EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 3rd December 2019, commencing at 09:30 in St Mary's Boardroom, EDGH

AGENDA			Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Monthly award winners	A	Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 1st October 2019	B		
4.	Matters Arising	C		
5.	Board Committee Chair's Feedback		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 7 (October) 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 1	Assurance	H	MD	

BREAK

STRATEGY

					Time:
10.	East Sussex Place Based Response to the Long Term Plan	Assurance	I	DS	1130 - 1145

GOVERNANCE AND ASSURANCE

					Time:
11.	CQC Inspection	Assurance	J	DCA	1145 - 1215
12.	Winter Flu Self-Assessment	Assurance	K	DHR	
13.	EDS2	Assurance	L	DCA	
14.	Review of Corporate Documents	Assurance	M	DCA	
15.	Quality Walks	Assurance	N	Chair	
16.	Board Sub Committee Minutes	Assurance	O	Chair	
17.	Trust Board meeting dates 2020	Information	P	Chair	

ITEMS FOR INFORMATION

				Time:
18.	Use of Trust Seal	Q	Chair	1215 - 1230
19.	Questions from members of the public (15 minutes maximum)		Chair	
20.	Date of Next Meeting: Tuesday 4th February, Hastings Centre, Hastings		Chair	

Chairman

Steve Phoenix

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

5th November 2019

Monthly Award Winners

Meeting information:			
Date of Meeting:	3rd December 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:

SEPTEMBER

September's winner was **Teresa Dann**, Matron of the Irvine Unit in Bexhill. Her nomination read:

Teresa has been the only Matron in post covering the Irvine Unit. This is a 42 bedded Unit which is generally managed by 2 Matrons.

Teresa has gone above and beyond to continually improve the Unit both for our staff and patients:-

- She has been pivotal in designing the Unit's Excellence in Care boards which are always themed, relevant and fun displaying the excellent standards of care and compliance within the Unit.
- Teresa approached the local bus depot and asked them to provide bus stop signage and she has researched and introduced a Dementia Bus stop area.
- Teresa instigated a Contemplation space (seaside area) within the unit which was painted by a Speech and Language Therapist and a patient.
- Teresa has implemented a "get up get moving" campaign which encourages .patients to join in with activities.
- Teresa has worked on making the reception more user friendly – harnessing and supporting volunteers.
- Board rounds and the intermediate care dashboard have been introduced within the unit and Teresa has supported this.

Teresa is a leader we need to clone she displays all the Trust Values and is like a whirl wind when asked to do anything you just know it is going to be done and completed to an amazing standard. This is all evidenced by the recent Quality Walk conducted by Monica Green and feedback following the Trust Mock Inspections.

OCTOBER

October's winner was Elizabeth Jorden, Assistant Quality Manager in HSDU at Eastbourne.

Her nomination read:

Seven HSDU staff technicians have completed their apprenticeships for Decontamination and Elizabeth has supported, guided and driven the staff members all the way through to their end point assessment. Her dedication and commitment in supporting staff throughout the process was second to none and she deserves recognition for her hard work. This was in addition to her normal role as an Assistant Quality Manager.

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 1st October 2019 at 09:30am in the St Peters Community Church Hall, Bexhill Old Town, Bexhill TN40 2HE.

Present:
Mr Steve Phoenix, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mrs Miranda Kavanagh, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Mrs Nicola Webber, Non-Executive Director
Mr Paresh Patel, Associate Non-Executive Director
Ms Carys Williams, Associate Non-Executive Director
Dr Adrian Bull, Chief Executive
Ms Vikki Carruth, Director of Nursing
Ms Monica Green, Director of Human Resources
Mr Jonathan Reid, Director of Finance
Dr David Walker, Medical Director
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Mrs Pauline Butterworth, Deputy Chief Operating Officer
Mr Garry East, Associate Director for Performance (until item 088/2019)
Chris Hodgson, Associate Director for Facilities and Estates (for item 091/2019 only)
Miss Janice Humber, Staff Side Chair
Mr Peter Palmer, Assistant Company Secretary (minutes)

078/2019 **Welcome**

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

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

   Mrs Catherine Ashton, Director of Strategy, Improvement & Planning
   Mrs Joe Chadwick-Bell, Deputy Chief Executive

3. Monthly Award Winners
   Mr Phoenix reported that the monthly award winners for July had been Samantha Teare, Therapy Assistant and Jane Ferguson, Clinical Ward Orderly, both from Rye Memorial Hospital. August's winner was Dr Rannie Nahas, Frailty Unit Consultant at Eastbourne.

079/2019 **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.

080/2019 **Minutes**

The minutes of the Trust Board meeting held on 6th August 2019 were considered and three 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.

081/2019 **Matters Arising**

No matters arising were noted.

082/2019 **Board Committees' Feedback**

1. Audit Committee

Mrs Webber reported that the Audit Committee had met on 26th September. Concerns had been raised about the Trust's ability to complete the national diabetes audit due to workforce capacity. The medicine division was highly engaged in resolving the issue; a previous issue of incorrect software had been resolved. A member of staff had been employed to enter data and was being supported by the Trust's clinical audit team. Potential issues with three other national audits had been discussed, with divisional teams focussed on resolving the issues. The Committee had endorsed the decision for the Trust to not participate in a national audit of inflammatory bowel disease as significant resource would be required to do so. The Trust would revisit this decision in the future should the participation requirements alter. Mrs Webber noted that she was assured that divisional management team had done all they could to support completion of the audit.

Two new risks had been added to the Trust risk register, concerning the deterioration of a Philips Skylight Gamma Camera in radiology at the Conquest and a lack of air conditioning in A&E at EDGH. Regular reviews of the risk register were undertaken by executives and senior leaders within the organisation.

Mrs Webber reported that the 2018/19 internal audit plan was almost complete with one final report awaited from auditors. The 2019/20 plan was on schedule. A recent focus of the Committee and auditor had been the closure of audit recommendations and good progress was being made. The 2018/19 external audit had been completed and planning for the 2019/20 audit was underway. Fire and Security annual reports had been presented to, and endorsed by the Committee.

2. Finance and Investment Committee

Mr Nealon reported that the Finance and Investment (F&I) Committee had met on 26th September. He reported that the Trust's planned deficit for 2019/20 was £34m. If the financial trajectory was met throughout the year then additional funding of £24m would be received by the Trust leading to a final deficit of £10m for the year. The Trust remained on track to meet the planned deficit after six months of the year, which Mr Nealon found to be very encouraging. He noted that the financial challenge to the organisation would increase during the second half of the year due to winter pressures. He explained that he was confident that the Trust would meet its financial target for the year, with good

grip and control of budgets being seen.

Mr Nealon noted that there was promising work on setting a system-wide budget for 2019/20 with good cooperation between organisations. He was pleased that the Trust had recently received capital funding for fire safety works. He emphasised the importance of ensuring that pressure to meet financial targets did not affect clinical performance.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had met on 12th September. The Committee had received an update on the Integrated Care System (ICS) workforce agenda; a workforce director had been appointed for the ICS, with a number of sub-groups formed that would review different aspects of workforce across the system. These included bank and agency rates and workforce development.

The Committee had discussed leadership development and talent management in the Trust and had received assurance about progress being made. They had also received updates on medical engagement and apprenticeships.

The results of the recent GMC survey had been presented; the results had seen 40 red flags reported in comparison to 25 the previous year. Work was being undertaken to understand why the results had declined, and what actions were needed to address the issues raised by the survey. Vacancy levels were recognised as a factor, but other organisations had similar vacancies. Benchmarking was being undertaken to understand how other Trusts were managing the issue.

Dr Walker explained that the GMC survey results had been very disappointing. The areas with red flags were largely those under operational pressure due to shortages of junior doctors or consultants, and recruitment was ongoing in those areas. Dr Bull noted that there had been some areas where significant improvement had been seen in the survey results.

Appraisal compliance in the organisation remained below 85% despite significant efforts to improve this. Mrs Kavanagh advised the POD Committee would continue to monitor progress.

Dr Bull noted that concerns had been raised about the accuracy of appraisal data in the organisation and a pilot scheme where divisions entered appraisal data manually on to ESR had commenced. Appraisal compliance when looked at over an 18 month period was over 90%, suggesting that most staff were receiving appraisals, although not necessarily within 12 months. The quality of appraisals being carried out, and the value that staff placed on these, was reflected in the annual staff survey results.

Mrs Kavanagh reported that 54% of consultants in the organisation now had a fully signed off job plan. Most consultants had a plan, but it was not always easy to get this comprehensively documented and fully approved. The Committee had received assurance about progress. Dr Walker noted that all non-locum consultants in the Trust had a job plan. 15% of plans had not been signed due to having been amended, with the remaining 25% under discussion.

4. Quality and Safety Committee

Mrs Churchward-Cardiff reported that the Quality and Safety (Q&S) Committee had met on 19th September. A very moving patient's story had been presented by a patient and her mother; the patient commented on the positivity that she had experienced throughout her stay. The Committee had received a presentation on the redesign of Musculoskeletal (MSK) services in the Trust, which would reduce waiting times for patients.

She reported that the 62 day cancer pathway had been discussed; some specialties were now working at full capacity. Mr Phoenix asked whether any investment into services was planned in order to increase capacity. Mr East explained that one of the limiting factors in cancer performance was the availability of diagnostic services. An external report had been commissioned in order to understand the increasing demand that was being seen and to identify what investment would be required to meet this.

Mr Phoenix noted the need for urgency in addressing the issues, asking whether progress had been made since the Board had discussed cancer performance in February. Dr Bull explained that a large amount of work had been undertaken during the year and that between March and June performance had been on the anticipated trajectory. The urology service played a large part in cancer performance and was currently two consultants short; the Trust had tried unsuccessfully to recruit to these positons for a significant time. A new breast cancer Associate Specialist had been recruited, along with two new haematologists. Mrs Butterworth explained that feedback, and an analysis of investment requirements following the external report would be presented to both the Q&S and F&I committees when it was available.

The Board noted the Committee Reports.

083/2019 **Board Assurance Framework**

Mrs Wells presented the Board Assurance Framework (BAF), reporting that one area relating to capital constraints in the organisation was rated as red.

Mrs Kavanagh asked whether Brexit planning should be included on the BAF. Mrs Wells explained that the risk associated with Brexit had only recently increased to 16, and if appropriate would be included on future versions BAF.

In response to a query about the risk associated with follow up appointments, Dr Bull explained that a new method of tracking them had been introduced giving a clear picture of the number of patients requiring follow up for treatment or screening. Introducing the new system and fully understanding the level of demand would ensure that patients awaiting treatment were automatically flagged. Mr East noted that very few trusts were able to track the number of follow up patients that they had and that the data was proving invaluable when undertaking business planning for 2020/21.

Mrs Webber reported that she had met with the team who managed patient appointments the previous week. They had queried whether plans were being made to ensure consistency of treatment across specialities and consultants. Mr East asked Mrs Webber to send him details of the query and agreed to follow this up with the booking team.

084/2019 **Chief Executive's Report**

Dr Bull reported that the Trust had seen a recent cluster of Never Events, explaining that these would be reviewed in detail by the Board in part 2 of the meeting. He noted that the report highlighted four Never Events that had taken place during the previous four months; since the report had been written there had been a fifth Never Event. Three of the events had involved a procedure being undertaken on the wrong side; one had involved a patient having a line inserted into a vein and not an artery; the final incident concerned a patient undergoing a blood transfusion being given the wrong blood type for a very short period. None of the Never Events resulted in significant harm to a patient, but the cluster of events in a short period meant that the Trust was taking a systemic approach to investigating the events.

A review group, led by senior clinicians, was being formed that would review the Root Cause Analyses (RCA) of all the events, alongside a review of policies and practises across the organisation. Recommendations from the group would be shared across the organisation. The Trust was determined to respond to the cluster of incidents in a strong, appropriate manner.

Mrs Kavanagh asked whether the Never Events were clustered in terms of timeframe, or thematically. Dr Bull confirmed that the five events had taken place in a short period of time; there had been no geographical or thematic link between the events.

Dr Bull reported that very positive feedback had been received about the Trust's moving and handling teams following a recent inspection from the Health and Safety Executive (HSE). They had also provided helpful feedback on the Trust's management of non-deliberate violence and aggression from patients. He noted that as the HSE had raised concerns following their inspection, the Trust would be liable for some of the costs of the inspection.

Mrs Churchward-Cardiff asked how the fees for the Trust following the inspection would be calculated. Mr Reid explained that the Trust would only be charged for the time taken by the HSE in reviewing the Trust's action plan in response to concerns that had been raised.

Dr Bull reported that the Trust had continued to be very busy during the summer, with attendances 9% above the same time the previous year. The organisation had responded well to this demand; the Trust's average length of stay was the lowest that it had been for some years, which had helped with the management of patients.

The first cohorts of nurses recruited from India were starting to join the Trust; over 100 had been recruited. They would be joining in groups of 10-12, initially as supernumerary staff on wards, while they worked towards UK accreditation.

A £13m loan had been secured which would be used to make wards at Eastbourne compliant with modern standards for fire compartmentation. This would also enable the Trust to address a long standing asbestos risk and additional opportunities for upgrading wards while this work was being undertaken would be investigated.

Extensive planning for Brexit was taking place throughout the organisation, led by Ms Ashton. Planning was also underway at regional and national levels, with the Trust well engaged at all levels.

85/2019 **QUALITY, SAFETY AND PERFORMANCE**

Integrated Performance Report Month 5 (August)

1. Quality & Safety

Mrs Carruth reported that a deep dive had been undertaken into falls resulting in harm in the organisation. A reduction in falls had been seen in August, but 12 falls resulting in harm had taken place in 2019, spread across divisions. RCAs had been completed for four of the falls, with others underway. Two of the falls had been assessed as being unavoidable as a result of patient choice.

She reported that there had been a slight increase in category two pressure ulcers, but no category three or four ulcers had been reported for the third consecutive month. One MRSA blood stream infection had been reported and had been subject to a detailed RCA where some potentially contributory lapses had been identified. Rates of clostridium difficile infections were within new limits.

An issue affecting one of the tablets that was used to collect Family and Friends data had been identified; as a result, the data had been revalidated showing across the organisation 97.8% of patients recommended the Trust.

Mrs Carruth reported that a slight upward trend in complaints had been seen over the previous three months and was being carefully monitored. No themes or trends had been identified.

She advised nursing associates roles were now included within the nursing fill rate data. Fill rates had remained static during the previous six months.

Dr Walker reported that there had been an error in the Summary Hospital-level Mortality Indicator (SHMI) data that had been submitted to NHSI in March 2019. This has caused the SHMI to rise to 129. The issue had been raised with NHSI and the data would be re-run. The Trust's Risk-Adjusted Mortality Index (RAMI) was 76; during the same period in 2018 it had been 86. Crude mortality continued to reduce and was at 1.44% compared to 1.75% for the same period in 2018. Dr Bull noted that the data issue had only been identified when a draft SHMI report had been received by the Trust.

Dr Bull noted that four year trends for some data were being presented for the first time. These clearly demonstrated the improvement that the Trust had made in areas such as complaints, falls and pressure ulcers.

2. Access and Delivery

Mrs Butterworth reported that the Trust's A&E performance against the four hour standard had reduced to 88.6% in August. This ranked the Trust 32nd out of 121 reporting organisations; the Trust would continue to try to meet the 95% target. The Trust had seen a 10.8% increase in A&E attendances and 6.2% increase in ambulance conveyances in comparison to August 2018. System-wide work had been undertaken to understand the reasons for the increasing attendances, including interviews with patients to understand why they had attended A&E.

Intermediate length of stay for patients rose slightly in August, but acute length of stay had reduced. It was anticipated that Urgent Treatment Centres at

Conquest and EDGH would be operational by December, and that they would treat 60% of A&E attendees.

Mr East reported that Referral to Treatment (RTT) performance in August had been 89.2%, slightly below July's performance. Performance reflected the pressure across the Trust as well as the increasing number of cancer referrals being received. Improvement plans had been developed which were reviewed on a weekly basis to ensure that they were effective. The Trust had not met diagnostic targets for a second month in a row. Non-obstetric ultrasound capacity had impacted on performance and the Trust was being supported by the CCG with additional ultrasound capacity in order to recover the positon.

Mr East reported that the Trust had achieved all of the cancer standards in August with the exception of the 62 day standard. Increasing demand was being seen for two week waits. Performance against the planned trajectory for meeting the 62 day standard had remained on target until June and had then faltered. Cancer diagnoses had increased by 17% compared to the previous year, and treatments had increased by 31%. NHS England had undertaken a recent review of cancer services within the organisation resulting in a lot of positive feedback. Improvements that were being looked at included ensuring that scans were booked within the correct timeframe, increasing reporting capacity in radiology and understanding why increased referrals were being received by the Trust.

Mrs Churchward-Cardiff explained that she was concerned about the increased pressure on services, noting that this could lead to a deterioration in performance in the future. She asked whether a global capacity plan was being developed for 2020/21, providing an overview of the entire cancer pathway and capacity throughout the organisation. Mr East explained that 2020/21 plans would separate cancer and outpatient resources providing a clearer picture of the organisation's capacity. Work was being undertaken at STP level to review capacity and demand; work was also being undertaken with the CCGs to understand where resources could be shared. Dr Bull noted that bed capacity modelling for cancer services was also being reviewed. Successful recruitment to urology and radiology services would have a significant positive impact on performance.

Mrs Butterworth explained that reviews of cancer performance formed a small part of wider conversations about how surges in activity would be managed by the organisation. Dr Bull noted that surges now took place in addition to the increased demand that was being seen, and it was therefore vital to fully understand the Trust's overflow capacity. Mrs Butterworth explained that growth assumptions and surge planning were reviewed every 8-12 weeks in order to manage the unprecedented demand.

Mr Patel asked when it was anticipated that the cancer trajectory would be recovered; Mr East anticipated that improvements would be seen in November and December, but cautioned that winter pressure might impact this.

Mrs Webber noted concern about waiting list numbers being reported, asking when the trajectory for these was expected to improve. Mr East explained that he was not concerned about the increased waiting list as there was a tendency for this to increase during the first half of each year, as a result of Easter and summer holidays, before reducing towards the end of each year. Mrs Webber said that it would be helpful to see longer term data in order to see if fluctuations were the result of anticipated seasonal variation.

3. Leadership and Culture

Miss Green reported that the total workforce spend in August had been £740k over budget. A reduction in spending on temporary staff of £25k compared to the previous month had been seen. The Trust's reliance on temporary staff continued to reduce. The overall vacancy rate also continued to reduce, by 0.5% in month and was now below 10%. Challenges remained in recruiting to some medical posts, but the Trust had seen 89 new staff join in one week in August. 40 overseas nurses were due to join the Trust in coming weeks, along with new radiographers.

A slight increase in staff sickness had been seen, but the overall rate was better than at the same time the previous year. The Trust was focussing on staff who were absent due to stress, anxiety and depression as this was increasing. Stress assessments were being undertaken in areas of concern in order to identify whether issues were work-related or external to work.

Mrs Kavanagh explained that she was concerned about the increase in staff citing anxiety, stress and depression as the reasons for sickness, asking for further details about the actions being taken to address this. Miss Green explained that focussed work was being undertaken in areas of the Trust where absence for these reasons was higher than elsewhere. Stress assessments, psychologist support from the occupational health team and a hotline for staff to call for support 24 hours a day had all been introduced. The issue was also being looked at on an STP wide basis as other organisations were also seeing increases. Mr Phoenix asked whether the data showing a large increase in July and August was correct and Miss Green confirmed that it was.

Dr Bull reported that discussions had been held with all of the Divisions about the issue. A significant proportion of the cases appeared to be due to factors external to work for staff. He noted that where stress was work related then the underlying causes could be addressed. External factors had the same effect on the organisation, but could not be addressed.

Miss Green reported that the 2019 staff survey had recently launched and would be open until December. Questions were set on a national level. The Trust had worked hard to share the changes that had been made as a result of the previous year's survey results, emphasising the importance of completing it to staff. A high potential programme had been launched for staff with a large number of applicants. Ten staff would be undertaking an intensive development programme.

Mrs Churchward-Cardiff noted that the medical staff workforce vacancy rate was the highest that it had been for a year, and asked whether this was a result of changes to the establishment. Miss Green confirmed that this was the case, noting that recruitment in some specialities remained challenging.

Mrs Kavanagh noted that although the overall vacancy rate was reducing it was still above planned levels. She asked whether more could be done to address vacancy rates. Miss Green explained that the Trust's vacancy rates were low in comparison to many other organisations. Vacancies were a national issue that were being looked at both regionally and nationally. Mr Reid reported that a number of new service models had recently been agreed, including additional staffing for some areas, which would help to address issues in the organisation. The Trust's substantive workforce would be increasing as a result.

Mrs Manson highlighted her concern about the increasing number of back problems recorded, with August seeing the highest number reported for 12 months. She asked whether the increase in stress and back problems were related. Dr Bull explained that the recent inspection by HSE had led to extremely positive feedback about moving and handling within the organisation, which had provided assurance that the Trust's approach was correct.

4. Finance

Mr Reid reported that despite operational pressures, teams across the Trust continued to maintain excellent grip and control on finance, with delivery of the financial plan at month 5. Good progress was being made towards reducing the Trust's monthly operational deficit from £3m to £2m by the end of the financial year. He forecast that the Trust's full financial plan for 2019/20 would be delivered.

Urgent care and non-elective activity was significantly above planned levels, generating significant income for the Trust. The Trust's contract with the CCG would be re-baselined for 2020/21 as a result. Agency spending was below plan, with a reducing trend on costs for temporary staff. The Trust had set a target for its Cost Improvement Programme (CIP) of £20m for 2019/20, with £15m of savings already identified and signed off. The programme was being supported by Dr Simon Dowse and was closely linked to work on Model Hospital and Getting it Right First Time (GIRFT) which would change how CIPs were delivered in the future.

Mr Nealon noted that he had been very encouraged by the way in which the recent focus of discussions at the F&I Committee had altered from being operational to more strategic discussions about how longer term operational efficiencies could lead to a true break even position for the Trust.

The Board noted the IPR Report for Month 5.

086/2019 **Learning from Deaths Quarter 4**

Dr Walker reported that a small group of six members of senior staff reviewed any deaths that took place in the Trust where there had been complaints from a relative or the coroner or a related Serious Incident report. Three deaths had been identified as avoidable in quarter three of 2018, but none since. He noted that the Learning from Deaths process had not seen a large national increase in the number of deaths identified as being avoidable, with most Trusts reporting relatively low numbers. He provided assurance that he was confident that the review process within the Trust was vigorous.

Mr Nealon noted that sepsis was the second highest cause of death and asked whether this was classified as potentially avoidable. Dr Walker explained that if a patient attended hospital with sepsis, was given appropriate antibiotics and fluids within an hour, and then still died than this would not be classified as avoidable as they had been appropriately treated. It would be avoidable if sepsis had not been detected and treated appropriately.

Dr Walker noted that issues with receiving reports back from external LeDeR reviews of paediatric deaths remained; the Trust was therefore undertaking internal reviews so that any learning from deaths could be quickly disseminated within the organisation. A national medical examiner had been appointed and would look to make regional appointments. It was hoped that this would improve the situation.

Mrs Webber asked whether more could be learnt from the data, including identifying deaths that had not been avoidable, but where there had been lapses in care. Dr Walker explained that this was already undertaken in divisional governance meetings; the quality of reviews being undertaken by consultants throughout the organisation had improved as a result of the Learning from Deaths process. Reviews now looked at care throughout pathways in a way that had not been done before.

087/2019 **7 day Working Self-Assessment**

Dr Walker presented the Trust's self-assessment on meeting the seven day working standards, noting the progress that had been made since the last report had been presented to the Board. All standards were now being met by the Trust with the exception of Standard 8, concerning speciality based ward reviews of patients at weekends. This was a difficult standard to meet as doctors working at weekends largely reviewed emergency patients; more than half of Trusts nationwide were not meeting this standard

Mrs Manson asked what action was being taken to meet Standard 8. Dr Walker explained that improved tracking of patients who required review would ensure that they were reviewed by a consultant. Once Nerve Centre was fully operational then the treatment requirements of patients could be tracked more closely, enabling the Trust to meet the standard.

Dr Walker noted that compliance with the standards was being measured by auditing patients notes, by auditing ward rounds, from Excellence in Care data and also by triangulation with complaints. Data collected from wards was not separated into weekends and weekdays and had demonstrated that reviews of patients within 14 hours were undertaken more consistently at weekends than weekdays as conflicting priorities for doctors reduced.

The Board noted the requirement to submit the self-assessment to NHSI and approved this.

088/2019 **STRATEGY**

STP Independent Chair Monthly Report

Mr Phoenix noted that the Sustainability and Transformation Partnership (STP) was now known as the Sussex Health and Care Partnership. He explained that the Independent Chair, Bob Alexander, would be writing regular updates and that these would be shared with the Board. The STP used to include East Surrey but was now focussed on Sussex, with the work undertaken by East Sussex Better Together considered as an exemplar for partnership working. Dr Bull explained that a response to the NHS long term plan was being produced by the Partnership; a draft version had been reviewed by the Board.

Mrs Manson asked whether these system-wide changes had been communicated widely within the Trust. Dr Bull explained that this had not yet taken place as the early details were not relevant to the majority of staff in the organisation. When details about changes that would affect staff emerged, including the move to becoming an Integrated Care Provider, they would be communicated to staff.

089/2019 **GOVERNANCE AND ASSURANCE**

Nursing Establishment Review

Mrs Carruth presented the review, noting that it had been discussed in detail by the F&I Committee. She explained that the review set out plans to increase the nursing establishment within the Trust by 34.1wte posts, with additional posts for the Medicine and DAS divisions. The financial impact for 2019/20 was anticipated as being around £250k, as recruitment, if approved, wouldn't take place until quarter four. The additional positions would ensure that wards continued to be safely staffed, would improve organisational productivity and would continue to ensure that agency HCAs were not required by the Trust. Any future changes to bed numbers in the organisation would lead to further reviews of the nursing establishment.

Mrs Churchward-Cardiff noted concern that the review requested investment in HCAs and not trained nursing staff. She asked whether HCAs would be asked to take on additional duties as a result. Mrs Carruth explained that a robust tool had been used to undertake the staffing review, looking at data in real time over the course of a month. She was assured that additional staff being requested would ensure that the organisation had the correct nursing skill mix; if registered nurses were required then they would be requested in the future. HCAs would not be asked to do anything different or new as a result of the review, and would not be asked to take on the role of registered nurses.

Dr Bull explained that an extensive review had been undertaken of the skill mix of nursing staff in the organisation. Mrs Carruth noted that trained nurses had been recruited from overseas to the Trust and would begin to fill nursing vacancies over the coming months. She noted that recruiting registered nurses remained challenging, but that the Trust had recruited to 80% of positions. Very few Trusts in the country were fully recruited to nursing positions.

Mrs Webber noted that the F&I Committee had asked for broader information about nursing across the organisation, including information from Lord Carter's review of NHS efficiency and on Weighted Activity Units from Model Hospital data. Mrs Carruth explained that there were two areas where the data concerning nursing establishments was being revalidated as a result of feedback from the F&I Committee. The original data had included ward clerks and specialist nurses who had been recruited in areas where consultants were particularly hard to recruit. The revalidation had shown no evidence that too many staff had been recruited, and she provided assurance that underlying assumptions in the review were correct.

Mr Reid noted that challenging and understanding the different components that compromised the overall workforce in the organisation was crucial. The nursing establishment review provided the Trust's annual check against national nursing standards and ensured that adequate staffing would be available to meet the needs of the Trust's business plans.

Mr Phoenix suggested that that Board should endorse the recommendations in the review, noting that wider issues in respect of the overall cost of the Trust's workforce would continue to be reviewed moving forwards. Scrutiny would continue to be undertaken by the F&I Committee.

The Board approved the additional nursing staffing requests.

090/2019 **Winter Planning 2019/20**

Mrs Butterworth presented the Winter Plan for 2019/20. She explained that the plan had been developed on a system-wide basis and included contributions from CCGs, adult social care, business intelligence and mental health colleagues. Plans were based on the current rate of activity growth, and included certain assumptions including a 40% reduction of super stranded patients, and an intended hospital occupancy rate of 85% on 23rd December 2019.

Based on the assumptions, a review of the number of beds in the hospital had taken place showing that, if all escalation beds that had been opened the previous year were to be opened this year then there would be a shortfall in beds of six at EDGH and seventeen at the Conquest. The Conquest had no further escalation capacity and any further measures would impact on surgical and RTT performance so were not being considered. Planned mitigations included GPs visiting patients in care homes in order to reduce the number of admissions, additional crisis support capacity, integrated discharge teams and Urgent Treatment Centres going live.

Mr Phoenix noted that the plan had been endorsed across the region, including support from regulators. He thanked Mrs Butterworth and her team for the huge amount of work that had gone into agreeing plans for winter across the system.

091/2019 **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.

i. Health & Safety

Mrs Carruth presented the Health and Safety Annual Report 2018/19, noting that it had been endorsed by the Q&S Committee.

Mrs Kavanagh reported that she had felt that the report could have included greater strategic context and information about the Trust's response to national issues. She also felt that a higher level of detail about the Trust's approach to health and safety could have been included. Mrs Carruth noted that she would be happy to discuss these issues for inclusion in the 2019/20 annual report.

The report was endorsed by the Board.

ii. Infection Control

Mrs Carruth presented the Infection Control Annual Report 2018/19, noting that it had been endorsed by Q&S Committee.

Mrs Churchward-Cardiff noted that infection control issues were regularly reported to the Q&S Committee by the Infection Control Committee, and were reported to the Board in IPRs.

The report was endorsed by the Board.

iii. Safeguarding

Mrs Carruth reported that it had been busy year for safeguarding in the Trust, with changes seen to working practice and the language used for safeguarding. Mrs Churchward-Cardiff advised the Q&S Committee had received a high level of assurance from the safeguarding team about work that was taking place across the system.

The report was endorsed by the Board.

iv. Fire

Mr Hodgson presented the 2018/19 Annual Fire Report. He reported that the two biggest risks to the Trust concerned fire compartmentation and residents' accommodation at EDGH. The residencies had a fire alarm system with minimal smoke detection, installed when they had been built. £580k of capital had been assigned to upgrade fire alarms and smoke detectors across residencies in 2019/20 which had commenced and would address the issue.

The Trust had been successful in securing a £13.86m loan to address the issues of fire compartmentation. This would be a significant project for the Trust, and would enable other issues to be addressed during the work, including clinical improvements.

The Trust had two fire safety advisors, who provided day-to-day advice and liaison both internally and externally with fire services. Up to date fire risk assessments had been carried out for every building, the Trust's fire policy was up to date and fire training was and mandatory for all staff. This was now being delivered electronically as part of a national programme, ensuring greater access for staff. A simulated evacuation had been undertaken at EDGH during 2019 to ensure that fire plans were effective.

Mrs Churchward-Cardiff asked whether there would be a loss of capacity at EDGH when wards were decamped for the fire compartmentalisation work to be undertaken. Mr Hodgson explained space would be created by moving staff without clinical functions, enabling wards to be decamped with minimal impact on patient beds.

Mrs Kavanagh asked for an update on the replacement of emergency lighting and Mr Hodgson explained that no funding had been allocated in 2019/20 for this. Parts of the system were being replaced, and a phased replacement programme would be introduced over the next 2-3 years.

The report was endorsed by the Board.

v. Guardian of Safe Working Hours

Dr Walker presented the paper, explaining that action had been taken to alleviate the pressure that doctors working on night time rotas had reported. No decision had been received from junior doctors on how fines from breaching Safe Working Hours requirements would be spent, and attendance from junior doctors at forums to discuss the matter had been poor.

Mrs Kavanagh asked why only a small proportion of doctors were exception reporting. Dr Walker explained that a greater number of exception reports were seen at times when new doctors joined the Trust. He did not feel that there was any stigma attached to the reporting of exceptions within the Trust. Plans were considered for Doctors' Assistants on wards where there were particular issues.

The report was endorsed by the Board.

092/2019 **Fire Compartmentalisation Capital Loan: Formal Approval of Request for Loan**

The Trust had successfully applied for a capital loan (an interim capital support facility agreement), to be able to undertake the fire compartmentalisation works at Eastbourne District General Hospital, from the Department of Health and Social Care (DHSC) via NHS Improvement. The loan value is £13.860m over a 3 year period commencing from 2019/20.

Mr Reid advised that the Trust was required to approve and ratify accepting the Interim Capital Support Facility Agreement from DHSC to be able to complete the fire compartmentalisation works.

The Board ratified the decision to apply and accept the capital loan from the DHSC via NHS Improvement for the fire compartmentalisation works.

093/2019 **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.

094/2019 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- Audit Committee, 24th may 2019
- POD Committee, 25th July 2019

The Minutes were received by the Board

095/2019 **Questions from Members of the Public**

Mr Phoenix reported that written responses would be provided to the questions submitted in advance of the meeting by Mr Campbell.

<u>Maternity</u>

Mrs Walke followed up on a question she had asked at August's Trust Board, concerning the review of maternity provision at North Cumbria, and requested that a review be undertaken by the Trust on maternity staffing at EDGH. She noted that this request was not being made because she felt that the current provision was unsafe, but noted that she had received some reports of issues arising as a result of unplanned transfers to the Conquest from EDGH.

She had spoken to the Chair of the Cumbria review who had felt that long term planning could make the return of consultant led maternity services at EDGH possible. The Chair had noted that an additional maternity led unit in Hastings would be a best case scenario.

Dr Bull explained that different areas had developed differing approaches to maternity provision. He was confident about the safety and quality of the current maternity services offered by the Trust. He explained that maternity services would continue to be reviewed on a system-wide basis, and that the Trust would undertake a review of maternity services in the future if necessary.

Mrs Walke noted that she would appreciate any long term plans to consider the provision of a midwife led unit on the outskirts of EDGH, allowing the current midwife led unit to return to being a consultant led maternity unit. She explained that the Save the DGH campaign would be happy to raise funds for this. Dr Bull noted that the midwifery team would welcome a standalone unit, noting that numbers of births in the current unit continued to increase.

Ambulance conveyances

Mrs Walke asked about how deaths in ambulances were recorded by both the Trust and by ambulance services, noting that the issue had been raised during a recent inquest. Dr Walker reported that discussions had taken place with the ambulance services about issues that took place outside the organisation but were relevant to the Trust. The Trust reported any issues that arose to the ambulance service who carried out a formal review, providing feedback to the Trust. Mrs Carruth explained that investigations into issues with transport had been undertaken by SeCAMB with no concerns about deaths in ambulances raised.

Mrs Walke explained that she was also concerned that ambulance crews were sometimes unsure about where patients should be conveyed. Dr Walker explained that ambulances had Standard Operating Procedures which informed them where to convey patients. Dr Bull noted that protocols had recently been revised and agreed with SeCAMB about where patients should be taken.

Overseas Recruitment

Mr Campbell asked whether the nurses that were joining the Trust from India would be grouped together when they joined the Trust. Miss Green explained that the Trust had developed a programme that would provide support and induction to the nurses, ensuring that they were welcomed and looked after when they joined the organisation.

Sepsis

Mr Campbell explained that a recent book called 'Invisible Women' had investigated gender bias. He explained that the treatment of heart failure had been discussed in the book and suggested that it would be helpful for a member of the Board to read the book. Dr Walker noted that a number of papers had been written about the under-treatment of women with cardiology problems, explaining that cardiology consultants were very aware of the issue. Mrs Carruth volunteered to read the book.

096/2019 **Date of Next Public Meeting**

Tuesday 3rd December, St Mary's Boardroom, EDGH

Signed ……

Position ……..

Date ……

Re East Sussex Healthcare NHS Trust Board meeting on 1st October 2019

Questions from the public

1. Reflecting the goals and principles set out in the 2020 Strategy, can the Board please give consideration to creating a method whereby the senior management and non-executive directors score their perception of the Trust's performance on a regular basis and publish the score in the Board papers. Quality should be clearly visible to those inside the organisation but for those outside to wait for a CQC inspection is too long to spot issues.

A. This is the purpose of the Integrated Performance Report and the comprehensive data contained in it. We are currently reviewing the format of those reports.

2. Do the wi-fi networks within the Trusts provide satisfactory levels of service in terms of speed and capacity to support all of the devices that are able to access them?

A. There are a small number of areas of weak signal which are known and mitigated.

3. Could the Improvement Hub give consideration to the benefits that could be gained by adding the following three headings to the summary sheet that precedes each Board paper to reflect the fact that every Trust activity should demonstrate their consideration in paper submitted.
    a. An improvement in healthcare; this would be a description of the benefits in healthcare being delivered as an outcome of the paper.
    b. A statement as to how this healthcare improvement can be measured in real terms i.e. without the use of phrases like "outcome framework".
    c. A statement as to how the actual improvement will be calculated and reported and be capable of comparison with that expected.

A. Thank you for the suggestion.

4. Why were the Bereavement teams selected for a number of quality walks as reported in the Board paper. (The Quality Walks are an example of an activity that should be able to identify improvement opportunities.)

A. Quality Walks are not about the Board identifying improvement opportunities but rather an opportunity to visit services and meet teams across the Trust and hear about their role, the things they are proud of and any challenges they face. It is also an opportunity for the Board to

triangulate what they hear in Committee and Board meetings. The bereavement team has two offices in CQ and DGH so they were visited separately.

5. Have the reasons for the recent increase in back issues as a cause of absence been identified?

A. No specific underlying causes have been identified.

6. What degree of certainty can the Chair of the Finance and Investment attribute to the Year End Financial Outturn forecast?

A. As reported at the Board.

C. Campbell 26th September 2019

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 1st October 2019 Trust Board Meeting

There were no matters arising from the meeting on 1st October 2019.

Board Assurance Framework

Meeting information:			
Date of Meeting:	3rd December 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

There are two areas where assurance has increased

2.1.3 follow up appointments due to strengthened controls and
2.2.1 accountability framework as actions are progressing and this will be reported to POD

The Board will be asked to approve these moving to green.

There is one area that remains red 4.2.1 due to capital constraints.

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

Senior Leaders Forum 12 September 2019
Quality and Safety Committee 21 November 2019
Audit Committee 28 November 2019

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

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

Assurance Framework - Key

RAG RATING:
Effective controls 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 - November 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	Revised Mar-18 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 QI strategy in place and improvement hub established . QSIR improvement utilised and training programme in place 'Excellence in Care' audit and reporting programme rolled out to in-patient areas to facilitate clinical areas in assessing themselves against Trust wide standards of care	Significant number of services rated Good by CQC in March 18 inspection. Progress reported to Q&S and action plan reviewed. Positive feedback from internal reviews undertaken of acute and community services involving external as well as Trust staff. Improved quality in a number of areas for example sepsis and reduced mortality		Use of Resources review took place October 2019 led by NHSI. CQC inspection taking place 5-6 November followed by Well Led Review on 10th and 11th December. Anticipate report will be finalised by end of February. Clinically led panel in place undertaking review of recent never events; outline report and initial recommendations developed and work ongoing.	Feb 20 Jan 20	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.	<u>Added May-17</u> 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. Full capacity and demand review being undertaken in recognition that referrals continue to increase; baseline capacity to be reset with analysis of potential requirement for additional substantive clinicians		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. Recovery plan and workforce plan being updated to reflect new demand Radiology specific actions being developed Cancer leadership structure under review System governance being reviewed and system workshop 11 Nov, focus on referrals and triage process	COO Dec 19	COO Q&S

Board Assurance Framework - November 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
2.1	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.	Revised Jan-18 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. Working party, including CAMHS and ESHT established to review /monitor existing services Inappropriate ward admissions recorded. 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.		Developed an escalation process with SPFT for management of children and young people under ESHT care but with a mental health need. Covers escalation when child/ young person has been admitted, with timescales for engagement with CAMHS/FEDS once admitted and also when medically fit for discharge	Dec-19	COO Q&S

		Added May-19 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 at specialty PTLs Training, competency assessment and guidance for booking and reception teams. Extensive validation and local procedures for patient on cancer pathways & urgent ophthalmology follow up appointment Failsafe Officer in post for Ophthalmology and additional activity to reduce follow ups particularly in Ophthalmology	Audit of 600 patients on the FU database has given a high level of confidence regarding data accuracy and therefore risk is reducing Reporting of follow up through Div IPRs who are responsible for action and registering risk if indicated.	▲	Risk reducing as greater levels of confidence in the quality of data on the FU list. Digital team exploring an alternative approach to allow 'time critical' follow up patients to be highlighted. However, options available to date are not functional. Risk is however lowered as Trust controls strengthened	Sep-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
2.2	There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.	Added Jan-19 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 and communicated across Trust including at Leadership Briefing	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	▲	Ongoing implementation and completion of action plan. Reviewed at POD Nov-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-19 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 submitted 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.	▲	STP wide (Sussex) response to the long term plan submitted. Includes a subset of placed based plans including the East Sussex Plan. Trust priorities incorporated in the plan and we continue to work closely with commissioners on how we ensure delivery of key objectives. Key programmes of work are focused on Acute Care, Planned Care and community based services.	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.	Added Sept-17 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 approved by Board (Oct-19) 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 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.	Mar-20	MD 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
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 Nov-19 4.1.1 Controls for financial delivery are robust, but the CIP challenge and financial plan 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&Q2 has a number of non-recurrent elements and full year programme has not yet been fully approved. Approval has now reached £18m of the £20m target, with a pipeline emerging to mitigate the remaining shortfall. Director of Finance regularly reviewing position with Programme Director and Deputy Director of Finance.	On-going review and monitoring to end of Mar 20	DoF F&I

Board Assurance Framework - November 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.	<u>Revised Apr-19</u> 4.2.1 The Trust has a five year plan, which makes a number of assumptions around external as well as internal funding. Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.	Moderate	Capital plan for 2019/20 in place, following a robust prioritisation process, aligned with the Capital Resource Limit of £13.6m. Essential work prioritised with estates, IT and medical equipment	Regular review by F&I and FISC committees 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. The Trust has been named as part of the HIP Programme (Phase 2) and has commenced dialogue with NHSI/E colleagues on next steps to secure significant funding over the next 3-5 years.		Delivering against the agreed capital plan remains challenging within a robust control framework. Capital Resource Group are holding spend within the current budget through monthly review of spend and forecast and careful prioritisation of the programme. Developing 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 December F&I meeting	On-going review and monitoring to end Mar-20	DoF F&I

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	Added Sept-17 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 undertaken on Seaford ward in June 2019 - will support refinement of evacuation plans		NHSI funding confirmed Sept-19 in order to facilitate additional fire compartmentation works. This will improve infrastructure and ensure compliance with ESFRS requirements. Programme of works has commenced and works likely to start on providing for decant facility in 2020 Q1,.	end Mar-2	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.	Added Nov-17 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 Cyber security awareness campaign commenced October 2019	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. Senior Leaders participating in IT / Cyber exercise delivered by Police South-East Regional Police Organised Crime Unit (Nov-19)	end Nov-19 end Jun-20	DF Audit Committee

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.	Added 2015 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. A&E, Microbiology. Continued Brand awareness through social media activity to promote the Trust has continued to see an increase in candidate applications overall.(Year on Year). Trust overall Time to hire holding at 72 days. (inc advertising/notice period) Labour turnover (10.4% September 19 vs 10.8% September 18). Trust vacancy trending at 10.4% in September 2019 vs 10.8% in September 2018.		Medical recruitment, hard to fill posts - 8 candidates in place sourced via Medacs, a further 7 posts at offer . Since May 2019 55 Band 5 Indian nurses arrived at Trust, with a further 25 due to arrive in November. Further c20 planned to arrive in January2020. Continued International sourcing of Medical candidates, including Radiographers and Sonographers. A further 6 Radiographers due to start with Trust in December 2019.	ongoing to end Mar-20	DHR POD

Chief Executive's Report

Meeting information:			
Date of Meeting:	3rd December 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:

Introduction

The Divisional Medical Chiefs came to the end of their three year tenures in November, Dr Simon Merritt (Medicine) and Dr Melanie Liebenburg (Women's, Children's) have both been re-appointed. Dr Gez Gould has been appointed as the new Chief for the Diagnostics, Anaesthetics & Surgery division. Dr Kate Murray is our new Chief Clinical Information Officer and Dr Ben Salt her deputy. The Director of Medical Education post will be interviewed shortly. Drs Wilkinson and Zaidi have been reappointed as Associate Medical Directors. In Medicine, Drs Dashora, Patel, and Newman have been appointed as deputies. In DAS, Drs Harris, Bate, and Faris have been appointed as deputies.

Never Events

As non-executives are aware, the Trust has reported five Never Events since April. Following discussion at the private board, a Clinical Practice Review Group was established to undertake a full review of the incidents and any issues of safety arising from them. A report will be published shortly on the outputs from the group.

Some early themes which have arisen include:-

- The appropriate use of checklists is pivotal to safety
- Distractions that affect situational awareness of the team can affect the safety of procedures
- Visual prompts are useful barriers to prevent error (e.g. "Stop Before You Block" posters)
- Standards and standardisation of procedures is a key area to ensure safety in performing invasive procedures. (e.g. Local Safety Standards for Invasive Procedures (LocSSIPs))

The next steps in the process include accessing wider feedback from all stakeholders, reviewing the approach to the WHO checklist across all areas, reinforcing the "Stop Before You Block"

communications and the use of the Central Venous Line insertion checklist. When the review is concluded there will need to be wider communication across all staff to embed the learning.

Operations

September and October have been particularly challenging months both locally and nationally with regard to delivery of the 4 hour standard; despite the Trust being recognised as a top performer in same day emergency care standards and long length of stay reductions.

The teams are working on a three year bed plan, assuming continued improvements in length of stay but continued increases in activity. This will be factored into the 19/20 business planning.

The Medicine division is continuing to recruit and further extend our ambulatory and frailty service, which will support continued improvements; the emergency departments are progressing with a strengthened urgent treatment centre model at the front door to our A&E departments.

Integrated Discharge Teams have been implemented across the two acute sites and will continue to embed and develop integrated working across divisions and social care at ward level, with strengthened board rounds introduced.

Delivery of the 62 day cancer standard continues to be challenging. We are reviewing system level governance with the CCG and are in discussion about a number of system actions that could help delivery, as well as the Trust's internal action plan.

Community services, ESHT, Adult Social Care and Sussex Community FT have been developing an East Sussex target operating model in line with the long term plan and building on our existing integrated service arrangements.

The implementation of NerveCentre, our live bed state and clinical tasking system, went live at EDGH on 11 November with Conquest following a week later. This is a significant change, moving away from paper based systems.

Health and Safety Executive Inspection

As a result of the inspection by the Health & Safety Executive in July 2019, the Trust received a Notification of Contravention Letter. The Trust was tasked to develop and submit by the 30th October an action plan to address the following key points:

- 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
- No quantification of the violence and aggression problem across the Trust.

The Trust established a Violence and Aggression Task and Finish Group under the leadership of the Director of Nursing (as executive lead for H&S) and the Head of Governance, with identified work streams to address the specific issues.

The improvement plan was submitted on time following sign off by the Executive Team. The Trust received notification on the 7th November 2019 from the HM Inspector Health & Safety that the HSE was satisfied that the Trust's proposed Violence and Aggression Improvement Plan and corresponding timetabled actions will sufficiently address the issues identified in the Notification of Contravention Letter (NOC) and that the NOC will be signed off as completed.

The task and finish group will continue to work towards the achievement of the milestones and report to the Health and Safety Steering Group and the Senior Leaders Forum.

Infection Prevention and Control

Clostridium difficile infection
ESHT is below the limit for 2019/20 with 36 cases reported at the end of October. Four cases were reported in October against a monthly limit of five.

There has been further reduction in Consultant Microbiologist staffing levels. There is currently only one consultant to cover all work within ESHT and advice to GPs. Working processes within the microbiology and IPC departments have been reviewed to try to reduce the impact while we try to recruit.

People, Leadership and Culture

A revised Education Strategy has been presented to Education Steering Group for comment.

Twelve month appraisal compliance data shows a slight increase again to 79.5%. An initial self-serve pilot in DAS for managers/supervisors in inputting completed appraisals onto ESR themselves has been a success. This was implemented by OOH on October 1st and is being rolled out across the Trust, supported by training and guidance notes from the Workforce Planning, Information and Resourcing Informatics Team.

Recruitment

The vacancy rate has seen another month on month reduction and is now 9.8%. There is a continued increase in the number of applications to the Trust for all roles.

Key and ongoing actions also being undertaken include:

- Following a visit to India in April this year, 89 candidates have been sourced to date and 80 international nurses have started with the Trust.
- A further 19 newly qualified nurses have joined the Trust.
- Targeted recruitment campaigns to support radiology and urgent care departments. Medacs and MSI agencies have been engaged to assist with these vacancies. Six radiographers are due to join the Trust in December.
- Relationships with Medacs continue to strengthen. To date eight medical staff are in post and a further seven offers of appointment are in the pipeline.

Communication and Engagement

CQC Inspection

A paper covering the recent CQC inspection forms part of the December Board pack. I would like to formally record thanks to everyone involved in the inspection. The CQC commented that they had been welcomed everywhere they went and were shown many examples of wonderful and innovative care. They will be visiting again for the well-led part of the inspection on 10th and 11th December and we anticipate that reports will be finalised and published by the end of February 2020

In October we received positive coverage on ITV's Meridian about the 100 new overseas staff who have joined the Trust over the last few months. The piece highlighted the importance of the NHS looking overseas to increase staffing numbers, alongside improving training roles and creating opportunities to develop our own staff. In a similar vein, we also received positive coverage about a number of new staff who joined the Trust after the closure of the Esperance in Eastbourne.

Our public engagement work continues and in September, 30 members of the public 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. Feedback from the event was excellent and we hope to run a similar event at Conquest. We are also making progress with our project to improve the experience of inpatients. As part of this work we have spoken to 120 recent patients to ask them what we can do to improve their experience. Patient cited noise at night, patient information and discharge letters as areas for improvement. These areas will form the basis for our next public meeting in February. All of this work is being highlighted in our new monthly e-newsletter aimed at our 2000 ESHT supporters. In November we also released our Autumn edition of ESHT News which contains information about reducing falls, spotting sepsis and how to access urgent care advice during the winter months.

In advance of winter we are joining with the NHS national and local winter campaign “help us help you”. We are distributing messages that encourage the use of NHS 111, GP Improved Access and pharmacies via social media, in ESHT News and across the Trust. In the coming weeks we will start to distribute an East Sussex focused leaflet highlighting the different urgent care services across East Sussex. Linked to this we are also supporting the local campaign encouraging front line staff to get their flu jab and all staff to complete the staff survey.

Finance

At Month 7, the Trust remains on track to deliver its financial plan for the year, as does the wider East Sussex Health system. If the Trust delivers our full year deficit plan of £34m, compared to £45m last year, then transformation funding of £24m will be made available to us. This will leave 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. Our operational run rate is slightly better than planned, a £2.13m deficit, at month 7. Because of this, we received transformation funding of £2.30m taking our reported in-month position into surplus. 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 7. Teams across the Trust are looking at options to both reduce the small gap which remains in the current year plans, and to start work on next year’s plans. Given the significant improvement in our financial position, we are anticipating a reduced cost improvement target for 2020/21, closer to national levels of anticipated efficiencies. Our initial plans suggest a likely target of £15m, reduced from £20m, and moving us to breakeven.

Urgent care activity levels remain considerably higher than system plans at the start of the year. Although the financial consequences are managed through the aligned incentive contract, this puts additional pressure on staff across the organisation. The Trust continues to work with key stakeholders through the Urgent Care Board to develop an appropriate response as well as ensuring that appropriate plans are in place for winter. 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 – with a particular focus on ensuring we deliver for patients on the 18 week and cancer pathways.

The East Sussex CCGs also met their financial plans at Month 7, and the whole system remains on track to deliver the 2019/20 financial plan. The East System has submitted a ‘plan for the East’ to meet the requirements of the NHS Long-Term Plan – and this indicates that the financial position for the system is likely to be more balanced in future years. The plan is co-ordinated through the East Sussex CFO group.

Capital spending for the year is on track. The Trust’s initial capital budget is £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 NHS Improvement on our applications for emergency capital funding, for significant infrastructure, equipment and maintenance, and has received confirmation that additional funding for medical equipment and backlog maintenance will be provided later in the financial year.

Strategic Development and Sustainability

QSIR

The first cohort of QSIR (Quality, Service Improvement and Redesign) practitioners presented their Improvement programmes in November. The QSIR Practitioner is a five day programme (spread over five months) aimed at providing participants with the skills, tools and techniques to design and implement more efficient and productive services and processes. The QSIR programme is supported by NHSE/I and our QI team at the Trust are all already qualified as QSIR trainers or are part way through this process. The Improvement programmes are all aligned to Trust objectives and include:

- To increase small for gestational age (SGA) detection rate from 28% to >40% by Oct 2020
- Implementation of surgical ambulatory care (SAEC) pathways
- Improvement of bowel dysfunction service
- To increase referral rates into the frailty medicines optimisation service so that it exceeds 50% of the total number of discharges from the frailty practitioner service per month
- To reduce the incidence of obstetric and sphincter injuries (OASI) at ESHT from the 3.3% or 67 cases in 2018/19
- To reduce unnecessary extended hospital stays by October 2019 and ensure that patients are discharged without delay when their acute care is complete
- Increase the % of zero length of stay admissions for patients over 75 years with no acute needs
- To improve the business planning process to ensure that it is effective and plans are monitored and tracked monthly by April 2020

Feedback from programme sponsors and participants has been extremely positive. Cohort two is already underway and a further two cohorts are already booked for the spring.

Integrated Performance Report – Month 7 - October 2019

Meeting information:	
Date of Meeting: 3rd December 2019	Agenda Item: 8
Meeting: Trust Board	Reporting Officer: Joe Chadwick-Bell

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

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

Summary:

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

The Executive Summary provides key highlights from the Trust Board IPR. The Board are asked to note the key issues highlighted below and complement the IPR, provided as an appendices to this summary. The report covers the period October 2019 (Month 7).

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?

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.

Quality and Safety

Falls	Overall falls position remains below the mean, which shows a positive position for the third month in a row when viewed as falls per 1000 bed days.
Pressure Ulcers	In October there were 26 category 2 ulcers declared in the acute hospitals, 20 in the community and 2 in our community hospitals, overall this is a reduction from 53 in September to 48 in October. There were no category 3 or 4 pressure ulcers reported in October. The community hospitals continue to report no category 3 or 4 pressure ulcers since October 2017. **Action:** Quarterly deep dives continue of category 2 and unstageable damage which are presented at the Patient Quality and Safety Group to review any lapses in care and share/embed learning.
VTE Assessment	0.2% below target of 95% and when comparing October 2019 to October 2018 is 1.2% lower.
Serious Incidents	At the end of October 2019 there were 40 Serious Incidents open in the system; 23 under investigation and within timescales, 10 are with the CCG for closure and 4 reported as SI's but requesting downgrade. There are 3 incidents are with the Healthcare Safety Investigation Branch (HSIB).
Infection Control	**MRSA bacteraemias** – Three hospital acquired infection (HAI) cases reported to date for 2019/20. No cases for October. **C. Difficile** - The limit for 2019/20 is 68 cases for ESHT, to include patients with prior healthcare exposure within 4 weeks of a positive sample. 36 cases have been attributed to ESHT to end of September. 4 cases were reported in October against a monthly limit of 5. 2 cases of Hospital Onset Healthcare Associated (HOHA) and 2 cases of Community Onset Healthcare Associated (COHA) infection. **Action:** Post infection reviews (PIRs) have taken place, decision pending CCG sign off.
Friends and Family Test (FFT)	October 2019 response rate is 44.9% (target 45%). There is a 1.6% variation when comparing the total number of FFTs against the same period last year. The response rate is 97.5%.
Complaints	**54 new complaints** were received in October and no overdue complaint responses. DAS Division has the highest rate of complaints per 1000 bed days at 3.5. Of the 18 complaints received, 9 related to Standard of Care category and of those there 6 were for lack of confidence in the delivery of care sub category. The speciality with the highest complaints was General Surgery with 8.
Care Hours Per Patient Day	Trust overall CHPPD has increased from 8.22 (September 19) to 8.37 (October 19) slightly above the recommendation of 8.2 against our peers and the latest national CHPPD in May 2019 which was 8.1. 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).

Access and Delivery

	Standard	Target	Performance Update
Urgent Care	A&E 4 hour standard	95%	The Trust 4 Hour performance standard in October was **81.2%** against a national performance of 83.6%. This ranked the Trust 65th out of 120 reporting organisations. The system 'Walk-In' centres and the Acute Trusts combined performance for October was **85.5%.**
Referral to Treatment (RTT)	18 week referral to treatment	92%	The RTT position for October was **90.4%,** demonstrating two consecutive months of improvement.
Diagnostics (DM01)	Less than 6 weeks	>0.99%	September (0.96%) & October **(0.57%)** have achieved.
Cancer	Two week wait referral	93%	**Two Week Wait** performance was **95.4%.** **62 Day** performance was **70.5%** for September compared to a national aggregate of 76.9% and a recovery trajectory of 80.3%.
	62 day urgent referral	85%	

Workforce

October 2019	Position	Commentary
Trust total workforce utilisation	6799.4 full time equivalent (FTE)	This is 412.4 FTE below the budgeted establishment, however, workforce expenditure is £896k over budget (budget £24,041k, actual expenditure £24,937k). Temporary expenditure of £3,056k represents a further reduction of £156k since last month. Substantive expenditure of £21,782k accounts for 87.3% of total expenditure whilst temporary expenditure of £3,056k equates to 12.3% of the total as follows: • Bank & Locum £2,174k (8.7%) • Agency £762k (3.1%) • Overtime £70k (0.3%) • Waiting List payments £49k (0.1%) *(the remaining 0.4% of expenditure is accounted for by the Apprenticeship Levy)*
Trust vacancy rate	10.5%	This is an increase of 0.7%. This is as a result of increases in budgeted establishment this month (+ 88.4 FTEs) including: • Ambulatory Care Business case • Funding of the Discharge Team workforce • New Information Security posts in Digital IT. Staff in post - numbers have actually increased by 29.7 FTEs. Current vacancies are 743.9 FTE (an increase of 58.7 FTE vacancies).
Annual turnover	10.4%	This remains constant, reflecting 619.0 FTE leavers in the rolling 12 months.
Monthly sickness	4.4%	This is an increase by 0.3%, compared to Sept.

	8500 FTE days lost to sickness	This is in line with the October monthly sickness rate last year and thus the overall annual sickness rate remains unchanged.
Mandatory training	88.4%	The compliance rate has increased again by 0.4%. Compliance rates have increased for all modules except for: • Moving & Handling (-1.1%) • Safeguarding Children Level 2 (-0.7%) • Deprivation of Liberties (-0.1%).
Appraisals	79.6%	Compliance has increased by 0.1% this month.

Finance

Operational Deficit	The Trust is £39k ahead of plan year to date and eligible for PSF (£3.4m) and FRF (£6.7m) funding, which is included in the financial position. The YTD value of the Aligned Incentive Contract with the East Sussex CCGs is also included in the financial position. Overspends are primarily in medical pay and are offset by underspends in A&C and AHP pay. Cost Improvement is £44k ahead of plan YTD. YTD non-pay overspends in tariff excluded drugs are offset in contract income.
Trust's spend on Agency Fees	Agency spend is £345k below plan YTD. The largest underspends are in the Tech staff group. All agency usage is reviewed by the T3 Pay Panel. There are requirements for agency to be used in difficult to recruit medical and AHP. Cost remain within the NHS Improvement ceiling for 2019.20.
Operating Costs	Overall operating costs are reporting £1.9m overspent against plan. Overspends are due to medical pay costs including agency, waiting list initiatives and locum (£0.9m), clinical supplies (£0.5m) and drugs (£0.8m). In line with an increase in non-elective activity. The Agenda for Change lump sum payment was made in Month 1 to all staff at the top of band (£0.9m). An arrears payment for Medical and Dental pay award was made in Month 6. Underspends in non-pay expenditure in relation to COIN (£0.2m) are offset in income.
Cost Improvement Plan	The Trust has over-delivered by £44k against its YTD plan. Despite this, there is underperformance in radiology outsourcing (£223k) and Urology locum (£45k) 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 Cost Improvement Programme target with £17.9m currently identified as process green. The Divisions are increasing their reliance on non-recurrent savings with the proportion of Month 7 non-recurrent savings at 21% an increase of 4% from Month 6 and 9% against the lowest at 12% in Month 4. The expectation was that we would have plans for the full £20.6m by now.

East Sussex Healthcare NHS
NHS Trust

MONTH 7 (OCTOBER 2019)

TRUST INTEGRATED PERFORMANCE REPORT

East Sussex Healthcare NHS Trust

Contents

QUALITY AND SAFETY

DIRECTOR OF NURSING & MEDICAL DIRECTOR

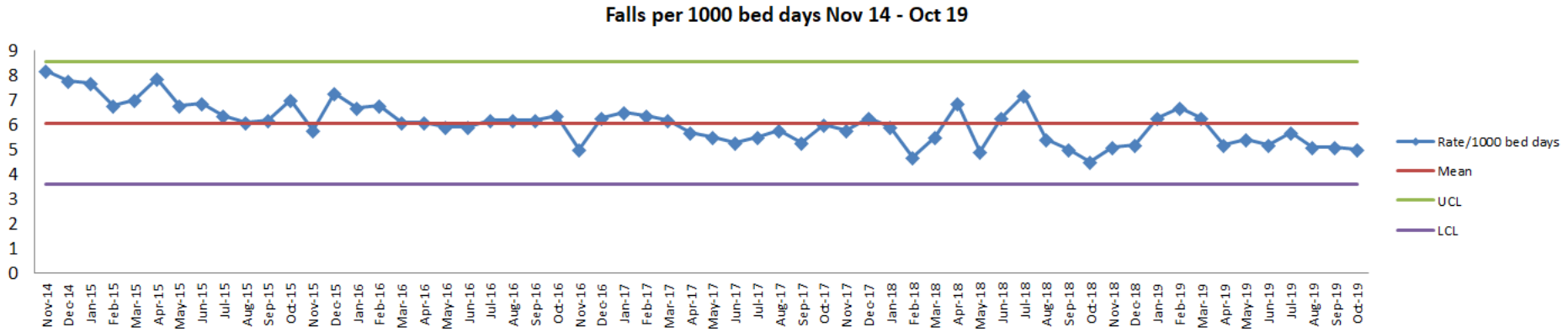
Safety

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-18	Oct-19	Var	2018/19	2019/20	Var		
Total falls	M	93	113	21.5%	865	793	-8.3%	120	
Number of no-harm falls	M	68	79	16.2%	625	576	-7.8%	88	
Number of minor/moderate falls	M	23	33	43.5%	233	204	-12.4%	30	
Number of major falls	0	2	1	-1	7	13	6	1	
Number of catastrophic falls	0	0	0	0	0	0	0	0	
All patient falls per 1000 Beddays	5.5	4.4	5.0	0.6	5.6	5.2	-0.44	5.3	
All patient falls with harm per 1000 Beddays	M	1.2	1.5	0.3	1.6	1.4	-0.14	1.4	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	2.2	2.1	-5.6%	1.9	2.1	15.5%	2.3	
Number of grade 2 pressure ulcers	M	46	47	2.2%	280	317	13.2%	50	
Number of grade 3 to 4 pressure ulcers	M	1	0	-1	5	10	5	1	
Pressure ulcer assessment compliance	M	85.0%	100.0%	15.0%	83.8%	85.7%	1.9%	82.8%	
VTE Assessment compliance	95.0%	96.0%	94.8%	-1.2%	95.7%	95.6%	-0.1%	95.9%	

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 October is 78% (national figure 73%).



- The rate per 1000 bed days is 5.0 which is lower than in September and is the target set by the Trust.
- In October there were 113 falls with 2 x severity 4 (one was originally reported as 3 so not shown in table above).

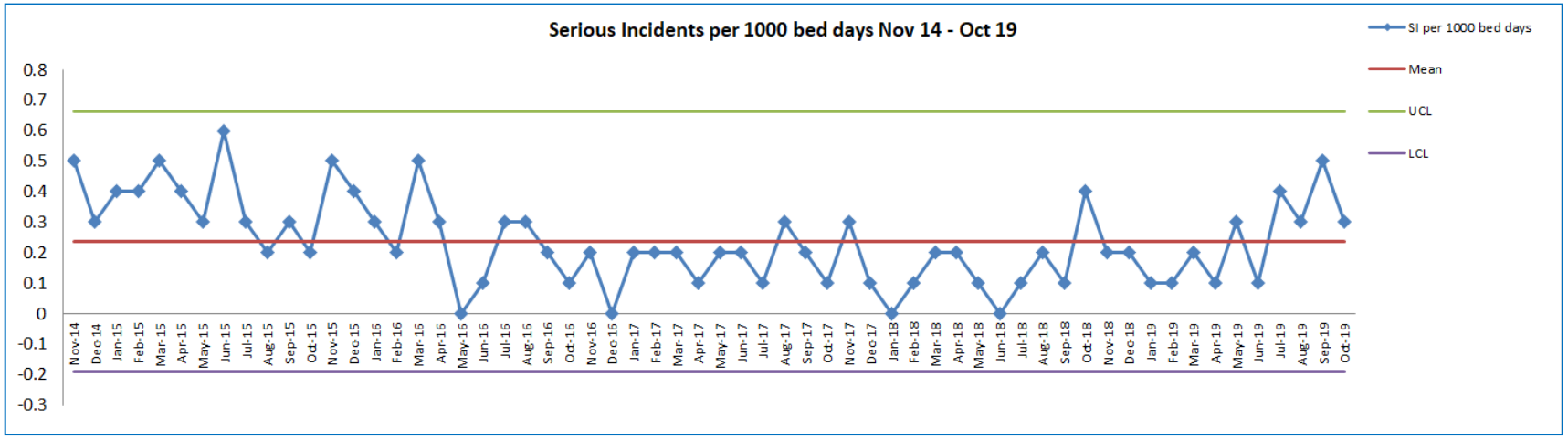
Safety

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-18	Oct-19	Var	2018/19	2019/20	Var		
Number of Serious Incidents	M	9	7	-2	27	45	18	5	
Number of Never Events	0	1	0	-1	1	5	4	0	

At the end of October 2019 there were 40 Serious Incidents open in the system; 23 under investigation and within timescales, 10 are with the CCG for closure and 4 reported as SI's but requesting downgrade. There are 3 incidents are with the HSIB.

There were 7 **serious incidents** reported on STEIS during October 2019:
1 x Tear injury sustained to ureter during caesarean section resulting in a major obstetric haemorrhage
2 x Fall to Fracture
1 x Treatment delay following lack of appointment to undertake a liver biopsy
1 x Incorrect strength of intraocular lens implanted
1 x Bladder injury and vaginal tear during a caesarean section requiring surgical repair
1 x patient admitted with poor nutritional intake, dehydration and hypoglycaemia. Patient developed diabetic ketoacidosis.

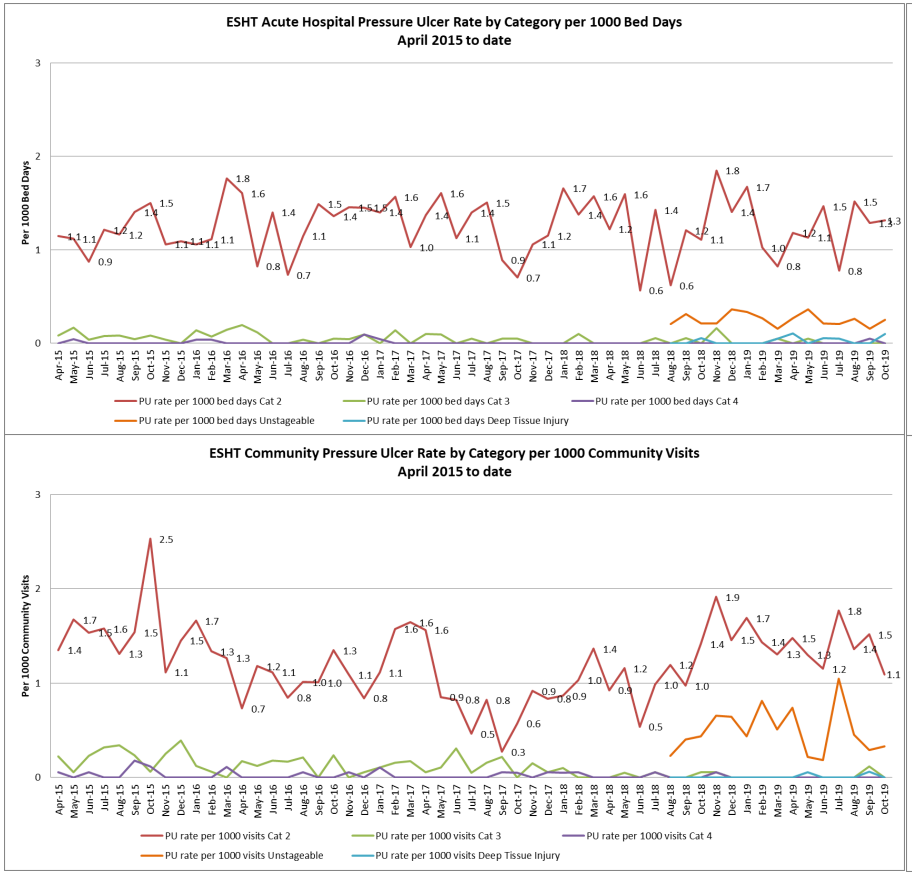


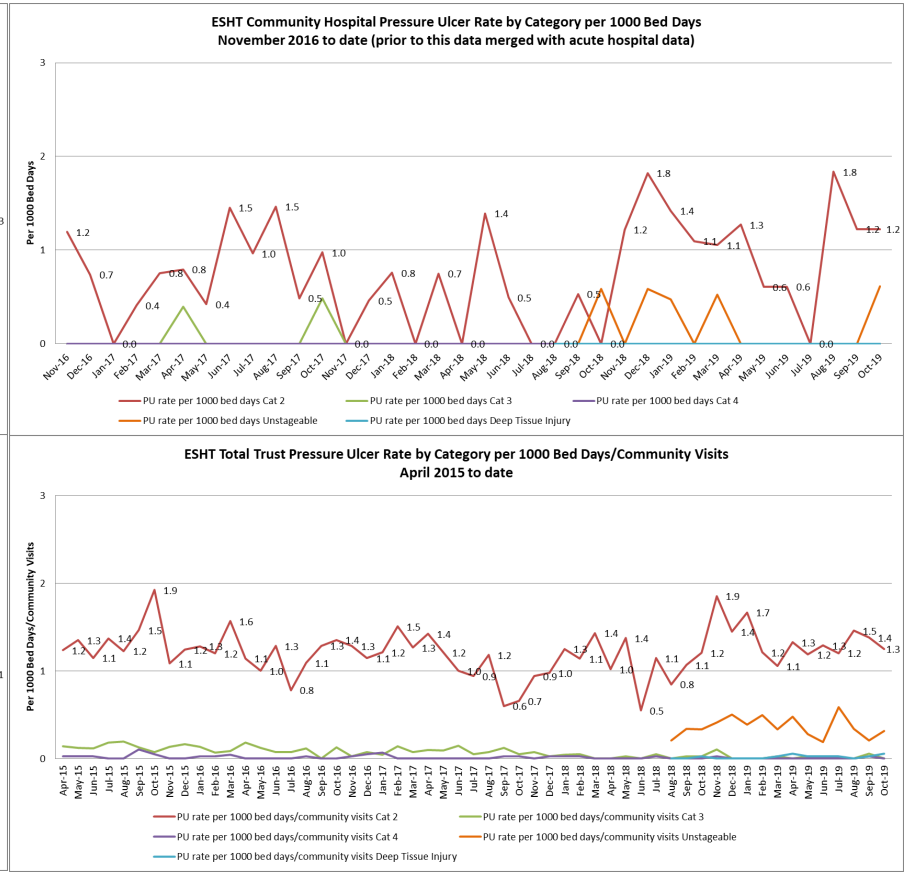
- **Duty of Candour**

For October 2019, the verbal DoC was 64% and written DoC was 82%. 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.

**Date incident reported may differ from the data incident happened*

Pressure Ulcer Incidents





In October there were 26 category 2 ulcers declared in the acute hospitals, 20 in the community and 2 in our community hospitals, overall this is a reduction from 53 in September to 48 in October.

There were no category 3 or 4 pressure ulcers reported in October. The community hospitals continue to report no category 3 or 4 pressure ulcers since October 2017.

Quarterly deep dives continue of category 2 and unstageable damage which are presented at the Patient Quality and Safety Group to review any lapses in care and share/embed learning.

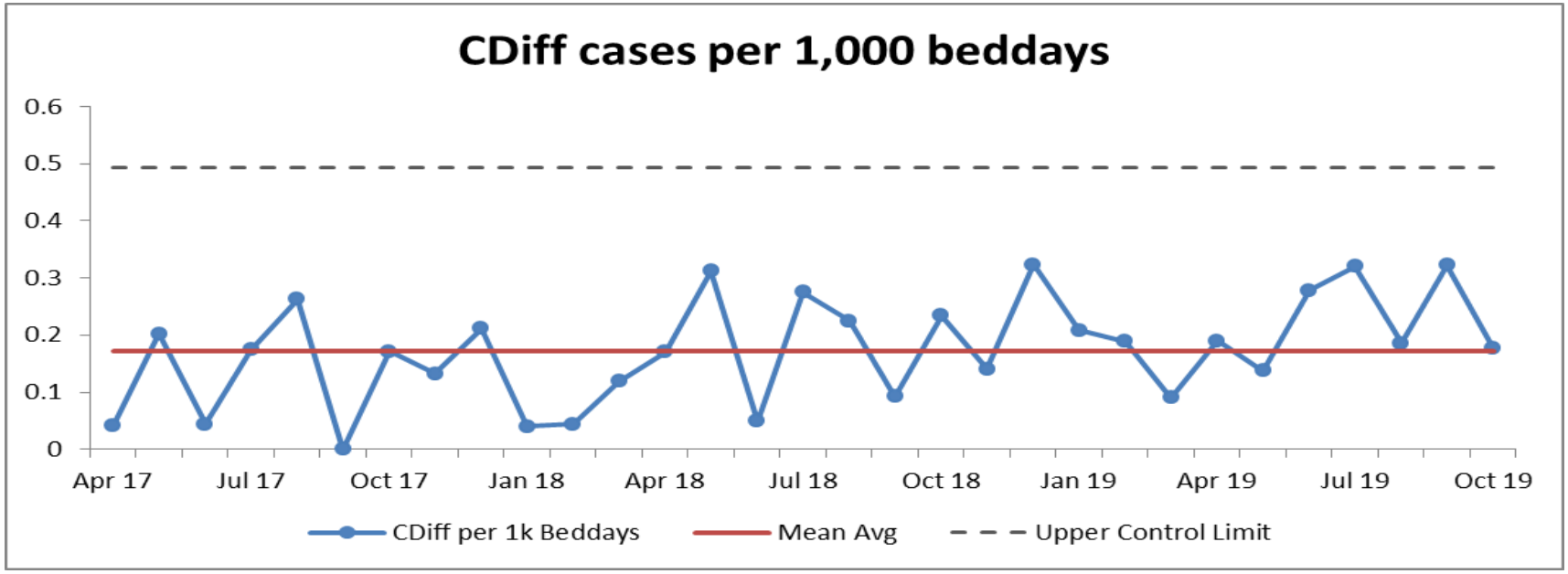
East Sussex Healthcare NHS
NHS Trust

Infection Control

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-18	Oct-19	Var	2018/19	2019/20	Var		
Number of MRSA Cases	0	0	0	0	1	3	2	0	
Number of Cdiff cases	4	5	4	-1	30	35	5	5	
Number of MSSA cases	M	1	3	2	10	10	0	2	

MRSA bacteraemias – Three HAI cases reported to date for 2019/20. No cases for October.

C. Difficile - The limit for 2019/20 is 68 cases for ESHT, to include patients with prior healthcare exposure within 4 weeks of a positive sample. 36 cases have been attributed to ESHT to end of September. 4 cases were reported in October against a monthly limit of 5. 2 cases of Hospital Onset Healthcare Associated (HOHA) and 2 cases of Community Onset Healthcare Associated (COHA) infection. PIRs have taken place, decision pending CCG sign off.



Infection Control

MSSA bacteraemia - Three HAI MSSA bacteraemias to report for October.

One case assessed as avoidable, related to an infection caused by a peripheral cannula inserted in A&E. The post infection review identifies that there was lack of documentation relating to assessment of the cannula when the patient was on AAU and Newington ward. The incident has been shared with the clinical team and addressed via the matron. Two other cases assessed as unavoidable.

Gram negative bacteraemia

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

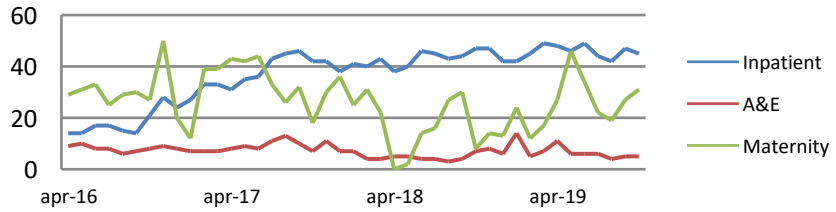
There were no Gram negative bacteraemias that were assessed as avoidable.

Serious incidents/outbreaks – Possible exposure to TB. A patient who was diagnosed with pulmonary tuberculosis (TB) had not been isolated for a period of four days as they were being treated as probable malignancy. Other patients in the same bay and ward staff were potentially exposed to the infection. Contact tracing has been undertaken and follow up arranged as appropriate. To date no patients or staff have presented with symptoms consistent with TB.

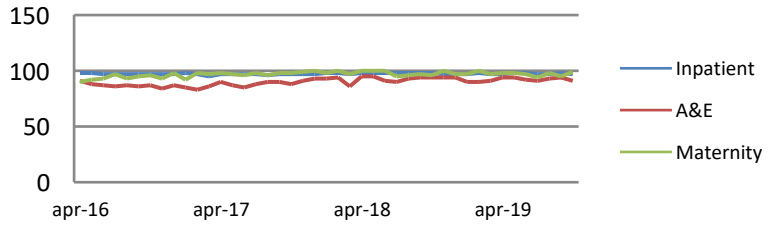
Patient Experience

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-18	Oct-19	Var	2018/19	2019/20	Var		
Inpatient FFT response rate	45.0%	46.5%	44.9%	-1.7%	43.4%	45.5%	2.1%	45.4%	
Inpatient FFT score	96.0%	97.5%	97.5%	0.1%	97.8%	97.5%	-0.3%	97.4%	
A&E FFT response rate	22.0%	7.5%	5.0%	-2.5%	4.5%	6.1%	1.5%	6.2%	
A&E FFT score	88.0%	93.7%	90.6%	-3.1%	93.3%	92.7%	-0.6%	92.3%	
Outpatient FFT Score	M	100.0%	96.7%	-3.3%	97.7%	97.7%	0.0%	97.5%	
Maternity FFT response rate	45.0%	8.0%	30.6%	22.6%	13.6%	29.5%	15.9%	24.0%	
Maternity FFT score	96.0%	95.7%	98.8%	3.1%	96.4%	97.2%	0.8%	97.4%	

FFT % Response Rate Apr 16 - Oct 19



FFT % Recommend Score Apr 16 - Oct 19



Examples of questionnaire comments in September:

Positive comments

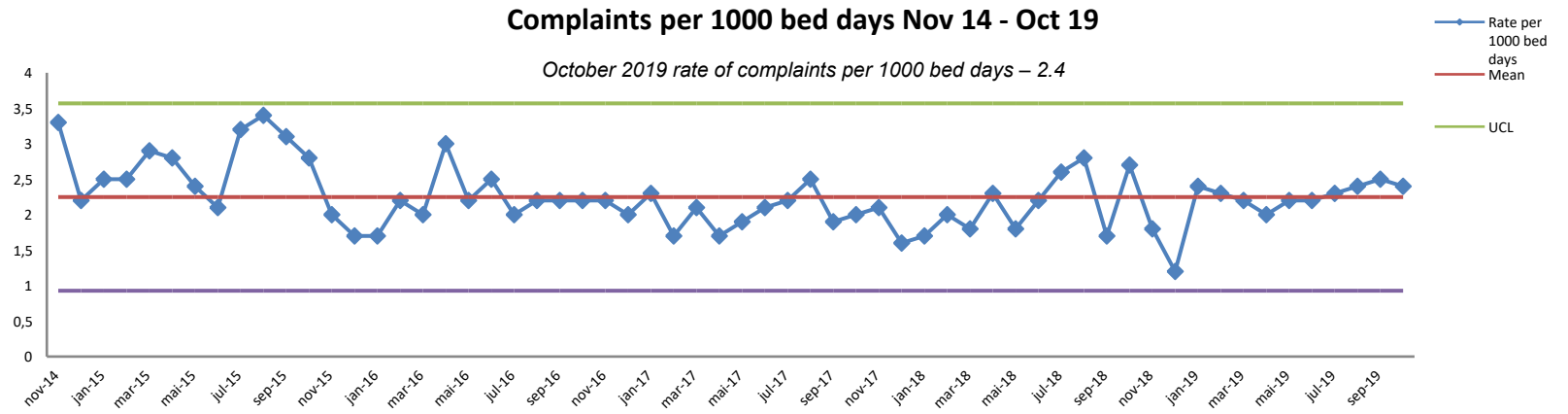
- "Always a smile and caring approach. Well done team.
- "Felt very cared for, pain was managed well and without complaint. All staff very nice and happy to answer any questions"
- The team were excellent, working together with doctors towards the care for their patients wellbeing"
- **Negative comments**
- "Could be better informed whilst waiting"
- "Cold ward. More blankets or heating"
- "2 gowns for dignity"

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

- Do you know who to contact if your condition deteriorates?
- Were you given enough notice about when you were going to be discharged from hospital?
- Did you feel involved in decisions about your discharge?

Complaints

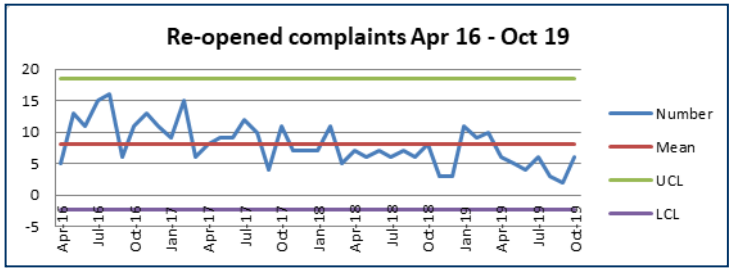
East Sussex Healthcare NHS Trust



54 new complaints were received in October and no overdue complaint responses.

DAS Division has the highest rate of complaints per 1000 bed days at 3.5. Of the 18 complaints received , 9 related to Standard of Care category and of those there 6 were for lack of confidence in the delivery of care sub category. The speciality with the highest complaints was General Surgery with 8.

There were 6 re-opened complaints in October, 4 more than in September. 3 were due to requests for meetings, 1 was unhappy with response related to continence product but now resolved and 2 had further questions following receipt of response.



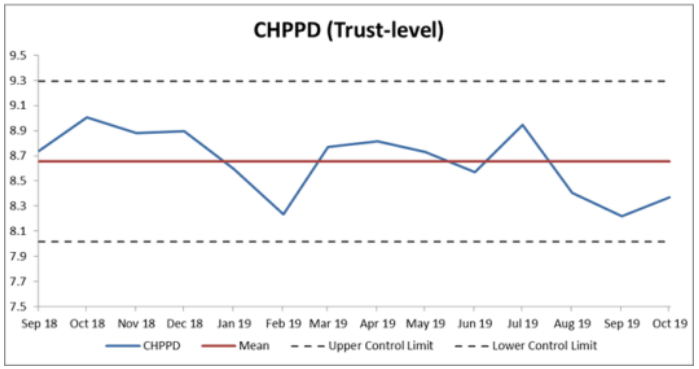
In October, there were three contacts from the Parliamentary and Health Service Ombudsman (PHSO).
Two were to make enquiries about cases they are considering for investigation and one was to report the outcome of a case they had investigated.
Enquiries: One enquiry is into a case where the complainant is concerned about the care and treatment her son received following his birth until his death a few months later in April 2017 and the other where the complainant is concerned about the care and treatment his late wife received in October 2017
Outcome: this relates to a mother's concern about her son's care and treatment following discharge from hospital with ongoing deteriorating health problems. The PHSO's investigation did not find any failings in the patient's care and have decided not to uphold the complaint.

Safer Staffing and Workforce

Fill Rate and CHPPD by Site	Day				Night				CHPPD
	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	
BEXHILL HOSPITAL	89.8%	120.0%			103.2%	121.2%			6.35
EASTBOURNE DISTRICT GENERAL HOSPITAL	85.4%	98.4%		100.0%	87.2%	107.0%		100.0%	8.53
CONQUEST HOSPITAL	85.3%	107.1%		100.0%	83.5%	112.8%			8.60
RYE HOSPITAL	99.6%	103.2%			95.3%	145.4%			6.06
Totals	85.7%	104.1%		100.0%	85.8%	111.0%		100.0%	8.37

Fill Rate and CHPPD by Division	Day				Night				CHPPD
	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	
Medicine	81.8%	105.4%		100.0%	85.5%	115.9%		100.0%	7.64
Out-of-Hospital	92.6%	116.6%			100.6%	124.7%			6.28
Surgery Anaesthetics & Diagnostics	88.7%	101.8%		100.0%	87.0%	100.9%			9.57
Women Children & Sexual Health	89.7%	85.4%			79.7%	91.9%			13.25
Totals	85.7%	104.1%			85.8%	111.0%			8.37

- Trust overall CHPPD has increased from 8.22 (September 19) to 8.37 (October 19) slightly above the recommendation of 8.2 against our peers and the latest national CHPPD in May 2019 which was 8.1.
- 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 are due to the number of vacancies in nursing (which is reducing due to recruitment of overseas nurses). However, frequent use of additional capacity and opening of escalation areas continues to cause significant additional pressure.
- Overall Trust level CHPPD is showing a downward trend over the last few months, which is more in line with peer Trusts. This will be monitored over the next few months.

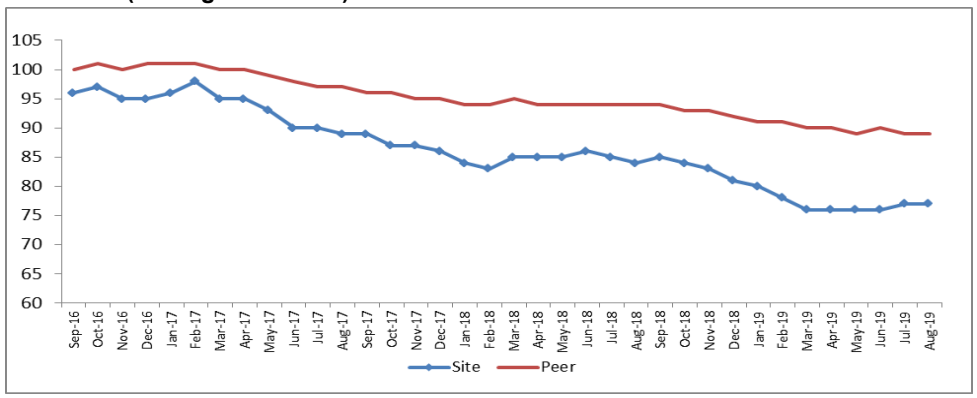


CHPPD = day + night shift hours for registered and unregistered nurses/midwives divided by daily count of patients in beds at 23.59 hrs.

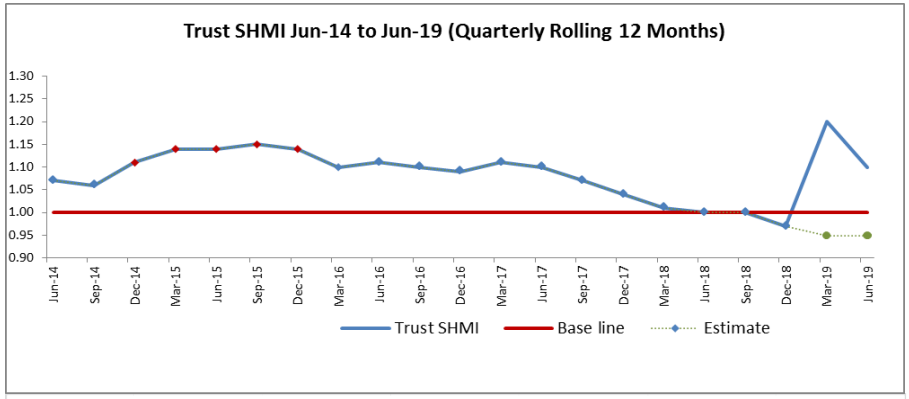
Mortality Metrics

East Sussex Healthcare NHS Trust

RAMI 18 (Rolling 12 months)



SHMI



Data published for the period Apr18 to Mar19 should be viewed with caution due to a technical error with the submission

SHMI for the period July 2018 to June 2019 is showing an index of 1.10. 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.

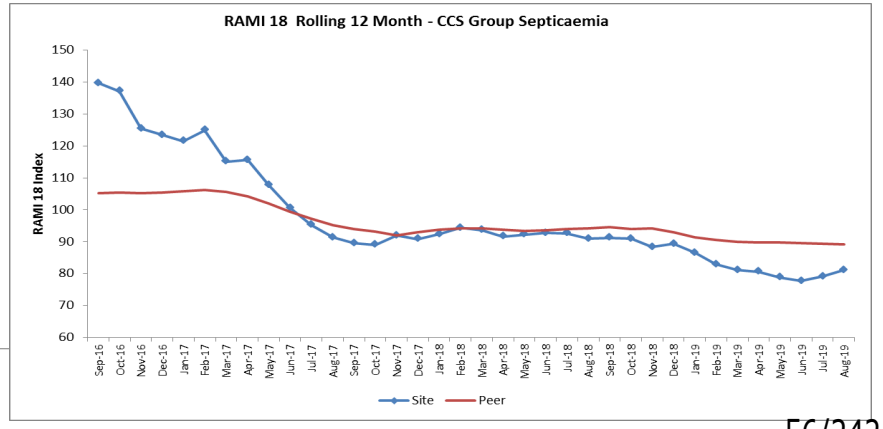
RAMI 18 – September 2018 to August 2019 (rolling 12 months) is **77** compared to 84 for the same period last year (September 2017 to August 2018). August 2018 to July 2019 was also 77.

RAMI 18 shows an August position of 67. The peer value for August is 89. The July position was 77 against a peer value of 81.

Crude mortality shows September 2018 to August 2019 at 1.46% compared to 1.70% for the same period last year.

The percentage of deaths reviewed within 3 months was 89% in July 2019, June 2019 was 81%.

Main causes of death during October 2019 (Mortality Database)	
Pneumonia	34
Cancer	18
Sepsis/Septicaemia	14
Chronic Obstructive Pulmonary Disease (COPD)	8
Dementia	7



Mortality Metrics

East Sussex Healthcare NHS Trust

Why we measure Mortality?

The rationale for measuring mortality rates is used as an indicator of hospital quality. It's aim is to:

- look for improvement in mortality rates over time,
- improve patient safety and
- reduce avoidable variation in care and outcomes.

More generally measuring Mortality rates has been described as being akin to a *smoke alarm*, it may signal something serious but more often than not it will go off for reasons unrelated to quality of care. However smoke alarms should never be ignored.
It must be emphasised that whatever importance is attached to the use of mortality data it is but one part of a comprehensive system and methods that the Trust uses to monitor and measure the quality and safety of care for patients.

The Trust use two indicators to measure mortality:

- RAMI
- SHMI

Risk Adjusted Mortality Index (RAMI)

This measured was developed by Caspe Healthcare Knowledge Systems (CHKS)[1] and is their approach to measuring hospital mortality. A measure which works by applying:

- No exclusions – all inpatients and deaths are included
- Includes occupied bed days as a currency in addition to the number of spells, to consider length of stay for chronic conditions.

RAMI measures risks directly from the proportion of patients who died in the reference group. It uses forward stepwise modelling so that most important and consistently known factors are considered before anything else. It uses reference data from Wales and Northern Ireland in addition to England. It has a selective approach to co-morbidity. Individual secondary diagnoses are scanned for the most significant.

[1]CHKS is one of the leading providers of healthcare intelligence and quality improvement services in the UK.

Summary Hospital Mortality Indicator (SHMI)

This is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge.

Access & Delivery

ACCESS AND DELIVERY

East Sussex Healthcare NHS
NHS Trust

Access and Delivery Summary

Increasing demand for Non-Elective Care and Cancer services continues to rise although October has seen the Trust achieve the Diagnostic standard for the second consecutive month along with a continued recovery of the RTT position. The 62 Cancer pathway remains a challenge with September seeing our lowest performance position for the past 12 months. Although final validation of Octobers Cancer performance is not due until December, early intelligence suggests an improving picture for October and November.

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 and as part of our preparation for winter we are focusing on:

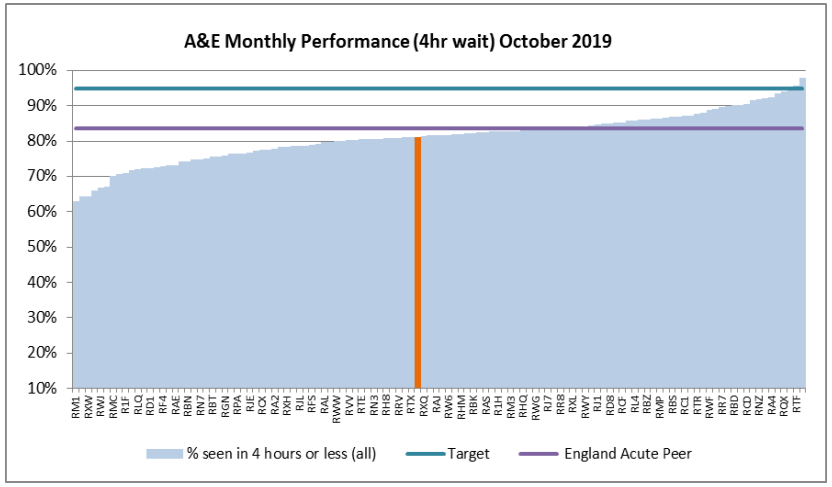
- Introduction of NerveCentre (Live Bed state) in November
- Achieving 30% Same Day Emergency care
- Increasing discharges before noon (home for lunch)
- Increasing weekend discharges
- Streaming patients to primary care clinicians in ED
- System partnership planning in order to increase patient flow throughout the whole system, not just acute services
- Focused GP support in Nursing homes to support admission avoidance

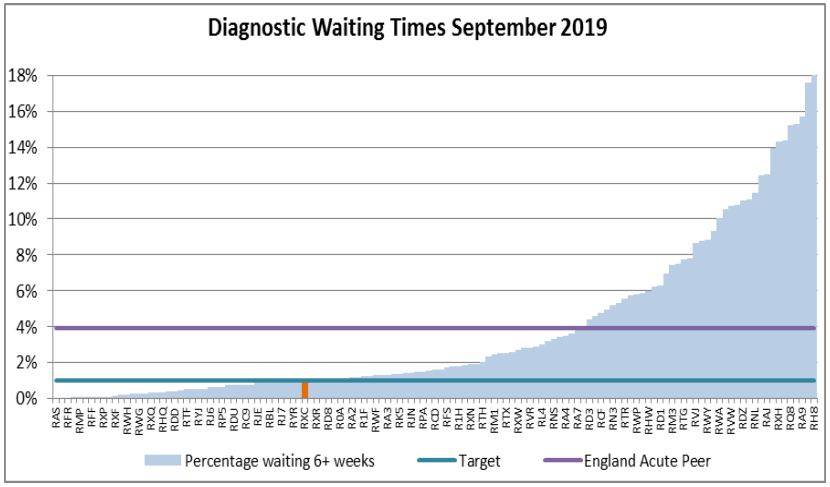
This summer has been one of the most challenging for A&E waiting times and performance in England since the four-hour target was introduced in 2004. Similar to the national picture, our Urgent Care services have seen non-elective activity continue to increase compared to the previous year (YTD 7.8% admissions, 8.8% attendances), this increasing demand is affecting the ability for the Trust to respond in a timely way and this is reflected in our local Urgent Care performance for October.

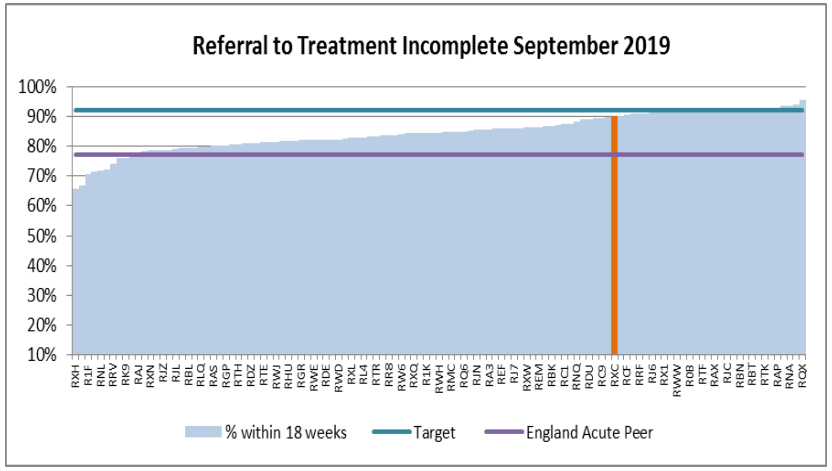
Peer Review

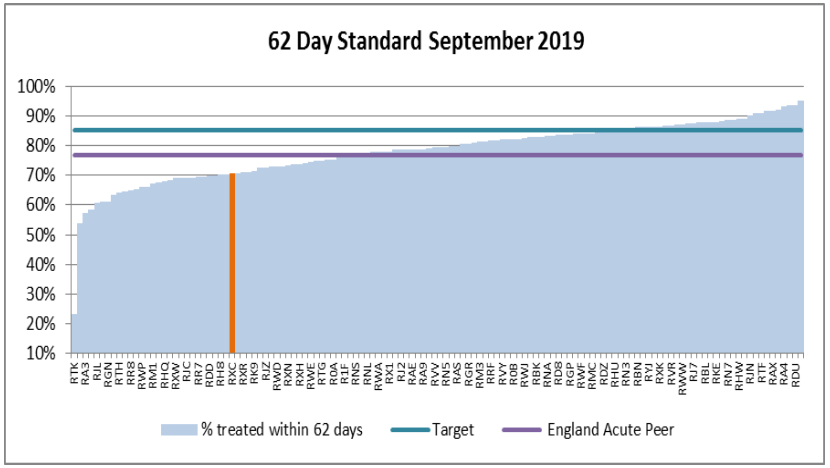
East Sussex Healthcare NHS Trust

Latest key access performance against Acute Hospital England Peer Group. ESHT performance denoted in orange.









* October Peer data not available for all performance standards at time of publishing final IPR report.

East Sussex Healthcare NHS
NHS Trust

URGENT CARE

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-18	Oct-19	Var	2018/19	2019/20	Var		
Four hour standard	95.0%	93.7%	81.2%	-12.6%	92.3%	87.5%	-4.8%	88.1%	
A&E Minor Performance	98.0%	97.0%	94.4%	-2.6%	96.6%	97.4%	0.8%	97.2%	
Four hour standard (Local System)	95.0%	94.8%	85.5%	-9.3%	94.0%	90.3%	-3.7%	90.8%	
12 Hour DTAs	0	0	0	0	0	0	0	0	
Unplanned re-attendance to Emergency Department	5.0%	3.6%	3.9%	0.3%	3.5%	3.8%	0.3%	3.7%	
% Patients waiting less than 15 minutes for assessment in ED	M	90.6%	85.1%	-5.5%	86.5%	84.9%	-1.6%	85.0%	
% Patients waiting less than 60 minutes for treatment in ED	M	52.4%	41.2%	-11.2%	49.8%	40.9%	-8.9%	42.3%	
% Patients waiting less than 120 minutes for treatment in ED	M	85.4%	70.4%	-15.0%	81.4%	71.2%	-10.1%	73.7%	
% Patients that left without being seen in ED	M	2.2%	3.0%	0.7%	2.2%	2.7%	0.4%	2.4%	
% Patients admitted from ED (Conversion rate)	M	29.3%	31.8%	2.5%	28.8%	29.9%	1.0%	30.7%	
Emergency Department attendances	M	10814	11662	7.8%	76215	82925	8.8%	11341	
Ambulance conveyances	M	3144	3592	14.2%	21762	23829	9.5%	3376	

The Trust 4 Hour performance standard in October was 81.2% against a national performance of 83.6%. This ranked the Trust 65th out of 120 reporting organisations. The system 'Walk-In' centres and the Acute Trusts combined performance for October was 85.5%.

Activity continues to be higher than previous years, A&E attendances are up 8.8% and ambulance conveyances are up 9.5% against the year to date comparison.

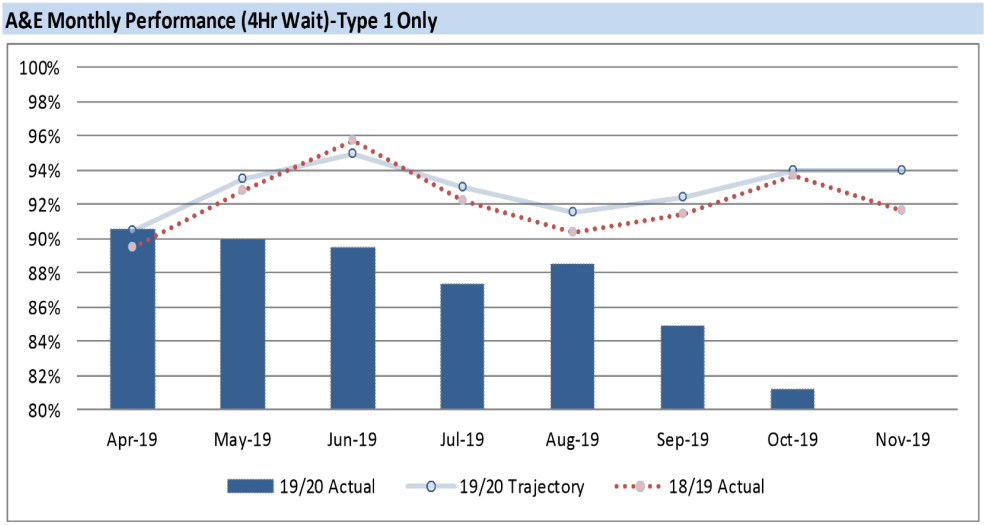
System recovery and transformation plans are overseen by the local A&E delivery board These aim to reduce unnecessary attendances and stream patients directly to gateway services rather than being treated in ED. These plans include:

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

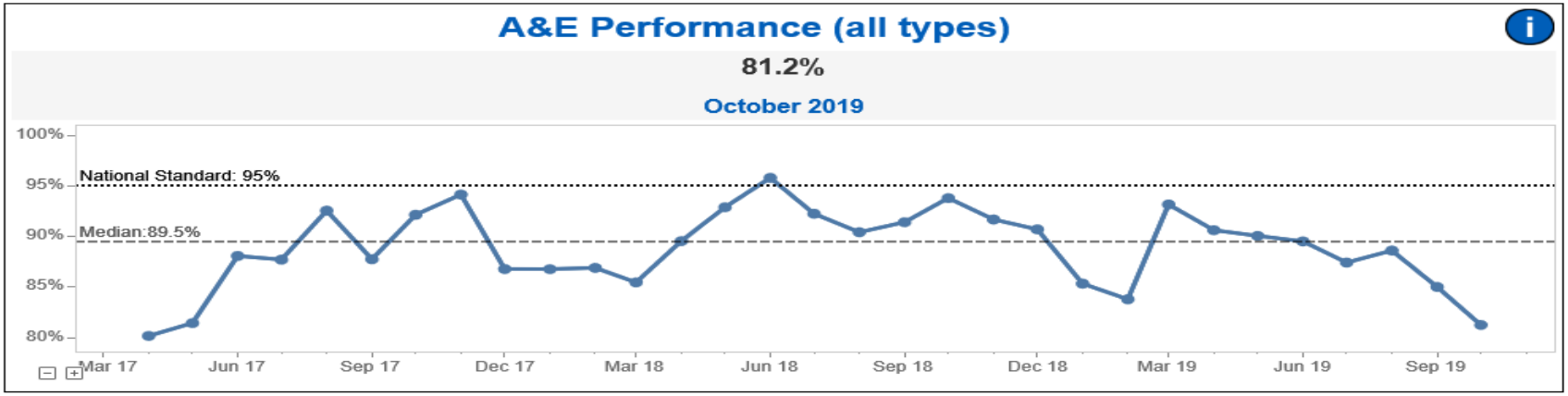
East Sussex Healthcare NHS Trust



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
19/20 Trajectory	90.5%	93.5%	95.0%	93.0%	91.5%	92.4%	94.0%	94.0%
19/20 Actual	90.6%	90.0%	89.5%	87.4%	88.6%	85.0%	81.2%	
18/19 Actual	*89.5%*	*92.8%*	*95.7%*	*92.2%*	*90.4%*	*91.4%*	*93.7%*	*91.6%*

- The Trusts' 4 hour performance for October 2019 was 81.19% (CONQ 79.38% and EDGH 82.98%).
- Minors performance for October retracted to 94.4%. Majors performance decreased by 4.2% to 72.7% from the September position.
- Ambulance conveyances have increased by 9.5% year to date.

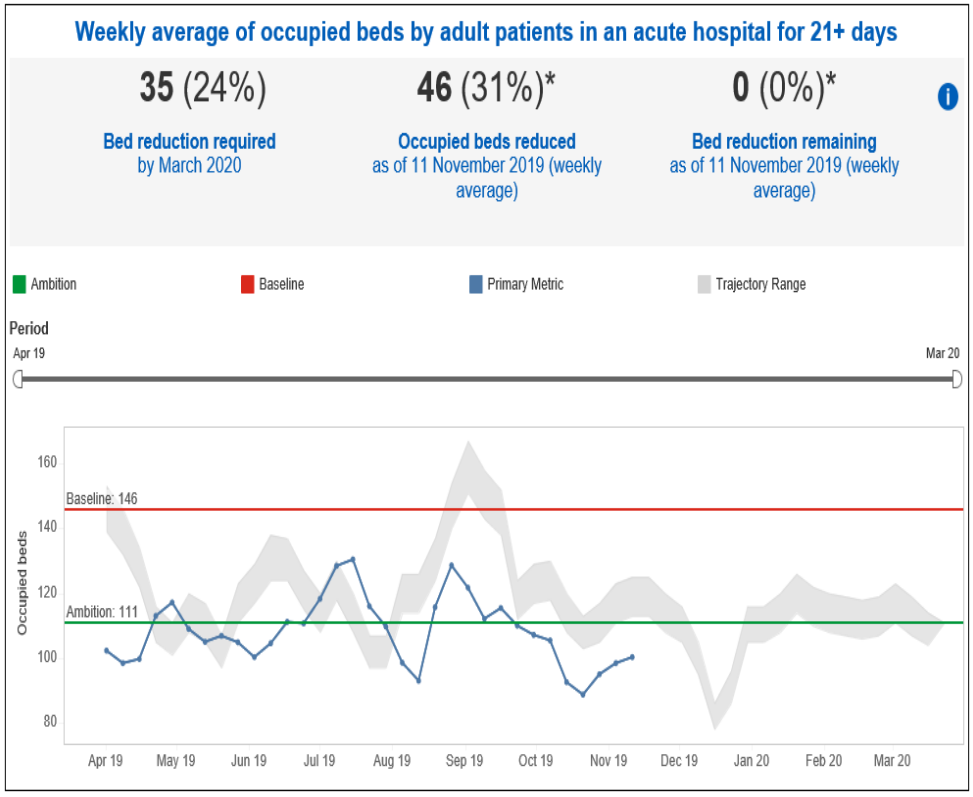
ESHT IT failures, including the loss of PAS commenced on 25/7 to 30/7, resulting in an inability to electronically capture A&E waiting times. A manual process ensued as per Trust DR. Validation was undertaken afterwards, where an accurate discharge time was not available a breach was recorded. The Trust position of 87.4% for July is the impact of this episode.



East Sussex Healthcare NHS
NHS Trust

Patient Flow Metrics

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-18	Oct-19	Var	2018/19	2019/20	Var		
Super Stranded (Census on last day of month)	M	96	93	-3	106	105	-1	105	
Avg Daily adult patients in acute hospital for 21+ days (NHSI metric)	111	122	97	-25	123	108	-15	109	
Delayed transfer of care national standard	3.5%	2.9%	2.8%	-0.1%	2.5%	3.1%	0.7%	3.5%	
Cancellations									
Urgent operations cancelled for a second time	0	0	0	0	4	0	-4	0	



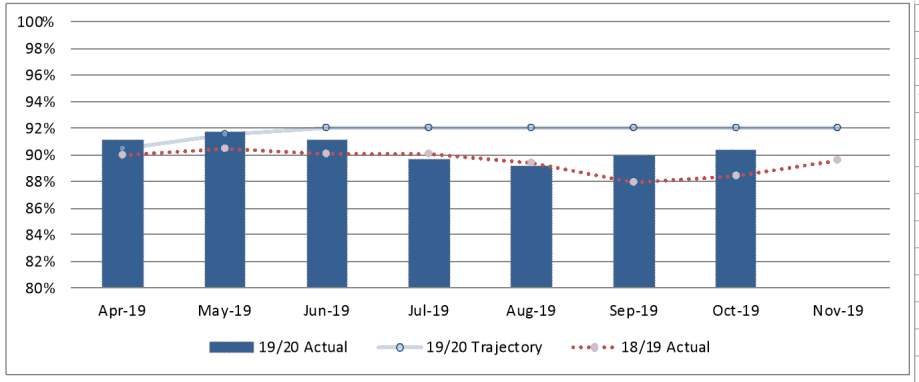
- The Trust, in line with NHSI priorities is moving to a revised set of patient flow metrics.
- The patient flow program is focusing on delivering:
  - reduced LLOS (21+ patients) by 40% - achieved
  - increase pre noon discharges to 40%
  - increase weekend discharges by 50% on Saturday and 25% on Sunday
- Same day emergency care 33% : October = 40%
- Development of integrated discharge team - achieved
- Specialty specific length of stay reductions with a particular focus on Gastroenterology and Frailty
- AEC at Conquest is opening at the end of December.

RTT

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-18	Oct-19	Var	2018/19	2019/20	Var		
RTT Incomplete standard	92.0%	88.4%	90.4%	2.0%	89.5%	90.5%	1.0%	90.5%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	3242	2831	-411	3242	2831	-411	2690	
RTT Total Waiting List Size	27156	27983	29434	1451	27983	29434	1451	27908	
RTT 52 week waiters	0	0	0	0	0	0	0	0	
RTT 35 week waiters	M	174	211	21.3%	174	211	21.3%	191	

RTT (Referral to Treatment 18 Weeks)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
19/20 Trajectory	90.5%	91.5%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
19/20 Actual	91.1%	91.8%	91.2%	89.7%	89.2%	90.0%	90.4%	
18/19 Actual	*90.0%*	*90.5%*	*90.1%*	*90.1%*	*89.4%*	*87.9%*	*88.4%*	*89.6%*

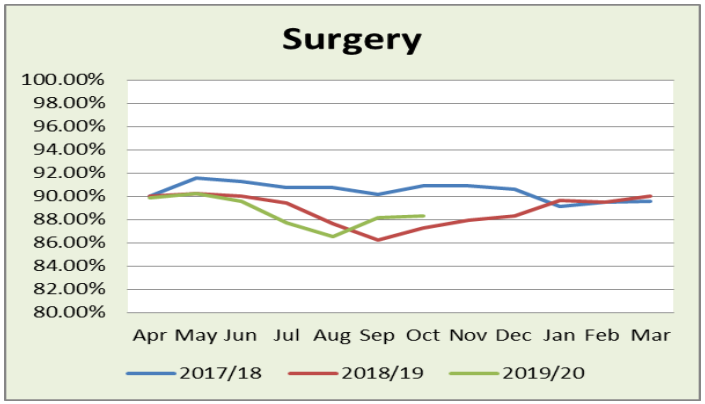
All Incomplete Pathways Main Specialty Report

Specialty	Breaches	Non Breaches	Total Cases	Performance	
General Surgery	434	4717	5151	91.57%	✗
Urology	313	2035	2348	86.67%	✗
Trauma and Orthoapedics	147	1219	1366	89.24%	✗
Ear, Nose & Throat (ENT)	498	2535	3033	83.58%	✗
Ophthalmology	372	3649	4021	90.75%	✗
Oral Surgery	166	1273	1439	88.46%	✗
General Medicine	0	1	1	100.00%	✓
Gastroenterology	222	2063	2285	90.28%	✗
Cardiology	22	1644	1666	98.68%	✓
Dermatology	9	1146	1155	99.22%	✓
Respiratory Medicine	16	545	561	97.15%	✓
Neurology	80	1315	1395	94.27%	✓
Rheumatology	0	362	362	100.00%	✓
Geriatric Medicine	9	223	232	96.12%	✓
Gynaecology	469	1985	2454	80.89%	✗
Other	74	1891	1965	96.23%	✓
Totals	**2831**	**26603**	**29434**	**90.38%**	✗

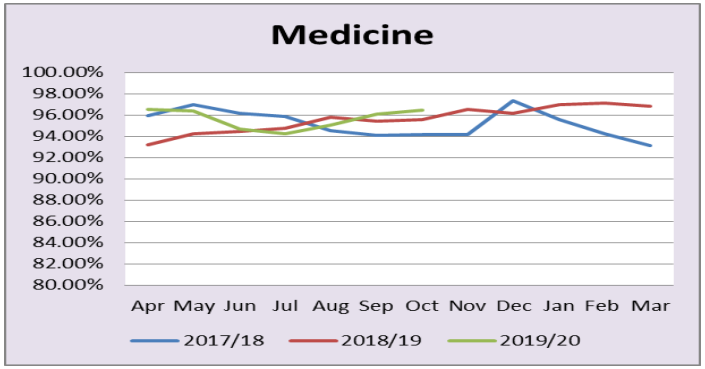
The RTT position for October was 90.4%, demonstrating two consecutive months of improvement. The Trust is still challenged by an increase in the number of patients being referred on a cancer pathway coupled with vacancies in some key specialties, this has impacted on available capacity throughout the summer months.

The Waiting list size is currently showing to be above target, although technical issues with the Trust Electronic Referral System (ERS) that have been identified in November which has meant that some pathways have been duplicated and that the actual waiting list size is 26857. This will be correctly reflected in the Month 8 IPR once the issue has been rectified. There is no patient harm or additional delay as part of this technical issue.

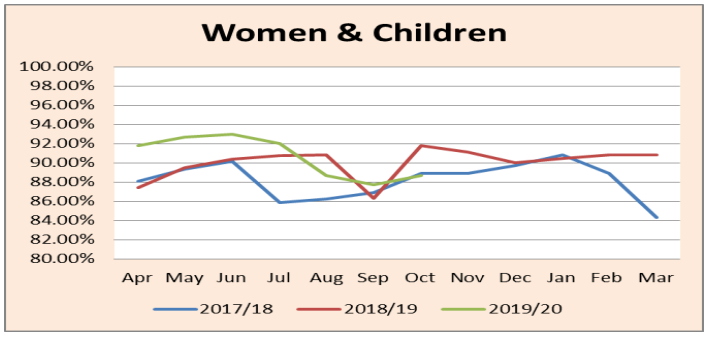
RTT



There are notable and sustainable improvements in the performance of T&O (89.44%) and Ophthalmology (90.73%) and the division collectively have improved month on month for the past 3 months.
T&O has focused capacity on the Hip & Knee modality, converting OP clinics to theatre sessions where possible and pooling patients to widen capacity to address backlog. The improvement has been higher than anticipated.
Ophthalmology continue to address the Follow Up' backlog whilst at the same time focusing on the admitted element of their long waiting patients.
ENT does remain a concern with demand outweighing capacity and waiting times growing to over 18 weeks for an Outpatient First Appointment. Recruitment is ongoing for clinicians and there is a Sussex wide redesign project underway.
General Surgery is expected to recover next month having narrowly missed 92% (91.95%) this month as the specialty juggles the demands for RTT as well as a high volume of 2ww referrals to manage.
Urology is also expected to recover by December 2019 although it also continues to flex it capacity with the demands of increasing cancer demands..



Medicine continues to collectively achieve RTT and has seen a month on month improvement from July, rising from 94.27% to 96.49%.
Gastro (90.28%) like General Surgery, has juggled competing demands with Cancer and DM01 but has remained steady at 90% and this should improve with the introduction of the new clinical assessment service easing pressure on Outpatient capacity.
All other specialties achieving.



Women & Children have seen an improvement in both specialties. Particularly around Gynaecology where the waiting time for an Outpatient First Appointment has reduced considerably, whilst at the same time addressing the admitted backlog of over 400 patients waiting over 18 weeks for treatment. Close scrutiny of theatre session utilisation and an increase in the uptake of "on offers" has seen the wait times come down significantly. Albeit still over 18 weeks, plans are in place to recruit an additional consultant to support RTT and Cancer.
Gynaecology RTT performance is expected to increase from 80.89% to over 85% come March 2020 whilst the waiting time for an Outpatient First Appointment is projected to reduce to 18 weeks by February 2020.

Diagnostics (DM01)

East Sussex Healthcare NHS
NHS Trust

Breach Rates	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Magnetic Resonance Imaging		0.00%	0.00%	0.51%	0.00%	0.00%	0.59%	1.62%
Computed Tomography		0.24%	0.00%	0.09%	0.33%	0.77%	1.15%	0.07%
Non-obstetric ultrasound		0.00%	4.15%	1.13%	1.33%	2.70%	0.72%	0.06%
Barium Enema		--	--	--	--	--	--	--
DEXA Scan		--	--	--	--	--	--	--
Audiology - Audiology Assessments		0.68%	0.38%	1.17%	3.80%	1.55%	0.00%	0.00%
Cardiology - echocardiography		--	0.00%	--	--	0.00%	0.00%	--
Cardiology - electrophysiology		--	--	--	--	--	--	--
Neurophysiology - peripheral neurophysiology		--	--	--	--	--	--	--
Respiratory physiology - sleep studies		16.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Urodynamics - pressures & flows		6.25%	4.17%	0.00%	0.00%	0.00%	0.00%	0.00%
Colonoscopy		1.05%	0.57%	0.96%	1.09%	1.32%	1.90%	0.00%
Flexi sigmoidoscopy		2.94%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cystoscopy		13.68%	11.76%	8.00%	19.44%	11.11%	18.75%	17.95%
Gastroscopy		1.40%	0.93%	0.36%	0.00%	2.61%	1.78%	0.00%
Total		**0.72%**	**2.09%**	**0.80%**	**1.02%**	**1.61%**	**0.96%**	**0.57%**

Waiting List	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Magnetic Resonance Imaging		1006	1002	972	1138	1088	1189	1418
Computed Tomography		849	966	1096	1207	1162	1219	1458
Non-obstetric ultrasound		2088	2290	2207	2478	2337	2217	1766
Barium Enema		0	0	0	0	0	0	0
DEXA Scan		0	0	0	0	0	0	0
Audiology - Audiology Assessments		293	266	256	316	322	302	293
Cardiology - echocardiography		0	1	0	0	1	1	0
Cardiology - electrophysiology		0	0	0	0	0	0	0
Neurophysiology - peripheral neurophysiology		0	0	0	0	0	0	0
Respiratory physiology - sleep studies		59	37	19	36	34	6	4
Urodynamics - pressures & flows		16	24	7	14	8	9	13
Colonoscopy		286	353	313	367	379	368	313
Flexi sigmoidoscopy		68	72	61	78	70	84	76
Cystoscopy		95	85	50	36	27	32	39
Gastroscopy		215	215	276	230	230	225	211
Total		**4975**	**5311**	**5257**	**5900**	**5658**	**5652**	**5591**

September & October have achieved the 1% standard. This is due to the additional capacity arranged for Ultrasound which has had workforce challenges with a scarcity of sonographers to support demand. In the main, this recovery has been reliant on WLIs and outsourcing of activity. The number of MRI breaches recorded were GA cases held by EDGH (InHealth) due to capacity constraints.
Cystoscopies, although low in numbers are a challenge that is currently being worked through with the specialty.

The increase in cancer referrals over the past 6 months has had an impact on the size of the Diagnostic waiting list.
Reporting times for Imaging continues to improve:

- CT down from 7 to 4 days
- MRI stable at 3 days
- Mammo down from 21 to 11 days

(average over past 3 months)

East Sussex Healthcare NHS Trust

CANCER STANDARDS

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-18	Sep-19	Var	2018/19	2019/20	Var		
Cancer 2WW Standard	93.0%	83.7%	95.4%	11.7%	93.1%	94.8%	1.7%	95.2%	
Cancer 62 day urgent referral standard	85.0%	59.7%	70.5%	10.9%	70.4%	75.8%	5.4%	75.7%	
Cancer 2WW Standard (breast symptoms)	93.0%	99.2%	96.4%	-2.8%	95.8%	93.7%	-2.1%	94.8%	
Cancer 31 day standard	96.0%	90.4%	97.9%	7.5%	93.6%	96.8%	3.2%	96.7%	
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%	75.0%	100.0%	25.0%	84.3%	100.0%	15.7%	95.4%	
Cancer 62 day screening standard	90.0%	61.9%	33.3%	-28.6%	62.2%	69.4%	7.2%	77.8%	

- Provisional October performance of circa 78%
- 62 Day performance was 70.5% for September compared to a national aggregate of 76.9% and a recovery trajectory of 80.3%. This ranked the Trust 119th out of 153 reporting organisations.
- Of the 120.5 treatments provided in September, there were 35.5 breaches. This is down compared to the 160 treatments in August although we experienced a higher number of breaches on August (40 in total)
- 1636 patients were seen under the two week wait referral pathway in September 2019, slightly down on the August number of
- Referrals continue to increase, especially in Lower GI, Breast, Skin, Gynae and Head & Neck.

CANCER PERFORMANCE & FORWARD VIEW

	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
2WW (93%)	91.0%	83.7%	96.8%	96.5%	96.0%	93.8%	96.3%	96.4%	96.4%	94.9%	94.7%	94.6%	92.8%	95.4%	97.0%
Breast Symptoms (93%)	95.4%	99.2%	94.2%	97.2%	93.4%	95.7%	97.8%	97.1%	93.5%	93.5%	93.0%	93.0%	93.0%	96.4%	99.3%
31 Day (96%)	90.7%	90.4%	91.2%	92.7%	96.7%	98.6%	98.4%	96.1%	96.1%	96.7%	94.0%	97.4%	98.9%	97.9%	98.4%
62 Day (85%)	68.0%	59.7%	66.3%	69.8%	80.7%	72.9%	80.3%	75.5%	81.6%	77.1%	73.1%	77.4%	74.7%	70.5%	78.5%
62 Day Screening (90%)	71.4%	61.9%	82.6%	100%	100%	63.6%	83.3%	100%	90.0%	92.3%	28.6%	100%	64.3%	33.3%	35.3%

The 62 day performance for October 2019 in the table above is based on an estimated position as the final upload deadline is not until 3rd December and other Trusts do not always complete their uploads/validation until this time. This does mean that we could see either an increase or decrease of the reported 78.5% of circa 1%.

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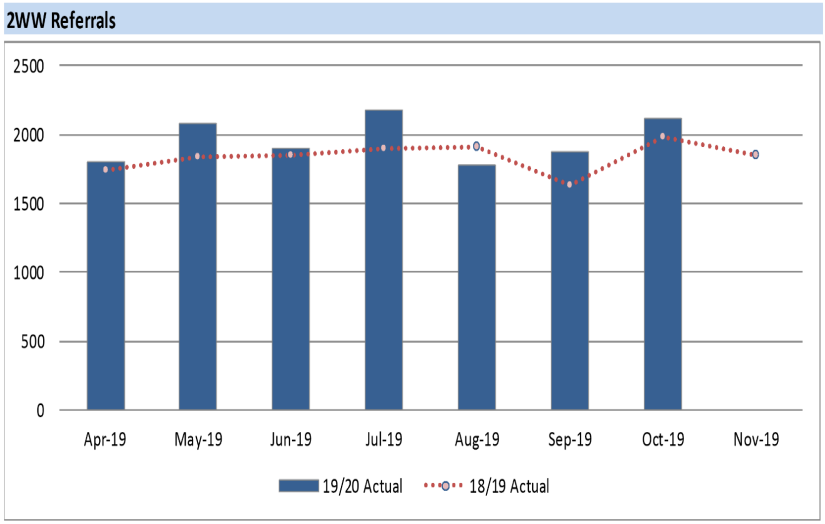
Cancer 2 Week Wait Referrals (September / October)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
19/20 Actual	1804	2076	1902	2173	1777	1871	2116	
18/19 Actual	*1736*	*1841*	*1855*	*1903*	*1912*	*1631*	*1980*	*1848*

There were 75 breaches out of 1,636 2WW patients first seen for **September 2019**.

The latest rolling twelve month referral numbers continue to be above those received in the previous twelve months (+8.0%). 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.

Key recovery actions including:

- Realign job plans and timetables to support introduction of triple assessment Breast clinics at EDGH
- One stop neck lump clinic to be introduced at EDGH
- Implement direct to CT Radiology for Upper GI service
- Development of joint Oncology clinics with Urology
- Endoscopy 3 sessional days to support BCSP
- Cancer Access policy review including GP referral and patient availability agreement.

Suspected Cancer Site	Nov 17-Oct 18	Nov 18-Oct 19	% Variance
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	1,702	1,816	6.7%
Other suspected cancers	28	19	-32.1%
Suspected brain/central nervous system tumours	58	112	93.1%
Suspected breast cancer	2,820	3,196	13.3%
Suspected childrens cancer	25	1	-96.0%
Suspected gynaecological cancers	1,654	1,829	10.6%
Suspected haematological malignancies (excluding acute leukaemia)	189	227	20.1%
Suspected head & neck cancers	2,096	2,242	7.0%
Suspected lower gastrointestinal cancers	3,732	4,456	19.4%
Suspected lung cancer	679	593	-12.7%
Suspected sarcomas	0	3	
Suspected skin cancers	3,830	4,107	7.2%
Suspected testicular cancers	196	259	32.1%
Suspected upper gastrointestinal cancers	1,684	1,661	-1.4%
Suspected urological cancers (excluding testicular)	2,317	2,162	-6.7%
Grand Total	**21,010**	**22,683**	**8.0%**

East Sussex Healthcare NHS
NHS Trust

Cancer Tumour Site Performance - September

September 2019 2WW Referral to First Treatment 62 Days

Tumour Site	Total treated	Treated within 62 days	Breaches	% meeting standard
Haematology	2.0	2.0	0.0	**100.0%**
Testicular	1.0	1.0	0.0	**100.0%**
Acute Leukaemia	1.0	1.0	0.0	**100.0%**
Other	1.0	1.0	0.0	**100.0%**
Skin	28.5	26.5	2.0	**93.0%**
Colorectal	16.0	14.0	2.0	**87.5%**
Upper GI	10.0	8.0	2.0	**80.0%**
Lung	9.5	7.5	2.0	**78.9%**
Urology	26.0	13.0	13.0	**50.0%**
Breast	19.0	9.0	10.0	**47.4%**
Gynaecology	3.5	1.5	2.0	**42.9%**
Head & Neck	3.0	0.5	2.5	**16.7%**
Totals:	**120.5**	**85.0**	**35.5**	**70.5%**

Activity

ACTIVITY

Acute Activity

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-18	Oct-19	Var	2018/19	2019/20	Var		
Emergency Department attendances	M	10814	11662	7.8%	76215	82925	8.8%	11341	
Ambulance conveyances	M	3144	3592	14.2%	21762	23829	9.5%	3376	
Elective spells	M	594	542	-8.8%	3817	3632	-4.8%	538	
Day Cases	M	4219	4347	3.0%	27452	28356	3.3%	4022	
Elective Beddays	M	1648	1790	8.6%	11351	11350	0.0%	1684	
Total Non-Elective Spells	M	4669	5185	11.1%	31958	34447	7.8%	4878	
Number of Emergency spells	M	4047	4563	12.8%	27871	30125	8.1%	4269	
Number of Maternity spells (ante and post partem)	M	333	333	0.0%	2181	2317	6.2%	323	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	289	289	0.0%	1906	2005	5.2%	285	
Non-Elective beddays	M	19598	20851	6.4%	141735	140626	-0.8%	20186	
LOS									
Elective Average Length of Stay	M	2.8	3.3	0.5	3.0	3.1	0.2	3.1	
Non-Elective Average Length of Stay	M	4.4	4.2	-0.2	4.5	4.1	-0.4	4.1	
Inpatient Average Length of Stay at intermediate care units	M	23.7	22.1	-1.6	26.1	24.5	-1.6	24.3	

*Non Elective Length of Stay represents total Trust including Acute and Community. These will be shown separately in all future reports.

East Sussex Healthcare NHS
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YTD Exception Reporting: Top 10 Outliers

First OP

SpecialtyName	Activity	Plan	Var (%)	
Trauma & Orthopaedics	8604	9268	-7.2%	-664
General Surgery	4108	4536	-9.4%	-428
Cardiology	3664	3999	-8.4%	-335
ENT	5204	5443	-4.4%	-239
Maxillo-Facial Surgery	2750	2972	-7.5%	-222
Obstetrics	1870	1632	14.6%	238
Dermatology	3150	2800	12.5%	350
Thoracic Medicine	2168	1790	21.1%	378
Gynaecology	4745	4227	12.3%	518
Ophthalmology	10460	9359	11.8%	1101
Total	**70034**	**69174**	**1.2%**	**860**

Day Case

SpecialtyName	Activity	Plan	Var (%)	
Maxillo-Facial Surgery	971	1152	-15.7%	-181
Trauma & Orthopaedics	1342	1480	-9.3%	-138
Cardiology	1305	1419	-8.0%	-114
Ophthalmology	2493	2555	-2.4%	-62
Endocrinology	277	279	-0.6%	-2
Dermatology	241	167	44.3%	74
Rheumatology	1270	1162	9.3%	108
Haematology	3751	3561	5.3%	190
Gastroenterology	5749	5480	4.9%	268
Clinical Oncology	4446	3796	17.1%	651
Total	**28547**	**27456**	**4.0%**	**1090**

Follow-Up OP

SpecialtyName	Activity	Plan	Var (%)	
Ophthalmology	39351	42156	-6.7%	-2805
General Surgery	4000	6265	-36.2%	-2265
Trauma & Orthopaedics	15367	17296	-11.2%	-1929
ENT	5472	6953	-21.3%	-1481
Urology	9213	10572	-12.9%	-1359
Obstetrics	2679	2568	4.3%	111
Cardiology	19984	19670	1.6%	314
Anaesthetics	338	14	2277.6%	324
Respiratory Physiology	3181	2810	13.2%	371
Clinical Oncology	5649	5206	8.5%	443
Total	**166207**	**179470**	**-7.4%**	**-13262**

Elective

SpecialtyName	Activity	Plan	Var (%)	
Urology	720	816	-11.7%	-96
General Surgery	342	423	-19.1%	-81
Cardiology	109	175	-37.9%	-66
Respiratory Physiology	195	256	-23.8%	-61
Gastroenterology	144	182	-20.9%	-38
Geriatric Medicine	13	5	148.8%	8
General Medicine	56	47	19.0%	9
ENT	185	164	13.0%	21
Haematology	182	140	29.7%	42
Thoracic Medicine	97	54	80.5%	43
Total	**3665**	**3925**	**-6.6%**	**-260**

Top five Specialties above and below plan by point of delivery shown for the first seven 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 which will eventually be recorded if all outstanding clinics are cashed up.

East Sussex Healthcare NHS
NHS Trust

ESHT WORKFORCE REPORT

- MONTH 7 (OCT 2019)

HR DIRECTORATE
Oct 2019
Version v2.0

East Sussex Healthcare NHS
NHS Trust

CONTENT

East Sussex Healthcare NHS
NHS Trust

TRUST OVERVIEW

TRUST														
WORKFORCE CAPACITY	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend line
Budgeted fte	6,915.7	6,915.1	6,906.1	7,031.9	7,033.8	7,033.8	7,054.8	7,026.4	7,031.9	7,070.5	7,065.2	7,123.4	7,211.8	
Total fte usage	6,622.4	6,737.3	6,655.5	6,575.2	6,682.6	6,841.9	6,754.9	6,650.6	6,659.1	6,655.8	6,701.7	6,784.6	6,799.4	
Variance	-293.3	-177.8	-250.6	-456.7	-351.2	-191.9	-299.9	-375.8	-372.9	-414.7	-363.5	-338.8	-412.4	
Substantive vacancies	576.4	556.6	595.9	693.2	659.1	641.4	670.6	700.6	677.8	722.7	688.1	685.2	743.9	
Fill rate	91.4%	91.7%	91.1%	89.8%	90.3%	90.6%	90.2%	89.7%	90.1%	89.5%	90.0%	90.2%	89.5%	
Bank fte usage (as % total fte usage)	6.8%	7.9%	7.6%	7.7%	7.1%	8.9%	8.0%	7.1%	7.0%	7.2%	7.5%	7.8%	7.4%	
Agency fte usage (as % total fte usage)	1.2%	1.4%	1.2%	1.2%	1.5%	1.5%	1.3%	1.4%	1.2%	1.4%	1.4%	1.4%	1.4%	
Turnover rate	10.7%	11.0%	11.1%	11.1%	10.9%	10.9%	11.0%	10.8%	10.7%	10.4%	10.3%	10.4%	10.4%	
Stability rate	91.4%	91.0%	90.9%	89.8%	91.1%	91.3%	91.5%	89.1%	91.3%	91.2%	91.0%	91.2%	89.4%	
SICKNESS ABSENCE	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend line
Annual sickness rate	4.4%	4.4%	4.3%	4.2%	4.3%	4.2%	4.2%	4.3%	4.3%	4.4%	4.4%	4.4%	4.4%	
Monthly sickness rate (%)	4.4%	4.6%	4.4%	4.7%	4.6%	4.0%	4.1%	3.9%	4.1%	4.6%	4.5%	4.1%	4.4%	
Short term sickness (<28 days)	50.1%	55.1%	51.3%	60.7%	59.1%	52.0%	54.4%	46.4%	44.8%	44.2%	43.7%	56.0%	52.9%	
Monthly long term sickness (28 days+)	49.9%	44.9%	48.7%	39.3%	40.9%	48.0%	45.6%	53.6%	55.2%	55.8%	56.3%	44.0%	47.1%	
MANDATORY TRAINING & APPRAISALS	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend line
Appraisal rate	79.5%	80.6%	81.3%	80.9%	79.8%	79.5%	78.7%	78.1%	77.0%	78.6%	78.6%	79.5%	79.6%	
Fire	88.2%	87.9%	87.2%	87.5%	87.2%	87.3%	87.5%	87.9%	88.0%	89.0%	89.9%	89.7%	90.5%	
Moving & Handling	90.2%	90.4%	90.3%	91.1%	91.2%	91.9%	92.4%	92.6%	92.5%	92.6%	92.7%	91.3%	90.2%	
Induction	91.3%	90.8%	91.1%	92.0%	92.1%	92.2%	94.1%	98.2%	92.6%	90.9%	91.8%	92.4%	94.4%	
Infec Control	90.9%	91.0%	91.0%	90.7%	90.6%	91.4%	91.7%	91.8%	91.9%	92.0%	92.6%	91.8%	92.3%	
Info Gov	82.0%	80.5%	79.3%	79.1%	76.2%	77.4%	79.8%	80.5%	81.6%	82.8%	83.6%	84.3%	86.3%	
Health & Safety	88.3%	87.6%	88.2%	87.6%	88.0%	88.3%	88.8%	90.2%	90.8%	91.4%	91.3%	91.5%	92.3%	
MCA	95.7%	95.1%	95.6%	95.6%	95.5%	95.6%	74.9%	73.6%	73.9%	73.6%	76.8%	74.5%	74.7%	
DoLs	94.9%	93.9%	94.4%	95.0%	95.0%	95.4%	72.3%	71.0%	72.1%	71.9%	71.9%	72.1%	72.0%	
Safeguarding Vulnerable Adults	87.2%	86.8%	87.2%	87.6%	87.5%	87.7%	88.4%	87.5%	88.2%	87.7%	87.9%	87.3%	87.5%	
Safeguarding Children Level 2	88.2%	88.0%	88.4%	88.5%	87.3%	88.3%	89.2%	87.6%	88.9%	89.1%	88.6%	88.5%	87.8%	

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

MONTHLY HEADLINES

- Trust total workforce utilisation for Oct 2019 is 6,799.4 fte which is 412.4 fte below the budgeted establishment, however, workforce expenditure is £896k over budget (budget £24,041k, actual expenditure £24,937k). Temporary expenditure of £3,056k represents a further reduction of £156k since last month.

- Substantive expenditure of £21,782k accounts for 87.3% of total expenditure whilst temporary expenditure of £3,056k equates to 12.3% of the total as follows:

  - Bank & Locum £2,174k (8.7%)
  - Agency £762k (3.1%)
  - Overtime £70k (0.3%)
  - Waiting List payments £49k (0.1%)

  (the remaining 0.4% of expenditure is accounted for by the Apprenticeship Levy)

- The Trust vacancy rate has increased by 0.7% to 10.5%. This is as a result of increases in budgeted establishment this month (+ 88.4 ftes) including the Ambulatory Care Business case, funding of the Discharge Team workforce and new Information Security posts in Digital IT. Staff in Post numbers have actually increased by 29.7 ftes. Current vacancies are 743.9 fte (an increase of 58.7 fte vacancies).

- Annual turnover remains constant at 10.4%, reflecting 619.0 fte leavers in the rolling 12 months.

- Monthly sickness has increased by 0.3%, compared to Sept, to 4.4% (8,500.0 fte days lost to sickness). This is in line with the October monthly sickness rate last year and thus the overall annual sickness rate remains unchanged at 4.4%.

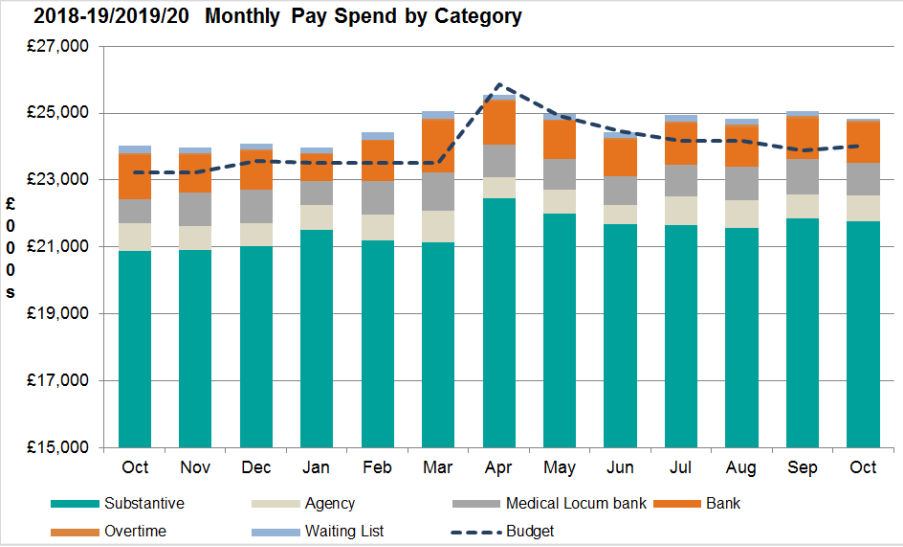
- The Mandatory Training compliance rate has increased again by 0.4% to 88.4%. Compliance rates have increased for all modules except for Moving & Handling (-1.1%), Safeguarding Children Level 2 (-0.7%) and Deprivation of Liberties (-0.1%).

- Appraisal compliance increased slightly by 0.1% this month to 79.6%.

East Sussex Healthcare NHS
NHS Trust

WORKFORCE EXPENDITURE

Actuals in Month (£000s)														
Category	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Trend line
Budget	£23,228	£23,231	£23,578	£23,528	£23,520	£23,520	£25,858	£24,908	£24,447	£24,185	£24,187	£23,898	£24,041	
Substantive	**£20,867**	**£20,905**	**£21,011**	**£21,519**	**£21,189**	**£21,126**	**£22,463**	**£22,009**	**£21,691**	**£21,658**	**£21,565**	**£21,845**	**£21,782**	
Agency	£833	£732	£687	£727	£772	£952	£611	£707	£558	£867	£831	£733	£762	
Medical Locum bank	£738	£979	£1,017	£731	£1,003	£1,137	£982	£914	£870	£943	£995	£1,056	£976	
Bank	£1,309	£1,131	£1,144	£799	£1,209	£1,557	£1,288	£1,133	£1,094	£1,213	£1,196	£1,210	£1,198	
Overtime	£51	£43	£49	£28	£36	£50	£62	£50	£55	£56	£62	£66	£70	
Waiting List	£225	£196	£180	£161	£224	£233	£140	£148	£174	£207	£180	£147	£49	
Total Temp Expenditure	**£3,156**	**£3,081**	**£3,077**	**£2,447**	**£3,244**	**£3,930**	**£3,083**	**£2,952**	**£2,751**	**£3,287**	**£3,262**	**£3,212**	**£3,056**	
Apprenticeship Levy	**£98**	**£96**	**£97**	**£98**	**£98**	**£98**	**£107**	**£98**	**£97**	**£102**	**£100**	**£104**	**£100**	
Total Spend	**£24,122**	**£24,082**	**£24,186**	**£24,064**	**£24,531**	**£25,153**	**£25,653**	**£25,060**	**£24,539**	**£25,047**	**£24,927**	**£25,162**	**£24,937**	



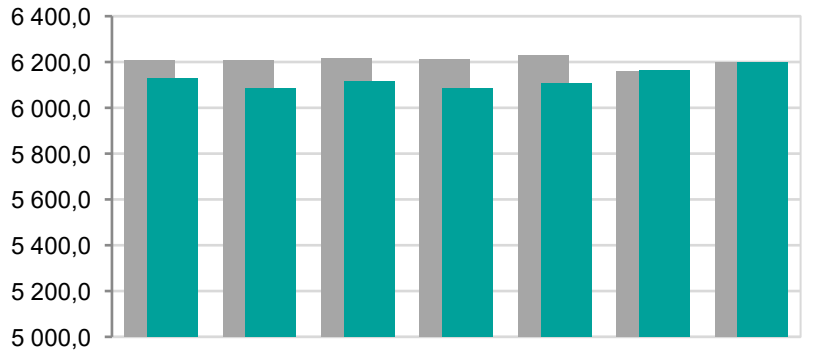
- **BUDGET** – Budget has increased by £143k since month 6, this is due to the implementation of enhanced ambulatory care across both acute sites.
- **SUBSTANTIVE** – Expenditure decreased by £64k this month, due to arrears payment of the 18/19 Medical & Dental pay award, paid in month 6.
- **AGENCY** - Expenditure increased by £29k this month, with an increase in A&C staff in IT Digital and Medical agency in Gastroenterology.
- **BANK –** Expenditure decreased by £11k this month, due to reductions in A&C bank usage in Clinical Admin and Finance
- **LOCUM -** Expenditure decreased by £81k overall this month, due to a peak in locum usage in month 6 in Paediatrics, Gynaecology, and Cardiology.
- **WLI -** Payments have decreased by £98k this month in line with decreases in elective activity in Ophthalmology and Radiology.

***Source data**: Finance Ledger*

East Sussex Healthcare NHS
NHS Trust

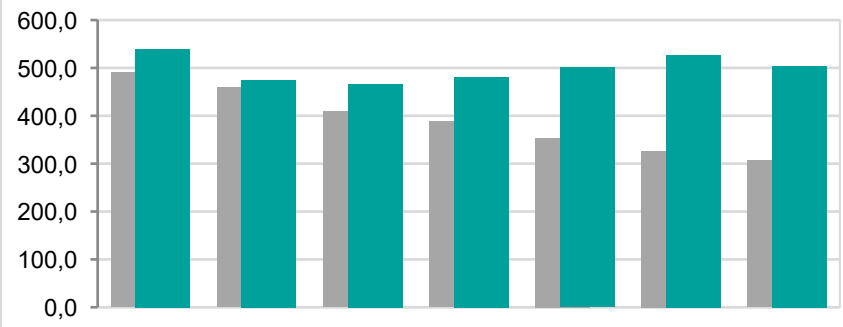
TRENDING FTE USAGE BY MONTH

Substantive FTE Usage 19/20



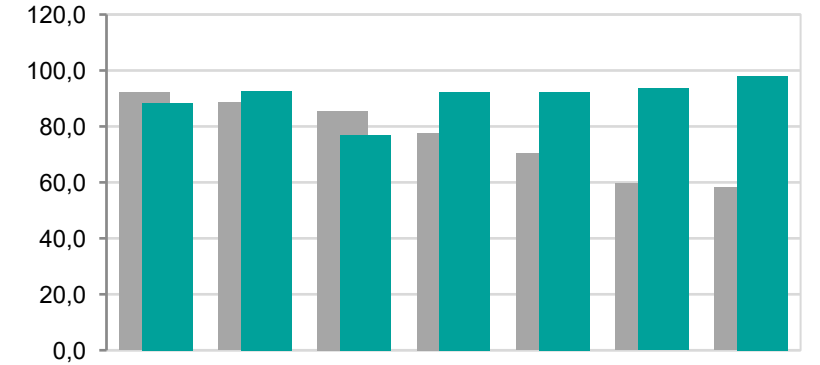
Plan	6 207,4	6 205,6	6 217,5	6 212,2	6 229,4	6 161,1	6 199,7
Actual	6 127,1	6 083,6	6 116,1	6 082,9	6 108,4	6 164,5	6 197,0

Bank & Locum FTE Usage 19/20



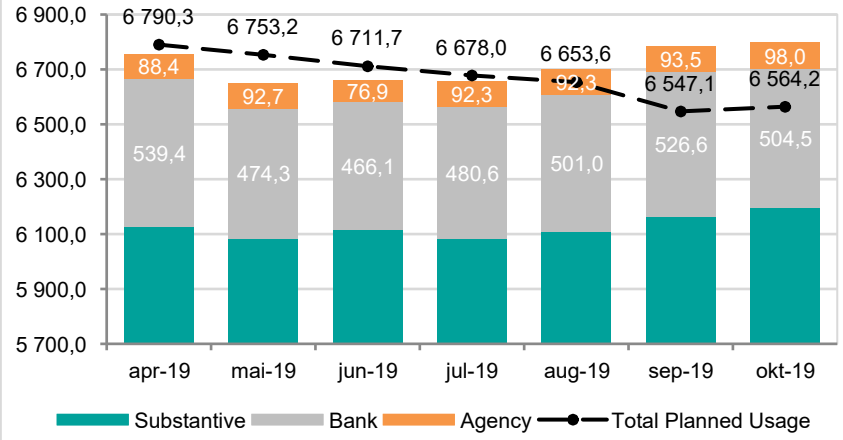
Plan	490,7	459,1	408,6	388,2	353,8	326,4	306,4
Actual	539,4	474,3	466,1	480,6	501,0	526,6	504,5

Agency FTE Usage 19/20



Plan	92,1	88,5	85,6	77,6	70,4	59,6	58,1
Actual	88,4	92,7	76,9	92,3	92,3	93,5	98,0

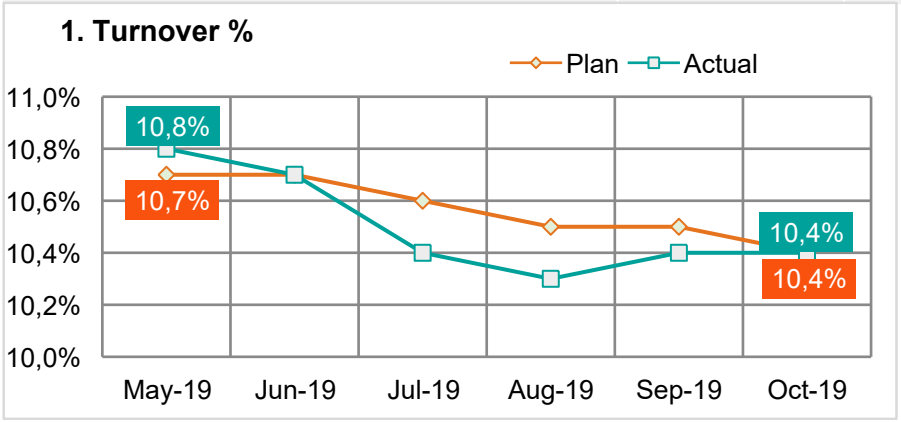
Total FTE Usage 19/20

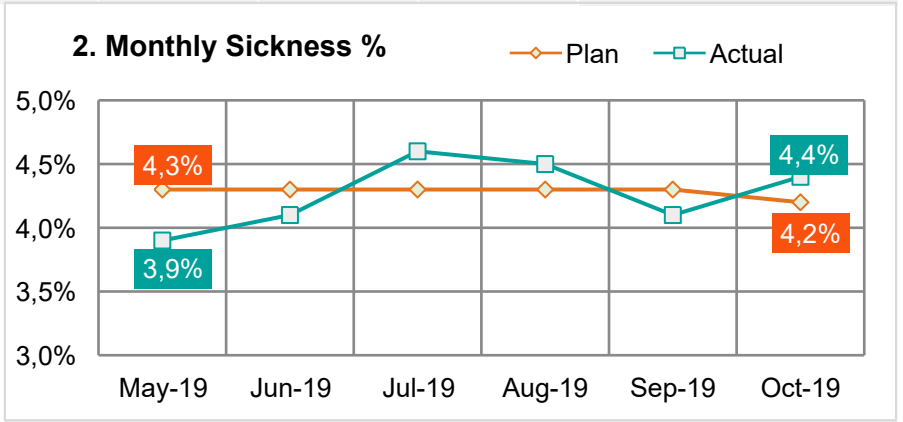


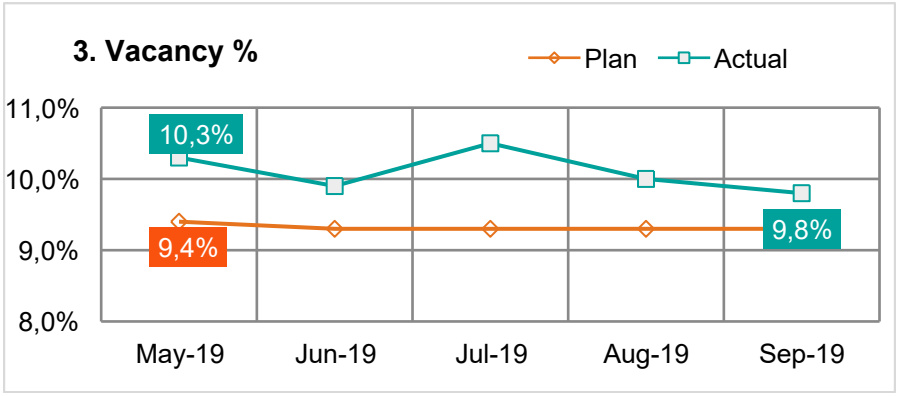
East Sussex Healthcare NHS Trust

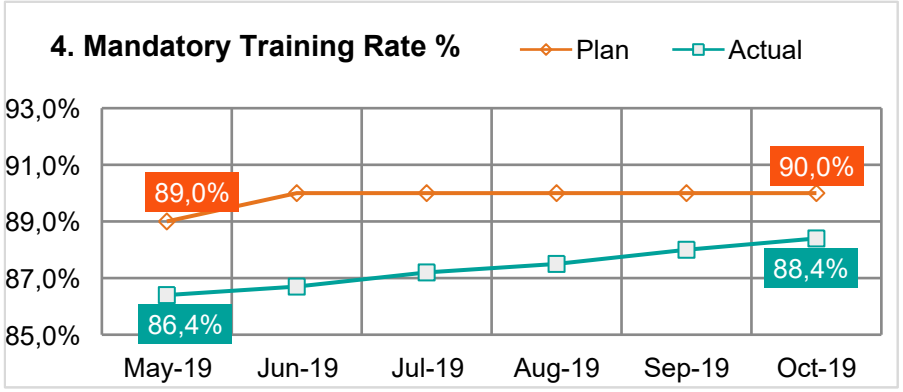
NHSI KPI'S - PLANNED v ACTUAL

Category	Plan/Actual	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Annual Turnover %	Plan	10.7%	10.7%	10.6%	10.5%	10.5%	10.4%
	Actual	10.8%	10.7%	10.4%	10.3%	10.4%	10.4%
Monthly Sickness %	Plan	4.3%	4.3%	4.3%	4.3%	4.3%	4.2%
	Actual	3.9%	4.1%	4.6%	4.5%	4.1%	4.4%
Vacancy Rate %	Plan	9.4%	9.3%	9.3%	9.3%	9.3%	9.2%
	Actual	10.3%	9.9%	10.5%	10.0%	9.8%	10.5%
Mandatory Training rate	Plan	89.0%	90.0%	90.0%	90.0%	90.0%	90.0%
	Actual	86.4%	86.7%	87.2%	87.5%	88.0%	88.4%







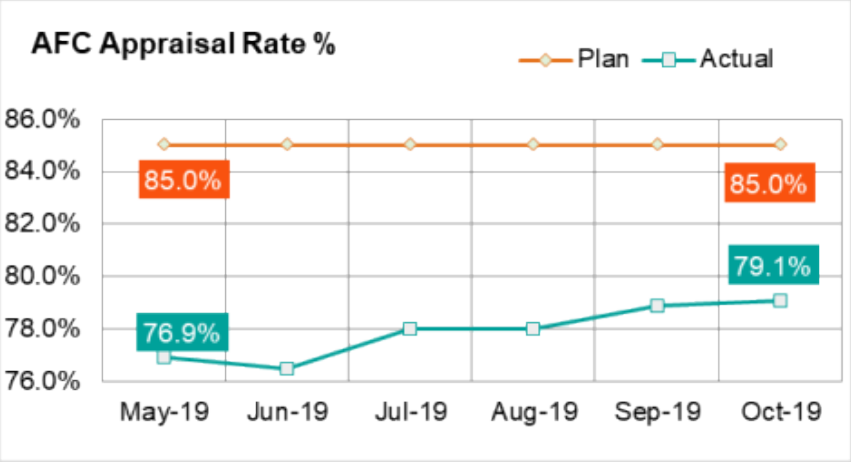


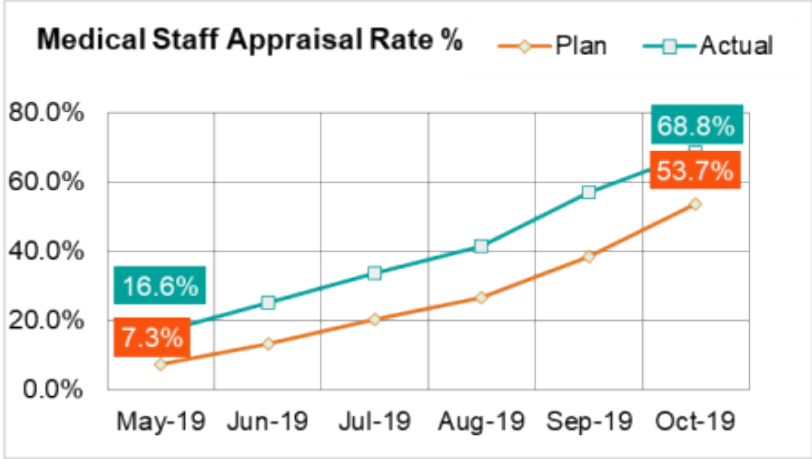
***Source data**: ESR & Finance Ledger*

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	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
AfC Appraisal Rate (rolling year)	Plan	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
	Actual	76.9%	76.5%	78.0%	78.0%	78.9%	79.1%
Medical Staff Appraisal Rate (Yr to date)	Plan	7.3%	13.5%	20.5%	26.8%	38.6%	53.7%
	Actual	16.6%	25.3%	33.9%	41.4%	57.0%	68.8%





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

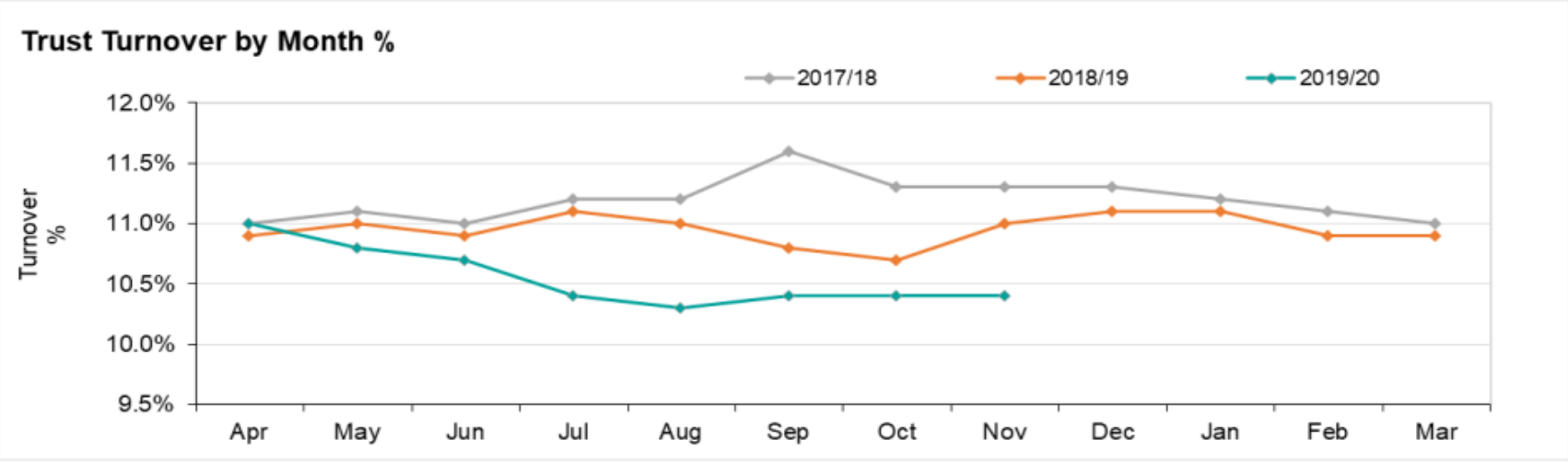
East Sussex Healthcare NHS
NHS Trust

TURNOVER TREND – STAFF GROUP

- Turnover rate for the Trust has remained unchanged at 10.4% which equates to 619.0 fte leavers in the last 12 months. Since May '19, the rate has been below the corresponding monthly turnover rate in 2018/19
- 10.3% Medical & Dental turnover equates to 31.2 fte leavers in the last 12 months, 3.8 ftes left in Oct. 10.6% Registered Nursing & Midwifery turnover equates to 196.0 fte leavers in year, 18.0 ftes left in Oct.
- Healthcare Scientist turnover has increased by 2.8% this month due to 3.0 fte leavers in Oct, 2.0 retirements in Pathology and 1.0 resignation in EME

TRUST TURNOVER BY STAFF GROUP (%)

Year on Year	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Trend line
Additional Clinical Services	12.3%	12.1%	12.0%	11.5%	11.2%	11.7%	11.6%	11.2%	11.1%	10.3%	10.3%	10.2%	10.0%	
Administrative and Clerical	12.0%	12.5%	12.8%	12.8%	12.9%	11.7%	11.3%	11.1%	11.1%	11.2%	11.1%	10.8%	10.2%	
Allied Health Professionals	10.5%	10.6%	10.9%	11.0%	12.4%	12.1%	11.7%	13.4%	13.3%	13.3%	13.9%	13.4%	13.0%	
Estates and Ancillary	8.2%	9.1%	9.1%	9.2%	8.8%	9.6%	10.4%	10.1%	10.1%	8.8%	8.9%	9.1%	9.1%	
Healthcare Scientists	10.1%	9.9%	12.0%	12.6%	10.9%	9.4%	10.0%	11.4%	9.3%	8.4%	8.2%	8.8%	11.6%	
Medical & Dental	10.4%	10.2%	10.1%	10.4%	9.4%	8.9%	8.3%	7.9%	8.3%	7.9%	7.8%	8.1%	10.3%	
Nursing & Midwifery Reg	10.1%	10.4%	10.7%	10.8%	10.4%	10.8%	11.1%	10.8%	10.6%	10.6%	10.3%	10.7%	10.6%	
Prof Scientific and Tech	8.2%	8.2%	6.9%	8.5%	7.4%	7.8%	8.5%	8.3%	9.1%	8.4%	9.0%	10.3%	9.2%	
TOTAL TRUST TURNOVER	**10.7%**	**11.0%**	**11.1%**	**11.1%**	**10.9%**	**10.9%**	**11.0%**	**10.8%**	**10.7%**	**10.4%**	**10.3%**	**10.4%**	**10.4%**	



***Source data**: ESR*

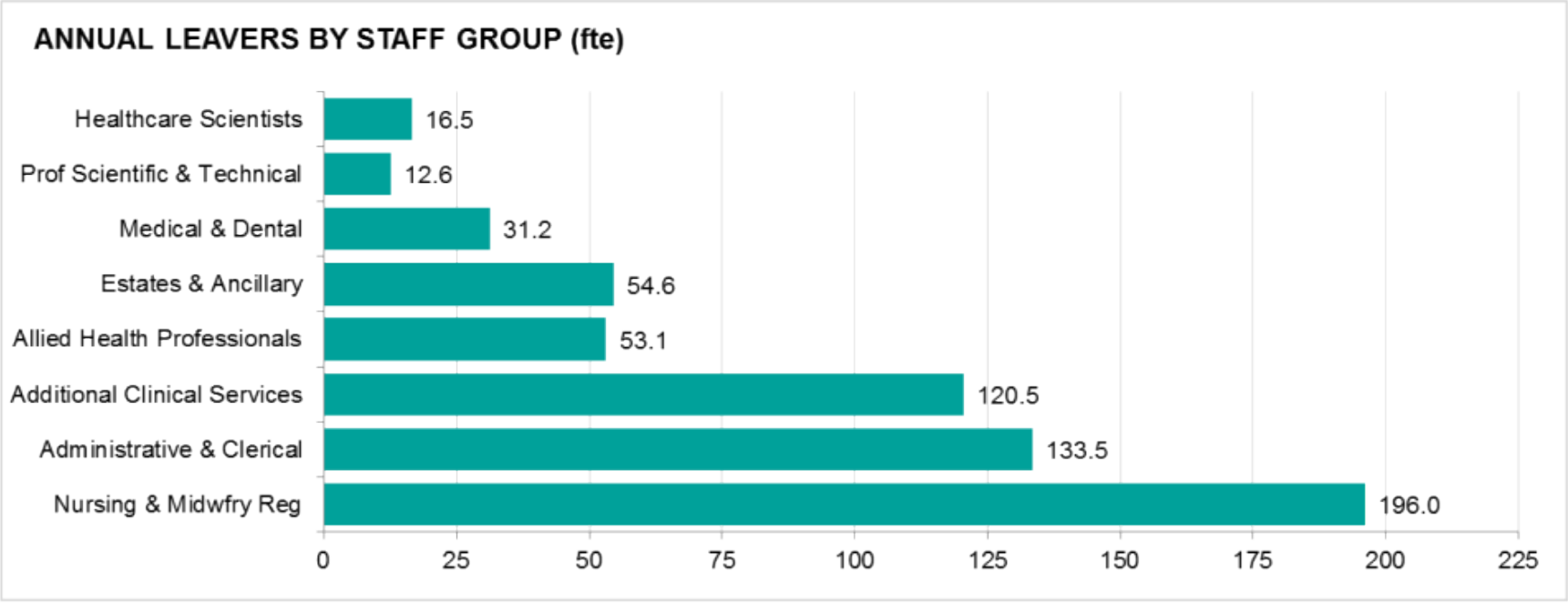
East Sussex Healthcare NHS
NHS Trust

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 increased by 1.8% this month

STAFF GROUPS	STABILITY > 1YR
Add Prof Scientific and Technic	92.0%
Additional Clinical Services	86.4%
Administrative and Clerical	90.4%
Allied Health Professionals	87.2%
Estates and Ancillary	90.8%
Healthcare Scientists	89.8%
Medical and Dental	87.8%
Nursing and Midwifery Registered	90.9%
TRUST	**89.4%**



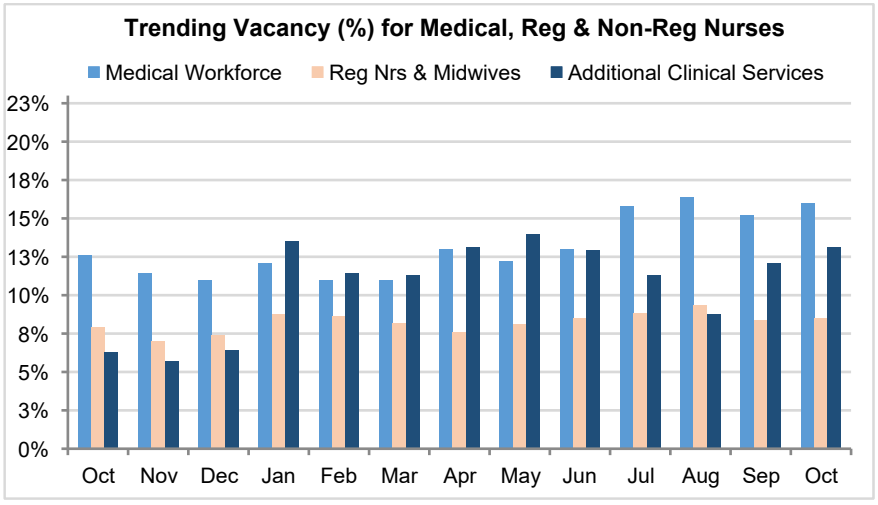
***Source data**: ESR*

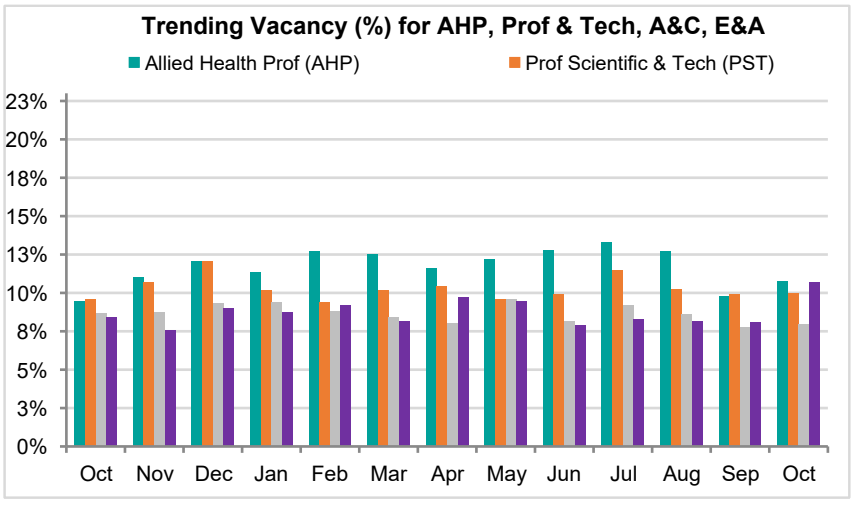
RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- Trust vacancy rate has increased by 0.7% to 10.5% (743.9 fte). This increase is solely due to increases in budgeted establishment in October due to the Ambulatory Care business case as well as funding for the existing workforce in the Discharge Teams and additional posts in Digital IT.
- To date 80 International Nurses have joined the Trust since May 2019. 6 Radiographers to join the Trust in December 2019.
- Work with Medacs agency continues with 8 candidates in post and a further 7 due to start by January 2020.

TRENDING VACANCY (%)

OCT 2018 TO OCT 2019	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Trend line
Medical Workforce	12.6%	11.4%	11.0%	12.1%	11.0%	11.0%	13.0%	12.2%	13.0%	15.8%	16.4%	15.2%	16.0%	
Reg Nrs & Midwives	7.9%	7.0%	7.4%	8.7%	8.6%	8.2%	7.6%	8.1%	8.5%	8.8%	9.4%	8.4%	8.5%	
Additional Clinical Services	6.3%	5.7%	6.4%	13.5%	11.4%	11.3%	13.1%	14.0%	12.9%	11.3%	8.7%	12.1%	13.1%	
Allied Health Prof (AHP)	9.5%	11.1%	12.1%	11.3%	12.7%	12.5%	11.6%	12.2%	12.8%	13.3%	12.7%	9.8%	10.8%	
Prof Scientific & Tech (PST)	9.6%	10.7%	12.1%	10.2%	9.4%	10.2%	10.5%	9.6%	9.9%	11.5%	10.3%	9.9%	10.0%	
Admin & Clerical	8.7%	8.8%	9.3%	9.4%	8.8%	8.4%	8.0%	9.6%	8.2%	9.2%	8.6%	7.8%	8.0%	
Estates & Ancillary (E&A)	8.4%	7.6%	9.0%	8.7%	9.2%	8.2%	9.7%	9.5%	7.9%	8.3%	8.2%	8.1%	10.7%	
TRUST	**8.6%**	**8.3%**	**8.9%**	**10.2%**	**9.7%**	**9.4%**	**9.8%**	**10.3%**	**9.9%**	**10.5%**	**10.0%**	**9.8%**	**10.5%**	





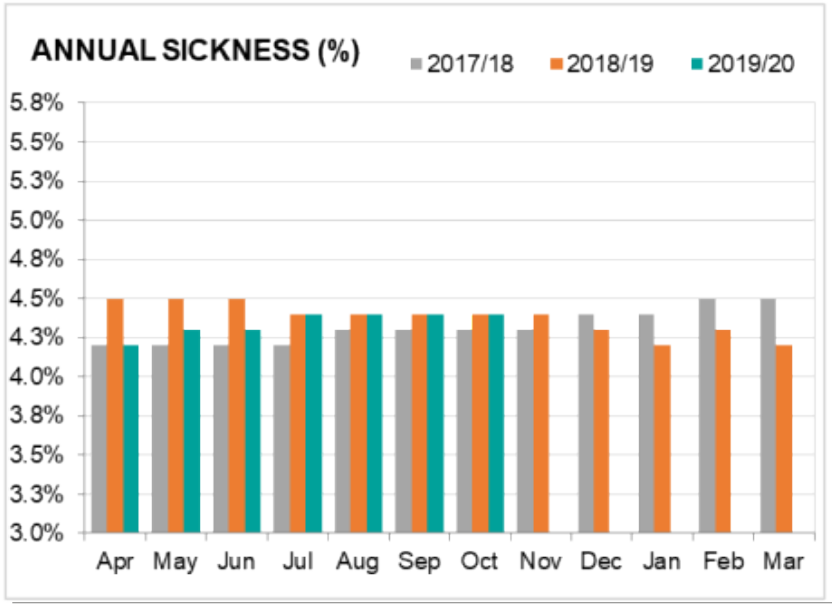
***Source data**: ESR & Finance Ledger*

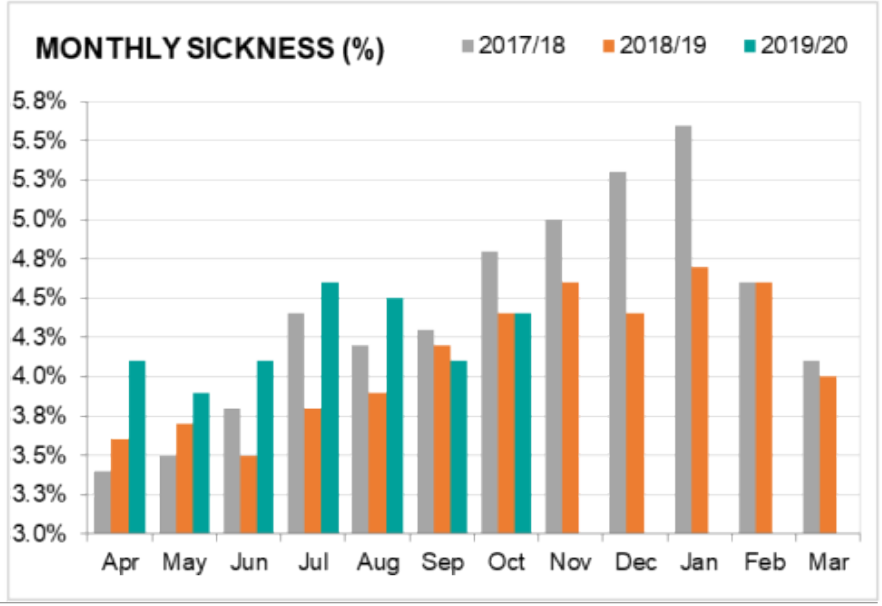
ABSENCE MANAGEMENT – SICKNESS RATES

- Monthly sickness has increased by 0.3% in Oct to 4.4% in line with seasonal trends (the rate usually increases in Oct and is the same as for Oct '18)
- Accordingly, the annual sickness rate has remained unchanged at 4.4%.
- The staff groups with the highest monthly sickness rates were Estates & Ancillary at 6.1% (+0.7%), Additional Clinical Services at 5.5% (up by 0.1%) and Registered Nurses & Midwives at 4.4% (up by 0.1%).

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%	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%	4.1%	4.4%					





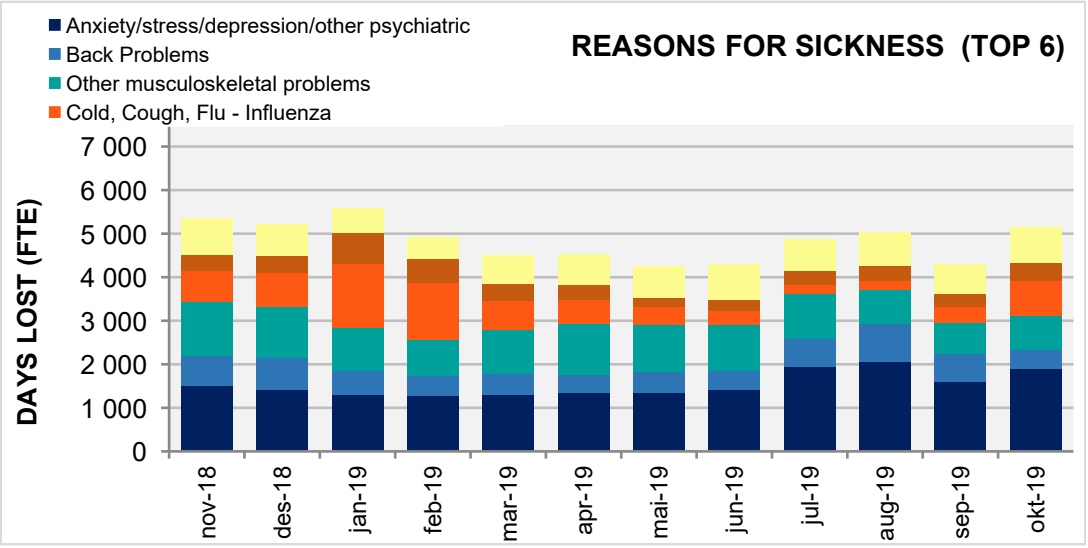
***Source data**: ESR*

East Sussex Healthcare NHS
NHS Trust

ABSENCE MANAGEMENT – SICKNESS REASONS

- Seasonal illnesses have increased this month with Cold, Cough, Flu increasing from 4.9% to 9.3% of total days lost to sickness (an increase of 428.6 fte days lost). Chest & respiratory problems have increased by 108.5 fte days lost.
- Anxiety/stress/depression illnesses have increased by 293.7 fte days lost this month. .
- Fte days lost to back problems have reduced, however, by 214.8 fte days lost.

TOP 6 - Year to Oct 19	Fte Days Lost by Month												
Reason for sickness	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend line
Anxiety/stress/depression/other psychiatric	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	1,603.7	1,897.4	
Back Problems	708.0	718.3	557.1	455.6	461.2	409.3	460.8	427.0	649.0	869.7	644.2	429.4	
Other musculoskeletal problems	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	708.1	790.4	
Cold, Cough, Flu - Influenza	730.2	788.3	1,474.1	1,300.1	662.3	537.0	397.7	324.2	206.9	190.2	375.7	804.3	
Chest & respiratory problems	371.3	393.2	705.9	568.4	384.5	363.2	216.0	242.6	317.7	358.3	300.3	408.8	
Gastrointestinal problems	829.0	724.7	566.9	485.4	656.8	704.8	731.2	809.5	730.8	762.5	667.3	809.4	



Top 10 in descending order (%) Oct 19		%
1	Anxiety/stress/depression/other	21.8%
2	Other known causes - not elsewhere classified	11.1%
3	Gastrointestinal problems	9.3%
4	Cold Cough Flu	9.3%
5	Other musculoskeletal problems	9.1%
6	Genitourinary & gynaecological disorders	5.9%
7	Unknown causes/ Not specified	5.3%
8	Back problems	4.9%
9	Chest & respiratory problems	4.7%
10	Benign and malignant tumours, cancers	3.8%
	TOP 10 REASONS	**85.2%**

***Source data**: ESR*

WELLBEING & ENGAGEMENT

Engagement

- Staff survey in progress with every Division receiving weekly communication and support to reach 60% Target. (As at 8 November, 45% response rate).

Health & Wellbeing

- Flu campaign continues, priority given to staff in acute clinical areas.
- Continued promotion of the new Employee Assistance programme “Care First”.

Leadership & Culture

- High potential programme for aspiring senior leaders launched
- A range of bespoke team development workshops have taken place
- Foundation in Coaching workshops held in conjunction with Health & Social Care colleagues
- Draft Behaviour framework, linked to Trust values, is being circulated for comment.

East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISAL COMPLIANCE BY DIVISION

APPRAISAL OVERVIEW

- The overall appraisal rate for the Trust has increased by 0.1% to 79.6%.

MANDATORY TRAINING

- Compliance overall has increased again this month by 0.4% to 88.4%. In September, the process for completion of eLearning for Fire, Health & Safety, Equality & Diversity, Moving & Handling and Infection Control was simplified and this is reflected in the increase in compliance with these topics.
- Learning & Development are working with the Moving & Handling team to address the drop in compliance. They have already provided additional dates for medics.
- New eLearning modules for MCA/DoLs are being reviewed and will then be uploaded to individuals ESR profiles for completion of eLearning.

DIVISION	APPRAISAL COMPLIANCE	
	12 mth	16 mth
Urgent Care	75.7%	86.6%
Medicine	78.3%	88.1%
Out of Hospital	75.0%	87.4%
Diag/Anaes/Surg	88.0%	95.1%
Womens, Child, S/Health	76.8%	88.3%
Estates & Facilities	82.3%	90.8%
Corporate	73.9%	87.5%
TRUST	**79.6%**	**89.8%**

												SAFEGUARDING	
DIVISION	FIRE SAFETY	MANUAL HANDLING	INDUCTION	INFECTION CONTROL	INFO GOV	HEALTH & SAFETY	MENTAL CAPACITY ACT	DEPRIV OF LIBERTIES	MCA/DOLS COMBINED	END OF LIFE CARE	CONFLICT RESOLUTION	VULNERABLE ADULTS (LEVEL 2)	CHILDREN (LEVEL 2)
Urgent Care	91.3%	85.4%	85.7%	89.5%	84.3%	90.6%	79.1%	76.6%	79.9%	52.3%	82.9%	84.3%	87.1%
Medicine	87.4%	85.0%	91.7%	89.6%	76.7%	88.3%	71.0%	69.4%	71.0%	60.1%	82.8%	84.5%	85.8%
Out of Hospital	89.1%	91.1%	98.0%	93.4%	85.8%	94.2%	71.9%	70.5%	72.1%	49.9%	88.7%	88.8%	89.5%
Diag/Anaes/Surg	90.9%	87.9%	90.6%	91.1%	88.4%	91.8%	77.4%	70.8%	77.5%	63.5%	85.7%	88.5%	88.9%
Womens, Child, S/Health	91.7%	90.0%	96.4%	91.0%	85.3%	89.9%	79.5%	78.1%	**79.6%**	28.1%	86.9%	89.2%	92.7%
Estates & Facilities	89.5%	95.4%	97.3%	96.2%	90.5%	95.7%	n/a	n/a	n/a	n/a	68.0%	n/a	n/a
Corporate	95.2%	97.6%	98.5%	95.8%	94.4%	96.4%	63.3%	60.7%	62.3%	87.5%	80.0%	87.1%	82.5%
TRUST	**90.5%**	**90.2%**	**94.4%**	**92.3%**	**86.3%**	**92.3%**	**74.5%**	**72.1%**	**74.6%**	**55.3%**	**85.2%**	**87.3%**	**88.5%**

Training & Appraisal Parameters: +85% **Green**, 75% to 85% **Amber**, < 75% **Red** *(End of Life Care not RAG rated as in 2nd year of 3 year trajectory)*

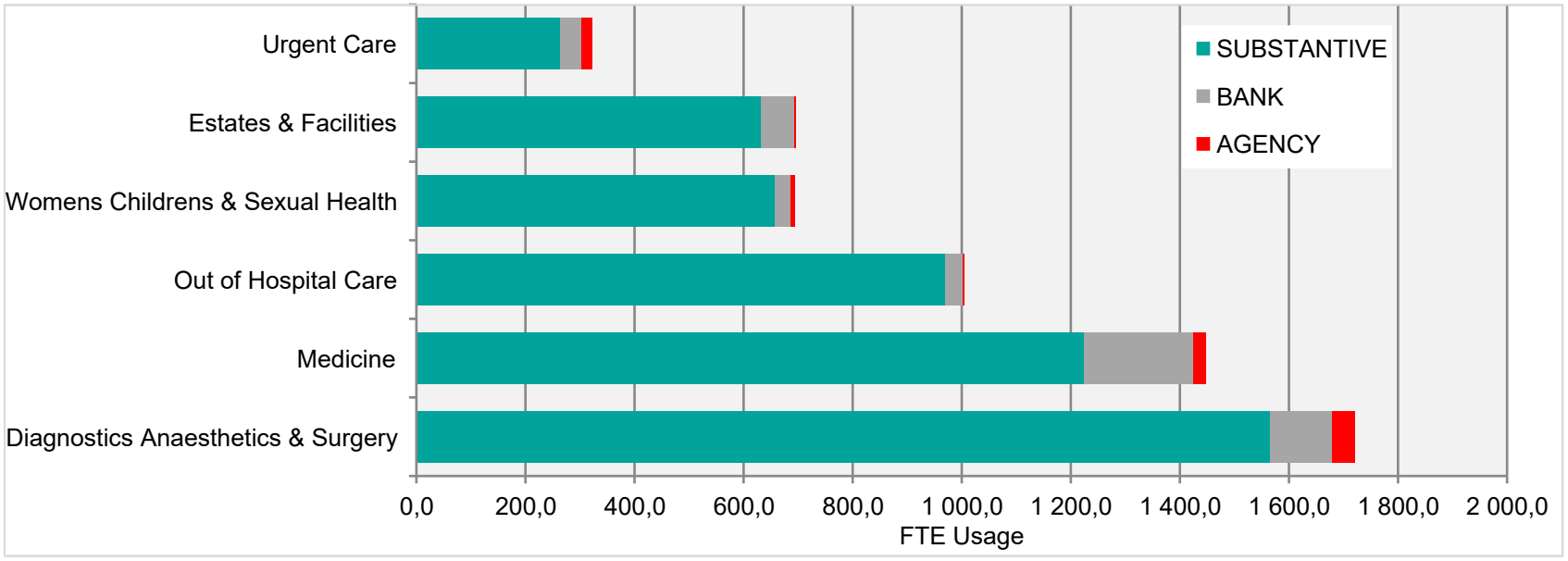
***Source data**: ESR*

APPENDIX

- Supporting documents

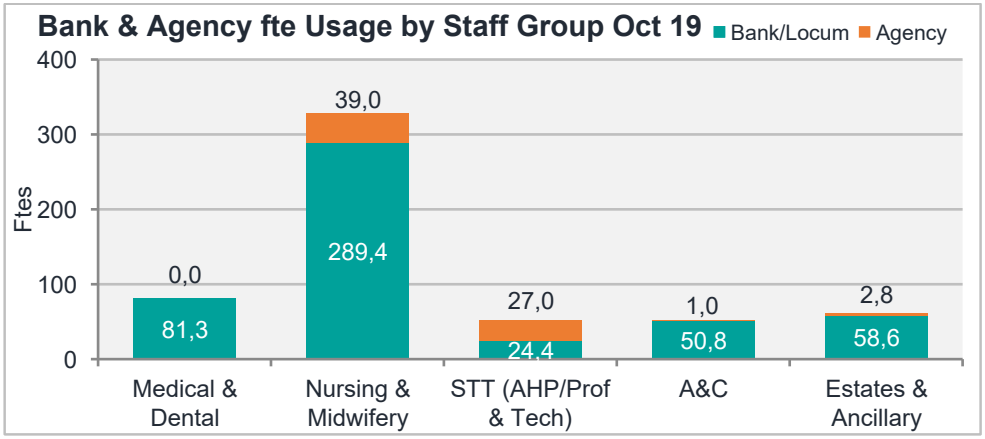
WORKFORCE UTILISATION BY DIVISION (FTE USAGE) – OCT '19

RESOURCE RATIO - MONTHLY					
DIVISION	**BUDGET FTE**	**SUBSTANTIVE**	**BANK**	**AGENCY**	**TOTAL**
Diagnostics Anaesthetics & Surgery	1,750.4	1,565.8	112.9	41.4	1,720.1
Medicine	1,610.4	1,224.6	201.1	22.1	1,447.9
Out of Hospital Care	1,084.9	969.3	32.2	3.1	1,004.5
Womens Childrens & Sexual Health	717.7	658.2	27.4	8.4	694.0
Estates & Facilities	724.8	632.2	60.2	2.8	695.2
Urgent Care	359.8	263.9	38.7	19.3	321.9
Corporate	963.8	825.5	32.0	1.0	858.5
TRUST	**7,211.8**	**6,196.9**	**504.5**	**98.0**	**6,799.4**



***Source data**: Finance Ledger*

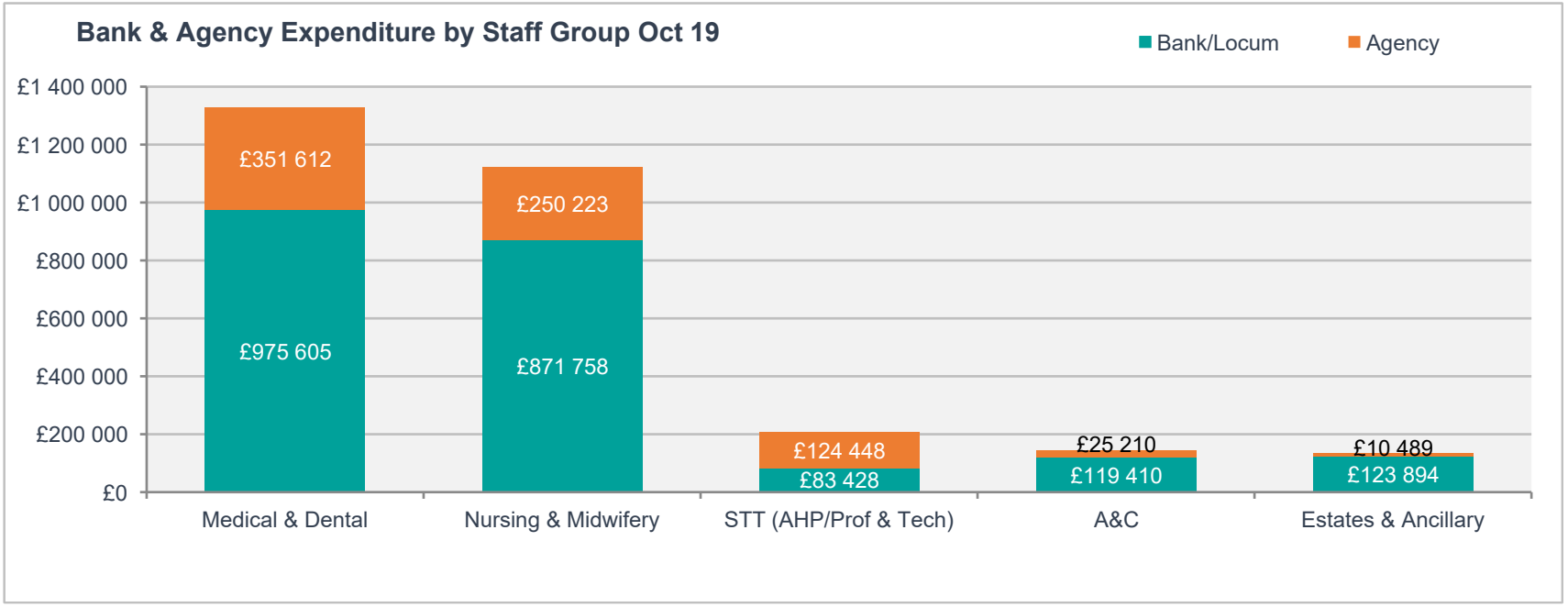
FLEXIBLE LABOUR – FTE & EXPENDITURE FOR OCT '19



Total temporary workforce expenditure reduced in Oct '19 against Sept '19 by £156K:

- Bank costs reduced by £11K
- Locum costs reduced by £81K
- Agency costs increased by £29K
- Overtime costs increased by £4K
- Waiting list costs reduced by £98K

(Source data: Finance Ledger M7)



***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 7

	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	(27,667)	(11,350)	(11,311)	39
Year End Forecast	(44,782)	(10,125)	(10,125)	0

The Trust is £39k ahead of plan YTD and eligible for PSF (£3.4m) and FRF (£6.7m) 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 £44k 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	(5,845)	(5,413)	(5,068)	345
Year End Forecast	(9,716)	(8,743)	(8,743)	0

Agency spend is £345k 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 £777k (13%) compared to the same period 2018/19.

Income

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	237,291	253,443	256,722	3,279
Year End Forecast	406,783	441,780	441,780	0

Underperformance on Outpatient (£2.0m) and elective activity (£1.6m) is offset,in the main, by under delivery of QIPP (£6.4m). The YTD value of the Aligned Incentive Contract with the ESBT CCGs is included in the financial position and is reducing income by £3.0m YTD. PSF (£3.4m), FRF (£6.7m) and MRET (£0.9m) 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	(260,475)	(260,536)	(262,474)	(1,938)
Year End Forecast	(445,874)	(444,666)	(444,666)	0

Overall operating costs are reporting £1.9m overspent against plan. Overspends are due to medical pay costs including agency, WLI and Locum (£0.9m), clinical supplies (£0.5m) and drugs (£0.8m), 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). An arrears payment for Medical & Dental pay award staff was made in Month 6. 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	10,705	10,749	44
Year End Forecast	20,603	20,603	0

The Trust has over delivered by £44k against its YTD plan. Despite this there is underperformance radiology outsourcing (£223k) and Urology Locum (£45k) 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 £17.9m currently identified as process green. The Divisions are increasing their reliance on non-recurrent savings with the proportion of M7 non-recurrent savings at 21% an increase of 4% from M6 and 9% against the lowest at 12% in M4. The expectation was that we would have plans for the full £20.6m by now.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	9,128	7,028
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	7,487	7,116	371
Year End Forecast	17,148	17,148	0

The CRL was revised to £17.1m following a sucessful application for £13.86m of emergency capital funding for fire compartmentalisation works over a 3 year period with £4.55m being received in 2019/20.
At M7 expenditure is £0.4m behind plan.The capital position is monitored on a monthly basis by the Capital Resource Group. The forecast will remain £361k below plan due to the MRI loss on disposal and consequent CDEL impact.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	51.83%	62.75%	82.41%	88.62%
NHS Invoices	68.82%	97.68%	86.55%	99.11%

52% of trade invoices were paid within 28 days which equates to 63% of the total value paid in month.

69% of NHS invoices were paid within contract or within 28 days of receipt which was 98% 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
Diagnostics, Anaesthetics & Surgery	1,750.39	1,720.06	30.33	949	(456)	(1,406)	1,986	(3,311)	(5,297)	3,829	3,829	0
Medicine	1,610.42	1,447.85	162.57	3,698	4,114	416	24,556	23,589	(967)	42,870	42,870	0
Urgent Care	359.82	321.92	37.90	1,098	1,503	405	7,099	7,965	866	10,604	10,604	0
Out of Hospital Care	1,084.91	1,004.50	80.41	(614)	(411)	203	(4,309)	(2,723)	1,586	(7,454)	(7,454)	0
Women's, Children's & Sexual Health	717.67	694.02	23.65	1,057	789	(269)	6,226	6,432	206	11,164	11,164	0
Estates & Facilities	724.79	695.15	29.64	(2,167)	(2,211)	(44)	(15,581)	(15,104)	477	(26,495)	(26,495)	0
Corporate	963.84	915.86	47.98	(3,855)	(3,840)	15	(28,548)	(26,595)	1,953	(49,513)	(49,513)	0
Central	0.00	0.08	(0.08)	31	713	682	(2,779)	(1,564)	1,215	4,869	4,869	0
Total	**7,211.84**	**6,799.44**	**412.40**	**197**	**200**	**3**	**(11,350)**	**(11,311)**	**39**	**(10,125)**	**(10,125)**	**0**

Key Risks

Key Risk 1	Medical pay costs, including WLI and locum increased (£0.9m overspend YTD)
Key Risk 2	Inpatient elective activity (elective, day case) £1.6m below plan YTD
Key Risk 3	Delivery of CIP plan

Mitigations

Mitigation 1	Recruitment to substantive medical posts including working with Medacs to fill hard to recruit roles. T3 pay costs controls include agency and locums. A detailed review of locum and agency overspends is being undertaken by Finance to further reduce agency spend by working with clinical units.
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 are 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 7

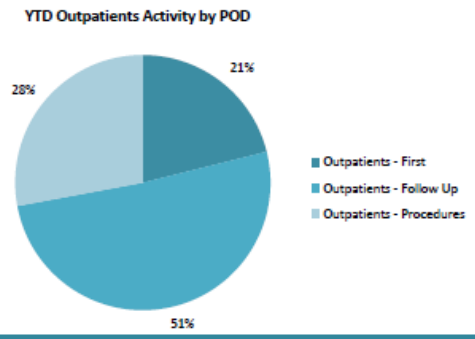
	In Month				Year to Date				Forecast Outturn		
	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Actual (£m)	Variance (£m)	19/20 Plan (£m)	19/20 FOT (£m)	Variance (£m)
NHS Patient Income	30.3	30.0	29.3	(0.7)	191.5	201.6	199.6	(2.0)	347.9	347.9	0.0
Tariff-Excluded Drugs & Devices	3.5	3.3	3.4	0.1	21.4	22.4	22.1	(0.3)	38.3	38.3	0.0
Private Patient / ICR	0.2	0.3	0.3	0.1	1.4	2.0	(1.6)	(3.5)	3.4	3.4	0.0
Other Non-Clinical Income	3.3	2.4	3.2	0.9	22.9	16.5	25.7	9.2	28.3	28.3	0.0
Total Income	**37.3**	**35.9**	**36.2**	**0.3**	**237.3**	**242.5**	**245.8**	**3.3**	**417.9**	**417.9**	**0.0**
Pay - Substantive	(21.2)	(21.7)	(22.0)	(0.3)	(148.7)	(152.1)	(155.2)	(3.1)	(262.6)	(262.6)	0.0
Pay - Bank	(2.0)	(1.7)	(2.2)	(0.5)	(15.6)	(14.0)	(15.1)	(1.1)	(22.8)	(22.8)	0.0
Pay - Agency	(0.8)	(0.7)	(0.8)	(0.1)	(5.8)	(5.4)	(5.1)	0.3	(8.7)	(8.7)	0.0
Total Pay	**(24.1)**	**(24.0)**	**(24.9)**	**(0.9)**	**(170.2)**	**(171.5)**	**(175.3)**	**(3.8)**	**(294.1)**	**(294.1)**	**0.0**
Drugs	(4.6)	(4.0)	(4.1)	(0.1)	(26.4)	(26.3)	(27.2)	(0.8)	(44.6)	(44.6)	0.0
Supplies & Services - Clinical	(3.1)	(3.0)	(3.0)	0.0	(20.2)	(19.0)	(18.9)	0.1	(32.2)	(32.2)	0.0
Supplies & Services - General	(0.3)	(0.3)	(0.4)	(0.1)	(2.6)	(2.3)	(2.3)	0.1	(4.0)	(4.0)	0.0
Purchase of Healthcare (non-NHS)	(0.5)	(0.5)	(0.5)	(0.0)	(3.4)	(3.6)	(3.6)	0.0	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(1.0)	(0.6)	(0.1)	0.5	(4.7)	(4.2)	(2.9)	1.3	(7.1)	(7.1)	0.0
Consultancy	(0.1)	(0.0)	0.0	0.1	(0.7)	(0.3)	(0.3)	(0.0)	(0.4)	(0.4)	0.0
Clinical Negligence	(0.9)	(0.8)	(0.8)	(0.0)	(5.9)	(5.3)	(5.6)	(0.3)	(8.9)	(8.9)	0.0
Premises	(1.6)	(1.2)	(1.1)	0.2	(8.2)	(8.9)	(8.3)	0.5	(15.0)	(15.0)	0.0
Depreciation	(1.0)	(1.0)	(1.1)	(0.0)	(7.3)	(7.3)	(7.5)	(0.2)	(12.6)	(12.6)	0.0
Other	(2.6)	(1.9)	(1.7)	0.2	(11.0)	(11.9)	(10.7)	1.2	(19.9)	(19.9)	0.0
Total Non-Pay	**(15.7)**	**(13.4)**	**(12.8)**	**0.6**	**(90.3)**	**(89.1)**	**(87.1)**	**1.9**	**(150.5)**	**(150.5)**	**0.0**
Total Operating Costs	**(39.8)**	**(37.4)**	**(37.7)**	**(0.3)**	**(260.5)**	**(260.6)**	**(262.5)**	**(1.9)**	**(444.7)**	**(444.7)**	**0.0**
Net Surplus/(Deficit) from Operations	**(2.5)**	**(1.6)**	**(1.5)**	**0.1**	**(23.2)**	**(18.1)**	**(16.7)**	**1.4**	**(26.8)**	**(26.8)**	**0.0**
Financing Costs	(0.6)	(0.6)	(0.6)	0.0	(4.5)	(4.2)	(4.2)	0.0	(7.2)	(7.2)	0.0
Total Non-Operating Costs	**(0.6)**	**(0.6)**	**(0.6)**	**0.0**	**(4.5)**	**(4.2)**	**(4.2)**	**0.0**	**(7.2)**	**(7.2)**	**0.0**
Total Costs	**(40.4)**	**(38.0)**	**(38.3)**	**(0.3)**	**(265.0)**	**(264.8)**	**(266.7)**	**(1.9)**	**(451.9)**	**(451.9)**	**0.0**
Net Surplus/(Deficit)	**(3.1)**	**(2.2)**	**(2.2)**	**0.0**	**(27.7)**	**(22.3)**	**(20.9)**	**1.4**	**(34.0)**	**(34.0)**	**0.0**
Donated Asset/Impairment Adjustment	(0.0)	0.0	(0.0)	(0.0)	0.0	0.0	(1.4)	(1.4)	0.0	0.0	0.0
Operational Surplus/(Deficit)	**(3.1)**	**(2.2)**	**(2.2)**	**0.0**	**(27.7)**	**(22.3)**	**(22.3)**	**0.0**	**(34.0)**	**(34.0)**	**0.0**
Provider Sustainability Fund	0.0	0.8	0.8	0.0	0.0	3.4	3.4	0.0	7.6	7.6	0.0
Financial Recovery Fund	0.0	1.5	1.5	0.0	0.0	6.7	6.7	0.0	14.8	14.8	0.0
Marginal Rate Emergency Tariff (MRET)	0.0	0.1	0.1	0.0	0.0	0.9	0.9	0.0	1.5	1.5	0.0
Net Surplus/(Deficit)	**(3.1)**	**0.2**	**0.2**	**0.0**	**(27.7)**	**(11.4)**	**(11.3)**	**0.0**	**(10.1)**	**(10.1)**	**0.0**

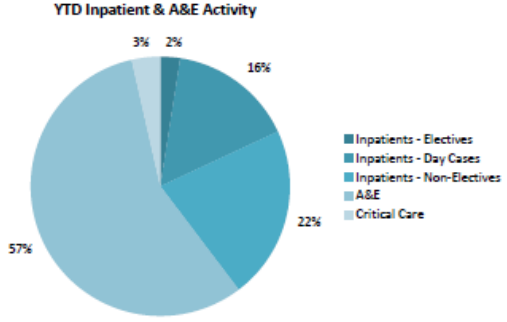
Summary & Next Steps

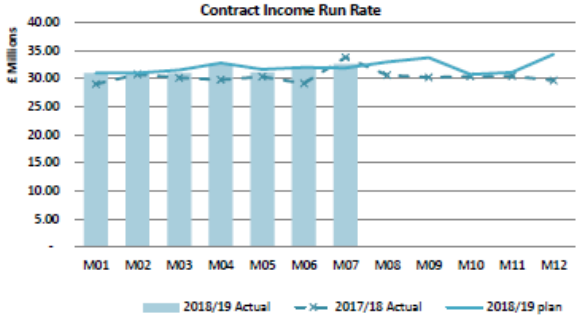
The Trust's YTD performance at M7 is £39k ahead of plan with CIP over performaning by £44k. Income was ahead of plan in the month and pay overspends continued in Medical, due to agency, locum and WLI payments. Outpatients activity is £0.5m below plan in month. The YTD impact of the Aligned Incentive Contract with the ESBT CCGs has been recognised in the financial position, as has £11.0m of PSF, FRF and MRET YTD. The Trust has received £0.6m of funding YTD for wage award pressures.

Income & Activity Summary - Month 7

	In Month								Year to Date								Forecast Outturn			
	18/19 Activity Actual	19/20 Activity Plan	19/20 Activity Actual	Activity Variance	18/19 Actual (£k)	19/20 Plan (£k)	19/20 Actual (£k)	Variance (£k)	18/19 Activity Actual	19/20 Activity Plan	19/20 Activity Actual	Activity Variance	18/19 Actual (£k)	19/20 Plan (£k)	19/20 Actual (£k)	Variance (£k)	19/20 Plan (£k)	19/20 FOT (£k)	Variance (£k)	
Contract Income																				
Inpatients - Electives	594	625	511	(114)	2,039	2,098	1,760	(338)	3,806	4,020	3,593	(427)	12,074	13,498	12,054	(1,444)	22,979	22,979	0	
Inpatients - Day Cases	3,452	3,603	3,517	(86)	2,624	2,693	2,846	154	23,059	23,178	22,802	(376)	17,191	17,323	17,169	(154)	29,491	29,491	0	
Inpatients - Non-Electives	4,306	4,501	4,418	(83)	9,197	10,043	10,513	470	29,697	30,939	31,619	680	62,883	69,035	69,756	721	121,311	121,311	0	
Outpatients	37,605	38,228	37,253	(975)	4,408	4,770	4,309	(461)	243,203	245,949	237,780	(8,169)	28,554	30,600	28,605	(1,995)	52,177	52,177	0	
A&E	10,862	11,523	11,714	191	1,493	1,767	1,825	58	76,652	81,820	82,962	1,142	10,522	12,546	12,746	200	21,111	21,111	0	
CQUIN	0	0	0	0	0	308	383	75	0	0	0	0	0	2,156	2,476	320	3,695	3,695	0	
Critical Care	694	746	677	(69)	705	826	720	(106)	5,222	5,144	5,195	51	5,605	5,676	5,948	273	9,973	9,973	0	
Direct Access	10,309	8,426	12,091	3,665	364	358	389	30	60,429	58,139	83,991	25,852	2,229	2,474	2,552	77	4,285	4,285	0	
ESBT	0	0	0	0	588	707	611	(96)	0	0	0	0	4,115	4,892	4,276	(616)	8,379	8,379	0	
Excess Bed Days	520	829	299	(530)	124	274	118	(157)	5,715	5,638	5,393	(245)	1,383	1,867	1,481	(386)	3,266	3,266	0	
Exclusions	0	0	210	210	3,506	3,272	3,331	59	0	0	1,646	1,646	21,443	22,397	22,374	(23)	38,294	38,294	0	
iMSK	0	0	0	0	118	123	123	0	0	0	0	0	829	859	861	3	1,472	1,472	0	
Maternity Pathway	565	570	555	(15)	577	608	585	(22)	3,915	3,930	3,858	(72)	4,068	4,193	4,208	16	7,268	7,268	0	
Unallocated QIPP	0	0	0	0	0	(919)	0	919	0	0	0	0	0	(6,434)	0	6,434	(11,029)	(11,029)	0	
AIC	0	0	0	0	0	0	(858)	(858)	0	0	0	0	0	0	(2,964)	(2,964)	0	0	0	
Other	335,589	306,987	315,579	8,592	6,120	4,934	5,800	866	2,149,689	2,118,116	2,210,839	92,723	40,209	40,675	40,131	(544)	71,939	71,939	0	
Contract Income Total	404,496	376,038	387,406	10,787	31,864	31,861	32,469	594	2,601,387	2,576,874	2,689,678	112,804	211,105	221,758	221,673	(85)	384,611	384,611	0	
Divisional Income					3,562	6,384	5,939	(445)					24,322	31,685	35,049	3,364	57,169	57,169	0	
Total Income	404,496	376,038	387,406	10,787	35,426	38,245	38,408	149	2,601,387	2,576,874	2,689,678	112,804	235,427	253,443	256,722	3,279	441,780	441,780	0	







Summary & Next steps

Inpatients - Electives & Day Cases (YTD) £1.6m behind plan -5.2%

Activity and income are behind plan at M7

The main areas of underperformance are Urology (£960k) Cardiology (£475k) and T&O (£544k). There is focused work with the divisions to understand the drivers for this and develop action plans.

Inpatients - Non-Electives (YTD) £0.7m above plan 1.0%

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) £2m behind plan -6.5%

Outpatient activity is behind plan for M7 and mainly relates to Ophthalmology (£549K), T&O (£639K) and Urology (£348K).

A&E (YTD) £0.2m above plan 1.6%

A&E activity is continuing to grow with 11,714 attendances in October 2019 being 7.2% higher than October 2018. YTD activity (Apr - Oct) is 8% higher than the same period in 2018/19

QIPP adjustment (YTD) £6.4m 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 £5.5m YTD over performance.

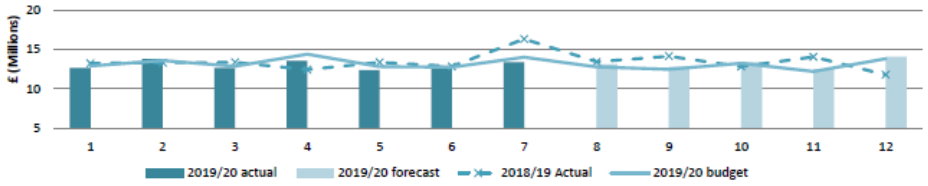
AIC Adjustment (YTD) £3m

The value of activity is currently £2.96m higher than the value of the AIC for Sussex CCGs.

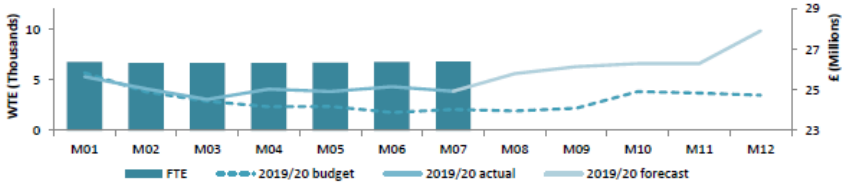
Expenditure & Workforce Summary - Month 7

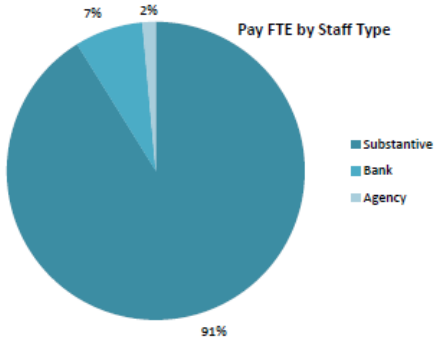
Cost Element	In Month								Year to Date				Forecast Outturn			
	18/19 WTE Actual	19/20 WTE Plan	19/20 WTE Actual	WTE Variance	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	19/20 Expenditure Variance (£k)	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	19/20 Expenditure Variance (£k)	19/20 Plan (£k)	19/20 FOT (£k)	Variance (£k)	
Administrative & Management	1305	1410	1321	90	3,535	4,025	3,741	284	25,674	27,319	26,046	1,273	47,277	47,277	0	
Ancillary	669	703	668	35	1,569	1,547	1,466	82	10,667	10,831	10,651	180	18,571	18,571	0	
Medical	671	772	725	47	6,013	6,190	6,122	68	41,361	42,700	43,624	(924)	74,719	74,719	0	
Nursing & Midwifery	3017	3250	3078	172	9,700	9,762	10,004	(242)	68,222	70,381	70,039	342	122,075	122,075	0	
Prof, Scientific & Tech	514	535	527	7	1,788	1,896	1,807	89	12,398	13,012	12,378	634	22,407	22,407	0	
Professions Allied to Medicine	467	542	481	61	1,607	1,864	1,665	199	10,963	13,140	11,645	1,495	22,579	22,579	0	
Other	0	0	0	1	(90)	(1,244)	133	(1,377)	869	(5,859)	941	(6,800)	(13,494)	(13,494)	0	
Total Pay	**6643**	**7212**	**6799**	**413**	**24,122**	**24,041**	**24,937**	**(896)**	**170,155**	**171,524**	**175,324**	**(3,800)**	**294,133**	**294,133**	**0**	
Services from Other NHS Bodies					1,005	501	117	384	4,729	3,572	2,863	709	6,056	6,056	0	
Clinical Negligence Premium					876	806	806	0	5,872	5,639	5,639	0	9,667	9,667	0	
Consultancy					103	35	(16)	51	664	250	255	(5)	381	381	0	
Drugs					1,276	1,049	981	68	6,465	6,015	6,394	(379)	10,258	10,258	0	
Drugs - Tariff Excluded					3,284	2,955	3,083	(128)	19,906	20,325	20,779	(454)	34,770	34,770	0	
Education and Training					97	201	54	146	559	1,413	326	1,087	2,422	2,422	0	
Establishment Expenses					839	668	862	(194)	5,071	4,632	4,508	125	7,999	7,999	0	
Premises					1,552	1,147	1,068	79	8,235	8,860	8,327	533	15,941	15,941	0	
Purchase of Healthcare from Non NHS Bodies					537	461	531	(70)	3,402	3,583	3,613	(29)	6,170	6,170	0	
Supplies and Services - Clinical					3,120	2,883	3,013	(130)	20,157	18,396	18,868	(472)	31,236	31,236	0	
Supplies and Services - General					284	338	432	(94)	2,551	2,416	2,268	148	4,150	4,150	0	
Other Non-Pay					10,511	2,362	1,829	533	12,710	13,953	13,311	642	21,483	21,483	0	
Total Non-Pay					**23,483**	**13,405**	**12,761**	**644**	**90,320**	**89,055**	**87,150**	**1,905**	**150,533**	**150,533**	**0**	
Total Expenditure	**6643**	**7212**	**6799**	**413**	**47,604**	**37,446**	**37,698**	**(252)**	**260,475**	**260,579**	**262,474**	**(1,895)**	**444,666**	**444,666**	**0**	

Non-Pay Monthly Run rate



Pay Monthly Run Rate vs FTE





Summary & Next Steps

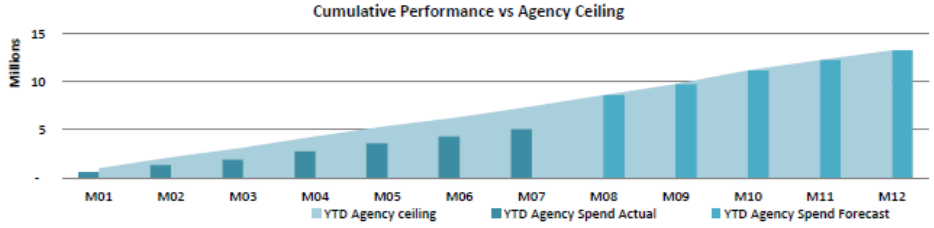
Medical pay is £0.9m overspent YTD (which includes waiting list initiative payments and agency covering vacancies), despite utilising 20WTE less than budget. Variances in Other Pay is attributable to vacancy factors applied to various specialties with historically high levels of clinical vacancies and unidentified pay CIP, spend is due largely to apprenticeship levy payments. Nursing & midwifery is underspent by £342k YTD due to vacancies, however nursing specialing is overspent by £423k YTD.

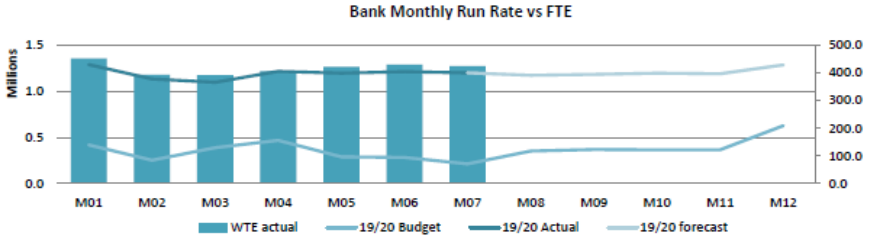
The non consolidated lump sum payment was made to AfC staff at the top of band in Month 1. Medical & Dental pay award arrears were paid in month 6.

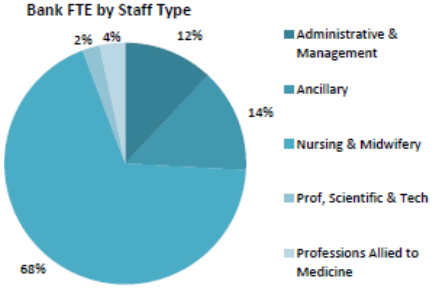
Tariff Excluded Drugs spend is showing £454k overspent, which is offset within Income, non-Tariff Excluded Drugs is £379k overspent YTD. Supplies & services - Clinical is overspent by £472k YTD due to non-elective activity overperformance.

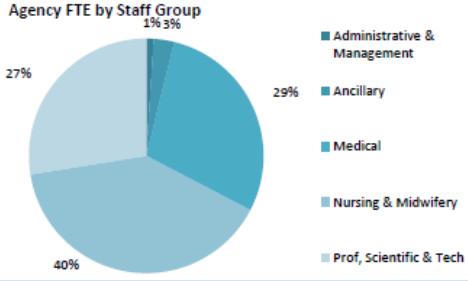
Temporary Workforce Summary - Month 7

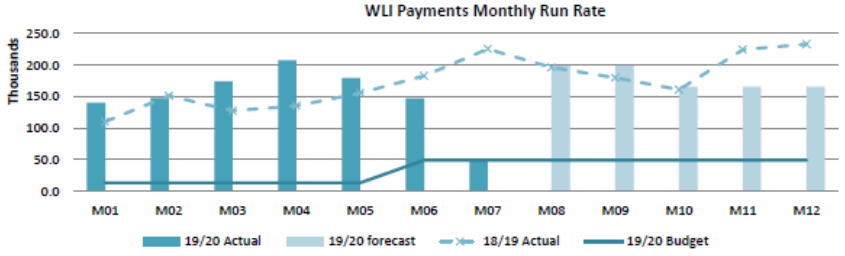
Cost Element	In Month								Year to Date				Forecast Outturn			
	18/19 WTE Actual	19/20 WTE Plan	19/20 WTE Actual	WTE Variance	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	Expenditure Variance (£k)	18/19 Expenditure Actual (£k)	19/20 Expenditure Plan (£k)	19/20 Expenditure Actual (£k)	Expenditure Variance (£k)	19/20 Plan (£k)	19/20 FOT (£k)	Variance (£k)	
Agency																
Administrative & Management	4	0	1	-1	57	48	25	23	408	365	363	2	601	601	0	
Ancillary	13	0	3	-3	75	48	10	38	471	365	206	159	601	601	0	
Medical	16	12	28	-16	344	262	352	(90)	2,120	2,049	2,417	(368)	3,336	3,336	0	
Nursing & Midwifery	34	0	39	-39	179	124	250	(126)	1,376	1,172	1,296	(124)	1,761	1,761	0	
Prof, Scientific & Tech	30	0	27	-27	179	198	124	74	1,470	1,463	786	677	2,444	2,444	0	
Total Agency	**97**	**12**	**98**	**-86**	**833**	**680**	**762**	**(82)**	**5,845**	**5,413**	**5,068**	**345**	**8,743**	**8,743**	**0**	
Bank																
Administrative & Management	47	5	51	-46	167	112	119	(8)	980	839	797	42	1,414	1,414	0	
Ancillary	43	22	59	-37	150	112	124	(12)	951	839	821	18	1,414	1,414	0	
Nursing & Midwifery	281	93	289	-196	907	579	872	(293)	6,498	5,421	6,186	(765)	8,302	8,302	0	
Prof, Scientific & Tech	11	0	10	-10	47	43	33	10	306	308	274	34	534	534	0	
Professions Allied to Medicine	8	6	14	-9	38	11	51	(40)	222	160	255	(95)	211	211	0	
Total Bank	**390**	**126**	**423**	**-297**	**1,309**	**856**	**1,198**	**(342)**	**8,958**	**7,567**	**8,333**	**(766)**	**11,874**	**11,874**	**0**	
Total Locum	**69**	**22**	**81**	**-60**	**738**	**828**	**976**	**(148)**	**6,630**	**6,448**	**6,735**	**(287)**	**10,895**	**10,895**	**0**	
Total Waiting List Initiative	**13**	**0**	**9**	**-9**	**225**	**49**	**49**	**0**	**1,089**	**167**	**1,046**	**(878)**	**415**	**415**	**0**	
Total Temporary Workforce	**569**	**160**	**612**	**-452**	**3,105**	**2,413**	**2,985**	**(572)**	**22,522**	**19,595**	**21,182**	**(1,586)**	**31,927**	**31,927**	**0**	











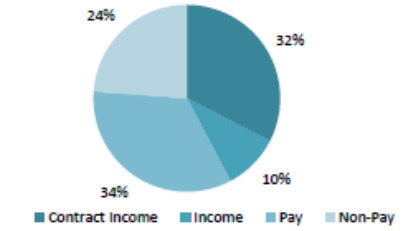
Summary & Next steps

Overall agency is £345k below plan YTD but £82k 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 11% compared to the same period in 18/19, high cost agency in IT Digital are part of a pass through cost. Total temporary staffing costs have fallen by 6% compared to the previous year (£1.3m lower). The T3 enhanced pay process will go live on 2 December.

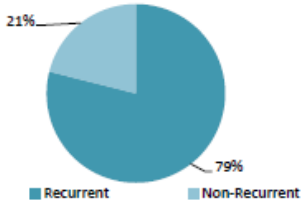
Cost Improvement Programme Summary - Month 7

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	441	434	-7	3,626	3,496	-130	5,594	5,506	-89	3,496	0
Income	28	150	123	494	1,045	551	1,651	1,600	-51	969	75
Pay	861	816	-45	4,183	3,648	-535	5,221	5,445	224	1,749	1,898
Non-Pay	485	417	-67	2,402	2,561	159	5,463	5,262	-202	2,270	291
Total Identified Schemes	**1,814**	**1,817**	**3**	**10,705**	**10,749**	**44**	**17,929**	**17,813**	**-116**	**8,484**	**2,265**
Pipeline/Unidentified	0	0	0	0	0	0	2,674	2,790	116	79%	21%
Total	**1,814**	**1,817**	**3**	**10,705**	**10,749**	**44**	**20,603**	**20,603**	**0**		

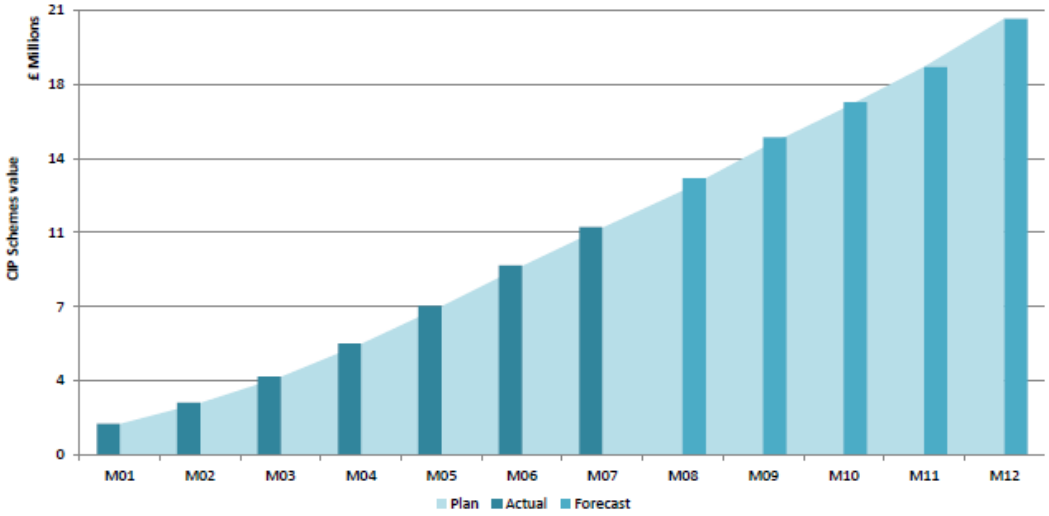
YTD CIP green schemes by category



YTD CIP green schemes recurrent/non-recurrent



CIP Performance



Summary & Next Steps

In Month: The Trust has delivered £1.817m against a total plan of £1.914m, showing a £3k overperformance in the month.

YTD: The Trust has delivered £10,749m against a total plan of £10.705m, showing a £44k overperformance year to date. The main underperforming schemes are Urology locum replacement with substantive (£45k), savings carried forward from 18/19 for bed modelling, where the beds remain open due to activity increases (£180k) Radiology Outsourcing (£223k), 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 the £20.6m plan. Against the £17.9m identified 'Green' scheme plan the Trust is forecasting £17.8m, an adverse outturn of £0.1m. This adverse variance is mainly due to Radiology Outsourcing (£193k), plus the bed modelling (£180k).

Recurrent/Non-recurrent split - The Divisions are increasing their reliance on non-recurrent savings with the proportion of M7 non-recurrent savings at 21% an increase of 4% from M6 and 9% against the lowest at 12% in M4. This will increase the 2020/21 CIP challenge as the plan assumes all savings will be delivered recurrently.

The expectation was that we would have plans for the full £20.6m by now.

Finance Report Divisional Summaries - Month 7

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				10,103	9,135	(968)	66,940	62,797	(4,143)	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 medical staffing pressures in Radiology, Urology and ENT. Clinical supplies costs in Theatres have underspent in month due to lower levels of elective activity, offset with unidentified non-pay CIP.
Divisional Income				386	516	130	2,741	2,853	112	4,672	4,672	0	
Pay	1,750.39	1,720.06	30.33	(7,056)	(7,383)	(326)	(50,129)	(51,283)	(1,154)	(85,932)	(85,932)	0	
Non-Pay				(2,484)	(2,725)	(242)	(17,566)	(17,678)	(112)	(30,259)	(30,259)	0	
Overall	**1,750.39**	**1,720.06**	**30.33**	**949**	**(456)**	**(1,406)**	**1,986**	**(3,311)**	**(5,297)**	**3,829**	**3,829**	**0**	
Medicine													
Contract Income				9,891	10,276	385	66,384	66,639	254	115,627	115,627	0	Medical pay is overspent (£31k YTD) with overspends in Gastroenterology & Elderly Care in order to meet operational targets; offset by underspends in Dermatology, Storke and Acute Medicine due to vacancies. The cost of open escalation wards continue to deteriorate pay and non-pay postions (£51k YTD). Seaford ward was funded in M6.
Divisional Income				139	168	28	1,019	1,052	33	1,802	1,802	0	
Pay	1,610.42	1,447.85	162.57	(5,643)	(5,449)	194	(37,746)	(38,488)	(742)	(65,702)	(65,702)	0	
Non-Pay				(689)	(880)	(191)	(5,101)	(5,613)	(513)	(8,857)	(8,857)	0	
Overall	**1,610.42**	**1,447.85**	**162.57**	**3,698**	**4,114**	**416**	**24,556**	**23,589**	**(967)**	**42,870**	**42,870**	**0**	
Urgent Care													
Contract Income				2,559	3,127	569	18,000	18,899	899	30,662	30,662	0	A&E activity and income are above plan YTD. Prescription booths income is below plan by £35k YTD. Pay is underspent by £31k YTD, of which £28k is in Nursing due offset by unidentified CIP (£154k). Private ambulances are overspending by £30k YTD.
Divisional Income				35	30	(5)	242	215	(27)	226	226	0	
Pay	359.82	321.92	37.90	(1,434)	(1,540)	(107)	(10,637)	(10,606)	31	(19,396)	(19,396)	0	
Non-Pay				(62)	(114)	(52)	(505)	(542)	(37)	(888)	(888)	0	
Overall	**359.82**	**321.92**	**37.90**	**1,098**	**1,503**	**405**	**7,099**	**7,965**	**866**	**10,604**	**10,604**	**0**	
Out of Hospital Care													
Contract Income				3,557	3,482	(75)	24,789	24,970	181	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. Drugs are £243k overspent year to date.
Divisional Income				301	411	110	2,269	2,436	168	3,862	3,862	0	
Pay	1,084.91	1,004.50	80.41	(3,428)	(3,162)	266	(23,762)	(22,422)	1,340	(40,793)	(40,793)	0	
Non-Pay				(1,045)	(1,142)	(97)	(7,605)	(7,708)	(103)	(13,074)	(13,074)	0	
Overall	**1,084.91**	**1,004.50**	**80.41**	**(614)**	**(411)**	**203**	**(4,309)**	**(2,723)**	**1,586**	**(7,454)**	**(7,454)**	**0**	
Women's, Children's & Sexual Health													
Contract Income				3,972	3,829	(142)	27,069	27,510	441	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. Pay overspends are largely due to locums cost to cover vacancies and sickness in Gynaecology. Non-pay overspends are due to Gynae OPD clinical supplies and glucose monitors as a result of increased activity levels.
Divisional Income				60	98	38	347	661	313	646	646	0	
Pay	717.67	694.02	23.65	(2,771)	(2,873)	(102)	(19,482)	(19,846)	(364)	(33,620)	(33,620)	0	
Non-Pay				(203)	(266)	(63)	(1,708)	(1,892)	(184)	(2,884)	(2,884)	0	
Overall	**717.67**	**694.02**	**23.65**	**1,057**	**789**	**(269)**	**6,226**	**6,432**	**206**	**11,164**	**11,164**	**0**	
Estates & Facilities													
Divisional Income				768	815	47	5,299	5,678	379	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. The non pay overspend in the month arises from laundry costs, which are offset in income over delivery.
Pay	724.79	695.15	29.64	(1,686)	(1,627)	59	(12,030)	(11,656)	374	(20,461)	(20,461)	0	
Non-Pay				(1,249)	(1,399)	(150)	(8,850)	(9,126)	(276)	(15,100)	(15,100)	0	
Overall	**724.79**	**695.15**	**29.64**	**(2,167)**	**(2,211)**	**(44)**	**(15,581)**	**(15,104)**	**477**	**(26,495)**	**(26,495)**	**0**	
Corporate													
Divisional Income				1,240	1,331	91	8,007	8,181	174	13,758	13,758	0	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. Non pay underspends are in Trust Board, and IT maintenance contracts.
Pay	963.84	915.86	47.98	(3,165)	(2,931)	234	(21,712)	(20,739)	972	(37,009)	(37,009)	0	
Non-Pay				(1,930)	(2,239)	(309)	(14,844)	(14,037)	807	(26,261)	(26,261)	0	
Overall	**963.84**	**915.86**	**47.98**	**(3,855)**	**(3,840)**	**15**	**(28,548)**	**(26,595)**	**1,953**	**(49,513)**	**(49,513)**	**0**	
Central													
Contract Income				1,779	2,765	986	18,575	20,857	2,283	33,401	33,401	0	Tariff exclusions income overperformance is offset entirely by non-pay overspends. 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				3,455	2,571	(884)	11,762	13,974	2,212	23,137	23,137	0	
Pay	0.00	0.08	(0.08)	1,142	29	(1,113)	3,974	(283)	(4,257)	8,781	8,781	0	
Non-Pay				(6,346)	(4,641)	1,705	(37,090)	(34,757)	2,334	(60,449)	(60,449)	0	
Overall	**0.00**	**0.08**	**(0.08)**	**31**	**725**	**694**	**(2,779)**	**(209)**	**2,571**	**4,869**	**4,869**	**0**	
Donated assets adjustment				**0**	**(12)**	**(12)**	**0**	**(1,356)**	**(1,356)**				
Total	**7,211.84**	**6,799.44**	**412.40**	**197**	**200**	**3**	**(11,350)**	**(11,311)**	**39**	**(10,125)**	**(10,125)**	**0**	

Statement of Financial Position - Month 7

	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	224.0	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	1.9	1.8	1.8	1.8		0.0
Non Current Assets	**227.3**	**233.1**	**228.0**	**233.1**	**233.1**	**233.1**		**0.0**
Inventories	6.8	6.7	6.2	6.7	6.7	6.7		0.0
Trade and Other Receivables	19.7	29.6	33.0	29.6	29.6	29.6		0.0
Cash and Cash Equivalents	2.1	2.1	9.1	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**	**48.3**	**38.5**	**38.5**	**38.5**		**0.0**
Trade and Other Payables	(23.2)	(7.3)	(32.7)	(7.3)	(7.3)	(7.3)		0.0
Borrowings	(59.2)	(1.1)	(1.7)	(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)	(0.3)	(0.4)	(0.4)	(0.4)		0.0
Other Liabilities	(1.3)	(2.2)	(4.2)	(2.2)	(2.2)	(2.2)		0.0
Current Liabilities	**(84.3)**	**(11.1)**	**(38.9)**	**(11.1)**	**(11.1)**	**(11.1)**		**0.0**
Borrowings	(143.6)	(242.4)	(219.3)	(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)	(241)	(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**	**16.0**	**15.9**	**15.9**	**16.0**		**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.

Cashflow & Borrowing Summary - Month 7

Short Term (13 week) Cashflow Forecast

	Actual (£k)				Forecast (£k)								
Week Ending (Friday)	04-Oct	11-Oct	18-Oct	25-Oct	01-Nov	08-Nov	15-Nov	22-Nov	29-Nov	06-Dec	13-Dec	20-Dec	27-Dec
Balance Brought Forward	11,701	10,103	7,937	24,597	11,450	9,597	8,471	36,715	11,043	9,378	6,066	36,170	24,973
Receipts													
WGA Income	619	80	30,808	41	432	106	29,275	700	152	152	30,362	152	152
Other Income	506	371	1,768	2,942	740	152	1,294	510	542	213	1,714	213	583
External Financing	0	0	2,047	0	0	3,200	2,087	0	0	0	0	2,164	0
Total Receipts	1,125	452	34,622	2,982	1,172	3,458	32,656	1,210	694	365	32,076	2,529	735
Payments													
Pay	(240)	(234)	(10,730)	(13,571)	(270)	(271)	(270)	(23,485)	(270)	(270)	(270)	(10,170)	(13,585)
Non-Pay	(2,468)	(2,383)	(3,564)	(2,548)	(2,753)	(4,313)	(4,142)	(3,090)	(2,090)	(3,406)	(1,702)	(3,094)	(2,590)
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	(15)	(0)	(3,668)	(11)	(2)	(0)	0	(306)	0	0	0	(462)	0
Total Payments	(2,723)	(2,617)	(17,962)	(16,129)	(3,025)	(4,584)	(4,412)	(26,882)	(2,360)	(3,676)	(1,972)	(13,726)	(16,175)
Net Cash Movement	(1,598)	(2,165)	16,660	(13,147)	(1,854)	(1,125)	28,243	(25,671)	(1,666)	(3,311)	30,104	(11,198)	(15,441)
Balance Carried Forward	10,103	7,937	24,597	11,450	9,597	8,471	36,715	11,043	9,378	6,066	36,170	24,973	9,532

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 Developmen	2,000	Dec 09	20	4.00%	1,167	41
Capital Loan 3 - Endoscopy Developmen	2,000	Jun 10	20	3.90%	1,200	42
Capital Loan 4 - Health Records	428	Mar 15	10	1.40%	300	4
Capital Loan 5 - Health Records	441	Mar 15	10	1.40%	309	4
Capital Loan 6 - Ambulatory Care	800	Feb 18	20	1.60%	800	12
Revolving Working Capital	31,300		5	3.50%	31,300	1,099
Interim Loan Agreement	35,218		3	1.50%	35,218	528
2016/17 Loans	23,144	Dec 16 - Mar 17	3	6.00%	21,300	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				200,743	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
Loan September 2019	2,160	Sep 19	3	3.50%	2,160	76
Loan October 2019	0					
Current Year Total	19,401				19,401	688
Total Loans	223,881				220,144	7,961

Summary & Next steps

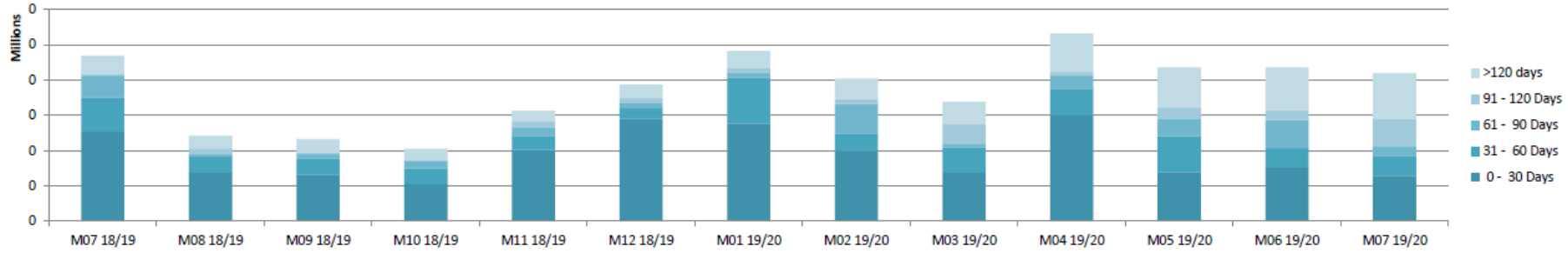
1. All existing loans are listed in the table on the left.

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.

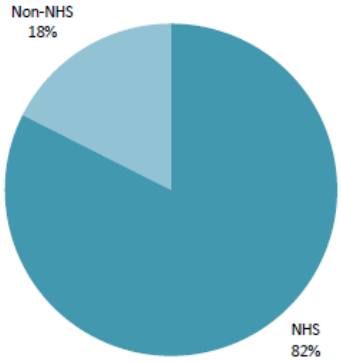
3. Confirmation has been received by DHSC that any loans due for repayment in Q4 have been extended by 6 months. There will be no change to existing T&Cs, interest will continue to be charged at the current rate for the duration of the extension.

Receivables Summary - Month 7

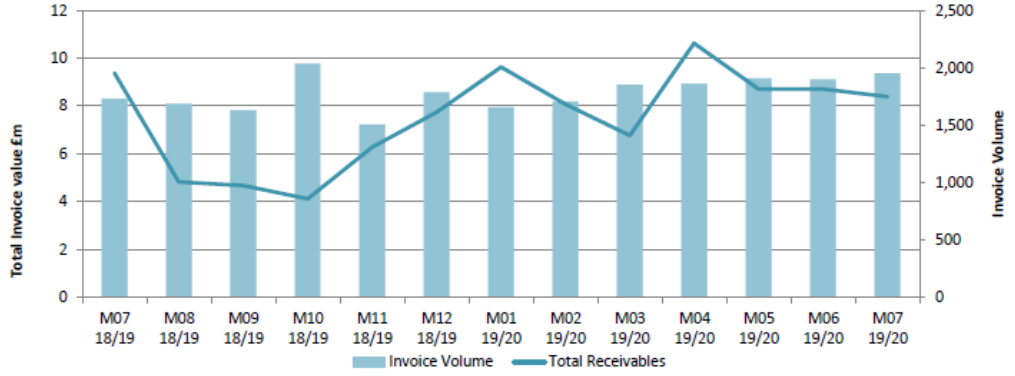
Receivables Aging Run rate (£k)													
Aging Profile	M07 18/19	M08 18/19	M09 18/19	M10 18/19	M11 18/19	M12 18/19	M01 19/20	M02 19/20	M03 19/20	M04 19/20	M05 19/20	M06 19/20	M07 19/20
0 - 30 Days	5,070	2,765	2,639	2,093	4,038	5,807	5,525	3,972	2,765	6,013	2,785	3,050	2,581
31 - 60 Days	1,918	894	910	896	786	600	2,602	1,005	1,418	1,501	2,027	1,097	1,129
61 - 90 Days	1,248	147	238	406	464	307	305	1,674	182	719	1,014	1,580	511
91 - 120 Days	131	321	101	101	352	251	270	279	1,118	211	637	537	1,578
>120 days	1,021	698	783	620	632	774	938	1,153	1,286	2,188	2,255	2,451	2,593
Total Receivables	9,389	4,825	4,670	4,116	6,272	7,739	9,639	8,083	6,768	10,632	8,717	8,715	8,393
Invoice Volume	1,732	1,688	1,632	2,037	1,508	1,788	1,655	1,705	1,852	1,862	1,911	1,899	1,952



Current Month % NHS vs Non-NHS by Value



Receivables Invoice Value vs Volume Run Rate

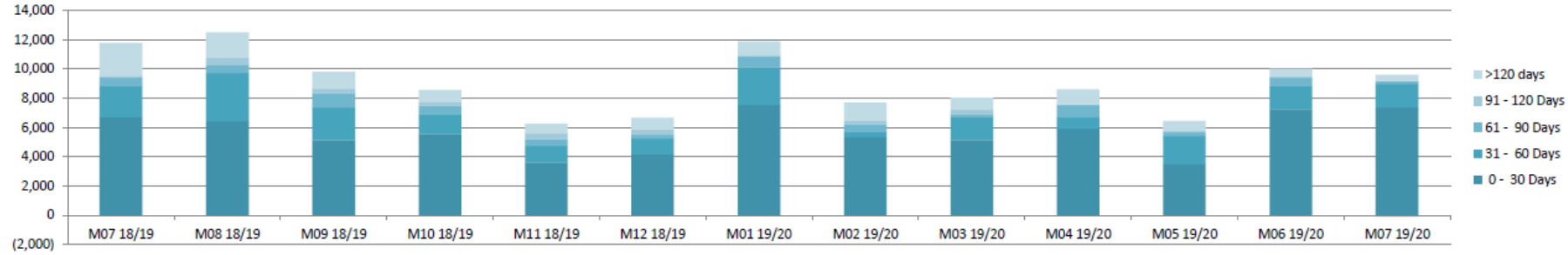


1. Reduction in receivables in month by £322k.
2. An adverse movement in total aged debt (> 31 days) by £147k in month.
3. Adverse movement in over 90 day debt of £1,183k in month.
4. Increase in debtor days in month by 3 days, 30 days in October (27 days in September).
5. 1,952 invoices on the sales ledger system at the end of the month (an increase of 53 in month).

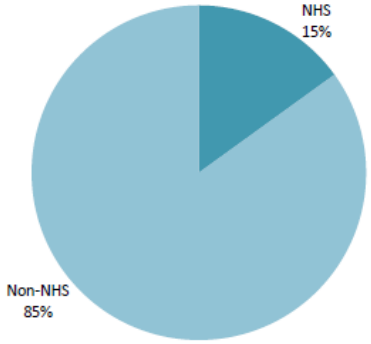
Payables Summary - Month 7

Payables Aging Run rate (£k)

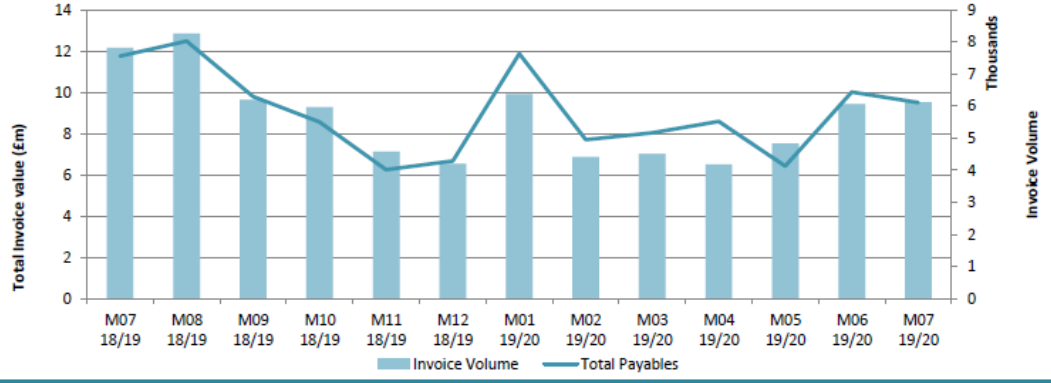
Aging Profile	M07 18/19	M08 18/19	M09 18/19	M10 18/19	M11 18/19	M12 18/19	M01 19/20	M02 19/20	M03 19/20	M04 19/20	M05 19/20	M06 19/20	M07 19/20
0 - 30 Days	6,708	6,410	5,109	5,530	3,611	4,151	7,517	5,324	5,133	5,927	3,476	7,249	7,370
31 - 60 Days	2,102	3,301	2,245	1,338	1,135	1,093	2,612	396	1,603	753	1,943	1,559	1,593
61 - 90 Days	599	600	986	629	442	253	735	494	133	842	241	595	213
91 - 120 Days	124	459	301	258	386	378	108	277	380	59	86	112	(87)
>120 days	2,233	1,725	1,169	806	675	801	909	1,217	788	1,020	681	510	427
Total Payables	**11,765**	**12,494**	**9,810**	**8,561**	**6,249**	**6,675**	**11,881**	**7,710**	**8,037**	**8,601**	**6,427**	**10,025**	**9,515**
Invoice Volume	**7,830**	**8,266**	**6,209**	**5,975**	**4,580**	**4,204**	**6,373**	**4,425**	**4,512**	**4,190**	**4,834**	**6,073**	**6,121**



Current Month % NHS vs Non-NHS by Value



Payables Invoice Value vs Volume Run Rate



1. A favourable movement in total creditors in month of £510k. Total creditors remains at £10m in October.
2. No change in creditor days in month (81 days in September).
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. 6,073 invoices on the purchase ledger system at the close of the month (increase of 1239 on August).

Capital Programme Summary - Month 7

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**	**5,604**	**3,740**	**5,725**	**3,404**	**(336)**
Backlog Maintenance	1,050	1,280	1,367	861	848	(519)
Central/Divisions	290	290	0	0	0	0
Digital	1,701	1,690	963	1,444	923	(40)
Estates	202	846	202	260	41	(161)
Medical Equipment	1,351	832	235	848	734	499
Finance	1,500	1,500	875	1,500	876	1
Unplanned urgents	339	396	105	177	79	(26)
Fire Compartmentalisation	0	4,550	0	500	0	0
Brought Forward - other	0	160	0	211	211	211
Total Owned	**13,148**	**17,148**	**7,487**	**11,526**	**7,116**	**(371)**
Donated	1,000	1,970	500	1,970	1,970	1,470
Less donated Income	(1,000)	(1,970)	(500)	(1,970)	(1,970)	(1,470)
Less disposal	0	(356)	(356)	0	(356)	0
Total	**13,148**	**16,792**	**7,487**	**11,526**	**6,760**	**(371)**

Capital Resource Limit	Source	£k
Opening Capital Resource Limit (CRL)		**17,148**
Forecast Capital Outturn		**17,148**
Closing Capital Resource Limit (CRL)		**17,148**
Variance		**0**

Summary & Next steps

1. The Capital Resource Limit (CRL) for 2019/20 has been revised at M6 to £17.1m following the Trust's successful application for £13.86m of emergency capital funding for fire compartmentalisation works over a 3 year period. £4.55m of capital will be received in 19/20.
2. The Capital Resource Group (CRG) meets on a monthly basis to monitor levels of capital expenditure and review progress against the CRL.
3. The forecast will remain £361k below plan due to the MRI loss on disposal and consequent CDEL impact.

Mortality Report – Learning from Deaths 1st April 2017 to 30th June 2019

Meeting information:			
Date of Meeting:	3rd December 2019	Agenda Item:	
Meeting:	Trust Board	Reporting Officer: David Walker	

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

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

Summary:

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

The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. The mortality database reflects the new review process and all plaudits and care concerns raised by family or carers of the deceased are recorded.
This report details the April 2017 – June 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.

The Regional Medical Examiner for England and Wales has now been appointed and has been in touch with us, so we are pushing ahead with local recruitment of medical examiners. 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 June 2019-20

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.

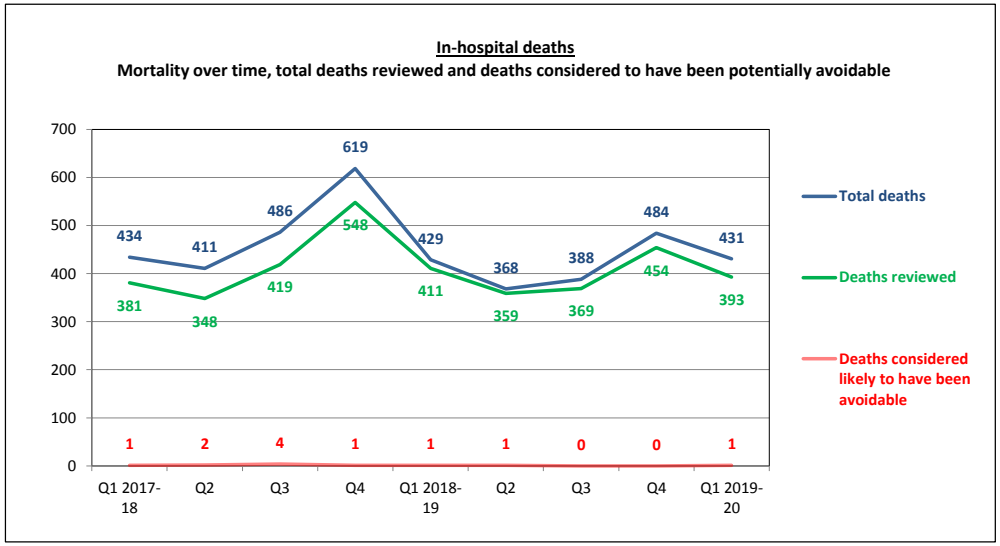
Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 08/11/2019)

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	2019-20	Q1

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
126	145	114	129	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
431	484	393	454	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
431	1669	393	1593	1	2



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	33.3%	This Quarter (QTD)	2	66.7%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	33.3%	This Year (YTD)	2	66.7%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%

Data above is as at 08/11/2019 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were no care concerns expressed to the Trust Bereavement team relating to Quarter 1 2019/20 deaths.
Complaints - Of the complaints closed during Quarter 1 2019/20 which were relating to 'bereavement', none have overall care ratings of 'poor' care on the mortality database.
Serious incidents - There was one severity 5 incident reported in Quarter 1 2019/20 which, after investigation, was downgraded to severity 3. This death was discussed at the Mortality Review Audit Group, where an avoidability rating of 4 - 'Possibly avoidable but not very likely' was agreed.
As at 08/11/2019 there are 368 April 2017 - June 2019 deaths still outstanding for review on the Mortality database.

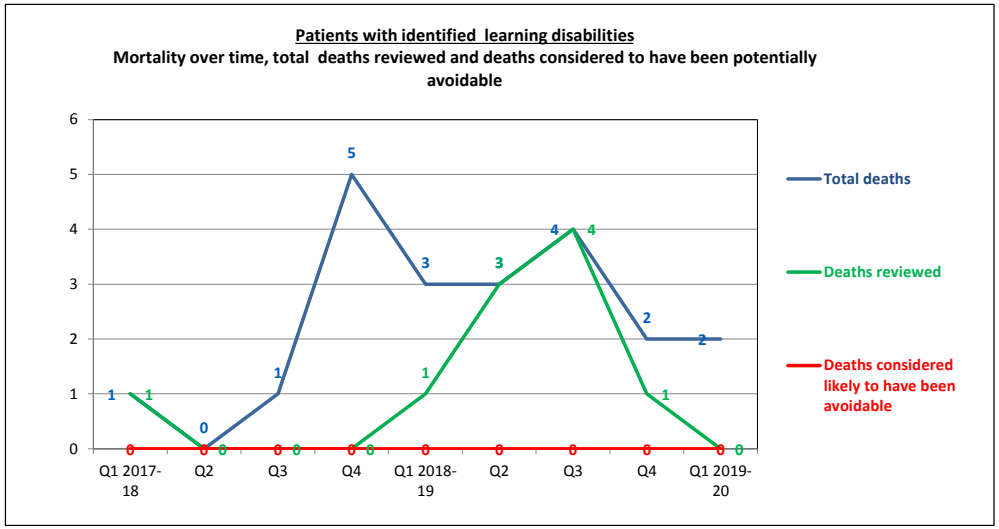
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 08/11/2019)

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	2019-20	Q1

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	2	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	12	0	9	0	0



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

East Sussex Place-Based Response to the Long Term Plan

Meeting information:			
Date of Meeting:	3rd December 2019	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Catherine Ashton

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

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

Summary:

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

The NHS Long Term Plan (LTP) issued earlier this year outlined a number of objectives for health and social care commissioners and providers to consider. Each STP area was required to develop a response to the LTP and within in this there are three placed based plans covering Western Sussex, Brighton and Hove and East Sussex.

The draft East Sussex Plan was submitted to NHSE/I on the 15th November

There is recognition by all system partners that there is still significant work required to strengthen and enhance the strategic plans and that they will then need to be translated into detailed operational delivery plans by the end of March 2020.

In particular the feedback on the draft plans suggests the need to:

- Further develop our understanding of the relationship between planning and service delivery at the neighbourhood, place and Sussex-wide levels
- Strengthen the role of primary and secondary prevention, including the narrative around Starting Well
- Strengthen the input from partners including Specialised Commissioning
- Further develop planning assumptions across the system
- Develop a clear delivery process for the strategy, including how we align, prioritise and make decisions

An integrated group chaired by commissioners which includes the Director of Strategy and is linked to the Directors of Finance group for East Sussex is now working on:

- Defining and/or updating projects, objectives, KPIs and benefits reflecting the programme priorities for 2020/21
- Feeding this into organisational operational and business planning processes for 2020/21
- Linking this with the work to develop financial modelling and assumptions at the Sussex-wide and East Sussex level, and the detailed plans for 2020/21 as they emerge
- Reviewing the integrated Outcomes Framework to ensure they reflect the LTP priorities

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

Finance and Investment Committee October 2019

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

Ratification of support for the draft submission, and agreement to review progress on delivery of the key priorities within the plan.

CQC Inspection Update Report

Meeting information:			
Date of Meeting:	3rd December 2018	Agenda Item:	11
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

Our Use of Resources review and core services inspection have now taken place on 2nd October and 5th, 6th and 7th November respectively. In addition the CQC held an engagement meeting on 15th and 16th October with a focus on Children and Young People and End of Life Care.

Following completion of the acute inspection on 6th November the CQC provided some informal feedback which was summarised in a letter received the following day.

Outpatient services (Conquest Hospital)

CQC commented positively on the:

- Management and maintenance of equipment
- Fracture clinic outreach services to hospice/care homes
- Visible leadership and staff engagement
- Delivery and management of the outpatient transformation programme

There were some concerns about the quality of the environment in the medical outpatients department.

End of life care services (acute/community)

They were complimentary about End of Life Care across both acute and community and noted the:

- Chaplaincy services provision
- Ease of referral and accessibility of the service
- Multiple very positive examples of a caring service with staff "going the extra mile" to meet individual needs
- Culture of EoLC permeating the whole organisation
- The implementation and management of advance care planning
- Collaborative and effective MDT working

Community adult services
Again very positive and highlighted

- The work of the frailty team
- Observed care was described as “wonderful”

Verbal feedback given on the 8th November highlighted the many examples of outstanding care and practice.

Children and young people’s services;
The CQC highlighted examples of caring behaviour and the effective medical cover and support to junior doctors. There were a number of emerging concerns for this service including:

- The management of records of competency in administering PGD’s
- Nursing staffing and its impact on the capacity of services
- Capacity of play specialist service
- Absence of seven-day availability of diagnostic services

The CQC will also be following up compliance with the operating model for emergency children’s services and the suitability of the A&E environment for children as part of their ongoing engagement activity.

We are considering any actions required to address the feedback and are also in the process of responding to requests for further information following the inspection.

We have received a timetable for the Well Led Inspection on 10th and 11th December and advised those being interviewed. We anticipate that we will receive the draft reports at the end of January 2020 for factual accuracy checking, with the final reports being published in February

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

Quality and Safety Committee 21st November 2019

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

The Board is asked to review and note the inspection update and feedback received.

Winter Flu Self-Assessment

Meeting information:	
Date of Meeting: 3rd December 2019	Agenda Item: 12
Meeting: Trust Board	Reporting Officer: Monica Green

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state: Public Health England			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Not necessary – outlined within the paper	

Summary:

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

1.1 Seasonal Influenza Campaign

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

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

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

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

1.2 ESHT Target for uptake by Frontline Health Care Workers

2017/18 – 70%
2018/19 – 75%
2019/20 – 80%

1.4 Evaluation and key points of learning from 2018/19Flu campaign:

Target to vaccinate 75% of front line staff – (3792 staff)

- Outreach approach – Flu walkabouts (out of hours), attending training, staff meetings and induction all increased uptake from front line staff.
- Use of Temporary Workforce Service Flu nurses during October to facilitate maximum opportunities for staff to access the Flu vaccine
- Feedback from anonymous decliners indicated that personal choice is the main reason for staff not having the vaccine – not believing that it is effective.
- Agreement from the board to keep a static denominator throughout the campaign. Audited at the end of the campaign. Found that the increase in the total number of front line staff from the beginning to the end of the campaign would not have impacted on the Trust reaching target but having to fluctuate the denominator month to month would have incurred significant administrative burden to the campaign.
- Clinical intelligence to target optimum times to catch front line staff
- Coordinating requests for Flu clinics and using a Flu bleep for on-site requests.
- Monthly Flu preparation meetings and weekly Flu calls from 1st October.
- Participation from stake holders across the Trust – shared responsibility for the Flu campaign.
- Workforce Intelligence data for IPRs to monitor & encourage uptake from front line workers
- Improved Communications – weekly message, high profile clinical staff promoting the vaccine, selfie-frames, social media – Twitter
- Engagement from senior clinical leaders from the outset
- Time taken to personally thank everyone involved in the 2018/19 Flu campaign via a letter from CEO.

Frontline staff % uptake since 2016

Staff Group	% uptake in 2016/17	% uptake in 2017/18	% uptake in 2018/19	% uptake as of 12.11.19
All Doctors	39%	62%	63%	58%
Qualified Nurses, midwives and health visitors	36%	60%	64%	47%
All other professionally qualified clinical staff, which comprises of:- (Qualified scientific, therapeutic and technical staff, Qualified allied health professionals, other qualified ST&T and qualified ambulance staff)	70%	95%	90%	90%
Support to clinical staff, which comprises of:- Support to doctors and nurses, Support to ST&T staff, Support to ambulance staff.	81%	81%	90%	63%
Total	53%	72%	76%	59%

1.5 Plan for 2019/20

Target to vaccinate 80% of front line staff – (4132 staff)

- Early evaluation and planning of the Flu campaign
- Continued participation from stake holders across the Trust – responsibility for success of the Flu campaign is Trust wide
- Build on and extend outreach approach
- Dedicated TWS Flu team responsible for recruitment, training and support for peer vaccinators – started in August and continuing throughout the campaign
- Request to all Heads of Nursing to nominate at least two peer vaccinators per area – frequently feeding back to Professional Advisory Group, areas with no peer vaccinators
- Request that all Infection Control Link nurses be peer vaccinators – feeding back to Infection Control Lead if sign up is low.
- Creation of a Flu Enquiry dedicated email to better field and respond to flu requests.
- Extending the coordination of requests for Flu clinics by front line staff – training, meetings etc
- Continued agreement to keep a static denominator throughout the campaign but will be audited again at the end to determine if this would have impacted on the final uptake figure.
- Targeting groups where the greatest increase in uptake is required – ie Doctors, qualified Nurses, Midwives and Health Visitors.

- Email to all patient facing staff aged over 65yrs to have the Trivalent flu vaccine.
- Continue to collect anonymised data from those who decline the vaccine.
- Continued engagement with senior clinical staff in promotion of the Flu campaign
- Continuing to expand on the use of social media – in particular Twitter
- Make research available to staff supporting the efficacy of the vaccine and the accumulative benefit to immunity of having the vaccine every year.
- Early agreement with Workforce information on the frequency and range of workforce intelligence available in terms of vaccine uptake for divisional IPRs
- Plans to identify areas of low uptake after the first reporting date in order to target efforts.
- Ensure recognition of all staff involved in delivery of the campaign is completed in March/April 2020.

1.6 Risks to success of the campaign

- Workload demands on existing front line staff to take on or fully deliver the peer vaccinator role.
- National delays and staggered delivery of the Flu vaccine has disrupted flow and momentum of the campaign.

2. DECISIONS AND AGREEMENT REQUIRED BY THE TRUST BOARD

- Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine, will be given the option to anonymously mark their reason for doing so.

- Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt.

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

Flu Team – monthly since May 2019
Infection Prevention and Control – Helen Tingley & Lisa Redmond – ongoing
HSSG – ongoing
CQUIN lead – Kevin Burns and Liz Lipsham – monthly since May 2019
OD & Engagement – Lorraine Mason – on agenda from October 2019

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

- Acknowledgement of the risks to achieving the 80% front line target for 2019/20

- Agreement to the planned approach to the Flu campaign 2019/20

Appendix 1 – Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine will be given the option to anonymously mark their reason for doing so.	**Yes – process established for anonymous decliners**
A2	Trust has ordered and provided the Quadrivalent (QIV) flu vaccine for healthcare workers and Trivalent flu vaccine for staff aged over 65yrs	**Yes**
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	**Yes attached**
A4	Agree on a board champion for flu campaign	**Yes – Monica Green**
A5	All board members receive flu vaccination and publicise this	**Flu nurse to attend Board meeting to offer the vaccine**
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	**Yes – linking with JSC**
A7	Flu team to meet regularly from September 2019	**Yes – preparation meetings since May**
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	**Yes – Simon Purkiss leading**
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	**Yes**
B3	Board and senior managers having their vaccinations to be publicised	**Yes – Simon Purkiss leading**
B4	Flu vaccination programme and access to vaccination on induction programmes	**Yes – included in Staff Engagement section and vaccines to be offered during induction**

B5	Programme to be publicised on screensavers, posters and social media	**Yes – Simon Purkiss leading**
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	**No – monthly feedback only possible – not feasible to provide a weekly update due to the volume of data to be entered**
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	**Yes – continuing to recruit in all areas. Improved training and support for 2019/20**
C2	Schedule for easy access drop in clinics agreed	**No – previous learning has shown that an outreach approach to the campaign is more successful in reaching front line staff. Drop-in clinics will be offered to non- front line staff later in the campaign.**
C3	Schedule for 24 hour mobile vaccinations to be agreed	**No – though vaccine will be made available out of hours to night staff and at weekends.**

		Previous learning has identified the optimum time to reach staff working out of hours therefore 24 hour access is not required.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	**Yes – Simon Purkiss leading**
D2	Success to be celebrated weekly	**Yes – weekly update in Comms**

Equality Delivery System (EDS2) 2018/19

Meeting information:	
Date of Meeting	Agenda Item:
Meeting: Trust Board	Reporting Officer: Kim Novis

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 Equality Delivery System (EDS2) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a toolkit that assists NHS organisations in improving their services, both as service providers to their local communities, and also as employers. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

Based on this evaluation and subsequent engagement with the NHS and key stakeholders, a refreshed EDS – known as EDS2 – was made available in November 201 and 2017/18's EDS2 report is attached.

EDS2 comprises four goals that lead to 18 outcomes, supporting the Trust in meeting its statutory obligations. The four goals are:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

This report highlights the progress on the outcomes of EDS2 with actions. EDS2 goals 3 and 4 are addressed in detail within other relevant reports (eg Workforce Race and Disability Equality Standards, Workforce data reports).

A further report on each of the outcomes will be produced in April 2020 along with the 2020 – 2024 Equality Objectives.

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

Quality & Safety Committee 21st November 2019

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

The Board is asked to receive assurance that the Trust is meeting its obligations under the Public Sector Equality Duty.

Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation

Meeting information:			
Date of Meeting:	3rd December 2018	Agenda Item:	14
Meeting:	Trust Board	Reporting Officer:	Jonathan Reid/Lynette Wells

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

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

Summary:

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

An annual review of the Standing Orders, Standing Financial Instructions and Scheme of Delegation has been performed and proposed revisions are outlined in the attached paper.

Full versions of the updated Standing Financial Instructions and Scheme of Delegation can be found in the Appendices to the Board paper if required.

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

Audit Committee 28th November 2019

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

The Board is asked to accept the Audit Committee recommendation to approve the proposed changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Annual Review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation

Introduction

The Trust Board is required to review the Standing Orders, Standing Financial Instructions and the Scheme of Delegation on an annual basis. The Audit Committee reviews and makes recommendation to the Board. The documents reviewed are:

- **Standing Orders**: cover all aspects of the conduct of the Trust, including governance, committees and their duties and responsibilities.
- **Standing Financial Instructions**: detail the financial conduct and governance of the Trust and requirements therein.
- **Scheme of Delegation**: lays down in detail the specifics of committee responsibilities and duties together with that of the executive and the officers to which delegated authority has been designated.

The review is carried out jointly by the Director of Finance and Director of Corporate Affairs.

The changes proposed are to the Standing Orders, Standing Financial Instructions and the Scheme of Delegation are detailed below.

Standing Orders

Page Number and Reference	Detail	Replaced with
P5 Introduction	Removed reference to the Trust operating community hospitals at Lewes and Crowborough	-

Standing Financial Instructions

Page Number and Reference	Detail	Replaced with
Page 7: 1.2.1 (h)	Removal of reference to NHS Act 1977	National Health Service Act 2006 and the Health and Social Care Act 2012
Page 42: 10.3	Removal of reference to NHS Act 1977	National Health Service Act 2006
Various	Department of Health	Department of Health and Social Care

Scheme of Delegation

No changes are proposed.

Quality Walks September - October 2019

Meeting information:			
Date of Meeting:	3rd December 2019	Agenda Item:	15
Meeting:	Trust Board	Reporting Officer:	Steve Phoenix, Chairman

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

32 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st September and 31st October 2019. In addition to the formal programme the Chief Executive has also visited 20 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 SEPTEMBER - OCTOBER 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 September and 31st October 2019.

Date	Service/Ward/Department	Site	Visit by
September			
2.9.19	Clinical Admin Team	Bexhill Hospital	Nicola Webber
2.9.19	Estates Department	Eastbourne	Vikki Carruth
2.9.19	Bladder and Bowel Team	Bexhill Hospital	Nicola Webber
5.9.19	Speech and Language Therapists	Bexhill Hospital	Karen Manson
10.9.19	Health Visitors	Peacehaven	Karen Manson
11.9.19	Health Visitors	Hastings	Karen Manson
16.9.19	Tressell Ward	Conquest	Vikki Carruth
16.9.19	Berwick ward	Eastbourne	Lynette Wells
16.9.19	Westham Ward	Eastbourne	Jonathan Reid
16.9.19	Out Patient Department	Conquest	Adrian Bull
16.9.19	Chaplaincy Team	Conquest	Adrian Bull
17.9.19	Finance Team	St Annes House	Karen Manson
17.9.19	Health Records	Eastbourne	Steve Phoenix
18.9.19	Health Visitors	Eastbourne	Miranda Kavanagh
18.9.19	Switchboard	Conquest	Lynette Wells
19.9.19	Chaplaincy	Conquest	Jackie Churchward-Cardiff
18.9.19	Pharmacy communication Meeting	Eastbourne	Adrian Bull
23.9.19	Site Team	Conquest	Adrian Bull
24.9.19	Junior Doctors Forum	Eastbourne	Adrian Bull
25.9.19	Palliative Care Team	Bexhill	Adrian Bull
25.9.19	Reception	Eastbourne	Nicola Webber
26.9.19	Egerton Ward	Conquest	Steve Phoenix
26.9.19	Vascular Access Team	Conquest	Jackie Churchward-Cardiff
October			
1.10.19	Theatres	EDGH	Jackie Churchward-Cardiff
3.10.19	Podiatry Governance Team Meeting	Avenue House	Adrian Bull
3.10.19	District Nursing Team	Station Plaza, Hastings	Karen Manson
3.10.19	Request for Information team	Eastbourne	Adrian Bull
04.10.19	Occupational Therapy	Bexhill	Adrian Bull
4.10.19	Irvine Unit	Bexhill Hospital	Adrian Bull
7.10.19	Fracture Clinic	Eastbourne	Adrian Bull
9.10.19	Hydrotherapy	Eastbourne	Adrian Bull
10.10.19	Uckfield Physiotherapy Team	Uckfield	Adrian Bull
11.10.19	Health Visiting Service SMT Meeting	Hailsham	Adrian Bull
16.10.19	Pharmacy communication Meeting	Conquest	Adrian Bull
17.10.19	Health Records	Conquest	Lynette Wells
17.10.19	Friston Ward	Eastbourne	David Walker
17.10.19	Fracture Clinic	Eastbourne	Catherine Ashton

22.10.19	Community Midwifery	Hastings	Karen Manson
22.10.19	Radiology	Conquest	Adrian Bull
24.10.19	Baird Ward	Conquest	Jackie Churchward-Cardiff
24.10.19	Chaplaincy Team	Eastbourne	Steve Phoenix
29.10.19	Mirlees Ward	Conquest	Catherine Ashton
29.10.19	Endoscopy Department	Conquest	Steve Phoenix
29.10.19	Organisational Development and Engagement team	Eastbourne	Karen Manson
29.10.19	Reception & Health Records	Bexhill	Adrian Bull
29.10.19	Site Team	Eastbourne	Monica Green
29.10.19	Diabetes and Endocrinology Dept.	Conquest	Jonathan Reid
29.10.19	Surgical Assessment Unit)	Conquest	Jonathan Reid
30.10.19	Women's and Children's Service	Eastbourne	Adrian Bull
31.10.19	Reception & Health Records	Eastbourne	Adrian Bull
31.10.19	Radiology	Eastbourne	Adrian Bull
31.10.19	Pharmacy	Eastbourne	Jackie Churchward-Cardiff

Minutes of a meeting of the

AUDIT COMMITTEE

held on Thursday 1st August at 1pm in St Mary's Boardroom, EDGH

Present: Mrs Nicola Webber, Non-Executive Director (Chair)
Ms Carys Williams, Associate Non-Executive Director

In attendance: Mr Jonathan Reid, Director of Finance
Mrs Lynette Wells, Director of Corporate Affairs
Dr James Wilkinson, Associate Medical Director
Mr Chris Lovegrove, Counter Fraud Manager, TiAA
Mr Adrian Mills, Senior Audit Manager, TiAA
Mr Giles Parratt, Audit Manager, TiAA
Mr Darren Wells, Engagement Lead, Grant Thornton
Mrs Imelda Donellan (item 048/19)

Ms Michelle Elphick, Associate Director DAS Division (item 044/19)
Mr Tim Leakey, Governance Lead DAS Division (item 044/19)
Mrs Liz Still, Head of Research (item 051/19)
Ms Nicola James, Clinical Effectiveness Facilitator (item 045/19)
Ms Lesley Houston, Deputy General Manager Medicine (item 045/19)

Action

041/19 Welcome and Apologies for Absence

Mrs Webber opened the meeting and it was noted that the meeting was quorate. Apologies for absence were received from:

Dr Adrian Bull, Chief Executive
Dr David Walker, Medical Director
Ms Vikki Carruth, Director of Nursing
Mr Barry Nealon, Non-Executive Director
Ms Saba Sadiq, Deputy Director of Finance
Mrs Emma Moore, Clinical Effectiveness Lead

042/19 Minutes

Minutes of the meeting held on 24th May2019 considered it was noted that Chris Lovegrove was not in attendance and this would be amended. There being no further revisions the minutes were agreed as an accurate record.

043/19 Matters Arising

The action log was reviewed. Mr Reid advised a trajectory for waivers would be brought to the next meeting.

Pharmacy write offs were high but Mr Reid confirmed he was confident the team had robust controls in place. The hot weather would impact write-offs

as the temperature affected durability of medicines due to the adequacy of storage and fridges.

It was noted that all other matters arising had been discharged or would be presented to a future meeting of the Committee.

044/19 Diagnostics, Anaesthetics and Surgery (DAS) Clinical Audit and Risk Register

Ms Elphick and Mr Leakey joined the meeting and provided an overview of the DAS division's clinical audit and risk register. Mrs Webber commented that the covering summary did not provide sufficient assurance in respect of mitigating actions even though it alluded to this. Verbal assurance was provided by the divisional representatives.

DAS Clinical Audit

A robust governance framework had been developed to ensure that the Division's clinical effectiveness and audits had been updated and regularly reviewed to ensure compliance and assurance. All new audits had to be agreed at the DAS Governance meeting before being submitted to the Clinical Effectiveness Lead. This ensured there was a substantive senior lead in place that would be accountable for each Audit/QIP and ensure that it was fully completed in a timely manner Any specialty with outstanding audits for a period of time was not permitted to commence any further audits/QIPs unless they were nationally mandated.

The division was participating in 20 national audits and good progress was being made. A process was in place for following up actions for completed clinical audits.

The Committee noted the improved performance in clinical audit by the division.

DAS Risk Register

There were 32 open risks on the DAS Risk Register and effective governance processes were in place to mitigate and control the risks. Two risks were scored 20:

- Insufficient Intensive Care Medicine Consultant Staff to deliver a 7 day Consultant led service to both acute sites. It was noted that funding was in place but there were difficulties recruiting as there was a national shortage of intensivists; this could impact the future sustainability of the ITU service. MEDACs was supporting with attracting candidates.

- Diabetic Eye Screening IT performance and server issues. The existing software was not compatible and this was a historic issue and a solution was being sought. This was being monitored at both

divisional level and at the DAS division monthly Integrated Performance Meeting which was chaired by the CEO.

Eight risks were rated 16 and these were detailed in the report. It was noted that all risks were discussed at the Senior Leaders Forum and at the Divisional IPR meeting.

The Committee thanked the Division for attending and providing the update.

045/19 Clinical Audit

Dr Wilkinson provided an overview of Trust wide clinical audit to the meeting. He advised that consideration was being given to merging the Clinical Effectiveness and the Clinical Outcomes Groups as there was a significant amount of overlap and it would be more efficient as the same people were being called to attend two Committees.

Clinical Audit Update

Of concern was that a number of national clinical audits were behind completion as they required intensive resources to complete the audits. This was particularly salient for the Diabetes and Respiratory mandated national audits. A monthly data submission tracker had been developed by the Clinical Effectiveness team to monitor progress and they were supporting where possible.

A discussion took place regarding the benefits of the national audits and whether additional resources were required to support clinicians in completing audits. Mr Reid suggested that support from quality improvement be further explored but it was felt this was not within their remit.

A position statement was requested from CEG to identify the specific gaps and possible solutions for the next meeting. Consideration should also be given to assessing non-compliance with national audits for inclusion on the risk register. **JW/EM**

National Diabetes Audit

Mrs Houston joined the meeting to discuss the national diabetes audit and annual submission. A partial submission had been submitted for the current year. There were three areas being evaluated to enable full compliance:

- The investment in software and specifically what other systems Trusts were using and ensuring the solution would interface with the integrated diabetes systems.
- The clinical lead was piloting a form on Evolve and this could be an option for recording the data.
- Identifying an individual to input all the data.

The recommendation would feed into the overall review of national audits.

Clinical Audit Annual Report

The Trust's clinical audit activity remained robust in 2018-2019 and clinical divisions actively engaged with clinical audit activity. It was noted that attendance by Divisional teams at the Clinical Effectiveness Group had remained challenging in the face of clinical pressures. The Clinical Effectiveness team continued to work closely with the Divisions in both tracking and supporting their audit activity.

There had been focus on the mandatory (Priority 1) national audits. These had increased in number year on year and despite the challenges highlighted in these minutes, participation in them had been good. The number of audits planned, but then abandoned before completion, had reduced from previous years following a strengthening of the controls on agreeing non-mandatory internal audits. There was an excellent field of strong applications for the Trust Audit Awards and the finalists' presentations and awards were well attended.

046/19 Board Assurance Framework and High Level Risk Register

Mrs Wells presented the Trust's Risk Register and Board Assurance Framework (BAF). She reported that there were 42 risks on the register, five of which were rated at 20. There were none were rated above 20.

Three new risks had been opened, all scored 16, these were in respect of limited bed capacity in critical care on both acute sites, GP awareness of patient's RESPECT wishes and delivery of the 19/20 financial plan.

Mrs Webber asked if bed capacity issues in critical care were due to increased admissions to the Unit and Mr Reid and Dr Wilkinson advised it was a combination of this and the need for available ward beds to move patients out of critical care within a set timescale.

The BAF was in the revised format which had been agreed at the Board seminar and addressed internal audit recommendations. It was a work in progress and further assurances were still to be added. There were no additions or proposals to remove items from the BAF. The Committee endorsed the revised BAF format.

047/19 Internal Audit

Audits

Mr Mills provided a summary of Internal Audit work completed at the Trust as at 18th July 2019. Nine final reports had been issued since the previous meeting. Two gave "Substantial" assurance, four gave "Reasonable" assurance, two gave "Limited" assurance and one was an advisory review without opinion. One further draft report had been issued with

"Reasonable" assurance.

The Waiting List audit was expected to receive Limited Assurance; management had requested an external view as they had concerns. End of Life Care had improved particularly in respect of governance and management however, received Limited Assurance as the Trust was not recording appropriately. Mr Reid provided an overview of the improvements in End of Life Care noting a strategy and plan was in place. A re-audit to test in greater detail was going to be requested. Link nurse audits were also taking placing. The Committee requested feedback at a future meeting. **VC**

The 2018/19 plan was discussed and it was noted that two 2018/19 reviews remained, one was at reporting stage and the other was in progress. Mr Parratt advised the Cost Improvement audit would be issued soon.

2019/20 Audit Plan

The 2019/20 Audit Plan was discussed and some minor revisions endorsed including replacing the planned Contracting Financial Governance audit with and Emergency Planning and Resilience audit. There were no concerns from auditors about areas removed from the plan and Mr Mills advised it covered core areas and items with significant risk. Those areas with limited assurance such as delayed transfers of care data were not scheduled to be re-audited. Mr Reid advised that in most cases of limited assurance management had requested internal audit conduct the review to support improvement and actions were then implemented. Mrs Webber proposed that those audits with limited assurance should be re-audited whether internally or through internal audit and this would be reviewed.

The Committee agreed the Audit Plan.

Recommendations Tracker

Mr Mills provided an overview of the status of internal audit recommendations monitored on TIAA's Client Portal system as at 18th July 2019. The Committee approved the closure of 41 recommendations and noted the progress on completion of other actions - 15 recommendations were due and 9 were not yet due. Mr Reid advised that there was a plan to resolve outstanding actions.

Mr Mills advised that Jo Lambourne had left audit and had joined the Trust in the Project Support Office. The Committee formally recorded their thanks to Mrs Lambourne.

048/19 Local Counter Fraud Service Progress Report

Mr Lovegrove advised that there were 2 new referrals that warranted further enquiries.

Fraud Awareness Presentations continued to be carried out at Trust Induction every two week and additional fraud awareness had also been delivered to a number of services between March and June 2019.

The 2018/19 National Fraud Initiative (NFI) had been issued and the high risk matches checked with no further action required from Counter Fraud.

The NHS Counter Fraud Authority had issued the first phase of a procurement exercise. It was noted that this was not mandatory and the Trust could choose whether to take part. Mr Reid advised the Trust would only be participating in the aspects that were of value to the organisation. It was noted that the Trust scored an overall Green in the Self Review Tool and this was submitted by the deadline

The latest Fraud Check had been issued to the Trust which highlighted the continuing risks of Mandate Fraud. A proactive review would be carried out later in the year.

049/19 External Audit

Mr Wells provided an overview of external audit matters.

Annual Audit Letter

The Committee received the annual audit letter which summarised the key findings arising from the work carried out at the Trust for the year ended 31 March 2019. Auditors gave an unqualified opinion on the Trust's financial statements on 28 May 2019. A going concern material uncertainty paragraph was included in the report on the Trust's financial statements to draw attention to the note which explained the basis on which the Trust has determined that it was still a going concern. This did not affect the audit opinion that the statements gave a true and fair view of the Trust's financial position and income and expenditure for the year.

Mrs Webber requested a revision to the value for money conclusion "demand for elective and emergency health care in the region had increased as expected". The growth was actually significantly more than anticipated and it was proposed and agreed that this would be clarified.

DW

Quality Account External Audit Report

It was noted that a qualified opinion had been issued on the Quality Account for 2018/19. Testing carried out by Internal Audit on the Venous Thromboembolism (VTE) found exceptions in two cases which affected the calculation of the indicator. Overall impact was neutral as one assessment had been incorrectly included and one incorrectly excluded from the numerator, but based on the sample size tested if this was extrapolated to the remaining population it could affect the overall indicator rate. It was

concluded that this affected compliance with the six dimensions of data quality set out in the guidance. This was an issue in previous audits and the action was reiterated. Mr Mills advised that a paper based system was always open to human error. The Committee asked whether there was an opportunity to automate this system and this would be explored. Mr Reid advised that data quality was being reviewed as part of the IPR and risks were being mapped and a framework was being developed. Feedback from the review would be presented to the Committee when completed. **JR**

050/19 Information Governance

Mrs Wells advised that the 2019/20 version of the Data Security Protection Toolkit (DSPT) had been released with the number of requirements increasing from 149 to 179; 86% of these were either rephrased or new and only 25 remain unaltered from 2018/19.

There had been nine instances of potential inappropriate access to systems found during routine Data Protection Officer audits and these had been passed to Human Resources for further investigation. JR/LW would discuss further whether there needed to be a wider audit and risk stratification and report back to the next meeting. IG training was discussed and this would also be included in the next report. **JR/LW**

29 information governance incidents had been reported (against 18 reported for the same period in 2018/19). It was noted the Trust does not have any incidents under investigation by the Information Commissioner's Office (ICO).

Information Governance Annual Report

Mrs Wells provided an overview of the Information Governance Annual Report. It had been another busy year with GDPR coming in to force in May 2018 and a new Data Security Protection Toolkit (DSPT) was introduced. The toolkit was submitted within time with all standards being met. Tiaa carried out an audit against the toolkit and gave a conclusion of 'reasonable assurance'.

During 2018/19 a total of 124 IG related incidents were reported on Datix; 124 were classified as severity level 1; 1 at level 2 and; 1 at level 3. Three incidents were reported via the DSPT website, but none reached the threshold for onward reporting to the Information Commissioner.

Mrs Wells formally thanked the IG team; they were a very small team who achieved a significant amount.

051/19 Research

Mrs Still presented the Trust's Research Annual Report. She highlighted that her team had moved into the Strategy Improvement and Planning (SIP) department in January 2019 and reported to the Trust Board through the Director for SIP. There was now a process for the research team to

report at the monthly SIP Integrated Performance meeting which was chaired by the CEO. The team were congratulated on winning two awards.

The 2019/20 Performance was on track to exceed pledges with 394 recruits against a target of 476. Studies were being supported in Oncology, Cardiology, Rheumatology, Physiotherapy, Podiatry, Paediatrics, Urology, Urogynae, Gastroenterology, Neurology, Anaesthetics, Critical Care, Orthopaedic surgery and Sexual Health. There were 58 studies open across the Trust with a further 24 in long term follow up. However, due to long term sickness in the team it was difficult to support requests for new areas of research.

Mrs Still highlighted that research terms of reference had been redrafted and advised research governance had changed, approvals were not required for each site but capacity and capability had to be confirmed. Discussion took place as to the appropriate forum for Research to report in to whether it was Audit or Quality and Safety. Mrs Still would discuss with the Director of Strategy and the Committee Chair would also consider this. **NW**

052/19 Tenders and Waivers

The Committee considered the single tender waivers authorised between 1st March and 30th June 2019. A total of 76 waivers with a cumulative value of £4.47m were approved during the period. Mrs Webber thanked Mr Reid and the team for the revised format of the report and assurance provided.

053/19 Review of Losses and Special Payments

A paper was received on the losses and special payments for the period April to June 2019. There were a total of 20 with a value of £35k; payments predominantly related to pharmacy stock write offs.

054/19 Annual Review of Terms of Reference and Work Programme

The Committee reviewed the Terms of Reference and would consider whether it should be mandated to have a NED representative from the Quality and Safety committee on Audit. It was considered beneficial to have the Medical Director/Director of Nursing or their nominated deputy in attendance. Consideration would also be given to where Research and Clinical Audit should report.

The Work Programme would also be reviewed by the Audit Chair, Director of Finance and Director of Corporate Affairs. It was agreed that papers needed to be succinct and front cover needs to be clearer. **NW/LW/JR**

A private meeting between auditors and the NEDs would be scheduled. **PP**

055/19 Date of Next Meeting

26th September at 1300 in the Committee Room, Conquest Hospital

Signed: ……..

Date: ……

Trust Board Meetings in Public 2020

4th February	0930 - 1230	Hastings Centre, Hastings
7th April	0930 - 1230	St Mark's Church, Bexhill
2nd June	0930 - 1230	St Mary's Boardroom, Eastbourne
7th July	1300 – 1700	AGM, St Mark's Church, Bexhill
4th August	0930 - 1230	Hastings Centre, Hastings
6th October	0930 - 1230	St Mark's Church, Bexhill
1st December	0930 - 1230	St Mary's Boardroom, Eastbourne

Use of Trust Seal

Meeting information:			
Date of Meeting:	3rd December 2019	Agenda Item:	18
Meeting:	Trust Board	Reporting Officer:	Chair

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

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

Summary:

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

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

21st November 2019 – Agreement for provision of homecare medicine services with Alcura UK Limited for a period of two years.

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

Not applicable.

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

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

Sussex
Health and Care Partnership

East Sussex Place-Based Response to the Long Term Plan

East Sussex Health and Social Care Plan

13 November 2019

Draft v6.2

East Sussex County Council

NHS

Table of Contents

Appendices

Executive Summary

Welcome to our East Sussex Health and Social Care Plan. The plan has been produced by the East Sussex Clinical Commissioning Groups[1], East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT), Sussex Community NHS Foundation Trust (SCFT), and Sussex Partnership NHS Foundation Trust (SPFT). We are a partnership of organisations working together to deliver health and social care in East Sussex. By breaking down barriers between health and social care, improving the health and wellbeing of local people, and reducing health inequalities we will deliver the right care and support, at the right time and in the right place for the people we serve.

Working with partners in primary care networks, district and borough councils, the voluntary and community sector and others, the plan sets out our longer term ambitions for our health and social care system in East Sussex, how we anticipate delivering this, and the work we will need to do collectively as a health and care system in the next year to improve the health and care of local people.

With advances in medicine and treatment, changing health and care needs, and new developments influencing wider society, we have to continually move forward so that in 10 years' time we have a health and care system that is fit for the future. In East Sussex the NHS and county council have been working closely together over recent years, alongside wider partners, to improve population health and wellbeing and reduce health inequalities, by breaking down barriers between health and social care to deliver the right services, in the right places, at the right time.

Thanks to this work we're seeing more treatment, care and support being delivered where people want it – in their own homes or locally in their community, by teams of GPs, nurses, therapists, social workers and proactive care practitioners from both the NHS and social care. This shift in the way we provide health and care means that many people are avoiding hospital altogether. And when they do need planned or urgent hospital care they're able to see clinicians and receive treatment more quickly and spend fewer unnecessary days in hospital, with better support when they go home. Here is a snapshot of some of our progress so far below:

- We have introduced the **award-winning i-Rock** services for young people in East Sussex (across Eastbourne, Hastings and Newhaven) who need help with mental health, wellbeing, housing, employment, education.
- We have trained local people to have over 5,000 'cancer conversations' with their fellow residents in Hastings and Bexhill, **to raise awareness of the signs and symptoms of cancer**, improve early diagnosis and help to save lives.
- We have introduced **Health and Social Care Connect** (HSCC) which is a fully integrated central point for health and adult social care enquiries, now available 24/7 for 365 days a year. This service helps people who are having difficulty taking care of themselves. The integrated service is able to arrange the immediate health attention required, as well as looking at home-based support that might be needed in the future.
- On-going development of **community health and social care services and initiatives**, including integrated health and social care teams, crisis response and proactive care, the Dementia Support Service; and the Joint Community Reablement Service and falls prevention services
- More information can be found on our Health and Social Care News website.

Building on these successes, this plan describes how we aim to further strengthen our work across the county through our East Sussex health and care programme to meet the needs of our population, including how we respond to our areas of deprivation and the significant older population that often have multiple-complex needs. By working in this joined-up way, we believe we're able to serve the whole of East Sussex even more effectively.

[1] Eastbourne, Hailsham and Seaford CCG; Hastings and Rother CCG; and High Weald Lewes Havens CCG

Our population

East Sussex has a population of approximately 555,000. Whilst it is well-known that it has amongst the highest proportions of over 65-year olds and over 85-year olds in the country, there are a range of other characteristics that are particular to East Sussex, as summarised below:

- Demand for health and social care will continue to increase, both as a result of the growth in the proportion of older people in the population and the complexity of their needs with increasing longevity, frailty and people with multiple conditions.
- There are inequalities within East Sussex in uptake of preventative services for example cancer screening.
- The number of children in need of help and protection is rising locally and nationally, linked to the increase in families experiencing financial difficulties.
- There is a growth in the numbers of children with statements of special educational needs and disability (SEND) or Education Health and Care Plans some of whom will have complex medical and care needs.

There is growing demand on both NHS and social care services. More and more local people will require support and care for long term conditions. By joining up the care we provide we will be better able to support people to live as independently as possible and achieve the best possible health outcomes for them. In the long term, we need a 'new service model for the 21st Century'[1] to ensure that good quality health and care is available for everyone who needs it. This is outlined in our East Sussex Health and Care Plan which:

- Describes what we will do to drive the changes we need to make to meet the health and care needs of people living in East Sussex, reduce health inequalities and deliver longer term sustainability.
- Sets out some key local priorities (below) to work on together, where we think we can have a real impact through working collectively, informed by NHS Long Term Plan and the views of local people.

What we will do

During 2020/21 our key priorities are to:

- Build on our existing progress to enhance **prevention, personalisation and reduce health inequalities** and the gap in life expectancy in the county. We will do this through coordinated action across all services that impact on the wider determinants of health such as housing, employment and leisure, as well as extending targeted approaches to empower people to make healthy choices across the whole life course to improve outcomes.
- Improve existing support to **children and young people** focusing on improving mental health and emotional wellbeing; support for vulnerable young people at risk and looked

[1] NHS LTP (January 2019) and NHS LTP Implementation Framework (June 2019)

after children; support for children and young people with disabilities; and through health promotion activities.

- Within our **community services**, continue to integrate health and social care services; work with our primary care networks to further support people with long term conditions and those in care homes, including action to support people at the end of their lives.
- Continue action to improve support for people with **urgent care** needs including: targeted support for vulnerable people; improvements in urgent care processes and systems to deliver more streamlined care; support people in care homes with urgent care needs; and complete the introduction of our Integrated Urgent Care model, for example Urgent Treatment Centres.
- Further improve services that deliver **planned care** for local people including: better outpatient care through new technology and better organisation of services (e.g. one-stop clinics); supporting people with musculoskeletal, cardiac, diabetic, ophthalmic and cancer needs; review existing services to ensure evidence-based interventions are in place; action to improve waits for treatment where this is too long; and continue to support best practice with prescribing and medicines.
- Expand our support for people with **mental health** needs by establishing single point of access; enhanced support in the community to help avoid unnecessary admissions; and working with housing and voluntary sectors to support those people who also have housing related needs.

Our plans and priorities have been informed by what local people have recently told us is important to them about their health and care, and we will contiue to test our plans with our stakeholders to guide how people want to be involved in shaping the way we deliver our ambitions.

This integrated plan provides the foundation for our next steps as a health and social care partnership. Over the next 3-5 years we will build on this work together to further integrate care around our population's needs by working together across our system to further improve health and care for local people. We believe that this is the best and most sustainable approach, enabling us to make the best use of the resources available in our area to meet the challenges of rising demand and financial pressures, and ensure local people have access to the services and support they need.

Strengthening our ability to deliver

This integration is often called an **Integrated Care Partnership** (ICP), which will strengthen how we plan, organise and deliver services together in East Sussex, supported by a clear approach to our communities, and informed by their needs. We are currently developing proposals for an ICP which we plan to develop from April 2020.

We want to ensure that local people receive the right services, in the right place, at the right time. This may mean access to and use of services will be different in the future. We aim to empower local people with the knowledge of how to best use available health and social care services, and how to best get the support they need, and we believe this plan gives us the opportunity to deliver the improved health and care that our local people deserve.

1. East Sussex Health and Social Care Plan

1.1. Introduction and context

The Sussex Health and Care Partnership (SH&CP) is required to submit medium term plans covering the expectations set out in the NHS Long Term Plan (LTP) to NHS England (NHSE). This includes the requirement to "deliver a new service model for the 21st Century"[2], and the transformation and integration plans that will need to be progressed to deliver this. The overarching submission is the Sussex Health and Care Strategy covering:

- Sussex-wide plans across specific priority clinical areas, including: mental health; cancer; prevention; urgent and emergency care; stroke; diabetes; Transforming Care Partnership (covering learning disabilities and autism for people with high support needs); maternity, and; reducing unwarranted clinical variation focussing on cardiovascular disease, musculoskeletal conditions and falls and fractures.
- Three place plans based on upper tier local authority areas - covering East Sussex, West Sussex and Brighton and Hove, outlining action to deliver NHS LTP commitments and priorities to meet local population health and social care needs.
- Sussex-wide plans for workforce, digital and estates.
- The finance and activity modelling that will underpin these plans.

Our local East Sussex plan is a joint health and social care plan, which reflects our strong history of integrated working in East Sussex, and builds on the progress we have made locally with priorities that we have been working on in 2019/20. Developed in partnership, the plan sets out how we will work together to address the commitments in the NHS LTP and local East Sussex priorities by ensuring there is a clear East Sussex health and social care plan to align with, and be part of, the Sussex Health and Care Strategy

This plan reflects population health and social care needs in East Sussex, and the learning from our own local development work on our journey towards integration since 2014. We have looked at benchmarking tools such as Get It Right First Time, Right Care and Model Hospital, and a series of recent independent reviews that have helped us further understand the drivers of demand. This has enabled us to further consolidate our objectives to support improvements to the quality of care and the ongoing financial recovery and stabilisation of our system.

Our work on integration to date provides a firm foundation for the next steps as it has piloted and delivered a range of improvements on our journey to a new model of integrated care, including:

- A comprehensive and co-ordinated range of preventative services including; the Healthy Child Programme; One You East Sussex; Making Every Contact Count; Healthy Hastings and Rother - aimed at reducing health inequalities in our most disadvantaged communities; Good Neighbour Schemes; taking forward the Patient Activation Measure and Shared Decision-Making to support greater levels of self-care, and; joint commissioning a range of early intervention and prevention services and support from the voluntary and community sector (VCS), including support for carers.
- On-going development of community health and social care services and initiatives, including integrated health and social care teams, crisis response and proactive care, the

[2] NHS Long Term Plan Implementation Framework (July 2019) a copy can be found here

Dementia Support Service; Health and Social Care Connect now available 24/7/365, and; the Joint Community Reablement Service and falls prevention services.

- Strong whole system performance against the Better Care Fund targets and the Care Quality Commission East Sussex Local Area Review.
- Piloting an integrated outcomes framework to better enable us to measure whether our work as a system (activity) was having the desired results (outcomes).
- Developing our approach to understanding and using our collective resources on a system-wide basis for the benefit of our population.

Our emphasis in this plan is on the **transformation priorities** we need to deliver jointly as a health and social care system to meet the future health and care needs of our population. The plan sets out the priorities for programmes of change covering **prevention, children and young people, community, urgent care, planned care and mental health** and how we will work more effectively together across our system, including primary care networks (PCNs), the voluntary and community sector (VCS) and district and borough councils and others to deliver a "new service model for the 21st century" grounded in the needs of our local population. The plan also describes the local implications for workforce planning, IT and digital and estates.

Our local plan is the platform for taking forward developing our local Integrated Care Partnership arrangements, as part of the wider development of the Sussex Integrated Care System. In summary our joint plan addresses:

- The NHS LTP commitments by ensuring there is a clear East Sussex plan that also contributes to, and integrates with, the Sussex Health and Care Strategy.
- The needs of the whole population of East Sussex across physical and mental health, and health and social care services for children and adults, from improving health and prevention through to primary and hospital-based care.
- A forward view from 2019/20 until 2023/24, fully taking into account the progress made to date and the priorities we have agreed, which are also consistent with the NHS LTP.
- The priorities in East Sussex for transformation and integration, and the work in 2020/21 needed to meet the health and care needs of our population, reduce health inequalities, and deliver outcomes on a sustainable basis.
- The arrangements for taking forward our Integrated Care Partnership including how we will work across our health and care system, the VCS and wider partners, to:
    - enable stronger coordination of health and care delivery to our population
    - make best use of our collective resources
    - shape our approach to integrated population health and social care commissioning in East Sussex
- How we will build on the comprehensive approaches to engagement undertaken to date and create a framework of continuous engagement with our stakeholders to underpin and inform our plans.
- We will also further develop the 3-5 year system financial model that will need to underpin our plans for change.

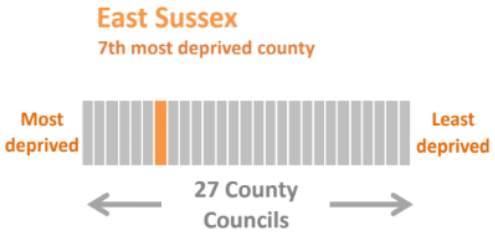
1.2. Our population health and social care needs

East Sussex is a county with contrasting characteristics across urban and rural communities. Health and its determinants are not distributed evenly across the county with a strong link between poverty and poor outcomes; although rurality can also have an impact on access to services. Overall, East Sussex is relatively deprived compared to other counties, but as figure 4 in Section

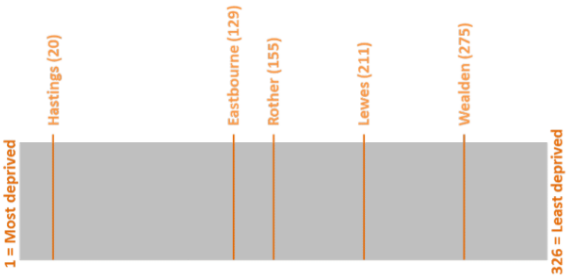
4.3 shows, there is significant variation in deprivation across the county and between primary care network populations which will result in differing health and social care needs. The proportion of people over 65 in East Sussex is considerably higher than nationally (26% vs 18%), and the proportion from Black and minority ethnic groups is smaller (8% vs 20%).

There are approximately 555,110 people living in the 1709 km^2 in East Sussex. In summary our population has the following characteristics:

Deprivation relatively high for a county…….and varies signficantly across East Sussex

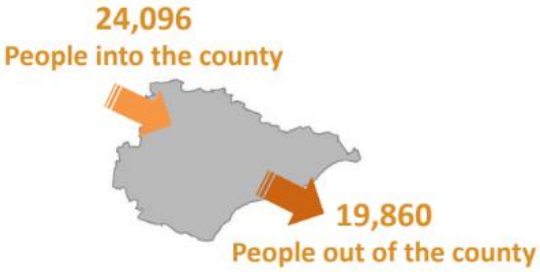


Deprivation By Lower Tier Local Authority, Index Of Multiple Deprivation, 2015

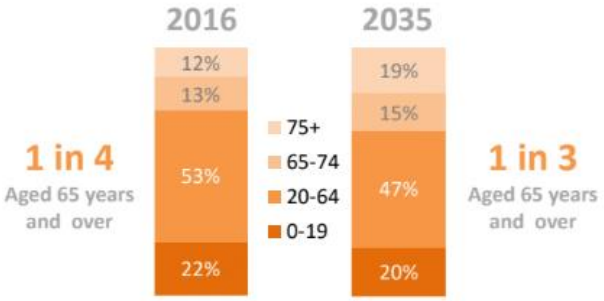


Most people live in urban areas

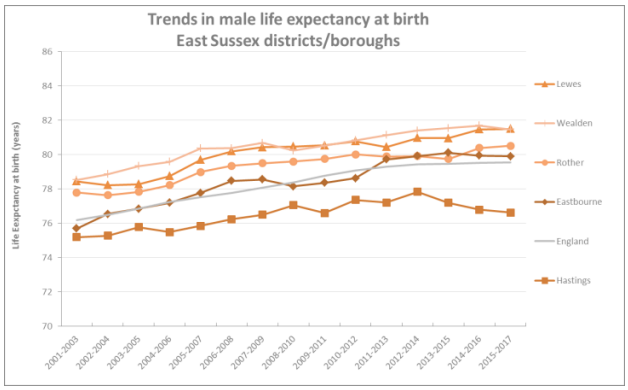
Our population is increasing….



..and getting older (more so than England)

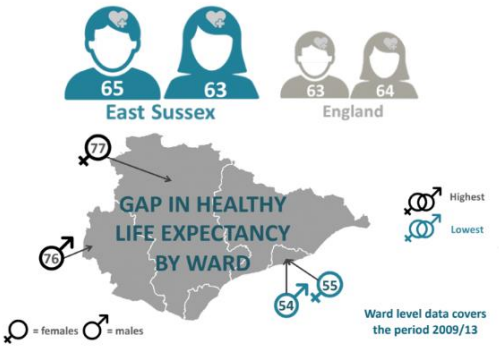


Like England, life expectancy is not increasing and has fallen for men in Hastings

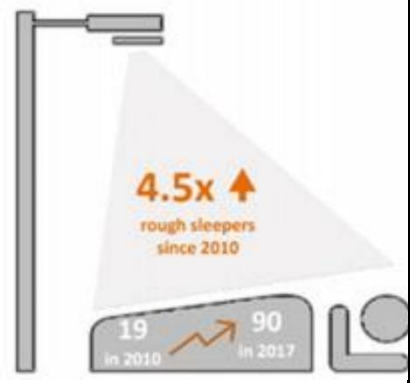
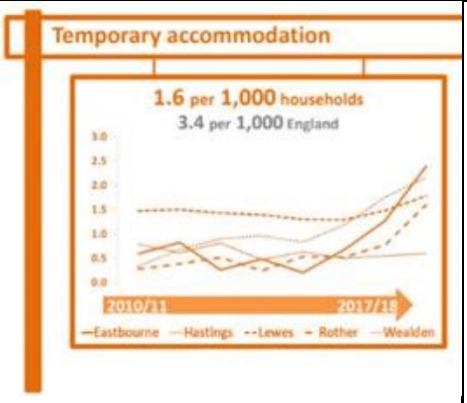


Illness and disability increase with age… ..but there are huge differences in when people become ill between wealthier and poorer areas

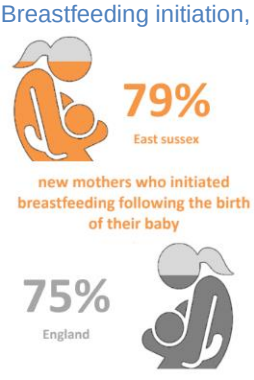
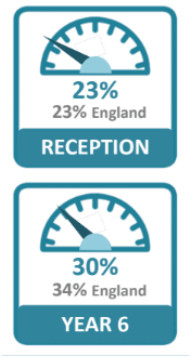
LONG TERM LIMITING ILLNESS OR DISABILITY, 2011



Housing needs - Access to a safe and secure place to live is a fundamental need for all people. Some of the most acute needs are increasing in East Sussex:

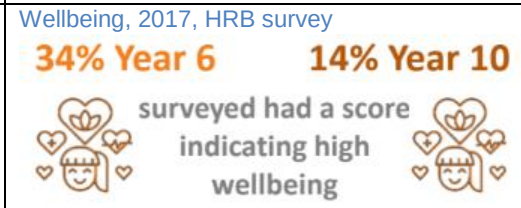
Rough sleepers increasing	Households in temporary accommodation increasing	Homeless households in priority need 2017/18
		

Best start in life, risk factors, chronic diseases and dementia

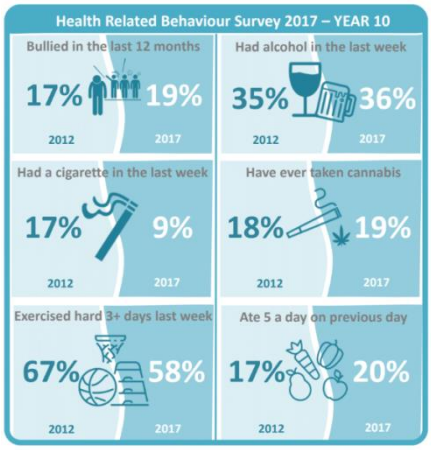
Smoking at time of delivery is higher than England	Breast-feeding intiation is higher than England	1 in 3 children age 10/11 are overweight or obese
		

Good school readiness

High wellbeing decreases between age 10-11 and age 14-15

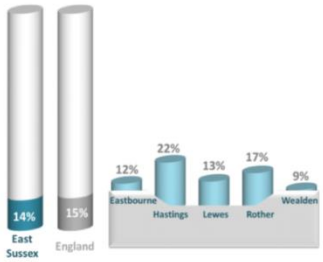


Some health-related behaviours in young people are improving, others getting worse



By adulthood almost 2 in 3 people are overweight or obese (varies by area)

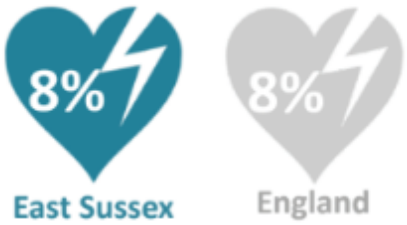
Smoking in adults varies by area



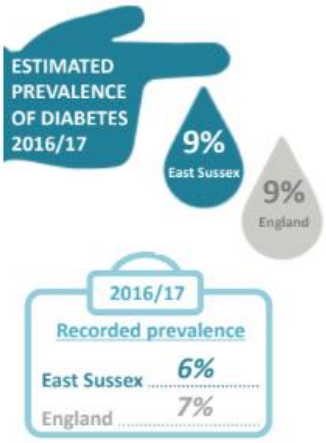
Over 1 in 4 adults in East Sussex drink too much alcohol

Over 1 in five adults are physically inactive

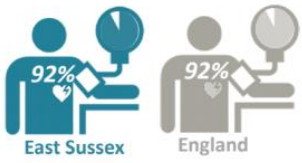
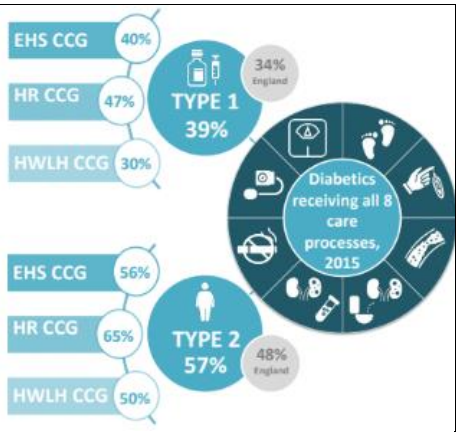
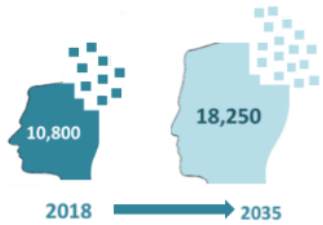
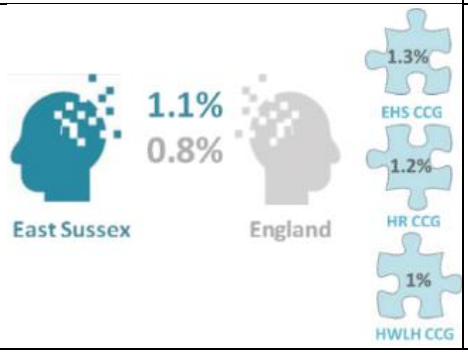
Chronic disease rates in East Sussex are similar to England:



Estimated Coronary Heart Disease (CHD) prevalence in 55-79 year olds, 2015



Diabetes

But there are variations in care between managing hypertension and managing diabetes	 **% of people with Coronary Heart Disease whose blood pressure is controlled 2016/17**	
Dementia cases predicted to increase as population ages	**Dementia rates higher than England (IGP recorded 2016/17).**	**1 in 3 cases of dementia could be prevented**
		

Causes of the gap in life expectancy

The biggest contributors to the inequalities in life expectancy in East Sussex are the same for men and women: circulatory disease, cancer and respiratory disease. Contributing preventable risk factors are smoking, poor air quality, alcohol, poor diet, and not enough physical activity. Social isolation is also known to result in reduced life expectancy.

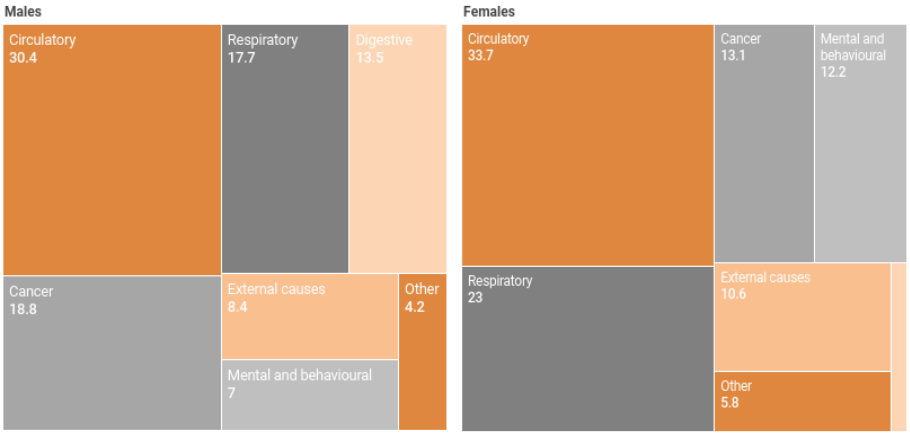


Figure 1 Causes of the gap in life expectancy between most and least deprived areas within East Sussex by gender

Key points

- Demand for health and social care will continue to increase, both as a result of the growth in the proportion of older people in the population and the complexity of their needs with increasing longevity, frailty and multi-morbidity.
- There are inequalities within East Sussex in uptake of preventative services e.g. cancer screening, immunisation and diabetes education programmes; other preventative services e.g. learning disability health checks have lower uptake in East Sussex (46%) compared to England (49%).

- The number of children in need of help and protection is rising locally and nationally, linked to the increase in families experiencing financial difficulties.
- There is a growth in the numbers of children with statements of SEND or Education Health and Care Plans some of whom will have complex medical and care needs.

In summary, East Sussex has among the highest proportions of over 65-year olds and over 85-year olds in the country, and within this many people live their later years in ill-health, often with more than one long term condition. There is growing demand on NHS and social care services as more and more people require support and care for long term conditions. Reducing health inequalities and the gap in life expectancy in the county also requires coordinated action with services that impact on the wider determinants of health such as housing, employment and leisure, as well as targeted approaches to empower people to make healthy choices across their whole lives to improve outcomes.

In the long term, for services to be sustainable for everyone who needs them, there is a need for a new model of care to proactively support the older and frail population, and those with multiple long term conditions, through a strong infrastructure of responsive, coordinated and integrated services delivered in communities. This needs to work with people's strengths to help them feel in control of their conditions with easy access to support from health and social care professionals in multi-disciplinary teams when it is needed. Personalised care, shared decision-making with clinical and care professionals and support to self-manage conditions, for example through the innovative use of digital, are all features of a new model of care for the 21st century. We also need to get better at enabling people to stay fit and healthy for longer.

The advent of primary care networks (PCNs) with a focus from 2020/21 on proactively managing population health and better anticipating care needs, and integrated working across health and social care, will enable us to deliver the best possible outcomes for local people, and achieve the best use of collective public resources in East Sussex. There is also a strong national and international evidence base that demonstrates the value of integrated working in improving patient and client experience and outcomes, as well as better value for money. Overall, we believe this will help to moderate demand for hospital services, protecting them so they are available when they are most needed by our population.

The information about East Sussex that has been used to understand our population health and care needs and the priorities for East Sussex can be found in the following documents:

East Sussex Joint Strategic Needs Assessment
http://www.eastsussexjsna.org.uk/
Director of Public Health Report 2018/19
http://www.eastsussexjsna.org.uk/publichealthreports
State of the County 2019, Focus on East Sussex (July 2019)
https://www.eastsussex.gov.uk/yourcouncil/about/keydocuments/stateofthe-county/

Supporting People to Live Well in East Sussex, the market position statement for adult services and support (April 2019)
https://www.eastsussex.gov.uk/media/13531/market-position-statement-2019.pdf

Sussex and East Surrey Sustainable Transformation Partnership Population Health Check
https://www.seshealthandcare.org.uk/2019/02/population-health-check-published-across-the-stp/

1.3. Who we are – our health and care system

The diagram (figure 2) below gives a flavour of the health and care organisations who work together to deliver health and care in East Sussex across primary, community, acute, mental health and social care and housing, and some of the wider range of services and assets we have in our communities that impact on people's health and wellbeing.

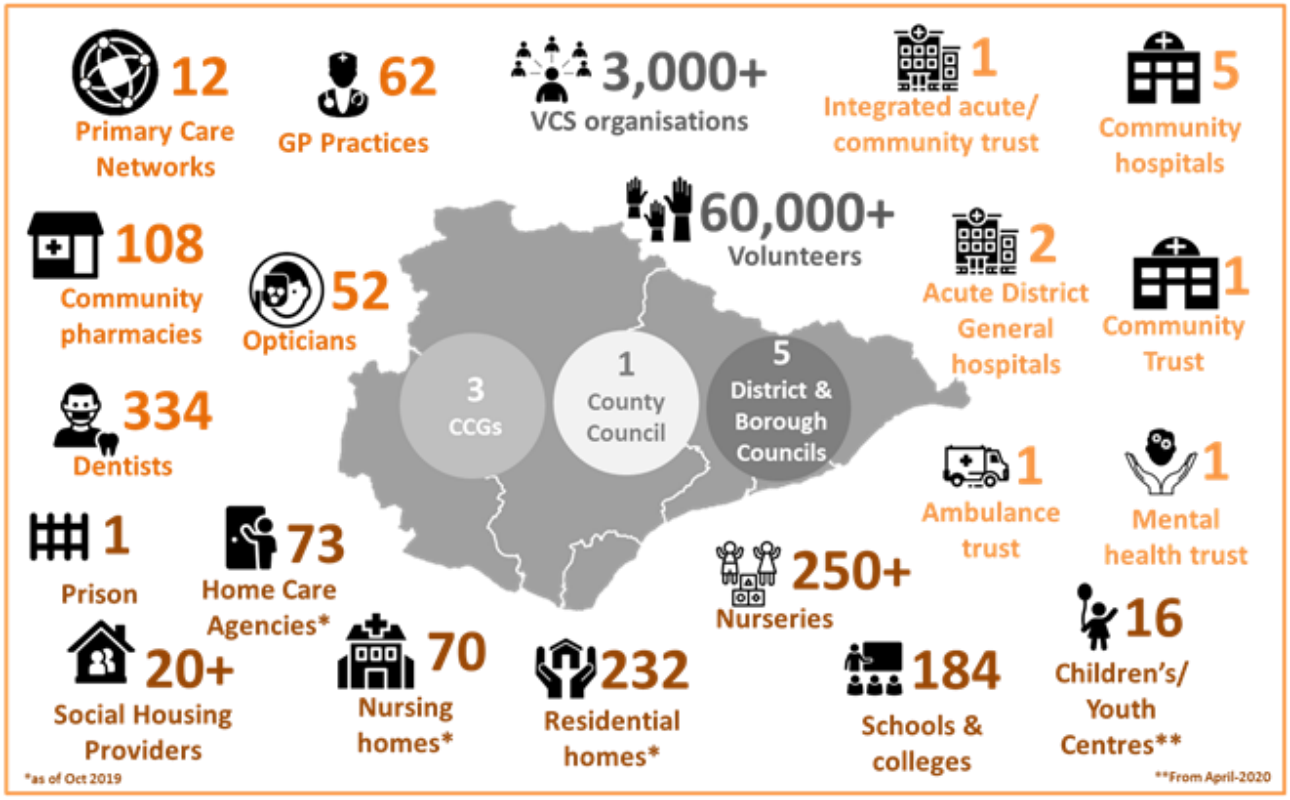


Figure 2 – a flavour of the organisations and networks in the East Sussex Health and Care System

Some of our population accesses hospital-based care outside of East Sussex, and we will work with partners outside of the East Sussex system, for example healthcare providers and primary care networks, and other integrated care partnerships, sustainable transformation partnerships and integrated care systems as they emerge, to support integrated care for our population.

1.4. Where we are now

The longer term overarching outcomes we have been working towards in East Sussex are improving: population health, the quality and experience of care, and the financial sustainability of services. In recent years we have progressed our integrated working in East Sussex through two programmes; East Sussex Better Together (ESBT) and Connecting 4 You (C4Y). Moving forward in 2019/20 it has been agreed to bring these two programmes together to provide the foundation for a single East Sussex health and social care programme.

In summary, during the latter part of 2018/19 and early 2019/20 we have taken steps as a system to secure agreement to the following:

- Bringing together our two East Sussex programmes (C4Y and ESBT) into a single programme for health and social care integration covering our whole population.

- Developing a joint East Sussex longer term plan for integration to take us beyond our immediate programme priorities in 2019/20, to address both local East Sussex health and social care priorities and delivering the NHS LTP.
- Putting in place partnership governance arrangements for our system to support this work, including reinforcing the system oversight role of our Health and Wellbeing Board (HWB). It is expected that this governance will evolve further as we move into the next phase of our plan and programme.
- Taking forward a proposal for our three East Sussex Clinical Commissioning Groups (CCGs) to merge into a single CCG for East Sussex (subject to application and approval by NHS England)
- In the context of the SH&CP ambition to become a Sussex Integrated Care System (ICS):
    - Developing integrated population health and care commissioning within East Sussex, as part of the wider strategic commissioning function of the SH&CP.
    - Developing an integrated care partnership (ICP) in East Sussex to support integrated delivery of health and social care, mirroring our population health and care commissioning footprint.

1.5. Where we want to get to

Our immediate programme and organisational priorities for 2019/20 reflect the continued need for grip on financial recovery; reducing pressure on hospital service delivery; improving community health and social care responsiveness, and; ensuring good use of, and shorter waits for, planned care. This was achieved through consolidating the financial recovery work and ESBT and C4Y objectives into a single programme with priorities for the next 6-12 months across urgent care, planned care and community.

Alongside delivery of 2019/20 plans our key priority in East Sussex has been to develop a longer term plan. This will enable health and social care in East Sussex to describe our next steps, building on the plans that are currently being implemented. Aligned to the SH&CP Sussex Health and Care Strategy, the plan strengthens the whole population focus across the East Sussex health and social care economy, as well as informing the priorities and plans for 2020/21.

In summary, our East Sussex plan is a joint health and social care plan that builds on what has already been delivered, to produce an up to date statement about our joint programme and anticipated plans for the next 3- 5 years, covering:

1. The needs of our whole East Sussex population and the outcomes required to meet them.
2. Our plans for driving the transformation and integration required to meet population health and care needs, reduce health inequalities and deliver longer-term sustainability, including our priorities for 2020/21.
3. The development of our East Sussex Integrated Care Partnership (ICP) to better support integrated delivery across our health and social care system, and integrated population health and care commissioning arrangements.

To underpin our plans we will also set out our understanding of our system financial model covering a three to five year period. This will set out the required shifts in investment to primary care and community health care, including meeting the new primary medical and community health services funding guarantee.

1.6. What we want to deliver

Informed by our local East Sussex County Council priorities[3] and NHS Long Term Plan[4,5] commitments, and engagement with our local communities, in the long term we expect to build on our integration work to date to deliver an integrated model of care with the following characteristics:

- A comprehensive approach to prevention, universal personal care and reducing health inequalities that cuts across our key clinical priorities and care pathways from enabling healthier behaviours and good wellbeing through to access to leisure, housing and other services that impact on the wider determinants of health, greater levels of self-management, shared decision-making, and personalised care and support planning, through to early intervention, proactive care and reablement.
- Full implementation of a common operating model for integrated community health and social care, working across our health and care system, the VCS and others to jointly deliver greater community health responsiveness in 2020/21, including:
    - Improved crisis response within two hours and reablement care within two days
    - Anticipatory care
    - Enhanced health in care homes
    - Structured medication reviews for priority groups
    - Personalised care and support planning, and early cancer diagnosis support
    - Social prescribing and community-based support
    - Better identification and support to improve outcomes for carers
    - The continued implementation of primary care improved access in 2019/20 and 2020/21
    - Building the capacity, workforce and partnerships to do this
- Close system working between our East Sussex CCGs, ESCC, East Sussex Healthcare NHS Trust, Sussex Partnership NHS Foundation Trust, Sussex Community NHS Foundation Trust, and our local PCNs, to ensure that Sussex-wide strategies and developments align with our local plans for integrated community health and social care and a comprehensive approach to prevention, universal personal care and reducing health inequalities
- Close system working across the local NHS and children's social care to deliver ESCC and NHS LTP priorities to support age-appropriate integrated care; integrating physical and mental health services; joint working between primary, community and acute services, and; supporting transition to adult services
- The continued implementation of our urgent care plans to reduce pressure on emergency hospital services including:
    - Meeting the A&E standard and agreed metrics for same day emergency care, and urgent and emergency care
    - Implementation of our integrated urgent care model and an integrated network of community and hospital-based care
    - Implementing Urgent Treatment Centres by December 2019
    - Implementing the new 111 and Clinical Assessment Service (CAS) by April 2020

[3] 'State of the County 2019, Focus on East Sussex' (July 2019), a copy can be found here
[4] NHS Long Term Plan (January 2019), a copy can be found here
[5] NHS Long Term Plan Implementation Framework(July 2019) a copy can be found here

- The continued implementation of our planned care programme including:
    - Driving efficiency and productivity in elective care pathways to reduce waiting lists
    - Enabling choice through expanding digital and online services
    - Transforming outpatients care and digitally enabling primary and outpatient care through the increased use of digital tools to transform how outpatient services are offered, and providing more options for virtual outpatient appointments in identified priority specialties, working with the Sussex Outpatient Transformation Board
    - Scaling up provision of First Contact Practitioners to enable faster access to diagnosis and treatment for people with musculoskeletal conditions and supporting more patients to effectively self-manage their conditions

The integrated model of care outlined above provides the foundation for the development of our proposals for implementing our East Sussex **Integrated Care Partnership** model. Our ICP will better enable delivery of these principles and priorities, as part of the wider development of the SH&CP into an **Integrated Care System.**

Through delivering this model we expect to better enable our system to deliver measurable improvements to the shared outcomes in our integrated Outcomes Framework. The integrated Outcomes Framework is a set of shared outcomes and measures developed in 2017, to support our collaboration and help us understand the impact of our work together as a health and social care system.

In 2019 we agreed to fully adopt this framework for our whole East Sussex population. We intend to refresh the framework to align with the East Sussex Health and Social Care Plan, and the supporting programmes of work. These outcomes have been developed with local people based on what matters to them about their health and social care services. Outcomes and measures are grouped together under the following four headings:

1.7. How we will deliver against the NHS Long Term Plan commitments and local priorities

Our local East Sussex work on integration and transformation to date aligns well with expectations set out in the NHS LTP and Implementation Framework. We have undertaken analysis that captures how we anticipate delivering commitments in the NHS Long Term Plan and our local priorities. This is being used to inform:

- Our individual organisational corporate strategies and operational business planning processes for 2020/21 and beyond, and the partnerships, programmes and projects through which we will deliver improvements to the quality of care
- Alignment with the SH&CP Sussex Health and Care Strategy clinical priorities and plans to support local implementation and delivery, including Sussex-wide strategies for workforce, digital and estates.

In addition, the LTP commitments have been consolidated with:

- Our local understanding of the priorities and objectives for our system to date
- The evidence base arising from independent diagnostic work in 2018/19 on the drivers of our system deficit, and benchmarking tools such as Model Hospital, Get it Right First Time and NHS Rightcare

This has given us a set of key priorities we need to focus on as a system in 2020/21, as realistic and achievable next steps to drive the changes needed to meet the health and care needs of our population sustainably in the coming years.

The priorities will be used to set objectives and key performance indicators (KPIs) for our work programmes for delivery in 2020/21, to be overseen by our Health and Wellbeing Board and supporting system partnership governance.

The priorities reflect our current understanding of the plans and next steps for our system, noting that some areas of the plan have already been initiated and some are at an earlier stage of development, programme definition and work up. This will continue to be tested across our system and key stakeholders to further scope, shape and agree programme plans for 2020/21 and beyond. Fundamental to this will be co-design and co-production of projects and inititiaves with patients, clients and carers to ensure that pathways are informed by lived experience.

There are strong links between all the programme areas and changes in one area may have benefits for others. For example, work under the community strand aimed at increasing capacity and efficiency will enable improved patient flow through hospital and reduced lengths of stay, as well as improved outcomes for people and their families.

Intervening at the earliest opportunity and preventing things from getting worse, as well as ensuring care is personalised, are all cross-cutting principles across our plan. We expect all new developments to consider opportunities for this as part of taking specific projects and initiatives forward.

Our overarching key priorities and the anticipated next steps we will take collectively in 2020/21 across prevention, children and young people, community, urgent care, planned care and mental health are summarised in the next section. Further detail about the background and approach in each area is set out in Appendices 1 – 6.

1.8. Summary of shared priorities for 2020/21

In this section we have set out our key areas of focus for 2020/21, to continue to drive the changes we need to see over the next 3-5 years. Further detail about the background and approach in each area can be found in Appendices 1 – 6.

1.8.1. Prevention personalisation and reducing health inequalities priorities

Priority	Next steps
Support with making healthier choices and action on health inequalities	• Implementing population health packs and working with primary care networks to explore popluation health management, risk stratification and target wider system partnership action across the broader determinants of health. • Work with SH&CP to use national guidance to set trajectories for narrowing inequalities in 2023/24 and 2028/29 to inform local wider system action planning • Specific partnership action to support healthier lifestyles and health inequalities; smoking, obesity and alocohol • Increasing screening and vaccinations programmes, tailoring our approach to areas of greatest need
Supporting self-care, self management and personalised care	• Begin to implement the NHS Comprehensive model of personalised care and the PCN Network Directed Enhanced Services (DES) contract requirements in 2020/21 • Ensuring opportunities for prevention, self-care, shared decision-making and personalised care planning and support are built into all pathway redesign priorities for planned care and end of life care • Review the patient activation measure pilot to inform further development of self care and and self management • Build on the rollout of wheelchair personal health budgets to identify further groups of people who may benefit from personal health budgets, for example people with continuing health needs
Social prescribing and community based support	• Implement an integrated social prescribing framework to reduce inequalities in health outcomes for local and diverse populations and improve mental health and wellbeing • Working closely with the voluntary and community sector align the PCN Network DES contract social prescribing investment with existing commissioned social prescribing commitments, such as the Community Connector Service, Primary Care Support Service and Carers prescriptions • Deliver an asset based wellbeing programme working with communities with poorer health and build strength-based solutions, adding to the range of support which social prescribers can signpost to
Preventing situations from getting worse	• Collaborate to begin to implement anticipatory care PCN network DES contract requirements from 2020/21 onwards, and link this with phased implementation of the target operating model for community health and social care services and multi-disciplinary care coordination working with primary care teams • Explore earlier intervention and targeting of falls prevention services at those who are at risk of a fall • Work with PCNs to help implement 'supporting carers in general practice - a framework of quality markers', and build on the Primary Care Support Service and Carers prescriptions, to ensure that better identification and support for carers in primary care is fully integrated into the new social prescribing link worker arrangements described above.

Improving outcomes for vulnerable and/or disadvantaged groups	• Widening access to physical health checks in primary care for people aged fourteenand over with a learning disability • Subject to the availability of funding continue to deliver initiatives to provide integrated support for rough sleepers • Commissioning housing related support services for those at risk of homelessness and support for carers • Support for vulnerable children and young people including action on County Lines and improving outcomes for children with special educational needs and disability (SEND)
Mental health and wellbeing	• Work towards of adopting the principles set out in the prevention concordat to enable a clear focus for cross sector action on better mental health for all • Build on and strengthen partnership work across the local NHS, social care, education, employment, housing, community resilience and cohesion, safety and justice and civil society, linking this with population health management approaches where possible

1.8.2. Children and Young People priorities

Improving children and young people's mental health and emotional wellbeing	• Improving our pathways and commissioning approach particularly with regard to Tier 4/ Secure/Specialist placements • Developing a coherent emotional wellbeing strategy which works with our schools to provide appropriate help at the earliest point and other action to help address forthcoming recommendations of the Sussex-wide independent strategic review of the whole pathway of emotional wellbeing and mental health services for children and young people
Disability Pathways	Further develop our work around integrating the education, health, and social care needs of children and young people aged 0 – 25, aimed at producing local solutions, including: • integrated health and social care budgets for children with the highest complex needs • exploring a single assessment pathway for autism spectrum disorder and attention deficit hyperactivity disorder, and other neurodevelopmental disorders • improving early planning for children who transiton into adult health and social care services • reviewing mental health support for children and young people with autism
Safeguarding (including Contextual Safeguarding)	• Further develop our pathways and service offer for young people at risk of criminal and sexual exploitation, physical and sexual harm, alcohol and substance misuse and review the service offer and needs for 18 – 25 year olds • Make strong links with the work taking place under the mental health and emotional wellbeing objectives
Universal Child Health Offer	• Ensure the provision of the Healthy Child Programme for under 5's through the Integrated Health Visiting and Children's Centres service • Support the delivery of the preventative health agenda through School Health Service. • Support nurseries, schools and hospitals to become health promoting settings

Looked after Children	• Ensure looked after children's needs are prioritised across health, social care and education to enable the best outcomes • Ensure mental health services are commissioned to optimise the emotional wellbeing of looked after children and previously looked after children

1.8.3. Community priorities

Implement Integrated Community Health and Social Care	• Continue to trial and roll out co-location to support joint working and care coordination for people with complex and multiple long term support needs • Progess a care coordination pilot for people with multiple long term condtions and support needs, including how to support enhanced case level collaboration with primary care, mental health and voluntary sector support services • Continue the wider rollout of home-based and bed-based Homefirst discharge pathways • Take forward therapy joint working to share skills, best practice and help create capacity • Consolidate the pilots and projects from Phase 1 of the community programme and begin to implement our agreed common target operating model to enable greater levels of multi-disciplinary working across primary medical care, community health, mental health and social care services. Strongly link and align this with: ○ PCN footprints to support effective multi-disciplinary working, including work to implement the PCN network DES contract for 2020/21 and risk stratification of local populations and proactive anticipatory care for those with multiple long-term conditions and/or assessed at high risk of unwarranted health outcomes ○ Developing further capacity in crisis response within two hours and reablement care within two days, noting the need to align the offer across the East Sussex footprint ○ Pathways for acute hospital-based care and discharge ○ Wider development and roll out of Enhanced Care in Care Homes
End of life care	• Ensure that End of life care strategies continue to be implemented to ensure the best end of life care for patients in the community working across primary and community health and social care teams and pathways, and in all settings of acute, secondary and primary care, hospices and care homes • Complete the case for change for anticipatory prescribing to meet the NICE Quality statement • Provide education opportunities for primary care • Link with other plans for supporting frailty and enhanced care in care homes and other community services as appropriate • Implement ReSPECT across acute, secondary and primary care providers and in hospices and care homes, to ensure personalised recommendations for a person's clinical care in a future emergency are taken account of

1.8.4. Urgent Care priorities

. High Intensity Users	• Further expand and focus on supporting patients with multiple needs with high numbers of A&E attendances and admissions

Ambulatory Emergency Care (AEC)	• Expansion of AEC at both EDGH and Conquest Hospital (Supporting Same Day Emergency Care)
Acute frailty	• Expansion of Acute Frailty teams and pathways to ensure the right support at the front door (Supporting Same Day Emergency Care)
Enhanced care in care homes	• Implement a range of initiatives to better support patients in care homes, build confidence for staff and avoid unnecessary admissions • Explore and develop how support can be delivered to people in care home settings in partnership with Primary Care Networks
Community Frailty/PEACE planning	Further rollout of Proactive Elderly Advance Care (PEACE) planning as part of personalised care and support planning roll-out; supporting people in care homes
Integrated Urgent Care model	• Rollout of enhanced NHS 111 and Clinical Assessment Service from 1st April 2020 • Rollout of UTCs at Eastbourne DGH, Conquest Hospital, Hastings and Lewes Victoria Hospital • Further development of the Minor Injuries Units in Crowborough and Uckfield to improve local access for same day care • Direct booking into Primary Care Improved and Extended Access, UTCs or other walk in services and sites being developed as part of the East Sussex integrated urgent care model • Increased utilisation of Primary Care Improved Access capacity • Take forward further interventions in winter 2019/20 and 2020/21, as a result of recent diagnostic work on the drivers of demand for A&E services.

1.8.5. Planned Care priorities

Outpatients	• Introducing video appointments, virtual fracture clinics, electronic correspondence for our patients
	• Expanding of successful approaches to:
	  ○ improve the timeliness of treatment
	  ○ improve the experience of patients on care pathways
	  ○ reduce unnecessary appointments
	  ○ introduce one-stop clinics specifically focusing on gastroenterology and breast cancer two-week wait

Musculoskeletal Services	• Meet the growth in demand in a sustainable way by: ○ Introducing First Contact Practitioners (FCPs) in GP surgeries designing the correct bespoke pathway to ensure timely recovery, minimised pain and improved independence

	○ Improving shared decision-making between specialist clinicians and patients with more complex conditions, alongside improved education on self-management ○ Enabling patients to self-refer to physiotherapy so they start treatment earlier at the onset of a condition
Evidence Based Interventions	Continue to review the latest evidence and change our recommended treatments where this evidence indicates areas that do not benefit our patients, allowing us to release capacity for the right treatments
Cardiology	Work together to agree a new model of cardiology care spanning general practice through to community services and hospital care, that: ○ Increases identification of heart conditions and related support for patients to self-manage their own heart health ○ Reduces variation in community-based cardiology assessments by standardising pathways, enabling more patients to be treated within a community setting to make best use of capacity ○ Supports the long term sustainability of hospital services
Diabetes	• Build on our success in implementing complex diabetes treatment in a community setting, and our expansion of urgent treatment for diabetics to: ○ Provide improved patient experience for people with diabetes by reducing unnecessary hospital appointments including outpatient appointments and hospital admissions ○ Provide improved access for psychological therapies for people living with diabetes that also have co-morbid depression/anxiety ○ Provide improved access to innovative technologies for glucose monitoring for patients with type 1 diabetes (includes flash and continuous glucose monitoring). • Develop a system plan to manage the predicted exponential growth in diabetes over the next 3 years.
Ophthalmology	Work closely with acute and community providers to ensure a seamless pathway, focussing on addressing the growing demand by repatriating care to our specialist community optometrists, releasing capacity in our hospital multidisciplinary teams to manage the more complex eye conditions.
26-week wait and capacity alerts	Implement a planned choice process for all patients who reach a 26-week wait, starting in areas with the longest waits, to give patients options to access care across NHS services in Sussex
Cancer	During 2020/21 we will build on existing work to take forward local plans in the following areas: • Continue to improve performance against the cancer constitutional waiting times standards and ensure sustainability, including the new 28 day faster diagnosis standard • Improve the uptake of screening targeting those areas with lower uptake and focus on inequalities • Strengthen the two-week wait process to ensure referrals are managed proactively • Implement personalised care pathways for breast cancer and develop plans for other specialties, with prostate and colorectal as priorities

Medicines optimisation	• Use NHS England-led propgrammes to optimise prescribing in a range of areas including diabetes, pain management, malnutrition and anticoagulation; and de-prescribing medicines no longer needed • Develop an Integrated Medicines Optimisation service between local Primary care Networks (PCNs) and East Sussex Healthcare Trust, to support the delivery of structured medication reviews and quality improvement • Continue the medicines optimisation in care homes service and work towards integration with the PCN structured medicines review and optimisation service, under the PCN Network Directed Enhanced Services (DES) contract in 2020/21 • Rollout the electronic transfer of medicines discharge information between hospital and community pharmacists; and implementation of a quality improvement process for pharmacy led interventions • Provide integrated vocational training programmes for pharmacists and pharmacy technicians across primary and secondary care, mental health and community services

1.8.6. Mental Health priorities

Single point of access - no 'wrong doors' and access to crisis pathways	• Expansion of NHS 111 so that it can take mental health referrals • Pilot a Single Point of Access (SPOA) for adults embedded within Health and Social Care Connect. • Simplify pathways to support joint working across mental health and social care teams
Community health and social care teams for adults with severe mental health issues	• Enhance integrated working through pathways, protocol development in relation to Approved Mental Health Professional duties, and access to crisis resolution and home treatment (CHRT) teams to help avoid unnecessary admissions • Link with phased development of the target operating model for community health and social are services, to deliver a more integrated and multi-disciplinary approach to meeting physical health and mental health needs
Supported Accommodation pathways	Deliver the review of supported accommodation pathways to inform work with housing teams to find long term solutions and take forward recommendations
Rough Sleeping	Pursue opportunities to bid for further funding post March 2020 from the Ministry of Housing, Communities and Local Government, to continue initiatives
Aftercare and support	Further develop joint leadership to support safe and timely discharge and coordination of care plans.
Access to children and young people's MH services	Implement the recommendations of the Sussex-wide independent strategic review of the whole pathway of emotional wellbeing and mental health services for children and young people

2. Summary roadmap

The high level milestones for the next five years are as follows:

When by	Milestone
August – November 2019	• East Sussex Health and Social Care Plan developed and finalised. • Submission of SH&CP Health and Care Strategy to NHS England.
December 2019	• Health and Wellbeing Board endorses East Sussex Health and Social Care Plan
January 2020	• Further implementation planning for delivey in 2020/21, including: ○ Further refinement of priority-setting, programme objectives and KPIs ○ Integrated outcomes framework refresh ○ Further testing with local system and stakeholders ○ Further development of proposals for our East Sussex ICP and population health and care commissioning
March 2020	• East Sussex Clinical Commissioning Groups merger process complete, subject to application and approval by NHS England • Agree proposals for our East Sussex Integrated Care Partnership • Agree proposals for our approach to integrated population health and care commissioning in East Sussex.
April 2020 – March 2021	• Delivery of 2020/21 transformation programme and LTP priorities. • Begin delivery (as per agreed proposals) of: ○ East Sussex Integrated Care Partnership ○ East Sussex Population Health and Care Commissioning ○ Next wave of PCN Network Contract DES requirements ○ Phase one of target operating model for community health and social care services • Continued financial stabilisation of system.
April 2021 – March 2022	• East Sussex Integrated Care Partnership in place • East Sussex Population Health and Care Commissioning in place. • Sussex Health and Care Integrated Care System in place. • Continued financial stabilisation of system
April 2022 – March 2023	• Further consolidation of our Integrated Care Partnership and population health and care commissioning arrangements • Continued financial stabilisation of system
April 2023 – March 2024	• Continued financial stabilisation of system. • Primary medical and community health service funding guarantee met.

3. Our approach to engaging with our stakeholders

3.1. Background

A comprehensive approach to engagement with local people (including patients, clients, our staff, the public and communities) across East Sussex has been a strong feature of our health and social care transformation programmes to date. This has been undertaken in partnership with Healthwatch and the voluntary and community sector (VCS) and is taken forward at all levels – including representation in strategy and planning, and using co-design principles to involve people in the commissioning of specific services, service design and project development.

Our overall strategy has been guided and supported by our joint East Sussex Communications and Engagement Steering Group which brings together communications and engagement leads from across our health and social care partner organisations, including Healthwatch. Moving forward a communications and engagement strategy will be produced to support the delivery of the East Sussex Plan.

Our approach has also been underpinned by the development an integrated outcomes framework in 2017/18, based on what is important to local people about their health and care. This is collectively owned and shared across our health and social care system. We aim to refresh our outcomes framework as part of our planning process to ensure it truly reflects the whole East Sussex population.

East Sussex was also involved in the SH&CP's wide ranging public engagement exercise about the NHS Long Term Plan during the Spring of 2019, culminating in the report 'Our Health and Care, Our Future'. This was a programme of engagement that took place across the whole of Sussex, in partnership with Healthwatch, and included events and online surveys. Detail is provided below about how this information has been used to inform and contribute to developing our East Sussex plan.

3.2. Equalities and diversity

The East Sussex Health and Care Partnership is fully committed to ensuring the improvement of the health and wellbeing of all our population and we will commission services in a way that enables us to take account of this. Recognising the high level nature of this plan, we will ensure that all of our projects and initiatives take account of our diverse population as we move towards implementation and delivery, including protected characteristics, as detailed in the Equalities Act.

In particular we expect to drive this forward through the ongoing implementation of personalised care that is designed take account of individual circumstances, differences and strengths. In addition we will ensure that diverse and seldom heard groups and communities are a key focus in the communications and engagement strategy that we will develop to support this plan, and the specific projects and developments within it. For example, through reaching out to parts of the community who may not traditionally get involved in our work, such as working age people, young people (16+), equalities groups and communities, and neighbourhood groups (with a focus on rural communities and areas of deprivation).

We are also undertaking a high level joint Equalities and Health Inequalities Impact Assessment (EHIA) screening of our East Sussex plan, with a view to flagging potential areas where future EHIAs will be needed for specific projects and initiatives. This will also inform the framework for continuous engagement with all of our stakeholders.

3.3 How we have used insight and key themes from recent engagement

A multi-agency East Sussex Plan Task Group was set up with nominated leads across our system, including representation from Healthwatch and the voluntary and community sector, to work together to guide and shape the development of the East Sussex Health and Social Care Plan.

An audit of existing insight from recent engagement events and exercises was undertaken to provide a snapshot of the key themes across East Sussex to help inform our plan, alongside our benchmarking. This included reviewing the East Sussex insight from the Phase 1 report from the Big Health and Care Conversation and Our Health and Care, Our Future[6] engagement on the NHS LTP (insight from Phase 2 will be added when available), as well as from the joint Shaping Health and Care events that were specific to East Sussex. The Adult Social Care and Health Listening to You survey, and the Children and Young People's Takeover Day 2018 , which focussed on mental health and wellbeing were also reviewed. A summary of the key themes is contained in Apppendix 7 grouped under the following headings:

- Joining up health and care services, partnership working and collaboration
- Communication, access to information and information sharing
- Digital
- Staffing resources and funding
- The role of the community sector, and social prescribing
- Health inequalities
- Prevention and supporting healthier choices
- Mental health
- Holistic and personal care
- Access to services and experience of services
- End of life care
- Multiple and complex needs

The themes from the audit have been used to help inform our ambitions for our longer term health and social care model (described in section 1.6), and have helped shape the priorities and next steps that we anticipate will enable progress in 2020/21 and onwards. The themes will continue to be used to inform next phase of planning for delivery, alongside more bespoke engagement.

The themes from the audit will also be used to support the refresh of our integrated outcomes framework for 2020/21 and ensuring it continues to reflect what matters to local people about their health and social care services.

3.4. Next steps – informing ongoing planning and implementation

Building on the comprehensive approaches to engagement undertaken to date, our priorities and next steps for transformation and integration will be used to create a framework of continuous engagement with our stakeholders. A system communications and engagement strategy will be

[6] The Our Health, Our Care, Our Future engagement was undertaken in two phases across Sussex. Phase one focused on a series of events where local stakeholders and the public were invited to share their views to inform our work; phase two focused on reaching out to parts of the community who may not traditionally get invovled in our work, for example working age people – including NHS staff, young people (16+), equalities groups and communities, and neighbourhood groups (with a focus on rural communities and areas of deprivation)

developed to support this.

We will continue to test our plans with our broad base of local stakeholders who are regularly in touch with us about developments. This will be done both through existing mechanisms such as the Patient Participation Groups Forum, the East Sussex Seniors Association (ESSA), and the East Sussex Inclusion Advisory Group (IAG), as well as new forms of engagement designed to reach people less likely to get involved, as they emerge.

Our system partnership governance has also been reviewed and has evolved and we have launched a new East Sussex Health and Social Care System Partnership Board, to ensure a broader system partnership to lead and oversee delivery of our plans, and development of our integrated care partnership proposals on behalf of the Health and Wellbeing Board. We will achieve this through aligning organisational plans across our health, social care and wellbeing system, involving all key stakeholders and taking action together. More information about this can be found in section 4.

We have recently entered into a new arrangement to strengthen the involvement of voluntary and community partners specifically. The new East Sussex 'Partnership Plus' forum brings partners together to take a different approach to how we work together and more effectively use our combined resources, by building on existing skills and knowledge and developing much better ways of working for the benefit of people in East Sussex. A joint planning group has been formed to identify community priorities, using our collective knowledge and data and move swiftly to 'doing' – taking action on the wider determinants of health as well as the role of the VCS in delivering health and care services and support.

4. Working together to deliver our plans

4.1 Our partnership governance

We have launched our East Sussex Health and Social Care System Partnership Board. This is a strategic planning body, enabling us to work together on behalf of the Health and Wellbeing Board to collectively oversee and lead the delivery of the system transformation required to:

- Meet the health and social care needs of our population
- Improve the health of or population and reduce health inequalities
- Respond to the NHS Long Term Plan and local priorities in East Sussex through overseeing the strategic development and delivery of our longer term plans, through aligning organisational plans across our health, social care and wellbeing system.

In order to do this effectively the new board involves a broad membership from across our system to ensure a clear focus on prevention and the wider determinants of health, as well as making improvements to the quality of care we deliver as a system. This includes primary care networks, NHS providers, district and borough councils, Healthwatch and the voluntary sector, alongside East Sussex CCGs and ESCC as statutory health and social care commissioners. The East Sussex Health and Social Care Executive Group will also continue to meet to ensure a clear focus on the operational performance of our programme priorities. This will be kept under review as our plans for our ICP and broader system working take shape.

The structure below shows the current key elements of our partnership governance and the lines of accountability. It will evolve over time, for example, as our East Sussex Integrated Care Partnership (ICP) emerges.

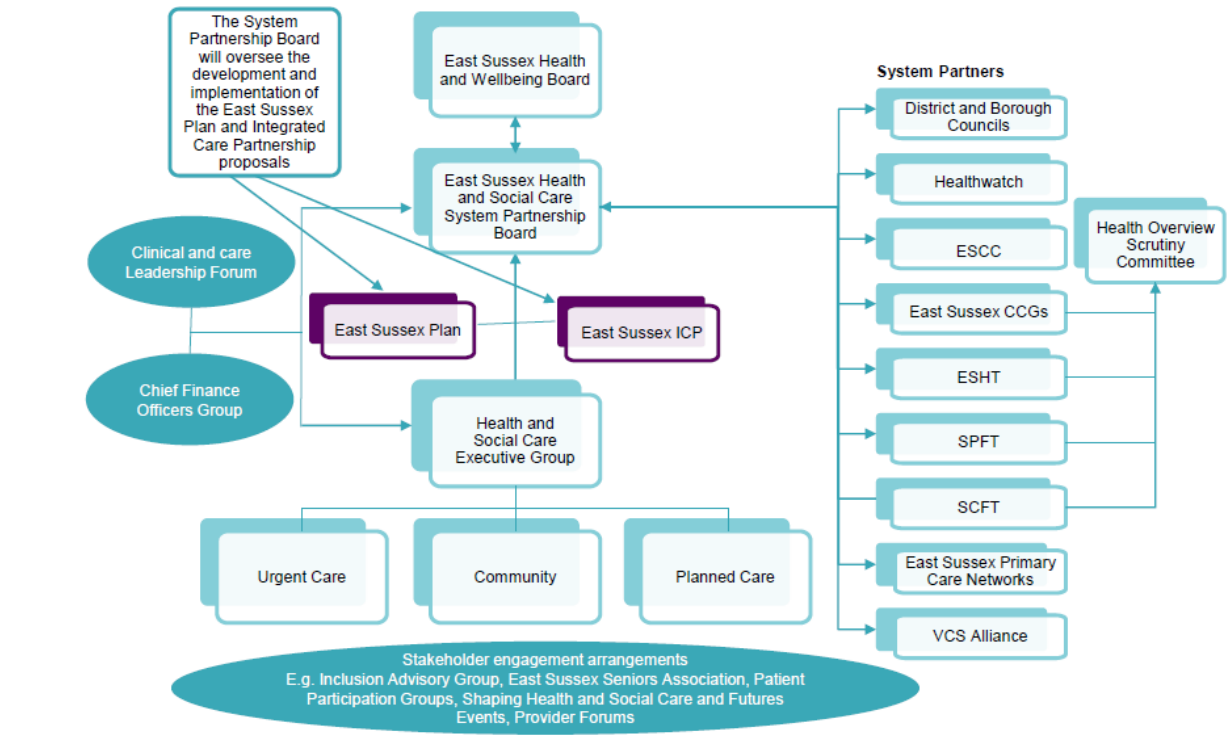


Figure 3: Key elements of partnership governance

4.2. Developing our integrated care partnership

Part of the work of the System Partnership Board will involve ensuring proposals are developed and implemented for our future East Sussex Integrated Care Partnership (ICP), with initial proposals being shaped for April 2020. The ICP will ultimately govern how we operate together in a more integrated way in our localities across all providers of primary, community, mental health and social care with consistent pathways into and out of hospital care when this is needed.

This includes ensuring there are strong links with services that have an impact on the broader determinants of health, for example those provided by district and borough councils and VCS services and support, for the benefit of our population. Over time it will develop to encompass relationships and pathways with services accessed by our population beyond the geography of East Sussex. For example, acute hospital services provided within Sussex and Kent, and specialist services within Sussex and beyond.

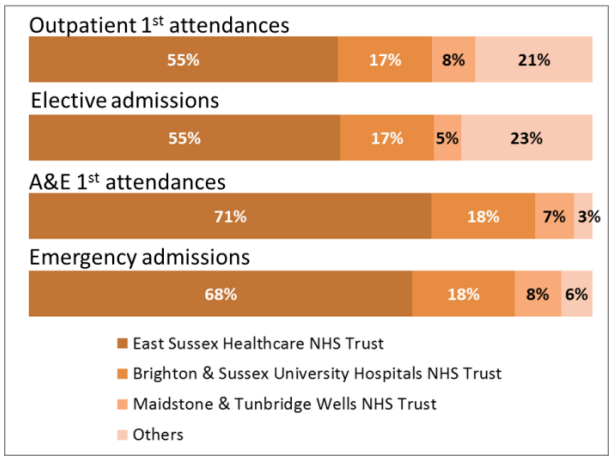


Figure 4: Hospital activity by provider for East Sussex residents in 2017/18
Source: Hospital Episode Statistics

The majority of East Sussex residents access services within the county, particularly for urgent care.

Our ICP will provide the framework for all providers of health, care and support working in East Sussex to come together to plan, organise and deliver services at the optimum scale to support quality and consistency - making the best use of our collective resources to deliver the outcomes and priorities for our population identified in the East Sussex plan. Proposals will be shaped to cover:

- The longer term objectives for the ICP and the overall model we will be working towards.
- The elements that need to be in place by April 2020.
- The specific actions that we will take to deliver the agreed ICP April 2020 proposals, for example agreeing and implementing the common operating model.
- A framework for managing health and social care resources in East Sussex to deliver the best possible outcomes

4.3. Supporting primary care network (PCN) development

There are 12 PCNs in East Sussex, established on footprints reflecting local relationships and previous locality working arrangements. All the PCNs are now operational, with identified clinical directors in place, and further delivery of primary care improved access is under way. An opportunity for PCNs to increase the pace of their partnership working has also been provided through the local offer of a PCN accelerator programme. Four specific areas of focus have been identified, for PCNs to accelerate and respond to the challenges and focus on:

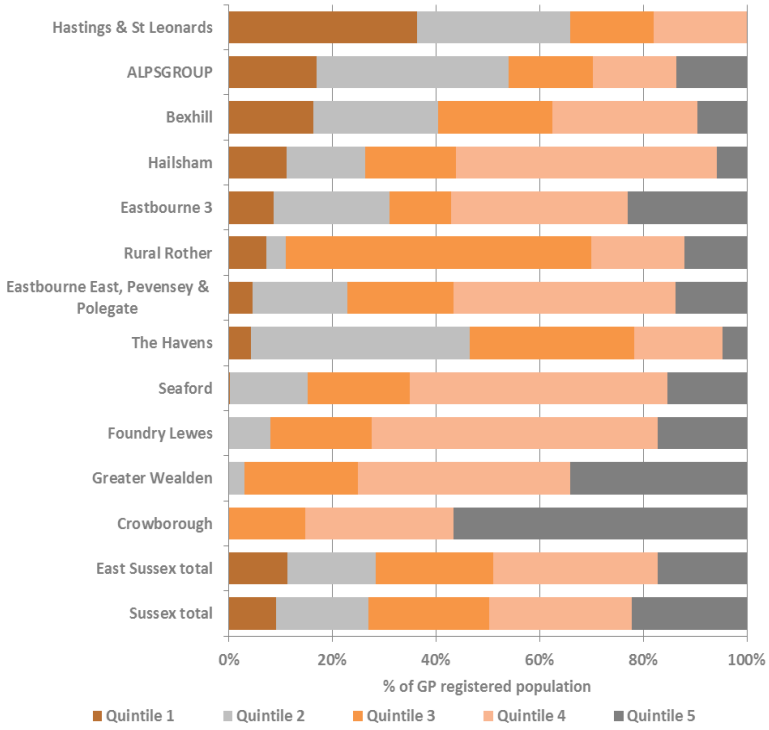
- The development and acceleration of a PCN to progress at pace, mature and deliver their ambition
- Delivery of the Sussex STP Clinical Variation Programme ambitions and requirements (Musculoskeletal falls, Diabetes, and Cardiovascular disease)
- Responses to the requirements of the LTP (including anticipatory care, personalised care and early diagnosis for cancer)
- Integrated joint working of the PCN with other providers to better support integrated care, MDTs and improve the PCN population health; and better integrate urgent or planned care pathways to improve system flow, avoid admission and improve value for money

Some PCNs are taking up the opportunities offered through the Additional Roles Reimbursement Scheme (ARRS), such as the employment of social prescribers and pharmacists (this will take into account existing extended roles that we have already implemented in the county), whereas others continue to explore their options. The CCGs are supporting them in these discussions, including exploring the potential for alignment with the current CCG commissioning of social prescribing.

Public Health are working to compile population health packs to help PCNs make informed decisions regarding their priorities for development and strategic direction. Poor health outcomes and the need for services are strongly associated with deprivation. Figure 4 illustrates the variation in deprivation profiles between PCNs – in Hastings and St Leonards over 30% of patients live in the nationally most deprived quintile, where as in Crowborough, over 50% of patients live in the least deprived quintile. PCNs are currently completing a self-assessment against the national NHSE maturity matrix, which will help shape their response to the recently published prospectus detailing the national support offer.

The Director of Primary Care meets regularly with each PCN to discuss their plans and how CCGs can support them, and the wider CCG primary and community care team members are being repositioned as more externally focussed in order to directly support PCNs. To share good practice and ensure progress is maintained, monthly CCG / PCN / provider meetings have been established, commencing in October, and quarterly Sussex-wide meetings will commence in November with support from the National Association of Primary Care.

Figure 5 – Primary Care networks by national deprivation quintile 1 = most deprived



There is a place for collective representation of the East Sussex PCNs on the new Health and Social Care System Partnership Board (SPB), alongside ESHT, SCFT, SPFT, the East Sussex CCGs, ESCC and wider system partners including the VCS. The SPB will oversee development of our East Sussex plan and ICP proposals, including the full implentation of our target operating model for community services, once this has been agreed. Arrangements are being put in place for full engagement of PCNs in the development and design of the target community operating model, including ensuring closer system working and integration with mental health services at the community and locality level.

Work is also being taken forward to develop Local Commissioned Services (LCS) in the context of PCNs and potential alignment across Sussex to include cancer LCS, respiratory / COPD LCSs and enhanced care in care homes LCS, and diabetes prevention, with consideration of provision on an individual PCN-basis. The diabetes prevention LCS will support the National Diabetes Prevention Programme. This will build on the schemes currently in place in East Sussex to ensure alignment.

There have been approaches to trialling and delivering multi-disciplinary working in community and primary care developed through our integrated care programmes to date. For example, SCFT implemented a programme of multi-agency team meetings (MATs) that bring together GP practices and community health, social care and voluntary sector services to address the needs of the most complex and vulnerable patients. The role and remit of MATs is now under review with SCFT and CCG clinical leads, with a view to re-aligning their operation to the new PCN model of working, including further consideration in the context of the work to develop a common operating model.

4.4 Our shared financial model

We are working to set out a description of our system financial model from 2020/21 to 2023/24 that demonstrates the shift in investment to primary care and community health care, including meeting the new primary medical and community health services funding guarantee.

There is Sussex-wide work on financial modelling which will inform the local model for East Sussex

and how we will narrow any gaps by 2023/24, as well as meet the required shifts. The work on the East Sussex system will link through to our priority programmes of work and will seek to take a whole East Sussex health and social care economy approach. This will also support operational and business plans for 2020/21 as the detail develops.

4.5 Managing shared risks

Key risks to this plan will be considered in detail as part of the next phase of planning to support delivery. Shared system risks will then be and logged and managed as part of our programme monitoring arrangements. At a high level our key shared risks to delivering the plan, and the new model of care overall, centre around recruitment and retention of our workforce, for example the potential impacts of introducing new roles in primary care, our system financial position, and capacity in our independent care sector market[7].

As outlined in this plan, through taking a more collaborative approach to recruitment and organisational development, and decisions about our collective resources and commissioning, we can have positive impacts on these areas to help manage these risks.

5. Supporting our system to deliver our plans

5.1. Our workforce

5.1.2. Sussex-wide developments

Across the Sussex Health and Care Partnership Human Resources (HR) and Organisational Development (OD) leads work together to coordinate HR, workforce and OD activities across Sussex, including design of development opportunities. In practical terms the workforce and OD priorities for Sussex have been agreed to ensure delivery against the NHS Interim People Plan and organised into five workstreams, including talent management and leadership development. Each workstream has, or is developing, a set of objectives and is led by a either an HR Director or Chief Nurse, or both, from within our Sussex system.

One of the underlying themes for several of the workstreams is addressing the skills gap identified following a baseline assessment carried out in the spring, with a particularly focus on nursing vacancy levels.

For primary care, Health Education England (HEE) has produced a new governance structure and standards for the evolving role of training hubs, previously known as Community Education Provider Networks (CEPNs).

The Sussex Health and Care Partnership have embraced this new way of working and created a Sussex Training Hub that will provide strategic direction for locality training hubs, such as the East Sussex Training Hub. Investment is being made by HEE to ensure the Sussex Training Hub and the locality training hubs have the necessary infrastructure to meet the standards required within the HEE maturity matrix, thereby enabling the training hubs to support the development of PCNs and their workforce plans. For example, this will take the form of workforce planning and workforce

[7] Supporting People to Live Well in East Sussex, the market position statement for adult services and support (April 2019)
https://www.eastsussex.gov.uk/media/13531/market-position-statement-2019.pdf

information resources at Sussex Training Hub level to provide a consistent approach to workforce planning in primary care.

5.1.3. East Sussex draft OD Strategy - our strategic vision

Within East Sussex we have established an **East Sussex Organisational Development Network** and a **Strategic Workforce Group**, to develop the relevant initiatives to ensure our East Sussex workforce of the future is well placed to deliver improved health and care for local people.

East Sussex OD leads have developed a deeper understanding of each other's organisations, building an East Sussex OD Network (the Greenhouse Group) and co-producing a draft 'place' People (OD) Strategy. Our workforce is critical to our success both at a macro and a micro level, they are the people who can make a success of system-wide transformation as well as being central to the experience of those who use our services. We believe that, underpinned by staff engagement, there are three key themes to empower our people to deliver the best integrated health and care for local people. We need to build:

- An East Sussex culture
- A thriving workforce
- High performing system leadership

All three themes are vital as each is integral to becoming a high performing system in East Sussex. The model below outlines the interdependency of these themes in delivering the system workforce that we need for the future of health and care locally.

5.1.4. Delivering this strategy

Our East Sussex OD Network will drive the delivery of this strategy, supported by the recently trained cohort of 42 OD practitioners, working closely with organisational communications and staff engagement teams. It will be important that this is driven in the context of our local East Sussex work to create an integrated care partnership that is financially sustainable for the future, and also aligns to the Sussex Health and Care Partnership. As such, our clear governance arrangements and senior support for this ambitious strategy are key to its success and delivery.

5.1.5. Translating the strategy into outcomes for local staff and local people

We anticipate that the key outcomes from the delivery of this strategy, based on local experience, specialist expertise and research will be:

- A clear, understood lived vision
- Shared values and behaviours
- Improved motivation, staff retention, ability to recruit
- A stable, adaptable, creative and innovative workforce
- Happy, healthy and productive staff

5.1.6. East Sussex Workforce priorities

We have an established Strategic Workforce Group (SWG) made up of senior workforce and HR professionals representing each of the East Sussex partner organisations. The SWG initially developed a two-year workforce strategy in 2016 designed to support the delivery of the workforce needed to achieve the integrated care models within three priority workstreams (Integrated Locality Teams, Urgent Care and Primary Care).

Each year the SWG reviews its strategic priorities to ensure the strategy continues to reflect the East Sussex workforce needs in terms of closer working and the introduction of new care models. This will play a critical part in furthering the integration agenda and the NHS LTP and local ambitions to implement our ICP and a Sussex integrated care system.

East Sussex Locality Training Hub priorities

The East Sussex Locality Training Hub works with available funding to deliver workforce training priorities. For example, Health Education England Kent Surrey Sussex (HEE KSS) has previously provided operational plan funding which was combined with GP Forward View investment by EHS and HR CCGs to implement care navigation in GP practices, bursaries for newly qualified GPs and funding a two-year GP Fellowship programme.

The East Sussex Locality Training Hub will use funding made available through CCGs, NHSE HEE KSS and the SH&CP to support the following identified priorities to help address the workforce issues within primary care:

- GP retention schemes funded via NHSE and SH&CP,
- Creation of educational incentive scheme/hubs to increase training within GP practices where this is currently lacking,
- Support for PCNs with developing workforce plans (as per the NHS LTP),
- Continued support to practices introducing care navigation.
- Support social prescribing implementation and ensure it complements care navigation.
- Creation of GP Fellowships (e.g. Digital Fellowship) to improve retention of newly qualified GPs and broaden experience.
- Creation of an East Sussex academy as part of long term recruitment plans.

Priorities to support local transformation

Overall the East Sussex workforce priorities for 2019/20 to help deliver our East Sussex integration and transformation plans have been agreed as follows:

- Support to deliver the Sussex workforce priorities, ensuring East Sussex representation on each of the five Sussex workforce workstreams.
- Identify opportunities for working collaboratively in terms of introducing new, blended, and/or enhanced roles to address the skills gap within East Sussex. This covers the potential workforce development needed to support transformation of integrated community and out of hospital care, urgent care, planned care and primary care, as well as the approach to the comprehensive model of personalised care.
- Design and delivery of the East Sussex OD plan (as described above).

5.2. Digital requirements

The East Sussex health and social care system is delivering on a long term digital strategy to support the care we give our people in line with the NHS Long Term Plan. Over the next five years we will continue to work closely with our partners across Sussex within the Sussex Health and Care Partnership to deliver on the following themes of the Locally Held Care Record (LHCR), remote care and the wider digital strategy described here from the a person-centred perspective:

- **Our connected care** – giving the practitioners who care for me the information they need from all the settings in which I receive care; ensuring that I only have to tell my story once; and that my journey through the health and care system is supported by clear messaging from one setting to another about my needs.
- **Transforming outpatients -** I do 'not have to attend outpatients unless I'm required to do so' by deploying remote care alternatives to traditional outpatient appointments.
- **Ourpersonalised health** – giving me access to, and control over, my own information. This means I will have greater agency in my care, allowing me to better understand my ability to take an active role in my wellbeing. It will allow me to communicate my needs more effectively and in better time with the right care professionals, allowing them to deliver their role more effectively. A citizen portal is also being developed within the cancer space. A Personal Health Record (PHR) uses a shared record approach which enables a citizen to access their health record through a single online identity. Within Sussex there is an ambition for all citizens to have access to their Personal Health Record and the Patient Knows Best solution has been procured to support people with multiple co-morbidities. A personalised approach to care that promotes patient empowerment in their health care is a key priority for the Surrey and Sussex Cancer Alliance.
- **Our population insight** – allowing our health and care system to have a better sense of itself; a better sense of what care is being delivered within a complex integrated network of health and care providers working as partners to serve 1.8 million people across Sussex; and through the evidence an integrated longitudinal health record for everyone will allow us to obtain, improving the outcomes we deliver through the services we provide.

As we deliver the LHCR across the next five years we will also support our health and social care workforce to benefit from a more integrated digital environment, including innovations in practice based on digital opportunities.

LTP	Priority	Themes	East Sussex initiatives
Empowering people	• Access to manage care • Long term conditions – telehealth and devices • Patients hold their care plan	Our Personalised Health	• PHR in cancer, diabetes and beyond online consultations. • Portals in social care. • Improve digital inclusion in our population. • Rationalisation of local service directories across CCG and Social care. • Integrating with the NHS App.

LTP	Priority	Themes	East Sussex initiatives
Supporting health and care professionals	• More satisfying place to work – more effective tools • Increasing pace to out of hospital based care	Our Direct Care	• Integrated Care Record allowing professionals a better view of the person they are caring for. • Supporting teams integrated across health and social care to better work together. • Smarter Working and Agile Practitioner – how technology can be harnessed to support more flexible and effective working practices. • GP digital fellow – to work with the system to support the move to a digital first model and grow a clinical digital lead network (reference CPILF).
Supporting clinical care	• Technologies enabling pathway re-design • Co-production between patients, clinicians and carers	Our Direct Care, Our Personalised Health, Our Population Insight	• Work with the developing LHCR to provide a new set of standards practitioners and service leaders can depend on to design new pathways, and helping to deliver a workforce that understands how digital can transform the way we deliver care. • Integrating use of digital across services, removing barriers to sharing care information between providers, and between our population and the practitioners delivering their care, allowing co-production of pathways and people to manage their care. Out of work with the Information Sharing Gateway to provide the governance to support increased sharing and the ES Integrated Care Record and prototype LHCR Orchestration Layer to provide the technology. • Digital work stream to support both outpatient and emergency department transformation.
Improving population health	• Population insight to understand greatest health • Provide evidence to	Our Population Insight	• East Sussex is an early adopter of the Sussex Integrated Dataset to support the transformation in social care and community health into integrated working by providing the evidence for the benefit of change.

LTP	Priority	Themes	East Sussex initiatives
	improve the way we change		
Improving clinical efficiency and safety	• Improving ways of working between practitioners, to allow more effective integrated working	Our Direct Care	• Integrated Care Record and Information Sharing Gateway

Our key NHS healthcare providers will also be working to deliver increased digital capability, in line with the national and regional programmes to ensure that services are digitally enabled. Our providers will agree a trajectory for improvement over the next five years, with associated investment, to build capabilities in key areas, including cybersecurity.

5.3. Estates requirements

5.3.1. Primary care premises

The delivery of improved GP premises is one cornerstone of the delivery of our LTP commitments, and specifically the future role of primary care and its transformation in relation to the GP Forward View and the PCNs. The provision of primary care premises that are appropriate, modern and fit for purpose and flexible enough to support the delivery of our plan is therefore key.

The CCGs are continuing their programme of upgrading practice premises in a very challenging financial climate.

5.3.2. Premises development

Across our CCG footprints we continue to have a number of primary care estate challenges which are exacerbated by ongoing local population growth. These include the size of the premises in relation to the registered population and the layout and the condition of the buildings, all of which can seriously impact on care delivery in various ways.

The CCGs have therefore been working with local GPs to assess the suitability of the primary care estate across our footprint. We have undertaken a prioritisation process, to enable us to see which practice developments should be regarded as most urgent and/or important. This has taken account of:

- Available square meterage Net Internal Area (NIA) per 1,000 registered patients.
- Known planned housing developments in the area.
- Practice-specific issues, such as suitability of facilities, expiry of leases/planning permission.
- Any CQC-related issues.

As part of our whole systems approach to locality development for health and social care services, and our drive to achieve integrated working, consideration for any new development

has also been given to:

- Ensuring practices have the ability to provide access to the full range of locally commissioned services (LCSs) for their patients.
- Ensuring there are no estates barriers to the co-ordination of extended hours across practices.
- Sharing front of house and back office facilities, clinical and non-clinical staff, where this is practical to avoid duplication and achieve economies of scale.
- Ensuring estates considerations are no barrier to practices' key role in teaching and training.
- Devising flexible approaches and using opportunities afforded by new digital initiatives.

These criteria have being used to prioritise outline proposals from practices for estates developments from a commissioning point of view.

The actual order in which proposals are being developed and presented is dependent on a number of factors, including the urgency with which the partnerships pursue the projects, the congruency of views between possible project partners, the ability to formulate an agreed potential outcome, and also the availability of developable sites and the ability to develop the proposal to financially stay within the framework as set out by the GP Premises Cost Directions.

5.3.4. Development Status

The CCGs are taking forward a significant number of primary care developments simultaneously to ensure that practices and now PCNs have the capacity and are well placed to deliver the additional services required going forward, including additional PCN services, integrated community hubs, new digitally-enabled ways of working and increasing outreach services from secondary care.

In EHS and HR CCGs there are currently eleven new-build developments underway or in planning and two significant extensions. This will give each of our eight PCNs at least one new facility or significant expansion capacity for service developments including those provided under the DES and those provided within the integrated hub model.

In order to support the delivery of better quality services and more efficient outcomes, there are 13 active primary care premises developments across EHS and HR. The CCGs' plans reflect the need to improve primary care estate and the financial implications of this are scheduled within the five year financial recovery plan.

HWLH CCG currently has one new development underway, which will provide not only a new primary care surgery for the three practices in Lewes, but will also enable integration with other health and social care providers and community and voluntary services.

Status	EHS CCG	HR CCG	HWLH CCG
Project commenced	3	1	1
Approved	3	3	1
OBC	1	2	1
Total	7	6	1

5.3.5. Acute and community estate

While it is acknowledged that ESHT and SCFT have areas of concern around the level of investment required to address the estates maintenance backlog, medical equipment and IT challenges, we are developing an ambitious programme to address these matters. The ESHT estate will be addressed through a combination of ESHT resources e.g. depreciation and external bids PDC, loans etc. ESHT has recently received approval for a loan of £13.86m to address the fire compartmentation issues at Eastbourne DGH. Delivering our urgent care programme will require significant investment at the 'front door' of our main emergency departments, alongside the development of Urgent Treatment Centres (UTCs). This sits alongside significant investment within the hospitals on backlog maintenance and infrastructure, medical equipment and digital capability. Working with and through the SH&CP digital and estates groups, these plans will continue to be refined and developed over the coming months. Capital schemes to improve clinical outcomes at the 'front door' include the development of a single assessment unit/UTC at Conquest Hospital (£6.28m) and the development of the UTC at Eastbourne DGH (£3.78m). N.B. this is wider investment around the 'front door' and doesn't preclude delivery of the UTC model by December 2019.

Through the development of the SH&CP estates strategy we are working with colleagues on developing capital bids for the single assessment unit/UTC at Conquest Hospital, UTC at Eastbourne DGH, cardiac catheter lab provision, ophthalmology service modernisation/relocation, day case unit at EDGH, non-clinical space rationalisation, medical day case unit and maternity.

SCFT is the main provider of adult community health services in High Weald Lewes Havens and occupies three community hospitals within the area: Lewes Victoria Hospital, Crowborough Hospital and Uckfield Hospital. NHS Property Services own these buildings and SCFT deliver the services. SCFT has been working with commissioners, GPs and NHS Property Services to develop proposals for an Urgent Teatement Centre at Lewes Victoria Hospital, enabling an enhanced offer for local people in line with our Integrated Urgent Care strategy. The minor injuries unit (MIU) at Lewes Victoria Hospital closed temporarily on 6 November 2019 to allow improvement works to upgrade it to a UTC to start. This work is scheduled to be completed by April 2020.

The integrated primary urgent care provision is also being reviewed across High Weald Lewes Havens, and having finalised the plans for the Lewes UTC, the CCG is now exploring options for expanding the offer at Uckfield and Crowborough MIUs with SCFT and other providers, including HERE (who have the contract for primary care improved access), IC24, and the recently formed PCNs.

In the longer term a further review is required to address:

- Distribution of beds to ensure safer staffing, cohorting and to improve system flows (the use of beds at Newhaven Rehab need to be considered as part of this)
- Address utilisation issues, particularly at Uckfield Community Hospital
- Continued investment to renew diagnostic imaging
- Addressing backlog repairs

The services and estates mapping will be complex given that the High Weald and Lewes community hospitals face three acute Trusts – ESHT, BSUH, and Maidstone and Tunbridge Wells (Crowborough). A whole system approach will be necessary to determine the required strategic

changes to this estate.

SCFT is also working with GPs in Lewes to establish the UTC at Lewes Victoria Hospital and to realise the opportunity of the Northern Quarter development that improves the primary care infrastructure in the town. Where there is no estates project per se, it should be noted that SCFT is committed to improving the integration of community health services in line with PCNs and this will drive future estates planning that will increasingly support primary care and community-based health services in a more integrated approach.

ESHT and the East Sussex CCGs are working together to redevelop/improve the provision of GP premises, for example in Seaford and Newhaven, and the establishment of community hubs. Similarly, SCFT is actively engaged with GPs within the Havens PCN to develop the Newhaven hub, which will enable the co-location of primary care and community health services (currently based at Newhaven Polyclinic) as well as other public services that have a positive impact on public health, particulary leisure.

Appendix 1
Prevention, personalisation and reducing health inequalities – programme summary

1. Background

In East Sussex we recognise that to fully realise the benefits of prevention, early intervention and personalisation for improving health and wellbeing and reducing health inequalities, our approach needs to be embedded throughout our health and care system and delivered in communities through working with voluntary and community sector partners, civic interventions and clinical and integrated care services.

There are general duties under the **Care Act 2014** to prevent, reduce or delay needs for care and support, including carers. Our local approach also fits with the NHS Long Term Plan (LTP) aims of supporting people to live longer, healthier lives through helping to make healthier choices easier, and treating avoidable illness early on.

To achieve this involves strong multi-agency working by providers of care and support in all settings. Our clinicians, care professionals, staff and volunteers across all services will be supported to make the most of the contact we have with clients and patients in a wide variety of settings, including when people have been admitted to hospital, to help people to improve their health and wellbeing. For example our training programme **Make Every Contact Count** is currently being rolled out to staff working in our health and care system, so that they know how to encourage changes in behaviours that have a positive effect on the health and wellbeing of individuals, communities and populations, and where best to signpost or refer people for support with improving health.

The diagram below illustrates three different ways that our East Sussex place can deliver prevention and reduce inequalities, in line with the specific needs of our local communities. This also draws out where a more standardised approach to some services across the Sussex Health and Care Partnership (SH&CP - our STP and emergent Integrated Care System) footprint will also strengthen impact across our shared population. Our approach will enable help where it is most needed in communities and population groups, and reflecting the real-life context of people's lives, in order to reduce the inequalities in health outcomes which exist within East Sussex.

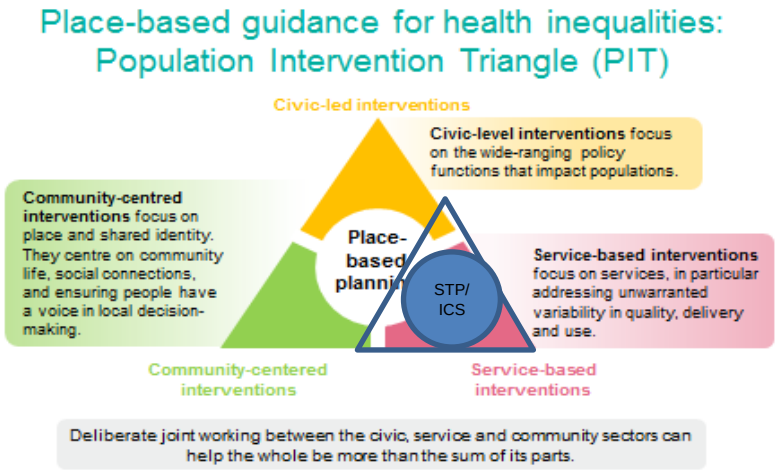


Figure 1 Place-based approaches to reducing inequalities and illustration of ICS main sphere of influence From PHE Addressing Health Inequalities Webinar (09.08.2019)

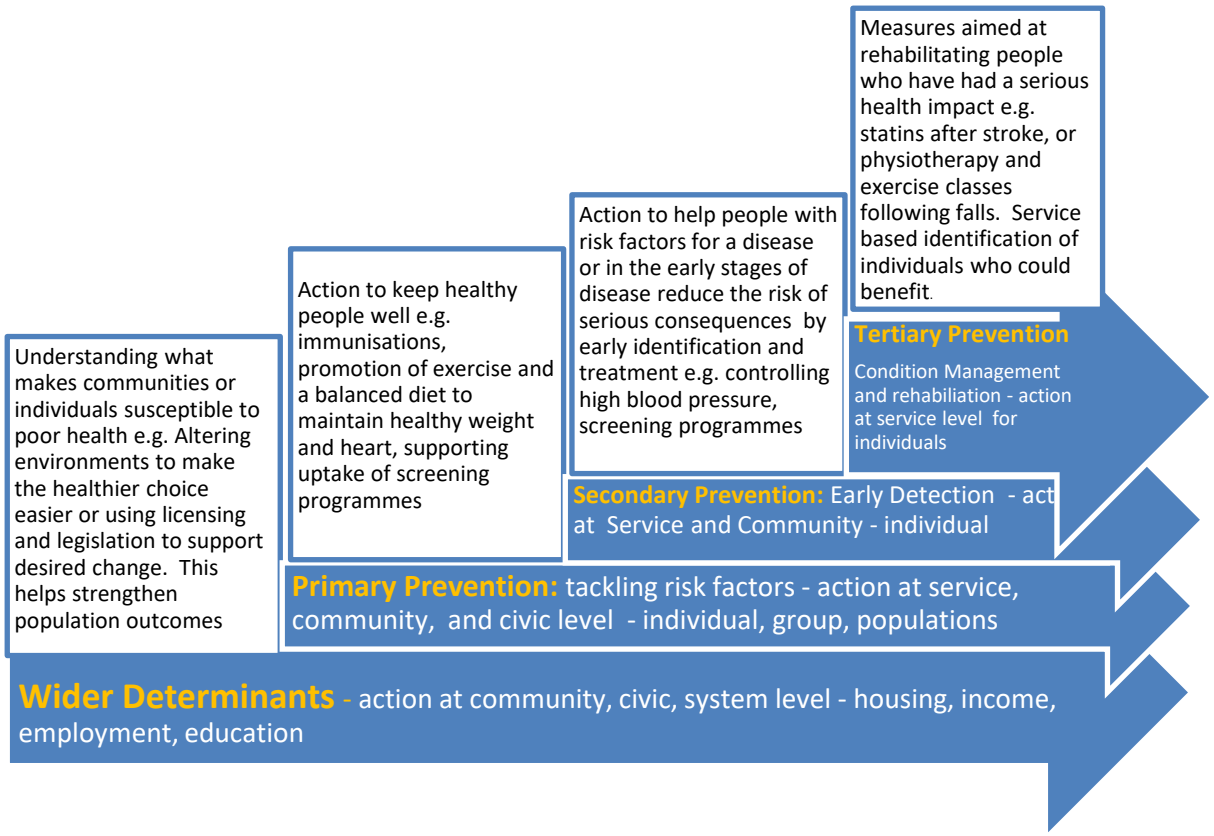
Our approach to prevention to date has ensured that it is embedded into the whole care across the life-course pathway, and covers:

- Giving every child the best start in life and supporting people to maintain good health and promoting healthy choices

- Helping people to help themselves and putting people more in control of long-term conditions through supporting greater levels of self-care, self-management and personalisation for example, through shared decision-making and personal health budgets
- Intervening early and proactively to prevent conditions and situations from getting worse, helping avoid unnecessary hospital admissions through stronger community pathways and support
- Enabling fast discharge to community environments where patients can be rehabilitated back to more independent living after an episode or spell in hospital.

This requires coordinated action by a range of partners and services from those that impact on the wider determinants of health, through to coordinated multi-disciplinary team work across primary, community, mental health and social care. Figure 2 gives a flavour of the four different levels of prevention.

Figure 2 - Definitions of prevention adapted from NHS England Population Health Management Flatpack



Our past work through ESBT and Connecting 4 You provides a strong foundation for work on prevention, personalisation and reducing health inequalities through ensuring we have a comprehensive and coordinated range of preventative services across all four levels of prevention. This includes:

- Commissioning the **Healthy Child Programme** – the 0-5 service is jointly delivered by health visitors, children's centre staff and family keyworkers, with the 5-19 healthy child programme delivered through the school health service.
- Supporting nurseries, schools and hospitals to become health promoting settings.
- Introduction of **One You East Sussex**, an integrated lifestyle service, which delivers individual behaviour change support.

- A longstanding approach to involving and supporting the active participation of people over 50, through our work with over 6,000 older people in the East Sussex Seniors Association (ESSA) and the seven member forums. Our established annual **UK Older People's Day** celebrations, now in its 12th year, provides an opportunity to promote a coordinated range of activities to promote healthy ageing, including opportunities for increasing exercise, reducing social isolation, and increasing participation in community activities.
- Providing **Making Every Contact Count (MECC)** training to health, social care, housing and voluntary and community sector staff and volunteers.
- Support for vulnerable people living in cold homes delivered by our **Warm Home Check Service**.
- **Healthy Hastings and Rother**, which aims to reduce health inequalities in our most disadvantaged communities. In order to find out more about the programme, which was launched in 2014, and its achievements, see: www.hastingsandrotherccg.nhs.uk/your-health/healthyhastingsandrother/
- As acknowledged by the Care Quality Commission (CQC), supporting our well-established voluntary and community sector in East Sussex to work with system partners to develop a number of services to help people to stay in their own homes.[8]
- In keeping with the above, our approach to investing in voluntary and community organisations in East Sussex helps to ensure that their critical role in supporting prevention, personalisation and reducing health inequalities, is recognised and supported to deliver outcomes. For example, **Take Home and Settle** and **Home from Hospital** services helping avoid hospital admissions and supporting hospital discharge pathways; **Supporting People** services; services and support for carers; the development of **Good Neighbour Schemes**, and; supper clubs for people living with dementia and their carers.
- Joint working through key partnership programmes such as **personal resilience** and **community resilience** to ensure a systematic approach to working with the strengths and assets in our communities across the county.
- Piloting the Patient Activation Measure (PAM) to help target support with self-care and self-management.
- Including **prevention and early intervention** in the diabetes care pathway redesign through GP-led multidisciplinary community teams as well as supporting greater levels of patient involvement in decision-making and self-care within care pathway
- Trialing **proactive care and assessments on frailty** as a feature of core health and social care pathways to identify and target support
- **Falls prevention services** provided jointly by our Joint Community Rehabilitation team and local leisure trusts Wave Leisure and Freedom Leisure, offering rehabilitation and reablement to adults within their own homes or community settings including equipment, exercise and mobility. Fracture liaison services are also provided for people who have had a fragility fracture, and targeted support is also provided to care homes offering risk assessment and management, training and falls monitoring and support to reduce risks for individual residents.

2. What do we want to achieve

Our aim is to promote, maintain and enhance people's wellbeing and independence in their communities so they are healthier, more resilient and are ultimately less likely to need formal health and social care services. We call this early intervention and prevention.

The overall outcomes we wish to achieve are:

- Improved population health and wellbeing
- Good communication and access to information for local people

[8] Care Quality Commission Local System Review of East Sussex (November 2017), page 28 https://www.cqc.org.uk/sites/default/files/20180126_east_sussex_local_system_review_report.pdf

- Sustainable services for the future
- Improved experience and quality of care and support

In order to do this, we will be seeking to continue our work with partners to support preventative interventions and commission services and support that:

- Use community-centred and asset based approaches that involve and empower individuals, schools and local communities to actively participate and take action on improving community health and wellbeing, providing appropriate help for mental or physical health problems at the earliest point and reducing health inequalities.
- Provide holistic integrated services based around the needs of children, young people and adults with disabilities enabling local solutions to our residents' needs.
- Provide support for people with long term conditions and support needs, and their carers and families to feel in control and independent, for example through personal health budgets and integrated care budgets, self-care and self-management techniques, and social prescribing to put people in touch with wider support and services available in communities to maximise their independence.
- Encourage people to take a more active role in maintaining and improving their own health, and support families and communities to stay as healthy and independent as possible.
- Support adults reaching, or at, a point of crisis by providing short-term outcomes-based support that enables them to regain their independence after the crisis has passed.

Impacts and savings from prevention are difficult to quantify precisely, with the time scale varying from a few months to many years. In addition, impacts are often accrued across the whole system, for example savings from reducing harmful alcohol consumption has an impact across a whole range of services including the police, social services and the health service, but are commissioned by local authorities.

We will continue to use the evidence base provided by tools such as the Public Health England Health Economics Evidence Resource and NICE Guidance, and our local business case development processes as appropriate, to guide how we can get the most impact and benefit for local people from all of our prevention interventions. We will also continue to measure whether we're improving health and wellbeing overall through our integrated Outcomes Framework.

3. Key priorities for 2020/21

The role of primary care and the twelve new **Primary Care Networks (PCNs)** in East Sussex will help us build on the comprehensive approach to prevention developed in recent years, and further consolidate it. Launched in July 2019, the PCNs bring together GPs to work together collectively and with other providers such as community health and social care services, mental health, pharmacies and voluntary organisations, to deliver certain services in a more integrated way for their patients and populations. This will enable people to experience well-planned services, appropriate to their needs, and seamless pathways.

Since July 2019, the continued implementation of primary care improved access and social prescribing link worker roles has been taken forward, with funding via the new PCN Network Directed Enhanced Services (DES) contract. Seven new service specifications will be published to build on this, presenting new opportunities to better understand the needs and assets of local communities, as well as individual strengths and risks, and tailor our collective resources to meet health and care need.

Timescale	Network DES contract specification
2020/21	• Structured Medicines Review and Optimisation • Enhanced care in care homes

2020/21 onwards	• Anticipatory care requirements • Personalised Care • Supporting Early Cancer diagnosis
2021/22 onwards	• CVD Prevention and Diagnosis • Tackling neighbourhood Inequalities

Through collaborating as partners across our system to support the delivery of these specifications, we will consolidate our learning and progress made to date in these areas, to strengthen our overall approach to prevention, personalisation and reducing health inequalities in our communities.

Our approach to prevention and early intervention is also **cross-cutting**, which means that it needs to align with the other priorities in our East Sussex plan, so that approaches to prevention, early intervention, personalisation and opportunities to reduce health inequalities are fully embedded as part of our plans for care pathways and services.

3.1. Support with making healthier choices and action on health inequalities

3.1.1 The wider determinants of health

The new PCNs are expected to help prevent ill health and tackle health inequalities through undertaking local needs analysis and proactive population health and prevention at the local level. By developing **population health management** approaches to better understand and predict needs before they arise, we will ensure that preventative actions reach the children, young people and adults who could benefit the most.

This applies whether interventions are delivered in the community, for example through the newly emerging PCNs and making links with civic and community partners, and the role of services such as housing and leisure, to impact the broader determinants of health, or through working with integrated community health and social care services and making sure services are accessible to all.

Public Health are working to compile **population health packs** to help PCNs and their local system partners to make informed decisions regarding their priorities for development and strategic direction. Poor health outcomes and need for services are strongly associated with deprivation, and we will use this opportunity to explore priorities for wider system partnership action across the wider determinants of health. This will include the further development of social prescribing pathways and community-based support in 2020/21 to support mental health and wellbeing.

As part of the next phase of prioritisation and delivery planning, we will also work with the SH&CP to use national guidance when it is published to set **trajectories for narrowing inequalities** in 2023/24 and 2028/29 to inform local wider system action planning.

3.1.2. Smoking, obesity and alcohol

The LTP also sets out some specific areas of action on smoking, obesity and alcohol as part of a stated aim for more action by the NHS on prevention and reducing health inequalities. This also reflects local priorities and we will continue to support this through our established partnerships that bring together a range of organisations to deliver programmes of work. As part of national enabling actions to support implementation at scale across the NHS, indicators and datasets will also be developed to monitor the impact of these prevention activities on health inequalities.

We have set out below how we will support prevention in these areas through existing partnerships and programmes. We have included the high level objectives, and more detail can be found in individual strategies and plans.

Smoking

Local action on smoking is taken forward through the work of the East Sussex Tobacco Control Partnership. The partnership is currently in the process of updating its strategy and there are also links to the Sussex-wide Local Maternity System objectives for saving babies' lives and prevention; the East Sussex Smoke-Free Pregnancy Partnership, and; the Illegal Tobacco Partnership. Our objectives are:

Wider Determinants	Primary Prevention	Secondary Prevention	Tertiary Prevention
• Reducing availability of tobacco	• Stopping people starting smoking	• Smoking Cessation Services – general population • Smoking cessation in pregnancy • Smoking cessation for pregnant women	• Smoking Cessation Services for high risk outpatients, and NHS inpatients (selected sites in 2020/21, with phased implementation for all from 2021/22)

Obesity

The East Sussex Healthy Weight Partnership takes forward local work on obesity, with links to the Sussex Local Maternity System (LMS) prevention workstream. Our objectives are:

Wider Determinants	Primary Prevention	Secondary Prevention	Tertiary Prevention
• Improving infrastructure to enable increased physical activity • Improving food environment	• Promoting physical activity • Promoting healthy eating	• Effective weight management services • Diabetes prevention programme (DPP), **(**targeted funding available for 20/21 and 21/22 for a small number of sites to test these ideas)	• Specialist weight management for BMI 30+ with T2DM or hypertension (potential targeted funding available for 2020/21 and 2021/22 for a small number of sites to test these ideas) • Enhanced Tier 3 services for people with more severe obesity and co-morbidities

Alcohol

Action on alcohol is overseen by the East Sussex Alcohol Partnership. The partnership is currently in the process of updating the East Sussex Alcohol Strategy. There are also links with the work of the Community Alcohol Partnership in Hastings. Our objectives are:

Wider determinants	Primary Prevention	Secondary Prevention	Tertiary Prevention
• Reducing availability of alcohol	• Supporting people to enjoy alcohol in moderation	• Supporting people to cut down and reducing alcohol-	• Effective detox services

		related harm to communities	• Alcohol Care Teams for hospitals with highest rates of alcohol dependent admissions (potential targeted funding available for 2020/21)

There may also be potential for national targeted funding to support action in the following areas, and we will explore opportunities if they arise:

Air pollution
Funding from the NHS Sustainable Development Unit to spread best practice in sustainable development, including improving air quality, plastics and carbon reduction to support action on air pollution, as well as action to reduce NHS production of pollutants (transport, buildings, purchasing etc).

Antimicrobial resistance
Support available to regions to drive progress in implementing the government's five-year national action plan to reduce overall antibiotic use and drug resistance.

3.1.3. Increasing screening and vaccinations programmes across East Sussex

We need to make a concerted effort to improve our rates of screening and immunisations to prevent avoidable diseases. This includes having a tailored approach to areas of greatest need by understanding the communities that suffer poorer access (such as through geography, deprivation or entrenched cultural values), and ensuring we have a greater focus on populations where there are lower rates of access and uptake. For example, trying new approaches to working with vaccine hesitant communities, and broadening the role of the wider workforce in opportunities for checking people's immunisation status and promoting the value of screening and immunisations.

3.2. Supporting self-care, self-management and personalised care

It has long been recognised that supporting people to be more in control of their health and social care, and building on their individual strengths and the assets within their circumstances, is key to successful prevention. The NHS LTP sets out the **NHS comprehensive model of personalised care** which has six main evidenced-based components:

- Shared decision making
- Enabling choice, including legal rights to choice
- Personalised care and support planning
- Social prescribing and community-based support (funding available through the Network DES Contract from 2019/20)
- Supported self-management
- Personal health budgets and integrated personal budgets

This model will be developed in full by PCNs by 2023/24 through the Network DES Contract national service specification for personalised care. Some services will be best delivered within a framework of wider local coordination and support. In 2020/21 we will make a start on this through building on our local evidence base for what works developed through our existing initiatives, pilots and pathways in the following ways:

- Ensuring that prevention, **self-care** and **self-management**, **shared decision-making**, **choice** and **personalised care and support planning** approaches are built in to identified

planned care pathway and **end of life care** developments in 2020/21, where appropriate, using NICE guidance and other available condition-specific tools.

- Reviewing our **patient activation measure** (PAM) pilot to inform further development of self-care and self-management. PAM is a way of assessing an individual's knowledge, skill, and confidence for managing their health and healthcare. Using it enables self-care and self-management approaches to be targeted appropriately. We have been testing the use of PAM in some healthcare settings since March 2018, and a review is expected in December 2019, which will inform next steps.

- Building on the rollout of **wheelchair personal health budgets** to identify further groups of people who could benefit from Personal Health Budgets and/or integrated personal budgets, for example for people with continuing healthcare needs.

During the next phase of prioritisation and delivery planning, we will work as a system to roll out personalisation more widely. This will include participating in work being undertaken on a Sussex-wide basis, to inform and define the expected trajectories for improvements over the next five years.

3.3. Social prescribing and community based support

In East Sussex, a partnership between the three CCGs, ESCC, the voluntary, community and social enterprise (VCSE) sector and other partners is taking forward developing and implementing an integrated **social prescribing** framework, in order to reduce inequalities in access and health outcomes for local and diverse populations, and improve **mental health and wellbeing.** Our approach aims to align **PCNs' social prescribing DES investment** with the benefits that have already been achieved, for example, through our existing commissioned social prescribing commitments such as the Community Connector Service.

The programme is being overseen by a multi-agency steering group with clinical input. The programme's 2019/20 key objectives include:

- Agreeing a consistent East Sussex social prescribing definition
- Establishing relationships and strengthening partnerships with PCNs
- Developing and agreeing outcome measures using NHSE's guidance
- Providing Continuing Professional Development (CPD) for linkworkers and other relevant multi-agency staff and volunteers
- Establishing consistent referral and support pathways
- Using Patient Activation Measures (PAM) to personalise support for people / patients

The newly commissioned **asset-based wellbeing** programme which will be delivered in partnership between the VCS and ESCC, will work with communities with poorer health outcomes in each of our districts and boroughs to identify what matters to them, and to build solutions from their strengths – including skills and knowledge, social networks and community organisations. These co-produced solutions will add to the range of support which social prescribers can signpost people to.

3.4. Preventing situations from getting worse

Building on our work to trial proactive care, in 2020/21 we will work collaboratively with PCNs to begin to implement **anticipatory care** as part of the PCN Network Contract requirements from 2020/21 onwards. This will introduce more proactive and intense care for patients assessed at being of high risk of unwarranted health outcomes, including patients receiving palliative care.

We will link this with the development of **multi-disciplinary care coordination** working with primary care teams, as part of our work to implement a target operating model for **community health and social care services**. More broadly, we will ensure that early intervention and

anticipatory, proactive care and reablement focussed aftercare is a key feature of the target operting model for community services. More information about our plans in this area can be found in Appendix 3.

Our longstanding **Home from Hospital** and **Take Home and Settle** services provided by voluntary organisations to support our community pathways for avoiding unnecessary unplanned admissions to hospital, and supporting successful discharge. Mobilisation of newly commissioned services will start in November 2019.

In the context of the unwarranted variation in falls programme across the Sussex Health and Care Partnership, our next steps for **falls prevention services** include exploring earlier intervention and targeting the services at those who are risk of falling, but are yet to fall, and looking at a primary care led fracture liaison service in the High Weald Lewes Havens area of the county.

Care for the Carers estimates that there are 66,269 **unpaid carers** in East Sussex looking after an ill, older or disabled family member, friend or partner. The role can have a big impact of a person's physical and mental wellbeing, as well as affecting them financially. Set out below are the estimated figures for each area, including approximately 3,000 young carers aged 5-17[9]:

- Wealden 18,549
- Lewes 13,027
- Rother 12,675
- Eastbourne 11,988
- Hastings 10,030

We will work with PCNs to help implement supporting carers in general practice a framework of quality markers (NHS England 2019) to help **better identify and support carers** of all ages, provide evidence for the Care Quality Commission and:

- Improve the health of carer and promote positive wellbeing
- Reduce carer crisis and family breakdown
- Reduce unwarranted variations in career support
- Meet demand more appropriately and better manage demand on services

Through our joint commissioning there are existing developments that currently support identification and support for carers:

- A Carers Social Prescription which is available in all GP practices in East Sussex, which can be populated from patient records and sent securely online, with Care For the Carers then making contact within two working days
- A Primary Care Support Service pilot which provides Community Support Workers with the overall aim of providing flexible and responsive short term interventions to patients with dementia and other long term conditions (including functional mental health and substance misuse), and their carers; and identifies carers not known to primary care/and/or not accessing support services
- A 'brief bite' carer awareness training offer is also available for busy practices

[9] Figures calculated by Care for the Carers based on projected growth from 2011 UK census figures

Based on the positive feedback received from GPs about these services, agreement has been secured to roll out the Primary Care Support Service on a county-wide basis. We will further build on these initiatives and explore ways to work with PCNs to ensure that identification and support for carers is fully integrated into the new **social prescribing** link worker arrangements described in paragraph 3.3. above.

3.5. Working together to improve health outcomes for vulnerable and/or disadvantaged groups in the population

Part of our work involves specific action where we know groups of people within our population are at risk of poor health outcomes. Current areas of focus include:

- Improving the healthcare needs of people with learning disabilities, through increasing **annual health checks** for people aged 14 years and over with a learning disability
- Our multi-agency **Rough Sleepers Initiative** which is integrating housing, health, mental health, substance misuse and social care and support to improve outcomes for rough sleepers. More information about this initiative can be found in Appendix 6.
- Recommissioning **housing-related support** services for people aged 16 years and over. In order to achieve integrated housing, health, employment and social care services and outcomes for people who are either homeless, or at risk of homelessness or living in housing that doesn't meet their needs or struggling to manage / maintain independence. New services will start in November 2020 as a result of partnership working between ESCC, district and borough councils, the VCS, NHS and the Department for Work and Pensions.
- In addition to the plans for **carers** set out in paragraph 3.4 above, we are implementing a new **outcomes-based commissioning model** for young and adult carers services. New services are due to start in November 2019, so that carers have the support they need to carry out their role in a sustainable way.
- Appendix 2 sets out a number of priorities to support vulnerable **children and young people** including promoting and protecting children, young people and families' needs in disadvantaged communities, action on County Lines and integrated working to improve outcomes of children with special educational needs and disability (SEND).

3.6. Mental health and wellbeing

The Five Year Forward View for Mental Health highlighted that more needs to be done on prevention to reduce inequalities, including a greater focus on preventing suicide. To support this Public Health England (PHE) have published the national Prevention Concordat for Better Mental Health for all (PHE, October 2019), to guide local areas in developing a coherent approach to better public mental health.

The concordat sets out ways to increase the focus needed on prevention and the services that impact on the wider determinants of mental health. This includes a shift towards prevention-focused leadership and action embedded throughout the mental health and wider system across the NHS, social care, education, employment, housing, community resilience and cohesion, safety and justice, and civil society. In turn, this will impact positively on the NHS and social care system by enabling early interventions and help.

The value of this approach has also been highlighted in:

- What Good Public Mental Health Looks Like. Public Health England & Association of Directors of Public Health (2019)
- Advancing our health: prevention in the 2020s Green Paper.
- Future in Mind. Promoting, protecting and improving our children and young people's mental health and wellbeing (DoH & NHSE 2015)
- Children and Young People's Transforming Mental Health Green Paper

- ‘Thriving at Work’ the Stevenson / Farmer review of mental health and employers (2017) highlights employers’ roles in promoting good mental health.
- Preventing suicide in England. A cross-government outcomes strategy to save lives (HMG 2012). The national suicide and self-harm prevention strategy for England sets out a blueprint for localities and signals the principle that ‘good prevention is also good suicide prevention’.

In East Sussex we recognise that promoting good mental health is key to preventing avoidable illness, improving outcomes for our population and reducing inequalities. We will work with all stakeholders across our system to explore and work towards ways of adopting the principles set out in the prevention concordat. This will enable a clear focus for our cross-sector action to deliver a tangible increase in the adoption of public mental health approaches.

A specific area of focus is children and young people’s (CYP) mental health under the work of the East Sussex CYP Mental Health Local Transformation Partnership. Our next steps will be informed by the outcomes of the Sussex-wide review of emotional support and wellbeing support for children and young people.

In summary our action in this area involves building on and strengthening our partnership working across the local NHS, social care, education, employment, housing, community resilience and cohesion, safety and justice, and civil society to further develop our approaches to public mental health. We will explore the potential to linking this with population health management approaches described in paragraph 3.1.1. to support targeted action in the following areas:

Wider Determinants	Primary Prevention	Secondary Prevention	Tertiary Prevention
• Providing children with the best start in life • Quality employment • Quality of housing and open spaces • Safe and connected communities	• Whole school approaches to promoting good mental health and emotional wellbeing • Workplace initiatives • Suicide prevention – social marketing and training for professionals • Reducing social isolation • Mental health promotion – Every Mind Matters • Improving smoking, diet and physical activity • Reducing substance misuse • Social Prescribing	• Working alongside our schools to provide appropriate help at the earliest point • Self-referral to Improved Access to Psychological Therapies (IAPT) • Crisis support via NHS 111 • Improving access to peri-natal services • Social prescribing • Integrated approaches to physical and mental health through our plans for care coordination and multi-disciplinary health and social care teams.	• Access to more specialist services if required but with step-down services in place • Crisis care

		• Supported accommodation pathways. • Crisis cafés • 24 hr crisis care • Therapeutic acute inpatient care • Back to work schemes	

Appendix 2
Children and Young People – programme summary

1. Background

The NHS Long Term Plan and local East Sussex priorities for children and young people require a strong partnership approach across our local NHS, East Sussex County Council, schools and the voluntary and community sector.

As part of the East Sussex Health and Social Care Plan, this appendix outlines out how we will continue to work closely as a system across NHS and Children's Services to support age-appropriate integrated care, including integrating physical and mental health services; joint working between primary, community and acute services; and supporting transition to adult services to improve outcomes for children and young people in East Sussex. Place-based integration of services and co-production with children, young people, families and carers will help us to:

- Support a strong start in life for our children and young people, including:
  - Promote and improve mental health and emotional wellbeing.
  - Work together to safeguard children.
  - Improve outcomes for children and young people with Special Education Needs and Disability (SEND).
- Support children and young people and families to live longer, healthier lives through helping them make healthier choices.

The following partnerships and boards have a key role in supporting the delivery of this work:

- The East Sussex Safeguarding Children Partnership which supports and enables all professionals working with children and families in East Sussex to work together to safeguard children and promote their welfare.

- The Children and Young People's Trust which works to improve outcomes for children and young people. In particular, it aims to support those who are vulnerable to poor outcomes.

- The East Sussex Children and Young People's Mental Health Local Transformation Plan Board which oversees the children and young people's mental health and wellbeing local transformation plan.

- The East Sussex Children and Families Strategic Planning Group which brings together senior decision makers/ officers across health, social care, education and public health in order to improve outcomes for children and families and support greater integration and or alignment of planning processes and service provision.

Our priorities for integrated working are informed by the current inspection regime which includes two local area, partnership inspections that look at how well we work as a system in the following areas:

- The Ofsted and Care Quality Commission (CQC) ***joint inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities***. East Sussex was inspected in December 2016 – East Sussex report
- The Ofsted, CQC, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and Her Majesty's Inspectorate of Probation ***Joint Targeted Area inspections*** which look at how effectively agencies are working together in their local area to help and protect children. Each set of joint inspections evaluates the multi-agency response to a particular issue or theme. Themes include safeguarding, mental health etc.

We are committed to ensuring that the voice of children and young people informs our work. Opportunities to get involved are at three levels:

- At the individual level, through direct involvement in personal care or support planning.
- Opportunities to help shape the design and development of services for children and young people.
- Informing strategic decision-making through mechanisms including the Youth Cabinet, Children in Care Council, Through Care Voice Group and in partnership with other youth voice groups through the Youth Voice Practitioners Network.

We will also work with our workforce across the system including schools, health, community health, social care, Primary Care Networks, nurseries and other childcare providers, and voluntary and community organisations to help deliver our shared objectives.

2. East Sussex priorities for transforming children and young people's services

We have looked at our priorities in the context of five key areas for integrated working:

- Children and young people's mental health and emotional wellbeing
- Disability pathways
- Safeguarding (including contextual safeguarding)
- Universal child health offer
- Looked after children

2.1. Children and young people's mental health and emotional wellbeing

Our objectives are:

- Improving our pathways and commissioning approach particularly with regard to tier 4/ secure/specialist placements.
- Developing a coherent emotional wellbeing strategy which works alongside our schools to provide appropriate help at the earliest point.

This priority will be delivered through our partnership work on the children and young people's mental health and wellbeing local transformation plan. There is also a Sussex-wide independent strategic review of children and young people's emotional health and wellbeing. The outcomes are due at the end of December, with a report due in January 2020, and the recommendations will be used to inform implementation planning in this area with a range of partners across our system.

Mental health services across the country have also been asked to increase access for children and young people as part of the five year forward view for mental health, and our work through the Local Transformation Plan sets this out in more detail.

Priority next steps to support this include:

- Pan-Sussex development of Care Education Treatment Reviews, led by CCGs, to prevent needs escalating and high cost hospital admissions.
- To support mental health and wellbeing consider a wider roll out of the general practice prescription pad initiative. Currently available in Hastings and Rother, this is a tool which enables GPs and other practice staff to refer parents, carers and young people to Open for Parents and / or I-Rock.
- Fully develop a dynamic risk register of children and young people at risk of hospital admissions with wrap around services in place

Work in this area has strong links with actions set out in Appendix 6.

2.2 Disability pathways

Our overall objective is to further develop our work around integrating the education, health, and social care needs of children and young people, aged 0 – 25, aimed at producing local solutions.

There is a growth in the numbers of children with statements of SEND or Education Health and Care Plans some of whom will have complex medical and care needs. Our SEND Strategy 2018-2021 is designed to improve outcomes for pupils with SEND across East Sussex and has four shared strategic aims which were jointly identified by professionals from education, health and social care and parent/carers and community groups:

- Improving communication with families, children and young people.
- Building capacity for inclusion in settings, schools, colleges and services.
- Effective transition at every stage including advanced planning of the journey of the child.
- High quality provision, services, outcomes and aspirations.

Where do we need to get to?

We need to:

- Improve the long term outcomes for children and young people with disabilities through earlier planning of transition into adult services.
- Improve joint commissioning arrangements to secure high quality provision for children and young people.
- Establish clear lines of responsibility and accountability for supporting children across universal targeted and specialist services.
- Build capacity in our providers to improve early identification and reduce the number of children moving into high cost provision.

How will we get there?

- All partners make a clear commitment to delivering the outcomes in the SEND strategy, through working together.
- Work jointly with parents and carers of children and young people with SEND to improve confidence in local provision and jointly commissioned support services.
- Commit to joint funding of new specialist provision to support children with Profound and Multiple Learning Difficulty (PMLD).

Digital

- Develop systems for the effective sharing of information regarding the assessment of children with SEND.

Our priority next steps to support this include:

- Review the commissioning of health providers for assessing children and young people with autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and other neurodevelopmental disorders, and explore a single assessment pathway.
- Review the current offer across education, health and care to children with PMLD and/or complex health needs alongside processes for the allocation of funding across different statutory agencies.
- Improve early planning for children who will transition into adult health and social care services, potentially starting in the areas of diabetes and neurodevelopmental disorders.
- Further develop the integration of social care personal budgets and personal health budgets for the highest need children with complex health needs.
- Review the commissioning of mental health support for children and young people with autism.

2.3. Safeguarding (including contextual safeguarding)

To improve our integrated approach to safeguarding and contextual safeguarding our objectives in this area are to:

- Further develop our pathways and service offer for young people at risk of criminal and sexual exploitation, physical and sexual harm, alcohol and substance misuse, and review of service offer and needs for 18-25 year olds.
- Make strong links with the work taking place under the mental health and wellbeing priority.

Where are we now

The number of children in need of help and protection is rising locally and nationally, potentially linked to the increase in families experiencing greater financial difficulties and an increasing awareness of the risks posed by exploitation/County Lines etc. One of our over-riding principles is to work, with partners, with the right children and families, in the right way, for the right amount of time to bring about change. We help to create a stable environment in which children can thrive and help families to develop resilience and coping strategies to avoid public service dependency. Individual and community responsibility is of fundamental importance in helping us manage demand over the coming years, supported by good public health services (particularly for young children).

The number of children (aged 0-17) will increase by 3% in the next three years. Our public health and targeted early help services help parents to care for their children in ways which effectively promote their development and well-being, so that they can make the most of their opportunities in early years education, school and college.

Where do we need to get to?

We need to:

- Use communities and individuals as resources e.g. via the volunteer programme in the 0-19 service, so that the health, wellbeing and development of children is a wider priority and not 'just the business' of statutory services.
- Further develop an integrated support offer that targets children and families early on and before problems become entrenched.
- Continue to develop confident and emotionally literate schools so that they can support children who are experiencing difficulties.
- Measure the effectiveness of our partnership response to children who are subject to criminal exploitation.

How will we get there?

- Look for quick wins and possible connections to highlight the needs of children and families in existing strategies such as in the Community Safety Plan, etc.
- Enhance existing training strategies so that we increase the capacity and confidence of a wider range of staff and partners in our communities.
- Look for all available external funding opportunities to increase resources for key priorities.
- Review existing systems and future service design.

Digital

- Develop an improved digital support offer and better signposting for children and their families.
- Explore the potential for the development of improved access for partners to contribute to assessment and safety planning for children.

Our priority next steps to support this include:

- Reviewing our current multi agency structures for young people presenting with high risk of serious violence/criminality and young people involved/at risk of criminal and or sexual exploitation.
- Delivering contextual safeguarding interventions where the need for Substance Misuse Service (SMS) expertise is identified by Multi Agency Child Exploitation (MACE) and multi-agency scoping meetings.
- Reviewing the current Public Health allocation for substance misuse (drugs and alcohol) and explore alternative allocations for prevention services.
- Reviewing Child Protection Information Sharing (CP-IS).
- Extending the health offer for children in secure accommodation at Lansdowne Secure Children's Home in line with the extension from a five to a 12-bedded unit.
- Considering the development of a consolidated approach to children suffering trauma e.g. Lansdowne, Youth Offending Team (YOT) and the NHS South East health and justice pathway.
- Extending support to care leavers who become parents and develop the role of corporate grandparents, in line with learning from serious case review.
- Continue to embed the new child death process which sits under the governance of local authorities and CCGs (formerly the responsibility of Local Safeguarding Children Boards)

2.4. Universal child health offer

Our work on integration to date provides a firm foundation for bringing together a coordinated range of preventative services that are critical to giving every child the best start in life, helping people to help themselves, and to stay healthy. Our objectives in this area are to further develop our integrated working to better enable:

- Provision of the Healthy Child Programme for under 5s through the integrated Health Visiting and Children's Centres service.
- Delivery of prevention interventions through the School Health Service.
- Nurseries, schools and hospitals to become health promoting settings.

Early identification is crucial to effective safeguarding. Effective delivery of the Healthy Child programmes, including universal development reviews for all children age 0-5, supports early identification of families with additional needs. This is delivered via an integrated service with health visitors for 0-5 year olds.

Where do we need to get to?

We need to:

- Give every child the best start in life and support people to maintain good health and promote healthy lifestyle choices.
- Strengthen integration across services.
- Work with needs identified at universal mandated reviews and providing enhanced support from a range of partners across services.
- Intervene early and proactively to prevent conditions and situations from getting worse.

Our priority next steps to support this include:

- Establishing a new 0-19 integrated service, structures, systems and evaluation data.
- Piloting evidence-based listening visits to support perinatal mental health.

This also has strong links to the action on reducing health inequalities set out in (Appendix 1).

2.5. Looked after Children

To improve our integrated approach to looked after children (LAC) and children previously looked after, our objectives in this area are to:

- Ensure looked after children's needs are prioritised across health, social care and education to enable best outcomes.
- Ensure mental health services are commissioned to optimise the emotional wellbeing of looked after children and previously looked after children.

Where are we now

The number of looked after children in East Sussex, as at 31 March 2019 is 600 a rate of 56.6 per 10,000. This is below the Income Deprivation Affecting Children Index (IDACI) rate of 60.7 (644 children).

Providing health assessments with statutory timescales is a challenge in East Sussex highlighted by increased reporting and assurance requirements from the CCG and the County Council.

Despite the fact that we have a designated service within the Child and Adolescent Mental Health Service (CAMHS) for LAC and within the Adopted Children CAMHS for previously looked after children, there are some challenges to accessing timely and appropriate emotional health support for these groups of children.

Where do we need to get to?

We need to:

- Further improve and sustain the health offer for looked after children by providing timely access to health reviews in line with statutory guidance with the aim to improve health outcomes.
- Improve assurance across all health services for looked after children to ensure services respond appropriately to their specific needs.
- Achieve enhanced access to emotional wellbeing services, with services commissioned adequately to meet looked after children's needs (including unaccompanied asylum seeking children)

How will we get there?

- Implementation of an enhanced Sussex wide service specification to meet statutory health requirements for looked after children
- Enhance the training strategy so that we increase the visibility of this group of children and the capacity and confidence of a wider range of staff and partners in our communities specifically around looked after children
- Sussex review of emotional wellbeing services will inform the commissioning for services to meet looked after children's needs

3. Summary of key priorities for 2020/21

To take forward close system working and ensure age-appropriate integrated care across physical and mental health services; joint working between primary, community and acute services; and support for transition to adult services we have agreed five key priorities for transforming children and young people's services:

Improving children and young people's mental health and emotional wellbeing

- Improving our pathways and commissioning approach particularly with regard to tier 4/secure/specialist placements.

- Developing a coherent emotional wellbeing strategy which works alongside our schools to provide appropriate help at the earliest point.

Disability pathways

Further develop our work around integrating the education, health, and social care needs of children and young people, aged 0-25, aimed at producing local solutions, including:

- Integrated health and social care budgets for children with the highest complex needs
- Exploring a single assessment pathway for autism spectrum disorder and attention deficit hyperactivity disorder, and other neurodevelopmental disorders
- Improving early planning for children who transition into adult health and social care services
- Reviewing mental health support for children and young people with autism

Safeguarding (including contextual safeguarding)

- Further develop our pathways and service offer for young people at risk of criminal and sexual exploitation, physical and sexual harm, alcohol and substance misuse, and review the service offer and needs for 18-25year olds.
- Make strong links with the work taking place under the mental health and wellbeing priority.

Universal child health offer

- Provision of the Healthy Child Programme for under 5s through the integrated Health Visiting and Children's Centres service.
- Support the delivery of the preventative interventions through School Health Service.
- Support nurseries, schools and hospitals to become health promoting settings.

Looked after Children

- Ensure looked after children's needs are prioritised across health, social care and education to enable best outcomes.
- Ensure mental health services are commissioned to optimise the emotional wellbeing of looked after children and previously looked after children.

Appendix 3
Community – programme summary
1. Background
Our work and initiatives on integration to date has piloted and delivered a range of improvements in our journey to a new model of integrated care and the ongoing development of community health and social care services and initiatives, including:

- health and social care teams
- crisis response and proactive care
- the Dementia Support Service
- Health and Social Care Connect (now available 24/7365 days a year)
- the Joint Community Reablement Service.

We will continue to make progress with this and most critically the joint management of community health and social care teams. We want to further build on the services we provide in people's homes or in the community. We will achieve this through making sure that there are clear, simple pathways for people accessing services in the community and build on the support we provide to people after they leave hospital. We also have plans to further integrate teams of health and care staff across the county, supported by a single leadership structure.

The priorities and projects for the community programme are a mix of our ongoing work to support integrated working and new work to embed, further develop and grow our integrated community health and social care model and other local priorities. This is informed by:

- The NHS Long Term Plan
- East Sussex Urgent and Emergency Care workshop (August 2019)
- System diagnostic work and reviews carried out by NHSE and Improvement and others into on the drivers of our East Sussex system deficit in 2018/19
- NHS Rightcare
- Model Hospital
- The learning and early outcomes of pilot projects taken forward this year.

Our approach is consistent with the NHS LTP direction for primary and community healthcare. This includes the establishment of Primary Care Networks; greater multi-disciplinary working across primary medical care and community health and social care to both support rapid response in a crisis; as well as a local approach to proactively managing population health and anticipating and preventing the escalation of health and care needs.

Phase one of our programme in 2019/20 set out a series of pragmatic and realistic steps to be taken over the next six to twelve months. These will progress fuller integration of community health and social care services, with the overall aim of supporting people's independence and long-term care closer to home, so that our acute hospital services are better able to respond to the needs of local people. In brief the projects have included:

- In Eastbourne, nursing and social care teams have come together to trial working from a shared base, to support more and better **joint working** including **care co-ordination** for people with complex and longer-term support needs. This pilot is guiding how joint working best functions, and will include engagement with primary care, mental health and voluntary services.
- New **'Home First'** pathways have been tested out. These are new, joined up pathways designed to get medically fit people home from hospital sooner, and to make sure that assessments for community support and decisions about longer term care are not made in hospital.
- Joint working between East Sussex County Council and East Sussex Healthcare NHS Trust Occupational Therapy staff is being developed, to **share skills, best practice and**

help create capacity. As a minimum this is expected to include developing a joint duty and triage service that will simplify and streamline the referral and allocation process; however, the planning is already moving on to look at fully integrating the service across community health and social care

- Work has also been taking place to look at the best ways for different teams and services to work together to **provide integrated, rapid response, community services** to support discharge from hospital and avoid unnecessary hospital admissions. An integrated multi-disciplinary model has been developed and is being explored with staff. The model is designed to ensure that there are no barriers or gaps in the rapid response service; when needed it will have the remit, skills and capacity to respond. This builds upon the continuing development of the Crisis Response service (referenced elsewhere in this summary) which will continue to avoid unnecessary admissions and attendances by managing medical crises in the community where appropriate.

Taking these specific projects and pilots forward in the context of wider improvements to the quality and experience of care for our residents in 2019/20, has led to the following progress and benefits:

- Successful pilots of Home First approaches have evidenced that people left hospital more quickly and had better outcomes when discharged under these pathways. The pathways are delivered by joint working between social care staff in acute settings and community health and social care reablement staff in the community. With improved joint patient-finding in acute settings these pathways are now progressing to full implementation. A single access point ensures patients are settled at home, in community beds or in nursing care with the support they need. These pathways are now progressing to full implementation.
- This has been a factor contributing towards the average length of stay in hospital and community clinical care beds performing better than expected - reducing unnecessary length of time in hospital; accelerating recovery, and; releasing bed capacity within our hospitals and community sites to meet demand.

2. Key priorities for 2020/21

Our ongoing focus for the services we provide in people's homes or in the community is to build capacity, identify instances where more joint working would be of benefit and have clear pathways for people accessing services.

A high level integrated target operating model for community health and social care in East Sussex has been developed with ESHT, SCFT and ESCC working together to design the model. This work is in its early stages and the intention is to use the model as a vehicle for engaging more widely with key partners – primary care, mental health and the voluntary and community sector - and also to identify the priority projects that will deliver the model. The target operating model is designed to meet the key strategic priorities for health and social care services; and thus is a key element of our response to the Long Term Plan.

Within the 'blueprint' provided by the target operating model in 2020/21 we will build on our work on the phase 1 projects and pilots described above, with some pragmatic and realistic steps towards fuller integration of community health and social care services. with the overall aim of supporting people's independence and long-term care closer to home, so that our acute hospital services are better able to respond to the needs of local people.

This includes continuing to make progress with:

- Building on the co-location pilot in Eastbourne, we are identifying and exploring opportunities for co-locating nursing and social care teams to trial working from a shared base, to support **joint working** and the **care co-ordination model** for people with complex

and longer-term support needs. We are currently looking at accommodation options in Hastings and St Leonards.

- Linked to co-location, we are also progressing a pilot on **care coordination** of people with multiple long term conditions and support needs, to test the benefits and inform how this sits within our wider target operating model for community health and social care. A key part of this will be developing mechanisms for enhanced case level collaboration with primary care, mental health and voluntary sector support services.
- Continuing to progress the wider roll out of **Home First** pathways, to make sure that assessments for community support and decisions about longer term care are not made in hospital so medically fit people can get home from hospital or another community setting sooner.
- Joint working between East Sussex County Council and East Sussex Healthcare NHS Trust Occupational Therapy staff will be developed, to **share skills, best practice and help create capacity**. We are currently looking at whether/how we move to a fully integrated community therapy service across social care and community health.
- A key element identified in the target operating model and currently being worked up is to provide **integrated, rapid response, community services** to support discharge from hospital and avoid unnecessary hospital admissions.

To enable greater levels of **multi-disciplinary working across primary medical care and community health, mental health and social care services** our next steps will focus on developing and implementing our agreed **common target operating model** for 2020/21. A key challenge will be to deliver the same service framework across the East Sussex footprint with levels of service flexed due to local population needs. This high level operating model will consolidate the pilots and projects from phase 1 of our community programme into a single county-wide approach aimed at delivering the following:

- Maximising independence and maintaining people in the community – helping people to live independently at home for longer
- Preventing unnecessary hospital attendances and admissions
- Reducing length of stay in hospital by supporting timely and effective hospital discharges
- Enabling system design and planning to optimise the use of all available resources

The target operating model for integrated core community health and social care services will help build the **capacity, workforce and partnerships** to do this, and will develop in a phased way to ensure alignment and strong relationships with:

- PCN footprints to support effective **multi-disciplinary team working** including work to implement the PCN Network DES Contract for 2020/21 and risk stratification of local populations, to enable **proactive anticipatory care** for those with multiple long-term conditions and/or assessed at high risk of unwarranted health outcomes
- Pathways for the acute hospital (ESHT) **Integrated Discharge Team** interfacing with the community Home First pathways
- Developing further capacity in **crisis response** within two hours and **reablement care** within two days; noting the need to align the offer across the East Sussex footprint.
- The next steps in relation to the wider development and roll out of **Enhanced Care in Care Homes** to reduce acute hospital admissions by enabling better early identification and forward care planning
- **Structured medication reviews** for priority groups
- **Personalised care and support planning**
- **Social prescribing** and community-based support
- Better identification and support to **improve outcomes for carers**
- The continued implementation of **Extended Access** in 2019/20 and 2020/21

End of life care (EOLC)

Across East Sussex high quality, individualised end of life care is effectively coordinated and integrated and provided to all those who need it, regardless of diagnosis or age. Where appropriate, conversations take place about death and dying at an early stage, supporting people to make plans and communicate these with those who are important to them. This care extends beyond death to include bereavement and support for families.

In EHS and HR, partners are working together to deliver the aims and ambitions for End of Life Care identified within the End of Life Care Strategy (2019-2022). The Strategy was developed with the following partners - East Sussex Healthcare NHS Trust, East Sussex County Council, Eastbourne, Hailsham & Seaford CCG and Hastings & Rother CCG, St Wilfrid's Hospice, St Michael's Hospice Chestnut Tree Hospice, Demelza Children's Hospice, Adult Social Care, Care for the Carers, Age UK Sussex and patient and parent representatives. The aim is to deliver joined up care to support patients, their family, carers and those close to them to live independently as possible and achieve the best outcomes.

To ensure the delivery of the strategy an implementation plan has been drafted with nine key workstreams:

- Sharing of information to ensure care is co-ordinated across agencies
- Improving staff capability through learning and development to ensure the workforce has the knowledge, skills and attitudes to delivery high quality care
- Communications and patient and public engagement to include the views of patients, their family and carers to improve care
- Improving patient care through clinical effectiveness and governance to ensure care meets national standards and staff delivering care are competent, confident and capable
- End of Life care strategy and implementation plans to ensure the vision is clear and we meet our aims
- Care of the dying to ensure best end of life care for patients in community and that it is delivered with compassion and dignity
- Care after death by treating every patient with dignity and respect and equally supporting the bereaved
- Care of the dying child to ensure appropriate and timely transition to adult services
- Out of hours care to ensure services are fully integrated and accessible to enable patients to remain in the community if this is their wish

End of Life Care Vision 2017-19 outlines a strategic vision for end of life care and recommended next steps in the High Weald Lewes Havens area. This is evidence based and has been developed with local partners, with six key ambitions:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care
- Access to community support

Plans are being taken forward to support the two key priorities for End of Life Care:

- Support and training to Care and Nursing Homes, including communication
- Ensuring the EOLC vision for HWLH links with other priority areas including Frailty and the Enhanced Health in Care Homes (EHCH) service, and community services.

A project board is being established to identify the priorities for 2020/21 and beyond to ensure delivery of the strategy. This will include exploring an East Sussex-wide approach and the possibility of bringing together existing working groups, and building on the implementation work currently being progress across the county including:

- The case for change for anticipatory prescribing to meet NICE Quality Statement for anticipatory prescribing
- Timetable of education for primary care
- Linking with other priority areas for example, Frailty and the Enhanced Health in Care Homes (EHCH) service, and appropriate areas of community services
- Multi-agency workshop for verification and certification of death to inform Sussex wide guidance.
- Implementation of ReSPECT across acute, secondary and primary care providers and in hospices and care homes, including; communication and engagement with the general public and other stakeholders; GP training; and digitalisation of the ReSPECT form. ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.

Appendix 4
Urgent Care – Programme Summary

1. Background

The key aim of the Urgent Care (UC) programme is to transform urgent and emergency care services in East Sussex to ensure that, in an emergency (i.e. serious or life threating conditions) or in case of an urgent (i.e. non-emergency) need, people are treated and supported in the most appropriate place by the right clinical and/or social care service.

Through working in partnership with local Primary Care Networks (PCNs), acute, community, mental health and social care services, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and the East Sussex CCGs, the programme places emphasis on avoiding unnecessary hospital admissions through:

- Building pathways and capacity within community and primary care services by developing urgent care pathways to support patients in their own home or community settings.
- Building on the services already provided in our Accident & Emergency (A&E) departments, acute medicine and surgical assessment units to make sure that those presenting to an acute site seeking urgent care are seen by the most appropriate clinician, treated, and either admitted or discharged as soon as is appropriate.

There are strong links to the community programme which is described more fully in Appendix 3. The East Sussex urgent care programme is also closely aligned with the Sussex Health and Care Partnership (SH&CP) Sussex-wide Urgent and Emergency Care (UEC) Strategy and Integrated Urgent Care (IUC) programme, to deliver a consistent and standardised approach to urgent and emergency care pathways across Sussex. The projects are a mix of existing work to implement and embed a new model of 24/7 NHS 111 Clinical Assessment Service (CAS) and Urgent Treatment Centres (UTCs), and further developing and growing the urgent care model and other local priorities informed by:

- The NHS Long Term Plan (LTP) and LTP Implementation Framework
- The Keogh Review (2013)
- Sussex Health and Care Partnership (SH&CP) UEC plans
- Urgent and Emergency Care System Demand Diagnostic 2018/19 (ESHT)
- Qualitative Research with Patients in A&E at the Conquest Hospital in Hastings and Eastbourne District General Hospital (August 2019)
- East Sussex Urgent and Emergency Care workshop (August 2019)
- System diagnostic work and reviews carried out by NHS England/Improvement and others into the drivers of our East Sussex system deficit in 2018/19
- NHS Rightcare, Model Hospital and Get it Right First Time (GIRFT)

The programme is making progress with significant improvements for our residents through delivering the following benefits:

- **Extending Ambulatory Care** Rapid multi-disciplinary team working, discharge assessment and follow up has meant that 42% of the patients admitted to hospital via A&E are discharged less than 24 hours after admission, leading to zero length of stay. This is particularly significant for our frail patients who are known to deteriorate rapidly if admitted to hospital.

- From December 2018- October 2019, our **High Intensity User service** saw **55** patients. In the period to August 2019, **352** A&E attendances and a further **98** non-elective admissions were avoided (accounting for 36 patients).
- **The Frail and Vulnerable Patient Scheme** This locally-commissioned GP service is focussed on moderately and severely frail patients with a Rockwood score[10] of 5-7, as well as palliative care patients. The scheme includes assessment, personalised care planning and reviews, medication reviews and a falls assessment. 6,462 care plans were produced in 2018/19 and these are being peer reviewed annually.
- **Urgent Treatment Centres** will be up and running in line with the national mandate by December 2019, providing consistent access to an urgent care service to diagnose and deal with many of the most common ailments for which people often go to A&E. This service will build on the success of our **GP Streaming Service,** which was successfully launched in October 2018 and enabled GPs and primary care practitioners to work more closely with A&E staff.
- **Primary Care Improved Access (PCIA)** – since October 2018 **PCIA** has delivered additional capacity within primary care for same-day primary care needs, and expanded patient choice by offering appointments after 6.30pm during weekdays and in the mornings on weekends and bank holidays
- **NHS 111 Clinical Assessment Service (CAS)** will become fully operational from 1st April 2020, and will offer local people a single point of access for urgent and emergency care services, including the ability to book appointments at UTCs or other walk in services, and also within primary care.
- **GP-led respiratory care** has reduced the number of hospital admissions for Chronic Obstructive Pulmonary Disease (COPD)
- Our approach to **end of life care** pathways has also been aligned to our Urgent Care model, more detail is set out about this in Appendix 3.

2. Key priorities for 2020/21

Our focus in 2020/21 includes continuing to implement, further develop and embed the following projects and initiatives:

2.1 Extending acute frailty

This looks to build in the appropriate interventions when people require hospital care to ensure they receive a timely frailty assessment, and supports patients to return home or to another appropriate care setting, when patients no longer require consultant-led care in an acute setting. Subsequent community services will also be aligned on discharge to reduce frailty severity where possible. The current focus is:

- Expansion of **acute frailty teams and pathways** to ensure right support at the hospital 'front-door'
- Supporting **Same Day Emergency Care (SDEC)**

[10] The Rockwood Score is a clinical frailty scale to assess needs and plan interventions

2.2 Extending Ambulatory Emergency Care (AEC)

AEC is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed, giving the opportunity to better manage patient flow, improve patient experience and reduce acute hospital admissions. AEC is already provided by our hospitals; however, this project looks to increase the availability of AEC to a minimum of 12 hours a day, 7 days a week. This will also help meet requirements in the NHS LTP to increase treatment and discharge from emergency care without an overnight stay. This is currently live in Eastbourne DGH and will be expanded to the Conquest Hospital to support **SDEC.**

2.3 Expanding our high intensity user service

To address the increased demand on our A&E services, in November 2018 a **high intensity user (HIU) service** went live in East Sussex. The HIU service (initially developed by NHS Blackpool) offers a robust way of reducing high unscheduled users of multiple services such as 999, NHS 111, A&E, General Practice and hospital admissions. This in turn frees front line resources to focus on more clients and reduce costs. It uses a health coaching approach, engaging with high users of services whose needs are often unable to be met fully by one area of service.

The service supports some of the most vulnerable clients within the community to flourish, whilst making the best use of available resources. The service is now fully operational with two key workers visiting high users of services with very significant improved outcomes evidenced already. Our next stage is to expand the scope and reach of the service to ensure patients who are frequent users of other services, (for example mental health, ambulance and primary care) are also identified and offered appropriate support (not always medical or clinical). The aim is to make sure these patients are enabled and empowered to manage times of crisis by utilising the most appropriate urgent or emergency care service.

2.4 Expanding Community Frailty/PEACE planning (advance care planning)

The Proactive Elderly Advance Care (PEACE) planning process and documentation helps health and care professionals to deliver the best care to frail, older people, based on a personalised approach to care and support planning. Combined with a Comprehensive Geriatric Assessment, PEACE Planning has been shown to reduce admissions by up to 83% and bed days by up to 94%[11]. It also offers improved outcomes for patients, families and carers (including health care and care home staff) through increased independence, confident decision-making, and by supporting patients to receive care and to die in their preferred place.

The Community Frailty Service currently completes around 230 PEACE plans per year. We anticipate rolling out PEACE planning to a greater number of patients as part of personalised care and support planning roll-out and supporting patients in care homes.

2.5 Integrated Urgent Care Model

Continuing to roll out and embed:

- **Urgent Treatment Centres (UTCs)** are GP-led services that are equipped to diagnose and deal with many less serious injuries and urgent ailments people often attend A&E for. Open at least 12 hours a day, every day, UTCs offer appointments that can be booked through NHS 111 or through a GP referral. This is an existing project as part of

[11] Audit of Frailty Service patients, April 2016-April 2019, activity 12 months before and after discharge

the national requirements to implement UTCs and develop a standardised approach to make best use of emergency care resources across Sussex. UTCs are intended to ease the pressure on hospitals, leaving other parts of the system free to treat the most serious cases. This includes reducing attendance at A&E and, in co-located services, provides the opportunity for streaming at the front door. These will be rolled out in Eastbourne DGH and the Conquest Hospital in Hastings by December 2019. There is currently a minor injuries unit (MIU) at Lewes Victoria Hospital and a plan has been agreed recently for a brief closure of this service, with interim arrangements in place to allow improvement works in readiness for the UTC to open in the Spring.

- We will also be developing the Minor Injuries Units in Crowborough and Uckfield to provide support for patients with minor ailments as well as injuries, through a mix of nursing and medical staffing these will provide opportunities to mitigate increasing demand on Emergency Departments and improve local access for same day care.

- As part of implementing UTCs we are reviewing our **walk-in centres** to ensure the right balance of services and to maximise the role of out of hospital services that complement the new UTC facilities.

- **Clinical Assessment Service** to support patients to navigate the optimal service 'channel' we will embed a single multi-disciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from April 2019 including:
  - Direct booking into **Primary Care Improved Access**
  - Direct booking into Primary Care Extended Access, UTCs or other walk in services and sites being developed as part of the East Sussex integrated urgent care model

- Increased utilisation of **Primary Care Improved Access** capacity – working with Primary Care Networks as a system to review location and access to those services

2.6 The **Locally Commissioned Service (LCS) for chronic respiratory conditions** provided by General Practice has been implemented, aimed at supporting the better management of respiratory conditions in the community to ensure people are less likely to deteriorate, and reducing emergency admissions. This project looks to measure the outcomes from providing training workshops, regular out of hospital reviews of medication, and medication application techniques.

3. Implementing the NHS Long Term Plan and new local priorities

In addition we are building on progress made with the above projects and initiatives to scope and implement the following priorities as part of our comprehensive model of urgent care:

3.1 Our **Ambulance Conveyances** project provides the ability for our ambulance staff, paramedics and GPs to contact our Crisis Response team via Health and Social Care Connect (HSCC) to avoid an unnecessary A&E admission, for common conditions that result in 999 calls and an unscheduled conveyance to A&E. It will include new clinical pathways that can be managed outside of hospital.

3.2 Reforms to hospital emergency care – **Same Day Emergency Care (SDEC).** New diagnostic and treatment practices allow patients to spend just hours in hospital rather than being admitted to a ward. This also helps relieve pressure elsewhere in the hospital and frees up beds for patients who need quick admission either for emergency care, or for a planned operation. Through moving to a comprehensive model of SDEC we will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third.

3.3 Enhanced care in care homes is aimed at developing and testing a range of initiatives that offer dedicated support to care homes, such as dedicated primary care ward rounds. This programme will build confidence for staff and avoid unnecessary admissions. It is currently at the exploration stage of looking to understand how appropriate support can be delivered to people in care home settings in partnership with Primary Care Networks. An enabler for all enhanced health in care homes projects is the alignment of care homes to specific practices. This process of alignment is underway.

3.4 The **NHS Clinical Standards Review** is due to be published in the Spring 2020. We will develop new ways to look after patients with the most serious illnesses or injuries, ensuring that they receive the best possible care in the shortest possible timeframe. In addition, the East Sussex A&E Delivery and Urgent Care Oversight Board are in the process of analysing the key drivers of demand behind the recent increases in A&E attendance and admissions, to scope further actions and interventions to take forward in winter 2019/20 and 2020/21.

4. Key milestones for urgent and emergency care

- In 2019 England will be covered by a 24/7 Integrated Urgent Care Service, accessible via NHS 111 or online.
- All hospitals with a major A&E department will:
    - Provide SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20.
    - Provide an acute frailty service for at least 70 hours a week. The service will work towards achieving clinical frailty assessment within 30 minutes of arrival.
    - Aim to record 100% of patient activity in A&E, UTCs and SDEC on the same system by March 2020.
    - Test and begin implementing the new emergency urgent care standards arising from the Clinical Standards Review, by November 2019.
    - Further reduce Delayed Transfers of Care in partnership with local authorities.
    - By 2023 the Clinical Assessment Service will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.

5. Summary of urgent care priorities for 2020/21

Working with partners across primary care, community, mental health, social care and ambulance services, the key focus of the Urgent Care programme is to transform urgent and emergency care services in East Sussex to ensure that, in an emergency, people are treated in the most appropriate place by the right clinical and/or social care service. The priorities are

closely aligned with the SH&CP plans for Urgent and Emergency Care and include a mix of work to implement Urgent Treatment Centres (UTCs) and local priorities:

High intensity users

- Further expand and focus on supporting patients with multiple needs and high numbers of A&E attendances and admissions.

Ambulatory Emergency Care (AEC)

- Expansion of AEC at both EDGH and the Conquest Hospital (Supporting Same Day Emergency Care)

Acute frailty

- Expansion of Acute Frailty teams and pathways to ensure the right support at the front door (Supporting Same Day Emergency Care).

Enhanced care in care homes

- Work with Primary Care Networks to develop and testing a range of initiatives that offer dedicated support to care homes, to better support patients in care homes, build confidence for staff and avoid unnecessary hospital admissions.

Community frailty/PEACE planning

- Further rollout of Proactive Elderly Advance Care planning as part of personalised care and support planning roll-out; supporting the cohort of patients in care homes.

Integrated Urgent Care

- Rollout of enhanced NHS 111 and Clinical Assessment Service from 1 April 2020.
- Rollout of UTCs at Eastbourne DGH, Conquest Hospital, Hastings and Lewes Victoria Hospital
- Direct booking into Primary Care Improved Access, UTCs or other walk in services and sites being developed as part of the East Sussex integrated urgent care model.
- Increased utilisation of Primary Care Improved Access capacity.

In addition the Local A&E Delivery and Urgent Care Oversight Board are in the process of analysing the key drivers of demand behind the recent increases in A&E attendance and admissions, to scope further interventions to take forward in winter 2019/20 and 2020/21.

Appendix 5
Planned Care – programme summary

1. Background
Our overall aim is to make sure that those people who are referred into hospital are seen and tested as quickly as possible. There will be quicker routes to tests, enhanced technology to detect any concerns faster and one stop clinics that will bring together consultations, tests, treatment and support in one place, at one time.

Planned care can be defined as routine services with planned appointments or interventions in hospitals, community settings and GP practices. This is also sometimes known as elective care and is any treatment that doesn't happen as an emergency and usually involves a prearranged appointment. Most patients are referred for planned care by their GP.

We want to make sure that those people who are referred into hospital are seen and treated as quickly as possible. There will be quicker routes to tests, enhanced technology to detect any concerns faster and one stop clinics that will bring together consultations, tests, treatment and support in one place, at one time.

The East Sussex planned care programme aims to optimise the use of resources across planned care pathways by reducing variation, and using evidenced based, clinically effective commissioning. This will ensure the best patient outcomes and experience and improve the productivity of acute and out of hospital planned care capacity. Our current focus is supporting more effective patient pathways between primary and acute care and working with the Sussex Outpatients Transformation Board to transform and digitally enable outpatients care.

Our local plans are informed by and developed in the context of the following:

- The NHS Long Term Plan
- NHS Rightcare
- Getting It Right First Time (GIRFT)
- Model Hospital
- Elective Care High Impact Interventions
- Guidance from the National Institute of Clinical Effectiveness (NICE) and the Royal Colleges
- Sussex Health and Care Partnership (SH&CP) Sussex-wide plans

Significant progress has been made with improving efficiency and productivity of planned care services across our system. This includes:

1.1 GP referral variation – our work with Primary Care to look at referral variation has led to a reduction in first outpatient appointments with no subsequent procedure or follow up. We are further developing this work through the establishment of a GP-led clinical reference group, under the banner ‘Right Referral, Right Route’. This group is peer reviewing referrals on a practice and specialty level, with professional development and learning being disseminated across primary care. The group is also fostering closer working relationships between primary and secondary care.

1.2 Ophthalmology – we have used a High Impact Intervention methodology to map ophthalmology demand and capacity locally. We have responded to these findings by:

- Undertaking intensive waiting list validation
- conducting virtual review by consultants
- introducing failsafe procedures and changes aimed at optimising clinics.

This has generated efficiencies in the system, for example through a reduction in patients waiting for follow up. Further work continues in 2019/20 on a clinical strategy for Ophthalmology.

1.3 Clinically effective commissioning - East Sussex successfully applied the clinically effective commissioning policies where procedures with limited evidence of benefit where initial conservative therapy is effective and where a threshold for intervention may be appropriate or where NHS provision may be inappropriate

1.4 Musculoskeletal services – In line with the Royal College of Radiologist guidance that does not support the use of MRI or CT scans when dealing with MSK presentations, we have worked with our local providers to review the diagnostics undertaken for MSK related conditions. Following this, processes were put in place to manage diagnostic requests and reject those that were not clinically appropriate. The one exception concerns suspicions of cancer, at which point the patient would be referred under the two-week wait rule. As a result, reductions in both MRI and CT scans have been realised.

1.5 Diabetes pathway redesign - this is a project implemented last year and has resulted in successfully avoiding amputations and improving preventative care, by providing GP led multidisciplinary community teams as well as greater levels of patient involvement in decision-making and self-care. East Sussex CCGs are now leading on Diabetes pathway re-design across the SH&CP, to further build on this model and inform a Sussex-wide approach.

1.6 Medicines optimisation – the East Sussex CCGs Medicines Management team works in partnership with ESHT Pharmacy team and other providers to deliver a highly effective structured programme designed to integrated Medicines Optimisation (MO) services to improve medicines use across care pathways.

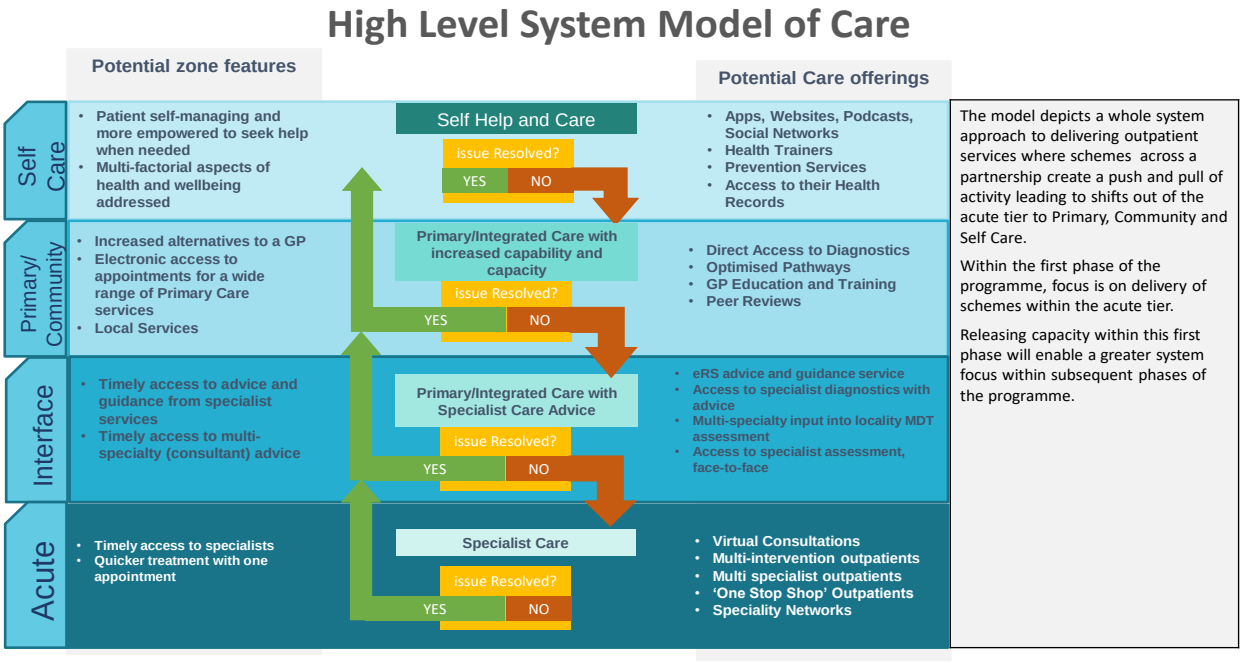
2. Key priorities for planned care in East Sussex

An outline of our key priorities for planned care in East Sussex is summarised below. All of our transformation priority areas will be underpinned by full pathway reviews. We will also ensure we reduce unwarranted variation and inefficiency in care pathways generally, by ensuring elimination of outdated concepts, introduction of one-stop diagnosis and reductions in unnecessary follow-ups wherever possible.

2.1 Outpatients

The vision for outpatient services developed by the system's stakeholders is:

"The East Sussex community will have timely access to specialist advice, care and treatment. This will be delivered through modern, efficient, and effective services that provide greater choice and less disruption to the daily lives of our community."



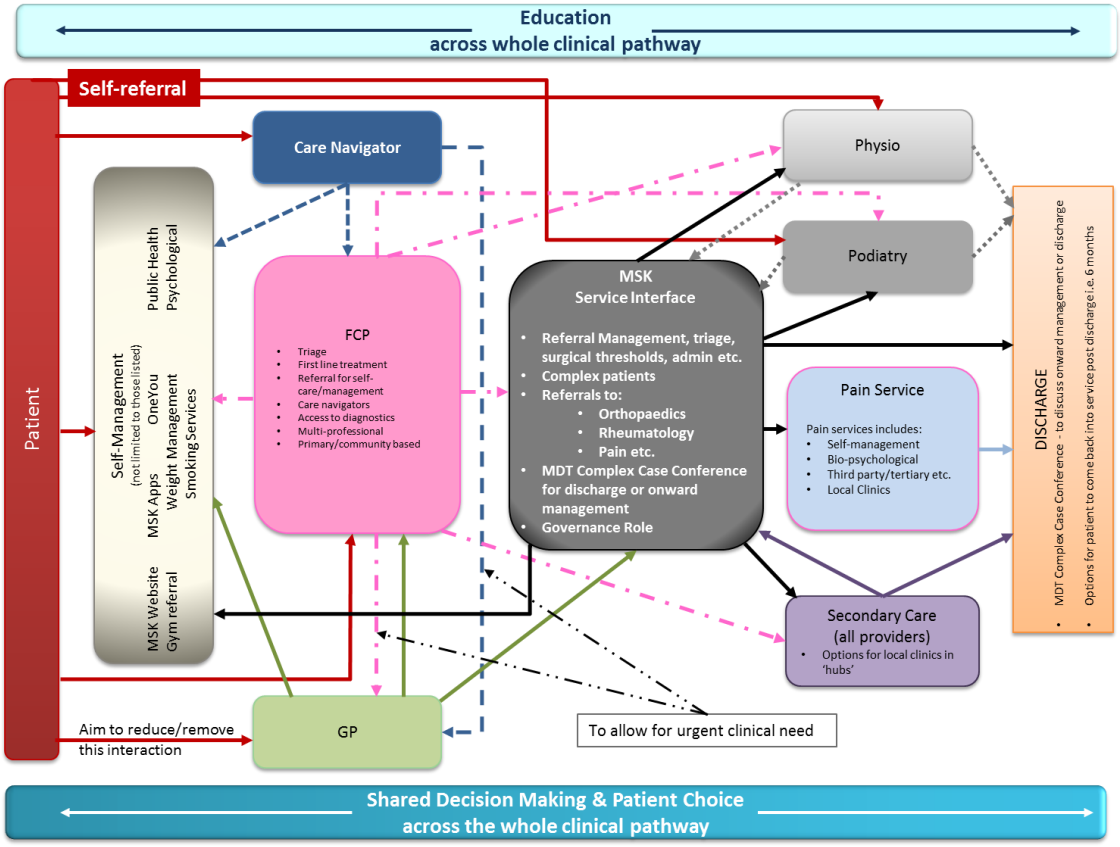
Outpatient appointments will be provided via the optimum channel i.e. video, telephone or face-to-face to ensure patients and clinicians are making best use of their time. East Sussex will have concluded and embedded optimal outpatient referrals by the end of 2019 enabling us to build on this to improve the efficiencies of the pathways.

2.1. Musculoskeletal (MSK) services in our area

In Eastbourne Hailsham and Seaford MSK Services are provided by Sussex MSK Partnership East, which offers a fully integrated service. The MSK triage (iMSK) service in Hastings and Rother is provided by East Sussex healthcare NHS Trust (ESHT). Our aim is to provide equity of service across East Sussex whilst aligning to the vision of NHS LTP and the transformation of MSK services - services delivered by the right person, in the right place, first time.

We are undertaking a review of MSK services, linked to our East Sussex MSK model, focussing on the reduction of unwarranted clinical variation of MSK services and re-design of the MSK community workforce to improve productivity. This includes first contact practitioners to provide faster diagnosis and treatment for people with MSK conditions. Pain management provision is also included in our redesign, including efficient use of community services. This programme is closely aligned with the SH&CP programme for MSK. The introduction of virtual fracture clinics will also form part of this programme.

Our agreed model of care is:



2.2. Evidence based interventions and clinically effective commissioning (CEC)

Part of a Sussex-wide programme, clinically effective commissioning (CEC) aims to review and standardise non-emergency treatments and procedures to reduce variation, reduce waste and make best use of limited resources. It supports referrers to use the appropriate guidelines agreed by clinical commissioners to ensure:

- unnecessary high-risk interventions are not carried out
- treatment is clinically effective

- management of referrals for procedures that are either not routinely funded, or require patients to meet certain eligibility criteria before they can receive treatment

This year more procedures will be reviewed with these principles in mind and work has commenced to implement the pathway redesigns.

2.3. Cardiology

Locally our population has high incidences of atrial fibrillation (AF) and heart failure (HF). These high incidences are driven by our older population and levels of deprivation described elsewhere in our Plan, which is why our work on health, wellbeing and prevention is so important. This is also a significant driver of elective and non-elective cardiology spend in secondary care. With AF cases, and stroke-related hospital admissions predicted to rise as the population ages, this could put significant pressure on primary and secondary care services.

Our work on cardiology is therefore focused on ensuring our local East Sussex services are designed to cope with these current and future challenges. We are aiming for a reduction in the use of isolated coronary angiography, an increase in identifying and supporting patients to self-manage their own heart health through using the patient activation measure tool, and a reduction in variation in spend/activity across our CCG areas. These aims will be delivered through application of NICE guidance to all interventions, equitable community cardiology services across East Sussex and reduction in unwarranted variation.

There are a range of projects focused on cardiology. These include looking to reduce variation in the way community cardiology provides community-based assessments for people who may have problems with their heart, blood pressure or breathing, and standardising the use of procedures such as Computerised Tomography (CT) scans and angiograms. This project is looking to standardise pathways across the east and west of the area and so more patients can be treated within the community setting to make best use of capacity. In acute cardiology, we are reviewing the acute model of care to support the long term clinical sustainability of the service.

2.4. Diabetes

The prevalence of type 2 diabetes across our area is 6.9% and is in line with the average for England. However, local data within our CCGs shows variation in care and outcomes – and our programme of work described in the next section looks to address this. Overall, we are aiming for:

- improved patient experience for people with diabetes
- reduction in outpatient appointments
- reduction in non-elective admissions
- reduction in amputations
- improved access for psychological therapies for people living with diabetes with co-morbid depression/anxiety and;
- improved workforce retention within our local services.
- improved access to innovative technologies for glucose monitoring for patients with type 1 diabetes (includes flash and continuous glucose monitoring).

Building on the success of service redesign now being rolled out across the Sussex system, we acknowledge predicted exponential growth in Diabetes, and will plan how we will manage this as a system over the next 3 years.

2.5. Ophthalmology

In response to an all-party parliamentary group on eye health capacity, NHS England has initiated a high impact intervention scheme, requiring Trusts and CCGs to work together to look at their demand and capacity in this area and come up with a plan to ensure the system is ready to respond. Across our CCGs, data is being reviewed from all acute trusts and community providers of ophthalmology services. The aim is to agree a solution to the predicted growth in the number of patients at risk of losing their sight. The role of **community ophthalmology** is central to this, with the longer term aim of expanding the remit of community providers to monitor stable patients and triage new conditions.

In East Sussex our work on this priority area that supports our patients to have a positive experience of care in the right place, first time. It aims to keep them well for longer, reducing or eliminating the risk of losing sight, with all the additional challenges that sight loss brings to the wider system and the economy. We know it requires our acute and community providers to work closely together to ensure a seamless pathway. We are working to ensure that our local system can respond to current and future demand in eye health for our patients.

We will implement a planned NHS-managed choice process for all patients who reach a 26-week wait, starting in areas with the longest waits and rolling out best practice through a combination of locally agreed targeted initiatives and nationally-driven pilots. This is currently being managed from a Sussex-wide position and local implementation plans will be developed in time for implementation by end of March 2020.

Over the coming months we will be working with Brighton and Sussex University Hospitals NHS Trust (BSUH), East Sussex Healthcare NHS Trust (ESHT) and Sussex Community NHS Foundation Trust (SCFT) and our other providers to ensure the 26-week-wait policy is fully implemented for April 2020. Where there are known issues we are currently seeking to commission further capacity from the local independent sector providers, and we are also exploring opportunities for patients across a wider regional geography, particularly where there is spare capacity and short waiting times. Leads from the East Sussex CCGs and ESHT have already been identified, and as part of the Sussex-wide work we will also work closely with Surrey Heartlands as a Fast Mover pilot site looking to share learning.

2.6. Cancer

Cancer is a national and local priority, as reflected by the National Cancer Strategy Achieving Word Class Outcomes for Cancer 2015-2020: A Strategy for England: Report of the Independent Cancer Taskforce Review[12] as well as the cancer plan for the Sussex Health and Care Strategy, which was signed off in April 2019. In the context of the Cancer Alliance and Sussex-wide cancer plan, our aim is to continue to improve operational performance to support early diagnosis and treatment and to support our population to manage their own health and wellbeing through personalised care.

The priority areas for cancer include: prevention, early diagnosis, patient experience, living with and beyond cancer (personalised care) and modernising cancer services. Through the work of the East Sussex Planned Care Oversight Board, and the clinical leadership of the East Sussex Cancer Action Group, we will build on existing work during 2020/21 to take forward local plans in the following areas:

- Continue to improve performance against the cancer constitutional waiting times standards and ensure sustainability, including the new 28 day faster diagnosis standard.
- Work with PCNs to improve the uptake of screening targeting those areas with lower uptake and focussing on health inequalities.
- Develop diagnostics working towards set up of the rapid diagnostic service.
- Continue to ensure implementation of timed pathways so support earlier diagnosis and treatment.
- Strengthening the two-week wait process to ensure referrals are managed proactively to improve the Referral to Treatment RTT) waiting times.

[12] Achieving Word Class Outcomes for Cancer 2015-2020 A Strategy for England; Report of the Independent Cancer Taskforce Review (2015) : http://www.cancerresearchuk.org/sites/default/files/achieving_world-%20class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

- Ensure personalised care pathways in breast are implemented and plans for other specialties are developed, with prostate and colorectal as priorities for 2020/21.

3. Sussex Health and Care Partnership (SH&CP) programmes

East Sussex is fully engaged with the programmes of work managed by the SH&CP with local representatives on all the workstreams. Some workstreams are in early stages; head and neck, dermatology, cardiology, and some more further developed, for example MSK and fractures and falls.

Head and neck

To develop a model of care using national evidence and best practice that will ensure the long term sustainability of head and neck services, address the challenges faced by current providers in delivering head and neck services for our population; and ensure improved outcomes for patients.

Dermatology

To develop a model of care using national evidence and best practice that will ensure the long term sustainability of the dermatology services, addresses the challenges faced by current providers in delivering dermatology services for our population; and ensure improved outcomes for patients.

Cardiology

To develop a model of care using national evidence and best practice that will ensure the long term sustainability of the cardiology services, addresses the challenges faced by current providers in delivering cardiology services for our population; and ensure improved outcomes for patients.

Fractures and falls

To develop a model of care that is based on prevention and improved outcomes following a fall or fracture. There were two initial falls oversight groups earlier this year where four priority areas were identified. These priority areas have developed into four task and finish groups covering:

- Low level falls prevention & osteoporosis identification
- Non injured falls at home
- Post A&E attendance/hospital admissions falls prevention
- Fracture liaison service development

Musculoskeletal Services (MSK)

The model under development looks at how we can improve the patient experience from the first point of contact, so that they see a clinician with specialised MSK skills at the earliest possible opportunity. This in turn will streamline the rest of the pathway, when a referral to secondary care is necessary.

The role of First Contact Practitioners (FCPs) is becoming central to this, and we are feeding into the evaluation of FCP pilots with insights from our own pilots locally, to inform these discussions. This will help us understand the best way to make use of FCPs. Extensive patient engagement is being undertaken at an STP wide level, with patient forums being approached locally, and clinicians, commissioners and service managers have been attending the STP wide workshops to design the model.

4. Planned Care Priorities for 2020/21

Our aim for 20/21 is to make sure that those people who are referred into hospital are seen and tested as quickly as possible. There will be quicker routes to tests, enhanced technology to detect any concerns faster and one stop clinics that will bring together consultations, tests, treatment and support in one place, at one time. We will do this by prioritising on the following areas:

- Outpatients
- Musculoskeletal services
- Evidence-based interventions

- Cardiology
- Diabetes
- Ophthalmology
- 26 week wait capacity alerts
- Cancer
- Medicines optimisation

4.1. Outpatients

During the last 2 years we have made significant improvements in the referral pathways for patients from GPs to hospitals consultants by working closely together to ensure the flow of communication is the most effective for our patient care. Next year we will build on this success by:

- Introducing video appointments, virtual fracture clinics, electronic correspondence for our patients
- Expanding of successful approaches to:
    - improve the timeliness of treatment
    - improve the experience of patients on care pathways
    - reduce unnecessary appointments
    - introduce one-stop clinics specifically focusing on gastroenterology and breast cancer two-week wait.

4.2. Musculoskeletal services

During the last two years we have introduced community-based specialist teams to care for patients with musculoskeletal conditions, ensuring interventions are appropriate to individual needs and pain is effectively managed. Next year we will focus on the sustainability of services to meet the growth in demand by:

- Introducing First Contact Practitioners (FCPs) in GP surgeries designing the correct bespoke pathway to ensure timely recovery, minimised pain and improved independence
- Improving shared decision-making between specialist clinicians and patients with more complex conditions, alongside improved education on self-management.
- Enabling patients to self-refer to physiotherapy so they start treatment earlier at the onset of a condition
-

4.3. Evidence based interventions

More is now known about what types of treatment improve outcomes for our patients and during the last year we have been ensuring patients do not undergo unnecessary invasive procedures. We will continue to review the latest evidence and change our recommended treatments where this evidence indicates areas that do not benefit our patients, allowing us to release capacity for the right treatments.

4.4. Cardiology

Locally, we see a high incidence of heart conditions, driven by our older population and levels of deprivation. Our specialist heart clinicians are working together to agree a new model of cardiology care spanning general practice through to community services and hospital care. We are aiming for a model that:

- Increases identification of heart conditions and related support for patients to self-manage their own heart health
- Reduces variation in community-based cardiology assessments by standardising pathways, enabling more patients to be treated within a community setting to make best use of capacity

- Supports the long term sustainability of hospital services

4.5. Diabetes

Building on our success in implementing complex diabetes treatment in a community setting, and our expansion of urgent treatment for diabetics, we will continue to refine these services to:

- Provide improved patient experience for people with diabetes by reducing unnecessary hospital appointments including outpatient appointments and hospital admissions
- Provide improved access for psychological therapies for people living with diabetes that also have co-morbid depression/anxiety
- Provide improved access to innovative technologies for glucose monitoring for patients with type 1 diabetes (includes flash and continuous glucose monitoring).

We recognise the predicted exponential growth in diabetes and we will develop a plan to manage this as a system over the next 3 years.

4.6. Ophthalmology

Our work on this priority area supports our patients have a positive experience of care in the right place, first time. It aims to keep them well for longer, reducing or eliminating the risk of losing sight, with all the additional challenges that sight loss brings to the wider system and the economy. We know it requires our acute and community providers to work closely together to ensure a seamless pathway. Our focus next year is to address the growing demand by repatriating care to our specialist community optometrists, releasing capacity in our hospital multidisciplinary teams to manage the more complex eye conditions.

4.7 26-week wait/capacity alerts

We know some of our patients are waiting too long for treatment. We will implement a planned choice process for all patients who reach a 26-week wait, starting in areas with the longest waits. This will give patients options to access care across NHS services in Sussex

4.8. Cancer

The priority areas for cancer include: prevention, early diagnosis, patient experience, living with and beyond cancer (personalised care) and modernising cancer services. We will build on existing work. During 2020/21 we will build on existing work to take forward local plans in the following areas:

- Continue to improve performance against the cancer constitutional waiting times standards and ensure sustainability, including the new 28 day faster diagnosis standard
- Improve the uptake of screening targeting those areas with lower uptake and focus on inequalities
- Strengthen the two-week wait process to ensure referrals are managed proactively
- Implement personalised care pathways for breast cancer and develop plans for other specialties, with prostate and colorectal as priorities

4.9 Medicines Optimisation

Through a structured programme of work, the East Sussex CCGs Medicines Management team works in partnership with ESHT Pharmacy team and other providers to deliver integrated Medicines Optimisation (MO) services to improve medicines use across care pathways. Building on recent successes, some of the key priorities for 2020-21 include:

- Improving **value for money** through specific projects aimed at optimising prescribing in a range of areas including diabetes, pain management, malnutrition and anticoagulation; as well as de-prescribing medicines no longer needed through NHS England led programmes such as low priority prescribing.

- Development of an Integrated Medicines Optimisation service between local GP Primary care Networks (PCNs) and East Sussex Healthcare Trust. This service will support the delivery of structured medication reviews and quality improvement in areas such as **antimicrobial stewardship** and **dependence forming medicines**.

- Continuation of successful **medicines optimisation in care homes** service to reduce inappropriate polypharmacy and working towards integration with the PCN structured **medicines review and optimisation service**, under the PCN Network Directed Enhanced Services (DES) contract in 2020/21.

- Focus on **medication safety** including rolling out the electronic transfer of medicines discharge information between hospital and community pharmacists; and implementation of a quality improvement process for pharmacy led interventions to enhance medication safety in General practice.

- **Integrated vocational training programmes** for pharmacists and pharmacy technicians across primary and secondary care, mental health and community services.

5. Enabling delivery of planned care

In order to deliver the plans detailed above there are a number of key enablers that will ensure success.

Digital

Digital enablers such as Patient Knows Best and virtual fracture clinics are two areas looking to reduce waste on pathways and reduce patient travelling requirements to improve patient experience and outcomes. The initial focus will be on ophthalmology, gynaecology, and urology.

Workforce redesign

Robust workforce planning is a key enabler of the planned care efficiency and transformation programmes. Robust processes are in place with high quality data integrity and increased breadth and depth of insight to underpin short-term, medium term and long-term strategic planning. Cohesive workforce strategies are in place that balance quality and safety with financial sustainability through the identification of workforce optimisation principles that will support the future work programmes.

Appendix 6
Mental Health – programme summary
1. Background

The NHS LTP requirements for delivering a "new service model for the 21st century" by 2024, include the following ambitions:

- Better care for major health conditions: improving mental health services
- Meeting the mental health investment standard for adults, and children and young people's mental health services (new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24)
- Delivering the Five Year Forward View for Mental Health and NHS LTP commitments
- NHS-led provider collaboratives for specialised mental health, learning disability and autism services
- Stabilisation and expansion of core community teams of adults and older adults with severe mental health illnesses
- Testing and rolling out adult community access standards once agreed; services for people with specific and complex needs including people with a diagnosis of 'personality disorder'; Early Intervention in Psychosis (EIP); adult eating disorders and mental health community rehabilitation; and developing services for 18-25 year olds
- Fair share transformation funding from 2021/22 to 2023/24 to deliver the above services in new models of care integrated with primary care networks

Our work on mental health takes place in the context of the Sussex Health and Care Partnership (SH&CP) mental health programme priorities, and local implementation to support closer system working between physical and mental health, community health and social care, and primary care.

The overall vision for the SH&CP mental health programme is that by 2025, all people with mental health problems in Sussex will have access to high quality, evidence-based care and treatment. This will be delivered by integrated statutory, local authority and third sector services that are accessible, well connected with the wider community, and which intervene as early as possible to prevent mental ill health.

The SH&CP mental health programme priorities have been developed as a result of extensive public engagement with service users, carers, partner agencies, providers and commissioners. This has evolved through the Sussex Partnership NHS Foundation Trust (SPFT) Clinical Strategy (March 2017) and the STP Mental Health Case for Change (November 2017). The latest version of the SH&CP mental health programme takes account of NHS Long Term Plan commitments, with workstreams that seek to address the following priorities:

- Perinatal Mental Health
- Children and Young People's (CYP) Mental Health – including CYP Crisis
- Adult Common Mental Illnesses – Improving Access to Psychological Therapies (IAPT)
- Adult Severe Mental Illnesses (SMI) Community Care
- Adult Liaison Mental Health
- Adult Crisis Alternatives
- Ambulance mental health provision (all ages)
- Therapeutic Acute Mental Health Inpatient Care
- Suicide Reduction and Bereavement Support
- Rough Sleeping Mental Health Support

The SH&CP programme for mental health also has ambitions to further develop and strengthen the role of housing and third sector partners. A task and finish group (Sector Connector) has been

developed to support this diverse sector to influence change, and engage more fully in the work of our mental health programme. Proposals are being developed to:

- Enhance representation from housing and the third sector on the programme board
- Develop an East Sussex mental health forum (alongside mental health forums across Sussex)
- Develop an overarching mental health partnership board across Sussex.

Robust estates plans will also be key to the successful transformation of community, patient flow and rehabilitation workstreams including the development of more supported housing for local people. The LTP commitments expect an increase of over 600 staff over a 5 year period, so new models for providing work spaces and hubs for staff will be a priority. More joined up working will lead to teams being co-located. There are also some stretching targets for remodeling community support and providing crisis support in the Sussex-wide plans, and this will require new facilities, with crisis cafés being embedded and located within local communities.

The plans for mental health are set out in full in the SH&CP Strategy Delivery Plan and response to the NHS LTP.

2. Transformation funding

In addition, **transformation funding** has recently been awarded to the Sussex Health and Care Partnership and this will enable SH&CP to build on the work we are already doing to improve patient and family experience of mental health services.

Specific areas of development include:

- **Children and young people**
  The East Sussex CCGs and East Sussex County Council (ESCC) have been awarded funding to set up three Mental Health Support Teams (MHSTs) covering approximately 24,000 pupils / 60 schools in total, focussing on groups of schools in areas with highest levels of need. These teams will provide specialist support to children and young people, through one-to-one and group psychological support, and working with families. This will build on the whole-school work on mental health and emotional wellbeing that is already underway, as well as provide additional support for children and young people with emerging problems, aligning with support pathways for individual children.

  Schools, pupils and parents will be involved in the design of the teams and the project is being delivered through an MHST implementation group with members from East Sussex CCGs and Child and Adolescent Mental Health Services (CAMHS) alongside a range of ESCC services working in schools, and Public Health.

- **Crisis resolution / home treatment**
  More specialist roles will be introduced to our existing 24/7 crisis resolution/home treatment teams to provide psychological interventions to prevent people from relapsing and having to be admitted to hospital.

- **Expansion of psychiatric liaison teams**
  A bid has been submitted to expand existing psychiatric liaison provision at Eastbourne District General Hospital (EDGH) and the Conquest Hospital in Hastings to enable the criteria for 24/7 provision of specialist mental health support set by NHS England to be fully met. This is already provided at the Royal Sussex Hospital in Brighton, and a similar bid is being explored for the Princess Royal Hospital in Haywards Heath.

- **Crisis cafés**
  Four new crisis cafés will be set up across Sussex, and will be open for 46 hours a week including evenings and weekends. The cafés offer an alternative to A&E for people who need specialist mental health support and use the expertise of our third sector partners. They are also accessible for people with learning disabilities and autism. There is already a

crisis café in Hastings, The Sanctuary, and the options are being explored for another crisis café elsewhere in the county.

- **Ambulance triage**

  The ambulance triage service involves qualified psychiatric nurses attending incidents where a person does not need medical or paramedical attention, but appears to be experiencing some form of mental health crisis. Within East Sussex we are currently reviewing existing ambulance triage services with a view to rolling out more widely.

- **Street triage**

  We will extend the successful street triage scheme to operate for 84 hours a week right across Sussex. We were one of the first systems in the country to develop this joint scheme between the police and mental health services, which involves a police officer and qualified psychiatric nurse attending incidents where a person is experiencing some form of mental health crisis. A review will take place with Sussex Police during the remainder of 2019/20, to see if the model needs to be refreshed.

3. Key priorities for 2020/21 in East Sussex

Initial workshops and discussions have taken place locally to further define the scope and nature of the work to build on existing Sussex-wide mental health plans and understand the specific developments for East Sussex. This has helped identify specific areas that will support closer system working across physical and mental health, community health and social care, and primary care. Information on our priorities to support better mental health and wellbeing for all can be found in Appendix 1.

The following areas are being taken forward in East Sussex and will be built on further in 2020/21:

- **Single point of access - no 'wrong doors' and access to crisis pathways**
  In order to enable people to easily access services, wherever they present, we are seeking to invest in the expansion of NHS 111 so that it can take mental health referrals. A pilot Single Point of Access (SPOA) for adults is also being developed for Eastbourne, embedded within Health and Social Care Connect (HSCC). In addition, pathways have been simplified and a joint operational policy is being co-produced to support joint working across mental health and social care teams.

- **Supporting people in the community through community health and social care teams for adults with severe mental health issues**
  Work is being taken forward by ESCC Adult Social Care and SPFT across a number of operational areas to enhance integrated working through community health and social care teams for people with severe mental health problems. This includes resource and quality practice panel processes, protocol development in relation to Approved Mental Health Professional (AMHP) duties, and access to Crisis Resolution and Home Treatment (CHRT) teams to help avoid unnecessary admissions. In addition, joint management meetings are being reviewed to ensure representation is appropriate for collaborating to solve problems.

  To enable better outcomes for people with serious mental illnesses through the wider integration of mental health teams and multi-disciplinary working, we are considering how to deliver a more integrated and multi-disciplinary approach to meeting physical health and mental health needs as part of the target operating model for community health and social are services.

- **Supported accommodation pathways**

  A review of supported accommodation pathways is taking place. This will identify people using mental health services that need specific housing support, to inform work with housing teams to find long term solutions.

  Supported accommodation is currently commissioned by Adult Social Care to provide medium-term (average of 18 months) accommodation-based support for:

  - Adults who are homeless
  - Adults who have mental health needs and are homeless
  - Young people who are 16-25 years old and homeless
  - Young parents and homeless

  There are currently 89 beds across mental health and homelessness, and 160 beds across young parents and young people, for a total of 249 beds. This provision will be recommissioned from December 2020.

  This offers an opportunity to re-consider how services are commissioned and delivered to meet the joint working requirements of Adult Social Care and its partners, including Children's Services, local housing authorities, registered social landlords, and the wider local population, including:

  - A sufficient supply of accommodation-based support to enable clients with Care Act/Children's Act/Homelessness Reduction Act-eligible needs and those at greater risk of eligible needs to live independently as quickly and sustainably as possible
  - An effective system of planning, allocating, managing and retaining oversight of accommodation
  - An opportunity to strengthen supported accommodation provision to support a wider range of needs, including more complex and challenging behaviour, in more appropriate settings, for example, smaller units of self-contained accommodation for people with higher levels of need, and step down flats within larger accommodation support-units to prepare for fully independent living
  - How supported accommodation can best be provided for a range of clients groups that struggle to maintain independent living and require support

- **Rough sleeping**

  The first round of funding through the rough sleeping initiative (RSI) has been crucial in establishing a multi-disciplinary approach to tackling rough sleeping. We have formed a multi-disciplinary team of health, mental health, social care and substance misuse professionals who are responsible for carrying out holistic assessments of each individual's needs. The team are led by the Rough Sleeping Initiative Project Co-Ordinator who has worked alongside each of the services to develop a new pathway for rough sleepers. The team has an outreach focus, which ensures direct access to statutory services for rough sleepers, who would otherwise be unable to access this support via traditional routes. The work of the team is supported by enhanced outreach and day centre provision in both Eastbourne and Hastings.

  In October 2019, 23 people were rough sleeping in Eastbourne and 30 people in Hastings. Since the project started, the RSI has supported 213 individual rough sleepers.

  A second initiative, 'rough sleeper's initiative 2' operates across Lewes, Wealden and Bexhill. This is a team of two navigators who work to offer outreach services to entrenched rough sleepers. The project launched in July 2019 to improve access to housing and support services for entrenched rough sleepers living in rural East Sussex.

The funding for these initiatives is currently available from the Ministry of Housing, Communities and Local Government until March 2020, and we will be pursuing opportunities to bid for funding for a further year.

- **Aftercare and support**
  To ensure people get the best support and aftercare, a new delayed transfers of care network has been established, with joint leadership from Sussex Partnership Foundation NHS Trust and ESCC Adult Social Care Services and weekly discharge meetings to support safe and timely discharge. A live section 117 register has also been implemented to better coordinate care across teams.

- **Access to children and young people's mental health services**
  An independent strategic review of the whole pathway of emotional wellbeing and mental health services for young people is taking place across Sussex. This has involved engagement with staff, partners and those who use services across the pathway. The outcomes are due at the end of December 2019, and this will inform implementation planning with a range of partners across our system.
  Services across the country have also been asked to increase access for children and young people as part of the five year forward view for mental health, and our work through the East Sussex Children and Young People Mental Health and Wellbeing Local Transformation Plan sets this out in more detail. There is also some more detail in Appendix 2.

Appendix 7

Summary of key themes from the audit of recent engagement activity in East Sussex

Theme	Which reports?
Joining up health and care services, partnership working and collaboration • People told us we needed to have better co-ordination across the health and care system in order to improve people's experience of receiving services and make the system less confusing (pathways, information sharing, joined up working). They also talked about the importance of partnership working and involving the right people and organisations, the ongoing challenges to integration, the importance of collaboration and co-design – for example involving Patient Participation Groups (PPGs) in commissioning. In the Our Health & Care Our Future (OH&COF) engagement people fed back that the creation of multi-disciplinary 'Health Hubs' was a great opportunity.	• Healthwatch • OH&COF[13] • SH&C[14] Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation • Listening To You • Takeover Day 2018: Mental Health and Emotional Wellbeing
Communication, access to information, and information sharing • People consistently told us we need to improve access to information, and improve communication about services, between staff, between organisations and to patients about their care. People told us we need to have integrated IT systems and record sharing, but that we should consider confidentiality and how people's information is used.	• Healthwatch • OH&COF • SH&C Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation • Listening To You • Takeover Day 2018: Mental Health and Emotional Wellbeing
Digital • People gave positive feedback about increasing use of digital services and innovations, and that it could help make best use of resources. They also said we must ensure we don't exclude people who may not be able to access digital services.	• OH&COF • SH&C Spring '18 • SH&C Autumn '18
Staffing, resources and funding • People acknowledged increased demand for care and appreciate honest conversations, but also emphasised the importance of having more/enough staff, that resources must	• Healthwatch • OH&COF • SH&C Spring '18

[13] Our Health and Care Our Future

[14] Shaping Health and Care

Theme	Which reports?
be adequately planned for the future and for the population (for example where there is new housing), and gave views on where they thought resources should be directed and how to make best use of existing staff. There is sometimes a mismatch between what people feel they need and what the system is offering. The need for more GPs was a common theme.	• Big Health and Care Conversation • Listeing To You
The role of the voluntary and community sector, and social prescribing • The importance and value of the voluntary and community sector and social prescribing was highlighted throughout the engagement, and people said that it should be adequately planned and resourced. People taking part in the Healthwatch mental health focus groups said VCS organisations are picking up services no longer provided by the statutory sector.	• Healthwatch • OH&COF • SH&C Autumn '18 • Big health and Care Conversation
Health inequalities • People agreed that there shouldn't be 'postcode lotteries' for care, and said that there are still significant health inequalities to address. The issue of transport and access for rural communities was raised consistently.	• Healthwatch • OH&COF • Big Health and Care Conversation
Prevention and supporting healthier choices • People are aware of, and agree with, the importance of their own choices in living healthy and independent lives, but said that the healthcare system and staff also play an important role in prevention. People said access to information, education, services and facilities is important, alongside addressing barriers to access.	• Healthwatch • OH&COF • SH&C Spring '18 • SH&C Autumn '18 • Big Health and Care Conversation
Mental health • Issues discussed around mental health services include access, waiting times, support to meet people's needs, communication with people about their care. • People also raised communication with people about their care and support for those with autism and dementia during these sessions • Issues discussed around young people's mental health services included access to services and experience.	• Healthwatch • OH&COF • Big Health and Care Conversation • Takeover Day 2018: Mental Health and Emotional Wellbeing
Holistic and personalised care • People highlighted the importance of a holistic approach and more personalised care, including ''non-medical'' solutions, a joined up system, and support from healthcare professionals to help them make their own or joint choices.	• Healthwatch • OH&COF • Big Health and Care Conversation
Access to services and experience of services • There was lots of feedback from people about difficulty accessing services or not feeling they are getting enough support. For example, lack of co-ordination in the system,	• Healthwatch • OH&COF • SH&C Spring '18

Theme	Which reports?
availability and timeliness of appointments, availability of GPs/ health care professionals or treatment, continuity of care and gaps in services, and home care provision. As above, support for young people's mental health needs was also a common point of feedback.	• Big Health and Care Conversation • Listening To You
End of life care • People highlighted the importance of better conversations and support around end of life care, including conversations with their GP.	• Healthwatch • OH&COF • Big Health and Care Conversation
Multiple and complex needs • People with multiple or complex needs find it more difficult to access the support that they need.	• Healthwatch • OH&COF

The Equality Delivery System (EDS2)

Progress Report 2018/19

Goal 1: Better health outcomes		
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	**Achieving**
	Current activity/process: Through 2018/19 a new contract to improve telecommunications through the use of VOIP commenced. Telephone interpreting services offered to patients who do speak or understand English will not be as readily available using telephones. A plan is in place to ensure patients are not negatively affected by this change through the use of video and audio interpreting on Trust iPads. **Planned activity/improvement:** Equality Lead to review tender processes with procurement leads to support Equality Impact assessments. Update training to ensure Equality Impact Assessments are embedded into procurement processes. This will use local and national data to capture relevant information to ensure that contracts and services are designed to meet the health needs of local communities. **How will it be evidenced and graded:** • Application of procurement Equality Impact Assessments to be reviewed by Equality Lead • Audit process	
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	**Developing**
	Current activity/process: Demand for interpreters can exceed the number of interpreters available. Local interpreters continue to be scarce. Video interpreting trials took place across Conquest Hospital Following the end of the Service Level Agreement (SLA) to supply face to face interpreters, telephone interpreters, and bilingual advocates, the Trust developed a new internal process to provide greater support to staff and patients. Language and communication needs continue to be assessed and met in a variety of ways using a simplified system that is now supported by a dedicated 'Accessible Information Team'. A new contract for the supply of interpreters is being explored to enable staff to continue meeting their patients' communication needs. **Planned activity/improvement:** Identify supplier to provide face to face interpreters. Introduce video and audio interpreting to mitigate difficulties obtaining face to face interpreting. Video BSL will support bridging the gap when Deaf patients present needing urgent/unplanned care. **How will it be evidenced and graded:** • A completed policy • Feedback from Deaf User Group	

1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	**Developing**
	Current activity/process: The Accessible Information Standard sets out how people with communication needs arising from a disability must have their communication needs met. The Trust has been identifying processes to ensure the 5 steps are implemented to identify, record, highlight, share and meet communication needs. Some Deaf patients have not had access to interpreting services due to incompatible IT systems being unable to transfer information on communication needs. GP referrals do not always highlight a patients' communication needs and can also contribute to interpreters attending appointments. **Planned activity/improvement:** A task and finish group has been formed to identify how the 5 steps can be implemented. An action plan and policy to support the processes will be developed to provide clear robust guidance. ESHT and the CCG Equality Leads will review the current GP-Hospital referral process and invite Deaf communities to form a user group to provide insight and feedback on progress. **How will it be evidenced and graded:** • A completed policy • Feedback from Deaf User Group	
1.4	When people use the NHS their safety is prioritised and they are free from mistakes, mistreatment and abuse	**Developing**
	Current activity/process: Serious incident reporting is completed through Datix. Equality related incidents are reviewed and reported to the Equality lead for further evaluation and to ensure lessons are learned. Falls continue to be a risk for older persons. The Trust has a Falls Prevention Steering Group which meet monthly. The Prevention and Management of Patient Slips, Trips and Falls Policy provides information and guidance to staff to ensure a consistent and safe approach to the prevention of falls and the safe management of people who do fall. Risk assessments are carried out on all people aged over 65 within 12hrs of admission (4hrs in A&E). **Planned activity/improvement:** The Falls Prevention team consistently work towards reducing the risk and number of falls. The team plan to develop a checklist that can be completed by patients and their families/carers to identify and remove further risk. Other innovative ideas will continue to be explored. **How will it be evidenced and graded:** • Reviewing the number of falls and injuries relating to falls	

1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	**Achieving**
	Current activity/process: East Sussex Healthcare NHS Trust is a 'Health Promoting Trust' with dedicated 'Making Every Contact Count' (MECC) Leads working to help everyone in our community lead happier, healthier lives. With 3 – 4 training sessions available to staff each month, more staff continue to be trained to equip themselves to promote Healthy living at every possible opportunity. We are excited to announce the launch of a new MECC app. **Planned activity/improvement:** The MECC team plan to launch the new MECC app. The app will be installed on all trust iPads, allowing for easy access on the wards enabling greater up-to-date resources and signposting to be available instantly. The app will also facilitate easy referrals to One You East Sussex, STAR and other local health providers. **How will it be evidenced and graded:** • Feedback from users	
	Goal 2: Improved patient access and experience	
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	**Developing**
	Current activity/process: The Trust aims to provide all d/Deaf patients that communicate using British Sign Language (BSL) are provided with a face to face interpreter. d/Deaf people who use the Trust services can provide their communication preferences which the Trust aims to fulfil. Due to the Trust using several IT systems, communication needs are not always known. Occasionally this has led to interpreters not being booked causing delays to care and/or treatment. **Planned activity/improvement:** Following a pilot of video interpreting at the Conquest the Trust plans to implement video interpreting on the acute sites enabling on-demand video interpreting to assist in improving access for BSL users. The Equality Team will meet regularly to with d/Deaf communities to review the initiative and receive feedback. **How will it be evidenced and graded:** • Reviewing feedback • Progress on AIS Action Plan	

2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	**Developing**
	Current activity/process: The Planning together Policy ensures information is accessible, relevant and tailored to the individual's specific needs, supported by tools such as materials, and communication aids as appropriate to enable a person to make an informed choice whilst addressing concerns and respecting beliefs. The Trust has a process that provides Braille, large print and easy read as well as providing information in alternative foreign spoken languages. The AIS requires all communication and Information needs (arising from a disability) are met by all NHS organisations. Currently the Trust is not always able to identify patients that require information in alternative formats and is working towards full compliance with the AIS. **Planned activity/improvement:** Part of the plan to embed the AIS includes embedding a streamlined process for identifying communication needs. **How will it be evidenced and graded:** • Through monitoring progress of the AIS	
2.3	People report positive experiences of the NHS	**Developing**
	Current activity/process: The Friends and Family Test (FFT) is a key tool used to measure patient experience of the Trust. The FFT does not provide the Trust with equalities information to identify each of the protected characteristics. Through monitoring formal complaints and concerns raised with PALS, d/Deaf people were disproportionately reporting experiencing issues when accessing the Trust. As a result the E&D team have been listening to the concerns of the local Deaf community to identify where the issues stem. **Planned activity/improvement:** Holding regular engagement meetings with the Deaf community to receive feedback and identify and implement innovative ways to improve access and experience. **How will it be evidenced and graded:** • Reviewing feedback taken at the engagement meetings • Monitoring complaints and concerns raised by d/Deaf patients	

2.4	People's complaints about services are handled respectfully and efficiently	**Developing**
	Current activity/process: The top three themes for complaints in 2018/19 remain the same as 2017/18. They were Standard of Care, Communication and Patient Pathways. The Trust has two timescales for investigating complaints; non-complex complaints - 30 working day timeframe and complex complaints - 45 working days. At the end of 2018/19, the Trust had responded to 100% of non-complex complaints in time, with 92% of complex complaints being responded to in time. These are further and commendable improvements compare to 2016/17 (54% and 53% respectively) and 2017/18 (83% and 71% respectively). Trust continues its commitment to treating complaints seriously by improving and respecting the importance of handling complaints efficiently and effectively. **Planned activity/improvement:** To consider how both PALS and the Complaints Team can engage with protected groups to review the concerns/complaints process and how accessible it is to those groups. **How will it be evidenced and graded:** • Annual Complaints Report	
	Goal 3: A representative and supported workforce	
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**Achieving**
	Current activity/process: The Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) provides detailed data on recruitment equality for disabled and BME people and is explored further in those reports. The Trust has developed action plans to ensure that Disability and Race equality is considered during recruitment processes. The Trust has three relevant staff networks that aims to reduce barriers and provide a safe space for LGBT+, Disabled and BME staff to come and share their experiences and receive support. The members also provide insight into the barriers and perceptions of the recruitment and retention processes. Through understanding difficulties, that may be experienced or perceived by some people with protected characteristics, the recruitment team are able to review its processes and further advance equality in those areas. **Planned activity/improvement:** Continue to engage with the staff networks to identify ways of improving representation at all levels for all protected characteristics. Review the way the 'Guaranteed Interview Scheme' is applied, including how reasonable adjustments are requested and made for disabled applicants. **How will it be evidenced and graded:** • Updates to policies to improve reasonable adjustments process at interview • Using The WDES and WRES relative likelihood scores that compare non-disabled/disabled successful applicants and White/BME successful applicants	

3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**Undeveloped**
	Current activity/process: The Gender Pay Gap is a national reporting toolkit that requires all employers employing over 250 people to report on gender pay. The Trust publishes a detailed equal pay audit annually. Currently the largest pay gap between the genders exists for senior clinicians. An action plan has been developed to explore the possible reasons for the gap. **Planned activity/improvement:** Options will be explored to develop a working group that will identify and address the gender pay gap. A gender equality staff network will also be explored. **How will it be evidenced and graded:** • Using the Gender Pay Gap annual report.	
3.3	Training and development opportunities are taken up and positively evaluated by all staff	**Developing**
	Current activity/process: All training opportunities are communicated widely using various platforms (posters, flyers, emails). Additional support is offered to staff for Elearning. Training opportunities for BME staff are regularly offered and fully supported/funded. Feedback is requested on training sessions that are delivered at the Trust which is then evaluated and fed back to the trainers. Equalities information is not currently collected on feedback forms. Access to non-mandatory training is collected and reported in the WDES and WRES reports. A disproportionate gap is reported to be experienced between disabled and non-disabled staff and between BME and white staff accessing career development opportunities **Planned activity/improvement:** Continue to engage with the staff networks to identify training needs. Develop training sessions to support career development for disabled staff. Continue to encourage participation through the networks and beyond to support all staff with a protected characteristic to fulfil their potential. Explore including equalities information on training feedback forms to identify whether learning outcomes are being met by all staff attending training provided by Trust staff. **How will it be evidenced and graded:** • Using The WDES and WRES metric outcomes that compare non-disabled/disabled and White/BME reported access to non-mandatory training as well as career development opportunities • Feedback from network members • Feedback from training sessions	

3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	**Developing**
	Current activity/process: The Trust has taken many steps to address Bullying & Harassment (B&H). Through listening and engagement events and to gain greater understanding of cultures and behaviours, the Trust has used its Values to promote positive behaviours, and identify and address poor behaviours through relevant Trust policy. The 'Speak up Guardian' has provided a safe and confidential platform to staff who have needed support. **Planned activity/improvement:** Continue to engage with the staff network members holding engagement listening events with BME, Disabled and LGBT+ staff to explore ways of identifying and addressing B&H. Further listening events are planned to identify and address violent and aggressive behaviours. **How will it be evidenced and graded:** • National NHS Staff survey and Pulse survey outcomes • Listening events • Datix incident reporting	
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**Developing**
	Current activity/process: Flexible working options are promoted in the Trust and requests are welcomed. Many flexible working arrangements are requested and processed locally by service managers/team leaders without the knowledge of Human Resources (HR). Data for flexible working options is not a centralised process. Previous reviews to centralise the process identified potential delays to requests which would not be consistent with the needs of the service or the way people lead their lives, especially where short term flexible working was required at short notice. **Planned activity/improvement:** Flexible working requests will remain within the individual services and HR will assist where any request cannot be accommodated. **How will it be evidenced and graded:** • HR will provide data where flexible working requests have not been fulfilled.	

3.6	Staff report positive experiences of their membership of the workforce	**Developing**
	Current activity/process: Through listening and engagement events greater understanding of cultures and behaviours has informed the way the Trust has promoted its Values of positive behaviours. Excellence is identified through workforce rewards and recognition. **Planned activity/improvement:** Continue to engage with the staff network members holding engagement listening events with BME, Disabled and LGBT+ staff to explore ways of identifying and improving staff experience at ESHT. **How will it be evidenced and graded:** • National NHS Staff survey, Staff Friends & Family Test and Pulse surveys • Network members' feedback	
	Goal 4: Inclusive leadership:	
4.1	Boards and other senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	**Developing**
	Current activity/process: ESHT Trust Board and other senior leaders routinely demonstrate their commitment to promoting equality within and beyond the Trust. Examples of commitment include the Chief Executive Chairing the Staff BME Network; the Director of Human Resources Chairing the Staff Disability Network; the Equality Lead Chairs the Deaf user Group which is attended by the CCG Equality lead to promote collaborative working in the locality. Further areas include Human Resource managers working to support employment opportunities for apprenticeships, recruiting talented and skilled people from overseas, as well as supporting development for employment opportunities for young people with learning disabilities through Project SEARCH. Project SEARCH is a joint project between the local authority, college and ESHT. One of Project SEARCH's most unique attributes is its emphasis on collaboration. ESHT play an integral role providing work placements for the interns to gain skills and experience that enables them to later progress into paid employment. **Planned activity/improvement:** Continue to promote the staff networks and identify ways of improving equality at all levels in all areas of the Trust and beyond. In 2019 ESHT will pledge to support employment equality for people with learning disabilities. HR managers to provide support at the staff network meetings and to ensure equality data is reliable to support annual reporting. **How will it be evidenced and graded:** • Publish ESHT pledge to support employment equality for people with learning disabilities • Explore options of engagement events with local people with protected characteristics to support policy development	

4.2	Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed	**Achieving**
	Current activity/process: Conducting Equality Impact Assessments on all Trust policies that came before the Trust Board and other major committees was a 2015 – 2019 Equality Objective (full details can be found in the Equality Objectives 2015-19 document on the Trust website). This objective was successfully developed and was embedded into policy development and ratification process. **Planned activity/improvement:** As part of the 2019 – 2023 Equality Objectives, Equality Impact Assessments will be reviewed and further developed to ensure commissioned services, tender processes and Projects and Business Cases are subjected to the same Equality Impact scrutiny. **How will it be evidenced and graded:** • Ratification of Equality Impact Assessment template document and process • Audits on Equality Impact Assessment effectiveness	
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**Developing**
	Current activity/process: Through 2018/19 Human Resource Managers and the Equality Lead reviewed staff complaints relating to disability along with listening to feedback from the Staff Disability Network members on the level of support they received in the workplace from their line managers. Themes included line mangers being committed to supporting disabled staff but didn't always know how to. HR Managers and the E&D Lead used this information to scope and simplify the process for requesting reasonable adjustments, followed by developing a bespoke training package for managers on managing and supporting disabled staff in the workplace. The Staff engagement & Wellbeing team facilitated sessions to promote positive cultures and inclusion within the workplace including managing and reducing stress, smoking cessation, promoting healthy weight & lifestyles. **Planned activity/improvement:** Delivery of regular 'Managing Disability in the Workplace' training sessions to Managers to ensure managers are equip to support disabled staff. A further area for planned improvement is supporting managers to support Transgender staff and patients. Through developing two separate policies (staff policy/patient policy), managers will be guided to ensure they are equipped with the knowledge and understanding of the issues that Transgender people often face in the workplace (staff policy) and when accessing healthcare (patient policy). **How will it be evidenced and graded:** • Delivery and feedback on 'Managing Disability in the Workplace' training sessions • Ratification, delivery and feedback on the 'Transitioning at Work Policy' and 'Supporting Transgender People in Healthcare Policy '	

Patient Equalities Analysis to Support EDS2 Report 2018/19

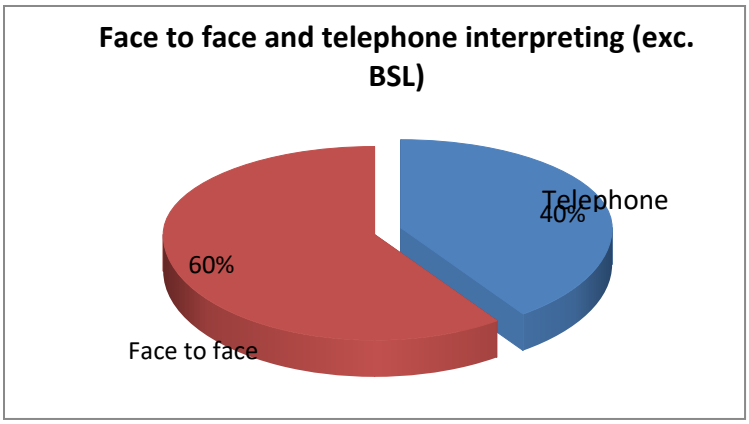
All interpreting supplied to patients, service users or carers during 2018/19

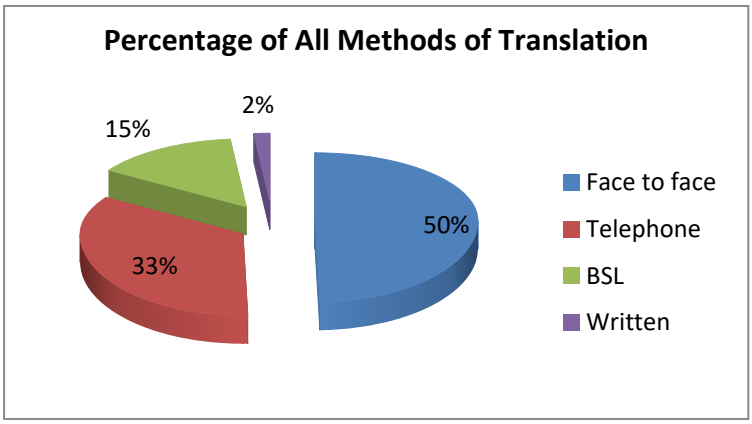
Language	Telephone interpreting 2018/19	Face to Face interpreting	Total	Translated documents
Albanian	26	30	56	
Amharic		1	1	
Arabic	81	78	159	2
Armenian		2	2	
Bengali	33	30	63	
Bulgarian	9	12	21	2
Cantonese	17	25	42	1
Czech	7	15	22	3
Dari		1	1	
Eritrean		1	1	
Farsi	11	23	34	
French	3	4	7	4
German			0	1
Greek	1	3	4	
Hungarian	5	10	15	
Italian	11	8	19	
Japanese		1	1	
Latvian	4	4	8	1
Lithuanian	12	15	27	
Mandarin	46	59	105	
Pashto		1	1	
Polish	40	69	109	1
Portugese	32	52	84	3
Romainian	24	27	51	2
Russian	21	38	59	2
Slovak	5	7	12	
Somali	2	5	7	
Sorani	27	15	42	
Spanish	3	36	39	1
Sudanese		1	1	
Syrian		22	22	
Tagalog		2	2	
Tamil	3	5	8	
Thai		5	5	
Tigrinya	4	6	10	
Turkish	28	49	77	
Urdu	2	3	5	
Vietnamese	5	20	25	
Yoruba		2	2	
Zaghawa		1	1	
Total	**462**	**901**	**1363**	**26**

Interpreting data continued…

Sensory Support	Number of Interpreters provided	Number of Translated documents
British Sign Language	213	0
Braille	NA	3

ESHT Interpreting Methods (%) 2018/19

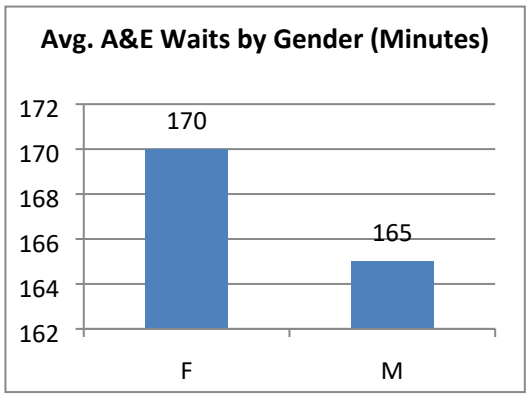


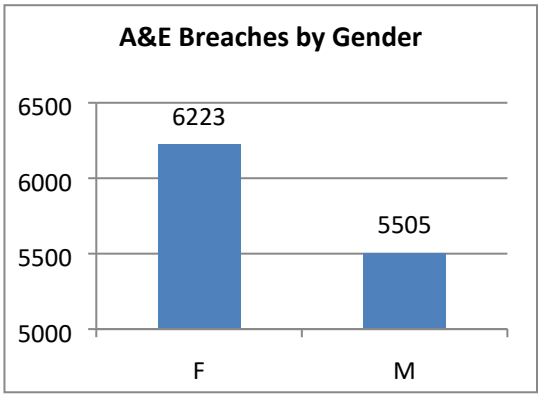


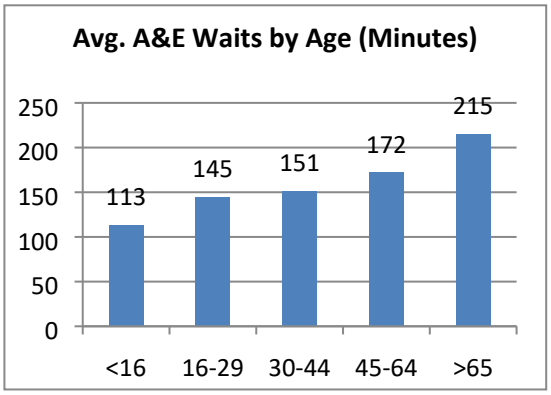
Appointments requiring interpreter support not proceeding during 2018/19

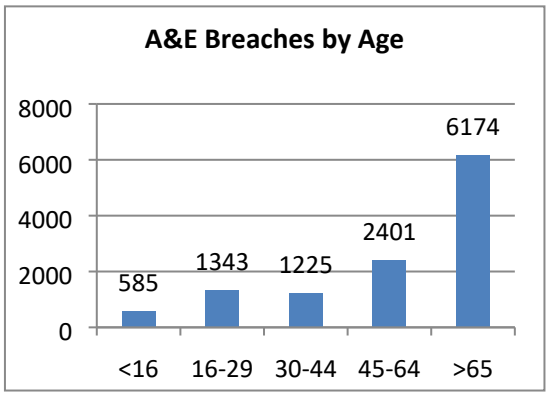
Reason	Number of missed appointments
Patient Did Not Attend	**12**
Interpreter Did Not Attend	**16**
Interpreter not Available/Unfilled	**19**
Appointment Cancelled	**114**
Total	**161**

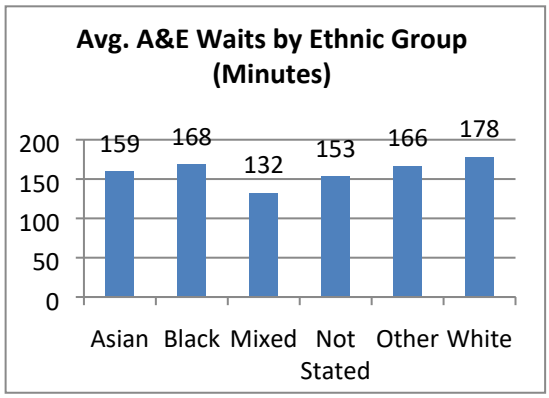
Accident & Emergency waiting times 2018/19

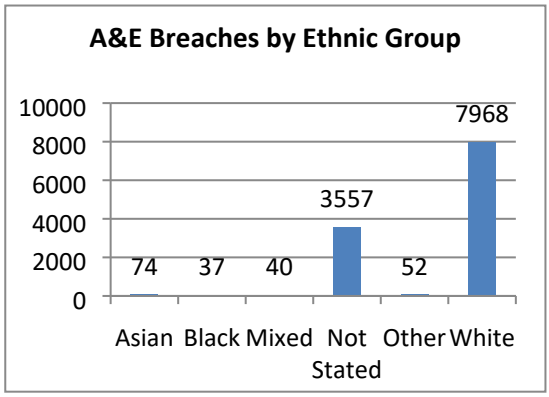












ESHT Risk Adjusted Mortality (RAMI) 2018 - April 2018 to March 2019 35 Years and Over by Age Band

	Male		Female		Total	
Age band	Observed deaths	RAMI	Observed deaths	RAMI	Observed deaths	RAMI
35-39	1	33	3	106	4	68
40-44	4	84	5	147	9	111
45-49	4	29	3	25	7	27
50-54	16	76	15	66	31	71
55-59	27	96	16	60	43	79
60-64	32	92	26	90	58	91
65-69	63	74	46	80	109	77
70-74	98	88	66	76	164	83
75-79	130	78	90	74	220	77
80-84	162	88	134	94	296	91
85-89	143	61	174	67	317	64
90+	126	82	192	80	318	81

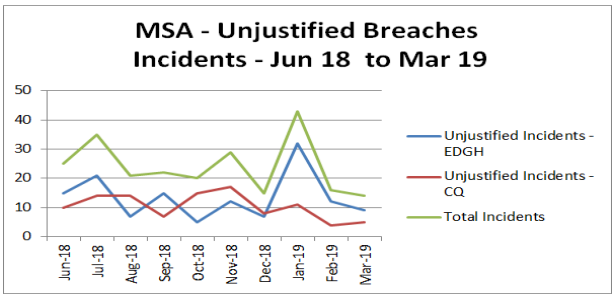
35+ Overall	806	78	770	77	1576	77

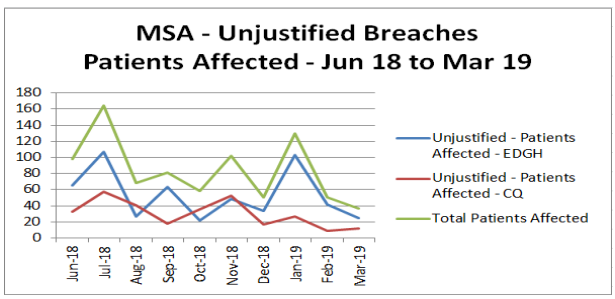
Mixed Sex Accommodation Breaches 2018/19

In March the total number of validated and reportable unjustified incidents for the Trust was 14, affecting 37 patients.

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

All steps were taken to move patients to single sex accommodation as soon as possible.
No complaints or concerns were raised regarding any mixing in March.





Access to Sexual Health by Area, Ethnicity, Sexual Orientation and Age Group 2018/19

Catchment	Female	Male	Total
Eastbourne	69.83%	30.17%	100.00%
Hastings	76.44%	23.56%	100.00%
Total	**72.95%**	**27.05%**	**100.00%**

Catchment	Total
Eastbourne	52.83%
Hastings	47.17%
Total	**100.00%**

Sexual Orientation	Female	Male	Total
Heterosexual	80.13%	19.87%	100.00%
Gay/Lesbian	3.54%	96.46%	100.00%
Bi-sexual	61.75%	38.25%	100.00%
Not Known	71.70%	28.30%	100.00%
Total	**72.95%**	**27.05%**	**100.00%**

Sexual Orientation	Total
Heterosexual	86.94%
Gay/Lesbian	8.25%
Bi-sexual	4.56%
Not Known	0.24%
Total	**100.00%**

Age Group	Female	Male	Total
Under 16	89.97%	10.03%	100.00%
16 to 19	83.47%	16.53%	100.00%
20-29	75.57%	24.43%	100.00%
30-39	70.45%	29.55%	100.00%
40-49	68.09%	31.91%	100.00%
50 to 59	45.01%	54.99%	100.00%
60 to 69	26.03%	73.97%	100.00%
70 Plus	22.52%	77.48%	100.00%
Total	**72.95%**	**27.05%**	**100.00%**

Age Group	Total
Under 16	2.85%
16 to 19	17.75%
20-29	42.30%
30-39	19.41%
40-49	10.38%
50 to 59	5.14%
60 to 69	1.58%
70 Plus	0.59%
Total	**100.00%**

Ethnicity	Female	Male	Total
British	73.38%	26.62%	100.00%
Any other White background	73.85%	26.15%	100.00%
Any other mixed background	68.63%	31.37%	100.00%
Any other Asian background	62.77%	37.23%	100.00%
African	76.68%	23.32%	100.00%
Any other Black background	58.70%	41.30%	100.00%
White and Black Caribbean	74.72%	25.28%	100.00%
Any other ethnic group	72.79%	27.21%	100.00%
White and Black African	61.87%	38.13%	100.00%
White and Asian	77.37%	22.63%	100.00%
Irish	66.88%	33.12%	100.00%
Caribbean	61.31%	38.69%	100.00%
Not stated	48.98%	51.02%	100.00%
Indian	82.19%	17.81%	100.00%
Bangladeshi	67.19%	32.81%	100.00%
Chinese	86.89%	13.11%	100.00%
Pakistani	17.14%	82.86%	100.00%
Unknown	100.00%	0.00%	100.00%
Total	**72.95%**	**27.05%**	**100.00%**

Ethnicity	Total
British	84.37%
Any other White background	7.03%
Any other mixed background	1.76%
Any other Asian background	1.15%
African	0.87%
Any other Black background	0.83%
White and Black Caribbean	0.80%
Any other ethnic group	0.66%
White and Black African	0.58%
White and Asian	0.55%
Irish	0.35%
Caribbean	0.31%
Not stated	0.22%
Indian	0.16%
Bangladeshi	0.14%
Chinese	0.14%
Pakistani	0.08%
Unknown	0.00%
Total	**100.00%**

Further breakdowns of data contained in this report are available upon request by contacting the Equality & Human Rights department.

This document is available, upon request, in alternative languages and formats, such as large print, Braille, Audio and electronic. Please contact the Equality and Human Rights Department for further information on: 01424 755255 ext 8353

Workforce Profile broken down by protected characteristics

East Sussex Healthcare NHS Trust employed 7133 people as of 31st March 2019

Workforce breakdown by protected characteristics.

Gender	Number of Employees	Percentage of Employees (%)
Female	5517	77.3%
Male	1616	22.7%
TOTAL	7133	100.0%

Age Group	Number of Employees	Percentage of Employees (%)
<=30 yrs old	1142	16.00%
31-45	2440	34.20%
46-60	2928	41.00%
60-79	623	8.70%
TOTAL	7133	100.00%

Disability	Number of Employees	Percentage of Employees (%)
Yes	233	3.30%
No	3988	55.90%
Not Declared/Undefined	2912	40.80%
TOTAL	7133	100.00%

Religion	Percentage of Employees (%)
Atheism	11.90%
Buddhism	0.70%
Christianity	38.80%
Hinduism	1.50%
Islam	1.50%
Jainism	0.00%
Judaism	0.10%
Other	7.20%
Sikhism	0.20%
Undisclosed / not stated	38.10%
TOTAL	100.00%

Ethnic Group	Number of Employees	Percentage of Employees (%)
White British/White Irish/White Other	5540	77.70%
BME	954	13.40%
Undefined/Not Stated	639	9.00%
TOTAL	7133	100.00%

Sexual Orientation	Percentage of Employees (%)
Bisexual	0.60%
Gay or Lesbian	1.10%
Heterosexual	64.10%
Other sexual orientation	0.00%
Undisclosed / not stated	34.20%
TOTAL	100.00%

2018/19 Recruitment Annual Monitoring

Percentage of shortlisting and appointment (Disability and Black & Minority Ethnic Group):

	Black & Minority Ethnic	White British/White Irish/White Other
Shortlisted	2467	10,838
Appointed	154	852
% Appointed from shortlisting	6.24%	7.86%

	With a Disability	Without a Disability
Shortlisted	811	11,177
Appointed	46	847
% Appointed from shortlisting	5.7%	7.6%

Maternity, adoption, paternity and paternity adoption leave taken during 2018/19

Staff taking Maternity, Paternity Adoption or Paternity Adoption Leave during 2018/19		
Protected Group	Maternity (%)	Paternity (%)
Ethnic Group		
White	85.64%	80.56%
BME	5.84%	11.11%
Not Stated	8.52%	8.33%
TOTAL	100.00%	100.00%
Sexual Orientation		
Heterosexual	76.40%	77.78%
LBGT	0.73%	2.78%
Not Stated	22.87%	19.44%
TOTAL	100.00%	100.00%

Sickness absence rate. Three year trend