safeguarding Operational Committee - Chaired by the Head of Safeguarding
Safeguarding Strategic Group – Chaired by the Director of Nursing
Q&S Committee
ESHT Board – Chaired by the Chief Executive
SAB Board - Chaired by the Head of the Safeguarding Board (Adults)
LSCB Board - Chaired by the Head of the Safeguarding Board (children)

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

To continue to support the Safeguarding Team with their statutory requirement to implement and deliver the action outlined in the safeguarding work plan.

Support the Safeguarding Teams contribution to the work undertaken by the Safeguarding Boards and the dissemination of learning and actions from presentations, case reviews and safeguarding audits.

Annual Fire Report

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	14.4
Meeting:	Trust Board	Reporting Officer:	Chris Hodgson

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

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

Summary:

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

The Annual Fire Safety Report (AFSR) for the period 1st April 2018- 31st March 2019 has been developed by the Fire Team and reviewed by the Associate Director of Estates and Facilities. It is presented as a record off activity and risks for that period (Appendix 1).

Although the risks have been in place for some time there has been considerable progress in mitigating them. EDGH fire alarm residency works are at construction stage, with work valued at £580,000. There remains a focus on mitigating the high scoring risks on an ongoing basis e.g. either through committing our own capital monies such as for the EDGH residences or by carrying out fire drills, exercises, training etc. Exercise Vulcan, a live exercise which simulated a fire and evacuation response on a ward and which has contributed to the development of the ESHT Evacuation Plan, was carried out at EDGH in June 2019.

We have recently received confirmation that our capital bid for £13.86m of funding for EDGH fire compartmentation works has been approved. This will be the single biggest investment in our estate for a number of years and the investment demonstrates confidence in the Trust moving forwards. It means that we will be able to undertake the improvements that our local fire service have advised are needed and we will also be able to make additional improvements to our estate during the works as wards will temporarily be decanted.

Notwithstanding this progress, it is noted that significant capital resources are required at both EDGH and Conquest, including the requirement to upgrade the compartmentation with EDGH Phase to comply with the relevant standards.

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

None

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

Note the report as attached and further note that the risks identified within the report are formally contained within existing risk assessments, as noted in the main body of the Annual Fire report.

EXECUTIVE SUMMARY

a) Fire Safety Policy:

The 2016 Fire Policy has been ratified and changes include:

- A revised Fire Incident management system.
- The remit regarding Fire Safety Protocols has been changed. All Protocols are now in the process of being combined into one document.

b) Non Compliance matters:

ESHT does not comply with the regulatory reform (Fire Safety) Order 2005 (RRO) in respect of:

- The Trust is currently carrying a combined risk **Major risk for** Fire- Physical Environment – Buildings and Services (Trust RR entry 1410, 1671 and 1643).

1. Inadequate Fire Compartmentation EDGH: including abnormal fire spread from external cladding arrangements at EDGH.

A business case reflecting the above mentioned hazards has been drafted by Arcadis, approved by the Trust Board and submitted to NHSi in February 2019 for funding. This along with the measures detailed in Appendix B-B2 have reduced the risk and possibility of that enforcement notice, albeit it should be noted that to comply with the relevant HTM's and achieve on-going compliance will require significant capital investment.

2. Failing Emergency Lighting- Conquest central battery system

3. Inadequate testing of Fire Dampers EDGH. Sample testing carried out, now on Estates PPM schedule.

4. Fire Compartmentation at the Irvine Unit – 2018-19 Improvements carried out and only minor issues to be resolved.

5. Non -Compliant of Fire Detection System in Single Room Accommodation at EDGH.
Three residency blocks out of seventeen blocks were initially identified by risk analysis for improvement/upgrade. These works have now been extended the cover the remaining 11 blocks of significant risk from sleeping occurring in the EDGH residences. Work expected to be completed for the first 3 blocks in Oct 2019, with the remaining blocks scheduled for completion by end of 2020 Q2.

East Sussex Fire and Rescue Service to visit all "single family" units to carry out Home Safety Visits.

6 EDGH Main Building Fire Alarm System
The Trust has received a Siemens Algorex fire system obsolescence notice from the contractor Siemens (refer to Appendix B5.2) Considerable capital investment will be required to address this risk.

An estates program group with appropriate external technical support has been set up to review the options and come up with a solution to this issue. A business case reflecting the above cost is contained with the business case which was submitted to NHSi in February 2019.

Comprehensive details of these risks are contained in Appendix A and B.

c) Compliance:

ESHT does comply with the RRO in respect of:

Fire Training: Mandatory Fire Training is at 87% of Trust Staff trained. There is a variation of 1-2% attendance each month depending on seasonal issues and other Trust pressures.

Fire Drills - 1672 Staff have been trained. An increase of 50% on 2017/18.
Fire drills involve a question and answer session and a walkthrough locating all ward/area compartment boundaries and fire equipment.

Theatres, Day Theatres, Emergency Dental and ITU Staff receive a more in depth training session involving bed pushes and real fire scenarios including patient needs at the time.
In the latter part of FY18/19, in conjunction with Trust Emergency planning, clinical and nursing colleagues, we are planning to facilitate a simulated part floor Phase 1 evacuation.

Fire Wardens- 77 Staff have been trained. . An increase of 10% on 2017/18.

1st Responder Fire Training - Mandatory fire incident management training for Porters, Clinical Site Managers, General Managers and on call Directors has taken place during Emergency Preparedness, Resilience & Response (EPRR) training days.

A 1st response incident response bag has accepted as integral to the Fire Incident Management system. All management roles will be identified by coloured tabards.

Exercise Vulcan, a live exercise which was planned to contribute to the development of the ESHT Evacuation Plan which simulated a fire and evacuation response on a ward was carried out on 27/6/19. The exercise was facilitated by EPPR colleges and a formal report/debrief is available.

d) Fire Risk Assessments:

The (RRO) includes requirement for all premises and areas within Trust premises to have a suitable and sufficient current Fire Risk Assessment and for a safe means of escape for all relevant persons to be maintained.

- 100% of the 169 **Acute** Hospital areas have been subject to risk assessments in the past 12 months.

- 100% of **Community sites** have been subject to risk assessments in the past 12 months.

Templates have been updated to include the consideration of Dangerous Substances in line with the recommendations of the 2018 Hackett Report.

e) Operational Maintenance:

The outcomes of the planned preventative maintenance of fire related equipment is increasing in nature as systems expand and national guidance is changed. Therefore the additional operational maintenance issues will require additional revenue funding year on year e.g. fire dampers and fire extinguisher technician training. Notwithstanding that no additional revenue funding was received, we did carry out fire damper inspection and testing within EDGH Phase 2 in March 2018. EDGH Phase 1 cannot be resolved until the asbestos is removed.

East Sussex Healthcare NHS Trust

Guardian of Safe Working Hours Annual Report

Meeting information:	
Date of Meeting: 1 October 2019	Agenda Item: 14.6
Meeting: Trust Board	Reporting Officer: Dr N Muhi-Iddin and Mr W Yousef

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

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

Summary:

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

- All junior doctors in training have transitioned to the New 2016 Contract TCS. 241 new trainees joined the Trust in August 2019.
- Areas showing vulnerability to exception reporting in 2018/19 include:
    - Gastroenterology, Geriatrics and Stroke at EDGH
    - Geriatrics and Cardiology at the Conquest
- Some areas that showed vulnerability in 2017/18 have improved, including ENT at EDGH and Endocrinology cross site.
- Overall, Medicine as a Division generates the most exception reports.
- Doctors in training have not agreed on how to spend the Guardian Fines available. The Guardian team are increasing the awareness of this issue amongst trainees and inviting more trainee representatives to the Junior Doctor Forums to encourage agreement on expenditure of £14,756.37.
- The rotas generating the most exception reports are night rotas followed by the general medical rotas.
- The main risks identified are long term gaps due to unfilled posts, mismatched rotas due to leave allocation and unpredictable gaps due to sickness.

Future plans:

- We will look to develop a robust system of Divisional rota administration within all specialities to ensure rota gaps are addressed and filled in a timely manner. This will ensure that safeguards are in place to reduce risks relating to unpredictable staff sickness. This administration system should have the appropriate protocols, designated responsibility and dedicated clinical input.
- Ongoing support to the Doctors in Training (DiT) and the Guardian team to ensure understanding among all staff to implement the Rules of the 2016 Contract.
- Ongoing support to clinical supervisors by Trust Education department and the Heads of Divisions and specialities to enable clinical supervisors to implement their responsibilities towards their trainees.
- To ensure that all educational and Clinical Supervisors continue to encourage DiT to comply with their work schedules and to respond swiftly and constructively with a supportive manner to all exception reports.

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

- People and Organisational Development Committee

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

The Board is asked to note the Guardian of Safe Working Hours Annual Report, and future plans.

Guardian of Safe Working Hours – Annual Report 2018/19

Purpose

- The purpose of this report is to provide an update to the Trust Board by the Guardians of Safe Working Hours (GOSWH), on compliance of junior doctors working hours with their work schedule

Background

- The 2016 Junior Doctors Contract came into effect on 3rd August 2016. Implementation guidance was published by NHS Employers. The total number of trainees across site that can exception report is 241.

Exception Reporting

- Trainees can exception report for a breach of working hours or for educational reasons. Training and information on exception reporting has been provided to trainees and they are given the opportunity to meet and discuss areas of concern with Medical Staffing, the GOSWH and the Director Medical Education.

- The remit of this report is to focus on Exception Reporting associated with safe working hours although there is some mention of educational related Exception Reports.

Exception Reporting Working Hours

- Trainees can submit exception reports for breaches in their contracted working hours as a result of longer hours worked, work intensity, missed breaks and unsafe work load. The exception report is reviewed by their clinical supervisor who can approve a compensatory time off in lieu (TOIL) or authorise payment for the additional hours worked. There is a requirement for the clinical supervisor to discuss or comment on the factors leading to the exception report event and a safe working flow chart pathway to follow if the additional work is part of a pattern

MONTHLY ANALYSIS OF EXCEPTION REPORTING

Month	Total Number of Posts (DiT)	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Month 01.08.18 - 06.08.19	Previous Year 02.08.17 - 31.07.18	No of ER's processed previous year 01.08.17 - 31.07.18	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees	Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay	Total Hours Paid Overall	Overall Cost of ER
Aug-18	240	17	32	Aug-17	100	43.75	**1077.14**	1.00	**37.05**	44.75	1114.19
Sep-18	240	10	24	Sep-17	74	41.50	**1036.93**	0.00	**0.00**	41.50	1036.93
Oct-18	240	4	7	Oct-17	67	13.00	**309.79**	0.00	**0.00**	13.00	309.79
Nov-18	240	6	14	Nov-17	45	28.50	**770.66**	0.00	**0.00**	28.50	770.66
Dec-18	240	8	11	Dec-17	27	15.00	**389.41**	1.50	56.69	16.50	446.10
Jan-19	241	10	24	Jan-18	22	21.25	**535.29**	3.00	**97.92**	24.25	633.21
Feb-19	241	8	15	Feb-18	20	22.25	**587.32**	0.75	**24.48**	0.00	611.80
Mar-19	241	6	9	Mar-18	14	10.50	**275.36**	3.50	**119.39**	14.00	394.75
Apr-19	241	4	8	Apr-18	47	10.00	**253.34**	1.00	**37.79**	11.00	291.13
May-19	241	7	6	May-18	28	15.50	**393.81**	2.00	**75.58**	17.50	469.39
Jun-19	241	6	13	Jun-18	17	14.25	**339.58**	4.00	**166.80**	18.25	506.38
Jul-19	241	3	7	Jul-18	13	7.00	**184.43**	0.00	**0.00**	7.00	184.43
Aug-19	241	6	7			8.50	**278.15**	0.00	**0.00**	0.00	278.15
										Total	**7046.91**

3.2 Working pattern reviews

- We have circa 25 Less Than Full Time Trainees (LTFT) and continue on a rotational basis (3 yearly) to undertake a bespoke work pattern unique to each trainee, to determine their flexible hours, pay and compliance in each specialty, in accordance with the BMA Good rostering Guide.

- During the year we continued to review all work patterns, principally based on comments made by the Junior doctors, trends identified from exception reports and any issues raised at the local Faculty Meetings. The Junior Doctors Forum includes a GOSWH agenda item.

- Below are some examples of issues that have been identified during the year, and the actions that have been taken to address them:

Eastbourne General, General Medicine FY1
The introduction of a second FY1 doctor on the night shift, with additional weekend twilight cover to support weekend working was welcomed by junior doctors. However, whilst night-time cover has been increased this has led to reduced daytime cover; increasing exception reports are being seen as a result, and this issue is being reviewed.

Conquest Paediatrics FY2, ST1 and Higher Trainees
Trainees frequently stayed late after morning handover; on both rota patterns the handover period was extended by 30 minutes allowing doctors to be paid for the additional time and providing excellent teaching opportunities.

Conquest General Surgery/Palliative Care, FY1
Dr Barclay has agreed to provide palliative supervision for this role, and working patterns have been changed to incorporate this. This affects 3 FY1s and rescheduled the days at St Wilfrid's Hospice whilst continuing to support the SAU at Conquest and maintaining their training.

Eastbourne General Medicine Higher Trainees
At the request of an Educational Fellow, the Tuesday and Wednesday long days were switched to different weeks to better meet work-life balance.

Eastbourne ENT F2
Following feedback from ENT FY2s, it was agreed they would attend the "Introduction to ENT Course at Brighton" and would not join the Hospital at Night for four weeks after joining the Trust. The four week ENT training will occur every four months at the beginning of each rotation and will lead to additional vacancies on rotas for these periods.

3.2.1 Guardian Fines

Guardian Fines

Period	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Period	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees	Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay	Total Hours Paid Overall	Overall Cost of Guardian Fines
07.12.16 - 30.04.17	76	379	254.25	**7369.78**	1	**43.46**	255.25	**7413.24**
01.05.17 - 31.07.17	28	153	279.55	**8089.73**	0	**0.00**	279.55	**8089.73**
01.08.17 - 31.10.17	50	241	74.15	**2372.69**	2	**78.86**	76.15	**2451.55**
01.11.17 - 05.12.17	20	50	1.00	**27.69**	0	**0.00**	1.00	**27.69**
06.12.17 - 31.03.18	26	83	0.00	**0.00**	2.3	**65.86**	2.30	**151.48**
01.04.18 - 31.07.18	17	105	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.08.18 - 30.11.18	24	82	12.00	**338.88**	0	**0.00**	12.00	**338.88**
01.12.18 - 31.03.19	22	57	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.04.19 - 31.07.19	16	45	0.00	**0.00**	0	**0.00**	0.00	**0.00**
				18198.77		188.18	TOTAL	**18472.57**

Guardian Fines total after penalty fine applications paid as of 12.08.19 £14,756.37

3.3 Exception Reporting Education Provision

- The trust received 10 education exception reports during the period 01.08.18 – 06.08.19. This is a reduction on the number of reports received in the previous year.
- Over all it is felt that exception reports submitted for missed Educational opportunities are underrepresented.
- It is recognised that when Trainees have an increased workload and miss breaks that they are also likely to miss scheduled educational sessions. Exception reports for education provision are dealt with by the Director of Medical Education as failure to deliver the Trust's contractual educational commitments could result in trainees being withdrawn from by the Deanery.
- The Guardians have attended or submitted reports with recommendations to all the Local Educational Board meetings within this period.

Action taken to address issues

- The Guardians addressed the comments of some of the trainees and trainers about difficulty in using the exception reporting system by producing illustrative videos for trainees and trainers published on the website.
- The Guardians communicate with juniors doctors when potential recurring themes have been identified in order to find out additional information and to relay concerns to seniors.
- The Guardians liaise with trainers and trainees in LFGs and LAB meetings to explain the importance of compliance with safe working hours and listening to trainees' concerns to escalate when necessary.
- The GOSWH Administrator emails all trainees at the start of their rotation advising them that the Trust encourages exception reporting and attaching guidance notes on how to submit an exception report.
- The Guardian team send reminders to supervisors to authorise exception reports. When the allowed time frame is breached (one week for payment) the Guardians authorise payment.

3.4 Conclusion/Summary

- There has been an overall reduction of the number of exceptions. The Guardians are pleased with the increased engagement of the Educational and Clinical supervisors. They are supported by the Medical Director and management team.
- Despite large numbers of exception reports that are authorised later than the one week guideline, the Guardian teams ensure that juniors are compensated on a timely manner.
- The reduction of fines reflects the work done to ensure that work schedule accommodates the exceptional extra few hours that juniors have to do above their schedule with less likelihood of breaching the maximum 48 hours per week.
- Service Managers and administrators should make more effort to cover rota gaps as issues relating to these constitute more than 40% of exception reports.
- All work patterns have been reviewed and are compliant. These are discussed at the Trust Oversight Group for Junior Doctor Rotations and the Working Hours meeting, chaired by the GOSWH.
- Dr Ratan Alexander was appointed as SuppoRTT and LTFT Champion for the Trust trainees on 1st April 2019;
- More Clinical/Educational Supervisors are now responding to ERs within 7 working days to exception reports.
- The Guardian team supported doctors in training rest facilities and the Trust Rest Facilities Policy to be re-circulated to doctors in training.
- The Guardian team acted on trainee feedback with increased attendance to Inductions, Grand Round events and a local faculty group meeting for all specialities which ensured more face to face contact with trainees.
- The Trust has agreed the principles of the BMA Fatigue and Facilities Charter. This is a standard agenda item on the Junior doctor forum meetings. Issues are discussed and problems addressed with the relevant departments regarding rest facilities and catering. Current negotiations are underway to improve the common room (Mess) facilities at Eastbourne.

Quality Walks July - August 2019

Meeting information:			
Date of Meeting:	1st October 2019	Agenda Item:	15
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:

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

33 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st July and 31st August 2019. In addition to the formal programme the Chief Executive has also visited 28 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 July and 31st August 2019.

Date	Service/Ward/Department	Site	Visit by
July			
2.7.19	Frailty Unit	Eastbourne DGH	Jackie Churchward-Cardiff
3.7.19	Maternity Bereavement Team	Conquest Hospital	Adrian Bull
5.7.19	Rye Memorial Hospital	Rye	Adrian Bull
5.7.19	iMSK Administration Team	Conquest Hospital	Adrian Bull
8.7.19	Occupational Therapy Department	Eastbourne DGH	Karen Manson
9.7.19	Critical Care	Eastbourne DGH	Steve Phoenix
9.7.19	Car Parking Team	Eastbourne DGH	Vikki Carruth
11.7.19	Patient Safety, Governance & Complaints Teams	Conquest Hospital	Steve Phoenix
12.7.19	Acute Admissions Unit and Ambulatory Care Unit	Conquest Hospital	Adrian Bull
12.7.19	Bereavement Team	Eastbourne DGH	Adrian Bull
16.7.19	Switchboard	Eastbourne DGH	Monica Green
16.7.19	First Steps Nursery	Conquest Hospital	Lynette Wells
16.7.19	Pathology Department	Conquest Hospital	Miranda Kavanagh
17.7.19	Cardiology & Endoscopy Booking Teams	Conquest Hospital	David Walker
17.7.19	Integrated Night Service	Bexhill Hospital	Lynette Wells
17.7.19	Safeguarding Team	Hailsham Health Centre	Miranda Kavanagh
18.7.19	Site Team	Conquest Hospital	Karen Manson
19.7.19	Clinical Admin Staff	Eastbourne DGH	Adrian Bull
22.7.19	Hastings Community Nurses	Station Plaza	Adrian Bull
22.7.19	HSDU	Conquest Hospital	Adrian Bull
22.7.19	Egerton - discharge lounge	Conquest Hospital	Karen Manson
23.7.19	Cookson Attenborough Ward	Conquest Hospital	Karen Manson
25.7.19	Adult and Paediatric Audiology	Eastbourne Park Primary Care Centre	Jackie Churchward-Cardiff
25.7.19	Bereavement Team	Eastbourne DGH	Lynette Wells
23.7.19	Judy Beard Unit	Conquest Hospital	Adrian Bull
26.7.19	Housekeeping Teams	Eastbourne DGH	Adrian Bull
29.7.19	Hospital Intervention Team	Conquest Hospital	Karen Manson
30.7.19	Dowling Unit	Bexhill Hospital	Karen Manson
30.7.19	Retinal screening Service	Bexhill Hospital	Karen Manson
30.7.19	Looked After Children Team	Centenary House, Eastbourne	Jonathan Reid
30.7.19	Hospital Intervention Team	Eastbourne DGH	Vikki Carruth
August			
5.8.19	Health & Safety Team	Eastbourne DGH	Adrian Bull

5.8.19	Theatres, Outpatients and Community Dental Service	Uckfield Hospital	Adrian Bull
5.8.19	Irvine Unit	Bexhill Hospital	Monica Green
6.8.19	Theatres and PACU	Conquest	Jackie Churchward-Cardiff
7.8.19	Theatres	Conquest	Adrian Bull
8.8.19	Facilities Department	Conquest	Steve Phoenix
8.8.19	Audiology	Eastbourne Park	Adrian Bull
9.8.19	Health records	Hailsham and Eastbourne	Adrian Bull
13.8.19	Theatres	Eastbourne	Adrian Bull
13.8.19	Pool Car Team	Eastbourne	Adrian Bull
13.8.19	Jubilee Eye Suite	Eastbourne	Vikki Carruth
14.8.19	Health Visitors	Hailsham and Seaford	Karen Manson
15.8.19	Matron's meeting	Eastbourne	Adrian Bull
15.8.19	Site Team	Eastbourne	Adrian Bull
16.8.19	Bereavement Office	Conquest	Adrian Bull
16.8.19	Junior Doctors Forum	Conquest	Adrian Bull
20.8.19	Pevensey Ward	Eastbourne	Steve Phoenix
22.8.19	Infection Prevention Control Team	Eastbourne	Adrian Bull
27.8.19	Dietetics	Conquest	David Walker
27.8.19	Littlegate supported employment Team	Conquest	Adrian Bull
28.8.19	Car Parking Team	Eastbourne	Adrian Bull
29.8.19	Car Parking	Conquest	Adrian Bull
29.8.19	Bereavement Team	Conquest	Nicola Webber
29.8.19	Outpatients Department	Conquest	Jonathan Reid
29.8.19	Sleep Studies Unit	Conquest	Lynette Wells
30.9.19	Friston Short Stay Paediatric Unit	EDGH	Adrian Bull

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Friday 24th May 2019 at 0900 in the St Mary's Boardroom, EDGH

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

In attendance: Ms Vikki Carruth, Director of Nursing
Mr Jonathan Reid, Director of Finance
Mrs Lynette Wells, Director of Corporate Affairs
Mr Andy Conlan, Engagement Manager, Grant Thornton
Mr Chris Lovegrove, Counterfraud Manager, TiAA
Ms Saba Sadiq, Deputy Director of Finance
Mr Mike Townsend, Regional Managing Director, TiAA
Mr Darren Wells, Engagement Lead, Grant Thornton
Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

035/19 Welcome and Apologies for Absence

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

Dr Adrian Bull, Chief Executive
Dr David Walker, Medical Director
Mr Adrian Mills, Audit Manager, TIAA
Mrs Emma Moore, Clinical Effectiveness Lead

036/19 Minutes of the meeting held on 28th March 2019

The minutes of the meeting held on 28th March 2019 were reviewed. One minor error was corrected, but they were otherwise agreed as an accurate record.

037/19 Quality Account 2018/19 Update

Mrs Carruth presented an update on progress in completing the Quality Account 2018/19, reporting that timelines for completion were being met. The Quality and Safety Committee would approve the Quality Account on behalf of the Board before it was submitted to regulators.

Mrs Webber asked whether Mrs Carruth had any concerns about the findings contained within the Quality Account. Mrs Carruth reported that the report concerning Venous thromboembolism (VTE) contained no surprises. Auditors had raised concerns that the pathology and infection control teams were reporting different numbers of clostridium difficile (c.diff) infections within the organisation. She would discuss the matter with the infection control and business intelligence teams to fully understand and resolve the issue.

Mrs Carruth explained that auditors had raised further concerns about the consistency of timescales for c.diff that were being reported by the Trust,

and explained that she would discuss the matter with Dr Walker. Mr Townsend noted that the internal audit report was still in draft form, explaining that he would include any updates from Mrs Carruth in the final report. .

Mrs Webber noted that auditors had commented that, following the publication of updated national guidance for the reporting of VTE, the Trust's local policy had not been updated. She asked whether a process that would pick up such issues would be developed. Mrs Carruth explained that the Trust had followed the updated guidance when it had been issued, but that the local policy had not yet been updated but that this would be addressed. Mr Reid added that the Trust retains a central database of policies and reminders are issued when the policy is due to be reviewed.

Mr Conlan explained that the external audit report would be updated prior to the Quality Account being finalised and did not anticipate that it would highlight any significant issues.

Annual Accounts and Report 2018/19

038/19 ISA260 Grant Thornton Annual Governance Report on the Annual Accounts 2018/19

i) Mr Wells presented Grant Thornton's audit findings, explaining that the draft statements that had been presented by the Trust for audit had been of a very high quality. Auditors had identified no errors that would alter the deficit position being reported. A final audit opinion would be offered when the audit files had been closed.

Mr Wells thanked the Trust's finance teams for the cooperation with auditors, and Mrs Webber reiterated this thanks on behalf of the Audit Committee.

Mr Conlan reported that the items noted within the report as being outstanding had almost all be finalised. He explained that auditors were very close to being able to sign off the Trust's accounts prior to the submission deadline on 28th May.

Mrs Webber queried whether the Trust's performance materiality was correctly reported in the Auditor's report. Mr Conlan reviewed this and confirmed that the report was incorrect and should read that performance materiality had decreased, not increased.

Mr Conlan explained that significant risks set out within the auditor's report had been tested and no further issues had been identified. The report had been centrally reviewed by Grant Thornton, to ensure consistency with other organisations, and some minor issues had been identified to the Trust.

Ms Sadiq presented an updated going concern statement, amended following the feedback from Grant Thornton. She explained that the Trust had already been aware of the issues identified. Mr Conlan noted that auditors had confirmed that the Trust was correctly applying accounting policies.

Mr Nealon asked for an update on the past transfer of properties from the Trust to NHS Property, noting that there had been concern that the Trust was being paying very high rent on these properties. Mr Reid explained that discussions were being held with NHS Property about rent charges. He explained that Finance Directors from across the STP were setting up a review of property services across region.

Mrs Webber asked about the increased property values that were being reported and Mr Reid explained that these had been set by the district valuer for the last two years and that both the Trust and auditors were comfortable with the values being reported.

Mr Conlan explained that the annual report and annual governance statement had been reviewed to ensure consistency and compliance with accounting standards. He reported that auditors expected to issue qualified opinions for VTE and c.diff data within the Quality Account and Mrs Wells agreed to update the annual governance statement to reflect this.

Mr Conlan reported that the Trust's value for money opinion had been issued based on whether the Trust offered value for money. He explained that the Trust's financial deficit position had resulted in a significant risk concerning financial sustainability being identified, and therefore an adverse conclusion had been offered. The auditor's report highlighted the significant improvement that the Trust had made.

Mr Nealon asked whether it was correct to report that the Trust needed to make £75.3m of efficiency savings, given that additional funding would be received if the Trust met its financial targets. Mr Reid explained that the Trust Board had approved a five year model setting out the financial targets that the organisation needed to deliver, explaining that the wording in the annual report reflected the savings from an accounting perspective.

Mr Conlan explained that one issue with a stock count had been identified during the audit work with a recommendation issued to the Trust as a result. A brand of drugs had changed names during the year and as a result had not been counted. He explained that this was an understandable human error, but noted that a similar issue had been identified the previous year. Mrs Webber asked what action was being taken to address the recurring issue and Mr Reid explained that the issue would be reviewed following the end of the financial year.

Mr Conlan reported that auditors were assured that all of their recommendations following the previous year's audit had been addressed by the Trust. Mrs Webber noted a recurring issue with ensuring that both IT and HR were informed in a timely manner when staff left and joined the Trust and asked Mr Reid to address the matter in the future.

Mr Conlan reported that minor audit adjustments included within the report had been addressed by the Trust to the auditor's satisfaction. He noted that the Trust showed differences in accounts above £300k with CCGs, but that auditors were happy that the difference did not represent a material misstatement in the accounts. Mrs Webber asked why this difference existed and Mr Reid explained that the two CCGs operated under joint management, and the differences in reported figures between the Trust

and the two CCGs netted off against each other. Mr Conlan noted that the differences were much smaller than those reported in the previous year, explaining that it was common to see this type of accounting difference at year end. In response to a question from Mr Nealon, Mr Reid explained that the reporting differences had no impact on the Trust's accounts with income and expenditure appropriately reported despite differing from the CCGs' accounts.

Mrs Webber thanked external auditors for their hard work.

ii) **The Committee approved the Annual Accounts 2018/19**

Annual Report including Annual Governance Statement
Mrs Wells reported that the Annual Report had been audited and reflected statutory requirements. She noted that it included the Annual Governance Statement, which would be updated to reflect the auditor's opinion. She thanked Jenna Khalfan and Mr Palmer for their work in producing the Annual Report, and explained that it would be shared with NHSI on 28th May prior to being formally received by the Board at the Trust's AGM in August.

Mrs Webber explained that she felt that the going concern statement within the Annual Report should be amended to make it clearer and the Committee agreed to her proposed changes.

Mrs Webber queried the disparity between the disclosure of Board salaries in bands, while the Medical Director's salary was stated in full due to his additional consultant salary. Ms Sadiq confirmed that the Medical Director had seen the salary disclosure and had approved it.

iii) Annual Accounts 2018/19
Mr Reid explained that the accounts had been reviewed by the Finance and Investment (F&I) Committee on a monthly basis in great detail as well as in other forums in the organisation. Major variances were highlighted at the start of the accounts.

Mrs Webber asked why an increase in interest was being reported and Ms Sadiq explained that while the Trust was paying lower rates of interest on some loans, it was paying 6% on others. The increased interest rate was a result of increased borrowing and changing interest rates. Mr Reid added that the Trust was reviewing its loan portfolio with the Department of Health and hoped to agree a consistent interest rate.

Mrs Webber asked what the Trust had disposed of for £100k and Mr Reid explained that this was from the sale of decommissioned scanning equipment.

Mrs Webber asked for further detail about the cash losses and ex gratia payments detailed in the accounts and Mr Reid explained that examples of these would be payments for lost patient belongings. He explained that drug write-offs were also included in this figure, noting that as the Trust's drug inventory had increased, write offs had also increased. A report would be presented to the Audit Committee in the future on actions being taken to address this issue.

Mrs Webber asked why non-NHS payables were lower than NHS payables and Ms Sadiq noted that the same issue had been raised at the F&I Committee and a report on the issue would be presented there.

Mr Nealon asked why borrowing had increased to £59m. Mr Reid explained that a large element of this would be as a result of the Trust's monthly deficit, as the Trust drew a working capital loan from the Department of Health each month. Some of the borrowings were paid back during the year and the figure reflected the value of the Trust's portfolio.

The Committee approved the Annual Accounts 2018/19

iv) Letter of Representation 2018/19

Mr Reid presented the letter of representation, explaining that it would be signed by the Chief Executive and himself following the Audit Committee.

Mrs Webber asked whether any deficiencies had been declared and Mr Reid explained that a number had been declared by the Trust. Mr Conlan confirmed that no issues had been identified during the audit that had not already been identified by the Trust.

The Committee noted the Letter of Representation.

v) Internal Audit Annual Report and Head of Internal Audit Opinion for 2018/19

Mr Townsend explained that the Audit Committee had received regular reports on the work of Internal Audit throughout the year, and that this work was summarised in their Annual Report. 83% of planned draft reports had been sent out by year end, with a number having been delayed. Mr Reid explained that the Trust had been slow to sign off a number of reports due to requiring additional assurance.

14 audits had been carried out during the 2018/19 and an overall opinion of reasonable assurance was offered for the year.

Mr Townsend reported that audits of the Board Assurance Framework and of Risk Management were at the final reporting stage, noting that audits that had offered limited assurance during the year had been summarised in the report.

039/19 Audit Committee Annual Report

Mrs Wells presented the Audit Committee Annual Report, noting that quoracy was a potential issue for the Committee. She reported that the Trust intended to recruit two Associate Non-Executive Directors, one of whom would join the Committee. Mrs Wells explained that the Annual Report would be presented to the Board in August.

040/19 Date of Next Meeting

The next meeting of the Audit Committee would be held on:
Thursday 1st August 2019, 1300-1500, St Mary's Boardroom, EDGH

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee

Thursday 25 July 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)
Ms Karen Manson, Non-Executive Director (KM)
Dr David Walker, Medical Director (DW)
Mr Jonathan Reid, Finance Director (JR)
Mrs Brenda Lynes O'Meara, Associate Director of Operations (BLO)
Ms Penny Wright, Head of Workforce Planning (PW)
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)
Mrs Hazel Tonge, Deputy Director of Nursing (HT)
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)
Mrs Jeanette Williams, Staff Engagement & Wellbeing Manager (JW)
Ms Jo Gahan, Head of Operational HR (JG)

In Attendance:

Ms Clare Hammond, HR Manager (CH)
Ms Isi Ojobo, Graduate Trainee (IO)
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: Mrs Vikki Carruth, Director of Nursing (VC) Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ) Mrs Kim Novis, Equality & Human Rights Lead (KN) Mrs Lesley Houston, Deputy GM – Medicine (LH) Ms Emma Chambers, Interim Assistant Director of Nursing (EC) Mr Salim Shubber, Director of Medical Education (SS) Mrs Jan Humber, Staff Side Chair (JH) Mrs Michelle Elphick, Associate Director of Operations (ME)	

2	**Minutes and Matters Arising** **2.1 Minutes of the previous meeting held on 23 May 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: Nursing Report Update provided. Trust Engagement Strategy with medical staff Update provided. Schwartz Rounds Information circulated. Accountability Framework The Accountability Framework document was discussed at the Trust Board and an agreed action plan had been devised. **Action: LW to provide an update on Accountability Framework Action Plan at the November 2019 / January 2020 POD meeting.**	**LW**
3	**Interim NHS People Plan** MG provided an overview of the Interim NHS People Plan, which described the national infrastructure established around it, future plans for its roll out and implications for the Trust. The full report would be shared at a future POD meeting once it is published. The plan has a number of themes: • Making the NHS the Best Place to Work • Improving our Leadership Culture • Addressing urgent Workforce Shortages • Delivering 21st Century Care • A new Operating Model for Workforce 7 national workstreams have been set up to further develop these themes: • Making the NHS the best place to work • Improving the leadership culture • Tackling urgent nursing workforce challenges • Releasing time for care • Workforce Re-design; optimising skills • Securing current and future supply • Analysis, insight and affordability MG reported that HR Directors had been asked to link into the 7 national workstreams and workforce sub-groups had been set up for each one. KM stated that once the final plan had been received it would be helpful to see a comparison of priorities for the Trust alongside national priorities. MG agreed to this but stated that there were likely to be very similar.	

	MK asked how the NHS would engage where the Trusts would be aligned. MG replied that this would be monitored through NHSI, through the regional Workforce Director for each area. MG also reported that there had been communication regarding a capability and capacity review of HR; being more supportive in what extra training and/or capacity would be required in HR functions to deliver this. MK asked whether the plan catered for all staff groups. MG confirmed that all workstreams had been set up and represented all staff groups whereby specific needs would be identified. TL stated that some new roles created for nurses had been to cover gaps in medical staffing and highlighted the need to look at service planning and workforce planning together.	
4	**Learning lessons to improve our people practices** JG provided an overview of the learning lessons to improve our people practices guidance. The report provided a summary of the HR improvement work in relation to disciplinary investigations and how these linked in with the national guidance. JG referred to an investigation and disciplinary procedure at a London Trust and gave a brief summary of the findings and learning of this case. Recommendations for HR: • Adhering to best practice • Applying a rigorous decision making methodology • Ensuring people are fully trained and competent to carry out their role • Assigning sufficient resources • Decisions relating to the implementation of suspensions/exclusions • Safeguarding people's health and wellbeing • Board level oversight JG highlighted the challenge of reducing the disproportionate numbers of BME staff as against white staff who had been taken through the process. Data had been gathered to inform the WRES which identified that numbers were quite high in terms of disproportionate value; across the whole NHS and locally. Work was currently underway to drill down on the data to understand what the Trust had contributed and comparisons with other Trusts. JG stated that standards would be looked at from the "Fair Experience for All" document re reducing the gap. JG stated that it would be beneficial for the Trust to look at a pre-formal action check undertaken by an Executive member of staff to provide authority for a formal process to take place. AB asked if it would be the Executive in the relevant area in which the issue had been raised or would it be a named Executive. MG suggested that in terms of consistency it would need to be one person. AB queried the amount of cases in a week; JG replied approximately 2 to 3 cases weekly. AB stated that this recommendation should be discussed at the Executive Team. **Action: Executive Director to undertake pre-formal action checks for staff disciplinary investigations. To be discussed at Executive Director meeting.**	**AB**

	KM queried the number of low level informal cases. JG replied that informal cases were not recorded but that HR were in discussion about a data system that could record informal cases. JG also highlighted that HR provided training and support for managers dealing with conflict within their areas but were not always involved. MK and DW agreed that informal documents/emails to the person concerned would support the informal resolution. MK referred to the concern regarding more formal cases for BME members of staff. JG confirmed that HR adhere to the policy around supporting staff involved in complaints and concerns; audit undertaken in which 90% of cases were being supported by the policy. MG referred to the fairness of the process and supporting staff going through the process; the Trust need to look at disability and race data to identify any disproportionate actions. KM asked how frequently this data would be shared at the POD Committee. JG replied that the data had been shared 6 monthly but WRES data had not been incorporated. **Action: WRES data to be shared quarterly with the POD Committee**	**JG**
5	**Health & Wellbeing Strategy – update on progress and delivery** JW provided an overview of the Health & Wellbeing Strategy. The strategy sets out 7 key priorities, which fit in well with the Interim NHS People Plan. Also a lot of indicators and metrics that are measured; staff FFT and staff survey. The recent staff survey drill down data indicated between 80-100% of staff at team level believed that the Trust took positive action on their health and wellbeing. JW summarised the Wellbeing Programmes for physical wellbeing and mental wellbeing, emotional and psychological support and highlighted the following areas in which staff felt would actively support their wellbeing at work: • Protected Time • Team level support • Physical environment • Community sites • Communications • Protected break times • Administrative support • Facilities for rest and break • Uniform • Take a break campaign Next Steps: • Develop Best Place to work website • Proactively use workforce data to identify the wellbeing needs of staff and prioritise initiatives to reduce turnover by 1% • Promote the “What matters to you fund! • Contribute to the reduction of sickness and absence • Support the implementation of the SAS Charter • Build on approach of maternity and cardiology in supporting staff to have protected time • Review the workforce data to ensure programmes are fully aligned to specific staff groups as required.	

	AB commended the team on their work. AB referred to the stress audit undertaken on urgent care and stated that stress audits were a really important part of health and wellbeing and should be included in the interventions within the report. AB referred to protected time and stated that the Trust needs to describe its health and wellbeing proposition to members of staff offering a range of optional topics/activities for both administration and clinical environments. A further challenge would be reminding staff to stop and think about their own health and wellbeing. DU suggested building these opportunities into any regular meetings held by departments. PS also highlighted some good practices undertaken particularly in the private sector and queried how some of these could be transferred to a clinical environment. KM suggested that the Executives need to model the behaviour. JW agreed that it would be important for the Executives to promote protected time to all staff. TL referred to flexible working and stated that a lot of the wards had different working patterns that HR would not be aware of and that a lot of opportunities were already in place.	
6	**Workforce Race Equality Standard (WRES)** LM provided a verbal overview of the WRES paper, which contains nine metrics that can be used to help NHS organisations identify and address race inequality. ESHT highlights: • Active BMA Network led by the CEO, which had been successful in raising awareness about the opportunities available for the BME community • Raising awareness re career development conversations and supporting staff with interview preparation • Regional leadership programmes specifically for the BME community • Number of speakers Areas of further work: • Declaration of ethnicity • Focusing on career progression programme • Holding a number of listening conversations aimed at understanding the experiences of BME staff • ESHT is part of the regional BME Network where good practice is shared • Introduced a Workforce Equality Group to support the BME Network It was noted that there was some incorrect data on the table relating to BME and white staff in each clinical and non-clinical pay band. LW agreed that there was a big issue with the data, which was thought to be a glitch in the TRAC system. PW agreed to resolve this situation. **Action: PW to resolve incorrect WRES data issue**	**PW**

	LW asked if there was a way to highlight the benefits of declaring their personal data. CH replied that this was being worked on as part of the staff disability network. The network had identified disparity in declaration from ESR and the staff survey. Ongoing work taking place on how to promote declaring disabilities and what positive benefits it would give the staff member as part of the Trust. IS asked if this was a project or were conversations taking place with staff members. LM confirmed that it was still in the planning stage and in terms of objectives key metrics would be measured and tracked. KM highlighted that the data was written in percentages which she found very unhelpful when interpreting the data and would prefer actual numbers. PW agreed to add numbers in future reports. **Action: PW to provide percentages as well as numbers in future reports.**	**PW**
7	**Workforce Safeguarding** PW provided an update of the Developing Workforce Safeguards (DWS) paper and the current position and proposed next steps to embed DWS into ESHT current mode of operation. DWS requires all Trusts to have safe, sustainable staffing at all times. PW referred to page 6 diagram, a list of expectations and key outcomes, how these would be measured and improved. Next steps: • to develop a detailed action plan where services and professions lack a nationally recognised tool to determine safe staffing requirements • To assure DWS is applied appropriately within a matrix organisation that covers aspects for both division and staff groups • Incorporate escalation procedures where appropriate in conjunction with professional and divisional leads • Incorporate recommendation and directives provided by regulatory bodies • Consider the benefits of engaging and working with the STP for future workforce solutions to incorporate regional and national risks with mitigations. TL stated that the key message would be how we decide what staff we need. In the past there had only been a clear methodology for inpatient nursing. This year, for the first time, work was underway on how the Trust demonstrates for other areas, how this had been done, what outcomes had been looked at and the pressures. It had also been really useful for workforce and business planning processes to be combined. MG reported that the workforce team were linking with the strategy team and divisions. Activity that the divisions would be required to be delivered was being looked at and then the workforce required. Business cases would be written with a menu of opportunities. JCB suggested that workforce and business planning should be discussed at the divisions Integrated Performance Review meetings.	

8	**People & Organisational Development (POD) Committee Annual Review** LW provided an overview of the POD annual review; questions had been circulated to the POD Committee members, responses collated and summarised. Feedback from the questions: • Decision Log to be developed • Feedback from the board • Input from divisions A discussion, with mixed views, took place regarding representatives from the divisions attending the POD Committee. Representatives of nursing and the medical workforce were already on the membership. JCB confirmed that the role of committee was for assurance. MK agreed but stated that it was also about culture, engagement and including people. A further discussion took place ensuring that staff actually contribute/benefit from attending meetings LW suggested inviting a division 6 months/year to present their area and culture. TL referred to the development of the STP groups and the new People plan and stated that things could change and new meetings established. MG reported that originally a communication had been sent out to all staff to brief them about the POD committee and anyone interested would be welcome to join; this ensured a number of staff representatives on the membership.	
9	**Terms of Reference** The Terms of Reference were agreed by the POD Committee.	
10	**Report from Health & Safety Steering Group and feedback from HSE visit** HT provided a verbal overview of the recent Health & Safety Executive inspection. Key Achievements: • HSE Team had been impressed by the dedication and enthusiasm of colleagues in the Trust • The Manual Handling Team and the management of manual handling in the Trust were praised in the approach ESHT adopted • Management of Violence and aggression; happy with the content and delivery of conflict resolution training and those in frailty found the additional dementia training very beneficial Key issues, risks and implications: • Manual Handling – the inspectors identified that in the community and theatres there were specific procurement issues which had not been resolved • Violence and aggression – The inspectors felt that the Trust did not have a full picture of the nature and extent of the issue and there was a lack of a clear strategic approach • It was announced that the Trust would be subject to a material breach which would be confirmed in writing anticipated to be by the end of July.	

	HT reported that a robust action plan was being developed. MK asked whether the material breach would become public knowledge. LW confirmed that the material breach would be made public. LW stated that the Trust need to be more aware of what HSE are looking for in future visits. Health and Safety Steering Group Item noted.	
11 **11.1** **11.2**	**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.	
12	**Any other business** There was no other business.	
13	**The next meeting of the Committee will take place on:** **Thursday 12 September 2019** **14:30 – 16:30** **St Mary's Boardroom, EDGH vc Room 3, Education Centre, Conquest**	

Dates of 2019 Meetings:

Date	Time	Venue	Call for Papers Date	Submission Deadline
Thursday 21st November	**10:00 – 12:00**	**St Mary's Boardroom EDGH vc Room 1, Ed Centre, Conquest**	**25.10.19**	**08.11.19**

East Sussex Healthcare NHS Trust

Overarching Health and Safety Annual Report

2018 - 2019

Health and Safety Annual Report 2018 – 2019

Executive Summary

The aim of the programme of work that was delivered by the specialties (Health & Safety, Medical Devices, and Moving & Handling) within Health and Safety was to ensure that the Trust was compliant with Health & Safety legislation. These three core functions contribute to the overall management of health and safety within the organisation.

The key achievements for 2018/2019 were:

- The implementation of the Assure online Health and Safety risk and audit software has enabled a more efficient tracking of departmental risk assessment and audits, alerting when audits are due and also ensuring accountability of actions to be taken as a potential result of audit. The software also enables scrutiny of documentation for each department prior to audit.
- The Trust does not have a Trust wide inventory of hazardous substances; the department worked with Procurement to identify all purchasing routes and control the purchases of all substances. Ad hoc inventories were undertaken and a stringent control exerted with the aim of significant assurance for 2019/ 20. The Health & Safety Department has also included the compilation of a Trust wide inventory of hazardous substances in their work plan for 2019/20.
- Medical Devices - There were no major/moderate incidents reported for this year and the incidents reported were addressed with additional training for the staff involved. There is an effective and robust training programme in place, with daily monitoring of Datix incidents and timely responses to issues that are raised.
- The latter half of the year was a challenging period for the Medical Devices Educators due to staff shortages; however they maintained and achieved compliance with mandatory training.
- Moving & Handling incidents - Whilst there have been small increases in severity 1 and 2 incidents in the first 3 quarters of 2018, a significant decrease in severity 3 incidents is evident, with just 1 incident in Q4. M&H continue to encourage reporting, with the aim of identifying issues before harm occurs.
- Moving & Handling training – Achieved the proposed staff training compliance mean of 90.1%, with all directorates been compliant for Quarter 4. All training materials have been updated in line with the National Back Exchange recommendations and bespoke training is provided to balance the needs of the acute and community teams.
- The dedicated staff in all three areas provide accessible services; the Health and Safety department hold Trust wide surgeries where staff can book time to discuss health and safety issues and concerns; the Medical Devices team continues to work closely with the relevant services and groups and are responsive to the needs of the clinical teams; and the Moving and Handling Team have an open and collaborative working relationship with staff across the Trust and are developing and encouraging M&H link roles.

The Key Risks identified for 2018/19 by ESHT were included in the work plan and were monitored by the Health & Safety Steering Group:

- Work related musculoskeletal disorders – Actions identified including raising awareness, improving physical and emotional resilience and good working practices are included in the Health & Well Being Strategy.
- Work related stress – the Stress policy has been revised. A number of initiatives are being taken forward to raise awareness and provide proactive support to staff. It is anticipated that once the new Occupational Health & Wellbeing IT system is fully established triangulation of Workforce data will be possible.
- Security, violence and aggression

- Needle stick and clinical sharps
- Purchasing and management of COSHH substances
- There were fourteen staff claims related to health and safety issues closed in 2018/19

Progress with security, violence and aggression; needle stick and clinical sharps; and the management of COSHH substances are outlined in the Health &Safety Department section of the report.

Overall 2018/19 was a challenging year with the re-configuration of the governance teams having a significant impact on service delivery. The teams continued to provide support, guidance, completion of audits and training to the organisation, and there is assurance that the Trust is compliant with all mandatory of health and safety requirements. However it is acknowledged that improvement is required with the Trust's internal monitoring systems e.g. completion of health and safety audits.
At the time of writing this report during July 2019 the organisation had undergone a two day inspection by the HSE with a focus on the management of violence and aggression and musculoskeletal disorders. The inspectors made special mention of the management of manual handling with positive feedback stating that the team had a good approach, were engaged and involved with the staff and had a consistent 90% compliance rate with training. However, the inspectors felt that the Trust did not have a full understanding of the extent and issues concerning violence and aggression therefore the organisation would be subject to a material breach. This has now been confirmed and actions arising from the report are being addressed under the leadership of the Executive Lead.

The work plans for 2019/2020 will deliver clarity on the compliance within the Trust to core requirements on health and safety risk assessments, control of substances hazardous to health, lone working and the assessments required for the management of violence and aggression. In addition the divisions and directorates will be supported to ensure and be assured that any gaps identified in the safe use and management of medical devices and moving and handling equipment have been identified and plans put into place to address them.

Training for health and safety, medical devices and moving and handling will continue to be provided by the three specialties as outlined in the Trust training programme and compliance will be monitored by the divisional and directorate governance groups, the Health & Safety Steering Group, the Clinical Procurement Group and the Education Steering Group.

The team will also support the Violence and Aggression Task and Finish Group in the development and implementation of the action plan to address the concerns raised during the Health & Safety Executive inspection in July 2019.

1. Introduction – Background and Context

The purpose of this report is to provide the Trust Board with an overview of activity and outcomes relating to the promotion and management of health and safety within East Sussex Healthcare NHS Trust. The reporting period is 1st April 2018 to 31st March 2019.

This report addresses the management of Health and Safety within the Trust incorporating the Health and Safety Department, Medical Devices Educators and the Moving and Handling Team in three distinct sections. Annual reports for the management of Fire Safety and security are presented as separate items to the Board.

The management of health and safety in the organisation is underpinned by the overarching Trust Health and Safety at Work Policy, May 2018.

As at 31st March 2018, the permanent staff headcount was 7131 staff. The head count of permanent staff as at 31st March 2019 was 7133. The average head count for 2018/19 was 7086 (this is taken across the 12 months during which staff numbers dropped further). (Source: ESHT Workforce Planning)

Trust Health and Safety Steering Group
The Trust Health and Safety Steering Group (HSSG), is chaired by the Director of Nursing (DON) and Governance who is the named Executive Lead for Health and Safety. The Group receives reports from Trust wide services including Fire Safety, Radiology, Medical Gas, Security, Waste and Asbestos as identified in the HSSG terms of reference. Staff Side Health and Safety are a standing item on the agenda, and health and safety related risk register entries are monitored on a cyclical basis at every meeting.
All organisations have a legal duty to put in place suitable arrangements to manage health and safety (H&S). Ideally, this should be recognised as being a part of the everyday process of conducting business and /or providing a service, and an integral part of workplace behaviours and attitudes. Notwithstanding a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced.

2. Legislation and Guidance

2.1 **The key pieces of legislation and guidance are**:

- **The Health & Safety at Work etc. Act 1974** provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.
  In particular it requires organisations to:
  - Provide a health and safety policy
  - Provide a safe and secure working environment
  - Provide safe suitable work equipment
  - Provide information, instruction, training and supervision
  - Provide adequate welfare facilities
- **Management of Health and Safety at Work Regulations 1999** which extends the provisions of the Health and Safety at Work etc. Act 1974 in particular the requirement to undertake suitable and sufficient risk assessments.
- **Management for Health and Safety (HSG65) 2013** guidance explains the Plan, Do, Check, Act approach and advises how an organisation can achieve a balance between the systems and behavioural aspects of management. It treats health and safety management as an integral part of good management rather than a stand-alone system.
- **Leading health and safety at work (INDG 417)** guidance sets out an agenda for the effective leadership of health and safety; it is designed for use by all directors, governors, trustees, officers and their equivalents in the private, public and third sectors. It applies to organisations of all sizes.

Protecting the health and safety of employees or members of the public who may be affected by an organisations activity is an essential part of risk management and must be led by the board.

2.2 **Working together with Trade Unions**

Staff-side is made up from members of East Sussex Healthcare NHS trust staff who are members of a Trade Union or Society, recognised by the Trust. The staff side members have been elected and/or appointed into their role of Health & Safety representatives through the trust recognised organisations and they are governed by **The Safety Representatives and Safety Committees Regulations 1977.** Staff side Health & Safety representatives are part of the consultation process into Health & Safety policies written by the management side of the Trust. They are involved in investigations, and may be consulted by the Health and Safety Executive (HSE) during Site inspections, and when necessary they also have a legal duty to consult with the HSE.

2.3 **Health and Safety Executive (HSE)**

The Health and Safety Executive regulates and enforces health and safety in the National Health Service with key formal interventional powers including prosecution.

2.3.1 **Memoranda**

A Memorandum of Understanding (MOU) between the Health and Safety Executive (HSE) and the Care Quality Commission (CQC)) came into effect on the 1st April 2015, to reflect the new enforcement powers granted to the CQC by the Regulated Activities Regulation 2014. It reflects the 2012 Liaison Agreement between the CQC and HSE that applied solely to healthcare.

The purpose of the MOU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public visiting these premises.

2.3.2 **Prosecutions, Interventions, Corporate Fine**

There have been no formal interventions in the Trust by the HSE during 1st April 2018 and 31st March 2019. An inspector from the HSE undertook a schedule inspection of the Pathology Department in December 2018 to examine the department including the containment laboratories. Verbal recommendations were made and an action plan developed.

However at the time of writing this report during July 2019 the organisation had undergone a two day inspection by the HSE with a focus on the management of violence and aggression and musculoskeletal disorders. The inspectors made special mention of the management of manual handling with positive feedback stating that the team had a good approach, were engaged and involved with the staff and had a consistent 90% compliance rate with training. However, the inspectors felt that the Trust did not have a full understanding of the extent and issues concerning violence and aggression therefore the organisation would be subject to a material breach. This has now been confirmed and actions arising from the report are being addressed under the leadership of the Executive Lead.

2.3.3 **Health and Safety Executive Work Plan**

In April 2018, the HSE announced an intention to undertake a programme of inspections of all NHS trusts as part of their forward work plan. The inspections would coincide with their annual focus and each year having a different theme and based on national intelligence and incident reports. The focus for 2018/19 was on stress and mental health, and Control of Substances Hazardous to Health (COSHH).

3. Claims

There were fourteen claims closed during 2018/19 specifically related to health and safety which was an increase on the nine claims settled in 2017/18. Of these fourteen incidents which were settled in the financial year, one dated back to 2013/14, four were from 2015, five from 2016, one from 2017 and three from 2018.

1 member of staff claimed for a repetitive process disorder

2 members of staff suffered injury when they were struck by a falling object
3 members of staff received moving and handling injuries
4 members of staff tripped over cables or obstacles
4 members of staff received injuries whilst falling due to uneven surfaces or object in the grounds

Liability type:
11 incidents of Employers Liability
3 incidents of Public Liability

1.0 Management of Health & Safety

All three services are headed by the Trust Risk and Health & Safety Lead who has strategic responsibility for health and safety. The lead for the Health & Safety Department is the Deputy Trust Lead for Health & Safety. During the reported period whilst restructuring of the governance services and recruitment was being undertaken the department comprised of 2.6 WTE to deliver the service including: competent health and safety advice; administration of the health and safety and risk assessment software Assure ©; specialist and core training and to support key groups on a corporate, divisional and local basis.

Key members of the department hold qualifications in general and specific health and safety subjects and undertake peer review, reflective practice, continuing, specialist and individual professional development with relevant professional bodies. The post of Chair of the South-East based network, Healthcare Risk Management Group is also held.

Health and Safety Management System – HSG65 published by the HSE as guidance on the implementation of health and safety indicates a cyclic approach to health and safety with an emphasis on continual improvement. The guidance indicates the 4 stage approach which is not mutually exclusive. All stages interrelate:

Plan: Defining and communicating acceptable standards of health and safety performance through policy and the allocation of resources;

Do: Identification of key risks and the monitoring of control measures including maintain and inspection;

Check: Measurement of health and safety performance including leading and lagging indicators, proactive and reactive methods, audits and incident investigation;

Act: Review of performance to inform improvement, implement lessons from incident investigations and identifying areas for improvement.

1.1 Trust Board / Directors

HSG65 states the role of Trust Board and directors in relation to Health and Safety and is summarised in the Leadership Checklist published by the HSE.

The Board is collectively responsible for providing leadership and direction and should set the direction for Health and Safety with ownership of key issues and risks with health and safety as a standing item on Board agendas

1.2 Divisional and Directorate Level Responsibilities

Division and directorate responsibilities are identified in the Health and Safety at Work Policy. With the exception of Corporate all divisions have a governance representative who report into the Trust Health and Safety Steering Group (HSSG). The expectations of the group are stated in the HSSG terms of reference and include defined parameters of reporting incidents and risks to expedite escalation and also feedback mechanisms as appropriate. All members of the group are expected to facilitate communication and dissemination from HSSG through their divisional and departmental management structure. For example lessons learned or issues identified through 13 week inspections and the 18 standard audits which are shared at the Group are fed back to divisions and departments.

1.3 Health and Safety Link Staff

An effective network of link staff willing to undertake and support key health and safety functions throughout all levels of the Trust has been progressing since 2014. Link staff receive regular communication from the Health and Safety department including newsletters, updated policies, ad hoc

visits, targeted support ‘surgeries’ and information ‘broadcasts’. The link staff have variable duties which are negotiated locally with the manager in charge of their area. Their duties may include undertaking 13 week inspections, risk assessments and working with the ward/department manager on the implementation of recommendations following the Occupational Health and Safety Management Systems audit.

2.0 Health & Safety Steering Group Work Plan

Objectives were identified and consulted on in November 2017 in order to inform the work plan for 2018/2019. However on reflection the HSSG felt that the work plan could not be delivered by the Group, and that it needed to be owned and managed locally with HSSG oversight. With the agreement at the May 2019 HSSG the objectives were devolved to the divisions and relevant specialities to incorporate into specific work plans.

3.0 Incidents reported

The information for this report was extracted from the incident reporting system. Incidents involving Moving & Handling and Medical Devices will be discussed in the applicable sections of this overarching Trust Health & Safety Annual Report.

3.1 Incident Classification and Categories
This report summarises Health and Safety related incidents as reported during the financial year, a full report on incidents is reported each financial quarter to the HSSG. Patient Safety incidents are not included in this report which focuses on staff and others who may be affected by the work activity, unless an incident has occurred to a patient resulting in an event categorised by the Reporting of Incidents, Diseases and Dangerous Regulations 2015 (as amended).

A full breakdown of incidents relating to security, violence and aggression and Fire are reported on to the HSSG by the relevant departments. Moving and Handling and Medical Devices incidents are presented as separate reports in the Overarching Trust Health & Safety Annual Report.

- Health and Safety related incidents
- Slips trips and falls
- Violence and Aggression
- Needle stick

3.2 **New incidents**
The chart below indicates 3 years new incidents on the date they were reported.

New incidents reported	Number	Month average	Mean	+/ - Mean	Severity 3+	% of total incidents
2016/ 17	1125	93.75	93.61	+0.14	44	3.91%
2017/ 18	1130	94.17	93.61	+0.56	54	4.78%
2018/ 19	1116	93	93.61	-0.61	65	5.82%

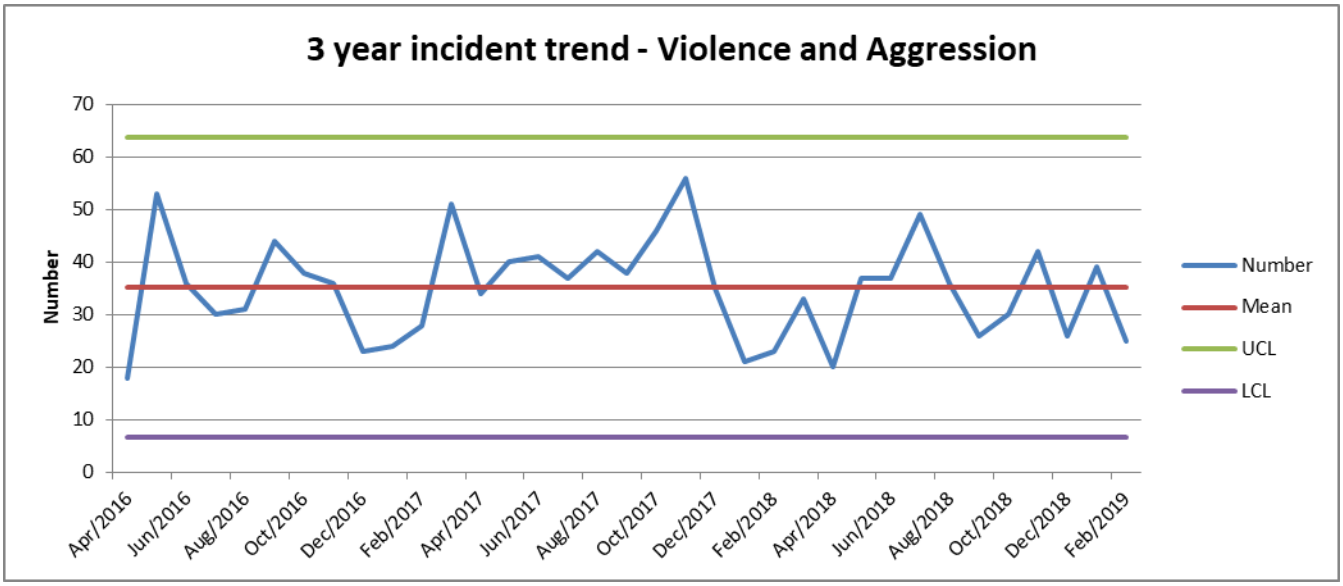
It has been concerning to note that despite a decrease of incidents by 0.61 against the month mean figures, the severity of incidents graded as a severity 3 or above has increased as a total percentage of

the incidents for the year. This increase has occurred across the organisation and no trends of significance identified. There is a potential that there has been decreased incident reporting for lower level incidents although this is unable to be confirmed via Datix reports.

3.3 Analysis of Type of Incident

The top three reported incidents were Security, Violence and Aggression; Slips, Trips and Falls; and Needle stick and Other Sharps

3.3.4 Security, Violence and Aggression.



The above statistical process control graph maps the three year trend. Initially this indicates there are no concerns however this may be due to under reporting of incidents.

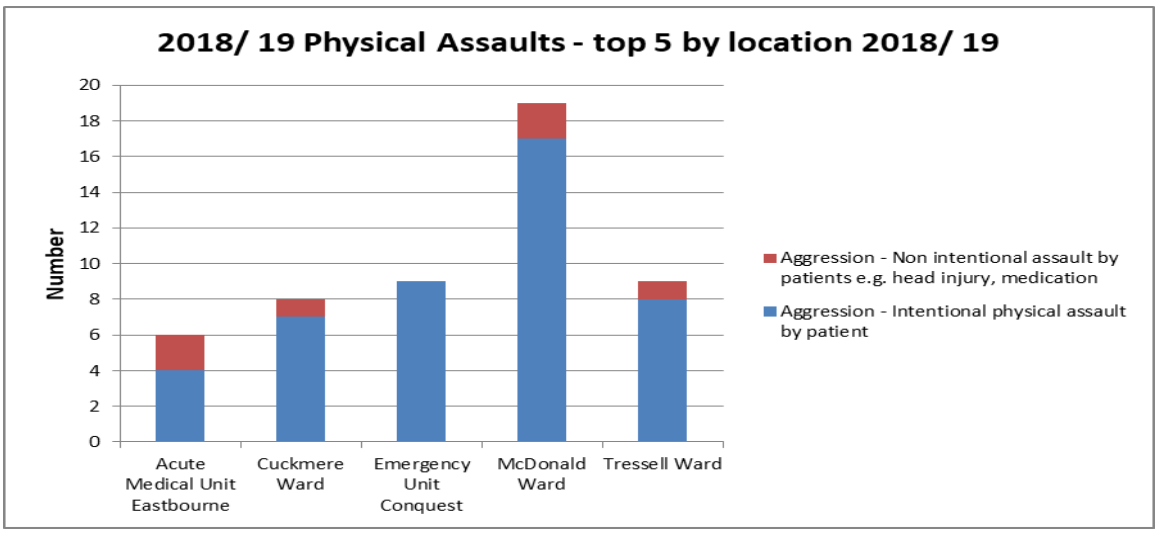
Whilst a full breakdown of incidents in this category is given in the Trust Security Departmental report, a brief analysis of incidents is given below in respect of physical and intentional violence and compares against clinical violence or aggression.

Violence and Aggression	Number	Month average	Mean	+/ - Mean	Number of all Physical	% of total incidents
2016/ 17	412	34.33	34.14	+0.19	155	37.62%
2017/ 18	446	37.17	34.14	+2.99	180	38.63%
2018/ 19	407	33.92	34.14	-0.22	139	34.15%

The number of physical incidents both clinical and non-clinically related reduced by 22.78% from the previous year, with the highest number being reported on Datix by MacDonald Ward. Due to the clinical condition of the patient on the higher reporting areas, clarity is needed along with validation from the incident handler that the category of intentional assault by patient is correct.

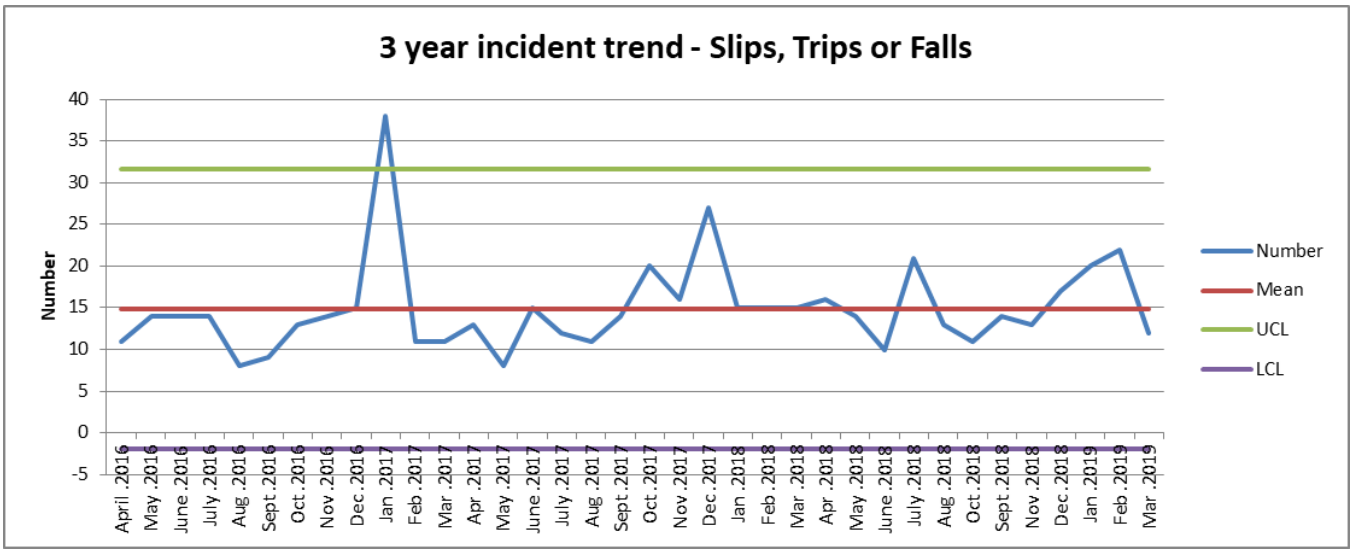
It has previously been reported throughout 2018/19 that there was an issue with the categorisation of incidents, with a clear recommendation that incidents relevant to specific services should be reviewed contemporaneously allowing for clarification of incident causation and follow-up where required.

The chart on the following page indicates the top 5 sites as identified on Datix where the highest number of physical assaults are reported. The chart indicates a high potential of mis-categorisation of incidents that resulted from a clinical condition and also under reporting of departments specifically Emergency Departments where the prevalence of violence or aggressions is nationally higher in comparison to other departments on acute sites. Regardless of the accuracy of the category, measures do need to be identified to reduce the risk to staff and others as a result of physical aggression so that this is not perceived as part of the job.



Measures to reduce or mitigate violence and aggression such as conflict resolution training and the introduction of body cameras being worn by the security team are in place. For full information the measures are identified in the Annual Security Report

3.3.5 Slips, Trips and Falls



New incidents reported	Number	Month average	Mean	+/ -	Severity 3+	% of total incidents
2016/ 17	172	14.33	14.89	-0.56	25	14.53%
2017/ 18	181	15.08	14.89	0.19	20	11.05%
2018/ 19	183	15.25	14.89	0.36	25	13.66%

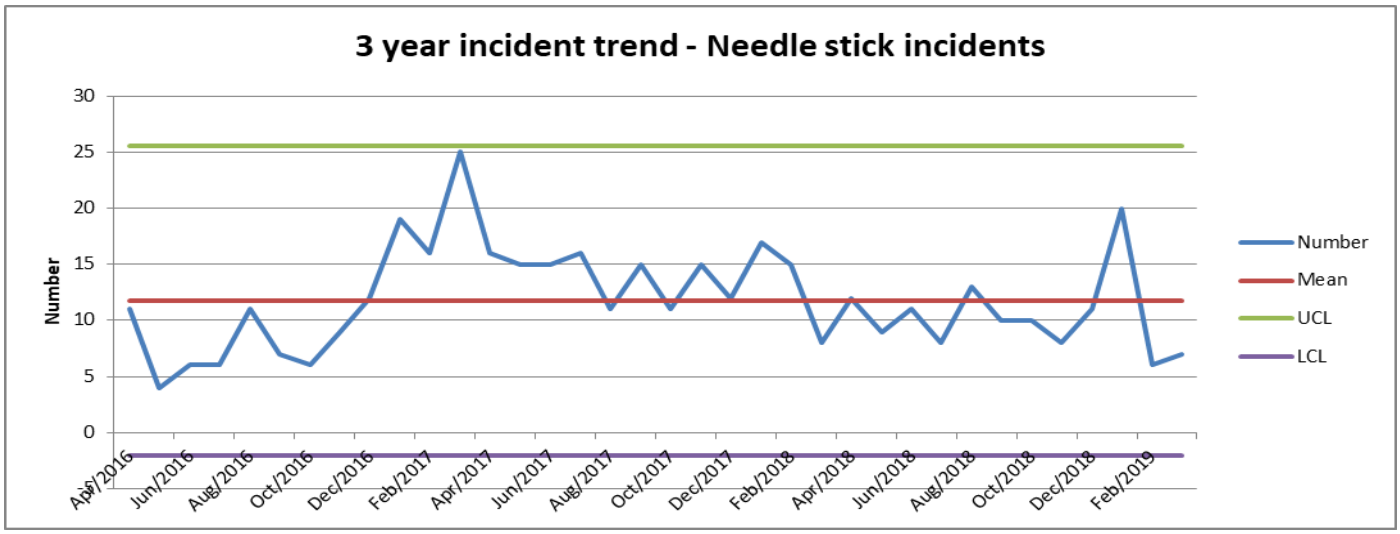
There were two concerns highlighted via Datix in previous reports which were readily identifiable as slippery surfaces caused by inclement weather; primarily ice. Peak incidents occurred in February (22) with varied causes although this resulted in 7 incidents graded as a severity of 3. Actions taken to reduce the risks from inclement weather include additional signage of where areas could potentially become slippery; and gritting of the grounds is undertaken regularly and monitored after rainfall which may wash the grit away.

Of a total 183 incidents reported across the year 25 resulted in an incident graded 3 and above. Trips and falls over objects or structures were the most commonly reported incident (58) and storage of items was often identified as the causal factor, along with environmental issues including holes in floor and uneven surfaces. Potential causal factors should be identified and addressed via the 13 week inspections and risk assessments. Some areas have completed entries on the risk register to escalate concerns.

The second most reported category was as a result of slipping on liquids or slippery surfaces during housekeeping activities. As a result of this the Shattered Lives campaign, which was run initially in 2013, will be refreshed as part of the Health and Safety departments work plan for 2019/ 20 to further raise awareness.

16 incidents occurred as the result of a member of staff or visitor suffering a fit, faint or collapse at work. Health and Safety department contacted managers to determine potential causal factors, referral pathways and also to advise on the completion of individual health assessments for staff once conditions were diagnosed. There was a high rate of potentially undiagnosed health conditions where environmental factors were not determined to be a key factor in this reporting year. Almost all resulted in no harm as a direct cause of the fall although two members of staff suffered a stroke whilst at work.

3.3.6 Needle stick incidents



The overall number of incidents involving needles has decreased this reporting year to 125 from a previous high of 166 in 2107/18. Whilst the decrease is pleasing, and percentage of incidents occurring as a result of exposure to 'dirty sharps' has risen to 65: overall 52% of all sharps incidents and also a three year high.

64 staff suffered a penetrating injury during procedures or as a result of poor disposal; 4 of these incidents were reported as a dangerous occurrence to the Health and Safety Executive due to high risk donor source. Each of these incidents were followed up to determine causal factors. The causal factors were varied however, 2 incidents could have been prevented if a safety device had been issued to the high risk donor source by the non ESHT prescriber. This matter has been raised with Clinical Commissioning Group and recommendations are being communicated to the Health and Safety Executive by Health and Safety of the national implications of prescribing safety devices for high risk individuals.

A 7 year review and analysis across the Trust to determine factors affecting the efficacy of the implementation of the Sharps Directive and causative factors was planned for June 2018/19 and led by the Health and Safety Department. The interim report identifying key findings including issues with disposal, problems with devices, training content and the availability and type of sharps bins was discussed at HSSG. The report has been provided to Infection Control to follow-up on the key findings, and to take further action as required and to work with Waste Management and Health & Safety with regards to the disposal issues.

4.0 RIDDOR events

A total 26 incidents were categorised as a RIDDOR event and were then reported to the Health and Safety Executive in 2018/ 19 in comparison to 2017/ 18: 22 and 26 in 2016/ 17.

	2016/17	2017/18	2018/19
+ 7 Day	29	16	16
Specified /Major	7	4	6
Dangerous Occurrences	0	2	4
Total	26	22	26

4.1 Staff RIDDOR events

There were a total of 25 staff related incidents reported as RIDDOR event during the reporting year. There have been a number of incidents where the information required to complete the report to the HSE was not forthcoming or clarification around length of absence was difficult to ascertain. A number of occasions occurred where a member of staff was absent prior to going on annual leave therefore the categorisation as a RIDDOR event could only be clarified on their return and this is a significant issue where the RIDDOR is an absence of 7 or more days. A medical diagnosis must be identified as well as cause and effect demonstrated prior to reporting the incident and this is not always possible to determine precisely.

Of concern is the number of incidents where a dangerous occurrence - specifically high risk needle stick injuries and fractures - were reported late to the HSE. Each late reported is a potential breach of the Regulations and may impact on the member of staff being triaged appropriately. In each case where there is a potential RIDDOR event, the Health and Safety department either visit the department or follow up with a phone call to reduce delay and ensure advice support and signposting.

4 staff were exposed to hazardous substances which were reported as a dangerous occurrence. All incidents were followed up by Health and Safety resulting in the planned full review of the efficacy of safer needles over 7 years.

Specific learning from these RIDDOR events includes an ongoing review of the use of kick steps in areas where there may be frequent use, with communication during audit and via Health and Safety Links. A review of risk assessment training to include the need to undertake risk assessments and implement mitigation where an existing health condition may have been diagnosed and adjustments to the role or working practices may be required. Castors on chairs were identified early in the reporting year as being the subject of near misses and low harm, and resulted in a bulletin sent to link staff, discussion at health and safety meetings, during audit and coordination with the Procurement Department to ensure familiarity with the requirements for castors.

4.2 Patients and Visitors

There was a single incident involving a visitor to Trust premises who fell in a car park. After investigation the visitor reveals that there was no identifiable cause however precautionary measures were taken after a review of the area.

There were no RIDDOR events to patients

5.0 Audits

5.1 Rationale

Audits are a leading indicator of the health and safety performance of the health and safety management at a local level.

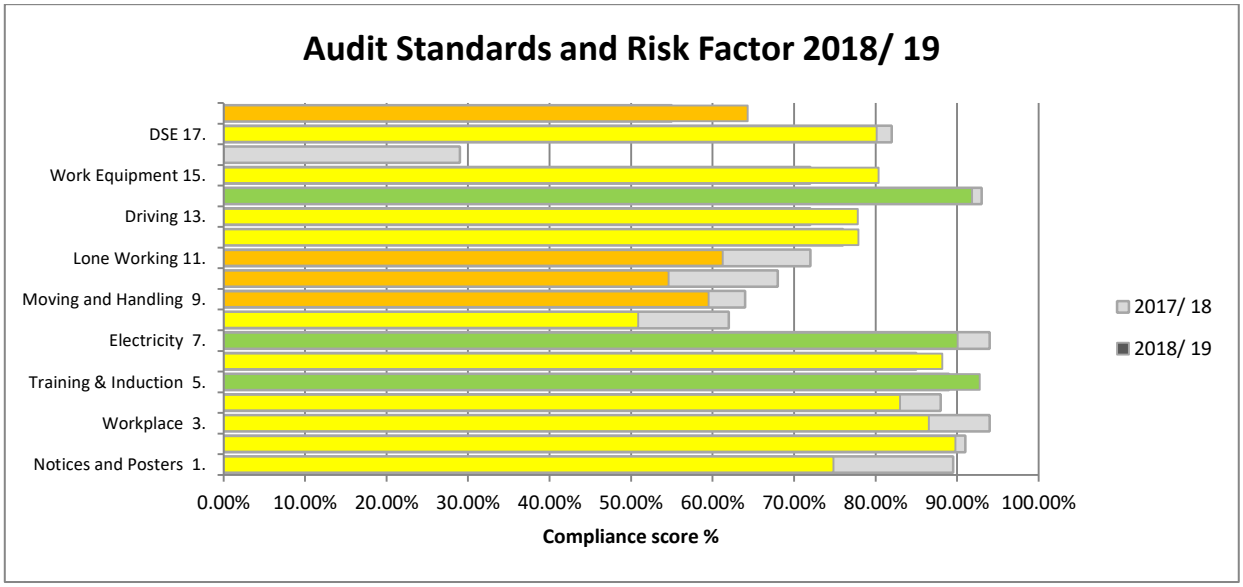
The audits have 18 specific standards that are based on legal compliance and adherence to Trust policy. Division of 18 standards enables an overview of compliance in specific risk factors. Evidence is looked for in all cases that risks have an escalation and feedback process where measures are required as a result of incident or risk assessment are not able to be undertaken at a local level and there is engagement and communication around risks and safe working practices.

The department has a KPI of completing a minimum of 100 audits per year and is a key method of determining the local management of health and safety enabling any deficits or areas of improvement to be identified and action or advice as needed. The restructure of Governance and subsequent staffing shortages within the department including long term sickness significantly impacted on the department's ability to undertake this key task. This resulted in 29 audits on the forward programme as significantly overdue at year end and is a priority for the department in 2019/ 20 once trained staffing levels are achieved.

It is important to bear in mind that the audit represents findings at the time of the audit and is reliant on evidence being able to be produced including embedding. Proportionate risk assessments and mitigation measures are actively encouraged. The table on the following page indicates Trust average for 2017/ 18 and 2018/ 19 and the resulting movements in each standard between the years.

5.2 Improvements Achieved

There is an overall increase in compliance by 0.26%.
Standards for training and induction, the provision of Personal Protective Equipment (PPE and electricity remain high and were evidenced through Medical Devices manuals and associated competencies, user checks taking place, the provision of RCD's where required and high levels of mandatory training. The majority of departments had clear delegated responsibilities for staff although in some departments those delegated responsibilities were not being undertaken.
The table below indicates average compliance achieved Trust wide for 2017/ 18 and 2018/ 19



5.3 Areas for Improvement

Assure has enabled a more comprehensive structure of the Trust to be determined and the Trust requires that every department has a minimum of one activity risk assessment: although this is proportionate to the scope, undertaking and complexity of the department.

It was reported in 2017/ 18 that the level of risk assessment and mitigation for Violence and Aggression, Stress and Lone Working have reduced from the previous year and this is also evidenced this reporting year, with inadequate measures to mitigate violence and aggression or for the protection of lone workers. Security assessments have been undertaken locally however they have not been recorded on Assure. This will be addressed in 2019/20.

Assessments for hazardous substances continues to improve with a significant programme of work led by Health and Safety to achieve a Trust wide inventory of hazardous substances that continues into 2019/ 20 and a restriction on purchases with the close cooperation of Procurement Department to ensure that new substances are assessed prior to use.

6.0 Training

During this year we provided a total of 2089 classroom places through 10 courses. With 6 classes cancelled due to:

- 3 staff sickness
- 3 under subscribed

A streamlining exercise was undertaken to improve efficiency and enable a reduced or potential for repeat ‘contact time’ whilst enabling learning outcomes to be achieved. Although compliance remained above 86% it did not reach the Board mandated level of 90%.

Non-attenders and withdrawals reduced to 10% which is an improvement on previous years and was aided by the introduction of a one week reminder for booked classes.

Investigations into the causes for non-compliance found the biggest challenges experienced were areas that had difficulty in releasing staff for training and also accessing/navigating the ESR system.

To help address this additional support was provided to 11 low compliance areas over the year running 12 team/group Cascade sessions as well as signposting for ESR support. The department also issued

reminders to staff of non-compliance, in order to both raise options awareness, and to better understand the reasons to enable us to provide the right kind of support.

There has been a significant reduction in the provision of higher level courses due to the need to increase both efficiency and savings. Whilst recommendations were given to attend a lower level course this did not give essential information that was needed either for very senior staff or service mangers with complex specialities and departments. To address this in 2019/ 20:

- IOSH for Senior Executives will be scheduled
- Level 3 Health and Safety will be reinvigorated enabling a comprehensive and tailored structure to the course specifically for the Trust

7.0 Assure – Health and Safety risk assessment and audit software

7.1 Improvements in Assure

- A Steering Group was established in July 2018 to provide key stakeholders with a platform to provide input into key decisions around Assure, to escalate user-raised issues, and review key pieces of documentation;
- Health and Safety surgeries take place where staff can book time to discuss Health and Safety issues or concerns, and the use of Assure is a key element of these surgeries
- Streamlining and simplification exercise to clarify issues of confidentiality;
- Amendment of COSHH Risk Assessment template to provide consistency and enable end user experience;
- Flexible training including basic and experienced user;
- Report templates developed for Governance Lead use;
- Close collaboration with the Occupational Health and Wellbeing Department for development of a Team-Based Stress assessment template continuing into 2019/ 20

7.2 Key Risks of Assure

- The reporting functions on Assure are still limited in their sophistication and require considerable effort to produce effective reports. In mitigation, the Health and Safety Team has developed reporting spreadsheets for use by Governance Leads which will require minimal maintenance once they are finalised; and is also investigating a new reporting module recently introduced by the developers to Assure.
- **Confidentiality**. The Trust is not assured of the ability to maintain confidentiality for individual ill-health risk assessments. This has been highlighted to the system developers as an issue to be resolved, and it continues to be emphasised in user training, user guides and assessments, such as the DSE Checklist, that confidential information is not to be uploaded to the system at this time.
- **Governance engagement and oversight**. While risk assessments are being initiated, they are not always being submitted by users, or approved by the relevant line manager when submitted. This issue is not being effectively identified and managed at Divisional/Directorate Governance level. However, report templates are being developed that will allow Governance Leads to recognise which areas are not submitting or approving documentation, allowing action to then be taken.
  In addition some areas feel that there are difficulties with the additional workload of inputting reports such as the 13 week inspection on to Assure as they do not have support resources to manage this.

8.0 Health & Safety Key risks

The Trust has a good reporting culture for patient safety incidents however health and safety incidents particularly those involving violence and aggression may be less likely to be reported. Reporting incidents will remain high on the Department's priority for 2019/ 20 and included in the relevant training programmes;

Incidents involving penetrating sharps injuries increased as a total percentage of all needle stick incidents reported; the 7 year analysis of incidents involving needles and sharps report was discussed at HSSG and requires further action by Infection Control department;

There is a risk that the information provided by the reporter may affect the correct categorisation of incidents, which in turn impacts of the accuracy of the report particularly with violent or aggressive incidents; It is a recommendation that all subject matter experts review incidents relating to their service delivery to take action, advise and direct as required;

There is limited assurance that the risk assessments and compliance with other health and safety documentation required by Trust policy and legislation are in place. This is due to lower engagement in some clinical and non-clinical areas. The reporting templates were reviewed and a comprehensive system of reporting was devised, with further development scheduled for 2019/20.

There is a risk that the Trust may be in breach of the Control of Substances Hazardous to Health Regulations 2002. It is caused by uncontrolled purchasing and the lack of assessment to ensure that risks are identified and mitigated; and the organisation does not have a trust wide inventory of hazardous substances. The department worked with Procurement to identify all purchasing routes to control the purchases of all substances. Ad hoc inventories were undertaken and a stringent control exerted with an aim for significant assurance in 2019/ 20.

The Health and Safety department developed a departmental work plan to ensure that Trust wide objectives including the compilation of a Trust wide inventory of hazardous substances and systems for the effective identification and protection of lone workers particularly in domiciliary and community settings would continue.

Health and Safety Team Objectives

- All Health and Safety Policies are reviewed and within date - achieved
- Competence and capability supported by effective Training Needs Analysis, quality assurances processes and departmental development and competencies - achieved
- Engagement and communication supported by the provision of specific Trust communications and the establishment of forums and access days - ongoing
- Accessible service supported by the delivery of Trust wide Health & Safety surgeries and the redevelopment of the Health and Safety extranet – Number of surgeries reduced due to staff resources in quarter 3 and 4.
- Risk reviews supported by analysis and quality assurance targets - ongoing
- Further development of Trust wide COSHH inventory database – partially achieved
- Incidents - to maintain an effective triage and communication for all 2+ graded health and safety related incidents – Difficult to maintain due to reduced staff resources.
- All RIDDOR events will be reported to the HSE within the specified time – this was not achieved as outlined in section 4.1
- Occupational Health and Safety Management Systems audit – to undertake a minimum of 25 per quarter – not achieved due to reduction in staff in quarter 3 and 4

The Health and Safety Department will ensure that for 2019/20:

- The Occupational Health and Safety Management audit tool will remain the principal tool to monitor performance and highlight deficiencies;
- A strategic and cyclic review of the gap analysis of the organisation in relation to Health and Safety Management is undertaken;
- All levels of the organisation are regularly informed of forthcoming local and national health and safety targets and incentives;
- The department continues to support the divisional and directorate Governance and Health and Safety leads to ensure and be assured of compliance and any gaps that have been identified.
- Effective benchmarking takes place against other healthcare providers of a diverse or similar operational profile.
- Datix is the Trust incident reporting database. The Trust maintains a positive incident reporting culture although further work is required to improve the processes around low level incident investigation;
- The support of specialist groups including Lone Worker Review Group, Emergency Preparedness Resilience and Response continues.

Medical Devices Team

1.0 Introduction

This report summarises of the management of medical devices during 1st April 2018 to 31st March 2019; and offers analysis of the data based on incidents reported on DatixWeb. It also includes training compliance for mandatory medical devices i.e. Infusion devices and safe use of oxygen, nebulisers, and oxygen saturation training

1.1 Key areas covered:

- At present all infusion devices and oxygen delivery devices are part of the mandatory training schedule for all qualified staff (Nursing, Allied Healthcare Professionals, and Midwives). The quarterly and yearly review is part of the Training Needs Analysis and in conjunction with incident reports, actions needed/taken, ensures we are providing training on the most relevant High risk devices.
- The overall average of training compliance for qualified staff on the mandatory medical devices.
- There are areas of lower engagement in Divisions for ensuring compliance with training and upkeep of the green medical devices folder. This is due in part to understaffing and heavy workloads. However, the overall average of 90% for medical devices folders is being maintained, some require update.
- Service delivery in medical devices has been impacted since October 2018 due to reduction in our staffing levels, currently one whole time equivalent staff member down. This has resulted in a very significant reduction in keeping pace with key functions in terms of additional training delivery, support, particularly in the community setting.
- Datix incidents are monitored daily by the medical devices educators to ensure a timely and effective response.
- Reporting of incidents is affected by the content of the information provided by the reporter, how it is extrapolated and this can reflect in inaccuracy of the report.

1.2 Work Plan

It has previously been identified in the quarterly reports that the following are recommendations for consideration by the medical devices educators and these have been addressed more thoroughly for this annual report.

- An active review of incidents and the categorisation of incidents by subject matter
- Deep cleansing of the raw data extrapolated from Datix and filtering with elimination of non-medical incidents
- Relevant information is captured on Datix including actions to prevent recurrence

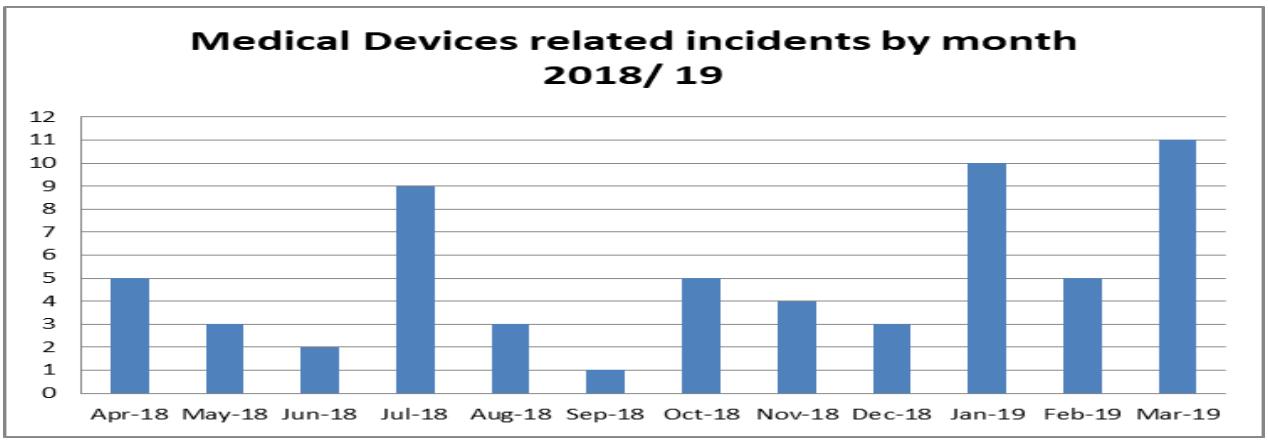
2. Incidents Reported

A review of the categories and sub-categories used to code incidents on Datix was undertaken as the complexity of these relating to Medical Devices will impact on the ability to achieve an efficient trend analysis.

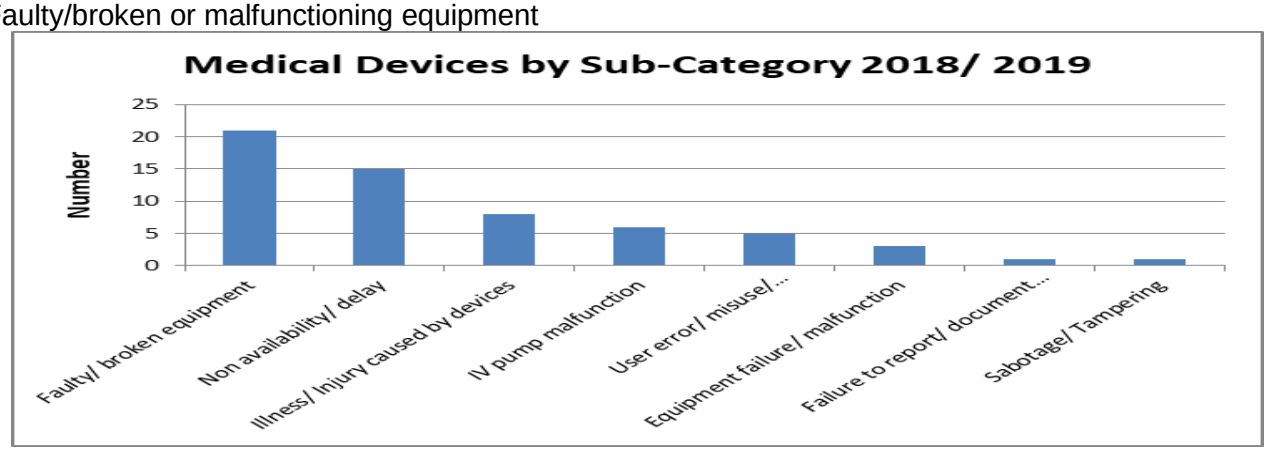
The categories and sub-categories of the incidents reported have been used in this report. This will be the method used for future reports to assist in accurately analysing the data/trends and our ability to benchmark moving forwards

The total number of new incidents reported was 750 reducing to 60 incidents following a deep cleanse of the raw data extrapolated from Datix. Going forward with the revised categories and subcategories this will the need for cleansing of the data will be reduced.

The tables below shows the trend of incidents reported across the one year period of medical devices by sub-category. Further reporting in the following years will allow us to compare shifts in trends with the same reporting method.

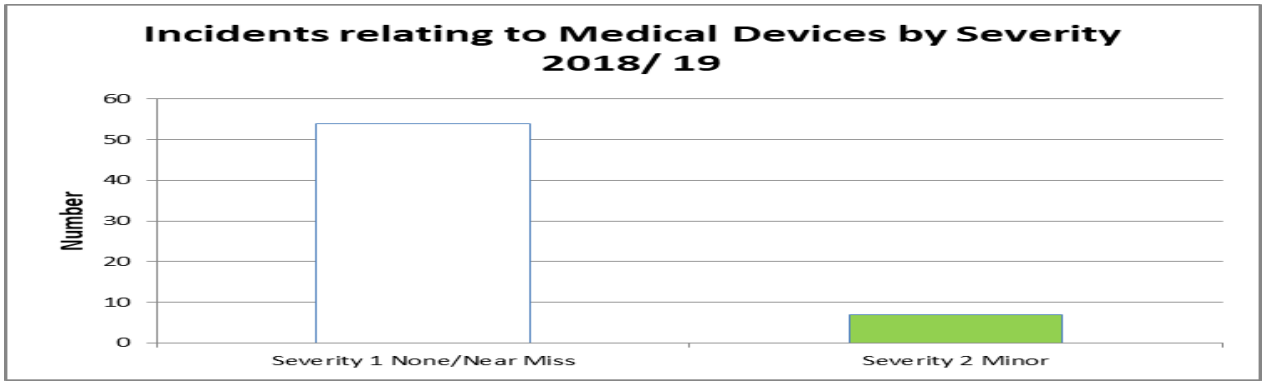


Review of the incidents in July 2018, and January and March 2019 show that the majority were due to Faulty/broken or malfunctioning equipment



2.1 Incident severity

Whilst the number of incidents vary across the year it is anticipated that with a continued emphasis on good training and incident reporting, the number of lower severity incidents would increase and the number of incidents graded as 3: moderate severity and above would decrease. An increase in reporting of lower severity incidents gives the ability to identify themes and trends. There has been a year on year improvement in the quality and number of incidents reported



2.2

Lessons learned

It is reassuring to note there were no major/moderate incidents reported for this year and the incidents reported were addressed with additional training for the staff involved. There is an effective and robust training programme in place, with daily monitoring of Datix incidents and timely responses to issues that are raised.

3.0 Training

3.1 Training Provision – Medical Devices Training Policy
During the year 2018/2019 there were 24 classroom based classes coordinated and delivered by the medical devices educators. These classes are booked through Learning and Development as per Trust policy. Staff who do not attend (DNA) booked sessions are followed up via learning & development and re-booked. Through engagement with the Electronic Staff record (ESR) we hope to identify the number of DNA's once their new reporting system has been recreated.

A total of 24 Trust induction sessions were delivered with new staff being trained with the standard most popular equipment used. Shorter ward update sessions were also provided. All training delivered is recorded onto the Trust electronic staff recording system (ESR).

3.2 Training Compliance

During the period the training data was collected it was identified that a number of staff were recently due for update session. Going forward the medical device's educators will ensure staff are booked for update sessions before becoming non-compliant.

It must be noted that there was reduced compliance with mandatory training due to a workforce reduction in the medical devices team for the latter part of the reporting year.

The report looks at the training compliance figures for mandatory medical devices. These devices are classed as High risk. At present all infusion devices and oxygen delivery devices are part of the mandatory training schedule for all qualified staff (Nursing, Allied Healthcare Professionals, and Midwives).

The figures give an overall average of training compliance for qualified staff on the mandatory medical devices. Things to take into account when using an overall average is that some areas will be 100% compliant and other areas may be considerably lower. For 2019/20 it is recommended that all clinical areas must achieve minimum of 80% for these devices.

These figures do not include the Health Care Assistant training for oxygen devices

The tables below indicate compliance rates for Mandatory training for the year.

708 Registered staff on Conquest acute wards

Mandatory Training Medical Devices – 2018/2019 Conquest Acute				
	Q1	**Q2**	**Q3**	**Q4**
Alaris	80%	82%	82%	85%
Baxter	79%	80%	82%	90%
McKinley	82%	82%	80%	88%
Oxygen Devices	77%	76%	78%	85%

495 Registered staff on EDGH acute wards

Mandatory Training Medical Devices – 2018/2019 EDGH Acute				
	Q1	**Q2**	**Q3**	**Q4**
Alaris	77%	79%	80%	85%
Baxter	70%	72%	74%	82%
McKinley	80%	82%	85%	85%
Oxygen Devices	75%	76%	78%	88%

39 Registered staff on intermediate area

Mandatory Training Medical Devices – 2018/2019 Intermediate				
	Q1 Rye	**Q4 Rye**	**Q1 Irvine**	**Q4 Irvine**
McKinley	100%	100%	85%	80%
Oxygen Devices	100%	100%	85%	80%

4.0 Medical Devices Folder

As part of the monitoring of medical device compliance all ward areas must have a medical device green folder. Within this folder there is an up-to-date equipment inventory for their ward area. The equipment has been categorised into High, Medium, Low risk. There is also an up-to date staff list/training needs analysis which is recorded on their individual staff check list; and other documentation such as how to access Trust documents such as the training policy, MDE's contact details etc.

Green Medical Devices Folder Compliance 2018/2019				
	Q1	**Q2**	**Q3**	**Q4**
Conquest (folders)	22	24	24	25/27
25 wards	81%	88%	88%	92%
EDGH (folders)	18	19	19	21/23
23 wards	78%	82%	82%	92%

There is very good support for these folders and compliance has risen to an overall average of 90%, however, some require update and this will be addressed when the medical devices team are fully established. The matron administrative assistants have also been included in the process which will hopefully enable all ward areas to achieve compliance.

5.0 Conclusion

Quarter 3 and 4 was a challenging period for the Medical Devices Educators due to staff shortages; however the team have maintained and achieved the scheduled mandatory training.

As part of monitoring medical devices compliance, each clinical area will have a spreadsheet to track compliance for the mandatory medical devices (kept in a shared medical devices folder) using the RAG rating system. It currently does not connect to the Trust ESR system but there is ongoing work to rectify this with Learning & Development and ESHT Digital.

Work plan for 2019/20

Adhere to the annual programme of work to ensure completion of requirements for the safe management of medical devices

To provide training to achieve compliance as per the medical devices training policy with particular inclusion of the intermediate care teams which will be monitored by the HSSG and Education Steering Group.

To continue to deliver evidenced-based training with completion of competencies, this will be monitored by quarterly reports to the HSSG.

To improve the RAG recording links for MDE's, the wards and IT systems to support monitoring of compliance.

To improve engagement with the Link Trainers in clinical areas, this will promote compliance with the management of medical devices.

To continue to work collaboratively with the HSSG, clinical procurement group and medical gases group to ensure compliance with the procurement and management of medical devices.

Source a dedicated training room for medical devices training cross site.

To develop the Extranet webpage by end 2020 with the green folder information, training, Link staff contacts, to be accessible by all staff.

Moving and Handling Team

1.0 Introduction

This report provides an overview of incidents with trend analysis, work completed for 2018/19, and the challenges and focus for 2019/2010. The Moving and Handling (M&H) Team consists of 3 full time proactive staff that work Trustwide in the acute and community.

2.0 KPIs 2018/2019

To acquire and maintain a mean average of 90% compliance in M&H training delivery which will be reported and monitored through the Health and Safety Steering group (HSSG) and Education Steering Group. This was achieved see section 4.1
To work with Estates to ensure all patients passive hoists are fit for purpose or have been identified for repair, enabling clinical access to patient hoist 365 days a year. To be monitored through LOLER quarterly meetings and DatixWeb Page incident report monitoring. This was achieved and is on-going.

3.0 Incidents reported

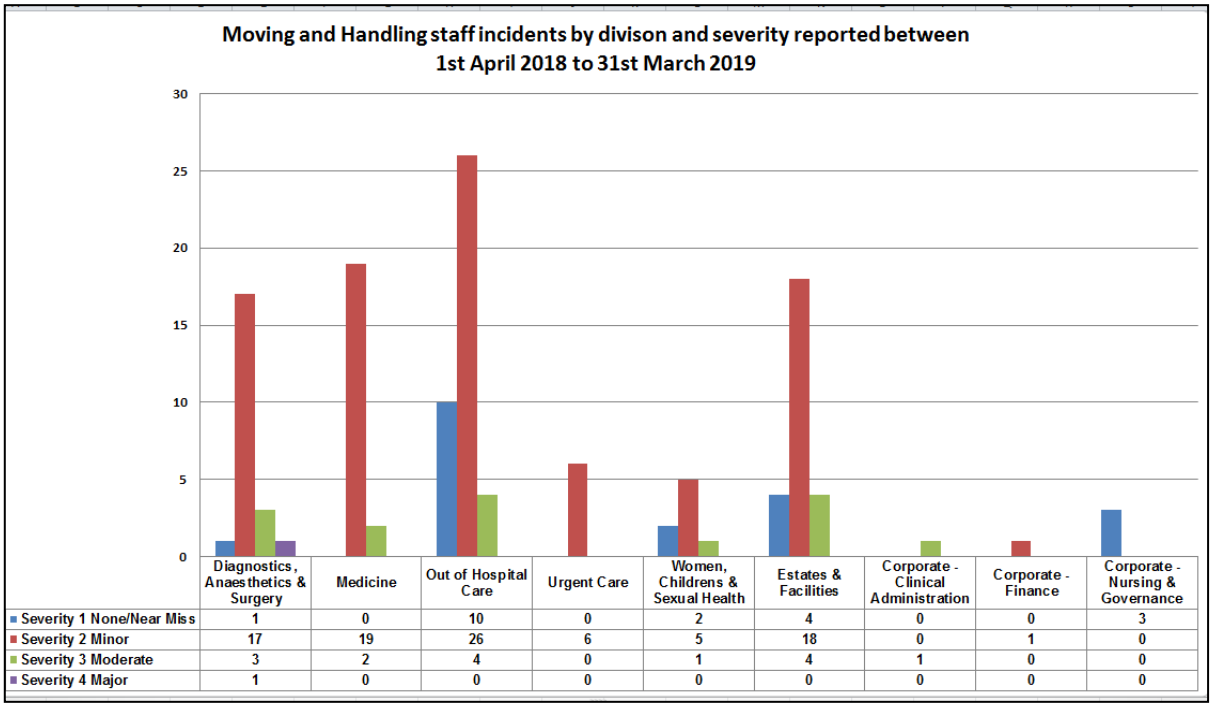
Figures reported in this summary are looking at reported data submitted between 1st April 2018 and 31st March 2019.

In the last 12 months there were 128 staff M&H incidents, Fig 1 shows the rolling total by sub category and financial quarter. Inanimate handling shows a significant decrease over the year from 14 to 4 incidents, with accumulative work related injuries increasing in the first 3 quarters, which identifies the need for closer working with Occupational Health.

Fig.1 M&H Incidents - Subcategorised (rolling 12 months)	Q1	Q2	Q3	Q4
Accident - Moving a patient	17	10	14	13
Accident - Moving a patient	14	7	6	4
Equipment (Operating/Using Machinery)	3	1	2	3
Patient fall while mobilising with Trust staff (staff injury)	4	1	1	4
Equipment - Non availability or delay	0	0	0	2
Impact with a static object	0	0	0	2
Accumulative work related injury	1	4	6	2
	40	24	31	33

3.1 Incidents by division/ directorate and severity

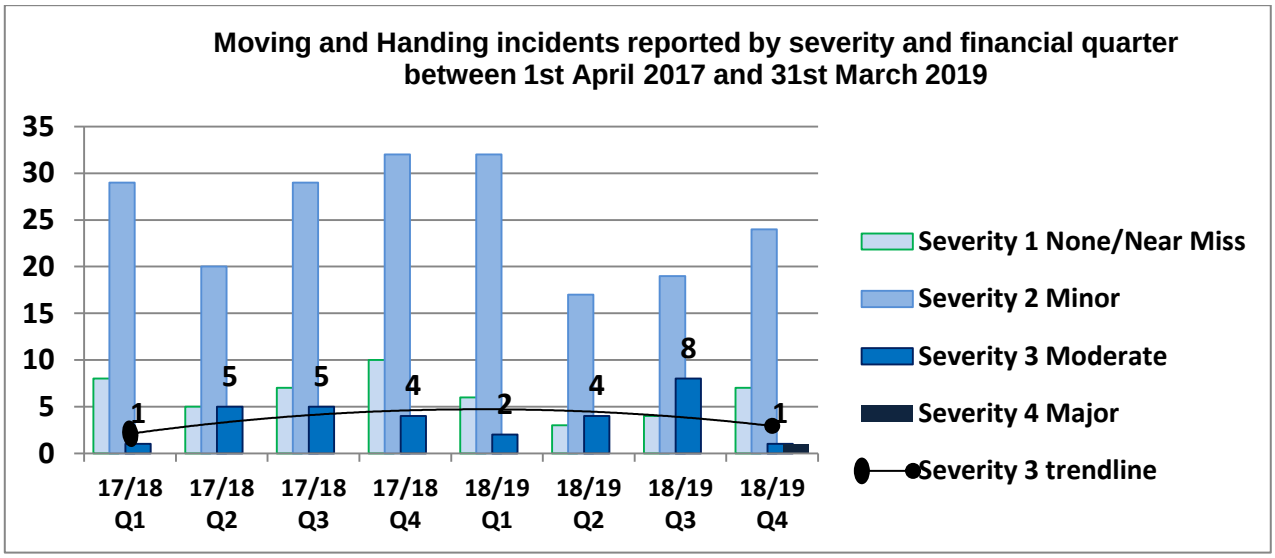
On review of incidents in Fig 2 below, by division/directorate and severity and in proportion to division/directorate size (see training summary) shows that the quality of information is improving and the numbers remain static but there are differences in divisions e.g. Diagnostic, Anaesthetic & Surgery (DAS) and Out of Hospital (OOH). Incident data across the divisions and directorates relates to a wide range of scenarios including environmental constraints in patient homes, prolonged resuscitation, human factors, and patient compliance with treatment and equipment shortages.



	Diagnostics, Anaesthetics & Surgery	Medicine	Out of Hospital Care	Urgent Care	Women, Childrens & Sexual Health	Estates & Facilities	Corporate - Clinical Administration	Corporate - Finance	Corporate - Nursing & Governance
Severity 1 None/Near Miss	1	0	10	0	2	4	0	0	3
Severity 2 Minor	17	19	26	6	5	18	0	1	0
Severity 3 Moderate	3	2	4	0	1	4	1	0	0
Severity 4 Major	1	0	0	0	0	0	0	0	0

The numbers are low, with nothing significant, but any issues are identified with proposed actions and included in quarterly reports and highlighted and escalated to the HSSG. The M&H Team are working with the practice educators in OOH for team specific training and equipment needs.

Fig 3 below shows a comparison of M&H incidents by severity over a 2 year period. There have been small increases in severity 1 and 2 incidents in the first 3 quarters of 2018; a significant decrease in severity 3 incidents is evident, with just 1 incident in Q4. M&H continue to encourage reporting, with the aim of identifying issues before harm occurs.



The number of severity 3 incidents the same as the previous financial year. The themes and trends were similar i.e. moving patients or objects; however there was an increase in the number of accumulative work related injuries and staff assisting falling patients.

3.2 RIDDOR Reports

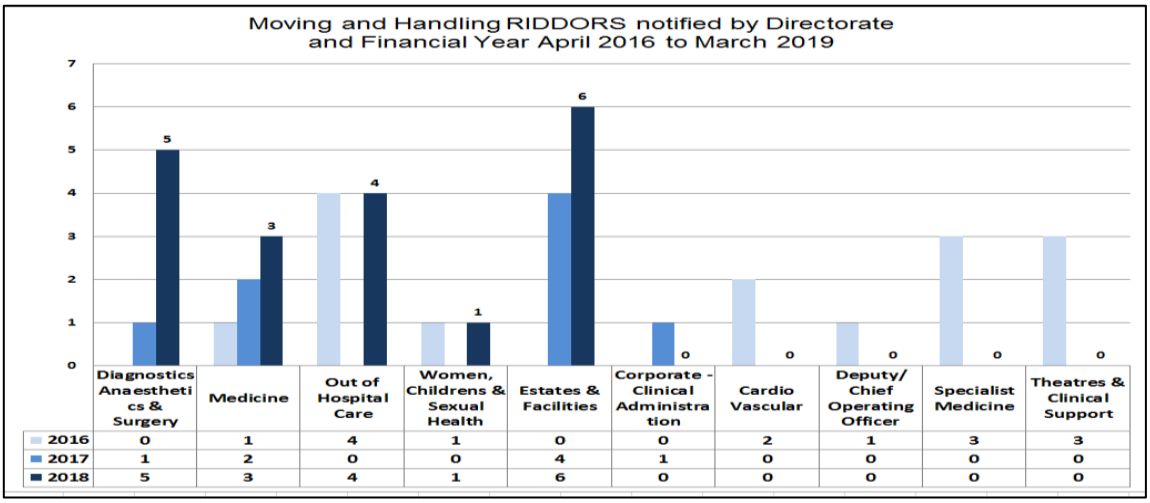
There were 17 M&H incidents reported as Over 7 day RIDDORs during the last 12 months:

- 8 of which relate to non-clinical activities including floor mopping and trolley movements,
- 5 relate to unexpected patient movements including overbalancing/ falling whilst mobilising,
- 2 relate to larger patient treatment,
- 1 relates to a community hoist manoeuvre
- 1 to a lateral patient transfer.

Initial reporting identified 8 incidents at severity 3 and 9 at severity 2.

The chart below shows a comparison across the Directorate over the last 3 years. When reviewing the 17 RIDDORS during the last 12 months by percentage of Directorate staffing the top 3 RIDDOR verses Directorate ratios are E&F at 1.4%, DAS at 0.29% and OOH at 0.27%.

Review of tasks undertaken, training and equipment available will be reviewed by the M&H Team with key stakeholders for DAS and OOH, and local induction and shadowing of task activities with Facilities staff to identify areas where additional support or change to process may be needed. There no incidents relating to the handling of patients who may exhibit aggressive behaviour.



	Diagnostics Anaesthetics & Surgery	Medicine	Out of Hospital Care	Women, Childrens & Sexual Health	Estates & Facilities	Corporate - Clinical Administration	Cardio Vascular	Deputy/ Chief Operating Officer	Specialist Medicine	Theatres & Clinical Support
2016	0	1	4	1	0	0	2	1	3	3
2017	1	2	0	0	4	1	0	0	0	0
2018	5	3	4	1	6	0	0	0	0	0

4.0 Key Achievements and Training

- Encouraged reporting and responded swiftly to incidents, with required reports being submitted to the Health and Safety Steering group (HSSG)
- Achieved proposed staff training compliance mean of 90.1%, with all directorates being green for the duration of Q4, for a ESHT staffing of 6827
- Refreshed all training materials, in line with the National Back Exchange (NBE) recommendations
- Engaged with Learning and Development for the ESHT national education streamlining project whilst balancing the bespoke training needs of community and acute staff
- M&H have facilitated product reviews and trials of equipment where need has been identified to review current practice
- M&H have led on the purchase of Trustwide equipment including x31 Stryker Transport Chairs (2018), x10 Raizers ® (2019) a device that lifts an uninjured person from the floor, supported the purchase of waste carts for the waste team and contributed towards the Trust hybrid mattresses rollout
- During the last 12 months the MHT have reviewed all patient documentation, and revised mobility assessment forms, collaboratively with therapists, that will reflect patient needs and

provide an overview of the patients mobility and activity daily, supporting the inclusion of a community Sussex wide Moving and Handling assessment and updated the in-patient paediatric assessment
- M&H Link roles have been encouraged with all depts., enabling closer 2 way communication and awareness of processes and procedures
- M&H have issued bimonthly Hot Topics through Trust Communications and set up a team twitter account, with follower numbers increasing to over 200 MHT twitter@ESHT_MHT
- MHT are members and continue to hold 3 roles on the Sussex Back Exchange Committee having also hosted 3 of the 12 meetings, including hosting a Bariatric and Paediatric skills day.

5.0 Collaborative working

M&H have membership or attend a number of internal groups/meetings that enable closer, open and collaborative working relationship with knowledge of Trust developments and staff needs including Weekly Huddle, HSSG, LOLER Compliance, Professional Advisory group, Organisational Development & Engagement Operational group, Falls Group, Pressure Ulcer review group and Pressure Ulcer Prevention Steering Group. The MHT also attends the Sussex Back Exchange monthly and host three meetings per year.

6.0 M&H Objectives 2019 /2020

- By the end of Q4 2020 to achieve a mean average of 92% compliance in M&H training delivery which will be reported and monitored through the Health and Safety Steering Group (HSSG) and Education Steering Group
- M&H will engage in organisational priorities including the support of the ESHT Overseas recruitment project, by providing 100% of the required capacity and delivery of M&H induction training, which will be monitored through the Education Steering Group
- By the end of Q4 2020 to review, identify and develop a plan to support the Out of Hospital Directorate nursing teams regarding patient handling activities in patient homes which will be monitored reported through a Task and Finish Group, that reported into the Professional Advisory Group
- By the end of Q4 2020 to identify and implement opportunities to ensure M&H equipment is streamlined with details of products loaded onto the Extranet
- To deliver a Back Care Awareness promotional event in Q3
- To develop the M&H Extranet pages by Q4 2020 with 100% of the equipment being trained by the M&H team having the required Risk Assessments on the Assure Database and training competencies accessible by all staff
- To work with Estates to ensure the all patient passive hoists are fit for purpose, or have been identified for repair, enabling clinical access 365 days a year which will be monitored through LOLER quarterly meetings and DatixWeb Page incident reporting

East Sussex Healthcare NHS
NHS Trust

Infection Prevention & Control

Annual Report
2018 - 2019

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

NHS
ESHT
Infection Prevention and Control

CONTENTS

Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2018/19. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements and challenges are presented.

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

Key points during 2018/19 are:-

- The number of MRSA bacteraemia cases reported was 2 unavoidable infections.
- *Clostridium difficile* infections (CDI) limit was exceeded. The trust reported 51 cases from 48 patients, against a limit of 40. There were 4 cases assessed as lapses in care which contributed to the development of CDI. 2 lapses due to antimicrobial prescribing and 2 related to cross infection. A recovery plan was produced in August 2018 to strengthen antimicrobial stewardship and IPC at clinical level. The incidence of CDI improved in quarter 3 and 4.
- There is a requirement to reduce E. coli blood stream infection by 10% each year. This year ESHT achieved a 7% reduction on the baseline. This year ESHT has participated in a new national improvement collaborative focusing on reducing E.coli bacteraemia associated with urinary tract infection. This work will continue into 2019/20 and requires a system wide approach as most of the infections occur initially in the community.
- The Trust is showing as a high outlier for orthopaedic surgical site infections in the national PHE report. The data relates to the period 2017/18 when an SI was completed in relation to increased cases. Current data indicates that the incidence of infection with orthopaedic hip and knee surgery has returned within national limits this year and this data will be reported in 2019.
- The Trust has/is signed up to two national projects to improve orthopaedic surgical site infection rates and reduce urinary tract infection related Gram negative bloodstream infections.
- ESHT experienced our busiest ever influenza season, with 450 patients diagnosed with the infection. There was an outbreak of influenza at EDGH involving 30 patients and a serious incident investigation has been submitted to the CCG for sign off. The outbreaks reflected delays in diagnosing index cases on wards which enabled the infection to spread to others. The outbreak occurred during high national prevalence and operational escalation when bed occupancy was 100%.
- Compliance with screening patients for Carbapenemase producing Enterobacteriaceae (CPE) has improved.
- Norovirus outbreaks occurred on individual wards and were managed in line with local and national policy without significant consequence.
- Hand hygiene compliance remains above 98%. The number of audits undertaken was reduced in the first half of the year as the reporting system was changed and

required ICLFs to be trained on the new system. As the year progressed, initial problems with the new system were addressed.

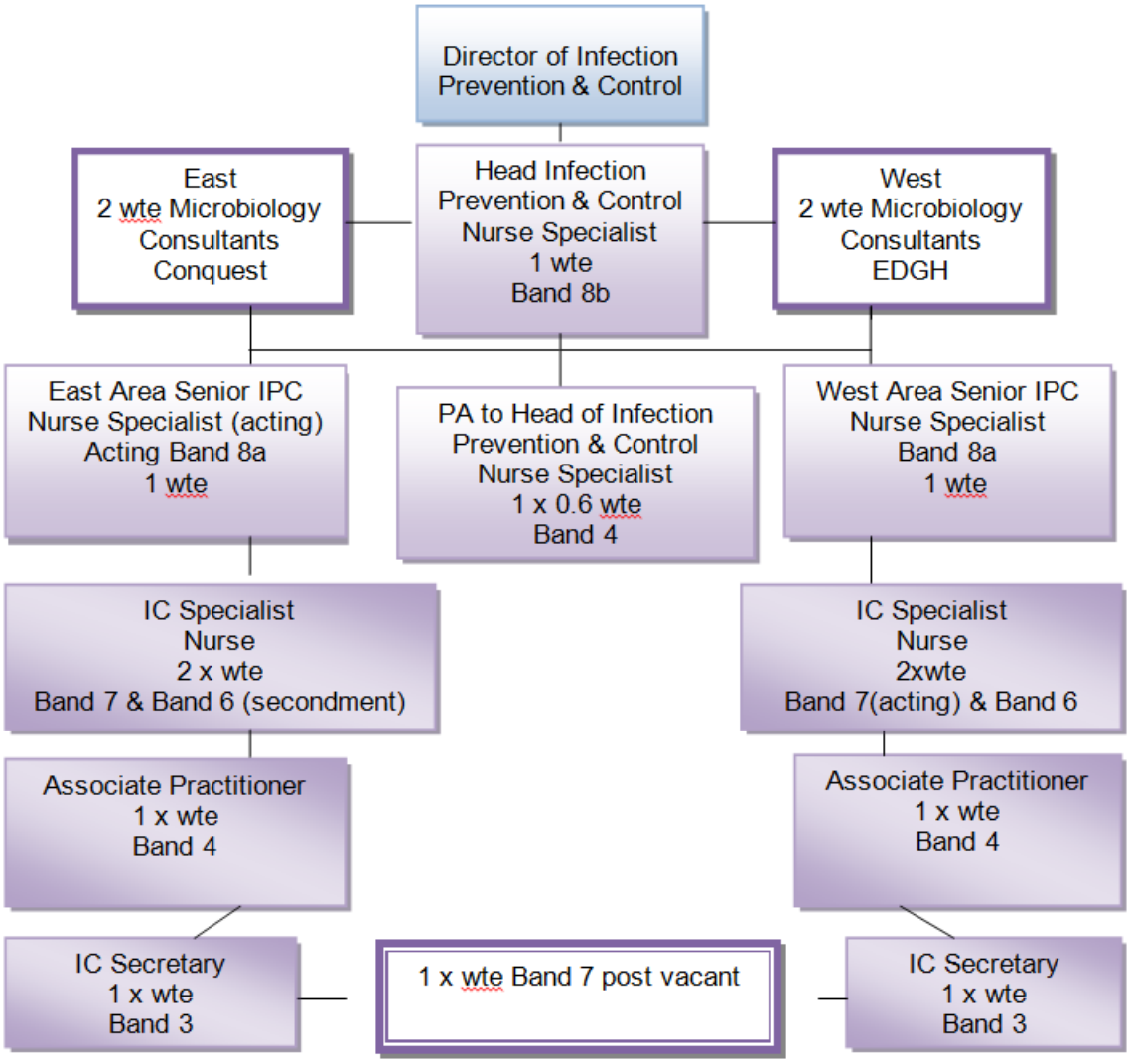
- Auditing of environmental and equipment cleanliness shows the trust is overall compliant with national specification of cleanliness (NSC). Staffing shortages within the NSC team led to a reduced number of audits being undertaken and this has been addressed following recruitment.
- Antimicrobial stewardship has been strengthened by the introduction of ward rounds in areas of high use. The overall use of antimicrobials in the trust remains higher than the national average but has reduced by 5% on the previous year. The trust has been advised that it will receive full payment for the CQUIN this year.
- Pseudomonas was isolated from an outlet in Special Care Baby Unit and this required considerable work by Estates and Facilities to resolve the problem.. There were no related infections on the unit. Water Safety continues to be well managed.

Lisa Redmond, Head of Infection Prevention and Control

1. Structure

The Director of Nursing is the Executive Lead and Director of Infection Prevention and Control (DIPC), and sits on the Trust Board.

Infection Prevention & Control Team Structure



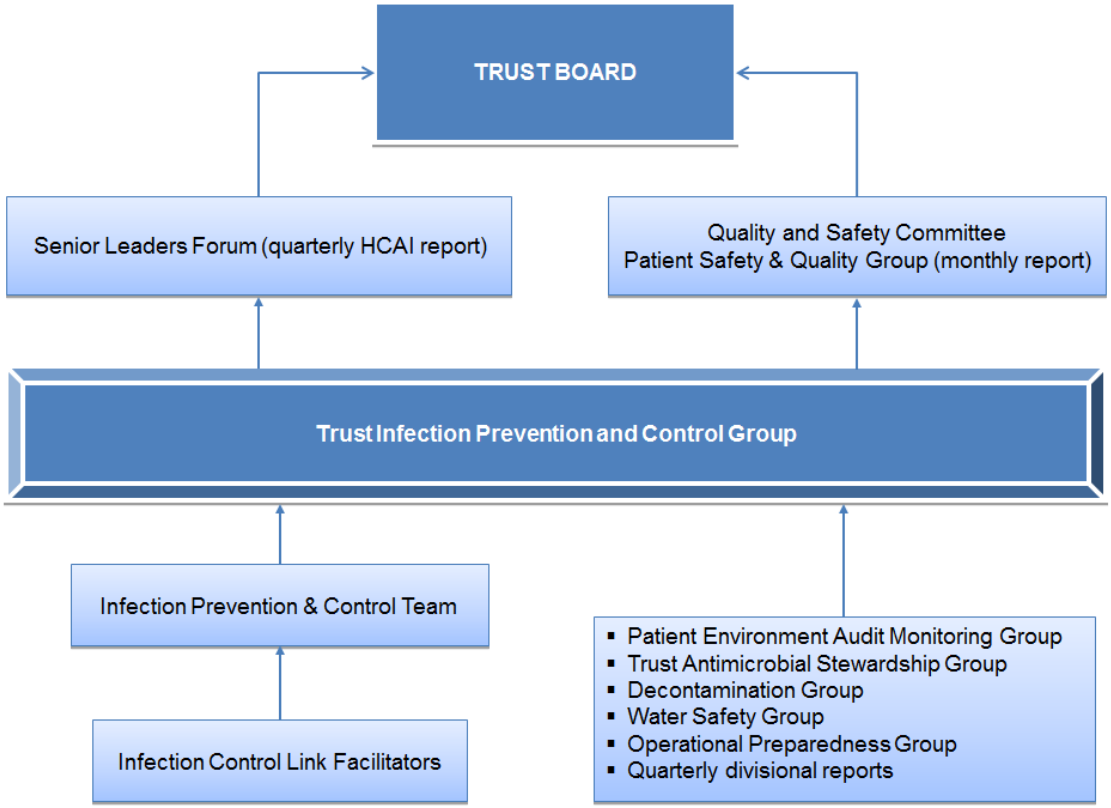
The IPCT comprises of specialist Infection Prevention and Control nurses and administrative staff. Two area teams (East and West) based in each of the acute hospital sites provide Infection Prevention and Control support to all ESHT services in their local area (acute, community, inpatient and domiciliary).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

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

Recruitment to the vacant Consultant Microbiologist/Infection Control Doctor post was completed, to commence on 1st April 2019, however there continues to be a vacancy within the service, and recruitment is ongoing.

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

1.1 Infection Prevention & Control internal reporting arrangements



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

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

1.2 Infection Prevention & Control external reporting arrangements

Externally, the DIPC or Head of IPC report directly on performance to the CCG Head of Quality and Nursing and the Clinical Quality Review Group (CQRG) held by the local clinical commissioning groups (CCGs);

- Hastings & Rother CCG
- Eastbourne Hailsham and Seaford CCG

1.3 Infection Control Link Facilitators

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

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

1.4 Joint working across the local health economy

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

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

The IPCT in collaboration with PHE, East Sussex County Council and the Network Group have continued to focus efforts on the reduction of catheter associated urinary tract infections in response to the new reduction targets set by NHS improvement. for reducing Gram negative bacteraemias by 50% across the whole health economy by 2021. In March 2019 the IPCT presented at the NHSI & Sussex and East Surrey Commissioners *E. coli* reduction programme event, which was also attended by the DIPC. It was agreed that collaborative working is required to tackle the problem of E. coli infection as the majority occur outside the hospital setting. A multi-agency working group is to be convened to identify strategies for improvement within East Sussex.

Surveillance of community acquired Gram-negative bacteraemias is undertaken by the ESHT IPC team on behalf of the local CCGs under a service level agreement.

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

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

Associate Practitioners within IPC support compliance monitoring against standards for cleanliness and infection control and provide real time feedback to clinical teams on their performance highlighting areas of good practice or the need for improvement.

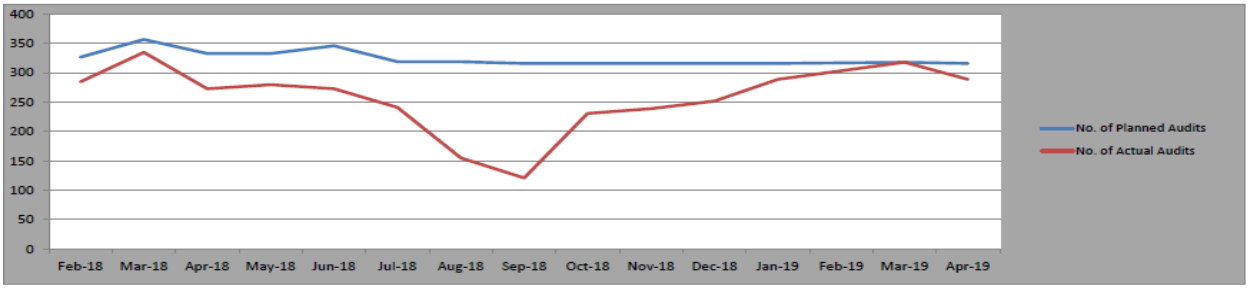
The TIPCG receives reports from Divisions as evidence of local compliance and assurance which is then reported to the Trust Patient Safety and Quality Group.

The CQC inspection in October 2016 reported that Infection Prevention and Control oversight had been significantly strengthened and following the re- inspection in 2018 they reported that "*Infection prevention and control was now a real strength*".

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

Number of NSC Audits Planned vs Number Completed

Month	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Mar-19	Apr-19
No. of Planned Audits	327	357	333	333	346	319	319	316	316	316	316	316	318	316
No. of Actual Audits	285	335	273	280	273	241	155	121	231	239	252	289	318	289



The number of audits undertaken was lower than planned due to staff leaving the team to take up other roles, subsequent recruitment is resolving this. The Trust NSC target score for Clinical (formerly Nursing) and Housekeeping was assessed as >92%, overall this was achieved although there were some low scoring areas. Where an area has consistently low scores they are asked to attend the Patient Environmental Audit Meeting (PEAM) to provide assurance of the actions being taken to address the low compliance.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
House Keeping	96.63%	97.38%	96.92%	97.08%	96.62%	98.01%	95.95%	97.28%	98.15%	96.80%	97.27%	96.69%
Clinical Staffing	88.47%	94.02%	89.21%	92.60%	91.60%	97.20%	96.01%	98.23%	98.44%	97.06%	95.34%	93.77%
Estates	91.51%	93.70%	92.82%	92.43%	92.06%	94.20%	91.82%	93.10%	90.73%	93.03%	91.02%	90.57%

The introduction of the Clinical Orderly role to support cleaning of clinical equipment has significantly improved compliance scores. Vacancies for the role can cause lower compliance. Lower estates scores relate to aging infrastructure which requires investment, works are prioritised by risk; the average annual score for estates (92%) is compliant with NSC.

3. Mandatory Surveillance

The Department of Health (DH) requires NHS Trusts to take part in a national mandatory and voluntary surveillance programme. This involves providing information

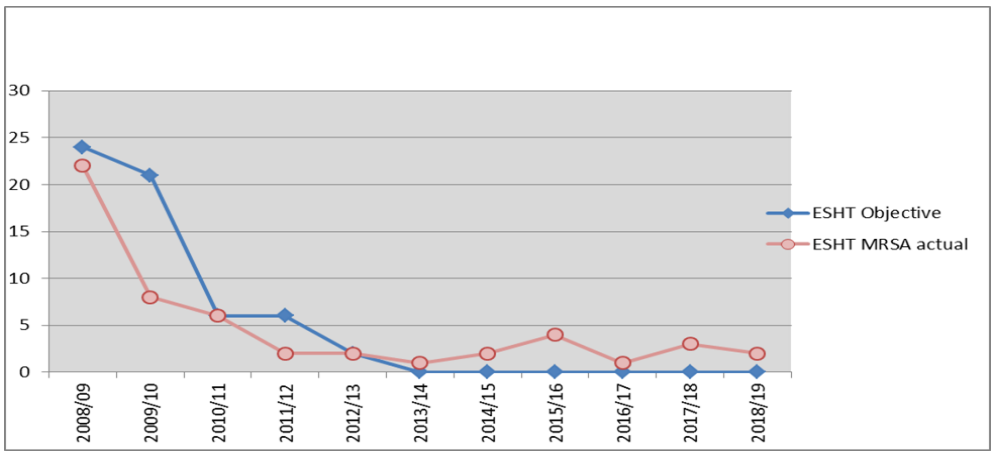
about a number of specific infections including bloodstream infections due to Meticillin resistant S*taphylococcus aureus* (MRSA bacteraemia) and diarrhoea due to *Clostridium difficile* infection (CDI).

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

Since 2011, bloodstream infections due to meticillin sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* have been added to the national mandatory surveillance. In 2017/18 a new Quality Premium was introduced to reduce the number of *E. coli* bacteraemias (community and HCAI) by at least 10% and mandatory reporting of *Pseudomonas aeruginosa* and *Klebsiella species* bacteraemias was also introduced. If surveillance identifies that the bacteraemia may have been related to our care then a PIR is conducted to identify if lessons can be learned.

3.1 MRSA bacteraemia

We continue to have a zero tolerance approach to cases of MRSA bacteraemia which could potentially be avoidable. ESHT reported 2 cases of MRSA bacteraemia in 2018/19 compared to four cases in 2017/18.



One case of hospital acquired (>48 hours) MRSA bacteraemia reported in August was assessed on PIR as related to a chronic leg ulcer and assessed as unavoidable.

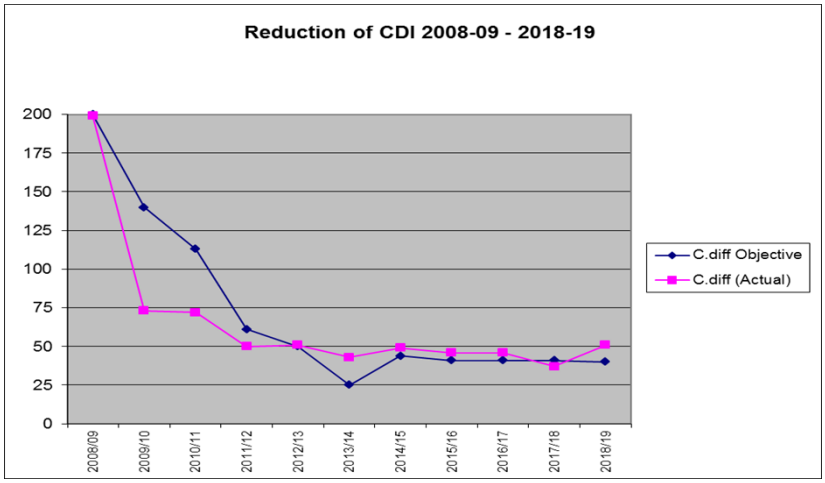
One case reported in March 2019 relates to a patient with longstanding MRSA colonisation, previous bacteraemia, complex medical condition that requires gastrostomy and vascular access. The patient has been in hospital since 2016. The findings of the PIR investigation were that the source of the MRSA bacteraemia was the patient's central venous catheter. The infection was assessed as unavoidable.

Preventing patients with MRSA colonisation of the skin developing subsequent infection is challenging, particularly in patients who have severe underlying conditions, skin

problems or require the insertion of intravenous lines and other devices as part of their treatment. For many years we have had in place regimes to screen all admissions and give topical antiseptics to the skin for patients with known MRSA colonisation. We continued screening all admissions to ESHT throughout 2018/19. Compliance with the Trust MRSA policy has improved significantly this year. A review of MRSA compliance showed that compliance with screening and decolonisation was over 80%.

3.2 *Clostridium difficile* infection (CDI)

The number of *C.difficile* infections reported annually within ESHT is shown in the chart below.



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

Each case of CDI diagnosed beyond 72 hours of admission undergoes a post infection review (PIR) investigation. Findings of these PIRs are presented to the DIPC who agrees with a representative from the local CCG if each case constitutes a lapse of care likely to have resulted in CDI, a lapse of care unlikely to have resulted in CDI or no lapse of care. In 2014/15 the DH revised the objectives for reduction of CDI for Trusts so that where no lapses in care have been identified Trusts may appeal to their local commissioners for these CDI cases not to count towards annual objectives. ESHT worked with the local Commissioners and agreed a process and criteria for review of all cases.

>72hrs CDI	2018/2019
No Lapse in Care	**19**
Lapse in Care likely to have contributed to outcome	**4**
Lapse in Care unlikely to have contributed to outcome	**28**
Pending	**0**
TOTAL cases (year to date)	**51**

The total number of C.difficile infection (CDI) cases for the year was 51, against limit of 40. This number of 51 relates to 48 patients – as 3 patients had a relapsed/recurrent C.difficile infection.

A post infection review was undertaken for each case and the vast majority of cases (47/51; 92%) were considered not preventable or had lapses in care identified which did not contribute to the development of CDI.

Risk factors for development of CDI
As expected, the majority of cases occurred in patients older than 65 years (42/51 cases; 82%); 12 cases (24%) in those older than 75 years and 15 cases (29%) in those greater than 85 years.

The majority of patients had 2 or more risks factors increasing risk of CDI – common associated risk factors included:

- Proton pump inhibitors: (34 cases; 67%)
- Chemotherapy/steroids: (17 cases; 33%)
- Previous history of C.difficile toxin/PCR positive stool specimens (13 cases; 25%)

Antimicrobial use: The three most common indications:

1. Sepsis
2. Respiratory tract infection
3. Urinary tract infection

Most commonly prescribed antibiotics:

1. Co-amoxiclav
2. Piperacillin-tazobactam (tazocin)
3. Gentamicin

The rate of mortality in ESHT related to sepsis had reduced significantly over 2018-2019 and this improvement in recognition and treatment of sepsis would be in keeping with the most common indication for and choice of antibiotic use in the CDI cases.

Another common feature amongst the cases reviewed relates to duration of antibiotic use – most commonly reflecting cumulative courses over a prolonged admission period or multiple admissions during a three month period prior to diagnosis of CDI.

This is likely multi-factorial – reflecting complicated infections and in some instances reflecting delayed discharges due to social circumstances which increases risk of nosocomial infections (e.g. hospital acquired pneumonia) with resultant further courses of antibiotics.

A recovery plan was agreed in August in response to high CDI rates in first two quarters of the year. Focused improvement on antimicrobial prescribing and raised awareness of the CDI policy.

Alert raised at Senior Leaders Forum (chaired by Chief Executive): From Quarter 2 when CDI rates were outside of limits, this was raised at the monthly Senior Leaders Forum and became a rolling agenda item to maintain focus for improvement.

Communications distributed to clinical staff (including medical and nursing staff) via ‘Team brief’ and ‘Focus On’, to raise awareness of high CDI rates, placing emphasis on importance of antimicrobial stewardship and infection prevention and control measures.

Post Infection Reviews (PIRs) show most patients had antimicrobials prescribed as per Trust policy. Some aspects of the policy were amended to promote compliance with best practice. The Trust remains an outlier for antimicrobial use despite reducing use by 5% this year. The trust has also significantly improved sepsis screening compliance and reduced mortality within the past year. The increase in CDI may be a consequence of these improvements but requires careful monitoring as increased prevalence can increase environmental bioburden and potential for transmission within the healthcare setting. As part of our recovery plan in quarter 3, antimicrobial stewardship ward rounds commenced on wards of high CDI numbers and were well received by clinical teams who actively participated.

Lapses in Care
The year ended with 4 lapses in care (Red). Two were due to non-compliance with antimicrobial prescribing best practice and occurred early in the year and two cases were a result of two separate incidences of cross infection from one patient to another.

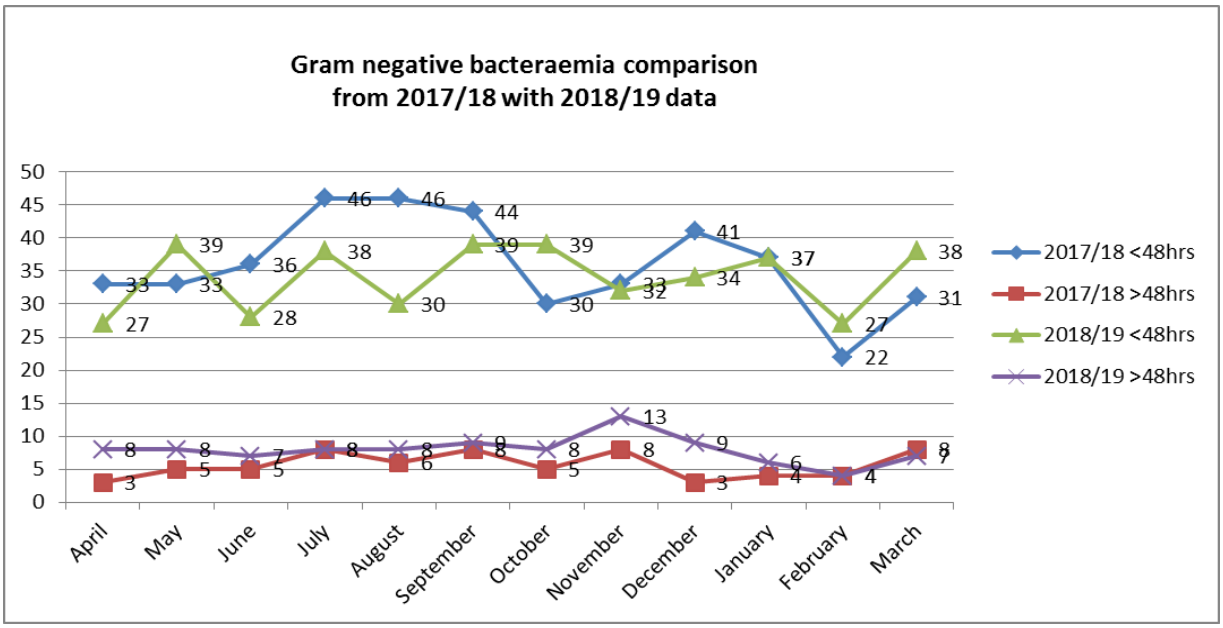
Outbreaks and Periods of Increased Incidence (PIIs)
In line with national guidelines, if there are two or more cases of CDI identified on the same ward within 28 days of each other these are investigated as a PII. Further tests are performed at a specialist reference laboratory to compare the *C. difficile*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

There were two incidences when two cases were shown to be related to each other, these occurred on Folkington (now Westham) ward and on Tressell ward. In each incident the acquisition case was reported as a lapse in care and additional control measures were instigated. Wards were actively engaged to minimise the risk of ongoing transmission. The incidents were reported to the patient safety group. No further escalation occurred.

3.3 *E.coli* Bacteraemias

The reporting of *E.coli* bacteraemia is mandatory for all provider Trusts. The Government announced plans to reduce healthcare associated Gram-negative bloodstream infections in England by 50% by 2021. *E.coli* bacteraemia represents 55% of all Gram negative infections therefore the initial focus is expected to be for Trusts to demonstrate a 10% reduction in both pre and post 48 hour cases with baseline data collected from January 2016 to December 2016. During this period ESHT reported 67 cases of E. coli bacteraemia compared to 62 cases this year, representing a reduction of 7%.

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



The graph indicates an increase in November; however the total for quarter 3 was 26 cases, similar to the previous two quarters. There was a higher number of biliary related E. coli bacteraemias during this quarter which were assessed as unavoidable.

Organism	Total	UTI source	CAUTI source	Biliary	Other	Unknown
E. coli	62	26	12	10	15	11
Klebsiella sp.	29	7	3	7	12	3
Pseudomonas	8	3	2	1	3	1
Total (%)	99	36	(17)	18	30	15

38% of GNBs are related to UTI of which 47% are assessed as CAUTI related. Biliary accounts for 19% and 31% are from other sources including gastro-intestinal, skin soft tissue and intravascular sources.

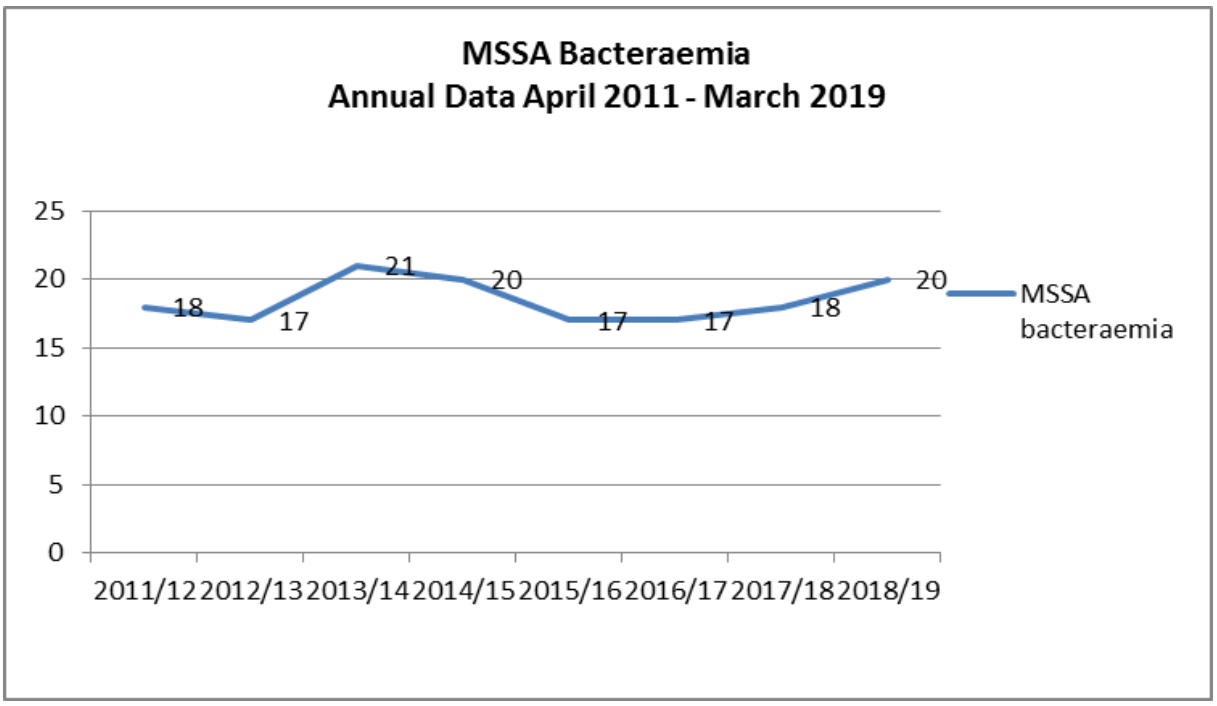
The IPC team reviews all cases of *E.coli* bacteraemia which are thought to be related to hospital acquired catheter associated urinary tract infections (CAUTI). Post Infection Reviews (PIRs) were completed in collaboration with the urology specialist nurse and clinicians involved in the patients care and once completed they are shared with the divisions. Further work is needed to understand why urinary tract infections are causing bloodstream infections. IPC has requested specialist review of these cases by the urology team to identify trends for improvement and this will be undertaken in the coming months.

The annual IPC study day which focused on reduction of Gram negative bacteraemias featured national expert speakers and was attended by the DIPC, ICLFs, Senior Nursing staff and colleagues from PHE, ESCC and CCGs.

This year ESHT has participated in a new national improvement collaborative focusing on reducing E.coli bacteraemia associated with urinary tract infection. This work will continue into 2019/20 and requires a system wide approach as most of the infections occur initially in the community.

3.4 Mandatory reporting of Methicillin sensitive Staphylococcus aureus

There is no reduction target set for these bloodstream infections. PIR is requested by IPC if it is considered that that the infection is HAI and related to practice i.e. vascular access devices, surgery.



The rate of MSSA bacteraemia at ESHT remains stable. Two cases were assessed as potentially avoidable, 1 case in August 2018 relating to central venous catheter and 1 case in March 2019 related to PVC line. On both occasions the clinical teams received support from the vascular access team and IPC.

3.5 Mandatory Surgical Site Infection Surveillance Scheme

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

Please note: PHE SSISS studies are undertaken prospectively and submitted quarterly but results are published 12 months retrospectively as infection rates are influenced by performance and readmissions within the audit population over each 12 month surveillance period. Finalised results are therefore only available up until end March 2018 although data from April 2018 onwards is within the surveillance system and continues to be analysed and officially reported by the PHE at the end of the following year. ESHT submitted data for the four quarters of the year (April 17 – March 2018).

Core data 1st April 2017 – 31st March 2018

Category of surgery	Number of procedures	Number of infections	Infection rate	Mean infection rate for all participating Trusts (data April 2011-March 2017)
Total hip replacement	421	8	1.9%	0.6% (95% CI 0.6-0.7%)
Total knee replacement	477	8*	1.7%*	0.6% (95% CI 0.6-0.6%)

Surgical site infection rates for prosthetic hip and knee surgery were higher than the national average which stands at 0.6%. The national report for 2017/18 currently shows 8 cases of knee infection. This is incorrect and we have received confirmation from PHE that “the 2017-18 Trust tables will be re-uploaded in December 2019 reflecting the change in the number of inpatient/readmission SSI cases for knee replacement from 8 to 6 for East Sussex. Subsequently, indicator data on the PHE Fingertips web site will also be refreshed for both 2017-18 and 2018-19 around this same time to align with these final results".

There was an increase in post-operative wound infections in Trauma & Orthopaedic patients during June, July and August 2017. The Infection Prevention and Control Team have undertaken an investigation at the time to establish if the higher rates represent an outbreak of infection. None of the 11 cases occurring during the peak incidence or the background cases have been shown to be linked by time, place and person and the same organism. The patient’s own bacteria on their skin was likely to be the source. During the peak incidence 8 of the 11 cases had MSSA isolated from the wound. Only two samples were available to send for further analysis and they were found to be different. Three further MSSA samples have been sent that were also shown to be different from each other and all the other samples tested. The available microbiological analysis does not indicate an outbreak. An action plan was initiated to address some practice issues identified during the investigation, which may have been contributing to the overall increased rate.

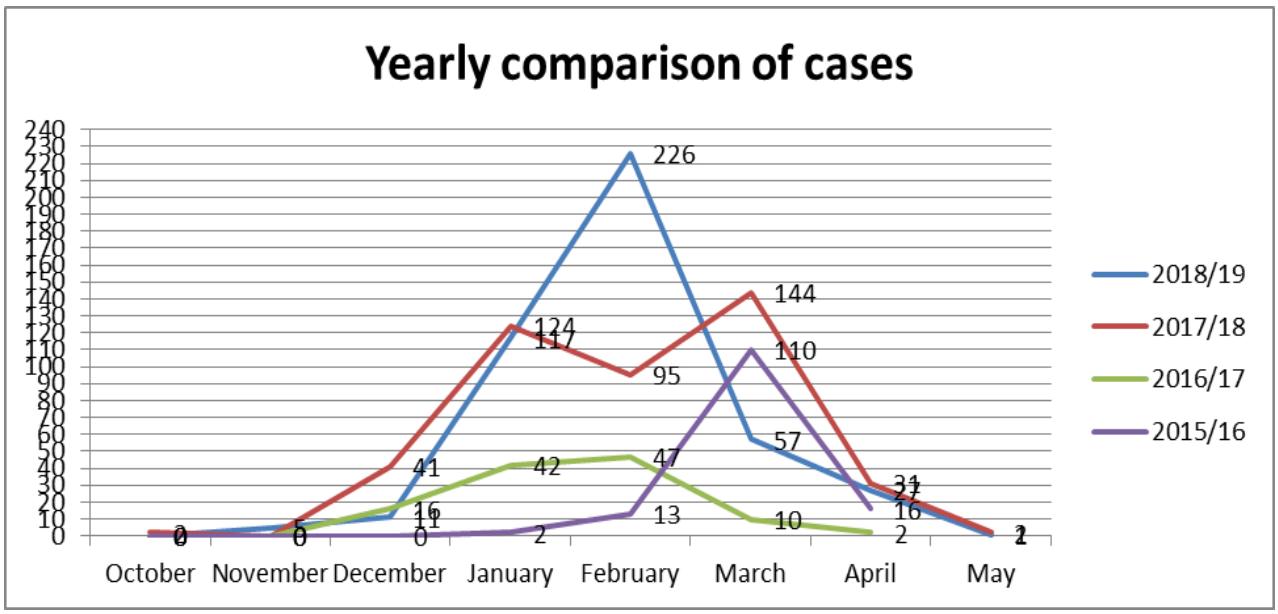
In addition, the process for agreeing cases that meet the definition for reporting to PHE has been strengthened. A new multi-professional group chaired by the Director of Nursing(DIPC) has been convened to assess cases prior to submission to PHE. Ongoing Surveillance of surgical site infection of spinal surgery will be undertaken on as part of the national voluntary scheme under Public Health England (PHE).

The higher background rate of surgical site infection in hip and knee surgery is being monitored by the orthopaedic surgical site infection surveillance nurse through the national mandatory surveillance of orthopaedic surgical site infection scheme. The number of cases being reported to PHE for 2018/19 appears to have returned to our usual level during 2019.

ESHT is taking part in a national study “Quality Improvement in Surgical Teams (QIST)” which intends to halve the rate of orthopaedic surgical site infection through the use of nasal and skin decolonisation of patients to prevent carriage of MSSA causing infection. Patients having planned primary hip and knee replacement surgery are invited to take part in the study which is being led by the orthopaedic team with collaboration from pharmacy, research, information management and IPC.

3.6 Influenza

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



We experienced our busiest influenza season to date, with over 450 cases diagnosed. Additional resources were provided to enable testing for influenza to be undertaken at both Conquest and EDGH so that results were available quickly. This new process worked well. The IPCT responded to each case of Influenza to assess the risk and provide advice to patients and staff. Patients were managed in line with national guidance and the Surrey and Sussex guidance for managing influenza patients in times of operational escalation. The majority of confirmed Influenza patients presented to the Trust with flu like symptoms on admission indicating that they had acquired the infection in the community (incubation period 1-4 days).

There was an outbreak of Influenza at EDGH, first detected on 4/2/19 involving Berwick, Seaford 3 and Seaford 4, Cuckmere wards. Detection of hospital acquired cases can be complicated by the fact that the swab taken to confirm influenza is a PCR test that can remain positive for several weeks after a patient has the infection therefore diagnosis of current influenza needs to be based largely on symptoms. Thirty patients were identified as probably acquiring influenza while in our care. The outbreak occurred during high prevalence of Influenza nationally and was challenging to manage at the time when the Trust was operationally working at OPEL 3. A serious incident investigation was undertaken and has been submitted to the CCG for sign off. An action plan related to lessons learnt during the influenza season and outbreak has been implemented.

Six patients who were initially assessed as possible hospital acquired infection and subsequently died with influenza on their death certificates were reviewed in detail by the Infection Control Doctor with input from the consultants caring for the patients. A comprehensive report (overseen by the DoN/DIPC and the Medical Director) was provided to patient safety. The review found that there were no lapses in care that contributed to the patients acquiring influenza and there was evidence of good practice.

Over 75% of ESHT frontline clinical staff have been vaccinated against seasonal influenza. This has been achieved as a result of the campaign managed by Occupational Health and Wellbeing and utilisation of a peer vaccination scheme.

4. Incidents related to infection

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

ESHT reports outbreaks of infection as possible serious incidents to the patient safety group who agree if an SI report or Amber (for internal learning) SI is required. These include incidents where there has been a significant impact on the running of the Trust's services (ward closures for example), or where there has been a severe impact on patient outcome. In addition to this the team undertook 43 risk assessments in response to organisms that could pose a risk to patients and/or staff in order to ensure they were safely managed.

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

Month	SI No	Incident
April 2018	Downgraded to severity 2 as no harm	Transmission of measles to a healthcare worker from a child and their mother who were both diagnosed and treated for measles (likely to have acquired abroad) at Conquest hospital. All recovered without harm.
May 2018	Downgraded to severity 2 as no harm	Three patients in the same or adjacent bed space probably acquired colonisation of MRSA during their stay on ITU at EDGH as their admission screening was negative. No harm caused.
February 2019	2019/4334	30 patients acquired influenza while being treated at EDGH during a period of high prevalence and operational escalation. A comprehensive investigation report has been submitted to the Patient Safety Group and CCG for sign off.

The outbreaks highlighted that there is a need to strengthen processes for contact tracing of staff and prescribing of prophylaxis treatment. IPC are working with Occupational Health and Wellbeing team to agree new process for contact tracing. The antimicrobial pharmacist is supporting with regard to prescribing procedures.

4.2 Norovirus

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

The following wards were closed due to outbreaks of confirmed Norovirus

Month	Area	No. of people affected	Duration of closure
July 2018	Newington ward	36	19 days
October 2018	Berwick ward	6	6 days
November 2018	MacDonald ward	24	10 days
March	Baird ward	37	7 days

The outbreaks were well managed by IPC and the Clinical Site team, in line with national guidance.

5. Emerging threats and operational preparedness

5.1 Carbapenemase-producing *Enterobacteriaceae*

Carbapenemase producing *Enterobacteriaceae* (CPE) are bacteria that are resistant to Penicillin, Cephalosporin and Carbapenem antibiotics and often have resistance to multiple other antibiotics. This means that there may be only one or two antibiotics that can be used to treat them. They are a potentially major problem because these bacteria cause common infections such as urinary tract and intra-abdominal infections. ESHT has seen very few cases of infection with these bacteria to date. However appropriate IPC measures are in place to manage the risk should a case arise.

The CPE policy was developed during 2015/16 and the IPCT re-audited compliance with policy this year.

No	Standards	Re - audit Compliance 2018/19	Previous Audit Compliance
1	A CPE risk assessment is carried out on every patient admitted to ESHT	69%	23.87%
2	At risk patients are isolated on admission	78%	54.44%
3	At risk patients are screened for CPE	93%	63.33%

The results show that the policy is now embedding into routine practice. This includes recognising patients admitted to the Trust who are at higher risk of being colonised/infected with CPE and isolating and screening these patients for CPE.

5.2 Operational preparedness

The Emergency Preparedness, Resilience & Response (EPRR) group established initially in response to the threat of VHF (Viral Haemorrhagic fever) including the Ebola virus, continues to function within the organisation to ensure ongoing plans are in place for potential risks including VHF cases and other emerging threats and diseases such as Pandemic Influenza and CPE. The EPRR manager reports to the TICPG on matters that impact on infection prevention and control.

6. Infection Prevention Activities and Innovation

6.1 Hand Hygiene Promotion

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

- Monitoring of compliance by clinical staff with monthly audits.
- Monthly hand hygiene promotional posters
- Training of ICLFs to undertake practical hand hygiene training of clinical staff.

- Providing training of all staff on induction (joining the organisation) and at regular mandatory updates.
- Ad-hoc training when indicated for focused improvement.
- Series of focussed hand hygiene promotion events for staff and patients including participation in the International World Hand Hygiene Day during May 2018.

The theme of this year focused on promoting awareness of “sepsis six” and we matched this with the royal college of nursing promotion around reducing glove usage to promote better hand hygiene. Clinical teams engaged in producing promotional material within their areas, using fun and innovative ways to show their support for the campaign.

6.1.2 Hand Hygiene Compliance

Monthly hand hygiene audits are undertaken by Infection Control Link Facilitators (ICLFs) measuring compliance by healthcare staff in direct contact with patients. Observations are made in each clinical area and feedback is given at the time of audit by the Infection Control Link Facilitator, staff responses are noted as part of the audit. Results are monitored to detect trends and act where frequent non-compliance occurs.

Recurring themes across both sites for 2018/19 identified that some staff failed to comply with the Trusts policy for hand hygiene and continued to wear long sleeves, watches, and jewellery whilst in clinical areas. All staff members were approached immediately to comply with the Trusts Infection Prevention and Control policies to ensure patient safety. Members of staff who have repeated observation of noncompliance were promptly advised to improve their practice by the clinical area matron.

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

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

Totals	April 2018		May 2018		June 2018		July 2018		Aug 2018		Sept 2018		Oct 2018		Nov 2018		Dec 2018		Jan 2019		Feb 2019		March 2019	
	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
EDGH Total	98	280	99	200	98	200	99	185	98	191	100	93	98	224	99	176	99	248	99	253	98	243	99	283
Conquest Total	98	193	98	233	97	220	98	281	97	207	98	179	99	243	99	173	99	246	98	210	99	299	99	268
Community Total	99	90	99	80	100	60	92	61	100	67	97	25	96	80	98	39	97	57	99	80	99	57	98	73
Trust Overall Compliance	98	563	98	503	98	480	98	527	98	465	98	297	98	555	98	388	99	551	99	543	99	599	99	624

In order to validate this data and provide assurance of its accuracy the associate practitioners in the IPC team audit compliance with hand hygiene and bare below the elbows. Their audits support that there is overall high level of compliance among trust staff.

In April 2018 the Trust's recording system (Meridian) for hand hygiene compliance was discontinued. To facilitate the transition from Meridian to Allocate My assure system the ICLFs were asked to submit paper copies of their hand hygiene audits.

The short transition period made it difficult to communicate an alternative plan with the ICLFs and as a result the first quarter of 2018/19 saw a marked reduction in hand hygiene observations undertaken within the Trust as the new recording system Allocate-My Assure for hand hygiene compliance was still experiencing operational issues. ICLFs were offered guidance and support by the Allocate, My Assure Team and the Infection, Prevention and Control Team. In Quarter 3 and 4 there was an increase in the number of hand hygiene audits submitted within the Trust compared with the previous months. This increase was due to improved compliance from staff inputting hand hygiene data via the new system Allocate-My Assure.

In March 2019, (Quarter 4), the IPCT recognised that the Trusts hand hygiene audit process for outpatient areas needed to be reviewed to ensure validity. There was concern about how valid it was for ICLFs to audit their staff in their area for hand hygiene compliance as many areas only have either lone working staff or staff that work behind closed doors when patient consultations were taking place. A “Fit to Care” hand hygiene compliance check list has been introduced to provide assurance that staff who cannot be audited have undergone the correct IPC training and have the right equipment to be compliant with IPC policies. The process has been successfully trialled and will be fully introduced for community and outpatient teams from 1st of April 2019. This new process will be developed further; to create an electronic version will be created on Allocate My Assure, for outpatients areas to input their hand hygiene compliance data.

6.2 Audit activity

The IPCT co-ordinates a number of planned and unplanned audits throughout each year to monitor compliance with core infection prevention and control standards and any areas of risk or concern which may arise as a result of incidents.

The following audits were completed:

- Monthly staff hand hygiene audits
- Quarterly Peer hand hygiene audits
- National Specification of Cleanliness audits reported and monitored monthly at TIPCG - compliant
- Re-audit of compliance with Control of Carbapenemase Producing *Enterobacteriaceae* (CPE). Audit no. 4027 – Improving compliance
- One together audit of compliance with best practice across the surgical pathway – pilot audit of 5 patients across orthopaedic pathway identified areas for improvement which are to be monitored by DAS governance.

6.3 Training and Education

The IP&C specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required. For example:

- Mandatory training on induction for all staff and volunteers
- Annual mandatory training for all clinical staff.
- Annual updates for clinical staff, patient facing staff, food handlers and other high risk groups
- 3-yearly mandatory training for non-clinical, non-patient facing staff.
- Training is provided monthly to ICLFs on the control and management of key infections for cascade to clinical teams.
- Focused training has been delivered directly to ward staff on control and management of CPE, CDI, MRSA and decontamination of beds and equipment.
- Train the trainer sessions in Hand Hygiene and Fit Testing of FFP3 masks (cascaded by ICLFs)

Compliance with attendance at mandatory induction and update sessions remains above 85% and is monitored by the Trust along with other mandatory components of the Trust mandatory training programme.

6.4 Professional Development

All specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings.

As well as utilising the in-house Learning & Development training programme team members have been supported in attending other essential specialist training and conferences required to maintain their professional practice to enable them to provide education and training to others in the organisation including:-

- Infection Prevention Society, London South Branch development days
- Annual Infection Prevention and Control Conference
- Mentoring skills development workshop
- Foundation degree in Health and Social Care
- Public Health Practitioners Register Course
- Functional skills assessment
- MSc in Infection Prevention and Control

7. Housekeeping Services

The housekeeping services for ESHT are provided by the in-house team within Estates and Facilities. Housekeeping resources are matched to each area in line with the National Specification for Cleanliness (NSC) guidelines and the associated risk ratings – Very high Risk, High Risk, Significant and low.

Regular audits in line with the National Specification for Cleanliness of all areas are undertaken by our independent NSC audit team to ensure that the Cleaning services are achieving the required standards and for 2018 – 19 we have consistently achieved a score of 96.87% compliance against a target score of 91.06%.

7.1 Deep clean programme

An important part of housekeeping services is to support the reduction of infections and meeting CQC regulation 12 “Cleanliness and infection Control”. We have a 24hr Rapid Response team on each acute site which supports the clinical operational demand and provides a service ‘out of hours’. The housekeeping team works in close partnership with IPCT and has worked on alternative ways of ensuring cleanliness standards are maintained. Weekly NSC review meetings are held to discuss standards in partnership with IPCT, and actions are drawn up to address low standards if needed in any areas until a structured deep clean plan can be established.

7.2 Activity

Housekeeping continued to receive demands from all areas for cleaning support from the Rapid Response Team including single rooms, bed space cleans, and others this averages at about 200+ calls per month per acute site. To meet this demand calls for cleans are prioritised and communication and support is structured from the IPCT and clinical site leads and clear plans are in place at all levels to ensure patient disruption is minimised

7.3 Service development

The Housekeeping department continues to use HPV Hydrogen Peroxide Vaporisation units to support the reduction of infections by destroying organisms, this process is undertaken by the rapid response team who are on site 24hrs and can be deployed to any site if called upon this will be sustained in the modernisation plan.

To support IPCT working practices and water safety we have revised our sink cleaning procedures. Standard operating procedures have been revised and training rolled out to all Housekeeping personnel.

As part of the Productive cleaning programme we are looking to introduce a ward / departmental handover book for our Housekeepers so that vital information can be passed from one shift to another, (E.G. which bays have been pulled or require deep cleaning). This is to help ensure that there is consistency in our cleaning services each day.

8. Antimicrobial Stewardship Activities and Innovation

The Trust has an established Antimicrobial Stewardship Group (ASG) has a core membership of a consultant microbiologist, medical consultant, Clinical Pharmacy Manager, Antimicrobial pharmacist and a CCG representative. The purpose of the ASG is to support the prudent prescribing of antimicrobials to reduce antimicrobial resistance rates. It does this by:

- Developing and maintaining evidence based antimicrobial policies and guidelines for use in secondary and primary care
- Ensuring safe and cost effective use of antimicrobials taking local, national and international bacterial resistance rates into account.
- Monitoring antimicrobial usage (reviewing daily divided doses, antimicrobial expenditure data and compliance to guidelines using a point prevalence audit) and addressing any issues that may arise.
- Undertaking audits on antimicrobial prescribing practice and MRSA decolonisation and providing feedback to TIPCG, ASG and MOG
- Providing advice to other specialist groups/committees on use of antimicrobials
- Providing education to staff on all matters relating to prescribing and administration of antimicrobials.
- Educating patients and members of the public on antimicrobial stewardship
- The lead antimicrobial pharmacist providing feedback from lesson learnt, following a Post Infection Reviews to the pharmacy team.

8.1 Antimicrobial Prescribing Policy and Guidelines

The adult and paediatric guidelines are reviewed, and updated if required, by the ASG on regular basis. The guidance is peer-reviewed, evidence based and specialist Consultants and/or AHP are consulted in writing prescribing advice. The antimicrobial guidelines are available on a smartphone app and desktop.

8.2 Multi-disciplinary Ward Rounds

The Consultant Microbiologists (CMM) and antimicrobial pharmacists continue to participate in daily Intensive Care Multi-disciplinary team ward rounds at both sites. In addition, there are weekly *Clostridium difficile* infection ward rounds, if necessary, at

both acute sites and a weekly ward round to discuss immunocompromised haematology-oncology patients on Pevensey ward at EDGH. The aim is to ensure specialist input into the highest risk/most critical patients in the hospitals.

Antimicrobial ward rounds with Consultant microbiologist, antimicrobial pharmacist and clinicians have been introduced on a limited number of wards at Eastbourne and Conquest hospitals. The aim is to reduce the inappropriate prescribing of antibiotics, reduce the risk of treatment failure and the possible development of antimicrobial resistance and provide support to the prescribing team. The clinical medical microbiologists have found the AMS ward rounds to be productive and there is good engagement from the clinicians.

The AMS ward round has made a number of interventions that include;

1. stopping treatment
2. escalating/ de-escalating the antibiotic
3. switching administration route from an intravenous to oral treatment
4. continuing current treatment and providing advice on duration/review date.

8.3 Training

The Trust antimicrobial e-learning module prescribing has been updated and is available on the internet. All Trust doctors are required to pass this module – as part of induction or at least every three years. In addition, the Consultant Microbiologists and pharmacy provide face to face teaching about antibiotic prescribing for FY1 and FY2 doctors.

For pharmacy, there is an antibiotic training pack to help support the development of rotational pharmacists in antimicrobial use and prescribing. This training pack is based on the Royal Pharmaceutical Society antimicrobial training guidance.

8.4 Antibiotic Incident reports

The lead antimicrobial pharmacist is also involved in reviewing of incidents reported on Datix involving antimicrobials. An antimicrobial and ward pharmacist, where possible, attends Post Infection Reviews.

8.5 Audit of antimicrobial usage

Improving antimicrobial stewardship at East Sussex Healthcare NHS Trust (ESHT) forms part of the quality improvement strategy for patient safety and help to reduce inappropriate prescribing and optimise antibiotic use. The Trust total antimicrobial consumption rate is monitored using pharmacy and admission data, the use of Public Health England (PHE) fingertip and Define.

The total antimicrobial use (Defined Daily Dose (DDD) / 1000 hospital admissions) for East Sussex Healthcare NHS Trust (ESHT) is greater when compared to average England and non-teaching hospital consumption.

	2017/18 (DDD/1000 hospital admission)	2018/19 (DDD/1000 hospital admission)	Comparing 2018/19 against 2017/18
ESHT	5481.2	5215.35	-4.9%
England (average)	4902.6	5024	+2.5%
ESHT vs. England average	+11.8%	+3.8%	

Post Infection Reviews (PIRs) show most patients had antimicrobials prescribed as per Trust policy. The Trust is an outlier for antimicrobial use but has reduced usage by 5% and significantly improved sepsis screening compliance and reduced mortality within the past year.

To monitor and provide assurance to the Trust, pharmacists undertake a monthly antimicrobial stewardship audit reviewing antimicrobial prescribing, by ward and consultant, to help identify any area(s) of concern and highlight where improvements can be made. Due to the audit workload, a monthly point prevalence survey is not feasible with the current staffing level. Implementation of the electronic prescribing and medication administration system (ePMA) in 2019/20 will address this problem. The ePMA should be able to highlight antimicrobial use by prescriber, ward and clinical division. In addition, a report on live prescribing will be provided and this will enable pharmacy and microbiology to target AMS ward rounds more effectively.

8.6 Antibiotic CQUIN 2018/19

The trust has been advised that it will receive full payment for the CQUIN this year.

9. Water Safety Incidents

9.1 *Legionella* species:

Legionella pneumophila serogroup 1 is the most virulent strain causing the majority of infections. The remaining non-pneumophila species (found in water and soil) are considered non-pathogenic until shown to cause disease, mainly associated with severely immunosuppressed patients.

Legionella pneumophila (serogroup 2-14) was isolated from a water sample in non-patient areas of Bexhill hospital in low numbers. Remedial measures were taken and the repeat result show further reduction in the level isolated. Estates and Facilities team are supporting regular flushing of the water outlet. The risk will be managed and monitored by the water safety group.

There has been no known hospital acquired cases of *Legionella* to date. Legionella sp. has not been identified at EDGH this year.

9.2 *Pseudomonas aeruginosa*

Pseudomonas has been detected in routine water sampling from an outlet in Special Care Baby Unit (SCBU) since August 2018. Tests were repeated in September and the hand wash basin in SCBU remained positive. IPC have reviewed the sink and there is a filter in place. Tap cleaning records were correct with tap cleaning and frequency of cleaning/flushing increased to four times daily (records indicate that this is completed 3-4 times daily). Repeat testing in Quarter 4 showed that there was minimal contamination of the outside of the tap, cleaning was effective but the water samples when the filter is removed were positive which indicated that there was source within the tap or pipework. The pipework has since been replaced and the tap moved to a higher position. Repeat water tests are clear of pseudomonas indicating that the problem has resolved. There have been no healthcare associated pseudomonas infections on the unit.

10. Clean care award

The quarterly clean care award was introduced during the end of 16/17. To win the award teams have to demonstrate the following:

- No preventable/avoidable infections
- 10 hand hygiene observations submitted each month
- Compliance with average monthly National Specifications for Cleanliness (NSC) audit scores
- Consistent attendance at the monthly Infection Control Link Facilitators meetings.

Winners of the Clean Care award 2018/19

Quarter 1	A&E Conquest and Dr Nahhas Team & Dr Nash EDGH
Quarter 2	MacDonald Ward, Conquest and Seaford 3 ward, EDGH
Quarter 3	Tressell Ward, Conquest and General OPD, EDGH
Quarter 4	Mirlees Ward, Conquest and Friston Ward, EDGH

11. Annual Programme of Work / Priorities for 2019/20

Taking into account the performance delivered by the Trust in 2018/19, the lessons learnt from the PIR investigations of MRSA bacteraemia, *Clostridium difficile* infections, and audits, work priorities will include:

Gram Negative Bacteraemia Reduction objective = 3 year reduction programme

- Audit of UTI related GNBs for Quality Improvement plan and active participation in Sussex regional improvement group.
- Work streams for prevention of UTI and CAUTI
- Training and Policy development

Improving rates of surgical site infection - Continuing the 18 month QIST research programme, for primary total Hip and Knee replacement surgery in order to reduce surgical site infection rate.

Revised CDI objectives - Revise IPC surveillance documentation to reflect new reporting algorithm. Support antimicrobial stewardship and timely feedback from PIRs.

Produce visitor and Patient information

- How to reduce your risk of infection – including action to reduce risk of UTI & CAUTI
- Reducing the risk of infection - Guidance for visitors

Influenza planning

- Support Vaccination programme
- Implement recommendations from SI report on Influenza.

Compliance with regulation 12, outcome 8

- Review of processes for contact tracing following exposure to infection.
- Agree training to support ANTT competence.

The above will be incorporated into the Infection Prevention and Control's Annual Programme of Work and monitored through the Infection Prevention and Control Group.

We endorse the Infection Prevention Society's vision that:
"No person is harmed by a preventable infection"

East Sussex Healthcare NHS Trust

Annual Safeguarding Report

2018 – 2019

Contents

East Sussex Healthcare NHS Trust Annual Safeguarding Report

1.0 Introduction

The 2018-2019 Annual Safeguarding Report provides the East Sussex Healthcare NHS Trust (ESHT) Board with an overview of; the safeguarding work undertaken during the year, the planned work to further improve safeguarding practice in 2019 – 2020 and an assurance position on the Trust's compliance with the legislative and regulatory framework. This includes;

- Working Together to Safeguard Children (2013, 2015, 2018)
- Children Act (1984, 2004) ESHT must be able to demonstrate that it safeguards children who access our care under section 11.
- Safeguarding Vulnerable Adults in line with the Care Act 2014 and Department of Health Care and Support Statutory Guidance issues under the Care Act 2014.
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment 2007.
- The Modern Slavery Act 2015
- Safeguarding Children and Young People: Roles and Competences for Health Care Staff (2015, 2019).
- Safeguarding Adults: Roles and Competences for Health Care Staff (2018).
- Female Genital Mutilation Act, 2003

2.0 Safeguarding Governance

2.1 ESHT Safeguarding

Providers of NHS funded healthcare are required by NHS England to comply with the Safeguarding Vulnerable People in the NHS Accountability Framework (2015). ESHT needs to demonstrate that it is has effective arrangements to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these arrangements are working. These arrangements include;

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults, as appropriate.
- A suite of policies including Safeguarding & Safeguarding Supervision
- Effective safeguarding training of all staff commensurate with their role and in accordance with;
    - Safeguarding Children and Young People: roles and competences for healthcare staff (Royal College of Paediatrics and Child Health, 2019)
    - Looked After Children: Knowledge, skills and competences of healthcare staff (Royal College of Paediatrics and Child Health, 2016).
    - Safeguarding Adults: Roles and Competences for Health Care Staff (2018).

- Effective safeguarding supervision arrangements for staff working with children/ families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies
- Named Safeguarding Professionals covering specific specialist areas
- Head of Safeguarding/ Mental Capacity Act assessment Lead/ Mental Health Lead posts.
- Compliance with the Head of Safeguarding having a statutory role for managing safeguarding allegations against staff, alongside Adult Social Care & HR colleagues.
- Developing an organisational culture where all staff are aware of their personal responsibility to report concerns and to ensure poor practice is identified and tackled.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance, including MCA (2005) and the Children's Act (1989 and 2004).

The Intercollegiate Document (2015, 2019) requires NHS organisations to have structured safeguarding leadership with clinical and safeguarding expertise. The Director of Nursing is the Executive Lead and strategically leads the safeguarding agenda has corporate responsibility to ensure effective trust wide safeguarding; expertise, arrangements and reporting are in place. The Director of Nursing supports the Head of Safeguarding and the Safeguarding team, and co-ordinates with the Divisional Associate Directors of Nursing; who are responsible for ensuring robust safeguarding arrangements and practice in each clinical division.

The governance and reporting arrangements, to provide floor to Board scrutiny and assurance, in place reflect the organisational structure divisionally and corporately. The Safeguarding Operational Group and Divisional Governance Meetings are held monthly and report into the bi-monthly Strategic Children and Adults Safeguarding Group, which reports to the Trust Board via the Quality and Safety Committee.

ESHT safeguarding policies for adults and children set out the key arrangements for safeguarding practice, roles and responsibilities. During 2018 – 2019;

- Safeguarding governance structures have been revised to improve operational understanding of safeguarding responsibilities.
- The Safeguarding Children Policy and Training has been updated to reflect current safeguarding issues, including Domestic Violence, PREVENT, Child Sexual Exploitation (CSE), County Lines, Cuckooing and Modern Slavery and Human Trafficking.
- A Policy for Allegations of Abuse against Staff provides a framework, relevant to both adult and child safeguarding, to support Trust professionals when dealing with such allegations.
- Compliance with all safeguarding policies being in date was maintained at 100% throughout 2018-2019.
- A Looked After Child policy has been written and presented to the policy group

Divisional safeguarding reporting, via a standardised reporting tool, has improved visibility of safeguarding practice in divisions, highlighted challenges and shared them for resolution. These reports are a standing item at every Strategic Children and Adults Safeguarding Group meeting. There is increasing divisional ownership and engagement across the safeguarding agenda and a resulting increase in workload for the safeguarding team.

2.2 System Safeguarding

The legislative and regulatory safeguarding requirements set out duties for ESHT to co-operate and support wider system safeguarding practice with our statutory partners, the Local Authority and the Police. The Director of Nursing is a member of both the Local Safeguarding Adults and the Local Safeguarding Children's Boards in East Sussex. The Head of Safeguarding and members of the team fully support the sub-committees, groups and processes of both safeguarding boards enabling ESHT to drive forward both the national and local safeguarding agenda in partnership. This supports ESHT to actively learn from safeguarding reviews, partner agency reports, national safeguarding challenges and local issues to drive improvements in our practice.

Safeguarding staff are involved in the East Sussex Better Together (ESBT) programme, developing integrated health and social care for the residents of East Sussex. The team provide safeguarding advice and expertise to a range of colleagues and Safeguarding Board members.

2.3 Care Quality Commission (CQC) Inspection

The CQC inspection of the Trust in March 2018 influenced the work planning of the Safeguarding Team during 2018-2019. This has led to a review of safeguarding arrangements both corporately

and within the divisions. Whilst noting the significant improvements from their previous inspection, they found;

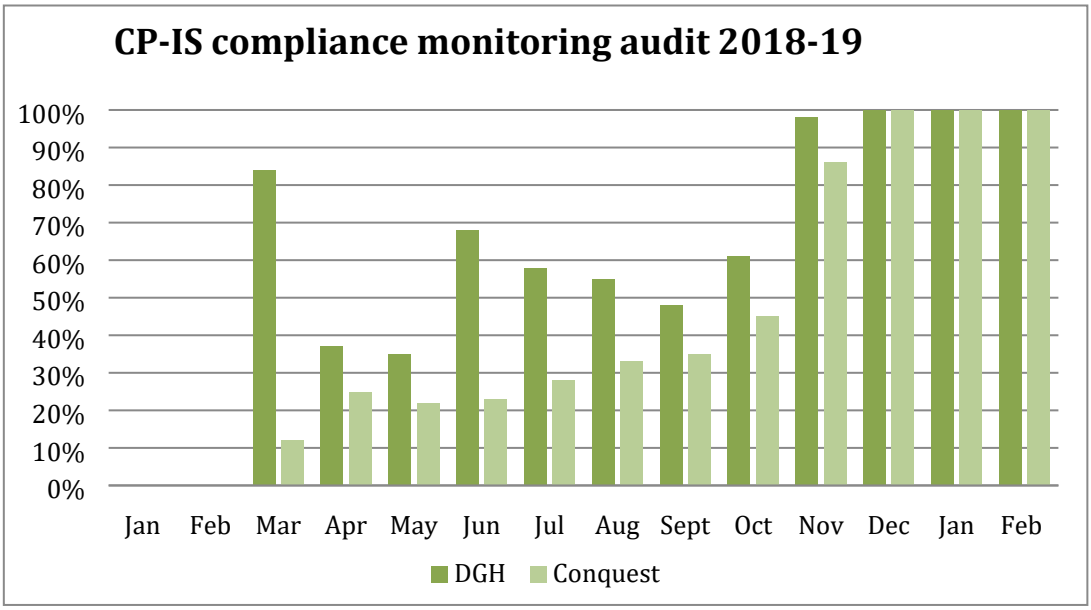
- There were robust safeguarding adults and children arrangements that were in line with current national guidance.
- The Trust had 'done much work on staff responsibilities in respect of the Mental Capacity Act, 2005, all Deprivation of Liberty Safeguard applications were appropriate and referrals to the Court of Protection were made when necessary.
- Staff knew how to access the safeguarding team and explained clearly how to make a safeguarding referral. Each area had a safeguarding champion who linked to the Trust's safeguarding team. Safeguarding vulnerable adults, children and young people was given sufficient priority.
- The Annual Report (2016-2017) provided evidence of learning from safeguarding incidents within the organisation and also from external reviews and investigations.
- Staff the CQC spoke with had the correct level of safeguarding training for their roles. However there were specific areas where compliance fell below expected standards; overall completion rate for medical and dental staff in Medicine was 83.4%, not all nursing staff in outpatient clinics where children were catered for were trained to safeguarding children level 3. This was targeted during 2018-2019 and now outpatients' department staff have been trained according to their role.
- Whilst training rates for the Mental Capacity Act (2005) exceeded the Trust's target of 90% and staff demonstrated good knowledge of this, an audit in autumn of 2018 indicated low compliance with documentation relating to mental capacity assessments in some areas. This was addressed over the following 12 months by offering MCA/DoLS mandatory training programme.

Overall, the Trust Board should be assured that it has robust safeguarding arrangements in place, that it can evidence learning through safeguarding leading to change and that staff have a commitment to safeguarding the people using our services. However, there will always be further improvements, changing requirements and best practice to embed through the organisation and this will be fully supported by the Director of Nursing as the executive lead.

3.0 <u>Key Achievements in Safeguarding 2018 – 2019 by various colleagues and teams</u>

- The Safeguarding Team were the winners of the Trusts Working in Partnership Award.
- The Safeguarding Team actively participated in the national Domestic Abuse Awareness campaign.
- They have proactively undertaken a review of the services provided to young people between 16–18 years from a safeguarding perspective, piloting a Safeguarding Transition Specialist Nurse role to oversee patients placed on adult wards and out-patient specialism such as diabetes.
- They have re-designed the Mental Capacity Act and Deprivation of Liberty training and support to staff, moving to e-solutions, following a review of training and staff knowledge. Our staff now have access to the NHS Safeguarding app and Media Training.
- The Head of Safeguarding has revised the collaborative working arrangements with Sussex Partnership NHS Foundation Trust to ensure interventions where patients are sectioned are recorded, compliance with training and improved practice with the Mental Health Act (2007) where detained patients are admitted to our inpatient beds.
- Colleagues have delivered training to key professionals using a risk based approach, to key teams in ESHT to ensure the rights of patients detained under the Mental Health Act are safeguarded.
- The team has refined safeguarding governance systems and processes delivering increased collaborative working with the divisions and visible assurance information for the Board.

- Colleagues have implemented the mandatory Child Protection Information System (CP-IS) in the emergency departments to ensure clinicians are supported to safeguard children achieving 100 % compliance in March 2019.



- Secured external funding for an Independent Domestic Violence Advisor (IDVA) working with the emergency departments, maternity services and Special Care Baby Unit to improve practice, documentation of risk and support affected persons. In March 2019 ESHT were informed by the CCG that funding stopped and service would cease in May 2019. This is being escalated and pursued by the DoN with senior CCG colleagues.
- Successfully raised the PREVENT profile, attending the Regional Prevent Board, and sharing information across the Trust through awareness and targeted WRAP training.
- Implemented the mandatory Female Genital Mutilation Information System (FGM-IS) in maternity.
- Maternity Safeguarding Midwives raised the profile of domestic abuse within maternity. Working with Maternity staff with strategies to enable them to discuss the issue of domestic abuse with all pregnant women antenatal and postnatal.
- Worked closely with Women's and Children's Division and Urgent Care to address concerns regarding the experiences of Mental Health patients, specifically through audit, review of the Risks upon the Trust Risk Register and development of a more robust process of monitoring the patients that are referred to Child and Adolescent Mental Health and Children's Social Care database (GDPR compliant) .
- Undertaken a GDPR review of information sharing.
- Increased the delivery of Safeguarding Supervision in Adult and Child Specialist areas, specifically the community which has managed self-neglect and complex caseloads.
- Contributed to LSCB Quality Assurance Subgroup in monitoring and evaluating the effectiveness of the work carried out by board partners by contributing to 4 multiagency audits (regulars case file, elective home educated, domestic abuse and fabricated or induced illness).
- Multi-agency Child Exploitation (MaCE) alerts have been added to e-searcher to identify young people at risk.

Throughout 2018–2019 ESHT is changing practice as a result of the learning from Safeguarding Case Reviews, including;

- A domestic abuse training package has been developed to improve staff knowledge and help staff support patients. Specialist domestic abuse workshops have been commenced for acute staff
- Developing a programme to support staff who are working with patients who self-neglect (Adult A - Safeguarding Adult Review)
- Safeguarding learning will inform the work underway regarding discharge planning (Adult C - Safeguarding Adult Review)
- A Child Serious Case Review (Child T) - has highlighted risks associated with vulnerable children who transition from Child to adult health and social care services. An innovative multiagency project is now being piloted where high risk safeguarding complex cases with chronic medical needs are now jointly supervised by both ESHT and the Local Area safeguarding team.
- Maternity services are improving their practice in relation the return of mother and baby hand held notes postnatal.

4.0 National Context

4.1 Child Safeguarding Arrangements

The Woods Report: A Review of the Local Safeguarding Children's Boards

This national report gained traction in 2018-19. Locally the Safeguarding Children's Board roles and functions were reviewed. The report sets out a new framework for improving the organisation and delivery of multi-agency arrangements to protect and safeguard children. It contains recommendations for government to consider with regard to Local Safeguarding Children Boards (LSCBs), Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). The LSB locally did not have any major changes.

Recommendations:

To replace the existing statutory arrangements for LSCBs and introduce a new statutory framework for multi-agency arrangements for child protection within a prescribed period. The three key agencies are health, police and local authorities. Local areas/regions would need to establish a plan which would describe how services would meet the new statutory framework, the existing legislative framework underpinning LSCBs should cease to operate as new arrangements come into being. Where an LSCB has been functioning effectively (as in East Sussex) there is an option to retain existing ways of working.

To discontinue Serious Case Reviews, and to establish an independent body at national level to oversee a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm. Providing new guidance to cover best practice in undertaking single and multi-agency inquiries, including the importance of a rapid response and transparency in publicising how an area has learned for the event and what has changed in local practice; and advising how learning can be reported through existing local accountability structures so as to ensure transparency and promote learning.

Child Death Overview Panels (CDOPs) are to move from the Department for Education to the Department of Health and consider how CDOPs can best be supported and sponsored within the arrangements of the NHS. If the national study recommends the introduction of a national database for CDOPs, the Department of Health should consider expediting its introduction in 2019.In recent years there have been Serious Case Reviews where there has been the death of a child and as a result it has remained funded within the ESHT Safeguarding budget.

The ESHT CDOP Specialist Nurse is a member of the panel. A review is held into each death to determine whether there are modifiable factors which may have contributed to the death. The most common modifiable factor continues to be inappropriate sleeping position for babies. East Sussex healthcare Trust (ESHT) have undertaken a review of the work regarding safe sleep advice/strategies and have shared this with all health colleagues within ESHT and external partners such as children's centres.

There had previously been a rise in suicide rates in young people but this has reduced locally over the last 4 years. However the mental health and resilience of young people remains a safeguarding issue which has been raised nationally and locally through the East Sussex Children and Young People's Mental Health and Wellbeing Transformation Plan (2015-2020). Mental Health care/provision is also noted to be a risk across the system for a variety of reasons at very senior levels. This is not a criticism of SPFT colleagues but a national issue in terms of commissioning and provision.

4.2 Learning Disabilities Safeguarding

The Trust has a Lead Nurse for Learning Disabilities, supporting and facilitating equality of care, access and treatment for children and adults with learning disabilities when they use ESHT services, ensuring our compliance with the Mental Capacity Act (2005) and the Equalities Act (2010) through training and clinical support.

There is a network of LD champions across all sites to promote best practice, which are supported by monthly network events, role update sessions and education around specific areas. The Lead Nurse for LD represents the Trust in the wider system and is a member of the Strategic Group.
ESHT fully participates in the LEDER programme, which ensures that all deaths of people with learning disabilities aged 4 years and over, are subject to external review following the nationally mandated processes. These reviews ensure all appropriate health and care records from all providers involved with the person are reviewed to identify learning.

The Head of Safeguarding represents the Trust on the East Sussex and Surrey STP LEDER Steering Group, which reports into the STP Transforming Care Group. The LEDER steering group ensures a collaborative commissioner and provider approach to investigation, learning across the STP and sharing of best practice to influence how services are provided the residents with LD.

The Learning Disability Standards have provided a better understanding of how ESHT can better meet the needs of our patients with Learning Disability and it is expected that moving forward during 2019/2020 the changes which are informed by our initial findings will gain momentum such as the 'flagging' on internal systems when a patient has a diagnosed LD. By flagging patients we will be better able to meet patients' needs and enhance the quality of the care patients receive.

4.3 Policing and Crime Act, 2017

The introduction of the Policing and Crime Act in December 2017 removed the use of police cells as places of safety for under 18 year olds, restricted the use of police cells as places of safety for adults being held under the Mental Health Act (2007); Section 135/6 powers, reducing the length of time someone can be held from 72 hours to 24 hours. During 2018/19 attendances into the Emergency Departments increased, as a result it has become vital that the Head of Safeguarding takes a more proactive role in monitoring the numbers of patient subject to sections and any incidents that occur.

Senior Trust staff and the safeguarding team continue to collaborate with the key stakeholders across the STP to agree aligned processes and procedures to implement the revised legislation locally. ESHT have seen, alongside other healthcare providers, an increase in mental health

related presentations to our emergency departments. On occasions there are no physical health needs at all. This picture is being reflected nationally and local partnership work continues to ensure people are safeguarded.

4.4 Multi – Agency Female Genital Mutilation (FGM) Guidance

ESHT has effective arrangements in place to meet the requirements set out in the Home Office guidance for FGM. The FGM Lead is responsible for all mandatory returns, monitoring local incidences of FGM and staff training and support to ensure we can identify females at risk, detect FGM and report it effectively. FGM-IS has been implemented. This is a national system that supports the early identification and ongoing safeguarding of girls under the age of 18, who have a family history of FGM.

The FGM-IS is a national IT system linked to the NHS spine that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who have a family history of Female Genital Mutilation (FGM). Nationwide implementation of FGM- IS began in August 2018. ESHT has fully implemented the system which is led by the Named and Deputy Named Midwife.

4.5 Continuing the work as a result of the Independent Inquiry into Child Sexual Abuse (Goddard Inquiry)

The output from the Goddard (July 2014) aimed to investigate institutional child sex abuse following the death of Jimmy Saville resulted in safeguarding policy review in 2018. The safeguarding team have proactively worked with ESHT staff to increase awareness of child sexual exploitation and abuse by the implementation of the Allegations of Abuse Against Staff Policy. Also ESHT have undertaken audits of high risk children, already known to the Missing and Sexual Exploitation Group, who attended our emergency departments. There is a weekly meeting to identify specific high risk children are flagged for updating information, discussion and planning at the Missing and Sexual Exploitation Group to safeguard them.

The Named Safeguarding Nurse for Community represents ESHT at the Multi Agency Child Exploitation Group (MaCE) and ensures learning is shared with the Trust. Child Safeguarding training, policies, procedures and checks have all been reviewed in response to improve awareness and action in response to these risks to children. Training focuses on ensuring staff are aware of the risk factors that make children and young people increasingly at risk of being missing and/or sexually exploited. It is known that these risks can increase a child or young person's risk of further exploitation in relation to being trafficked. Alerts have now been added to the e-searcher systems for those children identified as high risk of exploitation through the MaCE panel discussions.

East Sussex has a sizeable population of Looked After Children. This group, particularly those placed by other local authorities into the county, are known to be particularly vulnerable. ESHT has a significant role in relation to safeguarding children from this type of organised abuse.

4.6 The impact of County Lines

During 2018/19 Safeguarding Training and Supervision has included 'County Lines' which is the term used to describe the distribution of drugs from major cities into the counties. ESHT continues to support Emergency Department staff, Police and other agencies to identify children at risk of being drawn into serious crime including drug dealing and pressured into carry weapons. Community staff are especially well placed to identify when vulnerable adults and children are exploited through 'cuckooing' where drug dealers take over the house of a vulnerable adult and supply drugs from the address, using children as runner. The reporting of these concerns to Police

and Social Care are better understood and that there is a responsibility to protect our most vulnerable service users.

4.7 Modern Slavery/Human Trafficking

East Sussex LSCB, including its partner members, has pledged to reduce the risk of children being sexually exploited, trafficked or going missing from/ in East Sussex. Section 54(1) of the Modern Slavery Act (2015), places a legal requirement on ESHT to prepare our staff to identify patients at risk of modern slavery and being trafficked. Whilst it is not a mandated requirement yet to provide information centrally, ESHT continues to identify suspected cases which have been reported to the police. The Named Nurse community is listed within the March 2019 'Stop the Traffic', single point of contact directory for Modern Slavery.

4.8 The Care Act (2014) - Making Safeguarding Personal

It has been agreed that to enable ESHT to deliver MSP focused safeguarding practice, a framework of reflection and revised training alongside the learning from complaints, safeguarding enquiries and case reviews is required. The Care Act, 2014 defined safeguarding adults as 'protecting an adult's right to live in safety, free from abuse and neglect'. Making Safeguarding Personal (MSP) defines an approach to safeguarding which focuses on outcomes rather than process. It aims to answer, in partnership with the adult at risk / their advocate, three questions;

- What difference would they want or desire?
- How will you work with someone to enable that to happen?
- How will you know a difference has been made?

In 2018-2019 ESHT reviewed the way in which Adult Safeguarding cases are supported, with a special focus upon the community. Safeguarding Supervision has been implemented with a Policy to support its introduction and documentation to enable practitioners to evidence that they have applied a MSP approach to their care.

4.9 PREVENT

The Head of Safeguarding is the Trust lead for the PREVENT programme, which supports the local and national counter terrorism strategy, and is a requirement under the Counter Terrorism and Security Act, 2015.

Locally the Trust is active in the PREVENT Board and submits numbers of PREVENT referrals from health quarterly to the CCG and NHSE. Level 2 Safeguarding training has PREVENT Awareness training embedded within it for both children and adults, as radicalisation is considered comparable with other forms of abuse. WRAP training has been delivered to staff who require level 3 Safeguarding Training, the Trust Board attended such a session in early 2019. There were no referrals under PREVENT in 2018 – 2019.

4.10 Domestic Abuse and Multiagency Risk Assessment Conference (MARAC)

MARAC is a multiagency forum managing high risk cases of domestic abuse, stalking and honour based violence. Chaired by the police, they bring together statutory and voluntary partner organisations to share information and work collaboratively to safeguard the person at risk by developing a coordinated plan of protection. ESHT are members of both MARACs in East Sussex, where specialist nurses and midwives represent the Trust.

As a result of this Multi-Agency engagement in 2018/19 it was possible that confirmed cases of domestic abuse began to be flagged upon patient administration systems. Furthermore to

strengthen arrangements at the Conquest, the Care, Grow, Love organisation and the Hastings and Rother CCG funded an Independent Domestic Violence Advisor (IDVA) for 12 months. This post focused on supporting staff to identify domestic abuse and through the process of referral, once made. This support was highly valued by staff from different clinical areas but even more appreciated within high risk areas such as Maternity, Special Care Baby Unit and Emergency care settings. In early 2019 ESHT was informed that there was no longer funding for the post. ESHT Safeguarding Team consequently attended DV training in order to be able to continue with the work that was initiated by the IDVA. The Community Named Nurse has taken a lead in delivering training throughout ESHT. The DoN is escalating and pursuing this with senior CCG colleagues.

5.0 Local Case Reviews

A Domestic Homicide Review, Serious Case or Case Review is undertaken when it is identified learning following a referral to the Safeguarding Board regarding the management of a patient. Therefore this is a multi-agency undertaking with ESHT undertaking report writing, identifying lessons to be learnt, recommendations and attendance at a learning event. The external reviewer then writes a report which is published once it has agency sign off. The 3 cases for 2018/19 are yet to be published however the cases action plans will be brought to the Safeguarding Strategic Committee for the DoN to have assurance. Themes from the Case Reviews will inform our practice as an organisation and the Head of Safeguarding will provide briefings for staff involved.

6.0 Section 11 Audit

In 2018/19 ESHT completed the LSCB's Section 11 Audit (Children Act 2004). The purpose of this is aimed at improving the way key people and bodies safeguard and promote the welfare of children is crucial to better outcomes for all children. ESHT is required to participate as it places a statutory duty on key organisations to make arrangements to ensure that in discharging ESHT's functions we have regard to the need to safeguard and promote the welfare of children and young people. The self-evaluation toolkit enabled the Safeguarding Team to identify areas where further work was needed to meet the required standards and there were action plans in place to ensure that all Section 11 standards were met. Specific areas for further development include:

- ensuring senior members of staff receive safeguarding supervision,
- providing a patient safety leaflet for staying safe online,
- ensuring children are seen alone in Emergency Departments
- ensuring that all staff have the required checks in line with the Disclosure and Barring Service requirements.

Ongoing work is being undertaken to ensure that all staff are aware of private fostering arrangements, child exploitation and inclusion of significant males/fathers in all safeguarding risk assessment and safety planning.

7. 0 Safeguarding Work Plans

The work plans for all aspects of safeguarding and learning disabilities and the processes for reviewing and reporting progress, risks and compliance was revised as part of the overall review of safeguarding governance. There is now a monthly Safeguarding Work Plan meeting to ensure it is more responsive and reflective of the work undertaken by the Safeguarding team, As a result it is hoped that it accurately captures the learning, mitigations, planned developments and improvements in relation to national, regional and local guidance. The Safeguarding Children and Adults Strategic Group continue to monitor progress, compliance and risk management through the Head of Safeguarding Report and the Divisional Safeguarding Reports received at each meeting.

8.0 Safeguarding Activity

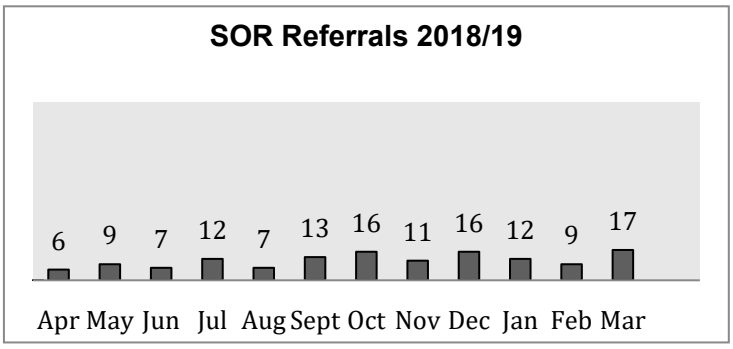
8.1 Safeguarding Referrals

Safeguarding referrals can be raised by staff, patients, family members or the public and are received by Social Care, who applies three key tests to decide if the concern raised meets the threshold for a Section 42 Adult Safeguarding concern. Of the referrals ASC receive, very few result in a Section 42 Enquiry. However this does not accurately reflect the work that is required in reaching that decision. Moving forward there needs to be better recording of the numbers of referrals received by ASC and a focus on the cause for concern. It is also hoped that it will be possible to illustrate the specific clinical areas involved. ESHT monitors all Deprivation of Liberties applications for authorisation by the Local Authority. During 2018/19 the number of referrals and authorisations remained consistent each quarter. In 2019/20 the process of referral to the DOLS office will change and clinical staff will have greater powers to request DOLS reducing the time it takes for the intervention to commence.

8.2 Safeguarding Children Referrals

Child safeguarding referral activity has remained unchanged over the last 2 year

Safeguarding Children Statement of Referrals



Children referred may have a Child Protection Plan (CPP) which indicates they are considered to be in need of protection from either neglect, physical, sexual or emotional abuse or a combination of one or more of these. The CPP details the concern and actions being taken to mitigate these and outcomes. In East Sussex the number of children with a CPP has remained unchanged at 476 as at March 2018.

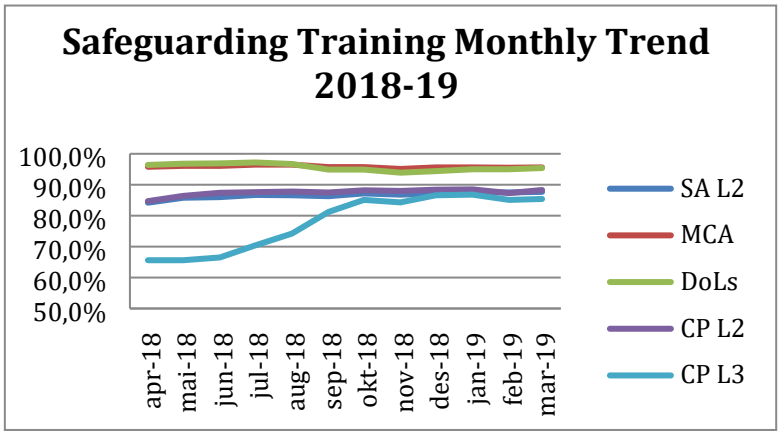
8.4 Safeguarding Training

The safeguarding team completed a training needs analysis in 2017, reviewing which staff needed which training to support their roles. Excellent training compliance across the Trust demonstrates commitment to training, with the CQC inspection in March 2018 reporting staff knowledge was generally good.

Further audits of staff understanding of Mental Capacity have indicated that despite a one off face to face training session, , clinical staff consider the concept of mental capacity assessment to be challenging, even for very senior staff. As a results the safeguarding team have worked with clinical staff to support capacity assessments and there has been a move away from this being perceived as a uniquely ASC role. As a result the decision was made to change the one off face to face session which reached high levels of training compliance to a mandatory every 3 year training for Band 6's and above. Consequently it is anticipated that there will be a fall in compliance with MCA training initially through the year but this will improve over time.

MCA training is now available on line and learning and development are working to improve access for staff to complete the training.

Safeguarding Training compliance



In 2018/19 the safeguarding team identified a number of staff who worked with children, whilst recognising it was not their main work, and to whom the requirement for Level 3 Child Safeguarding now applies. The teams within the divisions affected are working with the safeguarding team to improve compliance for these staff with a target of 85% compliance in April 2019. Serious Case Reviews which remain unpublished indicate that there is a need to break away from the traditional split between Child and Adult Social Care and the Safeguarding Team will adopt the "Think Family" approach in 2019/20. This will also incorporate the period of transition when a young person moves form child to adult services. It is anticipated that will be available for staff to book onto from September 2019.

9.0 The Mental Health Act – ESHT Duties

There is a service level agreement with Sussex Partnership NHS Foundation Trust (SPFT) to enable the Trust to meet its legal requirements to ensure patients admitted to our inpatient beds have their rights protected and their mental health care needs are met by the Responsible mental health clinician. The Head of Safeguarding attends regular meetings, escalating risk when necessary to the DoN. The Head of Safeguarding in 2018/19 has strived to improve safeguarding governance to monitor ESHT compliance and to work collaboratively with SPFT team to address any issues with non-compliance. This work has enabled the following:

- The site team have all been trained to undertake the duties of the receiving officer and maintain detained patients' rights.
- Section 135/136 training for ED staff continues to be delivered.
- Revision of the Policy for the Mental Health Act to support staff
- Audit arrangements to be agreed with SPFT to begin to measure compliance more systematically
- Completion and submission of the KP90 return on mental health activity

10.0 Looked After Children (LAC)

In 2018, the Looked after Children management structure within ESHT was reviewed during 2018/19. This led to the role of Named Nurse for Looked after Children focusing the clinical and safeguarding work within the team alongside a newly developed LAC Service Manager post providing day to day to managerial support. A significant change has been that from April 2018 health assessments for pre-school children moved from Health Visiting to the Looked after Children team, with the children retaining an allocated Health Visitor. ESHT has ensured that there

continues to be close liaison with the Local Authority with both the Service Manager and Named Nurse contributing to joint meetings with ESCC staff to share practice. There is an ongoing process of co-operation between ESCC administrators and ESHT to verify information to improve to improve the timeliness of health assessments.

The Looked after Children team are now required to provide data to the STP with regards to the numbers of assessment undertaken and whether these are within the appropriate timescales. Data was historically captured on paper and is now drawn from Systm1. Work is ongoing to ensure that the activity reported on System 1 aligns with the enquiries from the STP. A LAC policy is now in place and work has been undertaken to ensure the competencies of the Specialist Looked after Children's Nurses.

11.0 Conclusion

During 2018-2019 ESHT has given safeguarding a higher profile and requested greater assurance that the organisation is meeting its statutory and legislative duties. The Director of Nursing leads the strategic direction with senior leadership from the Head of Safeguarding and a passionate and committed team. The improved governance and reporting has provided a platform to promote divisional ownership and drive improvements. The CQC reported arrangements are robust and the Trust is supported by an expert team to deliver its functions.

The commitment to continue to improve front line staff practice and knowledge to enable ESHT to better safeguard the people using its services remains strong, and we are looking forward to a challenging year ahead.

Name: Sue Curties, Head of Safeguarding

Date: 12/09/2019

References

Intercollegiate Document: Safeguarding Children and Young People roles and competencies for healthcare staff (2014) Royal College of Paediatric and Child Health.

Intercollegiate Role Framework: Locked After Children Knowledge, Skill and Competences of healthcare staff (March 2015) Royal College of Paediatric and Child Health

Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018) Royal College of Nursing

Mental Capacity Act 2005 and the Deprivation of Liberties Code of Practice
https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

Equality Act (2010) HM Government

Working Together to Safeguard Children (2013,2015,2018) HM Government

Children Act (1984, 2004) HM Government

Care Act (2014) HM Government

The Modern Slavery Act (2015) HM Government

APPENDIX 1

SAFEGUARDING WORKPLAN 2019/2020

Action Number	Source	Requirement	Action	Executive Lead	Responsible PERSON	Progress
1	Children Act 1989 and 2004 and the Care Act 2014.	East Sussex Healthcare NHS Trust Safeguarding Team must ensure that it meets its statutory responsibilities identified within the Children Act 1989 and 2004 and the Care Act 2014.	Comply with the legislative guidance within the Safeguarding Acts and meet the statutory responsibilities Tranining compliance all staff all settings Documentation of MCA processes in records	DON	Head of Safeguarding	
2	Children Act (2014) Section 11 Audit	To ensure the duties of the Section 11(Children Act 2004) are complied with.	Complete section 11 action plan to address non compliances / improve pacrice.	DON	Head of Safeguarding April 2019	
3	LSCB SCR	To undertake the LSCB Child T Case Review	Investigate SCR and complete all actions to implement recommendations following publication by LSCB	DON	Named Nurses for children	
4	SAB SAAR	To undertake the Adult B Case Review	Complete all actions to implement recommendations following publication	DON	Named Nurse for adults	
5	NHSE/ NHSI	To comply with the LD Improvement Standards for NHS Trusts (2018)	Baseline assessment and action plan to address any concomplinaces with LD standards to achieve ESHT compliance	DON	Specialist Nurse Learning Disability	
6	CQC / Safeguarding Legisaltion	Competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with training and remedial action plans in place to address any non compliances	DON	Assistant Directors of Nursing April 2019	
7	CQC / Safeguarding Legisaltion	To ensure that there is a competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with safeguarding supervision and remedial action plans in place to address any non compliances	DON	Assistant Directors of Nursing April 2019	
8	Mental Health Act (2017)	To comply with the requirements set for acute NHS providers in relation to detained patients and staff competency	To comply with the legislative guidance within the Mental Health Act and meet the statutory responsibilities	DON	Deputy Chief Operating Officer	
9	Mental Health Act (2017)	To ensure the annual KP90 return is submitted for ESHT	Complete and submit the KP90 return annually	DON	Deputy Director of Nursing	
10	Prevent Statutory Duty (s26 Counter-Terrorism and Security Act 2015) to safeguard	To meet the statutory requirement to promote the national PREVENT strategy at a local level throughout the NHS	Ensure that there is a nominated lead for PREVENT, staff are trained in PREVENT Awareness and WRAP, and that the quarterly PREVENT return is submitted for ESHT	DON	Head of Safeguarding	
11	Female Genital Mutilation (FGM) Statutory Duty to safeguard	To meet the statutory requirement to promote the national FGM strategy at a local level throughout the NHS	Ensure that there is a lead for FGM, staff receive training in FGM Awareness at the appropriate level, and the quarterly FGM Return is submitted for ESHT	DON	Named Midwife	

East Sussex Healthcare NHS Trust

Annual Fire Safety Report

1st April 2018 – 31st March 2019

V2.2 06/09/19

In accordance with HTM 05-01 2013 “Managing Health Care Fire Safety”, the role of Fire Safety Manager is undertaken by Chris Hodgson, Associate Director of Estates and Facilities

Annual Fire Safety Report

April 1st 2018– 31st March 2019

CONTENTS

Annual Fire Safety Report

April 1st 2018– 31st March 2019

1.0 PURPOSE

This report provides information to the Trust Board highlighting the continuous improvement of the Fire Safety department, to report all relevant risks and make all necessary compliance recommendations.

1.1 Context

The key challenge for the Trust is to ensure a safe healthcare environment for all relevant persons, compliant with fire safety legislation.

The effective and continually improving management of fire safety is essential to preserve life, lower the impact of any fire on business continuity and care and is a legal requirements under the auspices of the RRO and the Department of Health Firecode suite of Hospital Technical Memorandums.

To ensure identification and appreciation of Fire Safety risks, monthly KPI reports are forwarded to the compliance manager and quarterly fire reports forwarded into the Fire Safety Manager and the Health and Safety Steering Group (HSSG).
Risk register entries are compiled to highlight statutory deficiencies as they occur and for risks scoring greater 15 and above, reviewed every month.

1.2 Legal background

The Regulatory Reform (Fire Safety Order) 2005 came into effect on 1 October 2006 and applies to England and Wales. The Fire Safety Order replaces previous fire safety legislation.

2.0 FIRE SAFETY POLICY & PROTOCOLS

2.1 Fire Policy

The Fire Policy was ratified in the latter part of 2017 and changes include a revised Fire Incident Management system.

2.2 Fire Safety Protocols

Fire Safety Protocols have been developed to assist staff with reference material for all aspects of Fire Safety Management identified in HTM 05-01. The suite of Fire Safety Protocols are now being "combined" into a more user friendly version.

3.0 FIRE TRAINING:

The current level of mandatory Fire Training as June 2018 data is at 88%. This high standard has been maintained for the last 4 years. This total may vary by 1-3% each month depending on seasonal issues and other Trust pressures.

Spaces have been allocated to accommodate 120% of Trust Staff during the first part of 19/20 to maintain this level of compliance.

The annual training needs analysis has been completed and the training presentation content amended accordingly. In the latter part of 2019 we will move to the national E-learning package, which will be supplemented with specific desk top exercises, drills and training for high risk clinical areas e.g. ITU, SCBU etc.

The training figures for the past three years are shown below for comparison.

Year	2016/17	2017/18	2018/19
Number of ESHT Staff	6476	6709	6827
Number of ESHT Staff in date	5504	5836	5939
Percentage	85%	87%	87%
Non ESHT Staff trained Volunteers, Sussex University and Doctors Surgery Staff)	504	380	134

3.1 Fire Warden Training and Fire Team Training

77 Fire wardens have received specific training by the Fire Department.

3.2 Practical Evacuation Exercises and Fire Drills

1672 Staff have received specific training on their local emergency procedures by the Fire Department.

This has included practical fire drills on a risk basis.

3.3 1st Responder Fire Training - Mandatory fire incident management training for Porters, Clinical Site Managers, General Managers and on call Directors has taken place during Emergency Preparedness, Resilience & Response (EPRR) training days.
All management roles will be identified by coloured tabards.

4.0 RISK ASSESSMENT

4.1 Risk Assessment

The Regulatory Reform (Fire Safety) Order 2005 (RRO) requires all Trust premises to have Fire Risk Assessments (FRAs) in place. Acute Sites and larger buildings are divided into Ward/Department FRAs. The suitability being assessed against the risk and a series of guidance notes specific to the accommodation type.

Compliance is confirmed by an annual external audit from the Trusts Authorising Engineer (AE). To ensure continuous improvement the FRA template has been amended during 2018/19 to include a pre FRA safety checklist.

Combined building and staff FRAs are carried out for Trust premises and Staff only FRAs for buildings leased by the Trust.

4.1.1 100% of the 169 Acute Hospital FRA areas due for audit have had risk assessments carried out in the past 12 months. 100% of Community premises due for audit have had risk assessments carried out in the past 12 months.

5.0 INCIDENT REPORTS

5.1 False Alarm Activations

Numbers of activations are monitored monthly with any alarm activation trends dealt with. Alarm activations are within the NHS national guide lines as a percentage of smoke detectors provided.

5.2 Fires and False Alarms

All reported fire incidents are investigated using the Datix system. Incidents that involve disruption are now subject to an Operational De-brief.

Two low risk fires occurred:

3/8/2018 - External Bin Fire EDGH

11/3/2019 - Internal light fitting in Pathology Stores

A table and analysis of all Fire Alarm activations is attached at **Appendix C.**

6.0 INFRASTRUCTURE RISKS

6.1. Infrastructure Risks

The Trust is currently carrying a Major risk in relation Patient and Staff Safety, Statutory Duty (enforcement) and service interruption. The risks have been identified from the outcome of Fire Risk Assessment findings and the requirements of East Sussex Fire and Rescue Service Audits.

The Trust has non -compliance issues in the areas of Fire Compartmentation, External cladding insulation, Emergency lighting, Fire Damper Testing and EDGH Residency fire alarms.

Details of these required improvements have been included in the Trust risk register and described in Appendix A and B.

6.2 Improvements

EDGH Phase 1 fire compartmentation lines, specifically certain fire compartment walls in Seaford and Hailsham areas has been improved during 2018/19 due to specific breach areas being remedied where no asbestos risk was present. The EDGH fire compartmentation business case which was submitted to NHSI on 22/2/19 seeks funding to eliminate the fire compartmentation risks (including obsolete fire alarm system).

Three residency blocks were initially identified for improvement. 2019; single point detection being installed in all other “shared” accommodation. East Sussex Fire and Rescue Service to visit all “single family” units to carry out Home Safety Visits. These works have now been extended the cover the remaining 11 blocks of significant risk from sleeping occurs in the EDGH residences.

In addition it is proposed that the single family buildings will have Home Safety Visits carried out by East Sussex Fire and Rescue Service.

6.3 Capital Investment

It is essential that capital investment to resolve those risks is provided on a recurring basis annually to demonstrate a responsible and proactive approach to dealing with fire safety issues and compliance requirements. Note the comments in section 6.2 around business cases submitted to NHSi for EDGH fire compartmentation.

7.0 OPERATIONAL MAINTENANCE

Operational maintenance includes the day to day maintenance of the both active and passive fire related equipment; including fire alarms, fire dampers, fire extinguishers, fire doors and emergency lighting systems.

The outcomes of that planned preventative maintenance of fire related equipment is increasing in nature as systems expand and national guidance is changed. There has been a review of planned preventative maintenance (PPM) systems to ensure that the relevant PPM is in place, some additional areas such as smoke vents systems at Conquest are being added to the PPM system.
Revenue budgets will need to be increased to compensate for the additional activity e.g. fire and smoke damper inspections to meet these challenging statutory requirements.

A summary is provided in **Appendix B.**

8.0 AUDIT AND REVIEW

8.1 An Audit of Trust Fire Safety Management systems is undertaken annually by the Authorised Engineer. This did not however take place in 2018/19. An audit took place on 14th-15th of May 2019 with a draft report issued which is being considered by the estates team.

8.2 Compliance with legal requirements in terms of fire is reviewed each Month by the Estates Department to provide Independent assurance and advice (with relevant KPI's such as the number or staff trained, FRA's undertaken etc.).

9.0 LIASION WITH EAST SUSSEX FIRE AND RESCUE SERVICE.

EDGH: 8 General Site Visits. Operational Crews – Focus on Compartmentation.
Conquest: 2 General Site Visits. Operational Crews - General Site Focus.
Two Fire Audits 1x High Dependency and Operating Theatres 14/6/18. 1x 15/2/19 South Wing Levels 1&2

EDGH- The General Manager Estates has held a technical based compartmentation meeting with the East Sussex Fire and Rescue Service on the 10th May 2019 to review works on compartmentation within EDGH Phase 1.

Appendix A – Infrastructure Risk Summary

ITEM	Reference Number	RISK ASSESSMENT					ACTION required Insert actions required to reduce/eliminate risk	COMMENTS
There is the risk that the organization will be non-compliant with Fire Safety Legislation. This is caused by a number of defective buildings and systems which may lead to failure of statutory duty inspections.	**1410**	Safety	4	3	**16**	Extreme	1. Inadequate Fire Compartmentation at EDGH; bus case for investment submitted to NHSI in Feb 2019 for £13.86m 2. Failing Emergency Lighting Conquest central battery system: 3. Inadequate testing of Fire Dampers EDGH (Phase 2) and Conquest	
		Statutory Duty / Inspections	4	3	**16**	Extreme		
		Service Interruption	4	3	**12**	Major		
		Statutory Duty / Inspections	4	3	**16**	Extreme		
		Service Interruption	4	3	**12**	Major		

Appendix A – Infrastructure Risk Summary

ITEM	Reference Number	RISK ASSESSMENT					ACTION required Insert actions required to reduce/eliminate risk	COMMENTS
Failure To Detect A Fire And Its Risk To Life At EDGH Residences	**1671**	Safety	4	4	**16**	Extreme	BS 5839 - 6:2013 Grade D L2 system Scope of works to be developed Tendered and works package approved, extended to 14 blocks as of July 2019 Works to be completed in FY19/20 in Jenner, Robertson & Gillies House. Other “shared” buildings have had single point (battery) smoke alarms installed in all bedrooms	
		Statutory Duty / Inspections	4	4	**16**	Extreme		
		Service Interruption	3	3	**9**	Major		

Appendix A – Infrastructure Risk Summary

ITEM	Reference Number	RISK ASSESSMENT					ACTION required Insert actions required to reduce/eliminate risk	COMMENTS
Abnormal fire spread from external cladding arrangements (Polystyrene cladding under white non-flammable cladding)	**1643**	Safety	3	3	**9**	Moderate	1. Business case submitted to NHSI in Feb 2019 address these risks. 2. Flammable risk removed on upgrading in specified areas –Urology and Seaford 1&2.	
		Statutory Duty / Inspections	3	3	**9**	Moderate		
		Service Interruption	3	3	**9**	Moderate		

Appendix B OPERATIONAL MAINTANENCE

B1.0 Fire Damper Testing and Maintenance

B1.1 EDGH:

Following an Estates and Facilities request to comply with national damper testing requirements, sample testing of Fire Dampers at EDGH was carried out. 40% of the sample were defective .Damper maintenance was not being carried out due previous removal of revenue funding.
Recommendation- A programme of maintenance and testing is being introduced (without additional revenue/resource.

Notwithstanding that no additional revenue funding was received, we did carry out fire damper inspection and testing within EDGH Phase 2 in March 2018. EDGH Phase 1 cannot be resolved until the asbestos is removed.
British Standards give very clear guidance that all fire dampers should be tested at regular intervals not exceeding 2 years and that spring operated fire dampers should be tested every 12 months and at even greater frequencies if in a dust laden environment.
Also the up to date record of damper location is a requirement of the 2015 Estates and Facilities Alert. Resources will need to be allocated to resolve this issue.

B1.2 Conquest:

Following an Estates and Facilities request to comply with national damper testing it was found that fire dampers were tested every 3 years, however the legal requirements is now bi-annually. This additional testing would require additional revenue support. No progress since 2015/16 report.
British Standards give very clear guidance that all fire dampers should be tested at regular intervals not exceeding 2 years and that spring operated fire dampers should be tested every 12 months and at even greater frequencies if in a dust laden environment.
Also the up to date record of damper location is a requirement of the 2015 Estates and Facilities Alert. Resources will need to be allocated to resolve this issue.

B2.0 Fire Compartmentation EDGH:

ESFRS recognised the Trust case that the 100% occupancy of Phase 1 levels 2&3 had varied the scope and timeframe of the fire compartment upgrading works.
ESFRS were in in broad agreement with the Trusts commitment to resolve the issue. However unless positive progress was made it was indicated that an enforcement notice may be served. Regular meetings between ESHT and ESFRS were scheduled in order to maintain relationships and update progress of the compartmentation project. The scope project is now complete. This has involved in depth co-operation and communication with all the relevant Staff areas.

ESFRS has visited regularly and as a result of close co-operation with ESFRS and works undertaken the potential for an enforcement notice has diminished, but remains a risk and a concern. These upgrades will not be sufficient for separation into fire zones, which is the ultimate goal, however further significant compartmentation works will be required to meet the HTM requirements.

Flammable polystyrene has been found between the white external cladding and the internal part of the building in the Phase 1 courtyards and should be removed. This work will be carried out when funding for the full HTM compartmentation works business case funding is forthcoming.

B3.0 Fire Compartmentation Conquest:

Breaches in the Conquest Hospital fire walls have been in-filled.
Installation of the 17 compartment fire doors will take place during 2019/20.
When these works are completed the Conquest in late 2019 then this will be assumed a Low risk.

B4.0 Conquest c**entral communal Emergency Lighting system:**

There are five separate automated test central systems linked together by a central controller to cover the communal areas. Part of the system has been updated over the last 2-years including Maternity, DeCham and Gardner, however the majority of the system is as now circa 15-20 years old and due to the age of the system, some replacement parts cannot be sourced either new or second hand. Auto test or system test reports cannot be accessed

(manaul testing has to take place) and there is a risk of whole or part failure of the system at any time.

B5.0 Residency Fire Alarms EDGH:

Three residency blocks out of seventeen blocks were initially identified by risk analysis for improvement/uprade. These works have now been extended the cover the remaining 11 blocks of significant risk from sleeping occuring in the EDGH residences. Work expected to be completed for the first 3 blocks in Oct 2019, with the remaining blocks scheduled for completion by end of 2020 Q2.

East Sussex Fire and Rescue Service to visit all “single family” units to carry out Home Safety Visits.

B5.1 EDGH Fire Alarm:

The replacement deadline is 2019 for AlgoRex field devices and 2020 for AlgoRex control panels. From 1st April 2019 onwards field detectors, manual call points, interface modules and beam detectors are not supported by the site contractor.

To ensure all elements of the fire alarm remain fully operational and the Trust is not left at risk of system failure considerable investment will be required. As noted in the main body of the report an estates program group with appropriate external technical support has been set up to review the options and come up with a solution to this issue. Funding to address the issue is part of hr EDH fire compartmentation business case. The Project manager is progressing and seeking quotes for design intent, supply and installation.

Manual call points and interface modules have been sourced to assist the safe operation of the fire alarm.

Appendix C Analysis of Fire Calls

Call Type	Conquest	Conquest Residencies	EDGH	EDGH Residencies	Bexhill& ABC
Fires.	2**	0	1*	0	0
False Alarms –Fire Service called.	9	0	17	1	4
False Alarms –Fire Service not required.	67	7	35	53	0
Total False Alarms.	76	7	52	54	4

*Light fitting in the Pathology Stores at EDGH on the 11-3-2019 at 0929hrs. A de-brief is being arranged by the EPRR team.

**Waste bin CQ Level 4 Medical Records. Smoking Shelter Bin.

Appendix D - Recommendations of the Fire Engineers (AE) Audit 2018/19

To follow after the receipt and review of the AE (Fire) Audit in mid-May 2019.