EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 10th February 2016, commencing at 10.00 am in the St Mary's Board Room, EDGH

	AGENDA		**Lead:**	**Time:**
1.	a) Chair's opening remarks b) Apologies for absence c) Making Every Contact Count d) Quality Walks		Chair	1000 – 1115
2.	Monthly award winner(s)		Chair	
3.	Declarations of interests		Chair	
4a.	Minutes of the Trust Board Meeting in public held on 2nd December 2015	A i	Chair	
4b.	Matters arising	B ii	Chair	
5.	Acting Chief Executive's report (verbal)		CEO	
6.	Board Assurance Framework	B	CSec	

QUALITY, SAFETY AND PERFORMANCE

					Time:
7.	Quality Improvement Plan	Assurance	C	CEO/DN	1115 – 1300
8.	Quality Improvement Director's Report (verbal)	Assurance		QID	
9.	Speak Up Guardian's Report (verbal)	Assurance		Ruth Agg	
10.	Performance and Finance report Month 9 (December) 1. Patient Safety, Clinical Effectiveness & Patient Experience 2. Access, Responsiveness & Community 3. Workforce 4. Finance	Assurance	D	 DN/MD COO HRD DF	
11.	Safe Nurse Staffing Levels report	Assurance	E	DN	

12.	Patient Experience Report Quarter 3 (October-December 2015)	Assurance	F	DN	
13.	End of Life Care	Assurance	G	MD	

STRATEGY

					Time:
14.	High Weald Maternity Pathway	Approval	I	CEO	1300 – 1325
15.	Business and Financial Planning 2016/17 Update	Approval	J	DF	

GOVERNANCE AND ASSURANCE

					Time:
16.	Emergency Preparedness	Approval	M	CEO	1325 - 1345
17.	Board sub-committees: a) Audit Committee b) Finance and Investment Committee c) Quality and Standards Committee d) Remuneration Committee e) Terms of Reference for People & Organisational Development Committee	Assurance	N	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
18.	Use of Trust Seal	O	Chair	1345 - 1400
19.	Questions from members of the public (15 minutes maximum)		Chair	
20.	Date of Next Meeting: Wednesday, 13th April, Lecture Theatre, Education Centre, Conquest		Chair	
21.	**To adopt the following motion:** *That representatives of the press and other members of the public will be excluded from Part 2 of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest* *(Section1(2) Public Bodies (Admission to Meetings) Act 1960)*		Chair	

David Clayton-Smith
Chairman

25th January 2016

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
CSec	Company Secretary
DCIS	Director of Clinical Information & Strategy
DF	Director of Finance
DN	Director of Nursing
HRD	Director of Human Resources
MD	Medical Director
QID	Quality Improvement Director

East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board
Agenda item:	1c i
Subject:	Making Every Contact Count (MECC) - Awareness and Update
Reporting Officer:	Penny Walker, MECC Project Lead for ESHT Liz Fellows, Assistant Director of Operations

Action: This paper is for **(please tick)**					
Assurance	X	**Approval**		**Decision**	

Purpose:

To raise awareness of the project within the Trust, of collaborative working between ESHT, Hastings and Rother CCG, Public Health ESCC, and healthy life style providers.

Introduction:

Many people in the Hastings & Rother area have significantly worse health outcomes than the rest of England. The aim of MECC is to create a healthier population; reduce NHS and social care costs; improve health outcomes and reduce health inequalities. This is achieved through enabling change by reaching as many people as possible with key health messages and signposting them to support services.

Analysis of Key Issues and Discussion Points Raised by the Report:

Through collaborative working with agencies, across the local health and social care economy, the Trust has launched a pilot to educate staff to adopt the principle of "making every contact count". This is achieved through conversations, advice and where appropriate onward referral to support services such as smoking cessation.

The programme is fully funded by Hastings & Rother CCG and currently each referral attracts an incentive payment.

The pilot stage has been successful and work is now underway to develop a business case to extend the programme wider in 2016/17.

Benefits:

If all public facing workers are provided with the confidence and skills to make every contact count it will support healthier lifestyles and reduce inequalities.

By raising awareness the programme supports staff health & well being and the Occupational Health team are part of the project team.

Risks and Implications

Operational pressures and vacancies restrict the availability of staff to attend the study sessions

Sustainability of programme – currently in early stages and needs continued and wider promotion to maintain awareness.

Assurance Provided:
This programme adopts the principle of collaborative working across health and social care in line with the East Sussex Better Together agenda.

Proposals and/or Recommendations
Support and commitment from the Trust Board for continued roll out into 2016-2017.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
It was identified that due to the nature of the pilot being only currently focused at the Hastings and Rother CCG area that there was an inequality across the Trust. The health needs for those living in the Hastings and Rother CCG area outweigh the inequality of those not being involved currently. In addition negotiations are underway with other CCGs to engage in the programme.

For further information or for any enquiries relating to this report please contact:	
Name: Penny Walker	**Contact details: penny.walker2@nhs.net** **Mob:07966981542**

Making Every Contact Count

What is Making Every Contact Count (MECC)?

The aim of MECC is to create a healthier population; reduce NHS and social care costs; improve health outcomes and reduce health inequalities. This is achieved through enabling change by reaching as many people as possible with key health messages and signposting them to support services.

Through education and training, public facing workers are encouraged to adopt the principle of "making every contact count". The education they receive will support workers to start a healthy conversation, either in the form of brief advice or a more enhanced brief intervention, supporting clients to access relevant services. MECC is applicable across all age groups and involves many aspects including:

- Stopping smoking – in all age groups, including pregnant women.
- Fuel, Poverty and Health awareness.
- Physical activity - Healthy Weight
- Alcohol awareness - Sensible drinking

Making Every Contact Count within East Sussex Healthcare NHS Trust is a collaborative approach for success, working with Hastings and Rother CCG, Public Health, East Sussex County Council and healthy lifestyle service providers.

Why is it important?

People cannot be forced to change, but by using opportunities to raise the issue of a healthy lifestyle in a non-threatening way, people's awareness, confidence and motivation to make changes to improve their lives may occur. Access to local health and lifestyle services may also be enhanced.

The responsibility to support individuals to think and act more healthily wherever possible, and guide them to any further help does not sit with a particular professional group or workforce. It embraces many roles as it emphasises prevention of problems and early intervention.

Having a good MECC conversation is about:

- Spotting opportunities to talk to people about their wellbeing. It does not mean every time you meet an individual a healthy lifestyle conversation will take place; it is about

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using the appropriate cues and opportunities to raise the issue of health and well-being.

- Being able and confident to start a conversation about a wellbeing matter.
- Being able and confident to deal with questions and issues as they arise.
- Assessing the motivation a person has to take action to improve their health and/or wellbeing.
- Providing information.
- Encouraging people to take actions to help themselves.
- Signposting to relevant services when required.

What does it mean for our organisation?

All our patient facing staff have conversations with members of the public every day and some of these maybe about difficult or sensitive subjects. Encouraging conversations about health is the underpinning objective of MECC. This includes helping organisations and their staff develop skills in relation to:

- Understanding the issues affecting wellbeing
- Engaging in a good MECC conversation – this includes acknowledging that not all contacts are MECC appropriate.
- Giving brief advice, encouraging self-care and signposting to services.
- The MECC program enables workforces to develop the skills and confidence to:
- Competence and confidence to make every appropriate contact count.
- Knowledge about local services and how to signpost people to enable them to access the right support.

The ESHT Call to Action

Many people in the Hastings & Rother area have significantly worse health outcomes than the rest of England as documented in the Reducing Health Inequalities in Hastings and Rother CCG (H&R) area report (2014). Below are a few of the statistics that are outlined in the report:

- H&R CCG have a population of 183,000, and contain the seven most deprived council wards in East Sussex.

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- 29% of children in Hastings and 19% in Rother live in poverty.
- Men in the most deprived areas of Hastings are expected to live 11 years less than those in other areas of the town – the biggest gap in the South East of England, life expectancy for both men and women is lower than the England average.
- Hastings is significantly worse than England for the percentage of women smoking in pregnancy, percentage of adults smoking, percentage of people with a long term condition smoking, general practice recording of smoking status of patients, smoking attributable hospital admissions and smoking attributable deaths.
- Hastings has significantly higher percentages of people with bad or very bad health compared with the rest of England with high rates of long term illness, disabilities, cancer, lung disease and heart problems.
- Hastings is significantly worse than England for alcohol attributable mortality for males, alcohol specific and alcohol attributable hospital admissions, admissions due to alcohol related harm.

In the summer of 2014, H&R CCG launched an action plan to tackle poor health in the area, including a call to action to implement MECC in all services that engage with the public. The CCG are funding the project within ESHT and are fully committed to its roll out into 2016-2017. At present they are offering additional financial incentives for every referral made to any of the healthy life style providers to support the organisation in the roll out.

Progress to date in the MECC pilot project.

1. ESHT have established a project board and appointed a project lead to oversee a pilot programme for the implementation of MECC.
2. Competencies developed by the Kent Surrey and Sussex MECC project manager, are now been recognised as the national tool for MECC education and the training has been adopted to deliver education within ESHT. The competencies meet the original MECC competences from 2009 and have been adapted to use skills for life for health professionals, including awareness of the local and national need for a healthier population, how to have a conversation, recognising an opportunity to have a conversation and taking this forward with the confidence to refer staff to the outside service providers and documentation.
3. Staff groups for the pilot were selected utilising experience from elsewhere in the country and the priority areas in H&R e.g. reducing smoking during pregnancy. The intention was to target groups within the nursing and midwifery workforce but this was later widened to Allied Health professionals and Health Visitors.
4. Forty staff have been trained in the first phase of the pilot (November/December 2015) from a range of wards and departments based at the Conquest Hospital.

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5. A further fourteen days have been booked with the outside training provider Zest Consultancy for the end of January and the whole of February to capture the remaining staff for the pilot stage.

6. Training days also include input from service providers such as:

- QUIT51 – smoking cessation service
- STAR- the alcohol and drug recovery service
- Re:balance - the weight management service
- Health Trainers
- Active Hastings and Active Rother
- Winter fuel and poverty service

7. Work has started on developing e referral, using existing technology to facilitate speedy referral and an effective audit trail. There is now an e referral form for QUIT51 on e-searcher, and the alcohol and drug recovery service STAR referral form is also going live in February via e-searcher, others service providers are developing referral forms to speed the referral process for individuals.

8. The project lead has presented at the "Start Well, Live Well, Age Well – Working together for a healthier East Sussex" event in Eastbourne in December to representatives of a wide range of organisations in East Sussex.

Performance

There is very little baseline data available to provide a benchmark. The service providers are being tasked with refining their record of referrals and this will be used as a baseline to drive the programme in 2016/17.

In the first month of programme the following referrals have been made:

Service	**Number of conversations/referrals**
QUIT 51	13 (12 via e referral)
Re:balance	11
Additional MECC conversations, no referral	4

Next Steps

1. Continued engagement with staff to undertake training.
2. Continued development of communication strategy for a wider audience
3. The appointment of MECC champions from areas where staff that have attended the MECC training in the first phase, this concept will be rolled out across all areas that are involved in the training.
4. Regular meetings will be arranged to support those who have attended the training on either a one to one basis in their clinical environment by the project lead or by attending champion meetings.
5. Fourteen days training set for the last two weeks of January and the whole of February 2016. Outside healthy life style providers are attending with stands and information over a working light lunch, for staff to review and discuss services.
6. MECC training has been adapted for maternity staff to incorporate MECC training and the requirements for revalidation. Maternity staff already undertake health promotion and have training as a core part of their role.
7. Monitoring of conversations that are undertaken by those trained that may not lead to a referral along with those conversations that do lead to a referral.
8. On-going evaluation of training and referral rates.
9. A business case to support the roll out of MECC across all relevant staff groups, supported by H&R CCG.
10. Engage with other CCGs regarding the potential expansion of the project across all local CCGs.
11. Ongoing collaborative working with Hastings and Rother CCG, Public Health, ESCC and all healthy life style service providers.

Making health improvement everyone's business.

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday, 2nd December 2015 at 10:00 am in the St Mary's Board Room, Eastbourne DGH

Present: Mrs Sue Bernhauser, Acting Chair
Mr Barry Nealon, Vice Chairman
Mr Charles Ellis, Non-Executive Director
Ms Miranda Kavanagh, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mrs Pauline Butterworth, Acting Chief Operating Officer
Dr David Hughes, Medical Director
Mr David Meikle, Interim Director of Finance
Mr Richard Sunley, Acting Chief Executive
Mrs Alice Webster, Director of Nursing

In attendance:
Mrs Jackie Churchward-Cardiff, Non-Executive Director designate
Ms Maggie Oldham, Improvement Director
Ms Jan Humber, Joint Staff Side Chairman
Mrs Lynette Wells, Company Secretary
Ms Moira Tenney, Deputy Director of Human Resources
Mrs Jeanette Williams, LiA representative (for item 098/2015c)
Ms Penny Morgan, Project Search Co-ordinator (for item 098/2015c)
Mrs Liz Fellows, Assistant Director – Operations (for item 113/2015)
Mrs Liz Still, Research & Development Manager (for item 112/2015)
Mrs Trish Richardson, Strategic Planning Project Manager (minutes)

098/2015 **Welcome and Apologies for Absence**

a) Chair's Opening Remarks

Ms Bernhauser welcomed everyone to the meeting of the Trust Board held in public including Miranda Kavanagh, new Non-Executive Director, and Jackie Churchward-Cardiff, new Non-Executive Director designate.

b) Apologies for Absence

Mrs Bernhauser reported that an apology for absence had been received from Monica Green, HR Director, and Moira Tenney, Deputy Director of HR, was deputising for her.

c) Project Search

Mrs Williams reported that the Trust was part of a network of 27 organisations who were participating in Project Search.

She outlined how the Trust was partnered with the local college, local authority and local supported employment organisation with the aim of supporting young people (aged 18-24) with learning disability and difficulties to develop lifelong employment skills. She highlighted how this programme demonstrated that the Trust was living out its core values within the organisation.

Ms Morgan, Project Search Co-ordinator, reported that there were 8 people on the current programme which had commenced in September and she was hoping to recruit a few more interns in January.

She reported that 11 interns had graduated from the previous programme in June and 8 had now found sustained employment - 73% compared to the national average 6%. The project continued to support those interns now in employment and continued to work with those interns who had not yet found employment. She highlighted the beneficial impact not only for the interns but also for their families.

Mrs Webster reported that the project had been shortlisted for Kent Surry and Sussex Multi-agency Project Award and they had taken some of the interns to the awards ceremony.

The Board thanked Mrs Williams and Ms Morgan for their presentation.

d) Feedback from Quality Walks

Mrs Bernhauser fed back on her visits to the District Nursing services in Eastbourne and Seaford and the Estates Department at the Conquest. She reported that the District Nurses were very enthusiastic and committed teams of nurses who, in the face of significant recruitment challenges to their teams, had decided to grow their own by recruiting staff nurses and supporting them to achieve their District Nursing qualification. She highlighted that the teams had seen a significant increase in delivering high dependency care in people's own homes and they were looking for opportunities to develop their roles and services they offered.

She noted that the teams were positive about using SystmOne so that they did not have to carry paper notes but access electronically but they highlighted that there were issues with the downloading of data which were being addressed.

Mrs Bernhauser reported that the Estates Department took up 25% of the footprint at the Conquest site and were involved in an intensive period of renovation of equipment and general maintenance work. They had recruitment challenges but maintained a good relationship with the ward staff.

The Board noted the report on quality walks.

099/2015 **Monthly Award Winners**

Mrs Bernhauser reported that the Monthly Award Winners for October were the PAS upgrade team who consisted of the Project Management Office, Change Management & IT staff and Mr Nealon had presented their certificate on 28th November. Mr Nealon reported that there had been 15 people in the team and the feedback had been that this was one of the IT conversion projects that had to achieve the changeover date at the end of September. Dr Slater reported that the PAS was the database which ran the entire business of the organisation and it had been critical to the organisation that the changeover went well.

100/2015 **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 Chair noted that there were no potential conflicts of interest declared.

101/2015 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 30th September 2015 were considered and agreed as an accurate account of the discussions held.

The minutes were signed by the Chair and would be lodged in the Register of Minutes.

b) Matters Arising

085/2015 - Information Governance (IG) Breach (Data Stick) Recommendations and Actions
It was confirmed that it had been reinforced to all staff that they should only use encrypted memory sticks, it was no longer possible to download data onto unencrypted sticks and the individual concerned had been through a disciplinary process.

102/2015 **Acting Chief Executive's Report (verbal)**

Mr Sunley reported on the following areas which would be discussed later in the meeting:

- Medical records – discussions were taking place with the staff and the union over how the service would be taken forward.

- Quality improvement plan – this plan was being embedded as the core of the business of the Trust.

- Emergency Departments – the management of urgent care was being reviewed in light of the CQC report, the improvement plan and the East Sussex Better Together programme

- Crowborough Midwifery Unit – the management of this service had been revisited with the Clinical Commissioning Group and it had been agreed in principle that the service would transfer to Maidstone and Tunbridge Wells. This was viewed as a positive direction of travel by both the local public and the commissioners as it was part of their Better Beginnings strategy.

- Public engagement – the first of a number of Big Conversations were being held that evening with support from Healthwatch.

103/2015 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework (BAF) had been considered at the Quality and Standards and Audit Committees at the beginning of November and the changes noted were self-explanatory. She highlighted that two areas were rated red – health records (item on the agenda) and the reconfiguration of the Emergency Departments - and a number of areas had increased in assurance.

She advised that in readiness for the next meeting she would review the BAF to align it with the revised Strategic Objectives.

Mrs Webster reported that in relation to 1.24 – Infection control – this item would be updated for the next meeting following recent activity that had been undertaken. **LW**

Ms Kavanagh commented that it was difficult to relate the papers to the outcomes and how the sources of assurance flowed into the outcomes. She suggested that it would be useful to have this summarised with a set of key indicators. Mrs Wells commented that assurances and outcomes were provided through the committee structure but suggested that time be taken at a Board seminar to see how the BAF could be further developed.

Mr Stevens asked about the quality of appraisals and Dr Hughes responded that the Revalidation Advisory Panel was reviewing the quality of appraisals undertaken for doctors including their development plans.

Mrs Tenney reported a new PDR process and policy was being introduced for the non-medical workforce linked to objectives, values and talent management. With the introduction of nursing and midwifery revalidation from April 2016 there would be similar quality controls as for the doctors.

Mrs Oldham asked when it was anticipated that there would be an improved response would be seen in the staff survey. Mrs Tenney advised that they were engaging with staff side regarding the new PDR and revalidation processes but realistically she did not anticipate an improvement would be seen until the 2016 staff survey but they also planned to monitor progress through internal surveys and the quarterly FFT. Mrs Bernhauser stated the Trust needed to ensure that all staff had the opportunity to have a meaningful conversation with their line manager at least once a year.

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

QUALITY, SAFETY AND PERFORMANCE

104/2015 **Quality Improvement Plan**

Mrs Webster presented a highlight report outlining progress since the last meeting and noted that the action plan was a dynamic document which was updated monthly on the Trust's website.

She reported that the executive and operational leads for the plan met on a weekly basis to ensure that there was pace in delivery and progress was maintained and, where change was made, it was sustainable.

She highlighted a staff engagement event in October which had celebrated the successes of junior bands of staff, had received tremendous feedback and it was planned to run it annually.

Mrs Webster reported that there were a number of activities taking place around governance processes and the Trust was continuing to work with external stakeholders. In addition, there had been a significant increase in incident reporting with a 40% increase from October 2014 which was a positive improvement.

She advised that the Trust had appointed Prederi to provide increased programme management support and help develop the skillset of staff within the Trust to move the plan forward in a sustainable way.
Mr Sunley commented that the amount of programme and project management support required to support areas to make sustainable changes should not be under-estimated and Mrs Bernhauser stated that the Board was under no illusion that the biggest challenge was engaging with staff and the community to move forward.

Ms Kavanagh asked how the plan was being communicated internally and being embedded through line management.

Mrs Webster advised that there was representation from all the clinical units at the weekly meetings and they were discussing this with staff in their regular meetings and information was flowing back to provide evidence of change. The intention was also to provide the plan on a page which would be available for all staff and a monthly team briefing system was being introduced to cascade information down and up through the organisation.

Mr Sunley highlighted that one of the main messages arising from the internal quality summits held with staff was that good communication was essential and work was taking place to improve communications in a variety of different methods. He now held a weekly open forum for staff which would also be taken out into the community in the new year.

Mrs Webster stated that the aim was to ensure that the plan became everybody's business in the organisation in continuously improving quality and not just a response to the CQC concerns.

Mrs Webster reported that the Trust was also working closely with Healthwatch and their volunteers in helping to address certain elements of the plan and the Trust was also working with the Health Overview and Scrutiny Committee on specific areas.

105/2015 **Quality Improvement Director's Report (verbal)**

Mrs Oldham stressed that the quality improvement plan was not the TDA's or CQC's plan but was the Trust's and her contribution was to support the Board in the development of the plan and its implementation and challenge where necessary in relation to pace and delivery and share experiences from other Trusts.

She had observed that the strategic objectives had not been realised and delivered within in the organisation and since moving into Special Measures the Board had reviewed the strategic objectives and updated and these had been included in the objective setting of the executive directors and would be cascaded through the organisation, supported by a revised governance structure as the current structure was very onerous and staff were disconnected.

She was confident that there was a desire to deliver the plan within the organisation but it had to cautious of initiative overload and this needed to be taken forward in a structured way with the staff.

Ms Humber commented that staff would welcome initiatives where they were involved in helping to make changes and, whilst there was more staff side involvement in developments, this still had to happen at the grass roots level.

Questions from members of the public:

Mr Lindsay asked why it was taking so long for the TDA to bring in a new Chairman and Chief Executive. Mrs Bernhauser advised that the previous Chairman had resigned suddenly and statutorily the Trust was not allowed to be without a Chair and she had stepped in to ensure continuity for the Trust. She was of the view that the new Chairman should appoint the new Chief Executive and this was supported by the TDA. The interviews for the Chairman were scheduled for 14th December and when that person appointed the interviews for the Chief Executive would follow.

Mrs Oldham highlighted that the appointment of the Chairman was the TDA's responsibility and the appointment of the Chief Executive was the Trust's responsibility.

Mr Campbell asked why Prederi had been appointed to act on the Quality Improvement Plan and Mr Sunley advised that the amount of project support required to lead change within the organisation should not be underestimated. Whilst the Trust had its own programme management office they were managing a number of projects and it was not possible to free up sufficient manpower in the short term to support the plan and therefore Prederi had been commissioned for a 5 week period to shape and review the plan and develop the internal programme management office skills required.

Mr Campbell asked who was the ultimate owner of the plan and responsible for its successful delivery and Mr Sunley advised that each of the areas within the plan had an identified executive lead and Mrs Webster was leading the process and would use reporting on the plan to hold the executive directors to account for their actions and the Board would also hold himself and the executives to account for its delivery.

Mr Lindsey asked how much were Prederi being paid and Mrs Oldham explained that when a Trust went into special measures an improvement director was appointed and funds could be made available for buddying arrangements. Mr Sunley advised that a procurement exercise had been undertaken to identify a company that would give good value.

The Board noted the Quality Improvement Plan report and the Improvement Director's verbal report.

106/2015 **Integrated Performance Reports – October 2015 (Month 7)**

a) Access and Responsiveness

Mrs Butterworth reported for RTT incompletes the Trust had achieved 92.7% against the national target of 92% and year to date was currently performing at 93%.

She advised that the Trust was currently achieving 93% year to date against the A&E target of 95% and there were a number of challenging issues due to the number of middle grade vacancies and a high usage of temporary workforce.

She reported that for diagnostics the Trust was reporting 1.9% in October against the 1% target which was due to radiology equipment breaking down and not being able to rebook patients within breach dates and an increase in gastroenterology activity. However, she expected this target to be delivered in November.

She reported in relation to the cancer targets which had not yet been validated for October the Trust had achieved the 2 week wait breast target but not the overall 2 week wait target but there was an improving trajectory and she anticipated that this target would be delivered in the next month.

In response to a query from Mrs Churchward-Cardiff re RTT, Mrs Butterworth advised that the PAS upgrade in September had resulted in reporting a falsely high backlog but this was gradually being reduced.

Mrs Churchward-Cardiff asked if the increasing activity within the community nursing service would impact on length of stay within the hospitals and Mrs Butterworth commented that one of the aims of the East Sussex Better Together programme was for more patients to be treated in the community, thereby reducing the number of attendances at A&E and a decrease in emergency admissions.

ii) Patient Safety

Mrs Webster reported that a Root Cause Analysis (RCA) had been undertaken for each MRSA case and a session had also been held where all cases had been linked cases together and 3 key areas had been identified – ensuring the history of the individual patients were known, compliance with screening and the application of decolonisation.

She advised that as a result a further programme of work was being introduced across the organisation supported by the TDA infection control service.

Dr Hughes reported that the Trust was compliant with the VTE assessment criteria but a cumbersome paper based recording system was currently being used and the decision had been take to re-invigorate the team with new medical leadership and senior nurse support to improve the promptness & accuracy of reporting. It was planned to transfer to an IT based system in the medium term.

Mrs Webster highlighted that there had been a reduction in the total number of falls in the month but the number of falls with injury had risen slightly.

She advised that for every fall where an injury occurs a RCA is undertaken.

She reported that there had been an increase in the number of incidents being reported which was a positive occurrence and a weekly patient safety summit had now been introduced where Trust senior clinicians reviewed all incidents graded 3, 4 and 5 reported in the previous week to understand the issues and make Trust-wide recommendations if required to ensure learning was shared across the organisation.

iii) Patient Experience

Mrs Webster reported that there had been a spike in the number of complaints and concerns in quarter 2 following the Information Governance breach but this had now been managed and dealt with.

She highlighted that there was still an issue in the number of FFT responses being received in the A&E departments and Healthwatch were providing some support in this area.

She reported that the number of mixed sex breaches should start to reduce as changes had been made to address issues within the Clinical Decision Unit in A&E.

Ms Kavanagh asked why there were no targets for the patient experience indicators and no data for compliments and Mrs Webster advised that the reporting structure was being changed and targets needed to be agreed.

iv) Workforce

Mrs Tenney reported that staff turnover was on a downwards trajectory and there was an improving picture in staff sickness as, although there was a seasonal trend element, sickness had risen significantly less than in previous years and a contributing factor was the well-being agenda for staff.

She reported that the overall vacancy rate for the Trust was 8.7%, of which 9.75% was medical, 9% nursing and 6.75% healthcare assistants (HCAs). There had been significant recruitment in HCAs and she predicted a positive situation by the end of the year. However, nursing and medical recruitment was much more challenging and nursing recruitment was taking place within the Philippines and Europe as well as taking on the next group of newly qualified staff in February. On the medical side recruitment was even more difficult, especially in the challenging environment of A&E and emergency medicine, and actions being taken included overseas recruitment, development of new roles and a different model of medical cover.

Mrs Tenney reported that there had been an increase in nursing and medical agency costs, the main reason being the high vacancy rates. She referred to the national caps on agency usage and advised that whilst this was challenging in the short term it would to help to reduce the actual costs.

Mr Nealon commented that a large amount of agency spend had been due to the winter wards remaining opening into the summer and noted that there were approximately 100 medically fit patients ready for discharge in the month and asked what measures were being taken to address the situation. Mrs Butterworth advised that the CCGs were supporting 30 discharge to assessment beds, were increasing intermediate capacity by 50 beds and Adult Social Care were funding extra enablement care through the Joint Community Rehabilitation teams.

v) Finance Report

Mr Meikle reported that the financial position had deteriorated during October and the Trust was reporting a £5.5m deficit in month against a planned deficit of £4.2m. The drivers for the worsening position were continued and increased spending on agency staff, provision of escalation beds and slippage in the cost improvement programme which was £1m off plan.

He advised that there was real pressure in delivering the planned deficit of £32.5m by the year end but, given the volatility of the cost base and potential mitigation through additional income and commissioner support, he could not confidently predict the forecast outturn at present but would provide this at the next meeting. **DM**

He reported that the Trust's cash facility had been increased by the TDA up to £35m and negotiations were taking place with the Department of Health for additional cash to support the plan. £6.2m of the capital programme of £11m had been spent year to date.

Ms Kavanagh asked what measures were in place to control discretionary expenditure and Mr Meikle advised that monthly accountability review meetings were held with clinical units and directorates to go through their financial position on a line by line basis, an efficiency group was reviewing the cost improvement programme and spend in line with the Lord Carter recommendations and the whole control environment was being reviewed.

Ms Kavanagh asked how the rump of aged debt over 60 days of £2m was being recovered and Mr Meikle stated that this had been discussed at Finance and Investment Committee and new credit control arrangements had been initiated and the position was starting to improve.

Mr Nealon reported that the Finance and Investment Committee monitored each individual operating unit and a deep dive took place each meeting into a particular area.

The Board noted the Performance, Workforce and Finance Reports for October 2015.

b) Current Quality Improvement Priorities

The Board noted the update on progress with the quality improvement priorities chosen for the Quality Account.

107/2015 **Safe Nurse & Midwifery Staffing Levels**

Mrs Webster presented the report for July, August and September and noted that there had been a red flag for healthcare support workers (HCSWs) at the Crowborough Birthing Centre. She advised that senior staff assessed the activity and, if there is not a requirement for the HCSW, they were not brought in and there had been no safety issues over the period in question.

She noted that within urgent care there had been a reduction in the number of registered nurses which related to vacancies and this was continuing to be monitored.

The Board noted the Safe Nurse & Midwifery Staffing Levels report.

108/2015 **Patient Experience Report Quarter 2 (July-September 2015)**

Mrs Webster presented the report and, in response to a query from Mr Stevens, advised as part of quality assurance complaints were reviewed to see if they did answer the complaint appropriately in the first instance. The complaints procedure had been changed during the year and a system established where when a complaint is received the complainant is contacted to confirm the details so that it is investigated properly. Mrs Webster reported that Healthwatch were also reviewing a selection of complaints to give an external view.

Ms Kavanagh asked how the Trust dealt with learning from complaints and Mrs Webster advised that if it related to an individual a 1:1 discussion was held or, if it related to one or more clinical areas, the ward or clinical unit reviewed and shared the learning including across the organisation if relevant and learning was also included within the Shared Learning in Practice newsletter.

Mrs Webster also referred to a series of DVDs that the Trust had commissioned which told the stories of 3 patients and their experiences of care within the Trust and these were now being shown as part of the induction for nursing students, registrants and HCSWs.

109/2015 **Mortality Report**

Dr Hughes presented the mortality report and highlighted that the Trust's SHMI was at 114 for October and the HSMR for July was at 100 and the rolling 12 month average was at 110, all of which were higher than the national average. He reported that the Trust sat within the leading value for national groups for death in low risk groups and it had not received a CUSUM alert since March 2014.

He advised that the use of the electronic mortality database for recording mortality reviews was now fully established although there remained some variation between consultants. The compliance with deaths reviewed within 3 months for quarter 1 2015-16 was currently 82%.

The Mortality Review Group (MRG) and Mortality Overview Group (MOG) continued to monitor mortality indices monthly and monthly mortality scorecards were now completed for all CUs and reviewed at MRG. Dr Hughes noted that the TDA had reviewed the Trust's processes and provided further guidance and advice in December.

Dr Hughes reported that there had been a spike in mortality in the last winter (2014/15) and detailed the steps that had been taken to improve pathways within respiratory and cardio-vascular. He outlined measures that were being taken to improve engagement and compliance.

He commented that in relation to weekend mortality an early review had not indicated any significant spike but this would be reviewed in more detail. He highlighted that there did appear to be increased mortality at times when the hospitals were under high pressure with the resultant increased number of bed moves and this was being reviewed.

He proposed that a deep dive review on mortality be held at a Board seminar early in the new year and this was agreed. **DH**

Mr Nealon asked if Dr Hughes was satisfied with the Trust's performance on mortality and Dr Hughes responded that changes Being put in place including changing the respiratory pathways and ensuring adherence to best practice guidelines through the Enhancing Quality programme would result in an improved performance over the coming winter.

Mr Ellis asked if Dr Hughes was satisfied that the Trust was doing everything possible to understand why mortality rates were higher than expected and Dr Hughes was confident that the Trust was doing all the right things to understand what was driving the indices and using this as an indicator of areas to promote reflective thinking throughout the organisation and significant progress was being made but it needed to be embedded further into the clinical units and directly into individual teams.

Ms Kavanagh noted that the CCGs were using Dr Foster and asked if there were any plans to review the system currently used by the Trust and Dr Hughes explained that the Trust had originally been with Dr Foster but had changed to CHKS as this was the system that the Strategic Health Authority had used but switching back could be explored if it was an advantage.

Ms Kavanagh asked how quickly issues were picked up and Dr Hughes explained that the MRG worked with the Business Intelligence department and CHKS to pick up issues of concern as soon as identified and the Trust also received CUSUM alerts.

Mrs Oldham reported that discussions were also taking place around the number of bed moves taking place at times of extreme pressure and Mrs Butterworth explained that the Trust was planning to move lower acuity patients who were medically fit for discharge into a cohorted area managed by a nursing/therapy led service which enabling patients to be moved more quickly from A&E. In addition, the cardio-vascular service was looking to introduce ambulatory triage for its patients as the outcomes demonstrated that it was better for patients rather than being kept in A&E. Both initiatives would help to reduce the number of bed moves.

110/2015 **End of Life Care**

This item was deferred to the next for a written report to be provided. **DH**

111/2015 **Research and Development (R&D)**

Mrs Still presented the report and noted that CRN KSS funding had been granted to ESHT with a 5% reduction in standard funding in relation to the previous year. The recruitment target for 2015/16 had increased by 15% and there had been an increase in activity to date from the same period last year. .

She reported that the Research Nurses were now managed by the R&D department which provided greater flexibility and able to support a broadening base of studies.

Ms Kavanagh suggested that it would be useful to have examples of case studies to the Board in future.

The Board noted the Research and Development report.

STRATEGY

112/2015 **Annual Business Planning Framework 2016-17**

Mr Meikle presented the report to provide assurance to the Board that around the production of the 2016-17 annual business plan.

Mrs Churchward-Cardiff asked if the 3.5% cost improvement was spread across all departments and Mr Meikle responded that in previous years that had been the approach but this year a more targeted approach was being taken based on the Lord Carter and strategy work and was still in the process of being agreed.

Mr Nealon commented that the process the previous year had been very good and the Clinical Units had taken ownership of their plans. He asked if the same process was happening again and that there would be sufficient time to ensure full engagement and the Board to have sufficient time to review the plans. Mr Meikle confirmed that the process had already started with the clinical unit and corporate departments and Mrs Webster confirmed that an integral part of the process was the quality impact assessment of the plans.

Mr Stevens referred to the workforce assumptions and Mr Meikle said that they assumed a balance by matching growth against the CCGs' commissioning intentions, eg avoidance schemes for A&E, elective primary care services.

The Board noted the process and the dates that have been selected for updates and decisions.

113/2015 **Health Records**

Mrs Fellows presented an update on the health records service and advised that the service had struggled for a number of years with ever increasing demands and issues had been on the risk register since 2005. A number of mitigating actions had been put in place but the service was not sustainable in its current operational format and significant investment is underway to address to provide a service fit for the future.

She advised that a project board, including staff side representatives, had been set up which had agreed the funding and site for the centralised service (Apex Way, Hailsham) and workstreams were now being established with representation from health records staff to determine the model of working.

Mrs Bernhauser commented that the health records staff were clearly unhappy at present and asked what actions were being taken to provide reassurance to them. Mrs Fellows reported that regular staff forums were held, staff were invited to attend and meet with managers across the spectrum and those staff involved in the workstreams were supported to attend the meetings and regular information was circulated out.

Mrs Oldham asked which Board sub-committee discussed the risks and implications in terms of destabilisation of the service prior to the move.

Mrs Fellows reported that in terms of the business planning funding was secured from the beginning of this financial year and the risks had been reviewed at the Corporate Leadership Team (CLT) and the Capital Approvals Group. The destabilisation of the service was an established risk but the risk acuity had increased significantly by the project board following the most recent engagement with staff and this had been reported through to CLT and the Clinical Management Executive.

Mrs Oldham asked if the Board had considered the risks associated with the way forward and was it ready for the move to go ahead. Mrs Bernhauser reported that in terms of the process and the plan the non-executive directors were aware but were not aware that health records staff had not been involved in the process.

Mr Nealon acknowledged from a health and safety viewpoint action had to be taken to provide better accommodation but he asked if Hailsham the right place to put the service and would the files be secure. Mrs Fellows advised that the Trust already provided health records from a number of sites, some of which were already offsite, and it was acknowledged that the ideal site would be in the Bexhill area. The estates team had undertaken a comprehensive review of existing sites and based on feasibility of sites and funding available the Hailsham site was the most feasible option. Mrs Fellows reported that the security team were reviewing the site but there was no indication at present that there were any significant concerns.

Mr Ellis reported that Quality and Standards Committee had undertaken a deep dive into health records and were of the view that the risks were sufficient to keep reviewing it at future meetings.

Ms Kavanagh was concerned that the culture change involved could affect the success of the project and more work was required in terms of staff engagement.

The Board noted the report and it was agreed that further discussions were required with staff on the proposed move to Hailsham before it could be signed off by the Board.

114/2015 **Strategic Objectives**

The Board approved the revised Strategic Objectives.

GOVERNANCE AND ASSURANCE

115/2015 **Annual Review of Corporate Documents**

Mrs Wells reported that she and Mr Meikle had reviewed the Standing Orders, Scheme of Delegation and Standing Financial Instructions and the proposed changes had been submitted to the Audit Committee who had ratified them and recommended them to the Board for approval.

The Trust Board ratified the Audit Committee's recommendation to approve the proposed changes to the Standing Orders, Standing Financial Instructions and Schedule of Matters Reserved to the Board and Scheme of Delegation.

116/2015 **Board Sub-Committee Reports**

a) Quality and Standards

Mr Ellis presented the report and highlighted the items in relation to the patient story, shared learning in practice and mandatory training.

The Board noted the report.

b) Finance and Investment

Mr Nealon presented the report and highlighted the items in relation to the end of the High Weald Lewes and Havens contract, agency/bank expenditure and deep dive into outlier clinical activity.

The Board noted the report.

c) Audit Committee

Mr Stevens reported that the Committee at its next meeting would be reviewing the updated high level Risk Register and Board Assurance Framework and the underlying clinical audit data.

The Board noted the report.

117/2015 **ITEMS FOR INFORMATION**

Use of Trust Seal

The Board noted the use of the Trust Seal on 13th October 2015 on the transfer of documents for Crowborough, Lewes and Uckfield Hospitals to NHS Property Services (due to the HWLH Community Service Transfer, effective 1st November 2015).

118/2015 **Meeting Dates for 2016**

The Board noted the Trust Board meeting dates for 2016.

119/2015 **Questions from Members of the Public**

a) Big Conversation

Mrs Walke asked for confirmation of the venue of the Big Conversation that evening and was informed that it was being held at the Congress Theatre Suite in Eastbourne..

b) Health Records

Mrs Walke asked if staff had met with executive directors and had reports been provided to non-executive directors about health records. Mrs Bernhauser responded that having seen some of the accommodation she saw any move as a positive one.

Mrs Walke asked if any GPs had expressed concerns about the move of the health records and Mrs Bernhauser was not aware of any.

c) Infections

Mrs Walke asked if the Trust was taking any research and development on infections in light of the nationally increasing infections. Mrs Bernhauser and Mrs Webster advised that the Trust received an analytical appraisal of infections, both nationally and regionally.

120/2015 **Date of Next Meeting**

Wednesday, 10th February 2016, at 10.00 am in the Cooden Beach Hotel, Cooden Beach.

121/2015 **Closed Session Resolution**

The Chair proposed that further to the relevant provisions of the Public Meetings Act 1960, representatives of the press and other members of the public should be excluded from Part 2 of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 2 December 2015 Trust Board Meeting

Agenda item	Action	Lead	Progress
102/2015	Report required on proposed transfer of Crowborough Maternity Unit to Maidstone and Tunbridge Wells	Acting Chief Executive	On Agenda
106/2015	Forecast outturn to be included in finance paper	Director of Finance	On Agenda
109/2015	Deep dive review on mortality to be included in Board seminar programme.	Medical Director	Scheduled for March 2016
110/2015	End of Life Care – written report required for Feb meeting	Medical Director	On Agenda

East Sussex Healthcare NHS Trust

Date of Meeting:	10 February 2016
Meeting:	Board Meeting
Agenda item:	6B
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Company Secretary

Action: This paper is for **(please tick)**					
Assurance	√	Approval		Decision	

Purpose:

Attached is the updated Board Assurance Framework (BAF) which brings together the strategic priorities and objectives of the organisation, with an assessment of their risks, the controls in place and details of the internal and external assurance along with associated actions.

Introduction:

The Assurance Framework has been reviewed and updated since the last meeting of the Board. Objectives have been revised following agreement at the last Board meeting and this has included the addition of the objective relating to workforce.

The BAF clearly demonstrates whether the gap in control or assurance remains unchanged, has increased or decreased since the last iteration. There are clear actions against identified gaps in control and assurance and these are individually RAG rated. Updates are clearly shown in red text. The attached risk register provides an overview of the high level risks facing the organisation and mitigating actions.

Analysis of Key Issues and Discussion Points Raised by the Report:

The Trust Board is asked to consider whether the main inherent/residual risks have been identified and that controls are appropriate to manage and mitigate the risks. The following gaps in control or assurance have been removed.

4.1.1 There is a gap in control because the final workforce strategy has been delayed as a result of market testing and service reconfigurations that have arisen or may arise from tenders. Workforce plan to be aligned with business planning

Workforce strategy now in place and will be reviewed during 2016/17 to incorporate the outputs of CU business planning due at end March 2016. An update on strategic workforce issues will be provided to the Board in February 2016.

4.1.2 Actions re HCA recruitment and TRAC removed.

End of November HCA net vacancies are 28.29 FTE, 3% vacancy rate, with a potential 54 FTE in the pipeline.
TRAC tool fully implemented and management reporting capability developed and now exploring the management and use of this information within the organisation.

2.1.1. Action re community transfer to HWLH complete
Transfer took place Nov 15

In addition 3.1.1, The assurance in respect of financial controls has moved from amber to red.

Benefits:
Identifying the principle strategic risks and gaps in control and assurance provides assurance to the Trust Board that there are effective controls and mitigation in place to support the Trust in achieving its strategic aims and objectives.

Risks and Implications
Failure to identify and monitor the strategic risks to the organisation will lead to an inability to demonstrate effective systems of internal control and an increase in the likelihood of adverse outcomes for the Trust.

Assurance Provided:
The BAF identifies the principle strategic risks to achieving the Trust's aims and objectives and the gaps in controls and assurance and subsequent actions being taken to mitigate these.

Proposals and/or Recommendations
The 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.

Consideration by other Committees
Quality and Standards Committee 12 January 2016 Audit Committee 20 January 2016

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None identified.

For further information or for any enquiries relating to this report please contact:	
Name: Lynette Wells, Company Secretary	**Contact details:** lynette.wells2@nhs.net

Assurance Framework - Key

RAG RATING:

Effective controls definitely in place and Board satisfied that appropriate assurances are available.
Effective controls thought to be in place but assurance are uncertain and/or possibly insufficient.
Effective controls may not be in place and/or appropriate assurances are not available to the Board

Status:

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

Key:	
Chief Executive	CEO
Chief Operating Officer	COO
Director of Nursing	DN
Director of Finance	DF
Director of Human Resources	HRD
Medical Director Strategy	MD(S)
Medical Director Governance	MD(G)

Committee:	
Finance and Investment Committee	F&I
Quality and Standards Committee	Q&S
Audit Committee	AC
Senior Leaders Forum	SLF

C indicated Gap in control
A indicates Gap in assurance

Strategic Objective 1: We will ensure safe patient care is our highest priority by delivering high quality services and clinical outcomes	
Risk 1.1 We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies	
Key controls	Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference Validation through external reviews and CQC inspection process. Effective processes in place to manage and monitor safe staffing levels
Positive assurances	Internal audit reports on governance systems and processes Weekly audits/peer reviews eg observations of practice Monthly reviews of data with each CU 'Quality walks' programme in place and forms part of Board objectives External visits register outcomes and actions reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is complaint with CQC fundamental standards.	CQC reports for March inspection published Sept 15, trust in special measures. Quality Improvement (QIP) plan reviewed and revised and submitted to CQC and TDA. Improvement Director working with the Trust. Internal quality summits in progress. Dec-15 External resource working with the Trust to develop PMO function and support management of QIP. Forward trajectory mapped and will be monitored.	end Mar-16	◄►	DN	Q&S SLF
1.1.2	C	In order to deliver an effective service, there is a requirement to improve controls in Health Records; to encompass systems and processes, storage capacity and quality of case note folders.	Implementation of business case commencing to include storage and tracking of health records. Continued issues with record availability being monitored and actions developed. Staff Forums/meetings taking place to manage staff communication and concerns. EDM contract signed and iFIT being introduced to track and monitor records. Oct-15 iFIT starting to embed with some good results but is a rolling improvement programme. Mitigating actions continue and are being extended to provide daily information re availability of notes. New escalation procedure for missing notes. Project to centralise Health Records is underway. Health records management structure under review to enhance supervision. Dec-15 Ongoing programme of work to support effective delivery of health records service in place and being monitored by SLF. Consultation taking place regarding health records structure.	end Mar-16	◄►	COO	Q&S SLF

Board Assurance Framework - January 2016

Strategic Objective 1: We will ensure safe patient care is our highest priority by delivering high quality services and clinical outcomes	
Risk 1.2 We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.	
Key controls	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with clinical units Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Monthly audit of national cleaning standards
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG compliance.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.2.1	C	Effective controls required to support the delivery of cancer metrics and ability to respond to demand and patient choice.	New monitoring tool developed by information department available to operations team. Trajectories for delivery identified and part of Trust Board performance report. IST review in July to supplement work with KSS Cancer network on pathway management. Aug-15 Monitoring tool trialled but data discrepancies remain; being reviewed with resolution target end of Aug. Poor performance results in June not meeting trajectory revised to 2WW and 31 days by end Sept, 61 days by end Mar. IST working with the Cancer Services team on a 'Scope of Works.' Oct-15 – Continued poor performance of targets in Aug and Sept. Cancer Recovery has now been merged with Trusts 8 high impact cancer priority plan. Focused piece of work taking pace to initially cover the 2ww performance position. Dec-15 – Challenges in meeting the 2WW standard continue although performance is improving on a monthly basis. Alterations to the set-up of the 2WW booking team and their processes are being implemented in order to improve performance.	end Mar-16	◄►	COO	SLF

Board Assurance Framework - January 2016

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.2.2	C	Emergency departments require reconfiguration to support effective patient assessment-treatment time and subsequent discharge to other specialist/bed areas. CQC report identified privacy and dignity issues.	Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place Capital bid with TDA to support expansion; outcome awaited, planning permission being sought in advance. Dec-15 Capital bid to be considered by ITFF at end of Feb.	end Jun-15	◄►	COO	SLF
1.2.3	A	Assurance is required that there are systems in place to develop and evidence shared learning from infection control incidents	Root Cause Analysis undertaken for all outbreaks and SIs and shared learning through governance structure. Cleaning controls in place and hand hygiene audited. Pevensey Ward separation of Day Unit from inpatients as interim measure until purpose built unit in place. Jun-15 Audit cleaning team strengthened. Infection control team being restructured, to increase management of audit / assurance process. Weekly walks round both sites with facilities and IC to review areas highlighted by the auditors as 'areas of risk'. Further assurance requested by Quality & Standards Committee. Aug-15 NSC Audit Group meeting and reviewing reporting of metrics. NSC audits scrutinised at Accountability Reviews. Oct 15 Reporting to Q&S Nov. Increased numbers of auditors recruited Meeting / Governance structure to be reviewed Nov-15 Dec-15 Continued review and shared learning. Infection control deep dive at Jan Q&S committee.	end Mar-16	◄►	DN	Q&S

Strategic Objective 1: We will ensure safe patient care is our highest priority by delivering high quality services and clinical outcomes							
Risk 1.2 Continued - We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.							
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.2.4	A	There is insufficient assurance that clinical laboratory diagnostics analytical equipment will be replaced in a timely way following internal approval of the managed service contract.	Agreed to replace via managed services contract. Full Business case agreed by Board but with TDA for approval. Aug-15 Additional information provided to TDA anticipate approval by end Sept-15 Oct-15 TDA approved FBC on the 30th Sept 15. Estates going out to tender. Dec-15 Final contractual issues being agreed, then implementation will commence.	end Mar-16	◄►	COO	F&I SLF
1.2.5	C	Assurance is required that plain films will be reported in a timely manner. Additional controls are needed to reduce the backlog of plain film reporting and delay in reporting non urgent radiological investigations.	Process in place to reduce plain film backlog to Sept 2010; no new patients added to backlog since April 2014. IST supporting the Trust with risk stratification relation to backlog pre 2010 and spot check audit. Oct-15 Plain film continues to be reported, no further adverse outcomes from backlog. Dec-15 Backlog continues to be reduced. Data integrity secured by investment in new system.	end Dec 15	◄►	COO/ MD(G)	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.2.6	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 Action plan in place to reduce waiting list; working in partnership with commissioner to develop service specification and care pathways Apr-15 Recruitment of two additional locum consultants. Jun-15 Waiting list required reduction delivered in May 2015 Aug-15 Backlog confirmed with CCG as now cleared. Now building a Patient Tracking List (PTL) for this service so that future activity can be monitored. Oct 15 – First draft of new PTL in place but being sense checked. Plan to have a follow up PTL in place for early Nov. Service spec and business case to be presented at Nov Contract Performance meeting with CCG. Dec-16 Business Case (BC) and PTL considered Dec. Further updates to the BC and PTL will be reviewed at Jan meeting.	end Jan16	◄►	COO	SLF Q&S
1.2.7	C	Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards with mental health and deliberate self harm diagnoses are assessed and treated appropriately.	Aug-15 Training requested from mental health team at CAMSH for ward nurses to ensure a competent and confident workforce. Mental health nurse requested via TWS to special the young people Reviewing options for cohorting mental health young people. Liaising with SPT and commissioners re purchasing adequate tier 4 beds. Oct-15 Creating amenity beds and liaising with SPT on a case by case basis for CAMHS patients Dec-15 Joint working with SPT, CAMHS recruiting assessor to support appropriate pathway for these young people.	end Mar-16	◄►	COO	SLF Q&S

Risk 1.3 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.	
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of SLF involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings Succession Planning
Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. Outcome of monitoring of safety and performance of reconfigured services to identify unintended consequences Personal Development Plans in place

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.3.1	A	Assurance is required that robust controls are in place in relation to mandatory training and appraisals are effective and evidenced by improved compliance in these two areas.	Mandatory training passport and e-assessments rolled out to support competency based local training. Additional mandatory sessions and bespoke training on request, temporary resource to help develop competency assessments. Training and support for line managers provided. Reduction in compliance flagged early to Clinical Units through performance meetings. Oct 15 – Compliance for mandatory training and appraisal is improving month on month and is a continuing upward trend. Specific actions to be taken over the next few months to support areas include: Tailoring mandatory courses to meet the needs of clinical units/departments. Continued review of mandatory training and appraisal compliance at Clinical Unit Accountability meetings and facilitated drop in/team sessions. Dec 15 - Mandatory Training – Aggregate Trust compliance rate at 30 Nov 15 of 86.5%. Highest achieved so far and reflects a continued trend of improving compliance. During the next few months we will continue to promote the availability of mandatory training including additional short courses. Appraisal – Achieved overall Trust compliance as at 30 Nov 15 of 81%. 2016 we are reviewing our Appraisal/PDR paperwork and this is currently going through the formal approval process. Activities are planned for early next year to engage managers and staff in the new process. Revised paperwork also includes the new requirements for nurse revalidation.	end Mar-16	◄►	HRD	Q&S SLF

Strategic Objective 2: We will enhance patients' experiences by working with local partnerships to meet the needs of our local population	
Risk 2.1 We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.	
Key controls	Develop effective relationships with CCGs and the TDA Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners and stakeholders
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Monthly performance and senior management meetings with CCG and TDA. Working with clinical commissioning exec via Better Together and Challenged Health Economy to identify priorities/strategic aims. Board to Board meetings with stakeholders. Membership of local Health Economy Boards and working groups Participant in clinical senates

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls and engagement are required to ensure the Trust can model and respond to the potential loss of any services and reconfiguration following tender exercises.	Working with prime provider to facilitate implementation of MSK model of care. Impact on current service configuration being determined. June 15 - Contract with MSK signed, long stop items to be agreed by end Sep 15. Oct-15 Long stop items agreed, ongoing work on developing and improving the model of care. Dec-15 Continued work with prime provider on model of care	end Mar-16	◄►	COO	SLF

Board Assurance Framework - January 2016

Strategic Objective 2: We will enhance patients' experiences by working with local partnerships to meet the needs of our local population							
Risk 2.2 We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.							
Key controls	Develop and embed key strategies that underpin the Integrated Business Plan (IBP): Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Organisational Development Strategy Effective business planning process						
Positive assurances	Two year integrated business plan in place Stakeholder engagement in developing plans Service delivery model in place Refreshing clinical strategy to ensure continued sustainable model of care in place						
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work on-going. Trust submitted 15/16 plans in line with TDA requirements. Next stage Clinical Strategy development work commences in May 2015 and is expected to conclude by November 2015 Dec-15 ESBT work continues. Board to Board meeting with Eastbourne, Hastings and Rother CCG took place Dec15.	end Mar 16	◄►	MD(S)	F&I SLF

Strategic Objective 2: We will enhance patients' experiences by working with local partnerships to meet the needs of our local population

Risk 2.3 We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners.

Key controls	Development of communications strategy Governance processes support and evidence organisational learning when things go wrong Quality Governance Framework and quality dashboard. Risk assessments Complaint and incident monitoring and shared learning Robust complaints process in place that supports early local resolution External, internal and clinical audit programmes in place Equality strategy and equality impact assessments
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives. Friends and Family feedback and national benchmarking Healthwatch reviews, PLACE audits and patient surveys Dr Foster/CHKS/HSMR/SHMI/RAMI data Audit opinion and reports and external reviews eg Royal College reviews Quality framework in place and priorities agreed, for Quality Account, CQUINs

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.3.1	A	Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience.	Incidents logged, issues escalated to SECAMB /CCG. Service spec reviewed by commissioner; Trust engaging with process. Apr-15 Inpatients - Trust has access to additional vehicles via Elite. Issue remains with outpatients. . Oct-15 Tender for service to be awarded end Oct with April implementation date. Will work with CCG and new provider to support improvement.	end Apr-16	◄►	COO	SLF
2.3.2	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Further controls are required to support delivery of an efficient service and good patient experience.	Review instigated to support implementation of focussed actions. Feb-15 Central team in place and systems being monitored. Considering developing specialist teams to support areas with complex processes. Apr-15 Close liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard. Aug-15 Weekly Dashboard now in place monitored by senior management team. Accountability Reviews for Clinical Admin service being set up. Oct-15 Reviewing processes to minimise short notice clinic cancellation and ensure appropriate clinical assessment of affected patients. New call management system ordered to address technical and resource issues in the appointments centre/provide enhanced service Review of 700+ letter templates underway to improve patient communication. SOPs and specialty booking rules agreed and implemented. Following review of call reminder system significant improvement in DNA rates, more scope within the programme. Dec-15 Continued progress in implementing service improvement. Call management system introduced.	end Mar-16	◄►	COO	SLF Q&S

Strategic Objective 3: 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.	
Risk 3.1 We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.	
Key controls	Clinical strategy development informed by commissioning intentions, with involvement of CCGs and stakeholders QIPP delivery managed through Trust governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work Modelling of impact of service changes and consequences Monthly monitoring of income and expenditure Accountability reviews in place
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Written reports to SLF on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored. Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.1.1	C	Require evidence to ensure achievement of the 2015/16 Financial Plan and prevent crystallisation of risks as follows: activity levels exceed baseline amount and are not paid for or paid for by CCGs/NHSE at marginal rate only; stranded costs arise from the transfer of the HWLH community contract; contractual fines and penalties are levied; activity, capacity and unplanned cost pressures arise; the CIP plan of £11.4m is not delivered; revenue costs of re-financing.	Contract arrangements incentivise both parties to reduce activity. Activity and delivery of CIPs regularly managed and monitored. Monthly accountability reviews in place and remedial action undertaken where necessary. Timely reporting of finance/activity/workforce performance in place. Regular reviews by BPSG, CLT, SLF, Finance & Investment Committee and Board. Aug15- End of Q1 run rate deficit was £0.7m adverse to Plan. There is now a TDA requirement to improve the year end deficit position by £1.8m. Oct 15 – End of Q2 run rate deficit £3.6m adverse to plan. Key drivers behind this deterioration of performance are increased spending on agency costs and CIP slippage. Recovery plan being developed to improve position. Dec 15 - run rate deficit has increased to £7.3m at the end of November 2015 as a result of increased spending on agency staff, continued use of escalation beds and slippage on CIPs. A recovery plan is being implemented that focusses on grip and control especially with regard to agency costs.	Commenced and on-going review and monitoring to end Mar-16	▼	DF	F&I

Risk 3.2 In running a significant deficit budget we are unable to invest in delivering and improving quality of care and patient outcomes. This could compromise our ability to invest in our ability to make investment in infrastructure and service improvement.	
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Monitoring by F&I Committee
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	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.	Essential work prioritised within Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. The Board approved a capital programme at its meeting on 2 June 2015. Delivery of this capital plan will be reported regularly to the Finance & Investment Committee and Board. Oct 15 – At the end of Q2 capital expenditure was £5.5m (marginally behind plan). The planning margin was being maintained, however as the programme is over committed, any new capital schemes will mean a re-prioritisation of the existing projects. Dec 15 – At the end of Nov 15 capital expenditure was £6.5m (marginally behind plan). The planning margin was being maintained, however as the programme is over committed, any new capital schemes will mean a re-prioritisation of the existing projects. An application is being submitted to the ITFF for additional capital investment to support the Quality Improvement Plan	On-going review and monitoring to end Mar-16	◄►	DF	F&I

Strategic Objective 3: 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.							
Risk 3.3: We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.							
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital Approvals Group and Finance and Investment Committee						
Positive assurances	Essential work prioritised with Estates, IT and medical equipment plans Capital approvals group meet monthly to review capital requirements and allocate resource accordingly Monitoring by Finance and Investment Committee						
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.3.1	C	There is a gap in control as a result of the Trust not having an aligned estates strategy in place.	Estates Strategy being developed. Progress updated presented to Board seminar in April. Substantive Head of Estates in post Aug-15 Presentation on progress to date at Board seminar in Jul-15 on track for submission to December Board. Dec-15 Estates strategy reviewed by Board, further engagement session planned.	end Dec-15	◄►	COO	F&I SLF
Risk 3.4 We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.							
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports						
Positive assurances	Policy documents and Board reporting reflect external policy Strategic development plans reflect external policy. Board seminar programme in place Business planning team established Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources						
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.4.1	A	In order to retain and develop services the trust requires the capacity and capability to effectively respond to tenders. Specialist skills are required to support Any Qualified Provider and tendering exercises by commissioners.	Business planning team in place and supported by PMO. Ongoing review of processes and evaluation of outcomes to identify learning. Tendering support in place with coaching for those involved in the process. Evaluation and lessons learnt assessment to take place to conclude by end August 2015 Oct-15 Portfolio moved to DF and being reviewed. Dec 15 - additional external resource has been commissioned by the Trust for a limited period with a specific objective of knowledge transfer.	end Mar-16	◄►	DF	SLF

Strategic Objective 4: We will show that we value our staff by developing them and engaging with them to ensure they have the right skills and knowledge to deliver effective patient care and are involved in decision making	
Risk 4.1 We are unable to effectively recruit our workforce and to positively engage with staff at all levels.	
Key controls	Workforce strategy approved Jun-15 - aligns workforce plans with strategic direction and other delivery plans; - ensures a link between workforce planning and quality measures Recruitment and Retention Strategy approved Jun-15 with planned ongoing monitoring Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data (plans to include vacancies) Rolling recruitment programme Monthly vacancy report and weekly recruitment report to CLT Nursing establishment and skill mix review undertaken and monitored by Board TRAC recruitment tool in place
Positive assurances	Training and resources for staff development Workforce planning aligned to strategic development and support Workforce assurance quarterly meetings with CCGs Implementing Values Based Recruitment and supported training programme Success with some 'hard to recruit to' posts Well functioning Temporary Workforce Service. Full participation in HEKSS Education commissioning process.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.1.1	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	Nursing Skill mix review now being widened to include original out of scope areas, to be completed by end June 2015. Aug-15 Nurse staffing levels review conducted Apr 2015 finalised and reported to Aug Board. Increased commissions in Foundation Degrees and Advanced Nurse Practitioners to support skill mix and development of new roles. Oct 15 – Nursing establishment half-year review undertaken Oct 15 to go to Board in Jan	end Jan-15	◄►	HRD	SLF
			International and European Recruitment Programme. Oct 15 – Philippines recruitment delayed until Nov due to visa restrictions; candidates not likely to commence in the Trust until Apr-16. Five doctors offered in Sept but only one accepted position; recruitment commenced again in India for middle grades A&E and other specialties. Meetings arranged with CU teams to agree recruitment priorities in the next 6 months. Strategic Workforce Planning to be incorporated into Business Planning process to include the exploration of new roles and skill mix to address shortage in specific staff groups Dec 15 - 173.52 FTE nurse vacancies at end of November. 7.8% Vacancy rate. 34 FTE start date pending, 38 overseas nurses appointed and expected to be available for work in Apr-16. 8 European nurses recruited with start dates in Jan/Feb. Further overseas and European recruitment campaigns planned for Jan and Mar. 23 Newly qualified staff due to start in February. Consultant vacancy rate 6% Middle and junior Drs 6.9% Overseas recruitment continued for Drs with little success to date and reviewing approach.	Apr-16	◄►	HRD	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.1.2	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	Value based recruitment to be incorporated into the recruitment process for all posts. Feb 15 - Implemented for newly qualified nurses. Apr 15 – Implemented for HCA's and plan being developed to extend to all staff groups as part of the R&R Strategy. Oct-15 Continuing implementation and embedding Dec 15 - No further update	end Mar-16	◄►	HRD	SLF
4.1.3	C	Assurance is required that the Trust has effective controls in place to maintain sufficient staffing levels in A&E; recruitment difficulties in consultant, middle grade and nursing. Deanery short falls in fill rate for junior positions.	Aug-15 Business continuity plans in place to cover short term difficulties. Overseas recruitment taking place. Longer term review of staff model planned. Dec-15 Discussion taking place with commissioners as part of East Sussex Better Together.	end Mar-16	◄►	COO	SLF

Strategic Objective 4: We will show that we value our staff by developing them and engaging with them to ensure they have the right skills and knowledge to deliver effective patient care and are involved in decision making.	
Risk 4.2 If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.	
Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and being embedded Staff Engagement Plan developed OD Strategy and Workstreams in place
Positive assurances	Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Embedding organisation values across the organisation - Values & Behaviours Implementation Plan Staff Engagement Action Plan Leadership Conversations National Leadership programmes Surveys conducted - Staff Survey/Staff FFT/GMC Survey Staff events and forums - "Unsung Heroes"

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.2.1	A	The CQC staff survey 2013 provided insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	Involved in national OD cultural change work. Meetings with CU teams to review staff survey. OD Strategy and workstreams approved, workstreams led by Exec and NED, staff invited to participate. Aug-15 Rollout of staff resilience training. Piloting use of 'electronic' staff forum graffiti boards in two areas. In response to Listening Conversations re Bullying and Harassment launching awareness campaign for staff in Sept which will be followed up with training and support for managers and staff. Oct-15. Unsung Hero week took place – very positive feedback. Campaign to encourage as many staff as possible to complete staff survey. Launched "what have you done to make a difference" postcard for staff to complete during Oct/Nov 2015 as part of ensuring that all staff know that 'Every Roles Counts.' Posters summarising some of the feedback from the post cards are displayed in staff restaurants Listening conversations continue to take place seeking a bottom up approach- most recent ones have linked to Health and Well Being and supporting our BME staff Bid for Human Factors funding to help develop safety culture by providing training and on-going support for Speak Out champions and to develop and implement a robust feedback mechanism when staff raise concerns. Dec 15 - Human Factors Bid successful, focus project agreed. Appointed Speak Up Guardian who is currently raising awareness of her role and feeding back any concerns directly to the Chief Executive. Series of workshops for managers on Engaging with Staff which have evaluated positively; feedback shared with General Managers. Seeking feedback from doctors on how they feel about Medical Engagement and are using the Medical Engagement Scale survey to do this Launched the Faculty of Medical Leadership Programme for senior doctors. Continuing with programme of Staff forums hosted by Exec Directors and in the new year these will happen in both community and hospital settings to allow all staff to have the opportunity to meet with Directors. Directors visited all their areas of responsibility leading up to Christmas to thank staff for their hard work.	end Mar-16	◄►	HRD	Q&S SLF
4.2.2	C	Transition in executive team and inability to successfully recruit to Chief Executive and Chairman posts could impact on Board effectiveness.	Aug-15 Chief Executive left July, Director of Strategy and Director of Finance leave the Trust at the end of September. Interim CEO and Director of Finance in place. Portfolio of Director of Strategy being redistributed. Oct-15 Recruitment processed commenced for CEO, Chairman and Chief Executive positions. Portfolios of existing directors and objectives reviewed. Jan-16 Substantive Chairman appointed. CEO and DoF interviews Jan'16.	end Mar-16	◄►	CEO/ Chair	Rem Comm/ Board

Strategic Objective 3: We will show that we value our staff by developing them and engag

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East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board
Agenda item:	7
Subject:	Quality Improvement Plan
Reporting Officer:	Alice Webster Director of Nursing

Action: This paper is for **(please tick)**					
Assurance	✓	**Approval**		**Decision**	
Purpose:					
To provide a highlight report of the Quality Improvement Plan developed from the recommendations made by the CQC in their reports published in March and September 2015 following the Chief Inspector of Hospitals visits in September 2014 and March 2015					

Introduction:

CQC inspections of the Trust were undertaken in March and April 2015, with the report published in September 2015. The overall rating of the Trust was 'inadequate' and the Trust was placed in special measures in September 2015 following recommendation from the Chief Inspector of Hospitals. A detailed Quality Improvement Plan has been developed to ensure that the Trust works together to achieve the commitment of delivering safe, high quality care for all of our patients.

The full Quality Improvement Plan and CQC reports are available at:
http://www.esht.nhs.uk/about-us/cqc-report/

Analysis of Key Issues and Discussion Points Raised by the Report:

The purpose of this report is to update on progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visits in September 2014 and March 2015. The aim of the programme is to ensure the Trust is able to respond to the recommendations made in the reports and make any improvements required in order to ensure compliance is met with the Regulations (2014) of the Health and Social Care Act 2008. This report provides an update on the following aspects in relation to the progress of the Quality Improvement Plan:

Overall Status update

The status update as at 22nd January 2016 shows the high level progress against the programme plan made in the previous 2 months. Progress planned in the next two months and significant risks threatening the programme outlining mitigation actions in place.

Current Quality Improvement Plan Dashboard

The dashboard shows the current overall progress of the Quality Improvement Plan

High Level Programme Plan
A 6 month forward view for the Quality Improvement Plan programme

Quality Improvement Communication Strategy
'The Everyone's Business' Communication Strategy provides a strong message that everyone has to play to maintain a safe and healthy environment for patients, colleagues and other visitors to the sites. It highlights key communication activities to engage with and share update information to staff, public and key stakeholders.

Quality Improvement Governance Structure
Following recent decisions to strengthen the reporting and support for the programme this shows the revised Governance Structure. Further changes will be made to the structure to ensure assurance at all levels of the improvement process.

Detailed Outstanding Warning Notice Actions Update
A detailed status update on addressing compliance against the warning notices

Benefits:
The report notes that there is progress being made against the actions and by addressing the recommendations services and patient care will be improved and the Trust will be compliant with CQC regulations.

Risks and Implications
Non-compliance with the action plan may mean the Trust is not providing high quality care and good experience for our patients. If the recommendations are not acted upon the Trust is also at risk of not meeting the Regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and may receive sanctions. Warning notices are in place for failure to fully comply with Regulations 10, 12, 15, 16, 17 and 18. The current operational pressures on the hospital are having an impact on the management of this large programme of work.

Assurance Provided:
Meetings take place weekly chaired by the Director of Nursing and attended by the Executive leads and Clinical Units representatives to update and monitor the action plan.

Review by other Committees/Groups (please state name and date)**:**
Senior Leaders Forum Jan-16 Quality and Standards Committee Jan-16 Clinical Quality Review Group (CCG) Jan-16

Proposals and/or Recommendations
The Board is asked to review and note the progress in implementing the quality improvement plan.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None identified.

For further information or for any enquiries relating to this report please contact:	
Name: Alice Webster Director of Nursing	**Contact details:** alice.webster@nhs.net

HIGHLIGHT REPORT – Trust Board 10th February 2016

East Sussex Healthcare NHS
NHS Trust

1. Introduction

The purpose of this report is to update on progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visits in September 2014 and March 2015. The aim of the programme is to ensure the Trust is able to respond to the recommendations made in the reports and make any improvements required in order to ensure compliance is met with the Regulations (2014) of the Health and Social Care Act 2008.

2. Status

This report provides an update on the following aspects in relation to the progress of the Quality Improvement Plan:

- **Overall Status update**
  The status update as at 22nd January 2016 shows the high level progress against the programme plan made in the previous 2 months. Progress planned in the next two months and significant risks threatening the programme outlining mitigation actions in place.

- **Current Quality Improvement Plan Dashboard**
  The dashboard shows the current overall progress of the Quality Improvement Plan

- **High Level Programme Plan**
  A 6 month forward view for the Quality Improvement Plan programme

- **Quality Improvement Communication Strategy**
  The Everyone's Business' Communication Strategy provides a strong message that everyone has to play to maintain a safe and healthy environment for patients, colleagues and other visitors to the sites. It highlights key communication activities to engage with and share update information to staff, public and key stakeholders.

- **Quality Improvement Governance Structure**
  Following recent decisions to strengthen the reporting and support for the programme this shows the revised Governance Structure. Further changes will be made to the structure to ensure assurance at all levels of the improvement process.

- **Detailed Outstanding Warning Notice Actions Update**
  A detailed status update on addressing compliance against the warning notices

Overall Project Status 

Overall Status Update

The Programme is currently in amber status due to the on-going assurance activities to baseline the trajectory and dashboard to ensure accurate reflection of progress. The programme team are focusing on assurance in the next two weeks, particularly scrutinising the actions relating to the warning notices due for compliance by the end of March 2016. ***The key milestones to be completed in February and March will focus on assuring our Trajectory and Warning Notice compliance:***

Milestone Name	Agreed Milestone Date	RAG	Comments
Updated Assured Trajectory Dashboard	2nd Feb 2016	G	Trajectory analysis on all linked actions in progress repeated quarterly
Updated Assured Summary Dashboard	2nd Feb 2016	G	Revised following trajectory analysis
Resources to support delivery of actions identified	8th Feb 2016	G	Additional staff: Service Improvement, Business Intelligence, IT technical, system config and development, Communication, HR, Trainers, administrative support.
Programme Resources identified and Governance agreed	29th Feb 2016	G	Support baseline of programme budget and detailed plan
Risk and Issue Analysis Complete	29th Feb 2016	G	Will provide risk profile of the programme. Risk and Issue Manager in post
Interdependencies across activities mapped	29th Feb 2016	G	Understand the impact of early or late delivery of actions on other objectives.
Compliance with Warning Notices	31st Mar 2016	A	Subject to analysis resulting in assurance to achieve this milestone

Overall Status Update

Overall Project Status 

Milestones completed during December 2015 and January 2016 are:

Milestone Name	Agreed Milestone Date	RAG	Comments
Internal and external Reporting Process embedded including Warning Notices	8th Jan 2016	G	Programme Reporting Manager in post and procedure embedded for internal and external stakeholders
Assurance from Quality and Standards Committee	12th Jan 2016	G	Assurance given
All actions, objectives and KPIs reviewed and aligned with CQC categories	22nd Jan 2016	A	Further review required. trajectory assurance activities in progress
Programme Risk Monitoring Process agreed.	15th Jan 2016	G	Risk now collated and monitored
Focus groups established on key areas to gain momentum	15th Jan 2016	G	e.g. compliance heat map by ward, mock CQC team, Stakeholder 360 feedback every quarter
Communications Improved Stage 1	29th January 2015	G	Twitter Accounts CEO DON, Increased public engagement, Team Brief launched, attending local organisation meetings, Objectives of Strategy, Trust Branding, analysis of website usage in readiness for improved website.

Overall Status Update

Overall Project Status 

Significant Risks to the Programme:

Risk	Impact	Priority	Owner	Mitigation
Achieving completion of all the warning notice actions by March 2016 remains a challenge	Further Enforcement Action	High	Richard Sunley	Trajectory assurance process in progress and will be embedded as a quarterly process. Highlighting areas of concern to the CQC.
Continued trust pressures resulting in Black Status impacting on staff capacity to progress actions	Delays to Quality Improvement Objectives	High	Richard Sunley	Risks to delivery raised through Programme Governance framework and support provided if possible.

Quality Improvement Dashboard

WELL-LED

Vision and Strategy

2	Support Staff Health and Well-Being (Schwartz Rounds)	Alice Webster	GREEN	Mar-16
3a	Improve MDT Working at Conquest Hospital - Morning Board Rounds	David Hughes	GREEN	Mar-16
3b	Improve MDT Working at Conquest Hospital - Shift Handover	David Hughes	GREEN	Mar-16
4	Listening to Staff Feedback	Monica Green / Alice Webster	AMBER	Mar-16
9	Build Relationships with the Public and Other Key Stakeholders	Lynette Wells	AMBER	Dec-15
22	Review the Leadership of Maternity Services	Pauline Butterworth	GREEN	Jan-16

Leadership of the Trust

1	Improve Staff Engagement and Satisfaction Levels	Monica Green	AMBER	Mar-16
5	Improve the Governance and Reporting of Incidents	Richard Sunley	AMBER	Apr-16
6	Minimise Harassment and Bullying of Staff	Monica Green	AMBER	Dec-16
17	Review Senior Management Team	CEO	AMBER	Mar-16

Governance, Risk Management and Quality Management

13	Reduce Staff Sickness and Absence Levels	Monica Green	GREEN	Sep-15
26	Improve the Governance and Reporting of Incidents	Alice Webster	AMBER	Feb-16
28	Strengthen the process to enable Learning from Incidents	Alice Webster	AMBER	Jun-16
29	Ensure Governance of Service Improvement and Patient Safety Initiatives	David Hughes / Alice Webster	AMBER	Oct-15

Culture Within the Trust

15	Increase Mandatory Training Levels	Monica Green	AMBER	Jan-16
16	Increase Staff Appraisal Rates	Monica Green	AMBER	Mar-16

RESPONSIVE

Service Planning and Delivery to meet the needs of Local People

11	Inform Patients of Outpatient issues in a timely manner	Pauline Butterworth	GREEN	Jan-16
19	Provide Facilities to reduce Repeated Journeys between home and Hospital	Pauline Butterworth	GREEN	Sep-15
20	Define a Strategy for Maternity Services	Pauline Butterworth	GREEN	Mar-16
21	Develop a Clear Vision for Maternity Services	Pauline Butterworth	GREEN	Jan-16
49	Women being Contacted by Midwives etc. after suffering loss	Alice Webster	AMBER	Mar-16

Meeting Individual Needs

8	Improve access to Translation Services	Lynette Wells	AMBER	Jun-16
30	Reduce Rates of Same Sex Breaches in Conquest CDU and A&E	Pauline Butterworth	AMBER	Jan-15
31	Implement Separate Areas / Cubicles in Conquest CDU and A&E	Richard Sunley	RED	Apr-16
32	Improve Privacy and Dignity in Radiology and OPD	Richard Sunley	RED	Apr-16

Review the Complaints Management Process

7	Review the Complaints Management Process	Alice Webster	AMBER	Mar-16

Access and Flow

38	Reduce number of Ward Moves	Pauline Butterworth	AMBER	Jan-16
39	Reduce Poor Discharges	Pauline Butterworth	AMBER	Oct-15
10a	Develop Standard Operating Procedures for Bookings	Pauline Butterworth	GREEN	Jan-16
10b	Monitor Outpatient Complaints and improve Responsiveness	Pauline Butterworth	AMBER	Dec-15

Actions highlighted in Purple are Warning Notice items

Names given are those of Executive Owners

Dates given are for the completion of actions

SAFE

Staffing

14	Adequate Staff Training for staff if working in Alternative Areas	Pauline Butterworth	GREEN	Mar-16
12	Recruit additional Staff	Alice Webster	AMBER	Mar-16
48	Consultant Cover in the A&E Department	David Hughes	RED	Mar-16
50	Support for Newly Qualified staff	Alice Webster	GREEN	Mar-16
51	Monitoring Quality and Safety in relation to Staffing Levels		AMBER	Mar-16
52	Fill Pathology & Histopathology Vacancies	David Hughes	AMBER	Mar-16

Medicines

25a	Create an Integrated and Patient Focussed Pharmacy Structure	David Hughes	GREEN	Nov-16
25b	Additional Medicines Management Control Measures	David Hughes	GREEN	Mar-16
25c	Create Centralised Medicines Management Governance Processes	David Hughes	GREEN	Mar-16
43	Secure Fridge Storage at Eastbourne MLU	Alice Webster	BLUE	Aug-15
44	Follow Guidance for Syntocinon	David Hughes	BLUE	Oct-15
45	IV Fluid storage not secure at Conquest A&E	Alice Webster	BLUE	Oct-15
46	TTA's and normal saline left at nurses stations	Alice Webster	AMBER	Oct-15

Incidents

27	Ensure correct oversight of Serious Incidents	David Hughes	AMBER	Mar-16

Environment and Equipment

40	Secure Oxygen Cylinders	Richard Sunley	BLUE	Oct-15
47	Unable to isolate the A&E department in the event of lock down being required	Pauline Butterworth	BLUE	Oct-15

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

34	Comply with Trust Consent to Treat Policy	David Hughes	AMBER	Apr-16

Cleanliness, Infection Control and Hygiene

33a	Ensure sustained and documented compliance with the National Specifications for Cleanliness	Alice Webster	AMBER	Mar-16
33b	Ensure consistent understanding and compliance with the Trust Hand Hygiene Policy	Alice Webster	AMBER	Dec-15
33c	Ensure robust governance and performance processes related to infection prevention and control	Alice Webster	AMBER	Mar-16

EFFECTIVE

Evidence Based Care and Treatment

36a	Audit compliance with National Pre-Eclampsia Guidance	Alice Webster	AMBER	Dec-15
36b	Audit compliance with National NBM Guidance	David Hughes	AMBER	Dec-15
36c	Audit compliance with National End of Life Care Guidance	David Hughes	AMBER	Dec-15
37	Comply with VTE Guidance	David Hughes	AMBER	May-16

Access to Information

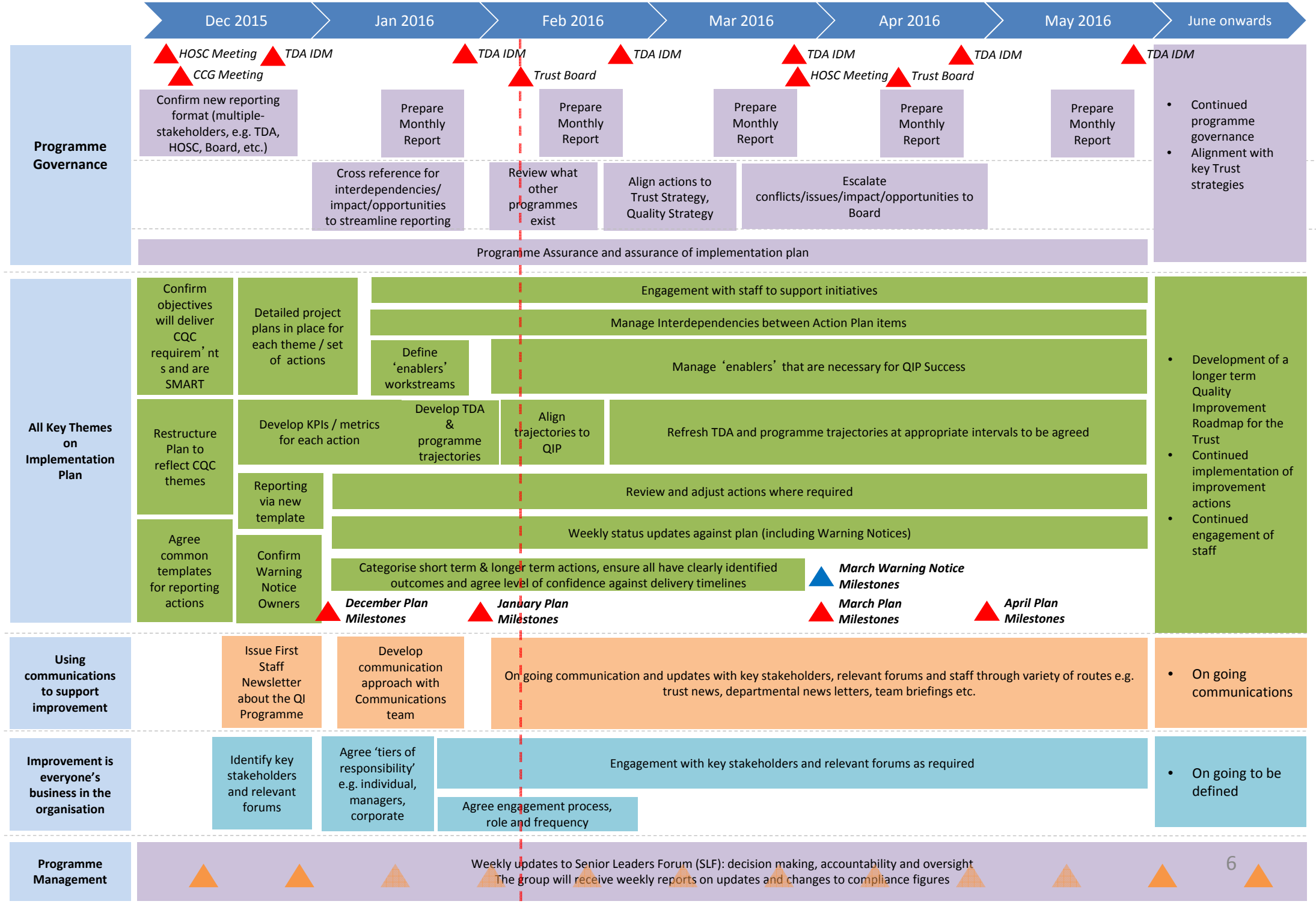
23	Improve Availability of Health Records	Pauline Butterworth	AMBER	Apr-16
24	Improve State of Repair of Health Records	Pauline Butterworth	AMBER	Apr-16
41	Review CHIS System	David Meikle	BLUE	Nov-15
42	Monitor Children's Services KPIs	Pauline Butterworth	BLUE	Sep-15

CARING

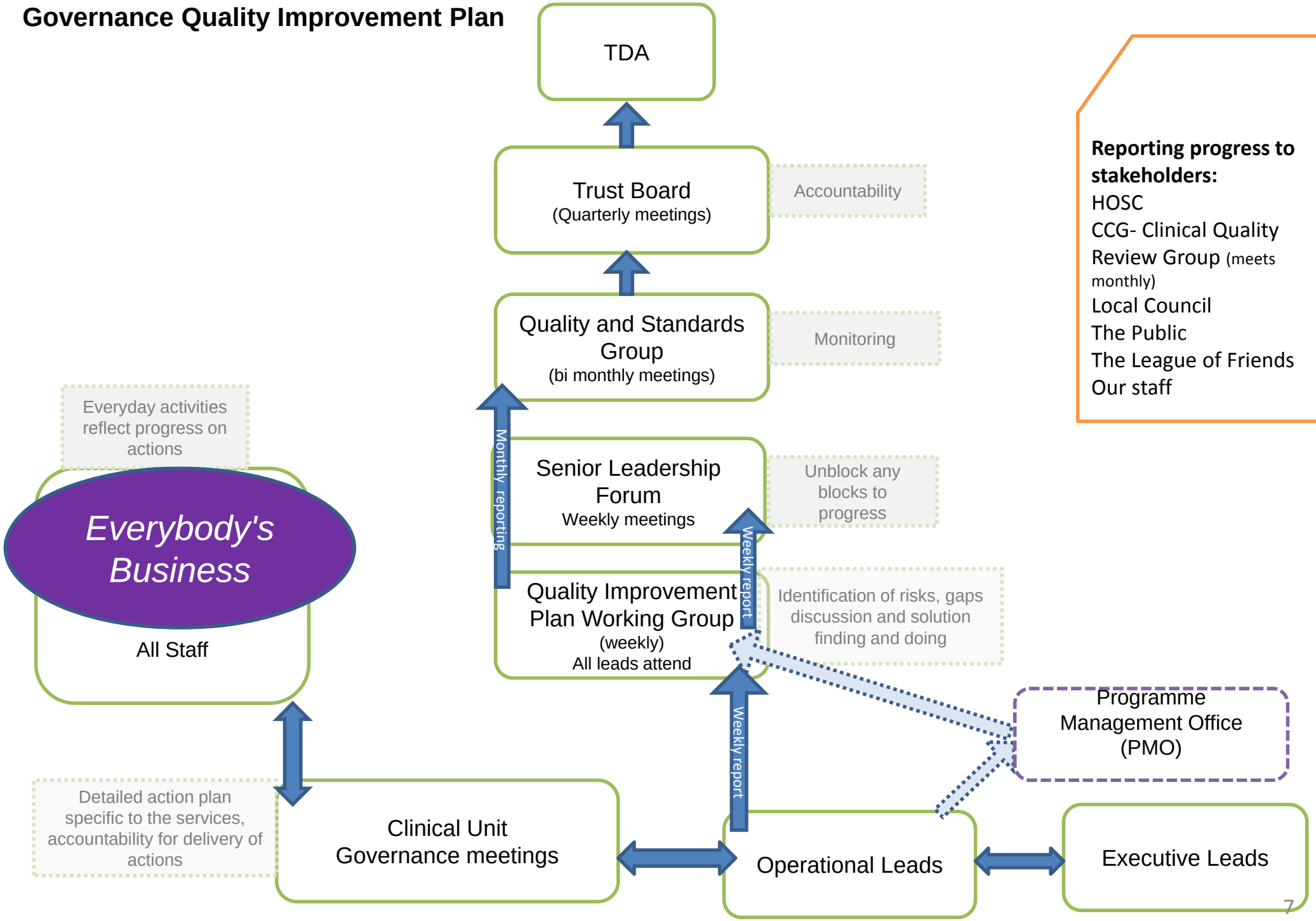
Understanding and Involvement of Patients and those close to them

18	Create Low Risk Birth Facilities at Conquest Hospital	Pauline Butterworth	GREEN	Dec-15

Appendix 1: High Level Programme Plan



Governance Quality Improvement Plan

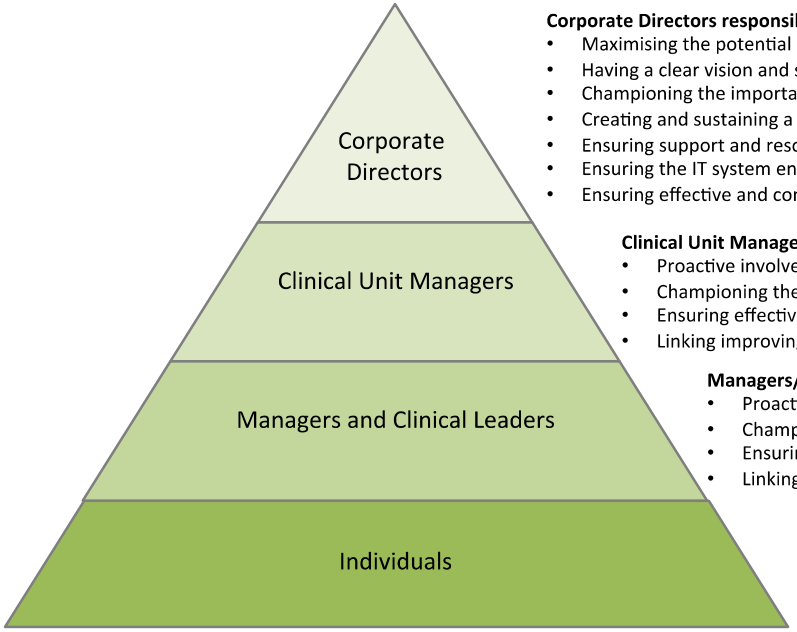


Introduction

At East Sussex Healthcare NHS Trust we are on a journey to ensure that we deliver the highest quality care and to maintain a safe and healthy environment for our patients, colleagues and visitors to our sites. We want East Sussex Healthcare NHS Trust to become one of the best performers in the South East and across the country. To achieve this we want staff and managers to work together to ensure the improvements we need. A detailed Quality Improvement Plan has been developed to ensure that we all work together to achieve our commitment of delivering safe, high quality care for all of our patients.

Making Quality everyone's business in the organisation

To really achieve substantial improvement in quality it has to been seen as everyone's business across the organisation from corporate level to front line practitioners.



Corporate Directors responsibility:

- Maximising the potential of the organisation
- Having a clear vision and strategy for improving quality and developing a learning environment
- Championing the importance and value of improving quality and safety
- Creating and sustaining a strong culture that listens and engages
- Ensuring support and resources are available for embedding quality and safety into everyday business
- Ensuring the IT system enables improving quality, reporting and learning
- Ensuring effective and consistent communication and engagement

Clinical Unit Managers responsibility:

- Proactive involvement in improvement and innovation as part of everyday business
- Championing the importance and value of improving quality
- Ensuring effective and consistent communication and engagement
- Linking improving quality to supervision, appraisals etc

Managers/Clinical Leaders responsibility:

- Proactive involvement in improvement and innovation as part of everyday business
- Championing the importance and value of improving quality
- Ensuring effective and consistent communication and engagement
- Linking improving quality to supervision, appraisals etc

Individual responsibility:

- Proactive involvement in improvement and innovation as part of everyday business
- Understanding the value and links to people, safety and clinical care and their own ongoing clinical practice
- Including improvement in personal objectives

Key messages

•We all have a responsibility to play our part to maintain a safe and healthy environment for our patients, colleagues and other visitors to the sites.

•Fundamental to this is for all staff to be up-to-date with and involved with improving quality

•Everyone has a responsibility for ensuring staff are aware of their responsibilities in improving and maintaining: individuals, managers, directors and the executive team

•Managers and staff will be working together to ensure we increase the number of staff who are aware and

•Improving quality is directly linked to patient safety and clinical care

•Improving quality is directly linked to staff, patient and public safety

•Improving and maintaining quality will be linked to appraisals and revalidation

Detailed Outstanding Warning Notice Status

WELL-LED	*Executive Owner*	*Status of Action*	*Dete Complete*
Governance, Risk Management and Quality Management			
26 Governance and Reporting of Incidents • Established Datix User Forum • Weekly Patient Safety Summit commenced 03/11/2015 • Daily review of severity 3, 4 and 5 incidents by the Trust Risk Lead and the Patient Safety Lead • DatixWeb reporting form revised and streamlined to make it simpler to complete • Function to enable automatic feedback on incidents to the reporters enabled. • Local clinical unit Feedback newsletters developed and shared.	Alice Webster	**AMBER**	**Feb 16**
	Status is Amber due to new processes in place but KPI's not yet evidenced due to IT issue. Also, sustainability of new governance and reporting procedures in progress but not complete/assured. The following actions planned to embed sustainability: • Risk Facilitators to complete Train the Trainer course • Increased ad hoc and formal training sessions • Quarter 2 2015/2016 Datix Feedback Newsletter • Shared learning in Practice (SLiP) • Monthly Risk report to Clinical Units and Directorate Functions to include a summary page which will identify three key learning points from the incidents reported for in depth discussion at Risk and Quality meetings. • Repeat audit of incidents to determine that the correct process is being followed. • Audit severity 3, 4 and 5 incidents to determine that correct process is being followed • Review and revise existing Incident Reporting & Management Policy and the Quality Governance Strategy and identify actions for completion.		

Detailed Status of Warning Notices

WELL-LED	*Executive Owner*	*Status of Action*	
Governance, Risk Management and Quality Management			
28 Learning from Incidents • Continued strengthening of multidisciplinary attendance at the Trust's Serious Incident Review Group • Datix Feedback Newsletters 2014/15 Quarter 3 and 4 published and distributed; Quarter 1 2015/16 published and distributed December 2016. • Falls Awareness sessions are in place on both acute sites and the 2016 programme has been released.	Alice Webster	**AMBER**	**June 16**
	The additional actions below will ensure embedding of the reporting and shared learning processes • Shared Learning in Practice Newsletter • Governance Team (Incidents/Serious Incidents/Complaints) to be an agenda item at Trust Nursing & Midwifery Group **The new Head of Governance and Associate Director of Governance need to be in post to pursue the following**: • Discussion with the Assistant Director Performance & Delivery re governance issues discussed at Accountability Reviews • Work with Director of Medical Education to include governance issues in education for doctors in training, and the Grand Rounds • Establish a Trust Patient Safety Group as a forum to share patient safety issues and learning.		

RESPONSIVE	*Executive Owner*	*Status of Action*	*Date Complete*
Review the Complaints Management Process			
7 Complaints Management Process • Complaints process reviewed and streamlined (due to be implemented February 2016). • Aligned Complaint Officers to attend Clinical Unit Governance meetings to discuss trends and themes of complaints per quarter (due to be implemented February 2016). • Weekly updates with Heads of Nursing to ensure complaints deadlines are met	Alice Webster	**AMBER**	**Mar 16**
	• Complaints handling training (aimed at band 6,7 & 8- due to be implemented March 2016). • 4c Policy to be reviewed (review to take place January 2016). • • Two HoNs have been met with, others are all scheduled to meet with Patient Experience Lead to discuss trends and themes of complaints for Q3. • All KPIs showing trend to improvement		

Detailed Status of Warning Notices

RESPONSIVE

Access and Flow

	Executive Owner	*Status of Action*	*Date Complete*
38 Ward Moves • -Comprehensive review of current practice required to ensure that ward moves are minimised. • Ward transferring out, to collect data daily and ensure information directed to the appropriate person in a timely manner (process tbc)	Pauline Butterworth	**AMBER**	**Jan 16**
	Process being developed 21.1.16 Multiple moves after 22:00 previously now Occasional moves after 22:00		
39 Discharges Process • LACE and Ticket home pilot completed on trial ward – awaiting results. • Designated CU representative reviewing CU discharges daily. • Adult Social Care integrated into Site Meetings. • CCGs facilitated audit review of all Medically fit for discharge patients.	Pauline Butterworth	**AMBER**	**Feb 16**
	• Shared learning of poor discharges across all CU's Risks to achieving are: • High bed Occupancy rates • Peaks in Emergency admission rates • Staffing to support opening of escalation areas		

RESPONSIVE	*Executive Owner*	*Status of Action*	*Current Performance / Sustainability*
Service Planning and Delivery to meet the needs of Local People			
49 Women being Contacted by Midwives etc. after suffering loss HOM to communicate with CCG to request that GP's inform community midwives and HV's of pregnancy losses that they are informed of them • HOM to communicate with CCG to request that GP's inform community midwives rather than HV's of early pregnancy (Midwives will do that when the woman books) Meeting with CCG on 22/1/16 • Any HV enquiries regarding on-going pregnancies are checked with community midwives rather than ward clerks checking on OASIS or E3 systems where there can be a delay in reporting HOM to email ward clerks on 25/1/16	Alice Webster	**AMBER**	**Mar-16**
	Continue to work with Health Visitors and Primary Care to develop a robust process to ensure that women are not contacted inappropriately after fetal or neonatal loss.		

Detailed Status of Warning Notices

SAFE	*Executive Owner*	*Status of Action*	*Date Complete*
Staffing			
14 Adequate Staff Training for staff if working in Alternative Areas • Improved planning and monitoring of staffing including use of e-roster • Developed staff induction and support programmes • Ensure staff have appropriate skillset and feel supported to move to alternative area	Pauline Butterworth	**GREEN**	**Mar 16**
48 Consultant Cover in the A&E Department • Locum Cover used to ensure maintenance of Consultant rota to ensure extend shop floor cover to 19:00hrs weekdays and 6hrs shop floor cover at weekends and Bank Holidays. • Regular advertisements for substantive and locum EM Consultants. • Procurement of recruitment agencies to support the recruitment process. • Fully engaged with CCG to develop new ways of working and development of Urgent Care model.	David Hughes	**RED**	**Mar 16**
	• National shortage of Emergency medicine Consultants all Emergency Departments are actively recruiting to meet RCEM guidelines. • Consultants are more likely to accept posts within Major Trauma Centres or Teaching Hospitals		
50 Support For Newly Qualified Staff • Implement a preceptorship programme	Alice Webster	**GREEN**	**Mar 16**

Detailed Status of Warning Notices

SAFE	*Executive Owner*	*Status of Action*	*Date Complete*
Staffing			
52 Fill Pathology & Histopathology Vacancies • Proactive international recruitment. Look at roles and responsibilities internally.	David Hughes	**AMBER**	**Mar 16**
	• Pathology department – 3.8 wte consultant posts not filled. Vacancy rate of 27.5% No clear strategy. • Recruitment and vacancy plan to be drawn up.		
Medicines			
25a Create an Integrated and Patient Focussed Pharmacy Structure • Substantive Chief Pharmacist in post • Permanent Pharmacy structure in place • Interim patient focussed structure during Chief Pharmacist appointment period to maintain operational service • Functional Pharmacy leadership team • Pharmacy service gap analysis against RPS Hospital Pharmacy Standards • Interim structures during of Chief Pharmacist appointment period in place • Chief Pharmacist (Acting or Substantial) reporting regular quarterly reports on medicines management to Quality Standards and/or CME • Development of a vision, strategy and business plan for pharmacy services (1,3 and 5 year view) • Workforce plan for pharmacy staffing and development in place	David Hughes	**GREEN**	**Nov 16**
	• Recruitment standards drafted • Chief Pharmacist met with finance 21/01/2016 to draft budgets • Meeting undertaken on draft Clinical Pharmacy Standards		

Detailed Status of Warning Notices

SAFE	Executive Owner	Status of Action	Date Complete
Medicines			
25b Additional Medicines Management Control Measures • SSHM and CD Audits nearing completion • Security of returns to pharmacy audited as part of an enhanced SSHM audit • New procedures rolled out and audited • Areas without thermometers being identified and new order being raised • Women's and Children's post ATR updated and requested • Pharmacy quality and financial performance meeting ToR's being written	David Hughes	**GREEN**	**Mar 16**
	• Women's and Children lead clinical unit pharmacist post needs finance approval • Lead operational pharmacists to develop new rotas for ward cover (integrated Tech / pharmacist) • All current CU pharmacists to confirm attendance at governance		
25c Create Centralised Medicines Management Governance process • Audit undertaken for SSHM • CD audits being brought into line with SSHM audits • Audit spreadsheet for SSHM audits updated • VTE incorporated into future auditing – audit form updated	David Hughes	**GREEN**	**Mar 16**
	• Audit spreadsheet completed • KPI work completed • KPIs to be used to measure performance at Lead Clinical Unit Pharmacist Meetings • Lead Medicines Management Nurse waiting for go ahead to attend TNMAG		
46 TTA's and normal saline left at nurses stations	Alice Webster	**AMBER**	**Mar 16**
• Locate separate cupboard for the TTA's to be stored until given to patients on discharge			

Detailed Status of Warning Notices

SAFE	*Executive Owner*	*Status of Action*	*Date Complete*
Cleanliness, Infection Control and Hygiene			
33b Ensure consistent understanding and compliance with the Trust Hand Hygiene Policy • Improve the Trust processes for auditing and monitoring compliance with Trust hand hygiene • -Increase focus on the Trust policy for Hand Hygiene and the importance of compliance	Alice Webster	**AMBER**	**Dec-15**
	• Results not clear due to rectifications required on Meridian Audit system		
37 Comply with VTE Guidance • Design VTE Strategy Action Plan and gain authorisation from Medical Director • Review and strengthen operational VTE Action Plan. • Gain authorisation from Medical Director • Distribute to VTE Group and board level monitoring groups including CQRG • Report against actions identified in the operational plan and VTE Strategy plan. • Launch revised R.A process	David Hughes	**AMBER**	**May 16**
	• Completed VTE strategy review and refresh including Trust VTE policy • Clear implementation of operational VTE Improvement plan with clear milestones/ KPIs, measures and supporting evidence.		

East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board Meeting
Agenda item:	10
Subject:	Integrated Performance Reports – November & December 2015 (Month 8 & 9)
Reporting Officers:	Finance Director Director of Human Resources Assistant Director of Performance & Delivery Associate Director for Knowledge Management

Action: This paper is for **(please tick)**					
Assurance	✓	**Approval**		**Decision**	

Purpose:

The attached document(s) provide information on the Trust's performance for the month of December 2015 (month 9). The month 8 report is included for reference and assurance.

Introduction:

The purpose of this paper is to inform the Finance & Investment Committee of organisational compliance against national and local key performance metrics.

Analysis of Key Issues and Discussion Points Raised by the Report:

- RTT incompletes continue to meet the 92% standard with a final figure of 92.1%.
- Diagnostic performance did not meet the < 1% target in December. The final position was 1.98% and was mainly due to capacity within Endoscopy.
- A&E performance remains challenged and under the target.
- Cancer targets remain challenged with only the 31 day standard being achieved although December showed improvement on November's position.
- The levels of falls have increased against the previous month.

Financial performance in month 9 was a run rate deficit of £4.9m which was £1.5m adverse to plan. This has increased the year to date deficit to £36.5m, which is £8.8m greater than plan. The impact on the forecast outturn of this deterioration in performance is currently being assessed, alongside any potential mitigation in actions that will recover the position. Any mitigation would ensure that patient safety and quality are not compromised through a Quality Impact Assessment review.

Benefits:
The report provides assurance where the Trust continues to deliver a high quality, safe service for patients combined with a high level of accessibility, and provides detail of where the standards are not being met.

Risks and Implications
Poor performance against the framework represents an increased risk of patient safety issues, reputational damage and as a number of the indicators are contractual targets there is a risk of financial penalties.

Assurance Provided:
This report includes all indicators contained within the Trust Development Authority's Accountability Framework for 2015/16 along with additional key, quality and performance information. The information contained within this report has been extracted from the Trust Data Warehouse in line with guidance supplied by the TDA.

Review by other Committees/Groups (please state name and date)**:**
Senior Leaders Forum 2nd February 2016 Finance and Investment 27th January 2016 Trust Board 10th February 2016

Proposals and/or Recommendations
To review the report in full and note Trust Performance.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Sarah Goldsack - Associate Director of Knowledge Management	sarah.goldsack@nhs.net
Garry East - Assistant Direct of Delivery & Performance	garryeast@nhs.net

Integrated Performance Report

M09 – December 2015

Presented by: Garry East – Assistant Director for Delivery & Performance

Sarah Goldsack - Associate Director of Knowledge Management

WHAT MATTERS TO YOU MATTERS TO US ALL

East Sussex Healthcare NHS Trust

Performance – December 2015

Key Issues

- Cancer performance
- Diagnostic Performance
- Never events
- A&E Performance

Key Risks

- Failure to deliver national and local targets and trajectories for improvement
- 18 week RTT Incompletes
- Financial position

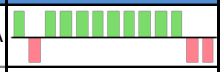
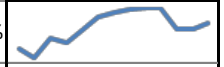
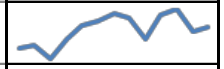
Action: The board are asked to note and accept this report.

Patient safety: Legal actions from unintentional harm to patients would normally be covered by negligence, an area of English tort (civil) law, providing the remedy of compensation. Case law is extensive. Criminal action could be pursued if investigation judged intentional harm and remedies will vary according to severity.

Staff safety: The Health and Safety at Work Act etc. 1974 may apply in respect of employee health and safety or non-clinical risk to patients (usually reported under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995).

The Care Quality Commission (CQC) regulates patient safety and quality of care and the CQC register and therefore license care services under the Health and Social Care Act 2009 and associated regulations. The health and safety executive regulates compliance with health and safety law. A raft of other regulators deals with safety of medicines, medical devices and other aspects.

Patient Safety – December 2015

Indicator Description	Target	Sep-15	Oct-15	Nov-15	Current Month Dec-15	Current Month Dec-14	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Never events - incidence rate	0	0	0	3	1	0	NA	4	0	NA	
Serious Incidents rate (per 1000 beddays)	Monitoring	3.32	2.71	2.74	2.90	2.20	32.1%	3.01	1.72	75.4%	
Medication errors causing serious harm - incidence rate	0	0	0	0.00	0	0	NA	0.00	0	NA	
% of Patient safety incidents that are harmful	0.50%	0.1%	0.4%	0.1%	0.0%	0.0%	NA	0.3%	0.2%	17.8%	
Patient Safety Incident Rate (Incidents/1000 Beddays)	37	38	40	34	36	31	15.1%	37	30	23%	
Patient safety incidents resulting in death or severe harm	0	1	4	1	0	0	NA	23	15	53.3%	

Standards: As indicated within target column

Commentary

Never Event: Wrong Implant/Prosthesis during cataract operation.

Falls: There is no obvious reason for this increase and therefore the falls steering group are reviewing the falls in this period to establish if there are any clear themes / trends.

Current year to date remains significantly lower than 2014/15.

Patient Safety – December 2015

Indicator Description	Target				Current Month			YTD			Trend
		Sep-15	Oct-15	Nov-15	Dec-15	Dec-14	Var	Curr Yr	Last Yr	Var	
Clostridium Difficile - Variance from plan	3.7	6	3	5	3	6	-3	36	41	-5	
MRSA bactaraemias rate	0	0	0	0	0	0	0	4	0	4	
VTE Risk Assessment	95%	96.1%	96.0%	96.7%	96.7%	96.0%	0.7%	96.5%	97.1%	-0.6%	
Number of Falls: no harm/near miss	105 p/m (1260 OT)	109	109	96	129	129.00	0.00	950.00	1059.00	-0.10	
Number of Falls: Minor/Moderate	48 p/m (581 OT)	37	62	43	60	68.00	-12%	501.00	515.00	-3%	
Number of Falls: Major/Catastrophic	0	0	0	0	0	0	#N/A	4	10	-60.0%	

Standards:

As indicated within target column

Commentary

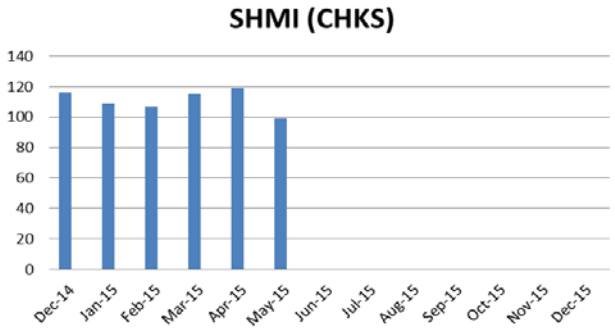
C-Difficile cases fell in December and are in line with plan.

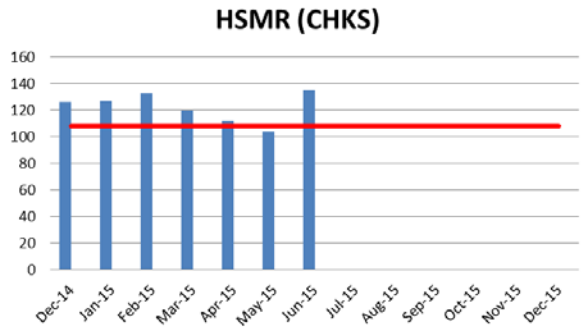
Falls increased compared to November, especially in the lower and mid categories. There is no clear reason for the increase and therefore the falls steering group are reviewing the falls in this period to establish if there are any clear themes / trends.

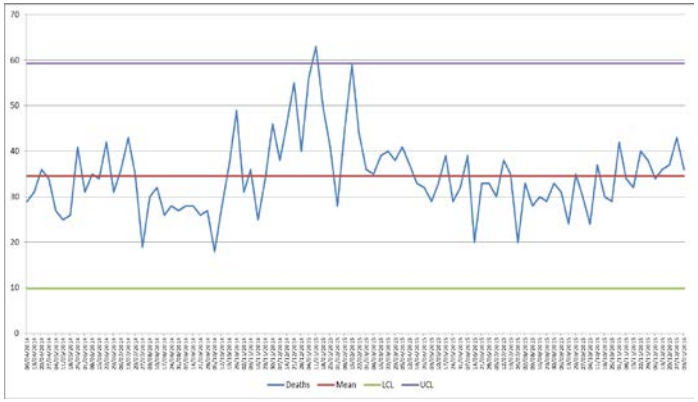
Current year to date remains significantly lower than 2014/15.

Clinical Effectiveness – December 2015

Indicator Description	Target	Sep-15	Oct-15	Nov-15	Current Month Dec-15	Current Month Dec-14	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Crude Mortality Rate	1.36%	1.46%	1.67%	1.95%	2.04%	2.44%	-16.6%			#N/A	
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	Monitoring	6.96%	7.36%	6.46%	4.77%	#N/A	NA			NA	







Standards:

As indicated within target column.

SHMI – Summary Hospital-Level Mortality Index. HSMR – Hospital Standardized Mortality Ratio. CHKS – Caspe Healthcare Knowledge Systems

Commentary

Crude mortality rate rose against the November, though remains lower than December 2014. So far this year, this represents an improvement on the previous winter. Given our demographic, we expect crude mortality to be higher than the UK average. Rates rise inevitably in winter across the UK and each winter our crude mortality rises more than the national average. The increase, (detailed data only to October) is driven by "influenza and pneumonia" and COPD; both the main anticipated winter mortality drivers.

Put in context, there are two observations to make:

1. The ESHT crude mortality rate for December 2015 is substantially lower than for December 2014 (2.04 Vs. 2.44)
2. Our crude mortality SPC chart pasted above shows that ESHT lie well within control limits. This chart runs from 6.4.14 to 9.1.15. The large peak mid-chart is last winter (went up in November and ended by March

This will be scrutinised over the remainder of the winter period through the trusts Mortality Review Group and Overview Group.

Clinical Effectiveness – December 2015

Indicator Description	Target				Current Month			YTD			Trend
		Sep-15	Oct-15	Nov-15	Dec-15	Dec-14	Var	Curr Yr	Last Yr	Var	
% Spending 90% time on Stroke Ward Monthly Monitoring	90.00%	76.6%	85.7%	92.3%	80.0%	87.8%	-8.8%	88.8%	91.3%	-2.7%	
Stroke:% to Stroke Unit <4hrs Monthly Monitoring	88.00%	77.3%	78.6%	88.5%	100.0%	68.8%	45.5%	80.5%	76.0%	5.9%	
Stroke: % scanned <1hr of arrival Monthly Monitoring	95.00%	78.7%	89.3%	84.6%	100.0%	79.6%	25.6%	78.9%	75.4%	4.7%	
Stroke: % scanned <12hr of arrival Monthly Monitoring	99.00%	100.0%	100.0%	100.0%	100.0%	95.9%	4.3%	97.9%	97.5%	0.4%	
	Nat Avg	Q3	Q4	Q1	15/16 Q2	14/15 Q1	Var				
% Spending 90% time on Stroke Ward FINAL SSNAP	86.10%	90.9%	93.0%	97.8%	96.5%	95.7%	0.8%				
Stroke:% to Stroke Unit <4hrs FINAL SSNAP	61.80%	74.2%	75.5%	87.0%	81.4%	80.4%	1.2%				
Stroke: % scanned <1hr of arrival FINAL SSNAP	47.40%	79.3%	78.4%	74.8%	84.9%	73.8%	15.0%				
Stroke: % scanned <12hr of arrival FINAL SSNAP	91.00%	95.7%	99.1%	99.2%	99.1%	99.2%	-0.1%				

Standards: As indicated within target column

Commentary

Stroke metrics for December should be reviewed with caution. Delays in data input will mean that the cohort of patients driving these percentages is too low for accurate analysis. November however, will have been updated to include all patients. November saw improvements in out of 4 monthly monitoring standards. The monthly monitoring standards are aspirational targets set by the Joint commissioners. In all standards, ESHT is performing significantly above the national average.

The data from the SSNAP report shows a maintained improvement in the overall SSNAP score at band C (60-70% achievement). Since quarter 1, ESHT improved in an additional patient-centred domain; domain 7-Speech and Language Therapy, improving from E to D rating, however discharge processes has reduced from A to B rating. In relation to our CCG stretch targets, ESHT is now meeting 15 of the targets; an increase from 6 targets met in quarter 1, and 12 met in quarter 2.

Stroke commentary continued on page 6

Specific areas of improvement noted in quarter 2 are:

- Increase in patients scanned within 1 hour of clock start
- Increase in applicable patients swallow screened within 4 hours of clock start.
- Increase in formal swallow assessment within 72 hours
- Increase in patients reported as requiring Speech and Language Therapy
- Increase in days in which Speech and Language is received.
- Improved compliance against therapy target for minutes of Speech and Language therapy received.
- Increase in patients assessed by Speech and Language therapist within 72 hours.
- Increase in patients mood and cognition screened by discharge.

The main areas to focus on where further improvement are required are:

- Thrombolysis – more patients requiring thrombolysis are being thrombolysed within 1 hour however more work is required to meet the stretch targets.
- Occupational Therapy (OT) – the following three measures have reduced; Patients assessed by OT within 72 hours, number of days when OT is received and patients reported as requiring OT.
- There has also been a slight decline in patients admitted directly to Stroke Unit within 4 hours of arrival
- Number of patients accessing skilled ESD.

Access and Responsiveness – December 2015

Indicator Description	Target	Sep-15	Oct-15	Nov-15	Current Month Dec-15	Current Month Dec-14	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
A&E Monthly Performance (4Hr Wait) - All Types (Reported)	95%	93.3%	91.2%	89.4%	86.7%	89.0%	-2.3%	92.6%	94.34%	-1.8%	
A&E Monthly Performance (4Hr Wait)-Type 1 Only	95%	91.4%	88.6%	88.3%	85.6%	86.0%	-0.4%	90.0%	92.47%	-2.7%	
Emergency A&E >12hr to Admission	0	0	0	0	0	0	0	1	1	0	

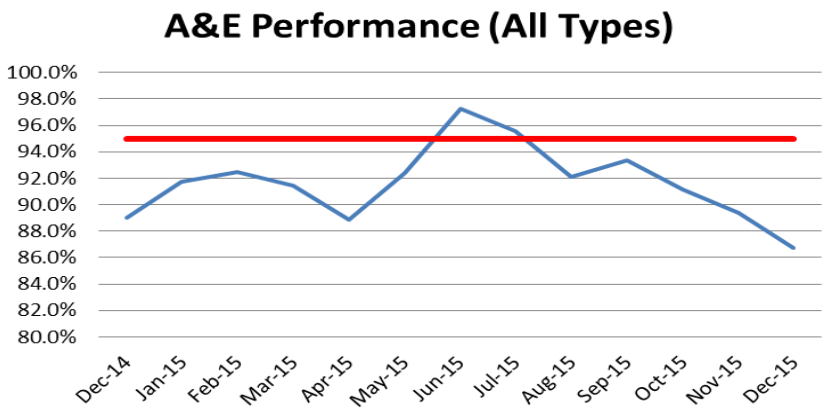
Standards:

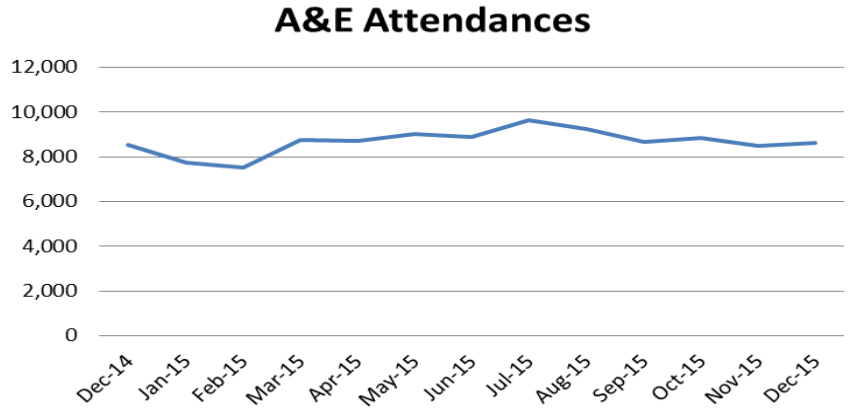
As indicated within target column.

A&E Performance graphs are available in Appendix 1.

Commentary

A&E performance declined in December. Performance is lower than at the same time in 2014/15. Demand on A&E services will be driving part of this decline. More significant though, will be the increased Non Elective length of stay. This is reducing the capacity to admit patients, and thus patients requiring admission from A&E will be waiting longer.





East Sussex Healthcare NHS
NHS Trust

Access and Responsiveness – December 2015

Indicator Description	Target	Sep-15	Oct-15	Nov-15	Current Month Dec-15	Current Month Dec-14	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Referral to Treatment Incomplete	92%	93.38%	92.71%	92.8%	92.1%	90.23%	1.9%	93.5%	92.38%	1.2%	
Referral to Treatment Incomplete 52+ Week Waiters	0	0	0	0	0	2	-100.0%	3	29	-89.7%	
Diagnostic waiting times	1.0%	2.16%	1.94%	0.96%	1.98%	1.29%	53.6%	1.74%		NA	

Standards:

As indicated within target column.

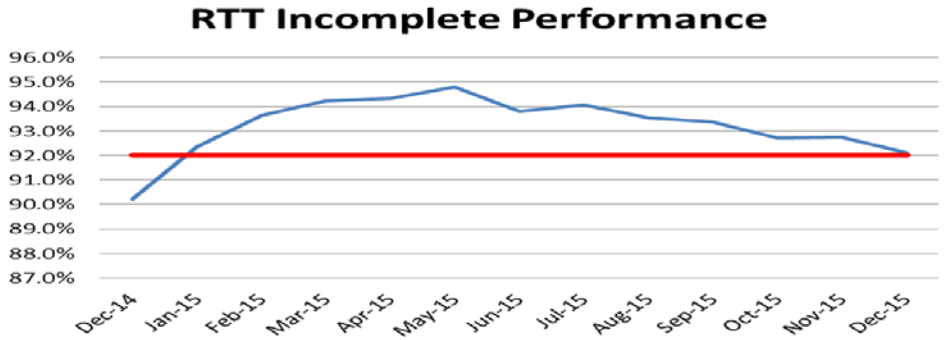
Elective Admissions Performance graphs are available in Appendix 2.

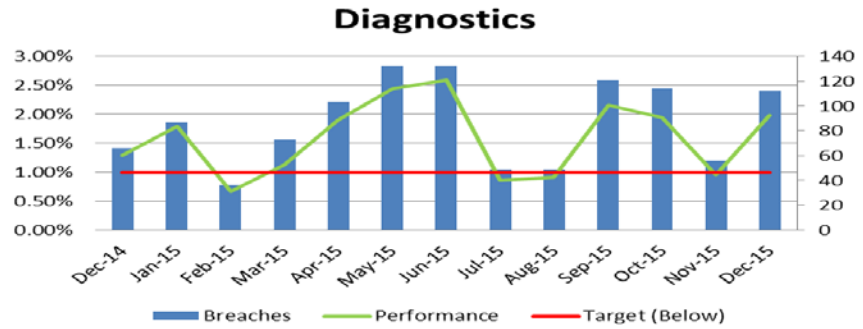
Commentary

RTT performance remains above target though have reduced from November. December was a challenging month which saw the trust lose elective capacity due to the Junior Doctors Industrial Action (50 elective and 300 Outpatient appointments, even though it was cancelled), winter pressures resulting in cancellations (approximately 105 in December), two days without power at EDGH (40 elective cases). All of these, along with the normal loss of capacity throughout the Christmas holiday period have resulted in a drop in performance.

Continued efforts to maximise capacity and ensure that RTT waiting lists are efficiently validated, will be required to ensure the Trust remains in an achieving position.

Diagnostic performance declined in December to 1.98%. Endoscopy and radiology capacity contributed to this decline. Work is on-going to effectively plan for capacity need in these modalities and ensure that diagnostic standards can be met.





WHAT MATTERS TO YOU MATTERS TO US ALL

Access and Responsiveness – November 2015 (Cancer performance shown 1 month in arrears)

Indicator Description	Target	Aug-15	Sep-15	Oct-15	Current Month Nov-15	Current Month Nov-14	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Two Week Wait Standard	93.0%	85.9%	87.6%	91.3%	89.9%	92.22%	-2.3%	90.5%	91.10%	-0.7%	
Breast Symptom Two Week Wait Standard	93.00%	75.8%	81.3%	89.1%	88.5%	93.75%	-5.3%	88.1%	88.63%	-0.6%	
31 Day Standard	96.0%	96.9%	98.9%	100.0%	97.4%	90.30%	7.1%	97.4%	95.36%	2.1%	
31 Day Subsequent Drug Standard	98.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%	100.0%	100.00%	0.0%	
31 Day Subsequent Surgery Standard	94.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%	100.0%	98.88%	1.1%	
62 Day Standard	85.0%	73.9%	74.5%	76.2%	75.4%	73.22%	2.2%	74.8%	78.37%	-4.6%	
62 Day Screening Standard	90.0%	87.5%	80.0%	84.6%	54.5%	83.33%	-28.8%	81.3%	82.76%	-1.8%	

Standards: As indicated within target column

Commentary

The above shows Cancer performance up to November 2015. The Trust will implement a live Cancer PTL in January 2016 which will enable greater and more frequent scrutiny to patients approaching 2 week or 62 day target dates.

The Trust is also working closely with CCGs and Primary care to reduce the number of patients unable to attend initial 2WW appointments.

52% of 2WW breaches (68 patients) in November breached due to patient choice delay of initial appointment.

90% of 2WW capacity breaches (53 patients) were in Upper GI (OGD capacity, OPA Capacity)

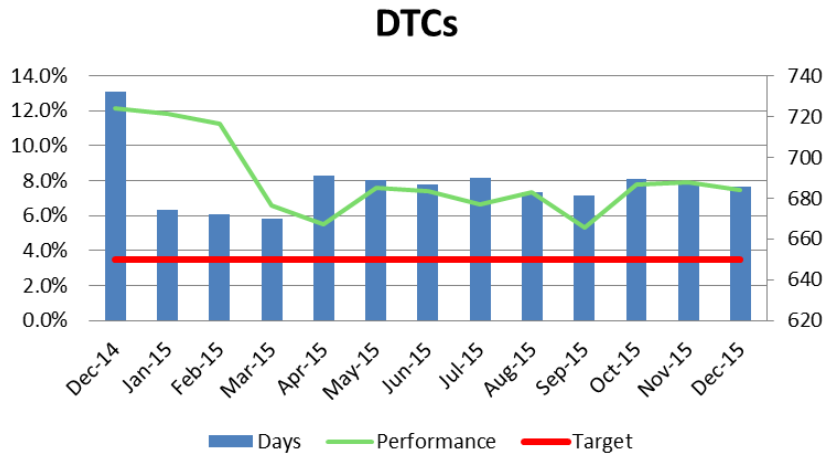
62 day breaches were made up of an assortment of reasons such as patient choice, diagnostic delays and complex pathways.

Access and Responsiveness – December 2015

Indicator Description	Target	Sep-15	Oct-15	Nov-15	Current Month Dec-15	Current Month Dec-14	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	0	0	0.0%	0	0	NA	
Proportion of patients not treated within 28 days of last minute cancellation	0.0%	0.0%	6.1%	0.0%							
Delayed Transfers of Care	3.5%	5.3%	7.8%	7.9%	7.5%	12.1%	-4.7%	6.9%	5.2%	33.9%	

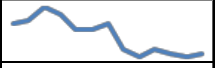
Standards: As indicated within target column

Commentary DTCs reduced across the Trust in December, though performance remains above the 3.5% target.



East Sussex Healthcare NHS
NHS Trust

Patient Experience – December 2015

Indicator Description	Target				Current Month			YTD			Trend
		Sep-15	Oct-15	Nov-15	Dec-15	Dec-14	Var	Curr Yr	Last Yr	Var	
Inpatient Scores from Friends and Family Test % positive	96.00%	97.5%	97.4%	98.8%	99.0%	96.6%	2.4%	97.8%	96.5%	1.4%	
A&E Scores from Friends and Family Test % positive	88.00%	92.6%	89.3%	91.1%	90.7%	86.9%	4.3%	89.9%	88.0%	2.3%	
Maternity Scores from Friends and Family Test % positive	96.00%	93.3%	95.1%	96.6%	95.5%	97.3%	-1.8%	95.1%	95.2%	-0.1%	
Inpatients response rate from Friends and Family Test	45.00%	15.3%	15.5%	13.5%	12.9%	46.5%	-72.3%	17.0%	47.3%	-64.0%	
A&E response rate from Friends and Family Test	25.00%	8.9%	7.9%	6.8%	7.7%	16.7%	-54.1%	10.1%	23.4%	-57.0%	
Written Complaints - Rate	Monitoring	3.10	2.79	2.90	2.12						
Percentage of new complaints respond to (within mandatory or agreed timescales)	95.00%	94.0%	84.0%	94.0%	95.2%						
Mixed Sex Accommodation Breaches	0	14	23	16	3	26	-88.4%	55	20	175.0%	

Standards: As indicated within target column

Commentary

Inpatient and A&E scoring from the FFT questionnaire remain at high levels and comfortably above target. Response rates are low however, which would mean some caution should be applied to these results.

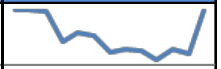
Maternity scoring fell below the required standard in December. Work is on-going to investigate specific themes that may have contributed to this and put in place relevant and appropriate interventions.

There were 3 MSA breaches in December, all occurring on Herstmonceux ward in EDGH.

December saw the trust achieve the 95% response rate for new complaints.

WHAT MATTERS TO YOU MATTERS TO US ALL

Workforce – December 2015

Indicator Description	Target	Pevious Months			Current Month			YTD			Trend
		Sep-15	Oct-15	Nov-15	Dec-15	Dec-14	Var	Curr Yr	Last Yr	Var	
Trust turnover rate	10.00%	11.8%	12.2%	12.1%	14.1%	14.1%	0.0%	12.5%	13.3%	-0.7%	
Trust level total sickness rate	3.30%	4.4%	4.5%	4.7%	4.5%	5.7%	-1.2%	4.4%	4.9%	-0.4%	
Total Trust vacancy rate	10.00%	8.9%		8.2%	8.1%	5.6%	2.6%	8.5%	4.4%	4.1%	
Temporary costs and overtime as % of total paybill	10.00%	15.7%	16.1%	17.3%	17.1%	10.2%	6.9%	16.6%	9.5%	7.1%	
Percentage of staff with annual appraisal	85.00%	77.6%	77.9%	81.8%	81.8%	68.3%	13.5%	76.9%	66.4%	10.5%	

Standards: As indicated within target column

Commentary

Actual workforce usage of staff in December was 6226.53 full time equivalents (ftes), 167.37 above budget. That is 10.38 ftes lower than last month.

Temporary staff expenditure was £3,667K in December (17.08% of total pay expenditure). This comprises £1,270 bank expenditure, £2,348 agency expenditure and £49K overtime. This is a reduction of £71K overall compared to November

There were 479.90 fte vacancies (a vacancy factor of 8.13%). This is a slight increase of 0.55 ftes, though the vacancy factor is 0.04% lower

Monthly sickness was 4.48%, a decrease of 0.12% from November. Annual sickness was 4.61%, a reduction of 0.11%

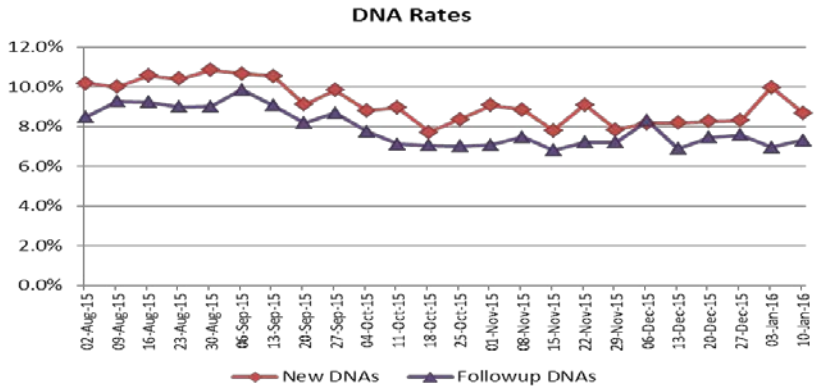
Mandatory training rates have slightly decreased this month, with the exception of Health & Safety, Deprivation of Liberties and Safeguarding Vulnerable Adults training.

Appraisal compliance increased by 0.02% to 81.85%

Full Workforce report available in section 2 of this report.

Activity/Effectiveness – December 2015

Indicator Description	Target	Previous Months			Current Month			YTD			Trend
		Sep-15	Oct-15	Nov-15	Dec-15	Dec-14	Var	Curr Yr	Last Yr	Var	
Primary Referrals	Previous Yr	8,864	9,135	8,464	8,092	8,316	-2.7%	78,968	79,195	-0.3%	
Cons to Cons Referrals	Previous Yr	1,415	1,518	1,447	1,185	1,513	-21.7%	13,405	14,054	-4.6%	
First OP Activity	Previous Yr	10,564	10,092	10,435	9,425	10,071	-6.4%	92,027	91,333	0.8%	
Subsequent OP Activity	Previous Yr	23,826	23,995	24,249	21,942	21,151	3.7%	207,776	201,866	2.9%	



Standards: As indicated within target column

Commentary

Year on year referrals are stable, though there are pockets of high variance. Dermatology and Gastroenterology particularly are showing an increase of 6% and 25% respectively. 2WW referrals are up 10%.

This is driving the slightly increased OP activity, compared to 2014/15. Capacity remains an issue and the Trust is underpinning the 2016/17 business planning process with a detailed demand and capacity programme.

DNA rates continue to show progress.

Activity/Effectiveness – December 2015

Indicator Description	Target	Previous Months			Current Month			YTD			Trend
		Sep-15	Oct-15	Nov-15	Dec-15	Dec-14	Var	Curr Yr	Last Yr	Var	
Elective IP Activity	Previous Yr	709	696	621	574	675	-15.0%	6,151	6,967	-11.7%	
Elective DC Activity	Previous Yr	3,794	3,729	3,811	3,505	3,411	2.8%	33,967	32,383	4.9%	
Non-Elective Activity	Previous Yr	3,832	3,860	3,639	3,823	4,183	-8.6%	35,204	36,284	-3.0%	
A&E Attendances	Previous Yr	8,685	8,846	8,476	8,612	8,536	0.9%	80,176	79,101	1.4%	
Average LOS Elective	3.0	3.1	3.0	3.0	3.4	3.2	5.6%	3.0	2.9	6.1%	
Average LOS Non-Elective	4.6	5.7	5.5	5.7	6.2	5.1	21.6%	5.5	5.1	7.7%	

Standards: As indicated within target column

Commentary

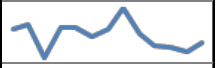
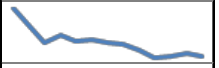
Year on year elective activity is showing an 11% negative variance. Non Elective is 3% lower.

NEL LOS is increasing, which will be increasing NEL bed days and thus reducing the potential elective capacity.

What this means is that there are less discharges across the Trust, and so less throughput, meaning activity will inevitably reduce.

The higher LOS will be increasing occupied bed days meaning the hospital will “feel” busy, but actual activity is down.

Community – December 2015

Indicator Description	Target	Pevious Months			Current Month			YTD			Trend
		Sep-15	Oct-15	Nov-15	Dec-15	Dec-14	Var	Curr Yr	Last Yr	Var	
Community Nursing Referrals	Monitoring	3,484	3,381	3,390	3,574	1,927	85.5%	26,892	14,242	88.8%	
Community Nursing Total Contacts	Monitoring	33,905	33,489	32,542	34,103	30,460	12.0%	306,713	176,499	73.8%	
Community Nursing Face to Face Contacts	Monitoring	18,926	18,835	18,467	19,109	20,070	-4.8%	176,535	112,244	57.3%	
% Patient Facing Time	60.00%	55.8%	56.2%	56.7%	56.0%	65.89%	-15.0%	57.6%	63.59%	-9.5%	
Community Nursing ALOS	42.00	38.4	44.7	32.3	32.5	50.99	-36.3%	42.4	40.86	3.8%	

Standards: As indicated within target column

Commentary

Volume of referrals plateaued for community nursing in October and November although December has seen a further increase. Referrals remain significantly higher than the baseline target.

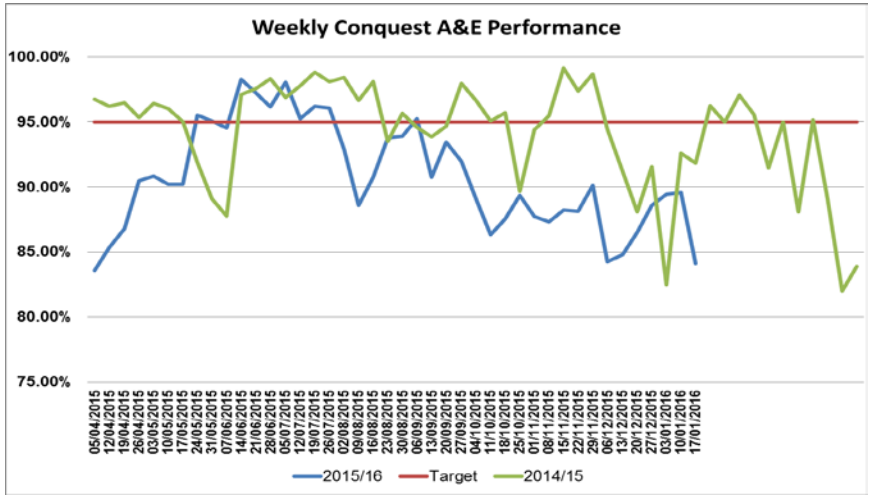
The Community Nursing teams are continuing to maintain a consistent response time performance.

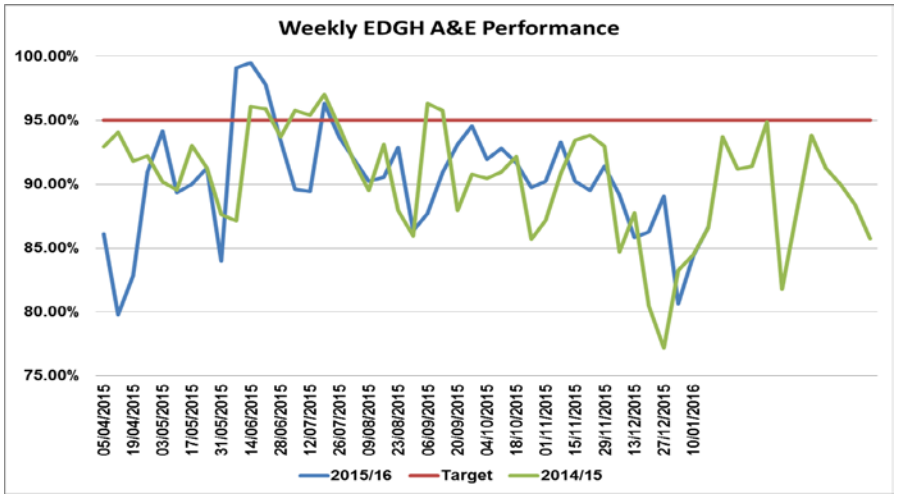
Finance – December 2015 (Full report available in section 3 of this report)

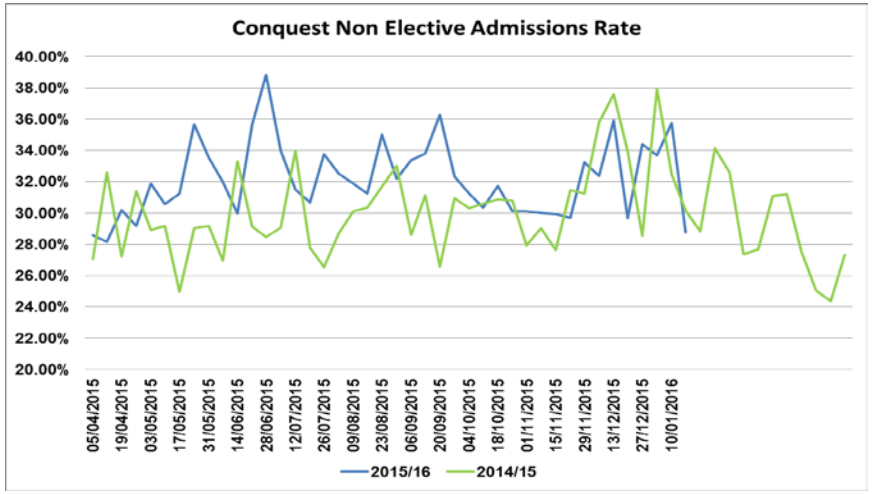
Financial Summary – December 2015

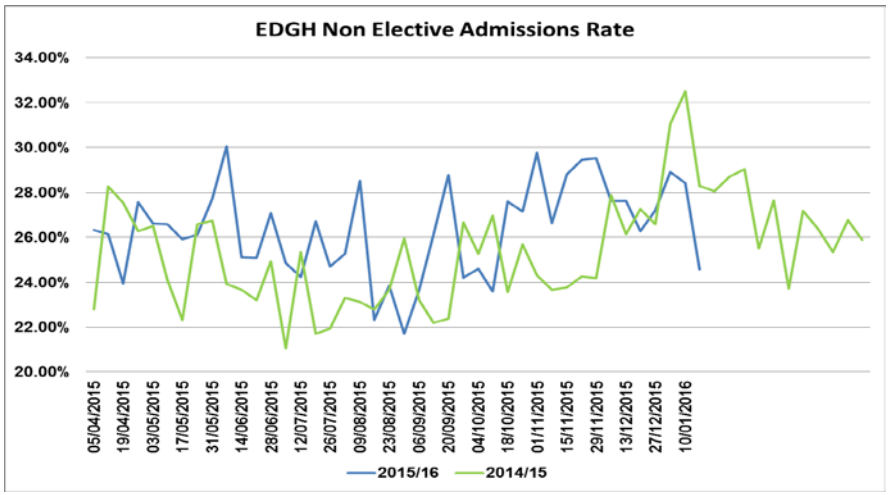
Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) finance risk assessment criteria are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria is red in month 9.	R
Financial Sustainability Risk Ratings	The Continuity of Services Risk Rating has been enhanced and is now referred to as the Financial Sustainability Risk Rating (FSRR). The FSRR builds on the previous ratings by retaining the Liquidity Ratio and Capital Servicing Capacity, but with additional risk ratings for I&E Margin and I&E Margin Variance from Plan (see page 13). The current rating for the Trust is red.	R
Financial Summary	The Trust performance in month 9 was a run rate deficit of £4.9m with an adverse variance against plan of £1.5m. Year to date the deficit stands at £36.5m which is £8.8m worse than plan.	R
Activity & Income	Total income received during December was £0.4m below planned levels increasing the year to date variance to £2.0m below plan. Tariff-Excluded Drugs and Devices (TEDDs) income under-performed by £0.3m in month, underperformance now stands at £1.8m YTD. There is however, a corresponding underspend of £1.8m on TEDDs expenditure so therefore, this has a zero effect on the bottom line.	A
Expenditure	Operating Pay costs are above plan by £1.1m in month and are cumulatively £7.6m above plan. This is mainly due to high agency spend covering escalation beds and clinical vacancies. Operating Non Pay costs are £0.8m above plan in month and are marginally above plan cumulatively. This is mainly due to the underspend on TEDDs (as detailed above). Total costs are now £7.2m overspent year to date.	R
CIP plans	The CIP achievement year to date was £6.6m which was below the plan of £8.0m.	A
Forecast Outturn	The forecast outturn reported to the TDA has now been revised to £48.7m deficit. This is £13.5m above the revised plan	R
Balance Sheet	DH loans have increased to £29.4m as a result of the continuing draw down of the working capital support. The full year RWCF agreed with the Trust Development Authority (TDA) is now £35.2m and discussion are on-going regarding this RWCF being converted into a working capital loan repayable over 5 years.	G
Cash Flow	An interim revolving working capital support facility agreement is currently in place and an application for re-financing has been submitted to the Independent Trust Financing Facility via the TDA. If approved, this will allow the repayment of the revolving working capital support to be replaced by an increased working capital loan repayable over 5 year to support the forecast deficit. At the end of month 9, the Trust has drawn down £29.4m of the current £35.2m facility.	A
Capital Programme	After 9 months capital expenditure has increased to £7.3m. The overall capital programme resource assumption has been revised to remove the interest bearing capital loan bid required to address the CQC quality improvement plan in the current financial year. This bid will now be included within a £16.5m interest bearing capital loan bid to the TDA as part of the 2016/17 capital planning process.	G

Appendix 1: A&E Performance Graphics

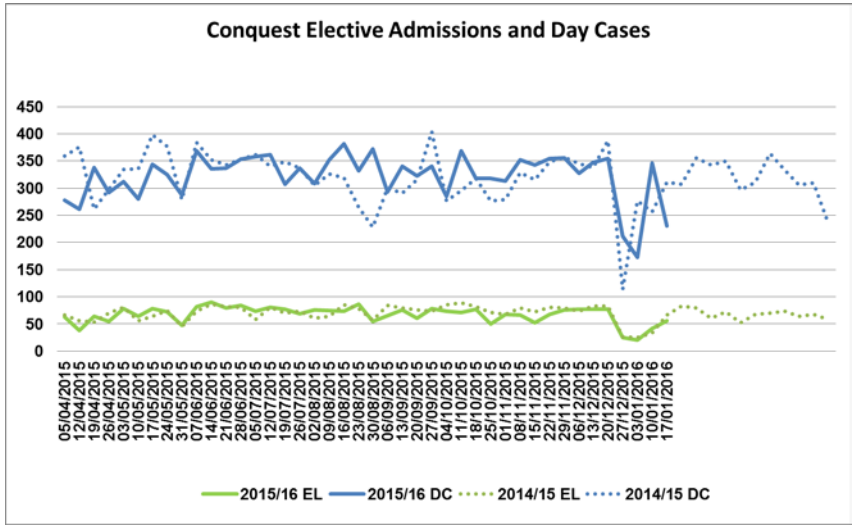


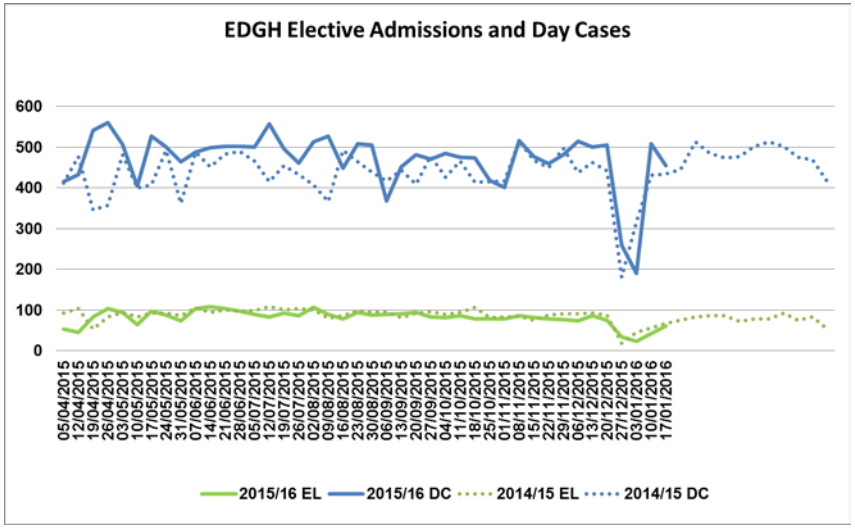


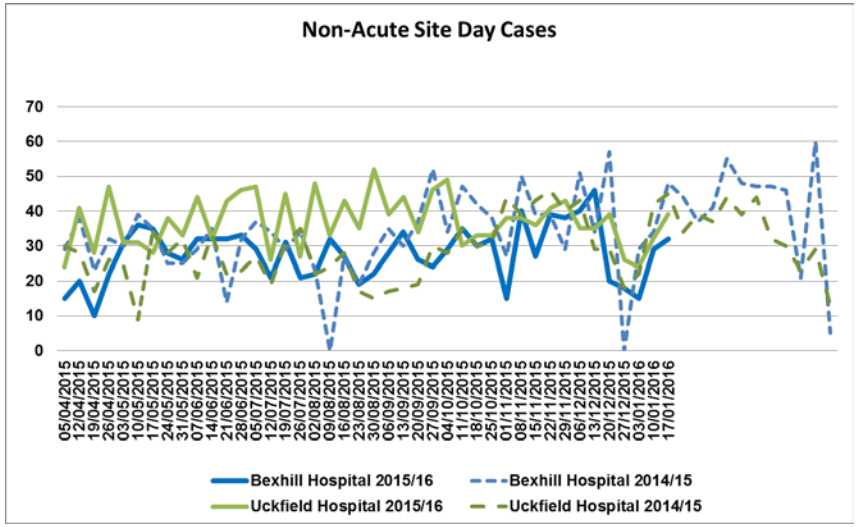


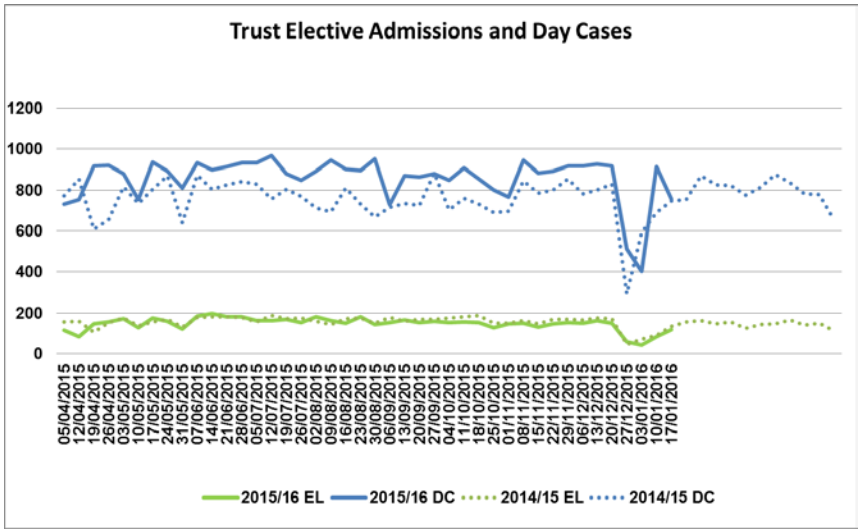


Appendix 2: Elective Admissions Performance Graphics









East Sussex Healthcare NHS
NHS Trust

WORKFORCE REPORT

DECEMBER 2015

WHAT MATTERS TO YOU MATTERS TO US ALL

East Sussex Healthcare NHS
NHS Trust

HEADLINES

WORKFORCE EXECUTIVE SUMMARY – KEY POINTS

- Actual workforce usage of staff in December was 6226.53 full time equivalents (ftes), 167.37 above budget. That is 10.38 ftes lower than last month.
- Temporary staff expenditure was £3,667K in December (17.08% of total pay expenditure). This comprises £1,270 bank expenditure, £2,348 agency expenditure and £49K overtime. This is a reduction of £71K overall compared to November
- There were 479.90 fte vacancies (a vacancy factor of 8.13%). This is a slight increase of 0.55 ftes, though the vacancy factor is 0.04% lower
- Annual turnover was 11.97% which represents 626.27 fte leavers in the last year
- Monthly sickness was 4.48%, a decrease of 0.12% from November. Annual sickness was 4.61%, a reduction of 0.11%
- Mandatory training rates have slightly decreased this month, with the exception of Health & Safety, Deprivation of Liberties and Safeguarding Vulnerable Adults training.
- Appraisal compliance increased by 0.02% to 81.85%

WHAT MATTERS TO YOU MATTERS TO US ALL

East Sussex Healthcare NHS
NHS Trust

TRUST OVERVIEW

TRUST	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Trend line
WORKFORCE CAPACITY													
Budgeted fte	6119.77	6125.54	6135.58	6173.71	6221.89	6197.01	6233.56	6239.90	6244.41	6240.44	6028.97	6059.16	
Total fte usage	6101.75	6142.01	6149.97	6185.06	6116.05	6181.61	6216.76	6243.02	6237.90	6281.08	6236.91	6226.53	
Variance	18.02	-16.47	-14.39	-11.35	105.84	15.4	16.8	-3.12	6.51	-40.64	-207.94	-167.37	
Permanent vacancies	394.53	366.04	369.29	524.43	536.35	520.61	556.18	542.99	542.14	514.02	479.35	479.90	
Fill rate	93.34%	93.83%	93.79%	91.36%	91.15%	91.43%	90.84%	91.09%	91.09%	91.55%	91.87%	91.87%	
Bank fte usage (as % total fte usage)	5.61%	6.29%	6.31%	6.77%	5.77%	6.07%	6.15%	6.42%	6.34%	6.34%	6.75%	6.68%	
Agency fte usage (as % total fte usage)	3.80%	3.33%	3.38%	4.11%	4.25%	4.53%	5.64%	5.33%	5.08%	5.30%	6.94%	6.45%	
WORKFORCE EFFICIENCY													
Annual sickness rate	4.82%	4.88%	4.94%	4.99%	4.99%	4.97%	4.94%	4.91%	4.86%	4.77%	4.72%	4.61%	
Monthly sickness rate (%)	5.26%	4.95%	4.77%	4.65%	4.24%	4.30%	4.21%	4.26%	4.36%	4.51%	4.60%	4.48%	
Turnover rate	12.92%	12.83%	11.98%	12.42%	12.30%	12.12%	12.26%	12.20%	11.77%	12.24%	12.07%	11.97%	
TRAINING & APPRAISALS													
Appraisal rate	70.64%	71.87%	74.68%	75.22%	74.88%	74.54%	75.03%	73.69%	77.60%	77.93%	81.83%	81.85%	
Fire	83.53%	83.64%	83.22%	81.52%	82.47%	82.82%	83.78%	83.03%	82.90%	82.77%	84.49%	83.49%	
Moving & Handling	80.33%	81.53%	81.08%	79.84%	82.97%	84.59%	85.44%	84.21%	85.24%	85.02%	85.81%	85.76%	
Induction	94.62%	94.91%	94.47%	95.16%	93.32%	93.64%	94.62%	90.95%	92.53%	91.89%	93.66%	90.95%	
Infec Control	86.55%	86.94%	86.41%	86.32%	86.27%	84.85%	85.78%	84.58%	85.82%	85.81%	86.83%	86.53%	
Info Gov	81.03%	78.82%	77.06%	75.99%	77.26%	81.89%	82.57%	82.38%	82.25%	83.41%	87.40%	86.42%	
Health & Safety	63.67%	65.06%	67.04%	68.79%	71.18%	73.36%	74.80%	75.47%	78.16%	80.03%	82.88%	83.67%	
MCA	91.00%	91.76%	92.36%	92.31%	92.48%	92.63%	93.02%	92.80%	93.18%	92.84%	93.39%	93.36%	
DoLs	86.56%	88.17%	89.09%	89.03%	89.64%	90.11%	90.88%	90.82%	91.44%	91.31%	91.81%	92.29%	
Safeguarding Vulnerable Adults	83.27%	84.65%	85.98%	72.98%	73.24%	74.38%	75.08%	74.62%	76.05%	76.05%	77.64%	78.06%	
Safeguarding Children Level 2	75.21%	76.21%	78.12%	77.90%	79.61%	79.87%	80.13%	79.19%	80.59%	80.40%	81.42%	80.75%	

WHAT MATTERS TO YOU
MATTERS TO US ALL

TRUST OVERVIEW

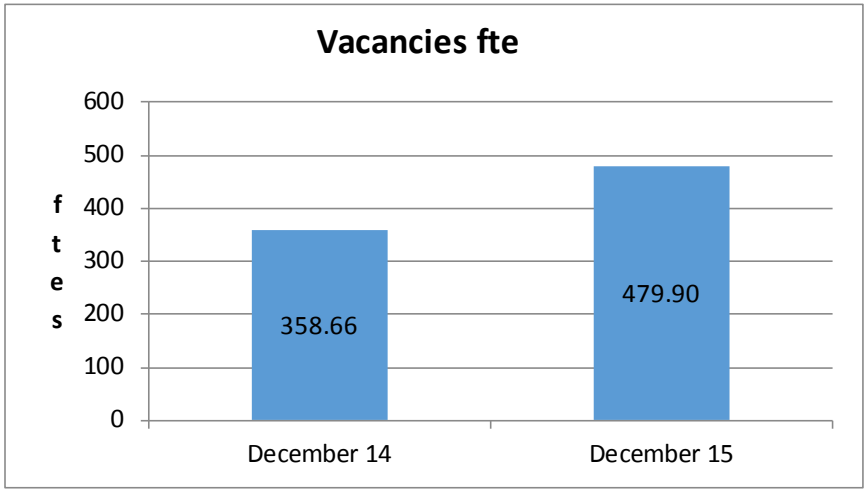
Clinical Units

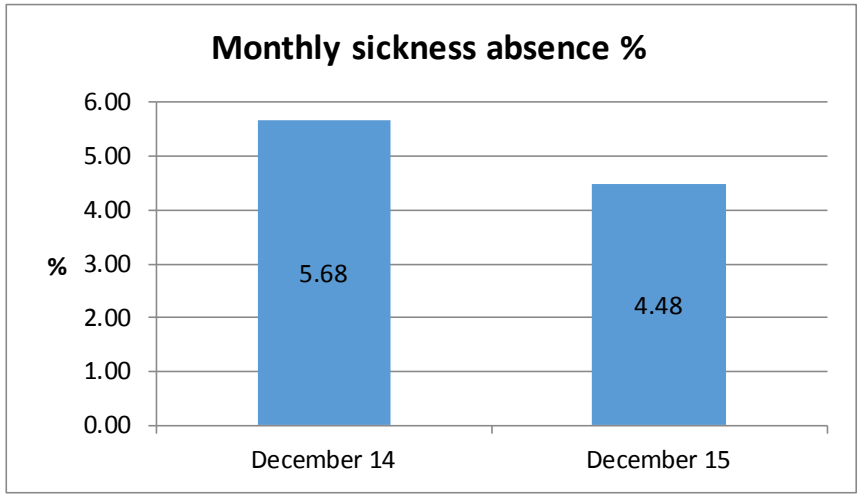
Dec-15	Budg estab fte	Actual worked fte	Vacancies fte	Vacancy trend since last month	Fill rate %	Monthly sickness %	Annual sickness %	Turnover	Temp staff expenditure	Appraised /exempt in last yr	Appraisal trend since last month
Theatres & Clinical Support	1,085.61	1,052.64	88.46	↓	91.69%	4.13%	4.61%	10.24%	£502,350	79.39%	↑
Cardiovascular Medicine	300.16	321.55	29.52	↑	90.17%	3.89%	3.89%	9.17%	£336,995	91.46%	↑
Urgent Care	553.92	662.49	44.33	↓	91.99%	4.74%	5.00%	12.53%	£1,017,092	77.08%	↓
Specialist Medicine	431.80	424.89	42.70	↓	90.11%	4.53%	4.12%	10.39%	£255,930	88.94%	↑
Out of Hospital Care	721.20	679.73	75.46	↓	89.54%	4.90%	5.37%	19.32%	£195,781	79.31%	↓
Surgery	726.16	823.62	61.05	↓	91.59%	4.13%	3.71%	10.55%	£732,833	87.57%	↓
Womens & Childrens	588.48	601.31	6.28	↓	98.93%	4.99%	4.68%	10.71%	£173,459	80.31%	↓
COO Operations	373.60	402.77	19.96	↑	94.66%	3.60%	4.76%	10.42%	£102,396	82.72%	↑
Estates & Facilities	687.94	699.60	63.45	↑	90.11%	6.29%	5.68%	8.19%	£221,807	72.94%	↓
Corporate	504.32	473.42	48.69	↓	90.22%	3.55%	4.05%	11.74%	£128,815	88.32%	↑
TRUST	6059.16	6226.53	479.90	↑	91.87%	4.48%	4.61%	11.97%	£3,667,458	81.85%	↑

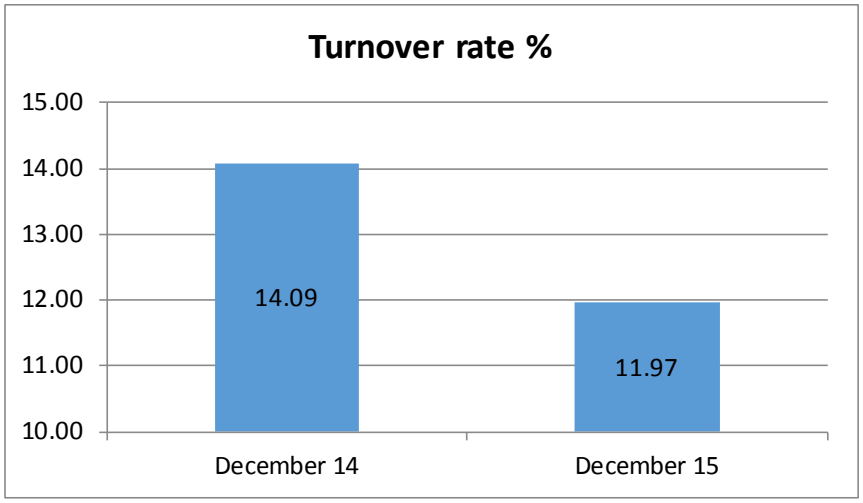
Staff Groups

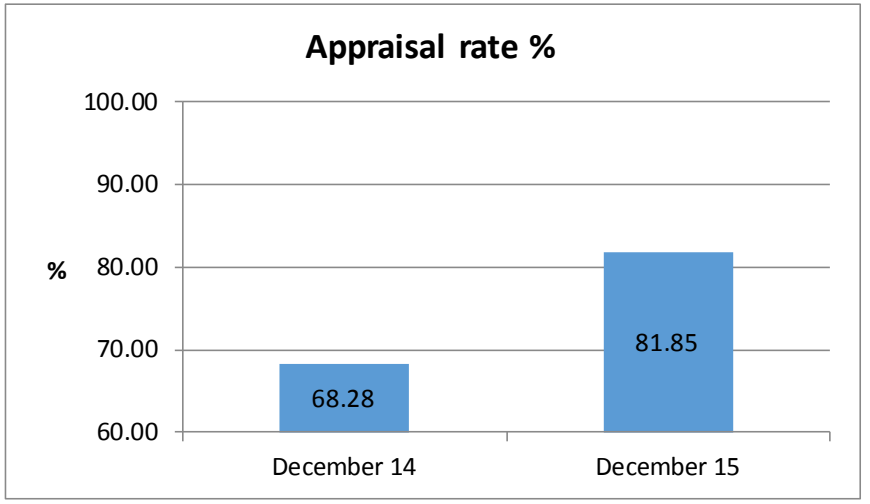
STAFF GROUPS	Budgeted estab. fte Dec 15	Actual (worked) fte Dec 15	Vacancies fte	Fill rate %	Monthly pay budget (£000s)	Monthly pay expend. (£000s)	Monthly sickness %	Turnover %	Appraised/ exempt in last yr
MEDICAL & DENTAL	583.92	610.24	57.61	89.85%	£4,594	£5,321	2.17%	15.58%	88.39%
NURSING & MIDWIFERY REGISTERED	1929.64	2001.93	195.37	89.70%	£6,796	£7,189	4.59%	10.68%	82.06%
SCIENTIFIC, THERAP & TECH	938.42	870.67	99.60	89.38%	£2,852	£2,862	3.45%	15.34%	75.93%
ADDITIONAL CLINICAL SERVICES	756.37	855.60	17.36	97.61%	£1,593	£1,782	5.65%	13.61%	84.85%
ADMINISTRATIVE & CLERICAL	1168.87	1177.51	79.19	93.08%	£3,054	£2,986	4.14%	11.07%	82.29%
ESTATES & ANCILLARY	681.94	712.58	30.78	95.09%	£1,495	£1,336	6.27%	8.11%	77.23%
TRUST	6059.16	6228.53	479.90	91.87%	£20,384	£21,476	4.48%	11.97%	81.85%

12 MONTH COMPARISONS



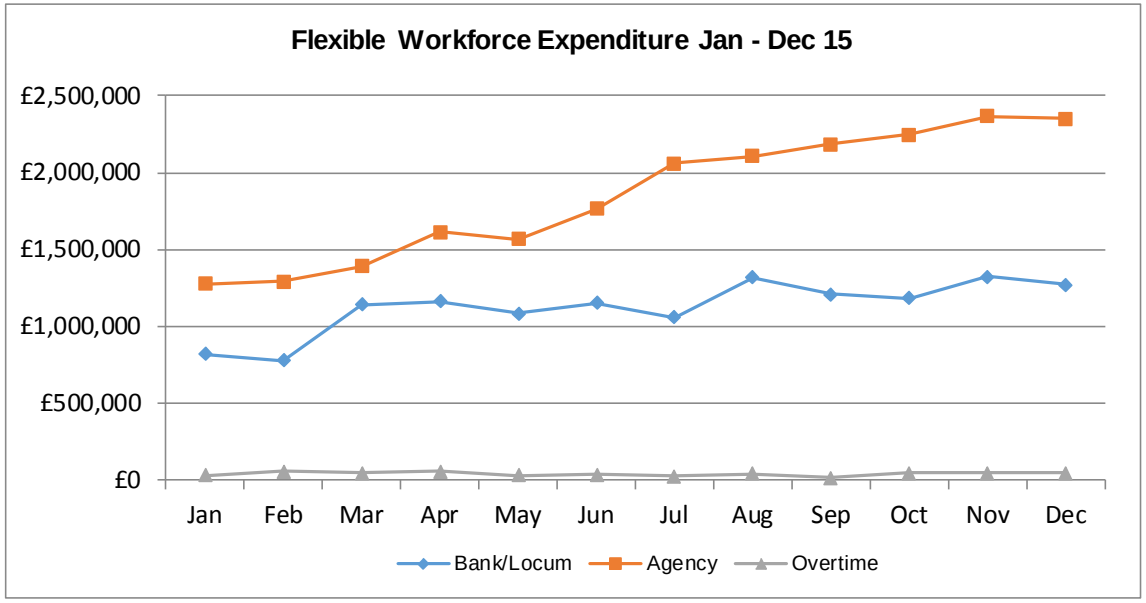


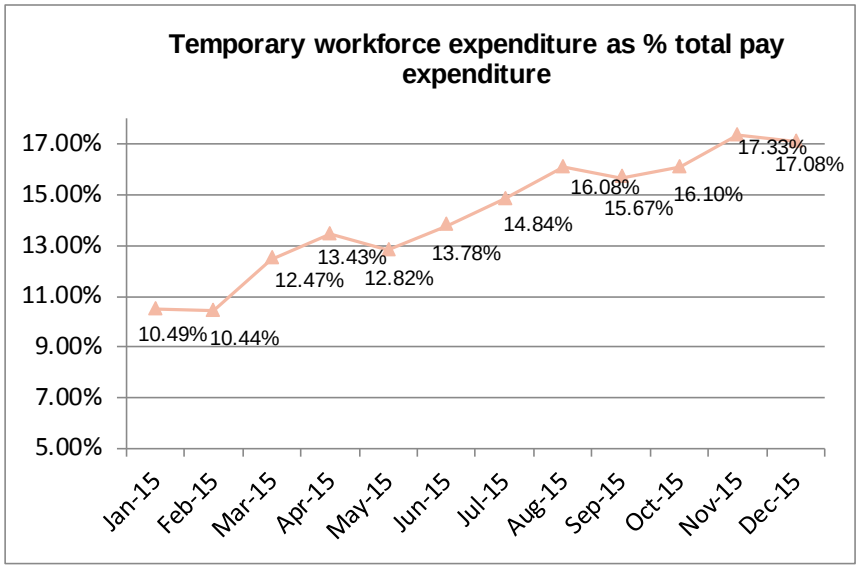




WHAT MATTERS TO YOU MATTERS TO US ALL

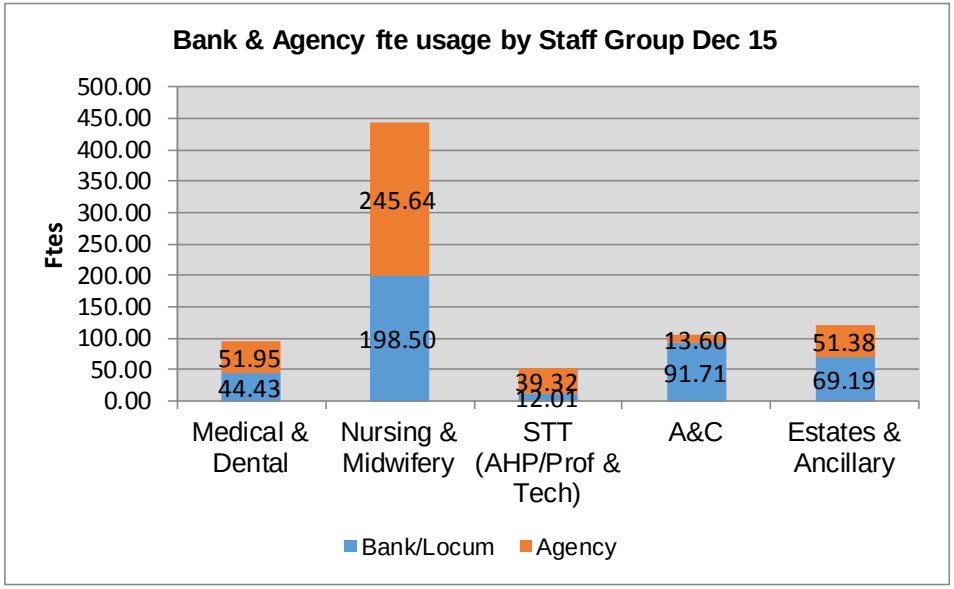
WORKFORCE USAGE

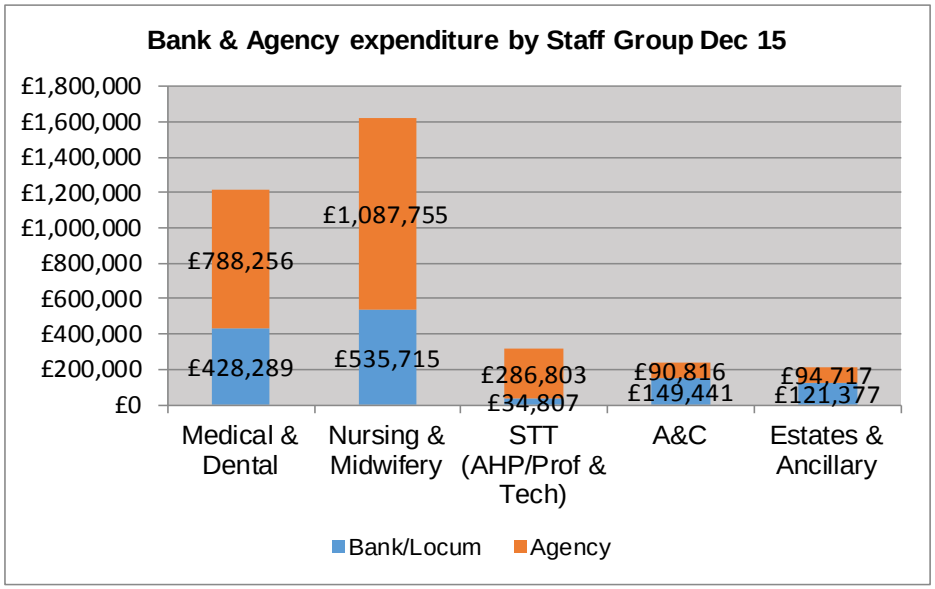




WHAT MATTERS TO YOU MATTERS TO US ALL

WORKFORCE USAGE





The budgeted establishment increased by 30.19 ftes this month largely due to the advent of winter funding for the Escalation wards, although these wards have been in continued use due to the levels of activity

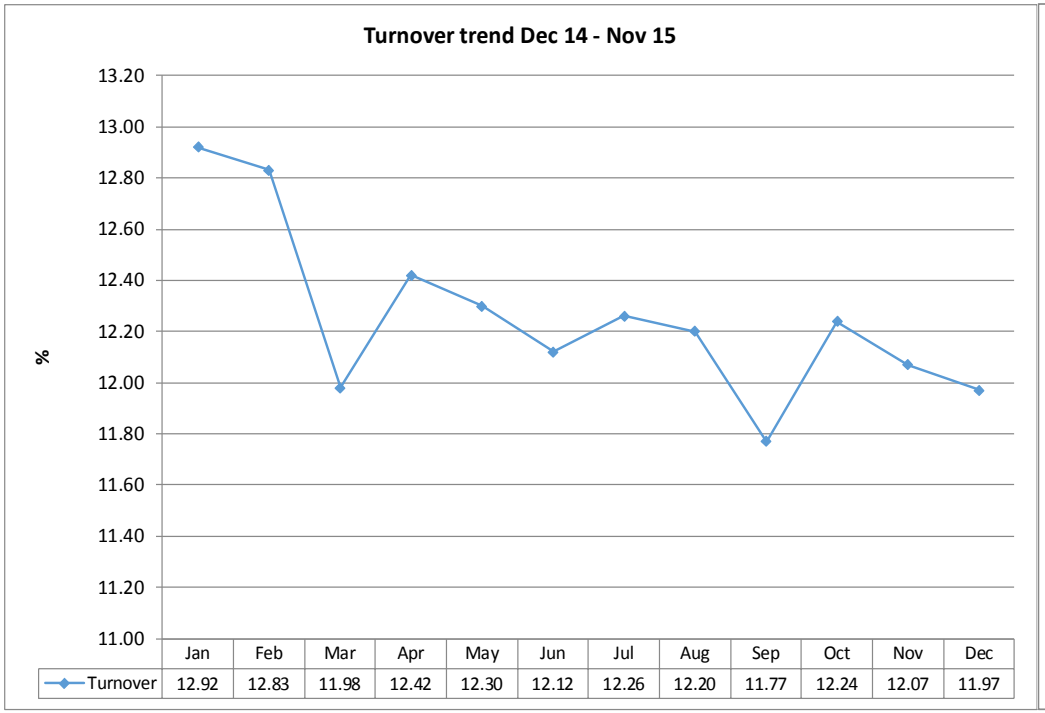
Temporary workforce expenditure decreased by £71K compared to November but remains high at £3667K for the month. Bank expenditure reduced by £54K and agency expenditure by £18K whilst overtime increased by £1K.

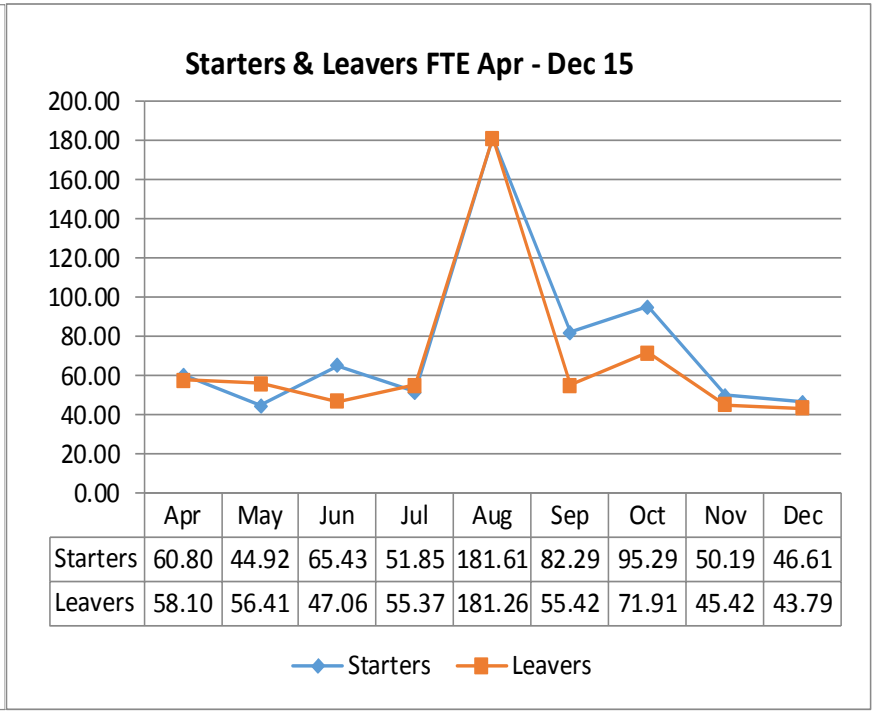
Temporary workforce expenditure remains high in Urgent Care due to medical and nursing vacancies in A&E, MAU and on the Frailty team, who have also been using agency staff to help reduce length of stay. A&E CDU remained open and there were escalation areas on Hailsham 2 and Seaford 2 at the end of December due to patient flow pressures resulting in Black Status for the Trust. Agency was also used for specialling on a number of wards and for maternity leave cover. In Surgery, a backlog of invoices were paid this month but there was also increased bank and agency usage on Seaford 4, as the Escalation ward, Hailsham 4 was covering medical & surgery patients until they could be transferred to Hailsham 2, as well as having a long term tracheotomy patient requiring specialling, Egerton also needed cover for specialling and high vacancies. There are also 2 General Surgery Consultants on long term sickness. Agency was also used for additional activity in Audiology.

Theatres used additional overtime in order to avoid agency costs. Agency usage in Facilities was higher due to the enhanced cleaning requirements during the winter months, which costs an extra £16K per month, whilst an additional £21K was used in Eastbourne Hospital Services for laundry contracts and extra activity which brought in an additional £36K income in December.

East Sussex Healthcare NHS
NHS Trust

TURNOVER & VACANCIES





Starters & Leavers (not inc Employee Transfers)	Apr-15		May-15		Jun-15		Jul-15		Aug-15		Sep-15		Oct-15		Nov-15		Dec-15	
STAFF GROUP	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr
Add Prof Scientific and Technic	1.00	1.80	0.00	1.00	0.64	2.80	0.73	1.20	0.00	1.40	3.60	1.00	0.00	2.00	0.20	1.00	3.00	0.00
Additional Clinical Services	15.51	8.02	9.82	12.33	16.28	7.24	17.75	9.77	11.01	18.02	19.67	9.30	5.01	8.43	19.50	9.02	17.67	8.17
Administrative and Clerical	8.13	11.80	14.31	11.44	22.41	8.09	13.31	4.79	5.40	11.75	8.12	12.55	10.56	10.03	8.40	10.44	1.49	6.53
Allied Health Professionals	3.40	2.88	3.60	2.00	5.00	7.00	4.40	9.00	11.10	6.50	4.79	5.48	5.77	3.67	4.00	2.00	0.00	3.91
Estates and Ancillary	3.73	4.88	0.00	4.76	2.07	2.07	4.00	3.76	4.00	3.00	4.00	2.11	3.27	5.08	2.00	6.85	5.04	2.36
Healthcare Scientists	2.00	0.60	3.00	1.00	4.00	0.00	2.00	4.00	2.00	3.00	4.00	1.00	0.00	0.00	0.85	4.00	2.00	1.00
Medical and Dental	10.05	9.60	5.60	9.00	4.00	5.60	3.50	5.49	139.93	116.33	19.90	14.55	37.20	27.10	6.30	1.60	10.80	7.80
Nursing and Midwifery Registered	16.99	18.52	8.59	14.88	11.03	14.27	6.16	16.36	8.17	19.26	13.72	9.43	33.48	15.60	8.93	10.51	6.61	13.02
Students	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	2.00	4.50	0.00	0.00	0.00	0.00	0.00	0.00	1.00
Grand Total	**60.80**	**58.10**	**44.92**	**56.41**	**65.43**	**47.06**	**51.85**	**55.37**	**181.61**	**181.26**	**82.29**	**55.42**	**95.29**	**71.91**	**50.19**	**45.42**	**46.61**	**43.79**

WHAT MATTERS TO YOU MATTERS TO US ALL

TURNOVER & VACANCIES

Trust fte vacancies increased marginally by 0.55 ftes in December. This was, however, due to the aforementioned increase in budgeted establishment on the Escalation wards and the overall vacancy rate was down from 8.17% in November to 8.13% in December. The medical vacancy rate was 10.15%, for registered nursing & midwives it was 10.30% and for unqualified nurses it was 2.39%.

Registered nurse and midwife numbers increased by 15.95 ftes in December. The Trust is awaiting start dates for the Philippine nurses who have been recruited but anticipate the first cohort of twelve will start in March 2016. A second trip to the Philippines is planned in April 2016. Seven nurses have been recruited from Spain and further EU recruitment is planned including a trip to Romania in March 2016. Twenty five newly qualified nurses from the February 2016 cohort have been interviewed and twenty one have accepted posts. They will start in February 2016 so will be working as registered nurses by March 2016.

Two Microbiology Consultants and a Radiology Consultant have been appointed with a further fourteen consultant posts in the recruitment process. Specialty Doctors have been appointed on the Medical Assessment Unit and in Care of the Elderly and, in all, there are twenty nine medical posts progressing through the recruitment process. Overseas recruitment of medical staff has not been particularly effective and the Trust is reconsidering how to effectively use medical recruitment agencies.

Unqualified nurse vacancies continue to reduce. The Trust is considering reinstating generic recruitment of these staff as the most efficient method of recruitment and to enable it to plan induction training.

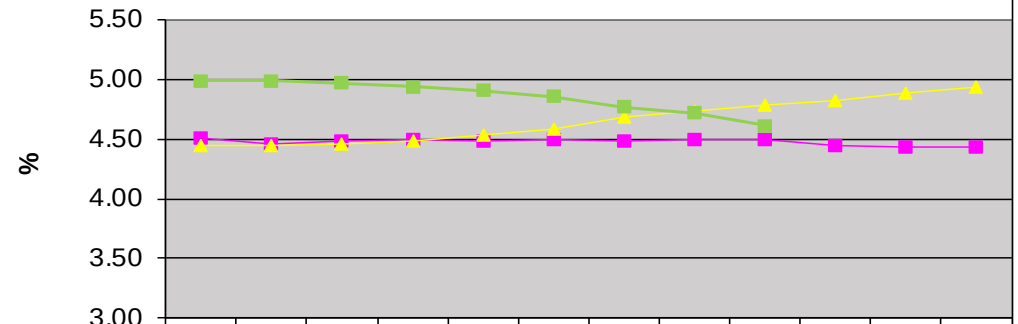
Recruitment are also working with Facilities management to better target and support their recruitment, as it is necessary to take a different approach with this group of staff.

Benchmarking of the recruitment process, after six months of the Trac system, demonstrates an average advertisement to start date agreed time of thirty seven working days for nurses & healthcare assistants (plus notice period). The reporting has highlighted the points in the process that are causing delays. Initially this was the authorisation part of the process but this is now very fast (average seven working days). Training and support can now be focussed on the other areas where delays are occurring.

East Sussex Healthcare NHS
NHS Trust

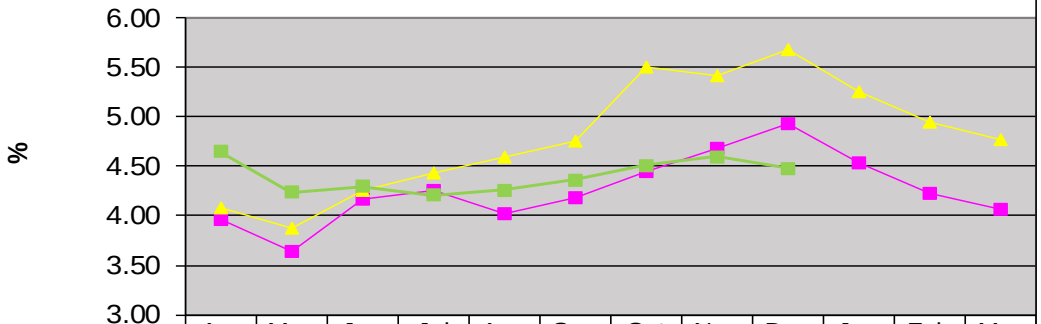
SICKNESS

Annual sickness rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14	4.51	4.46	4.48	4.50	4.49	4.50	4.49	4.50	4.50	4.44	4.43	4.43
2014/15	4.44	4.45	4.46	4.49	4.54	4.59	4.68	4.73	4.79	4.82	4.88	4.94
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77	4.72	4.61			

Monthly sickness rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14	3.97	3.64	4.17	4.26	4.02	4.19	4.45	4.69	4.94	4.54	4.23	4.07
2014/15	4.08	3.87	4.26	4.44	4.59	4.76	5.50	5.42	5.68	5.26	4.95	4.77
2015/16	4.65	4.24	4.30	4.21	4.26	4.36	4.51	4.6	4.48			

Monthly sickness has decreased by 0.12% this month and annual sickness by 0.11%. That is the seventh consecutive fall in the annual rate.

The reduction in the sickness rate can be attributed to the continued focus by Clinical Unit management and HR on the Support for you (S4U) project and the impact of the changes to the trigger points in the policy. There has also been a reduction in seasonal illnesses with absence due to cough, colds and flu 32% lower than in December 2014.

The focus will now be given to identifying sickness absence hot spots. Bi weekly meetings have been introduced within HR to review absence by each Clinical Unit and department. Monthly case management meetings have also been introduced with Occupational Health.

Evaluation of the impact of the new policy has started and a questionnaire will be sent out in January to obtain feedback from managers, employees and union representatives. This information will be shared at a review meeting in February.

Anxiety/stress/depression/other psychiatric illnesses remains the highest notified reason for sickness at 1721 fte days lost in the month. This is why it is proposed to roll out resilience training across the Trust, as discussed at the recent Board seminar.

WHAT MATTERS TO YOU MATTERS TO US ALL

East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISALS

Mandatory Training – Six Month Trend

Mandatory training course	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	6 month trend
Induction %	94.62	90.95	92.53	91.89	93.66	90.95	
Fire %	83.78	83.03	82.90	82.77	84.49	83.49	
Manual Handling %	85.44	84.21	85.24	85.02	85.81	85.76	
Infection Control %	85.78	84.58	85.82	85.81	86.83	86.53	
Info Gov %	82.57	82.38	82.25	83.41	87.40	86.42	
Health & Safety %	74.80	75.47	78.16	80.03	82.88	83.67	
Mental Capacity Act %	93.02	92.80	93.18	92.84	93.39	93.36	
Depriv of Liberties %	90.88	90.82	91.44	91.31	91.81	92.29	
Safeguard Vuln Adults	75.08	74.62	76.05	76.05	77.64	78.06	
Safeguard Child Level 2	80.13	79.19	80.59	80.40	81.42	80.75	

Clinical Unit Mandatory Training & Appraisals

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Appraisal compliance
Theatres & Clinical Support	81.97%	86.60%	88.89%	85.15%	86.31%	86.11%	93.00%	92.23%	76.89%	80.35%	79.39%
Cardiovascular Medicine	83.10%	84.14%	86.11%	80.34%	84.14%	73.45%	88.14%	88.79%	59.68%	57.71%	91.46%
Urgent Care	79.73%	83.56%	92.39%	80.31%	82.41%	77.06%	85.80%	87.12%	70.56%	71.40%	77.08%
Specialist Medicine	86.12%	88.52%	91.84%	85.41%	86.60%	82.30%	94.66%	90.13%	82.02%	80.00%	88.94%
Out of Hospital Care	85.16%	83.94%	92.65%	88.93%	84.89%	83.40%	97.36%	97.64%	84.77%	85.36%	79.31%
Surgery	85.73%	87.60%	89.29%	86.27%	94.13%	89.47%	95.43%	93.54%	82.16%	79.57%	87.57%
Womens & Childrens	86.84%	90.06%	95.16%	88.89%	85.09%	82.31%	93.95%	90.20%	77.28%	93.64%	80.31%
COO Operations	74.50%	85.84%	85.00%	79.60%	80.17%	64.02%	n/a	n/a	n/a	n/a	82.72%
Estates & Facilities	78.70%	72.93%	88.89%	90.09%	82.99%	89.79%	100.00%	100.00%	100.00%	100.00%	72.94%
Corporate	90.91%	96.25%	94.00%	94.07%	93.48%	91.70%	96.43%	98.59%	86.90%	86.46%	88.32%
TRUST	**83.49%**	**85.76%**	**90.95%**	**86.53%**	**86.42%**	**83.67%**	**93.36%**	**92.29%**	**78.06%**	**80.75%**	**81.85%**

(Green =85%+, Amber = 75-85% Red = <75%).

It is disappointing to see training compliance dip slightly in a number of subjects. Learning & Development (L&D) worked with the specialist trainers to ensure sufficient provision was in place from September to December but despite this, courses have not been fully booked and DNAs continue to be an issue. Some of the specialist trainers have also been targeting areas of low compliance to try to boost attendance and L&D have sent out the workbook options for Safeguarding and Information Governance monthly to Clinical Unit Leads.

There is concern that the potential for Black Status over the next couple of months will impact on compliance rates further but L&D/Specialist Trainers will review the latest training information and continue to target those areas in greatest need.

In the coming year, wards and departments who are struggling will be contacted to set up realistic advanced bookings for staff to maintain compliance, rather than just reacting to those about to go out of date.

WHAT MATTERS TO YOU MATTERS TO US ALL

East Sussex Healthcare NHS
NHS Trust

FINANCE REPORT – December 2015

David Meikle, Interim Director of Finance – January 2016

Financial Summary – December 2015

Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) finance risk assessment criteria are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria is red in month 9.	R
Financial Sustainability Risk Ratings	The Continuity of Services Risk Rating has been enhanced and is now referred to as the Financial Sustainability Risk Rating (FSRR). The FSRR builds on the previous ratings by retaining the Liquidity Ratio and Capital Servicing Capacity, but with additional risk ratings for I&E Margin and I&E Margin Variance from Plan (see page 13). The current rating for the Trust is red.	R
Financial Summary	The Trust performance in month 9 was a run rate deficit of £4.9m with an adverse variance against plan of £1.5m. Year to date the deficit stands at £36.5m which is £8.8m worse than plan.	R
Activity & Income	Total income received during December was £0.4m below planned levels increasing the year to date variance to £2.0m below plan. Tariff-Excluded Drugs and Devices (TEDDs) income under-performed by £0.3m in month, underperformance now stands at £1.8m YTD. There is however, a corresponding underspend of £1.8m on TEDDs expenditure so therefore, this has a zero effect on the bottom line.	A
Expenditure	Operating Pay costs are above plan by £1.1m in month and are cumulatively £7.6m above plan. This is mainly due to high agency spend covering escalation beds and clinical vacancies. Operating Non Pay costs are £0.8m above plan in month and are marginally above plan cumulatively. This is mainly due to the underspend on TEDDs (as detailed above). Total costs are now £7.2m overspent year to date.	R
CIP plans	The CIP achievement year to date was £6.6m which was below the plan of £8.0m.	A
Forecast Outturn	The forecast outturn reported to the TDA has now been revised to £48.7m deficit. This is £13.5m above the revised plan	R
Balance Sheet	DH loans have increased to £29.4m as a result of the continuing draw down of the working capital support. The full year RWCF agreed with the Trust Development Authority (TDA) is now £35.2m and discussion are on-going regarding this RWCF being converted into a working capital loan repayable over 5 years.	G
Cash Flow	An interim revolving working capital support facility agreement is currently in place and an application for re-financing has been submitted to the Independent Trust Financing Facility via the TDA. If approved, this will allow the repayment of the revolving working capital support to be replaced by an increased working capital loan repayable over 5 year to support the forecast deficit. At the end of month 9, the Trust has drawn down £29.4m of the current £35.2m facility.	A
Capital Programme	After 9 months capital expenditure has increased to £7.3m. The overall capital programme resource assumption has been revised to remove the interest bearing capital loan bid required to address the CQC quality improvement plan in the current financial year. This bid will now be included within a £16.5m interest bearing capital loan bid to the TDA as part of the 2016/17 capital planning process.	G

Income & Expenditure – December 2015

Headlines

• Total income in the month was £28.7m against a plan of £29.1m, an adverse variance of £0.4m and brings the YTD position to £2.0m below plan.

• Total costs in the month were £33.7m, this was £1.2m above plan. The YTD position is now £7.2m above plan.

• The £36.5m year to date deficit against plan was an adverse variance of £8.8m.

• Cost improvement plans of £11.4m have been developed for 2015/16 with a year to date achievement of £6.6m against a plan of £8.0m. The forecast delivery for the year is £9.2m.

• Operating pay costs in the month, including ad hoc costs, were £1.1m above plan and are now £7.6m above plan YTD.

• Operating Non Pay costs, including 3rd party costs, were £0.8m above plan in the month and are marginally above plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	22,181	22,732	551	212,230	214,959	2,729	287,872
Tariff-Excluded Drugs & Devices	2,704	2,452	-252	24,333	22,554	-1,779	31,453
Private Patient/ ICR	324	212	-112	2,913	2,137	-776	4,284
Trading Income	441	549	108	3,965	4,331	366	5,220
Other Non Clinical Income	3,431	2,747	-684	22,928	20,382	-2,546	27,180
Total Income	**29,081**	**28,692**	**-389**	**266,369**	**264,363**	**-2,006**	**356,009**
Pay Costs	-20,384	-21,418	-1,034	-184,960	-192,171	-7,211	-245,992
Ad hoc Costs	0	-58	-58	0	-374	-374	0
Non Pay Costs	-7,662	-8,649	-987	-69,382	-70,860	-1,478	-93,424
Tariff-Excluded Drugs & Devices	-2,704	-2,452	252	-24,333	-22,554	1,779	-31,453
3rd Party Costs	-3	-101	-98	-152	-697	-545	-42
Other	125	125	0	1,125	1,325	200	1,500
Total Operating Costs	**-30,628**	**-32,553**	**-1,925**	**-277,702**	**-285,331**	**-7,629**	**-369,411**
Surplus/- Deficit from Operations	**-1,547**	**-3,861**	**-2,314**	**-11,333**	**-20,968**	**-9,635**	**-13,402**
P/L on Asset Disposal	0	0	0	0	15	15	0
Depreciation	-1,090	-1,017	73	-9,806	-9,738	68	-13,075
Impairment	0	0	0	0	0	0	0
PDC Dividend	-647	-214	433	-5,822	-5,649	173	-7,763
Interest	-82	134	216	-733	-537	196	-978
Total Non Operating Costs	**-1,819**	**-1,097**	**722**	**-16,361**	**-15,909**	**452**	**-21,816**
Total Costs	**-32,447**	**-33,650**	**-1,203**	**-294,063**	**-301,240**	**-7,177**	**-391,227**
Net Surplus/-Deficit	**-3,366**	**-4,958**	**-1,592**	**-27,694**	**-36,877**	**-9,183**	**-35,218**
Donated Asset/Impairment Adjustment	0	60	60	0	337	337	0
Adjusted Net Surplus/-Deficit	**-3,366**	**-4,898**	**-1,532**	**-27,694**	**-36,540**	**-8,846**	**-35,218**

Cash Flow – December 2015

Headlines

- The cash balance at the end of the last financial year was £1.0m and the Trust is planning for a £2.1m cash balance at year-end as required by the Department of Health.
- Discussion are on-going with the TDA to replace the existing interim revolving working capital support facility (RWCF) with an increased working capital loan of £43.6m. The current RWCF is being accessed on a monthly basis and at the end of December £29.4m of the RWCF had been drawn down.
- The Trust has also withdrawn its request for an additional £7m of capital funding in respect of the CQC Quality Improvement Plan requirements in 15/16. This is now part of a revised ITFF application to the TDA for capital funding of £16.5m in 2016/17.

Cash Flow Statement April 2015 to March 2016

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2016	Feb	Mar
Cash Flow from Operations												
Operating Surplus/(Deficit)	-2,181	-2,346	-3,580	-1,092	-3,148	-3,715	-4,789	-4,977	-4,878	-3,552	-3,492	-3,209
Depreciation and Amortisation	1,095	1,095	1,108	1,108	1,109	1,093	1,093	1,019	1,017	1,028	1,028	1,270
Impairments												
Interest Paid	-81	-81	-81	-31	-89	-92	-113	-121	131	-84	-83	-63
Dividend (Paid)/Refunded	0					-4,247						-3,369
(Increase)/Decrease in Inventories	136	168	-68	103	90	-89	-28	589	-1,103	0	0	-902
(Increase)/Decrease in Trade and Other Receivables	-637	-371	-6	-1,836	-2,340	1,254	1,531	2,750	5,277	100	100	100
Increase/(Decrease) in Trade and Other Payables	2,859	1,725	434	-53	3,628	652	6,848	306	-5,056	1,566	1,154	-7,008
Provisions Utilised	-59	-10	0	33	10	-138	-98	8	10	-111	0	-118
Net Cash Inflow/(Outflow) from Operating Activities	**1,132**	**180**	**-2,193**	**-1,768**	**-740**	**-5,282**	**4,444**	**-426**	**-4,602**	**-1,053**	**-1,293**	**-13,299**
Cash Flows from Investing Activities:												
Interest Received	3	3	2	2	3	2	2	2	3	2	2	2
(Payments) for Property, Plant and Equipment	-1,817	-2,232	-1,567	-1,453	-1,365	-1,250	-1,441	-1,163	-838	-800	-1,400	-1,584
(Payments) for Intangible Assets	-42	-32	-40	-17	-28	-30	-29	-29	-62	-29	-29	-23
Net Cash Inflow/(Outflow) from Investing Activities	**-1,856**	**-2,261**	**-1,605**	**-1,468**	**-1,390**	**-1,278**	**-1,468**	**-1,190**	**-897**	**-827**	**-1,427**	**-1,605**
Net Cash Inflow/(Outflow) before Financing	**-724**	**-2,081**	**-3,798**	**-3,236**	**-2,130**	**-6,560**	**2,976**	**-1,616**	**-5,499**	**-1,880**	**-2,720**	**-14,904**
New Temporary PDC	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Revenue Support Loan	0	0	0	0	0	0	0	0	0	0	0	-43,600
Revenue Support Loans	7,440	936	4,039	3,000	2,000	2,000	2,000	2,000	6,000	2,000	2,000	10,185
New Permanent PDC	0	0	0	0	0	0	0	0	0	0	0	43,600
New Capital Loan	0	0	441	0	0	0	0	0	0	0	0	0
Loans and Finance Lease repaid	-40	-16	-28	-28	-28	-241	-28	-28	-28	-13	-13	-286
Net Cash Inflow/(Outflow) from Financing Activities	**7,400**	**920**	**4,452**	**2,972**	**1,972**	**1,759**	**1,972**	**1,972**	**5,972**	**1,987**	**1,987**	**9,899**
Net Increase/(Decrease) in Cash	**6,676**	**-1,161**	**654**	**-264**	**-158**	**-4,801**	**4,948**	**356**	**473**	**107**	**-733**	**-5,005**
Opening balance	1,008	7,684	6,523	7,177	6,913	6,755	1,954	6,902	7,258	7,731	7,838	7,105
Closing balance	7,684	6,523	7,177	6,913	6,755	1,954	6,902	7,258	7,731	7,838	7,105	2,100

Balance Sheet – December 2015

Headlines

• The overall value of property, plant & equipment has reduced due to the transfer of the High Weald, Lewes & Havens (HWLH) properties to NHS Property Services on 1st November 2015. This will be partially offset at year end by the indexation of assets.

• The year to date increase in current & non current borrowings is in respect of the working capital support facility which the Trust has requested an increase to £43.6m from the previous £35.2m. The existing facility is is being accessed from the DoH on a monthly basis.

• The planned application for re-financing is reflected in the forecast total taxpayers' equity.

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast March 2016
Non Current Assets			
Property plant and equipment	271,373	239,844	251,437
Intangilble Assets	1,293	1,597	1,647
Trade and other Receivables	1,184	1,291	680
	273,850	**242,732**	**253,764**
Current Assets			
Inventories	6,599	6,800	6,511
Trade receivables	12,637	4,223	6,101
Other receivables	6,800	8,192	8,392
Other current assets	0	0	0
Cash and cash equivalents	1,008	7,730	2,100
	27,044	**26,945**	**23,104**
Current Liabilities			
Trade payables	-6,972	-12,575	-6,239
Other payables	-20,535	-20,734	-22,350
DH Capital Investment Loan	-383	-427	-1,297
DH Working Capital Loan	0	-5,883	-8,720
Other Financial Liabilities	-335	-335	-468
Provisions	-591	-318	-568
	-28,816	**-40,272**	**-39,642**
Non Current Liabilities			
DH Capital Investment Loan	-3,583	-3,767	-2,683
Borrowings - Revenue Support Facility	0	0	0
DH Working Capital Loan	0	-23,532	-34,880
Other Financial Liabilities	-263	-11	0
Provisions	-2,588	-2,615	-2,778
	-6,434	**-29,925**	**-40,341**
Total Assets Employed	**265,644**	**199,480**	**196,885**
Financed by:			
Public Dividend Capital (PDC)	-153,530	-153,530	-153,530
Revaluation Reserve	-119,711	-109,697	-117,674
Retained Earnings Reserve	7,597	63,747	74,319
Total Taxpayers' Equity	**-265,644**	**-199,480**	**-196,885**

Receivables, Payables & Better Payments Practice Code Performance – December 2015

Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target achievement of BPPC is 95%.
- By value, year to date 83% of trade invoices has been achieved and 88% of NHS invoices.
- The Aged Debt (over 90 days) KPI is measured as a percentage of the total level of debt. The target is for this to be no more than 5%.
- The current Aged Debt KPI has reduced from 37% at 30th June to 13.8% at 31st December 2015.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	1,057	981	2,124	4,496
31 - 60 Days	410	547	892	7,154
61 -90 Days	204	228	615	219
91 - 120 Days	151	124	110	277
> 120 Days	770	800	482	670
Total	2,592	2,680	4,223	12,816

Trade Payables Aged Analysis - Purchase Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	3,827	6,099	4,508	6,612
31 - 60 Days	4,116	8,105	4,326	9,094
61 -90 Days	852	2,064	2,256	2,579
91 - 120 Days	205	328	793	279
> 120 Days	724	687	692	664
Total	9,724	17,283	12,575	19,228

Better Payments Practice Code	Month Number of Invoices	Month By Value	YTD Number of Invoices	YTD By Value
Trade invoices paid within contract or 30 days of receipt	61.37%	68.71%	80.30%	82.63%
NHS invoices paid within contract or 30 days of receipt	36.94%	70.49%	72.95%	88.29%

Key Performance Indicators – December 2015

TDA Finance Risk Assessment Criteria

• The TDA has set out its reporting requirements in the latest accountability framework.

• The finance metrics have been revised by the TDA to ensure that they focus on in year delivery against plan and the individual indicators are set out in the adjacent table.

• Although the majority of risk criteria are green, the Bottom-line I&E assessment (1a) has an overriding effect on the overall Trust rating. As the Trust has set a deficit plan this rating is red and under the revised TDA criteria, the overall Trust rating is red.

Monitor Financial Sustainability Risk Ratings

• The Trust has a liquidity ratio rating of 2, a capital servicing capacity ratio of 1, an I&E margin of 1 and a variance in I&E margin of 1. This results in an overall rating of 1.

Better Payments Practice Code (BPPC)

• Year to date performance is below the BPPC target for both Trade invoices and NHS invoices paid by value due to the difficult cash position which is being managed by the Trust.

TDA Finance Risk Assessment Criteria	Current Month	Plan
1a) Bottom line I&E – Forecast compared to plan.		
1b) Bottom line I&E position – Year to date actual compared to plan.		
2a) Actual efficiency recurring/non recurring compared to plan – Year to date actual compared to plan.		
2b) Actual efficiency recurring/non recurring compared to plan – forecast compared to plan.		
3) Forecast underlying surplus/deficit compared to plan.		
4) Forecast year end charge to capital resource limit.		
5) Is the Trust forecasting permanent PDC for liquidity purposes?		
6) Forecast achievement of stretch financial performance target		
Overall Trust TDA RAG Rating		

Monitor Financial Sustainability Risk Ratings	YTD Actual	YTD Plan
Liquidity Ratio Rating	2	1
Capital Servicing Capacity Rating	1	1
I&E margin rating	1	1
Variance in I&E margin rating	1	4
Overall Monitor Risk Rating	1	2

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	83	95
BPPC – NHS Invoices by value (%)	88	95

Activity & Contract Income – December 2015

Headlines

- Re-admission fines have been accrued based on planning assumptions in line with the 'cap & collar' contract.
- CQUIN performance is based on ESHT achieving more than 75% which provides 100% of agreed targets.
- A provision has been made against MSK contract performance but this is within the planned provision

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,278	3,478	200	30,590	33,458	2,868
Elective Inpatients	797	557	-240	7,436	6,057	-1,379
Emergency Inpatients	3,689	3,493	-196	32,724	31,857	-867
Total Inpatients	**7,764**	**7,528**	**-236**	**70,750**	**71,372**	**622**
Excess Bed Days	2,212	1,407	-805	19,630	17,176	-2,454
Total Excess Bed Days	**2,212**	**1,407**	**-805**	**19,630**	**17,176**	**-2,454**
Consultant First Attendances	6,893	7,755	862	68,904	70,954	2,050
Consultant Follow Ups	10,301	12,530	2,229	105,287	111,746	6,459
OP Procedures	4,001	4,005	4	39,868	39,867	-1
Other Outpatients inc WA & Nurse Led	11,702	11,427	-275	112,409	109,581	-2,828
Community Specialist	229	220	-9	1,945	1,534	-411
Total Outpatients	**33,126**	**35,937**	**2,811**	**328,413**	**333,682**	**5,269**
Chemotherapy Unbundled HRGs	498	828	330	4,999	5,690	691
Antenatal Pathways	273	296	23	2,809	2,734	-75
Post-natal Pathways	286	299	13	2,634	2,600	-34
A&E Attendances (excluding type 2's)	8,270	8,829	559	69,394	81,018	11,624
ITU Bed Days	551	529	-22	4,297	4,442	145
SCBU Bed Days	289	40	-249	2,349	2,599	250
Cardiology - Direct Access	45	84	39	454	593	139
Radiology - Direct Access	3,810	4,487	677	40,820	45,109	4,289
Pathology - Direct Access	229,383	254,135	24,752	2,448,665	2,453,779	5,114
Therapies - Direct Access	1,359	2,424	1,065	14,747	24,712	9,965
Audiology	524	919	395	6,876	9,051	2,175
Midwifery	7	16	9	101	113	12

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	3,985	3,409	-576	40,655	35,835	-3,832
Inpatients - Emergency	6,317	6,030	-287	56,032	53,201	-2,231
Excess Bed Days	484	308	-176	4,296	3,752	-380
Outpatients	3,487	3,809	322	34,446	35,539	730
Other Acute based Activity	2,113	2,536	423	21,035	23,398	1,222
Direct Access	590	713	123	6,308	6,829	304
Block Contract / Other	4,664	5,561	897	44,477	52,216	7,739
Re-admissions	0	-177	-177	0	-792	-792
CQUIN	542	543	1	4,981	4,981	1
Subtotal	22,182	22,732	550	212,230	214,959	2,761
Exclusions	2,703	2,452	-251	24,333	22,554	-1,779
GRAND TOTAL	**24,885**	**25,184**	**299**	**236,563**	**237,513**	**982**

Clinical Unit, Commercial & Corporate Performance (budgets) – December 2015

Headlines

Trust wide

Total Pay reported £1.1m overspend against the TDA plan in the month. £18.3m has been spent on agency in the first nine months of the year compared to £7.7m for the same period last year. Cumulatively pay was £7.6m overspent.

Clinical Units (CUs)

The overall clinical unit performance was £2.1m overspend in December against plan and £12.9m cumulatively.

The adverse position is mainly due to continued agency usage covering medical and nursing vacancies, and escalation beds (£0.3m per month). A shortfall on CIP savings also contributed to the adverse variance.

Non contract Income reported £0.8m under plan. £1.2m due to loss of HWLH services offset by £0.5m EDM income received .

Tariff-excluded drugs and devices reported £0.3m underspend in the month against plan, which was offset by Contract Income so overall has a neutral impact.

Estates and Facilities Directorate

December reported a £0.1m overspend in month due to slippage on CIP and continued agency usage in portering, housekeeping and laundry.

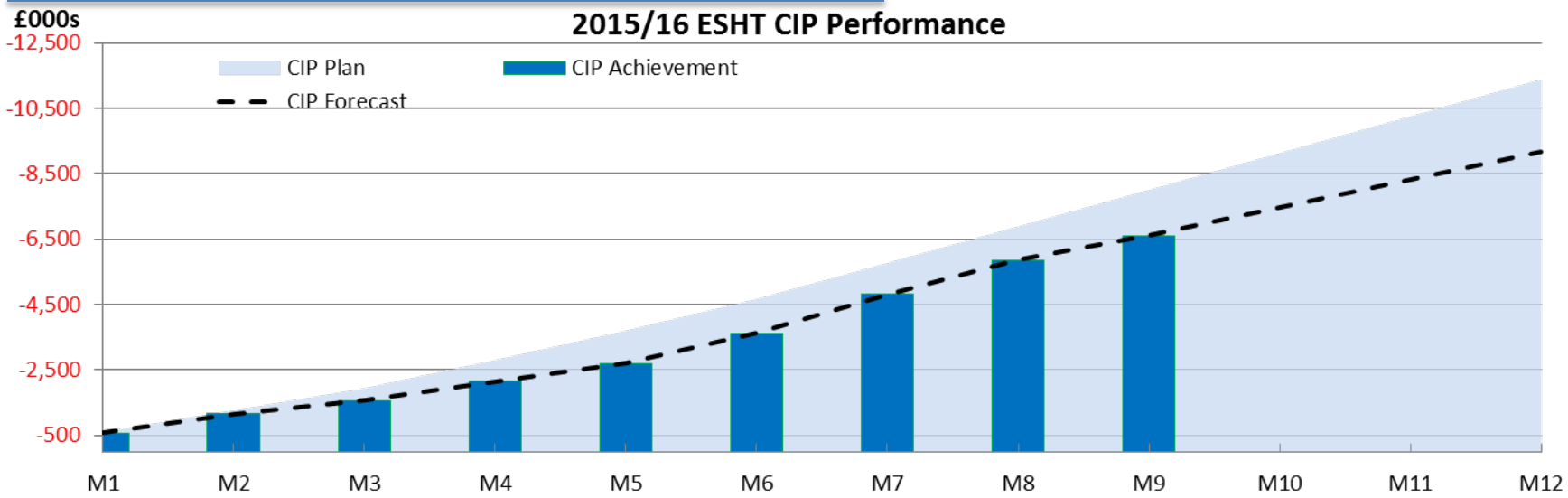
Corporate Services

Corporate Services was £0.3m off plan in month 9 due to EDM order (offset by income).

Income & Expenditure Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Urgent Care	-2,136	-2,785	-649	-18,579	-22,053	-3,474
Specialist Medicine	-1,613	-1,805	-192	-14,864	-16,044	-1,180
Cardiovascular	-1,169	-1,493	-324	-9,939	-12,123	-2,184
Surgery	-3,204	-3,729	-525	-29,672	-31,599	-1,927
Women & Children	-2,410	-2,487	-77	-21,932	-22,398	-466
Out of Hospital Care	-2,110	-2,221	-111	-23,961	-24,859	-898
Clinical Support	-6,151	-6,505	-354	-56,465	-60,266	-3,801
Tariff-Excluded Drugs & Devices	-2,704	-2,452	252	-24,333	-22,554	1,779
COO Operations	-957	-1,085	-128	-8,603	-9,366	-763
Total Clinical Units	**-22,454**	**-24,562**	**-2,108**	**-208,348**	**-221,262**	**-12,914**
Estates & Facilities	-2,152	-2,222	-70	-19,203	-19,478	-275
Corporate Services	-2,237	-2,569	-332	-20,283	-21,075	-792
Central Items	-2,399	-931	1,468	-21,363	-14,100	7,263
Total Central Areas	**-6,788**	**-5,722**	**1,066**	**-60,849**	**-54,653**	**6,196**
Contract Income	24,885	25,184	299	236,563	237,513	950
Income	991	142	-849	4,940	1,525	-3,415
Donated Asset/Impairment Adjustment	0	60	60	0	337	337
Adjusted Net Surplus/- Deficit	**-3,366**	**-4,898**	**-1,532**	**-27,694**	**-36,540**	**-8,846**

Workforce Plan FTE	Workforce Actual FTE	Pay Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
554	662	Urgent Care	-2,034	-2,662	-628	-17,679	-20,982	-3,303
432	425	Specialist Medicine	-1,512	-1,581	-69	-13,824	-14,393	-569
300	322	Cardiovascular	-1,103	-1,329	-226	-9,289	-11,145	-1,856
726	824	Surgery	-2,827	-3,338	-511	-26,044	-27,939	-1,895
588	601	Women & Children	-2,244	-2,354	-110	-20,395	-21,049	-654
721	680	Out of Hospital Care	-1,918	-2,014	-96	-21,405	-21,940	-535
1,086	1,053	Clinical Support	-3,998	-4,113	-115	-36,820	-38,279	-1,459
374	403	COO Operations	-892	-946	-54	-8,059	-8,492	-433
4,781	**4,969**	**Total Clinical Units**	**-16,528**	**-18,337**	**-1,809**	**-153,515**	**-164,219**	**-10,704**
688	700	Estates & Facilities	-1,378	-1,384	-6	-12,539	-12,748	-209
590	558	Corporate Services	-1,712	-1,781	-69	-15,140	-15,548	-408
1,278	**1,258**	**Total Non-Clinical Divisions**	**-3,090**	**-3,165**	**-75**	**-27,679**	**-28,296**	**-617**
0	**0**	Central Items	-766	26	792	-3,766	-30	3,736
6,059	**6,227**	**Total Pay Analysis**	**-20,384**	**-21,476**	**-1,092**	**-184,960**	**-192,545**	**-7,585**

2015/16 ESHT CIP Performance to date – Month 9

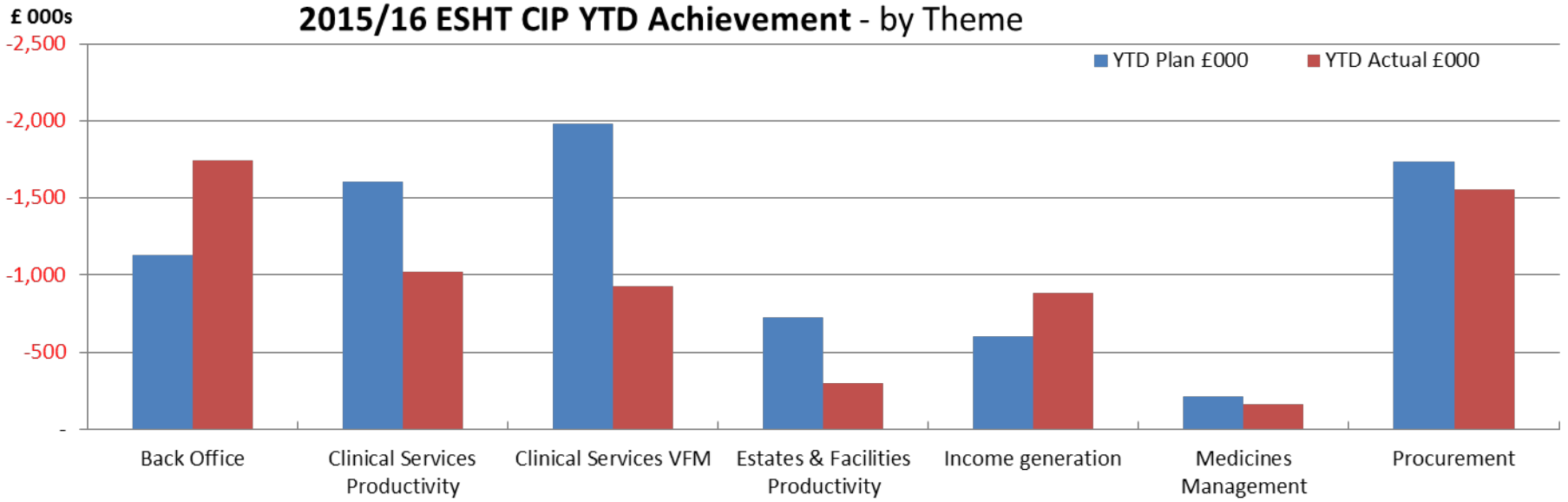


	In Month			Year to Date			Forecast		
Clinical Unit	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast mth 9 £000	Variance FOT £000
Cardiovascular Medicine	-83	-55	-27	-611	-695	84	-859	-874	15
Estates and Facilities	-172	-135	-37	-1,070	-706	-364	-1,585	-1,096	-489
Corporate	-210	-130	-81	-1,650	-1,692	42	-2,281	-2,272	-8
Specialist Medicine	-35	-22	-12	-299	-226	-72	-403	-263	-140
Surgery	-140	-98	-43	-1,083	-539	-544	-1,504	-709	-795
Trustwide	-3	-	-3	205	-	205	161	-270	431
Urgent Care	-35	-13	-21	-215	-138	-77	-320	-180	-140
Womens Health & Childrens Services	-62	-110	48	-475	-632	157	-660	-688	28
Contract Income	-42	-42	-	-375	-375	-	-500	-500	-
Out of Hospital Care	-53	-5	-48	-475	-122	-353	-633	-140	-493
Clinical Support	-282	-143	-140	-1,942	-1,475	-467	-2,790	-2,169	-621
Total	**-1,116**	**-752**	**-364**	**-7,990**	**-6,601**	**-1,389**	**-11,375**	**-9,161**	**-2,214**

East Sussex Healthcare NHS
NHS Trust

2015/16 ESHT CIP Performance by Theme – Month 9

TDA Theme	In Month			Year to Date			Forecast		
	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast £000	Variance FOT £000
Back Office	-139	-138	-1	-1,130	-1,742	612	-1,547	-2,324	777
Clinical Services Productivity	-235	-150	-85	-1,609	-1,023	-586	-2,319	-1,300	-1,019
Clinical Services VFM	-274	-172	-102	-1,983	-926	-1,057	-2,805	-1,098	-1,707
Estates & Facilities Productivity	-127	-27	-100	-722	-302	-420	-1,105	-350	-755
Income generation	-67	-91	24	-599	-885	286	-800	-1,431	631
Medicines Management	-28	-15	-13	-209	-164	-45	-293	-247	-46
Procurement	-246	-159	-87	-1,738	-1,558	-180	-2,506	-2,412	-94
Total	**-1,116**	**-752**	**-364**	**-7,990**	**-6,601**	**-1,389**	**-11,375**	**-9,161**	**-2,214**



East Sussex Healthcare NHS
NHS Trust

Year on Year Comparisons – December 2015

Headlines

- Total Inpatient activity to date is 0.2% higher than last year's level.
- Total outpatients are 1.6% higher than last year although outpatient procedures are 1.4% down
- Total A&E attendances are 1.7% higher than last year.
- Total income is £23.5m (8.2%) down on the same period last year, this includes £13.5m (4.7%) of the £18.0m commissioner support in 2014/15 that is not available in the current year.
- Total expenditure is £11.2m (3.9%) up on the same period last year.

Activity	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	33,458	31,801	1,657	5.2%
Elective Inpatients	6,057	6880	-823	-12.0%
Emergency Inpatients	31,857	32,572	-715	-2.2%
Total Inpatients	**71,372**	**71,253**	**119**	**0.2%**
Elective Excess Bed Days	1,352	1,605	-253	-15.8%
Non elective Excess Bed Days	15,824	16,564	-740	-4.5%
Total Excess Bed Days	**17,176**	**18,169**	**-993**	**-5.5%**
Consultant First Attendances	70,954	69,568	1,386	2.0%
Consultant Follow Ups	111,746	107,103	4,643	4.3%
OP Procedures	39,867	40,428	-561	-1.4%
Other Outpatients (WA & Nurse Led)	109,581	109,508	73	0.1%
Community Specialist	1,534	1,674	-140	-8.4%
Total Outpatients	**333,682**	**328,281**	**5,401**	**1.6%**
Chemotherapy Unbundled HRGs	5,690	5,064	626	12.4%
Antenatal Pathways	2,734	2,651	83	3.1%
Post-natal Pathways	2,600	2,443	157	6.4%
A&E Attendances (excluding type 2's)	81,018	79,687	1,331	1.7%
ITU Bed Days	4,442	4,419	23	0.5%
SCBU Bed Days	2,599	2,398	201	8.4%
Cardiology - Direct Access	593	558	35	6.3%
Radiology - Direct Access	45,109	42,036	3,073	7.3%
Pathology - Direct Access	2,453,779	2,429,854	23,925	1.0%
Therapies - Direct Access	24,712	28,755	-4,043	-14.1%
Audiology	9,051	13,427	-4,376	-32.6%
Midwifery	113	93	20	21.5%

£000s	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	237,513	260,450	-22,937	-8.8%
Private Patient/ RTA	2,137	2,554	-417	-16.3%
Trading Income	4,331	3,922	409	10.4%
Other Non Clinical Income	20,382	20,948	-566	-2.7%
Total Income	**264,363**	**287,874**	**-23,511**	**-8.2%**
Pay Costs	-192,545	-183,783	-8,762	-4.8%
Non Pay Costs	-94,111	-92,557	-1,554	-1.7%
Other	1,325	1,650	-325	19.7%
Total Direct Costs	-285,331	-274,690	-10,641	-3.9%
Surplus/-Deficit from Operations	**-20,968**	**13,184**	**-34,152**	**259.0%**
Profit/Loss on Asset Disposal	15	23	-8	
Depreciation	-9,738	-9,286	-452	-4.9%
Impairment	0	0	0	
PDC Dividend	-5,649	-5,962	313	5.2%
Interest	-537	-120	-417	-347.5%
Total Indirect Costs	-15,909	-15,345	-564	-3.7%
Total Costs	**-301,240**	**-290,035**	**-11,205**	**-3.9%**
Net Surplus/-Deficit	**-36,877**	**-2,161**	**-34,716**	**-1606.5%**
Donated Asset / Other Adjustment	337	377	-40	10.6%
Normalised Net Surplus/-Deficit	**-36,540**	**-1,784**	**-34,756**	**-1948.2%**

Capital Programme – December 2015

Headlines

Year to Date Performance:-
The overall capital programme resource assumption has been revised to reflect the assumption that the proposed £7m interest bearing capital loan to support the CQC quality improvement plan is now unlikely to be approved in the current financial year. This has now been removed from the 2015/16 resource assumptions. The bid will now be included within a £16.5m interest bearing capital loan bid to the TDA as part of the 2016/17 capital planning process.

After nine months of the financial year, capital expenditure has increased to £7.3m. Significant year to date expenditure is in respect of the Pevensey Ward redevelopment, medical equipment purchase and minor capital schemes.

Commitments entered into now amount to £10.2m compared to the total capital resource of £11.8m. The current over planning margin has increased to £1,470k which is considered manageable, in light of the current level of commitments and forecast slippage anticipated within the capital programme.

The Capital Approvals Group (CAG) continues to monitor the capital programme, paying particular attention to the ongoing risks associated with limited capital resource.

Capital Investment Programme £000s	2015/16 Capital Programme	Expenditure at Month 9
Capital Resources		
Depreciation	11,820	
CQC Exceptional Capital Additional Bid - Not progres	0	
Additional Capital Loan - Health Records Storage	441	
League of Friends Support	1,121	
Cap Investment Loan Principal Repayment	-427	
Gross Capital Resource	12,955	
Less Donated Income	-1,121	
Capital Resource Limit (CRL)	**11,834**	-
Capital Investment		
CQC Quality Improvement Plan Proposals	0	0
Medical Equipment	1,939	1,227
IT Systems	1,028	553
Electronic Document Management	835	292
Child Health Information System	673	193
PAS Upgrade	373	140
Backlog Maintenance	1,546	192
Infrastructure Improvements - Modernisation of Inpatient Environment and Facilities	700	390
Pevensey Ward	2,055	1,801
Minor Capital Schemes	1,500	1,325
Health Records	881	441
Other various	1,774	708
Sub Total	**13,304**	**7,262**
Donated Asset Purchases	1,121	538
Donated Asset Funding	-1,121	-538
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**13,304**	**7,262**
Overplanning Margin (-) Underplanning (+)	-1,470	0
Net Capital Charge against the CRL	**11,834**	**7,262**

Financial Sustainability Risk Ratings – December 2015

Headlines

Financial Sustainability Risk Ratings (FSRR):-

- Liquidity Ratio (days)
  - Days of operating costs held in cash or cash equivalent forms.
- Capital Service Capacity Ratio (times)
  - The degree to which the organisation's generated income covers its financial obligations.
- Income and expenditure (I&E) Margin
  - The degree to which the organisation is operating at a surplus/deficit.
- Variance in I&E Margin
  - The variance between an organisation's planned I&E margin and its actual I&E margin within the year.

- Monitor assigns ratings between 1 and 4 to each component of the FSRR with 1 being the worst rating and 4 the best. The overall rating is the average of the four.
- The Trust has a liquidity ratio of -13 days, a rating of 2.
- The capital servicing ratio of -3.22 results in a rating of 1.
- The I&E margin of -14.0% results in a rating of 1.
- The variance in I&E margin is -3.5%, a rating of 1.
- As a result the overall Trust rating is 1.

Liquidity Ratio (days) £000s	2014/15 Outturn	2015/16 YTD
Opening Current Assets	27,044	26,945
Opening Current Liabilities	-28,815	-34,389
Net Current Assets/Liabilities	-1,771	-7,444
Inventories	-6,599	-6,800
Adj Net Current Assets/Liabilities	**-8,370**	**-14,244**
Divided by:		
Total costs in year	364,471	285,331
Multiply by (days)	360	270
Liquidity Ratio	**-8**	**-13**

Capital Servicing Capacity (times) £000s	2014/15 Outturn Actual	2015/16 YTD Plan	2015/16 YTD Actual
Net Surplus / Deficit (-) After Tax	473	-27,694	-36,877
Less:			
Donated Asset Income Adjustment	-1,107	-941	-538
Interest Expense	235	752	558
Profit/Loss on Sale of Assets	-29	0	-15
Depreciation & Amortisation	12,265	9,806	9,738
Impairments	-629	0	0
PDC Dividend	8,073	5,822	5,649
Revenue Available for Debt Service	**19,281**	**-12,255**	**-21,485**
Interest Expense	235	752	558
PDC Dividend	8,073	5,822	5,649
Temporary PDC repayment			
Working capital loan repayment	18,171	213	213
Capital loan repayment	320	280	252
	26,799	7,067	6,672
Capital Serving Capacity	**0.72**	**-1.73**	**-3.22**

Financial Efficiency £000s	2014/15 Outturn Actual	2015/16 YTD Plan	2015/16 YTD Actual	2015/16 YTD Variance
Normalised Net surplus/ deficit	88	-27,694	-36,877	
Less fixed asset impairments/disposals	-29	0	-15	
	59	-27,694	-36,892	
Divided by:				
Total Income (excl donated assets)	383,768	-265,428	-263,825	
I&E Margin	**0.0%**	**-10.4%**	**-14.0%**	**-3.5%**

Financial Risks & Mitigating Actions – December 2015

Summary	
RISKS:-	
The following areas of risk have been identified in achieving the projected year end £35.2m deficit.	
1) Application of fines and penalties above planned levels.	
2) Shortfall of activity and income on the MSK contract.	
3) The value of activity falls below the risk share threshold in the main contract and is paid at the marginal rate.	
4) Stranded costs implications of competitive tendering, notably HWLH community services.	
5) Continuation of activity and capacity cost pressures, e.g. Escalation Wards, Radiology capacity	
6) Unplanned operational cost pressures, e.g. continued high use of agency staff.	
7) Non delivery of CIPs.	
8) Revenue cost implications of re-financing.	
9) Non delivery of the additional in-year saving.	
MITIGATING ACTIONS:-	
The following mitigations have been identified to offset the risks identified above.	
1) Additional CCG funding (Healthy Hastings, Winter, QIP).	
2) Additional funding to offset HWLH stranded costs.	
3) Reduction in expenditure through discretionary spend controls and additional cost improvement schemes.	
4) Tighter controls on authorisation of Agency expenditure.	

East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board
Agenda item:	11 E
Subject:	Safe Nurse & Midwifery Staffing Levels, September 15 – November 15
Reporting Officer:	Alice Webster, Director of Nursing

Action: This paper is for **(please tick)**					
Assurance	x	**Approval**		**Decision**	

Purpose:

- To provide a report on nurse staffing levels on acute inpatient and community hospital wards.
- To provide information to support the consideration of the nursing, midwifery and care staff workforce capacity from ward to Board, alongside quality indicators.

Introduction:

This report has been prepared in response to the requirements of the National Quality Board (November 2013) and more recently published NICE guidance, "Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals" (July 2014).

Analysis of Key Issues and Discussion Points Raised by the Report:

- Appropriate Nurse staffing levels are critical to patient safety
- The Trust has systems in place to address and manage variations with support from senior nursing staff
- Quality metrics and contributory factors are fully explored within the N&M Quality Review Group

Benefits:

- Maintaining adequate nurse/midwife staffing levels and skill mix is a key factor in reducing harm and poorer outcomes.

Risks and Implications

- It is acknowledged that these figures are an average across the month but the breakdown of this information is available at http://www.esht.nhs.uk/nursing/staffing-levels/
- This report does not negate the challenges of recruiting and maintaining a workforce that is robust and sustainable, without resorting to agency support.

Assurance Provided:

The Trust has responded to the expectations of the NQB and NHS England and can demonstrate that all inpatient areas are assessed and monitored with regard to nurse staffing levels and related quality indicators.

Review by other Committees/Groups (please state name and date)**:**

Reviewed by Heads of Nursing/Ops Team

Proposals and/or Recommendations
The Trust Board is asked to note and consider the content of the attached report..

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None identified

For further information or for any enquiries relating to this report please contact:	
Name: Alice Webster, Director of Nursing Elizabeth Fellows, Assistant Director of Operations	**Contact details:** **01323 417400 ext 5855** **01323 417400 ext 4389**

East Sussex Healthcare NHS Trust

SAFE NURSE & MIDWIFERY STAFFING LEVELS

1. Introduction

1.1 This report has been prepared in response to the requirements of the National Quality Board (November 2013) and more recently published National Institute for Health and Care Excellence (NICE) guidance, "Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals" (July 2014).

The current mandated reporting requirements also include the following inpatient areas: Paediatrics, Midwifery and Community Hospitals. It does not include escalation areas that are required during periods of high activity i.e. winter pressures.

2. Background

2.1 Following the publication of the NQB guidance "How to ensure the right people, with the right skills, are in the right place at the right time" the Board is expected to receive regular updates on nursing workforce information, staffing capacity and capability.

2.2 In order to facilitate this, a dashboard has been developed from the Unify return and NICE guidance which allows the monitoring of nurse staffing levels against quality indicators that are proven to be directly related to staffing levels i.e. falls, acquired pressure ulcers and medication errors in relation to preparation and administration.

2.3 NICE also provides evidence that there is increased harm when there is less than 75% of the agreed Registered Nurse (RN) requirement on a shift.

3. Current Report – September 15 to November 15

3.1 The dashboards in Appendix 1, 2 & 3 have been prepared to reflect the above requirements for September, October and November 2015.

3.2 In November 2015 three community hospitals transferred to Sussex Community Trust and are no longer reported by the ESHT.

3.3 Throughout this period all areas maintained 75% or more of the required RN levels based on their planned establishment and professional judgment on the day.

3.4 Where the figure displayed is greater than 100% this is due to additional needs within the area, such as 1:1 supervision of vulnerable patients or to backfill lower ratio of Registered Nurse or Health Care Assistant workforce.

3.5 All these quality indicators are closely monitored within patient safety and quality forums.

4. Conclusion/Recommendation

The emphasis of this reporting process is not numbers but safe patient care. The data must be considered alongside operational variations and professional judgement of the relevant senior nurse in each clinical area who is supported by a nominated 'Head of Nursing' for the day.

Whilst the information in this paper demonstrates that average staffing levels have been maintained over the period of each month it does not fully incorporate or reflect differing daily demand. Nor does it consider other key workforce factors such as challenges in recruitment, maternity leave, absence rates and the impact of escalation areas.

This overview provides assurance that the systems and processes in place allow the Trust to monitor the provision of safe care in our inpatient wards, responding to changes in activity and demand. It does not however negate the challenges of recruiting and maintaining a workforce that is robust and sustainable.

Alice Webster
Director of Nursing

Elizabeth Fellows
Assistant Director of Operations

Appendix 1

Sep-15	CCU	Average fill day rate - registered nurses/midwives (%)	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	92.20%	119.90%	96.80%	97.00%		2	
CCU EDGH	Cardiovascular Clinical Unit	88.40%	-	88.70%	-		1	
James CCU	Cardiovascular Clinical Unit	97.00%	101.20%	94.30%	120.00%		7	1
Michelham	Cardiovascular Clinical Unit	80.40%	98.90%	98.30%	98.30%		2	
Stroke Unit EDGH	Cardiovascular Clinical Unit	88.20%	99.30%	95.00%	99.40%		5	3
	Cardiovascular Clinical Unit Total					0	17	4
Crowborough Intermediate Beds	Out of Hospital	93.00%	97.90%	92.80%	113.30%		2	
Uckfield Intermediate Care Beds	Out of Hospital	101.80%	97.00%	94.10%	107.00%	1	1	
Irvine Unit	Out of Hospital	82.70%	98.50%	88.30%	95.80%	3	11	
Lewes Intermediate care	Out of Hospital	101.90%	81.60%	93.90%	95.90%		4	1
Rye Intermediate Care Beds	Out of Hospital	95.10%	105.20%	100.00%	100.10%		1	
	Out of Hospital Total					4	19	1
Cuckmere	Specialist Medicine	115.90%	102.00%	98.50%	85.80%		2	1
Jevington	Specialist Medicine	104.70%	105.70%	93.20%	102.10%	3	1	1
Pevensey	Specialist Medicine	96.70%	100.00%	100.00%	93.30%	1		1
Wellington	Specialist Medicine	112.80%	99.00%	91.10%	105.00%		5	1
	Specialist Medicine Total					4	8	4
Benson Trauma	Surgery	83.40%	106.60%	98.30%	101.10%	5	6	1
Cookson Devas Elective	Surgery	95.80%	104.20%	85.00%	83.30%			
De Cham	Surgery	89.60%	102.20%	90.70%	106.70%	1	3	2
Egerton Trauma	Surgery	92.30%	90.00%	91.70%	91.70%	3	3	2
Gardner	Surgery	81.30%	115.10%	100.00%	101.30%		1	1
Hailsham 3 (Orthopaedic Elective)	Surgery	83.60%	87.90%	105.00%	93.90%			1
Hailsham 4	Surgery	86.10%	95.30%	101.30%	105.40%	1	4	2
RT SAU	Surgery	94.40%	105.00%	84.60%	109.80%	1	4	
Seaford 4 Urology	Surgery	93.90%	109.00%	102.30%	97.40%	2	2	1
	Surgery Total					13	23	10
Cookson Attenborough - Surgical short Stay	Theatres and Clinical Support	96.70%	103.30%	100.00%	100.00%			
ITU/HDU Conquest	Theatres and Clinical Support	92.00%	100.00%	83.60%	100.00%	1		1
ITU/HDU EDGH	Theatres and Clinical Support	95.90%	100.00%	91.90%	-			3
	Theatres and Clinical Support					1	0	4
AAU Conquest	Urgent Care	89.60%	104.80%	91.10%	102.20%			1
Baird MAU	Urgent Care	84.70%	108.30%	83.30%	106.70%	2	2	1
MacDonald	Urgent Care	80.20%	100.80%	92.00%	99.50%	2	3	
Newington	Urgent Care	85.70%	109.10%	81.10%	96.50%	1	6	
Seaford 1	Urgent Care	88.20%	83.80%	92.00%	95.80%			
Seaford 3/MSSU	Urgent Care	87.08%	123.19%	98.89%	178.16%		4	
	Urgent Care Total					5	15	2
Crowborough Birthing Unit	Women and Children	92.40%	88.80%	98.10%	93.50%			
EMU	Women and Children	84.90%	83.30%	85.10%	100.00%			
Frank Shaw	Women and Children	85.90%	114.30%	95.00%	95.70%		1	3
Kipling	Women and Children	97.40%	86.00%	87.10%	90.00%			
Mirrlees	Women and Children	83.60%	100.80%	97.80%	100.30%			1
SCBU	Women and Children	101.70%	100.00%	98.90%	100.90%			1
	Women and Children Total					0	1	5
	Grand Total					27	83	30

Appendix 2

Oct-15	CCU	Average fill day rate - registered nurses/midwives (%)	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	94.00%	104.50%	99.10%	130.10%	1	8	1
CCU EDGH	Cardiovascular Clinical Unit	93.00%	-	95.70%	100.00%		2	1
James CCU	Cardiovascular Clinical Unit	107.00%	91.30%	92.60%	106.50%		4	
Michelham	Cardiovascular Clinical Unit	87.00%	92.30%	95.20%	96.60%	1		
Stroke Unit EDGH	Cardiovascular Clinical Unit	96.90%	107.10%	101.10%	86.50%		3	5
	Cardiovascular Clinical Unit Total					2	17	7
Crowborough Intermediate Beds	Out of Hospital	89.60%	100.80%	100.60%	78.30%	1	5	1
Uckfield Intermediate Care Beds	Out of Hospital	101.90%	99.90%	100.50%	94.00%		1	
Irvine Unit	Out of Hospital	98.30%	105.10%	92.70%	103.20%		9	1
Lewes Intermediate care	Out of Hospital	98.00%	92.80%	96.10%	80.20%		8	1
Rye Intermediate Care Beds	Out of Hospital	107.50%	104.60%	106.50%	98.40%		4	
	Out of Hospital Total					1	27	3
Cuckmere	Specialist Medicine	90.70%	96.90%	100.00%	112.90%	2	3	
Jevington	Specialist Medicine	107.80%	83.10%	101.10%	84.70%	5	5	1
Pevensey	Specialist Medicine	101.90%	90.90%	100.00%	100.00%			
Wellington	Specialist Medicine	110.10%	81.70%	103.20%	84.90%	1	4	1
	Specialist Medicine Total					8	12	2
Benson Trauma	Surgery	88.70%	108.40%	100.00%	115.10%	2	4	1
Cookson Devas Elective	Surgery	95.00%	114.80%	86.80%	103.20%		4	
De Cham	Surgery	103.70%	101.40%	100.40%	109.70%	2	5	
Egerton Trauma	Surgery	82.40%	84.30%	90.30%	97.70%	3	2	1
Gardner	Surgery	93.10%	98.60%	82.60%	109.00%		1	1
Hailsham 3 (Orthopaedic Elective)	Surgery	96.20%	112.30%	93.50%	120.40%	1	2	1
Hailsham 4	Surgery	106.50%	97.30%	100.30%	97.10%	1	5	
RT SAU	Surgery	87.70%	107.20%	81.60%	91.60%		3	1
Seaford 4 Urology	Surgery	97.10%	99.10%	97.90%	92.60%		5	1
	Surgery Total					9	31	6
Cookson Attenborough - Surgical short Stay	Theatres and Clinical Support	100.00%	99.90%	100.10%	100.00%		1	
ITU/HDU Conquest	Theatres and Clinical Support	87.00%	100.00%	97.60%	100.00%			1
ITU/HDU EDGH	Theatres and Clinical Support	102.00%	85.50%	108.80%	-			1
	Theatres and Clinical Support Total					0	1	2
AAU Conquest	Urgent Care	106.90%	94.30%	97.80%	106.80%	1	4	
Baird MAU	Urgent Care	90.70%	101.60%	87.60%	115.70%	5	4	1
MacDonald	Urgent Care	98.10%	94.10%	104.80%	100.90%	5	3	
Newington	Urgent Care	114.50%	107.00%	83.90%	110.60%	2	5	1
Seaford 1	Urgent Care	97.10%	102.30%	90.90%	94.60%			
Seaford 2/MSSU	Urgent Care							
	Urgent Care Total					13	16	2
Crowborough Birthing Unit	Women and Children	97.50%	92.40%	101.80%	100.80%			
EMU	Women and Children	80.50%	84.30%	100.00%	87.10%			
Frank Shaw	Women and Children	102.30%	101.10%	95.40%	95.90%			
Kipling	Women and Children	116.80%	102.80%	85.30%	81.00%			1
Mirrlees	Women and Children	99.00%	98.00%	100.60%	97.30%			
SCBU	Women and Children	97.50%	106.40%	102.90%	83.90%			1
	Women and Children Total					0	0	2
	Grand Total					33	104	24

Appendix 3

Nov-15	CCU	Average fill day rate - registered nurses/midwives (%	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	98.60%	114.00%	100.40%	96.90%	3	2	4
CCU EDGH	Cardiovascular Clinical Unit	95.04%	100.00%	91.11%	100.00%	2	1	2
James CCU	Cardiovascular Clinical Unit	104.00%	93.30%	94.70%	100.00%	1	1	1
Michelham	Cardiovascular Clinical Unit	84.10%	90.40%	98.40%	95.40%		2	
Stroke Unit EDGH	Cardiovascular Clinical Unit	96.60%	101.20%	95.00%	96.70%	1	9	2
	Cardiovascular Clinical Unit Total					7	15	9
Irvine Unit	Out of Hospital	89.20%	114.80%	102.50%	108.00%	2	7	2
Rye Intermediate Care Beds	Out of Hospital	110.50%	103.50%	113.30%	93.30%		5	
	Out of Hospital Total					2	12	2
Cuckmere	Specialist Medicine	119.00%	91.10%	100.00%	102.60%	2	2	1
Jevington	Specialist Medicine	99.60%	105.00%	103.30%	92.90%		4	1
Pevensey	Specialist Medicine	100.20%	100.00%	100.00%	96.70%			
Wellington	Specialist Medicine	110.20%	81.50%	87.80%	123.30%		2	1
	Specialist Medicine Total					2	8	3
Benson Trauma	Surgery	94.70%	106.40%	98.30%	116.70%		8	1
Cookson Devas Elective	Surgery	92.10%	84.60%	86.70%	112.80%		3	2
De Cham	Surgery	88.30%	106.70%	90.00%	97.80%		4	
Egerton Trauma	Surgery	91.30%	96.70%	85.40%	138.40%		3	2
Gardner	Surgery	87.60%	90.00%	81.10%	136.70%		3	
Hailsham 3 (Orthopaedic Elective)	Surgery	96.70%	106.00%	95.10%	89.70%		1	1
Hailsham 4	Surgery	85.00%	85.10%	110.50%	81.10%	2	3	1
RT SAU	Surgery	85.50%	97.90%	90.30%	108.90%	1	1	1
Seaford 4 Urology	Surgery	99.10%	96.60%	109.80%	89.20%	1	3	1
	Surgery Total					4	29	9
Cookson Attenborough - Surgical short Stay	Theatres and Clinical Support	98.10%	100.60%	93.30%	104.80%		2	2
ITU/HDU Conquest	Theatres and Clinical Support	88.20%	100.00%	92.80%	90.00%		3	2
ITU/HDU EDGH	Theatres and Clinical Support	94.40%	90.60%	80.00%	100.00%			1
	Theatres and Clinical Support Total					0	5	5
AAU Conquest	Urgent Care	93.30%	100.40%	114.40%	105.00%		6	
Baird MAU	Urgent Care	88.60%	105.80%	101.10%	123.30%	2	2	1
MacDonald	Urgent Care	101.50%	106.80%	84.40%	108.00%		4	
Newington	Urgent Care	85.60%	112.50%	95.00%	91.30%	1	3	
Seaford 1	Urgent Care	90.40%	86.90%	92.00%	94.70%			
Seaford 2/MSSU	Urgent Care							
	Urgent Care Total					3	15	1
Crowborough Birthing Unit	Women and Children	95.90%	82.20%	93.90%	100.90%			
EMU	Women and Children	92.20%	83.60%	100.00%	86.70%			
Frank Shaw	Women and Children	104.00%	105.80%	92.30%	91.10%			2
Kipling	Women and Children	101.70%	97.30%	86.80%	90.80%			1
Mirrlees	Women and Children	98.10%	103.40%	101.00%	80.40%	1		1
SCBU	Women and Children	91.30%	100.00%	92.80%	86.70%			
	Women and Children Total					1	0	4
	Grand Total					19	84	33

East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board
Agenda item:	
Subject:	Nurse Staffing Levels
Reporting Officer:	Alice Webster, Director of Nursing

Action: This paper is for **(please tick)**					
Assurance		**Approval**	✓	**Decision**	

Purpose:

The purpose of this report is to Identify how the review has taken place noting the methodology for reviewing and setting safe staffing levels all of which have influenced the recommendations in this paper.

Introduction:

The report is presented to give an update on the process of how the trust has implemented the recommendations of the publication "How to ensure the right people, with the right skills are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability" by the National Quality Board.
The aims of the review were to:

- Review the productivity and skill mix of the existing workforce
- Propose and agree a workforce plan / establishment by ward and unit if required

Analysis of Key Issues and Discussion Points Raised by the Report:

Determining nursing, midwifery and care staffing requirements is a complex process, requiring input from all levels within the nursing and midwifery staffing structure. Using an evidence-based tool is a critical part of making staffing decisions, and will ensure that these decisions are based on patient care needs and expert professional opinion.

As recommended the review team used the NICE validated Shelford Safer Nursing Care Tool (SNCT) alongside triangulation with:

- Existing budgeted establishments
- Professional Judgement (Finance Establishment calculator)
- Patient experience feedback, quality and safety metrics
- Local intelligence i.e. ward geography, numbers of side rooms, shifts required, speciality

Benefits:

Identifying the benefits of an organisational approach to staffing reviews within nursing.
Meeting the responsibilities of boards in ensuring firstly that safe staffing levels are set and consequently that appropriate staff are in place to meet these levels.
Improved quality of care and better outcomes for patients.

Risks and Implications
Increased risk of requiring on going Temporary Workforce Increased risk to patient safety Reduction in positive patient outcomes

Assurance Provided:
This paper serves to provide an update on identifying areas of achievement and areas for development

Review by other Committees/Groups (please state name and date)**:**
Quality and Standards Committee/Patient Safety and Clinical Improvement Group 3.3.14

Proposals and/or Recommendations

The Board is asked to agree the proposed establishments detailed in Appendix 1 to support safe and effective care of inpatients within the Trust, and to support the clinical units in their budget setting for 2016/17 to this level.

The Board is asked to agree the proposed establishments detailed in Appendix 1 to support safe and effective care of inpatients within the Trust.

The board is asked to agree their on-going support to the recruitment up to 110% (where appropriate) for Nursing staff

The board is asked to note and agree as priorities the following actions to be undertaken for the next 6 months:

- Review of inpatient bed based services at ESHT.
- Administration review to support 7 day a week service.
- Reduction in agency usage. Complete stop of agency usage for Health Care assistants from April 2016
- Review of the management of patients that require 'enhanced observations.'
- Full review of the management of the health roster system to include a review of the function and capability of the allocate system
- Review of 100% supervisory time for matrons.
- Review of allocation of uplift for mandatory training

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None.

For further information or for any enquiries relating to this report please contact:	
Name Lucy Scragg Alex Graham	**Contact details:** 01424 7552550 ext 6302

East Sussex Healthcare NHS
NHS Trust

NURSE STAFFING LEVELS Review

1. Background

Following the Report of the Francis Inquiry and the Berwick Review into Patient Safety, NICE (National Institute of Central Excellence) was asked by the Department of Health and NHS England to produce guidelines on safe staffing in the NHS. The focus of work is on nursing and midwifery staffing, including nursing support staff, to ensure an appropriate balance of skill-mix across the whole team on the wards and in other settings. In July 2014 Nice published it guidance Safe staffing for nursing in adult inpatients wards in acute hospital setting

Following the staff establishment review reported to the Trust Board in April 2014 in response to the NICE guidance the senior nursing team has undertaken the fourth, twice yearly review. This took place in October 2015, with the input of Ward Matrons and Heads of Nursing in all inpatient areas.

As recommended the review team used the NICE validated Shelford Safer Nursing Care Tool (SNCT) alongside triangulation with:

- Existing budgeted establishments
- Professional Judgement (Finance Establishment calculator)
- Patient experience feedback, quality and safety metrics
- Local intelligence i.e. ward geography, numbers of side rooms, shifts required, speciality

1.1 Of the areas that were in scope for this establishment review (Appendix 1) it is also recognised that the SNCT tool is not designed for use in a number of acute inpatient areas. These areas include the following:

- Paediatrics inpatients.
- Medical and surgical assessment units.
- Special care.

Therefore alternative professional recognised tools and professional judgement have been used in these areas.

1.3 Moving forward to achieve a review all nursing establishments in 2016 areas that fall outside the SCNT tool are being reviewed within their clinical units using professional tools on staffing guidance

- Intensive care/HDU
- Accident and emergency
- Maternity
- Outpatients
- Community nursing
- Theatres

Since the staffing establishment review in March 2015 an announcement was made in June 2015 that NHS England have asked NICE to suspend the safe staffing programme for A&E. There is an expectation that this work will be taken forward as part of NHS England's wider programme of work to help the NHS deal with the challenges it is facing over the next few years. At the time of this report we are waiting to hear how this will be taken forward.

2. Methodology

2.1 All Ward matrons and Heads of Nursing were advised of the plan to undertake data collection, using the SNCT. As per the SCNT the data collection took place for 4 weeks (Mon – Fri only) in October 2015. The SNCT records the acuity of patients, staffing levels and other influencing factors e.g. Number of admissions/discharges.

2.2 Guidance was issued on the use of the SNCT and an electronic data collection tool was developed. This tool also enabled the calculation of suggested whole time equivalent levels, based on the SNCT.

2.3 Each area also recalculated using the Finance model, based on the current ward configuration, recognising some of the changes in models of care and specialty of wards since the prior review took place.

2.5 Following completion of the data collection a spread sheet was developed to compare the results of the SNCT and finance/professional model with the existing establishment for each area. (appendix 1) These findings were discussed at a professional review meeting and proposals were put forward for the establishment for each area. There were a number of factors considered in this meeting such as the quality performance of each area, specialist requirements and the number of patient requiring 1:1 care for a variety of reasons.

2.6 All establishments were considered with a consistent approach to uplift in line with current Trust policy:

- 50% supervisory time for Ward matrons.
- 18 % local uplift for annual leave, training and absence.
- 3% central uplift fund for exceptional circumstances e.g. Maternity leave or long term absence as this cannot be consistently applied across all areas.

2.7 Throughout the process of review finance have been involved in the discussions with clinical units

2. 8 The results of this exercise are available in Appendix 1.

3. Findings

3.1 The establishment reviews demonstrate a robust method of determining the required establishment for each area and allow consideration of all key factors.

3.2: It is recognised that the agreed establishment does not reflect the entire requirement for nurse staffing levels that occur during periods of high activity or special requirements such as 1:1 care for airway management of personal safety. As a result there is a Safe Staffing escalation policy that is used on a daily basis within the Trust.

3.3 It is also recognised that even though there have been bed reductions there are minimum staffing levels that are recommended from professional bodies that need to be acknowledged. I.e. Royal College of Nursing.

3.4: During October 2015 there were a number of areas that opened beds above budgeted nursing establishment these were as follows'

- Hailsham 4 EDGH between 2-6 beds

- Hailsham 3 EDGH between 2-6 beds
- Irvine unit generic beds additional 7 beds

This had an impact on the results of the safer staffing results seen in appendix 1/ The following areas did not collect data

- Gardener : Ward closed for refurbishment during the establishment review
- Tressell: Expectation that this was short term area
- Folkington: At the time of review situated across 2 ward areas as a temporary arrangement

Both escalation areas will have planned data collection in March 2016.

4. Escalation

As part of the establishment review the two escalation area opened at the time of the review were Tressell ward 28 beds, Conquest Hospital and Folkington ward 27 beds, EDGH. Both these areas are still open as escalation and the staffing costs are outlined below.

	RN	HCA/	Ancillary	Ward clerk/Admin increase	Total	£'000 proposed cost
Tressell (Conquest Escalation)	15.70	20.27	-	1.18	37.16	**(1,150)**
Folkington (EDGH Escalation)	15.70	20.27	1.18	1.18	38.34	**(1,177)**
Maternity leave allowance (3%)						**(53)**
Total Escalation wards	**31.41**	**40.54**	**1.18**	**2.36**	**75.49**	**(2,380)**

5. Special shifts 'enhanced observations'

In the course of this review the number of 'Specialing shifts' used, has also been considered. These shifts are commonly used to provide one to one care for patients who may be confused and wandering, therefore at risk of absconding or falling and sustaining injury. Because these shifts are in addition to the current ward establishments they are frequently filled by agency workers who are not permanent staff and come at a premium cost to the Trust. The Trust has seen a considerable increase in the use of such shifts over the last year and further work is being carried out to ensure a robust process for obtaining 'specials' for

patients is in place and there can be a reduction in the use of temporary staff with the increase in establishment, reducing the clinical risk.

In the establishment review meetings it was discussed to whether the staff required for special observations should be part of the established workforce. It was agreed that this workforce needed to be looked at separately as the usage and frequency of its use fluctuates been department and temporary workforce model option is being discussed.

6. Skill mix

Consideration has been given to staffing skill mix. It is proposed that the Band 7 matrons would remain 50 /50 with a review of administrative support for the ward areas. This piece of work is currently being reviewed via the Lord carter nursing workforce project group.

As part of the establishment review there has been a review of the band 6 nurse establishment for ward areas and the review recommends that for

- **Gateway areas:** Recommendation that there is a band 6 member of staff on duty each shift 7 days a week.
- **Medical/Surgical wards:** Recommendation that there is a band 6 on duty each 24 hours 7 days a week.

The benefits of the skill mix review is the create 7 day a week leadership in all inpatient areas. For those areas that are gateways and areas with higher acuity this is to ensure that there is the right levels of leadership working in our inpatient units both in hours and importantly out of hours to ensure patent safety, improve length of stay and promote leadership.

7. Uplift for essential training

Through the establishment review meetings with the clinical units it was highlighted that the 3 % uplift for essential training in some speciality areas such as A&E, SCUBU, paediatrics, cardiology does not adequately meet the required backfill for these areas

8. Finance

The proposed increase to staffing establishment represents an investment in nursing establishments. Evidently, whilst this is a significant requirement for investment proposed at a time of financial challenge, the recommendations of this are that this is a sustainable method of providing safe staffing levels and reducing temporary staffing spends.

Each of the CU's proposed staffing investment

Clinical Unit	Difference from current budget					
	RN	HCA/ B4	Ancillary	Ward clerk/Admin increase	Total	£'000
Urgent Care	3.27	13.22	11.14	1.07	**28.71**	-£757
Specialist Medicine	-0.48	5.02	0.00	1.28	**5.83**	-£140
Cardiovascular	7.37	3.98	1.18	1.07	**13.59**	-£465
Surgery	-0.96	11.68	0.00	1.52	**12.24**	-£372
Out of Hospital	4.71	-6.14	2.89	-0.37	**1.08**	-£11
Women and Children's	0.48	-0.36	0.00	0.31	**0.43**	£96
Maternity leave central allowance	0.00	0.00	0.00	0.00	**0.00**	-£49
Total difference from current budget	**14.39**	**27.40**	**15.22**	**4.87**	**61.88**	**-£1,697**

	Requested changes	
	FTE	£'000
Current Budget	**965.11**	**-33,715**
Senior band 6 cover out of hours (increase skill mix from Band 5)	0.00	-36
Ward clerks and admin increase to cover annual leave cover	4.87	-128
Additional Band 4's	2.57	-79
Additional HCA's across wards	24.83	-634
Clinical orderlies	15.22	-358
Additional band 5's	14.39	-533
Other (skill mix/ maternity leave increase)	0.00	70
Increase requested to existing budget	**61.88**	**-1,697**
Proposed Establishment (excluding escalation)	**1,026.99**	**(35,413)**

Permanent staff across these ward areas as per December 2015 reports shows there are 901.47 FTE in post (includes nursing and admin/clinical orderlies), therefore with the additional proposed establishment there will be 201 FTE vacancies which would need to be recruited up to (this includes escalation areas). These are not all registered nursing posts as identified in the previous table. Need to consider as part of recruitment trajectory and factor in the potential risk of further agency premium costs which are not currently reflected in the proposed establishment cost above.

The latest Forecast out turn suggests a current spend of £36.5m across these ward areas by the end of the year 2015/16, this includes £5.6m agency spend (excludes escalation areas). Assuming 50% of the agency spend (£2.8m) is the premium cost over and above vacancy levels the proposed establishment of £35.4m equates to £1.7m increase funding compared to current spend rates.

Special observations and any agency requirements over and above establishment are not factored into the proposed establishment of £35.4m and will need to be considered when reviewing affordability against forecast outturn which would include cost of these.

Each of the clinical units has this financial planning being placed into their own forcasts.

9. Benefits of investment

The triangulation of the many layers of information and evidence, alongside professional scrutiny and organisational knowledge provides a strong indication of the required establishment and skill mix in all adult inpatient areas.

The National Quality Board report (2014) outlines the importance of ensuring that staffing is appropriate and refers to multiple studies that link low staffing levels to poorer patient outcomes and increased mortality rates. Professor Sir Bruce Keogh's (2013) review of 14 hospitals with higher mortality rates also found a correlation between patient to staff ratios and higher hospital mortality rates. This establishment review is proposing that with this investment into the inpatient areas we expect to see clear benefits to staff and patients which will include improved patients safety, improved patient experience, improved length of stay, reduced readmissions, an improved staff experience which in turns leads to better recruitment and retention.

10. Recommendations and Next steps

The staffing establishment review is a rolling programme of 6 month review in line with the SCNT guidance (NICE validated Shelford Safer Nursing Care Tool). The next staffing review data collection is programmed for March 2016.

The Board is asked to agree the proposed establishments detailed in Appendix 1 to support safe and effective care of inpatients within the Trust, and to support the clinical units in their budget setting for 2016/17 to this level.

The Board is asked to agree the proposed establishments detailed in Appendix 1 to support safe and effective care of inpatients within the Trust.

The board is asked to agree their on-going support to the recruitment up to 110% (where appropriate) for Nursing staff

The board is asked to note and agree as priorities the following actions to be undertaken for the next 6 months:

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- Full review of the management of the health roster system to include a review of the function and capability of the allocate system
- Review of 100% supervisory time for matrons.
- Review of allocation of uplift for mandatory training

Lucy Scragg
Assistant Director of Nursing

Alex Graham –
Head of Financial Management

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Shelford – Safer Nursing Care Tool – 2013 Produced in conjunction with the Association of UK University Hospitals *http://shelfordgroup.org/library/documents/130719_Shelford_Safer_Nursing_FINAL.pdf*

East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board
Agenda item:	12 F
Subject:	Patient Experience Q3 2015/16
Reporting Officer:	Alice Webster

Action: This paper is for **(please tick)**					
Assurance	x	**Approval**		**Decision**	

Purpose:

To inform the Trust board about Q3 feedback from patient's about their experience when using services provided by the organisation.

Introduction:

Patient Experience provides feedback from patients and the public on their experience of the Trust. The information in this report outlines the Trusts position in Quarter 3 in the following areas:

- Complaints including Parliamentary and Health Service Ombudsman (PHSO)
- Patient Advice and Liaison (PALs)
- Friends and Family Test (FFT)
- NHS Choices

Analysis of Key Issues and Discussion Points Raised by the Report:

Complaints and PHOS

In Q3, the Trust received 160 new complaints compared to 224 in Q2; this represents a decrease of 29%. During Q2 there was an increase in complaints due to the information governance breach which resulted in formal complaints being raised.

The number of complaints closed during Q3 was 239, this is an increase of 25%compared to Q2 which was 179. This increase in closed complaints demonstrates the focused efforts the team, Patient Experience Lead, Interim Head of Governance and Clinical Units have made to ensure our overdue complaints were responded to.

Q3 witnessed a disappointing drop in the percentage of complaints responded to within timescale (October 17.4%, November 13% and December 9.68%), coupled with the focus being on responding to overdue complaints and a number of black status incidents.

At the end of Q3, there were 74 complaints overdue, this remains the same as at the end of Q2. In Q3 there was an increase in the failure to provide statements and draft responses that adequately and fully responded to the complainants issues raised.

Complaint themes for Q3 remain the same: communication, standard of care, patient pathway, attitude and discharge.

Top five Clinical Units for Q3 were, Surgery, Specialist Medicine, Urgent Care, Women and Children and Theatres and Clinical Support.

Doctors remain to be in receipt of the highest number of complaints against profession.
During Q3, the Trust received a total of four contacts from the PHSO, all four contacts were to

request copies of our complaint files in order to consider further investigation.

During Q3 the PHSO closed three complaints, two were partially upheld and one was not upheld.

PALs

During Q3, PALs continued to experience high volumes of contacts (October 707, November 676 and December 543) due to the difficulties with patients accessing the appointments line. The majority of PALs contacts (943) were to raise a concern.

The top themes for PALs contacts were: communication, patient pathway, standard of care, provision of services and attitude of staff.

Friends and Family Test

The overall satisfaction score of all patients surveyed during Q3 was, 90.47% of all patients who used the Trusts services were satisfied. This overall satisfaction score has remained static from Q2 (90.2%).

NHS Choices

A total of 47 narratives were posted on NHS Choices during Q3, this is an increase of 15% in posts compared to Q2.

Of the 47 narratives 30 gave three stars or above with positive comments and 9 gave two stars or below with negative comments.

Benefits:

Triangulation at department, service and ward level with regular review of their patient feedback data arising from FFT, complaints, NHS choices, PALS and compliments is used to help improve services; patient pathways and front line care.

During Q4 meetings have been set up for the Patient Experience Lead and Heads of Nursing to review complaints and PALs trends and themes per Clinical Unit.

Risks and Implications

Responding to patients complaints within timescales, the number of out of time complaints continues to be an issue for the Trust. The number of reopened complaints continues to be of concern. Implications could be the reputation of the Trust in handling complaints.

Assurance Provided:

Additional Complaint Officer posts (2.8 wte) have been successfully recruited to and two Officer have now started in post.

Quarterly meetings with Clinical Units now take place to review complaints and PALs data and actions set.

Review by other Committees/Groups (please state name and date):

Quality and Standards Committee

Proposals and/or Recommendations

- Responding to patient complaints- significantly improve on the number of overdue complaints. Complaints Officers will be aligned to Clinical Units, and support the investigating manager with statement collection and completing the draft response.

- Implement a post complaint survey- this is in draft format and due to be presented at the Patient Experience Steering Group on the 21 January 2016.
- To work with Healthwatch to complete the complaint peer review process.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?

For further information or for any enquiries relating to this report please contact:	
Name: Amy Reilly	**Contact details:** 07813 369481

East Sussex Healthcare NHS Trust

Patient Experience Report
Quarter 3 2015/16

1.0 Introduction

This report provides an overview of feedback from patients and the public on their experience of the Trust. It outlines the Trusts position in Quarter 3 (Q3), October-December 2015, in the following areas:

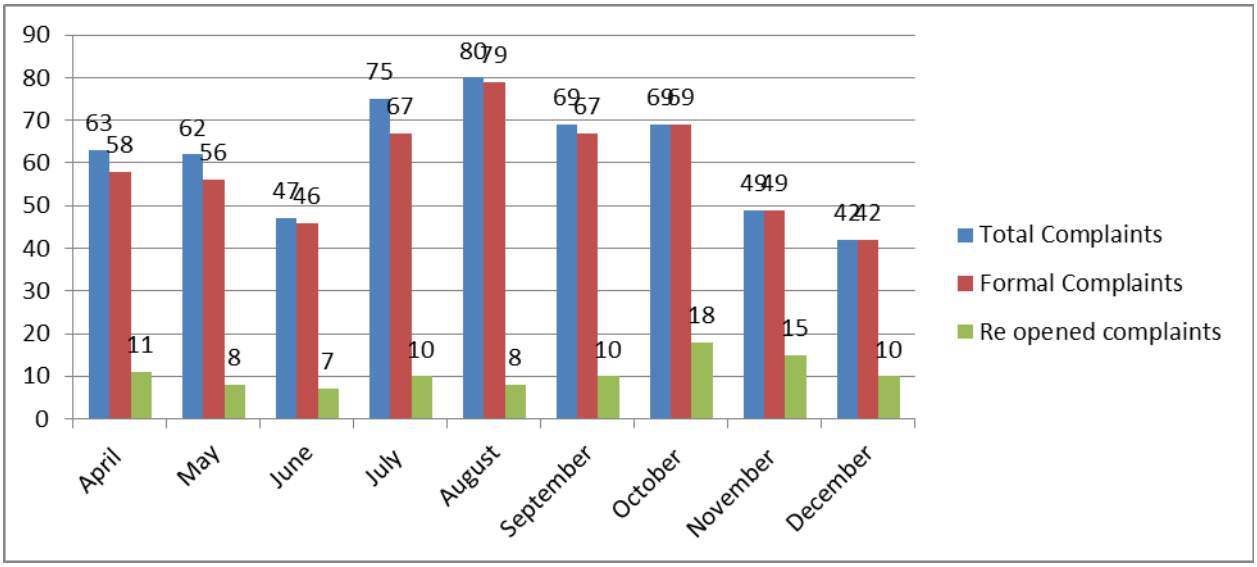
- Complaints including Parliamentary and Health Service Ombudsman (PHSO)
- Patient Advice and Liaison Service (PALs)
- Friends and Family Test (FFT)
- NHS Choices

2.0 Complaints Summary (including Parliamentary and Health Service Ombudsman)

2.1 In Q3, the Trust received 160 new complaints compared to 224 in Q2; this represents a decrease of 29%. During Q2 there was however, an increase of 23% in complaints received largely as a result of the Information Governance breach.

The following chart shows the total number of complaints, formal complaints and reopened received per month:

New Complaints received in Q1, Q2 and Q3



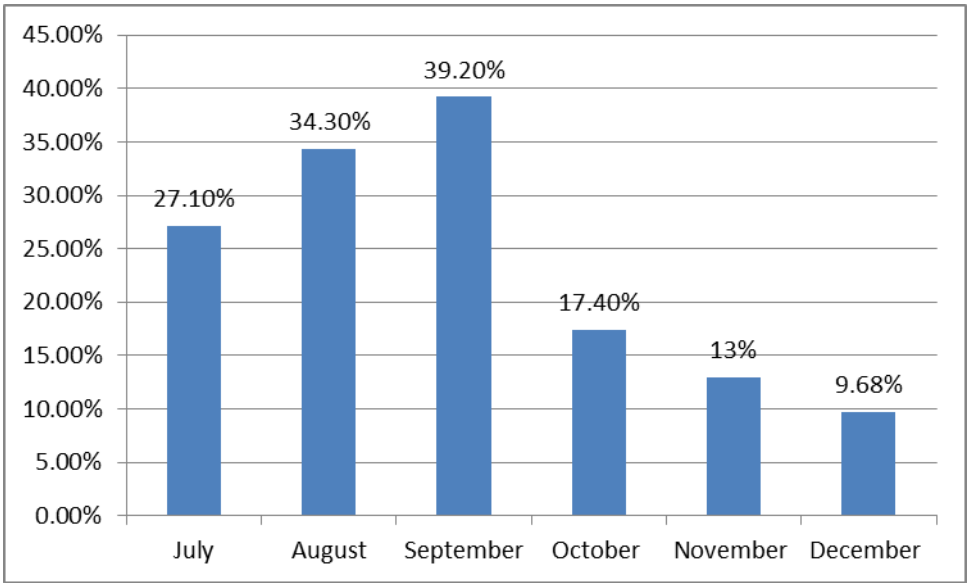
2.2 In Q3 91.3% of complaints were acknowledged within three working days, this is a decrease compared to 93.3% in Q2. Those complaints which were not acknowledged within the regulated time scale were complex in nature, difficult to determine the responsible agency or Clinical Unit, required additional time to triage due to the complexity of the issues raised. It is recognised that complaints should be acknowledged and action is being taken to rectify this. One of the actions being taken is for all complainants to receive a telephone contact from the investigating Complaints Officer to acknowledge the complaint with a follow up letter confirming the issues raised within the complaint. This process hopes

to make the complainant feel listened to, confirm or clarify the points raised, so we investigate and respond appropriately.

2.3 The number of complaints closed during Q3 was 239; an increase of 25% compared to Q2 which was 179. This increase in closed complaints demonstrates the focused efforts the team made to ensure our overdue complaints were responded to.

The chart below shows the percentage of complaints closed in time during Q3.

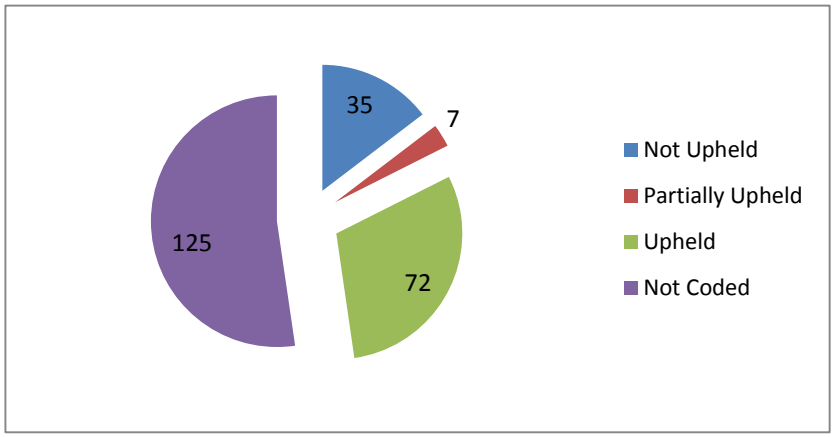
Complaints closed in time



Q3 witnessed a disappointing drop in the percentage of complaints responded to within timescale, coupled with the focus being on responding to overdue complaints and a number of black status incidents. Complaints Officers have been aligned to Clinical Units to assist with the investigation, statement collecting and compiling the draft response, the aim is for an improvement in the quality of the draft from the Clinical Units and quicker response times.

2.4 In Q3, the "partially upheld" category was reinstated to more fairly reflect the status of complaints responded to. The following chart shows the number of complaints closed with the outcome recorded as "upheld", "partially upheld", "not upheld" or "not coded" on Datix:

Status of Closed Complaints



It is disappointing to note the number of closed complaints that do not have a status recorded. There is clearly more work to be done with clinical units to collate the status of closed complaints, and for consideration and discussion on who is best placed to decide the status and identify the actions and learning that arises. This is something the proposed changes to the complaints handling process should seek to address for improved recording during Q4.

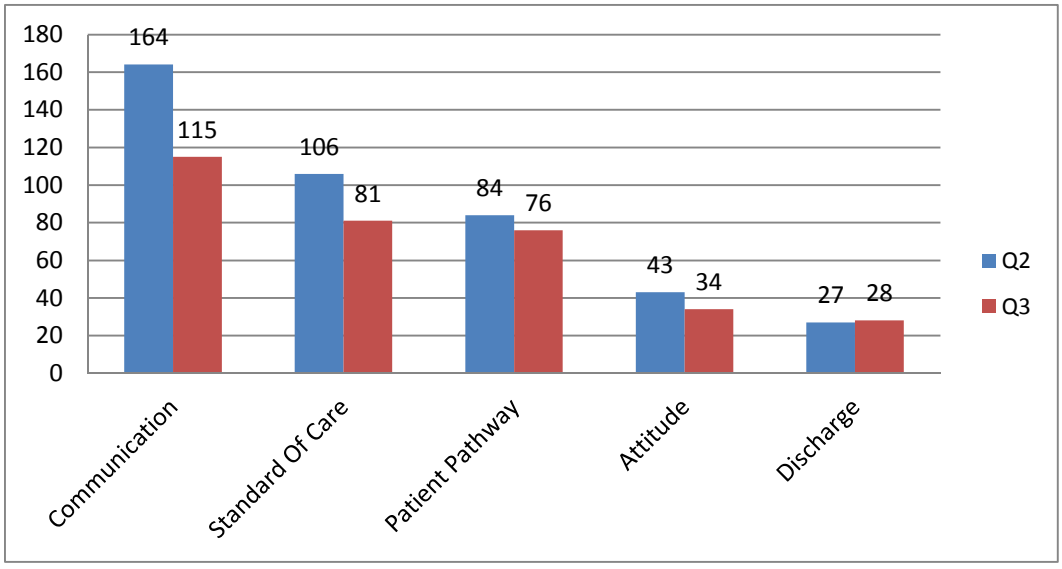
Where a complaint is not upheld, there is still the opportunity to learn why the complainant has complained and the need to understand the motives and feelings of the complainant. This is something we plan of seeking through the use of our post complaint survey and Healthwatch peer review of complaints which is taking place in February 2016.

2.5 At the end of Q3, there were 74 complaints overdue. This remains the same position as at the end of Q2, despite a significant increase in the number of complaint responses sent out. As previously reported, the Complaints Department is working with Clinical Units to support the provision of timely and comprehensive complaints investigations, collation of statements and production of fair, balanced responses that meet the quality assurance standards.

In Q3 there was an increase in the failure to provide statements and draft responses that adequately or fully responded to the complaint issues, despite a more robust triage system being put in place, and this resulted in protracted delays in finalising draft responses. Additionally, Q3 witnessed an increase in delays in Clinical Units approving final draft responses. The Trust's black status has in part compounded the situation and once again, it is anticipated that the proposed changes to the complaints handling process and closer alignment between the Clinical Units and the Complaints Department will go some significant way to address this. It is vital that improvements are made as the Complaints Department continues to handle increasing dissatisfaction from complainants as a result of delays in providing complaint responses.

2.6 The chart below shows the complaint themes for Q3, the chart sets out the top five subjects and compares them against Q2 data:

Top 5 Complaint Themes



Each complaint received can also be allocated a sub-subject/ theme to further define the dissatisfaction raised by a complainant if necessary/ required. In Q3, the sub-subjects/ themes are as follows:

Communication	**115**
Confidentiality issues	2
Conflicting Information	3
Delayed communication/information	5
Unable to contact department	7
Inappropriate/conflicting communication	6
Lack of communication/information	41
Language barriers	1
Listening & respecting patient choice	8
Misleading information	1
Breaking of bad news	3
Verbal information for patients/relative	25
Written information for patients/relatives	13
Patient Pathway	76
Admission issues	2
Appointment issues	36
Inaccurate prescribing	2
Referral delays	4
Delays in access to service/ treatment	27
Transfer	5
Attitude	34
Unhappy with attitude	34
Discharge	28
Lack of care package	8
Inappropriate	17
Delayed discharge	1
Lack of information for discharge	3
Standard of Care	81
Lack of assistance with basic needs	6
Overall care	25
Lack of confidence in delivery of care	13
Missed diagnosis	17
Inaccurate diagnosis	3
Medication error	4
Pain control	12
Lack of privacy and dignity	1

NOTE: one complaint may have numerous subjects.

Communication remains the top theme for a complaint, work continues within Patient Experience Teams to address this:

- Medical Education adding a ‘Communications’ element to the Junior Drs teaching programme, as a large number of the complaints you have received have been around communication between our Junior Drs and patients.

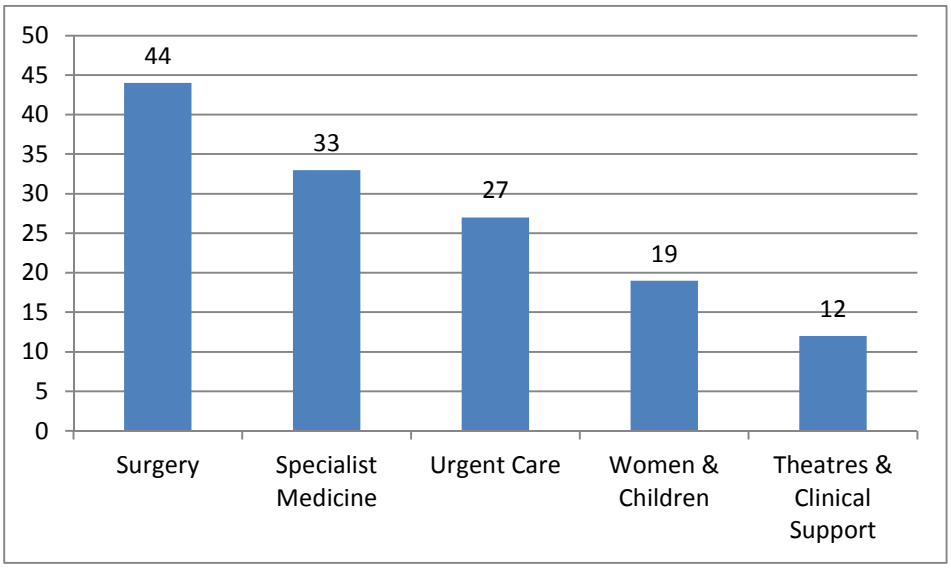
- "Hello my name is…." Will be monitored through the use of the Friends and Family Test, this hopes to be launched in Q4.

- Patient Information continues to be monitored through the Quality Improvement Plan and the Patient Experience Manager is focussing on two specialities per quarter.

- The annual Dignity Day will be held on the 1 February 2016, one of the presentations and table work pieces is to focus on communication (verbal, nonverbal and listening skills). All staff groups have been invited to this event, no medics have expressed an interest so far. Dr Grace, Consultant Haematologist will be presenting "demonstrating compassion".

2.7 The chart below reflects the number of complaints received or re-opened in Q3 as a top 5 by Clinical Unit (as recorded on Datix):

Top 5 Clinical Units

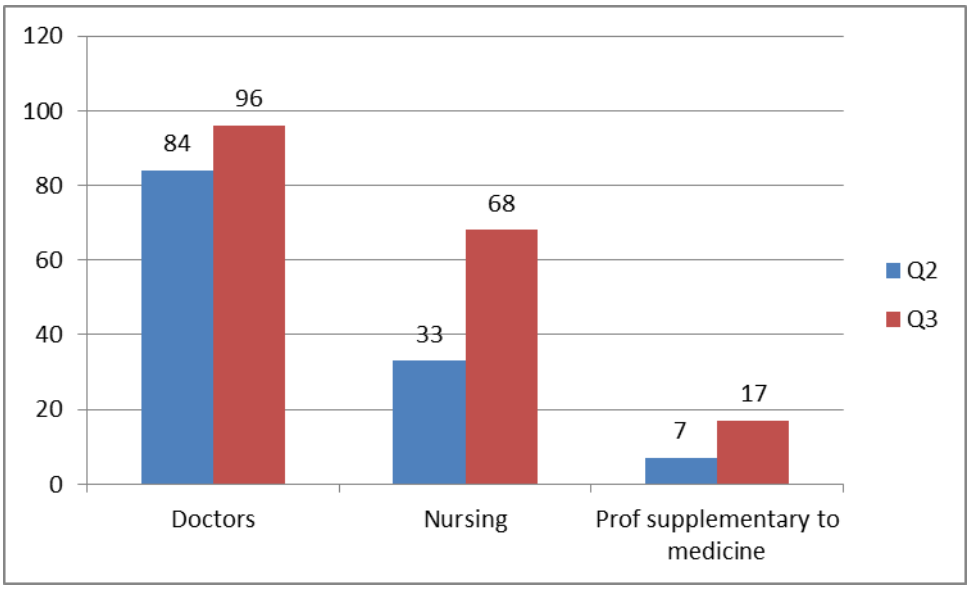


*The top three Clinical Units remain the same as Q2.

Monitored through the ESHT Improvement Plan the Patient Experience Lead will be meeting with all Heads of Nursing to discuss the themes raised through complaints and actions set. It is thought this will be a more productive use of time rather than looking at individual complaints themes and actions. This will be completed quarterly and continue to be monitored.

2.8 The chart below reflects the professions of staff groups when a complaint has been raised against that profession (please note: "other" includes administrators) during Q2 and Q3.

Complaints against professions in Q2 and Q3



*NOTE: some complaints may reference dissatisfaction with various professions, and each profession will be recorded on Datix.

In Q2, the profession field within Datix was realigned to meet K041a reporting requirements and as such, it is not possible to provide a more specific breakdown of complaints by profession and themes for Q3. The complaints department will seek a solution to this issue for Q4 reporting wherever possible.

2.9 During Q3, the Trust received a total of four contacts from the Parliamentary and Health Service Ombudsman Enquiries (PHSO). All four contacts were to request copies of complaint files in order to consider if further investigate a complaint we have responded to. At the time of reporting, the Trust had not received a decision from the PHSO on these cases.

During Q3 the PHSO closed 3 complaints, two were partially upheld and one was not upheld.

- Case 1 (partially upheld) - this case related to an Out of Hospital Care complaint; the PHSO asked the Trust to apologise to the family, and develop an action plan to improve the monitoring of patient's on the Irvine Unit.

- Case 2 (partially upheld) – awaiting action plan.

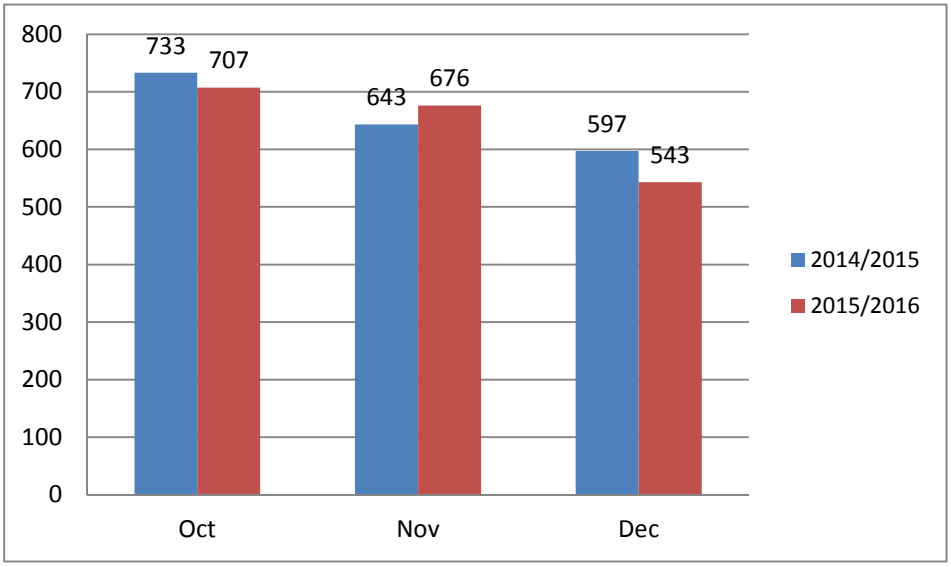
- Case 3 (not upheld) - the PHSO decided not to uphold one of the complaints it had investigated.

3.0 Patient Advice and Liaison Service (PALS)

3.1 During Q3, PALs continued to experience high volumes of contact due to the difficulties patients were having in contacting the appointments line and various internal departments relating to follow up appointments.

The following chart reflects the number of PALs contacts received by month in Q3, and compares this with data from Q3 2014/15.

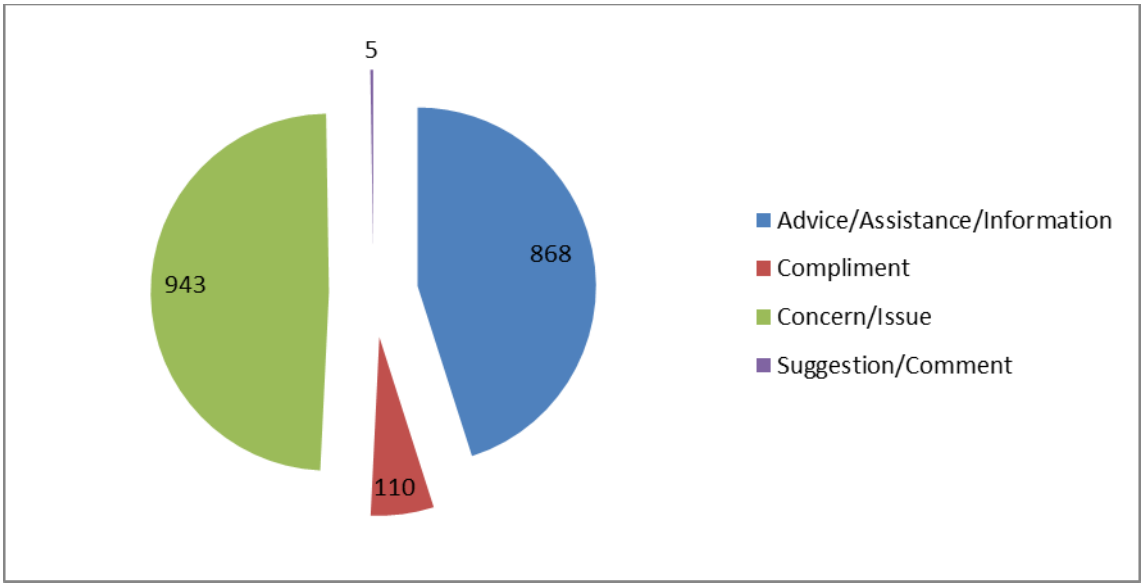
PALs contacts in Q3 2015/16 compared to 2014/15



The total number of PALs contacts received during Q3 was 1926, this is a decrease of 15% in contacts compared to Q2 which was 2265. Q2 saw a spike in contacts due to the information governance breach.

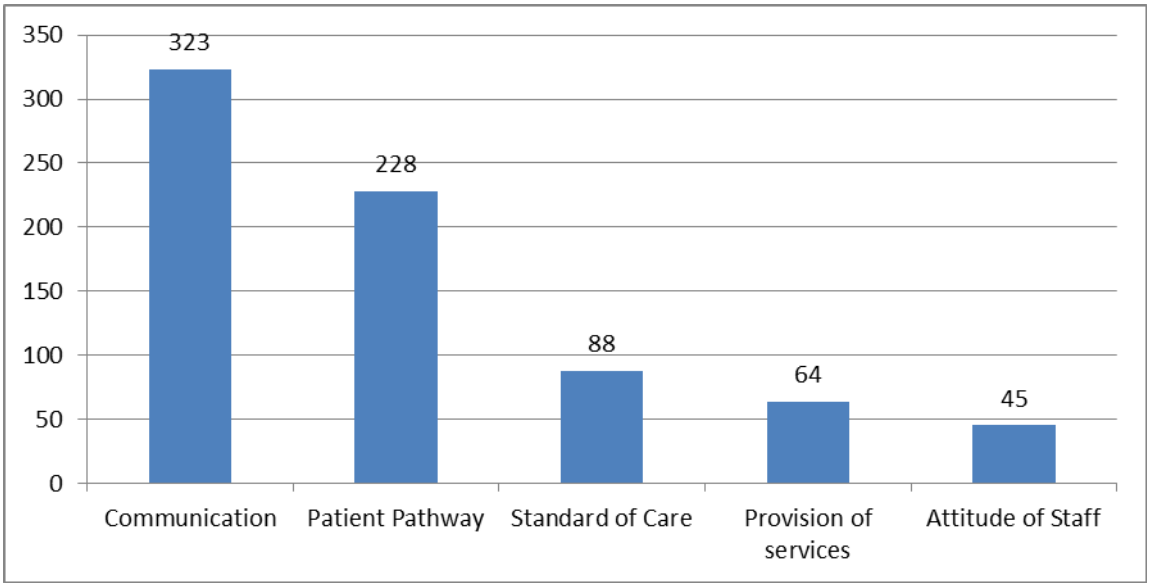
3.2 The following chart reflects the types of contacts which PALs received in Q3:

Types of PALs contacts recieved Q3



The above chart demonstrates that “concerns/ issues” are the biggest cause of contact for Q3. The following table breaks down the top five subjects recorded under “concerns/issues” as:

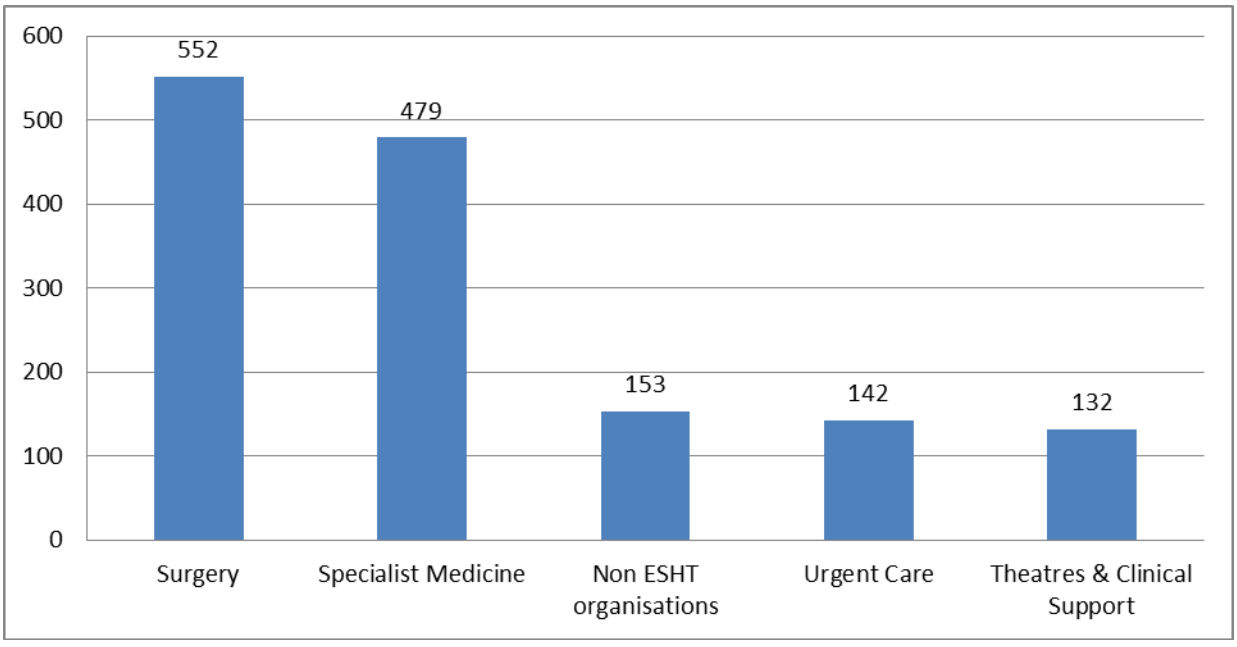
Top 5 subjects recorded under “concerns/issues”



3.3 PALs continue to provide a rapid access point of contact for patients, their families and carers. In Q3, PALs responded to 92% of all contacts within two working days. The response rate continues to increase by 1% from Q1 to Q2, Q2 to Q3.

3.4 PALs contact are broadly equal at both sites (56% DGH and 44% Conquest). The following chart reflects PALs contacts by top 5 Clinical Units in Q3:

PALs contacts- top 5 Clinical Units



Surgery continues to be in receipt of the highest number of contacts, the table below breaks down the contacts by subject type.

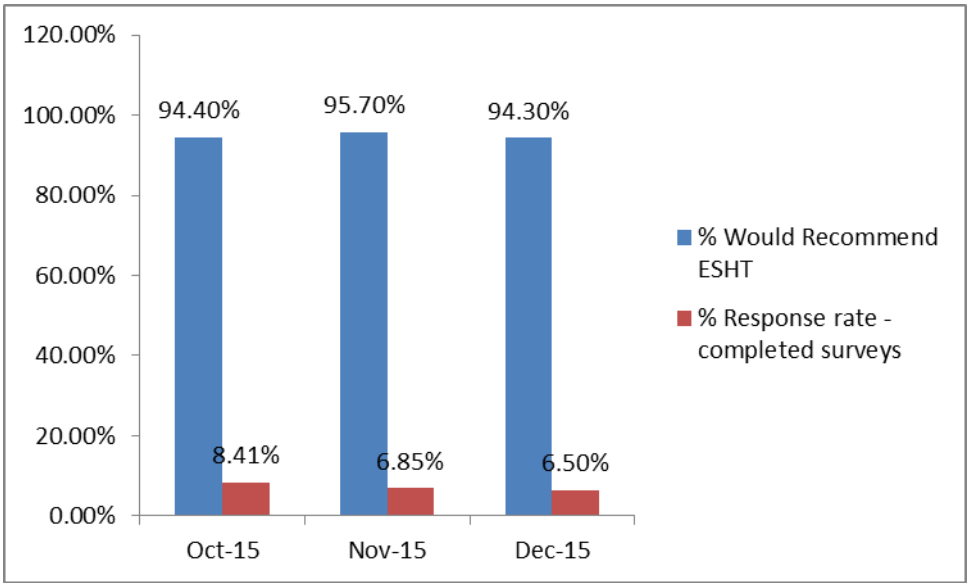
PALs contacts by Clinical Unit and subject type

	Surgery	Specialist Medicine	Urgent Care	Theatres & Clinical Support
Patient Pathway	107	73	8	14
Communication	77	141	13	23
Compliment	45	25	0	8
Standard Of Care	26	14	25	0
Provison Of Services	24	15	0	0
Discharge	0	0	12	0
Attitude	0	0	3	0
Results Of Tests	0	0	0	8
Attitude Of Staff	0	0	0	6

This data is shared with Heads of Nursing when discussing complaint themes, PALs data can then be used more proactively by the Clinical Units.

4.0 Friends and Family Test (FFT) Patient feedback

4.1 FFT Trust wide results Q3 (% recommended and response rate)



4.2 The overall satisfaction score of all patients surveyed during Q3 was, **90.47%** of all patients who used the Trusts services were satisfied. This overall satisfaction score has remained static from Q2 (90.2%).

4.3 Inpatient areas achieved an overall satisfaction rating of **89.66%** compared to **89.47%** in Q2. The overall satisfaction has remained static.

4.4 The Emergency departments achieved an overall satisfaction rating of **86%** compared to **86.44%** in Q2. The overall satisfaction has remained static.

4.5 The Labour and Birth departments achieved an overall satisfaction rating of **88.97%** compared to **87.55%** in Q2. The overall satisfaction has increased by 1-2**%**.

4.6 As highlighted in previous reports the collection of FFT data is to be refined as the Trust has committed to upgrade to the Meridian system. Currently the Business Intelligence team are working with Optimum on ensuring the structures are correct to reflect the Trust activity.

4.7 Sample Patient Feedback from Family and Friends Free Text

✓ Staff were wonderful, doctors informative, surroundings were clean and tidy

✓ They are all lovely and very helpful and made me feel very confident (OP)

✓ I am a repeat visitor and am always treated by name with sincerity and warmth by All of the staff. Whilst I would rather not be in hospital I couldn't ask for a better team to be in the care of. It's a pleasure to see them. (inpatient)

✗ Reduce the wait. Clean waiting area/check regularly as dirty bandages/cups/mud was left for whole waiting time. Do not make patients walk through crowded waiting room clutching an open urine sample. Label urine sample not just leave it on a table. (A&E patient)

4.8 Ward feedback

As part of the FFT programme, the Trust has developed 'You said; We did' Boards. Ward Matrons can access the free text feedback from the Meridian system to populate these Boards. Patient Experience Volunteers have been working with the wards to ensure these are updated regularly. The following tables provide some extracts of the ITU Board

You Said	**We Did**
ITU:	
"I Didn't know if it was 8am or 8pm and had no idea what day it was"	We have now bought large clocks that have the 24hr clock and day/date visible
"The unit is noisy"	We have spoken to staff about noise level and highlighted the need to turn down alarms level to an appropriate level. We

	have a noise ear which has a green amber red indicator (ensuring safety
I was really scared going back to the ward	Our outreach team are working with the ward increasing their knowledge on what ITU patients often struggle with. We have, with your help, designed a discharge booklet to help both patients and their relatives when they leave ITU

5.0 NHS Choices

5.1 NHS choices is a website where service users can post comments about their experiences of using NHS services. The Patient Experience Manager acknowledges thanks and responds to these comments and signposts to other services as appropriate. All comments are shared with the relevant manager/ department and disseminated to all Patient Experience Champions for distribution amongst their teams.

There is also a facility for service users to rate the service using a star rating from 1 to 5 stars with 1 being a poor rating to 5 being excellent.

5.2 A total of 47 narratives were posted on NHS choices during Quarter 3, this is an increase of 15% in posts compared to 55 in Q2. Of the 47 narratives posted 30 gave three stars or above with positive comments and 9 gave two stars or below with negative comments.

5.3 The following table shows the themes from the 55 narratives received in Q2.

For excellent ratings:	For low ratings
Staff kindness, efficiency and caring attitude.	**Waiting times in Accident and Emergency**
Good communication.	**Communication: Neurology.**
Many staff and departments praised for their standards of care.	**Organisation of appointments.**
	Telephone contact

5.4 Some examples of the comments received and the feedback provided are shown below.

Comments received	Our replies
'Performance of hospital consultations and procedures' Having returned to the UK from 10 years in Cyprus and aware of the negative publicity the NHS is receiving I can only say that the service I have received has been exemplary and cannot be faulted. I am 71 years old and have a pacemaker but consider myself relatively fit. Nevertheless over the past year I have undergone several procedures including a colonoscopy, ablation and replacement of the pacemaker. I have had consultations and tests prior to these	Thank you so much for providing feedback on your good experiences with Cardiology at Eastbourne DGH. As a Trust we are committed to providing high quality care and positive patient experiences. Your posting clearly recognises that this has always been the case in your experience. Please be assured that your posting will be shared with the cardiology staff who will be happy to read your comments. We send you our warmest wishes.

procedures and numerous other outpatient checkups in relation to my heart condition. On each and every occasion I have visited the hospital I have been treated with the utmost courtesy, care and professionalism. The appointments arranged have been timely and on time. The atmosphere and care provided in the theatres has been astonishing. I truly believe I could not have received better care in any private hospital in the country. I can only say that I have been truly blessed. I usually comment that if I continue to receive this level of service I will never die. Cannot comment on same sex accommodation.	

My father's treatment in MacDonald Ward My father has just spent nearly four weeks in MacDonald Ward fighting a series of infections. My sisters and I were extremely impressed with the care that he received from everyone there. Between us we managed to visit nearly every day and we received regular updates from the doctors and nursing staff. Everyone deserves full marks for effort, cheerfulness and above all patience. Dad has now moved to a nearby rehabilitation unit and is looking forward to returning home in the new year.	Thank you for your positive posting on NHS Choices about the care your father received from staff on MacDonald ward at the Conquest Hospital. Postings such as yours truly recognise the fantastic work they do. It will be a pleasure to share your comments with them, as it's always encouraging for staff to receive good feedback. We wish you and your family a Happy New Year and we hope that your father is continuing to make good progress.

6.0 Analysis and conclusion

6.1 The number of new complaints is decreasing and it is hoped that with new processes in place the complaints team will achieve compliance with both acknowledging a complaint and responding to a complaint within timescale.

6.2 Closed complaints to clearly identify if the complaint was “upheld”, “partially upheld” or “not upheld” to identify learning and actions which can then be shared throughout the Trust.

6.3 Top five categories continue to remain the same for both PALS and Complaints, further analysis is to be undertaken and meetings with Heads of Nursing to identify actions relating to themes of complaints and PALs contacts.

6.4 ESHT Improvement Plan will monitor our progress towards acknowledging complaints, responding to complaints and complaints being re-opened.

6.5 Triangulation at a team level consists of each department, service and ward regularly reviewing their patient feedback data arising from FFT, complaints, NHS choices, PALS and compliments. Now the Complaints and PALs Manager is in post regular meetings will be held between the Patient Experience Lead, Complaints and PALs Manager and the Patient Experience Manager to triangulate this information and create work plans.

6.6 Patient Experience work plan has been devised for 2015/2016 and is shared and monitored at the Patient Experience Steering Group. Clinical Units are required to have a representative at each meeting who is responsible for taking back the lessons learnt. This meeting still requires attendance from a "Medical" representative.

6.7 NHS Choices continues to provide us with rich patient feedback; we will respond to and share accordingly. Healthwatch have also established a feedback centre, we work closely with Healthwatch to ensure we capture the data they collate. Alongside this we also receive patient and GP feedback via "one click" some thought needs to take place as to how we report on this as sometimes it is not given to us in a timely manner or missing vital information in order for us to categories.

7.0 Recommendations and Actions from the Report

Activity	Action	Timescale
Responding to patient complaints.	Significantly improve on the number of out of time complaints- this is being monitored through the weekly improvement plan.	**Process implemented with ongoing monitoring**
Implement post complaint survey	Survey to be sent to complainants	**December 2015-** this has been delayed, due to start March 2016
Meet with Clinical Units to review process for completing actions arising from complaints.	Meet Quarterly with Clinical Units to review the progress towards completing the actions from themes of complaints.	**To review Q3 data-** dates set with Heads of Nurses for January and February 2016.
To work with Healthwatch to complete the complaint peer review process.	Support Healthwatch Volunteers to undertake a peer review of the complaint responses and processes from a complainant's perspective.	**February- March 2016**

East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board
Agenda item:	12G
Subject:	End of Life Care
Reporting Officer:	Dr David Hughes Executive Lead End of Life Care

Action: This paper is for **(please tick)**					
Assurance	✓	**Approval**	✓	**Decision**	

Purpose:

To provide assurance of progress with End of Life Care improvements within ESHT and to seek approval for the End of Life Care Strategy.

Introduction:

End of Life Care was highlighted within the CQC report as an area requiring improvement. This paper will provide an update and assurance around progress to date. This is a major project of transformation and requires multiple actions and projects.

Analysis of Key Issues and Discussion Points Raised by the Report:

- Update on CQC recommendations.
- Proposed End of Life Care Strategy.
- Update on audit programme.
- Update on McKinley T34 syringe driver availability, training and policy.
- Monitoring of End of Life Care Quality Indicators.
- Rapid Discharge Planning.
- Complaints monitoring.
- Patient and Carer Experience.
- End of Life Care Team.
- End of Life Care Training update.

Benefits:

- To ensure that all patients receive the highest standards of End of Life and Palliative Care wherever that care is provided by ESHT staff.

Risks and Implications

- The risks of not implementing a full and comprehensive End of Life care programme within ESHT are that we do not meet the quality, governance and safety recommendations made

by the CQC in a timely manner. It is within ESHT's objectives and expected values and behaviours that we offer compassionate and dignified care to all patients and carers.

Assurance Provided:

- The Specialist Medicine Clinical Unit is working to ensure sufficient resources and support is provided to the EOLC team to enable them to support ESHT in its ambitions for EOLC. EOLC is represented at Board Level by the EOLC Executive Lead, Dr David Hughes, Medical Director.

Review by other Committees/Groups (please state name and date)**:**

Specialist Medicine Clinical Unit Clinical Governance Meetings.
Trust Nursing, Midwifery and Allied Healthcare Group (TNMAG)
Medicines Management Committee (for medicine related issues)

Proposals and/or Recommendations

The Board is asked to note the programme of work outlined in this document to support the Trust in providing a high standard of end of life care.

The Board is requested to approve the proposed EOLC Strategy attached as Appendix A.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)

What risk to Equality & Human Rights (if any) has been identified from the impact assessment?

None identified – the EOLC Strategy's purpose is to provide high quality care at the end of life to all patients regardless of protected characteristics.

For further information or for any enquiries relating to this report please contact:

Name: Dr Debbie Benson	**Contact details: debbiebenson@nhs.net**

ESHT End of Life Care Trust Board Report Q3 2015

1. Introduction

End of Life Care was highlighted within the CQC report as an area requiring improvement. This paper will provide an update and assurance around progress to date. This is a major project of transformation and requires multiple actions and projects.

2. Update on CQC Recommendations

An action plan has been developed to address the issues raised by the CQC. All actions are currently in line with the plan and some actions have been completed. There is also a local End of Life Care Team work plan for specific actions that feed into the trust action plan.

3. End of Life Care ESHT Strategy

The End of Life Care Team requests that the Trust Board give their approval to the ESHT End of Life Care Strategy which is based on National Guidance and local needs. Attached as Appendix 1

4. Audit

The National Care of the Dying in Hospitals Audit has been completed successfully within EDGH and the Conquest hospital. This has also been completed by more than 80 other Trusts and will therefore provide ESHT with useful benchmarking against peers. The date for when the results will become available in 2016 has not yet been released but it is anticipated that this will be before May 2016.

5. McKinley T34 Syringe Drivers

The CQC report noted that all palliative care patients needing syringe drivers should have McKinley syringe drivers, so that continuity in symptom control would be provided on transfer into a community setting. The CQC reminded the Trust that they should be compliant with this recommendation by Dec 2015.

Since that time, ESHT have launched a new syringe driver policy, produced new syringe driver charts and collected data on training and the number of syringe drivers available. Additional syringe drivers have now been ordered so that all areas within the acute and community settings have access. Adequate numbers of syringe drivers will ensure that all patients requiring this specialist delivery of medication at the end of life have equitable and easy access.

The Heads of Nursing have emphasised to all clinical areas the vital importance of syringe driver training for all qualified nurses in ward areas and a targeted emphasis on this training need has been running since October 2015. Challenges have been acknowledged around the accuracy of the data produced regarding training and as such a snap shot survey was carried out in all ward areas by the Lead Cancer and EOLC Manager. The aim of this audit was to identify true levels of uptake and gaps in training which can then be taken forward and addressed on an individual or ward based basis. This mini-audit in Dec 2015 showed high levels (>80%) of essential syringe driver training for staff on wards which have frequent EOLC patients. On other gateway wards, such as short stay surgical wards, uptake was lower. At the recent TNMAG meeting (Jan

15th) it was agreed that senior nurses would be identified within the Trust who could act as super-users who could support those wards when needed.

6. Monitoring of Quality Indicators

Some broad indicators of the quality of end of life care for patients on the acute wards are now collected on the Meridian data-base, providing for the first time some on-going record of some aspects of care. The data collected so far, shows some improvement in the use of McKinley syringe drivers, but continues to show poor use of the rapid discharge pathway to support patients to be discharged from hospital in a timely manner when they wish to die at home.

Other data appears to be inconsistently or non-sensibly entered and the previous EOLC facilitator had concerns about the quality of data entry and hence the reliability of the data. It was not known if other areas have similar concerns or whether this was due to the fact that the questions are new and so this was discussed at the recent TNMAG meeting on January 15th. At that meeting it was acknowledged that staff may need support in understanding these questions and how to fill them out. The new EOLC facilitators will include this in their work plan.

7. Rapid Discharge Planning

Part of the difficulty surrounding rapid discharge planning has been the loss of discharge co-ordinators from the Trust. The responsibility has currently been transferred to the ward staff and it is the EOLC team's understanding that ward based staff have been trained to complete the Continuing Health Care Fast Track referrals which enable patients with a life expectancy of 4-6 weeks to access NHS funding for their care outside hospital.

8. Complaints Monitoring

A review of the core themes of End of Life Care complaints made to the Trust (acute and community) has been commenced from the beginning of October 2015. The complaints will continue to be investigated in the usual way within the appropriate department, but will also be collated for recurrent themes by the Lead Cancer and EOLC manager. These themes will be reviewed at least twice yearly to inform future EOLC teaching by the EOLC facilitators and others.

9. Patient and Carer Experience

The SPC Lead and EOLC Advisory Lead, together with the previous EOLC facilitator have been working with the patient experience team to explore whether the latter team could administer/support a survey of bereaved carers. This was another area which the CQC suggested ESHT needed to consider and is a national recommendation. A number of surveys used in other settings and Trusts have been reviewed, and will be discussed at the Patient Experience Steering Group on January 21st. TNMAG gave support for this proposal on January 15th.

Supported by the ESHT charitable fund, the Specialist Palliative Care team proposed the introduction of "Comfort Packs" for relatives and friends of patients who are dying in the acute setting but do not want to leave the bedside. The SPC lead has contacted the Volunteer Lead who can offer support to put the packs together and at TNMAG Jan 15th the proposal was that this could be led by an interested HCA or EOLC champion. In addition to this work for families, the Lead Cancer Manager, EOLC nurse and the new

EOLC facilitator have reviewed the facilities available for overnight accommodation for relatives of seriously ill patients. Money has again been secured to refurbish the rooms on both sites. This will complement the work already done around the availability of free parking for the duration of this difficult period.

10. End of Life Care Team Developments

Unfortunately there was only one EOLC facilitator in post between August 2014 and November 2015 within ESHT. This has significantly limited the development of EOLC initiatives within the Trust. In addition the EOLC steering group has been effectively disbanded in part due to the unforeseen unavailability of its Chair, who was active in progressing EOLC initiatives within the Trust. In addition, in November 2015 the remaining EOLC facilitator left and the trust was without an EOLC facilitator for about a month. A new EOLC facilitator has now been appointed and inducted into the Trust on the Hastings & Rother side and a second EOLC facilitator has been appointed and is expected to start by the end of February 2016.

The appointment of the new facilitator times well with the restructuring of EOLC within NHS England and their plans to re-promote the 'Transforming Programme' which aims to improve EOLC in acute hospitals. The aim would be to re-launch the Transform program in Spring/Summer 2016. The EOLC non-pay budget has now been received in the Specialist Medicine Unit and the plan is to support EOLC information, education and improvements with a fixed term project administrator appointment.

11. End of Life Care Training

Records of training kept by the departing EOLC facilitator have shown that between 30-40% of nursing staff in the last 3 years have received some EOLC teaching as part of the 5 year programme. EOLC & SPC is part of the induction of all new FY1 doctors and of their subsequent education sessions. It is also part of the induction of all nurses. The SPC teams in the acute setting have supported the education session on symptom control on the wards. It is still not clear however, whether we, as a Trust, wish a session on EOLC to be part of mandatory training for any group of healthcare professionals; this is a national recommendation.

12. Conclusion

The Board is asked to note the programme of work outlined in this document to support the Trust in providing a high standard of end of life care.

The Board is requested to approve the proposed EOLC Strategy attached as Appendix A.

Authors

Dr Debbie Benson

Dee Daly

Sarah Callaghan

APPENDIX A

Proposed EOLC Strategy for ESHT (acute and community)

1. Objective (Vision)

To ensure the end of life care (EOLC) provided by ESHT whether in the community or acute setting is of the highest standard achievable.

To work with other providers of EOLC in East Sussex to ensure continuity of care across primary and secondary care settings through shared care, collaborative working and supporting the integration of information systems.

2. Background

EOLC is provided across the acute and community sectors by a wide range of generalist and specialist ESHT staff. In the acute sector, the EOLC is provided directly by ESHT employees. In the community however, this care is provided in collaboration with other providers, such as GPs, socials services and hospices and requires ESHT engagement with other organisations and the CCGs to ensure patient safety, a high quality of care and an excellent patient experience.

Thus the ESHT EOLC strategy has two primary focuses. The first is 'internal' and is to ensure that the EOLC delivered to patients within ESHT-managed environments or directly by ESHT staff in the community setting is of the highest standard. This requires a knowledgeable, skilled and confident workforce with a compassionate attitude, who practice patient centred care and learn from mistakes to minimise any risks to patients and those caring for them. In turn this requires (a) education and training which embeds best practice, (b) information, guidance and documentation which supports care delivery, (c) a robust governance system which provides organisational learning and promotes patient safety and seeks to improve patient experience and (d) a sufficiently resourced specialist palliative care team to provide expert advice and support.

The second aspect of the EOLC is 'external' and relates to ESHT's need to engage with local CCGs and other providers to review and develop EOLC services in order to improve the care, safety and patient experience throughout the EOLC journey. This is consistent with the newly published NHS 5 year plan and with national and regional guidance on EOLC. This requires clear, committed and experienced leadership within the Trust, supported by the Trust Board.

3. Aims

The aim of this strategy is to establish a framework within ESHT which supports the delivery of high quality EOLC to all patients in the acute and community settings.

The structure aims to support responsible leadership in EOLC, clinical and corporate governance across all community and acute services that provide EOLC and a responsive, caring and well trained workforce.

4. Framework

The proposed framework is as follows:

4.1 Executive Lead for EOLC

- The Executive EOLC Lead is the Medical Director and has ultimate responsibility for the quality of EOLC delivered across ESHT.
- The lead will ensure EOLC strategy will become integrated into the wider Trust strategy and Quality Improvement Plan and that EOLC will continue to be a standing item at Trust Board meetings.
- The executive lead for EOLC will work with the Senior Leadership Forum (SLF), the Trust Board and the relevant clinical units, as well as other departments within the Trust (e.g. IT services), to ensure that the EOLC Team has sufficient resources to meet the agreed priority objective for EOLC.
- The Executive EOLC Lead will ensure that Trust-wide communication of EOLC priorities, policies and plans, is supported by the Communication Department and by other members of SLF, the Trust Board and relevant clinical units (such as through the CEO/Director of Nursing weekly news letters or information via payroll)

4.2 The Senior Leadership Forum

The Senior Leadership Forum will have the following responsibilities:

- To agree the operational priorities for the Trust in regard to improving EOLC, in line with national and regional guidance (including the EOLC Strategy, 2008; NICE guidelines, The 5 priorities of care of the dying, LACPD 2014) as recommended by the End of Life Care Team.
- To determine the resource and other requirements to meet the operational priorities.

4.3 The End of Life Care Team

The EOLC team will

- Create an action plan based on the agreed priorities and resource availability.
- Oversee the carrying out of those priorities which have been agreed and have sufficient resources to be undertaken.
- Report regularly to the EOLC Executive Lead on the progress towards achieving the operational priorities.
- Advise/liaise/work with other relevant groups or individuals (e.g. HONs/educational leads) within ESHT to ensure priorities are embedded within the Trust.
- Review the extent and content of the EOLC education delivered within the Trust and to liaise with the Trust education lead as needed.

- In conjunction with the Governance Team, the Complaints Team and the Clinical Units establish trends and ensure that learning is shared across ESHT.

- The EOLC Team meetings will respond to 'internal' ESHT needs which support the development of ESHT EOLC strategy and operations; but it will invite and link with 'external' other agencies in projects which require collaboration with other organisations and CCGs.

4.4 The EOLC Strategic Lead

- Will have ultimate responsibility to ensure that the recommendations of the EOLC Team are communicated to the Executive EOLC Lead.

4.5 The EOLC Clinical Advisory Lead

- Will provide expert advice (e.g. from a background of specialist palliative care) to the EOLC Team in relation to national and regional/local recommendations or programmes addressing EOLC issues. They will use their clinical expertise to guide related operational changes. They will support the EOLC Strategic Lead in their duties and help direct the work of the EOLC Facilitators.

- The EOLC priorities will be addressed by the establishment of Task and Finish groups, whose membership will be agreed between the EOLC Team and the Executive Lead for EOLC.

  Suggested priorities for 2015/2016 are

  i. Rapid discharge from hospital

  ii. Care in the last days of life

  iii. Patient and carer feedback

  iv. Universal electronic patient records to hold Advance care plans

4.6 EOLC Facilitators

The Trust will establish two EOLC Facilitator posts whose primary (but not exclusive roles) are outlines below:

- To raise the profile of EOLC (current issues, policies, service developments – local and national) within ESHT through provision of appropriate education, training and information to ESHT staff across all healthcare professionals

- To support the development, promotion and audit of new EOLC developments within ESHT (e.g. 5 priorities of care for the dying patient, preferred priorities of care, advance care planning).

- To educate, support and guide ESHT staff in the delivery of high quality EOLC using multiple teaching techniques including ward based, workshops and e-learning sessions.

- To ensure ESHT staff have access to appropriate and up to date resources to allow provision of high quality EOLC through maintenance and updating of EOLC 'webpage' and resource packs.
- To participate/lead on audit in EOLC with at least one audit a year agreed with EOLC Lead.
- To organise bi-annual ESHT EOLC 'conferences'.
- To contribute to and support an ESHT EOLC magazine.
- To work closely with those providing clinical specialist EOLC care to ensure consistency of education.

The activities of the EOLC facilitator will be guided by the EOLC action plan and the EOLC Executive Lead, EOLC Strategic Lead and EOLC Advisory Lead. The EOLC Facilitators may be asked to work in the acute Trust or Community setting, depending on the needs of the Trust and their expertise.

5. EOLC Governance Framework

Establishment of a new governance reporting structure for EOLC within the acute and community Trust. This structure will feed into existing governance structures and meetings within ESHT. This will ensure that Trust-wide learning from EOLC incidents, complaints and key performance indicators is disseminated by ESHT governance leads.

The key features of the proposed governance structures are as follows:

- The Meridian System is used to collect nursing key quality indicators (to be agreed by the EOLC Executive Lead) of EOLC on the hospital wards. This data will be reviewed by the EOLC Facilitators who will collate a report to be fed into the TNMAG to ensure corporate governance of EOLC. The report will also be presented to the Trust Board to guide relevant aspects of strategy, e.g. educational needs.
- SystmOne is used in the Community setting to collect Key Performance Indicators (to be agreed by the EOLC Executive Lead) of EOLC in the community setting. This governance process will start once SystmOne is fully rolled out in the Trust. It will require IT support to develop a suitable collection system and again would be anticipated as feeding into the TNMAG and its themes into the Trust Board.
- Internally identified risks and incidents relating to EOLC in both acute and community settings will be obtained from the Datix system by that department. The incidents will continue to be investigated by the Clinical Units. They will also be reviewed by the EOLC Facilitators who will collate emerging themes, to feed into the Quality and Standards Committee for corporate governance review and the EOLC Team to influence EOLC priority setting and strategy recommendations.
- Complaints from patient and carers about issues related to EOLC will be collected by the complaints department. The complaints will continue to be investigated by the Clinical Units. They will also be reviewed by the EOLC Facilitators who will collate

emerging themes, to feed into the Quality and Standards Committee and the EOLC Team to influence priority setting and strategy recommendations.

- All unexpected deaths in hospital and those that result in a formal complaint should be discussed at the relevant medical Morbidity and Mortality meeting (once investigation completed). This would be to allow learning to be shared amongst medical and surgical colleagues.

- The education department: (i) ensures that all EOLC training is registered on ESR and (ii) provides a bi-annual report for EOLC Team on training attendances.

- The EOLC Facilitators audit one or two priority aspects of EOLC across the Trust at a practice level; these priorities will be determined by the EOLC Team.

- The EOLC Champions will be the ward matrons within the acute Trust and the district nurses within the community teams, to ensure the most senior team members support EOLC developments. The EOLC Champions for their wards will have responsibility to cascade/model good practice in EOLC and ensure ward staff are aware of EOLC initiatives, guidelines, documentation, and opportunity for EOLC education.

6. National Audits

In addition to the creation of an internal governance structure, ESHT will commit to participate in related national audits so that it can benchmark its EOLC activity against other Trusts, and to further learn where it needs to improve practice. This may require additional resources.

7. Engagement with Commissioners and Other Providers of EOLC

ESHT will ensure regular engagement between the EOLC Executive Lead (or deputy) within ESHT, the local commissioners and other local providers of EOLC, to work towards a healthcare system which provides seamless EOLC for patients and carers, in line with national policies and recommendations.

East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board Meeting in Public
Agenda item:	14
Subject:	Transfer of Crowborough Birthing Centre and Community Midwifery services within High Weald to MTW
Reporting Officer:	Richard Sunley Acting Chief Executive

Action: This paper is for **(please tick)**					
Assurance		**Approval**		**Decision**	√

Purpose:

The attached report provides an overview of the proposed transfer of services provided from Crowborough Birthing Centre and Community midwifery services within High Weald localities to Maidstone and Tunbridge Wells NHS Trust (MTW).

Introduction:

High Weald Lewes and Havens CCG have held discussions with MTW around MTW providing the service within Crowborough Birthing Centre and Community midwifery services currently provided by ESHT.

MTW have also written an Expression of Interest to the CCG stating that the paper contains a high level proposal setting out the rational for MTW taking on the role of provider of maternity services at Crowborough Hospital.

In addition, at a public meeting of the CCG Governing Board in September 2015 the CCG agreed to undertake soft market testing with local providers regarding the agreed model for the optimum maternity journey.

Analysis of Key Issues and Discussion Points Raised by the Report:

A paper was presented to the Corporate Leadership Team on 29th October 2015 explaining that the CU were proposing that CLT considered the option of transferring the CBC to MTW as a formal transfer rather than part of a procurement competitive tendering process.

The birthing activity is limited within the Unit due to a number of drivers primarily geographical location to Tunbridge Wells; inability to recruit over recent months which has led to closure of the unit on occasions; transfer of staff to support acute unit and requirement to support a stand-alone unit with qualified midwives with very low activity levels. As well as the above drivers the transfer of Crowborough Hospital to NHS Property Services from 1st November 2015 also provides ESHT with an opportunity to review ESHT services provided within the property as ESHT are no longer the majority occupier.

Benefits:

Strategic vision focused on delivery of maternity services across the East and West of the county. Pathways currently to MTW from Crowborough. CIP saving for the Clinical Unit.

Risks and Implications

Transfer of midwifery staff to MTW

Assurance Provided:
The Trust will work closely with MTW to support an effective transition to minimise risk.

Review by other Committees/Groups (please state name and date)**:**
CLT, 29th October 2015 Board review January 2016

Proposals and/or Recommendations
The Trust Board is asked to review and formally agree the proposal to transfer Crowborough Birthing Centre and Community midwifery services within High Weald localities to Maidstone and Tunbridge Wells NHS Trust (MTW).

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None identified

For further information or for any enquiries relating to this report please contact:	
Name: Michele Small General Manager	**Contact details:** michelesmall@nhs.net

Crowborough Birthing Centre and Community Midwifery Services for HWLH localities

January 2016

Section 1

Transfer of Maternity services provided within Crowborough Birthing Centre and Community midwifery services for High Weald localities to Maidstone and Tunbridge Wells NHS Trust.

Brief Description:
High Weald Lewes and Havens CCG have held discussions with MTW around MTW providing the service within Crowborough Birthing Centre and Community midwifery currently provided by ESHT. MTW have also written an Expression of Interest to the CCG stating that the paper contains a high level proposal setting out the rational for MTW taking on the role of provider of maternity services at Crowborough Hospital. In addition at a public meeting of the CCG Governing Board in September 2015 the CCG agreed to undertake soft market testing with local providers regarding the agreed model for the optimum maternity journey.

Section 2 Executive Summary

A paper was presented to the Corporate Leadership Team on 29th October 2015 explaining that the CU were proposing that CLT considered the option of transferring the CBC to MTW as a formal transfer rather than part of a procurement competitive tendering process. The birthing activity is limited within the Unit due to a number of drivers primarily geographical location to Tunbridge Wells; inability to recruit over recent months which has led to closure of the unit on occasions; transfer of staff to support acute unit and requirement to support a stand-alone unit with qualified midwives with very low activity levels. As well as the above drivers the transfer of Crowborough Hospital to NHS Property Services from 1st November 2015 also provides ESHT with an opportunity to review ESHT services provided within the property as ESHT are no longer the majority occupier.

Strategic Context:
In Jan 2014 to Dec 2014 there were 176 births at Crowborough and approximately 800 women with a postcode in the community area of Crowborough had their baby at the Pembury site. MTW state that if they were the lead provider for Crowborough it is highly likely that this trend would be reversed and more women would give birth in their local Birthing Centre. MTW state that they would welcome the opportunity to increase the number of births at Crowborough and would provide women with an improved maternity pathway, and the pathway would be provided by one provider MTW but women would be able to choose to go to Conquest Hospital or Princess Royal at Haywards Heath if they choose.

If the CCG pursued the formal procurement route of issuing notice to ESHT then this could be a lengthy process for all concerned. At the CLT meeting it was agreed that there should be agreement in principle to transfer the services to MTW however the final decision would be taken by the Trust Board. To avoid any delay and to ensure the process was open and transparent staff were informed of this agreement in principle. In addition the CU management met with staff on the Crowborough Birthing Centre to discuss any concerns they may have. HR clarified following the meeting that the staff would be subject to TUPE and staff were duly informed of this.

Section 3 Option Appraisal

Two options were considered by the CLT and Option 2 was agreed and recommended.

Option 1 Do Nothing

Retain management of Crowborough Birthing Centre within ESHT with low birth numbers and pathway for mothers to go to MTW. Possibility of HWLH going out to procurement for the service and serving ESHT with notice.

Option 2

Agreement between ESHT/HWLH CCG and MTW to transfer service over to MTW and ESHT staff to be subject to TUPE.

Section 4 Workforce

Impact on workforce:

Job title	Band	WTE
Band 7		1.80
Band 6		10.00
Band 2		5.00

Section 5 Activity, Income and Costs

Impact on activity Yes ☐

Deliveries at Crowborough 1/1/2014 - 31/09/2015

2014			2015	
JAN	15		JAN	13
FEB	16		FEB	8
MAR	15		MAR	24
APR	14		APR	10
MAY	11		MAY	14
JUN	16		JUN	12
JUL	13		JUL	19
AUG	15		AUG	10
SEP	21		SEP	14
OCT	9			
NOV	16			
DEC	15			
TOTAL	**176**		**TOTAL**	**124**

The following table outlines the costs and income including an apportionment of the Maternity Block contract. This takes account of the £80k stranded costs. However this demonstrates that there will be an overall saving to ESHT as a result of the transfer. This supports the decision transfer to MTW in tandem with the practicalities of the transfer such as staffing and the current pathway is to MTW.

	Net Budget	Forecast to year end
	£	£
Crowborough Maternity Services	760,951	855,109
Estimated Overhead based on activity Q1	80,170	80,170
Gross Cost	**841,121**	**935,279**
Tariff Income: Based on 6 months activity to year end	- 300,000	- 300,000
Pro rated allocation Block Contract £2.6m	- 276,147	- 276,147
Income	**- 576,147**	**- 576,147**
Total Net Cost	**264,974**	**359,132**
Direct Net Cost	**184,804**	**278,962**
Potential stranded cost*	**80,170**	**80,170**
*Expected to increase due to reapportionment of the same relating to HW&L failed tender		

Section 6 Conclusion

The Corporate Leadership Team supported the transfer to MTW and as a result an agreement in principle statement was agreed between HWLH CCG, ESHT and MTW to confirm that this agreement in principle was in place, however the final sign off would be the responsibility of ESHT's Trust Board.

East Sussex Healthcare NHS Trust

Date of Meeting:	19th February 2016
Meeting:	Trust Board
Agenda item:	15 J
Subject:	Business Planning Update
Reporting Officer:	David Meikle

Action: This paper is for **(please tick)**					
Assurance	✓	**Approval**	✓	**Decision**	

Purpose:

To provide the Board with the progress on the business planning process and set out the broad financial assumptions for budget setting and cost improvement plans.

To seek agreement of delegated authority for the Finance and Investment Committee to sign off the Final Business Plan prior to submission to the Trust Development Authority.

Introduction:

The main planning guidance document Delivering the Forward View: NHS planning guidance 2016/17 to 2020/21 sets out the planning assumptions and priorities for the NHS for the coming year and beyond, reflecting both the government's Mandate to NHS England for 2016/17 and the on-going implementation of the Five Year Forward View.

It requires NHS commissioners and providers to submit two separate but interconnected plans in 2016:

A strategic, local health and care system Sustainability and Transformation Plan (STP), covering the period October 2016 to March 2021;

An operational plan by each organisation for 2016/17, that should be consistent with the emerging local strategy and completed in time to enable contract sign-off by the end of March 2016.

This paper provides details on the operational plan and progress towards its submission.

Analysis of Key Issues and Discussion Points Raised by the Report:

All providers will have in place robust, integrated operating plans for 2016/17 - that demonstrate the delivery of safe, high quality services; and achievement of, or delivery of recovery milestones for, access standards.

Through a combination of provider actions to improve efficiency, the expected tariff arrangements, and the deployment of the Sustainability and Transformation Fund (STF): there will be an improved financial position compared to 2015/16 for all providers and an aggregate break-even position for the provider sector.

Benefits:
To give assurance that ESHT can meet the TDA and national timetable to submit a credible operational plan with finance, activity and workforce information.

Risks and Implications
Failure to plan in a robust, comprehensive and triangulated manner may result in poor performance and increased scrutiny/intervention

Assurance Provided:
The timetable provides key dates for review and sign off by the senior leadership, the executive and the Trust Board.

Review by other Committees/Groups (please state name and date)**:**
The Senior Leadership Forum has already agreed the timetable and proposals to sign off the Trust's plans.

Proposals and/or Recommendations
The Board is asked to note: • the progress to date on the business planning timetable, • the risks and mitigations in providing a robust and credible plan and approve • delegated authority for the Finance and Investment Committee to sign off the Final Business Plan prior to submission to the Trust Development Authority.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None

For further information or for any enquiries relating to this report please contact:	
Name: Gary Bryant	**Contact details:** garybryant@nhs.net

EAST SUSSEX HEALTHCARE NHS TRUST

BUSINESS PLANNING 2016/17

1. Introduction

1.1 The main planning guidance document *Delivering the Forward View: NHS planning guidance 2016/17 to 2020/21* sets out the planning assumptions and priorities for the NHS for the coming year and beyond, reflecting both the government's Mandate to NHS England for 2016/17 and the on-going implementation of the Five Year Forward View.

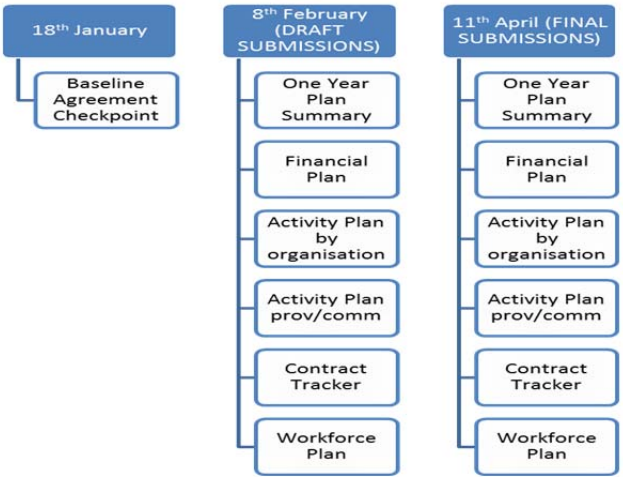
1.2 It requires NHS commissioners and providers to submit two separate but interconnected plans in 2016:

- a strategic, local health and care system Sustainability and Transformation Plan (STP), covering the period October 2016 to March 2021;

- an operational plan by each organisation for 2016/17, that should be consistent with the emerging local strategy and completed in time to enable contract sign-off by the end of March 2016.

1.3 This paper provides details on the operational plan and progress towards its submission.

1.4 The submission requirements are as follows:



2. National Must Do's (5 applicable to ESHT out of 9)

2.1 Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement.

2.2 Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

2.3 Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

2.4 Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

2.5 Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

2.6 The one year operational plans from the clinical units **must show**:

- How they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance). Ensure that each clinical unit has reviewed their capacity for 2016/17, along with the expected demand and identified productivity improvements (non-cash releasing) to meet the expected demand. (See 2.1 above).

- How they intend to contribute to efficiency savings of 2%. These must be cash releasing and be identified and reduced against issued budgets. They cannot be cost avoidance schemes, cost reduction over and above current budgets, or productivity improvements (reduction of length of stay). (See 2.1 above).

2.7 Plans to deliver the key must-dos. Clinical units should concentrate on their top 3 plans as a starting point, and any investment needs to be supported by a business case. (See 2.2-2.4 above).

2.8 How quality and safety will be maintained and improved for patients. Again additional costs must be supported by a business case. (See 2.5 above).

2.9 How risks across the clinical unit plans have been identified and mitigated through an agreed contingency plan;

3. Major Assumption Changes (from the November Board paper)

3.1 The major changes have been:

3.1.1 Tariff uplift of 1.1% rather than a deflator of 1.6%
3.1.2 A baseline CIP plan from each CU of 2% (rather than 3.5%), but with further cost reductions expected to be linked to productivity gains from the outcome of the Lord Carter review.
3.1.3 A cost inflation uplift of 3.1% to cover wage awards, changes in pension rules and non- pay inflation.

4. Other assumptions unchanged:

4.1 Activity growth c1% per annum based on demographic change statistics
4.2 No change in coding/case mix
4.3 'Cap and Collar' risk share with CCGs continues into all future years at current tariff-based activity/income levels
4.4 Future activity/income growth for local CCGs is negated by 'East Sussex Better Together' initiatives
4.5 Readmission penalty £2m but no other penalties for 'locals'
4.6 CQUIN received in full
4.7 No further loss of or reduction in services

Those assumptions will be tested through the planning round with both the clinical units and commissioners as contracts are agreed including activity and demand plans.

5. Budget Setting

5.1 The starting position of all clinical units is the forecast outturn at month 9 with adjustments made for all non-recurrent items, to arrive at a recurrent 2016/17 position. Challenge will be made where current costs are higher than 2015/16 recurrent budgets, and unless supported by robust business plans (as below), then those additional costs will not be funded in 2016/17. In addition:

5.2 Pay

5.2.1 All vacant posts at month 9 will be funded.

5.2.2 From 1st April the national rules on agency spend is expected to be a major driver on reducing costs and therefore the proposal is to fund all clinical units an agency premium of 55% on 3% of their total pay costs. This premium is available in year to support short term vacancy cover for all staff groups. This equates to c£4.m, an overall reduction on the current wage bill of c£8m, after taking into account substantive vacancies.

5.2.3 All current pay pressures, where cost and FTE is above establishment must be supported by plans to mitigate or provide evidence to support a permanent increase in staffing. For nursing, an example would be bed number increases, ward acuity changes etc. Medical staff changes should be supported by agreed demand and capacity plans. Executive support must be provided.

5.2.4 Wage award, incremental drift and the change in NI costs will be funded as per national guidance.

5.3 Non Pay

5.3.1 Inflation will be targeted against known increases (such as CNST). The default for non-pay should be zero inflation across most budget lines. Procurement savings, supported by the Head of Procurement should be identified as part of the clinical units CIP plans (see below)

5.4 Income

5.4.1 There is a tariff uplift of 1.1%

5.4.2 There should be no assumption around increased patient income to fund cost pressures or developments unless explicitly supported by commissioners.

5.4.3 Other income should be uplifted to cover increased costs, and all SLA's should be reviewed to ensure an appropriate margin is achieved.

5.5 Cost Improvement Plans (CIP)

5.5.1 Unidentified and non-recurrent CIP from 2015/16 will be rolled forward and each clinical unit will need to continue to meet these savings targets in addition to the 2016/17 target.

5.5.2 For 2016/16 CIP plans are to be 2% of issued 2016/17 budgets, both for pay and non-pay. These savings must be cash releasing and therefore can only be achieved by reducing **BOTH** budget and costs.

5.5.3 All CIP plans must be signed off by the QIA panel and will be monitored monthly internally via the Efficiency Improvement Group (EIG) and externally via the Trust's TDA returns.

5.6 Cost reductions and cost avoidance

5.6.1 Reducing costs from 2015/16 levels where no budget exists are not CIP plans but should be part of the clinical units plans to

bring them back into financial balance as part of the national Must Do's.

5.6.2 Similarly, in year plans to mitigate cost pressures are not CIP plans, but should be used to ensure financial balance is maintained.

5.6.3 Productivity improvements such as improving length of stay, increasing theatre utilisation are not generally cash releasing but should be used to support capacity shortfalls where funding is not agreed.

6. Timetable to completion

6.1 The key dates are:

Planning Away Day	CU Presentations	26 Jan
First Draft Submission	TDA Upload	8 Feb
Board Seminar	CU plan sign off	16 Mar
Finance & Investment Committee	Business Plan sign off	30 Mar
Final Submission	TDA Upload	11 Apr

6.2 The full planning timetable is attached in appendix 1

7. Key Risks

7.1 The timetable is short which provides little time to review, challenge and finalise clinical unit plans. This in turn will mean a short period in which to consolidate those plans and create robust budgets for both finance and activity.

7.2 Clinical Units are distracted from the business planning process due to operational pressures across the hospitals and in the community.

7.3 Negotiations with Commissioners may provide further challenges in meeting the must do's around performance and finances

7.4 There currently no agreement with the TDA as to what the "control total" for ESHT is to achieve in 2016/17.

7.5 CIP plans are not well developed by clinical units, and the lord Carter findings not yet fully understood by the whole of the organisation. The first meeting of the Efficiency Improvement Group met last week to provide governance to this process.

8. Conclusion

8.1 Guidance has now been received for the planning process which ESHT is committed to

8.2 A robust timetable is in place to meet the tight deadlines on plan submissions

8.3 The clinical units are working towards their business plans but need continuing support from the centre to complete

David Meikle
Interim Director of Finance
21 January 2016

APPENDIX 1

Business Planning 2016/17
Timetable and Key Dates

Trust Meeting	Order of Business	Date	Papers Due
Senior Leadership Forum	Update on Operational Plan and set out expectations and timetable	19 January 2016	15 January 2016
Business Development Group	Operational Plan update. Co-ordination of sections	20 January 2016	At least day before
Business Planning away day	CU presentations to SLF	26 January 2016	Presented
Business Development Group	Operational Plan Update. Feedback from away day. Progress report on Finance, Activity, workforce, Contract negotiation feedback	27 January 2016	At least day before
Finance & Investment Committee	Business Planning Update. Financial Assumptions	27 January 2016	20 January 2016
TDA Annual Planning Submission	Review of submission documents and update from leads	28 January 2016	Presented
Senior Leadership Forum	Draft Submission for sign off	2 February 2016	29 January 2016
Business Development Group	Triangulation review	3 February 2016	Tabled?
TDA Annual Planning Submission	Final submission review	5 February 2016	Presented
First Plan Submission	**TDA upload**	**8 February (noon)**	**8 February 2016**
Business Planning away day backup			
Business Development Group	Activity and Capacity review. Finance update	10 February 2016	Tabled?
Business Development Group	Contract negotiation feedback and triangulation	17 February 2016	At least day before
Finance & Investment Committee	Business Planning Update	24 February 2016	17 February 2016
Business Development Group	Progress review	24 February 2016	
Business Development Group	Progress review	2 March 2016	
Business Development Group	Progress review	9 March 2016	
Board Seminar	Final CU presentations and sign off of operational plans, budgets, activity and workforce	16 March 2016	Presented
Business Development Group	Progress review	23 March 2016	
Business Development Group	Progress review	30 March 2016	
Finance & Investment Committee	Business Planning Final sign off	30 March 2016	23 March 2016
Operational Plans Review Meeting	Progress review, F&I update	31 March 2016	
Senior Leadership Forum	Update on final Operational Plan sign off	5 April 2016	29 March 2016
Final Submission	**TDA Upload**	**11 April (noon)**	**11 April 2016**

Public Statement for 10th February 2016 Board Meeting on the ESHT's Preparedness for a Major Incident.

This Trust is a Category 1 Responder as defined in the Civil Contingencies Act 2004 and maintains Emergency Plans to enable us to respond quickly and effectively to a variety of incidents that may give rise to a significant increase in the number of patients arriving at our Emergency Departments.

Following the tragic events in Paris on November 13th 2015 the Trust has undertaken a review of its arrangements for responding to a Major Incident to ensure that our Plans are fit for purpose. These reviews have been followed by a practical test of our alerting systems to ensure that, if there was a Major Incident somewhere in Sussex, we could inform, and call in, additional staff to our hospitals to deal with the casualties.

In addition we have also ensured that, if it were needed, we could increase our ability, and capacity, to treat the most seriously injured.

The Trust will continue to regularly review its plans to respond to Major Incidents, regardless of the cause, and to continue to plan, train and test our response capability individually, as part of the wider NHS and with our multi-agency partners within the Sussex Resilience Forum.

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 4th November 2015 at 10.00am in the Bob Webster Seminar Room, EDGH

Present: Mr Mike Stevens, Non-Executive Director (Chair)
Mr Barry Nealon, Non-Executive Director

In attendance

Ms Janine Combrinck, BDO
Ms Deidre Connors, Head of Nursing, Specialist Medicine (for item 6)
Mr Jody Etherington, BDO
Ms Sarah Goldsack, Associate Director of Knowledge Management (for item 4)
Mr Stephen Hoaen, Head of Financial Services
Dr David Hughes, Medical Director (Clinical Governance)
Mr David Meikle, Director of Finance
Mr Adrian Mills, Audit Manager, TIAA
Mr Mike Townsend, Regional Managing Director, TIAA
Mrs Lynette Wells, Company Secretary
Mr Steffan Wilkinson, Counter Fraud Manager, TIAA
Mr Keith Wilshire, Interim Clinical Effectiveness Lead (for item 7)
Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

1. Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions were made.

Apologies for absence were received from:

Mrs Sue Bernhauser, Non-Executive Director
Mr Richard Sunley, Acting Chief Executive
Mrs Alice Webster, Director of Nursing

2. Minutes of the meeting held on 3rd August 2015

i) The minutes of the meeting were reviewed and agreed as an accurate record.

ii) Matters Arising

The following verbal updates were provided:

Audit Committee Annual Report

Mr Stevens reported that he had met with Dr Hughes in order to discuss the Clinical Audit Guide for NHS Boards and Partners which had been published by HQIP in January 2015. He provided a copy of this guidance to Mr Wilshere and asked Mr Wilshere to send him his views on the extent to which the Trust already complied with the new guidance and what changes needed to be made in order to comply with the guidance to the fullest extent. **KW**

Out of Date Trust Policies

Mrs Wells presented a list of out of date Trust policies and explained that the Policy Group had been working hard to reduce the number. She noted that the responsible person for each policy on the list had been informed of the need to review or update the policy or to remove it from the Trust's database if it was no longer relevant, and that this work was on-going.

Mr Stevens asked for a revised list of out of date policies to be sent to him, including narrative about which policies were considered to be out of date, so that he could be fully assured about the process of removing policies from the database. Mrs Wells said that she would ask the Policy group to provide this information to Mr Stevens. **LW**

Internal Audit Plan

Mr Townsend noted that due to the recent serious Information Governance breach within the Trust, a further audit on information governance had been arranged which would encompass progress on actions taken against audit recommendations from the previous audit on Data Security Measures and Data Loss in 2011/12.

3. Board Assurance Framework and High Level Risk Register

Mrs Wells presented the Board Assurance Framework (BAF) and high level Risk Register.

Mrs Wells explained that the BAF had been presented at the recent Quality and Standards meeting and a deep dive into Health Records had occurred. She reported that the issues around mandatory training had also been looked at in detail.

Mrs Wells reported that large amounts of work were being undertaken in order to improve staffing levels within the Trust and the tracking and storage of notes within Health Records. She noted that this work was unlikely to be concluded before the end of 2015. Ms Goldsack explained that the iFIT Health Record tracking system was now in place and was being incrementally rolled out across the

Trust. She explained that this would improve the availability of medical records for clinicians by electronically tracking health records throughout the Trust.

Mr Stevens asked about the extent of risks to patients that existed when health records were not available to clinicians, and Mrs Wells replied that partial electronic records were available to mitigate the risk to patients, and that if there were any patient safety concerns then appointments were re-booked. If this occurred then an incident would be logged on the datix system.

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

4. Clinical Coding Audit Update

Ms Goldsack explained that she was presenting the Clinical Coding Audit to the Committee in order to provide assurance about the quality of clinical coding within the Trust. She reported that a number of staff had left the clinical coding department during 2015 and that as a result of this agency staff had been engaged. She noted that an external audit had been undertaken to ensure that standards of coding were being maintained by agency staff, and that the results of the audit placed the Trust into level 2 of the clinical governance toolkit. She noted that the issues raised within the audit were tracked on the clinical audit action plan and were reviewed on a monthly basis.

Mr Stevens asked whether the recommendations made by the audit were being completed, and Ms Goldsack replied that the team were trying hard to implement them. She explained that one of the major issues the coding team was facing was in centralising the teams on both sites. This had been achieved at the Conquest, but a suitable space had not been found at EDGH and work was being done in order to find or create an appropriate space. Ms Goldsack noted that many of the recommendations made within the audit were linked to the on-going improvements within Health Records.

Mr Stevens asked whether any plans were in place for undertaking coding within the Trust more effectively. Ms Goldsack explained that three trials of different ways of working were currently being undertaken to test whether working practices could be improved.

Mr Meikle asked whether the Clinical Coding audit addressed the concerns raised by the external auditors and Mr Etherington replied that the department had shown clear improvements in their practices. He noted that the Trust Board was now receiving clear information about Clinical Coding and was focussed on ensuring the

quality of coding that was undertaken. He noted that many of the concerns that had been raised by BDO had been addressed by the external audit.

Ms Goldsack explained that Mr Meikle was supporting the Clinical Coding team in addressing their accommodation issues, and that new coding staff would be employed in order to help reduce the Trust's coding backlog. She agreed to update the Committee on progress against the audit recommendations in March 2016.

5. Research Governance Annual Report

Unfortunately Mrs Still did not attend the meeting, so it was agreed that the paper would be tabled at the next Audit Committee meeting in January 2016.

6. Clinical Unit Risk Register Reviews

Specialist Medicine

Ms Connors reported on the following risks for the Specialist Medicine Clinical Unit:

1268 - Inadequate Provision of medical Records Trustwide
Ms Connors explained that unavailability of Health Records for clinicians posed risks. She said that processes were in place to mitigate these risks, but that some consultants would rearrange a patient if their notes were unavailable. A paperless trial was being undertaken in some clinics to see if this would be a workable solution. Dr Hughes noted that some specialities would be able to carry out appointments without having access to paper health records, but that for many doctors it was vital to have relevant information about their patients available.

1260 – Patient Safety on Escalation Areas
Ms Connors explained that risks existed around the high level of nursing vacancies across her clinical unit and that plans were on-going to place more student nurses onto wards in order to mitigate this situation. She noted that recruitment of nurses from the Philippines was being planned.

1294 – Endoscopy Surveillance Backlog
Ms Connors noted that the endoscopy surveillance backlog was in being reviewed under a recovery plan and that progress in implementing this plan was being monitored on a daily basis in order to improve patient tracking.

999 – National Cancer Targets
Ms Connors noted that the Trust's progress on meeting national cancer targets was being monitored on a weekly and daily basis.

She explained that work was being carried out across the Trust in order to meet the national targets.

1270 – Lack of Regular Housekeeping Staff
Ms Connors reported that a review of housekeeping was being undertaken, but that she was not currently assured that her clinical unit was compliant with national cleaning standards due to a lack of staff and cleaning hours. She explained that she hoped that the issues would be resolved once the new regime recommended by the recent procurement review had been started.

1275 – Inadequate Facilities for Minor Operations
Ms Connors reported that a business case had been submitted in order to improve the current minor operations area at the Conquest, which was in need of improvement. She noted that minor improvements were also necessary at EDGH.

Mr Nealon suggested that the Friends of Conquest and EDGH could be approached to see if they would be willing to assist, as clear benefits would be attained for relatively small costs.

1077 – Chemotherapy Care
Ms Connors reported that the system the Trust had in place for scheduling chemotherapy care had originally not worked as effectively as had been hoped, but that it had been updated and was now improved. She explained that a further update to the system was available, but that purchasing this would have capital implications for the Trust and would require installation of the update across the entire Sussex Network in order to be worthwhile.

1361 – Non-Invasive Ventilation (NIV) Machines
Ms Connors explained that the NIV service was awaiting the outcome of a submission for tender, and that recently six NIV machines had been purchased for use in the community and for inpatients.

The Committee noted the Specialist Medicine Clinical Unit's risk register report.

7. Clinical Audit Update on the Forward Plan and progress to date (15/16 and legacy plans)

Mr Wilshere presented the Committee with an overview of the planned clinical audit programme for 2015/16, and noted that of the 199 audits that should have begun, 115 had commenced. He explained that he felt that the Trust was trying to undertake too many audits, and that whilst the Trust were broadly meeting mandatory audit requirements, they were failing to undertake sufficient level 2 audits as these were not being prioritised by the Trust or clinicians.

Mr Wilshere explained that level 4 audits had the best completion rate within the Trust. This was due to trainee doctors having to become involved in an audit as part of their training. He explained that these audits were often not well planned and recorded, and that he was concerned that considerable time and money was being spent on ineffective audits.

Dr Hughes said that administrative support for audits was being put into place within each Clinical Unit in order to improve the quality of audits undertaken. He noted that clinical leadership for audit had already been put in place in some Clinical Units, and that a process was underway to appoint clinical leadership throughout the Trust. Mr Wilshere explained that he planned to check the quality of every audit proposal made within the Trust, with support from Dr Hughes, to ensure that all audits undertaken were of an appropriate quality.

Mr Wilshere noted that the National Diabetes Adult Audit had been flagged as 'Red' on the forward plan, and Dr Hughes explained that this audit could not be completed due to incompatibility with the Trust's IT infrastructure. Mrs Wells explained that resolving the IT issues would have cost around £50k, and the Trust had not considered that this was the best use of funds.

Mr Wilshere noted that the Trust had a considerable legacy of action points following audits stretching back over a number of years that had not been completed. He proposed that a review of all the action points was undertaken in order to remove any actions that had been completed or were no longer relevant, and said that he would provide a report on his progress at the next meeting of the Audit Committee. **KW**

The Committee noted the Clinical Audit Update on the Forward Plan and progress to date (15/16 and legacy plans).

8. Internal Audit

a) Progress Report

Mr Townsend reported that six final audit reports had been produced, two with a limited and four with reasonable assurances. He noted that the final audit report remaining from 2014/15, in respect of e-rostering, had been finalised. He reported that all fieldwork due for Quarters 1 and 2 had been completed and that reviews for this work were now at the reporting stage.

Mr Townsend noted that Appendix C of the report included the key findings of the review of data loss prevention that had been undertaken, and that the review gave the Trust reasonable assurance. He explained that it was no longer possible to download files from computers attached to the Trust's network, but that a

possible risk had been identified relating to computers that were not attached to the network. Mr Meikle agreed to ask the IT department for details of computers that may be affected by this issue. **DM**

Mr Nealon commented that the Trust had undergone a number of changes in IT leadership in the past few years, and that he was concerned that the Trust's business continuity plans for IT were not sufficiently robust. Mr Stevens replied that although the Trust's IT systems had seen great improvement over the last few years, he was not able to give assurance that appropriate continuity plans were in place. He asked Mr Meikle to arrange for a report to be brought to the next Audit Committee meeting in order to provide assurance of the Trust's plans. **DM**

The Committee noted the Internal Audit Progress Report.

b) Audit Recommendations Tracker

Ms Wells reported that following a meeting with tiaa, the Trust were now using tiaa's electronic audit tracker rather than their own database. She explained that a comprehensive review of the actions on the database had taken place, and that many of the actions could now be closed, pending approval from the Audit Committee. She presented the audit recommendations tracker, along with proposed updates, to the Committee for their approval.

The Committee approved the updates made to the Audit Recommendations Tracker.

9. Local Counter Fraud Service Progress Report

a) Investigations Update

Mr Wilkinson provided an update on tiaa's reactive work to the Committee.

The Committee noted the Local Counter Fraud Service Investigations Update.

b) Fraud Awareness Survey Results 2014/15

Mr Wilkinson presented the Fraud Awareness Survey Results for 2014/15 and noted that 94% of staff had said that they would be happy to report fraud, and that in a test exercise 90% of staff had been able to correctly identify an example of fraud.

Mrs Wells reported that a Speak Up/Speak Out Guardian had recently been appointed to the Trust, with Speak Up/Speak Out Champions offering further support throughout the Trust. She explained that this would offer staff a further avenue through which to

raise any concerns that they may have, including suspected fraud.

The Committee noted the Fraud Awareness Survey Results 2014/15

c) Local Counter Fraud Progress Report

Mr Wilkinson noted that a new tool for reporting fraud online was due to be introduced in December 2015, and that this would be publicised to staff. He noted that a new edition of the FraudStop newsletter was due to be circulated to all Trust employees during the next week.

Mr Wilkinson reported that an audit of declarations of interest was being carried out, which would, in the first instance, be focussing on staff who had not submitted a declaration, and cross checking them against outside interests registered with Companies House.

The Committee noted the Local Counter Fraud Progress Report

10. External Audit Progress Report (verbal report)

Ms Combrinck explained that Bobby Grant had recently left BDO, and that she would be taking over as audit partner from him. Mr Stevens welcomed her to the Trust.

Mr Etherington apologised for the lack of written paper, and noted that the deadline for submitting the Trust's Annual Report was 22nd April 2016, with signing off due to take place on 2nd June 2016. He noted that the Audit Committee was due to meet on 1st June 2016, which was aligned with the date for signing off the Annual Report.

The Committee noted the External Audit Progress Report.

11. Tenders & Waivers Report

Mr Meikle presented the Tenders & Waivers Report, but noted that he wanted to revisit the reporting process as no mention was made within the report of any procurement from the estates or IT departments. He noted that the report showed an improvement in the number, and value, of waivers.

Mr Stevens asked about the process for ensuring the validity of the reasons given for requiring waivers and Mr Meikle explained that this was carried out by the procurement team. Mr Nealon asked how the Trust ensured that any agreed tenders did not have additional items added to them once they had been approved, and Mr Meikle explained that accountability reviews were held with Clinical Units where challenges were made to any proposed flexibility within agreements. Mr Meikle noted that he planned to revise the process

to ensure that any changes were approved by the Finance & Investment Committee and were challenged under the Cost Improvement Programme to ensure that they were necessary. He explained that a Trustwide review of procurement was being undertaken and that this would include a review of the tendering process.

The Committee noted the Tenders and Waivers Report.

12. Review of Losses and Special Payments

Mr Meikle noted that the volume and value of losses and special payments was greater than those in the previous financial year. He advised that there had been a one-off loss of £35k due to the loss of the wheelchair tender.

Mr Wilkinson explained that he would like to review the form presented to patients when they claimed for the loss of personal belongings to include wording that would allow the Trust to follow up any claims that they felt may be fraudulent.

Mr Nealon asked about the write offs associated with pharmacy, and Mr Hoaen explained that this was mainly due to stock going out of date, or the partial use of vials of drugs which had to be written off once opened.

The Committee noted the Review of Losses and Special Payments.

13. Review of Declarations of Interests, Gifts & Hospitality

Mrs Wells explained that national guidance for a 'Sunshine Rule' for logging gifts and hospitality from pharmaceutical companies was due to be introduced, and that the Trust's policy would be revised accordingly. She reported that the process for collecting declarations had been changed for 2015/16, and that electronic submissions were now being accepted for the first time.

Mrs Wells noted that the number of declaration of gifts and hospitality received were substantially less than she would expect to see, and that messages had recently been sent to all staff to reinforce the importance of making declarations when appropriate.

Mr Stevens asked whether staff should be sent forms at the end of each financial year asking them to declare that they had received either nothing or something, rather than the current system where staff had to proactively declare any gifts. It was agreed that this would be trialled. **PP**

The Committee noted the Review of Declarations of Interests,

Gifts & Hospitality.

14. Information Governance Toolkit Update

Mrs Wells provided an overview of the current status of the Information Governance Toolkit. Revisions to the toolkit requirements were discussed and it was noted that there were significant changes to 11 of the 45 requirements. For 2015/16 the initial submission made in July was 26% and the mid-year, end of October, submission was 42%. To achieve a satisfactory or green score the year-end target requirement was a minimum of level 2 for the 45 requirements or 66%, whichever was higher. It was noted that the current position was 11 at level 0, 11 at level 1, 22 at level 2 and 1 at level 3. The Information Governance Manager was working hard to facilitate compliance and continues to meet with leads to provide support. Mrs Wells commented that lack of engagement in some areas was disappointing despite the fact that the toolkit has been in place for a number of years. However, she remained confident that we would achieve level 2. It was noted that the audit would take place in two parts one before Christmas and one after, which was a successful method last year.

The committee reviewed the IG incidents and discussed the data stick breach; a comprehensive Root Cause Analysis had been undertaken and a number of actions agreed. Mrs Wells advised that two incidents had been reported to the ICO, the second related to a handover sheet. The ICO had confirmed that they were satisfied with the Trust handling of both matters and had closed their case files. The number of IG incidents reported had increased probably due to the increased awareness across the Trust.
The Committee noted that they had not been advised of any data breaches where there was not a clear legal basis for sharing the information. This reporting was required as evidence for the Information Governance Toolkit.

The Committee noted the Information Governance Toolkit Update.

15. Annual Review of Corporate Documents

Mrs Wells noted that the Trust was required to review its Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation on an annual basis. She explained that the main revisions to the Corporate Documents were due to members of staff leaving the Trust, and in making minor changes to processes. She asked the Committee to approve the proposed changes.

The Committee approved the changes proposed within the Annual Review of Corporate Documents

Meeting Dates 2016 and Work Planner 2016

16.

The Committee asked for a Clinical Coding Update to be added to the planner for March, and an update on IT to be added for January 2016. Mrs Wells asked for any further suggestions to be sent to her following the meeting.

The Committee approved the Meeting Dates 2016 and Work Planner 2016

17. Date of Next Meeting

The next meeting of the Audit Committee will be held on:

Wednesday, 20th January 2016, at 10.00 am in the Committee Room, Conquest Hospital.

Signed: ……..

Date: ……

East Sussex Healthcare NHS Trust

AUDIT COMMITTEE

1. Introduction

1.1 Since the last Board meeting an Audit Committee meeting has been held on 20th January 2016 and a summary of the matters discussed at that meeting is provided below.

1.2 The minutes of the meeting held on 4th November 2015 are attached at Appendix 1.

2. Board Assurance Framework and Risk Register Review

2.1 The Company Secretary presented the Board Assurance Framework and it was reviewed and discussed by the Committee.

2.2 She advised the Committee that she expected risks relating to HCA recruitment and the transfer of services to HWLH could be expected to be removed from the Framework in the near future.

2.3 She presented the updated Risk Register to the Committee, noting that there was an expectation that estates would be adding risks to the register in the near future due to a evaluation work being carried out within the Trust.

2.4 The Committee noted the report and the actions being taken to manage the risks.

3. Urgent Care Clinical Unit Clinical Audit and Risk Register Review

3.1 The General Manager of the Urgent Care Clinical Unit presented the Committee with an overview of the Clinical Unit's progress in undertaking, and completing, Clinical Audits. She noted that three major audits were currently being undertaken on VTE, sedation in adults and vital signs in children.

3.2 She presented the CU's Risk Register to the Committee, noting that main risk faced by the CU was around staffing levels.

3.3 The Committee noted the Clinical Unit's Audit and Risk Register Review.

4. ESHT Benchmarking Against Revised Guidelines and Standards for clinical audit

4.1 The Interim Clinical Effectiveness Lead presented a benchmark on the Trust's position against newly published national standards for audit.

4.2 He advised that 10 principles were set out amongst the guidelines that Trusts should be following and that he had graded ESHT's progress against these 10 principles.

4.3 The Committee discussed the results of the Benchmarking and the actions that were being taken to improve the Trust's performance in undertaking and completing clinical audits.

5. Clinical Audit Forward Plan 2015-16 Report

5.1 The Interim Clinical Effectiveness Lead presented the report and noted that the Trust had been unable to participate in the National Adult Diabetes Audit as it did not have the required specialist software.

5.2 The Committee discussed the difficulties that had been faced in completing a non-mandated national blood transfusion audit during 2015/16 and the fact that this might become a mandatory audit in 2016/17.

5.3 The Committee discussed the level of risk that existed around incomplete audits, and what actions could be taken to reduce incidences of incomplete audit.

6. Internal Audit

6.1 The Committee received the progress report and noted that three audits had been completed since the last meeting and reviewed their conclusions.

7. Local Counter Fraud Service Progress Report

7.1 The Committee received the progress report and noted the actions being taken in respect of on-going investigations. It noted that 5 new enquiries had been opened since the meeting in November 2015, accruing savings for the Trust of £13k.

7.2 The Committee discussed whether the Trust's whistleblowing policy could include a direct link to the Counter Fraud services for staff.

7.3 The Committee noted the report.

8. External Audit

8.1 The external auditor presented the report to the Committee and noted that the audit plan would be brought before the Committee in March.

9. Tenders & Waivers Report

9.1 The Director of Finance presented a report on the Tenders and Waivers between 1.10.15 and 31.12.15 which was noted by the Committee.

10. Information Governance Toolkit Report

10.1 The Company Secretary presented an Information Governance Toolkit update. She noted that the Trust reset its evidence base to zero every year in order to ensure that evidence presented was up-to-date. She explained that she was confident that the Trust would achieve level 2 in 2015/16.

11 Losses & Special Payments Review

11.1 The Director of Finance presented a report on Losses & Special Payments.

Mike Stevens
Audit Committee Chairman

2nd February 2016

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 16th December 2015 at 9.30am – 11.30am, in St Mary's Board Room, Eastbourne DGH

Present
Mr Barry Nealon, Non-Executive Director (chair)
Ms Jackie Churchward-Cardiff, Non-Executive Director
Mr David Meikle, Interim Director of Finance
Mr Philip Astell, Deputy Director of Finance
Mr Richard Sunley, Acting Chief Executive
Mrs Pauline Butterworth, Acting Chief Operating Officer
Dr David Hughes, Medical Director

In attendance
Mrs Sue Bernhauser, Acting Chair
Mrs Maggie Oldham, Improvement Director
Mrs Lesley Walton, Programme Manager (for item 3)
Mrs Alex Graham, Head of Financial Management (for item 5)
Mrs Jo Brandt, Head of Planning & Performance (for item 8 & 9)
Mr Ajay Channana, Head of Procurement (for item 12)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to meeting and, in particular, welcomed Ms Jackie Churchward-Cardiff to her first meeting of the Finance & Investment Committee. Apologies were received from Mr Mike Stephens.	**Action**
2.	**Minutes of Meeting of 25 November 2015** The minutes of the meeting held on 25 November 2015 were agreed as an accurate record.	
3.	**Matters Arising** (i) Estates & Facilities CIP The Committee received an update report on the position around the CIP programme within Estates and Facilities. It was reported that the CIPs for FY 16/17 were being developed in advance of FY 16/17 and that expenditure in the current financial year was being closely	

	managed. The Committee felt there should be much tighter controls around the accountability of the CIP programmes. Mr Meikle reported the CIP programme is managed through the Accountability Reviews and that these will be discussed at the new Productivity and Efficiency Group. <u>(ii) ITFF Application and LTFM</u> It was noted that the final ITFF application letter and LTFM was presented to the Trust Board for formal agreement at its meeting on 2 December 2015. <u>(iii) Recruitment Trajectory</u> This was discussed under item 6 below. <u>(iv) Community Rebasing Project</u> This was discussed under item 7 below. <u>(v) PMO Project Update</u> Mrs Walton presented an update report providing more detail and further information on the Pathology Managed Equipment, Vital PAC and the Community & Child Health project as requested at the November Finance & Investment committee meeting. The Chairman asked for a more detailed update on Pathology for the January 2016 meeting. Mrs Walton provided further information on the benefits of Vital PAC. It was agreed that Mrs Butterworth would liaise with Dr Slater outside the meeting to assure the benefits of Vital PAC were fully communicated to all the Trust staff. <u>(vi) Procurement Update</u> Mr Astell reported that a new Efficiency Improvement Group was being set up and a meeting to discuss this was scheduled for January. The Group would have Non Executive Director representation. The Chairman reported that the Board was interested in receiving feedback on the Lord Carter report. It was agreed that a Lord Carter report update would be presented to the January 2016 Finance & Investment Committee meeting. <u>(vii) HWLH Community Transition Update</u>	**LW** **PB** **PA**

	Mr Meikle circulated a summary of the PWC impact assessment on ESHT loss of Community Services Contract for information. The full report will be emailed to the Group following the meeting. A more detailed report on Stranded Costs would also be presented at the next meeting.	**DM**
4(i)	**Integrated Performance Report – Month 8** Mrs Butterworth gave a brief performance update at month 8. Due to the timing of the Committee a full Integrated Performance report was not available for this meeting. It was noted that A&E has been significantly challenged around achieving 4 hour standard. However the Trust continues to meet its RTT incomplete target and will achieve diagnostics and breast 2 week wait alongside the 31 day standard. **Action** **The Committee noted the Performance update at month 8.**	
4(ii)	**Flash Report - Month 8** The Committee received a flash report providing an update on the financial position as at month 8. Due to the timing of the Finance & Investment Committee, a full finance report was not available. In month, income had underachieved and expenditure had overspent. The year to date run rate was a deficit of £31.6m which was £7.3m worse than the revised plan. The Committee challenged the reasons behind the deteriorating position and asked that a report on grip and control measures be presented to the next meeting. **Action** **The Committee noted the month 8 position.**	**DM**
5.	**2015/16 Forecast Outturn & Downside Case (deep dive) Presentation and Discussion** Mr Meikle presented a briefing on the financial performance for 2015/16 and highlighted the following key messages: • In month 8 (November 2015) the Trust generated a £5.8m deficit, £2.3m greater than plan • This had increased the year to date deficit to £31.6m, £7.3m greater than plan • Key drivers of the deterioration performance were: increasing agency costs, escalation beds, quality improvement plan implementation costs and CIP slippage	

	• A number of scenarios exist regarding the forecast outturn. Due to volatility in the cost base and the uncertainty in potential income streams, further time is needed in order to determine the year end position. When the month 9 position is reported, a definitive forecast outcome scenarios will be presented. The Committee received information on the forecast outturn scenarios, and detailed information of agency spend by clinical unit. Mr Meikle highlighted the following recovery actions were in place: • Establishment of a Temporary Workforce Review Group with a wide remit to review all aspects of temporary workforce spending including deep dives into specific areas of concern • Compliance with the recommended actions in the agency cost reduction tool • Compliance with the recommended actions in the Grip and Control Checklist which will increase review of all discretionary spending • Continued discussions with the commissioners re: additional income (Healthy Hastings, QIP support, stranded cost support, Winter Funding) • Review of possible service/activity reductions in Q4 It was noted that Mr Meikle had attended the Start the Week Meeting to re-inforce control measures. Mrs Butterworth explained how the temporary workforce is managed on a day to day service and stressed that there were very clear control measures in place. Mr Meikle circulated information to the Committee on agency costs, including a diagnostic tool received from Monitor on how to reduce the use of agency staff. The Committee also received a copy of a grip and control document issued by the TDA. **Action** **The Committee noted the report.**	**DM**
6.	**Recruitment Trajectory** Mr Meikle presented a report updating the Committee on vacancies and recruitment plans across the Clinical Units of the Trust. The reduction of the Trust's temporary workforce is a key objective as the Trust strives to increase quality and reduce costs. A robust recruitment plan with specific actions and timelines linked to a reduction in temporary staff is critical in giving the Board assurance that this objective is being implemented.	

	It was noted that the next stage would be to map these plans against permanent workforce turnover projections and temporary workforce projections in order to measure and monitor progress; highlighting risks and opportunities. The Committee received assurance that workforce plans were in place and were being implemented. It was agreed that this item would be reviewed by the Committee on a Quarterly basis. **Action** **The Committee noted the report.**	**CK**
7.	**Community Rebasing Project** Mr Astell reported that the initial phase of this project had been successful in achieving an additional £4m of CCG funding for community services in 2014/15. The project was discontinued earlier this year but was now being restarted in order to ensure that the further potential benefits can be delivered. It was noted that the schedule of costs (rebasing matrix) would need to be to be updated and the Trust would need to look at the allocation of overheads including the reallocation of the 'stranded' overheads from the loss of the HWLH community contract In parallel with the costing work the service specifications are being re-drawn and discussed with the commissioners to ensure that there is a proper alignment between the resources employed and the services and specifications being agreed to. The commissioners have agreed to engage in the process on the basis that this is cost neutral overall and have agreed to an independent review of the outcome. It was noted that the Community Rebasing project will help to drive the data quality agenda. A further update will be provided at the March 2016 Finance & Investment Committee. **Action:** **This Committee noted the Community Rebasing Project update.**	**PA**
8.	**EBITDA Quarterly Report - Q2** Mrs Brandt presented the Committee with the 2015-2016 Q2 EBITDA statement, the 2015-2016 quarterly EBITDA comparison statement and the Patient Cost Benchmarking opportunity cost statement. Mrs Brandt summarised the top 5 specialities that were highlighted as	

	a concern due to the EBITDA deficit. The Committee noted: - The 2015-2016 Q2 EBITDA deficit position for the clinical units - The number of service lines that have negative EBITDA - The 2015-2016 quarterly EBITDA variances. - The effect on the 2015-16 EBITDA of using Patient Cost Benchmarking average unit costs when applied to ESHT inpatient activity for top 5 specialties only. Fines & Penalties were not included within the Q2 EBITDA and the 2015-2016 Q2 EBITDA statement had been reconciled to the Trust's finance report. A Urology deep dive will be presented at the January 2016 meeting. **Action:** **The Committee noted the EBITDA statement position and recommended that the Committee continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews, and to return at a subsequent meeting to update on their progress.**	**JB**
9.	**2014-15 Reference Costs RCI** Mrs Brandt presented the published 2014-15 reference cost index. She explained that reference costs are the average unit cost to the NHS of providing defined services in a given financial year to NHS patients in England and are collected annually by the Department of Health. The accuracy of the data has improved year on year due to refinements in the guidance and the collection process. The reference cost index (RCI) is the measure of the relative efficiency of NHS trusts which shows the actual cost of a trust's casemix delivered at national average cost. The committee noted the 2014-15 reference cost index of 101, an improvement on the 2013-14 reference cost index which was 104. It was noted that the Trust had reconciled the 2014-15 reference cost return to the 2014-15 final financial accounts, to ensure that all relevant costs were reported. Mrs Brandt updated the Committee on a recent mandated reference cost audit undertaken by PWC on behalf of Monitor and provided some detail around the areas involved. It was noted that overall it was a good audit, however there were some issues around coding resource. Mr Meikle explained the plans in place to address some of	

	these issues. It was agreed that Mrs Brandt would provide an update on the issues arising from this audit and the actions taken at the March 2016 Finance & Investment Committee. It was also agreed that issues relating to coding would be flagged on the risk register. It was noted that the reference costs guidance for 2015/16 had recently been issued and was more prescriptive than that of last year. **Action:** **The Committee noted the reference cost index and recommended that the Trust use Department of Health reference costs benchmarking software as an enabler to identify CIP schemes, and consider the reference cost index when considering service change.**	**JB** **DM**
10.	**Tenders Schedule and Business Cases** The Committee received a schedule providing up update on current tenders as at 8 December 2015. The schedule is monitored by the Business Development Group (BDG) on a fortnightly basis. Any new Pre-Qualification Questionnaire (PQQ) or tender proposals are considered by the Corporate Leadership Team (CLT) to determine whether a potential bid by the Trust would meet a number of key criteria. The Committee noted the position of the following PQQ/tenders in the pipeline: • Community Diabetes Service for Brighton & Hove and High Weald Lewes & Havens CCGs • Integrated Sexual Health and HIV Service • Non-Invasive Ventilation Service It was noted that the Trust had been notified on 14 December 2015 that it had won the tender on the Integrated Sexual Health and HIV Service. **Action** **The Committee noted the update on tenders and service developments.**	
11.	**Job Planning – Quarterly Update** Dr Hughes gave an update on the Job planning position. The Trust had introduced a more rigorous and robust method of job planning this year to ensure that consultant activity was fully aligned	

	with Trust plans and there is the most productive use of consultant time and clinical facilities. Monthly scrutiny meetings have been undertaken with each CU from August 2014 through to March 2015. Regular contact with them continues by the Assistant Medical Director – Workforce and the revalidation and job planning team to ensure progress continues to be made and that the job plans reflect the workload and activity the Trust needs to undertake. All consultants have job plans that are being reviewed annually aiming to achieve standards based on the new job planning guidance. The Committee received an update on job planning compliance and their trajectories provided by each Clinical Unit. **Action** **The Committee recommended that this work continues.**	
12.	**Business Cases for Review** **Managed Print Solution Project (Enterprise Printing) Update** Mr Meikle presented an update on the progress on the Managed Print Solution (Enterprise Printing) project. Mr Channana provided the Committee with an update on the Procurement options that the trust had been looking at, and summarised the benefits to rationalising the number of aging printers/ photocopiers and scanners on the two acute sites; replacing them with modern devices with a fully managed enterprise wide print solution from single supplier. A draft Full Business Case will be presented to the F&I Committee in January 2016 to ask for approval to proceed with the tender process to secure an appropriate supplier with a view to roll-out completed to the two acute sites by the end of December 2016. **Action** **The Committee noted the update on the project and the draft FBC will be presented to the meeting in January 2016.**	**DM**
13.	**2015/16 Work Programme** The 2015/16 work programme was reviewed. It was agreed that the following items would be added to the work programme: Lord Carter update – January 2016	

	Enterprise Printing Draft FBC - January 2016 Capital Programme and 5 year plan – February 2016 Community Rebasing - March 2016 Recruitment Trajectory – March 2016 Update on issues arising from Reference Cost Audit - March 2016 **Action** **The Committee noted the work programme and update.**	
14.	**Date of Next Meeting** The next meeting will take place on Wednesday 27 January 2016 at 9.30am – 11.30am in the Princess Alice Room, Eastbourne DGH	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 21st October 2015 at 9.30am – 11.30am, in the Committee Room, Conquest

Present
Mr Barry Nealon, Non-Executive Director (chair)
Professor Jon Cohen, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mr Richard Sunley, Acting Chief Executive
Mr David Meikle, Director of Finance
Mr Philip Astell, Deputy Director of Finance

In attendance
Mrs Sue Bernhauser, Acting Chairman
Mrs Maggie Oldham, Improvement Director
Mr Steve Hoaen, Head of Financial Services (for item 6)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee meeting and in particular Mrs Oldham and Mrs Bernhauser were welcomed to their first meeting. Apologies were received from Dr David Hughes.	**Action**
2.	**Minutes of Meeting of 23 September 2015** The minutes of the meeting held on 23 September 2015 were agreed as an accurate record.	
3.	**Matters Arising** (i) Abridged Minutes of meeting of 23 September 2015 The abridged minutes of the meeting of 23 September 2015 were noted and agreed. This version would be sent to Pete Palmer for the Trust Board. (ii) PMO Update ***Vitalpac Update*** Mr Sunley gave an update on the Vitalpac version 3. upgrade. It was noted that tests were being carried out and the Trust was expecting to	

	go live with an upgraded core nursing module on 14 December 2015. ***Level of resource in PMO Office*** Mr Sunley reported that lengthy discussions had taken place regarding the level of resource in the PMO office with particular focus on the improvement plan. A report had been requested by 19 October 2015 on how resources could be freed up and used in a more focused way. It was noted that a meeting was scheduled to look at scoping what needs to be done to try and improve the project management support to the improvement plan. It was noted that Executive Team were focused on this as a priority. ***JAG Accreditation*** Mr Sunley gave a brief update on the JAG accreditation position. It was noted that the Trust was still struggling with waiting times. The planned building work was ongoing. It was felt that more project management time was required to work through this project. It was agreed that a further detailed report would be requested for the next meeting. <u>(iii) Annual Review of Committee Effectiveness</u> The revised Finance & Investment Committee Terms of reference were presented to the September Board Meeting. <u>(iv) Finance Update – Month 5</u> The financial recovery plan was discussed under agenda item 4C below.	**RS**
4(i)	**Performance Report – Month 5** Mr Sunley presented the month 5 Performance Report which detailed the Trust's in month performance against key trust metrics as well as activity and workforce indicators. The report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15. Overall Performance Score: 4 (from a possible 5) <u>Responsiveness Domain</u>: 3 Although the Trusts A&E Performance dipped this month, improved performance in the Cancer 31 Day Target means that this domain has remained at a score of 3. 9 out of the 17 indicators for this domain were achieved this month. The Trust maintained the Diagnostic standard but unfortunately the	

	Trust did not achieve the Two Week Wait Cancer standard. The other indicators which were not achieved this month were: • A&E • Referral to Treatment Admitted and Non Admitted • Cancer 2 Week Wait Standard • Cancer 62 Day Standard • Cancer 62 Day Standard for Screening • Cancer Breast 2 Week Wait Standard • Delayed Transfers of Care <u>Effectiveness Domain</u>: 5 The domain remained at a 5, achieving in all indicators with the exception of SHMI. <u>Safe Domain</u>: 3 There were a total of 7 cases of C-Difficile in August. 2 cases of MRSA were reporting in August. <u>Caring Domain</u>: 5 All indicators were achieved. <u>Well Led Domain</u>: 2 Friends and Family response remained below the 30% standard because we now have to include all day case and all children in the return (previously these had been excluded). This has increased the denominator but not the numerator and thus dropped the percentage. **The Committee noted the Performance Report for month 5 and noted the Trust Performance against each domain and the Workforce update.**	
4(ii)	**Performance Report – Month 6** A Performance report for month 6 was tabled. Mr Meikle reported that it was the intention was to bring the Performance Report and the finance report in parallel. It was noted that there were still a number of gaps in the performance report. Mr Sunley gave an update on the month 6 position and the following key issues were noted: <u>Referral to Treatment (RTT/18 Weeks)</u> The Trust continues to achieve the 'Incomplete' standard of 92% with a September position of 93.38% The drop in performance against previous months continues as expected as part of the separation of Sussex MSK Partnership data from August onwards. As of June 2015, the Admitted and Non-Admitted RTT targets were abolished and Trusts will now only be held accountable for meeting	

	the 92% 'incomplete' RTT target. This indicator requires that a minimum of 92% of patients on an incomplete pathway (waiting list) should be waiting less than 18 weeks from receipt of referral. This standard includes all patients who are yet to receive their first definitive treatment or discharge and also includes all patients who are still waiting for an outpatient appointment, diagnostic test or elective admission. The Trusts Admitted position for September was 76.82% against a target of 90%. The Non-Admitted position was 87.59% against a target of 95%. Both pathways continue to be particularly challenging and this is being monitored via the Trusts weekly PTL meetings. <u>Diagnostic Waiting Times</u> Diagnostics failed the wait time target predominantly within Endoscopy and Radiology. <u>A&E compliance</u> Conquest remains challenged with bed flow. An A&E improvement plan is currently in development. It was noted that the Trust was struggling with recruitment in A&E. <u>Cancer performance</u> These figures were not yet available <u>Delayed Transfers of care</u> DTCs are aggregated (Acute and Non-Acute combined) within the accountability framework's responsiveness Domain. Slight improvements seen across acute and non-acute during September. The Committee expressed their concerns with regard to A&E and requested that a report is presented to the Trust Board. **The Committee noted the performance update for month 6.**	**RS**
4(iii)	**Finance Update – Month 6** Mr Meikle gave an update on the Month 6 financial position. It was noted that the Trust's financial position was £3.6m adverse to plan for the first six months. Cost improvements to date were £1.1m (23%) behind plan and were just 31.5% of the full year target. There was heavy reliance on agency staffing to meet vacancies and	

	the associated costs have increased substantially. The Trust needs to apply to the ITFF for additional cash funding to meet its requirements. It was noted that the Trust had put in place a number of measures for financial improvement but there remained a significant risk to delivery of the financial plan for the year. The Chairman asked if the high cost drugs spend could be highlighted in future reports to help identify where the real variances were. **The Committee noted the financial position as at Month 6.**	**DM**
4(iv)	**Financial Recovery Plan and Downside Case** A financial recovery plan was tabled and Mr Meikle and Mr Astell gave an outline of the: • Income assumptions in forecast • Expenditure assumptions in forecast • Forecast outcome summary • 2015/16 downside side at Month 6 • Potential mitigations • Cash flow assumptions • Cash flow projection **The Committee noted the latest forecast outturn, its cash impact and the potential downside scenario.**	
5.	**Mid Year Financial Performance Review** Mr Meikle presented the Committee with an overview of financial performance in the first six months, and highlighted the key issues and risks. He provided assurance to the Committee that all practical steps were being taken to address adverse performance to date. It was noted that the Trust was currently facing an unprecedented level of financial challenge in the current year, driven by local pressures, many of which were not new, and well-publicised national issues being faced across the NHS. These pressures were reflected in the adverse financial position against plan to month 6. Mr Meikle reported that he was planning to undertake a deep dive into the cost improvement programme within the next few weeks. **The Committee noted the key issues highlighted in the report.**	**DM**

7.	**2015/16 Review of Capital Programme Outcome** The Committee received an update of capital business case outcomes as at the 30th September 2015. The following capital business cases had been considered by the Capital Approvals Group (CAG) and the Finance & Investment Committee and are being progressed as part of the capital programme. • Electronic document management • Oasis PAS upgrade, including clinic manager implementation • Health Records – introduction of a bar coding identification system and improved physical storage • Infrastructure improvements – modernisation of inpatient environment and facilities • Pevensey development • Windows 7 Office 2010 migration The Committee were pleased to note that the control mechanism had worked well and that the projects had been managed and controlled within the budget allocated. It was agreed that this would be fed back to the Capital Approvals Group. **The Committee noted the current position on live capital business cases considered by the Capital Approvals Group (CAG) and by the Finance & Investment Committee 2015/16 year to date.**	
6.	**Quarterly Review of Aged Debts** Mr Hoaen presented a report showing the current level of aged debt at the end of September 2015, split between NHS and non NHS and segmented into operational categories. It was noted that overall levels of debt over 90 days old had continued to reduce, from £2.778m at the end of June to £1.974m at the end of September. The percentage of over 90 day debt to the total debt had reduced from 37% at 30 June 2015 to 29% at 30 September 2015. The target remains at 5%, so although progress continues to be made, the Trust was not yet in compliance with this KPI. Mr Hoaen gave the Committee an overview on the difficulties in achieving this target including the main accounts to be targeted and the actions to be taken. The Committee agreed that legal action should be taken for non payment of debts over a long period.	

	The Committee asked to see continuous improvement and that appropriate action is taken for non payment of aged debts. **The Committee noted the current aged debt position.**	
8.	**Capital Programme Mid Year Review** The Committee received an update on the mid-year review of the capital programme for information. It was noted that the report was approved by the Trust Board on 30 September 2015. The 2015/16 capital programme was planned on the assumption that the Trust would have available to it two main sources of funding: • Planned clinical strategy exceptional public dividend (PDC) capital £17.4m which was subject to approval by the TDA • Internal generated capital funding planned within the limit of depreciation • Total capital resources £29.2m This had been discussed by the Executive Team and a new Estates Strategy was being developed which takes into account the Quality Improvement Plan. It was noted that the capital pressures the Trust was facing were very significant with backlog pressures on maintenance, medical equipment and IT at a time when it also continued to be under pressure on its revenue performance. The report updated the finance & Investment Committee on: • The current performance of the capital programme • The current capital plan which had been revised by the Capital Approvals Group (CAG) in order to manage the capital plan within the capital resource limit (CRL) and in order to meet the changing capital requirements of the Trust. **The Committee noted the current performance of the capital programme and approved the revised capital plan in order that the Trust does not breach its capital resource limit (CRL) as at 31 March 2016.**	
9(i)	**Tender & Service Development Schedule** The Committee received a schedule which provided an update on current tenders and service developments as at 14 October 2015. **The Committee noted the update on tenders and service**	

	developments.	
9(ii)	**HWLH Community Transition: Update** The transition was progressing as expected and there was currently no further update to report. **The Committee noted the position of the HWLH Community Transition.**	
10.	**Making Better Use of Government Resource Services & Service Delivery Platforms** Mr Astell updated the Committee of progress with the Department of Health invitation to take part in a review of Government support services and delivery platforms. **The Finance & Investment Committee noted the latest progress with this project.**	
11.	**Business Cases** **The Committee noted that there were no business cases to review.**	
12.	**2015 Work Programme** The updated work programme was noted. **Action** **The Committee noted the revised work programme.**	
13.	**Date of Next Meeting** The next meeting will take place on Wednesday 25 November 2015 at 9.30am – 11.30am in the Committee Room, Conquest.	

East Sussex Healthcare NHS Trust (ESHT)

Quality and Standards Committee

Minutes of the Quality and Standards Committee Meeting

Monday, 2 November 2015
Committee Room, Conquest Hospital

Present:
Mrs Sue Bernhauser, Non-Executive Director
Mrs Sue Allen, Interim Head of Governance
Mrs Pauline Butterworth, Acting Chief Operating Officer
Mrs Janet Colvert, Ex-Officio Committee Member
Mr Charles Ellis, Non-Executive Director (Chair)
Dr David Hughes, Medical Director
Ms Emma Tate, Head of Clinical Improvement
Mrs Moira Tenney, Deputy Director of Human Resources
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary

In attendance:
Mrs Jo Byers, Head of Clinical Administration for 6.1
Mrs Jayne Cannon, Head of Nursing, Surgery for 4.5
Mrs Edel Cousins, Assistant Director of HR (Workforce Development) for 4.1
Mrs Sara Songhurst, Deputy Director of Nursing
Mr Paul Relf, Head of Nursing, Clinical Support and Theatres

Mrs Susan Cambell, PA to Director of Nursing (minutes)

1.0 Welcome and Apologies for Absence

Mr Ellis welcomed participants to the Quality and Standards Committee meeting and confirmed that the Committee was quorate.

Mr Ellis noted apologies for absence had been received from;

Ms Tina Lloyd, Assistant Director of Nursing Infection Prevention and Control
Ms Elizabeth Mackie, Volunteer & Community Liaison Manager, Healthwatch
Mr Richard Sunley, Acting Chief Executive Officer
Dr James Wilkinson, Assistant Medical Director, Quality
Dr Jamal Zaidi, Assistant Medical Director, Workforce

2.0 Shared Learning in Practice

Mr Relf, Head of Nursing for Theatres and Clinical Support was welcomed to the meeting where he led a shared learning in practice discussion. This issue was pertinent to Theatres and Surgery and it was noted that the learning had

been shared with theatre staff and the surgical clinical unit.

3.0 Minutes and Matters Arising

3.1 Minutes of the Previous Meeting

Minutes of the Quality and Standards Committee meeting held on 1 September 2015 were considered and agreed.

The Committee noted the disbandment of the Patient Safety and Clinical Improvement Group (PSCIG) and this had impacted on the Quality and Standards Committee work programme and agenda.

3.2 Matters Arising

The action log was reviewed and updated.

4.1 Mandatory Training and Appraisal Compliance

Mrs Cousins, Assistant Director of HR (Workforce Development) was welcomed to the meeting and highlighted the key areas for discussion. It was noted that the mandatory training and appraisal compliance had reverted to red = <75%, amber = 75-85% and green 85%+ RAG rating and Mrs Webster requested that this decision was clarified at the next Corporate Leadership Team (CLT) meeting. **AW**

The Committee noted that mandatory training compliance percentages, although small, had increased month on month and the upward trend continued. Mrs Cousins stated that during 2015/16 sufficient training places had been planned to meet training needs. These included drop-in sessions and e-learning when appropriate, however, the IT issues faced by some staff trying to access e-learning were acknowledged. Mrs Butterworth highlighted the need for training sessions to go ahead, even when only a small number of staff attend.

Mrs Cousins confirmed that where there were specific issues, for example the backlog of appraisals, action continued to be taken but a long-term sustainable solution to address these had yet to be found. Mrs Cousins described the development of a business case to help with the timeliness of data input. She confirmed that the options would include both centralization and the use of local resources. Mrs Cousins agreed to investigate large numbers of appraisals being undertaken by one manager. Mrs Tenney commented that a re-launch of the appraisal process was underway. The Committee agreed that this should be seen as quality improvement tool and assurance that all staff are engaged in a quality, meaningful experience, linked to the Trust values. **EC**

4.2 **HR Incident Report.**

Mrs Tenney presented a detailed report which provided assurance that formal staff incidents and complaints, including Employment Tribunal claims, raised between 1 April and 30 September 2015, had been managed, investigated and acted upon in accordance with Trust policies. Mrs Tenney stated that in order to progress investigations in a timely manner, Capsticks Employee Relationship Services had been commissioned to undertake three investigations and discussions were underway with a view to using the independent external service in the future. Mrs Webster highlighted the difficulties in finding mutually convenient times for all participants when undertaking grievances which had caused long delays.

Mrs Tenney highlighted the introduction of the Speak Up and Speak Out campaign. This had resulted in the recruitment of over 20 Speak Up supporters who were currently being trained. Mrs Tenney confirmed that an independent Speak Up Guardian had been appointed and would commence in post on 1 December 2015. Mrs Tenney confirmed that the number of contacts along with any key themes and outcomes would be reported at future meetings.

Mrs Tenney described the work undertaken so far around harassment and bullying engagement workshops for managers, staff awareness sessions and leaflets. Mrs Butterworth confirmed that General Managers were now represented at the Joint Staff Committee (JSC) which ensured that the clinical units would be made aware of any concerns.

4.3 **Healthcare Acquired Infections (HCAI) Report Quarter 2, 2015-16**

Mrs Webster presented the report on behalf of the Assistant Director of Infection Prevention and Control and confirmed that the National Standard Cleaning (NSC) statistics would be available at the next meeting.

Mrs Webster confirmed that the Trust had reported four cases of Meticillin resistant staphylococcus aureus bacteraemia (MRSA) in the first half of 2015/16. She confirmed that this was higher than in previous years and the Trust was now an outlier nationally. Mrs Webster requested that representation from Urgent Care and Surgery clinical units be invited to the next meeting to discuss this in more detail. **SC**

Mrs Webster highlighted the forthcoming Director of Infection Prevention and Control vacancy and Dr Hughes stated that whilst the post would go out to advert, Dr Hughes would be undertaking the role as an interim measure.

Mrs Webster confirmed that the Trust had welcomed support from the Trust Development Agency (TDA) in addressing key priorities.

4.4 **Theatres and Clinical Support Quality and Governance Report**

Mr Relf presented the quality and governance report which included key themes and trends around incidents and risks identified in the Theatres and Clinical Support units. Mr Relf confirmed that the newly created Governance Facilitator role and access to live data would assist with compliance issues. Mrs Wells sought assurance around induction procedures and mandatory training compliance for long-term agency staff, particularly within Theatres, and Mr Relf confirmed that this was now evidenced within the clinical unit.

4.5 **Surgery Governance Report**

Mrs Cannon, Head of Nursing Surgery was welcomed to meeting where she presented a detailed quality and governance report that related to key areas identified within the Surgery clinical unit. Mrs Cannon confirmed that, in response to Care Quality Commission (CQC) concerns, the unit had made changes in regard to daily checks. Mrs Cannon informed the Committee that the unit were actively recruiting, and this included rotational posts where staff could enhance their experience and along with overseas recruitment.

Mrs Bernhauser reminded the Committee that the TDA was sighted on the housekeeping issues experienced by the Trust and that this needed to be an area of focus. Mrs Webster described the National Standard Cleaning scoring system which would come into effect in the near future and provide live data to nursing staff. Mrs Butterworth sought assurance that there was a process in place to 'close the loop' with regard to nursing scores and the Committee requested that they have sight of the Trust Infection Control Group (TICG) minutes. **SC**

5.1 **Quality Improvement Plan Highlight Report**

Mrs Webster updated the Committee on the progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visits in September 2014 and March 2015. Mrs Webster explained that the organisation worked within the themes identified in the CQC's overarching Trust report and an action plan ensured that all the 'must do' recommendations were being addressed.

Mrs Webster confirmed that sub groups monitored areas identified for closer scrutiny and the plan was made available to staff via the Extranet. The Quality Improvement Plan group met weekly and the clinical units and executive directors were represented. Mrs Webster described the difficulties in evidencing the progress and developments made, for example around the annual staff survey, but confirmed the Business Intelligence team was involved in this.

5.2 **Integrated Quality Report – Quarter 2, July– September 2015**

Mrs Allen, Interim Head of Governance provided the Committee with detailed information on patient experience, patient safety and Morbidity and Mortality activity within the Trust between July and September 2015. Mrs Allen confirmed that falls and pressure ulcers remained the highest patient safety incidents reported and communication was the theme for the highest number of complaints and Patient Advice Liaison (PALs) contacts. Mrs Webster explained that performance data would be included in future reports. It was acknowledged that whilst the Friends and Family Test (FFT) satisfaction scores were excellent, this related to a small number of responses.

Mrs Butterworth requested a complaints report giving a breakdown of the issues be presented at the next meeting. **AW**

Mrs Wells requested a Mortality and Morbidity report be included in the next Quality and Standards Committee agenda with a focus on the Summary Hospital-level Mortality Indicator (SHMI) and the capturing co-morbidities. Mrs Butterworth highlighted the extra governance posts and dedicated clinical coding support to help with these issues. **DH/JW**

5.3 **Weekly Patient Safety Summit Report**

Mrs Webster described a new initiative to provide the Committee with assurance on the Trust's approach to reviewing incidents on a weekly basis. This would ensure that the Trust promoted a culture of learning through review and reflection of incidents and near misses. The Weekly Patient Safety Summit (WPSS) group would also ensure that the Trust was compliant with its statutory duty of candour requirements.

6.0 **Deep Dive into Health Records**

Mrs Byers, Head of Clinical Administration was welcomed to the meeting where she presented the report which outlined the key issues and the Trust's plans to address identified areas for improvement within the Health Records department. Mrs Byers confirmed that the overall aim of the improvement programme was to provide a safe, effective and sustainable service for the next 5-10 years. Mrs Byers described the guidance that had been issues to staff to submit an individual incident form, should there be any concern regarding a patient's care as a result of health records being unavailable. Mrs Webster sought clarification around the triage of incident forms when case notes were not available and Mrs Byers agreed to investigate this further. The number of theatre cases cancelled were discussed and Mrs Butterworth sought assurance on how Trust performance and patients were adversely affected when operations were cancelled due to missing notes.

To enhance communication between clinical administration and clinical units, Mrs Byers confirmed that workshops had been scheduled and Mrs Webster suggested a programme of shadowing might also strengthen this.

Mrs Byers described the perceived benefits to patients when the new centralised telephone booking system was installed at the end of 2015.

7.0 **Sub Committee Minutes**

The following items were noted by the Committee;

7.1 Minutes from the Trust Health and Safety Steering Group meeting held on 22 September 2015.

7.2 Out of Hospital Clinical Unit Governance meeting held on 13 October 2015.

8.0 **Any Other Business**

8.1 **Serious Incidents Timeline**

Following concerns raised by Mrs Bernhauser, Mrs Butterworth stated that the Trust Patient Safety Lead would be meeting with Clinical Unit Leads, Heads of Nursing and General Managers to discuss serious incidents and the timelines that needed to be adhered to. An update would be requested for the next meeting. **SC**

9.0 **For Information**

9.1 Board Assurance Framework and High Level Risk Register. Any comments should be sent to Mrs Wells.

9.2 External Visits report 1 April – 30 September 2015

9.3 NRLS Organisation Patient Safety Incident Report

9.4 Plus Size (bariatric) Working Group Update

10.0 **Date of the Next Meeting**

Tuesday, 12 January 2016
2.30pm – 4.30pm
St Mary's Boardroom, Eastbourne District General Hospital

DRAFT

East Sussex Healthcare NHS Trust

REMUNERATION COMMITTEE

1. Introduction

The Remuneration Committee met on the 21 October 2015 and 13th January 2016 and a summary of the matters discussed at this meeting is provided below.

2. Acting Chief Executive, Director of Finance, Chief Operating Officer and Chairman

The Committee reviewed the interim and acting up arrangements in place until substantive appointments were made.

3 TDA Approvals Process for Appointments on Salaries over £142.5k

The Committee reviewed TDA guidance on established pay ranges for the Chief Executive and Director of Finance roles. The Treasury approval process for obtaining approval for VSM pay which exceeds the Prime Minister's £142,500 salary and mandated inclusion of "earn back" of up to 10% of salary through delivery of performance objectives were noted.

3. Clinical Excellence Awards

The Committee reviewed and ratified the recommendation made by the Clinical Excellence Awards Local Awarding Committee which met on 16 December 2015.

The Panel's evaluations were quality based and it recommended making 19 of the 31 available awards, at a recurring cost of £98k. The Committee was assured that those receiving awards had completed all job planning and mandatory training; a robust governance process was in place and Clinical Unit leads were required to sign off all applications.

East Sussex Healthcare NHS Trust

People and Organisational Development Committee

Terms of Reference

1. Constitution and Purpose

The Board has resolved to establish a Committee of the Board to be known as the People and Organisational Development Committee (the Committee).

The Committee's remit will encompass strategic oversight of workforce development, planning and performance. It will provide assurance to the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting the Trust objectives and organisational success.

2. Membership

Non-Executive Director (Chair)
Non-Executive Director
Director of Human Resources
Medical Director
Director of Nursing
Chief Operating Officer
Staff Side Chair
Deputy Director of Human Resources
Assistant Director of Human Resources – Workforce Development
Company Secretary
Director of Medical Education
Associate Medical Director – Workforce
Equality & Human Rights Lead

Other Board members may attend by open invitation.

3. Quorum

The Committee shall be quorate when one third of members are present. Nominated Deputies will count towards the quorum.

4. Attendance

Other staff, including members of the Human Resources Directorate may attend to address specific agenda items.

5. Frequency of meetings and administration

The Committee will meet quarterly. The Chair can call a meeting at any time if issues arise. Administrative support for the Committee will be provided by the PA to the Director of Human Resources.

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6. Duties

To monitor and advise on:

- The strategy for people in ESHT, its implementation, and key trends in human resource metrics
- Equality and diversity in the workforce;
- The strategic and assurance processes for the management of human resources risks to include health, safety and wellbeing; and the quality of implementation of those processes
- External developments, best practice and trends in employment practice;
- Staff recruitment, retention and talent management,
- Staff engagement;
- The incentive and reward strategy for ESHT, its integrity and effectiveness, including performance management
- Organisation development/organisational change management;
- Training and development activity;
- Any other significant matters relating to the performance and development of the workforce.

To convene task and finish groups to undertake specific work identified by itself or the Trust Board.

7. Parent Committees and reporting procedure

The Committee Chairman will report activities to the Trust Board following each meeting or as required.

These Terms of Reference shall be reviewed by the Committee and Trust Board at least annually. In addition, the Committee shall undertake a self-assessment of its effectiveness on at least an annual basis and this will be timetabled into the schedule of Committee business.

8. Sub-Committees and reporting procedure

Education Steering Group
Staff Engagement and Wellbeing Group
OD Monitoring Group
HR Quality & Standards Meeting

DRAFT

East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board
Agenda item:	18
Subject:	Use of Trust Seal
Reporting Officer:	David Clayton-Smith, Chair

Action: This paper is for **(please tick)**					
Assurance	√	**Approval**		**Decision**	
Purpose:					
To keep the Board informed of the use of the Trust Seal since the last Board meeting.					

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

Analysis of Key Issues and Discussion Points Raised by the Report:
Use of Trust Seal **26th January 2016** – Transfer of Unit 5/6 Apex Way Lease form from NHS Property Services to ESHT & Land register documents.

Proposals and/or Recommendations
The Board is asked to note the use of the Trust Seal since the last Board meeting.

For further information or for any enquiries relating to this report please contact:	
Name: Lynette Wells, Company Secretary	**Contact details:** lynette.wells2@nhs.net