EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 12th October 2016, commencing at 11:00 in the Lecture Theatre, Education Centre, Conquest

	AGENDA		**Lead:**	**Time:**
1.	a) Chair's opening remarks b) Apologies for absence c) Monthly award winner(s)		Chair	
2.	VitalPAC Update	A	Kate Murray/ Claire Lippiat	
3.	Quality Walks	B	Chair	
4.	Declarations of interests		Chair	
5a.	Minutes of the Trust Board Meeting in public held on 3rd August 2016	C	Chair	
5b.	Matters arising	D		
6.	Chief Executive's Report	E	CEO	
7.	Speak Up Guardian's Report	F	Ruth Agg	
8.	Board Assurance Framework	G	DCA	

QUALITY, SAFETY AND PERFORMANCE

					Time:
9.	ESHT 2020 Improvement Programme	Assurance	H	CEO/DN	
10.	Integrated Performance Report Month 6 (August) 1. Performance 2. Finance 3. Workforce	Assurance	I	DN/MD COO HRD DF	

STRATEGY

					Time:
11.	Urgent Care and the 4 hour Trajectory	Assurance	J	COO	
12.	Annual Business Plan Quarter 2	Approval	K	DF	

13.	Winter Preparedness	Assurance	L	COO	
14.	Capital Programme Mid-Year Review	Assurance	M	DF	
15.	2016 NHS Premises Assurance Model Update	Assurance	N	Chris Hodgson	
16.	Risk and Quality Delivery Strategy	Assurance	O	DN	

GOVERNANCE AND ASSURANCE

					Time:
17.	a) Infection Prevention Annual Report b) Workforce Race Equality Standard (WRES) Annual Report c) Safeguarding Annual Report d) Fire Safety Annual Report	Assurance	P	MD/DN /COO/ HRD	
18.	Board sub-committees: a) Audit Committee b) Finance & Investment Committee c) People and Organisational Development Committee *Including Revised Terms of Reference* d) Quality & Safety Committee	Assurance	Q	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
19.	Questions from members of the public (15 minutes maximum)		Chair	
20.	Date of Next Meeting: Wednesday 14th December, St Mary's Board Room, EDGH		Chair	

David Clayton Smith

David Clayton-Smith
Chairman

14th September 2016

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
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:	12th October 2016
Meeting:	Trust Board
Agenda item:	2
Subject:	Deteriorating Patient Review- A Quality Improvement Project using VitalPAC
Reporting Officer:	Kate Murray- Consultant Anaesthetist/ Clinical Lead VitalPAC

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

Purpose:

The purpose of this document is to provide ESHT Trust Board members with an update on the implementation of VitalPAC and its impact on preventing harm and keeping patients safe whilst on our acute wards.

Introduction:

VitalPAC is an electronic system that allows us to see patient Observation Charts in real time from all adult medical and surgical ward areas within ESHT. It was introduced in March 2014 and was fully implemented across all acute adult wards by August 2014.

The VitalPAC system ensures complete sets of observations are taken and encourages teams of nurses to take observations on time. It automatically calculates the NEWS score and provides the Nursing team at the bedside with advice (according to ESHT protocol) about escalation to the Outreach, Medical/Surgical and Critical Care Teams should that score be critical or high.

The transparency of the system ensures that high or Critical NEWS scores are visible to the Critical Care Outreach Team and Critical Care Medical team across the Trust, and it is also visible to the ward teams when distant from the ward area. This has encouraged a different way of working that is pro-active and highly productive, increasing the number of patients that our Outreach Team review and leading to earlier intervention in Deteriorating Patients. This combined with Medical Emergency Team calls has led to improved and more consistent patient safety on our wards both day and night.

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

The Quality Improvement Project began in September of 2014 with key aims in mind.

The rationale was to target and improve the number of observations taken “on time” on our wards through the use of our electronic observation system - VitalPAC. The percentage of observations “taken on time” for each ward was used as a performance indicator tool. The premise being that this would improve recognition of deteriorating patients (consistent use of NEWS scores) and lead to earlier escalation and intervention.

Outreach Nursing input was also changed to be a pro-active process rather than reactive one – encouraging the use of the VitalPAC technology to help target deteriorating patients.

Overall we wanted to change ward culture to be more aware of the benefits of early escalation for unwell and critically ill patients with our ultimate aim being a demonstrable reduction in the Trust Cardiac Arrest rate.

1.**Observations taken on time – the VitalPAC Challenge**

It was recognised after the introduction of the VitalPAC system that ward based observations were often late, similarly the number of observations taken at night were not consistent. We also had good audit evidence from prior to the introduction of VitalPAC that escalation processes when patients were deteriorating was not consistent – and only 30-35% of all patients with a high NEWS were escalated appropriately. There were also critical and serious incidents reported concerning lack of escalation and late observations – many of those incidents led to late intervention and late admission to Critical Care.

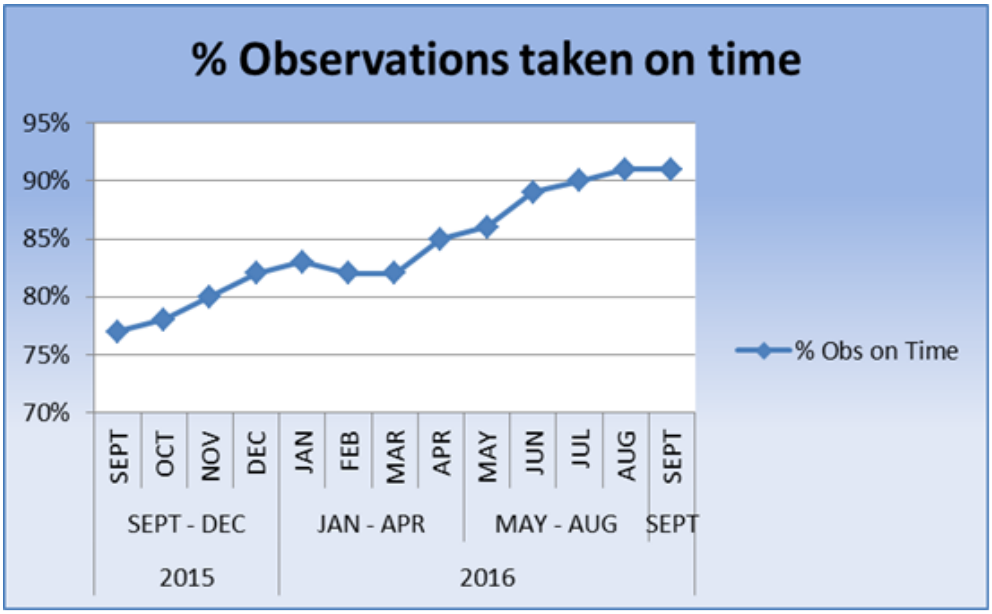
Good quality data from other VitalPAC sites and published data suggested that utilising the VitalPAC performance data could lead to an improvement in ward observations being taken on time, encourage timely escalation to Critical Care and have an impact on the admission rate to Critical Care and the cardiac arrest rate within the Trust.

We started the QI project in conjunction with the VitalPAC team, Critical Care Outreach and Senior Nursing. Cheryl Sparkes – Matron for Outreach joined forces with Sara Songhurst (Deputy Director of Nursing) and Clare Lippiatt (VitalPAC Project Manager/ Lead Nurse) to feedback the performance data to each ward area. The performance data was used as a Quality Improvement tool which was utilised in VitalPAC Challenge Meetings – and they provided a platform for discussion around a range of issues – but getting it “right first time” was a common theme, along with timely escalation for deterioration.

Initially the data was just released to the individual ward area, however very rapidly we made the data available to all ward teams so that different wards could compare their performance. The data was released in a “traffic light” chart – with high performing wards in green and those with work to do in red.

Monthly VitalPAC Challenge meetings were held for each “red ward” to discuss their performance. The purpose of the meetings was to offer help and assistance to red wards to encourage them to get into the green. A target for the next month was agreed between the team and technical support delivered for issues or problems relating to devices or wifi. Heads of Nursing, Matrons and Band 6 nurses attend these meetings. If unable to attend, the challenge meeting is taken to the ward where issues can be discussed and support offered to help improve compliance.

In the past year the performance across the Trust has consistently improved. We started in September 2015 with 77% of observations taken on time and have hit a high in September 2016 with 91% of observations taken on time (See Appendix 1). We are able to benchmark our performance against other VitalPAC Trusts and we are now one of the top 5 performing Trusts across the UK for Observations on time.



2. Recognition of Deteriorating Patients

Recognition of deterioration has been a key element in this project and a common theme across the VitalPAC Challenge meetings. Education and "on the ward learning" has been pro-actively supported. We have established Outreach link nurses for every ward – who provide targeted support to those wards in the red zone.

Outreach have delivered consistent education to supplement and support the nursing team across the Trust:

- ALERT courses monthly
- AKI, Sepsis and tracheostomy courses bi-monthly
- BEACHES – new course for HCA's delivered

Junior Doctor education – Foundation Programme delivered by Dr Murray and Dr Vondras on the Acutely Deteriorating Patient and Sepsis. ALERT Course for all new Foundation Doctors prior to start of placement.

3. Outreach Working Pattern;

Following the introduction of VitalPAC all patients' observation charts are visible electronically across the Trust. Utilising this transparency and visibility has been a key aim of VitalPAC Project.

The Outreach Team have welcomed this and changed the way they work as a result. Prior to VitalPAC they walked the wards and relied upon nursing teams to escalate via the bleep system those patients who had a high or critical NEWS score. Now they use the desktop or the iPad to identify where sick patients are pro-actively and regularly arrive on the ward prior to the nursing team calling. It allows them to seek out and intervene earlier preventing admission to Critical Care (see Appendix 2). It has led to increased productivity of our Outreach team with an increase in the number of visits over the past year.

2013 Referrals 2845 Follow ups 755

2014 Referrals 2710 Follow ups 676
2015 Referrals 3053 Follow ups 658
2016 Referrals 2358 Follow ups 494 (Still 3 months of winter to go)

We have also better established MET and SET calls for those patients with NEWS of 9 and above – leading to early involvement of the ITU Medical team. This system is now in place 24/7.

4. Ward Culture

Culture is the most difficult aspect of any project to change – yet also the most vital. We believe that the regular use of the QI tool (% of observations on time) with the repeated dialogue at Challenge Meetings of the rationale – patient safety, earlier escalation and intervention has raised the profile of the Deteriorating Patient throughout the Trust.

NEWS scores are now used regularly at Handover between medical and nursing teams, and are used as a criteria for early ward round review. The use of VitalPAC technology has made NEWS scores visible in every area and are the basis of many referrals to Critical Care. MET and SET calls are commonplace indicating earlier recognition with appropriate escalation and cardiac arrests unusual – showing the shift in ward culture has been from late rescue to prevention.

5. Cardiac Arrest Rate Reduction

Overall we have seen a great improvement in the percentage of observations taken on time – for the entire Trust we have moved from only 75% of observations being on time to our most recent high of 91%. Our target is 92% and we are still working through the VitalPAC Challenge meetings to encourage and change ward working – so that they focus on observations at the right time – first time.

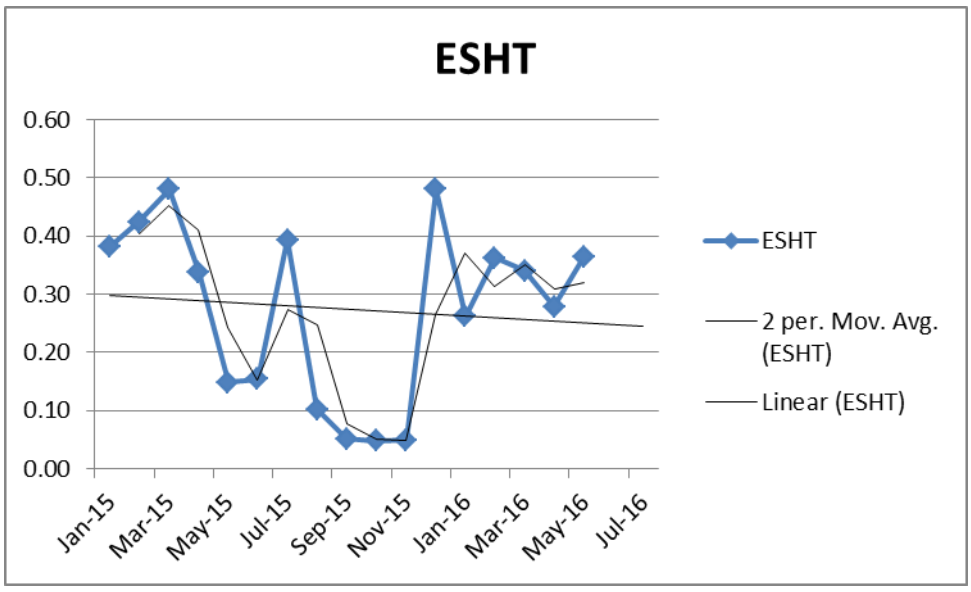
My belief is that the increased number of observations on time combined with the pro-active way of working in the Outreach team, increased emphasis on escalation plans, MET and SET calls - have all contributed to the reduction in the cardiac arrest rate.

We are also seeing a signal in our Intensive Care data that would suggest a downward trend in the number of Level 3 bed days over the past 18 months on both sites – which suggests earlier intervention is leading to a decrease in the need for organ support.

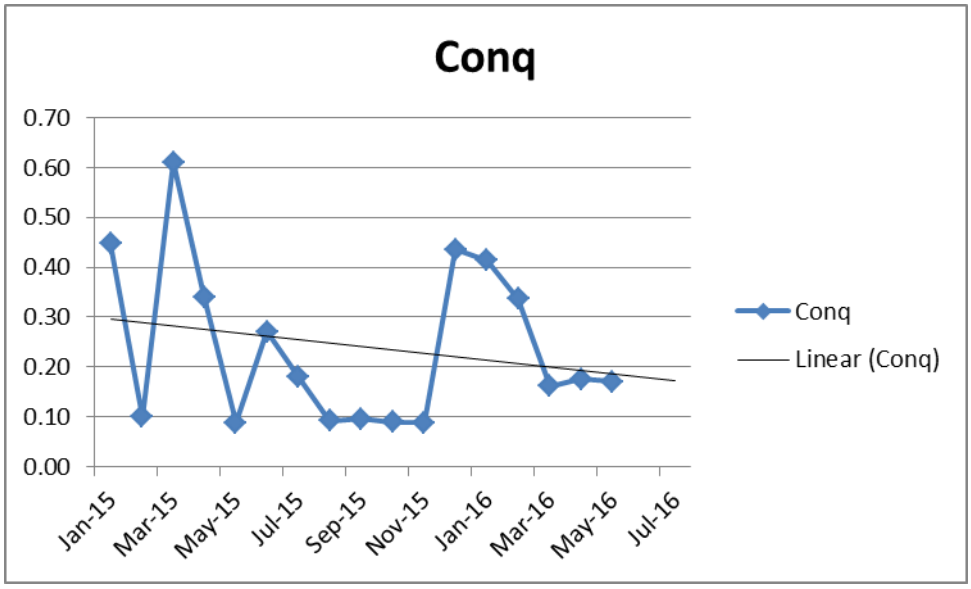
We still need to focus in this area, and consolidate on the improvements we have made. Increased activity, agency nursing and black status may also effect the wards performance and compliance with taking observations and escalating - but we need to work on having processes in place that continue to deliver for our patients in a consistent way regardless of the overall activity of the hospital.

Benefits:

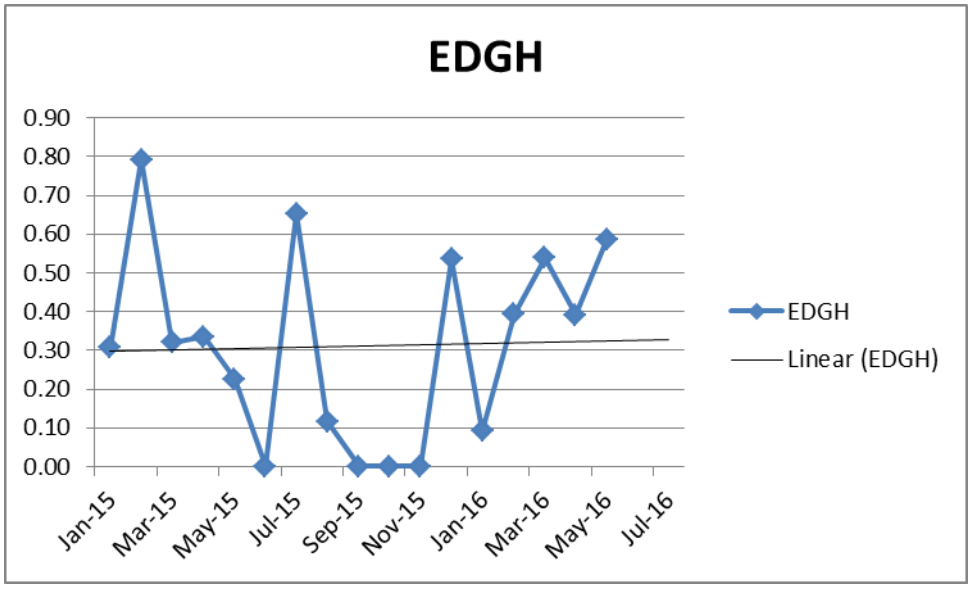
- Reduction in cardiac arrest rate:



(Fig 1. Cardiac arrest rate per 1000 bed days for ESHT from Jan 15 to June 16)



(Fig. 2 Cardiac arrest rate per 1000 bed days for Conquest Hospital Jan 15 to June 16)



(Fig. 3 Cardiac arrest rate per 1000 bed days for EDGH Jan 15 to June 16)

- Targeted care from the Outreach Team for sick and critically high NEWS scoring patients 24/7
- Visibility and transparency of data – allowing all unwell patients to be seen across ESHT
- Influence on ward culture – developing a "Patient Safety Culture"
- Embedding safe processes for Deteriorating Patients
- Long term improving mortality for all ESHT patients and reducing length of stay

Risks and Implications
Staff engagement Limited resources within the project, including business intelligence

Assurance Provided:
Quarterly VitalPAC Monitoring Groups chaired by the Deputy Director of Nursing and attended by the VitalPAC Clinical Lead, Lead Nurse Outreach team, Lead Nurse Clinical Systems and Clinical Systems Administrator. IT and finance lead also in attendance. Monthly meetings take place between the Stakeholder Groups including Outreach, Matrons, IV Leads and Specialist Nursing teams.

Review by other Committees/Groups (please state name and date)**:**
IM&T Steering Group- monthly

Proposals and/or Recommendations
The Board is asked to review and note the success of the project to date.

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: Kate Murray	**Contact details:** kate.murray5@nhs.net

APPENDIX 1

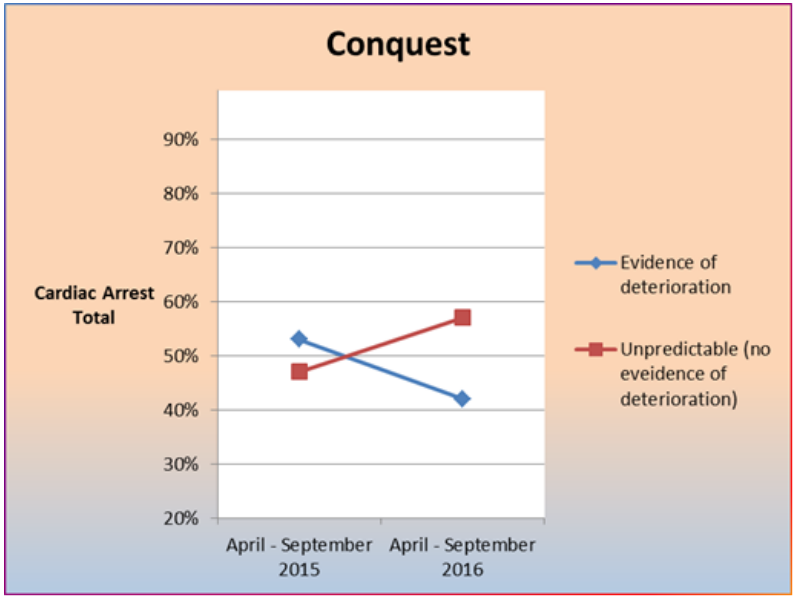
VITALPAC PERFORMANCE DATA

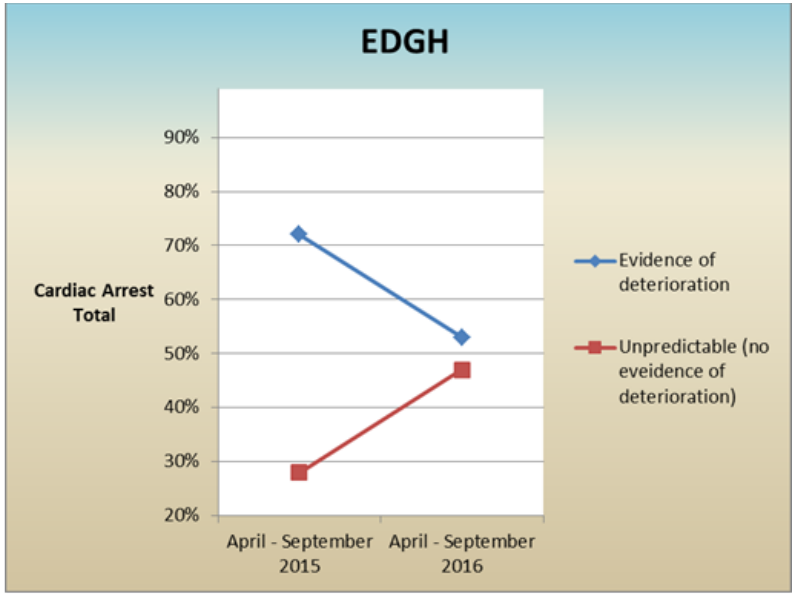
Sept 2016 Weeks 1 and 2

Excellent >92%		Needs Improvement <91.9%	
99%	Folkington	91%	CSDU EDGH
98%	Seaford 3	90%	Hailsham 2
97%	Wellington	90%	Cuckmere
97%	Cook Devas	89%	Jevington
96%	Pevensey	88%	Baird MAU
95%	Macdonald	87%	Hailsham 4
94%	Mirlees	86%	Hailsham 3
94%	CCU Conq	86%	Newington
94%	Seaford 4	86%	Seaford 1 MAU
93%	Benson	85%	Gardner
93%	Egerton	85%	E Dean
93%	Berwick	85%	SAU
93%	James	80%	CCU EDGH
93%	Sovereign		
93%	Tressell		
92%	Michelham		
92%	DeCham		
92%	Cook atten		
92%	AAU		

APPENDIX 2

Reduction in the deterioration of pre-arrest patients (Conquest and EDGH)





East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	3
Subject:	Quality Walks May - August 2016
Reporting Officer:	Alice Webster

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

Purpose:

This paper provides a summary of the Quality Walks that have taken place during May, June, July and August 2016.

Introduction:

Quality Walks are currently carried out by Board members and the Executive team and are either planned or carried out on an ad hoc basis. They are intended to provide an opportunity to observe and review care being delivered, listen to feedback from patient's, visitors and staff and enable quality improvement actions to be identified and addressed from a variety of sources in order to provide assurance to the Board of the quality of care across the services and locations throughout the Trust. The walks currently focus on the following themes:

- How communication and engagement can be strengthened
- Reporting, action and learning from incidents and risks
- Fundamental safety issues – cleanliness, drug security, records management
- Other issues

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

36 services/departments were visited as part of the Quality Walk programme by the Executive Team between 1st May and 31st August as detailed below. The Chief Executive and Director of Finance have also visited over 40 departments and staff groups in addition to the formal programme.

Date	Time	Service	Site	Visit by
3.5.16	11am	Theatres	EDGH	David Clayton-Smith
11.5.16	4pm	Newington	Conquest	Sue Bernhauser
12.5.16	9am	James Ward/CCU	Conquest	Jackie Churchwood-Cardiff
19.5.16	11am	Kipling	Conquest	Monica Green
25.5.16	10am	Hailsham Health Centre	Hailsham	Sue Bernhauser
26.5.16	8.30am	Outpatients	Bexhill	Andrew Slater
27.5.16	9.30am	Children's Development Unit	EDGH	Alice Webster
1.6.16	9.30am	Sleep Disorder Service	Conquest	Monica Green
1.6.16	1pm	Pathology	Conquest	Sue Bernhauser
1.6.16	2.30pm	Physiotherapy	Conquest	Andy Slater
3.6.16	1.00pm	Baird	Conquest	Pauline Butterworth
8.6.16	5.30pm	Seaford 4	EDGH	Jackie Churchwood-Cardiff
8.6.16	7.30pm	Pevensey	EDGH	Jackie Churchwood-Cardiff
9.6.16	9.00am	ITU	Conquest	Jackie Churchwood-Cardiff

14.6.16	11am	Wellington	Conquest	Barry Nealon
15.6.16	11am	Stroke Unit	EDGH	Pauline Butterworth
16.6.16	2 - 4pm	Gardner	Conquest	Alice Webster
17.6.16	9.30am	Endoscopy	EDGH	Monica Green
17.6.16	2pm	Jubilee Eye Suite	EDGH	Alice Webster
21.6.15	11am	OPD	EDGH	David Clayton-Smith
27.6.16	10am	Firwood - Community Stroke Team JCR Team - First Bed Unit	Hampden Park	David Hughes
29.6.16	12pm	Radiology	EDGH	Mike Stevens
4.7.16	2pm	Folkington	EDGH	David Hughes
18.7.16	11am	McCartney Unit	Conquest	Andy Slater
27.7.16	12pm	Endoscopy	Conquest	Mike Stevens
27.7.16	2pm	OPD	Conquest	Monica Green
27.7.16	11am	Arthur Blackman Clinic	St Leonards	Sue Bernhauser
27.7.16	2pm	Seaford Health Centre	Seaford	Sue Bernhauser
17.8.16	11am	Polegate Ward	EDGH	Jackie Churchwood-Cardiff
17.8.16	2pm	Theatres	Conquest	Jackie Churchwood-Cardiff
18.8.16	11.30am	Infection Control	Conquest	Monica Green
19.8.16	9.30am	Friston (SSPAU)	EDGH	Miranda Kavanagh
19.8.16	11.30am	Community Paediatric Team	EDGH	Miranda Kavanagh
19.8.16	1.30pm	Seaford 1(MAU)	EDGH	Miranda Kavanagh
19.8.16	3.00pm	Diabetes & Endocrinology	EDGH	Miranda Kavanagh
22.8.16	11am	Seaford 3	EDGH	Pauline Butterworth

All of these visits were pre-arranged and the Ward or Unit Manager was notified in advance to expect the visit, other adhoc visits may have taken place, but reports have not yet been received. At the time of writing the report feedback forms had been received relating to 22 of the visits to individual services or departments, copies of which have been passed on to the relevant managers for information.

Summary of Observations and Findings during May, June, July and August relating to the themes collated from the feedback forms.

How communication and engagement can be strengthened

There was a general theme that communication across the organisation is improving. Comments noted included Matrons stating that they felt well supported through their professional line and able to contact the Director of Nursing or CEO, or talk to Executive Board members if they needed to. In some areas there was evidence of a strong team ethos between staff and medical colleagues and in others where activity makes ward meetings difficult newsletters are being produced to disseminate information. In one area a communication hub/booth has been introduced in the staff area where information and updates are displayed

Reporting, action and learning from incidents and risks

Community staff continue to have issues with the reliability of SystmOne when staff require Wi-Fi to download patient records particularly for the ‘out of hours’ teams.
The pathology teams find covering the ‘out of hours’ services a challenge and are relying significantly on staff goodwill and high cost locums. Theatres also reported key concerns regarding staff recruitment and retention and staff morale and commented that staff are recruited and time invested to provide high quality training but after about 6 months often leave for more lucrative positions with an agency or in London.

Fundamental safety issues – cleanliness, drug security, records management

There was evidence of Safety Huddles being implemented and well received by staff, it was noted that one consultant stated they were very proud of the effective multi-disciplinary approach to all aspects of care and management.

Obtaining health records in a timely way is still an issue in some areas (particularly noted in endoscopy) however this was reported as improved in the outpatients areas visited.
The introduction of clinical orderlies in many areas to support nursing in maintaining cleanliness standards have been well received and are having a positive impact.

Other Issues
In the community there has been a welcome increase in nurses in the locality with the appointment of the frailty nurses, who now work closely with community nursing teams.
Comments were received that the recruitment process for staff is seen as too slow and the TRAC system has led to more administrative tasks being undertaken by the matrons or ward sisters. In some cases staff felt that TRAC had increased the delay in recruiting, especially in the early stage of the process.
A comment was made that mentoring time for student nurses had to be taken in the personal time of staff as the pace of the ward precluded time during shifts.
The fabric of some areas were noted as looking very "tired" and would benefit from a refresh and suggestions have been made to approach the League of Friends for support with funding some improvements.
The reliability and punctuality of patient transport is vital to those reliant on it to receive treatment when planned and the recent issues with the new provider have added stress to this patient group and required further flexibility from some staff.
The diabetes and endocrinology department reported that some of the **c**hanges to the administrative teams had impacted negatively on the booking process for their clinics.

Patient feedback
One patient and her daughter who were waiting for a nursing home bed could not have spoken more highly about the care and consideration they had both received stating that the patient had received good care and that the family had been involved and given updates and information in a timely way. They praised the staff for always going the extra mile under the Matron's leadership.
Other patients' comments included experiencing calm and friendly environments as well as the skill and knowledge of the nursing staff.
Unreliability of Wi-Fi was a significant irritant for patients trying to maintain contact with relatives and there were also comments that the patient menu can become repetitive for longer term patients.

Benefits:
Quality Walks are an opportunity for the views of staff, patients and visitors to be sought by the Board and help raise the profile of patient safety and compliance standards within the Trust. It enables the Board members to identify areas of excellence, identify risks and ensure Board visibility within the organisation.

Risks and Implications
Any risks identified are acted upon and escalated to the risk register as appropriate

Assurance Provided:
Any actions identified at a Quality Walk are agreed at the time and it is noted who will be responsible for taking forward the action.

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	✓
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
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.	

Review by other Committees/Groups (please state name and date)**:**
None

Proposals and/or Recommendations
The Board are asked to note the report and agree if any changes to the current themes are required.

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

For further information or for any enquiries relating to this report please contact:	
Name: Hilary White Head of Compliance	**Contact details:** Hilary.White2@nhs.net

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Wednesday, 3rd August 2016 at 11:15 in the Ashdown Room, Uckfield Civic Centre.

Present: Mr David Clayton-Smith, Chairman
Dr Adrian Bull, Chief Executive
Mrs Pauline Butterworth, Acting Chief Operating Officer
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mr Barry Nealon, Vice Chairman
Ms Miranda Kavanagh, Non-Executive Director
Mrs Alice Webster, Director of Nursing

In attendance:
Mr Philip Astell, Acting Director of Finance
Ms Monica Green, Director of Human Resources
Ms Sally Herne, Improvement Director
Miss Jan Humber, Joint Staff Side Chair
Mrs Lynette Wells, Director of Corporate Affairs
Dr Debbie McGreevy, Assistant Director, Revalidation (for item 070/2016)
Mr Pete Palmer, Assistant Company Secretary (minutes)

057/2016 **Welcome and Apologies for Absence**

a) Chair's Opening Remarks

Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He reported that much had happened in the two months since the previous Board meeting, including further discussions with the East Sussex Better Together (ESBT) team. Mr Clayton-Smith noted that he had been asked to Chair the ESBT Board, and that he was delighted to have accepted this role, and that Dr Bull had also taken a leading role in the ESBT process.

Mr Clayton-Smith noted that this would have been Dr Hughes' and Dr Slater's last Board meeting and he formally placed on record his thanks to them both for their contribution. It was noted that Mr Astell was attending for the new Director of Finance, Mr Reid.

b) Apologies for Absence

Mr Clayton-Smith reported that apologies for absence had been received from:

Mrs Sue Bernhauser, Non-Executive Director
Mr Mike Stevens, Non-Executive Director

Mrs Catherine Ashton, Associate Director of Strategic Development
Dr David Hughes, Medical Director
Mr Jonathan Reid, Director of Finance
Dr Andrew Slater, Director of Clinical Information & Strategy

c) Monthly Award Winners

Mr Clayton-Smith reported that the monthly award winner for June was Ben Sinden, a painter of the maintenance team. He explained that he had won the award for coming in to the hospital outside of his working hours in order to paint a mural on the wall of a newly decorated ultrasound room, in order to improve the environment for young patients.

058/2016 **Feedback from Quality Walks**

Mr Nealon reported that he had been delighted to have helped to open the Trust's new Health Records Centre in Apex Way. He recalled that his first quality walks upon joining the Trust had been to the health records departments at EDGH and the Conquest and that he had found the environments to be poor, many members of staff had been on long term sick leave and notes had regularly gone missing.

He explained that the Trust had agreed that relocating storage of notes to an external location was the best solution to address these issues, and that he had found the new facility at Apex Way to be a substantial improvement. He said that he had received positive feedback from staff about the move, but noted that there were logistical issues that were being resolved as a result of records being stored off site. He explained that the issues were being mitigated by bar coding all records to ensure that they were trackable, which had greatly reduced incidences of missing records, and that deliveries of notes to the Trust's sites occurred six times a day.

Mr Nealon reported the process of moving existing notes to the new site was still ongoing, slightly increasing the possibility of unavailability of notes until it was completed. He explained that during the transition to the new site around 5% of notes had been unavailable when needed, noting that this figure was already reducing towards a target of 1%. Mr Nealon said that he believed that the move to Apex Way would benefit the Trust in the long term, and would help with the transition to Electronic Document Management in the future.

Dr Bull reported that he had received a letter from a member of public asking about the provision of emergency access to notes following the move to Apex Way, and explained that records of tests, results and previous clinical correspondence were available electronically to staff. He noted that it took less than two hours for notes to be delivered from Apex Way in an emergency.

Mrs Webster reported that she had been to Bexhill hospital where she had visited the Irvine unit. She said that she had found the environment

within the Irvine Unit to be very clean, but noted that it looking tired. She explained that staff had reported frustration about the length of time that it took for estates work to be undertaken, and that she had held discussions with the Estates team about how this could be improved. Mrs Webster said that staff had praised the relationship they enjoyed with Bexhill's League of Friends and the support that they received. She also noted that the Unit made excellent use of the external areas that were available to them.

Mrs Webster reported that she had also visited the Jubilee Eye Suite at EDGH and had found it hard to find with poor signage. She said that she had spoken to the Estates team about improving this. Mrs Webster was impressed the Suite, it was productive and the team were all clear about their roles. It was spotlessly clean, but noted that it also looked tired.

Mrs Webster said that staff had reported some issues with notes not being collected from the Suite in a timely manner, but that they had begun to see improvements since Apex Way had been opened. She said that the feedback she had received from patients during her visit had been exceptional and had been full of praise for the department. She explained that staff were incredibly proud of the service they provided, and that they had told her of their desire to continue to improve. She said that staff had expressed frustration about the difficulties they faced in making environmental improvements.

Mrs Webster asked members of the Board to continue to undertake informal visits to all areas of the Trust, and to ensure that areas were not overlooked. She said that staff were always very happy to be visited by Board members at any time.

The Board noted the feedback on quality walks.

059/2016 **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.

060/2016 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 8th June 2016 were considered and were 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

053/2016 – Revised Q&S Committee Terms of Reference
Mr Clayton-Smith noted that the revised Quality and Safety Committee Terms of Reference were being presented for Board approval under item 062/2016 (d).

055/2016 – Summary of work undertaken by the Improvement Director
Mr Clayton-Smith explained that information on the work undertaken by the Improvement Director was included within the Chief Executive's report being presented to the Board.

Dr Bull explained Dr Herne worked very closely with the Trust, alongside the Executive team, but that she was employed by NHS Improvement (NHSI) in order to bring an external view and challenge to the Trust, while helping to improve services. He noted that Dr Herne's role was not one that could take ownership of the Trust's issues in the long term, as it was a temporary role, but that she did take the lead with specific short term interventions. He explained that she provided a valuable bridge into the resources of NHSI, which had included the recent mock inspections, and interviews and workshops in preparation for the CQC inspections. Dr Bull said that as the new executive team established itself it would aim to make Dr Herne's role superfluous to the organisation.

Dr Herne noted that no cost to the Trust was incurred by her presence, and explained that she would be happy to discuss her role with members of the public.

061/2016 **Chief Executive's Report**

Dr Bull reported that the Trust had undertaken mock inspections during June and July over the course of four days in preparation for the CQC's inspection of the Trust in October. He explained that members of Healthwatch, stakeholders and members of staff had been involved in undertaking the inspections, and said that the process had been helpful. He reported that in some areas that had been inspected feedback had been exceptional, whereas in other areas there were basic issues that needed to be addressed.

Dr Bull said that he felt that there was no inherent reason why the Trust could not be outstanding in everything it did, but that standards were currently inconsistently applied within the Trust. He explained that work was being undertaken to ensure the spread of exceptional practice throughout the Trust, and that formally led peer reviews of Wards would be introduced.

Dr Bull said that action was being taken to address the issues reported during the mock inspections. He noted that the Trust aspired to be an organisation where staff were proud to work, where the public could be confident in the service they received, and explained that the Trust was not just working towards the CQC inspection in October but on improving into the long term.

Dr Bull reported that the post of Medical Director had been advertised both internally and externally and that Dr David Walker had been appointed to the position and that he would begin on 5th September. He reported that Mrs Catherine Ashton had been appointed as Director of Strategy, Innovation and Planning.

Mr Clayton-Smith said that he was very pleased to see that levels of staff sickness were the lowest they had been for two years. Dr Bull explained that the Trust considered staff health to be a good indicator of the morale and sense of wellbeing of the organisation. He said that the reduced levels of sickness, in combination with the recent good results of Pulse surveys, were encouraging signs.

Mr Clayton Smith asked how work being undertaken by the newly formed Urgent Care Programme Board would support the challenges in A&E. Dr Bull replied that resolving the issues found within Urgent Care was a hospital wide challenge, and explained that a comprehensive plan was needed to ensure a resilient flow of patients through hospital in order to reduce waiting times. He explained that Consultants throughout the Trust had been challenged about how they managed patients to ensure that they went to the right place at the right time, and about how specialities were working together.

Dr Bull explained that the Urgent Care Programme Board would be clinically led by a Consultant, with a senior manager given specific responsibility for driving the process. Mrs Butterworth noted that the Urgent Care Programme Board would be reviewing additional metrics to those that were normally looked at in order to fully understand the problems and issues that existed. She said that they would be meeting on a monthly basis.

062/2016 **Board Sub Committee Reports**

Mr Clayton-Smith explained that the Committees carried out a large amount of important work for the Trust, and that he had asked for the their reports to be presented earlier on the agenda in order to give them additional prominence.

a) <u>Audit Committee</u>

Mrs Wells reported that the Audit Committee had received the Board Assurance Framework (BAF), and that discussion had taken place about the RAG rating for mortality. She noted that the Committee had received a comprehensive report on the 2014/15 Reference Costs Audit.

She reported that the Trust had received an unqualified true and fair opinion on their financial statements for the year ending 31st March 2016. Mrs Wells reported that the Trust had been issued with a qualified assurance report on the Quality Account, which related to the lack of an auditable trail on the downgrading of incidents on DATIX. This has been addressed and a response to the report would be presented at the next meeting of the Audit Committee. She reported that the Audit Committee had been very pleased that the Trust had achieved level 2 with their submissions to the Information Governance Toolkit with a score of 71%.

The Board noted the Audit Committee report.

b) Finance and Investment Committee

Mr Nealon reported that a transformation fund had potentially been made available to the Trust, but that the Trust would have to realise savings in order to access this additional funding.

He explained that a robust process had taken place to review priorities for spending the £11million of existing capital and that the Finance and Investment Committee were assured that the priorities within the Capital Programme 2016/19 were correct, noting that more capital would be needed to carry out all the improvements needed by the Trust. He explained that the Trust could bid for a potential £34million additional capital from NHSI, and that a bid had been submitted for £6 million. Mr Nealon said that improvement work undertaken with this money would be aligned to both the Trust's 5 year strategy and 5 year finance plan, and once these pieces of work had been a completed an additional bid could be submitted.

Mr Nealon reported that the 2014/15 reference cost audit had looked at the methods used by the Trust to compile figures and report activity, which had to be done in compliance with Monitor guidelines. He explained that the process had undergone external audit, and that the Trust had been found to be marginally non-compliant. Mr Nealon said that, following meetings between the Trust and the auditors, the auditors were satisfied that appropriate measures had been taken to ensure that the Trust would be compliant in the future and that the Finance and Investment Committee were also assured that Trust would be compliant.

In response to a query from Mr Clayton-Smith, Mr Nealon explained that the Trust had a team focussed on realising potential savings identified by Lord Carter, and that the Trust hoped to realise 20% of these potential identified savings.

The Board noted the Finance and Investment Committee report.

c) People and Organisational Development Committee

Ms Kavanagh noted that the People and Organisational Development

Committee had met for the second time on 1st June. She reported that a communication had been sent to staff following the first meeting, and that staff had attended the meeting as observers and had made a good contribution to the meeting. She said that the Terms of Reference for the Committee had been agreed, and would be presented for Board approval in October. **MK**

Ms Kavanagh reported that the Trust's Organisational Development Strategy would be presented at September's Committee meeting and that a five year workforce plan was being drafted. She explained that the results of the Trust's Pulse Surveys were reviewed by the Committee, and had shown that the Trust needed to provide feedback about concerns that were raised in a more timely fashion and to demonstrate that actions were being taken as a result of the feedback.

Ms Kavanagh reported that a review of recruitment hotspots within the Trust had taken place, and methods of making the Trust more attractive to potential recruits had been discussed.

The Board noted the People and Organisational Development Committee Minutes

d) Quality and Safety Committee

Mrs Churchward-Cardiff highlighted that the Committee had been renamed to the Quality and Safety Committee. She said that a re-audit of the Trust's compliance with Duty of Candour had shown a big improvement, but that further improvements still needed to be made to the Trust's responses to complaints. Improvements had been made within the Trust in medicines management, and estates work had begun which would improve the privacy and dignity of patients within the radiology and paediatric departments.

Mrs Wells reported that the son of a patient had attended the Committee to speak about the care that his father had received while in the Trust, which had been very important in humanising the experience of patients for the Committee.

The Board noted the Quality and Safety Committee Minutes, and approved the revised Terms of Reference.

064/2016 **Board Assurance Framework**

Mrs Wells explained that changes had been made to the Board Assurance Framework (BAF) following the review undertaken by the Board at the Seminar in July. She highlighted that four areas within the BAF had been rated as red.

- Reconfiguration of A&E departments
- Mortality indices
- The Trust's financial position

- Patient transport

She explained that an additional gap in assurance had been added to the document, highlighting the greater focus required on developing clinical leadership within the Trust.

In response to a question from Mrs Churchward-Cardiff, Mrs Butterworth explained that recruitment of A&E Liaison Nurses had begun. Dr Bull explained that the Business Case for the posts had been completed in conjunction with commissioners and the Sussex Partnership Trust.

Mrs Kavanagh asked what success in improving mortality levels would look like for the Trust and whether the Trust had a goal of bringing mortality down to an expected level? Dr Bull replied that a number of different ways of measuring mortality were utilised, with different ratios looking at different conditions and times. He advised that the level of the Standardised Hospital Mortality Indicator had recently reduced slightly. Dr Bull explained that the Trust's target was to get mortality levels back to the level that was expected, and then to continue to improve beyond that point, ultimately aiming to be in the top 10% in the country. This process would take some time, not least because of the built in delay in the reporting of the figures.

Mrs Churchward-Cardiff asked what actions the Trust were taking to mitigate the changes to nurse training being introduced in 2017 and Ms Green reported that the Trust was working very closely with Health Education England to assess the possible impact of the changes. She explained that an update would be provided to the Board in October when the work had been completed. **MG**

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

065/2016 **ESHT 2020 Improvement Programme**

Mrs Webster presented a highlight report outlining progress made on the Trust's 2020 Improvement Programme. She explained that no project milestones were rated red, although there were still some that remained with an amber rating. She noted that information about additional actions being taken was included within the report and that significant risks to the programme were detailed. Mrs Webster noted that the Trust's key achievements were highlighted, including changes led by maternity staff to on-calls for community midwives which had led to more consistent support for mothers wanting home births.

In response to a question from Ms Kavanagh, Ms Green explained that

the 'Floor to Board' dashboard would allow for high level review and comparison of clinical areas within the Trust which would be relatable to staff.

Dr Herne asked why mortality was rated red on the BAF, but received an amber rating within the 2020 Programme Update. Dr Bull explained that the amber rating within the 2020 Programme Update reflected that the Trust were making progress but had not yet achieved its ambition. He noted that the BAF provided a grading for the risk and was therefore looking at a different metric.

Mrs Churchward-Cardiff asked why the Trust's audit compliance was rated red for Root Cause Analyses (RCAs) carried out following both venous thromboembolisms and pressure ulcers. Mrs Webster replied that they were rated red because only a small number of RCAs should have been undertaken, and the few that had not been undertaken made a big difference to the completion rate.

Mrs Churchward-Cardiff noted her disappointment that objectives needed to be set for pain relief for emergency patients, and Mrs Webster explained that the wording of the objective should be amended to accurately reflect that patients were not being left in pain while a score was assessed.

The Board noted the report updating the Trust's progress on the 2020 Improvement Programme.

066/2016 **Integrated Performance Reports – June 2016 (Month 3)**

i) Patient Safety & Clinical Effectiveness

Mrs Webster reported that Quality and Safety Committee had received the report. Dr Bull noted that the mortality rate reported on section 1.4 was for crude mortality, and explained that future mortality reports would incorporate all of the mortality ratios in order to provide a more complete picture of mortality within the Trust.

ii) Performance, Access and Responsiveness

Mrs Butterworth reported that A&E continued to under-perform against targets due to the significant challenges that existed around patient flow. She reported that work was being undertaken in conjunction with the CCGs and with adult social care to resolve the issues.

Mrs Butterworth reported that Referral to Treatment performance for June had been 89.5% against a target of 92%. She said that meetings had taken place with CCGs and continued to be held on a weekly basis in order to meet the target by October. She explained that theatre and clinic utilisation would be increased, additional lists would be undertaken and work with private providers would be carried out in order to improve

performance.

She reported that the Trust was in a sustainable position of delivering against all cancer standards, with the exception of the 62 day standard. She said that a deep dive would be undertaken into urology in order to further understand the issues being faced in meeting this standard. Mrs Butterworth reported that meeting diagnostic waiting time targets continued to be challenging, and that an endoscopy vanguard was on site to assist the Trust in this area.

Mr Nealon asked whether patients were bypassing primary care and coming directly to A&E and Mrs Butterworth confirmed that this was the case. She explained that patient pathways through primary care were being reviewed by the CCGs in order to try to reduce hospital attendances.

iii) Finance

In response to a query from Mrs Churchward-Cardiff , Dr Bull explained that the Trust continued to review its operating costs. He noted that Mr Reid had met with General Managers to discuss the challenges the Trust faced, and the need to improve the financial position.

Dr Bull explained that a number of areas where significant impact could be made had been identified. He noted that addressing these issues may require some initial investment but this would result in efficiencies in the long term. He explained that it would be counterproductive to begin short term measures that would cut costs but that were not sustainable. He reported that a positive reaction to the financial plans from Medical Leaders and General Managers had been received.

Mr Clayton-Smith asked if a detailed review of the actions being taken to improve the Trust's finances could be presented to the Board at the next meeting. **JR**

iv) Workforce

Mr Nealon asked if the new arrangements for paying bank staff on a weekly basis had made an impact and Ms Green replied that they had only been introduced in August, but that they should encourage staff to work on the bank rather than joining agencies. She explained that this should reduce agency expenditure for the Trust.

The Board noted the Performance, Workforce and Finance Reports for June 2016.

067/2016 **Safe Nurse & Midwifery Staffing Levels**

Mrs Webster presented a report detailing nursing and midwifery levels across the Trust, noting that this information would be included within the

Integrated Performance Report in the future. She reported that work was ongoing with Berwick Ward to understand the increase in the number of medication errors being reported.

She explained that average fill nursing rates of over 100% related to extra capacity or requirement for patients who required one to one care.

Dr Bull noted that it would be useful for community nurse staffing levels to be included in the report in the future. **AW**

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

068/2016 **Quality Report (Quarter 1)**

Mrs Webster presented the report and explained that it was a more succinct version than had been submitted at previous Board meetings. She explained that analyses and actions from the recent inpatient survey results would be presented to the Quality and Safety Committee.

She reported that responses to the Friends and Family Test remained poor. She noted that NHSI had benchmarked the Trust against other organisations and had reported that the Trust was not an outlier in this regard and that poor responses rates were a national issue. Mrs Webster said that the Quality and Safety Group would be undertaking a detailed review of the Friends and Family Test, and would present their findings to the Quality and Safety Committee.

The Board noted the Patient Experience Report

069/2016 **Annual Business Plan Quarter 1**

Mr Astell presented the Quarterly Update on the Annual Business Plan to the Board, noting that it supported the Trust's Quality Improvement Plan, workforce planning and the Trust's financial plans.

The Board noted the Annual Business Plan Quarter 1

GOVERNANCE AND ASSURANCE

070/2016 **Nursing and Medical Revalidation Update**

Dr McGreevy introduced the members of her team, Jo Gibson, Agheta Khalique and Polly Moore-Weeks, explaining that they had provided intensive support to nurses and midwives as they undertook their revalidation. She explained that the revalidation was carried out over a three yearly cycle, and provided assurance that the nurses and midwives could practice safely and effectively. She reported that all nurses who had been due to undergo revalidation had done so in a timely way so far, with the exception of one nurse who had been granted an extension due to long term absence.

Mrs Webster thanked Dr McGreevy and her team for all of their hard work, noting that nurses had reported that the revalidation process to be straightforward and enjoyable. Mrs Churchward-Cardiff said that she felt that the strong revalidation team was an asset for the Trust, and that staff benefited greatly from their support.

In response to a question from Mr Clayton-Smith, Dr McGreevy explained that the Trust would hope to see greater retention of staff due to the support they received during the revalidation process.

Dr McGreevy reported that the third annual audit of medical appraisal had been published in July 2016 and that this benchmarked ESHT against other acute Trusts in England. She said that during 2015/16 96.8% of doctors at ESHT completed their appraisal, compared to an average of 86.6% of doctors across the country. Dr McGreevy said that she was proud of the manner in which doctors were engaging with the revalidation process, and about the quality of the appraisals being carried out.

Mr Clayton-Smith thanked the revalidation team for all their hard work.

The Board noted the Nursing and Medical Revalidation Update

071/2016 **Equality Delivery System**

Mrs Wells explained that the refreshed Equality Delivery System (EDS2) was the Trust's annual equality report, providing equality data on services, patients and staff. She said that a large amount of work had been undertaken to improve equality and diversity within the Trust, but that the Trust was not yet good enough at ensuring that this work was properly evidenced. She noted that focused work would be undertaken to ensure that evidence would be easier to collect into the future.

Dr Bull reported that a significant piece of very successful work in resolving issues that existed in the Trust around language and communication had recently been completed, and thanked the Equality and Human Rights Lead, Kim Novis, for her hard work.

Mrs Churchward-Cardiff noted that there was a marked difference between the percentage of white / BME applicants and white / BME appointments and Mrs Wells said this had been reviewed and she would ask Ms Novis for some narrative about the figures presented and circulate this to the Board. LW

The Board noted the Equality Delivery System report

072/2016 Health and Safety Annual Report

a) Mrs Webster explained that the Health and Safety annual report had been reviewed in depth by the Quality and Safety Committee. She said that it showed the progress that continued to be made by the Trust in improving health and safety, but noted that there was always more that could be done.

She reported that Estates and Facilities were improving their health and safety engagement by holding regular meetings, chaired by the Associate Director of Estates and Facilities. Mrs Webster said that the Trust's manual handling team were making good progress with training staff and improving the work place environment, and that a change of personnel within the medical devices team was making an impact.

Mr Clayton-Smith noted that a recurring theme from quality walks was the length of time it took for estates to complete little jobs within the Trust. Mrs Wells explained that this was a key theme that had emerged from the mock inspections, and that the estates team were working hard to address this..

Mrs Churchward-Cardiff asked how the Trust were addressing the high number of incidents of violence and aggression in out of hospital care and urgent care that were being reported. Mrs Butterworth replied that work was ongoing to provide support for staff and mechanisms were being improved to ensure that incidents were reported and investigated.

Mr Clayton-Smith asked about the timeline for a plan to be devised to reduce the risk to staff of violence and aggression and Mrs Butterworth said that she would advise the Board on progress at the next meeting. **PB**

The Board noted the Health & Safety report

b) Workforce Strategy 2016/17

Ms Green explained that the Workforce Strategy 2016/17 considered the workforce needs of the Trust into the future and that it had been approved by the People and Organisational Committee. She said that it had been circulated to senior leaders within the Trust for feedback, and that this had been incorporated into the strategy.

Mrs Churchward-Cardiff noted that violence and aggression towards staff was not covered within the strategy and asked that this be incorporated. She also suggested that guidance on incorporating the use of Healthroster more fully should be included within the strategy.

The Board approved the End of Year Workforce Strategy, noting that revisions would need to be undertaken.

ITEMS FOR INFORMATION

073/2016 **Questions from Members of the Public**

a) Apex Way

Ms Walke asked whether all of the Trust's records would now be available electronically following the move to Apex Way, or whether this was just the case for historic records? Dr Bull replied that clinical correspondence and test results for all patients' records were already electronically available. He noted that full Electronic Document Management was due to be introduced into the Trust in October 2016, explaining that this was another important step to becoming paper-free. He noted that the Trust had to be able to show plans to becoming paper-free by 2020, and said that he expected that by 2020 the Trust would be paper-light.

b) Prescriptions

Ms Walke explained that, following an ophthalmic appointment, a GP would not prescribe the same medication as the hospital as a better, cheaper medicine was available over the counter. Dr Bull explained that the Trust's Medicines Management Group was reviewing issues such as this, and would include a review of the cost of prescriptions as part of their programme of work.

c) Mortality Rates

Ms Walke explained that she felt that it was important to recognise that there were a number of different metrics looked at by the various mortality rates, and asked why the performance report only included the crude mortality rate? Dr Bull explained that the crude mortality rate measured the actual number of deaths that occurred, and that the various other ratios were derived from calculations that looked at the age of patients, the context of their care and the conditions they lived in to come up with expected number of deaths, which were then compared to crude mortality. He explained that the Trust's mortality figures were slightly higher than expected, but noted that this did not mean that there was a higher risk of death for patients than in other hospitals. He explained that the Trust needed to continue to improve to ensure that the risk was as low as possible.

d) Trust Reports

Ms Walke said that reports produced by the Trust did not reflect the fact that the Trust was integrated very well.

e) Counterterrorism Training

Ms Walke explained that she had volunteered to help with Eastbourne's airborne display, and had received training in health and safety as a result. She said three quarters of this training had been dedicated to terrorism, and suggested that staff from the Trust could benefit from

similar training.

074/2016 **Date of Next Meeting**

Wednesday, 12th October 2016, at 1230 in Lecture Theatre, Education Centre, Conquest Hospital.

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 3rd August 2016 Trust Board Meeting

Agenda item	Action	Lead	Progress
062/2016 c)	Revised Terms of Reference and membership for People and Organisational Development Committee to be approved by Board	Miranda Kavanagh	On Agenda
064/2016	Update on review of impact on changes to nurse training to be provided	Monica Green/Alice Webster	Verbal Update to be provided
066/2016 iii)	Detailed review of the actions being taken to improve the Trust's finances to be presented	Jonathon Reid	Discussed in Private Board Meeting 12th October 2016
067/2016	Safe Nurse and Midwifery Staffing Report to include community nurse staffing levels	Alice Webster	Community Staffing Levels to be included once data is available
072/2016 a)	Update on progress of plan to reduce the risk of violence and aggression towards community staff	Pauline Butterworth	Verbal Update to be provided

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	6
Subject:	Chief Executive's update
Reporting Officer:	Dr Adrian Bull

Action: This paper is for **(please tick)**					
Assurance	X	**Approval**		**Decision**	
Purpose:					
The purpose of this report is to provide the Board with a summary update from the CEO's perspective.					

Chief Executive's Update

1. Introduction

At the time of writing the CQC inspection is underway. A verbal update on first feedback will be given at the Board meeting.

2. Safety and Patient Experience

2.1 Quality and Safety

Patient Transport services remain unsatisfactory, although concerns have lessened. The report of the audit review of the commissioning process is available from HLWH CCG and has been presented to the HOSC. Performance data from Coperforma however remain unreliable. Poor patient experience and potential safety issues are being monitored and the Datix reporting of this is being closely observed.

High numbers of urgent admissions have put pressure on capacity across the organisation (see below). This has required urgent medical cases to be 'boarded out' in surgical wards, compromising our elective care work and requiring us to manage patients in the wrong ward environment. Extra bed capacity has been opened up within both sites which places an added pressure onto the system and particularly to the workforce which is monitored in light of the fluctuation of bed numbers and acuity of patients. This is being monitored and is reviewed at the four times daily site management meetings.

Currently work is progressing to standardise Safety Huddles. The feedback in the areas from staff involved - of all disciplines - is very positive.

2.2 Patient Experience

'Mouth Care Matters' is a Health Education Kent, Surrey and Sussex (HEKSS) funded initiative utilising trained professionals to improve the oral health of hospitalised adult patients through training and education. Oral health deteriorates in hospital, which has an impact on patient dignity, nutrition and safety. Through training, education and offering the team's skills, knowledge, support and tools, we can create a programme that improves patients overall health and wellbeing. ESHT have been successful in a bid to HEE (KSS) for funding for a 1 year project for a "mouth care matters" lead. This post is now out to advert.

NHS Choices (www.nhs.uk) was launched in 2007 and is the official website of the National Health Service in England. With over 48 million visitors per month, it has become the UK's biggest health website accounting for a quarter of all health-related web traffic. Reviews left on NHS Choices continue to be written and both of the acute sites now have a rating of 4 stars. The community sites are not reported in this way.

3. People, leadership, culture

3.1 Operational HR

Workforce Change
Formal staff consultations are on-going in the following areas:-

- Soft FM TUPE transfer to NHS Property Services – 83 staff affected
- HSDU and Endoscopy - 7 day working - 100 staff impacted

- Microbiology – single siting at EDGH 32 staff impacted at Conquest site
- Outpatient booking – new working patterns
- Physio Outpatient Administration - centralisation at EDGH from community site

Junior Doctors Contract
Preparation for the implementation of the new Junior Doctors contract effective 5th October 2016. The first speciality to be involved will be gynaecology. There will be a progressive roll out across the organisation. It is already anticipated that this will present a risk to the organisation of shortages in junior doctor cover due to the restrictive nature of the contract and the threat of fines. Dr Barry Phillips has been appointed interim Guardian of Safe Working Hours. An assessment of the impact of the new contract has been commissioned and contingency plans will be developed.

3.2 Staff Engagement & Wellbeing

The ESHT Vine programme has commenced with over 300 staff volunteering to be ESHT Vine Champions. In the first instance the aim is to create a network through which key messages can be communicated across the organisation, and informal views from across the organisation can be gathered in. The champions were invited to a drop in session to find out more about the role which involves sharing the theme of the week as widely as possible in anticipation of the CQC inspection. Those who attended the drop in sessions were extremely positive. We will be working with the champions to plan the next stage of this programme which will evolve ESHT Vine into a network of champions for our values.

A celebration event, led by our Clinical Education Team, celebrating the work of all of our staff who are mentors took place at Cooden Beach and was well attended, as well as being supported by colleagues from HEE(KSS) and Brighton University.

3.3 Workforce Development

In collaboration with East Sussex County Council and Sussex Downs College, Project Search has started with 11 new interns for the 16/17 academic year. The programme has nearly 40 different departments offering placements to interns, with many new departments confirmed for this year. The project aims to give young people with learning disabilities/difficulties the skills to gain competitive paid employment rather than the typical volunteering roles often associated with adults with learning difficulties or disabilities. Last year ten interns graduated from Project SEARCH in East Sussex with eight graduates having found sustainable employment to date.

The Doctors Assistant Pilot has been launched. It is funded by HEE-KSS. There will be 3 posts in SAU and 3 in MAU for a pilot period of six months, commencing in late November/early December.

4. Delivery and Access

There is a full report on operational delivery in the Board papers. We continue to be behind trajectory on both elective and urgent care waiting time targets. The programme of work that has been set up to improve this unsatisfactory position is describe in the paper. During September the organisation was put onto Black status for a week, being on red status for the remainder of the time. This reflects the pressure that the organisation is under – which is consistent with the national picture. Key elements of the plan include a) revised operational procedures in the EDs, b) a revised medical model across our wards and assessment units, c) continued focus

on sustaining patients in their homes with integrated OOH teams, d) greater focus on the core elements of successful discharge from hospital based on the SAFER model, e) small increase in capacity to enable discharge of patients deemed medically fit f) strengthened governance of improvement project and operational delivery.

5. Strategy

ESHT continues to work with commissioners on the delivery of ESBT and most recently we have been working closely with the CCGs and local authority to consider the system architecture that will enable us to deliver a safe and sustainable health and social care in East Sussex, and the wider aspirations of the STP. We are moving forward with the strategic planning of an Accountable Care Organisation which will require as part of its mechanism a far more joined up approach to planning, financial control and integrated delivery with quality and patient safety at the heart of all system transformation.

6. Recommendations

The Board is asked to note the contents of the report and receive the update.

Dr Adrian Bull
Chief Executive

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	6
Subject:	Speak Up Guardian's Report
Reporting Officer:	Ruth Agg

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

Purpose:

To provide an update to the Board on the work being undertaken by the Speak Up Guardian, and to highlight and themes and concerns that have been identified.

Introduction:

The Francis Inquiry and subsequent reports, including the Freedom to Speak Up review, have reinforced the need for organisational culture change.

ESHT is committed to supporting any members of staff who are worried about an issue, wrongdoing or risk which affects them or others. This includes any areas of poor practice, attitudes or inappropriate behaviour within our organisation.

The Trust believes in encouraging openness and transparency in all that we do, and ensuring that there will be no negative comeback for individuals who have acted responsibly in highlighting issues that could put the people we care for at risk in any way.

The Trust has a zero tolerance approach to any unacceptable behaviour towards an individual raising concerns such as reprisals, bullying, harassment or victimisation.

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

- 103 face to face contacts, staff from Band 1 to senior staff members have contacted the Speak up Guardian with a range of concerns. Staff from both acute hospitals, and community hospitals and community staff have contacted the service.
- No BME or LGBT concerns raised via Speak up Guardian for this 6 month period.
- The newly appointed National Speak up Guardian Dr Henrietta Hughes takes up post on 4.10.2016 and her post will guide and support the role.
- Patient safety is about quality and effectiveness of services and links to patient experience - the patient is at the end of everything we do.
- There is not one department that doesn't contribute to the delivery of patient care; we all play a part in effecting patient care.
- The role of the Speak Up Guardian is evolving. Improved communication is enabling staff to raise concerns with line managers and is a crucial part of the role. The Speak Up Guardian reports directly to the Chief Executive.

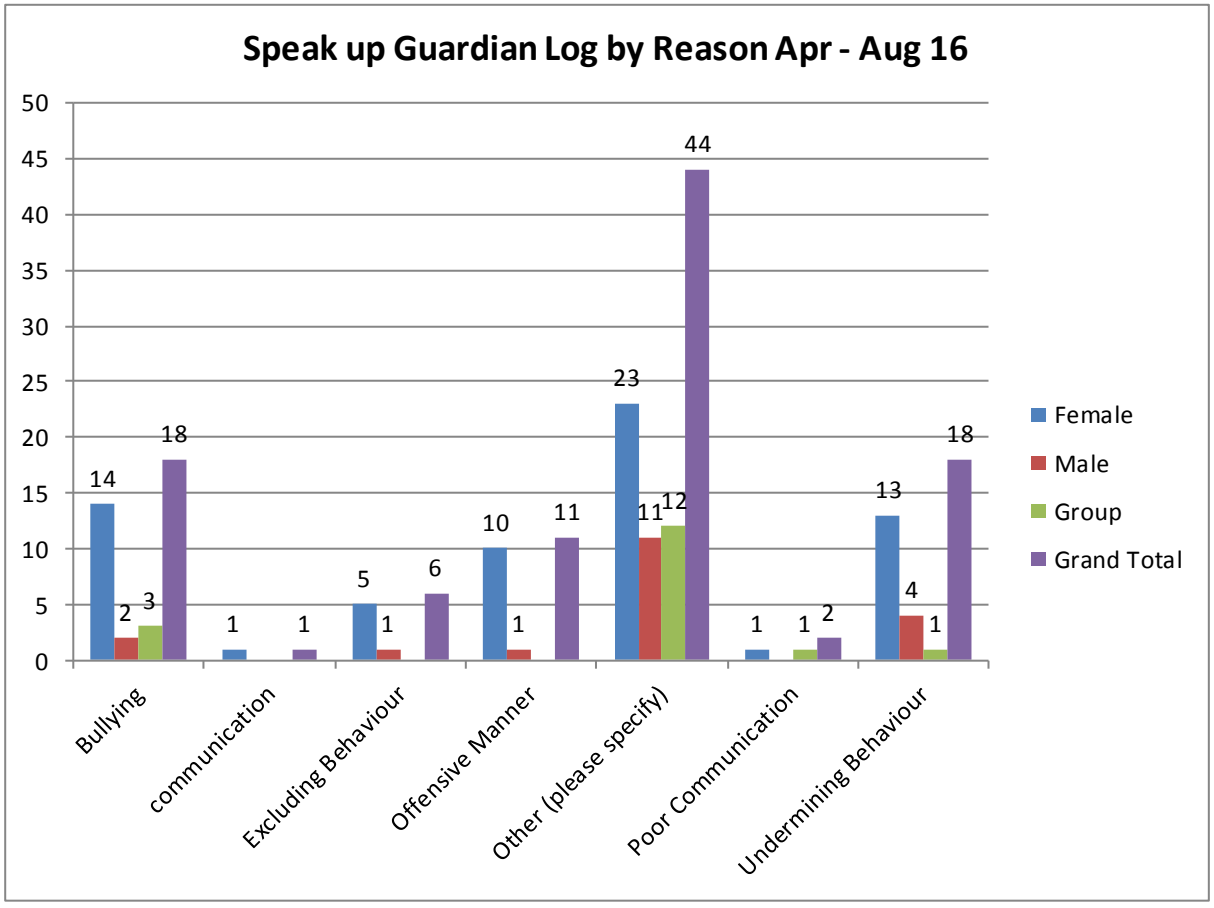
Proposals and/or Recommendations
The Boards is asked to note the Speak Up Guardian's report

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
No impact has been identified.

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Ruth Agg, Speak Up Guardian	01323 417400 Ext 5778 Mobile 07920 087 059

SPEAK UP GUARDIAN UPDATE APRIL 2016 – 1ST AUGUST 2016

Count Apr- Aug 16 (All)				
	Female	Male	Group	Grand Total
Bullying	14	2	3	18
Communication	1			1
Excluding Behaviour	5	1		6
Offensive Manner	10	1		11
Other (please specify)	23	11	12	44
Poor Communication	1		1	2
Undermining Behaviour	13	4	1	18
Grand Total	**67**	**19**	**17**	**103**
Count (Open)				
	Female	Male	Group	Grand Total
Bullying	7		2	8
Excluding Behaviour	2	1		3
Offensive Manner	1			1
Other (please specify)	2		2	4
Poor Communication			1	1
Undermining Behaviour	4	2		6
Grand Total	**16**	**3**	**5**	**24**



Conclusions

- Staff are coming forward to share their concerns.
- Staff are feeding back that they are happy for the concerns that they raised to be documented and shared with Dr Adrian Bull with their consent.
- Trust Values greatly support the raising of concerns and are a useful tool for staff to use when raising concerns.
- Plans for 2017/18 to provided dedicated training for staff at all levels of the organisation in order to support them in raising concerns.
- Staff who have used the service have provided positive feedback on the work being undertaken by the Speak Up Guardian.

Ruth Agg
Speak Up Guardian

East Sussex Healthcare NHS Trust

Date of Meeting:	12 October 2016
Meeting:	Audit Committee
Agenda item:	8
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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 and clearly demonstrates whether the gap in control or assurance remains unchanged, has increased or decreased since the last iteration. There are actions against identified gaps in control and assurance and these are individually RAG rated and updates marked in red

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

There are 3 areas rated red on the BAF:

2.1.2 Emergency department reconfiguration/patient flow
3.3.1 Patient transport
4.1.1 Finance

There is a proposal to remove the following gaps in control:

4.3.1 There is a gap in control as a result of the Trust not having an aligned estates strategy in place.
Proposal to remove as estates strategy developed and capital now picked up in 4.2.1

Benefits:

Identifying the principal strategic risks to the organisation provides assurance to the Trust Board that these risks are effectively controlled and mitigated which supports 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 consider whether the main inherent/residual risks have been identified and that actions area appropriate to manage the risks. The Board is asked to agree the removal of the gap in control outlined above.

Consideration by other Committees
Audit Committee/Quality and Standards Committee 21 September 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:	**Contact details:**
Lynette Wells, Director of Corporate Affairs	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
Director of Strategy	DS
Medical Director	MD

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 Objectives:
1.	Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
2.	All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.
3.	We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.
4.	We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.
5.	We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.
	Risks:
1.1	We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies.
2.1	We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.
2.2	There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.
3.1	We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.
3.2	We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.
3.3	We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners
4.1	We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.
4.2	In running a significant deficit budget we 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.
4.3	We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan
4.4	We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.
5.1	We are unable to effectively recruit our workforce and to positively engage with staff at all levels.
5.2	If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

Strategic Objective 1: Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients							
Risk 1.1 We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies							
Key controls			Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference Effective processes in place to manage and monitor safe staffing levels PMO function supporting quality improvement programme iFIT introduced to track and monitor health records EDM implementation plan being developed Comprehensive quality improvement plan in place with forward trajectory of progress against actions.				
Positive assurances			Internal audit reports on governance systems and processes Weekly audits/peer reviews eg observations of practice Monthly reviews of 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 Deep dives into QIP areas such as staff engagement, mortality and medicines management				
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	March CQC inspection reports published Sept 15, trust in special measures. Quality Improvement plan developed Improvement Director working with the Trust. Mar-16 In depth review of all warning notice actions by exec team . QIP monitored by stakeholders, medicines management and incident deep dive took place Mar-16. May-16 2020 Quality Improvement Priorities agreed and key metrics developed to support compliance and monitoring. Commenced preparation for Autumn CQC inspection. Jul-16 Mock inspection took place end June, further mock planned end of July. Sep-16 Continued monitoring of QIP and preparation for CQC inspection.	end Oct-16	◄►	DN	Q&S SLF
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
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.	Oct-15 iFIT embedding with rolling improvement programme. Mitigating actions continue and extended to provide daily information re availability of notes. New escalation procedure for missing notes. Centralisation of Health Records and records management structure reviewed. Dec-15 Ongoing programme of work to support effective delivery of health records service monitored by SLF. Consultation taking place re health records structure. Mar 16 - Significant reduction in missing notes, positive feedback from clinicians.. Storage remains challenging but is being addressed through the development of an off-site facility. Repairs continue but ultimate solution is the EDM programme. May-16 Marked improvement in the availability of records. Progressing offsite record storage Sept-16 New centralised storage facility open, 4 month transition plan to this facility. Short term rise in incidents regarding temporary notes due to the transition period which is monitored daily/reported weekly. Clear escalation processes in place to avoid impact on patient care. Issues regarding tracking of files outside of Health Records is being challenged and positive engagement encouraged. EDM preparation ongoing.	end Dec-16	◄►	COO	Q&S SLF

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.	
Risk 2.1 We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.	
Key controls	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with 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) processes and monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Cleaning controls in place and hand hygiene audited. Bare below the elbow policy in place Monthly audit of national cleaning standards Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure Cancer metric monitoring tool developed and trajectories for delivery identified, part of Trust Board performance report.
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**
2.1.1	C	Effective controls required to support the delivery of cancer metrics and ability to respond to demand and patient choice.	IST review to supplement work with KSS Cancer network on pathway management. Focused work to improve 2ww performance position. Mar-16 - Achieved 2WW breast symptomatic in Jan and both standards in Feb. In addition, TDA support provided 2 days per week to focus on sustainability and 62 day achievement. May-16 Ongoing review and strengthened processes supporting improved performance against cancer metrics. 2WW achieved Feb/Mar, breast symptomatic not achieved Mar, 62 days improving. Jul-16 Achieved 2 week wait and 31 day standard for last quarter. Clinically led Cancer Partnership Board commenced June . Cancer Action Plan providing continued improvements such as the reduction on 2 week wait triage delays. Sept-16 Continued achievement of 2WW and 31 day standards. Number of actions in place to support progress in 62 day achievement.	end Oct-16	◄►	COO	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.1.2	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. ED has impact on patient flow, use of gateway areas, ambulatory care and adherence to pathways of care.	Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place Capital bid with TDA for review to support expansion; outcome awaited, planning permission being sought in advance. Dec-15 Capital bid to be considered by ITFF at end of Feb. Mar-16 AHSN developing proposal to support the Trust with patient flow in A&E areas which will have a positive impact on privacy and dignity. Risk remains red as reconfiguration still required. May-16 Finance application being redeveloped for submission to ITFF to support capital plans. Jul-16 Trust prioritising reconfigurations from own capital programme to support effective patient pathways and address privacy and dignity issues. Finance application being redeveloped for ITFF. Sept-16 Urgent Care Programme Board established. Multi-disciplinary summit being planned to further support improved patient flow.	end Dec-16	◄►	COO	SLF
2.1.3	A	Assurance is required that there are effective systems in place to minimise infection control incidents and share learning throughout the organisation.	Jun-Dec 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'. NSC increased number of auditors and audits scrutinised at Accountability Reviews. Continued review and shared learning. Infection control deep dive at Jan Q&S committee. Mar-16 External assurance visits via CCG, TDA and External DIPC, Head of Estates and IC Lead. Awaiting report immediate action required in 2 out of 6 areas following one visit. Nothing further identified in remaining assurance visits form the CCG. Control dashboard being developed and planned to be part of the accountability review meetings. Single comprehensive action plan and annual programme of work being developed for April 2016. Assurance moved from Green to Amber. May-16 Bare below the elbows policy implemented in all clinical and ward areas. Increased compliance with national cleaning specification standards. Jul-16 Further work required to ensure BBE policy is embedded. Increased numbers of C Diff on EDGH site being closely monitored with support from CCG and NHS Imp. Talent work working with the Infection control team to manage the cultural change element of the embedding IC into practice. Sep-16 Increased monitoring of compliance by the IPCT & Hand hygiene peer audits undertaken. Trends from lessons learned from CDI RCAs monitored and discussed at relevant meeting for shared learning. Re-audit of MRSA compliance demonstrated slight improvement. Further work required to improve compliance.	end Aug-16	◄►	DN	Q&S

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.

Risk 2.1 Continued - We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.1.4	A	Mortality levels above expected range and assurance is required that there are robust mechanisms in place to understand the metrics and implement best practice.	Mar-16 Focussed action plan being developed. Identified top 10 drivers for elevated indices and reviewing pathways for cause in these groups. Internal mortality summit planned April 2016. Mortality Overview Group in place and additional governance review of deaths using data from the Bereavement Office. Peer review and support being accessed. May-16 Mortality meeting held with clinicians 20 May. Weekly review of deaths undertaken by consultant and senior coder. Work underway to understand further co-morbidity profile of our patients. A number of clinical pathway reviews in place to reduce risks eg colitis, deteriorating patient, gastroenterology. Jul-16 Mortality Improvement project expanded to incorporate AKI, Pneumonia, Sepsis. Project manager (full time) for mortality improvement project interviews being held in July. Sept-16 Full time project manager now in post. Plans in development following scope prioritisation. New Medical Director to review programme. SHMI reduced from 114 to 111 now within the normal range.	end Jul-16	◄►	MD	Q&S
2.1.5	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 to Oct-15 Action plan implemented and waiting list backlog cleared. Patient Tracking List developed and activity being monitored. Dec-15 Business Case (BC) and PTL considered Dec. Further updates to the BC and PTL will be reviewed at Jan meeting. Mar-16 CCG reviewed community paediatric business case, negotiations taking place. Following approval of business case substantive recruitment will take place to reduce the reliance on locums. Date moved to Sept to recognise recruitment timeframe. May-16 – Implementation timeframe of the recruitment plan is currently worked up. This will allow the service to build a recovery trajectory to reduce the waiting time and list size. Jul-16 Wait time to be seen reduced to 6 months for initial community paediatrician assessment. Active recruitment for CDC coordinator and 2 substantive consultant posts. 2 locum consultants start 4th July. Further part time locum consultant starting Aug. Sept-16 Locums in place. Difficulties in division of acute and community patients undertaking validation exercise, moving to Systm one which will support this.	end Dec-16	◄►	COO	SLF Q&S
2.1.6	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 CAMHS 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-Mar 16 Creating amenity beds and liaising with SPT on a case by case basis for CAMHS patients. Joint working with SPT, CAMHS recruiting assessor to support appropriate pathway for these young people. Continued working with CAMHS and SPT to develop pathway. May-16 A& E Liaison Nurse appointed to Conquest, equivalent being recruited to DGH. HoN requested in-reach pathway from CAMHS for these pts and daily ward visit. HoN attending urgent help/crisis meeting care and attending CAMHS transformation board to raise profile of young people in crisis with commissioners and gain adequate investment for this cohort. Jul-16 Out of hours urgent help service increased weekend capacity from 2 to 4 staff. Business case submitted to CCG to increase workforce to meet the need of CYP in crisis. Awaiting decision. Meeting to be held 8th July to review the A& E Liaison Nurse at Conquest role. Training requested from mental health team at CAMHS for ward nurses. Sept-16 Improving system CAMHs Liaison nurse available every day. Some inappropriate admissions still but these are individually reviewed.	end Jul-16	◄►	COO	SLF Q&S

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.2.1	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.	Mar 16 - Appraisal process and paperwork redesigned along with a development programme for Appraisers. New L&D manager started Feb and key objectives to review mandatory training, develop competency work and identify further efficiencies. Rating moved from amber to green. May-16. Compliance trend for mandatory training and appraisals continues towards 90% target. To support appraisal, Engaging for Development Masterclasses have been planned in June and July. Revised paperwork for Appraisal will be launched in July 2016. Jul-16 Mandatory training and appraisal trend continues upwards - continued support of CUs and departments to maintain compliance. Development Masterclasses well attended. Reviewing best practice in other organisations to consider automated mandatory training booking. DNA levels for training being reviewed. Sept-16 – Mandatory training levels are still sitting just below 90% but the current level of compliance is being sustained. Aiming for sustainable 90%+ by March 2017. Continued focus on areas of low compliance and provision of support. Still a high number of DNAs reviewing whether to implement 'penalties' for DNAs. Frontline pressure is often a factor in DNAs and therefore ensuring availability of staff to allow other staff to be released for training is also a factor in achieving compliance.	end Mar-17	◄► Mar-16	HRD	POD SLF
2.2.2	A	The Trust needs to develop and support its clinical leadership to empower them to lead quality improvement in order to realise the ambition of becoming an outstanding organisation by 2020.	Jul-16 Reviewing medical leadership roles to ensure they are appropriately resourced. Faculty of Medical Leadership Programme in place. CEO leading regular meetings with consultant body. Medical education team continue to work with junior doctors to improve engagement and enhanced support. New Medical Director appointment (subject to central approval) Revision and reappointment of all key medical role job descriptions: CU Lead; Speciality Lead; Chairs of Clinical Boards (urgent care, elective, cancer); Chairs and ToR of key Medical Clinical Governance sub committees. Sept-16 New Medical Director in post, progressing appointments of Chiefs and deputies.	end Mar-17	◄►	MD	POD

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.	
Risk 3.1 We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.	
Risk 3.2 We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.	
Key controls	Develop effective relationships with commissioners and regulators Proactive engagement in STP and ESBT Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners and stakeholders Develop and embed key strategies that underpin the Integrated Business Plan (IBP) Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Organisational Development Strategy Effective business planning process
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Monthly performance and senior management meetings with CCG and TDA. Working with clinical commissioning exec via East Sussex Better Together and Challenged Health Economy to identify priorities/strategic aims. Board to Board meetings with stakeholders. Membership of local Health Economy Boards and working groups 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**
3.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work on-going. Trust developing clinical strategy. Dec-15 ESBT work continues. Board to Board meeting with Eastbourne, Hastings and Rother CCG took place Dec15. Mar-16 SPT footprint agreed. Trust to work with stakeholders to develop strategic plans. Board Seminar planned April 16. May-16 Trust fully engaged with SPT and ESBT programmes. Trust strategy being developed and "stakes in the ground" identified. Priority specialities for clinical strategy development identified and specific work commenced Jul-16 Continuing to work closely with commissioners on aligning ESBT plans with the emerging clinical strategy. Multiple integrated strategic planning workstreams underway and recruiting to better support the planning process. Sept-16 STP for Sussex and East Surrey now incorporates placed based care (ESBT) as one of its key elements. We continue to work proactively with commissioners and other providers to ensure that opportunities to deliver efficiencies at scale and pace are maximised. This includes working across STP boundaries. ESHT CEO is now joint SRO with CCG and ESCC leaders in the emerging Accountable Care Organisation Steering Group which will develop the delivery mechanism by which the challenged health economy issues will be tackled.	end Dec 16	◄►	DS	F&I SLF

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.	
Risk 3.3 We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners.	
Key controls	Development of communications strategy Governance processes support and evidence organisational learning when things go wrong Quality Governance Framework and quality dashboard. Risk assessments Complaint and incident monitoring and shared learning Robust complaints process in place that supports early local resolution External, internal and clinical audit programmes in place Equality strategy and equality impact assessments
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives. Friends and Family feedback and national benchmarking Healthwatch reviews, PLACE audits and patient surveys Dr Foster/CHKS/HSMR/SHMI/RAMI data Audit opinion and reports and external reviews eg Royal College reviews Quality framework in place and priorities agreed, for Quality Account, CQUINs

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.3.1	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. Mar-16 New provider in place, managed service contract. Working with provider to ensure effective transition from SECAMB. Effectiveness of service will be monitored. May-16 Following handover to new provider there have been significant service problems impacting on patient care and experience. In addition there has been an increase in DNA rates and loss of procedure time due to failure to collect patients and late arrivals. There is an operational group in place, monitoring of incidents and this has been escalated both internally and externally. All Trust in Sussex are experiencing the same issues and there is a CEO summit w/c 31.5.16 Jul-16 Some improvement on inward bound journeys but still subject to weekly monitoring across Sussex both at operational and strategic level. Independent review of procurement and transition underway by TIAA. Sept-16 Number of incidents regarding transport have reduced but additional dedicated vehicles are still required. Significant adverse publicity continues and is causing ongoing concern to patients. SI has been raised by CCG. Formal investigation into level of harm is being led by CCG. Overall lack of confidence in stability and sustainability of the service	end Nov-16	◄► May-16	COO	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.2	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Shortage of staff in appointment and admissions booking teams 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 -Dec15 Close liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard. Reviewed processes to minimise short notice clinic cancellation and ensure appropriate clinical assessment of affected patients. New call management system introduced to address technical and resource issues in appointments centre/provide enhanced service Review of 700+ letter templates underway to improve patient communication. SOPs and specialty booking rules agreed and implemented. March 16 – 80% referrals registered within 48hrs of receipt, scanned on to e searcher to minimise paper referrals going missing. First specialty about to go live with e referral system, continued roll out through 16/17. Staff capacity/demand remains an issue and is being addressed through business planning. Planning to develop some self- service check in facilities in 16/17 May-16 Business Case for Clinic Manager and Self-Serve check in underway with PMO and IT. New structure with additional resources for OP booking to support retention of staff due for implementation by end of July 16. Informal staff engagement underway. Jul-16 Progressing with new structure but will require formal consultation to extend operational hours, improving access for patients, which is primary cause of complaints. Clinic Manager business case to be submitted to BDG in July. Sept-16 Consultation with staff and additional recruitment completed, training underway and new structure will be in place by Oct/Nov 16.Clinic Manager Case approved but is subject to PAS hardware and software upgrades. Project expected to start Nov-16 for implementation by Spring 17.	end Mar-17	◄►	COO	SLF Q&S

Strategic Objective 4: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.	
Risk 4.1 We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.	
Key controls	Clinical strategy development informed by commissioning intentions, with involvement of CCGs and stakeholders QIPP delivery managed through Trust governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work Modelling of impact of service changes and consequences Monthly monitoring of income and expenditure Accountability reviews in place
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**
4.1.1	C	Require evidence to ensure achievement of the 2016/17 Financial Plan and prevent crystallisation of risks as follows: activity and income targets are not achieved; contractual fines and penalties are levied; activity, capacity and unplanned cost pressures arise; the CIP plan is not delivered;	PBR contract in place. 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. May-16 – Month 1 performance £0.5m adverse to plan. CIP plan for month achieved. Income broadly in line with plan; non-elective over performance offsetting elective shortfall arising from doctors' strike. Fines and penalties incurred – Trust will discuss with commissioners reinvestment of these. Pay costs in line with plan with a significant reduction in agency costs. Capacity cost pressures incurred – Trust will recover some of these through Tariff while premium cost of delivery to be discussed with commissioners. Integrated performance meetings in place, chaired by the CEO; continuing oversight by F&I Committee; Efficiency Improvement Group driving financial improvement, including opportunities from Lord Carter review. Jul-16 - Month 2 performance remains adverse to plan, although CIP plan for the month achieved and agency spend reducing. Income is slightly behind plan, but elective activity both behind plan and incurring 'send away' costs. Emergency activity ahead of plan, but associated costs also above plan. Recovery plan for elective and emergency activity under development for Improvement Board (Jul-16) and discussion with CCG. Fines and Penalties risk reduced due to agreement on S&F funding and refreshed control total, but increased CIP target. DoF refreshing CIP development and implementation process, and reviewing detail of temporary staffing spend plans. Risk will require consistent monitoring over remainder of financial year. Sept-16 - Month 4 remains adverse to financial plan, after an improvement in Month 3 stemming from a full formal close-down and opportunity review. Key pressures remain agency spend, CIP delivery and cost of operational pressures. Financial Recovery Plan developed and shared with Trust Finance and Investment Committee, and with Executive Directors. New Financial Improvement and Sustainability Committee being formed to ensure Executive leadership and oversight of both strategic and operational finance. Additional capacity secured within finance team, including short-term ad hoc cost-limited consulting support on temporary resourcing. The level of risk remains significant, but the Trust is developing a measured and coherent response to the key issues.	Commenced and on-going review and monitoring to end Mar-17	◄►	DF	F&I

Risk 4.2 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 Essential work prioritised within Estates, IT and medical equipment plans
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. Trust achieved its CRL in 2015/16

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.2.1	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.	May-16 – Capital programme has been submitted to NHSI as part of the 2016/17 business planning submission. The Trust Board will undertake a further review the capital programme with a view to ensuring that priorities for spend are correct within the limited funds available, including any urgent elements from the Estates Strategy. The Board will also look at medium term priorities to help shape a business case to the Department of Health for a capital loan to support requirements over and above 'core' capital funding. Jul-16 - 5 year capital plan agreed by FIC and reviewed in Board Seminar. Discussions opened with NHSI around submission of capital bid, with £5m initial amount included in refreshed submitted plan. DoF reviewing internal capacity to develop FBC for submission in Q£ for £35m, and interim bid, in partnership with DoN, in Q2. Finance and Estates teams reviewing alternative sources for finance for discussion in September 2016 FIC. Sep-16 - Additional support secured for development of both £35m overarching capital bid, and in-year initial bids for £5m to support delivery of financial plan. Capital Review Group taking forward both bid development and prioritisation process, the management of in-year expenditure, and the exploration of alternative sources of financing. Initial LTFM includes refreshed capital requirements and being refined to support submission of bid pipelines.	On-going review and monitoring to end Mar-17	◄►	DF	F&I

Strategic Objective 4: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.							
Risk 4.3: We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.							
Key controls			Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital 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**
4.3.1	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. Mar-16 Estates strategy will be considered at May Board seminar. May-16 Producing clear statement of agreed capital programme for 16/17 and a forward five year plan for capital and estates development projects to support clinical strategy. This will be the basis of the bid for additional (PDC) funding. Jul-16 Capital programme reviewed at Board Seminar July 16. Proposal to remove as strategy developed and capital now picked up in 4.2.1	end Sep-16	◄►	COO	F&I SLF

Risk 4.4 We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.	
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports
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**
4.4.1	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.	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. Mar-16 as above Trust successful in Sexual Health Tender. May-16 Business planning team dispersed to support other projects, support required for tendering exercises will form part of portfolio of Director of Strategy. Assurance level moved from Green to Amber. Jul-16 - Trust recruiting for Business Development team, with specific focus on building support for tender planning and submission. DoF reviewing with DoS the forward Commercial Strategy for Trust, including alignment with Clinical Strategy development. Sep-16 - appointments made within Business Development Team, and substantive Director of Strategy, Innovation and Planning appointed with key leadership role. Five year financial plan in first iteration, including commercial strategy, and DoF/DoS working on first iteration of Commercial Strategy, within addition support secured for development work and pending MSK procurement.	end Jun-16	◀▶ May-16	DF	SLF

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

Risk 5.1 We are unable to effectively recruit our workforce and to positively engage with staff at all levels.

Key controls	Workforce strategy 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**
5.1.1	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	May-16 Recruitment hotspots are Medical Consultants, A&E, Histopathology, Stroke, Gastroenterology, Other areas of focus are Dermatology, Obstetrics, Neurology, Haematology Paediatrics Middle Grades – A&E, Geriatrics, followed by Gastro and Orthodontics. Task and finish groups with CUs to develop a recruitment and retention strategy which includes skill mix review, international recruitment. Use of head hunters to identify suitable candidates. Registered Nurses – Increase in establishment has resulted in the vacancy rate increasing. This will continue to be addressed through a combination of on-going overseas recruitment and newly qualified and UK recruitment. Anticipated that a fill rate for Registered Nurses will be 93% by April 2017, and 97% by April 2018 Reviewing current recruitment marketing strategy and developing new literature and addition to the corporate website to promote ESHT as a place to work. Jul-16 Developing Trust competence and pay grade for junior doctors which will be an extension to the current specialty doctor posts. Reviewing the impact of the change to funding of nurse training from Sept 17 where pre and post reg training will be funded through student loans. Sept-16 Working with headhunters to attract candidates; appointed one histopathologist. Trust Associate Specialist Role approved to improve retention of existing middle grade Drs and may be used to attract senior middle grade medics. Overseas nurses commenced and vacancy fill rate is on target. HCA up to establishment and focus bank recruitment to reduce agency usage New marketing materials available to promote the Trust and social media being used to advertise posts. Launched the use of social media to advertise posts through Linked in Facebook and twitter initial response has been positive. Workshop planned Nov with CU's to develop short, medium and long-term solutions to recruitment issues. Participating in NHS Employers Retention programme which starts in October.	end Mar-17	◄►	HRD	SLF

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
5.1.3	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. Mar-16 Recruitment taking place however short falls in staffing remains. Mitigating actions such as use of long term locums Jul-16 Working with ESBT to develop GP triages in A&E. Post currently in recruitment process. Sep-16 Successful recruited consultant and specialist A&E registrars. Number of vacancies in registered nurses in MAU being actively monitored and mitigating actions in place.	end Sep-16	◄►	COO	SLF

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

Risk 5.2 If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and being embedded Staff Engagement Plan developed OD Strategy and Workstreams in place
Positive assurances	Clinical 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**
5.2.1	A	The CQC staff surveys provide insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	May-16 Staff survey results – three priorities have been identified for improvement for 2016/17. Clinical units are working on action plans for their local issues . Cultural review has been commissioned and will commence April 2016 Number of local staff engagement initiatives are taking place across the trust . Pharmacy introduced suggestion boxes and are acting on feedback. Out of hospitals CU sharing work they have been doing to transform services Staff forums and listening conversations continue to take place with regular feedback on new initiatives. Trust annual awards took place with over 250 staff attending Most clinical units have completed action plans in response to staff survey International Nurses day conference celebrated achievements of all our nurses Take a Break campaign launched - all work areas given a basket of healthy snacks and advice and guidance on the importance of taking breaks and how to make the most of them. Chief executive has been visiting different staff groups as part of his induction Jul-16 Comprehensive programme of staff engagement continues. Supporting CUs to deliver local action plans. Pulse surveys taking place and responding to cultural review. Staff focus groups taken place to support quality improvement. Sept-16 Most recent Staff FFT had the highest response rate since 2014 and a significant increase in the number of staff who would recommend ESHT as a place for treatment and as a place to work . Most recent pulse survey that focused on communication between managers and staff demonstrated improvement. We are focusing specific pieces of work on areas where our pulse survey's show low levels of staff engagement despite considerable effort from the leadership teams.	end Apr-17	◄►	HRD	POD SLF

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	9
Subject:	ESHT 2020 Improvement Programme
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 ESHT 2020 Improvement Programme initially 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 was developed to ensure that the Trust worked together to achieve the commitment of delivering safe, high quality care for all of our patients. This has now been transitioned into the ESHT 2020 Programme providing robust governance for all improvements linked to strategic objectives

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 improvement Plan:

1. **Highlights and Milestones**
   This section describes the outcomes of the Warning Notice deep dive exercise and how this has informed the future delivery of the programme

2. **Project Summary Dashboard**
   For each objective this shows the current delivery and sustainability RAG

status including KPIs where appropriate.

3. **Key activities and Significant Risks**
   Risks that potentially seriously threaten the progress of the Improvement Plan

4. **Improvements**
   Update of outcomes from the Improvement Programme that have already been met improving the quality and efficiency of our care.

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, medical capacity and financial pressures on the hospital are having an impact on the progress of this large programme of work.

Assurance Provided:
Improvement Sub-Committee meetings attended by Executive Leads and Patient Experience Liaison Representatives take place monthly chaired by the Chief Executive, weekly meetings take place between the Senior Responsible Owner of the ESHT 2020 Programme, Alice Webster – Director of Nursing and the ESHT 2020 Programme Manager, Lesley Walton. Monthly meetings take place between the Project Executives the Project Manager and the Clinical/Non Clinical Improvement Leads.

Review by other Committees/Groups (please state name and date)**:**
Senior Leaders Forum September 2016 Quality and Safety Committee September 2016 Improvement Sub-Committee September 2016

Proposals and/or Recommendations
The Committee is asked to review and note the progress in implementing the ESHT 2020 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

East Sussex Healthcare NHS
NHS Trust

10th October 2016

ESHT TRUST BOARD REPORT

ESHT 2020 Improvement Programme Update

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 ESHT 2020 Improvement 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.

ESHT 2020 Improvement programme Status

This report provides an update on the following aspects from the last two months:

1. Highlights and Milestones
2. Project Summary Dashboard
3. Next key activities and Significant Risks
4. Improvements

Programme Highlights The main focus since the last report to the Committee has been the progression of the 11 projects that are currently delivering improvements. Key highlights are:

- ESHT 2020 Improvement Programme Sub-Committee chaired by Dr. Adrian Bull meets monthly. Assurance and decisions on priorities e.g. new patient flow triggers and procedures to be designed to improve the discharge.
- Project Manager joined to manage Mortality and Morbidity full time. Long term plans and immediate further improvements in progress.
- Plan developed to further improve consent processes
- Medical handover procedure reviewed and activities for standardisation and improvement progressing. Nurse/midwifery handover improvement work commenced
- Appointed Ward Improvement Manager
- Service Improvement posts advertised and interviews w/c 3rd October.
- Warning Notice Stocktake, Consent Action Report and Mortality Summary reports provided to the Trust Board in readiness for the CQC Inspection.

Programme Highlights The main focus since the last report to the Committee has been the progression of the 11 projects that are currently delivering improvements. Key highlights are:

- Safety Huddles continue to be embedded across the Trust
- Evidence provided to CQC as requested in preparation for inspection on 3rd October
- External Stakeholder survey showed a significant improvement the perception of engaging and working with ESHT.
- Improvements in 2 week cancer wait processes now showing reliable sustainable performance
- Revised medical model for A&E agreed i.e. more senior consultant presence in A&E
- Outsourced endoscopy backlog and extended service facilities availability to address waiting list.
- Maternity Summit held to rationalise all plans to one project and provided dedicated project management to support tracking against the plan.

East Sussex Healthcare NHS
NHS Trust

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments
SRO - Alice Webster				
Vision	04-Apr-16	Alice Webster	C	
Set Up Programme Board	31-Mar-16	Lesley Walton	C	
Programme Governance, Assurance and Terms of	09-May-16	Lesley Walton	C	
Programme Plan	30-Apr-16	Lesley Walton	C	
Communications and Engagement Strategy	30-Apr-16	Suzanne Gouch	C	
Benefits Management Strategy	30-Aug-16	Catherine Ashton	C	
Resource Management Strategy	31-May-16	Lesley Walton	C	
Risk Management and Issue Resolution Strategy	31-May-16	Lesley Walton	C	
Programme Gateway Assurance	30-Sep-16	HSCIC	C	
Programme Gateway Assurance	31-Jan-17	Internal/External (TBC)	G	
Programme Gateway Assurance	31-Jul-17	Internal/External (TBC)	G	
Delivering The Capabilities - PROJECT DOSSIER				
Programme Management Office Capability and Capacity for sustainable improvement	30-Jul-16	Jonathan Reid	C	
Service Improvement Hub Established	31st Dec-2016	Catherine Ashton	G	Recruitment in progress.
Warning Notice Compliance	30-Dec-16	Alice Webster	A	Warning Notice Stocktake identified VTE as main area of concern. Action plan in progress.
Mortality and Morbidity Project Complete	31-Mar-18	David Walker	G	Full time project manager now in post. Plans in development following scope prioritisation.
Cleanliness, Infection and Prevention Control Project Complete	30-Nov-16	Alice Webster	G	Project due to close. Decision on whether enough improvement made and robust BAU to sustain improving.
Evidence Base Care Project Complete	30-Nov-16	David Walker	A	No project manager. Review to be held on scope with programme manager and Medical Director
Medicines Management Project Complete	16th July 2015	David Hughes	C	
Workforce Capacity Capability & Engagement Project Complete	31-Dec-17	Monica Green	A	Medical recruitment and culture change key challenges
Effective Relationships with External Stakeholders & the Public Project Complete	31-Mar-17	Lynette Wells	A	Project to be expanded to develop robust governance and feedback on relationships with the public.
Governance Project Complete	28-Feb-17	Ashley Parrott	A	New governance structure embedding. Response from CU and learning from complaints is a concern
Health Records Project Complete	30-Jun-16	Liz Fellows	C	
Patient Flow Project Complete	31-Mar-17	Pauline Butterworth	R	Need sustained delivery of the A&E and RTT constitutional standards. Discharge processes need more focus
Maternity Project Complete	30-Dec-17	Pauline Butterworth	A	Plans not fully coordinated for further improvements - dedicated project manager assigned
Secure and Safe Premises and Faculties Complete	30-Nov-16	Chris Hodgson	C	Confirmation of A&E lockdown and securing of remaining Oxygen Cylinders
Ward Improvement project Complete	30-Sep-17	Alice Webster	G	Clinical Facilitator out to advert. Immediate ward improvements ongoing e.g. safety huddles, improvement huddles, common themes
Mock Inspection	22-Jun-16	Lynette Wells	C	
Mock Inspection	27-Jul-16	Lynette Wells	C	
CQC Inspection	03-Oct-17	Lynette Wells	C	

A	MORTALITY AND MORBIDITY PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Improve the Process and Governance of Mortality and Morbidity (IP 53)				
	Increase percentage of Mortality Cases reviewed within three months of death	31-Dec-16	95%	76%	
	Audit compliance with VTE Guidance (IP 37)				
	Increase Rate of VTE Assessments undertaken within 24h of admission	31-Dec-16	95%	98%	
	Percentage of Fatal PE RCAs undertaken within 3 months	31-Mar-17	98%		
	Percentage of Non-Fatal PE RCAs undertaken within 3 months	31-Mar-17	98%		
	Number of preventable DVTs	31-Mar-17	0		
	Number of preventable Non-Fatal PEs	31-Mar-17	0		
	Number of preventable Fatal PEs	31-Mar-17	0		
	Annual VTE audit embedded	31-Mar-17	100%		
	Audit compliance with National End of Life Care Guidance (IP 36c)				
	Complete End of Life Care Audits	31-Aug-16	100%	100%	n/a
	Review and re-launch EoLC Policies	01-Oct-16	100%	80%	n/a
	EoLC Strategy Approved	31-Jul-16	100%	100%	n/a
	Increase EoLC Training for Clinical Staff	31-Mar-17	80%	60%	

Project Executive: David Walker

Full time project manager and change analyst now working on this project. Project scope confirmed; Mortality Governance improvements and improve best practice for VTE, EOLC, Sepsis, AKI, Pneumonia, and COPD pathways. The Trust held a 'Sock It To Sepsis' themed week to raise awareness with staff of new tools and escalation routes when Sepsis is suspected and educate patients and carers on key signs. Trust governance processes reviewed and points of failure being addressed e.g. rate of Mortality Review groups held improved to 76% towards the end of September. Further review if the governance process will inform further actions. VTE specialist Nurse back in the Trust and multiple activities in progress to review backlog of RCAs for VTE patients. Consultant leads identified for each area for VTE RCA. KPIs for VTE agreed to monitor improvement.

A	EVIDENCE BASED CARE PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Hospital Handover Standardised				
	Implement standard operational policy for Hospital Handover@ Night	30-Nov-16	100%	30%	n/a
	Implement standard operational policy for Hospital Nurse Day Handover	30-Nov-16	100%	10%	n/a
	Regular Audit of Compliance of Handover Operational Policies	30-Nov-16	100%	0%	n/a
	Compliance with Handover Operational Policies	30-Dec-16	100%	0%	n/a
	Trust Consent Policy				
	Increase Percentage of Consent Forms signed by the Nurse/Doctor and the Patient	30-Nov-16	100%	100%	n/a
	Reduce Patient refusal for surgery on the day of the procedure	30-Nov-16	0		
	Increase use of Formal Capacity Assessment when using Form 4 of Mental Capacity Act	30-Nov-16	90%	71%	n/a
	Audit compliance with National Nil-By-Mouth Guidance				
	Undertake Nil-By-Mouth Audit	30-Nov-16	100%	50%	n/a
	Monitoring Pain Relief Effectiveness in the Emergency Department				
	Monitor the effectiveness of Pain Relief in the Emergency Department by FFT	30-Nov-16	100%	50%	n/a
	Pain Assessment Strategy for Dementia Patients				
	Implement audit of Patients with Dementia to ensure Correct Pain Assessment Used	30-Nov-16	100%	20%	n/a
	Pain Assessment Strategy for Learning Disability Patients				
	Implement audit of Patients with Learning Disabilities to ensure Correct Pain Assessment Used	30-Nov-16	100%	30%	n/a

Project Executive: David Walker

Project currently has no project management due to project managers focusing on Maternity, Mortality and Patient Flow however improvements are progressing in all areas as part of improvement groups e.g. Hospital @Night, Medical Handover by LiA. The project will be reviewed with the Medical Director to assess if the improvements need to be realigned to governance groups as part of BAU or the scope reviewed and project resourced. Recent progress made is the agreement of the Hospital @Night policy and the future vision and plans agreed for the Consent Group held in September.

G	ENVIRONMENTAL CLEANLINESS AND INFECTION PREVENTION AND CONTROL PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Sustained and documented compliance with the National Specifications for Cleanliness (IP 33a)				
	Increase Number of NSC Audits Undertaken	31-Jul-16	100%	86%	
	Increase NSC Audit Score (Overall Trust)	31-Jul-16	93%	95%	
	Increase NSC Audit Score (Nursing)	31-Jul-16	93%	94%	
	Increase NSC Audit Score (Housekeeping)	31-Jul-16	93%	96%	
	Increase NSC Audit Score (Estates / Maintenance)	30-Nov-16	93%	83%	
	Consistent understanding and compliance with the Trust Hand Hygiene Policy (IP 33b)				
	Increase Percentage of Hand Hygiene Audits Completed	31-Jul-16	100%	96%	
	Increase Hand Hygiene Audits Pass Rate	31-Jul-16	100%	98%	
	Robust governance and performance processes related to Cleanliness and Infection Prevention and Control (IP 33c)				
	Establish monthly Patient Environment Audit Monitoring Group	31-Mar-16	n/a	100%	n/a
	Report Cleanliness to the Trust Infection Control Group (TICG)	31-Mar-16	n/a	100%	n/a

Project Executive: Alice Webster

Improvements now progressing through the Trust Infection and Prevention Control (TIPC) Group. Discussion at the next Improvement Sub-Committee to decide if the TIPC group is now best placed to continue improvements as full project management may no longer add value. Main KPI of concern is the audit scores for Estates but this is being addressed by the long term plans to improve the environment as part of the estate improvement plans. Hand Hygiene may need a second wave of focus to review if the audit frequency is considered to infrequent.

A	GOVERNANCE PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Incident Management (IP 26)				
	Increase Rate of Incident Reporting	30-Sep-16	Monitoring	1952	
	Reduce number of Patient safety incidents 3,4,5	30-Sep-16	Monitoring	32	
	Reduce harm- high % no harm or near miss	30-Sep-16	71%	86%	
	Improve Timeliness of RCA Incident Reporting to CCG	30-Sep-16	90%	69%	
	Number of Serious Incidents Kept Open by the CCG	30-Sep-16	6	14	
	Shared Learning from Incidents (IP 28(27))				
	Final Incident closure results in feedback- number of unclosed incidents in system	01-Feb-17	monitoring	166	
	Complaint Management (IP 7)				
	Complaints Acknowledged within 3 days	30-Jun-16	100%	100%	
	Complaints Responded to within locally agreed guidelines	30-Sep-16	100%	33%	
	Reduce Complaints Re-opened per month	30-Sep-16	5	16	
	Reduce Number of Formal Complaints	30-Sep-16	20	51	
	Increase in satisfaction with complaints process	30-Sep-16	Monitoring		
	Ensure that the trust has a robust and effective governance process and structure in place (IP29)				
	Clinical governance organogram in place	30-Sep-16	100%	100%	n/a
	Committee structure approved	30-Sep-16	100%	100%	n/a
	Patient Experience (IP56)				
	Increase in total Trust FFT responses rate	31-Aug-16	Monitoring	1778	
	Total Trust FFT score	31-Aug-16	95%	93%	
	Duty of Candour (IP55)				
	Audit of moderate and severe harm incidents v compliance with Duty of candour process:	31-Aug-16	100%	61%	n/a
	Audit of follow up letter within 10 days to notify of investigation (for moderate and above incidents)	31-Aug-16	100%	65%	n/a
	Sharing investigation and discussion	31-Aug-16	100%		

Project Executive: Ashley Parrott

Progress has been made on clearing the SI backlog and a more robust procedure embedded to ensure learning actions are followed through. The new process should continue to show improvements in the KPIs. Complaints responsiveness following initial acknowledgement is now the focus improve the effectiveness of the process to ensure full RCA is conducted in a streamlined way by providing governance support and targeted easy to assimilate information.

G	SECURE PREMISES AND FACILITIES PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Privacy & Dignity in ED for people with mental health issues (IP 31)				
	Complete Estates Work in ED Conquest for people with Mental Health issues	30-Jun-16	100%	100%	n/a
	Complete Estates Work in ED EDGH for people with Mental Health issues	31-Apr-17	100%	50%	n/a
	Privacy and Dignity in Radiology and OPD (IP 32)				
	Complete Estates Work to Facilitate Privacy and Dignity in Radiology EDGH	31-Apr-17	100%	25.0%	n/a
	Complete Estates Work to Facilitate Privacy and Dignity in Radiology Conquest	31-Apr-17	100%	50.0%	n/a
	Complete Estates work to ensure safety and security for paediatric assessment CQ 32c	31-Apr-17	100%	25.0%	n/a
	Complete estates work to facilitate privacy and dignity in Urology 32d	31-Apr-17	100%	12.5%	n/a
	Secure Oxygen Cylinders (IP 40)				
	Secure All Oxygen Cyclinders	30-Sep-16	100%	100%	n/a
	A&E department isolation in the event of lock down being required (IP 47)				
	Fit Electronic Lock to A&E Department Door at Conquest Hospital	31-Mar-16	100%	100%	n/a
	Medical equipment checks (IP64)				
	Systems in place to ensure medical equipment and devices are checked and maintained	31-Aug-16	100%		n/a

Project Executive: Chris Hodgson

All estates improvements are complete or ongoing as part of Estates work plans. The medical equipment improvements are now being taken forward as part of the Medical Devices Group. This project will now be recommended for closure at the next Improvement Sub-Committee.

A	WORKFORCE CAPABILITY, CAPACITY & ENGAGEMENT	Due Date	Target	Latest Metric	Six-Month Trend
	Staff Engagement and Satisfaction Levels (IP 1)				
	Increase Overall Annual Staff Engagement Score	31-Dec-18	4.50	3.46	n/a
	Increase quarterly Pulse Survey Staff Engagement Score	31-Dec-18	4.50	3.46	n/a
	Improve quarterly Staff Family and Friends Test Score	31-Dec-18	67%	72%	n/a
	Improve quarterly Staff Family and Friends Test Response Rate	31-Dec-18	20%	17%	n/a
	Reduce Staff Turnover Rate	31-Mar-17	10.0%	9.8%	
	Staff Health and Well-Being (IP 2)				
	Increase the number of annual team stress risk assessments (introduced from Sep16)	31-Dec-18	90%		n/a
	Increase the number of emotional resilience training sessions available for staff (introduced from Sep16)	31-Dec-18	24 per year		n/a
	Introduce Staff Health Checks for staff between 40-70 years (introduced from Sep16)	31-Dec-18	1200 per year		n/a
	Reduce Staff Work Related Stress Levels (Annual) (KF17)	31-Dec-18	33%	40%	n/a
	Listening to Staff Feedback (IP 4)				
	Increase the Percentage of Staff Reporting Improved Communication in the Pulse Survey	31-Dec-18	25%	35%	n/a
	Percentage of Staff Reporting Good Communication between senior management and staff (KF6)	31-Dec-18	30%	35%	n/a
	Harassment and Bullying of Staff (IP 6)				
	Increase the number of staff reporting formal Dignity at Work concerns	31-Dec-18	Monitoring	38	
	Reduce the number of unresolved concerns raised by staff through the Speak Up Guardian	31-Dec-18	Monitoring	13	n/a
	Decrease Percentage of Staff experiencing Harassessment, Bullying or abuse from Staff (KF26)	31-Dec-18	0%	33%	n/a
	Staff Vacancies (IP 12)				
	Increase Overall Staff Fill Rate	31-Mar-17	100.0%	92.0%	
	Increase Medical and Dental Fill Rate	31-Mar-17	100.0%	84.7%	
	Increase Registered Nurses and Midwives Fill Rate	31-Mar-17	100.0%	90.7%	
	Increase Scientific, Therapeutic and Technical Fill Rate	31-Mar-17	100.0%	89.8%	
	Increase Additional Clinical Services Fill Rate (including HCAs)	31-Mar-17	100.0%	90.6%	
	Increase Administrative and Clerical Fill Rate	31-Mar-17	100.0%	91.3%	
	Increase Estates and Ancillary Fill Rate	31-Mar-17	100.0%	91.7%	
	Consultant Cover in the A&E Department (IP 48)				
	Increase Urgent Care (inc. A&E Department) Fill Rate	31-Mar-17	100%	87.2%	
	Pathology & Histopathology Vacancies (IP 52)				
	Increase Theatres and Support Services (inc.Pathology and HistoPathology Departments) Fill Rate	31-Mar-17	100%	95.7%	
	Increase Scientific, Therapeutic and Technical Fill Rate	31-Mar-17	100%	89.8%	
	Staff Sickness Absence Levels (IP 13)				
	Reduce Staff Sickness Absence Levels (Annual)	31-Mar-17	5.0%	4.4%	
	Reduce Staff Sickness Absence Levels (Monthly)	31-Mar-17	3.3%	4.1%	
	Staff Training for staff working in Alternative Areas (IP 14)				
	Provide Policy for requesting staff in alternative areas	31-Mar-16	n/a	100%	n/a
	Mandatory Training Levels (IP 15)				
	Increase Staff Mandatory Training Levels	31-Dec-18	90%	87.2%	
	Staff Appraisal Rates (IP 16)				
	Increase Staff Appraisal Rates	30-Jun-16	90%	85.8%	
	Senior Management Team Review (IP 17)				
	Senior Management Team Review Complete	30-Jun-16	n/a	100%	n/a
	Support for Newly Qualified staff (IP 50)				
	Number of Newly Qualified Staff in Preceptorship Programme	31-Mar-16	100%	100%	n/a
	Monitoring Quality and Safety in relation to Staffing Levels (IP 51)				
	Reduce Number of Incidents Related to Low Staffing Levels	31-Mar-17	0		
	Contracted Security Staff (IP64)				
	Ensure security staff undertake ESHT induction and mandatory training courses	30-Jun-16	100%	100%	n/a

A WORKFORCE CAPACITY, CAPABILITY AND ENGAGEMENT PROJECT

Project Executive: Monica Green

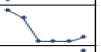
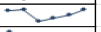
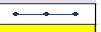
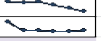
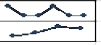
Challenges remain in recruiting registered nursing, medical and ED staff. Ongoing international recruitment. High pass rate, 76%, at ESHT for *objective structured clinical examination (*OSCE) for international staff . Indicative results from our most recent Staff Friends and Family Test show that 74.5% of staff would recommend ESHT as a place to receive care and 58% would recommend it as a place to work (up from 65% and 46% respectively for the same period last year). Staff engagement activities: launched the unsung hero's award, preceptorship awards. Culture remains a challenge and the recent CQC inspection will provide feedback on themes to inform ongoing improvements.

East Sussex Healthcare NHS
NHS Trust

R PATIENT FLOW PROJECT

Project Executive: Pauline Butterworth

Centralisation of health records continued at Apex Way. Improvement actions commenced in A&E - initial assessment/streaming at triage, escalation protocols re-implemented, introduction of Rapid Access & Treatment (RAT) and enhanced ENP rota introduced at EDGH. Recruitment process for 6 x paediatric nurses in A&E commenced. Clinical Lead for Urgent and Emergency Care appointed – Dr Kate Murray. Discussions continued with clinicians on the principles of the medical model for the Trust. Discharge action plan reviewed and updated at Discharge Improvement Group. SAFER patient flow pilot to commence wc 10th October. In-reach trials into EDGH and Conquest continued from Bowes House, Firwood House and Bexhill Irvine Unit respectively. Cancer recovery – deep dive undertaken on urology, testing of Radiology PTL report commenced, 1 Nurse Adviser role to commence in August to support the challenges presented by patient choice and compliance with investigation and treatment pathways. Endoscopy Vanguard unit became operational from 15th August to mid-October to clear the waiting list backlog. Revised Trust Access Policy approved at Senior Leaders Forum. RTT – additional actions undertaken to provide further capacity in general surgery, urology, T&O, Max-Fax and ENT. Privacy & Dignity questions added to Radiology FFT. Key decision in September was to focus on improvements on triggers to escalate early actions to improve discharge e.g. standardisation of board/ward rounds

R	PATIENT FLOW PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Outpatient Department Flow (IP 10a, 10b, 10c and 11)				
	Reduction in DNAs for New Appointments	30-Nov-16	8.0%	8.8%	
	Reduction in DNAs for Follow-Up Appointments	30-Nov-16	8.0%	8.5%	
	Reduce Outpatient Complaints received via PALS, formal complaints or incident reporting regarding patient experience during appointment	30-Nov-16	5	9	
	Percentage of GP letters completed within 7 days	28-Feb-17	80.0%	67.0%	
	Percentage of outpatient clinic cancellations with less than 6 weeks notice	31-Dec-16	10.0%	37.0%	
	Number of New and Follow Up Appointments Cancelled by hospital as overall % of average outpatients bookings	31-Dec-16	10.0%	22.0%	
	Rates of Same Sex Breaches				
	Reduce Number of Same Sex Accommodation Breaches (10pm-6am)	31-Mar-16	0	0	
	Privacy & Dignity in Radiology (IP 32b)				
	Reduction in complaints by patients in Radiology regarding privacy & dignity	30-Jun-16	1	0	
	Improved response to FFT questions re privacy & dignity	31-Nov-16			
	Access and Responsiveness (IP 35)				
	Meet A&E Four Hour Standard	31-Mar-17	89.0%	79.5%	
	Consistently Achieve the Two-Week Wait Cancer Targets	30-Jun-16	93.0%	97.1%	
	Meet 62 day Cancer Target	31-Mar-17	85.0%	75.3%	
	Meet 92% RTT Target	31-Mar-17	92.0%	87.5%	
	Reduce Diagnostic Breaches to <1%	31-Mar-17	<1%	3.04%	
	Ward Moves (IP 38)				
	Reduce Number of Ward Moves Out-of-Hours (2200-0600) for non-clinical reasons	31-Mar-17	0	80	
	Reduce Number of Ward Moves In-Hours (0600-2200) for non-clinical reasons	31-Mar-17	0		
	Discharge Process (IP 39)				
	Reduce Number of Complaints relating to quality and safety of the discharge process	30-Nov-16	5	7	
	Reduction in the number of Safeguarding alerts relating to quality and safety of discharges	30-Nov-16	0	2	
	Reduction in the number of incidents relating to the quality and safety of discharges	30-Nov-16	5	82	
	Surgical Assessment Unit Waiting Times (IP57)				
	Process in place to monitor the length of stay and outcomes for SAU patients	31-Jul-16	n/a	100%	n/a
	Waiting times for assessment				
	Urology Unit Patient Flow at EDGH (IP58)				
	Unit reconfigured to enable it to cope with the current service demand and address patient flow	n/a	n/a	100%	n/a
	Improved response to Q1 FFT (patient satisfaction)	30-Apr-16	90%	95%	
	Theatre Planning (IP59)				
	Increase in overall utilisation of theatres	30-Nov-16	85%	90%	
	Day Surgery Patient Flow at EDGH (IP60)				
	Improved response to Q1 FFT (patient satisfaction)	30-Jun-16	90%	97%	
	Theatres Recovery Patient Flow at EDGH (IP61)				
	Reduction in percentage of patients waiting over an hour in PACU	30-Nov-16	5	40	
	Availability of Health Records (IP 23)				
	Less than 1% of Health Records not available for Outpatient Appointments	31-May-16	<1%	3.9%	
	Reduce number of Surgical Operations Cancelled due to non-availability of Notes	31-May-16	0	0	
	Reduction in the number of temporary files produced Trust-wide	30-Nov-16	400	1317	
	State of Repair of Health Records (IP 24)				
	Reduction in Number of DATIX Incidents Relating to Medical Record Quality	30-Nov-16	1	0	n/a
	CHIS System Review (IP 41)				
	Review of CHIS System Complete	31-Mar-16	n/a	100%	n/a
	Children's Services KPIs Monitoring (IP 42)				
	Children's Services KPIs Available for Monitoring	31-Mar-16	n/a	100%	n/a

East Sussex Healthcare NHS
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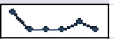
R **PATIENT FLOW PROJECT**

Project Executive: Pauline Butterworth

Centralisation of health records continued at Apex Way. Improvement actions commenced in A&E - initial assessment/streaming at triage, escalation protocols re-implemented, introduction of Rapid Access & Treatment (RAT) and enhanced ENP rota introduced at EDGH. Recruitment process for 6 x paediatric nurses in A&E commenced. Clinical Lead for Urgent and Emergency Care appointed – Dr Kate Murray. First Urgent and Emergency Care Board held. Discussions continued with clinicians on the principles of the medical model for the Trust. Discharge action plan reviewed and updated at Discharge Improvement Group. SAFER patient flow pilot to commence wc 10th October. In-reach trials into EDGH and Conquest continued from Bowes House, Firwood House and Bexhill Irvine Unit respectively. Cancer recovery – deep dive undertaken on urology, testing of Radiology PTL report commenced, 1 Nurse Adviser role to commence in August to support the challenges presented by patient choice and compliance with investigation and treatment pathways. Endoscopy Vanguard unit became operational from 15th August to mid-October to clear the waiting list backlog. Revised Trust Access Policy approved at Senior Leaders Forum. RTT – additional actions undertaken to provide further capacity in general surgery, urology, T&O, Max-Fax and ENT. Privacy & Dignity questions added to Radiology FFT. Key decision in September to focus on triggers to escalate early actions to improve discharge e.g. standardisation of board/ward rounds

A	MATERNITY PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Low Risk Birth Facilities at Conquest Hospital (IP 18)				
	Complete Low Risk Birth Facilities at Conquest Hospital	30-Nov-16	n/a	100%	n/a
	Facilities to reduce Repeated Journeys between home and Hospital (IP 19)				
	Complete Facilities to Reduce Repeated Journeys	30-Sep-16	n/a	20%	n/a
	Develop and communicate a clear vision and strategy for maternity services across East Sussex (IP20)				
	Complete Maternity Services Vision	31-Mar-16	n/a	100%	n/a
	Complete Maternity Service strategic plan	01-Aug-16	n/a	50%	n/a
	Information to make an informed choice about Place of Birth available (IP 21)				
	Produce additional Information to Allow Informed Choice to be Made	30-Jul-16	n/a	100%	n/a
	Leadership and Culture of Maternity Services (IP 22)				
	Complete a review of the Maternity Services Leadership	31-Mar-16	n/a	100%	n/a
	Correct ratio of supervisiors 1:15	01-Jul-16	01:15		
	Follow Guidance for Syntocinon (IP 44)				
	Compliance with syntocinon guidelines	01-Jul-16	100%	80%	n/a
	Women being Contacted by Midwives etc. after suffering pregnancy loss (IP 49)				
	Reduce Inappropriate Communication Incidents to Zero	31-Mar-16	0	0	
	Audit compliance with National Pre-Eclampsia Guidance (IP 36a)				
	Compliance with pre-eclampsia guidelines	31-May-16	100%	80%	n/a
	Appropriate staffing in place (IP62)				
	Midwife staffing meets national standards 1:28 births	01-Aug-16	01:28		
	Mothers in labour to be given one-to-one Midwife support	01-Aug-16	100%		
	Enhance the number of hours dedicated to management and specialist roles	01-Aug-16	8%		

A MATERNITY PROJECT

Project Executive: Pauline Butterworth

This project has delivered some minor improvements. Low risk birthing unit implemented, web site pages and leaflets have been developed to inform women birth options, processes for inappropriate contact following a pregnancy loss have reduced significantly. The Maternity vision has been approved but the strategy still needs to be developed. Guidance in place for staff to reduce unnecessary journeys. Further scoping and KPI development required to address other areas requiring improvements e.g. midwife capacity. Strategic planning is developing with staff and commissioners. Business cases developed for further specialist posts, new ways of working to release time to care. Focus is now on review and improvement of the maternity dashboard, leadership and culture, integration with initiatives such as ESBT and STP.

A	EFFECTIVE RELATIONSHIPS WITH EXTERNAL STAKEHOLDERS AND THE PUBLIC	Due Date	Target	Latest Metric	Six-Month Trend
	Translation Service (IP 8)				
	New Translation Service Contract Awarded	30-Jun-16	n/a	100%	n/a
	Staff awareness of translation services	01-Sep-16			
	Number of incidents relating to translation services	01-Nov-16			
	Relationships with the Public and Other Key Stakeholders (IP 9)				
	Engagement and communication strategy and plan in place	01-Sep-16	n/a	10.00%	n/a
	Increase in positive feedback from stakeholders	01-Sep-16			

Project Executive: Lynette Wells

Improvements have been progressed by holding more events with the public and external stakeholders. Local groups have been contacted to offer opportunities for discussions with the Trust. Joint initiative with the 'save the DGH' group has resulted in the first joint press release. This project still requires further development KPI development to include the Communications and engagement Strategy, increase the number of engagement events and survey of external stakeholders. Objective owners reviewing additional KPIs. Communications Strategy ready for approval and launch to the Trust. External partners participated in the CQC Mock Inspection 22nd/23rd June. Meetings held with CCGs to discuss Sustainable Transformation Programme. Translation service contract awarded, programme of staff training to be rolled out.

Next Activities

- Continue to progress project improvements with particular focus on Patient Flow and discharge processes, Maternity and Mortality and Morbidity Assurance projects.
- Review of Improvement Projects based on the feedback from the CQC
- CQC Trajectory forward view based on the feedback from the CQC
- Arrange meeting with all the ESHT Vine volunteers to obtain feedback on the scheme to inform the Ambassador programme.

Significant Risks:

- Risks to improvement progress due to staff recruitment of key senior clinical roles within Medical, ED, Registered Nursing, Radiology, Histopathology and Dental

- Operational pressures impacting on staff capacity to work on improvements

East Sussex Healthcare NHS
NHS Trust

Recent improvements

- The 2 week wait and 31 day cancer target standards are being met consistently and sustainably.
- Additional endoscopy capacity is being provided with a modern self-contained endoscopy unit at Conquest Hospital now operational and additional capacity created within the existing unit at Eastbourne DGH.

- A redesign of the workforce model in the emergency department is helping to address the shortage of emergency medicine doctors. Individuals with the potential to become emergency speciality doctors are now identified and offered the required education, training and support with a tailor made specialty and associate specialist doctor rotation allowing them to obtain additional skills.

- Pregnant women are now able to self-refer to a midwife, speeding up their access to maternity care. It is recognised that the earlier a woman seeks advice once she knows that she is pregnant, the more informed she will be to make decisions about her pregnancy.

Recent improvements (continued)

- ‘Sock it to Sepsis’ week was held during September with visits to every acute ward to raise awareness and launch new sepsis screening and treatment tools.

Recent improvements

- A number of improvements are being seen in our stroke service since it was centralised in July 2013, including:
    - The proportion of patients with a suspected stroke who are scanned within one hour of arrival at hospital has increased from 55.5% to 86.5%.
    - The average time between arrival at hospital and having a scan has reduced from 51 minutes to 29 minutes.
    - The proportion of patients staying at least 90% of their stay on the Stroke Unit has improved from 87% to 96%.

Recent improvements (continued)

- Indicative results from our most recent Staff Friends and Family Test show that 74.5% of staff would recommend ESHT as a place to receive care and 58% would recommend it as a place to work (up from 65% and 46% respectively for the same period last year)

- Compliance with End of Life Care training for staff who work closely with patients and their families/carers has increased from 36% (April 2016) to 60%

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board Meeting
Agenda item:	10
Subject:	Integrated Performance Reports – August 2016 (Month 5)
Reporting Officers:	Director of Finance Director of Human Resources Chief Operating Officer

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 August 2015 (Month 5).

Introduction:

The purpose of this paper is to inform the Executive Directors of organisational compliance against national and local key performance metrics, of delivery of Trust targets and plans, and to provide detailed information on the financial position for review and scrutiny.

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

There are four key performance areas which have agreed trajectories in place for performance over the 2016/17 financial year. These areas are robustly performance managed by NHSI and the CCGs and, in addition to measuring that we are providing high quality patient care, they are reputationally and financially important to the Trust.

These are: A&E (4 hours), RTT (18 week incomplete), Diagnostics (6 weeks), Cancer (62 days). The Trust failed to reach the trajectory for all four areas in August (July for cancer as this is reported one month in arrears).

August	A&E	RTT	Diagnostics	Cancer
Trajectory	90.93%	92.30%	3.04%	77.80%
Actual	79.5%	87.50%	1.48%	75.30%

The Trust has a detailed set of recovery plans for each of these key areas, overseen both by the relevant Board and the Executive Directors.

The Trust has a financial plan, agreed with NHSI, which delivers a £31.3m deficit – moving from the original plan of £48m through an increase in the efficiency challenge of £6m and additional funding from the Department of Health of £10.4m.

The Trust's financial performance moved off plan at Month 5, after an improvement was

reported at Month 3. The Trust reported a year to date deficit of £22.9m, against a planned deficit of £17.2m – a £5.7m adverse variance from plan, of which £1.7m reflects a reduction in STP funding received. The key drivers for the movement off plan are challenges in the delivery of agency cost reductions, increased costs for the treatment of urgent and planned care patients above plan, and a shortfall in the delivery of cost improvement scheme savings.

The Trust has a recovery plan in development and is forecasting delivery of the full year planned deficit of £31.3m. Cash flow remains a continued area of focus for the Trust, with additional cash drawn down from the agreed loans with the Department of Health made available from clinical commissioners. Capital expenditure remains within acceptable limits, although the level of capital expenditure in the year to date is lower than planned, and the Trust will continue to carefully monitor capital expenditure over the remainder of the financial year.

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. Please note the Framework for 2016/7 for NHS Improvement has now completed the consultation and details regarding the Single Oversight Framework have been released. These are currently being reviewed to ensure compliance.

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

FIC Meeting 27th September 2016
Executive Directors 12th October 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?
N/A

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

East Sussex Healthcare NHS
NHS Trust

Month 5 - August 2016

TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS Trust

Contents

East Sussex Healthcare NHS
NHS Trust

AUGUST 2016

Key Issues

- **All four of the key trajectories (A&E, RTT, Diagnostics and Cancer 62 Days) failed to meet the planned level of performance and are under the national targets.**
- **Incident reporting has increased**
- **FFT response rates remain low**
- **Emergency C Section rate has improved but remains outside the target level**
- **Finance is adverse to plan at Month 5**

Key Risks

- **Delivery against the agreed trajectories for improvement against the 4 key constitutional standards**
- **Delivery against the agreed financial plan**

Safety & Quality: 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 June 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 Safety & Quality 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 deal with safety of medicines, medical devices and other aspects.

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

2020 Metrics

2020 METRICS

East Sussex Healthcare NHS
NHS Trust

2020 Metrics: Safety & Quality

Safety and Quality

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Aug-15	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	862	969	880	924	916	956	978	1054	1078	1012	1499	1799	799	55.6%	6442	4383	47.0%	
Total Non-ESHT patients safety incidents reported	M	118	122	104	73	122	110	84	314	242	148	166	147	118	24.6%	1017	588	73.0%	
Falls Assessment Compliance	M	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	97.6%	99.3%	98.0%	98.8%	98.9%	98.3%	99.4%	98.4%	#DIV/0!	#DIV/0!	98.8%		#VALUE!	
Pressure Ulcer Assessment Compliance	M	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	95.9%	93.0%	91.4%	93.4%	86.9%	87.0%	91.9%	86.7%	#DIV/0!	#DIV/0!	89.3%		#VALUE!	
No of MRSA cases	0	0	0	0	0	0	0	0	0	0	0	0	0	2	-2	0	4	-4	
No of CDI cases	4	6	3	5	3	4	3	5	2	7	7	2	6	7	-1	24	19	5	
No of MSSA cases	0	3	0	0	0	0	1	1	1	0	2	0	0	3	-3	3	6	-3	
Mixed sex accomodation breaches	0	14	23	16	3	27	29	0	0	0	0	0	0	0	0	0	18	-18	
No of complaints reported	R	97	102	63	58	62	72	88	103	83	85	70	82	111	-35.4%	423	479	-11.7%	
All ward moves	M	2114	2371	2377	2310	2254	2316	2331	2304	2347	2265	2322	2323	2120	8.7%	11561	11467	0.8%	
Crude Mortality Rate	M	1.5%	1.7%	1.9%	2.0%	2.1%	1.9%	2.3%	2.0%	1.7%	1.5%	1.4%	1.4%	1.7%	-0.3%	1.6%	1.7%	-0.1%	
HSMR (CHKS)	100	109	97	104	110	102	106	97	111										
SHMI (CHKS)	100	111	105	116	110	107													

These metrics are planned to support the delivery of the Trust's 2020 strategy, which is available on the Trust website.

East Sussex Healthcare NHS Trust

2020 Metrics: Access & Delivery

Access and Delivery

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Aug-15	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	89.7%	91.4%	88.6%	88.4%	85.6%	84.2%	84.8%	79.0%	83.9%	85.0%	83.2%	82.6%	79.5%	89.7%	-10.2%	82.8%	91.1%	-8.3%	
A&E 12 Hour trolley waits	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	1	0	
A&E Unplanned re-attendance	5.0%	2.9%	3.1%	2.4%	2.9%	3.0%	3.0%	3.4%	3.0%	3.3%	3.3%	2.8%	3.0%	2.9%	2.9%	0.0%	3.1%	3.3%	-0.2%	
A&E Time to Initial Assessment (% Ambulance conveyances within 15 minutes)	M	94.1%	94.5%	95.7%	96.0%	95.0%	92.2%	92.1%	88.5%	94.3%	93.1%	90.7%	91.8%	90.1%	94.1%	-4.0%	92.0%	96.1%	-4.2%	
A&E Time to Treatment (% within 60 Minutes)	M	49.2%	52.1%	50.2%	53.9%	49.6%	52.4%	48.1%	42.0%	47.0%	40.1%	36.6%	36.7%	36.7%	49.2%	-12.6%	39.3%	49.5%	-10.2%	
A&E Left before seen	5.0%	2.0%	1.5%	1.9%	1.3%	1.6%	2.1%	2.6%	2.7%	2.1%	2.2%	1.3%	1.4%	1.4%	2.0%	-0.6%	1.6%	1.9%	-0.3%	
Non Elective Conversion Rate	M	24.4%	26.5%	25.1%	26.7%	27.5%	27.5%	26.8%	24.8%	26.5%	24.6%	25.1%	23.5%	23.4%	24.4%	-1.0%			#VALUE!	
A&E Cubicle Waiters (average number per day)	M	48	51	49	49	50	51	51	51	48	51	50	51	52	48	4	63	65	-2	
Zero Length of Stay NEL admissions	R	543	541	465	437	433	435	454	461	524	464	467	431	433	543	-25.4%	2319	2795	-17.0%	
% Zero LOS NEL Ambulatory admissions	M	41.5%	39.2%	37.8%	38.4%	36.5%	38.4%	37.6%	37.1%	41.3%	37.3%	36.4%	35.1%	35.5%	41.5%	-14.4%	37.1%	40.6%	-3.5%	
Total Non Elective Beddays	M	21094	20792	22567	22360	23141	25732	24170	25700	23644	22663	21659	21934	22972	21094	8.2%	112872	108971	3.6%	
RTT Incomplete (%patients waiting over 18 weeks)	92.0%	93.5%	93.4%	92.7%	92.8%	92.1%	92.1%	92.2%	90.5%	90.2%	90.7%	89.5%	88.5%	87.5%	93.5%	-6.1%	89.2%	94.1%	-4.9%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Diagnostic performance (% patients waiting over 6 weeks)	1.0%	0.9%	2.2%	1.9%	1.0%	2.0%	3.8%	2.4%	6.7%	2.9%	2.7%	2.6%	2.2%	3.0%	0.9%	2.1%	97.3%	98.3%	-1.0%	
Cancer 2WW standard	93.0%	85.9%	87.6%	91.3%	89.9%	91.9%	92.5%	94.9%	96.9%	96.0%	95.6%	96.5%	97.1%	97.3%			96.5%	91.0%	5.5%	
Cancer 2WW standard (Breast Symptoms)	93.0%	75.8%	81.3%	89.1%	88.5%	90.0%	99.1%	93.0%	90.0%	93.2%	98.5%	96.9%	95.8%	95.8%			96.1%	89.0%	7.1%	
Cancer 31 Day standard	96.0%	96.9%	98.9%	100.0%	97.4%	98.3%	96.9%	98.8%	99.3%	98.5%	99.4%	98.3%	97.7%	99.1%			98.6%	96.5%	2.1%	
Cancer 31 Day subsequent drug treatment	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	0.0%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	0.0%	
Cancer 62 day urgent referral standard	85.0%	73.9%	74.5%	76.2%	75.4%	80.6%	73.0%	70.5%	79.4%	67.6%	68.3%	82.3%	75.3%	79.5%			75.3%	74.5%	0.8%	
Cancer 62 day screening standard	90.0%	87.5%	80.0%	84.6%	54.5%	60.0%	33.3%	100.0%	42.9%	100.0%	66.7%	62.5%	100.0%	88.9%			82.4%	85.7%	-3.4%	
Delayed Transfer of Care	3.5%	7.4%	5.3%	7.8%	7.9%	7.5%	7.5%	10.8%	9.4%	5.3%	5.7%	7.0%	7.7%	8.0%	7.4%	0.6%	6.7%	6.9%	-0.2%	
Outpatient appointment cancellations < 6 weeks	R	27	35	20	29	41	21	21	18	14	29	47	34	37	27	27.0%	161	186	-13.4%	
Outpatient appointment cancellations > 6 weeks	R	1188	1319	1196	977	1287	1064	1134	1554	1126	1014	1258	1413	1531	1188	22.4%	6342	6256	1.4%	

East Sussex Healthcare NHS Trust

2020 Metrics: Leadership &Culture

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Aug-15	Var	Yr	Last Yr	Var	
Trust Turnover rate	10.0%	11.8%	12.2%	12.1%	14.1%	11.8%	11.3%	10.6%	10.3%	10.0%	10.0%	10.0%	9.8%	12.2%	-2.4%	10.0%	12.5%	-2.5%	
Temporary costs and overtime as a % of total paybill	10.0%	15.7%	16.1%	17.3%	17.1%	17.2%	17.7%	18.7%	15.0%	14.7%	15.5%	15.0%	16.2%	16.1%	0.2%	15.3%	16.6%	-1.3%	
Proportion of staff with up to date annual appraisal	85.0%	77.6%	77.9%	81.8%	81.8%	83.2%	85.3%	87.3%	88.5%	89.8%	88.1%	86.3%	87.0%	73.6%	13.4%	87.9%	74.6%	13.3%	

2020 progress is reviewed on a regular basis by the Trust Board and the Improvement Committee

Quality and Safety

QUALITY AND SAFETY

1. Indicators
2. Serious Incidents, Never Events and Incidents
3. Friends and Family Test
4. Complaints
5. Mortality
6. Clinical Engagement
7. Safer Staffing

East Sussex Healthcare NHS
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Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Aug-15	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	799	862	969	880	924	916	956	978	1054	1078	1012	1499	1799	799	125.2%	6442	4383	47.0%	
% Patient safety incidents with no harm/near miss	70.0%	67.1%	72.5%	68.9%	67.6%	65.5%	66.9%	70.8%	67.8%	64.7%	66.8%	72.3%	83.8%	86.3%	67.1%	19.2%	76.7%	64.5%	12.3%	
% Patient safety incidents causing sever harm/death	0	0.5%	0.1%	0.3%	0.0%	0.4%	0.2%	0.1%	0.7%	0.2%	0.3%	0.1%	0.1%	0.2%	0.5%	-0.3%	0.2%	0.4%	-0.3%	
Total Non-ESHT patients safety incidents reported	M	118	118	122	104	73	122	110	84	314	242	148	166	147	118	24.6%	1017	588	73.0%	
No of never events reported	0	0	0	0	3	1	0	0	0	1	0	0	0	0	0	0	1	0	1	
No of serious incidents reported	M	9	1	8	10	11	8	4	11	7	1	6	6	5	9	-4	25	47	-22	
No of moderate incidents reported	M	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0		
Total Falls per 1000 beddays	7	6.1	6.2	7.0	5.8	7.3	6.7	6.8	6.1	6.0	5.9	5.9	6.2	6.2	6.1	0.0	6.0	6.8	-0.8	
Total falls reported	M	143	142	172	140	181	183	178	169	153	147	144	152	156	143	9.1%	752	816	-7.8%	
No of falls no harm	M	104	106	109	97	122	119	122	118	99	99	100	109	116	104	11.5%	523	509	2.8%	
No of falls minor/moderate	M	38	36	63	43	59	64	56	51	54	48	44	43	39	38	2.6%	228	303	-24.8%	
No of falls major/catastrophic	M	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	4	-3	
Falls Assessment Compliance	M						97.6%	99.3%	98.0%	98.8%	98.9%	98.3%	99.4%	98.4%			98.8%			
No of pressure ulcers grade 3 & 4 (trust acquired)	R	7	6	4	5	8	9	7	5	6	6	2	2	6	7	-1	22	29	-7	
No of pressure ulcers grade 2 (trust acquired)	R	52	62	80	51	53	53	54	73	63	45	52	32	47	52	-5	239	271	0	
Pressure Ulcer Assessment Compliance	M						95.9%	93.0%	91.4%	93.4%	86.9%	87.0%	91.9%	86.7%			89.3%			
No of medication administration incidents	M	19	17	22	19	29	18	23	17	29	25	16	32	24	19	0	126	108	0	
Medication errors causing severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Observations completed on time (per protocol)	M	69.8%	70.6%	71.6%	73.5%	75.8%	76.3%	76.9%	76.8%	79.7%	80.7%	83.4%	82.5%	84.2%	69.8%	14.4%	82.1%	68.4%	13.7%	
No of MRSA cases	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	-2	0	4	-4	
No of CDI cases	4	7	6	3	5	3	4	3	5	2	7	7	2	6	7	-1	24	19	5	
No of MSSA cases	0	3	3	0	0	0	0	1	1	1	0	2	0	0	3	-3	3	6	-3	

Indicators

Safety thermometer overall score	92.0%	93.0%	93.3%	94.0%	94.1%	94.6%	95.3%	93.0%	94.0%	93.0%	93.6%	#DIV/0!	95.4%	93.0%	93.0%	0.1%	6.3%	6.4%	-0.2%	
% of VTE risk assessments completed	95.0%	96.4%	96.1%	95.9%	96.7%	96.7%	96.5%	95.8%	94.9%	95.2%	97.9%	98.1%	97.9%	96.8%	96.4%	0.4%	97.2%	96.9%	0.3%	
Emergency C-Section rate	9.0%			16.2%	14.4%	12.4%	16.0%	17.9%	12.8%	15.4%	13.4%	14.5%	12.6%	11.9%			13.5%			
Mixed sex accomodation breaches	0	0	14	23	16	3	27	29	0	0	0	0	0	0	0	0	0	18	-18	
Inpatient FFT Response rate	45.0%	15.4%	15.3%	15.5%	13.5%	12.9%	11.5%	13.1%	13.3%	14.0%	13.9%	17.0%	17.3%	14.9%	15.4%	-0.5%	15.5%	20.6%	-5.2%	
Inpatient FFT Score (% positive)	96.0%	97.8%	97.5%	97.4%	98.8%	99.0%	97.9%	98.0%	97.8%	98.9%	99.1%	97.4%	98.1%	97.8%	97.8%	0.0%	98.2%	97.5%	0.7%	
A&E FFT Response rate	22.0%	7.1%	8.9%	7.9%	6.8%	7.7%	8.2%	8.0%	6.5%	9.0%	9.9%	8.4%	7.7%	6.0%	7.1%	-1.1%	8.2%	12.1%	-3.9%	
A&E FFT Score (% positive)	88.0%	90.8%	92.6%	89.3%	91.1%	90.7%	92.9%	91.0%	88.3%	93.5%	89.8%	88.3%	89.7%	89.2%	90.8%	-1.7%	90.1%	89.4%	0.8%	
Maternity FFT Response rate	45.0%				28.7%	21.9%	27.8%	20.3%	24.2%	29.2%	30.7%	33.2%	25.4%	29.0%			29.3%			
Maternity FFT Score (% positive)	96.0%				96.6%	95.5%	95.9%	90.4%	95.2%	92.1%	93.0%	94.4%	97.2%	94.1%			94.2%			
No of complaints reported	R	111	97	102	63	58	62	72	88	103	83	85	70	82	111	-26.1%	423	479	11.7%	
All ward moves	M	2120	2114	2371	2377	2310	2254	2316	2331	2304	2347	2265	2322	2323	2120	9.6%	11561	11467	0.8%	
Night ward moves	M	449	396	466	411	476	462	461	512	470	436	409	420	449	449	0.0%	2184	2282	-4.3%	
Crude Mortality Rate	M	1.7%	1.5%	1.7%	1.9%	2.0%	2.1%	1.9%	2.3%	2.0%	1.7%	1.5%	1.4%	1.4%	1.7%	-0.3%	1.6%	1.7%	-0.1%	
HSMR (CHKS)	100	109	97	104	110	102	106	97	111											
SHMI (CHKS)	100	111	105	116	110	107														
% Spending 90% time on Stroke Ward Monthly Monitoring	90.0%	86.5%	81.5%	92.5%	89.6%	89.6%	93.5%	97.9%	92.9%	100.0%	95.2%	91.9%	92.3%	91.7%	86.5%	5.1%	94.5%	90.8%	3.7%	
Stroke:% to Stroke Unit <4hrs Monthly Monitoring	88.0%	82.4%	78.4%	76.3%	80.9%	83.3%	80.0%	77.1%	78.6%	85.3%	76.2%	82.9%	82.1%	100.0%	82.4%	17.6%	82.7%	80.5%	2.3%	
Stroke: % scanned <1hr of arrival Monthly Monitoring	95.0%	84.6%	79.6%	85.0%	85.4%	81.3%	84.8%	85.4%	83.9%	91.2%	78.6%	81.1%	87.2%	91.7%	84.6%	7.1%	84.8%	77.3%	7.5%	
Stroke: % scanned <12hr of arrival Monthly Monitoring	99.0%	98.1%	100.0%	100.0%	97.9%	100.0%	100.0%	100.0%	96.4%	100.0%	97.6%	100.0%	100.0%	100.0%	98.1%	1.9%	99.4%	97.1%	2.3%	

Note: SHMI shown is month by month index score and not rolling 12 months.

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Quality Overview

There were 4 serious incidents reported as occurring in August. These were: one diagnostic delay; two falls to fracture; one adverse media due to 12 hour breach

No new Never Events have been reported.

Infection control reported no incidents of MRSA or MSSA in August however there were 6 reported cases of CDIFF

The emergency caesarean rate has continued to reduce but still remains about the target threshold

No overnight mixed sex accommodation breaches were reported

FFT response rate continue to be lower than the targets

2. Serious Incidents

Excellent progress has been made to clear the backlog of serious incidents and improving the quality of the investigation and subsequent reports. The last two CCG panels closed all but 1 serious incident reports with the one given a conditional closure. This demonstrates the improvement in the quality.

All actions identified from the serious incidents are now inputted on the Datix system so they can be tracked centrally to ensure completion. From September the Clinical Effectiveness Team has started to test the robustness of some actions implemented to determine if changes embedded and working well.

62 Serious Incidents Open

5 submitted and returned for further work by ESHT (2 remain from 2015). All others are within the timescales or currently with the CCG for review

Never Events

Nov 15 - Oral Ketamine administered intravenously – WEB32560

- No harm to patient
- Report completed but requires some changes/editions. Report was kept open by CCG and Governance Team are working on the updates required with the Clinical Unit. CLOSED by the CCG on 25/08/16 . Actions tracked on Datix system.

Nov 15 - Naso-gastric tube misplaced – WEB33428

- No permanent harm to patient but extended stay.
- Report submitted to Clinical Commissioning Group – Was kept open by CCG but has been resubmitted . Closed by CCG on the 28/7/16. Actions recorded and tracked through Datix system.

Nov 15 - Retained foreign object post-procedure (swab in Cardiology) - WEB33528

- Report submitted to CCG but kept open. Resubmitted and closed by CCG on 28/7/16. Actions recorded and tracked through Datix system.

Dec 15 - Insertion of incorrect intraocular lens - WEB34622

- Vision deteriorated and requires laser treatment at Queen Victoria Hospital.
- Report has been submitted and has been returned by CCG triage – Governance team resubmitted to CCG on the 15/8/16. Actions will be uploaded onto Datix and tracked for progress.

April 2016 - Wrong route administration of medication – WEB38549

- Report submitted but minor update required. Re-submitted to CCG on the 29/7/16 for scrutiny panel.
- Actions will be uploaded onto Datix and tracked for progress.

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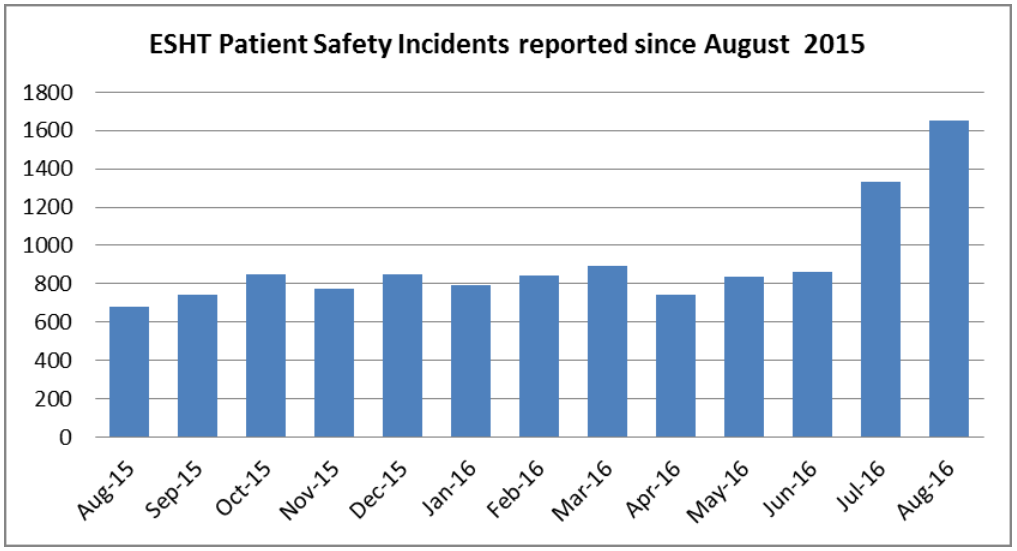
Incidents



There has been a steep increase in reported incidents (per 1000 bed days) over the last two months

- This is predominantly in the “no harm/near miss category”
- The biggest increase relates to Health Records and missing or incomplete notes (766 incidents)
- It is anticipated that The Health Record Service Improvement Project will address the issues and improvements will be noticed by year end.

3. FFT

Plan to improve A&E response rate

- Continue to develop the postcard system using the main FFT question, plus two other key questions and space for comments on the back;

Plan to improve the inpatient response rate

- Review of the areas with the lowest response rates to resolve any potential issues
- Establish league table by ward to promote competition;
- Champions will be identified and the lowest wards with response rates will be supported to improve.

4. Complaints

The complaints backlog has started to reduce on a weekly basis with the number overdue now at 38 in August (69 in March 2016) and there are 146 open complaints.

100% of all complaints reported in August were acknowledged within 3 working days.

There were 14 re-opened cases by the Complaints Team during the month where the complainant did not feel all original concerns were answered.

Since April 2016 there have been 7 cases referred to the Parliamentary and Health Service Ombudsman Enquiries (PHSO). None have had a confirmed decision to date.

The Complaints team has increased their face to face support with the Clinical Units to manage the responses. The actions identified once the final report has been approved are now being recorded on the Datix system.

The next step is to track these to ensure completed.

Processes to deal with the complaints more efficiently and effectively. This new process is due to come into effect in September.

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5. Mortality

SHMI has decreased to 1.11 and is now within the EXPECTED range.

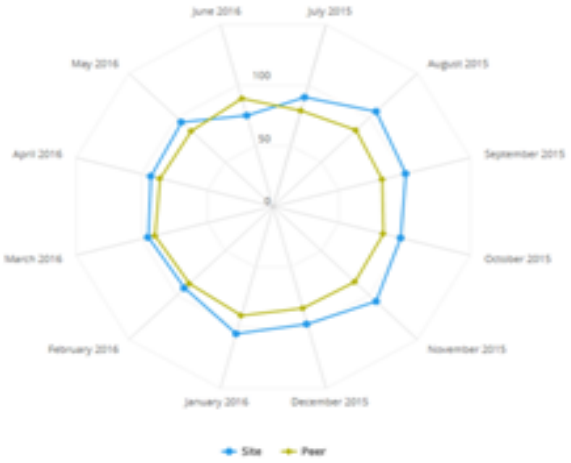
The revised Clinical Outcome Group is to be established from September

Targetted work continues to be undertaken on Mortality and Morbidity within the Quality Improvement Programme.

Crude mortality remains lower than the same period last year.

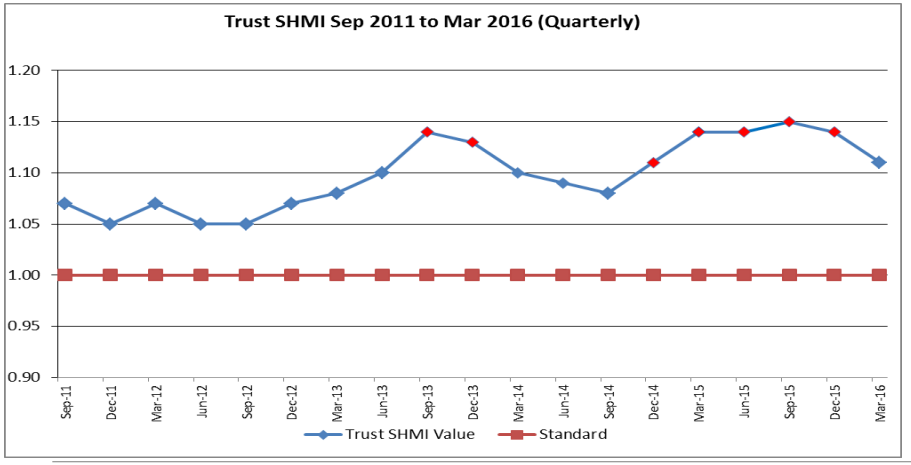
RAMI shows an improved position over the last 4 months although June is still pending final validation

RAMI



Main causes of death during August 2016	
Pneumonia	20
Sepsis	11
Respiratory Failure	6
Multi Organ Failure	4
Myocardial infarction	4

SHMI (Rolling 12 months)



Deaths reviewed within 3 months	Feb-16	Mar-16	Apr-16	May-16
TRUST	57%	63%	64%	61%

6. Clinical engagement and leadership

- Project Manager recruited and in post (August 2016)
- New Medical Director (David Walker, September 2016) appointed and is the Executive Lead for the Mortality and Morbidity Project
- First Mortality and Morbidity Project Board held (21 September 2016) with new leads in post
- Revised Scope for the Mortality and Morbidity Project agreed in principle at the Project Board
- Focus on Mortality reviews (timeliness and completeness) by Consultants
- New Mortality governance structure, to report into the Patient Safety Group
- Mortality data discussion to become part of Consultant appraisal
- Workshop held (August 2016) to discuss the Mortality Review Process

7. Safer Staffing

	Day		Night	
Site Name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
BEXHILL HOSPITAL	98.1%	104.5%	95.4%	117.6%
CONQUEST HOSPITAL	95.6%	105.5%	93.8%	117.4%
EASTBOURNE DISTRICT GENERAL HOSPITAL	100.9%	121.4%	98.1%	133.1%

Access & Delivery

ACCESS AND DELIVERY

1. Indicators
2. Elective Care
3. Emergency Care
4. Cancer

Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Aug-15	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	89.7%	91.4%	88.6%	88.4%	85.6%	84.2%	84.8%	79.0%	83.9%	85.0%	83.2%	82.6%	79.5%	89.7%	-10.2%	82.8%	91.1%	-8.3%	
A&E 12 Hour trolley waits	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	1	0	
A&E Unplanned re-attendance	5.0%	2.9%	3.1%	2.4%	2.9%	3.0%	3.0%	3.4%	3.0%	3.3%	3.3%	2.8%	3.0%	2.9%	2.9%	0.0%	3.1%	3.3%	-0.2%	
A&E Time to Initial Assessment (% Ambulance conveyances within 15 minutes)	M	94.1%	94.5%	95.7%	96.0%	95.0%	92.2%	92.1%	88.5%	94.3%	93.1%	90.7%	91.8%	90.1%	94.1%	-4.0%	92.0%	96.1%	-4.2%	
A&E Time to Treatment (% within 60 Minutes)	M	49.2%	52.1%	50.2%	53.9%	49.6%	52.4%	48.1%	42.0%	47.0%	40.1%	36.6%	36.7%	36.7%	49.2%	-12.6%	39.3%	49.5%	-10.2%	
A&E Left before seen	M	2.0%	1.5%	1.9%	1.3%	1.6%	2.1%	2.6%	2.7%	2.1%	2.2%	1.3%	1.4%	1.4%	2.0%	-0.6%	1.6%	1.9%	-0.3%	
Non Elective Conversion Rate	M	91.3%	95.6%	95.0%	96.9%	95.8%	96.4%	96.6%	96.2%	96.0%	96.6%	95.7%	96.9%	95.2%	91.3%	3.8%	96.1%	92.7%	3.4%	
A&E Cubicle Waiters (average number per day)	M	45	47	49	49	50	51	51	51	48	51	50	51	52	47	5	63	63	0	
Number of zero LOS NEL Ambulatory admissions	R	543	541	465	437	433	435	454	461	524	464	467	431	434	543	-20.1%	2320	2795	17.0%	
% Zero LOS NEL Ambulatory admissions	M	41.5%	39.2%	37.8%	38.4%	36.5%	38.4%	37.6%	37.1%	41.3%	37.3%	36.4%	35.1%	35.5%	41.5%	-14.3%	37.2%	40.6%	-3.5%	
Total Non Elective Beddays	M	21094	20792	22567	22360	23141	25757	24199	25731	23707	22877	21947	22245	23283	21094	10.4%	114059	108971	4.7%	
RTT Incomplete (%patients waiting over 18 weeks)	92.0%	93.5%	93.4%	92.7%	92.8%	92.1%	92.1%	92.2%	90.5%	90.2%	90.7%	89.5%	88.5%	87.5%	93.5%	-6.1%	89.2%	94.1%	-4.9%	
RTT Backlog (number of patients waiting over 18 weeks)	M	1611	1719	2009	2010	2198	2273	2268	2823	2936	2931	3399	3791	4239	1611	163.1%	143180	122174	17.2%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
RTT 35 week waiters	0	0	22	14	23	20	44	74	84	112	140	172	185	180	0	180	789	0	789	
Diagnostic performance (% patients waiting over 6 weeks)	1.0%	0.9%	2.2%	1.9%	1.0%	2.0%	3.8%	2.4%	6.7%	2.9%	2.7%	2.6%	2.2%	3.0%	0.9%	2.1%	97.3%	98.3%	-1.0%	

Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Aug-15	Var	Yr	Last Yr	Var	
Cancer 2WW standard	93.0%	85.9%	87.6%	91.3%	89.9%	91.9%	92.5%	94.9%	96.9%	96.0%	95.6%	96.5%	97.1%		85.9%		96.3%	91.0%	5.3%	
Cancer 2WW standard (Breast Symptoms)	93.0%	75.8%	81.3%	89.1%	88.5%	90.0%	99.1%	93.0%	90.0%	93.2%	98.5%	96.9%	95.8%		75.8%		96.2%	89.0%	7.2%	
Cancer 31 Day standard	96.0%	96.9%	98.9%	100.0%	97.4%	98.3%	96.9%	98.8%	99.3%	98.5%	99.4%	98.3%	97.7%		96.9%		98.5%	96.5%	2.0%	
Cancer 31 Day subsequent drug treatment	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	0.0%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	0.0%	
Cancer 62 day urgent referral standard	85.0%	73.9%	74.5%	76.2%	75.4%	80.6%	73.0%	70.5%	79.4%	67.6%	68.3%	82.3%	75.3%		73.9%		74.0%	74.5%	-0.5%	
Cancer 62 day screening standard	90.0%	87.5%	80.0%	84.6%	54.5%	60.0%	33.3%	100.0%	42.9%	100.0%	66.7%	62.5%	100.0%		87.5%		78.8%	85.7%	-6.9%	
Urgent operations cancelled for a 2nd time	0	0	0	0	1	1	1	2	1	0	0	0	0	0	0	0	0	0	0	
Proportion of patients not re-booked within 28 days of last minute cancellation	0.0%	2.9%	0.0%	6.1%	0.0%	0.0%	0.0%	5.7%	6.6%	0.0%	0.0%	0.0%	#DIV/0!	9.1%	2.9%	6.1%	1.0%	4.3%	-3.3%	
Delayed Transfer of Care	3.5%	7.4%	5.3%	7.8%	7.9%	7.5%	7.5%	10.8%	9.4%	5.3%	5.7%	7.0%	7.7%	8.0%	7.4%	0.6%	6.7%	6.9%	-0.2%	
Outpatient appointment cancellations < 6 weeks	R	27	35	20	29	41	21	21	18	14	29	47	34	38	27	40.7%	162	186	-12.9%	
Outpatient appointment cancellations > 6 weeks	R	1188	1319	1196	977	1287	1064	1134	1554	1126	1014	1255	1409	1536	1188	29.3%	6340	6256	1.3%	
% Spending 90% time on Stroke Ward Monthly Monitoring	90.0%	86.5%	81.5%	92.5%	89.6%	89.6%	93.5%	97.9%	92.9%	100.0%	95.2%	91.9%	92.3%	91.7%	86.5%	5.1%	94.5%	90.8%	3.7%	
Stroke:% to Stroke Unit <4hrs Monthly Monitoring	88.0%	82.4%	78.4%	76.3%	80.9%	83.3%	80.0%	77.1%	78.6%	85.3%	76.2%	82.9%	82.1%	100.0%	82.4%	17.6%	82.7%	80.5%	2.3%	
Stroke: % scanned <1hr of arrival Monthly Monitoring	95.0%	84.6%	79.6%	85.0%	85.4%	81.3%	84.8%	85.4%	83.9%	91.2%	78.6%	81.1%	87.2%	91.7%	84.6%	7.1%	84.8%	77.3%	7.5%	
Stroke: % scanned <12hr of arrival Monthly Monitoring	99.0%	98.1%	100.0%	100.0%	97.9%	100.0%	100.0%	100.0%	96.4%	100.0%	97.6%	100.0%	100.0%	100.0%	98.1%	1.9%	99.4%	97.1%	2.3%	

East Sussex Healthcare NHS Trust

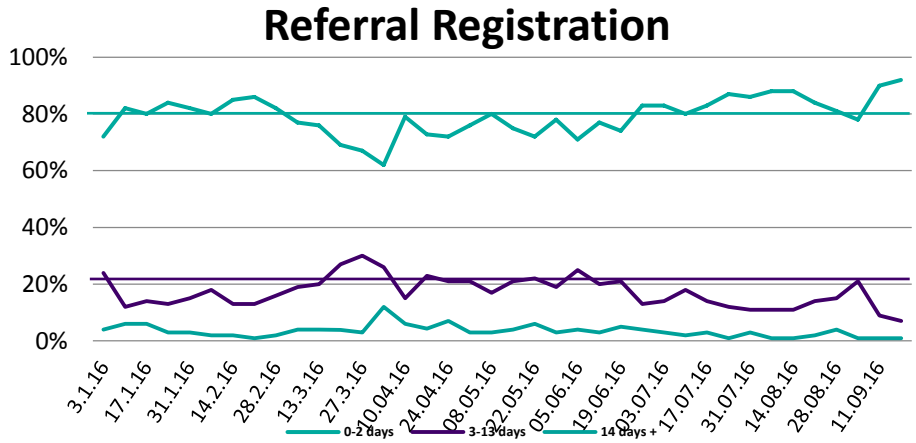
Access and Delivery overview

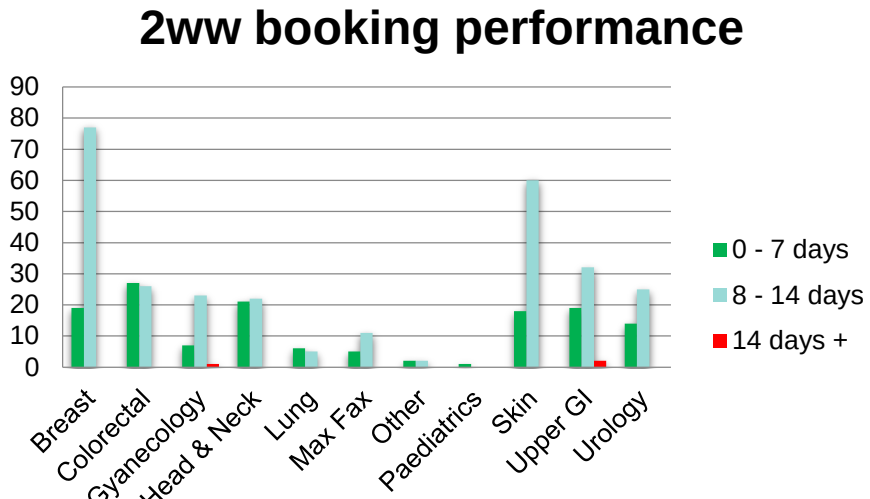
- The trust remains challenged against the key constitutional targets and trajectories
- A&E performance was 79.5% against the 95% standard
- RTT incompletes was 87.5% against the 92% standard
- Diagnostics achieved 3.04% against the 1% target
- Cancer 62 Days achieved 75.3% against the 85% standard (for July, one month in arrears)
- No urgent operations were cancelled for a second time
- Delayed transfers of care increased to 8.0%

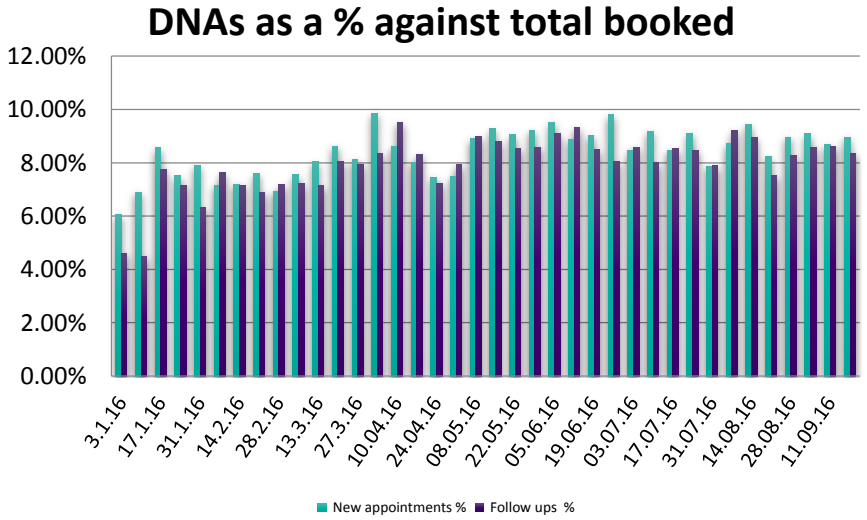
East Sussex Healthcare NHS Trust

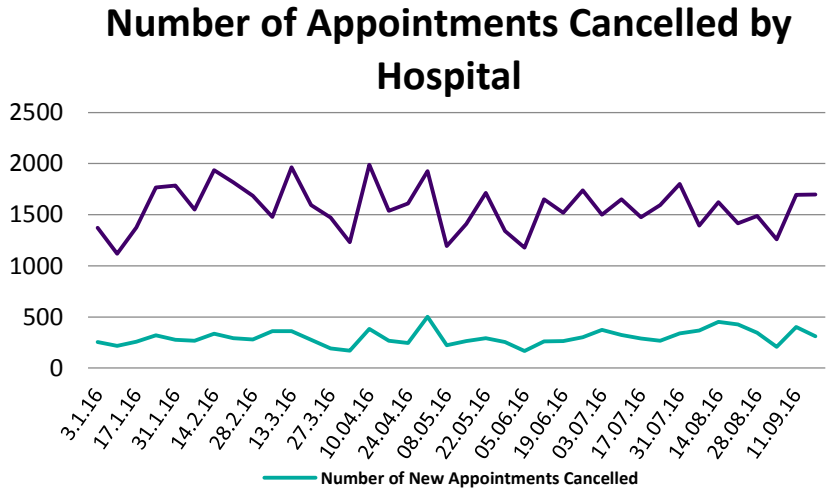
ELECTIVE CARE

Outpatients









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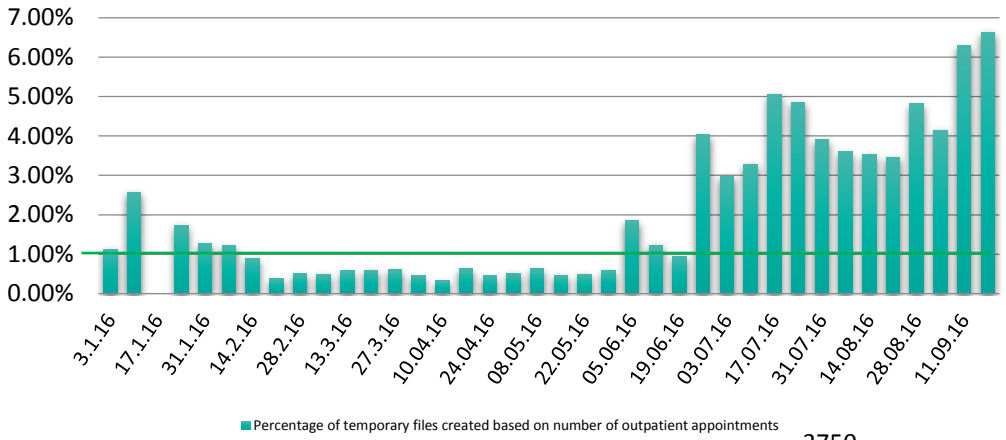
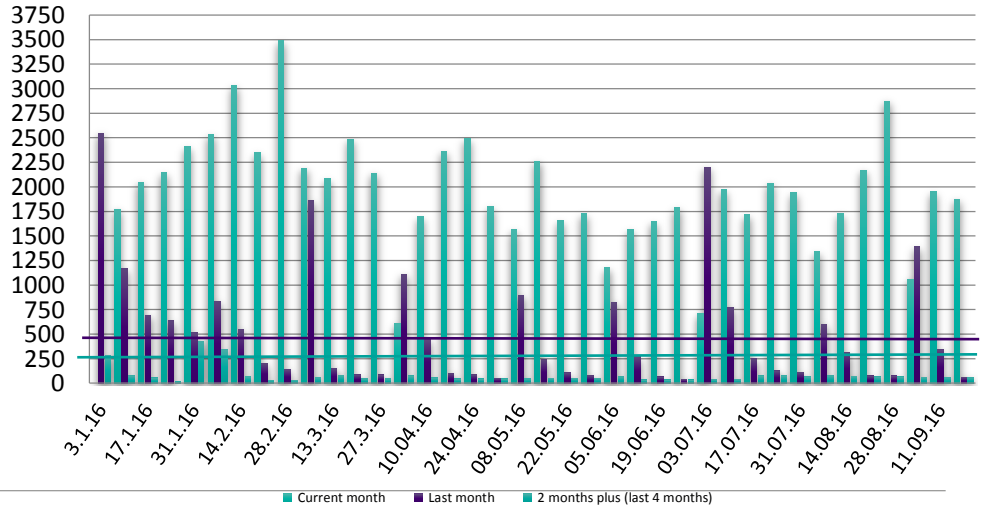
Percentage of temporary files created based on number of outpatient appointments



Temporary notes have continued to increase as a result of the move of health records to Apex Way. The anticipated reduction has not yet been apparent due to the prolonged transfer of notes and reduction in temporary staff. Additional recovery steps have been taken and therefore improvement in position in the following month.

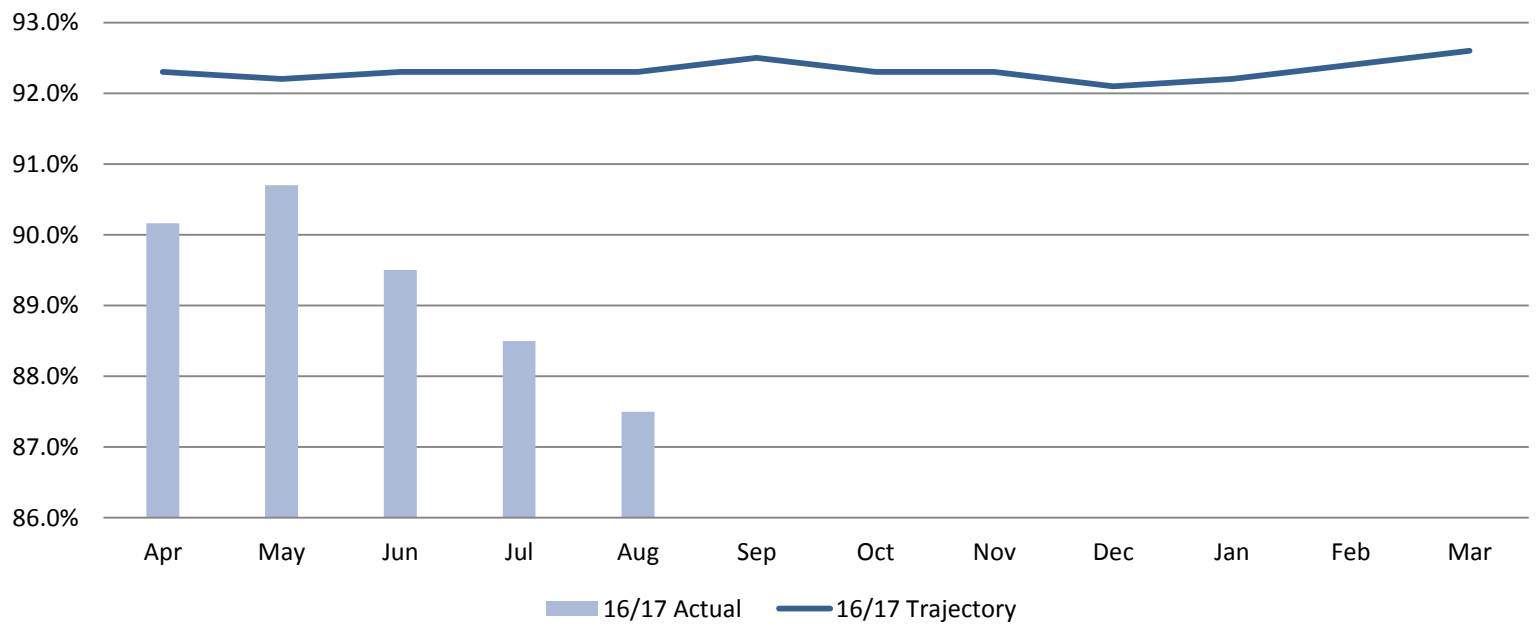
Incomplete cashing up is continuing to improve.

Incomplete cashing up



2. RTT

August performance was 87.5% against the trajectory of 92.3%. This represents the third consecutive month with a decline in performance.



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RTT

RTT review of the Capacity & Demand gap has been completed. Additional work, via In-house initiatives and independent providers has been identified although there remain a capacity gap in order to recovery to a sustainable 92% minimum position.

Work is being considered with an external provider to provided targetted support to gynaecology, ophthalmology and ENT in order to support the inpatient position.

The CCGs have endeavoured to find 3rd party support but this has as yet not been available.

The detailed plan and the gap analysis are attached as appendix 1

East Sussex Healthcare NHS Trust

Diagnostics

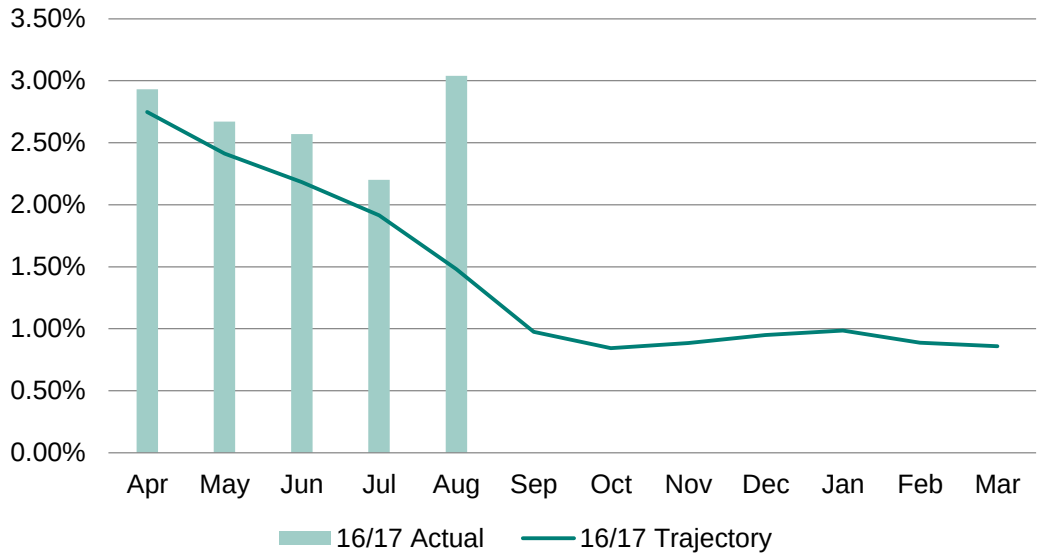
August performance was 3.04% against the trajectory of 1.48%

Delivery of the 1% standard will be achieved by the end of September had been anticipated however this has been impacted by a breakdown with a CT scanner causing an increase in radiological breaches.

Completed Actions

Both the 3rd room in Endoscopy at the EFGH and the Vanguard unit in Hastings are now operationally and this is seeing improvements in the endoscopy figures.

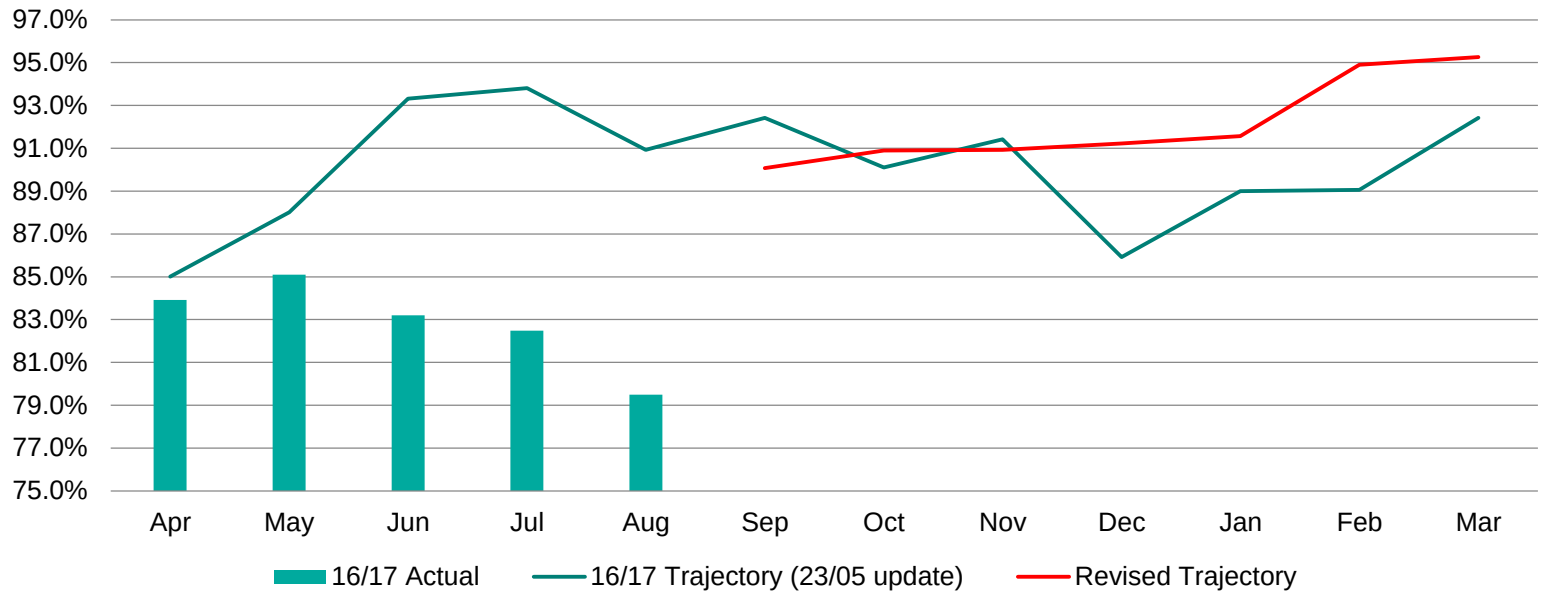
The business case for 7 day working has been approved – will be implemented by October 2016



EMERGENCY CARE

East Sussex Healthcare NHS Trust

A&E Trajectory

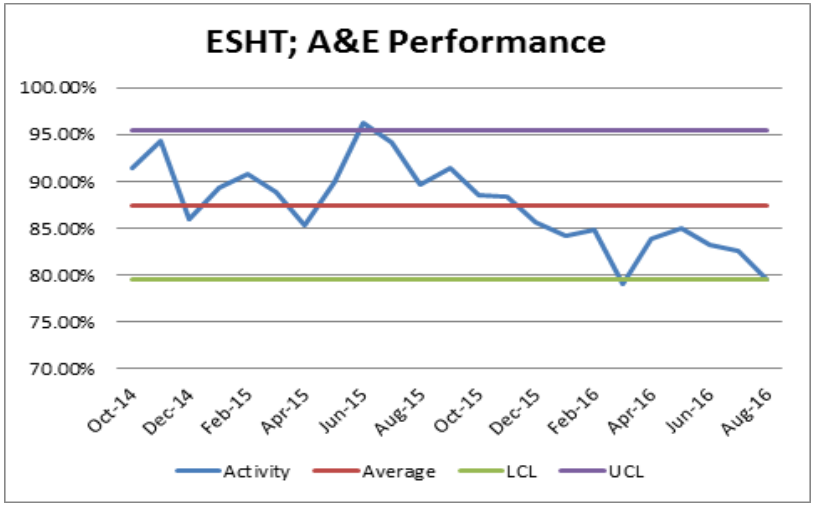


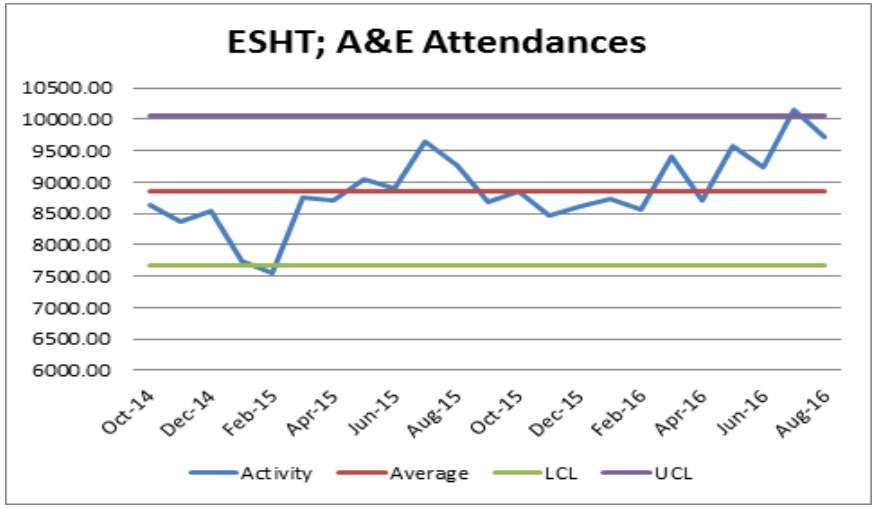
A&E

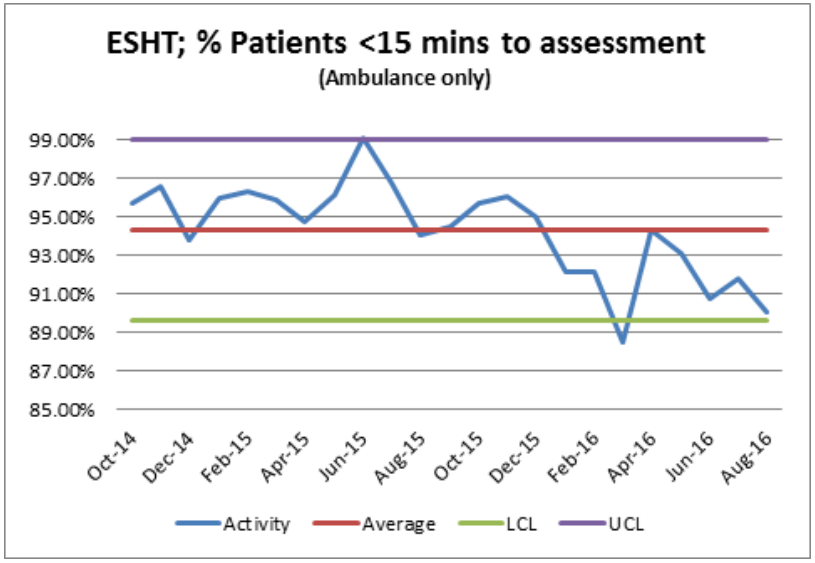
A&E performance deteriorated further during August

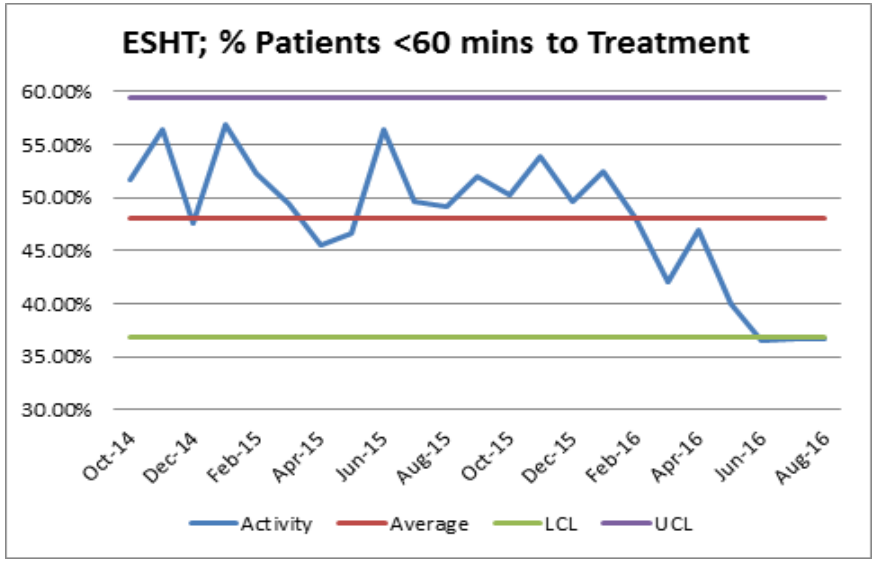
Attendances were up across both sites by 4% on the year to date figure and 17% against the same month last year.

An A&E Improvement Plan is in place and monitored weekly against the 9 improvement areas to ensure the anticipated impact is being realised.


ESHT; A&E Performance
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Activity
Average
LCL
UCL


ESHT; A&E Attendances
10500.00
10000.00
9500.00
9000.00
8500.00
8000.00
7500.00
7000.00
6500.00
6000.00
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Activity
Average
LCL
UCL


ESHT; % Patients <15 mins to assessment
(Ambulance only)
99.00%
97.00%
95.00%
93.00%
91.00%
89.00%
87.00%
85.00%
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Activity
Average
LCL
UCL


ESHT; % Patients <60 mins to Treatment
60.00%
55.00%
50.00%
45.00%
40.00%
35.00%
30.00%
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Activity
Average
LCL
UCL

Output (What are we trying to achieve)	By when	Action (How are we going to do it)
Streaming protocols both sites	Sep-16	Agree protocols with each speciality
		Review and agree pathways with gateway areas - nurse:nurse, doctor:doctor
		Review cas cards each morning for non-compliance and escalate to relevant General Manager
		Feed non-compliance rates into monthly CU IPR meetings
Ambulatory emergency care both sites	Sep-16	Pathways for ambulatory care in place
		Staffing levels and skill-mix in place to enable service to be extended
Rapid Access Treatment core hours EDGH	Sep-16	Consultant led service to operate in core hours
		Impact data to be compiled
ENP rota at Conquest	Sep-16	Staffing levels in place to run service
		PAS update required to ensure correct recording of "minors" in discharge stream
Enhanced Co-ordinator function both sites	Sep-16	Nurse in charge to be moved from operational management
		B6 nurses to manage flow in majors
		Establishment, skill-mix and rotas to be in place
Escalation protocols	Sep-16	Policy agreed for each site
		Responsibilities to be agreed with speciality Service Managers and Ward Matrons
Revision of nursing rotas to match activity	Dec-16	Capacity and demand review undertaken
		New rotas drawn up to match activity
		Consultation to take place on new rotas
		Trained nurse and HCA being added to twilight shift on next rota at CQ
Rapid Access Treatment core hours Conquest	Dec-16	Pilot for one week at end of Aug and collect impact data
		Discussions to take place with consultants to gain support for service
Implement Frailty model	Feb-17	Frailty model benefits to be realised

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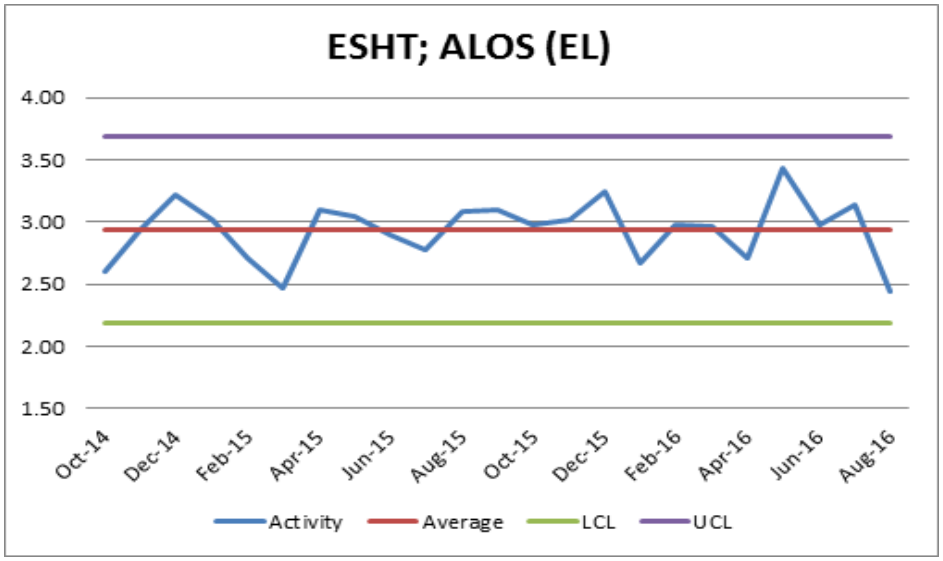

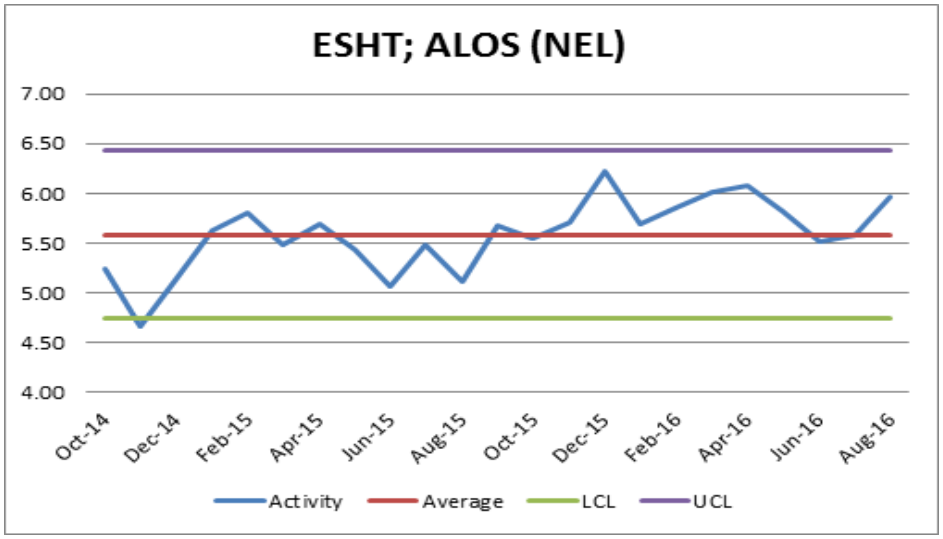

Length of stay

- Overall ytd Elective length of stay is static; primarily die to the reduction seen in August.
- Non-Elective length of stay is up by approximately half a day on the same period last year.

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CANCER

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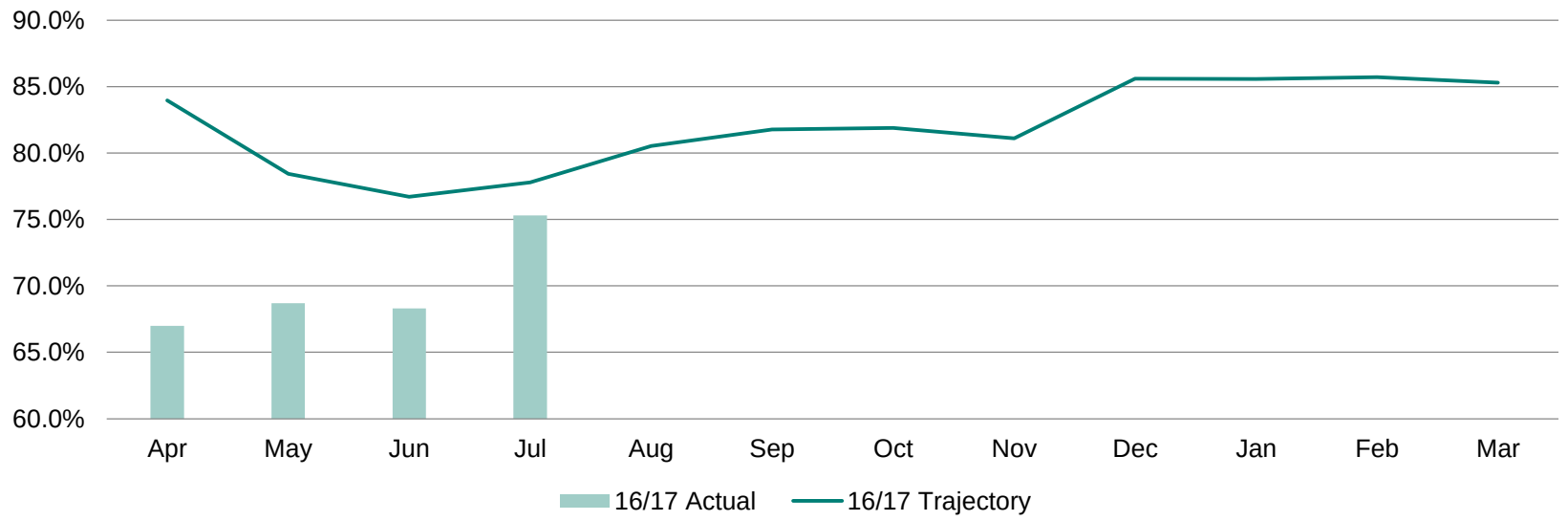
CANCER

Achieved: 2 week wait

Achieved: 31 Day Standard

Did not achieve trajectory for 62 Day Standard. 75.3% against trajectory target of 77.8%



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Completed Actions

Improved waiting times for Endoscopy procedures

Bid made to NHSI jointly with BSUH and CCG support for shared MP MRI scan reporting facility from BSUH in exchange for increased access at EDGH for Brighton patients. Bid also included specialist imaged fusion software to support the prostate pathway and the project management support for Order Comms.

Planned Actions

Last ten patient review of Head & Neck and Colorectal (October 2016)

Strengthening link with BSUH as tertiary Centre in order to jointly 38 day transfer patients via a joint PTL.

The third Urology Deep Dive session is arranged for 14th October with all relevant parties to discuss progress and review pathway. In addition the MDT have re-reviewed the pathway and made amendments which will reduce the waiting times further – pathway to be reviewed at meeting.

The Diagnostic PTL has been produced but is still undergoing validation and testing.

Funding for the Nurse Advisor to support patient choice challenges within the 62 day and TWW pathways has been agreed. Successful candidate appointed, start date pending.

Collaborative piece of work with CCG leads to define NG12 2WW criteria to ensure compliance with guidance and appropriately targeted referrals.

Finance & Capital

FINANCE

East Sussex Healthcare NHS
NHS Trust

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Financial Headlines

East Sussex Healthcare NHS
NHS Trust

The Trust reported delivery of plan at Q1, but noted the level of risk in plans moving into Month 4 and 5. As the Trust moves towards Month 6, a full closedown process is in place, alongside the agreed recovery actions, to move the financial position closer to plan. However, the level of risk, both in terms of Trust delivery of efficiency plans, and in terms of the affordability of actual activity levels for clinical activity, remains high. The Finance and Investment Committee reviews the financial position and forecast in detail on a monthly basis and has requested a robust recovery trajectory for the October 2016 meeting

Executive team have agreed series of actions:

- increased capacity in finance/operations for delivery of CIPs
- increased capacity in contracting/performance for operational delivery
- temporary workforce team moving to Finance, strengthened clinical leadership and weekly review

DoF meeting all Divisional Leads to review forecasts and identify opportunities for full year

FINANCE REPORT – August 2016

Jonathan Reid, Director of Finance – September 2016

Financial Summary – August 2016

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 5.	R
Revised Plan	The Trust has agreed a new financial plan with NHS Improvement. This is based on a deficit plan 'control total' of £31.3m, replacing the original planned deficit of £48.0m. This is to be achieved by the Trust delivering further financial improvements of £6.3m and receiving a contribution from the national Strategic Transformation Fund (STF) of £10.4m. The revised plan sets an enhanced cost improvement target of £14.5m, compared to the original plan of £10.8m. The STF funding is contingent on meeting key financial and operational targets and the plan assumes these will be met in full.	R
Financial Summary	The Trust performance in month 5 was a run rate deficit of £4.7m with an adverse variance against plan of £2.0m. Sustainability and Transformation Funding (STF) of £10.4m has been agreed for 2016/17 and £2.6m of this has been factored into the month 5 position. Year to date the deficit now stands at £22.9m which is £5.7m worse than plan.	R
Income	Total income received during August was £0.2m above planned levels however, non-achievement of STF in the month, reduced income by 0.9m. It is essential for the Trust to recover the STF over the coming months. The year to date variance is now £1.0m above plan. Tariff-Excluded Drugs and Devices (TEDDs) income over-performed by £0.1m in month, over-performance now stands at £0.5m YTD. There is however, a corresponding overspend of £0.5m on TEDDs expenditure so therefore, this has a zero effect on the bottom line.	G
Expenditure	Operating Pay costs are above plan by £1.3m in month and are cumulatively £2.4m above plan. Operating Non Pay costs are £1.0m above plan in month and are £4.6m above plan cumulatively. Total costs are now £6.8m overspent year to date	R
CIP plans	The CIP plan for 2016/17 has been increased from £10.8m to £14.5m. CIP achievement year to date was £1.5m, £1.3m below the plan.	R
Forecast Outturn	The forecast outturn position is anticipated to be in line with the revised £31.3m deficit plan. There are significant risks associated with delivery of this position, and the Trust has a clear recovery plan, reviewed by Executive Directors and FIC.	G
Balance Sheet	DH loans have increased by £23.0m in year as a result of the draw down of the revolving working capital facility.	G
Cash Flow	The cash position of the Trust remains challenging as a result of the revenue financial deficit. This continues to result in increasing creditor values and poor performance against the Better Payment Practice Code.	A
Capital Programme	The charge against the Capital Resource Limit (CRL) is £3.1m year to date. The current over planning margin stands at £1.8m and this will be kept under review to ensure the Trust does not exceed its capital resource limit at 31st March 2017.	G

Income & Expenditure – August 2016

Headlines

• Total income in the month was £30.8m against a plan of £30.6m, a favourable variance of £0.2m. The YTD position is £1.0m above plan.

• Total costs in the month were £35.5m, this was £2.3m above plan. The YTD position is now £6.8m above plan.

• The £22.9m year to date deficit against plan was an adverse variance of £5.7m

• Cost improvement plans of £14.5m have been developed for 2016/17 with a YTD achievement of £1.5m.

• Operating pay costs in the month, including ad hoc costs, were £1.3m above plan and are now £2.4m above plan YTD.

• Operating Non Pay costs, including third party costs, were £1.0m above plan in the month and are now £4.6m above plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	25,013	24,841	-172	122,617	122,674	57	296,887
Tariff-Excluded Drugs & Devices	2,608	2,697	89	13,042	13,562	520	31,300
Private Patient/ ICR	243	204	-39	1,216	1,145	-71	2,919
Trading Income	483	425	-58	2,419	2,074	-345	3,631
Other Non Clinical Income	2,217	2,601	384	11,549	12,414	865	29,148
Total Income	**30,564**	**30,768**	**204**	**150,843**	**151,869**	**1,026**	**363,885**
Pay Costs	-21,228	-22,503	-1,275	-108,415	-110,849	-2,434	-254,067
Non Pay Costs	-7,768	-8,723	-955	-38,583	-42,620	-4,037	-91,076
Tariff-Excluded Drugs & Devices	-2,608	-2,697	-89	-13,042	-13,562	-520	-31,300
Total Operating Costs	**-31,604**	**-33,923**	**-2,319**	**-160,040**	**-167,031**	**-6,991**	**-376,443**
Surplus/- Deficit from Operations	**-1,040**	**-3,155**	**-2,115**	**-9,197**	**-15,162**	**-5,965**	**-12,558**
P/L on Asset Disposal	0	0	0	0	0	0	0
Depreciation	-1,043	-1,043	0	-5,216	-5,208	8	-12,519
Impairment	0	0	0	0	0	0	0
PDC Dividend	-430	-430	0	-2,151	-2,151	0	-5,162
Interest	-135	-85	50	-671	-448	223	-1,611
Total Non Operating Costs	**-1,608**	**-1,558**	**50**	**-8,038**	**-7,807**	**231**	**-19,292**
Total Costs	**-33,212**	**-35,481**	**-2,269**	**-168,078**	**-174,838**	**-6,760**	**-395,735**
Net Surplus/-Deficit	**-2,648**	**-4,713**	**-2,065**	**-17,235**	**-22,969**	**-5,734**	**-31,850**
Donated Asset/Impairment Adjustment	0	24	24	0	46	46	0
Adjusted Net Surplus/-Deficit	**-2,648**	**-4,689**	**-2,041**	**-17,235**	**-22,923**	**-5,688**	**-31,850**

Cash Flow – August 2016

Headlines

• The cash position of the Trust remains extremely challenging. It is planned to meet the £2.1m balance at 31st March 2017 as required by the Department of Health. Based on current projections, this will involve extending supplier and BPPC payment terms.

• To ease the cash position the Trust has in place a revolving working capital facility (RWCF) draw down of £31.3m against which £23.0m was drawn down at 31st August 2016.

• This new RWCF loan is repayable in April 2020.

• In addition an agreed cash advance of £12m was received in July from the CCGs. This was used to reduce trade creditors in July and is repayable in March 2017.

• Should the Trust be unable to deliver its planned £31.3m deficit the level of trade & other payables would increase further and that could risk non-delivery of goods and services.

Cash Flow Statement April 2016 to March 2017

£000s	Apr Actual	May Actual	Jun Actual	July Actual	Aug Actual	Sept Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast
Cash Flow from Operations												
Operating Surplus/(Deficit)	-4,616	-5,384	-2,004	-4,169	-4,198	-1,956	-2,287	-1,690	-1,769	-1,153	-1,230	5,929
Depreciation and Amortisation	1,039	1,040	1,042	1,044	1,044	1,043	1,043	1,043	1,043	1,044	1,044	1,050
Operating Surplus/(Deficit)	-3,577	-4,344	-962	-3,125	-3,154	-913	-1,244	-647	-726	-109	-186	6,979
Interest Paid	-177	-176	96	-114	-87	-66	-1	-1	-1	-1	-269	-842
Dividend (Paid)/Refunded						-2,209						-2,953
(Increase)/Decrease in Inventories	-90	209	-182	102	114							-153
(Increase)/Decrease in Trade and Other Receivables	-2,003	-1,684	-2,895	7,473	854	150	500	0	0	500	-107	-458
Cash advance from CCGs				12,000								-12,000
Increase/(Decrease) in Trade and Other Payables	1,574	2,598	-2,164	-17,056	-532	3,437	4,254	-1,327	-6,222	283	2,784	11,443
Provisions Utilised	11	11	10	-46	11	-40	-40	-40	-40	-40	-40	-229
Net Cash Inflow/(Outflow) from Operating Activities	**-4,262**	**-3,386**	**-6,097**	**-766**	**-2,794**	**359**	**3,469**	**-2,015**	**-6,989**	**633**	**2,182**	**1,787**
Cash Flows from Investing Activities:												
Interest Received	2	3	2	2	2	3	2	2	3	2	2	3
(Payments) for Property, Plant and Equipment	-978	-937	-1,069	-537	-206	-915	-1,000	-1,000	-2,000	-3,000	-3,000	-2,775
(Payments) for Intangible Assets	-35	-20	-1	-24	-7	-40	-40	-40	-40	-40	-40	-153
Net Cash Inflow/(Outflow) from Investing Activities	**-1,011**	**-954**	**-1,068**	**-559**	**-211**	**-952**	**-1,038**	**-1,038**	**-2,037**	**-3,038**	**-3,038**	**-2,925**
Net Cash Inflow/(Outflow) before Financing	**-5,273**	**-4,340**	**-7,165**	**-1,325**	**-3,005**	**-593**	**2,431**	**-3,053**	**-9,026**	**-2,405**	**-856**	**-1,138**
New Capital PDC	0	0	0	0	0	0	0	0	0	0	0	0
Revolving Working Capital Facility (RWCF)	7,290	4,982	3,930	4,163	2,648	2,507	1,725	1,725	1,725	605	0	0
Repayment of RWCF	0	0	0	0	0	0	0	0	0	0	0	0
New interim revenue support facility	0	0	0	0	0	0	0	0	0	0	0	0
New Capital Loan	0	0	0	0	0	0	0	0	5,000	0	0	0
Loans and Finance Lease repaid	0	0	0	0	0	-126	0	0	0	0	0	-426
Net Cash Inflow/(Outflow) from Financing Activities	7,290	4,982	3,930	4,163	2,648	2,381	1,725	1,725	6,725	605	0	-426
Net Increase/(Decrease) in Cash	2,017	642	-3,235	2,838	-357	1,788	4,156	-1,328	-2,301	-1,800	-856	-1,564
Opening balance	2,100	4,117	4,759	1,524	4,362	4,005	5,793	9,949	8,621	6,320	4,520	3,664
Closing balance	4,117	4,759	1,524	4,362	4,005	5,793	9,949	8,621	6,320	4,520	3,664	2,100

Balance Sheet – August 2016

Headlines

• The forecast increase in non current borrowings is in respect of the interim revolving working capital support facility (RWCF) required to finance the planned £31.3m revenue deficit.

• The reduction in the forecast retained earnings reserve is also a result of the planned deficit.

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Plan March 2017
Non Current Assets			
Property plant and equipment	231,172	229,250	244,661
Intangilble Assets	1,650	1,737	2,130
Trade and other Receivables	1,193	1,236	1,193
	234,015	**232,223**	**247,984**
Current Assets			
Inventories	6,472	6,320	6,341
Trade receivables	8,397	7,909	5,773
Other receivables	8,146	6,846	5,601
Other current assets	0	0	0
Cash and cash equivalents	2,100	4,005	2,100
	25,115	**25,080**	**19,815**
Current Liabilities			
Trade payables	-13,571	-14,721	-12,639
Other payables	-25,618	-22,599	-23,812
DH Capital Investment Loan	-427	-427	-427
DH Working Capital Loan	0	0	0
Other Financial Liabilities	0	0	0
Provisions	-253	-260	-552
	-39,869	**-38,007**	**-37,430**
Non Current Liabilities			
DH Capital Investment Loan	-3,767	-3,553	-7,876
Borrowings - Revenue Support Facility	-35,004	-58,231	-66,518
DH Working Capital Loan	0	0	0
Other Financial Liabilities	0	0	0
Provisions	-2,709	-2,700	-2,902
	-41,480	**-64,484**	**-77,296**
Total Assets Employed	**177,781**	**154,812**	**153,073**
Financed by:			
Public Dividend Capital (PDC)	153,562	153,562	153,562
Revaluation Reserve	98,247	98,247	104,746
Retained Earnings Reserve	-74,028	-96,997	-105,235
Total Taxpayers' Equity	**177,781**	**154,812**	**153,073**

Receivables, Payables & Better Payment Practice Code Performance – August 2016

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, in month 44% of trade invoices has been achieved and 91% 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 is 26% at 31st August 2016.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	NHS Debt Outstanding		Non-NHS Debt Outstanding	
	Current Month £000s	Previous Month £000s	Current Month £000s	Previous Month £000s
0 - 30 Days	2,352	4,599	686	720
31 - 60 Days	1,207	1,432	404	254
61 -90 Days	1,107	264	104	46
91 - 120 Days	162	118	23	75
> 120 Days	767	738	1,097	1,060
Total	5,595	7,151	2,314	2,155

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	5,884	6,324	6,246	7,340
31 - 60 Days	3,651	3,720	5,414	4,882
61 -90 Days	398	588	1,253	1,097
91 - 120 Days	279	286	637	626
> 120 Days	1,387	1,469	1,171	1,080
Total	11,599	12,387	14,721	15,025

Better Payment 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	45.87%	44.42%	35.94%	41.82%
NHS invoices paid within contract or 30 days of receipt	30.53%	90.68%	28.36%	75.43%

Key Performance Indicators – August 2016

TDA Finance Risk Assessment Criteria

• NHS Improvement (NHSI) has set out its reporting requirements in the latest accountability framework.

• The finance metrics have been revised by NHSI 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 in the plan, 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 1, 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 Payment Practice Code (BPPC)

• YTD 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?		
Overall Trust TDA RAG Rating		

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

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	42	95
BPPC – NHS Invoices by value (%)	75	95

Activity & Contract Income – August 2016

Headlines

- The Trust is on a PbR Contract with the 3 local CCGs for 2016/17. This is a change to the 'Cap & Collar' Risk share contract in 2015/16.
- The planned activity in the table on the right represents the TDA plan and not the activity contracted by CCGs & NHSE.
- NHS Patient Income at month 5 was £0.6m above the TDA plan.
- This is mainly linked to: Electives (including Day cases) over performance in Medicine £1.06m(Gen Med , Gastroenterology & Cardio Vascular), Surgery £936k (T&O & Urology). Non-Electives over performance in Medicine £1.3m (General Medicine & Gastroenterology), partially offset by Block underperformance (M4&5 STF funding reduction, ESBT reduction in funding – offset by reduced spend)
- As a result of the conditions of the STF, a provision for Fines & Penalties of £10k has been made relating to MSSA breaches.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,760	3,523	-237	18,116	16,467	-1,649
Elective Inpatients	686	599	-87	3,306	3,287	-19
Emergency Inpatients	3,665	3,468	-197	18,089	17,505	-584
Total Inpatients	**8,111**	**7,590**	**-521**	**39,511**	**37,259**	**-2,252**
Excess Bed Days	2,237	2,119	-118	11,017	11,231	214
Total Excess Bed Days	**2,237**	**2,119**	**-118**	**11,017**	**11,231**	**214**
Consultant First Attendances	8,277	7,569	-708	39,881	39,187	-694
Consultant Follow Ups	12,934	11,807	-1,127	62,319	62,732	413
OP Procedures	4,719	4,356	-363	22,737	21,666	-1,071
Other Outpatients inc WA & Nurse Led	12,701	12,601	-100	61,197	64,568	3,371
Community Specialist	181	313	132	869	1,165	296
Total Outpatients	**38,812**	**36,646**	**-2,166**	**187,003**	**189,318**	**2,315**
Chemotherapy Unbundled HRGs	645	1,433	788	3,111	6,235	3,124
Antenatal Pathways	324	307	-17	1,565	1,419	-146
Post-natal Pathways	299	343	44	1,440	1,442	2
A&E Attendances (excluding type 2's)	9,476	9,817	341	46,769	48,151	1,382
ITU Bed Days	517	579	62	2,554	2,554	0
SCBU Bed Days	309	173	-136	1,524	1,279	-245
Cardiology - Direct Access	71	22	-49	342	354	12
Radiology - Direct Access	5,345	5,571	226	25,756	28,245	2,489
Pathology - Direct Access	289,732	275,151	-14,581	1,395,978	1,394,178	-1,800
Therapies - Direct Access	2,662	2,826	164	12,824	13,881	1,057
Audiology	1,063	860	-203	5,118	3,594	-1,524
Midwifery	14	10	-4	65	48	-17

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,288	4,330	42	20,661	22,032	1,371
Inpatients - Emergency	6,310	6,635	325	31,143	32,469	1,326
Excess Bed Days	494	458	-36	2,433	2,436	3
Outpatients	4,185	3,967	-218	20,161	20,495	334
Other Acute based Activity	2,839	2,733	-106	13,920	13,332	-588
Direct Access	808	811	3	3,896	4,107	211
Block Contract	10,130	4,521	-5,609	26,904	23,843	-3,061
Fines & Penalties	0	259	259	0	-10	-10
Other	-4,521	835	5,356	1,099	1,451	352
CQUIN	480	292	-188	2,400	2,519	119
Subtotal	25,013	24,841	-172	122,617	122,674	57
Exclusions	2,608	2,697	89	13,042	13,562	520
GRAND TOTAL	**27,621**	**27,538**	**-83**	**135,659**	**136,236**	**577**

Clinical Unit, Estates & Corporate Performance (budgets) – August 2016

Headlines

Pay

Total Pay reported an overspend of £1.3m against plan in the month and £2.4m year to date, under delivery on pay CIP target at £0.9m April-August.

Total agency spend in August has increased to £2.2m and cumulative spend to £9.8m month 1-5. Continued use of nursing agency to cover vacancies and escalation areas, actively recruiting from overseas to reduce reliance on agency. Average spend of £0.7m per month on medical agency covering vacancies.

A detailed review of temporary workforce costs is underway as part of the financial recovery plan.

Non pay

Total non pay recorded a £0.9m overspend in August and cumulatively £3.8m. Under delivery against non pay CIP target of £0.4m.

Surgery and Specialist Medicine have outsourced activity to help with capacity pressures, which have overspent £1.5m cumulatively. Other non pay pressures include minor improvements and equipment purchases.

Tariff Exclusions were £0.5m overspent to date, offset by over delivery on income.

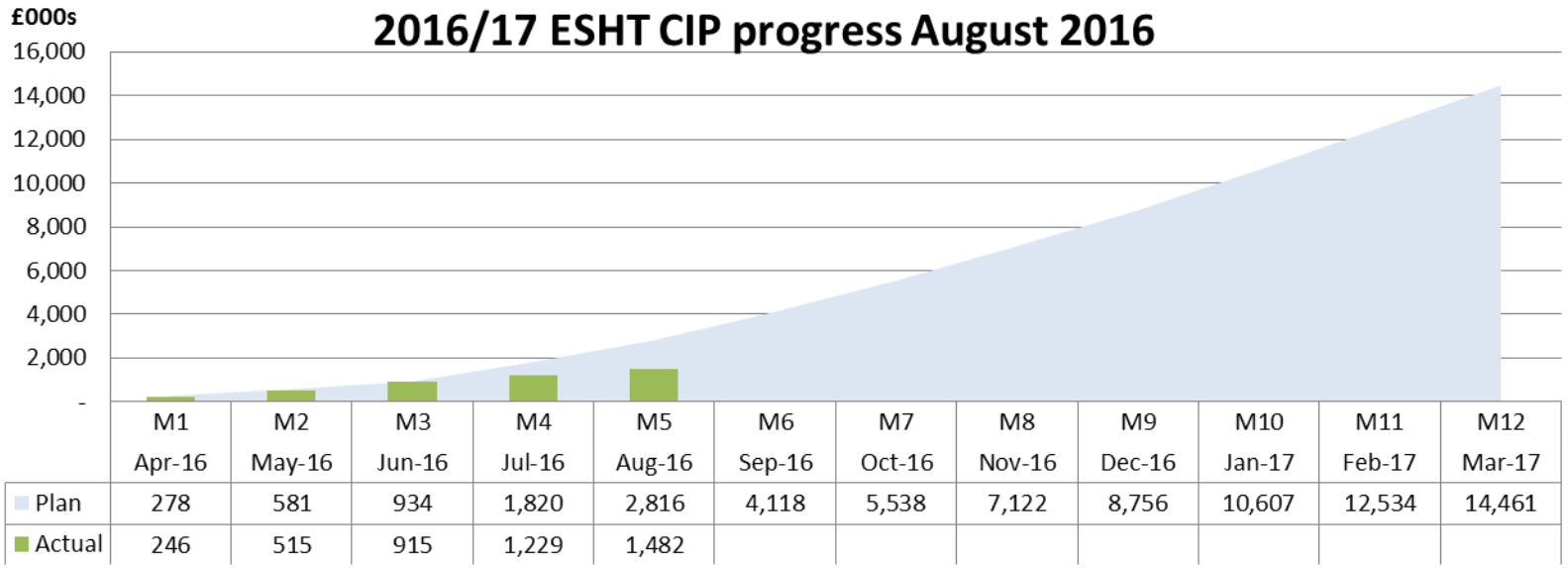
Income

Non-contract Income reported ahead of plan in the month by £0.5m. This is partly due to delay in community facilities transfer, and additional income received for Making Every Contact Count.

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	-1,070	-1,107	-37	-5,349	-5,431	-82
Medicine	-4,477	-5,500	-1,023	-23,289	-26,133	-2,844
Surgery	-3,347	-3,746	-399	-16,509	-18,985	-2,476
Women & Children	-2,820	-2,482	338	-12,834	-12,379	455
Out of Hospital Care	-2,327	-2,408	-81	-11,626	-11,906	-280
Clinical Support	-6,549	-7,345	-796	-33,498	-35,850	-2,352
Tariff-Excluded Drugs & Devices	-2,608	-2,697	-89	-13,042	-13,562	-520
COO Operations	-1,058	-867	191	-5,248	-5,643	-395
Total Clinical Units	**-24,256**	**-26,152**	**-1,896**	**-121,395**	**-129,889**	**-8,494**
Estates & Facilities	-1,900	-2,074	-174	-9,681	-10,447	-766
Corporate Services	-2,413	-2,892	-479	-12,089	-13,469	-1,380
Central Items	-1,693	-1,143	550	-10,225	-6,427	3,798
Total Central Areas	**-6,006**	**-6,109**	**-103**	**-31,995**	**-30,343**	**1,652**
Contract Income	27,621	27,538	-83	135,659	136,236	577
Non-contract Income	-7	10	17	496	1,027	531
Donated Asset/Impairment Adjustment	0	24	24	0	46	46
Adjusted Net Surplus/- Deficit	**-2,648**	**-4,689**	**-2,041**	**-17,235**	**-22,923**	**-5,688**

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
244	242	Urgent Care	-1,014	-1,038	-24	-5,079	-5,098	-19
1,152	1,218	Medicine	-3,985	-4,611	-626	-20,766	-22,496	-1,730
799	819	Surgery	-3,110	-3,355	-245	-15,324	-16,314	-990
612	564	Women & Children	-2,605	-2,229	376	-11,880	-11,306	574
772	751	Out of Hospital Care	-2,094	-2,272	-178	-10,669	-11,214	-545
1,113	1,131	Clinical Support	-4,251	-4,573	-322	-21,566	-22,483	-917
392	437	COO Operations	-1,023	-1,063	-40	-5,008	-5,238	-230
5,085	**5,163**	**Total Clinical Units**	**-18,082**	**-19,141**	**-1,059**	**-90,292**	**-94,149**	**-3,857**
694	736	Estates & Facilities	-1,431	-1,503	-72	-7,090	-7,532	-442
616	567	Corporate Services	-1,885	-1,846	39	-9,272	-9,105	167
1,310	**1,302**	**Total Non-Clinical Divisions**	**-3,316**	**-3,349**	**-33**	**-16,362**	**-16,637**	**-275**
0	**0**	Central Items	170	-13	-183	-1,761	-63	1,698
6,395	**6,465**	**Total Pay Analysis**	**-21,228**	**-22,503**	**-1,275**	**-108,415**	**-110,849**	**-2,434**

2016/17 ESHT CIP Performance to date – Month 05



	M1 Apr-16	M2 May-16	M3 Jun-16	M4 Jul-16	M5 Aug-16	M6 Sep-16	M7 Oct-16	M8 Nov-16	M9 Dec-16	M10 Jan-17	M11 Feb-17	M12 Mar-17
Plan	278	581	934	1,820	2,816	4,118	5,538	7,122	8,756	10,607	12,534	14,461
Actual	246	515	915	1,229	1,482							

Theme	YTD Plan £000	YTD Actual £000	YTD Var £000
Clinical services productivity	227	228	-1
Corporate, admininstrative estates	418	234	184
Direct engagement	84	-	84
IM&T schemes	120	-	120
Income generation	115	129	-14
Lord Carter	1,057	-	1,057
Medicines Management	65	275	-210
Procurement	700	540	160
Redesign	30	76	-46
Stretched target	-	-	-
Total	**2,816**	**1,482**	**1,334**

Clinical Unit	YTD Plan £000	YTD Actual £000	YTD Var £000
Estates & Facilities	346	123	223
Operational COO	110	57	53
Corporate	418	234	183
Specialist Medicine	423	80	342
Surgery	404	361	43
Urgent	93	8	85
Women's & Children's	328	280	47
Out of Hospital	198	-	198
Clinical Support	770	337	433
Trustwide	-274	-	-274
Total	**2,816**	**1,482**	**1,334**

Year on Year Comparisons – August 2016

Headlines

- Total Inpatient activity to date is 9.0% lower than last year's level.
- Total outpatients are 1.5% higher than last year.
- Total A&E attendances are 5.3% higher than last year.
- Total income is £2.0m (1.4%) up on the same period last year.
- Total expenditure is £9.0m (5.4%) up on the same period last year.

Activity	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	16,467	18,988	-2,521	-13.3%
Elective Inpatients	3,287	3461	-174	-5.0%
Emergency Inpatients	17,505	18,498	-993	-5.4%
Total Inpatients	**37,259**	**40,947**	**-3,688**	**-9.0%**
Elective Excess Bed Days	882	985	-103	-10.5%
Non elective Excess Bed Days	10,349	9,494	855	9.0%
Total Excess Bed Days	**11,231**	**10,479**	**752**	**7.2%**
Consultant First Attendances	39,187	39,717	-530	-1.3%
Consultant Follow Ups	62,732	61,282	1,450	2.4%
OP Procedures	21,666	21,979	-313	-1.4%
Other Outpatients (WA & Nurse Led)	64,568	62,690	1,878	3.0%
Community Specialist	1,165	834	331	39.7%
Total Outpatients	**189,318**	**186,502**	**2,816**	**1.5%**
Chemotherapy Unbundled HRGs	6,235	3,115	3,120	100.2%
Antenatal Pathways	1,419	1,490	-71	-4.8%
Post-natal Pathways	1,442	1,499	-57	-3.8%
A&E Attendances (excluding type 2's)	48,151	45,740	2,411	5.3%
ITU Bed Days	2,554	2,300	254	11.0%
SCBU Bed Days	1,279	1,703	-424	-24.9%
Cardiology - Direct Access	354	356	-2	-0.6%
Radiology - Direct Access	28,245	25,268	2,977	11.8%
Pathology - Direct Access	1,394,178	1,354,756	39,422	2.9%
Therapies - Direct Access	13,881	14,338	-457	-3.2%
Audiology	3,594	4,915	-1,321	-26.9%
Midwifery	48	65	-17	-26.2%

Income £000s	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	136,236	135,367	869	0.6%
Private Patient/ RTA	1,145	1,225	-80	-6.5%
Trading Income	2,074	2,390	-316	-13.2%
Other Non Clinical Income	12,414	10,853	1,561	14.4%
Total Income	**151,869**	**149,835**	**2,034**	**1.4%**
Pay Costs	-110,849	-106,155	-4,694	-4.4%
Non Pay Costs	-57,124	-51,135	-5,989	-11.7%
Other	942	625	317	
Total Direct Costs	-167,031	-156,665	-10,366	-6.6%
Surplus/-Deficit from Operations	**-15,162**	**-6,830**	**-8,332**	**-122.0%**
Profit/Loss on Asset Disposal	0	6	-6	
Depreciation	-5,208	-5,516	308	5.6%
Impairment	0	0	0	
PDC Dividend	-2,151	-3,338	1,187	35.6%
Interest	-448	-351	-97	-27.6%
Total Indirect Costs	-7,807	-9,199	1,392	15.1%
Total Costs	**-174,838**	**-165,864**	**-8,974**	**-5.4%**
Net Surplus/-Deficit	**-22,969**	**-16,029**	**-6,940**	**-43.3%**
Donated Asset / Other Adjustment	46	240	-194	80.8%
Normalised Net Surplus/-Deficit	**-22,923**	**-15,789**	**-7,134**	**-45.2%**

Capital Programme – August 2016

Headlines

The overall capital programme of £11.0m currently excludes a bid for £5m of additional capital resources which are required to address urgent estates delivery plan issues. This bid for additional resources has been excluded from the current year capital resource limit pending development of the business case and subsequent approval by NHS Improvement.

Year to Date performance:-
After five months of the financial year, capital expenditure has increased to £3.1m across a range of headings. Commitments currently entered into amount to £6.6m.

The over-planning margin has also increased to £1.8m following the approvals made at the August joint Business Development Group & Capital Resource Group meeting.

A review of forecast capital expenditure is continuing and this will include a review of the over-planning margin to ensure that the Trust does not exceed its capital resource limit at financial year end.

Capital Investment Programme £000s	2016/17 Capital Programme	Expenditure at Month 5
Capital Resources		
Depreciation	11,519	
Interest Bearing Capital Loan Application. (Not currently approved by the NHSI.)	0	
League of Friends Support	1,000	
Cap Investment Loan Principal Repayment	-552	
Gross Capital Resource	11,967	
Less Donated Income	-1,000	
Capital Resource Limit (CRL)	**10,967**	**-**
Capital Investment		
Medical Equipment *	713	0
IT Systems	2,780	402
Electronic Document Management	1,112	293
Estates Strategy	2,500	39
Backlog Maintenance	2,258	190
Minor Capital Schemes	1,000	942
Pathology CLD	797	421
Vital Pac	338	155
Project Management	106	36
Brought Forward Commitments - Various	1,166	547
Sub Total	**12,770**	**3,025**
Donated Asset Purchases	1,000	348
Donated Asset Funding	-1,000	-320
Net Donated Assets	**0**	28
Sub Total Capital Schemes	**12,770**	**3,053**
Overplanning Margin (-) Underplanning (+)	-1,803	0
Net Capital Charge against the CRL	**10,967**	**3,053**

* Note: Inaddition medical equipment with a capital equivalent value of £2m is planned to be funded through revenue leasing in 2016/17.

Financial Sustainability Risk Ratings – August 2016

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 liquidity ratio of -17 days, a rating of 1.
  - The capital servicing capacity ratio of -5.94 results in a rating of 1.
  - The I&E margin of -15.2% results in a rating of 1.
  - The variance in I&E margin is -3.7%, a rating of 1.
  - As a result the overall Trust rating is 1.

Liquidity Ratio (days) £000s	2015/16 Outturn	2016/17 YTD
Opening Current Assets	25,115	25,080
Opening Current Liabilities	-39,869	-38,007
Net Current Assets/Liabilities	-14,754	-12,927
Inventories	-6,472	-6,320
Adj Net Current Assets/Liabilities	**-21,226**	**-19,247**
Divided by:		
Total costs in year	383,768	167,031
Multiply by (days)	360	150
Liquidity Ratio	**-20**	**-17**

Capital Servicing Capacity (times) £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual
Net Surplus / Deficit (-) After Tax	-47,759	-17,235	-22,969
Less:			
Donated Asset Income Adjustment	-947	-417	-348
Interest Expense	846	683	458
Profit/Loss on Sale of Assets	-29	0	0
Depreciation & Amortisation	12,664	5,216	5,208
Impairments	-411	0	0
PDC Dividend	6,940	2,151	2,151
Revenue Available for Debt Service	**-28,696**	**-9,602**	**-15,500**
Interest Expense	846	683	458
PDC Dividend	6,940	2,151	2,151
Temporary PDC repayment			
Working capital loan repayment	31,842		
Capital loan repayment	335		
	39,963	2,834	2,609
Capital Serving Capacity	**-0.72**	**-3.39**	**-5.94**

Financial Efficiency £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual	2016/17 YTD Variance
Normalised Net surplus/ deficit	-47,759	-17,235	-22,969	
Less fixed asset impairments/disposals	-440	0	0	
	-48,199	-17,235	-22,969	
Divided by:				
Total Income (excl donated assets)	-355,205	-150,426	-151,521	
I&E Margin	**-13.6%**	**-11.5%**	**-15.2%**	**-3.7%**

Financial Risks & Mitigating Actions – August 2016

Summary	
The Trust is actively revisiting the key assumptions underlying the financial plan and developing the 5 year Long Term Financial sustainability plan. A Financial Recovery plan is being developed to address the 2016/17 deficit, which includes four main workstreams to mitigate the financial pressures. This includes a detailed review of temporary workforce, increased procurement controls, efficiency review of theatre utilisation and length of stay improvements. The Director of finance has been in discussion with service leads to develop the action plans required.	
RISKS:-	**MITIGATING ACTIONS:-**
The following areas of risk have been identified in achieving the projected year end £31.3m deficit.	**The following mitigations have been identified to offset the risks identified above.**
1) Increased activity and capacity cost pressures, e.g. Junior Doctors' strike, RTT pressures, Escalation Wards, Radiology capacity and scoping.	Reduction in expenditure through discretionary spend controls and additional cost improvement schemes.
2) Unplanned operational cost pressures leading to reliance of agency staff at premium rates	Temporary Workforce Review. Tighter controls on authorisation of agency expenditure, success in international recruitment and negotiation of agency rates within prescribed caps.
3) Shortfall on delivery of CIPs.	Progress to be monitored through Integrated Performance Reviews and the Financial Improvement and Sustainability Committee
4) Fines and penalties exceed planned levels,.	Reinvestment by commissioners, as part of STF framework.
5) Under delivery of activity and income plans.	Improvement Programme; Patient Flow Project, Theatre maximisation Project.
6) STF funding is not secured as financial and operational targets are not met.	Ensure delivery of financial and operational targets recovered by year end.

Sustainability and Strategy

SUSTAINABILITY

1. STP
2. Developments

1. STP

- ESHT is participating fully in the STP.
- The East Sussex Better Together financial model underpins the STP financial model.
- The “Place Based Planning” element is being led by the ESHT Finance Director with the intention of refining and delivering the assumptions regarding integrated care delivery (ESBT)
- The Finance Directors (Provider productivity) group is working with a shared assumption of savings between 2-3% (East Sussex – 3%) including joint working across back offices, pathology, imaging (tbc) amongst other areas

2. Developments

Frailty – a multi agency frailty group has been established in East Sussex with representation from local authority, commissioners and providers. The group will develop an integrated frailty pathway and will then co-design an appropriate model to deliver the pathway.

Urgent Care – as part of the East Sussex Better Together programme a board has been established to redesign and drive forward innovation in how we deliver urgent care across the pathway.

Accountable Care – In East Sussex we recognise the challenge in whole system working and the opportunity for us to develop a sustainable provider model that meets the requirements and needs of the population. We are currently exploring with our partners how an accountable care model can support our shared ambition for high quality safe and sustainable services.

Leadership & Culture

LEADERSHIP & CULTURE

1. Workforce Executive Summary
2. Overview
3. Recruitment
4. Turnover
5. Workforce Expenditure
6. Absence
7. Mandatory Training
8. Engagement

East Sussex Healthcare NHS
NHS Trust

1. WORKFORCE EXECUTIVE SUMMARY – KEY POINTS

Actual workforce usage of staff in August was 6465.06 full time equivalents (ftes), 70.33 ftes above budgeted establishment.

Temporary staff expenditure was £3,655K in August (16.24% of total pay expenditure). This comprised £1,418K bank expenditure, £2,189K agency expenditure and £48K overtime. This is an increase of £338K overall compared to July.

There were 496.62 fte vacancies (a vacancy factor of 7.99%). This was a decrease of 67.56 fte vacancies.

Annual turnover was 9.76% which represents 521.99 fte leavers in the last year. This is a decrease of 0.26% compared to last month.

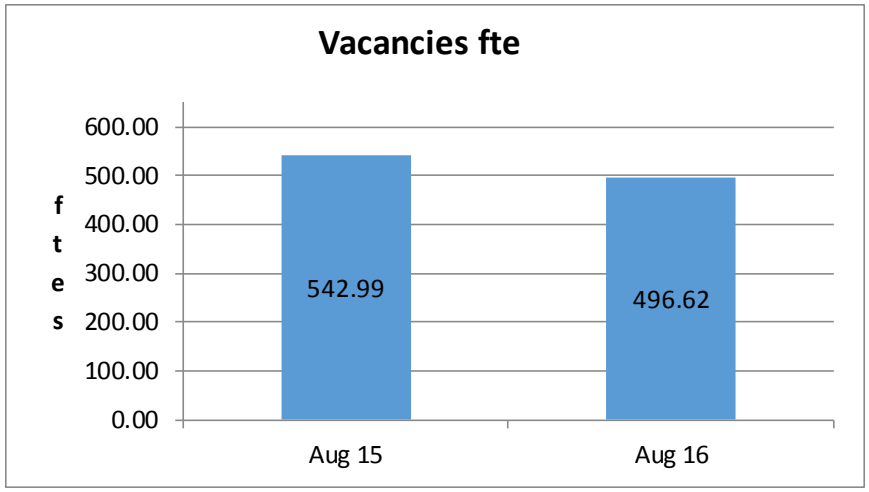
Monthly sickness was 4.10%, a marginal increase of 0.02% from July. The annual sickness rate was 4.39%, a slight decrease of 0.01%.

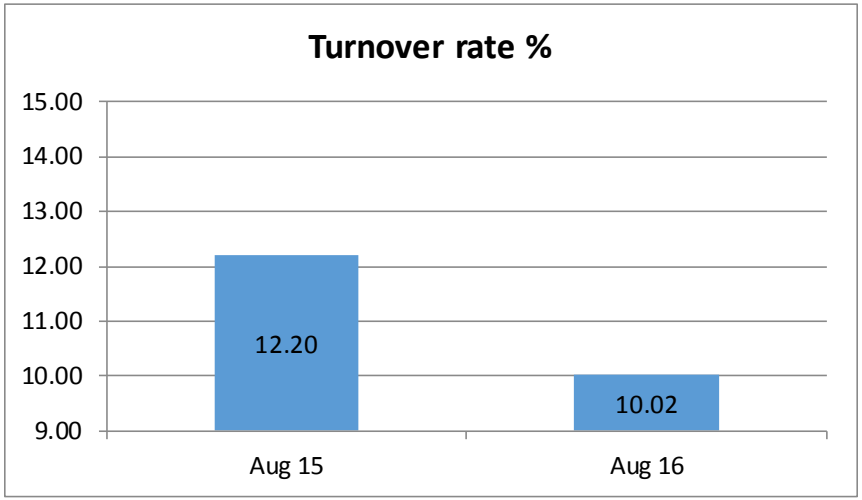
The overall mandatory training rate decreased by 0.59% to 87.24% as compliance rates fell marginally across all the mandatory courses, with the exception of Safeguarding Children Level 2.

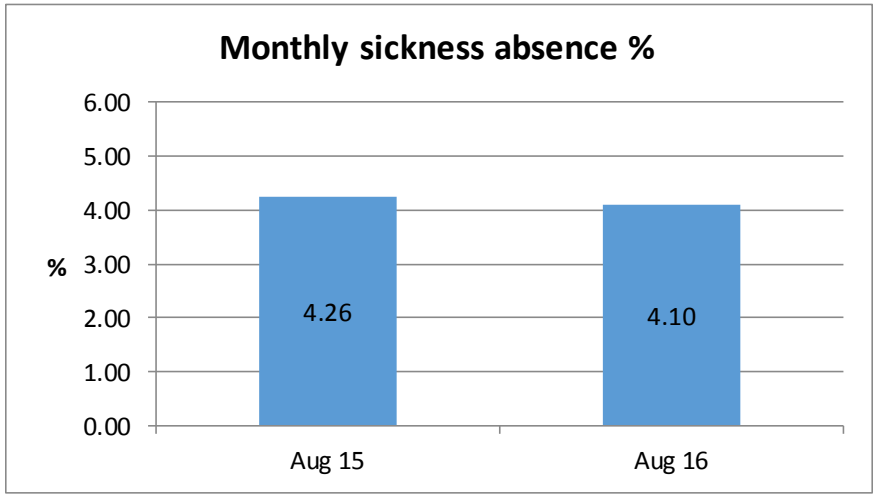
Appraisal compliance increased by 1.24% to 87.01%

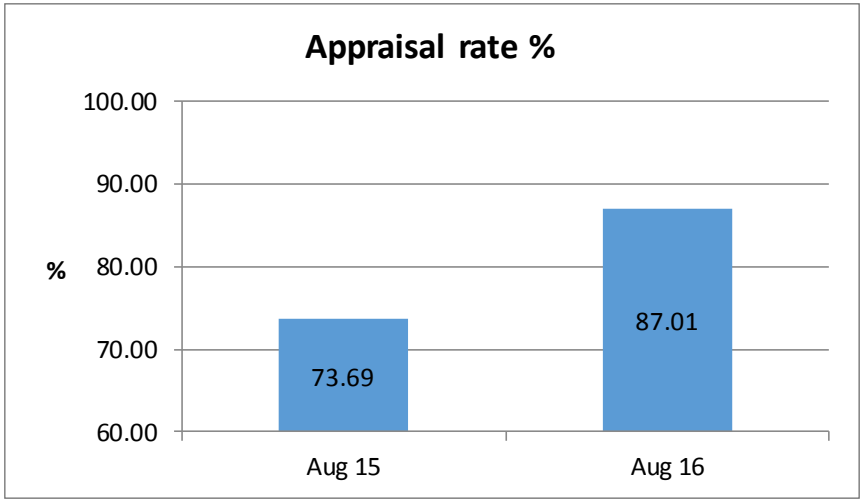
2. Overview

TRUST	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Trend line
WORKFORCE CAPACITY													
Budgeted fte	6244.41	6240.44	6028.97	6059.16	6057.38	6057.36	6057.39	6368.93	6381.23	6437.07	6328.78	6394.73	
Total fte usage	6237.90	6281.08	6236.91	6226.53	6282.89	6334.88	6492.33	6320.64	6340.02	6370.72	6380.32	6465.06	
Variance	6.51	-40.64	-207.94	-167.37	-225.51	-277.52	-434.94	48.29	41.21	66.35	-51.54	-70.33	
Permanent vacancies	542.14	514.02	479.35	479.90	464.71	422.43	342.18	606.76	579.45	611.23	564.18	496.62	
Fill rate	91.09%	91.55%	91.83%	91.87%	92.12%	92.84%	94.20%	90.17%	90.66%	90.23%	90.94%	92.01%	
Bank fte usage (as % total fte usage)	6.34%	6.34%	6.75%	6.68%	6.27%	6.65%	6.58%	6.97%	6.23%	6.26%	6.40%	6.31%	
Agency fte usage (as % total fte usage)	5.08%	5.30%	6.94%	6.45%	7.35%	7.06%	8.09%	5.29%	5.37%	5.49%	5.32%	5.71%	
WORKFORCE EFFICIENCY													
Annual sickness rate	4.86%	4.77%	4.72%	4.61%	4.54%	4.53%	4.53%	4.50%	4.46%	4.42%	4.40%	4.39%	
Monthly sickness rate (%)	4.36%	4.51%	4.60%	4.48%	4.45%	5.10%	4.79%	4.18%	3.94%	3.77%	4.08%	4.10%	
Turnover rate	11.77%	12.24%	12.07%	11.97%	11.79%	11.28%	10.62%	10.25%	10.00%	10.03%	10.02%	9.76%	
TRAINING & APPRAISALS													
Appraisal rate	77.60%	77.93%	81.83%	81.85%	83.34%	85.29%	87.26%	88.47%	89.68%	88.07%	85.77%	87.01%	
Fire	82.90%	82.77%	84.49%	83.49%	83.96%	85.07%	85.31%	86.25%	87.01%	87.62%	86.91%	85.51%	
Moving & Handling	85.24%	85.02%	85.81%	85.76%	86.93%	88.09%	88.25%	89.43%	89.57%	89.91%	90.58%	90.09%	
Induction	92.53%	91.89%	93.66%	90.95%	91.97%	92.79%	93.83%	93.67%	94.69%	94.38%	94.50%	93.73%	
Infec Control	85.82%	85.81%	86.83%	86.53%	86.99%	87.86%	87.37%	87.92%	88.40%	89.24%	88.97%	87.95%	
Info Gov	82.25%	83.41%	87.40%	86.42%	86.81%	86.23%	85.49%	84.78%	84.48%	84.51%	83.86%	83.64%	
Health & Safety	78.16%	80.03%	82.88%	83.67%	84.42%	85.35%	85.94%	86.74%	87.42%	87.95%	88.05%	87.75%	
MCA	93.18%	92.84%	93.39%	93.36%	93.10%	93.40%	93.10%	93.92%	93.37%	94.13%	94.09%	93.83%	
DoLs	91.44%	91.31%	91.81%	92.29%	92.78%	93.29%	93.81%	94.06%	95.35%	95.04%	95.68%	95.64%	
Safeguarding Vulnerable Adults	76.05%	76.05%	77.64%	78.06%	78.28%	79.06%	79.71%	81.54%	81.37%	83.10%	83.82%	83.06%	
Safeguarding Children Level 2	80.59%	80.40%	81.42%	80.75%	81.45%	82.46%	82.12%	83.25%	83.35%	82.93%	82.35%	82.43%	


Vacancies fte
600.00
500.00
400.00
300.00
200.00
100.00
0.00
ftes
542.99
496.62
Aug 15
Aug 16


Turnover rate %
15.00
14.00
13.00
12.00
11.00
10.00
9.00
12.20
10.02
Aug 15
Aug 16


Monthly sickness absence %
6.00
5.00
4.00
3.00
2.00
1.00
0.00
%
4.26
4.10
Aug 15
Aug 16


Appraisal rate %
100.00
90.00
80.00
70.00
60.00
%
73.69
87.01
Aug 15
Aug 16

3. Recruitment

The vacancy rates for key clinical staff groups have fallen this month. The medical vacancy rate has reduced by a further 1.90% to 12.37% (70.70 fte vacancies), for registered nursing & midwives the rate has reduced by a further 0.82% to 7.35% (144.10 ftes) whilst for unqualified nurses it has reduced by a further 2.74% to 4.38% (30.25 ftes).

The Trust annual turnover rate continues to fall, to a new historic low, at 9.76%, which equates to 521.99 fte leavers in year.

60 EU nurses have started in the Trust although 5 nurses have left the programme. 7 Filipino nurses started in September with another 30 nurses in the pipeline. There are plans to recruit an additional 50 nurses from the EU in 2016. The first 2 radiographers from the Philippines arrive in September with a further 18 in the pipeline.

The priority areas for medical recruitment remain Stroke and A&E. Placements have been arranged in A&E starting in September. Placements have also been arranged in Histopathology and a locum consultant in Haematology, will start on 26th September.

Open days and regular interview events are planned during October for unqualified nurses and there are plans to recruit another 150 unqualified nurses to the bank.

Facilities have 2 open days for substantive and bank recruitment planned for the 6th and 7th October

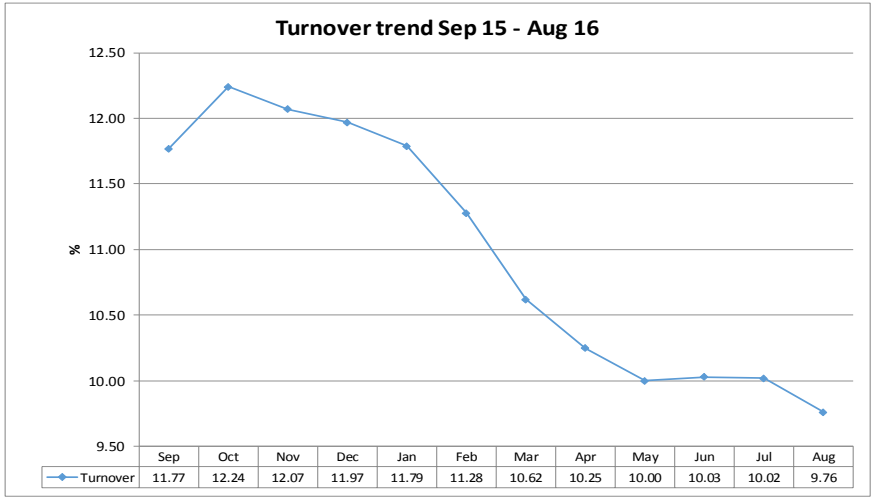
Facebook and twitter recruitment accounts are now live and showing very positive results.

A Workforce summit is planned for November for all Clinical Units to review recruitment/succession planning and future workforce requirements.

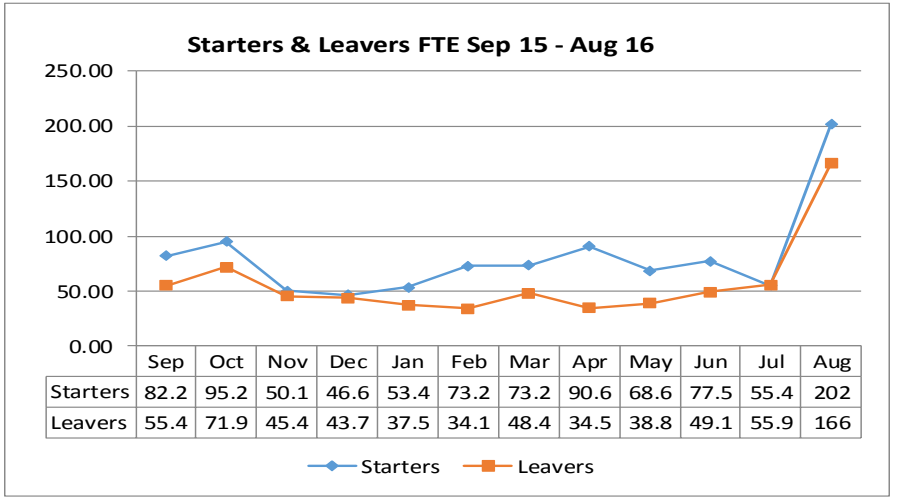
East Sussex Healthcare NHS Trust

4. Turnover

The steep increase seen in August is reflective of the junior doctors change over



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Turnover	11.77	12.24	12.07	11.97	11.79	11.28	10.62	10.25	10.00	10.03	10.02	9.76



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Starters	82.2	95.2	50.1	46.6	53.4	73.2	73.2	90.6	68.6	77.5	55.4	202
Leavers	55.4	71.9	45.4	43.7	37.5	34.1	48.4	34.5	38.8	49.1	55.9	166

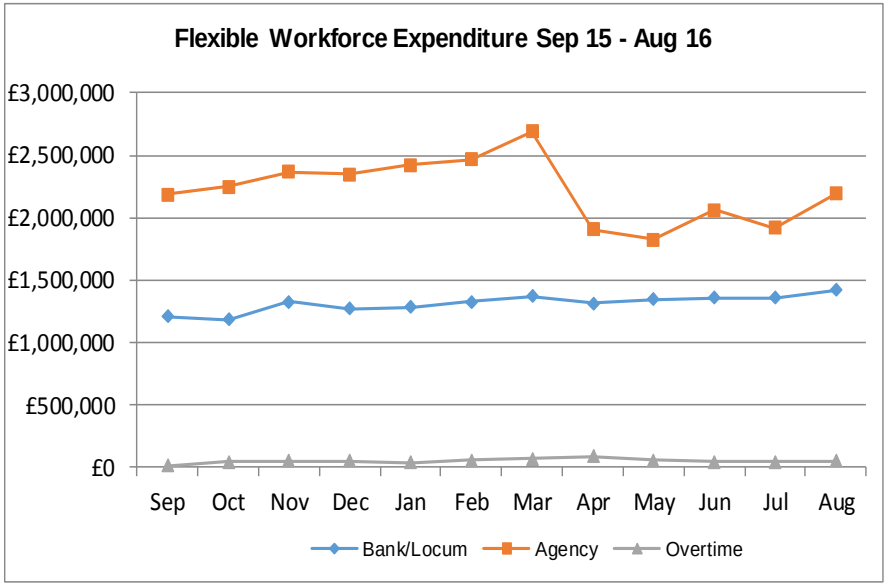
5. Workforce Expenditure

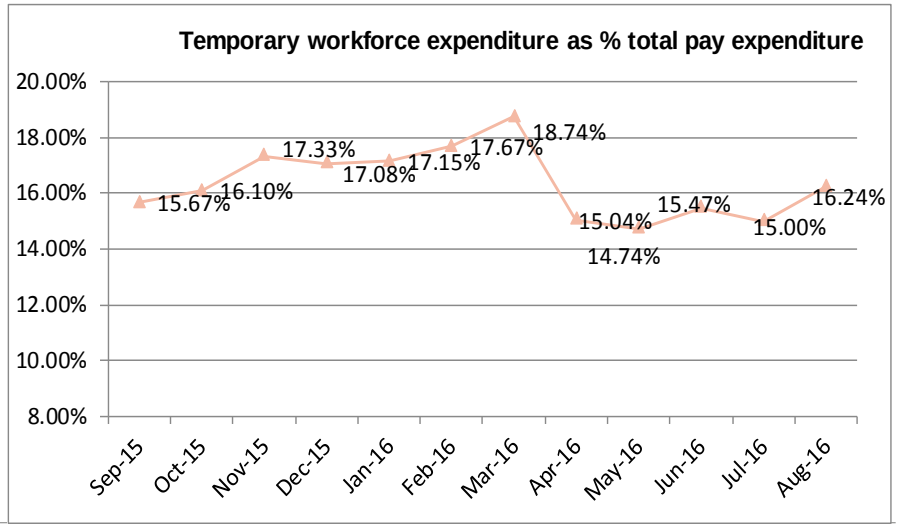
Temporary workforce expenditure has increased by £338K compared to July, this includes increases of £63K in bank expenditure, £271K in agency expenditure and £4K additional overtime.

The areas with the highest agency expenditure include medical staffing in Gastroenterology, Geriatrics, Womens & Childrens and nurse agency on the MAU wards and AAU, Jevington , Newington wards and the Stroke Unit.

Agency use has increased in the Contracting and Procurement whilst Clinical Coding recruitment means that this should reduce shortly. There was additional use of portering bank staff at Eastbourne, due to high sickness, whilst there was increased agency use in the Eastbourne Hospital Services area of Facilities due to extra activity which will result in additional income.

Additional bank usage occurred in Trauma & Orthopaedics plus the payment of backpay owing to a medical locum.





6. Absence

Monthly Sickness	2015	2016
March	4.77%	4.79%
April	4.65%	4.18%
May	4.24%	3.94%
June	4.30%	3.77%
July	4.21%	4.08%
August	4.26%	4.10%

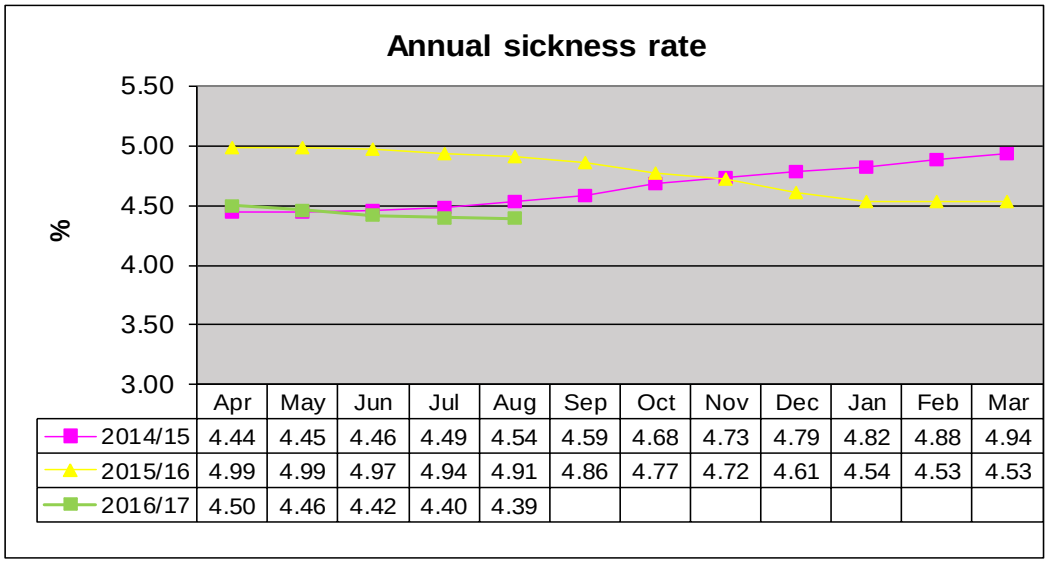
Monthly sickness has marginally increased this month by 0.02% to 4.10%.

The annual sickness rate has continued to decrease, by a further 0.01%, to 4.39%.

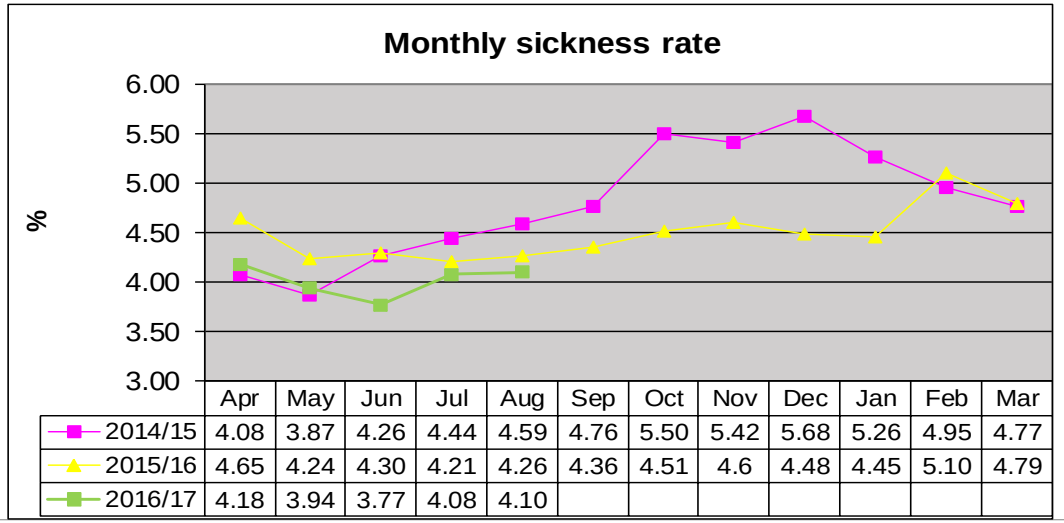
The highest rates of monthly sickness were amongst Professional, Scientific & Technical staff at 6.20% and Estates & Ancillary staff at 6.16%.

Figures from the Health & Social Care Information Centre show the monthly sickness rates for NHS Trusts, in May 2016, as 3.96%, at a time when our rate was 3.94%.

The highest reasons for sickness were musculoskeletal problems (other than back problems) and anxiety/stress/ depression/other psychiatric illnesses. Both have reduced since last month.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	4.54	4.53	4.53
2016/17	4.50	4.46	4.42	4.40	4.39							



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	4.45	5.10	4.79
2016/17	4.18	3.94	3.77	4.08	4.10							

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7. Mandatory Training

Mandatory training course	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	6 month trend
Induction %	93.83	93.67	94.69	94.38	94.50	93.73	
Fire %	85.31	86.25	87.01	87.62	86.91	85.51	
Manual Handling %	88.25	89.43	89.57	89.91	90.58	90.09	
Infection Control %	87.37	87.92	88.40	89.24	88.97	87.95	
Info Gov %	85.49	84.78	84.48	84.51	83.86	83.64	
Health & Safety %	85.94	86.74	87.42	87.95	88.05	87.75	
Mental Capacity Act %	93.10	93.92	93.37	94.13	94.09	93.83	
Depriv of Liberties %	93.81	94.06	95.35	95.04	95.68	95.64	
Safeguard Vuln Adults	79.71	81.54	81.37	83.10	83.82	83.06	
Safeguard Child Level 2	82.12	83.25	83.35	82.93	82.35	82.43	

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	87.42%	91.83%	97.09%	88.06%	89.26%	90.27%	95.98%	98.66%	85.98%	85.51%	88.45%
Urgent Care	78.74%	82.61%	84.62%	79.71%	62.32%	78.26%	86.74%	84.93%	75.69%	75.69%	82.38%
Medicine	85.49%	86.13%	92.13%	85.22%	78.70%	83.47%	90.34%	94.46%	81.08%	77.39%	88.07%
Out of Hospital Care	86.87%	93.01%	95.37%	93.37%	85.40%	88.59%	97.60%	99.06%	86.93%	82.13%	88.42%
Surgery	83.96%	89.18%	90.38%	84.88%	77.57%	88.66%	94.31%	95.37%	79.64%	81.89%	92.26%
Womens & Childrens	82.37%	85.90%	91.38%	83.49%	78.53%	86.38%	93.42%	92.80%	82.71%	89.01%	78.55%
COO Operations	87.47%	94.37%	94.23%	87.21%	91.05%	78.01%	n/a	n/a	n/a	n/a	81.63%
Estates & Facilities	80.60%	88.72%	97.96%	90.08%	87.52%	92.78%	100.00%	100.00%	100.00%	100.00%	86.35%
Corporate	92.55%	97.64%	100.00%	95.45%	92.00%	94.73%	100.00%	98.39%	95.95%	95.45%	88.64%
TRUST	**85.51%**	**90.09%**	**93.73%**	**87.95%**	**83.64%**	**87.75%**	**93.83%**	**95.64%**	**83.06%**	**82.43%**	**87.01%**

Additional pressures during August, including leave and absences have see a small deterioration in Mandatory Training figures. These are expected to improve over September.

The appraisal rate has improved and is up by 1.24% to 87.01%.

New appraisal paperwork has been introduced in September which provides clearer links to Trust objectives and values, as well as a 4 point rating scale to allow the opportunity for wider differentiation and to support talent management and development.

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

East Sussex Healthcare NHS Trust

8. Engagement

Clinical units are continuing to develop and implement their local plans for improving staff engagement and are following up on key actions linked to the last staff survey.

Clinical Administration have started a specific project with managers with the aim of ensuring that staff in this area will feel more engaged in their work .

The ESHT Vine programme has commenced with over three hundred staff asked to be ESHT Vine Champions. The Champions were invited to a drop in session to find out more about the role, which involves sharing the Trust theme of the week as widely as possible. Those who attended the drop in sessions were extremely positive. The Staff Engagement team will be working with the Champions to plan the next stage of this programme.

A celebration event, led by our Clinical Education Team, took place at the Cooden Beach Hotel, to celebrate the work of all of our staff who are mentors.

Plans are well underway for the Unsung Heroes celebration week in October This will include roadshows around the different sites sharing the good work all our support staff do and a celebration day where our Unsung Awards will be presented.

Arrangements have been made for the next annual Staff Attitude Survey which should be sent out to all staff at the end of September.

Activity

ACTIVITY

1. Activity overview

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Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Aug-15	Var	Yr	Last Yr	Var	
Primary Referrals	M	8019	8867	9145	8493	8194	8551	9360	9166	9241	9035	9534	8836	9088	8019	13.3%	45734	44416	3.0%	
Cons to Cons Referrals	M	1386	1418	1523	1471	1224	1278	1279	1293	1404	1425	2006	1651	1433	1386	3.4%	7919	7842	1.0%	
First OP Activity	M	10763	11862	11194	11525	10659	10297	11109	10988	10701	10878	11896	10793	11768	10763	9.3%	56036	57096	-1.9%	
Subsequent OP Activity	M	24062	26527	26189	26429	24469	24746	25648	25845	25406	25677	26906	24155	25745	24062	7.0%	127889	125457	1.9%	
New:FU Ratio	M	2.2	2.2	2.3	2.3	2.3	2.4	2.3	2.4	2.4	2.4	2.3	2.2	2.2	2.2	0.0	2.3	2.2	0.1	
Elective IP Activity	M	710	710	696	621	567	511	604	627	596	697	656	713	648	710	-8.7%	3310	3551	-6.8%	
Elective DC Activity	M	3753	3795	3733	3818	3532	3629	3800	3773	3512	3822	4114	4028	4147	3753	10.5%	19623	19130	2.6%	
Non-Elective Activity	M	3738	3833	3866	3641	3827	3800	3920	4077	4038	3772	3791	3875	3804	3738	1.8%	19280	20050	-3.8%	
A&E Attendances	M	8299	8685	8846	8476	8612	8731	8571	9398	8715	9573	9240	10144	9711	8299	17.0%	47383	45557	4.0%	
Ambulance Conveyances	M	2835	2755	2820	2823	2984	3072	2873	3106	2781	3010	2918	2954	2974	2835	4.9%	14637	14077	4.0%	
Average LOS Elective	M	3.1	3.1	3.0	3.0	3.2	2.7	3.0	3.0	2.7	3.4	3.0	3.1	2.4	3.1	-0.6	2.96	2.97	0.0	
Average LOS Non-Elective	M	5.1	5.7	5.5	5.7	6.2	5.7	5.9	6.0	6.1	5.8	5.5	5.6	5.9	5.1	0.8	5.79	5.36	0.4	

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Aug-15	Var	Yr	Last Yr	Var	
Community Nursing Referrals	M	2979	3485	3382	3391	3577	3974	3765	3840	3900	3770	3961	3991	3966	2979	33.1%	19588	13061	50.0%	
Community Nursing Total Contacts	M	34456	33905	33493	32544	34110	34210	32702	34518	33651	35501	36020	33700	34991	34456	1.6%	173863	172679	0.7%	
Community Nursing Face to Face Contacts	M	19743	18923	18836	18467	19111	18851	18386	19536	19123	20064	19516	19044	19682	19743	-0.3%	97429	101204	-3.7%	
% Patient Facing Time	60.0%	57.3%	55.8%	56.2%	56.7%	56.0%	55.1%	56.2%	56.6%	56.8%	56.5%	54.2%	56.5%	56.2%	57.3%	-1.1%	56.0%	58.6%	-2.6%	
Community Nursing ALOS	42.0	28.1	25.8	26.0	24.1	24.6	23.2	21.9	20.1	18.1	15.2	11.7	9.1	5.9	28.1	-22.2	11.94	34.40	-22.5	
SALT WL <13 Weeks %	85.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%			79.6%			
Podiatry WL <13 Weeks %	85.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%			80.3%			
Dietetics WL <13 Weeks %	85.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%				73.6%			
MSK WL <13 Weeks %	85.0%			100.0%	100.0%	98.0%	96.4%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%			99.2%			
SALT Total WL	M	0	0	125	116	107	110	115	117	146	160	0	176	202	0	202	684	0	684	
Podiatry WL Total WL	M	0	0	694	665	652	715	729	749	841	830	0	998	842	0	842	3511	0	3511	
Dietetics WL Total WL	M	0	0	295	269	249	246	195	146	73	32	0	43	0	0	0	148	0	148	
MSK WL Total WL	M	0	0	290	400	1068	1089	1143	211	101	101	0	1922	1922	0	1922	4046	0	4046	
IP ALOS (including Irvine Stroke Unit)	M	25.5	26.1	22.3	30.7	30.0	27.5	32.5	31.1	30.6	33.3	25.8	30.9	35.4	25.5	9.9	31.25	24.01	7.2	
IP Activity (including Irvine Stroke Unit)	M	138	165	131	119	121	88	72	89	92	97	85	85	87	138	-37.0%	446	765	-41.7%	

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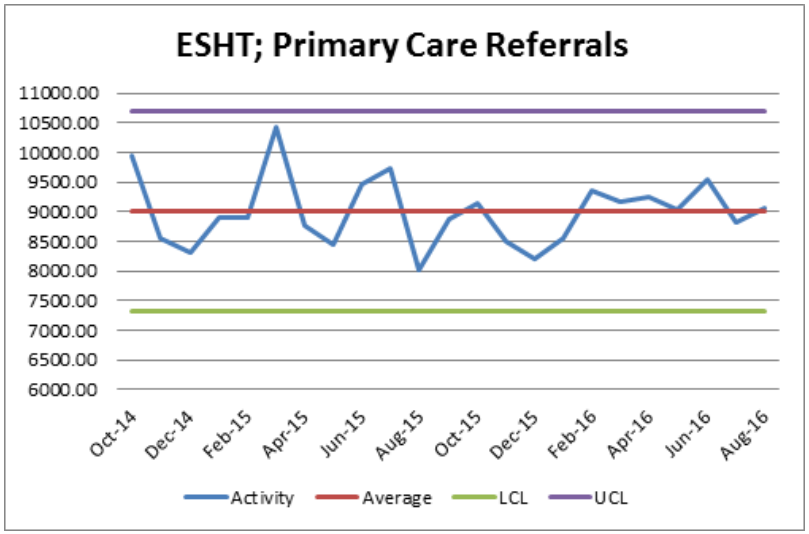
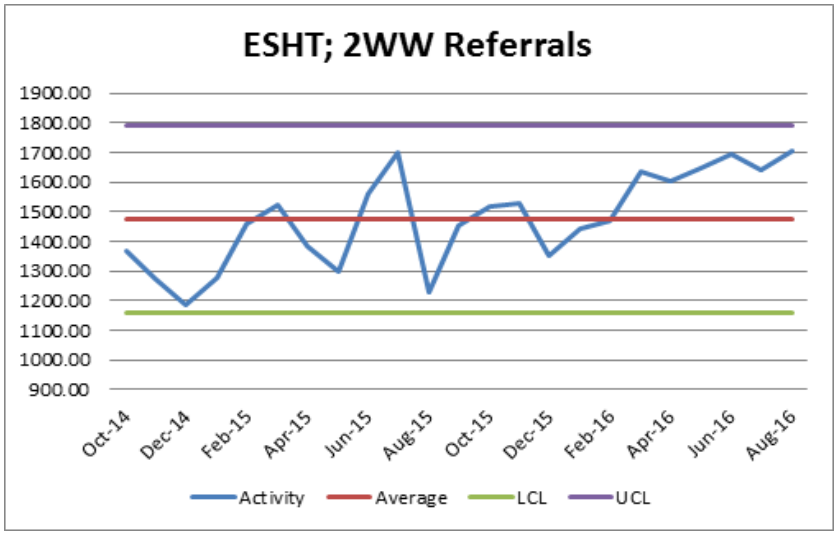
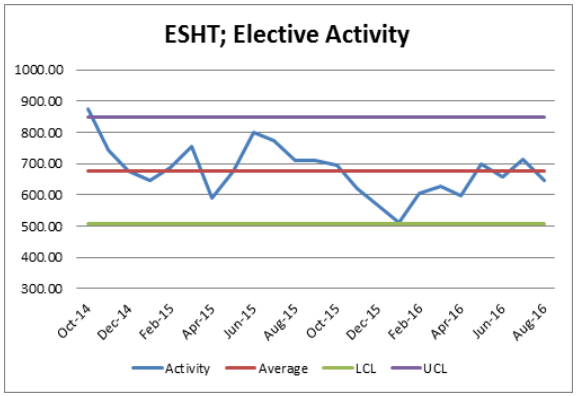
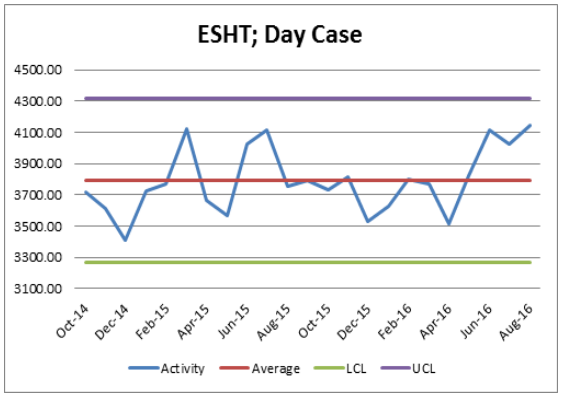
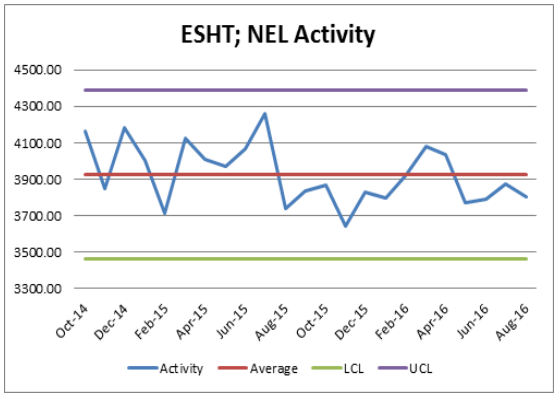











WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	11
Subject:	Urgent and Emergency Care Improvement Programme
Reporting Officer:	Matt Hardwick

Action: This paper is for **(please tick)**

Assurance	X	**Approval**		**Decision**	

Purpose:

ESHT 2020 states in its first strategic objective states: "Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients."

This paper outlines the details of the Trust's Urgent & Emergency Care Improvement Plan and provides a summary of five key workstreams that underpin the plan.

Introduction:

Demand for Urgent and Emergency Care (UEC) continues to grow nationally. The 2 A&E departments within ESHT have seen a 3.6% rise in attendances and a 2.9% rise in admissions via A&E over the past 12 months.

Patient safety remains the primary concern within the Emergency Departments (EDs) and as such the Trust is required to respond to this rising demand by providing prompt safe, high quality and effective care in its Emergency, Assessment and Gateway areas.

Clinical outcomes, mortality ratings and patient and staff well being will all clearly be impacted by poor Emergency Department (ED) performance and inadequate patient flow through acute, assessment and gateway areas. Effective inflow and outflow through EDs are equally essential in ensuring that non elective patient pathways are timely, efficient, and delivered in the optimum setting for each patient.

The Trust's performance against the national 4 hour A%E standard is inadequate and ESHT is currently amongst the poorest performing Trusts nationally. This is illustrated in Appendix 2 below that demonstrates a steady deterioration in performance against the 4 hour standard from June 2015

It is clear from the performance data, as well as reviews of operational effectiveness and staff feedback, that changes in the way the organisation delivers Urgent & Emergency Care are required. In addition, the wider local health and social care economy (the "system") has offered observation and support in improving the Trust's offer to those patients on non-elective pathways.

Appendices 1 -3 illustrate the rise in numbers of patients admitted via the EDs and the impact of admissions on performance against the 4 hour national standard

In March 2016 the Trust commissioned the North West's Academic Health Science Network (AHSN) Utilisation Management unit to review UEC low across both acute sites, to diagnose issues contributing to poor flow, and to make recommendations for improvement in ED flow and operational performance.

Site visits were carried out in April and May 2016 and a report with recommendations subsequently produced.

In July 2016 the Trust appointed to a new Hospital Director (HD) role for a 12 month period with a view to driving Urgent and Emergency Care improvements as well as taking the lead on operational issues across the Trust. The first cut of the ESHT Urgent Care Improvement Programme was produced and a weekly improvement project group convened, chaired by the HD

In August 2016: NHS Improvement (NHSI) published a national A&E Improvement Plan with the expectation that all systems will implement by November 2016.

The AHSN recommendations and the NHSI plan now form the basis of the Trust's UEC Improvement Programme.

This paper refers to the detailed project plan (produced and supported by the Trust PMO) and includes a summary document of the plan, broken down into 5 key themes.

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

The detailed project plan (Project Plan UEC v 19.0) is included with this paper in order that a full detailed overview can be reviewed. The improvement programme will continue over a period of months and is an ambitious programme of change that cuts across all operational aspects of the Trust's business.

The summary document Urgent Emergency Care Improvement Programme Trust Board provides a themed breakdown of key initiatives

The document Medical Model Urgent Emergency Care provides summary slides of a proposed new model of care for patients on non-elective pathways. This model was developed by senior decision makers at two clinical summit events held over Summer 2016 and is soon to be ratified at the Urgent and Emergency Care Board. The document should be read alongside "Medical Model to support EUC – Proposal notes" , which provides detail of the key principles of the new model of working – significantly the availability of specialists during the presentation and assessment stage of non-elective pathways where required leading to earlier onset of specialist care and treatment as required, in a setting appropriate for that patient

The summary plan provides details of the UEC Improvement Programme, themed into 5 key areas:

1. Improvements in A&E
2. Medical Model
3. Patient Flow/Discharge Planning
4. Capacity Planning
5. Governance

Benefits:

This improvement plan provides a level of detail and a number of actions that will contribute to an improvement in non-elective and elective flow across the Trust's acute and community sites.

Underpinning this plan is a detailed Project Plan supported by the PMO and updated weekly at a UEC Improvement Project Group chaired by the Hospital Director(HD)

Risks and Implications

There is a risk that the large scope of change, evident in the numerous actions identified within the project plan, proceeds in an uncoordinated way, with variable pace and grip. To mitigate this, the HD will drive the project via the weekly project groups, with support PMO and the Clinical Chair of the UEC board. The Chief Operating Officer is the Senior Responsible Owner of the Improvement Programme

Assurance Provided:

The Urgent & Emergency Care Board meets monthly to provide governance to the Improvement Programme and to oversee progress

- The UEC Board :
  - Is chaired by a clinician
  - Is cross-organisational
  - Will oversee the delivery of the UEC Improvement work plan
  - Reports to the executive via the Medical Division's Integrated Performance Review

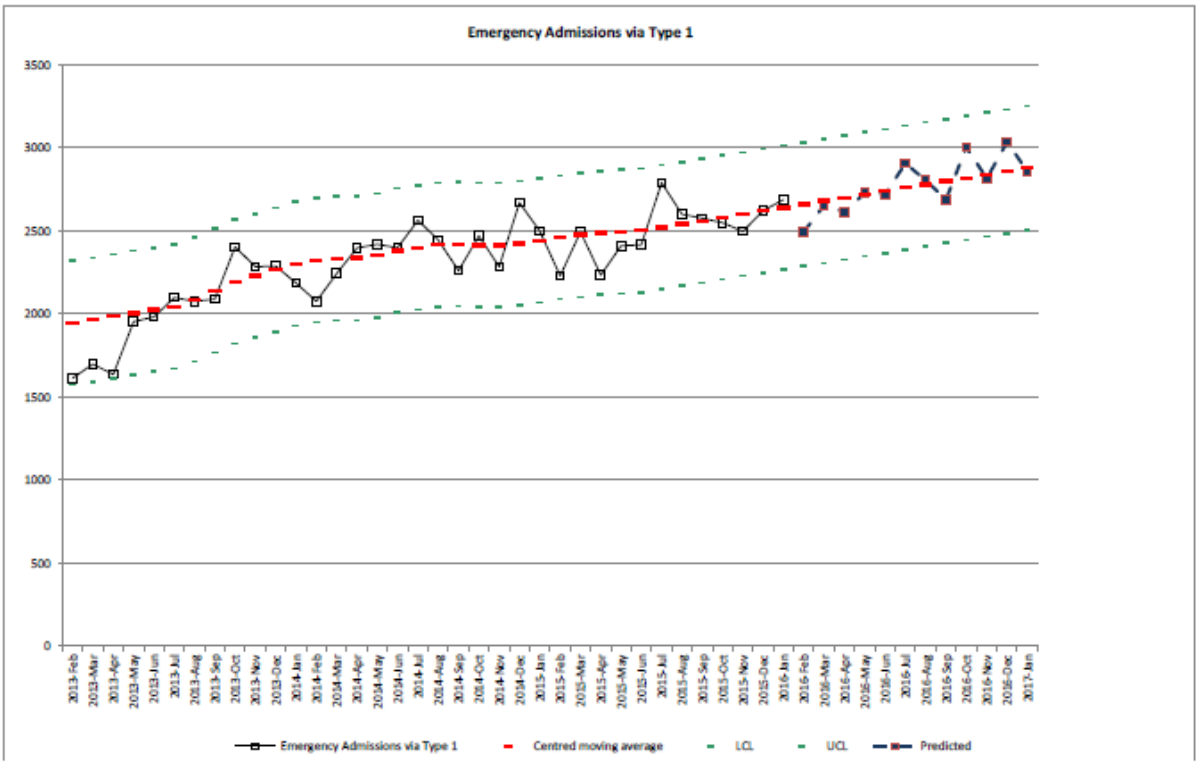
- The programme's objective is to improve emergency flow through our hospitals in order to improve:
  - Patient experience
  - Clinical outcomes
  - Staff experience and well-being

Proposals and/or Recommendations

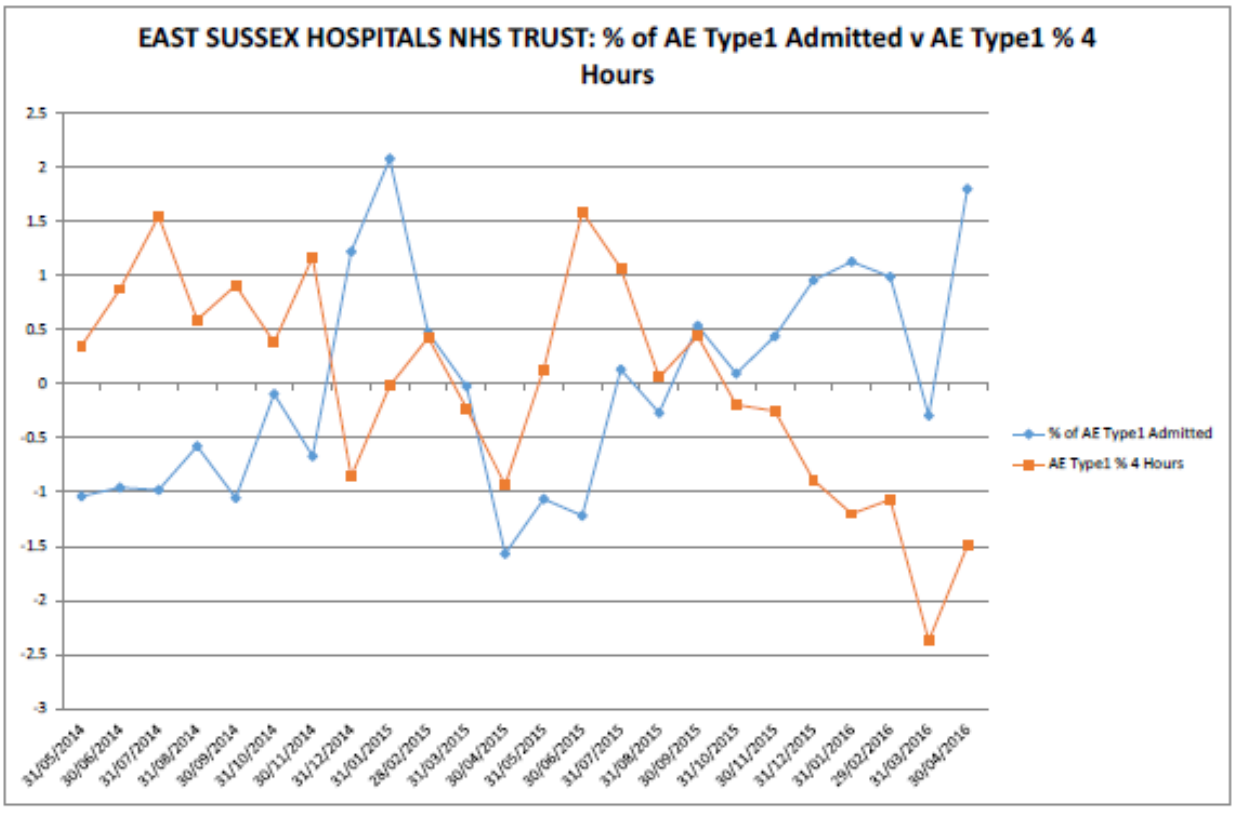
The Board are asked to note the contents of the Improvement Plan and to endorse this

For further information or for any enquiries relating to this report please contact:	
Name: Matt Hardwick **Hospital Director**	**Contact details: Ext. 7013**

Appendix 1- Emergency admissions showing a steady rise during the AHSN review period (Feb 2013 – Jan 2016)



Appendix 2 The data show an inverse relationship between ED '% T1 admitted' and 'T1 %4hr performance', i.e. as the proportion of admissions increases the % performance drops. A key issue for the Trust is the increasing conversion rate, so while 'Total Emergency admission' numbers have been fairly static over the 3 years reporting period 'Emergency Admissions Type 1' (via A&E) have increased steadily in the same period.



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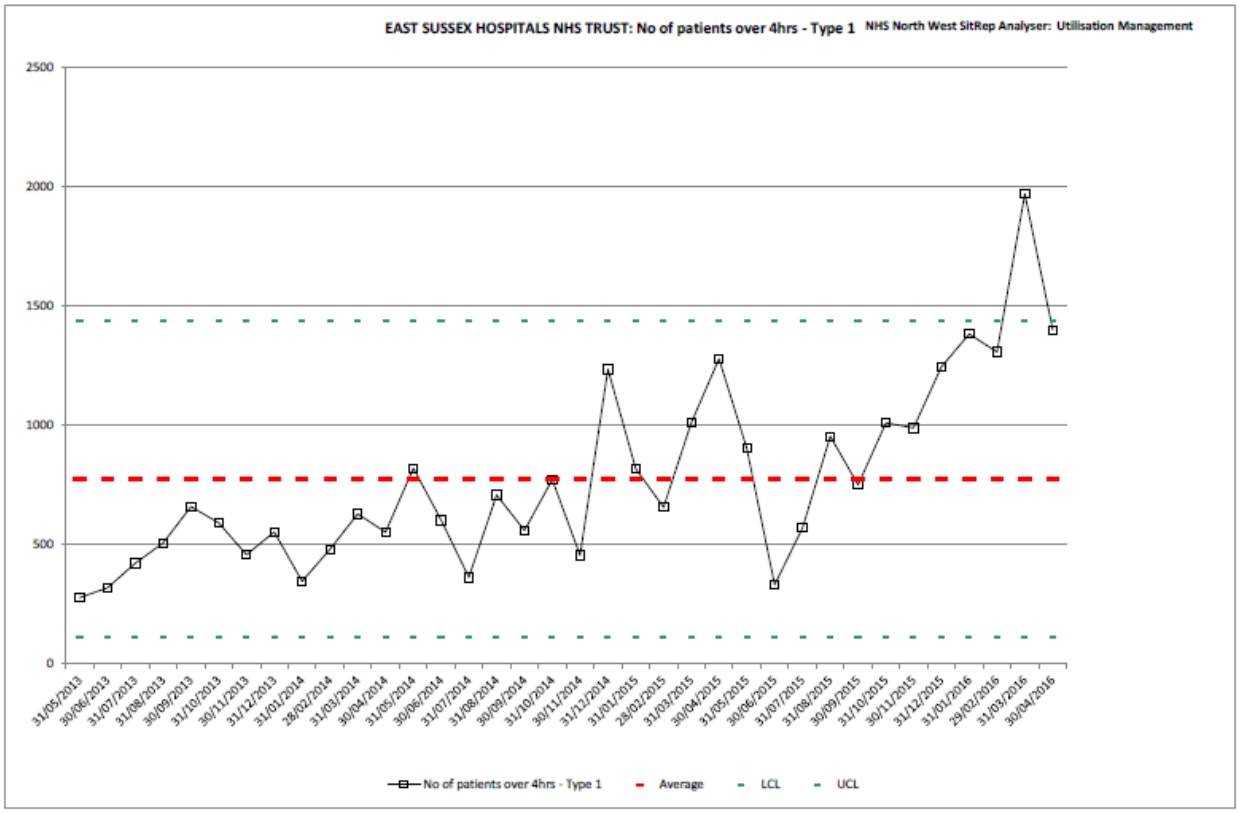
Appendix 3 Number of patients over 4hours Type 1



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TRUST BOARD

URGENT AND EMERGENCY CARE IMPROVEMENT PROGRAMME

5 KEY ACTIONS

Matt Hardwick
October 2016

A&E Process Improvements

- Initial assessment by senior doctor and streaming protocols implemented consistently across all specialties
- Rapid Assessment and Treatment (RAT) by senior clinicians implemented on both sites, in 4 hour “bursts”
- Staffing of all grades at 90% of complement; shifts staffed at 90% complement
- Nursing staff rosters flexed to meet daily peaks in demand
- Healthcare Assistant (HCA) in place to support ambulance handover during high activity periods in ED; handover times monitored at < 30mins. Continue to work closely with SECAmb to enhance patient safety during handover
- Ambulatory care facilities extended and protected; Ambulatory facilities for Surgery & Medicine introduced with immediate access to diagnostics as an alternative to admission via Acute Medical Unit (AMU)
- 4 hour standard for the treatment of “ minors” to be 100%
- “Discharge to Assess” protocols in place; Extended Hospital Inreach Team (HIT) fully effective.
- Clinical Decision Unit operational both sites. <24 hour length of stay achieved.
- Admit to assess protocols operational – assessment units are short stay with a “rule out “ mandate
- Out of Hospital pathways & processes strengthened to reduce attendances at ED that could be seen elsewhere

Revise Medical Model

- AMU established on both sites. <72 hour maximum length of stay implemented and achieved
- AMU on call physician presence increased to 1PA in the afternoons and at weekends
- Specialist medical input to AMU agreed and in job plans - (specialist available “in person” or via telephone advice)
- Hospital Inreach Teams established for Department of Medicine for the Elderly (DME) wards on both acute sites
- Frailty pathway to be established – includes streaming from ED/AMUs & direct booking in to “hot” clinics
- Direct admissions from GP referral improved– both to wards and to AMUs
- All metrics outlined here to be tracked and monitored for compliance

Patient Flow & Discharge Planning

- Admission avoidance strategies monitored & supported (e.g. Frailty teams, Crisis Response Teams, JCRs).
- SAFER Bundle implemented across both acute sites initially with subsequent roll out to Community settings
- SAFER bundle to include: All bedded patients to have confirmed Expected Date of Discharge (EDD), including EDD for transfer from ICU to ward, set within 14 hours by a Consultant. Daily reporting on achievement of EDDs.
- No EDD to be missed through delay in ESHT investigations/reports/assessment. EDDs can only be amended by a Consultant
- Green/Red Day initiative introduced across all wards – a green day indicates " an action" has taken place on a patient's pathway that day. Red days are to be eliminated or severely restricted
- All wards to have daily consultant/senior medic led Board & Ward round prior to midday. Ideally Board Round at 08:00 and ward round from 09:00. The Ward Round should proceed as follows: sickest patients first; then those with potential for discharge that day; then the remainder
- 40% discharges (or transfers from ward to discharge lounge) each day achieved by midday – tracked per ward
- Weekly MDT, including social services, all bedded areas for long stay patients of > 6 days

Develop Right Size Capacity

- Elective/surgical capacity to be ring fenced & protected. Urgent/medical patient hospital in-patient capacity to be seen as maximum capacity for these patients. Overspill of medical patients into surgical wards to be made only by exception & authorisation by Associate Medical Director /Hospital Director. Achievement to be tracked daily.

- Hospital inpatient capacity to be optimised. Sleep Studies unit to move offsite in order to enhance Day case facilities at the Conquest. This area to be protected. Further concentration of elective surgery at EDGH.

- Optimise day case provision of care – review all planned overnight stays & minimise – e.g. TPN patients to be day case only. Ensure robust pre-assessment processes in place to minimise risk conversion of day cases to overnight stays

- Urgent creation of additional step down/discharge to assess capacity in local community settings. 19 beds to be secured at Hastings Court and 10 at St Wilfrid's Hospice (Eastbourne)

- Domestic Care Support team to be created and provided by ESHT in order to deliver immediate 'packages of care' (currently funded by social services)– resource for 30 patients to be provided to enable immediate discharge home without delays / waiting for adult social care packages to commence

Strengthen Governance

- ☐ Chief Operating Officer to be the Senior Responsible Owner for the project
- ☐ Hospital Director/Associate Medical Director/Deputy Director of Nursing site leadership teams to take responsibility for daily operations
- ☐ Daily site safety meetings to ensure achievement of operational standards.
- ☐ Programme & performance to be tracked through Urgent & Emergency Care Board and Improvement Programme Steering Group
- ☐ Urgent Care Board to report through Medicine Division Integrated Performance Reviews
- ☐ Urgent Care Board to link to system-wide A&E Delivery Board (was East Sussex Better Together Urgent Care Board) and Hospital Flow and Discharge Group (was East Sussex System Resilience Group)
- ☐ Performance dashboard to be created showing processes/outputs/outcomes

Urgent and Emergency Care Improvement Project Plan

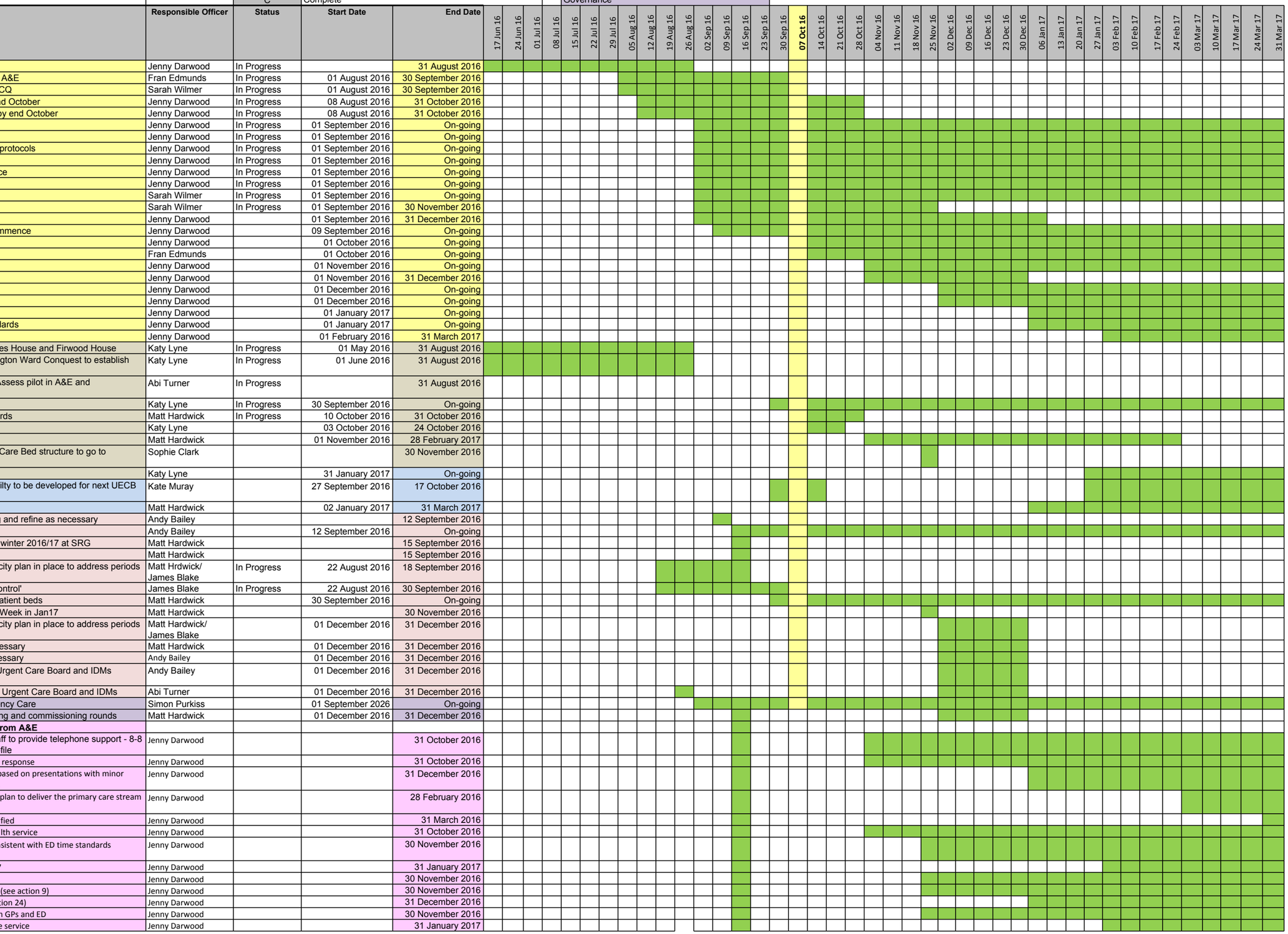
Urgent and Emergency Care Improvement Project

KEY		
G	Project delivering - no concerns	
A	Project Delivering with concerns being managed	
R	Project not delivering serious concerns	
U	Unplanned	
C	Complete	

A&E actions
Patient Flow and Assertive Discharge
Medical Model
Capacity Planning & Use of Information
Governance

A&E Rapid Imp Guidance: Streaming to Amb & Primary Care from A&E
A&E Rapid Imp Guidance: Improved Patient Flow
AHSN Recommendations

No	Actions	Responsible Officer	Status	Start Date	End Date
1	Review of initial assessment/streaming pilot	Jenny Darwood	In Progress		31 August 2016
2	Recruitment process for Paediatric Nurses in A&E	Fran Edmunds	In Progress	01 August 2016	30 September 2016
3	Recruitment process for Practice Dev Nurse CQ	Sarah Wilmer	In Progress	01 August 2016	30 September 2016
4	Redraft frailty job plans to be phased in by end October	Jenny Darwood	In Progress	08 August 2016	31 October 2016
5	Redraft remaining job plans to be phased in by end October	Jenny Darwood	In Progress	08 August 2016	31 October 2016
6	Implement ENP rota CQ	Jenny Darwood	In Progress	01 September 2016	On-going
7	Implement escalation protocols	Jenny Darwood	In Progress	01 September 2016	On-going
8	Implement final initial assessment/streaming protocols	Jenny Darwood	In Progress	01 September 2016	On-going
9	Implement streaming protocols	Jenny Darwood	In Progress	01 September 2016	On-going
10	Implement ambulatory emergency care service	Jenny Darwood	In Progress	01 September 2016	On-going
11	Implement Enhanced Co-ordinator function	Jenny Darwood	In Progress	01 September 2016	On-going
12	Implement RAT core hours EDGH	Sarah Wilmer	In Progress	01 September 2016	On-going
13	Deputy Heads of Nursing commence in post	Sarah Wilmer	In Progress	01 September 2016	30 November 2016
14	Nursing staff consultation on new rotas	Jenny Darwood		01 September 2016	31 December 2016
15	Review of internal professional standards commence	Jenny Darwood		09 September 2016	On-going
16	Ambulance Handover HCAs commence	Jenny Darwood		01 October 2016	On-going
17	Implement ENP rota EDGH	Fran Edmunds		01 October 2016	On-going
18	Paediatric nurses in A&E commence in post	Jenny Darwood		01 November 2016	On-going
19	Locum consultant starts Conquest	Jenny Darwood		01 November 2016	31 December 2016
20	Implement RAT core hours CQ	Jenny Darwood		01 December 2016	On-going
21	Review of frailty model commences	Jenny Darwood		01 December 2016	On-going
22	Implementation of new nursing rotas	Jenny Darwood		01 January 2017	On-going
23	Implement revised internal professional standards	Jenny Darwood		01 January 2017	On-going
24	Implement revised frailty model	Jenny Darwood		01 February 2016	31 March 2017
25	In-reach trial into Eastbourne DGH from Bowes House and Firwood House	Katy Lyne	In Progress	01 May 2016	31 August 2016
26	In reach trial from Bexhill Irvine Unit to Newington Ward Conquest to establish 'Ready for Rehab' model	Katy Lyne	In Progress	01 June 2016	31 August 2016
27	Consideration to be given to a Discharge to Assess pilot in A&E and implementation date	Abi Turner	In Progress		31 August 2016
28	Extend HIT team hours to 1800 finish	Katy Lyne	In Progress	30 September 2016	On-going
29	Implementation of SAFER bundle pilot - 4 wards	Matt Hardwick	In Progress	10 October 2016	31 October 2016
30	Review of in-reach trials	Katy Lyne		03 October 2016	24 October 2016
31	Roll-out of SAFER bundle across wards	Matt Hardwick		01 November 2016	28 February 2017
32	Business case for revised ASC Intermediate Care Bed structure to go to Governing Bodies for approval	Sophie Clark			30 November 2016
33	Extend HIT team hours to 2000 finish	Katy Lyne		31 January 2017	On-going
34	Model for AMU day , in reach support and frailty to be developed for next UECB meeting	Kate Muray		27 September 2016	17 October 2016
35	Revised medical model to be implemented	Matt Hardwick		02 January 2017	31 March 2017
36	Review how Urgent Care metrics are working and refine as necessary	Andy Bailey			12 September 2016
37	BI tools go live	Andy Bailey		12 September 2016	On-going
38	System level priority actions to be agreed for winter 2016/17 at SRG	Matt Hardwick			15 September 2016
39	SRG sign-off system dashboard	Matt Hardwick			15 September 2016
40	Ensure forward look for Oct-Dec16 and capacity plan in place to address periods of demand	Matt Hrdwick/ James Blake	In Progress	22 August 2016	18 September 2016
41	Agree capacity needed to create 'calm and control'	James Blake	In Progress	22 August 2016	30 September 2016
42	Implementation of ring-fencing of elective inpatient beds	Matt Hardwick		30 September 2016	On-going
43	Decision to be taken whether to hold Perfect Week in Jan17	Matt Hardwick			30 November 2016
44	Ensure forward look for Jan-Mar17 and capacity plan in place to address periods of demand	Matt Hardwick/ James Blake		01 December 2016	31 December 2016
45	Review escalation protocol and refine as necessary	Matt Hardwick		01 December 2016	31 December 2016
46	Review system dashboard and refine as necessary	Andy Bailey		01 December 2016	31 December 2016
47	Ensure capacity impact data is available for Urgent Care Board and IDMs	Andy Bailey		01 December 2016	31 December 2016
48	Ensure discharge impact data is available for Urgent Care Board and IDMs	Abi Turner		01 December 2016	31 December 2016
49	Implement Comms plan for Urgent & Emergency Care	Simon Purkiss		01 September 2026	On-going
50	Identify priorities for 2017/18 business planning and commissioning rounds	Matt Hardwick		01 December 2016	31 December 2016
51	**Streaming to Ambulance & Primary Care from A&E**				
52	1.1 Establish availability of senior medical staff to provide telephone support - 8-8 service to start with and adapt to demand profile	Jenny Darwood			31 October 2016
53	1.1 Agree time response standards for telephone response	Jenny Darwood			31 October 2016
54	1.2 Evaluate the need for a primary care stream based on presentations with minor illness, mental health and chronic disease - <20%	Jenny Darwood			31 December 2016
55	1.2 Design a primary care practitioner workforce plan to deliver the primary care stream service if justified	Jenny Darwood			28 February 2016
56	1.2 Establish a primary care stream service if justified	Jenny Darwood			31 March 2016
57	1.3 Evaluate the need for 24/7 liaison mental health service	Jenny Darwood			31 October 2016
58	1.3 Agree quality & time standards for access consistent with ED time standards	Jenny Darwood			30 November 2016
59	1.3 Establish access to mental health service 24/7	Jenny Darwood			31 January 2017
60	1.4 Ambulatory Emergency Care (see action 10)	Jenny Darwood			30 November 2016
61	1.5 Streaming to an appropriate assessment unit (see action 9)	Jenny Darwood			30 November 2016
62	1.6 Acute frailty service to be established (see action 24)	Jenny Darwood			31 December 2016
63	1.7 Direct admission to speciality ward areas from GPs and ED	Jenny Darwood			30 November 2016
64	1.8 Rapid response community/intermediate care service	Jenny Darwood			31 January 2017



65	**Improved Patient Flow**				
66	4.1 Implement SAFER bundle on all wards and audit the implemention of the 5 elements of the SAFER bundle	Matt Hardwick			28 February 2017
67	4.2 Consider implementing red and green day approach as part of the SAFER patient flow bundle	Matt Hardwick			28 February 2017
68	4.3 Carry out a baseline audit to establish use of EDD and CDD	Matt Hardwick			30 September 2016
69	4.3 Embed a clear definition of EDDs and CDDs in Trust policy	Matt Hardwick			30 November 2016
70	4.3 Plan for 50% of all patients to have an EDD linked to CCDs within 14 hours of admission to a ward	Matt Hardwick			31 December 2016
71	4.3 Plan for 75% of all patients to have an EDD linked to CCDs within 14 hours of admission to a ward	Matt Hardwick			31 March 2017
72	4.3 Audit the implementation of EDDs linked to CDDs	Matt Hardwick			28 February 2017
73	4.4 Test use of ward round checklists for 2 weeks by at least 2 consultant teams	Matt Hardwick			31 October 2016
74	4.4 Progressively roll-out checklists to be used on all wards	Matt Hardwick			31 March 2017
75	4.5 Implement internal professional standards	Matt Hardwick			31 December 2016
76	**Emergency Department - Do Now**				
77	Reiterate 4hr standard is a Trust-wide responsibility - tie up with 57	Kate Murray		01 October 2016	On-going
78	Review and revise criteria/protocol for both ED observation areas in line with clinical needs of ED patient cohorts and protect these spaces from use as breach avoidance areas	Jenny Darwood		01 November 2016	30 November 2016
79	**ED Performance - Do Now**				
80	Remind staff that the ED standard is primarily a quality standard and that attainment of at least 95% should reflect embedded and responsive high quality systems and processes	Jenny Darwood		01 October 2016	On-going
81	Adopt the philosophy and build the arrangements to support the ideal of "if care cannot be completed in 4 hours, it cannot be completed in ED or by ED clinicians	Kate Murray		01 October 2016	On-going
82	Engage with all wards and departments and reiterate their respective roles and responsibilities regards the 4 hour standard	Matt Hardwick		01 October 2016	On-going
83	**Data Quality - Do Now**				
84	Re-evaluate how ED records patient arrival and particularly patient left department to ensure that performance reports accurately and precisely	Jenny Darwood		01 October 2016	On-going
85	Improve data quality related to recording arrival and left department times in order to more precisely identify actual performance levels	Jenny Darwood		01 October 2016	On-going
86	All clinical staff to be reminded of their responsibility to keep accurate records and this should be randomly audited and compliance with accurate data recording should be consistently reviewed as part of all staffs' PDP/PDR process	Jenny Darwood		01 October 2016	On-going
87	Each step in patient ED journeys to be actively monitored in order to establish whether/which ED processes can be improved and to highlight delays that are related to speciality response and/or discharge processes that delay admission - a) Arrival to triage times in each area of the ED b) Arrival to be seen by clinician times in each area of the ED: RCEM standard 1 hour c) Arrival to referral times for each cohort of patients which should not habitually exceed 2 hours d) Arrival to left ED times	Jenny Darwood		01 October 2016	31 October 2016
88	**Admission & In-house Speciality Teams - Do Now**				
89	Review, and revise where applicable, protocol for assessment areas, eg 'assess to admit', 'assess to discharge'	Jenny Darwood		01 October 2016	31 October 2016
90	Monitor and manage adherence to protocol for assessment areas, and review in line with changing patient needs over time	Jenny Darwood		01 October 2016	31 October 2016
91	Protect assessment space to avoid using as: a) a 'stepping stone' to ward beds where it is clear a ward bed is required; b) a 'holding' area or alternative to a ward bed; c) a breach avoidance space.	Jenny Darwood		01 October 2016	On-going
92	Aim to reduce LoS in assessment areas in line with protocol and clinical needs of patient cohorts in order to maximise assessment capability	Jenny Darwood		01 October 2016	On-going
93	Review reason/s for step reduction in direct admission numbers around Mar/Apr14 and re-assess the need for asessment spaces in line with other recommendations related to increasing direct admission numbers and the zero day rate	Andy Bailey		01 October 2016	31 October 2016
94	Mandate declaration of empty beds as they become vacant, unless there is an exceptional circumstance, eg cardiac arrest on the ward	Sara Songhurst		01 October 2016	On-going
95	Review and standardise the format of MDT meetings, focus on specified discharge dates including: a) who should attend; b) who will do what and by when; c) identify and communicate patients with potential to exit via the discharge lounge	Kate Murray		01 October 2016	28 February 2017
96	Examine ways to improve bed availability which more closely maps the ED requirement for beds through better utilisation of discharge lounges, increased speciality response/senior response from admitting teams	Matt Hardwick		01 October 2016	31 March 2017
97	Increase direct admission numbers in order to reduce the number of patients accessing hospital resources via ED	Kate Murray		01 October 2016	31 March 2017
98	Use analysis of data to review assessment service capacity with clinicians (where capacity is seen as resources not beds per se) and the current configuration of assessment space	James Blake		01 October 2016	31 October 2016
99	**Activity Prediction - Do Now**				
100	Activity predictions should be calculated based on the upper limits of expected activity, not averages, data should also be seasonally adjusted and trend	Andy Bailey		01 October 2016	31 October 2016

101	Work to predict more than one day ahead and communicate likely requirements to ward staff and community partners	Matt Hardwick		01 October 2016	31 October 2017
102	Establish and articulae the required discharge numbers (based on expected upper limit admission numbers) which will bring the organisation into balance each day.	Andy Bailey		01 October 2016	31 October 2017
103	Ensure all discharge patients have a discharge time and an expectation that the	Matt Hardwick		01 October 2016	28 February 2017
104	**Support Services - Do Now**				
105	Communicate clear expectations of what is required of staff, eg discharge times and shift from using vague language such as 'soon' or 'later'	Matt Hardwick		01 October 2016	28 February 2017
106	Undertake a review of diagnostic service provision in the context of known and predicted in-patient and out-patient activity levels, set 'maximum wait time' KPIs, in particular for urgent requests and monitor to understand key issues when 'wait times' are not achieved and review opportunities to extend support and diagnostic services to correspond with 'demand', eg across to 7 days for 18 hours per day	Michele Elphick		01 October 2016	28 February 2017
107	Review and reiterate the criteria for accessing the Discharge Lounge, and the locations and facilities in order to maximise potential for increasing throughput	Matt Hardwick		01 October 2016	28 February 2017
108	Utilise the information generated by Discharge Lounge staff in order to develop the service in line with organisational requirements/changes	Matt Hardwick		01 October 2016	28 February 2017
109	Consider a low/zero tolerance from wards that do not use Discharge Lounge when there is no demonstrable clinical reason	Sara Songhurst		01 October 2016	28 February 2017
110	Carry out a review of administrative processes to establish the extent to which poor or lack of necessary equipment impacts on efficiency	Matt Hardwick		01 October 2016	28 February 2017
111	Manage 'demand' including implementing escalation measures, addressing the ability to respond clinically, ie the ability to actively treat, rather than opening beds in order to queue patients	Kate Murray		01 October 2016	31 March 2017
112	**Trust and Partner Organisations - Do Now**				
113	Ensure every consult has an outcome and supports patients progression on their pathway	Kate Murray		01 October 2016	28 February 2017
114	Review together definitions/terminology, eg 'medically fit' (MFFD) versus 'community fit', using national definitions where there are available and agreeing common language where local definitions are required	Matt Hardwick		01 October 2016	28 February 2017
115	**Emergency Department - Do Soon**				
116	Consider every wait beyond 12 hours total time in ED (total time as measured from arrival) as a potential critical incident	Kate Murray		01 November 2016	On-going
117	Establish the escalation point/time for patients approaching a total time of in ED of 12 hours, eg 8 hours or 10 hours, and escalate to the appropriate on-call Director and Speciality Consultant for timely resolution	Jenny Darwood		01 November 2016	30 November 2016
118	Monitor and manage 'excess' cubicle hours, ie all waits over 4 hours, aiming to reduce the impact on patients and ED staff capability	Jenny Darwood		01 November 2016	30 November 2016
119	Formalise triage processes with the use of clinical criteria such as 'Manchester Triage'	Sara Songhurst		01 November 2016	30 November 2016
120	**Admission & In-house Speciality Teams - Do Soon**				
121	Review with senior clinicians (assessment area leads in particular), diagnostics and other in-house teams ways of working that would enable an increase in the number of short stay admissions	Kate Murray		01 November 2016	31 March 2017
122	Review medical cover arrangements and expectations for response times out of hours and at weekends	Kate Murray		01 November 2016	31 March 2017
123	Review practices and/or protocol that currently allow patients to back track in the system	Jenny Darwood		01 November 2016	31 March 2017
124	Consider implementing a formal 'triage' process for direct admissions in order to improve pathway quality and to demonstrate a method of clinical risk stratification	Kate Murray		01 November 2016	31 March 2017
125	Record, monitor and manage wait times for direct admissions in order to understand and address cause/s of any delays, eg overnight backlogs	Jenny Darwood		01 November 2016	On-going
126	Work to ensure medical outliers have inputs equivalent to patients on base wards	Kate Murray		01 November 2016	31 March 2017
127	Allocate/ring-fence specific resource/s to maintain the momentum of engagement with clinical leaders to support actions related to clinical pathways, increasing the Trust's zero day rate and reducing LoS	Kate Murray		01 November 2016	31 March 2017
128	**Activity Prediction - Do Soon**				
129	Review, and revise if necessary, escalation plans, otherwise work to the plans, avoid disregarding them in periods of sustained escalation	Matt Hardfwick		01 November 2016	On-going
130	Work through policy development/SOPs to reduce dependence on individuals in order to attain sustainable systems and processes	Matt Hardwick		01 November 2016	On-going
131	**Length of Stay - Do Soon**				
132	Carry out further analysis of discharge cohorts to fully understand the 'case mix' and address any mismatch between the type (speciality) of beds that become available; by time of day, day of the week and compared to what is actually required	Andy Bailey		01 November 2016	28 February 2017
133	**Trust and Partner Organisations - Do Soon**				
134	Review and amend where applicable the frequency of 'panel' meetings related to provision of equipment and/or funding	Abi Turner		01 November 2016	On-going
135	Establish timeframes for 'waits', 'referral to assessment' (eg by care homes); 'assessment to response' (ie is the patient/client accepted?); 'acceptance to discharge'	Matt Hardwick		01 November 2016	30 November 2016
136	Engage with clinicians to establish which conditions actually need follow up, which require GP input and which could potentially be managed through other services, eg non-Type 1 facilities	Kate Murray		01 November 2016	31 March 2017

137	Work together to ensure robust arrangements for GP and other health care professional (HCP) referrals direct to assessment services where possible through: a) development of additional direct referral protocols with speciality clinicians b) implementing flexible capacity arrangements in assessment units, ie avoiding precise limitations on patient numbers so that direct admission routes do not fail through lack of assessment beds	Jenny Darwood		01 November 2016	31 March 2017	
138	Review weekend working arrangements in order to improve patients timely acces to the most appropriate service/s, reduce unnecessary hospitalisation ad reduce the effects of 'peaks and troughs' which contribute to system pressure particularly at the start of the week	Kate Murray		01 January 2017	31 March 2017	
139	Trust partners should monitor and manage occupied bed days as the primary measure of hospitalisation rather than emergency admissions as there is an inherent conflict between 4 hour compliance and containing overall admissions	Andy Bailey		01 November 2016	On-going	
140	CCGs should, if not already in place, consider a local tariff for short stay admissions that reflects the assessment costs of patients in short stay assessment areas in order to incentivise true capacity to treat	Jenny Darwood		01 November 2016	31 March 2017	
141	CCGs should consider a 'cap and collar' on admissions greater than 1 day LoS to incentivise that any new activity associated with increased admission rates exhibits specifically as short stay admissions	Jenny Darwood		01 November 2016	31 March 2017	
142	**Admission and In-house Speciality Teams - Do Later**					
143	Monitor any delays from GP referral to patient arrival and work with ambulance services to understand and address causative factors	Jenny Darwood		01 January 2017	On-going	
144	Develop services profiled for an ageing population and use data to establish likely growth in numbers and health and social care needs. In the interim: a) strive to allocate resources to achieve equitable access and outcome for older people and at the same time reduce unnecessary bed delays b) review and amend the approach to older people's needs and services (where service is the ability to assess/treat/manage appropriately rather than just a bed space) c) if not already in place develop a frailty strategy that includes sufficient capacity to assess, manage, support and discharge older people in a much more timely way than at present d) establish the 'complexity' of local populations and aim to manage these in a more holistic way, ie all partners should target 'step down' that provides a range of specialist support. Hub models have been shown to work well in other settings.	ESBT		01 January 2017	On-going	
145	**Length of Stay - Do Later**					
146	Consider implementing a 'stipulated length of stay' for common admission groups (ICD10 or HRG) that is based on the time required to complete the key elements of a care pathway, referencing best practice guidance such as 'Map of Medicine' or Advancing Quality Pathways	Matt Hardwick - combine with 154		01 January 2017	28 February 2017	
147	**Trust and Partner Organisations - Do Later**					
148	Include all parties in discussions as managing 'out of area' activity (discharging across boundaries) can be problematic and small numbers of 'out of area' patients can contribute to a disproportionately high number of bed days	Matt Hardwick		01 January 2017	On-going	
149	**Recommendations to be picked up through ESBT**					
150	Consider adopting/developing a ' discharge to assesss' approach			01 October 2016		
151	Trust and partners should prioritise admission avoidance schemes and initiatives to reduce hospital length of stay specifically for older people			01 November 2016		
152	Agree a common baseline for what is 'acute' or hospital level care and that which can safely be delivered in a community setting in order that patients continue to progress to discharge where this is appropriate, acknowledging that some patients such as elderly/clinically fragile, will fluctuate in terms of clinical needs but that hospital need not be the default place of care			01 November 2016		
153	Work together and use data to review what is required of community services/facilities, including care homes, based on patient/client population needs. This should take account of clinical needs, inputs related to 'complexity' (eg confused, non-compliant patients, those who need assistance to mobilise and those with rehabilitation potential			01 November 2016		
154	Examine opportunities to divert people from ED provision through the developmetn of alternative pathways ensuring that patients' needs can be met through alternatives to hospital where this is clinically appropriate			01 November 2016		
155	Use available data to evaluate their future model/s of care delivery in anticipation of an ageing population, that the average non-elective patient will be a pensioner and that the most elderly, ie over 85 years, will consume twice as many hospital bed days as another other group unless alternatives are focussed on older, 'complex' cohorts			01 November 2016		
156	Evaluate the potential to commission targeted services for the most frail and oldest patients with a view to reducing overall hospitalisation as measured by occupied bed days per 1,000 population for patients over 65 years			01 November 2016		
157	Work with community partners on predicting activity at site level and anticipating likely requirements for placements, packages of care, etc. and consider incorporating into winter plans/health and social care economy response			01 January 2017		

Actions
Electronic breach analysis implemented in Emergency departments
ESBT & SRG approval to fund 3 x Paediatric Nurses in A&E per site
Frailty Practitioners commenced & logging patients on IBIS
Workforce Capacity & Demand Review
Review of Service Manager structure & consultation
Specialist Nurses & Sussex Partnership Trust (SPT) log patients on IBIS
Amy Collis on Intraprenneur for Ambulance Handover delays
Revised Service Manager structure implemented
1 x Middle Grade/SHO commenced EDGH
Recruitment process for Amb Handover Support Nurses
HCAs supporting initial assessment/streaming pilots
5 x Safety Huddles a day implemented
Revised initial assessment protocols implemented
Deputy Heads of Nursing Interviews
2 x Middle Grade commenced EDGH
Draft SOPs/clinical protocols for key processes, eg triage, nurse ordered diagnostics, for sign-off at CU business meeting
Ensure all SOPs have final approval and shared with departmental team
AFC banding for Paediatric Nurses for A&E (3 x posts per site) to be agreed
Locum consultant starts EDGH
1 x SpR and 1 x Speciality doctor commences Conquest
A&E B7 Nurse Awayday - Leadership & Engagement
1 x Middle Grade/SHO commences Conquest
Review EKBI reporting tools
Produce mock-up of IDM level dashboard
Generate, agree and go live with two tests of change
Produce first cut of capacity plan
Decision on which EKBI tools to procure/replicate
Decision whether to provide long range 'forward look' internally through SHREWD or through AHSN and to include all gateway areas
Decision to be made on UC metrics to be added to CU performance reports
Carry out forward look on demand for 1st-7th October 2016
Frailty Practitioners and Crisis response teams working closely with HIT team
Discussions taking place with commissioners over extension of working hours of the HIT teams
Deep dive on discharge developments at Emergency Care project group
Agree common definition of 'good to go' at Discharge Improvement Group
Project group deep dive with HoNs on the SAFER Patient Flow Bundle, ie EDD, flow, early discharge, weekly review of extended los patients, and support for piloting on a ward each site
Discussions with HONs to decide which wards to pilot SAFER patient care bundle and date for implementation

Proposal for revised ASC Intermediate Care Bed structure to go to Integrated Locality Working Group 17/08/16
Organise summit for consultants
Draft presentation for ESBT Urgent Care Board
Obtain ESBT Urgent Care Board commitment to support work & lead names from partner organisations
Presentation of draft principles of ESHT model of care, rules, behaviours and workforce implications to IDM
Impact data of test of changes to be presented to IDM
Agree principles of revised medical model with consultants including testing assumptions
Principles of revised medical model to be discussed with CU and Speciality Leads
Further consultants workshop to agree medical model - 13.09.16
Commence comms planning for medical model and urgent care vision
Draft UCB TORs for sign-off at first meeting
Appoint chair of Urgent Care Board (UCB)
Draft Urgent Care vision for sign-off at Urgent Care Board
Date for First Urgent Care Board agreed
Build on the workdone around site meetings; using the key 'pressure indicators' such as: a) ED attendances; b) Discharge numbers; c) Medical outlier numbers.
Ensure levels of escalation are communicated to hospital and community partners (if they cannot attend)
Resist moving staff from the Discharge Lounge areas to cover other areas, especially at busy times, as this reduces the ability to increase/maintain flow and ultimately contributes to ED backlog
Actively monitor and manage 4-12 hour waits throughout each hour of delay rather than at 4 hours and then 12 hours

Responsible Officer	Status	Start Date	End Date
Jenny Darwood	Complete	01 May 2016	On-going
Jenny Darwood	Complete		31 May 2016
Jenny Darwood	Complete	09 May 2016	On-going
Jenny Darwood	Complete	21 May 2016	29-Jun-16
Jenny Darwood	Complete	03 June 2016	8-Jul-16
Jenny Darwood	Complete	01 July 2016	On-going
Jenny Darwood	Complete	02 July 2016	On-going
Jenny Darwood	Complete	11 July 2016	On-going
Jenny Darwood	Complete	11 July 2016	On-going
Jenny Darwood	Complete	11 July 2016	08 August 2016
John Fletcher	Complete	13 July 2016	31 August 2016
Jenny Darwood	Complete	13 July 2016	On-going
Jenny Darwood	Complete	13 July 2016	On-going
Jenny Darwood	Complete	22 July 2016	25 July 2016
Jenny Darwood	Complete	28 July 2016	On-going
Jenny Darwood	Complete		31 July 2016
Jenny Darwood	Complete	31 July 2016	On-going
Fran Edmunds	Complete		31 July 2016
Jenny Darwood	Complete	01 August 2016	on-going
Jenny Darwood	Complete	04 August 2016	11 September 2016
Jenny Darwood	Complete		07 August 2016
Jenny Darwood	Complete	15 August 2016	On-going
Matt Hardwick	Complete		20 June 2016
Andy Bailey	Complete		22 June 2016
Matt Hardwick	Complete		30 June 2016
James Blake	Complete		01 July 2016
Matt Hardwick	Complete		31 July 2016
Matt Hardwick	Complete		31 July 2016
Matt Hardwick/ Jenny Darwood/ Andy Bailey	Complete		15 August 2016
James Blake	Complete	15 August 2016	31 August 2016
Katy Lyne	Complete	01 July 2016	On-going
Katy Lyne	Complete	01 July 2016	05 August 2016
Abi Turner	Complete		22 July 2016
Sarah Wilmer	Complete	22 July 2016	25 July 2016
Matt Hardwick	Complete		29 July 2016
Matt Hardwick	Complete	29 July 2016	31 August 2016

Sophie Clark	Complete		17 August 2016
Matt Hardwick	Complete		30 June 2016
Matt Hardwick	Complete		30 June 2016
Matt Hardwick	Complete		01 July 2016
Matt Hardwick	Complete		15 July 2016
Matt Hardwick	Complete		15 July 2016
Matt Hardwick	Complete		21 July 2016
Pauline Butterworth/ Matt Hardwick	Complete	23 July 2016	##########
Matt Hardwick	Complete		##########
Matt Hardwick/ Simon Purkiss	Complete		13 July 2016
Matt Hardwick	Complete		31 July 2016
Pauline Butterworth	Complete		31 July 2016
Jenny Darwood	Complete		31 August 2016
Kate Murray	Complete	19 August 2016	31 August 2016
Matt Hardwick	Complete		
Matt Hardwick	Complete		
Matt Hardwick	Complete	01 October 2016	
Matt Hardwick	Complete		

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	
Subject:	Annual Business Plan – Quarterly Update Q2
Reporting Officer:	Jonathan Reid, Director of Finance

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

Purpose:

The Trust approved an annual business plan in private board during April 2016. The plan followed the national planning framework, and although it did not articulate specific objectives for the year, it did set out the key areas of focus for the 2016/17 financial year. Specific objectives for the Trust for 2016/17 and future years have now been articulated in the 2020 paper, which has subsequently been approved by the Board and the Board will receive regular updates on progress. This paper provides an overview of the key deliverables under the 2016/17 Business Plan.

Introduction:

The Trust produced an initial business plan for 2016/17 which was developed in partnership with the Clinical Units. The business plan was a useful starting point for the plans for the year, but has subsequently been supplemented and to a large degree superceded by the ESHT 2020 plan, which puts in place a strategic framework for the Trust, and sets out a series of measureable outcomes. The Trust's business plan remains in place and this paper sets out progress against the key priorities identified in the plan. Planning for 2017/18 has commenced, and the Trust is working to align the local plans articulated in ESHT 2020, East Sussex Better Together and the STP plans with the nationally directed planning timetable.

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

The 2016/17 Business Plan was approved by the Trust's Finance and Investment Committee in March 2016. It described a series of priority areas of focus and the actions the Trust would take to address key challenges and risks. These have been reviewed and a summary of action against each key issue is provided, covering the areas of quality and safety, activity and workforce and finance. The report does not capture all of the key areas of activity across the Trust, but provides assurance that the Trust is delivering on the commitments made in April 2016. For each of the key areas, a description of board scrutiny and assurance routes is provided, as are the actions in place to mitigate identified risks.

Benefits:

This paper has described progress against the initial business plan for 2016/17. The

review provides evidence of good progress in a number of priory areas, but also identifies a number of areas of challenge - and there is a continued need for focus by the Trust Board and Executive Directors on delivery.

Risks and Implications

The key risks identified in the review of the business plan are threefold and echo the risks set out in the Board Assurance Framework:

- **Quality** – the Quality Improvement Plan is an ambitious document, setting out a number of high priority actions which require rapid implementation. The Trust has good arrangements in place to support delivery, but this needs continued focus and engagement, inside and outside the organisation;

- **Workforce** – the Trust has had considerable success in recruitment, but there remain a number of key areas of the workforce where there are shortfalls in available staff, and in consequence a heavy reliance on temporary resourcing. This has significant financial consequences and can create additional pressures for substantive staff. This remains a key area of focus for the Trust;

- **Finance** – the Trust has identified significant risk in the financial forecast for the year, and has put in place mitigating actions. This risk sits in the context of very significant financial challenges across the local and national NHS, which requires a continued daily focus on financial delivery.

Assurance Provided:

Process is planned and timescales achievable.

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

n/a

Proposals and/or Recommendations

The Trust Board is requested to note this 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?

No impact has been identified from the review of this report.

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

Name: Jonathan Reid, Director of Finance and Estates	**Contact details: jonathan.reid@nhs.net**

1. Quality and Safety

Business Plan 2016/17	
Quality Improvement Plan *Central to the business plan for 2016/17 is the delivery of the Quality Improvement Plan, which articulates the key priorities stemming from both the CQC inspection and the need to drive up quality and safety standards across the organisation.*	
Progress	**Actions and Risks**
• The QIP is supported by robust programme and project management arrangements, and with a programme board which includes key external stakeholders. It is also scrutinised and supported by NHSI, NHSE and the local CCGs. • The QIP continues to deliver on key workstreams – emerging risks are identified and managed through the programme board. The most significant risks identified through the programme are in relation to flow and capacity management across the Trust. The CQC are inspecting the Trust in October, and will test progress against the QIP.	• The priorities of the QIP are aimed at supporting medium-to-long-term improvement across the Trust, but also at supporting readiness for the forthcoming CQC inspection. • Following the CQC inspection in October 2016, the Trust will be refreshing the QIP and ensuring emerging themes and issues are recognised. • Looking forward, past the QIP, the Trust continues to develop an Improvement function, supported by an improvement capacity within the organisation. Recruitment to the function is underway.
Patient Experience and Safety *The business plan set out the Trust's plans to improve, over and above the QIP, patient experience and safety – with a specific focus on complaints and learning through the reporting of incidents, and a wider exercise to strengthen clinical governance.*	
Progress	**Actions and Risks**
• The complaints process has been reviewed and a number of key improvements implemented. Progress is reported in the Integrated Performance Report on a monthly basis. • The number of reported incidents has increased, and the number of serious incidents has decreased, and the processes for learning from incidents have been strengthened. Progress is reported in the Integrated Performance Report on a monthly basis. • Work continues to strengthen clinical governance across the organisation, and within Clinical Units, overseen by the Quality and Standards Committee.	• The key risk in respect of continued improvements to patient experience and safety remains the capacity of clinical and operational staff to manage the level of demand that they face on a daily basis, whilst seeking to make significant improvements to processes and outcomes. • Staff across the Trust continue to prioritise this work and clinical governance continues to improve. Risks to delivery are reviewed by the Trust Board, with assurance through the Quality and Standards Committee. • The Trust also provides assurance to NHSI and CCGs on a monthly basis around key issues for Quality and Safety. The results of the CQC inspection in October 2016 will give an early insight into the sustainability of progress.

Clinical Effectiveness and Quality Impact Assessment

The business plan included a number of key actions around improving clinical effectiveness and outcomes for patients, including action on VTE, and a robust Quality Impact Assessment process (ensuring that efficiencies and significant service changes do not adversely impact on the quality of care provided).

Progress	Actions and Risks
• The arrangements for measuring and monitoring clinical effectiveness across the Trust are strengthening, and the Clinical Effectiveness group is now fully established and working well. • The Trust has an established Quality Impact Assessment process, but following review by internal audit and by the Director of Finance, this has been refreshed to ensure that all key projects and programmes are included within the QIA review process.	• The strengthening of the arrangements to secure improved clinical effectiveness needs continued focus and support, and the allocation of resources. • The QIA refresh has not identified areas where current CIP or service change proposals have created a risk to quality. However, there is a significant shortfall in identified and deliverable CIPs, and the new CIP pipeline will require continued review through the QIA process. Additional support has been secured to support both the development of CIP programme, and delivery of efficiency improvements.

2. Activity and Finance

Business Plan 2016/17	
Delivering the Contract *The Trust signed a contract in April 2016 reflecting the key priorities identified in the Business Plan 2016/17 – a move to payment by results, implementation of demand and capacity planning, and joint delivery of East Sussex Better Together.*	
Progress	**Actions and Risks**
• Payment by results continues to evolve, and the Trust has an improved understanding of the activity it is undertaking. The Trust is working closely with the CCG around the formalised reconciliation process, which is proving challenging on all sides due to the level of technical detail involved. • Coding and income recovery have improved, and are robust, and the Trust is in regular dialogue with the CCG around contract developments, noting the limited resources available within the local health economy. • The Trust is making good progress on delivering the ESBT schemes. The key area of risk is around delivery of the required capacity to meet national performance standards, and the financial impact of this additional work.	• The position is largely unchanged from quarter 1, and the Trust and the CCG continue to work together to ensure delivery of system financial plans. The key risk for the Trust and the local health economy is around management of demand and capacity, to meet national standards around access and performance, and to do so in a way which is financially sustainable for both the Trust and the CCGs. The Trust has a detailed demand and capacity plan, which sets out the required capacity, and is jointly developing this with the CCGs to ensure agreed actions to secure optimal benefit for patients, the Trust and the local health economy. • The Trust is behind trajectory for both 18 weeks and A&E access standards, but has a recovery plan. This risk is significant and is reviewed at Finance and Investment Committee and at Trust Board.
Delivering on Carter *As one of the pilot sites for the national Carter programme, the Trust has been an advocate for the benefits to be secured. The 2016/17 plan set out the Trust's aspiration to turn the outputs from Carter into improved operational delivery and efficiencies.*	
Progress	**Actions and Risks**
• The Trust has a high level of engagement with the national Carter Team, and this engagement is distributed across the organisation with key managers and leaders supporting this work. A small central team in finance undertakes detailed analytical work and supports 'deep dives' which are undertaken jointly with clinical teams. • The Carter work also informs future plans for service change, and has been shared with Clinical Commissioners.	• The Carter programme is proceeding well, but in September 2016, the programme management and support arrangements are were refreshed to ensure that the benefits identified through the key workstreams are more clearly articulated and are supported through to implementation. • In Q2, the Trust is working to develop both the new Model Hospital dashboard and the Pharmacy Transformation Plan.

Delivering the Financial Plan
The Trust set a deficit budget of £48m for 2016/17, with cost improvements of £10.7m, agency reduction of £8.2m, and a capital plan of £12m. This plan is supported by a cash plan, which assumes drawdown of working capital support from the Department of Health of £31.3m.

Progress	Actions and Risks
• Cash and capital are delivering on plan – although adverse performance in the financial position has created significant pressure on cash flow. This is managed carefully by the Finance Team. • The Trust is overspending against operational plans at Month 5, and is working to secure an improvement in position at Month 6. The risk of £25m to the full year identified at Q1 has reduced to £19m. • Progress on developing and implementing detailed cost improvement plans (CIPS) has been slower than planned, and agency reductions are proving challenging. However, external support and additional resource has been secured and a more robust financial recovery plan is in development.	• The Director of Finance has agreed a series of recovery actions with the Executive Directors to support a reduction in the overall risk to the financial plan. Increased capacity has been secured across the organisation to support the development of more detailed and robust cost improvement plans for immediate in-year delivery, alongside the broader Carter plans, and a refreshed set of arrangements for managing temporary resource have been put in place. • The Director of Operations and the wider Operations/Finance teams are focusing on working jointly with CCGs to ensure appropriate management of demand and capacity. Progress and risks are reviewed on a monthly basis by the Finance Committee.

3. Workforce

Business Plan 2016/17	
Recruitment *The operating plan for 2016/17 assumed a 2.2% reduction in overall workforce, delivered by substantively recruiting to vacancies. Agency usage was planned to reduce by 57.7% and bank usage by 6.4%, with the Trust increasing the substantive workforce by 2.6%.*	
Progress	**Actions and Risks**
• The Trust is making good progress at Month 6 against the recruitment plans, with significant improvements in levels of substantive areas in a number of key areas. • Turnover has fallen and the substantive workforce is growing – although there are areas where levels of substantive staff are not as high as required. • Challenges remain in respect of reductions in the temporary workforce, particularly in respect of agency expenditure, which is adverse to plan. • The Head of Recruitment who is working closely with HR and Operational colleagues to ensure delivery of the key priorities.	• There remain a number of significant challenges in delivering this business plan objective, given local and national workforce shortages. In the short term, this means that the Trust is not delivering on its plans for reduction in temporary expenditure. In the medium-term, the Trust needs to (and is actively doing so) explore new workforce models for care delivery in key specialities, in partnership with key stakeholders across the local health economy. This work is overseen through the Executive Directors, and workforce data is considered at the Quality and Standards Committee. • Further work is required on developing the workforce plan for the Trust, and this will continue in Q3 alongside the development of the long-term financial model for the organisation. During Q2, considerable work has been undertaken on understanding the scope of the workforce challenge, both within the Trust and across ESBT programme plans – ensuring that at Q3 the plan can be developed in more detail.
Staffing Shortages *Management of staffing shortages was identified as a key risk in the Business Plan for 2016/17, with the consequential risk of impact on delivery of care or key services*.	
Progress	**Actions and Risks**
• The Trust has a number of mitigations in place to support the management of staffing shortfalls, with staffing levels regularly reviewed during the year by the Trust Board, and by the Quality and Standards Committee. Crucially, the Trust has daily roster reviews and a robust escalation process, with clear processes for moving staff where appropriate.	• The Trust has processes in place to manage the delivery of services in the context of staffing shortages. However, there are two key risks which emerge – the sustainability of service delivery (stemming from the pressures on substantive teams) and the financial consequences of using additional temporary resource.

• Immediate shortfalls in staffing are managed through the recruitment of temporary resource and, as a consequence, although the Trust continues to provide safe care, the level of temporary staffing usage continues to increase.	• In July 2016, the Trust has agreed to a reshaping of the temporary resourcing team, with increased clinical leadership and a move to the Finance Directorate. This team continues to support the development and management of the total temporary workforce across the Trust.
Staff Engagement and Wellbeing *The Business Plan set out how the Trust would develop a staff engagement team, with a detailed action plan, and would focus on significantly improving engagement with staff across the organisation – and wider stakeholders.*	
Progress	**Actions and Risks**
• The team is in place and working at pace to build engagement across the organisation. • Support, training and engagement events are in train, and at each Integrated Performance Review, staff engagement is discussed with Clinical Units to establish progress and any support required.	• This remains a key priority for the Trust's Board and leaders across the organisation. It is reflected on the Trust's Board Assurance Framework, and progress is considered by the Trust at the Quality and Standards Committee.

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	13
Subject:	Winter Preparedness
Reporting Officer:	Matt Hardwick

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

Purpose:

To provide assurance around plans to ensure continuity of service and safe patient care during the forthcoming 2016/17 winter period.

Introduction:

The attached capacity/ winter plan exists to ensure that the Trust has a coordinated and appropriate response to season variations in both elective and emergency activity. It is accepted that these pressures can occur at any time throughout the year and thus this plan will be activated whenever the executive and operational teams deem it to be necessary.

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

The capacity/ winter plan aims to ensure that:

- Seamless, safe timely care can be provided dissipate variations in demand.
- The Trust is able to deliver its contracted position, access and performance standards and operation standards.
- Available resources are optimised both internally and within the local system in respect of bed usage.
- Robust plans and responses to plans are in place in conjunction with the wider system.

Benefits:

Additional clinical space has been identified across the Trust, in advance of the winter period, to address surges in demand for non-elective pathways.
An agreed set of actions for elective and non-elective care in the context of seasonal demand have been outlined.
This will ensure a consistent approach to the delivery of operational standards.

Risks and Implications

There is a risk that the additional capacity identify across the organisation may be insufficient in addressing any unprecedented surge in demand.
The implications of this include an increased risk to patient safety, a detrimental impact on clinical

outcomes and may lead to negative impact on staff wellbeing.

Assurance Provided:

ESHT has detailed and robust plans to address activity surges over winter 2016/17 and that these plans have been developed in the context of the wider East Sussex system.

Proposals and/or Recommendations

The Board are asked to review and endorse the attached 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?

No risks have been identified.

For further information or for any enquiries relating to this report please contact:	
Name: Matt Hardwick	**Contact details: Ext. 7013**

East Sussex Healthcare NHS
NHS Trust

CAPACITY/SURGE PLAN 2016/17

Produced By :	Title/Directorate	Date:
Matt Hardwick	Hospital Director	September 2016

Person Responsible for Monitoring Compliance& Review	Pauline Butterworth, Chief Operating Officer
Signature& Date	September 2016

Multi-disciplinary Evaluation/Approval

Name	Title/Specialty	Date:
Executive Directors		04.10.16
Operational Preparedness		

Ratification Committee

Issue Number (Administrative use only)	Date of Issue& Version	Next Review Date	Date Ratified	Name of Committee/Board/Group
		Sept 2017		

CONTENTS

East Sussex Healthcare NHS Trust

CAPACITY/WINTER PLAN

2016/17

1. Introduction

1.1 This plan exists to ensure that the Trust has a co-ordinated and appropriate response to seasonal variations in both elective and emergency activity. It is accepted that these pressures can occur at any time throughout the year and thus this plan will be activated whenever the executive team deem it to be necessary. This plan will be available to be read on the Trust's extranet.

1.2 The aim of this plan is to ensure that:

- Seamless, safe and timely care is provided despite variations in demand.
- The Trust is able to continue to maintain its contracted position, targets and operational standards.
- The best use is made of available resources both internally and in the local health economy in respect of bed usage.
- Robust plans and responses to variations are in place in conjunction with the local health economy

2. Structure of plan

The operating model and communication approach is a key component of the overall plan. Decisions must be made in a structured way and communication must be consistent, both internally and externally.

Capacity and escalation plans are necessary to define the steps that each service will take to manage demand. Clear guidance of the actions to be taken are laid out in both the Trust's Escalation Resource Plan (ERP) (see Appendix 1) and the Trust and Divisional Business Continuity Plans (BCPs) which can be accessed via the Intranet.

A defined forward planning and decision making framework is highlighted in the plan to ensure coordination and an effective response.

The plan is aligned to the East Sussex Whole System Surge Plan which is being led by the Hastings and Rother Clinical Commissioning Group (CCG) management lead.

3. Operational Readiness

3.1 Executive and Operational Lead

The Chief Operating Officer is leading the Trust's preparations for winter pressures, through the Operational Preparedness Group, which has representatives from all Divisions, the Programme Management Office, support services, Business Intelligence, IT, Infection Control, Communications and Estates.

Communications to staff relating to necessary ward moves, service redesigns and patient pathway changes that support winter readiness are subject to a communication plan led by the Communication team.

The Chief Operating Officer or their deputy is responsible for leading any business continuity incident that arises from winter pressures, including infection outbreaks.

3.2 Managing Capacity

Internally forward planning and monitoring will be carried out through operational meetings chaired by the Chief Operating Officer.

Any alterations in bed complement due to capital/refurbishment plans are discussed and signed off by the Executive Directors group before being taken further in the organisation. This is to ensure that cross divisional issues are discussed and planned so no actions are taken in isolation. Any immediate actions arising from the operational group or arising from severe daily operational pressures, which are required to maintain service delivery, will be communicated via the site conference calls and bed status report. Other actions will be communicated widely through the communication plan throughout the winter period.

The whole systems operational group meet via conference call weekly to discuss delayed transfers of care (DTCs) and plans to reduce these as well as whole system demand and capacity issues. There continues to be a drive to reduce the number of DTCs within both hospital sites and reflects the commitment from all organisations involved to work together in new and different ways to ensure that the number of patients delayed is minimised and that any associated risk is shared across organisations.

The whole systems task group will be convened if deemed necessary by the Chief Operating Officer or their nominated deputy (Executive Director out of hours) as per the Whole Systems Escalation process (WSEP)

The decision to open or close identified escalation beds will be agreed by the Chief Operating Officer or their nominated deputy (or Executive Director out of hours) but only after the following has happened:-

- Discussion has been had between the Divisions at Associate Director of Nursing (ADN) level so communications about opening winter areas is

agreed across Divisions, and staffing plans can be made operational

- A plan for de-escalation is agreed
- Clear review and governance arrangements throughout escalation and de-escalation are agreed by the ADNs (or nominated deputies out of hours)

The bed utilisation plan for next day electives will be formulated in the daily elective (TCI) meetings (on both sites) held with the site team and relevant general managers. **This meeting must be inclusive of all Divisions**.

The Trust and Divisional business continuity plans will be used when adverse events occur. This is a separate process from major incident planning.

Monitoring of infection control issues will be carried out at the bed conference calls. Representatives from the infection control team will attend and work with the site team to place patients appropriately and give advice. In the event of an infection outbreak being declared business continuity plans will be set in place, clinical leadership given by the DIPC, and operational leadership led by the Chief Operating Officer.

The Surgery Division must maintain elective activity within surgical and DSU bed stock in order to achieve and maintain delivery of 18 week access targets. Surgery will also be required to manage any surge in emergency surgical or trauma activity within its own bed stock.

The Urgent Care Clinical Unit must manage the activity surges relating to emergency medical presentations to the Emergency Departments (EDs) and Medical Assessment Units (MAUs). Senior Clinicians within the clinical unit have responsibility for ensuring patient flow is maintained by ensuring active discharge management occurs in all areas.

The Medical Division is responsible for ensuring patient flow is maintained in the acute wards with daily senior board rounds and robust Multi Disciplinary working. However, it is recognised that even with very active discharge management, demand in the peak winter periods is such that additional capacity may be required. To this end, the Operational Preparedness Group is overseeing plans to provide escalation wards on both acute sites. Escalation plans must also take account of the likely need for flexing bed capacity upwards in the community settings and managing isolation rooms appropriately for infection outbreaks.

Additional capacity will be available in the following areas:-

HASTINGS & ROTHER

- Up to 19 beds in a locally sourced nursing home – *(nb Adult Social Care (ASC) to identify appropriate nursing facility and ASC practitioners to fully collaborate with ESHT staff to identify suitable patients for transfer)*

- Intermediate Care facilities – to be managed by Out of Hospital Clinical Unit:

- 12 beds Bexhill Irvine Unit ; 5 beds Rye Memorial Hospital

EASTBOURNE, HAILSHAM & SEAFORD

- Up to 20 additional beds at a locally sourced nursing home
- 10 NHS beds on Michelham Unit – to be managed by Surgery & Theatres Division
- 17 beds on Seaford 2 – to be managed by Medical Division

Therapy and support services are aware that they will need to factor these additional beds into their plans from 1st December. Facilities should also factor these areas into their plans from 1st December for a 4 month period

If capacity issues persist and if occupancy levels become significantly unsafe:

Below is a list of potential areas which the senior operational group has identified as possible escalation areas. There are risks attached to using these areas in terms of impacting elective activity. This list does not attempt to prioritise the use of these, decisions to use these areas are based on all factors relating to activity planned, staffing, patient condition and expected discharges.

HASTINGS & ROTHER

- Cookson Devas ward - 6 beds orthopaedic patients only – to be managed by Surgery & Theatres Division
- Cookson Attenborough/DSU 19 beds to be managed by Surgery & Theatres Division
- Sleep Studies – 4 beds
- In absolute extremis and only when the site is at significant risk of compromised patient safety:
- Judy Beard Unit – up to 12 beds

EASTBOURNE, HAILSHAM & SEAFORD

- Hailsham 3 – 6 beds – to be managed by Surgery & Theatres Division
- Hailsham 2 -14 beds – to be managed by Medicine Division

(nb This plan assumes that Hailsham 3 reverts to its steady state use as an elective Orthopaedic ward and that Hailsham 2 is emptied in advance of winter surge)

3.3 Site Management

The site managers co-ordinate elective and emergency patient flow on both hospital sites, and work closely with the Hospital Director, Divisional Managers, Heads of Nursing and the Chief Operating Officer or their deputy. In addition, they

will deal with site issues. Staffing issues are the responsibility of the clinical matrons and ward managers within the Divisions during the hours of 8.00 am – 4.00 pm, and will be overseen and appropriate actions taken by the site team out of these hours.

In escalation (Red status for > 72 hours or Black status) there are four cross site bed conference calls held at 09.30,12.00, 15.00 &17:30 hours. Operational staff use a task list (contained within the ERP) which gives guidance on internal triggers & actions required at times of escalation.

The Whole System Escalation Plan (WSEP) has been developed which will support the Trust in its management of bed pressures. The policy includes triggers for escalation and incorporates interventions required to support ESHT by all local partners. All GP surgeries have been informed about the Integrated Locality Teams and how to access them. This will be reinforced through the system-wide A&E Delivery Board and Hospital Flow & Discharge to Assess Group (formerly System Resilience Group)

The Chief Operating Officer (COO) will require updates from the Hospital Director or a nominated General Manager of the day relating to escalation issues, with assurance that the escalation plan has been followed. The COO or their deputy will provide support/advice /intervention as required. This will be the executive on call out of hours.

General communications of actions taken at the conference calls will be by the bed report (sent out via email). The on call manager for the day will take handover no later than 4.30pm. The executive on call must also be fully aware of the operational situation if the trust is on red or black status. Actions in the bed report will be linked to the indicators and triggers in the ERP. The site team must communicate clearly all actions identified at the 9.30 am bed conference call to all relevant staff and agencies, by 10am. General Managers from each Division will support in this (e.g. contacting Consultants On Call/ HoNs/Adult Social Care etc.). The actions must be clear with expected outcomes and timescales for reporting back to the site office.

Each morning, the site team will produce a list of outliers (medical and surgical specialties) for distribution to the medical teams. This is to ensure that the patient whereabouts are known and medical teams and multi disciplinary teams (MDTs) should manage the outliers proactively with the aim of repatriating them to appropriate speciality beds as soon as possible or ensuring timely discharge, 7 days per week.

- Stroke & Trauma patients are to have direct access to specialty beds (Network and SOE assurance has been sought on this)

- The site teams are to concentrate on ensuring patient flow. Nursing staffing is to be managed by clinical matrons & medical staffing by general managers.

- No patients are to be admitted from any access point unless agreed by the site teams.

- The admissions areas will not be used as in-patient areas.

- A daily winter situation report (SITREP) is agreed by a designated executive director and reported to the CCG.

3.4 Additional Support for Patient Flow

Named ASC workers are allocated to all medical wards and meet twice weekly to do board rounds on their wards with the discharge nurses and the lead nurse for the ward. In addition, MDTs are now attended by ASC and the discharge nurse. This is vital to ensuring ward staff have accurate and current information relating to discharge planning. Adult Social care representatives will attend the daily site meetings if the Trust is in an escalation status of Red or Black.

Additional medical support is in place for Saturday and Sunday to review in patients and ensure weekend discharges.

Hospital Intervention Team (HIT) will continue to cover weekends for Accident & Emergency (A&E), Medical Assessment Unit (MAU) and Medical Short Stay Unit (MSSU) on both sites.

There will be an extended bed conference on Friday at 17:00 to discuss plans for weekend or bank holidays, including identified patients for discharge.

Additional Patient Transport Service (PTS) arrangements for the winter period and throughout Christmas and the New Year will be in place and confirmation will be discussed at the daily site meetings as required. This will be led by the Hospital Director or their nominated deputy.

Twice weekly whole systems operational meetings to continue, concentrating on appropriate placement of patients in the community and DTC's.

Health & Social Care Connect (HSCC) to circulate daily information of bed availability and demand, including number of patients that have been referred and those accepted. In return, providers to ensure HSCC have provider status available in the morning every day, so patient placement can be prioritized appropriately.

3.5 Cancellation of Surgery

In the event of ***excessive*** demand and elective surgery needs to be cancelled, the following process must be adhered to.

The designation of beds for the next day for electives will be carried out in the daily elective meeting held with the site team and relevant general managers.

All Divisions must be represented in this planning process to ensure all patients are prioritized according to clinical need and safety. Any proposed cancellations must be discussed with the Chief Operating Officer or their deputy.

- Decision
  The decision to cancel a scheduled elective operation lies with the Chief Operating Officer or nominated deputy (usually the Hospital Director). The decision will be made in conjunction with the General Manager, the admitting Consultant and the site team and after the Protocol for Cancellation of Operations has been implemented.

- Reporting
  The cancellation(s) will be enacted and rebooked as per the Trust Elective Care Access Policy

- Follow up action
  Following cancellation of any elective operation the Surgery & Theatres Division in conjunction with Clinical Administration CU is responsible for ensuring that the patient is given a date either on day of cancellation or within the next two working days.

The Admissions staff are responsible for ensuring that the PAS record includes details of previous cancellations. This information will be taken into account should further cancellations be required.

3.6 Mortuary Services

The Trust currently has storage capacity as follows:

Mortuary	**Fridge**	**Freezer**	**Overflow**	**Bariatric (Included in total)**	**Contingency (internal option 1)**
Conquest	60 without activation of freezer including the large deceased fridge	5 Deepfreeze spaces	16 without activating bariatric spaces	2 Bariatric (bed spaces)	Space identified in the mortuary corridor to erect 1 temporary unit (12 spaces)
EDGH	60	5	24	2 Bariatric spaces (bed spaces)	Space identified in store where 2 temporary units can be housed (24 spaces)
Total	120	10	40	4	36

There are 12 Temporary Body stores that could go to any site.

There are also mortuary facilities at Bexhill Hospital

The Trust has good working relationships with the local funeral directors who have in the past responded, as able, to requests for support in times of increased demand, including weekends and Bank Holidays. It is anticipated that this level of service will continue and 28th - 30th December will be deemed to be routine working days.

Monitoring of the body stores will be undertaken on a daily basis, and decisions will be made at times of peak demand for storage about utilising the Eastbourne store to support the Conquest site.

3.7 Christmas and New Year Plans

The Trust will produce a document detailing service arrangements to enable smooth consistent service delivery during the Christmas and New Year period by 1st December.

3.8 Flu Pandemic Implementation Strategy

The Trust has previously provided details of its contingency plans and expert groups to facilitate integrated planning and delivery of a pandemic response with partner agencies throughout the health economy (including the CCGs, Public Health, NHS Sussex, SECAMB and local authorities).

If a pandemic occurs, as per national definitions, the Hospital Coordination Group will meet on a daily basis and business continuity will be in place. The Emergency Planning Lead, the DIPC and Assistant Director of Infection Control will lead.

3.9 Major incident escalation

The Trust has a Major Incident Plan and participates in the health economy and system wide emergency planning groups. .

3.10 Human Resources

The Trust is currently projecting a budgeted staffing establishment of 6395 fte.

All trusts are monitored on a monthly, through FIMS/WIMS returns. There is also access to Trust information through the electronic staff record data warehouse.

The Trust uses to E Rostering in most areas which provides an appropriate skill mix, better management of annual leave and a cost effective off duty.

4. NHS/Social Care Joint Arrangements

The development of community based services is essential to reduce dependence on the acute setting and to provide an alternative to hospital admission.

All referrals for intermediate care assessment are dealt with by a single point of access telephone number (ICAP) which is responded to by a clinician and appropriate action taken to ensure patients are assessed for suitability for intermediate care and for the transfer to be expedited by the team as required.

A single telephone access number system (PSL) operates which takes all calls for GP emergencies and is responded to by a clinician

The WSEP has been developed which will support the Trust in its management of bed pressures. The policy includes triggers for escalation and incorporates interventions required to support ESHT by all local partners.

The health economy is optimizing arrangements for discharge into community/social care by providing 7 day a week out of hours access to community and social care teams.

Actions are being taken to minimize inappropriate attendances through alternative routes. CCG led communications across the county are in place.

5. Critical Care Services

ESHT has the funded capacity for 11 Level 3 Critical Care beds (Conquest 6, EDGH 5) and 8 Level 2 Critical Care beds (Conquest 5, EDGH 3). This capacity can be flexed to meet demand.

The Critical Care Outreach Team provides support, both clinically and educationally, to the ward staff and junior doctors in order that patients may be prevented from requiring Level 2 or Level 3 support in the intensive care units. This level of support prevents a number of admissions to the units and operates on a 24/7, 365 day basis. It also has a crucial role in following up patients discharged from critical care and helping to avert re-admissions.

The Critical Care Units only look outside our transfer network for Critical Care beds once all potential of 'in network placements' have been exhausted.

5.1 Critical Care Reporting Arrangements

The impact of pressures on the critical care bed state is reported in the following ways:

- Cancelled operations due to lack of an ITU bed are reported through the daily "cancelled operations" list
- Use of extra non funded beds or any change in category (from Level 2 to

Level 3) are reported through the WardWatcher©system and reported by the Critical Care Audit Nurse. This information is sent via Business Intelligence to the South East Coast Critical Care Network

- Transfers of patients to other Critical Care Units are recorded on the Critical Care Transfer Form. The clinical matron/general manager for critical care will be informed and will in turn inform the Chief Executive via the Chief Operating Officer.

- Out of hours site managers are informed who will escalate information to the executive team via the On Call Manager.

- All transfers out of our Network will be reported to the relevant Chief Executive and Regional Director.

5.2 Escalation of Critical Care Services

In the event that there is insufficient funded capacity to meet the demand for critical care services, the following actions will be taken:

It is possible to ventilate in the theatre recovery area for a limited period of time, whilst arrangements are made to either transfer a patient from critical care to a general ward, or arrange to transfer a patient to another critical care unit within ESHT.

- In the event that there are no beds within ESHT, other critical care units within the local transfer Network will be approached for a bed. If necessary, the patient will remain in theatre recovery until a bed is located.

- In the event that it is considered necessary to undertake a transfer, arrangements are in place via the Policy for the Management of Critical Care Beds and Sussex Critical Care Network Inter-hospital Transfer Protocol. This will be a Consultant-to-Consultant referral. The Chief Executive will be informed of this decision.

- It is possible to ventilate in the Accident and Emergency Department in life threatening circumstances only, until either theatre recovery or the critical care unit is able to take the patient.

- Discussions will be held between the critical care consultants and the clinical matron or unit managers to assess whether it is possible to mobilise nursing staff from one unit to another if the risk in moving patients is too great.

6. Preventative measures

The Trust is participating in the NHS flu immunisation strategy for seasonal flu, including the strategic purchasing of the recommended flu vaccine.

The staff vaccination programme is now underway, with a series of clinics arranged across the Trust's sites. Occupational Health has this as a clear

priority for the coming months. A variety of internal communications is being used to advertise and promote clinics.

The Trust's communication department co-operates with communication leads from the local CCGs and Social Services to ensure that the media relation plans for winter are agreed and in place, including the campaigns, 'Choose Well' and 'Keep Safe in Winter'.

7. Communications

The Head of Communications will ensure that all external communications are

directed at the right areas and that local communities are aware of how they can help their local NHS.

The Trust co-operates with communication leads from the local CCGs, ASC & SECAMB to ensure that the media relations plans for winter are agreed and in place.

This ensures a whole health economy approach and a consistent message throughout East Sussex.

There are established procedures for handling reactive media relations and adhoc adverse incidents/crisis for some time. Robust out-of-hours on-call arrangements are in place for directors and senior managers.

The Trust provides proactive information to NHS Improvement (NHSI), CCGs and Local Health Resilience Partnership (LHRP) via a daily SITREP and capacity management tool. The Trust will use appropriate spokespersons including the Chief Executive, Chief Operating Officer, Director of Nursing, Medical Director and Divisional Directors.

The Director of Strategy, together with the Head of Communications, takes the lead in the event of adverse publicity about services, supported, if necessary, by the Chief Executive, Chief Operating Officer, Chairman, the executive team and board directors.

A communications infrastructure is in place for supporting Trust work. It includes team briefing, core brief, e-mail, Extranet and Internet facilities to help the timely cascading of information.

Front line staff must report operational problems or issues to their line managers. Any media contacts are reported to the Head of Communications.

Staff are kept informed about preparations for winter through the existing communications infrastructure. This guidance will be made widely available on the Trust's extranet for all staff to access, or for internal service cascade. CCG, ASC and SECAMB information re support available from other departments and agencies are circulated when available.

The communications department has robust plans in place to ensure their ability to support national programmes of public information in relation to the use of Health Services.

East Sussex Healthcare NHS
NHS Trust

Appendix 1

ADMINISTRATIVE GUIDANCE NOTES

Escalation Resource Plan
DRAFT 5

Written/Produced By:	Title/Directorate	Date:
Matt Hardwick	Hospital Director	Sept 2016

Person Responsible for Monitoring Compliance & Review	Chief Operating Officer
Signature & Date	

Multi-disciplinaryEvaluation/Approval

Name	Title/Speciality	Date:
Operational Preparedness Group		TBA
Executive Directors Forum		04.10.16

Ratification Committee

Issue Number (Administrative use only)	Date of Issue & Version	Next Review Date	Date Ratified	Name of Committee/Board/Group

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Escalation Resource Plan

1. Background

Within the NHS it is now recognised that 'overcapacity' can occur at any time of the year and has introduced the philosophy of 'whole system capacity planning' (HSC 2001/014). The response of the Trust is to produce an Escalation Resource Plan (ERP) which triggers specific measures when the Trust is operating beyond normal capacity.

2. Purpose of Guidance:

The purpose of the policy is to ensure that the Trust maintains patient safety and service delivery, when experiencing capacity pressures. This is vital in maintaining public confidence and the reputation of the Trust. It is to ensure that all disciplines are clear on the actions required at various degrees of pressure and that processes are in place to enable an efficient response.

3. Process to Follow:

Cross site operational conference calls are held three times a day (9.30, 13.00, 16.30)
A bed report and action plan is provided immediately after each operational conference call detailing the current and predicted situation within the organization, taking into consideration other 'whole system' issues.

A decision is made about the operational status, based on internal KPIs and judgment about expected pressures on the day. Intelligence from other providers may require us to move our services to escalation if the whole system is under significant pressure.
The operational status of the organization is based on 4 levels:

- ERP Level 1 (Normal service - Green)
- ERP Level 2 (Concern – Amber)
- ERP Level 3 (Concern – Red)
- ERP Level 4 (Potential Service failure - BLACK)

The plan is in operation at all times and should generally operate at level 1, when the Trust is in a steady state. The decision as to the current level is based on the factors/ triggers detailed below.

Changes to the response level will be communicated via the 'bed report and action plan' (please refer to Appendix 1) sent via email following each conference call. Additional communications will be discussed at the conference calls as required as per plan (Appendix 1), according to level of escalation.

The four levels or response are designed to increase operational resources in line with demand, to cope with periods of high activity and maintain the service provision.

4. ERP Levels

ERP Level 1- Normal service - Green

The Trust is operating normally. Demand is at expected levels and being managed effectively. Resourcing is satisfactory and therefore workload is considered acceptable. There are no excessive demands on the Trust due to weather, significant events, NHS capacity or technology issues. **The Trust is meeting its key performance targets.**

ERP Level 2 - Concern – Amber

Five or more of the following factors/triggers need to be met before declaring this level:

- Over 10 **confirmed** A&E Breaches across site in previous 12 hours
- Less than 10 beds closed per site
- <6 beds available on MAU or <2 beds on SAU, per site before 10.00am hrs
- Medical outliers >15 but <30 per site
- <10 additional beds open per site
- DTC's across site between <24 but <30
- Difficulty admitting TCI's but no cancellations on day
- Nursing Staffing issues - <10 staff per shift, per site
- Medical staffing issues affecting front end or service delivery e.g. assessment times in A&E >4hrs<6hrs
- Up to 5 Ambulances unable to off load within 30 minutes within a defined 8 hour period (0.00hrs_08.00hrs, 08.00hrs_16.00hrs. 16.00hrs-00.00hrs)
- Less than 10 additional beds open across site
- Less than 1, level 3 critical care beds per site
- Less than 20 discharges identified per site (potential & confirmed)

Actions required to be taken at this level are in appendix 1

ERP Level 3 - Severe Pressure – Red

Six or more of the following factors/triggers need to be met before declaring this level:

- A&E flow KPIs are not being achieved
- Over 20 **confirmed** A&E breaches across site in the previous 6 hours
- No beds available in MAU/SAU
- More than 10 beds closed per site
- More than 20 additional beds open per site
- DTC's across site above 30
- Medical outliers >30
- Electivecancellations24hrspreviously
- TCI's cancelled on the day
- Nurse Staffing issues - >10 nursing staff per shift, per site
- Medical staffing issues affecting front end or service delivery, e.g. assessment times in A&E >6 hours
- More than 6 ambulances unable to offload within 30 minutes within a defined 8 hour period (0.00hrs -08.00hrs, 08.00hrs -16.00hrs, 16.00hrs-00.00hrs)
- No level 3 critical care beds per site

- Less than 5 discharges identified per site
- No beds available on MAU or SAU across site

Actions required to be taken at the level are in appendix 1.

ERP Level 4 - Potential Service failure - BLACK

Factors/Triggers at level 4 are:

- When RED triggers have continued for over 72 hours and not expected to resolve within the next 24 hours, the Chief Operating officer/Deputy must be informed, so that they can take a decision about whether to liaise with the Whole Systems Group *for consideration of escalation* to BLACK status. (Director on call out of hours). Black status may trigger a decision by the Chief Operating Officer or nominated deputy to declare the Trust to be in Business Continuity, and implement the BC plans. (See Trust policy). However, the Chief Operating Officer or their nominated deputy may decide that on the balance of all information available, red status can continue for a defined period of time, but with agreed short review times.

- If the Trust is unable to maintain normal services (normal can include operating at red status) due to adverse incidents, (e.g. severe weather conditions, infection outbreak, extraordinary depletion of resources, loss of priority fuel supplies) Business Continuity will likely be called if there is no obvious resolution within 4hours. In these cases, business continuity plans will be activated (see Trust and Divisional business continuity plans). Business Continuity meetings must have a note taker (loggist) assigned and a full pack of notes and information relating to the management of the incident must be maintained and kept for evaluation once BC has been stood down.

- Inform Chief Executive

5. Co-ordination & Assessment of information

- The Hospital Director or nominated General Manager will chair the daily bed conference calls where the assessment of triggers will be carried out and the current operational level agreed. The Chief Operating Officer /Exec on call will be advised when escalation to red occurs. This is to ensure Senior overview of operational pressures is maintained at all times.

- Current and any change in operational status be disseminated via the 'Bed report and action plan' by email, following every conference call. In times of extreme pressure, additional information will be circulated via communications team.

- The daily bed conference calls will be the focal point for discussions and actions relating to escalation. If business continuity is implemented, the clinical site management offices will be the central hub for communication and meetings.

- The Chief Operating Officer/Deputy will consider additional meetings and frequency as required.

- **The escalation process and bed reports are widely published. Every member of staff has a responsibility to know the current level of status and what action is required of them.**

ERPLEVEL1- NORMALSERVICE				
ERPLEVEL1-NORMALSERVICE	ACTION	RESPONSIBLE	IMPACT	REVIEW
	Staffing		PREVENTATIVEACTIONSREQUIREDTOSUSTAINPERFORMANCEANDPATIENTCARE	REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALLS
	Highlight daily staffing shortages to CMs to report back within an agreed time frame	CSMs/CMs		
	Weekend staffing cover required for forward planning, report back within an agreed timeframe	CMs/CSMs		
	Staffing cover for bank holiday period required for forward planning, report back within an agreed time frame	CMs/CSMs		
	Patient Flow, Ward Rounds, Discharges			
	Limited discharges-escalate to General Managers (Divisions)	CSMs/CMs/GMs		
	Identify early discharges, expedite confirmed discharges using the Discharge Lounge	CSMs		
	Potential discharges- clarify plan, and action as necessary	CSMs/ Ward Teams		
	Ensure all ward rounds have commenced by 9.30am,escalate to GMs if not achieved	CSMs/GMs		
	Deliver Discharge pro forma & reinforce need for info to be available by 12pm	CSMs		
	Reinforce discharge benchmark for each ward	CSMs/ HON		
	Patient Flow-A&E			
	Monitor Pt flow at front end, liaise with A&E leads for hourly SitRep	CSMs both sites		
	Highlightallpotentialbreachesat2.45hoursthatdonothaveaplan	A&E Leads/CSMs both Sites		
	Highlightallpotentialbreachesat3.15hoursthatdonothaveaplan	CSMs Both sites to CM		
	A&E Lead to advise CSMs if Ambulances cannot be offloaded>15 mins	A&E Leads/CSMs both Sites		
	Escalate all ambulance queuing issues to HoN Acute Medicine, if wait times likely to exceed 30mins	CSMs Both sites/HON		
	Report>3ambulanceswaitingtooffloadatanygiventimetoCM	CSMs Both sites/ HON		
	Escalate all unresolved site issues to CM	CSMs Both sites/ HON		
	Critical Care Beds			
	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSMs both sites /ITU Consultants		
	Infection Control			
	ICN review of side room provision (Monday & Wednesday)	ICN both sites/CSMs		
	ICN review of specific infection control issues	ICN both sites/CSMs		
	Whole Systems			
	Twice weekly Operational Conference Call	DN/CM,CSD		
	Board Rounds- Mon AM/Wed PM	HON		

ERPLevel1 – Normal Service - Green - Notes
1.The Trust is operating normally
2.Demand is at expected levels and being managed effectively
3.Resourcing is satisfactory therefore work is considered and acceptable
4.There are no excessive demands on the Trust due to weather, significant events NHS Capacity or technology issues
5.The Trust is meeting its key performance targets

ERP Level 2 Concern five triggers need to be met for declaring this level:					
	TRIGGERS	**ACTIONS**	**RESPONSIBLE**	**IMPACT**	**REVIEW**
ERPLEVEL2-CONCERN	**Staffing**	**Staffing**		**PREVENTATIVEACTIONREQUIREDTOSUSTAINPERFORMANCEANDPATEINTCARE**	**REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALL**
	Staffing issues-<10 nursing staff per shift, per Site	Highlight daily staffing shortages to HON's to report back within an agreed time frame	CSMs/HON		
		Weekend staffing cover required for forward planning, report back within an agreed timeframe	HON/CSMs both sites		
		Staffing cover for bank holiday period required for forward planning ,report back within an agreed timeframe	HON/CSMs both sites		
	Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E>4hoursbut<6hours	Review Medical Staffing Cover for key areas	GMs		
	Patient Flow, Ward Rounds, Discharges	**Patient Flow, Ward Rounds, Discharges**			
	<6bedsavailableonMAUor<2beds available on SAU across the Site	Early discharges, utilize discharge lounge in order to create capacity in gateway areas	CSMs/MAU/SAU Teams		
	<20discharges(potential and confirmed) Identified per Site	Limited discharges- escalate to Planned and Urgent Care Divisions GMs and HoNs	CSMs/HON/GMs		
		Identify yearly discharges, expedite confirmed discharges using the Discharge lounge	CSMs both Sites		
		Potential discharges-clarify plan, expedite as able	CSMs/ Ward Teams		
		Ensure that all ward round shave commenced by 9.30am,escalatetoGM'sif not achieved	CSMs both sites/ GM's		
		Deliver Discharge proforma to all wards and reinforce need for info to be available by12pm	CSMs both sites		
		Reinforce discharge benchmark for each ward	CSMs both sites/ GMs		
	Medical outliers>15but<30perSite	Identify medical outliers, ensure robust management plan in place	Medical Teams		
	<10bedsclosedperSite	Review rationale for closed beds and report at cross site conference call	CSMs both Sites		
	<20additionalbedsopenperSite	Review rationale for additional open beds and report at cross site conference call	CSMs both Sites		
		Review cancellation on urgent/ cancer stream TCI's	CSMs/GMs		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERPLEVEL3-CONCERN	**Patient Flow- A&E**	**Patient Flow-A&E**		PREVENTATIVEACTIONREQUIREDTOSUSTAINPERFORMANCEANDPATEINT CARE	REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALL
	Over10confirmedA&Ebreachesacross thesiteintheprevious12hours	Monitor Pt flow at front end, liaise with A&E leads for hourly Sit Rep	CSMs both sites		
		Contact IC-24 Current operational status	CSMs both Sites		
		Highlight all potential breaches at 2.45 hours that do not have a plan	A&E Leads/CSMs both Sites		
		Highlight all potential breaches at 3.00 hours that do not have a plan	CSMs Both sites		
	Upto5Ambulancesunabletooffload within30minuteswithinadefined8hour period(0.00Hrs- 08.00Hrs,08.00Hrs-16.00Hrs,16.00Hrs-00.00Hrs)	A&E Lead to advise CSMs if Ambulances cannot be off loaded within 15mins	A&E Leads/CSMs both Sites		
		Escalate all ambulance queuing issues to HON Acute Medicine if wait times likely to exceed30mins	CSMs Both sites o HON		
		Report>3ambulanceswaitingtooffloadatanygiven time to HON Acute Medicine.	CSMs Bothsitesto CM,CSD		
		Liaise with SECAmb regarding current operational status	CSM/HoN		
		Escalate all unresolved site issues to CM	CSMs Both sites to CM		
	Critical Care Beds	**Critical Care Beds**			
	<1Level3criticalcarebedperSite	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSMs both sites liaise with ITU Consultants		
	Infection Control	**Infection Control**			
	Infection Control Issues impacting on bed capacity	ICN review of sideroom provision(Monday& Wednesday)	ICN both sites to CSMs		
		ICN review of specific infection control issues	ICN both sites to CSMs		
	Whole Systems	**Whole Systems**			
	DTC's acrossSite> 24but<30	Twice weekly Operational Conference Call	CSM Patient flow		
		Board Rounds-Mon AM/ Wed PM	HoNs		

ERPLevel2-Concern-Notes
1.AdditionalAttendeesat cross site conference call–Nursing leads all Divisions, GMs Divisional Representatives
2.Outof Hours-GMtochairthecrosssiteconferencecallsandattendeitherhospitalsiteasrequired.GM to remain on site till 23:00at least.

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ERPLevel3 - Severe Pressure-Sixormoreofthefollowingtriggersneed tobemet before declaring thislevel:					
	TRIGGERS	**ACTIONS**	**RESPONSIBLE**	**REVIEW**	**IMPACT**
ERPLEVEL3-SEVEREPRESSURE	**Staffing**	**Staffing**		PREVENTATIVEACTIONREQUIREDTOSUSTAINPERFORMANCEANDPATEINT CARE	REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALL
	Staffing issues- >10 nursing staff per shift, per Site	Highlight daily nursing shortages to HONs to report back within an agreed time frame, review use of specialist nurses & review use of alternative staffing groups	CSMs/ HONs		
		No short notice leave to be granted<48hours/review non essential training, consider re-scheduling	Divisional Chiefs & ADNs		
		Weekend staffing cover required for forward planning, report back within an agreed timeframe	HON to CSMs both sites		
		Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe	HON to CSMs both sites		
	Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E>6 hours	Re-deploy medical staff to the front end	Divisional Chiefs		
		Medical study leave/ training sessions to be reviewed & stopped as necessary	Divisional Chiefs		
		Audit half days to be cancelled	Divisional Chiefs		
		Consider use of locums	Divisional Chiefs		
	Patient Flow, Discharges	**Patient Flow, Ward Rounds, Discharges**			
	No beds available on MAU Or SAU across the Site	Early discharges, utilise discharge lounge in order to create capacity in acute access points	CSMs/ Ward Teams		
	Lessthan5discharges identified per Site	Limited discharges- escalate to Urgent and Planned Division Ads and Divisional Administrators	CSMs/ADS/HONs/GMs		
		Identify early discharges, expedite confirmed discharges using the Discharge lounge	CSMs both Sites		
		Potential discharges- clarify plan, and action as necessary	CSMs/WardTeams		
		Continue Grand Rounds	Divisional Directors to report back to CSM's		
		Deliver Discharge proforma & reinforce benchmark, info to be available by12pm	CSMs both sites		
		Reinforce discharge benchmark for each ward	CSMs both sites HONs		

	TRIGGERS	ACTIONS	RESPONSIBLE	REVIEW	IMPACT
ERPLEVEL3-SEVEREPRESSURE	**Patient Flow**	**Patient Flow-Bed Capacity**		PREVENTATIVEACTIONREQUIREDTOSUSTAINPERFORMANCEANDPATEINT CARE	REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALL
	Morethan10bedsclosed per Site	Review rationale for closed beds and report at crosssite conference call	CSMs both Sites		
	More than 20 additional beds open per the Site	Review rationale for additional open beds and report at cross site conference call	CSMs both Sites		
	TCI's cancelled on the day	Review plan going forward for TCIs except urgent and cancer stream. No cancellations without agreement of COO/HD	CSMs both Sites		
	Electivecancellations24 hours previously				
	Patient Flow- A&E	**Patient Flow-A&E**			
	A&E flow KPIs not being met	Monitor Pt flow at front end, liaise with A&E leads for hourly Sit Rep	CSMs both sites		
	Over20confirmedA&E Breaches across the Site inthepreviously6hours	Contact CCGs recurrent operational status, request alternatives pathways/admission avoidance	CSMs both Sites		
		Highlightallpotentialbreachesat2.45hoursthatdo not have a plan	A&E Leads to CSMs both Sites		
		Highlightallpotentialbreachesat3.15hoursthatdonothavea plan	CSMs Both sites/HON		
		Open additional bed capacity including day surgery & other clinical areas	CSMs both sites		
	Morethan6Ambulances unabletooffloadwithin30 minuteswithinadefined8 hour period(0.00Hrs-08.00Hrs,08.00Hrs-16.00Hrs,16.00Hrs-00.00Hrs)	A&E Lead to advise CSMs if Ambulances cannot be offloaded> 1hour,implementcohorting	A&E Leads to CSMs both Sites		
		Escalate all ambulance queuing issues to CM if wait times exceed 30mins	CSMs Both sites/HON		
		Report >3 ambulances waiting to off load at any given time to CM	CSMs Both sites/HON		
		Liaise with SECamb regarding operational status, consider Divert	Chief Operating Office/HD		
		Escalate all unresolved site issues to Patient Flow Manager	CSMs Both sites/ HON		

ERPLEVEL3-SEVEREPRESSURE	TRIGGERS	ACTIONS	RESPONSIBLE	REVIEW	IMPACT
	Critical Care Beds	**Critical Care Beds**		PREVENTATIVEACTION REQUIREDTOSUSTAIN PERFORMANCEANDPATEINT CARE	REPORTBACKTOTHREETIMES DAILYCROSSSITE CONFERENCECALL
	No Level 3 critical care beds per site	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSMs both sites liaise with ITU Consultants		
	Infection Control	**Infection Control**			
	Infection Control Issues impacting on bed capacity	ICN review of side room provision (Monday & Wednesday)	ICN both sites to CSMs		
		ICN review of specific infection control issues	ICN both sites to CSMs		
	Whole Systems	**Whole Systems**			
	DTCs across Site>30	Increase Operational Conference Calls to daily	DN/CM, CSD with Whole System		
		Board Rounds – Mon AM/Wed PM	CMs		
		Chief Operating Officer/Deputy to inform whole systems task group	COO/HD		

Notes:
1.AdditionalattendeesatBedMeetings-DivisionalDirectors,COO&/ or DeputyCOO,ADsADNsSenior Facilities representation
2. Representation from A&E Leads
3.ASC&PCTProvidertobepresentat9.30hoursand12.00hrsbedmeetings
4.Outof Hours-GM to attend bed meeting and either Hospital Site as required. Must remain on site till 7pm handover at least.
5.Outof Hours-ExeconCalltochairbedmeetingsandattendeitherHospitalSiteasrequired

ERPLevel 4–Potential Service Failure-Triggers:

1.**When the RED Triggers continue for over 72hours and are not expected to resolve within the next 24hours**.COO or deputy to Liaise with Whole Systems Task Group for consideration to elevate to Black Status:

2.Implement Business Continuity Plans due to inability of the Trust to maintain normal service delivery due to adverse events e.g. severe weather conditions,infection utbreak,extraordinarydepletionofresources,lossofpriorityfuelsupplies-

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERPLEVEL4- POTENTIALSERVICEFAILURE	**Staffing**	**Staffing**		POTENTIALSERVICEFAILUREWHICHWILLAFFECTPERFORMANCEAND PATIENTCARE	REPORTBACKTOCROSSSITECONFERENCECALL
	Staffing issues- >10 nursing staff per shift, per Site	Highlight daily nursing shortages to HONs to report back within an agreed timeframe, review use of specialist nurses & review use of alternative staffing groups	CSMs/ HONs		
		No short notice leave to be granted<48hours/ review non essential training, consider re-scheduling	Divisional Chiefs and GMs/ ADNs		
		Weekend staffing cover required for forward planning, report back within an agreed timeframe	HONs to CSMs both sites		
		Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe	HONs to CSMs both sites		
	Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E>6 hours	Re-deploy medical staff to the frontend	Divisional Chiefs & GMs		
		Medical study leave/ training sessions to be reviewed& stopped as necessary	Divisional Chiefs & GMs		
		Audit half days to be cancelled	Divisional Chiefs & GMs		
		Consider use of agency staff	Divisional Chiefs & GMs		
	Patient Flow, Ward Rounds, Discharges	**Patient Flow, Ward Rounds, Discharges**			
	Lessthan5discharges identified per Site	Limited discharges – escalate to urgent Care and Planned Care Divisions and Divisional Administrators	CSMs/ HONs/GMs		
		Identify early discharges, expedite confirmed discharges using the Discharge lounge	CSMs both Sites		
		Potential discharges-clarify plan and action as necessary	CSMs/ Ward Teams		
		Instigate Grand Rounds	Divisional Chiefs		
		Deliver Discharge proforma &reinforce benchmark,infotobeavailableby12pm,reinforce discharge benchmark	CSMs both sites		
		Cancel all TCI's (last resort)	GMs/Admissions Team		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERPLEVEL4-POTENTIALSERVICEFAILURE	**Patient Flow**	**Patient Flow-Bed Capacity**		POTENTIALSERVICEFAILUREWHICHWILLAFFECTPERFORMANCEANDPATIENT CARE	REPORTBACKTOCROSSSITECONFERENCECALL
	No beds available on MAU or SAU across the Site	Early discharges, utilize discharge lounge in order to create capacity in gateway areas	CSMs/ Ward Teams		
	Morethan10beds closed per Site	Review rationale for closed beds and report at cross site conference call	CSMs both Sites		
	More than 20 additional beds open per the Site	Review rationale for additional open beds and report at cross site conference call	CSMs both Sites		
	TCI's cancelled on the day	Review plan going forward for TCI's except urgent and cancer stream	CSMs both Sites		
	Electivecancellations24 hours previously				
	Patient Flow- A&E	**Patient Flow-A&E**			
	A&E performance is below 98%	Monitor flow at front end, liaise with A&E leads for hourly Sit Rep	CSMs both sites		
	Over20breachesacross thesiteintheprevious6 hours, all extra capacity beds open	Highlightallpotentialbreachesat2.45hoursthatdonot have a plan	A&E Leads to CSMs both Sites		
		Contact HERMES/PCT(GP's),South East Healthcare: current operational status,request alternative pathways/ admission avoidance	CSMs both Sites		
		Highlight all potential breaches at 3.15hours that do not have a plan	CSMs Both sites to HoN		
	Morethan6Ambulances unable to off load within 30minuteswithina defined8hourperiod (0.00Hrs-08.00Hrs, 08.00Hrs-16.00Hrs, 16.00Hrs-00.00Hrs)	Escalate all ambulance queuing issues to Clinical Matron, CSDif waittimesexceed30mins	CSMs Both sites to HoN		
		Report>3ambulanceswaitingtooffloadatanygiventimeto HoN Acute medicine and patient Flow Manager.	CSMs Both sites to HoN		
		Liaise with SECamb regarding operational status, consider Divert	Chief Operating Officer/ Hospital Director		
		Escalate all un-resolvable site issues to Patient Flow Manager	CSMs both Sites		
	Critical Care Beds	**Critical Care Beds**			
	NoLevel3 critical care beds per site	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSMs both sites liaise with ITU Consultants		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERPLEVEL4	**Infection Control**	**Infection Control**		POTENTIALSERVICE FAILURE	REPORTBACKTO CROSSSITE CONFERENCECALL
	Infection Control Issues impacting on bed capacity	ICN review of sideroom provision (Monday & Wednesday)	ICN both sites to CSMs		
		ICN review of specific infection control issues	ICN both sites to CSMs		
	Whole Systems	**Whole Systems**			
	DTC's across Site>30	Daily Operational Conference Call	DN/Hospital Director		
		Board Rounds-Mon AM/Wed PM-addin Friday	HoNs		
		Daily Whole Systems Task Group	Chief Operating Officer/Hospital Director Exec Director OoHs		

Notes:

1. Additional attendees at Bed Meetings-Divisional Chiefs ,COO,ADNs
2. Facilities representation
2. Representation from A&E Leads
3.In Hours– COO/Hospital Director **Out of Hours, Exec Director on call.**
4.Out of Hours-Manager on call to attend bed meeting and either Hospital Site as required. Must remain on site till 11pm at least M-F & chair both daily site meetings at weekends
5.Out of Hours-ExeconCalltochairbedmeetingsandattendeitherhospitalSiteasrequired
6. For additional actions please refer to Trust Business Continuity Plan

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board Meeting
Agenda item:	14
Subject:	Q2 Mid-Year Review of the 2016/17 Capital Programme
Reporting Officer:	Jonathan Reid, Director of Finance

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

Purpose:

This report updates the Trust Board on the performance of the capital programme after the first five months of the financial year.

Introduction:

This report is being brought to the Trust Board for information and approval.

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

The Trust set a capital plan, reflecting internally generated funds available of £11m, and a continued aspiration to secure £5m capital funding in the form of a loan from NHS Improvement/ Department of Health. At the end of month 5, year to date capital expenditure amounts to £3.1m. The capital programme has an over planning margin of £1.8m which is considered acceptable at this stage of the financial year – and is regularly tested for deliverability within the Capital Resource Group.

The Business Development Group (BDG)/Capital Resource Group (CRG) joint meetings – chaired by the Director of Finance - will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital.

The Trust continues to develop a 'pipeline' of business cases to support an application for capital loan, including strengthening the telephony infrastructure, extending the roll-out of SystmOne, and improving a range of clinical support functions. The next capital report at Q3 will provide further details of the emerging forward programme.

Benefits:

The Trust Board has assurance on the development, management and control of the capital programme.

Risks and Implications

The Trust continues to face a number of risks in relation to the total value of capital resource available to meet the capital needs of the Trust.

Assurance Provided:

The Trust Board has assurance on the development, management and control of the capital programme.

Review by other Committees/Groups (please state name and date)**:**
Merged Business Development Group (BDG)/Capital Resource Group (CRG), 21st September 2016.

Proposals and/or Recommendations
The Trust Board is asked to:- i) Note the current performance of the capital programme. ii) Note the risks associated with limited capital. iii) Note that the BDG/CRG will continue to monitor the capital programme on a monthly basis to ensure that the Trust does not exceed its capital resource limit at 31st March 2017. iv) Note the continued work on the business cases to be submitted in respect of the £5.0m capital loan request in the current financial year.

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: Jonathan Reid, Director of Finance	**Contact details:** jonathan.reid@nhs.net

Trust Board Meeting
Capital Programme Mid-Year Review

Introduction:

1 This report provides a mid-year review of the 2016/17 capital programme for the Trust Board.

2 This paper also reflects the recommendations made at the September merged Business Development Group (BDG) and Capital Resource Group (CRG) meeting which was held on 21st September 2016.

3 The merged Business Development Group (BDG) and Capital Resource Group (CRG) meeting will also continue to review and monitor the 2016/17 capital programme on a monthly basis, paying particular attention to the risks associated with limited capital.

Summary

4 The 2016/17 capital programme has two main potential sources of funding :-

- Internally generated capital funding planned within the limit of depreciation, £11.0m. This depreciation funds the currently approved 2016/17 capital resource limit (CRL) of the Trust.
- A potential further £5.0m could become available, funded from an interest bearing capital loan, but this will be subject to the Trust submitting a business case to the NHS Improvement (NHSI) for approval. This additional funding will only become available if the NHSI approve the business case.
- The currently approved capital resource (CRL) is therefore £11.0m with the potential for this to increase by a further £5m.
- At the present time the 2016/17 trust capital programme is planned on the basis of an £11.0m CRL

5 The capital programme has also been revised in order to meet the demands of the Trust. This has increased the initially planned over commitment from £950k to an over planning margin of £1,803k. It should be noted that potential pressures and savings are forecast to potentially increase the planned over commitment to £1,828k.

Capital Programme Position at Month 5 – 31st August 2016.

6 At the end of month 5 the year to date current capital expenditure amounts to £3.1m.

7 Commitments entered into increase the current and committed capital expenditure level to £6.6m. The forecast over planning outturn at the mid-year stage is for potential capital expenditure of £12.8m which gives rise to an over planning margin of £1.8m compared to the Trust capital programme of £11.0m.

8 Over Planning Position as at 31st August 2016:-

	£000s
Planned Over Planning Margin 31st August 2016	1,803
Pressures : Pathology Clinical laboratory Design	170
Estates - Boiler replacement	40
Pevensey residual expenditure	15
Reductions:- IT GS1 slippage	-60
IT EDM slippage	-40
IT Vital Pac slippage	-100
Revised Forecast Over Planning Margin	**1,828**
IT Desk Top Refresh potential revenue leasing replacing currently planned capital purchase	-300
Net Forecast Over planning Margin	**1,528**

9 This level of over planning is considered acceptable at this stage of the financial year in view of the proposed content of the capital programme. It will be brought back in line with the CRL budget principally through the prioritisation of as yet uncommitted IT and Estates expenditure by the merged Business Development Group (BDG) and Capital Resource Group (CRG) group.

10 The merged Business Development Group (BDG) and Capital Resource Group (CRG) meeting will also continue to review and monitor the capital programme over commitment paying particular attention to the risks associated with ongoing capital pressures and limited capital resource to ensure that the Trust does not exceed its capital resource limit at 31st March 2017.

Current Capital Programme

11 In order to meet the changing capital requirements of the Trust the current 2016/17 capital programme has been revised by the merged BDG/CRG. The revised capital programme is set out below:-

Capital Programme	2016/17 Plan Including Proposed Capital Loan £000s	2016/17 Current CRL Programme £000s	Expenditure Month 5 £000s
Capital Resources			
Depreciation	11,519	11,519	
League of Friends Support	1,000	1,000	
Interest Bearing Capital Loan	5,000	0	
Capital Investment Loans Principal Repayment	-552	-552	
Sub Total	16,967	11,967	
Less Donated Income	-1,000	-1,000	
Total NHS Capital Financing (Capital Resource Limit)	**15,967**	**10,967**	
Planned Capital Expenditure			
Clinical Strategy Interest Bearing Capital Loan	5,000	0	0
Medical Equipment	0	713	0
Core IT Systems	2,100	2,100	267
Electronic Document Management	1,112	1,112	293
IT Other	680	680	135
Estates Strategy	2,500	2,500	39
Estates Backlog Maintenance	2,258	2,258	190
Minor capital	1,000	1,000	942
Other Schemes:-			
- Pathology CLD	727	797	421
- Vital Pac	338	338	155
- Project Management	106	106	36
- Brought Forward Schemes	1,096	1,166	547
Sub Total	**16,917**	**12,770**	**3,025**
Donated Asset Purchases	1,000	1,000	348
Donated Asset Funding	-1,000	-1,000	-320
Net Donated Assets	**0**	**0**	**28**
Sub Total Capital Schemes	**16,917**	**12,770**	**3,053**
Over Planning Margin	-950	-1,803	
Total Capital Expenditure	**15,967**	**10,967**	**3,053**

- The increase in the over planning margin from £950k to £1,803k is principally in respect of approved medical equipment including the proposed purchase of re-profiling beds throughout the Trust.

NHSI Capital Support Bid

12 The Trust is seeking to submit a series of business cases in the current financial year for the additional interest bearing capital loan support required in years 2 to 5 of the proposed capital programme for construction schemes, medical equipment and IT equipment that support the clinical strategy and improve and enhance where appropriate the clinical environment.

Recommendations

14 The Trust Board is asked to:-

i) Note the current performance of the capital programme.
ii) Note the risks associated with limited capital.
iii) Note that the BDG/CRG will continue to monitor the capital programme on a monthly basis to ensure that the Trust does not exceed its capital resource limit at 31st March 2017
iv) Note the ongoing work on the pipeline of business cases to be submitted for the £5.0m capital loan request in the current financial year.

Jonathan Reid
Director of Finance
30 September 2016

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	15
Subject:	2016 Premises Assurance Model Update
Reporting Officer:	Chris Hodgson, Associate Director, Estates and Facilities

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

Purpose:

The purpose of this report is to:

- Present an update on the progress made on Premises Assurance Model (PAM) for East Sussex Healthcare NHS Trust

Introduction:

As noted within the June 2016 Board report, PAM is a management tool developed by the Department of Health (DH) to provide a nationally consistent approach to evaluate NHS premises performance against a set of common indicators. It delivers a basis for:

- Self-assurance on the premises in which NHS healthcare is delivered
- driving premises-related performance improvements throughout the system

It is designed to be used locally by NHS organisations for Board reporting, and externally to provide assurance to Regulators and Commissioners.

A structured process has been developed to ensure a robust approach is adopted for undertaking the assessment and PAM comprises of five domains:

- safety
- patient experience
- efficiency
- effectiveness
- organisational governance

The NHS PAM covers both estates (the physical fabric of buildings) and facilities (the services that are directly linked to the estate i.e. food, cleaning etc.). Although the NHS PAM includes security questions, it is important to note this area is the responsibility of NHS Protect and not the DH. It is based on a series of Self Assessed Questions (SAQ's) with the option to respond :

- Outstanding
- Good
- Requires minimal improvement
- Requires moderate improvement
- Inadequate

The prompt sheets focus on specific legislation and/or DH estate guidance.

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

As noted within the June 2016 report to the Board, the Estates and Facilities Department (EFM) we have carried out a further self-assessment of each domain in September 2016

Through mapping our CQC evidence requirements and actual information recorded against the PAM requirements, we identified areas for improvement in evidence collection.

This evidence has now been mapped and collated where appropriate into a central electronic repository; this is to aid the annual assessment process and to have information readily accessible in a central location for access by regulators/commissioners.

The evidencing of this data has helped us to improve our score from 54 to 71 in the overall domain rating for Good. This improvement in performance has been primarily in the safety domain for Soft FM services.

The overall PAM score summary scores for all 5 domains and the Hard and Soft FM safety metrics for 2015/16 which have been derived via the assessment process and are summarised in Appendix 1. We consider the results to be fair assessment of our services and approach.

The top five priority areas that arise out of the needs moderate improvement' categories that we will target for improvement are as follows:

1. Safety – Hard FM

There are external Authorising Engineer reports which have been undertaken in 2016 e.g. Fire, Pressure systems, ventilation and these reports which require a full technical review and costs attributed as appropriate.

2. Patient Experience

We need to improve engagement with staff and this should then result in improved patient experience. For example we will continue to build upon the Porters working hours consultation and commence the externally supported Housekeeping productive cleaning program.

3. Efficiency

We will build upon the draft 16/17 EFM business plan to illustrate our approach to dealing with the challenging cost efficiency/improvement program and continue to work with on the Lord Carter iniative on EFM aspects of the model hospital program.

4. Effectiveness

We will develop the 17/18 EFM business plan in the latter part of Q3 and ensure it aligns with the Trust business plan and is transparent about how EFM contributes to the overall organisation, whilst ensuring that it sets objectives/goals which are related to both EFM and the overall ESHT approach.

5. Organisational Governance

Whilst we acknowledge the strides made in improving our internal governance processes within EFM, we acknowledge that the further work is required with our staff to ensure we encourage a culture of candour, openness, honesty as well as continuing to respect and value our EFM staff. We will build upon the work we are undertaking as outlined in section 2 and also explore ways to improve cross site supervisor reviews/team working and Band 1/2 team briefings/meetings.

Next steps

1. Establish a goal to reduce the " Requires moderate improvement" from current score of 57 down to 28 by end of FY17/18 Q1, noting sections 1-5 priorities as above
2. Share the model with colleagues who manage HSDU and Telecoms for them to carry out their own self-assessment
3. Review performance quarterly at the EFM Governance meeting

Benefits:

- Assurance through a nationally recognised EFM standard

Risks and Implications
• Resources required in the long term to achieve significantly beyond the current performance/score

Assurance Provided:
• The PAM assessment has been completed and performance will be monitored through quarterly reports to the EFM Governance meetings.

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	x
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
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.	x

Review by other Committees/Groups (please state name and date)**:**
None

Proposals and/or Recommendations
The Board are asked to note the results of the PAM assessment.

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: Chris Hodgson Associate Director of Estates and Facilities	**Contact details:** (13) 4175

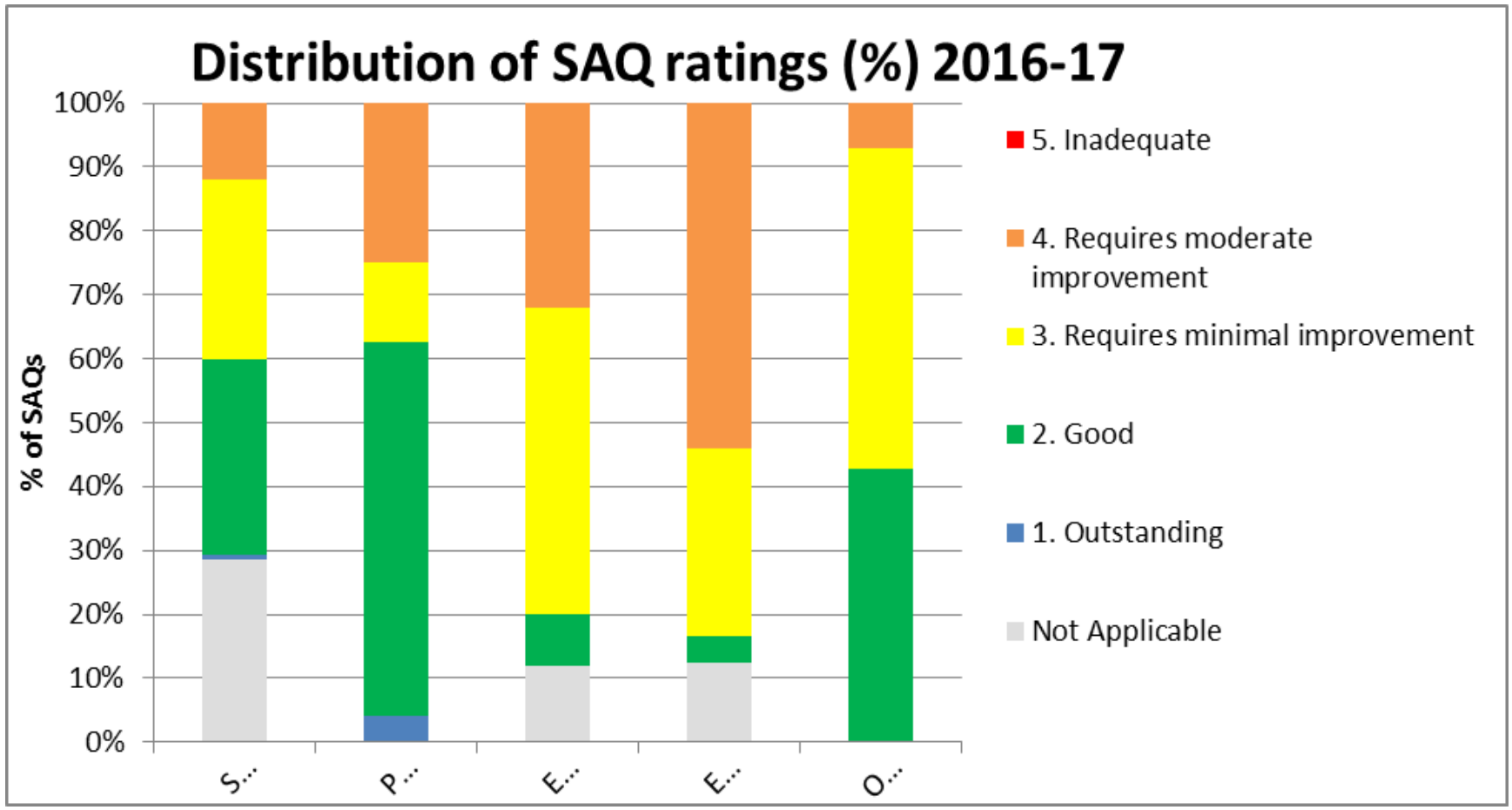
Appendix 1- SAQ scoring summary

Table 1 Sept 2016 update

2016-17							
Overall Domain Rating:	Not Applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate	**Total**
Safety	66	2	(71) 54	(65) 80	(28) 30	0	232
Patient Experience	0	1	14	3	6	0	24
Efficiency	3	0	2	12	8	0	25
Effectiveness	3	0	1	7	13	0	24
Organisation Governance	0	0	12	14	2	0	28
Total	***72***	***3***	***(100) 83***	***(101) 116***	***(57) 59***	***0***	***333***

Notes
1-Revised September 2016
2-All figures in brackets are changes in scoring arising from a review of the initial May 2016 assessment results. All scores not in brackets remain unaffected from the September 2016 assessment.

Figure 1, Distribution of SAQ ratings



Notes

1- Column 1:Safety Column 2:Patient Experience Column 3:Efficiency Column 4: Effectiveness Column 5: Organisation Governance

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	16
Subject:	Risk and Quality Delivery Strategy
Reporting Officer:	Alice Webster

Action: This paper is for **(please tick)**

Assurance		**Approval**	x	**Decision**	

Purpose:

To provide a document for the Trust that details an overview of the governance structure. This should enable staff and external organisations to understand how the communication of clinical governance is achieved between the committees/groups, Clinical Divisions and Corporate functions. This should demonstrate how concerns such as risks, incidents, complaints are identified, analysed and acted upon (improvement), and escalated where required from floor to Board.

This document is a re-write designed to replace the existing risk strategy and the governance strategy and to provide the framework supporting the Trust Quality Strategy.

Introduction:

This document has been approved by the Quality and Safety Committee, and incorporates the trust vision and strategic objectives detailed in the 2020 strategy.

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

N/A

Benefits:

To provide a single document for staff to understand the Governance Structure and assurance to external organisations we have robust governance structure in place.

Risks and Implications

Failure to have a Trust wide document detailing the Governance Structure and links with Divisions/Clinical Units could affect staff awareness of systems and importance, future procurement bids and external assessments.

Assurance Provided:

N/A

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	x
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
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.	

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

Proposals and/or Recommendations
To ratify the document

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: Ashley Parrott	**Contact details:** 07972244079

East Sussex Healthcare NHS
NHS Trust

Risk and Quality Delivery Strategy

Version:	V1.5
Ratified by:	Quality and Safety Committee
Date ratified:	Sept
Name of author and title:	Ashley Parrott, Associate Director of Governance
Date Written:	September 2016
Name of responsible committee/individual:	Quality and Safety Committee
Date issued:	
Issue number:	
Review date:	September 17
Target audience:	All staff
Compliance with CQC outcome	Outcome 16
Compliance with any other external requirements (e.g. Information Governance)	Information Governance Toolkit 301, 302 and 307

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Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0 2012038	January 2012	Margaret England	New organisation	Full revision
V1.1 2012179	August 2012	Emily Keeble	Organisational change and to meet compliance requirements	Altered to reflect changes in group structures including terms of reference many of which have been updated. Inclusion of patient safety group and divisional quality groups. Development of the monitoring arrangements.
V1.2	January 2013	Emily Keeble	Changes post-NHSLA inspection	Revised monitoring table
V1.3	February 2014	Emily Keeble/Lynette Wells	Annual Review	Removal of reference to NHSLA Replacement of Trust Strategic Objectives Replaced SIC with Annual Governance Statement Removal of reference to Divisions
V1.4	April 2015	Emily Keeble	Annual Review	Minor changes
V1.5	August 2016	Ashley Parrott	Reflect changes to structure and processes	Re-write and name change to incorporate two strategies into one (Governance Strategy)

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Quality and Safety Committee	Quality and Safety Committee	Sept 2016

Table of Contents

1. Statement of Intent

East Sussex Healthcare NHS Trust is committed to continuously improving the outcomes for its patients and achieving excellence in patient care. It recognises that it has a statutory and regulatory duty to ensure that systems of control and governance are in place to monitor and improve the quality of care provided and reduce the impact of any risks that could affect patient care, staff and the organisation.

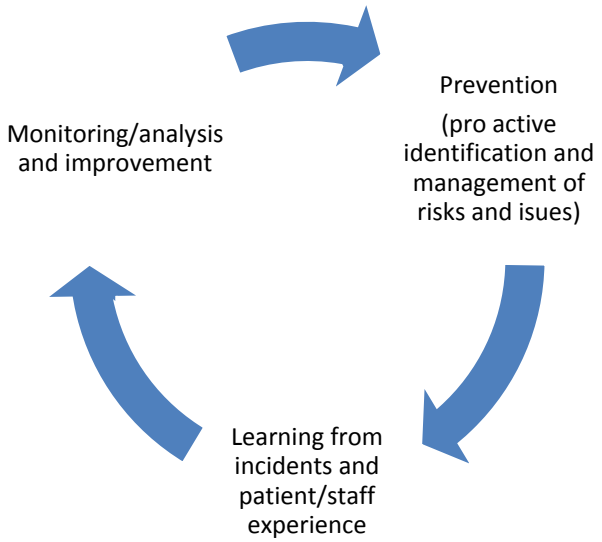
The Trust Board recognises that risk management is integral to good governance and management practice and is committed to ensuring this is firmly embedded within the culture of the organisation. As such, the Risk and Quality Delivery Strategy must be implemented throughout all levels of the organisation.

2. Introduction

The aim of the Risk and Quality Delivery Strategy is to outline the trust governance structure to support the delivery for the three domains of quality (patient safety, patient experience and clinical effectiveness) and to outline the systems in place to manage them effectively. This will be achieved through the effective use of core governance systems such as risk management, incident reporting, complaints management and audit and compliance. This document will provide the framework to deliver the trust Quality Strategy through central and Division/Clinical Unit governance structures.

This strategy is supported by a number of policies such as the Risk Management Policy and Procedure, Incident Reporting and Management Policy and Managing Complaints Policy and is also aligned to ESHT 2020 our Strategic Priorities for Improvement.

The system to support risk and quality delivery within the organisation is grouped into 3 core areas as shown below:



3. Strategic Objectives

The Trust vision statement is:

"ESHT combines community and hospital services to provide safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex."

To support the statement above there are 5 Key Strategic Objectives (KSO's) that are also detailed in the trust 20:20 strategy:

1. Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
2. All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfill their roles.
3. We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.
4. We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.
5. We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.

Quality care has 3 specific domains which are:

- Patient Safety
- Patient experience
- Clinical effectiveness

4. The governance structure with specific committees and groups with quality and risk responsibilities

4.1 Governance Structure Chart

The structure chart below demonstrates the ward to board approach to governance with the central corporate functions providing support to deliver the 3 core areas.
The Trust has established a committee reporting structure based around the 5 key sections which are:

- Quality and Safety
- Leadership and culture
- Clinical Strategy
- Access and operational delivery
- Financial control and capital development

Within each of these sections there are specific committee/group structures as detailed in **Appendix A**. All these groups perform vital functions to ensure the delivery of high quality care. There are terms of reference in place reviewed annually for all the committees and groups within the trust that detail the specific functions, reporting arrangements, membership and frequency of meetings.

Governance Structure

Central Support

Prevention

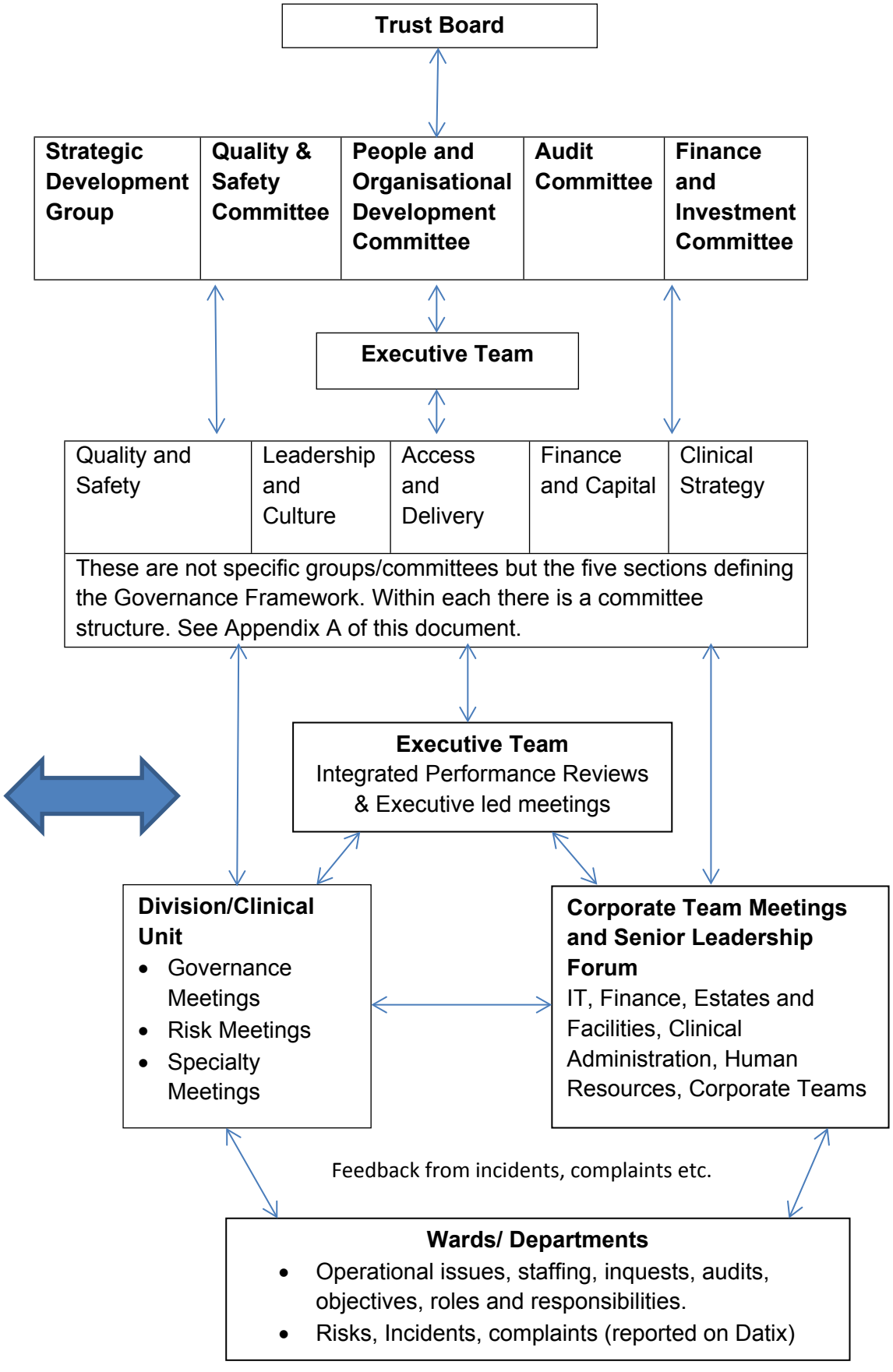
- Risk register
- Risk assessment
- Staff skills, recruitment & training
- IT systems
- Compliance with national guidance and standards
- Polices

Learning from experience

- Incident management (investigations and identification of actions to improve)
- Patient feedback (FFT and Complaints, user forums, engagement)
- Staff feedback
- Claims/Inquests
- Mortality and morbidity reviews

Monitoring, Analysis and Improvement

- Audit
- Testing actions
- Improvement Hub



4.2 Trust Board

The Board is accountable for ensuring the effectiveness of the risk management systems and internal controls within the Trust. The Audit Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and compliance with CQC registration standards. The Board is required to gain assurance that all risks have been identified and are being appropriately managed and the Board Assurance Framework appears on the Board agenda bi monthly. The Board is also responsible for the quality of care provided to patients and the safety of staff. This will be achieved through delegation of specific duties to sub committees and groups to monitor, challenge and embed change for continuous improvement.

4.3 Audit Committee

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

In relation to its role in risk management the Committee will review the adequacy and effectiveness of:

- The Board Assurance Framework;
- The risk management system;
- The Annual Governance Statement together with an accompanying Internal Audit Statement (within Annual report and Quality Account);
- External audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible.

4.4 Quality and Safety Committee

The Quality and Safety Committee ensure, on behalf of the Board, that taking account of best practice, there are effective structures and systems in place that support the continuous improvement of quality services, safeguard high standards of patient care and evidence effective risk management. This committee seeks assurance the safety and quality structure is effective and identifying, managing and improving risk and quality, and supporting the quality strategy. This committee will seek assurance on behalf of the Board the functions within the Trust are effective in their monitoring, analysis and response to quality and risk issues.

4.5 Finance and Investment Committee

Although high quality care will reduce cost through improved safety and effectiveness this committee will ensure on behalf of the Board the Trust has the appropriate finances to maintain a safe and effective system that can support quality improvement initiatives. It will also provide recommendations and assurance to the Board on:

- The future financial risks of the organisation
- The integrity of the Trust's financial structure
- Delivery of the Trust financial plan.

4.6 People and Organisational Development Committee

This Committee will ensure there is a managed programme for providing a skilled workforce that reacts early to planned and enforced changes in service delivery.

4.7 Strategic Development Group

The Strategic Development Group (SDG) is the group that will provide leadership and oversight to support ESHTs strategic plan. The group will ensure organisational alignment with national strategy, with the Sustainability and Transformation Plan (STP) and with the local commissioning intentions of East Sussex Better Together (ESBT).

4.8 Executive Team

The Trust Executive Team will be aware of the quality and risk concerns and successes for the Trust to respond swiftly where required and ensure the correct committee/group is managing the situation appropriately. This may be through an individual Executive Director or to the whole Executive Team. Issues identified by the Executive team will be cascaded to the appropriate committee/group. The/members of the Executive Team have responsibility for approving new corporate risks prior to uploading on the trust risk register. This will be done though single sign off or at the Integrated Performance Review Meetings.

4.9 Division/Clinical Unit Integrated Performance Meetings

These meetings provide the opportunity for each Division/Clinical Unit to share quality and performance qualitative and quantitative data and subsequent concerns and successes with the Executive Team. The core aim is to ensure each Division /Clinical Unit is aware of their quality and safety risks, performance and delivery risks and to provide assurance to the Executive Team quality improvement plans are in place and working to address issues.

4.10 Division/Clinical Unit Governance Meetings

The Governance meetings are for each Division/Clinical Unit to share issues, risks and learning from events with its team members and to establish actions to resolve them. This will provide the background information and discussion to the Integrated Performance Reviews. There are specific sections such as risks, incidents, complaints, mortality, and infection control to ensure the learning is discussed and shared.

4.11 Patient Safety and Quality Group

The Patient Safety and Quality Group has two key functions which are to:

- Provide a broad overview of Trust patient safety, patient experience and clinical effectiveness to identify trends and ensure findings are acted upon. This includes regular reviews of serious and amber incidents, other incidents, complaints, inquests and claims;
- To review and monitor the work plans and their progress for the senior groups/committees within the Quality and Safety Group itself. These are the Clinical Outcomes Group (includes mortality), Clinical Effectiveness Group, Infection Prevention Control Group, Medicines Optimisation Group, Safeguarding Group and the Health and Safety Group.

4.12 Improvement Sub Committee

The members of this group will initially to act as the ESHT 2020 Improvement Programme Board with the following main areas of responsibility:

- Ensure strategic projects have followed the Trust Business Case approval process with realistic benefit profiles and allocated funding
- Design, review and agree the programme governance, plans, approving the tranches, phasing and timescales between each phase
- Monitor the progress against the programme plan
- Ensure the programme is delivering the vision and raise concerns when that assurance is not perceived.
- Challenge unrealistic objectives and unmeasured activities

4.13 Corporate Functions – Team Meetings

Within Corporate Services there are specific teams such as Estates and Facilities, Finance, Human Resources, Assurance and Strategy and Operations. These teams will all hold monthly meetings where risks and quality improvements are included on the agenda. Sign off for new corporate risks will be by the Executive lead for the specific service. Concerns or issues to the organisation will be reported to the appropriate group/committee for action.

4.14 Relationships between Committees

In order to ensure a co-ordinated and holistic approach to the management of quality delivery and risk, there is cross membership between the committees detailed in the structures **(see Appendix A).** All the committees/groups are responsible for ensuring that risks in the area of responsibility are managed and reported (escalated) to their reporting committee/group as detailed in their terms of reference.

4.15 The Division / Clinical Unit Structure

For effective delivery of quality each Division/Clinical Unit must have a Governance Structure that manages delivery but also quality and risk as these ultimately drive performance. The specific structure for each is detailed in **Appendix B** of this strategy. There are and can be differences between the Divisions in their structure however all must ensure the following are robustly managed:

- Risk identification and management (risk register) – Review and update of current risks and identification and management of new risks;
- Incident management – Regular review of incidents for the division to identify trends and themes that can be addressed, and ensure investigations completed as per Trust policy;
- Serious and Moderate incident management – To ensure the investigations are completed on time and the duty of candour legislation is applied effectively. To share learning and complete actions identified to prevent re-occurrence;
- Complaints management - Review of trends and themes and appropriate management of dealing with complaints to ensure responses provided within the correct timeframe;
- Claims and Inquests – To be aware of these and ensure actions completed to prevent re-occurrence where failings identified;
- Mortality and morbidity reviews – To ensure all deaths are reviewed within the Trust policy timescales and learning and actions from cases are completed;
- Audit of effectiveness – To ensure compliance with national audit and best practice guidance and local audit completed with learning from all areas actioned;

- Workforce – to manage workforce in terms of recruitment, appraisals and training;
- Health and Safety (H&S) – To monitor H&S issues and incidents and act accordingly to provide a safe environment for staff, patients and visitors;
- Infection Prevention and Control – to monitor compliance with cleanliness standards and address learning from reported infections;
- Safeguarding (adults and children) – To ensure compliance with Trust policy;
- Monitor performance and quality – To use performance dashboards/measures and act on concerns. To monitor the Division/Clinical Unit Quality Dashboard and deep dive into wards /departments delivering poor or excellent performance and learn from these to support them and other areas;
- Quality Improvement - To identify quality improvement requirements (from all the above) and support teams in providing resources and monitoring delivery of these;

5. Duties of Key Individuals

5.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that an effective risk management system and a system of internal control is in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance. As Accountable Officer, the Chief Executive is, through review of internal control systems, responsible for completing the Annual Governance Statement. The Chief Executive will ensure that the responsibilities for the management and co-ordination of quality delivery and risk are clear and that the structure outlined in this document is maintained.

5.2 Medical Director/Director of Nursing

The Medical Director and the Director of Nursing have delegated responsibility for ensuring and overseeing the implementation of appropriate governance systems which includes the development and maintenance of risk management and quality processes. They will provide the leadership to ensure the Trust undertakes this function in accordance with best practice, legal and statutory duties and will lead the Trust's approach on achieving compliance with standards relating to quality.

5.3 Director of Strategy

The Director of Strategy has delegated responsibility for leading the strategic direction for the organisation taking into account governance and risk management to ensure effective delivery against Trust business plan targets. This post will also be responsible for the improvement programme.

5.4 Director of Finance

The Director of Finance has delegated responsibility for ensuring the implementation of financial risk management and to seek and provide wherever possible available resources for quality improvement work within the Trust. This role has overall responsibility for the Project Management Office and Knowledge Management supported by the Associate Director of Knowledge Management and the Improvement Programme Manager.

5.5 Director of Corporate Affairs

The Director of Corporate Affairs leads on the development and management of the Board Assurance Framework and ensures that the organisation keeps abreast of best practice, legal and statutory requirements and national guidance.

5.6 Associate Director of Governance

The Associate Director of Governance has overall responsibility to ensure the central governance team and functions are effective and supporting the Divisions/Clinical Units/Departments to deliver their quality and risk responsibilities. This includes supporting the Divisions and Clinical Units to have robust structures with a Trust wide framework in place to review and identify areas for improvement and to learn from successes.

5.7 Head of Governance

The Head of Governance is responsible for the central governance team which provides specialist support and advice on the implementation of the Risk Management. The central team will ensure there is support, advice and systems in place for incident management, risk management, clinical effectiveness, health and safety and patient experience. Specific roles from senior team members will be detailed within the relevant policies (e.g. Risk Management Policy and Procedure)

5.8 Division and Clinical Unit Leads, Heads of Nursing and Governance, General Managers and Senior Managers for Corporate Functions.

This staff group is critical for effective delivery of risk and quality improvement as they need to understand the systems in place and ensure fully embedded within their structure and teams. They must provide the resources within their areas to deliver on the core functions detailed in section 4.14 of this document.

5.9 All Managers

All levels of management must understand and implement this strategy and comply with Trust policies. They must ensure that adequate resources are made available to provide safe systems of work; this will include making provision for risk assessments, appropriate control measures, raising outstanding concerns, ensuring safe working procedures / practices and continued monitoring and revision of these. They will promote risk management and health and safety awareness among all staff by example and ensure that staff are appropriately trained and competent for assessing risks and determining adequate control measures within the working environment. They will support staff in identifying and delivering quality improvement work to continuously improve care, efficiency and eliminate harm.

All Managers are authorised to:

- Ensure that appropriate and effective risk management processes are in place within their area of responsibility and that all staff are aware of the risks within their working environment;
- Ensure all necessary risk assessments are carried out within their department;
- Implement and monitor any identified risk management control measures within their scope of responsibility;
- Review a summary of all incidents and risks within their teams and disseminating this information to ensure that appropriate learning takes place;
- Communicate risk management within their departments;

- Identify areas for improvement and work with teams to deliver these (internal and/or corporate teams).

5.10 All staff

All members of staff have an individual responsibility for the management of risk and quality and will:

- Be aware of and comply with the Trust's Risk Management Policy and Procedure;
- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Trust's business;
- Comply with the Incident Reporting and Management Policy by reporting all types of incidents and near misses through the appropriate processes;
- Be responsible for attending any mandatory and relevant education and training events;
- Identify and raise areas in need of improvement to their line manager;
- Provide safe clinical practice in diagnosis and treatment
- Be aware of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures appertaining to their particular division /unit location

6. Prevention of Harm

Prevention of harm requires an effective risk management and quality system to identify potential risks and act on them swiftly to mitigate or reduce the likelihood of the event happening or impact (consequence) should it occur. It also requires governance systems to be in place and followed such as policies and procedures, compliance with best practice and standards and recruiting and maintaining a skilled workforce.

6.1 Risk Approach, Identification and Register (Please refer to the Risk Management Policy and Procedure for process detail)

Definition of Risk Management:
Risk Management is the term applied to a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process, in a way that will enable organisations to minimise losses and maximise opportunities. It is as much about identifying opportunities as avoiding or mitigating losses.

Definition of Risk:
Risk can be defined as 'the possibility of incurring misfortune or loss,' (Oxford English Dictionary) for example through an unexpected event happening that may either cause harm or have an impact upon patients, staff, visitors, partner organisations, strategic objectives, assets and/or reputation. In particular:

- Any element which has the potential to damage or threaten the achievement of the objectives, programmes or service delivery of the organisation,
- Anything that could damage the reputation of the organisation and undermine the public's confidence in it
- Failure to guard against impropriety, malpractice, waste or poor value for money
- Failure to comply with regulations such as those covering Health and Safety and the environment and the Care Quality Commission (CQC) fundamental standards.
- An inability to respond to or manage changed circumstances in a way that prevents or minimises adverse effects on the delivery of services.

Risk Assessment Process
The following steps must be taken when completing a risk assessment:

- Establish the context
- Risk identification
- Risk assessment
- Evaluation and Ranking
- Risk Treatment
- Monitor and review
- Communicate and Consult
- Escalation

Assessment Form/Scoring System
Once a risk has been identified it must be assessed and approved following the Risk Management Policy and Procedure available on the Trust intranet. The Risk assessment tool must be completed and approved prior to sending to the Trust Risk Team for uploading on the Datix system. Once approved it will be loaded onto the Datix or Assure system and will be live for review and sharing. Assessment and grading of risks is completed by using the National Patient Safety Agency (2008) framework as detailed in the Risk Management Policy and Procedure

Risks are approved, shared and communicated through the following systems:

Board Assurance Framework

- Risks to the achievement of trust Key Strategic Objectives
- Reported to: Trust Board, Quality & Safety Committee
- Stored: Executive Shared Folder

The Board Assurance Framework is a strategic risk management tool reporting key risks to the achievement of its aims and objectives. The Board Assurance Framework is used by the Trust Board to ensure that all identified risks are focused upon and that effective controls are in place thus providing assurance that a robust risk management system underpins the delivery of the organisation's principal aims and objectives. It highlights gaps in the effectiveness of controls or of assurance and informs the Board of the areas where it should be scrutinising the controls the organisation has in place to manage the principle risks.

Corporate Risk Register

- All Local risks 15 and above
- Reported to: Trust Board, Quality & Safety, Specific Groups/Committees, Divisions/Clinical Units
- Stored: Datix system

These risks are corporate in name due to the high level risk rating therefore there could be a significant threat to service delivery or safety for the organisation. The Corporate Risks receive more scrutiny and ensure members of the Trust Board are aware of them and have the opportunity to challenge the adequacy of controls in place and suitability of planned actions. These risks are stored on the Datix system and will remain as a permanent record whether open or closed on the system. Sign off to approve these risks for a rating of 15 or above must be done by an Executive Director either at the Integrated Performance review or if a Corporate function through the Lead Executive for the department.

Local Risks

- All risks assigned to a specific department and or Division/Clinical Unit
- Reported/reviewed: Division/ Clinical Unit/Departments
- Stored: Datix system

These risks are Local in name because they are owned and managed by the departments and Divisions. They can originate directly from a Division/Clinical Unit or from a department working within it. These risks under 15 in rating will be managed, monitored, reviewed and shared within the Division/Clinical Unit structure. Should they require escalation following a review and re-grading they will become a corporate risk. All these Local risks are stored on the Datix system to allow ease of access and escalation. These include patient safety risk assessments such as opening new escalation areas

Generic Department Risks

- All local department risk assessments required for legislation such as lone worker, COSHH, Moving and Handling, Fire safety
- Reported/reviewed: Departments, Health and Safety Team, Health and safety Group
- Stored: Assure system

These are legislative risk assessments required to ensure compliance with the Health and Safety at Work Act 1974. They are generic assessments to ensure the safety and welfare of staff is well managed at department level. These are recorded on the ASSURE system and will only be escalated and recorded on the Datix system as Local or Corporate risks if there has been a number of incidents or an increased risk for the specific generic risk that cannot be managed by the department. The Generic Department Risk assessments are populated directly onto the ASSURE system and then approved by a manager before becoming live and available for review by other staff and teams.

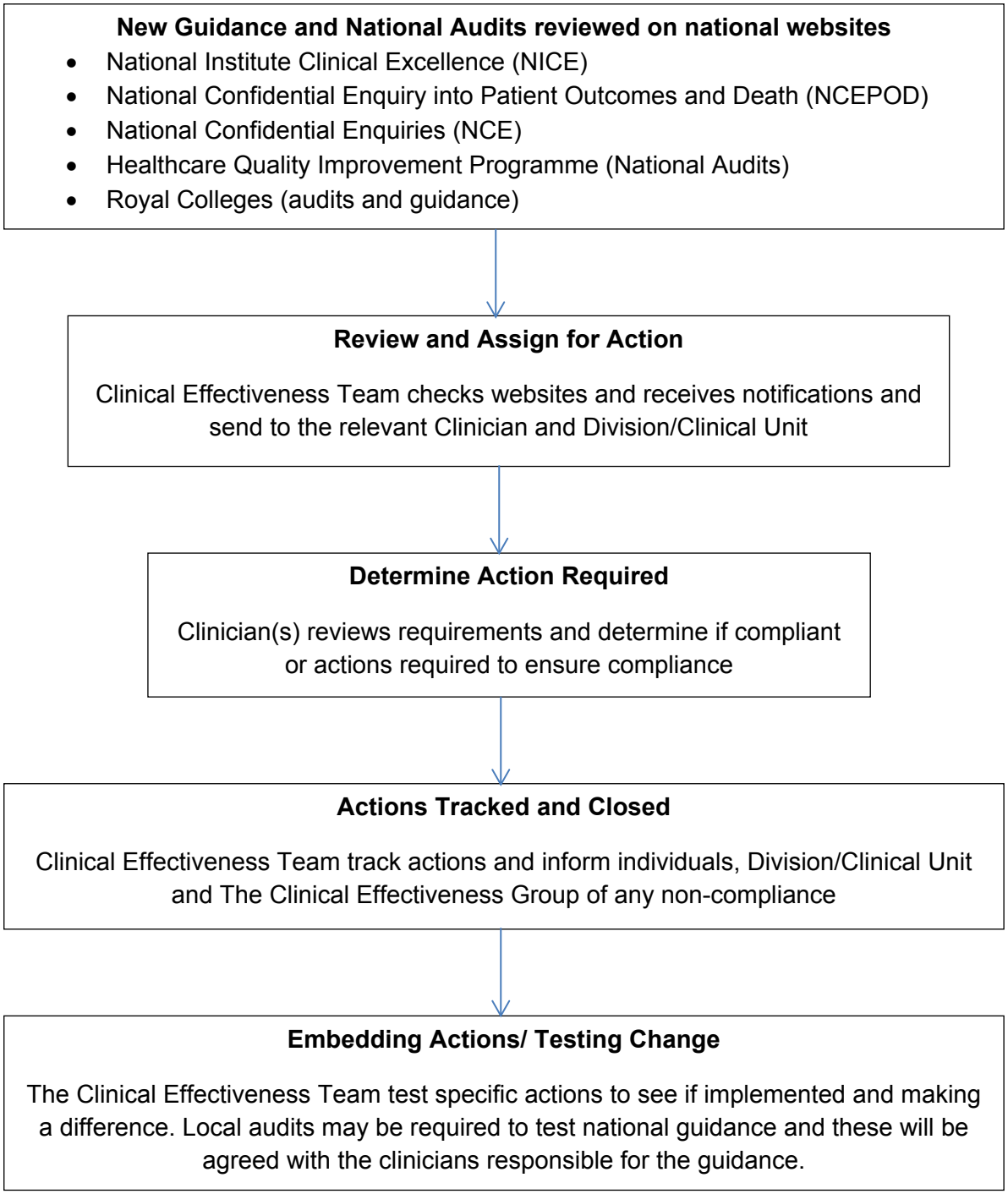
Monitoring and Reviewing Risks

All risks must be owned by the Division/Clinical Unit or Corporate Function and the Departments responsible. A lead manager is assigned to each risk to ensure it is reviewed on a monthly basis. Each Corporate risk is assigned to a responsible senior Group/Committee to ensure they are discussed and challenged in terms of their controls in place, rating and have appropriate actions assigned. Awareness of the risks and controls must be communicated to teams involved through Governance meetings, risk meetings and department team meetings.

The Governance Team manages the risk management software (Datix and ASSURE) to look for duplicated risks, trends and provide support to staff in completing and reviewing risks.

6.2 Compliance with national guidance and standards

National standards and guidance are usually an outcome from learning, audit and experience and therefore important for the Trust to recognise this and ensure recommendations are implemented to prevent harm to patients and improve the quality of care provided. The Clinical Effectiveness Team within the Governance Team structure identify new guidance and disseminate to the appropriate Clinicians and specialties for review and actions as detailed in the chart below:



The Clinical Effectiveness Group is responsible to monitor and respond to compliance with the process outlined above. Further information is within the Audit Policy and the NICE Policy

6.3 Staff skills, recruitment & training

To deliver quality care there must be a highly trained workforce who are positive about their work environment. The Trust recognises this and has in place through the Leadership and Culture Section a committee structure to deliver education, support and change programmes. The Education Steering Group which includes executive attendance from the Director of HR, Director of Nursing, and Medical Director ensures there are systems in place for the training and development of staff. There is a Corporate Human Resources (HR) Function with specific teams to manage the following:

- Learning & Development – manages the process for statutory and mandatory training, as well as other role essential, soft skills, and training. In conjunction with Clinical Education they also oversee the process of applying for funding for external training and development. In addition Workforce Development leads support the delivery of leadership and management development for staff.
- Clinical Education – Oversees the training and development for all clinical (non-medical) staff, including supporting students on placement, supporting newly qualified staff, and managing contracts with our partner Higher Education Institutes.
- Medical Education – Oversees the training and development of all Doctors in Training and some areas of development for Consultants and Staff Grade Doctors.
- Occupational Health - provides support to staff with health issues, and this department also includes Health & Wellbeing Co-Ordinators who look at ways of improving the health and wellbeing of our staff.

The Electronic Staff Record (ESR) system records training and staff details and regular reports are produced which detail compliance with statutory and mandatory training, and outline how we are spending education funding.
The HR department establish systems for appraisals and monitor compliance as described in the main Human resources Policies available through the trust extranet.

6.4 IT Systems

Information Technology Systems allow clinical teams to store and review data and flag up clinical concerns and findings. These are integral to patient safety and are in widespread use within the Trust and are tracked centrally on the information asset register managed by the Information Technology Department. There is a specific information governance manager in place to monitor and provide advice on Data Protection.

6.5 Policy Management

The existence and compliance with operational policies is crucial for ensuring there are safe and effective systems in place for the organisation as these are produced from best practice and national recommendations where identified. There is a Policy Management Group in place to sign off/approve the documents before they are uploaded onto the Policy Management System. The Policies are available through the trust Extranet and are tracked for expiry dates by the Governance Team. Each individual author and Division/Clinical Unit or Corporate Department is responsible for updating the documents when reminded of forthcoming expiry date.

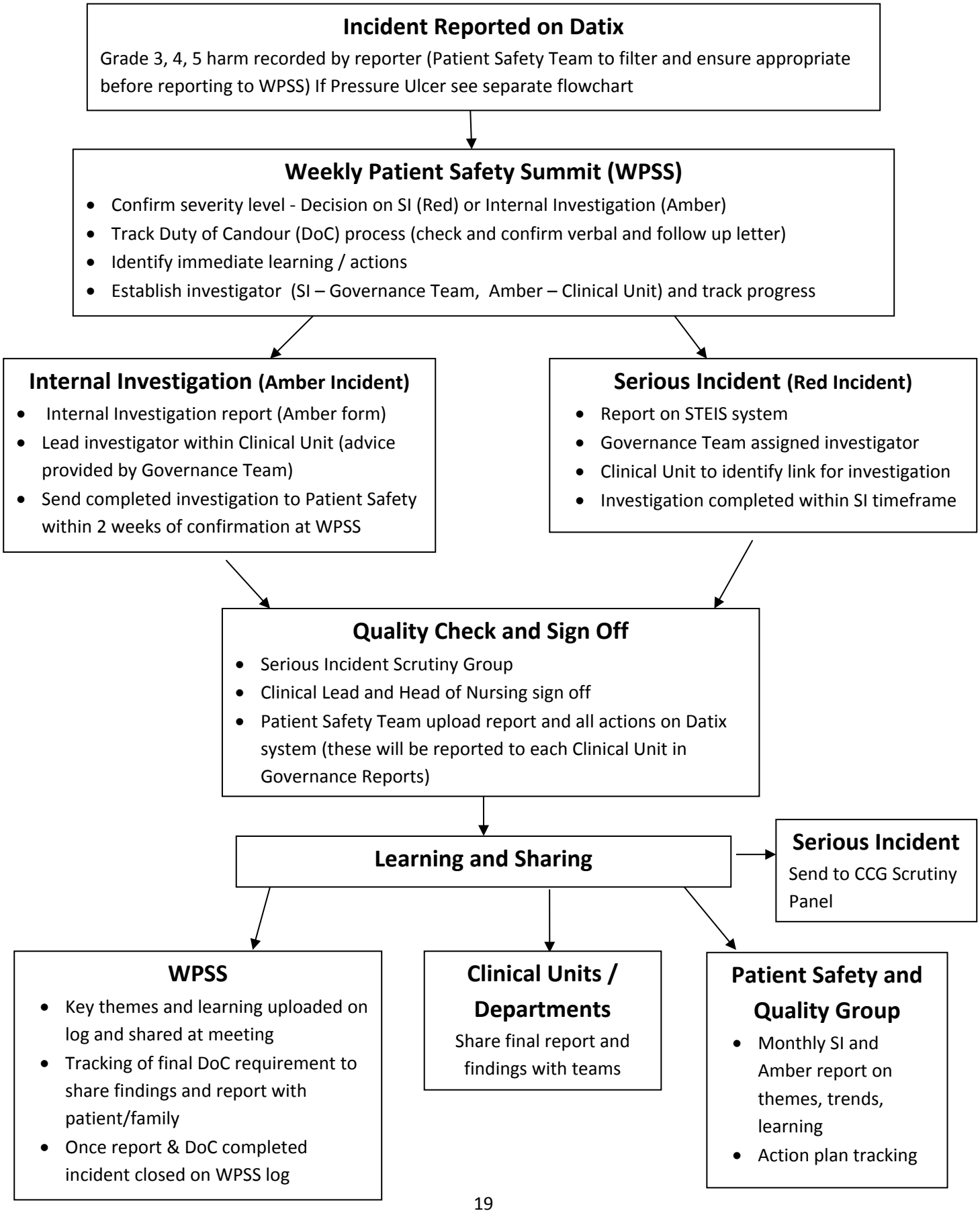
7. Learning from Experience

Learning from experience is generally achieved through incident investigations and patient feedback from complaints, user forums and questionnaires / surveys. Staff and department meetings, safety huddles and mortality reviews and audits can also provide learning opportunities along with other methods for individual and group learning. This section will focus on the processes in place for incidents, complaints, patient experience, mortality reviews, claims and inquests.

7.1 **Incident Management** (Please refer to the Incident Reporting and Management Policy for full details)

The central risk management system for the Trust is Datix which is used to record and store all reported incidents. Staff report the incident they have witnessed or were involved in directly onto the electronic system using the Datix incident form. There is a process from this point to track the incident and ensure it is managed and investigated as detailed in the Incident Reporting and Management Policy. Incidents are graded by severity at the point of reporting and then reviewed during the investigation process. All incidents with initial grading of 3 (moderate), 4 (major) and 5 (catastrophic) are reported to the Weekly Patient Safety Summit (WPSS) where a decision is made to confirm grading, declare and conduct a serious incident investigation, undertake an internal “Amber” investigation for moderate harm or downgrade and complete the standard investigation on Datix system. The process for this is outlined below:

Serious Incident (SI) and Moderate Incident Flowchart (grade 3, 4 and 5 severity)



The Serious incidents are investigated by members of the Governance team trained in Root cause Analysis to ensure the following:

- Independent review of the incident;
- Involvement of patient and or relatives in the investigation process;
- Ensure a high standard report using the same format;
- Independent discussions with people to ensure learning from all staff involved;
- Ensure effective compliance with the Duty of Candour;
- Increased support to the clinical teams saving them time away from patient contact.

An Amber (moderate) incident investigation is conducted when moderate harm has occurred however the event does not meet the NHS England criteria for reporting as a serious incident. This investigation will be robust and scrutinised centrally with the results shared with the patient and or family as part of the Duty of Candour process. An Amber investigation may also be conducted where the level of harm is unknown but the WPSS believe there are learning opportunities.

All Serious Incidents and Amber investigations are scrutinised at the Trust Serious Incident Scrutiny Group to provide assurance the investigation was robust and the key learning points have been identified. Once approved by this group as shown in the flowchart above the incident and findings can be shared with the teams involved and with the patient.

All other incident investigations are conducted by the allocated investigator and once completed are checked by the central Datix team and finally approved on the system. Once finally approved the specific incident feedback provided by the investigator is sent to the reporter of the incident electronically.

Learning from serious and amber incident reports is shared to members of the Serious Incident Scrutiny Group, Senior Leaders Forum and the Patient Safety and Quality Group to provide an overview of the organisation and ensure the event is not only known within the specialty or Division it occurred within. Each report is also shared and discussed at the Division/Clinical Unit Governance meeting where it must then be cascaded down to the relevant departments.

Learning and sharing all other incidents is achieved through the following methods:

- Individual feedback to the reporter;
- Discussion at department meetings;
- Discussion at Division/Clinical Unit Risk meetings and or their Governance Meetings;
- Incident analysis report for the whole trust reviewed at the Patient Safety and Quality Group (PSQG) on a monthly basis.

Specific trends identified by the Governance Team will be taken for discussion at the PSQG to determine the course of action. This could be to establish a task and finish group or to place under increase surveillance.

All required actions from serious and moderate incidents will be recorded on the Datix system and tracked for completion. This will provide assurance the organisation acts on findings from the incidents that can be tested to see if embedded in practice and effective.

Further detail on testing the learning from incidents is detailed in the monitoring and analysis in section 8 of this document.

7.2 Patient Feedback

Patient feedback is essential for any service to receive and action trends to improve the quality of care. This should always be encouraged whether positive or negative and the ethos must be to welcome any feedback.

The Patient Experience Steering Group is responsible for managing patient experience and providing the direction for the organisation. There will be 4 patient representatives on this group to provide feedback and challenge. The four key areas within the patient experience agenda are Friends and Family Test and patient questionnaires, complaints and patient advice and liaison service, volunteer support and patient information. The full process for managing complaints is detailed within the Managing Complaints Policy. There is a specific Complaints and Patient Advice and Liaison Service Team with all contacts formal and informal recorded on the Datix system. Formal complaints are responded to within the 35 or 45 day timeframe depending on the complexity and signed off by the Chief Executive. All actions the Trust will take stated in the response letter are recorded on the Datix system and tracked for compliance.

The Meridian system is the platform in place to record all the patient feedback from questionnaires and the Friends and Family Test. This enables the information to be shared with the departments and Divisions/Clinical Units. The Patient Experience Manager is responsible for recording and disseminating the information and the department managers are responsible for ensuring the information is collected within their department.

Trends and themes from patient experience must be identified and shared with the Divisions/Clinical Units. This will be achieved through the Patient Experience Team monthly report and deep dive on specific areas. The Patient Experience Steering Group will identify trends and feedback to the services providing the care requesting actions to be taken for improvement. Specific learning from complaints is shared at the Division/Clinical Unit Risk and or Governance meetings.

The Patient Engagement Team attends user forums and communicates to the wider community to seek feedback from the services delivered by the Trust.

7.3 Staff Engagement

A positive workforce is known to improve quality of care and services therefore staff feedback is essential to track this and act wherever possible to improve staff experience. The HR department has a Staff Engagement Team responsible for obtaining feedback and tracking improvement. This is in the form of forums, questionnaires and focus groups.

7.4 Inquests and Claims

Claims and Inquests are managed by the Trust Legal Department. The process for inquests is detailed below:

- Legal team informed of forthcoming inquest
- Legal team review the case and determine risk of claim and whether potential patient harm caused;
- If potential harm/risk identified the Legal team contact Patient Safety Team and ensure the details of the case and responsible Division/Clinical Unit are reported to the next Weekly Patient Safety Summit for discussion and agreed action. This could result in a Serious Incident or Amber investigation being conducted. The Patient Safety Team will check to determine if an incident has been recorded previously involving the patient;

- Investigation tracked as part of WPSS but managed by the Legal Team;
- Findings of report shared with Coroner on request (once report approved at serious Incident Scrutiny Group);

Claims Process below:

- Claim reviewed by Legal Team to determine if relating to patient safety;
- Where potential for patient safety concern Legal Team contact the Patient Safety Team who will check for related incidents/events on Datix system;
- If none reported will be identified at the next WPSS for discussion and confirmation of required action.

Learning from the inquest or claim will be included within the Division/Clinical Unit Governance Report and a summary report of all inquests and claims and lessons learnt will be reported to the Patient Safety and Quality Group on a monthly basis.

7.5 Mortality Reviews

Mortality reviews are crucial for identifying any lapse in care and or potential for learning and should be carried out in line with the Mortality and Morbidity Review Policy. There is a mortality database for recording and grading deaths to determine if expected or unexpected. The result of this will instigate review at specialty mortality review meetings. The Clinical Outcomes Group chaired by the Medical Director has specific responsibility to ensure there is a robust process for death reviews and learning. Feedback from these will be to the specialties attending the mortality reviews and to the members of the Clinical Outcomes Group who will share the findings across the organisation. Feedback and key issues identified will be reported to the Patient Safety and Quality Group. The actions identified from the mortality reviews are recorded on the database and tracked by the Clinical Outcomes Group for progress.

8. Monitoring, Analysis and Improvement

As described within this document there are systems in place for incidents, complaints, managing risks, inquests, patient feedback and staff feedback. The final part of the cycle is to make improvements to quality care and reduce risk of harm through learning from these events. This will be achieved through the following areas.

8.1 Audit

The Clinical Effectiveness Team manages the Trust audit programme which includes the national audits as described earlier and also local audits. In addition there is the Meridian system that enables departments and the Trust to set up regular audit programmes for staff to enter results directly and receive reports on progress. For example this can be for compliance to falls risk assessments or Purpose T assessments for prevention of pressure ulcers. The Clinical Effectiveness Team is responsible for this system and ensuring all the audits are aligned to the Trust needs and areas identified in need of improvement. The results of these audits will be incorporated into the specific improvement programmes or task and finish groups to measure the impact of change and monitor performance. The Clinical Effectiveness Group will receive reports on the overall audit programme for the Trust.

8.2 Testing Actions

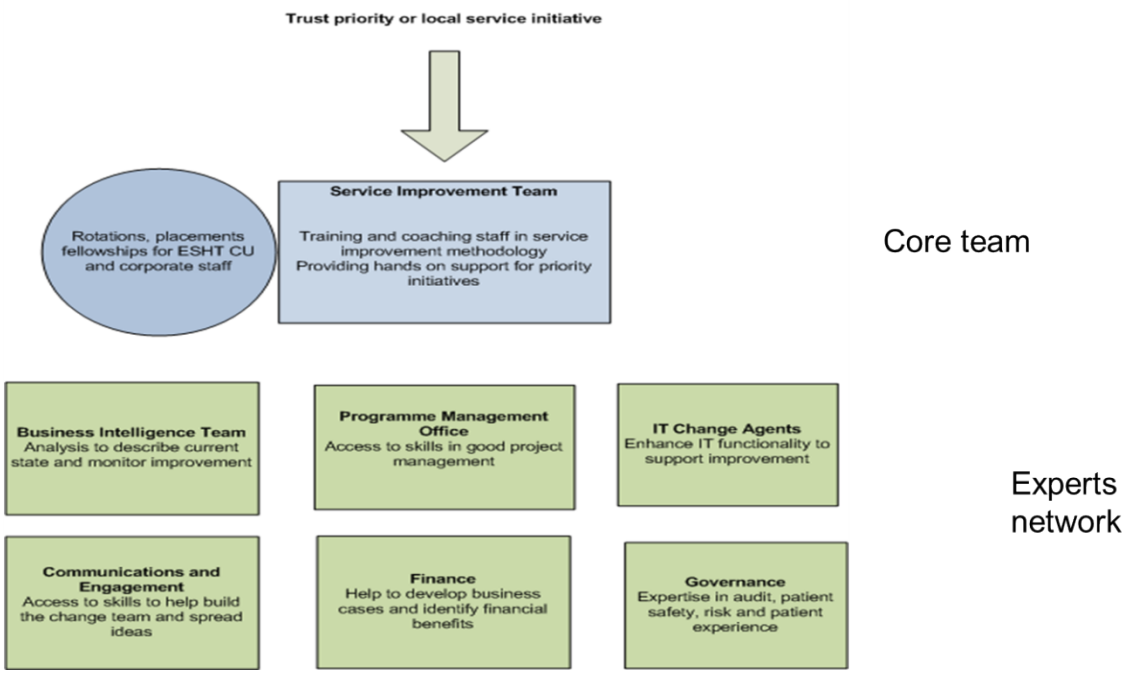
Actions following Serious and Amber incidents and complaints are loaded onto the Datix system and tracked by Divisions/Clinical Units and core Groups such as the Patient Safety and Quality Group. The effectiveness of these actions and knowledge of whether they are making a difference are important to demonstrate changes, or to recognise if an ineffective response to a problem. The Clinical Effectiveness Team will select through guidance from the Patient Safety and Quality Group a theme each month and test to see if the actions have been completed and embedded into a service and are having a positive impact on change. The results of these will be reported to the Clinical Effectiveness Group and the patient Safety and Quality Group. The findings will also be fed back to staff in the relevant departments and also through the “Learning in Practice” newsletter.

8.3 Improvement

In most cases identified actions following incidents, inquests, claims and complaints can be completed by teams or individuals responsible for that service and can be achieved swiftly. This could be in the form of task and finish groups, some of which could have help from staff with improvement skills. As described in section 8.2 above they can be reported back to the departments to demonstrate what has been done or changed as a result and for trends and themes tested by the Clinical Effectiveness Team to determine if embedded in practice.

When a trend or particular safety concern has been identified that does not have an immediate fix or is a wicked problem in nature it will require input from experts in improvement methodology. These cases and issues will be identified through the Patient Safety and Quality Group (information fed through from sub groups), or Divisional Integrated Performance Reviews and decisions made to establish task and finish groups and or involve the service improvement hub. This as described below will consist of a core team of improvement experts utilising other expert teams within the organisation. The work load for this team and prioritisation of projects/improvement work will be guided by the Improvement Sub Committee to ensure there is control and awareness of all the improvement programmes and projects within the Trust. Prioritisation for these projects/improvement schemes can be achieved through a simple assessment of the risk and level of impact on quality care and positive financial return. Support to these schemes will also be provided through the Project Management Office and the Listening into Action Programme Team coordinated through the Improvement Sub Committee. The improvement hub will also offer opportunities to staff that will support a culture of continuous improvement within the organisation through coaching, training in specific improvement techniques and secondment opportunities.

The Hub



8.4 Demonstrating improvement and sharing information

The Trust will share improvement programmes and schemes through the following schemes/documents:

- Quality Account – This document will describe the main quality account priorities for the year ahead and will provide a report on the achievements to the previous year priorities. This will also include the Sign up to Safety Campaign initiatives. Progress on these priorities is reported during the year to the Patient Safety and Quality Group. Clinical outcomes form various specialties will also be reported within this document.
- Commissioning for Quality and Innovation (CQUINs) – These are improvement schemes agreed with the Lead Clinical Commissioning Group that are linked to achievement payments. There is a CQUIN manager in place for the Trust reporting to the Associate Director of Knowledge Management. The schemes and progress towards them are reported to the Patient Safety and Quality Group.
- Reports to Trust Board, Quality and Safety Committee and other senior Groups – Comprehensive reports submitted to these committees and groups will include regular tracking of metrics such as the Integrated Performance Dashboard (includes the Quality Ward to Board Dashboard) and specific measure to track progress on work plans for the key groups. Reports are produced covering all aspects of quality to these groups.
- The Divisions/Clinical Units receive a Monthly Governance Report that details all aspects of governance such as risks, incident, mortality, complaints, inquests, patient experience from the previous month. A summary triangulating this information is provided within the main document to enable the department to see the key issues and to use as the escalation/summary to the Integrated Performance Reviews for each Division/Clinical Unit. These summaries are produced by members of the Governance team but can be supplemented further by the Head of Nursing/Clinical Leads as part of their analysis process.

- Each Group under the Safety and Quality Structure will have a workplan for the year set and tracked by the Patient Safety and Quality Group. These set the direction and priority of work required for each group to improve quality. The 2016/17 workplan is detailed within **Appendix C** below.

9. Annual Governance Statement

Each year the Board is required to produce an Annual Governance Statement which is signed off by the Chief Executive as the Accountable Officer. The Governance Statement records the stewardship of the organisation to supplement the accounts. The document outlines how successfully the organisation has coped with the challenges it faces and of how vulnerable the organisation's performance is or might be. This statement draws together position statements and evidence on governance, risk management and control, to provide a coherent and consistent reporting mechanism. The Board is required to provide evidence that the principle risks to achieving trust objectives have been identified and are being managed. As such the risk register supports the Assurance Framework in driving the Board agenda.

10. Equality and Human Rights Statement

An equality impact assessment has been carried out in order to establish that this policy does not discriminate or have a detrimental impact upon employees or service users on the grounds of disability, age, race, gender, sexual orientation, religion or belief. The issues to note are:

1. To ensure equal access to risk management staff training
2. To consider equality, discrimination and human rights related risks for inclusion on risk registers
3. To recognise the Equality and Human Rights Commission as an external inspector
4. To consider the Equality and Human Rights Analyses (EHRA) when assessing relevant risks

11. Copy Available

An electronic copy of this document is available on the Trust Intranet page under 'document search'.
Stakeholders can access a copy through the Trust website.

12. Strategy Review Arrangement

This Strategy is ratified by the Patient Safety and Quality Committee on behalf of the Trust Board and will be reviewed annually in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of the Trust.

13. Supporting and Related Documents

The Risk Management Strategy should be read in conjunction with:

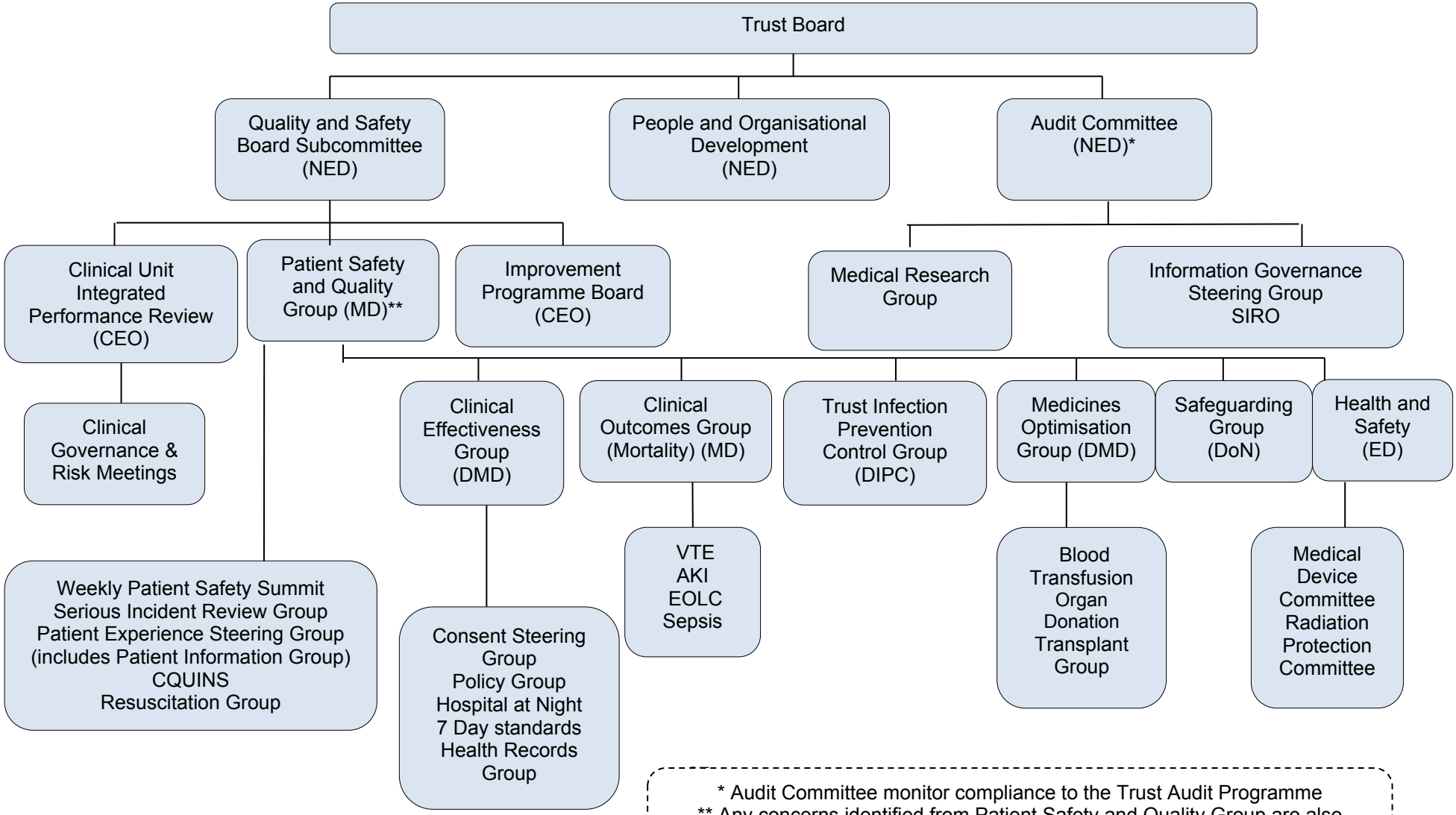
ESHT Risk Assessment (General) Policy
ESHT Health and Safety Policy
ESHT Incident Reporting and Management Policy
ESHT Risk Management Policy and Procedure
ESHT Learning and Development Strategy and Policy
ESHT Mandatory Training Policy
ESHT Managing Complaints Policy

14. Useful References

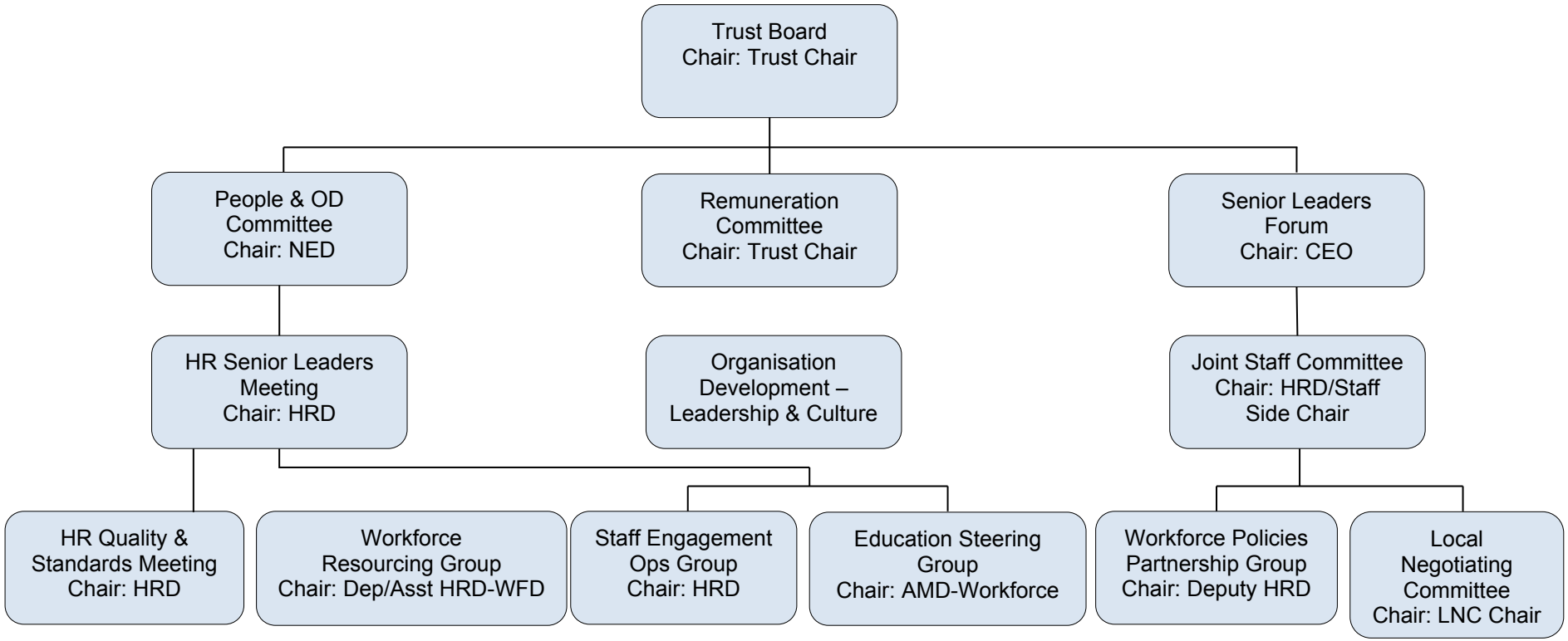
Public Interest Disclosure Act 1998 (Department of Health circular HSC 1999/198)
NHSLA Risk Management Standards 2011/12
Health and Safety at Work Act 1974
Governance in the NHS (HSC2000/005) NHS Executive (February 2001)
Governance in the NHS Statement on Internal Control 2001/2002 and Beyond (including supplementary guidance) of 2002/2003 NHS Executive (March 2002)
NPSA 'Healthcare risk assessment made easy' (March 2007)
Australian Standard, Risk Management AS/NZS 4360:2004

Appendix A - Committee/Group Structures

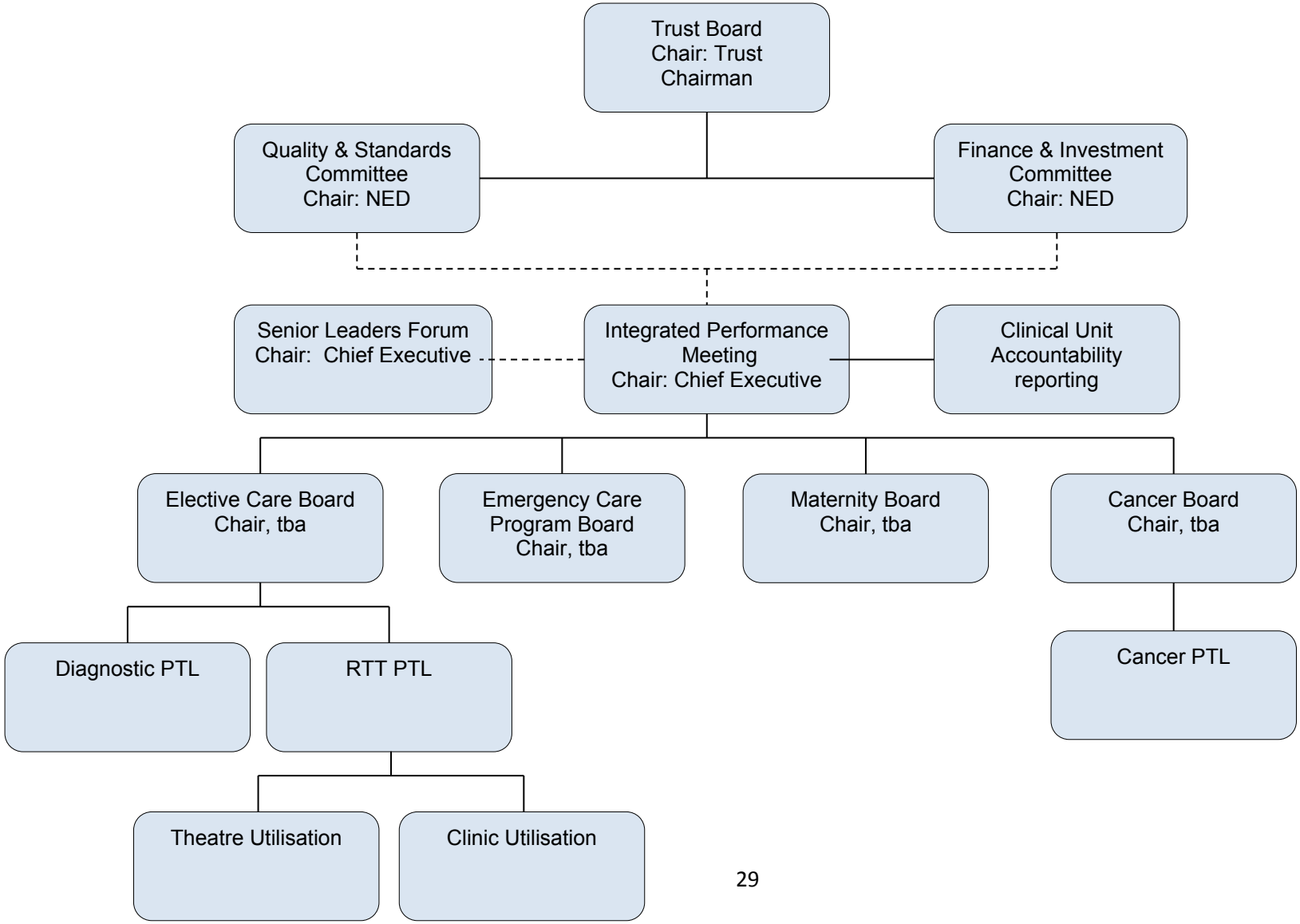
SAFETY & QUALITY



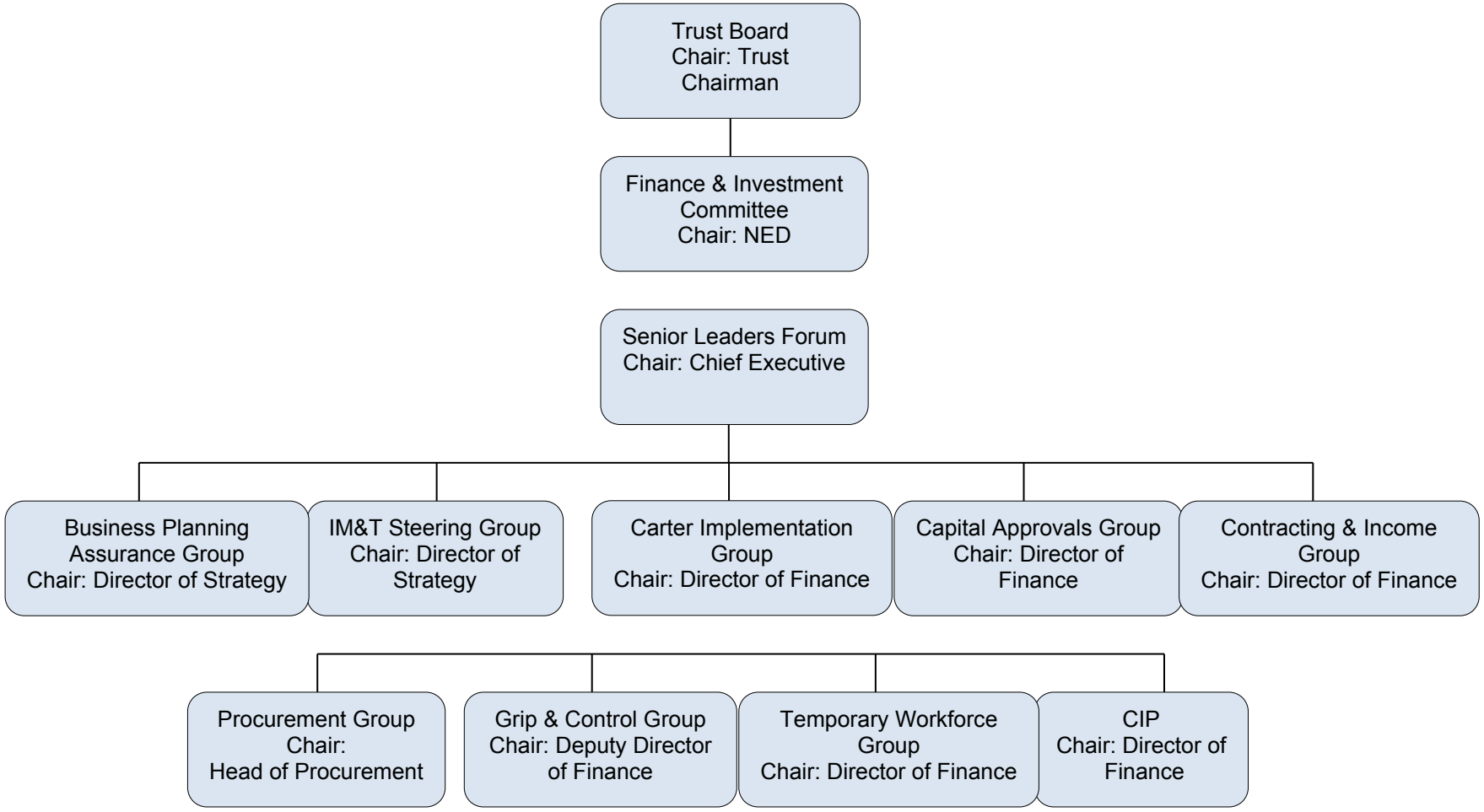
LEADERSHIP & CULTURE



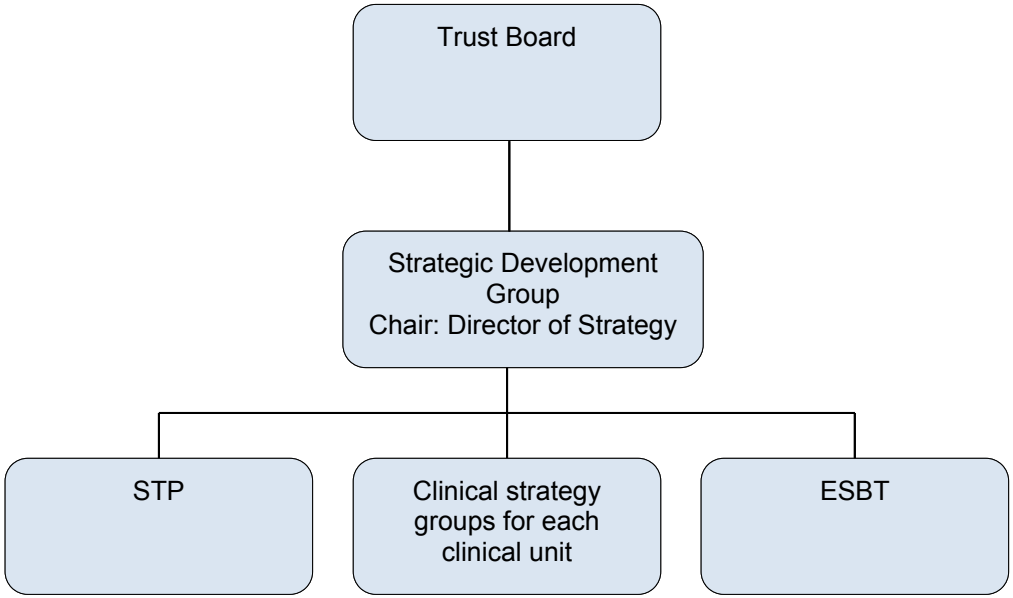
ACCESS & DELIVERY



FINANCE & CAPITAL

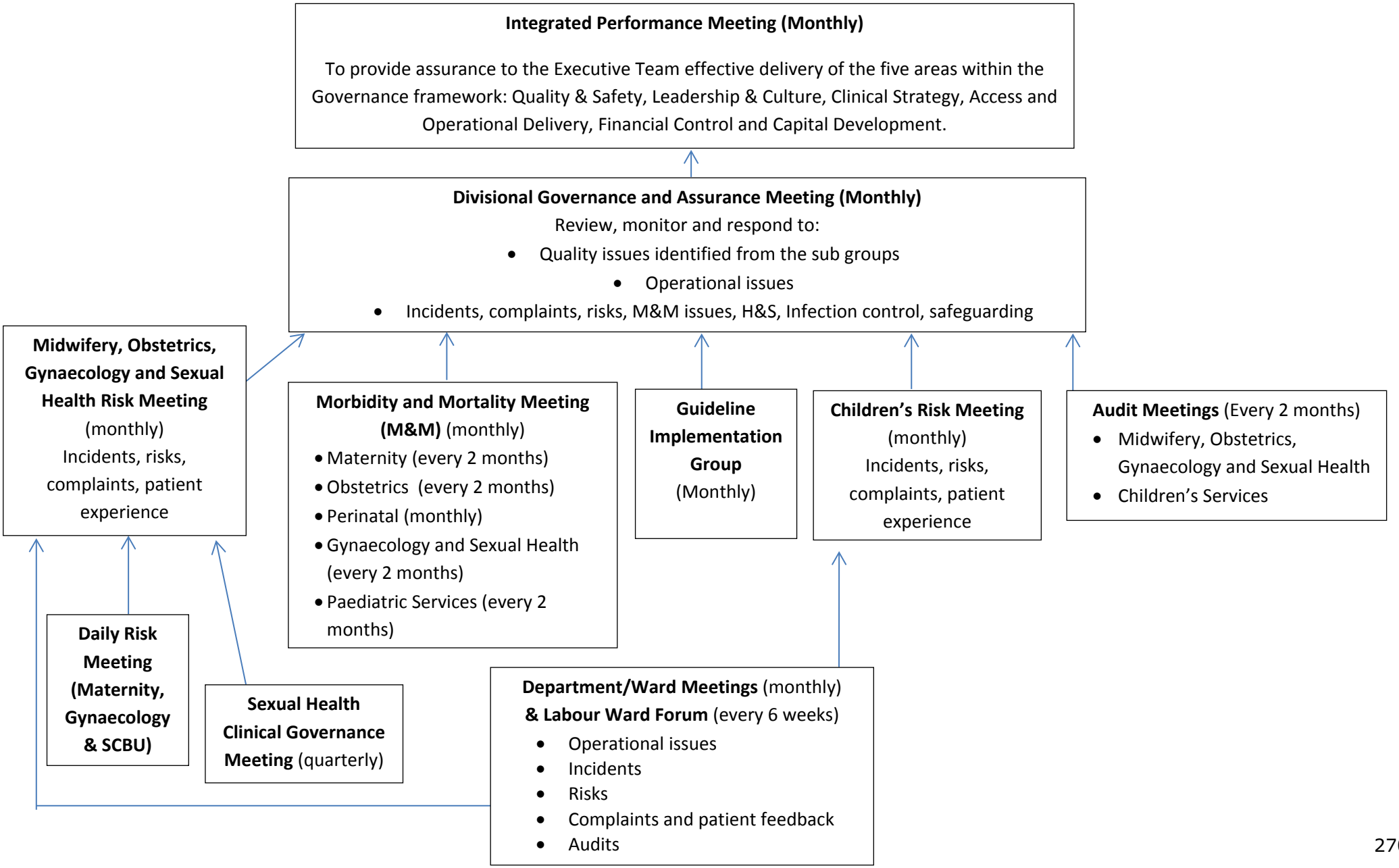


GOVERNANCE FOR STRATEGY



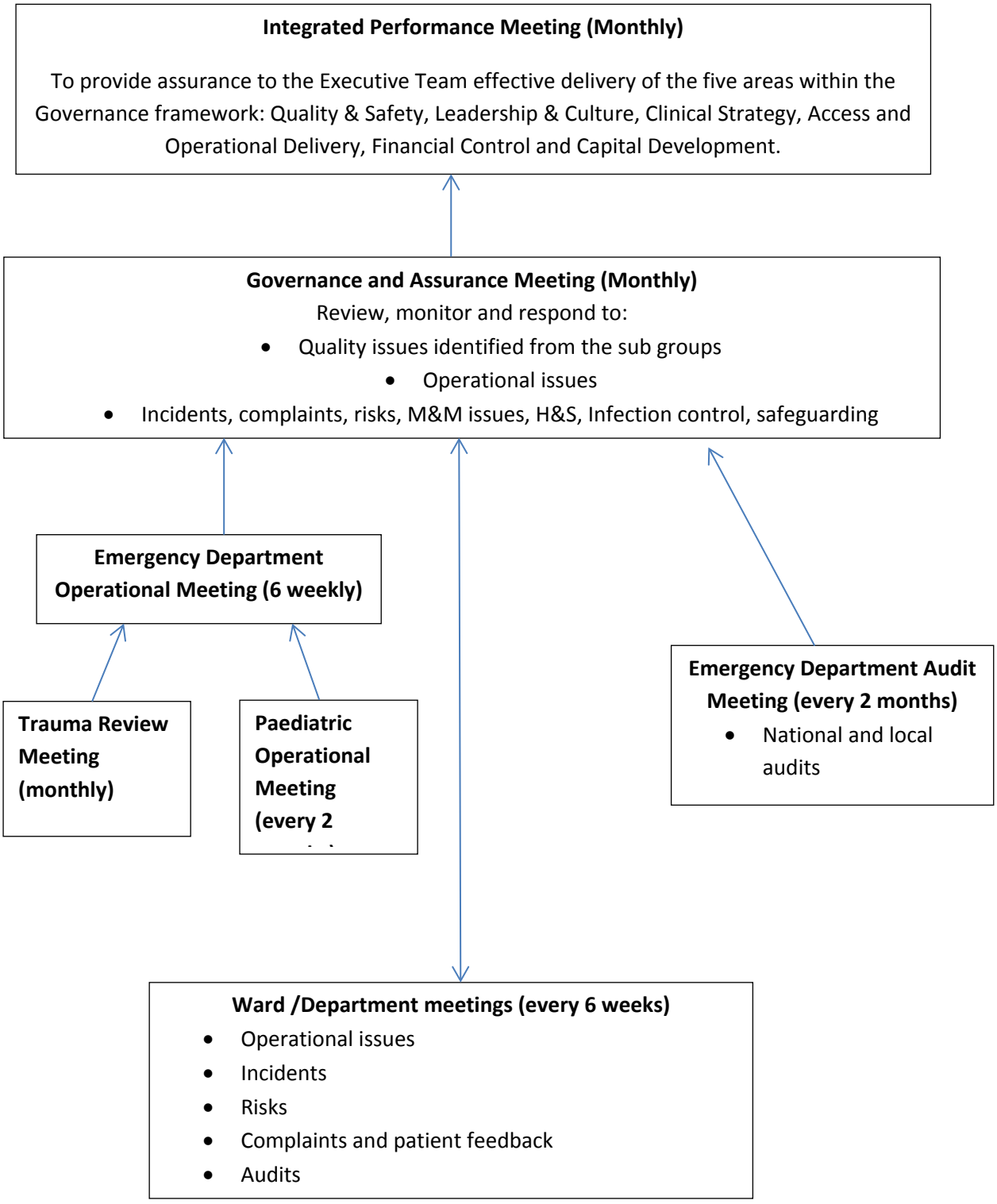
Appendix B – Division/Clinical Unit Governance Structures

Women Children and Sexual Health Division Governance Structure

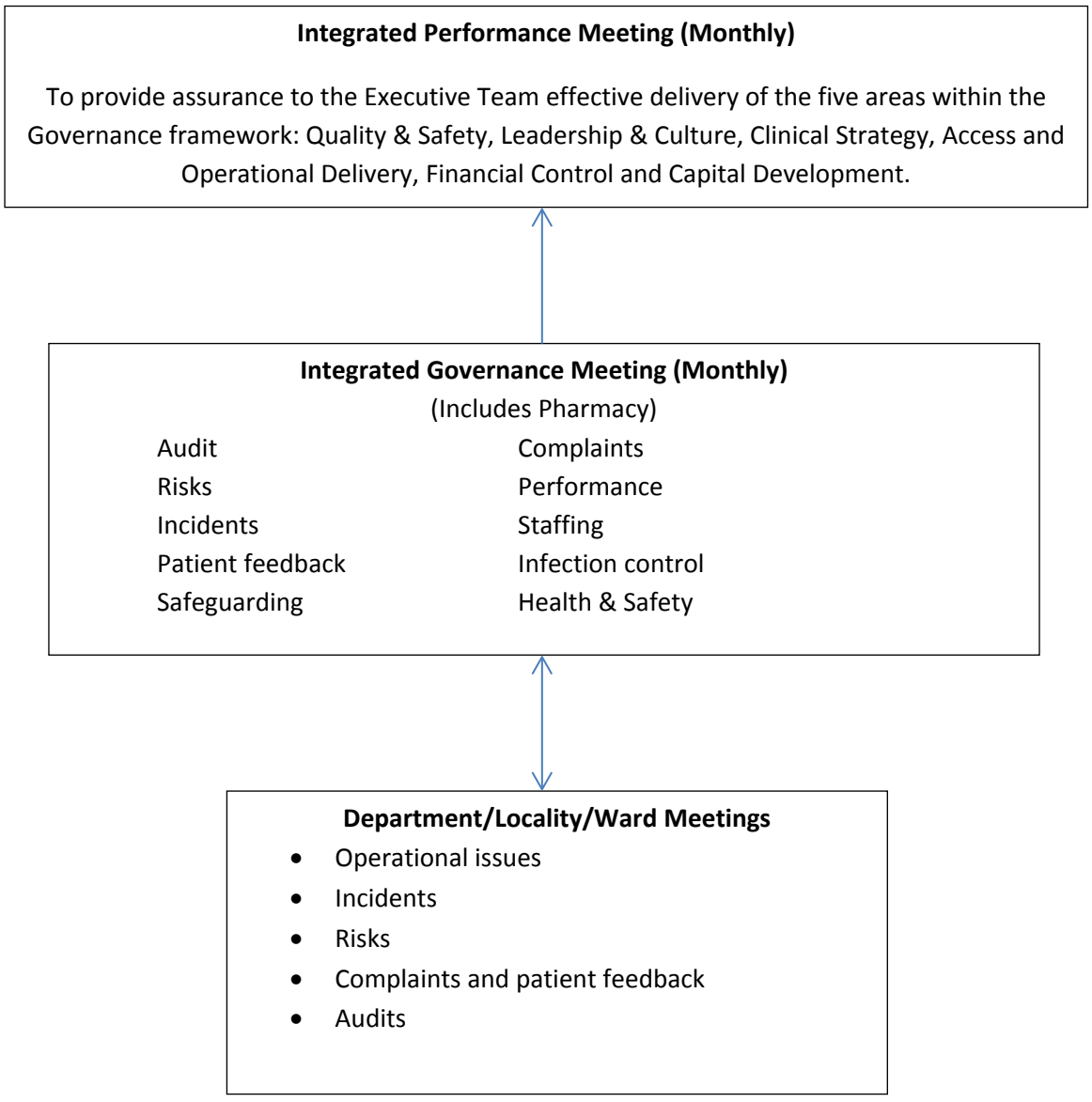


Urgent Care Clinical Unit

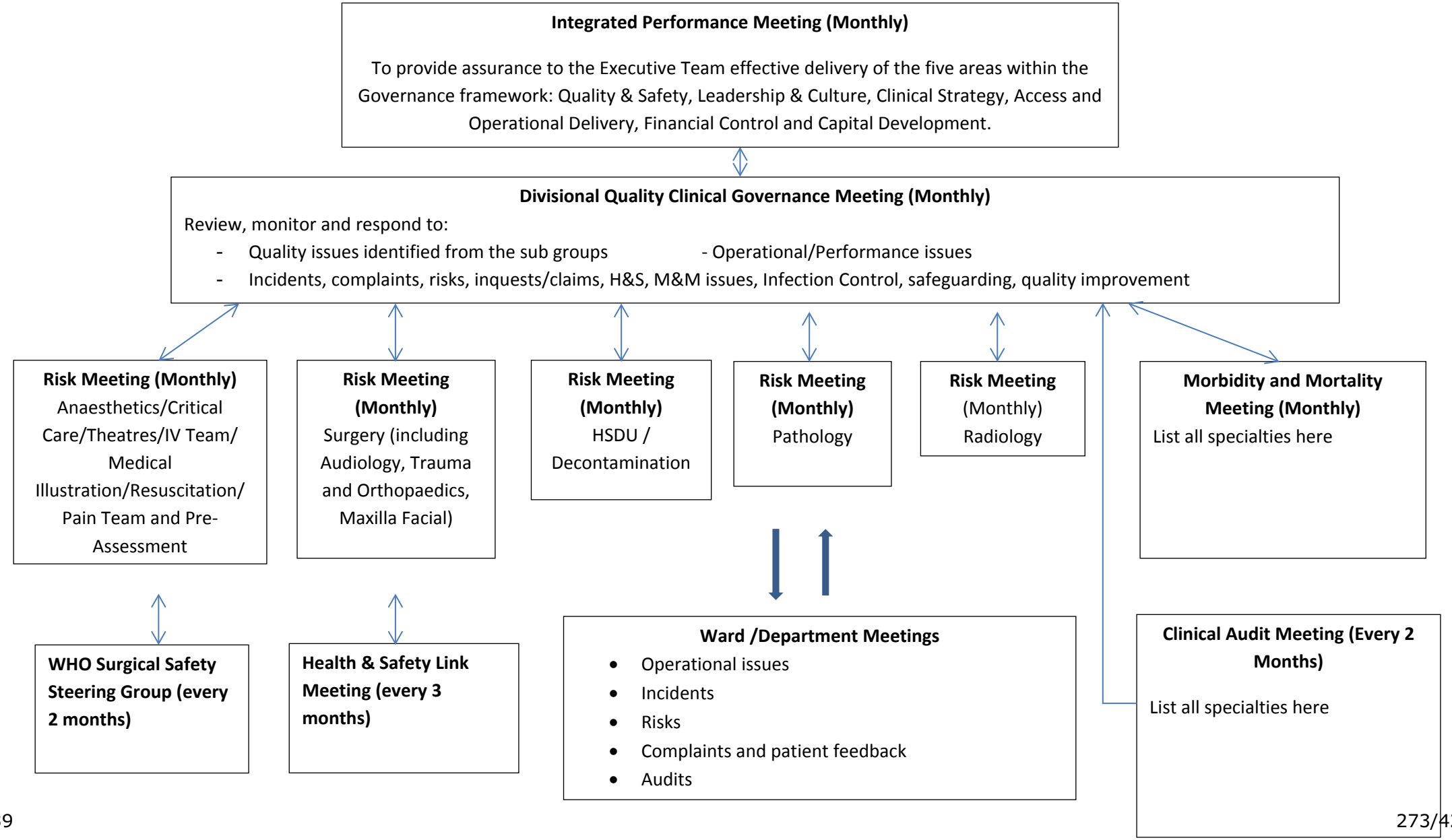
Governance Structure



Out of Hospital Division



Surgery Anaesthetics and Diagnostics Division



Medicine Division

Integrated Performance Meeting (Monthly)

To provide assurance to the Executive Team effective delivery of the five areas within the Governance framework: Quality & Safety, Leadership & Culture, Clinical Strategy, Access and Operational Delivery, Financial Control and Capital Development.

Divisional Quality Clinical Governance Meeting (Monthly)

Review, monitor and respond to:

- Quality issues identified from the sub groups
- Operational/Performance issues
- Incidents, complaints, risks, inquests/claims, H&S, M&M issues, Infection Control, safeguarding, quality improvement

Specialty Meeting (Monthly)

To cover all aspects within:

Quality and Safety, Leadership and culture, Clinical Strategy, Access and Operational Delivery, Financial Control and Capital Development

The following specialties will have meetings:

- Cardiology
- Respiratory
- Frailty
- Haematology
- Acute Medicine
- Stroke
- Dermatology
- Neurology
- Rheumatology
- Gastroenterology and Endoscopy
- Diabetes and endocrinology

Clinical Audit Meeting (Quarterly)

Cardiology
Stroke
Rheumatology,
Neurology &
Dermatology
Frailty
Haematology
Respiratory
Gastroenterology & Endoscopy
Diabetes and endocrinology

Ward /Department Meetings

- Operational issues
- Incidents
- Risks
- Complaints and patient feedback
- Audits

Morbidity and Mortality Meeting (Monthly)

Cardiology
Stroke
Rheumatology
Frailty
Haematology
Respiratory
Acute Medicine
Gastroenterology & Endoscopy
Diabetes and endocrinology

Appendix C – Work Plan – 2016/17

Quality and Safety Committee Structure Work Plan 2016/17

The Patient Safety and Quality Group (PSQG) will ensure each main group under the Quality and Safety Structure has a clear work plan aligned to the Patient Safety and Quality Strategy (incorporating ESHT 2020) that has key metrics in place to measure the progress and or outcome. The measurement of these will be reported to the Group for each meeting and should wherever possible be in a run chart format to enable effective improvement tracking. This document is a proposal of the priorities for each group for discussion at the September 2016 meeting. Each group reporting into PSQG has been asked to determine priorities that will need to be approved. Once priorities confirmed metrics will be determined. The safety and quality metrics detailed in the ESHT 2020 have all been incorporated in the metrics detailed below.

1. Patient Safety and Quality

1.1 Work plan

- Establish work plans for all main groups with improvement metrics in place for each (run charts);
- Establish robust governance system across all divisions/Clinical Unit supported centrally;
- Establish robust system to triangulate incidents, complaints and claims/inquests providing the ability to recognise and respond to areas of concern/trends (effective use of Datix reporting and analysis);
- Review and manage the Meridian Audit programme to provide a cohesive quality improvement measurement programme for departments;
- Develop a ward quality accreditation system based on data from quality dashboard, Meridian audit and quality visits (CREWS);
- Monitor patient experience through surveys, forums and mixed sex breach data and act on findings to inform change and improve experience survey results and complaint reduction;
- Ensure compliance with the Duty of Candour continues to improve;
- Produce and embed the floor to board quality dashboard;
- Embed the Serious Incident and Moderate incident investigation and learning process to produce timely, robust reports and act on findings;
- Continue with the patient fall task and finish group to reduce patient falls with harm;
- Reduce pressure ulcers grade 2 and above acquired whilst in trust care;
- Reduce patient transfers from ward to ward;
- Establish the complaints process, clear the backlog and act on findings and trends to reduce the overall number of formal complaints.

1.2 Metrics

Key outcome metrics to provide on a monthly basis in the form of a run chart to track improvements and identify where interventions made an impact:

- Number of complaints reported;
- Total number of open complaints in the system;
- Number of SI's reported;
- Patient falls with harm ;
- Pressure ulcers grade 2 and above;
- Mixed sex breaches;
- Duty of candour compliance with each stage;
- Outstanding amber incidents;
- Outstanding/overdue serious incidents;
- Number of transfers reported.

2. Medicines Optimisation Group

2.1 Work Plan

- Improving omitted and delayed medicines;
- Screening/ improving the quality of medication discharges;
- Improving medicines management and reconciliation;
- Antimicrobial Stewardship;
- Increased reporting and learning from medication incidents.

2.2 Metrics

Key outcome metric to provide on a monthly basis in the form of a run chart to track improvements and identify where interventions made an impact:

- Compliance with controlled drug checks;
- Compliance with medication reviews;
- Medication administration incidents;
- Medication Prescribing incidents;
- Controlled drug incidents.

3. Clinical Effectiveness Group

3.1 Work plan

- To ensure that a work plan for each reporting sub group is developed and in place for 2016/17 (to include Enhanced Recovery and Enhanced Quality)
- To monitor and ensure that the Trust participates in all required mandated national audits and acts upon findings appropriately, developing local action plans where required
- To monitor and ensure progress and full completion of local Trust audits and acts upon findings appropriately, producing full reports and developing local action plans where required
- Clinical record keeping standards – to ensure that a robust programme is in place to track and monitor compliance

- Consent - to track and monitor compliance with consent, and ensure 'SMART' actions are set to tackle areas of non-compliance
- To monitor and review the robustness of completed actions, ensuring that they have been effectively embedded across the Trust
- To highlight and effectively share lessons learnt and identified good practice as a result of Clinical Effectiveness activity widely across the Trust
- To progress with the 7 day care standards

3.2 Metrics

Key outcome metric to provide on a monthly basis in the form of a run chart to track improvements and identify where interventions made an impact:

- A number still to be determined for the work plan above.
- Number of patient safety incidents causing harm occurring during the night

4. Clinical Outcomes Group

4.1 Work Plan

- Conduct a complete review of the current mortality review process (includes database)
- Change and or improve the mortality review process (includes database)
- Ensure mortality drivers are reported to the Group and improvements in each area being made (sepsis, AKI, VTE)
- Monitor and achieve the End of Life Care strategy requirements
- Produce an overall document detailing outcome measures (such as PROMs and PREMs) for all specialties (work with Clinical Effectiveness Team)

4.2 Metrics

Key outcome metric to provide on a monthly basis in the form of a run chart to track improvements and identify where interventions made an impact:

- Reported Sepsis Cases per month
- Reported death/ITU admission from Sepsis per month
- AKI admission to ITU per month
- No of deaths relating to AKI per month
- Actual VTE reported cases per month
- No of deaths relating to VTE per month
- EOLC – Need to set something to track the strategy/plan
- Standardised mortality ratio per month
- No of Outcomes identified from each specialty across the trust per month (this is to track our progress on meeting and recording outcomes available for the first year to then identify gaps and determine how to track and share data in future)

5. Infection Prevention and Control Group – To be confirmed (although there is a comprehensive action plan in place)

6. Safeguarding Group – To be confirmed

7. Health and Safety Group – To be confirmed

These will be developed and in place by the end of October 16.

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	19 a
Subject:	Infection Prevention and Control Annual Report 2015-16
Reporting Officer:	Lesley Smith, Lead Infection Prevention and Control Nurse

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

Purpose:

This paper sets out the key activities, incidents and achievements of the Trust relating to Infection Prevention and Control during 2015-16 and the key priorities for the programme of work for 2016-17

Introduction:

This Annual report provides information related to the key activities, incidents and achievements of the IPC service. During 2015-16 the National Specification of Cleanliness audit team and the IV team were part of the Infection Prevention and Control (IPC) service. From the 1st April 2016 the IV team moved into theatre and clinical supports clinical unit and the NSC audit team moved to Estates and Facilities in January 2016.

The Infection Prevention & Control team (IPCT) continued to work closely with internal and external key other stakeholders in relation to strategies for prevention of infection including Clinical specialities, Estates and Facilities, Public Health England, East Sussex County Council and Regional Specialist Laboratories.

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

- During 2015/16 the number of MRSA bacteraemia cases reported increased to four cases compared to two in the previous year. There have been no further cases since August 2015.
- There was a reduction in cases of *Clostridium difficile* infection (46 cases compared to 49 in the previous year). Of the 46 cases of CDI, nine were judged as no lapse in care. Of the remaining 37 cases six were considered lapses in care that may have contributed to the patient developing CDI and 31 were lapses in care that were unlikely to have contributed to the patient developing CDI.
- There were two CDI outbreaks at ESHT. Both outbreaks were small and both involved

the transmission of *C. difficile* from one patient to one other. These cases were classified as lapses in care.

- Orthopaedic surgical site infections for hip and knee replacement surgery remained below the national average.
- The Trust had one outbreak of Norovirus gastroenteritis that was reported as a serious incident (SI).
- There was an unprecedented number of laboratory confirmed cases of Influenza at the Conquest site including an outbreak on one ward which was reported as a Serious Incident.
- *Legionella species* was isolated from water supplies in several areas at the Conquest site. No patients have developed *Legionella* infection as a result of this and the situation is being monitored. Measures have been put in place to reduce the risk of infection and finding a long-term solution to the problem is being monitored and agreed by the Trust Water safety Group

Benefits:

Provides a formal account of the activities and achievements in 2015-16 in relation to Infection prevention and control and outlines the key priorities for 2016-17

Risks and Implications

There was an increase in the number of MRSA bacteraemia from 2 cases during 2014-15 to 4 cases in 2015-16. The post infection reviews identified areas for improvement with adherence to the Trust's management of MRSA policy. The IPCT continue to work closely with staff to share the findings of the investigations and auditing compliance with the policy.

Water safety issues related to *Legionella species* isolated from water samples on the Conquest site. Considerable remedial work has been undertaken which has demonstrated some improvement although *Legionella species* continue to be isolated. There is no evidence of patients acquiring *Legionella* during this incident and ongoing monitoring and actions have been taken to further mitigate the risk.

Evidence of transmission of *Clostridium difficile* infection indicating possible failings in Infection Prevention and Control precautions.

Unable to complete structured deep cleaning of wards programme due to operational actively, restricted bed capacity and lack of a decant area.

Assurance Provided:

The Infection Prevention and Control Team in collaboration with Trust colleagues effectively identified and managed outbreaks in line with local and National guidelines.

Operational systems and processes were agreed and implemented to managing the high numbers of influenza cases at the Conquest site The Trust continues to seek the support of the Head of Infection Prevention and Control (South) from NHS Improvement (formally Trust Development Authority) in response to finding from external inspections and challenges related to IPC

Review by other Committees/Groups (please state name and date):
Trust Infection Prevention and Control Group 31/08/16 Quality and Safety Committee 21/09/16

Proposals and/or Recommendations
To receive the Annual Report 15/16 for Infection Prevention and Control

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

For further information or for any enquiries relating to this report please contact:	
Name: Lesley Smith (Lead Infection Prevention and Control Nurse	**Contact details: 07827 992964**

East Sussex Healthcare NHS
NHS Trust

August 2016

INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2015/16

"Infection Prevention & Control is everyone's business"

CONTENTS

Executive Summary

Preventing avoidable infections is a key priority for the NHS and all NHS healthcare providers. Prevention and control of healthcare associated infections (HCAIs) is also a priority for East Sussex Healthcare Trust (ESHT) which has developed programmes of activities to embrace national initiatives and reduce infection rates. Whilst ESHT employs a team of specialist nurses and support staff to advise and co-ordinate activities to prevent and control infection it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area. The Trust reports performance and activities related to infection prevention and control regularly throughout the year to the local commissioning groups (CCGs).

This report outlines the activities of ESHT relating to infection prevention and control for the financial year 2015/16. It also presents arrangements to allow early identification of patients with infections, measures taken to reduce the spread of infections to others and it also reviews the accountability arrangements relating to infection control, audit, surveillance and education.

Key points during 2015/16 are:-

- The Infection Prevention & Control team (IPCT) continued to work closely with other stakeholders in relation to strategies for prevention of infection including Public Health England, East Sussex County Council and Regional Specialist Laboratories and other experts.
- During 2015/16 the number of MRSA bacteraemia cases reported increased to four cases compared to two in the previous year. There have been no further cases since August 2015.
- There was a reduction in cases of CDI (46 cases compared to 49 in the previous year). Of the 46 cases of CDI, nine were judged as no lapse in care. Of the remaining 37 cases six were considered lapses in care that may have contributed to the patient developing CDI and 31 were lapses in care that were unlikely to have contributed to the patient developing CDI.
- The IPCT has continued to co-ordinate programmes of activity related to infection prevention and control (IP&C) within the organisation, providing education and training, clinical advice and exploring new ways of engaging with clinical staff within the diverse organisation to reduce the risk of infection to patients in our care both in and out of hospital.
- Orthopaedic surgical site infections for hip and knee replacement surgery remained below the national average.
- The Trust had one outbreak of Norovirus gastroenteritis that was reported as a serious incident (SI).
- There was an unprecedented number of laboratory confirmed cases of Influenza at the Conquest site including an outbreak on one ward which was reported as a Serious Incident.
- *Legionella species* was isolated from water supplies in several areas at the Conquest site. No patients have developed *Legionella* infection as a result of this and the situation is being monitored. Measures have been put in place to reduce the risk of infection and finding a long-term solution to the problem is being monitored and agreed by the Trust Water safety Group

Dr Anne Wilson
Consultant Medical Microbiologist and Director of Infection Prevention & Control

1 Structure

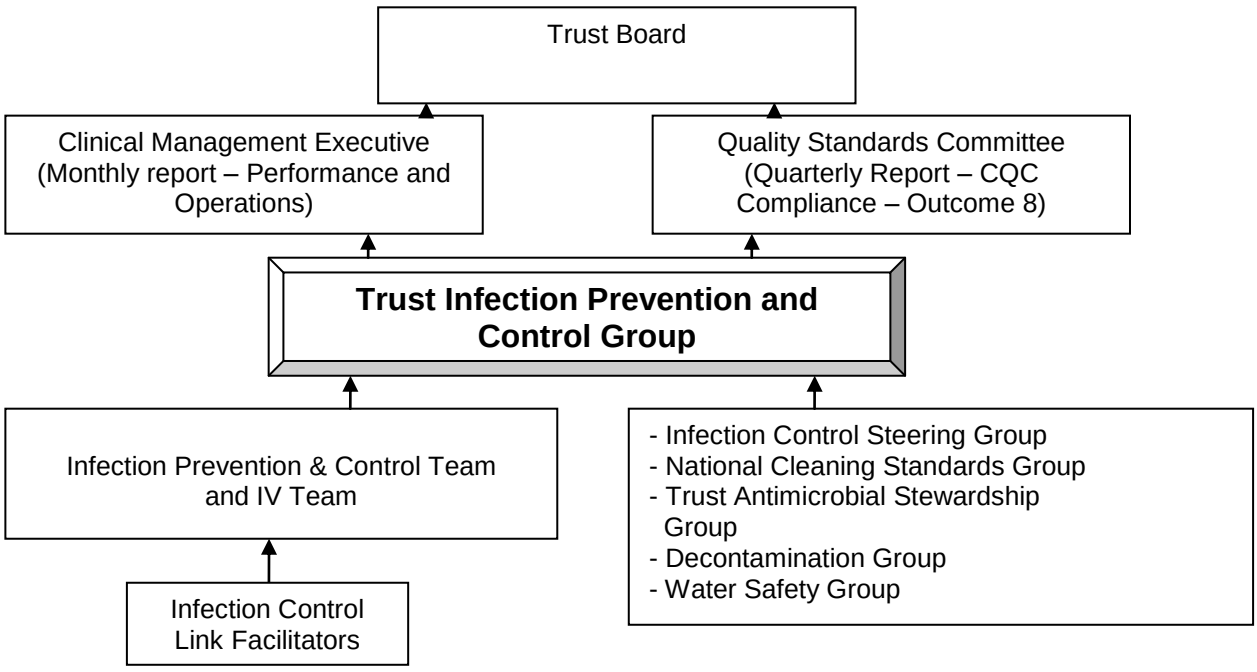
The Director of Nursing is the Executive Lead for Infection Prevention & Control within the Trust and sits on the Trust Board.

During 2015/16, there have been several changes of personnel in the role of Trust Director of Infection Prevention & Control (DIPC). Dr Barry Phillips (Consultant Anaesthetist and Intensive Care) held the post of DIPC until October 2015 followed by Dr David Hughes (Trust Medical Director) who took on the post temporarily until it could be filled. Since April 2016 Dr Anne Wilson (Consultant Medical Microbiologist) has been the DIPC. The DIPC is supported by Tina Lloyd, Assistant Director of Infection Prevention & Control (ADIPC) who reports to the Director of Nursing.

The Trust Infection Prevention and Control Group (TIPCG) is chaired by the DIPC, ADIPC or the Director of Nursing. The Group meets monthly and has wide representation from throughout the Trust including from clinical units, occupational health, pharmacy, commercial division and also external membership from the local department of Public Health England (PHE). The TIPCG reports monthly to Clinical Management Executive regarding performance and operational issues and also reports quarterly to the Quality & Standards Group regarding compliance against Outcome 8 Regulation 12 “Cleanliness and Infection Control” Health & Social Care Act 2008. (See reporting structure in 1.1)

Each of the Clinical Units report directly to the TIPCG and report on compliance with regulatory standards for IP&C. Clinical Matrons and Clinical Managers have the responsibility for the prevention and control of infection in their local area in line with national and local policies and guidelines. Each clinical department has appointed an Infection Control Link Facilitator (ICLF) who with educational support and guidance from the IPCT is responsible for cascading and monitoring compliance with infection prevention and control practices at local level.

1.1 Infection Prevention & Control internal reporting arrangements



1.2 Infection Prevention & Control external reporting arrangements

Externally, the Assistant DIPC also reports directly on performance to the Clinical Quality Review Group (CQRG) held by three local clinical commissioning groups (CCGs);

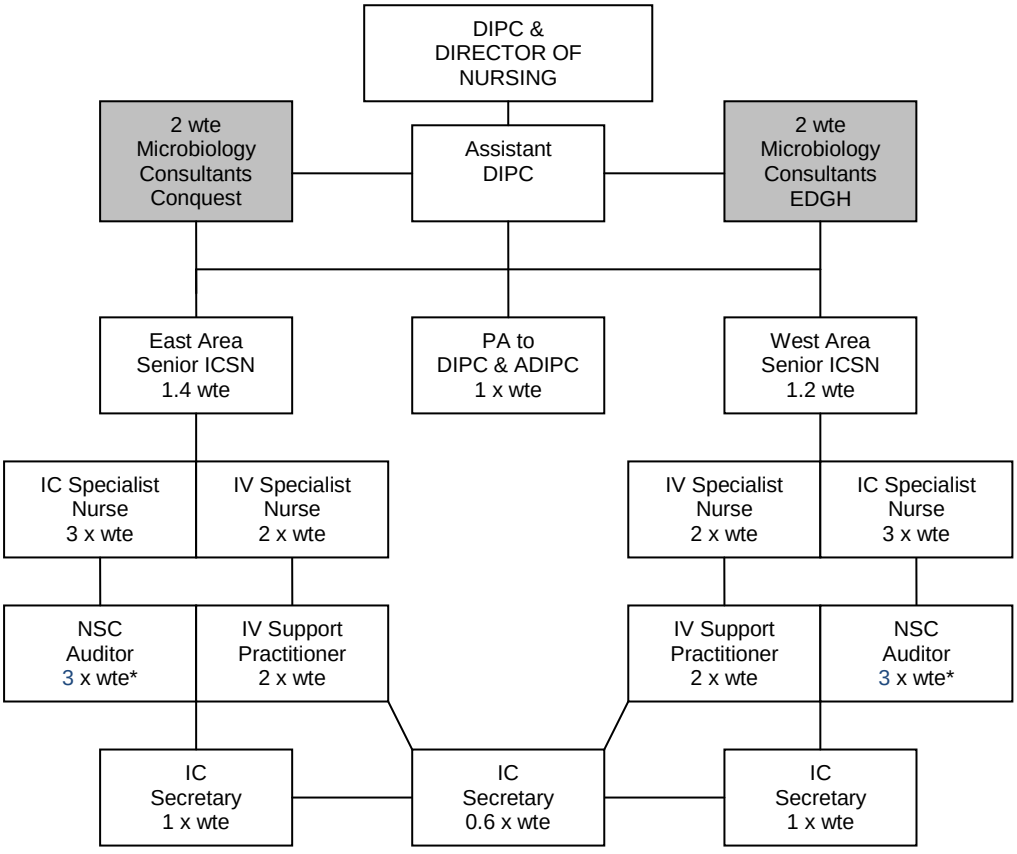
- Hastings & Rother CCG
- Eastbourne Hailsham and Seaford CCG
- High Weald, Lewes Havens CCG

1.3 Infection Prevention & Control structure

The IPCT comprises of specialist infection control nurses, specialist intravenous (IV) therapy nurses, IV support practitioners and administrative staff and the environmental audit team.

Two area teams (East and West) based in each of the acute hospital sites provide infection prevention and control support to all ESHT services in their local area (acute, community, inpatient and domiciliary).

Interim IP&C team structure



**prior to March 2015 2 x wte in each area*

In addition to the IPCT, the Trust also funds 4 x wte Consultant Microbiologist posts (2 on each acute site) based within Clinical Support CU who work closely with the IPCT, one of whom holds the Lead Infection Control Doctor responsibility.

1 x wte Orthopaedic Surgical Site Infection Surveillance Nurse is appointed within the Surgery CU and 1 x wte Antimicrobial Prescribing Lead post is appointed within Pharmacy/Clinical Support CU.

The NSC audit team establishment was increased from 4 to 6 in order to meet frequency of audits required

1.4 Vacancies

At the end of 15/16 there were 2 WTE IC Specialist Nurse Vacancies. One vacancy from the East team and one from the West team.

1.5 Infection Control Link Facilitators

At any one time there are between 80 – 100 Link Facilitators across the Trust. ICLFs, with educational support and guidance from the IPCT, are responsible for cascading and monitoring compliance with infection prevention and control practices at local level. Those in high risk areas attend monthly meetings held by the IPCT.

The ICLFs are provided with education and training from the specialist IPCT and other relevant specialists. In addition the Trust also encourages and supports ICLFs to undertake further training to support them in their role. A number of ICLFs have completed a Level 6 module at Brighton University “Principles and Practice of Infection Prevention & Control”.

The ICLFs are responsible for the completion of monthly hand hygiene audits, other Trustwide audits, cascade training and implementation of new policies and paperwork etc. under the guidance of the IPCT.

The results of the monthly hand hygiene compliance audits are readily available on the Trust electronic information system (Meridian). Ward Matrons are required to report regularly to the Director of Nursing to provide evidence of action to improve if indicated. If repeated non-compliance by an individual member of staff is reported this is escalated to their line manager to performance manage.

1.6 Joint working across the local health economy

The Trust IPCT has worked closely with Clinical Commissioning Group (CCG) Infection Control Nurse and Public Health England (PHE) colleagues towards joint strategies for the reduction of healthcare associated infections which can lead to hospital admission. The Assistant DIPC reports monthly to the CCG Quality Performance Review Group (QPRG) and quarterly to the East Sussex HCAI Working Group.

The infection control specialist nurses are members of the Infection Prevention Specialists Regional Network Meeting who share and discuss local initiatives, innovations and work towards common goals across Sussex.

The IPCT in collaboration with PHE, East Sussex County Council and the Network Group have continued to focus efforts on the reduction of catheter associated urinary tract infections.

2. Compliance with Outcome 8 Regulation 12 "Cleanliness and Infection Control" Health & Social Care Act 2008

The Trust is required to undertake self-assessment against Care Quality Commission (CQC) standards and regulations, develop action plans for improvement if required and provide evidence of compliance, including against Outcome 8 which specifically relates to cleanliness and infection control.

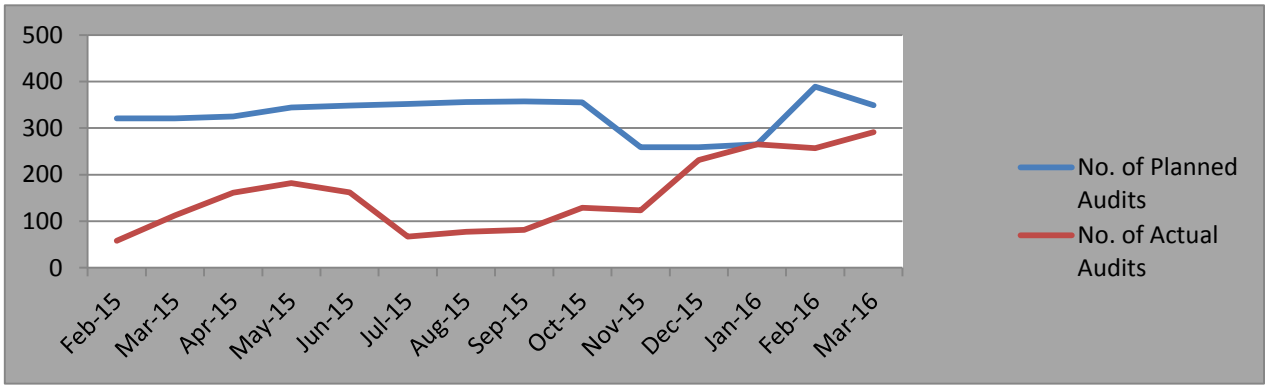
The TIPCG reviews generic self-assessment against Outcome 8 and receives reports from Clinical Units as evidence of local compliance and assurance which is then reported quarterly to the Trust Quality & Standards Committee.

One of the greatest challenges to the Trust in demonstrating compliance against Outcome 8 is in the provision of isolation facilities to meet the increasing demand due to emerging threats and diseases and for those at most risk. During 2015/16 a major refurbishment of the haematology and oncology unit at the Eastbourne DGH site was completed. The refurbishment provided much needed bespoke isolation facilities to meet the needs of this vulnerable group of patients as well as dedicated day care facilities separated from the ward.

The CQC undertook an inspection in ESHT between the March and April 2015. The findings of the investigation report were published in September 2015 and included recommendations regarding improving compliance with environmental cleanliness, hand hygiene and staff adherence to policy.

During February 2016 the Trust received a visit from the Trust Development Authority (TDA) to review IP&C systems and Process with the primary focus on *Clostridium difficile* infections. The finding from both these reports have been included in the IPCTs action plans to support the annual programme of work.

The number of NSC audits completed continues to increase in order to meet the frequency required for the National specification of Cleanliness Guidelines. The NSC audits continue to be monitored through the TIPCG and the CUs accountability meetings. (See table below for planned versus actual numbers of audits).



Following a consultation process which started in December 2015 the NSC audit team moved from the Infection Control Service to Estates and Facilities in January 2016.

2.1 Patient feedback of issues related to cleanliness

The CQC survey of adult inpatients in 2015 asked patients about their experience of their inpatient stay. Three of these questions related to cleanliness and IPC. These were:

Q17. In your opinion, how clean was the hospital room or ward that you were in?
Q18. How clean were the toilets and bathrooms that you used in hospital?
Q20. Were hand-wash gels available for patients and visitors to use?

In all three questions, the ESHT scored well with 8.9/10, 8.4/10 and 9.5/10 respectively.

3. Mandatory Surveillance

The Department of Health (DH) requires NHS Trusts to provide information about the number of specific infections seen in that Trust. This forms part of a national mandatory and voluntary surveillance programme. The infections monitored as part of the mandatory surveillance programme include bloodstream infections due to Meticillin resistant S*taphylococcus aureus* (MRSA bacteraemia) and diarrhoea due to *Clostridium difficile* infection (CDI).

Each NHS Trust is set an annual objective for numbers of MRSA bacteraemias and CDI. Initially the DH set targets to reduce these infections over a period of several years. Up until April 2014 ESHT showed a significant reduction in both infections over the preceding five years reducing MRSA bacteraemias by 95% and CDI infections by 78%. After the initial reduction in the number of infections, the DH recognised that not all cases of CDI are avoidable and that the focus should be on the concept of preventing avoidable harm. All cases of MRSA bacteraemia and CDI diagnosed and apportioned to the Trust are investigated by a root cause analysis (RCA) by a multi-disciplinary team to ensure any potential lessons learnt are acted upon and shared across the organisation. Cases of CDI are reported as being a lapse in care likely to have resulted in CDI, a lapse in care unlikely to have resulted in CDI or no lapse in care.

Since 2011, bloodstream infections due to meticillin sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* have been added to the national mandatory surveillance. However, these infections are more often community acquired and at the moment no hospital or Trust objectives for reduction have been set hence these have not been included in this report.

3.1 MRSA bacteraemia

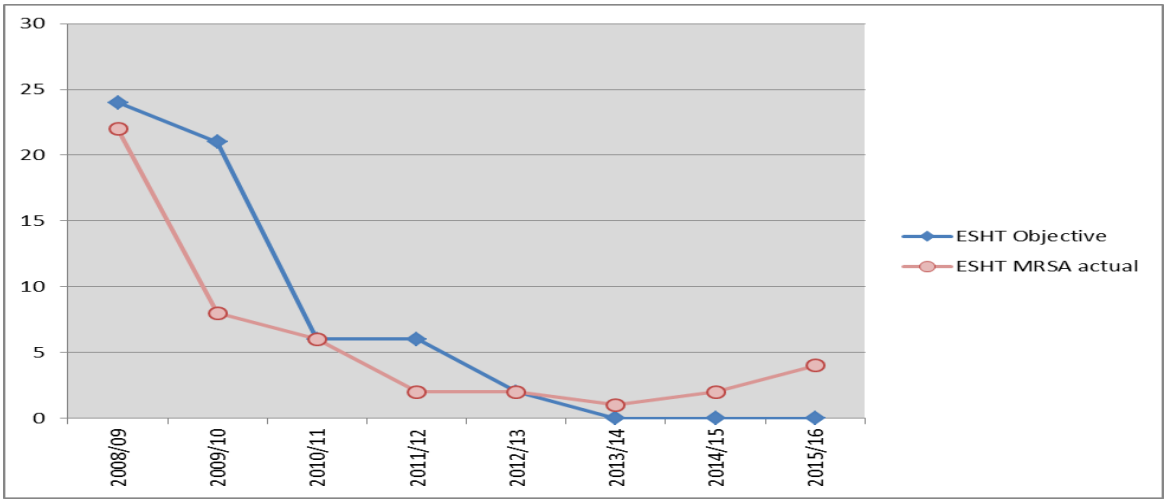
A zero tolerance approach is given to cases of MRSA bacteraemia which could potentially be avoidable. ESHT reported four cases of MRSA bacteraemia in 2015/16 compared to two cases in 2014/15. Three of these cases occurred in patients known to be colonised with MRSA. The RCAs showed that there was a delay in starting topical antiseptics to the skin in all three of these cases (topical antiseptics are used to reduce the number of MRSA bacteria on the skin). Trying to improve compliance with the current Trust MRSA policy has been the subject of much work by the IPCT this financial year. There have been no cases of MRSA bacteraemia since August 2015.

MRSA – 2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Post 48hrs	1	1	0	0	2	0	0	0	0	0	0	0	4
Trust attributable cases	1	1	0	0	2	0	0	0	0	0	0	0	4

It is a challenge for Trusts to prevent patients with MRSA colonisation of the skin developing subsequent infection. This is particularly true in the case of patients who have severe underlying conditions, poor skin or require the insertion of intravenous lines and other devices as part of their treatment. Regimes to screen all admissions and give topical antiseptics to the skin are in place for those patients with known MRSA colonisation. In 2014/15 new guidance was published by the DH that recommended a move away from routine MRSA screening of all admissions towards a risk based screening strategy whereby only those at high risk of MRSA would be screened. ESHT has continued to screen all admissions throughout 2015/16 and will review the DH guidance during 2016/17.

The table below shows the number of cases of MRSA bacteraemia reported since 2008. It should be noted that prior to 2011 the data reported was for the previous acute organisation (East Sussex Hospitals NHS Trust) only.

Reduction of MRSA cases reported between 2008/09 and 2015/16



3.2 Clostridium difficile infection (CDI)

The number of *C.difficile* infections reported annually within ESHT is shown in the chart below. In 2015/16 the Trust reported 46 cases of CDI against an objective of no more than 41.

Each case of CDI diagnosed beyond 72 hours of admission undergoes an RCA investigation. Findings of these RCAs are presented to the Trust Infection Control Steering Group who agree with a representative from the local CCG if each case constitutes a lapse of care likely to have resulted in CDI, a lapse of care unlikely to have resulted in CDI or no lapse of care. In 2014/15 the DH revised the objectives for reduction of CDI for Trusts so that where no lapses in care have been identified; Trusts

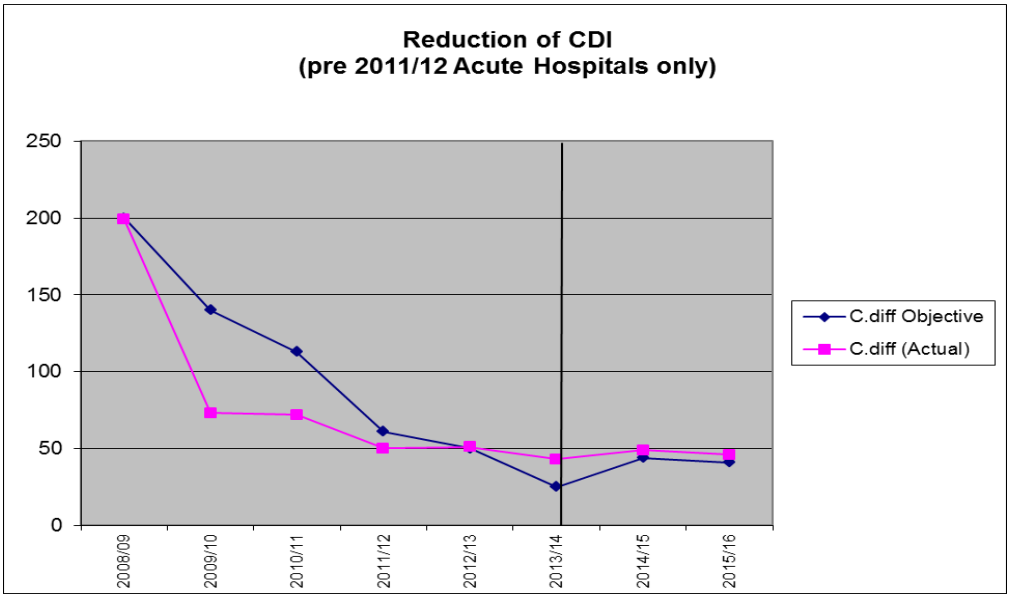
may appeal to their local commissioners for these CDI cases not to count towards annual objectives. ESHT worked with the local Commissioners and agreed a process and criteria for review of all cases. Of the 46 cases of CDI, nine were judged as no lapse in care. Of the remaining 37 cases, six were considered lapses in care that may have contributed to the patient developing CDI and 31 were lapses in care that were unlikely to have contributed to the patient developing CDI.

In line with national guidelines, where two or more cases of CDI were identified on the same ward within 28 days of each other these were investigated as periods of increased incidence (PIIs). Further tests were performed at a specialist reference laboratory to compare the *C. difficile* bacteria and to see if they were the same type (known as ribotyping).

As a result of previous outbreak investigations, recommendations had been made regarding improvements and upgrade of the inpatient environment on the surgical wards at the Conquest Hospital. This work was done during 2015/16 but unfortunately one CDI outbreak occurred during the improvement work whilst surgical patients had been transferred to Tressell ward (normally a medical ward). There were two CDI outbreaks (including this one) at ESHT. Both outbreaks were small and both involved the transmission of *C. difficile* from one patient to one other. These cases were classified as lapses in care.

Of the 37 cases considered lapses in care that were unlikely or likely to have contributed to the patient developing CDI the most common area for improvement was related to National Specification of Cleanliness audit scores not reaching the expected level (31/37 cases). The Infection Control Steering Group chaired monthly by the Deputy Chief Executive Officer reviewed progress against actions and recommendations made following the RCA investigation of each case of CDI.

Reduction of CDI cases reported between 2008/09 – 2015/16



Please note that prior to 2011/12 the number of cases reported are related to acute inpatients only. From 2012/13 onwards the number of cases also includes cases reported from the additional community inpatient beds following integration.

3.3 Surgical Site Surveillance

As required by the DH, ESHT undertakes continuous orthopaedic surgical site infection (SSI) surveillance at the Eastbourne District General Hospital (EDGH) and The Conquest Hospital Hastings (CHH). Since 2004 all NHS Trusts undertaking orthopaedic surgery are required to complete the mandatory surveillance study program devised by the Surgical Site Infection Surveillance Service (SSISS) Public Health England (PHE) for a minimum of three consecutive months per year. Currently over 60% of participants submit continuous surveillance and since January 2010, ESHT have maintained this recommended gold standard and practiced a continuous study to establish any patterns or trends over time. A standardised set of demographic and operation-related details were submitted for every patient undergoing Hip and Knee Prosthetic Replacement Surgery including re-surfacing and revision (excluding 1st stage revision where spacer implant is used) and the study covered surgical procedure, inpatient stay, post discharge reports and complete relevant data of any case readmitted with a SSI during the first post-operative year.

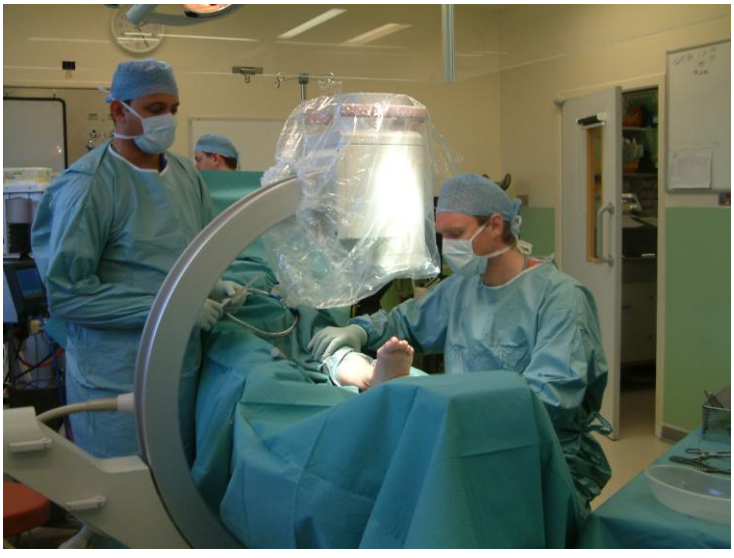
Please note: PHE SSISS studies need to be undertaken prospectively and submitted quarterly but results are published 12 months retrospectively as infection rates are influenced by performance and readmissions within the audit population over each 12 month surveillance period.

Finalised results are therefore only available up until end March 2015 although data from April 2015 onwards is within the surveillance system and continues to be analysed and officially reported by the PHE at the end of the following year.

Core data 1st April 2014 – 31st March 2015

Category of surgery	Number of procedures	Number of infections	Infection rate	Mean infection rate for all participating Trusts
Total hip replacement	311	1	0.3%	0.7%
Total knee replacement	390	0	0.0%	0.6%

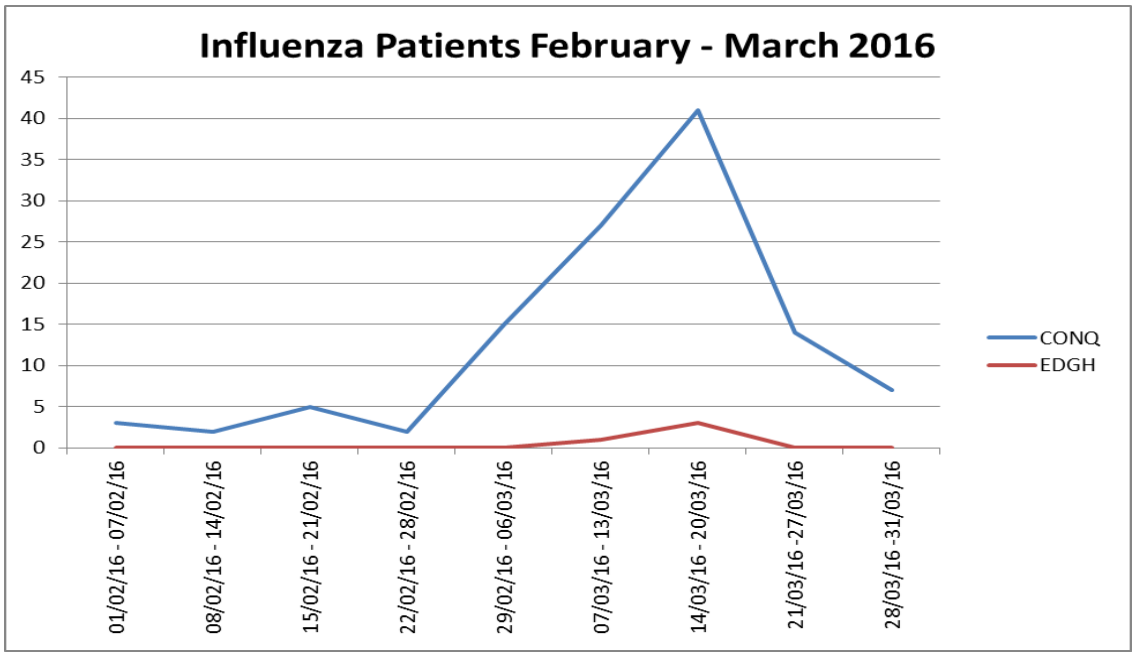
Surgical site infection rates for both hip and knee replacement surgery were lower than the national mean according to the most recent PHE SSISS Annual Report.



3.4 Influenza

Whilst there is no national surveillance programme for Influenza, all acute provider trusts are required to report on a weekly basis during the Influenza season the number of cases of Influenza requiring admission to intensive care to determine the burden on critical care units nationally.

An unprecedented number of laboratory-confirmed cases of Influenza were seen during February and March 2016 (158 cases in total). This was particularly evident at the CHH which saw 129 of the 158 cases with 108 requiring admission (the graph below demonstrates the increase in cases over time). Public Health England and East Sussex County Council (ESCC) were informed of this rise in cases. It was also acknowledged that there was a general increased prevalence in the Hastings and Rother area. The Health Protection specialist from ESCC advised that there was a 5% reduction in vaccine uptake reported in this area which could account for the increase seen. At ESHT 41% of staff were vaccinated. The predominant strain was Influenza A (H1N1) which was considered well matched to the vaccine.



A total of 12 patients were admitted to critical care due to the severity of their Influenza infection.

The IPCT responded to each case of Influenza to assess the risk and provide advice to patients and staff. A Cohort area was established on Baird ward to assist in managing the high numbers of patients affected. The majority of patients presented with flu like symptoms on admission indicating that they had acquired the infection in the community (incubation period 1-4 days). A total of eight patients appeared to have possibly acquired the infection whilst in hospital as they presented with symptoms after the maximum four day incubation period. Each case was investigated by the IPCT. A serious incident investigation was carried out on three of these eight cases because they were all in the same bay on the same ward with the same strain of Influenza A (H1N1) indicating that cross infection is likely to have occurred.

For comparison, during 2014/15 a total of 169 patients were tested for Influenza in ESHT, 146 resulted negative and 23 resulted positive.

4 Incidents related to infection

4.1 Incidents managed by the Infection Prevention & Control Team

ESHT reports outbreaks of infection as serious incidents to the local Clinical Commissioning Groups (CCGs). These include incidents where there has been a significant impact on the running of the Trust's services (ward closures for example), or where there has been a severe impact on patient outcome.

In 2015/16 the Trust reported seven serious incidents that were investigated and managed by the IPCT. The RCA investigations and subsequent recommendations and completion of actions are monitored by the TIPCG.

The table below provides a brief outline of these incidents.

Month	SI No	Incident
April 2015	2015/16462	MRSA bacteraemia death EDGH
November 2015	2015/36765	Outbreak of *Clostridium difficile* infection, Gardner Ward CHH
December 2015	2015/38446	Outbreak of *Clostridium difficile* infection, Decham Ward CHH
December 2015	2015/39841	Major outbreak of Norovirus, EDGH
February 2016	2015/5208	*Clostridium difficile* infection death, Tressell Ward, CHH
February 2016	2016/6731	Outbreak of scabies, Newington Ward, CHH
March 2016	2016/8232	Outbreak of Influenza, Decham Ward, CHH

4.2 CDI mortality incidents managed by Clinical Units

The Trust routinely reports any deaths where CDI is recorded on Part 1 of the death certificate as a serious incident (see also above). This does not necessarily mean that the death was a serious incident. It does however reflect how seriously the Trust takes the prevention, management and control of CDI. The purpose of the SIs is to determine whether the patient's diagnosis and treatment have been managed appropriately in line with Trust and national guidance. Some of the cases are admitted to the Trust with known CDI or are diagnosed within 72hrs of admission and are therefore not attributable to ESHT. The Trust, however, works closely with the CCGs to ensure best practice across the local health economy for CDI

5 Emerging threats and operational preparedness

5.1 Ebola

Ebola virus disease (EVD) is a rare but severe infection caused by Ebola virus. From March 2014 to February 2016 there was a large outbreak of Ebola virus in West Africa with widespread and intense transmission in Guinea, Liberia and Sierra Leone. It was

the largest ever known outbreak of disease and prompted the World Health Organisation (WHO) to declare a public health emergency of international concern in August 2014.

In response the Trust established an Ebola Preparedness Group to respond to regular updates and information regarding provision of facilities and resources to enable the safe admission and treatment of any suspected cases returning from the affected areas.

A dedicated isolation facility and staff were identified at EDGH and stringent processes and procedures agreed to triage patients at risk following guidance by the Advisory Committee on Dangerous Pathogens (ACDP).

The Ebola outbreak was officially declared over in January 2016. There were no laboratory confirmed cases of Ebola infection at ESHT during the outbreak.

5.2 Carbapenemase-producing Enterobacteriaceae

Carbapenemase producing *Enterobacteriaceae* (CPE) are bacteria that are resistant to Penicillin, Cephalosporin and Carbapenem antibiotics and often have resistance to multiple other antibiotics used commonly. This means that there may be only one or two antibiotics that can be used to treat them. This is a potentially major problem because these bacteria cause common infections such as urinary tract and intra-abdominal infections. ESHT has seen very few cases and does not have a major problem with these bacteria. However appropriate infection prevention and control measures are required to be place to manage the risk should a case arise. The CPE policy with associated implementation plan was developed during 2015/16 and the IPCT is working to embed the required actions into routine practice.

5.3 Operational preparedness

The operational preparedness group established initially in response to the threat of Ebola continues to function within the organisation to ensure ongoing plans are in place for potential Ebola cases and other emerging threats and diseases including Pandemic Influenza and CPE.

6 Infection Prevention Activities and Innovation

6.1 Hand Hygiene Promotion

The Trust IPCT co-ordinates an annual programme to promote effective hand hygiene throughout the organisation including;

- Monitoring of compliance by clinical staff with monthly audits.
- Monthly hand hygiene promotional posters
- Series of focussed hand hygiene promotion events for staff and patients including participation in the International World Hand Hand Hygiene Day on 5th May 2015. Which promoted hand hygiene through social media and the use of #SafeHands
- Training of ICLFs to facilitate cascade training at local level of practical hand hygiene technique.
- Providing training of all staff on induction (joining the organisation) and at regular mandatory updates.
- Ad-hoc training when indicated for focussed improvement.

6.1.2 Hand Hygiene Compliance

Monthly hand hygiene audits are undertaken by ICLFs measuring compliance by healthcare staff in direct contact with patients. Observations are made in each clinical area and feedback is given at the time of audit by the ICLF. Staff responses are noted as part of the audit and results are monitored to detect trends and act where frequent non-compliance occurs.

From July 2015 any staff member identified as non-compliant was sent a letter copied to their line manager outlining any improvement required. Repeat non-compliance will result in Performance Improvement Plans being implemented and disciplinary procedure where appropriate. This will also be escalated by email to the Director of Nursing if it is a nursing member of staff or the Medical Director if a member of Medical staff is observed. For other units the appropriate Manager would be informed.

In February, there was a change in how the compliance was scored; previously each observation has been divided by question with each question in an observation scoring with a maximum potential score of 10%. The scoring now reflects each observation as a whole, and reflects a score of 10% if the observation is compliant and 0% if any aspect of the observation is non-compliant.

The chart below provides details of the overall Trust compliance and the number of observations undertaken each month, the number of non-compliance and the number of letters sent to non-compliant individuals (please note letters started being sent from July).

The ICLFs have been reminded during their meetings that 10 observations should be completed every month. The results for January identified 28 areas that did not submit audits with eight areas which hadn't submitted for two consecutive months. These areas were contacted offering additional support and training. In March only one area (escalation area) did not submit any hand hygiene audits.

Results: 2015/16

	Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
Overall Trust compliance (%)	98.46	98.17	98.84	98.2	98.4	98.77	98.99	98.49	99.32	99	98.03	98.12
No. of audits	680	643	623	693	640	630	745	710	622	603	610	637
Non-Compliance				21	17	15	14	19	8	9	12	12
No. of letters sent	-	-	-	7	3	7	4	9	7	5	5	6
No. of areas that did not submit audits	-	-	-	-	-	-	-	-	-	28	18	1

(data obtained from Meridian)

6.2 Audit activity

The IPCT co-ordinates a number of planned and unplanned audits throughout each year to monitor compliance with core infection prevention and control standards and any areas of risk or concern which may arise as a result of incidents.

The planned programme of audits outlined for 2015/16 was reviewed during the year to ensure the highest priority audits were completed. These were:

- Monthly staff hand hygiene audits (see above)
- National Specification of Cleanliness audits reported and monitored monthly at TIPCG
- Audit of compliance of availability of hand hygiene facilities for domiciliary staff
- Audit of the management of known MRSA patients
- Audit of traditional scrubbing
- Re-audit of compliance with the use of peripheral venous assessment documentation (PVAD) in the management of patients with peripheral venous cannulas

6.3 Training and Education

The IP&C specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required. For example;

- Mandatory training on induction for all staff and volunteers
- Annual updates for clinical staff, patient facing staff, food handlers and other high risk groups
- 3-yearly updates for non-clinical, non-patient facing staff.
- Training is provided monthly to ICLFs on the control and management of key infections for cascade to clinical teams.
- Focused training has been delivered directly to ward staff on control and management of CPE and CDI and decontamination of beds and equipment.
- Train the trainer sessions in Hand Hygiene and Fit Testing of FFP3 masks (cascaded by ICLFs)

Compliance with attendance at mandatory induction and update sessions is monitored by the Trust along with other mandatory components of the Trust mandatory training programme.

6.4 Professional Development

All specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings.

As well as utilising the in-house Learning & Development training programme team members have been supported in attending other essential specialist training and conferences required to maintain their professional practice to enable them to provide education and training to others in the organisation including:-

- Infection Prevention Society, London South Branch development days

- Annual infection Prevention and Control Conference
- Non-medical prescribing update
- Visiting other Trusts to learn from others experiences in implementing programmes of improvement (VitalPAC and IV devices)
- Mentoring skills development workshop
- Water Safety Conference and Workshop
- Team clinical supervision resilience training
- Carbapenemase-producing enterobacteriaceae toolkit launch

7 Intravenous Therapy Team Activities and Innovation

The IV team works as part of the infection control team. Management and service development is led by a Senior Infection Control Nurse Specialist. The team recently been consisted of two lead nurses (Band 7) and two specialist practitioners (band 6) and four support staff (band 3) working at Conquest and EDGH. Funding to increase staffing establishment was approved in the last year and a further two band 6 specialist practitioners have been recruited to support long line insertion and patient pathways. These new posts plus recruitment to a vacant post has resulted in recruitment of three new members of staff who joined the team in May and June 2015. The team provides a 7 day service including bank holidays from 08:00 – 19:00 to the acute hospitals. Long line placements are usually undertaken Mondays – Fridays.

The team support clinical staff by inserting catheters for venous access, troubleshooting problems with lines, cannulation and blood taking, dressing changes and advice on best practice in IV therapy to in-patients at ESHT and also supports community based staff as requested.

7.1 Clinical practice

The IV Team has had 13,931 clinical contacts during the year.*

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar*	Total
Blood Cultures taken	107	93	83	105	79	90	93	116	86	92	58	38	**1040**
Cannulations done	540	515	527	590	553	479	451	463	311	448	362	123	**5362**
Blood tests taken	419	387	325	426	424	384	340	370	285	372	310	120	**4162**
Change of Dressings done	102	133	117	159	144	151	167	184	186	181	169	114	**1807**
Leaderflex done	1	0	4	4	2	3	1	7	2	4	5	0	**33**
Midlines done	11	5	7	14	10	14	29	18	41	22	23	18	**212**
PICC Insertions done	35	25	32	56	37	56	56	56	71	72	51	55	**602**
PICC/Hickman Reviewed	35	35	43	58	45	51	41	39	24	59	27	40	**497**
Failed (bloods and cannula)	22	14	11	13	15	16	19	19	18	39	15	15	**216**
													13931

* Data for March is Conquest only

In addition the team has also provided clinical supervision to staff gaining competence in IV skills and assisted with insertion troubleshooting of portacaths.

Cannulation has been the highest demand to the service provision. Cannulation training is available within ESHT and is provided by the IV team. Staff should seek assistance with cannulation when they have been unsuccessful themselves. When there is increased clinical activity or reduced staffing levels the IV team support ward staff with cannulation and venepuncture.

The provision of blood culture is carried out by each member of the team as long as it is clinically indicated. MAU has the highest number of blood culture requests carried out by the IV Team, even though most staff have been trained by the IV team to take blood cultures. The IV team should be called to perform venepuncture only in those patients who are difficult to bleed. When staff are clinically very busy they will also request the support of the IV team. At weekends and bank holidays there is a reduced service in phlebotomy which increases demand on the IV team.

The number of long lines inserted has significantly increased to support clinical care and promote vessel health preservation. Three new practitioners have been recruited and trained; two of these posts were additional substantive posts. Additional Nautilus equipment was purchased to support increased PICC insertion and reduce the time and cost of X-ray confirmation.

Daily routine checking of venous access documentation (VAD) is undertaken by the Band 3 support workers, on patients with PICCs, Midline and LeaderFlex. The IV Team changes the dressing and assesses the line within the first 24 hours post insertion and every 7-10 days afterwards.

7.2 Training and education of clinical staff

- Vene-cannulation training has been revised to include venepuncture training, reducing the need to train staff externally; this is delivered on a monthly basis.
- Blood Culture training for 5th Year Medical Students six times per year on each site.
- Formative OSCE for Blood Culture once every year.
- Blood Culture and Cannulation with FY1 and FY2 as part of their induction.
- Blood Culture assessment for doctors and nurses.
- Mentoring new doctors and nurses with vene-cannulation technique.
- Advocating best practice with highlighting ANTT principles and adherence to infection prevention and control practices to all health care workers.
- Promoting vessel health preservation.
- Training on Vascular Access Devices offered on both EDGH and Conquest sites monthly to update staff on good clinical practice.
- Training for IV additives was introduced last year for acute and community Trust staff to access. The training is now established in the Learning and Development programme and the Trust no longer purchases this type of training from external providers. This training also provides opportunity to practice ANTT.

7.3 Audit & surveillance

Compliance with the use of Peripheral Intravenous Cannula Documentation (PVAD) has been audited and demonstrated that cannulas in the Trust are safely maintained but that documentation of this still needs improvement. As a result the VitalPAC has been

chosen as the single method of documentation for cannula care and the PVAD paper tool has been discontinued. The Trust blood culture contaminant rate remains below the nationally accepted level of 3% (DH 2010). Root causes analysis is undertaken on bacteraemia that are considered to be IV line related. This has improved consistency in care as clinical teams have action IV team recommendations.

7.4 Professional development

All specialist nurses within the team maintain professional competence and attend relevant study and training. Members of the team have attended national and international conferences. Additional training has been undertaken to support the new and existing IV practitioners on best practice PICC placement and the use of Nautilus guided PICC placement and best practice PICC procedures.

7.5 Service development

Leaderflex and midline placement has been embedded into practice at Conquest Hospital in addition to the long running service at EDGH. This allows greater flexibility and choice for intravenous access. The use of Midlines and Leaderflex is also a less expensive option for patients who require intravenous access for six weeks or less.

Three Nautilus machines have now been purchased for the team by the League of Friends at both Conquest and EDGH. The Nautilus enables the IV team to quickly locate the tip of the PICC line and enable them to safely document that the PICC is safe and ready to use. The machine uses ECG technology, and connected to the PICC line being inserted into the patients arm. A peak in P wave is noticed when the PICC tip lies at the cavo-atrial junction, the most ideal area to place the tip of the PICC. All specialist practitioners in the IV team have been trained to use this technology to confirm correct placement of PICCs. The team have been using both Nautilus and x-ray to confirm position which has endorsed the reliability of ECG technology to confirm correct position. The PICC policy has been revised to reflect this change in practice. Ratification of the policy will enable the team to take a task and finish approach to PICC placement which should improve productivity and time management. Patients will be able to receive intravenous treatment via the PICC immediately after the IV practitioner has completed the procedure reducing the in-convenience and time delay associated with x-ray.

A new service has been established for patients with PICC lines in the East of the Trust. The PICC maintenance clinic now runs twice weekly from the Bexhill site. The clinic offers assessment, weekly dressing change, maintaining line patency, blood collection and if required disconnection of chemotherapy infusion pumps. The clinics were established following need to support ambulatory patients and can currently accommodate eight patients each and there is increasing demand for similar service to be provided for ambulatory patients in the other areas. The Team have recently introduced the Friend and Family test in paper form for service users to gain feedback on their perception of the new service.

Development of Outpatient Parenteral Antimicrobial Pathway (OPAT) for patients at ESHT is underway this year with the IV team keen to support its development.

The team were proud to be chosen as one of the finalists in the Quality Improvement category of the ESHT annual staff awards and attended the event at the De la Warr Pavilion.

A Review of the IV team as part of a wider review of the Infection Prevention and Control Service was undertaken. As a result it was agreed that from 1st April 2016, the IV Team would become part of Theatres and Clinical Support Clinical Unit.

8 Housekeeping Services

The housekeeping services for ESHT are provided by an in-house team within Estates and Facilities. In partnership with a DH representative, the housekeeping service has undergone a full review and standardised working practices to meet the objective of achieving a more productive, efficient and cost effective cleaning service which meets the clinical service demands and patient care. As a result of this service review a modernisation plan was created and given full approval by the board and the management team. The implementation of the plan began in February 2016.

8.1 Deep clean programme

An important part of housekeeping services is to support the reduction of infections and meeting CQC regulation 12 “Cleanliness and infection Control”. Due to continuous patient pressures housekeeping has been unable to undertake a structured deep clean plan of patient areas as per recommendations within NHS Cleanliness Standards documentation in 2014/15 through lack of decant areas (vacant ward to allow emptying of wards that require a deep clean). The housekeeping team works in close partnership with IPCT and has worked on alternative ways of ensuring cleanliness standards are maintained, this includes the introduction of an enhanced cleaning team, and by introducing weekly quality meetings to discuss standards in partnership with IPCT, maintenance, and clinical partners and actions are drawn up to address low standards if needed in any areas until a structured deep clean plan can be established.

8.2 Activity

Housekeeping continued to receive demands from all areas for cleaning support from the Rapid Response Team including single rooms, bed space cleans, and others this averages at about 200+ calls per month per acute site. To meet this demand calls for cleans are prioritised and communication and support is structured from the IPCT and clinical site leads and clear plans are in place at all levels to ensure patient disruption is minimised

8.3 Service development

The Housekeeping department continues to use HPV Hydrogen Peroxide Vaporisation units to support the reduction of infections by destroying organisms, this process is undertaken by the rapid response team who are on site 24hrs and can be deployed to any site if called upon this will be sustained in the modernisation plan.

9 Antimicrobial Stewardship Activities and Innovation

The Trust has an established Antimicrobial Stewardship Group (ASG) which has a core membership of an antimicrobial pharmacist, consultant microbiologist, medical consultant, Clinical Pharmacy Manager and a CCG representative. The purpose of the ASG is to support the prudent prescribing of antimicrobials to reduce antimicrobial resistance rates. It does this by:

- Developing and maintaining evidence based antimicrobial policies and guidelines for use in secondary and primary care
- Ensuring safe and cost effective use of antimicrobials taking local, national and international bacterial resistance rates into account.
- Monitoring antimicrobial usage (reviewing daily divided doses, antimicrobial expenditure data and compliance to policy using a point prevalence audit) and addressing any issues that may arise.
- Providing advice to other specialist groups/committees on use of antimicrobials
- Providing education to staff on all matters relating to prescribing and administration of antimicrobials.
- Educating patients and members of the public on antimicrobial stewardship.

During the last financial year the activities of the ASG were as follows:

9.1 Antimicrobial Prescribing Policy

During 2015/16, work continued on updating the Antimicrobial Prescribing Policy for Adults and Children which contains the antimicrobial formulary of drugs. The policy contains peer-reviewed, evidence based guidelines on common infections and a large number of specialist Consultants are involved. Additional chapters such as Ophthalmology and Intensive Care are being included. At present, the Antimicrobial Prescribing Policy is available on the staff Extranet for access by staff in areas where patient related activities take place. In addition, the Antimicrobial Prescribing Policy is summarised and printed onto pocket sized summary cards which are distributed to all training grade doctors for easy access to the policy at point of care (e.g. at patient's bedside).

Funding to create a smartphone app of the Antimicrobial Prescribing Policy so that prescribers can download it onto their smartphone and use as required instead of carrying disposable cards has been approved. This innovative approach has been taken up by a number of Trusts nationally and will improve access and help with policy updates. It is due to be introduced during 2016/17.

9.2 Multi-disciplinary Ward Rounds

The antimicrobial pharmacists and Consultant Microbiologists (CM) participate in daily Intensive Care ward rounds and weekly *Clostridium difficile* Infection ward rounds at both acute sites. This is in order to provide specialist input into the highest risk/most critical patients in the hospitals.

In 2015/16 a new Urology ward round was introduced to support the Urologists with the treatment of complex urological infections.

9.3 Training

A Trust e-learning module on antimicrobial prescribing is available on the internet. It contains an assessment that all new doctors have to pass at induction and all Trust doctors have to undertake every three years. The Trust Pharmacist antibiotic training pack continues to be used to help support the development of rotational pharmacists in relation to antimicrobial prescribing in line with Royal Pharmaceutical Society antimicrobial training guidance.

9.4 Outpatient parental antibiotics therapy (OPAT) service

In conjunction with Commissioners and Primary Care, ASG developed Admission Avoidance Pathways and is piloting an OPAT service. Treatment pathways are processes developed to keep patients out of acute care or reduce length of hospital stay. This work is on-going from 2014/15.

9.5 *European Antibiotics Awareness Day and World Antibiotic Awareness Week*

The lead antimicrobial pharmacist led a campaign in November 2015 to promote European Antibiotics Awareness Day and World Antibiotic Awareness Week. The aim was to educate patients and the general public on antibiotics. Activities undertaken were posters in common areas, articles in local bulletins/paper, on the intranet and handing out of leaflets.

9.6 Antibiotic prescriptions / algorithms

The lead antimicrobial pharmacist has also created algorithms for clinical pharmacists to follow when presented with antimicrobial prescriptions on their wards. These are meant to aid pharmacist's to query prescriptions, appropriately switch from intravenous to oral antibiotics and how to dose toxic antibiotics. This helps reduce inappropriate prescribing, switching early to oral antibiotics and reduces risk to patients from side effects, multi-resistant bacteria, hospital acquired infections and has proved a useful tool to aid pharmacists in the clinical screening of prescriptions.

9.7 Audits

The lead antimicrobial pharmacist also conducts monthly snapshot audits to monitor the quality of antimicrobial prescribing within the trust. This is done at ward level by clinical pharmacists and helps ascertain any issues with prescribing that is then dealt with by the ward pharmacist. The audit data is given to the TIPCG and fed back to the CUs.

9.8 Incident reports

The lead antimicrobial pharmacist is also involved in reviewing of incident reports involving antimicrobials and also participates in root cause analysis of patients who have come to harm where antimicrobials may have directly or indirectly been involved such as RCAs of *Clostridium difficile* cases.

9.9 Innovation

9.9.1 Antibiotic intervention system on eSearcher

During 2016/17 there is a plan to introduce monitoring of restricted antibiotics using the Trusts eSearcher system. This will be used by ward Pharmacists to alert the Consultant Microbiologists to restricted antibiotics that are not being used in line with the Trust antimicrobial prescribing policy. The aim is for the Consultant Microbiologist to "police" the use of restricted antibiotics and advise alternatives where possible.

9.10 Antibiotic CQUIN 2016/17

In 2016/17 the DH will introduce a new antimicrobial stewardship CQUIN for acute NHS Trusts. The aim of this is to reduce the total antibiotic use (including Tazocin and Meropenem specifically) and to ensure that antibiotics are reviewed within 72 hours of starting them.

10. Water Safety Incidents

10.1 Elevated Legionella counts in water sampling, Conquest Hospital, Hastings

Elevated Legionella counts have been reported at the Conquest Hospital, Hastings. A set of twenty site-wide water samples were taken on 20th July 2015 which indicated the presence of *Legionella pneumophila* (Groups 2-14) at levels between 100 – 1000 cfu/l in both Decham Ward and within Outpatients Area A. The presence of *L. pneumophila* was also detected within the water system served by Plant Room 103.

Initial actions and investigations were implemented in line with the Trust policy and Public Health England (PHE) notified. The Extraordinary Water Safety Group continues to be held to manage and monitor investigations, and additional controls. Despite additional control measures the water sample taken on the 18th & 19th January 2016 detected non-pneumophila on Decham and Macdonald ward. The results have been fully reviewed with the Authorising Engineer who acknowledged that improvements had been seen but the issues were not eradicated. The decision has therefore been made to go out for tender for a chemical dosing system.

The ADIPC has also provided a briefing for the local Public Health team to seek additional expert advice. A meeting is to be arranged with the PHE water safety experts and representative from the Estates department, IPCT and the DIPC to seek assurance on the actions taken to date and advice on any further actions required. No cases of hospital-acquired *Legionella* infection have been detected.

11 Annual Programme of Work / Priorities for 2016/17

Taking into account the performance delivered by the Trust in 2015/16, the lessons learnt from the root cause analysis investigations of MRSA bacteraemia, *Clostridium difficile* infections and the findings of the CQC investigation reports, the Trust is working with the Head of Infection Prevention & Control for the Trust Development Authority (South) to review the work priorities for 2016/17 to include:

(i) Programme of improvement and audit to demonstrate assurance of compliance by all staff with infection control policies

(ii) Reduction of healthcare associated infections

(iii) Support the delivery of the local Antimicrobial Resistance Strategy, initiatives and CQUIN

(iv) Meet mandatory reporting and surveillance requirements related to HCAI

(v) Robust procedures to identify and respond where a need for improvement is identified.

(vi) Further patient involvement and feedback from Infection Prevention and Control experience

(vii) Lessons learned from incidents, root cause analysis investigations and post infection reviews to disseminated and imbedded for shared learning

(viii) Seasonal influenza preparedness planning to focus on increasing staff awareness and vaccine uptake

(ix) Peer auditing of hand hygiene compliance to be undertaken to provide further assurance of data provided

(x) The presenting and processing of *Clostridium difficile* RCAs to be reviewed to ensure multidisciplinary involvement and Trust wide learning

(xi) Review and update all infection prevention and control polices to reflect latest best practice guidance and recommendations

The above will be incorporated into the Infection Prevention and Control's Annual Programme of Work for 2016/2017 with key performance indicators. This will be monitored through the Infection Prevention and Control's integrated action plan.

We endorse the Infection Prevention Society's vision that:
"No person is harmed by a preventable infection"

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	17
Subject:	Workforce Race Equality Standard (WRES)
Reporting Officer:	Kim Novis

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

Purpose:

This report provides details of the nine key metrics of the Workforce Race Equality Standard. The Board is asked to receive the report and note the plans to develop and support BME staff.

Introduction:

WRES was introduced into the standard NHS Contract from April 2015. WRES is a toolkit that can be used to assist NHS organisations to identify and address Race inequality.

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

The report highlights that whilst the Trust is representative of the populations it serves overall, there are pockets that require further attention. The EDS2/WRES steering group will devise an action plan and monitor the 9 metrics following the BME Network meeting.

Metric 1, BME non-clinical bands 4,5 & 6 have particularly low levels of BME staff and therefore this will be analysed further to ascertain the reasons surrounding this.

Metric 5 – 8 are NHS Staff Survey results saw an increase in staff reporting and experiencing incidents relating to Bullying & Harassment. It should be noted that the survey was collected prior to initiatives being implemented and the Speak Up Guardian had only just been appointed. It is hoped that an improvement will be reported in the next NHS Staff Survey.

Metric 2 analyses the likelihood of BME staff being recruited compared to white staff which has seen a small improvement and whilst a white person is 1.67 times more likely to be recruited, progress is being made to ensure ESHT retains its reputation as an equal opportunities employer.

Metric 3 has also seen an improvement in disciplinary/grievances as BME staff were zero times more likely to enter into a formal disciplinary process.

Metric 4 is used to identify access to non-mandatory training. Unfortunately data is not collected on courses that are organised locally within CU/departments and also free university courses/conferences. Often the booking form requires a lead booker and number of places required. This is currently being explored as the Trust must also improve on areas where data collection is incomplete or unavailable.

Benefits:
The WRES assists the Trust in meeting its legal obligations as an equal opportunities employer and to comply with the Public Sector Equality Duty. The standard will also assist the Trust in identifying and addressing any racial inequalities and thus providing a more inclusive workforce.

Risks and Implications
Metric 1 requires a true percentage of BME figures. This was discussed at length with Director of HR, NHS England and discussions with workforce development and feel that due to numbers being so small that ESHT will report whole percentages for each band, clinical and non-clinical There is incompleteness of data sets due to how access to non-mandatory training is captured. Workforce development looked at ways to capture this data more accurately for 2015-16 reporting, but have identified this will take longer to address. Non-compliance with WRES would be a breach of the NHS standard contract.

Assurance Provided:
The paper provides assurance of the process in place to support implementation and monitoring of WRES.

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	x
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
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.	
Review by other Committees/Groups (please state name and date)**:**	
EDS2/WRES Group 5th September 2016	

Proposals and/or Recommendations
The Board is asked to review the Workforce Race Equality Standard and initial mapping against the metrics and note the proposals to improve data collection and monitoring.

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: Kim Novis **Equality Diversity and Human Rights Lead**	**Contact details:** Kim.novis@nhs.net ext (14) 8677

East Sussex Healthcare NHS
NHS Trust

The Workforce Race Equality Standard (WRES)

2015/16

The Workforce Race Equality Standard

1. Introduction

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

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

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

The regulators, the Care Quality Commission (CQC), National Trust Development Agency (NDTA) and Monitor, will monitor the WRES and EDS2 to help assess whether NHS organisations are well-led.

2. Data Collection and Monitoring

The 2014/15 WRES report highlighted the importance of having processes for collecting robust data. The Trust continued to develop and improve data collection methods during 2015/16.

East Sussex Healthcare NHS Trust's baseline data were used to identify area's that required improvement. Each metric was considered at the EDS2/WRES steering groups and action plans developed accordingly. The steps the Trust has taken can be found under 'Highlights from 2015/16'.

3. Progress from 2014/15

2015/16 has seen many changes and improvements for staff. Ruth Agg was appointed as the dedicated 'Speak Up Guardian' for The Trust. The role of the 'Speak Up Guardian' supports staff when raising an issue, wrongdoing or risk which affects them or others. This includes areas of poor practice, attitudes or inappropriate behaviour within the organisation. The organisation has promoted its zero tolerance approach towards unacceptable behaviour, bullying, unlawful discrimination, harassment and victimisation by enabling staff to raise their concerns knowing that they will be supported and feel confident in raising their concerns.

To support the Trust in meeting its legal obligations the Trust Equality Objectives were developed. Trust Equality Objectives were developed using the EDS2 and WRES indicators. The full document can be found on the Trust website.

In November 2015, development of the Black, Asian & Minority Ethnic (BAME) Listening Group enabled the Trust to support staff and identify areas where staff felt improvement was required in order to achieve equality of opportunity. Each WRES indicator was explained and the 2014/15 figures discussed.

Highlights from 2015/16

- Listening into Action (LiA) held a session for BAME staff at both acute hospital sites. This group discussed areas of good practice and areas that required improvements.
- LiA agreed to take forward opportunities for shadowing. This will be implemented in 2016/17.
- Development of the BAME Staff Group/Network Chaired by the Chief Executive.
- Cultural review was undertaken by an external facilitator.
- Cultural Support Workshops were delivered to support overseas doctors with their written and spoken English language skills. The workshops encouraged looking at different backgrounds and sharing cultures.
- Several staff were supported to attend the NHS BME Conference held at the Park Lane Hotel in London.
- The Staff Engagement and Operations Group introduced equalities monitoring to the Staff Friends and Family Test (SFFT) to enable the Trust to identify whether there is a general difference of reporting amongst the protected characteristics. This is highlighted in the EDS2 report.

4. Workforce Race Equality Standard Metrics 2015/16

Workforce metrics For each of these four workforce indicators, the Standard compares the metrics for white and BME staff.	
1.	**Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce** **Note: Organisations should undertake this calculation separately for nonclinical and for clinical staff**
	❖ **12.33% of all staff identified as BME** ❖ **79.61% of all staff identified as White British or White Other** ❖ **8.05% of staff's ethnicity was unknown and are excluded from calculations.** ❖ 9.83% of all employed BME staff were employed in bands 8-9 and VSM ❖ 6.96% of all employed White British or White Other staff were employed in bands 8-9 and VSM ❖ 17.95% of staff employed in Bands 8 - 9 and VSM identified as BME ❖ 82.05% of staff employed in Bands 8 - 9 and VSM identified as White British or White Other. ❖ 90.17% of all employed BME staff were employed in bands 1-7 ❖ 93.04% of all employed White British or White Other staff were employed in bands 1-7. ❖ 10.8% of staff employed in Bands 1 - 7 identified as BME ❖ 89.2% of staff employed in Bands 1 - 7 identified as White British or White Other. **Clinical & Non-clinical** ❖ 16.5% of all clinical staff identified as BME ❖ 83.5% of all clinical staff identified as White British or White Other. ❖ 5.79% of all non-clinical staff identified as BME ❖ 94.21% of all non-clinical staff identified as White British or White Other.

Percentage of BME and White staff in each clinical and non-clinical pay band

	Non-Clinical		Clinical	
Band	**BME %**	**White %**	**BME %**	**White %**
1	11.95	88.05	3.45	96.55
2	6.87	93.13	13.50	86.50
3	4.12	95.88	10.95	89.05
4	1.64	98.36	3.51	96.49
5	2.92	97.08	23.32	76.68
6	2.44	97.56	7.99	92.01
7	4.08	95.92	6.21	93.79
8a	7.69	92.31	10.98	89.02
8b	6.25	93.75	0.00	100.00
8c	8.33	91.67	9.09	90.91
8d	0.00	100.00	0.00	100.00
VSM	0.00	100.00	0.00	100.00
Cons			28.11	71.89
Career Grade			61.18	38.82
Trainee			49.07	50.93
Other			25.00	75.00
Total	**5.79**	**94.21**	**16.50**	**83.50**

2.	**Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.**
	2015/16 The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 1.67 times greater. **2014/15** The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 1.89 times greater.
3.	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year**
	2014/15 – 2015/16 Staff identified as BME were 0 times more likely to enter the formal disciplinary process compared to staff identified as White British or White other.

4.	**Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff**
	Available figures demonstrate White staff were 1.25 times more likely to access non-mandatory training compared to BME staff. Note: Caution must be taken when forming judgments on data for those accessing non-mandatory training due to how these data are captured. Line managers often block book places on conferences and university workshops, the booking forms require a line manager's name plus the number of attendees and not necessarily individual names. Therefore identifying members of staff who have attended these non-mandatory training events has proved challenging. Where staff have been identified this has been reported. Improvements to how these data will be collected are currently under review.
National NHS Staff Survey findings For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for white and BME staff	
5.	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**
	2015/16 results ❖ 32.05% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. ❖ 34.04% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. **2014/15 results** ❖ 31.31% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. ❖ 26.17% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6.	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**
	2015/16 results ❖ 31.51% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. ❖ 34.04% of BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. **2014/15 results** ❖ 26.04% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. ❖ 24.6% of BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months.

7.	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**
	2015/16 results ❖ 84.89% of White respondents believed they were provided with equal opportunities for career progression or promotion. ❖ 63.7% of BME respondents believed they were provided with equal opportunities for career progression or promotion. **2014/15 results** ❖ 85.09% of White respondents believed they were provided with equal opportunities for career progression or promotion. ❖ 70.07% of BME respondents believed they were provided with equal opportunities for career progression or promotion.
8.	**Q 17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**
	2015/16 results ❖ 7.8% of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. ❖ 10.92% of BME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. **2014/15 results** ❖ 6.63% White of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. ❖ 12.35% BME of BME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background.
Boards Does the Board meet the requirement on Board membership in 9?	
9.	**Percentage difference between the organisations' Board voting membership and its overall workforce**
	All voting members of ESHT Trust Board identify as White British or White other. Vacancies for Trust Board positions are widely advertised and communicated to the NHS BME Network. No applicants identified as BME for ESHT Trust Board positions in 2015/16. In 2015/16 the Percentage difference between the organisations' Board voting membership and its overall workforce was 13.4% In 2014/15 the Percentage difference between the organisations' Board voting membership and its overall workforce was 12.6%

Timeline Action Plan for 2016/17

April – June 2016

- Develop BAME Staff Group/Network

July 2016

- Submit WRES figures and action plan via Unify 2
- Present WRES report to Quality & Standards Committee
- Advertise BAME Group to all staff

August 2016

- WRES data submitted
- Develop report and action plan.

September 2016

- EDS2/WRES Steering Group Meet
    a. Devise plan to address outcomes from WRES report
    b. Identify / confirm Leads for EDS2 Outcomes (some link with WRES) and relevant WRES metrics
    c. Identify data monitoring and collection methods for EDS2 & WRES.
    d. Confirm data collection dates, deadlines and methods.
    e. Agree engagement
- Implement engagement plans / activities for EDS2 & WRES
- BAME Staff Group/Network to meet
    a. WRES explained
    b. Agree ToR
    c. Develop Actions
- Publish full action plan for Race Equality at East Sussex Healthcare NHS Trust

January 2017

- BAME Staff Group/Network meeting

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

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	19c
Subject:	Safeguarding Annual Report for Adults and Children
Reporting Officer:	Alice Webster

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

Purpose:

This paper provides with a summary of the work over the past financial year 15/16 for East Sussex Healthcare Trust. This paper is the annual Board paper, produced in July 2016.

Introduction:

Detail is presented to provide both context of safeguarding and a summary of the activity of the work accomplished through 2015/2016 and a resume of the planned activities for 2016/2017

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

Review of 2015/16 key actions for safeguarding adults and children
Update of current National reports
Local plan for 16/17

Benefits:

To advise the Board of the significant work in progress within the organisation regarding Safeguarding Adults at Risk and Safeguarding Children

Risks and Implications

Areas where we are not meeting statutory requirements will be identified and action plans developed to mitigate/remove risk.

Assurance Provided:

This report provides assurance to the Trust Board for Safeguarding Adults at Risk and Safeguarding Children.

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

Safeguarding Adults and Children Strategic Group
Safeguarding Adults Operational Group
Safeguarding Children's Operational Group
TNMAG – 19 August 2016
Quality and Safety Committee – 21 September 2016

Local Safeguarding Children's Liaison Group (Any service issues affecting safe delivery of the safeguarding children service are reported to this Sub-group of the LSCB)

Proposals and/or Recommendations
The Board is asked to note the contents of this paper and to have assurance around processes in place to protect adults and children at risk

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:	**Contact details:**
Brenda Lynes-O'Meara (Interim GM for W&C)	07900680616
Sue Curties (Interim Head of Safeguarding)	07769934777

East Sussex Healthcare NHS Trust

Annual Safeguarding Report

1. Introduction

1.1 This paper informs East Sussex Healthcare Trust (ESHT) Board of current high level key issues regarding safeguarding adults and children within ESHT.

1.2 ESHT is committed to working in partnership with key stakeholders to ensure that the adults and children at risk in East Sussex are identified in a timely manner and protected from harm. The purpose of this report is to:

- Provide ESHT Trust Board with an overview of the safeguarding activity undertaken in 2015/16 and outline those areas requiring further development

- Outline the safeguarding priorities for the forthcoming year 2016/17

2. This report deals collectively with adults and children's safeguarding including a summary of key documents / data and national strategy and guidance

East Sussex Healthcare Trust continues to meet its statutory responsibilities in the care and protection of clients and patients of all ages. Existing statute underpins the work of colleagues supporting health care practitioners delivering services to children in line with Section 11 of the Children Act 2004. This runs as a thread throughout those sections below pertaining to the work of the Safeguarding Children Team. The introduction of the Care Act in April 2015, updated in spring 2016 provides a statutory footing with the establishment of Safeguarding Adult Boards. Safeguarding teams continue to deliver a high quality and credible service whilst continually reflecting on areas for improvement.

The diagram on the following page represents the diversity of work undertaken by the Safeguarding Team:

2.1 Safeguarding Children

2.1.1 Working Together to Safeguard Children.

Working Together to Safeguard Children was updated in 2015 and provides the multiagency guidelines for practice. The revisions included changes to:

- The referral of allegations against those who work with children
- Notifiable incidents involving the care of a child
- The definition of serious harm for the purposes of serious case reviews
- A focus on Early Help

The guidance emphasises that effective safeguarding systems are those where:

The needs and wishes of each child are paramount and that every child receives early help support to prevent a problem escalating.

All professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children;

All professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care;

High quality professionals are able to use their expert judgment to put the child's needs at the heart of the safeguarding system so that the right solution can be found for each individual child;

All professionals contribute to whatever actions are needed to safeguard and promote a child's welfare and take part in regularly reviewing the outcomes for the child against specific plans and outcomes.

Effective safeguarding arrangements should be underpinned by two key principles:

- Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part.
- A child-centered approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

Early intervention and relationship-based practice is used to engage families and effect a positive impact on the child

2.1.2 The Intercollegiate Document (2014, RCPCH)

This document describes six levels of competences and provides model role descriptions for Named and Designated safeguarding professionals, setting out competency levels for all healthcare staff.

In order to protect children and young people from harm, all healthcare staff must have the competencies to recognise child maltreatment and to take effective action as appropriate to their role. It is the duty of employers to ensure that those working for them clearly understand their contractual obligations within the employing organisation, and it is the responsibility of employers to facilitate access to training and education which enable the organisation to fulfil its aims, objectives and statutory duties effectively and safely.

ESHT safeguarding training at levels 1, 2 and 3 is designed to meet these competencies. All community staff complete competencies with the support of the Community Safeguarding Team and their Line Managers. Acute Paediatric staff work on their competencies with the support of the Specialist Nurse (Paediatric Liaison). The Safeguarding Supervision Policy, updated 2016, includes the competency assessment and the need for staff to ensure they fulfil these requirements.

The Intercollegiate Document for Looked after Children (RCPCH 2015) has been included within the Acute/Community training programmes to raise staff awareness of this vulnerable group of children/Young People and to improve staff knowledge of specific legislation and responsibilities.

2.1.3 Children Act 1989 Children Act 2004 (Children's Services) Regulations 2005

We continue to work within the boundaries of The Children Act 1989. The document aims to ensure that the welfare of the child remains paramount, working in partnership with parents to protect the child from harm. The Act was intended to strengthen the child's legal position; to give him/her equal rights, feelings and wishes; and to ensure children were consulted and kept informed. The Children Act 2004 aims to further improve children's lives and gives the legal underpinning to 'Every Child Matters: Change for Children' (2004).

In response to changes in the Children Act 2004 from April 2006, education and social care services for children have been brought together under a director of children's services in each local authority. In response to the governments "**Better Together" Agenda (2015)** East Sussex County Council (ESCC) and ESHT have worked with Local Authority commissioners to provide an Integrated Health Visiting and Children's Centre Service (IHVCC Service) which commenced in April 2016. The service continues to develop and will ensure that there is a clear focus on Early Help provision for families/children. In conjunction with the development of the IHVCC Service, there have been major changes in the referral systems and management of referrals to East Sussex Children's Social Care. The changes have been designed to ensure that all referrals receive support at the appropriate level from a multiagency professional with the requisite skills. ESHT Safeguarding Team, work closely with ESCC to ensure that an effective, safe service is being provided to children at risk whilst service development and change is underway.

2.1.4 The Children and Young Person Act 2008

Has also been introduced. Its main purpose is to effect the recommendations set out in the White Paper 'Care Matters: Transforming the Lives of Children and Young People in Care' and "forms part of the Government's programme to ensure children and young people receive high quality care and support."

The Act includes provisions in relation to the well-being of children and young people and private fostering. It has a particular focus on older young people in care and those making the transition from care.

Other Acts closely linked to the Children Act are:

a) Protection of Children Act 1999
b) Safeguarding Vulnerable Groups Act 2006
c) Childcare Act 2006

In 2015 statutory guidance 'Promoting the health and well-being of looked after children was re-issued. ESHT, as a key provider, commissioned to undertake statutory health assessments, has audited Looked After children services and effected required changes.

3.1 Local and National Case Reviews

ESHT Safeguarding Team incorporate themes and lessons learnt from both local and national case review through supervision and training sessions.

3.1.1 Saville Review (2013)

The Saville review in May 2013 resulted in both Safeguarding Adults and Children's Boards producing an action plan to ensure policies and procedures are in place within local services, providing assurance that vulnerable adults and Children are protected from the risk of exploitation. ESHT have reviewed all related policies within adult and children's services. The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust was published in June 2014. ESHT have reviewed this report and made adjustment to process and policy.

3.1.2 Goddard Independent Inquiry into Child Sexual Abuse, 2015

The Independent Inquiry into Child Sexual Abuse was launched in March, 2015 and will be chaired by the Hon. Dame Lowell Goddard. It will investigate whether public bodies and other non-statutory institutions have taken seriously their duty of care to protect children from sexual abuse in England and Wales. ESHT have taken a proactive stance towards the inquiry completing a checklist for the Clinical Commissioning Group outlining how safeguarding is managed within the Trust.

3.1.3 Independent Enquiry into Child Sexual Exploitation (CSE), Rotherham, (2014)

ESHT response to Rotherham:

- LSCB sub-groups at Gold, Silver and Bronze level have been set up to manage CSE at strategic and operational level. WISE and MACSE (Multiagency child sexual exploitation meeting) At the Bronze operational the MACSE meeting shares information to identify vulnerable young people within our community and designs multiagency plans to reduce risk/minimize harm to children and young people.

- Kent School Nursing and the ESHT Looked after Children Team are represented at these meetings. Named Nurses receive the minutes from the meetings. Information is shared as appropriate.

- ESHT safeguarding training and the ESHT Child Protection Policy includes raising CSE awareness within community and acute healthcare settings. There is a clear referral pathway for staff to follow.

- The Local Safeguarding Children Board has specialist CSE training for staff in order to raise awareness.

- A CSE Specialist Nurse has recently been employed by CCG to improve information-sharing and CSE processes. She will attend the Bronze MACSE group and Multiagency.

- Staff working closely with vulnerable groups are encouraged to attend the specialist training provided by the LSCB. (This training is mandatory for Band 6 School Nurses. ESHT Sexual Health Teams have appointed CSE Leads to ensure staff have access to specialist support within their teams).

3.1.4 The Woods Report: A Review of the Local Safeguarding Children's Boards 2016

This is a national report which reviews the Local Safeguarding Children's Board roles and functions. The report sets out a new framework for improving the organisation and delivery of multi-agency arrangements to protect and safeguard children. It contains recommendations for government to consider with regard to Local Safeguarding Children Boards (LSCBs), Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs).

The recommendations are:

1. Multi-agency arrangements for protecting children

- To replace the existing statutory arrangements for LSCBs and introduce a new statutory framework for multi-agency arrangements for child protection.

- To require all areas to move towards new multi-agency arrangements for protecting children within a prescribed period. The three key agencies are health, police and local authorities. Local areas/regions would need to establish a plan which would describe how services would: meet the new statutory framework; the existing legislative framework underpinning LSCBs should cease to operate as new arrangements come into being.

- Where an LSCB has been functioning effectively (as in East Sussex) there is an option to retain existing ways of working.

2. Serious Case Reviews

To discontinue Serious Case Reviews, and to establish an independent body at national level to oversee a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm.

The Department for Education are to set out key tasks for the new body to determine. These should include:

- the creation of a new national learning framework

- the process by which the notification of an event takes place

- the process for establishing a National Serious Case Inquiry (NSCI)

- best practice guidance on delivering a proportionate approach at local level to conduct a Local Learning Inquiries (LLIs)

- providing new guidance to cover best practice in undertaking single and multi-agency inquiries, including the importance of a rapid response and transparency in publicising how an area has learned for the event and what has changed in local practice; and advising how learning can be reported through existing local accountability structures so as to ensure transparency and promote learning.

3. Child Death Overview Panels (CDOPs)

- CDOPs to move from the Department for Education to the Department of Health who should consider how CDOPs can best be supported and sponsored within the arrangements of the NHS.

- If the national study recommends the introduction of a national database for CDOPs, the Department of Health should consider expediting its introduction.

- The Department of Health should determine how CDOPs can be organised on a regional basis with sub-regional structures to promote learning and dissemination. They should also give consideration to the membership of CDOP to ensure appropriate representation from both health and non-medical agencies.

- In considering a common national standard for high quality serious incident investigations for child death the Health Safety Investigation Branch of the NHS should consider the role CDOPs will play in this process.

- The Department of Health should consider the role that Health and Wellbeing Boards and the Joint Strategic Needs Assessment play in dealing with child deaths and the role of a CDOP

4 .1 Multiagency Partnership Working

4.1 .1Section 11 of the Children Act 2004

Section 11 of the Children Act 2004 (duty to safeguard and promote the welfare of children) sets out specific duties on agencies with regard to safeguarding.

The Section 11 Audit is completed bi-annually through self-assessment. The audit was submitted to the LSCB in March 2016. An action plan is in place to address those areas that have an amber RAG rating as follows:

- The need for additions to the safeguarding and supervision policy referring to risks/protective factors presented by significant males, PREVENT counter-terrorism strategy and online safety (for staff). These policies are currently under review.

- Named Professionals to receive Safer Recruitment training from LSCB the (ESHT are awaiting provision from the LSCB).

- To ensure CSE that is addressed in all relevant ESHT assessments it is included in level 3 training in order to make staff aware that this should be a consideration in all Paediatric assessments. The introduction of the CSE nurse role and the proposed attendance at the across site Safeguarding Children's meeting will enable to service to review the children and young person's most at risk. The paediatric liaison nurses scrutinise all children's and young person's admissions and any children who are deemed to be at risk are referred to the Single Point of Advice within Children's Social Care.

4.2 Changes to Commissioning of Services

- Kent Primary Community Health Services Trust is now the provider for The School Health Service (previously the ESHT School Nursing Service). The provision of child protection

supervision and level 3 safeguarding training remains with the ESHT Community Safeguarding Children Team.

- Kent Primary Community Health Services Trust is now the provider of LAC medical services commissioned to undertake initial health assessments within 20 working days of children entering care, adoption and permanence medicals and to provide Designated Doctor and Adoption and Permanence Medical Advisor roles.

- The commissioning of the Health Visiting Service transferred to the local authority in October 2015 and the IHVCC Service has been developed.

- The Looked After Children (LAC) contract will be reviewed in September 2016, ESHT are currently working with commissioners with the aim of gaining this contract within ESHT's portfolio.

5.1 Staffing

In accordance with the Intercollegiate Document, 2015 the Community Safeguarding Children Team has one full-time Named Nurse and a Deputy Named Nurse. There is a full-time Named Nurse to oversee the acute services.

ESHT has 2 Named Doctors who cover acute/community. The Designated Nurse and Doctor activity remains with CCG's.

The Designated Nurse for Looked after Children activity remains within ESHT working with ESHT Looked After Children Nursing Team and KCHT medical team.

5.1.1 Annual activity: source ESCC June, 2016

The reduction in the number of CP, CIN and LAC cases reflect the changes in multiagency working in East Sussex as the result of THRIVE. THRIVE was a 3-year ESCC transformation programme launched in April 2012, aiming to change the way practitioners worked with vulnerable children, young people and families. The project aimed to reduce referrals to children's social care; the number of children on child protection plans and the number of looked after children. THRIVE enabled the delivery of early help to families thereby reducing escalation of risk, subsequent costs and reduction of CP, CIN and LAC cases.

Area reviewed	Number of cases		
	2014	**2015**	**2016**
LAC	534	549	562
Lac & CP Plan	42	15	11
CP Plan	547	463 plus 14 unborn	383
CIN	2586	2314	850

5.1.2 Child Safeguarding Training

Overall Trust % Trained	Level 1 Safeguarding children All staff	Level 2 Safeguarding Children Clinical staff	Level 3 Safeguarding Children Staff working directly with children
March 2016	100%	82.12%	85.89%
March 2015	100%	78.12%	87.42%
March 2014	100%	56.41%	78.56%
March 2013	100%	39.04%	42.74%
March 2012	100%	65.0% (Combined level 2 & 3)	N/A

- There has been a sustained improvement in compliance with Safeguarding Children Training within ESHT since 2012.
- Staff evaluation of the training has been positive.
- Level 1 Child Safeguarding leaflets are distributed throughout ESHT to all staff twice a year to maintain a focus on child safeguarding.

LSCB multiagency training is available to relevant ESHT staff and Early Help workforce development training is still available to those staff working in multiagency early help settings. Staff must now access training via the ESCC Learning Portal which has experienced some early implementation difficulties resulting in a decrease in ESHT staff undertaking LSCB courses. This situation is now improving.

5.1.3 Domestic Abuse/ Training (Adults and Children)

- Mandatory domestic violence training for community and acute staff is on-going.
- The East Sussex Safer Communities Partnership Domestic Abuse Strategy, 2014-2019 consultation has taken place.
- The Named Nurse Community sits on the MARAC Quality and Audit Group which reviews multiagency management of MARAC cases. The Designated Adult Safeguarding manager attends when required.
- ESHT are signed up to the MARAC Operating Protocol.
- MARAC cases are now reviewed fortnightly on both sides of the county by acute and community staff.
- Claire's Law Domestic Violence Disclosure Scheme (DVDS) has been rolled out across Sussex. Staff have access to appropriate referral forms.

- Alerts are entered onto IT systems for community and acute staff.

- Joint Targeted Area Inspections were launched by the government in January, 2016. Four inspectorates (Ofsted, Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMIP) will jointly assess how local authorities, the police, health, probation and youth offending services are working together in an area to identify, support and protect vulnerable children and young people. The new short inspections will allow inspectorates to be more responsive, targeting specific areas of interest and concern. They will also identify areas for improvement and highlight good practice from which others can learn. The inspection round commencing September, 2016 will focus on Domestic Abuse.

5.1.4 Serious Case Reviews (SCR)/Multiagency Reviews (MAR)

Summary of Activity

- The SCR for child K was published in June 2015.
- There are a number of reviews currently underway

Reports are publically available on the LSCB website. ESHT has a number of completed action plans relating to the SCR's and MAR's, all are available for scrutiny upon request.

5.1.5 Progress of action plans relating to SCRs/MARs

No outstanding actions for SCRs/MARs

5.1.6 Early Help Intervention.

There is a continued focus on Early Help intervention in line withThe Munro Review of Child Protection: 2012. The Integrated Health Visitor and Children's Centre Service (IHVCC Service) commenced in April 2016 and provides a process to manage early help referrals and to ensure that they receive the appropriate intervention in a timely way from the appropriate professional. The Named Nurse Community will be involved in the oversight and auditing of HVCC Service activity.

5.1.7 Child Sexual Exploitation (CSE)

During 2013/ staff received specific level 3 training covering CSE- recognition; responsibility and referral pathways.

In line with Working Together; ESHT Safeguarding Guidelines cover the potential of CSE risk whilst receiving care, within Maternity services an Additional Support Form (ASF) is generated for clients aged 18 or below. This collates information including CSE indicators, including Childhood sexual abuse; Domestic abuse, family breakdown; Physical and emotional deprivation, bullying and parents with high level of vulnerabilities.

CSE remains a consideration within wider forums such as MARAC (Multi-Agency Risk Assessment Conference) and has been successful in identifying a perpetrator to a number of vulnerable young women in the area in 2015.

- CSE is covered within Level 2 and 3 ESHT CP training.
- Named Nurses and Midwives are the contact point for health services for all Child Safeguarding queries.
- Referral pathways for CSE are in place, Police are undertaking a data collection within East Sussex and specialist WISE workers are in place to support case management.
- A dedicated CSE worker has been employed on a fixed term contract by the CCG.

5.1.8 Record-Keeping

Systmone online recording system has been implemented within ESHT community health visiting and safeguarding services.

A user group is in place to manage initial difficulties with implementation. Online records will support improved Child Safeguarding information-sharing.

CP-IS will enable us to access information regarding children at risk at level 4 and will replace the Children's Index. ESHT and the local authority is at the implementation stage.

Better Together also aims to enable improved data-sharing between ESCC and ESHT staff.

6.1 Improving Quality within Child Safeguarding/Audits

ESHT continue to improve quality of care within safeguarding, the audit programme supports this process.

6.1.1 Audit Programme 2015/2016

Community

- **Referrals to Duty and Assessment Team 2015/16** An audit to assess the quality of referrals into DAT from Health Visitor, Midwifery, Acute and Family Nurse Partnership Staff. Actions from the audit are now complete.

- **Supervision Audit, 2015/16**: An audit to assess the quality of child protection supervision and appropriate use of documentation. Actions from the audit are now complete.

- Named Nurse Community sits on **Multi Agency Risk Conference (MARAC) Quality and Audit Group** which reviews selected cases quarterly and makes recommendations for learning/ improving practice.

- **Multi Agency Risk Conference (MARAC) Quality and Audit Group** recommendation, 2015: Named Nurse Community completed a dip check of how cases are 'flagged and tagged' within ESHT service areas. Actions from this audit are now complete following the sign-up to the MARAC Operating Protocol which requires all staff to 'flag and tag' MARAC cases.

Acute

- **CAMHs Pathway Audit** (re-audit), due for completion July 2016. This audit is aimed at looking at the times that patients present into the Emergency Departments, their presentations, whether risk assessments are undertaken and to consider the usefulness of the CAMHs Pathway introduced 3 years ago.

- Proposed audit **Quality and accuracy of the information recorded by acute staff when submitting Statement of Referrals to SPOA (CSC)** due for completion January 2017. This is in response to the changes in the referrals into children's social care and the development of training in completing the referral forms based upon the Continuum of Need in the Acute setting.

Looked-After Children statutory health reviews

ESHT Looked-After Children Nursing Team is commissioned to undertake statutory health reviews for looked after children aged 5-18 who have been in care for over 1 year. A total of 433 assessments were under taken, an increase from 410 in the previous year. 357 of the assessments were undertaken for children and young people looked after by East Sussex Children Services residing both in and outside of the county. 316 (89%) were undertaken within statutory timescales. 71 assessments were undertaken for hosted children in a placement in East Sussex, looked after by another local authority. 62 (87%) were undertaken within 4 weeks of the request. Following audit issues relating to quality and timescales were identified relating to the assessments undertaken for babies and children by the health visiting service. Corrective measures have been in put in place to address this.

Safeguarding Adults

The Care Act

This year has seen the introduction of the Care Act 2014 . In relation to safeguarding, the Care Act progress has been as identified below;

- In line with Care Act recommendations, the East Susses SAB recruited Graham Bartlett as Independent Chair in July 2015
- The process for Safeguarding Enquires has been reviewed with a new electronic system installed to support this work
- Serious case reviews are now mandatory. No reviews have been identified during 2015
- Duty to cooperate over the supply of information is embedded within practice, an updated Information sharing policy is now in place between ESHT and ASC
- There is duty on local authorities to find advocacy for people who do not have anyone else to speak up for them, this is now in place.
- Re-enact existing duties to protect people's property when in residential care or hospital
- A duty of candour has been placed on providers about failings in hospital and care settings and create a new offence for providers of supplying false or misleading information

The Act provides sets of regulations (2014) and an updated statutory guidance and regulation, published in March 2016. The initial legal framework came into effect on 1 April 2015.

The Care Act and its supporting guidance place a series of new duties and responsibilities on local authorities about care and support for adults. Chapter 14 of the Care and Support Statutory Guidance provides guidance on sections 42 – 46 of The Care Act 2014. This guidance replaces the "No secrets guidance".

The updated statutory guidance published in March 2016, include:

- Clarification of Enquiries under section 42 in relation to those who self-neglect
- New definition of Domestic Violence to reflect ne legislation
- Additional information about financial abuse
- Clarified the need for a strategic and accountable lead for safeguarding at senior level

Adult Safeguarding what it is and why it matters

Safeguarding means protecting an adults right to live in safety, free from abuse and neglect, while at the same time making sure the adults wellbeing is promoted including, where appropriate having regard to their views, wishes, feelings and beliefs in deciding on any action.
Organisations should always promote the adults wellbeing in their safeguarding arrangements.
Professionals and other staff should not be advocating "safety" measures that do not take account of individual well-being, as defined in **Section 1 of the Care Act**.

The Care Act requires that each local authority **must**

- Make enquiries, or cause others to do so, if an adult is experiencing, or is at risk of abuse or neglect – the enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so by whom
- Set up a safeguarding adults Board
- Arrange where appropriate for independent advocate representation
- Co-operate with each of its relevant partners (**section 6 of the care Act**)

The aims of adult safeguarding are to:

- Stop abuse or neglect wherever possible
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Safeguard adults in a way that supports them in making choices and having control about how they want to live
- Promote an approach that concentrates on improving life for the adult concerned
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect

In the UK we know that more than 342,000 older people suffer some form of abuse every year. Abuse can be categorised into a number of types. In the UK we know that more than 342,000 older people suffer some form of abuse every year. Abuse can be categorised into a number of types

- Discriminatory abuse
- Physical abuse
- Sexual abuse
- Psychological abuse
- Financial or Material abuse

- Neglect and acts of omission
- Domestic Violence
- Self-neglect
- Modern Slavery
- Organisational abuse

7.1 NHS Guidance regarding Safeguarding Adults

This was published in March 2011 by the Department of Health following a review of "No Secrets 2000". It is statutory guidance that outlines the responsibilities for practitioners, managers, NHS Boards and Commissioners for safeguarding adults work. New safeguarding principles were published in May 2011 and are as follows:

- Empowerment
- Protection
- Prevention
- Proportionality
- Partnership
- Accountability

These principles are a key feature of the Care Act 2014

7.2 Disclosure and Barring Service (DBS)

The Vetting and Barring Scheme and the role of the Independent Safeguarding Authority (ISA) were reviewed along with the Criminal Records Bureau in 2011. The Protection of Freedoms Act (2012) led to the creation of the Disclosure and Barring service which requires a reduced number of people working in specific regulated activity (including healthcare) to be registered. The impact on ESHT includes the need for job adverts to specify whether the job includes regulated activity. In addition, regulated activity providers (including healthcare) have a legal duty to refer to the DBS if a member of staff is permanently removed from regulated activity.

7.6 Multiagency Partnership Working

Section 11 of the Children Act 2004 (duty to safeguard and promote the welfare of children) sets out specific duties on agencies with regard to safeguarding.

The Adult Safeguarding Audit is completed annually through self-assessment. The audit was submitted to the SAB in November 2015. There were no actions required following this audit.

A website for the Safeguarding Adults Board has been progressing over the past 3 months in-line with Board objectives. The website is now up and running and can be found on the link below. It is aimed at both the public and professionals alike, containing information such as what safeguarding is, how to raise concerns, training, and what the SAB's priorities currently are. Please note, some sections of the website are still in development, it will develop over time to keep in line with current safeguarding matters.

http://www.eastsussexsab.org.uk/

The Pan Sussex Multi Agency Policy & Procedures has been updated by Adult Social Care following the revision of the Care and Support Statutory Guidance (CSSG) published in March 2016. A summary of the key changes is available via the above link on Edition 3 from July 2016. Please access through the link above.

7.7 Key NHS Safeguarding Adults Board Developments

The SAB set up a budget for 2015 – 16 for the first time, financial contributions included that from East Sussex Healthcare trust.

The Governance and structure of the SAB has been reviewed. Sussex Police have taken Chair of the Performance, Quality and Audit sub-group. A multi-agency training group has been established, in line with recommendations in the Care Act to enhance multi-agency learning. Healthwatch continue to Chair the Client and Carers sub-group.

Two multi-agency learning events were held in relation to the experience of Domestic Abuse among older people, the SAB now has an action plan that includes tasks to ensure that Domestic Abuse within the older age population is better understood and responded to.

7.8 Trust Developments

The Safeguarding of Adults and Children is part of the portfolio for the Assistant Director of Nursing for Safeguarding. Safeguarding leads now sit corporately. The Director of Nursing is a member of the Safeguarding Adult and Children's Board.

IDVA

This project is seeking to embed an Independent Domestic Violence Advisor (IDVA) within A&E at the Conquest Hospital. This post is currently being recruited to through the CCG.
There is a growing evidence base[1], including in Brighton & Hove and West Sussex, to show that a hospital based IDVA service is an ideal setting in which to help increase reporting and offer confidential advice and support to victims, especially those most at risk of escalating violence. Within ESHT this project will be supported through the Safeguarding service.

Best Interest Assessors

The Law Commission are in the process of reviewing The Deprivation of Liberty Safeguards (DoLS) addendum (2009). A consultation paper was published in July 2015, which set out a comprehensive replacement scheme for DoLS. An interim statement was issued in May 2016, recommending a more streamlined, straightforward and flexible scheme for managing DoLS authorisations. The responsibility will be shifted away from the Care provider onto the commissioning body such as the NHS or Local Authority. In preparation for this change (final response is due December 2016), two of the Safeguarding Adults team leads have undergone the Best Interests Assessors Training (BIA), for the Deprivation of Liberty Safeguards, at Brighton University. A county wide discussion has been scheduled with regards to managing assessments in health.

[1] IDVA Literature Review – Zoe Hobson MOPAC E&I – August 2014

Prevent

This is one of four streams from a Home Office Strategy called CONTEST. Three of these streams support the prevention of terrorism, PREVENT it deals with preventing Radicalisation. PREVENT has been handed to the DoH as the NHS is seen as one of the largest organisations in the country with the most number of contacts with the public. Statics suggest that in England alone, the NHS has 350,000 contacts per day.

The safeguarding lead role includes being the Trust's PREVENT Lead. Staff, Adult and Children safeguarding leads, have been trained by NHS England to deliver training in Wrap3 (PREVENT) to all staff. PREVENT has been on a statutory footing since July 2015. ESHT is represented on the East Sussex PREVENT Board, chaired by the Police. Training within ESHT is cascaded to all staff through the Safeguarding Induction and three year updates. ESHT has not had any referrals to date.

Learning Disabilities

The ESHT Learning Disability (LD) lead is a core member of the safeguarding adult's team within the Trust. Her function is to support and facilitate equality of health care for adult patients with learning disabilities; improving patient experience and outcomes. Central to the care delivery for this vulnerable group of patients is adherence to the Mental Capacity Act 2005 and the provision of reasonable adjustments as required by the Equality Act 2010. The lead supports delivery of training with an emphasis on vulnerabilities and reasonable adjustments.

Currently 78% of Trust's sites have an identified LD champion. LD champions are from both clinical and non-clinical background and their role includes promotion of best practice in the context of the care and treatment of patients with learning disabilities. ESHT LD champions meet at network events co-ordinated monthly and receive role updates and education around specific topics. In 2015 this included consideration of the Mental Capacity Act 2005, the role of the Independent Mental Capacity Advocate (IMCA) and appropriate application to practice. Additionally other topics include; communication and people with learning disabilities, introduction to challenging behaviour, introduction to autism and key information on specific conditions associated with individual syndromes.

The Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) was published in 2013. The Lead Nurse has considered recommendations from this enquiry in supporting delivery of work streams, specific to secondary care settings. This has included developments in Mental Capacity Act training, work to improve access to appropriate investigations and review through completion of a mortality audit.

The Lead nurse also works closely with colleagues in Sussex Partnership NHS Foundation Trust, and East Sussex County Council community adult social care teams, providing information relating to access, equality of care and patient experience.

She continues to raise the profile of the role at ward and department level. She liaises with patients, carers, wards and departments offering advice, supporting interventions and promoting the needs of patients with learning disabilities. This work ensures adherence to the Mental Capacity Act, encouraging high standards of best interest decision making with regard to issues around capacity to give consent. The work of the LD Lead Nurse also includes the

assessment of additional 1:1 support requirements review of the efficacy and timeliness of proactive discharge planning. This practitioner is also influential in creating individual reasonably adjusted care pathways for patients identified as having increased health needs, behaviour which challenges and for those who require major adjustments to their care pathway.

8.0 Training

Mandatory Training (ESHT)

Safety days cover both Adult and Child mandatory training; these sessions are delivered on appointment and 3 yearly following appointments for all patient facing staff within ESHT. Feedback analysis demonstrates a clear learning and practical knowledge application following training sessions.

All mandatory training criteria relating to Mental Capacity Act/ Safeguarding and DoLS is available via learning and development.

Training figures show a steady increase over the past year in line with the three year training plan for safeguarding, although a dip is noted in Level 2 safeguarding training, due to large numbers of staff requiring level 2 training from March 16. Online level two training is on-going, with the addition of a workbook which was launched in September 2015 in anticipation of this. Targeted work continues with Allied Health Professionals and Medical staff.

Following the re-issue of Looked after children: Knowledge, skills and competences of Healthcare staff intercollegiate role framework safeguarding training at all levels has been updated to include these requirements for all staff and those working directly with looked after children.

Adult Safeguarding Training figures

Overall Trust % Trained	**Level2 Safeguarding Adults** ***All clinical staff***	**Mental Capacity Act**	**Deprivation of Liberty safeguards**
March 2016	79.71%	93.10%	93.81%
March 2015	85.98%	92.36%	89.09%
March 2014	77.07%	84.86%	76.19%
March 2013	76.27%	80.56%	72.60%
March 2012	59.43%	69.78%	50.18%

Overview of Substantiated alerts comparative data

Alerts against ESHT	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Total Number of concerns	156	146	56	27
Total Number of upheld concerns	53	27	22	8

Data evidences a reduction of overall substantiated adult safeguarding alerts. An overview of actions for the Trust is captured within the table below.

Analysis of safeguarding alerts

ESHT Adult Safeguarding team hold a database of all action taken based on alerts raised, outcome and related action taken. Action taken during 15/16 includes action as described below. This action links to other risk identified within ESHT including Incidents reported and Serious Incidents reported. The Trust has reviewed the Integrated Patient Documentation including a separate discharge summary booklet to be used with all in-patients. The use of the SBAR (Situation, background, assessment and treatment) handover tool, to aid communication between wards/departments when transferring patients has now been used across the Trust for 18 months and has significantly reduced the number of Concerns being taken forward in relation to safe handover.

Analysis of Data

Response to actions identified during 2014/15 Adults and Children

Action Identified 2014/15	ESHT action taken during 15/16
Correct implementation of the MCA 2005	Mandatory training for MCA reviewed Ad hoc 'Lite Bites' sessions provided at clinical area level during 2015/16 Consent Audit completed in March 2016, demonstrating improved compliance with Consent Form 4
White Ribbon Campaign	ESHT has applied for this status
Putting PREVENT Duty on a Statutory Footing	Safeguarding staff have received training through NHS England to deliver this funtion Targeted, extended training sessions currently in progress
Communication and discharge planning issues within Safeguarding	Updated patient Admission, Transfer & Discharge policy ratified and cascaded Use of SBAR tool Electronic discharge letters to GP are not mandatory within ESHT Review of Integrated patient documentation (IPD) undertaken, a trial of a discharge checklist is ongoing at EDGH IPD 5 printed August 2016
Safeguarding patient property and valuables	Patient monies and property reviewed by the Trusts auditors Pilot of revised property disclaimer completed with a positive response. Updated disclaimer is included in IPD 5

Examination of vulnerable patients	Chaperone policy reviewed and updated, work carried out within Clinical Units, specifically Urgent Care, Women and Children's and Out-patients in introducing robust use of this policy
Assessment and care of patients with mental health issues	Mental Health Triage Tool agreed and in use A&E. Mental Health Liaison Nurse in place for Adults and since May 2016 a Child Mental Health Liaison nurse is now in place, this includes working closely with SPFT

Actions identified during 15/16 Adults and Children

Action Identified during 15/16	**ESHT action taken to date**
Staff need to understand and Correctly implement MCA/DoLS 2005	Consent Audit completed. Recommendations implemented through the Consent group. "Lite Bite" sessions held at ward level to support staff in practice for MCA and DoLS. Reviewed and updated the Trust DoLs leaflet, printed and disseminated to staff during level 2 training (also available on the extranet) An MCA/DoLs audit is planned for July 2016. Staff invited to attend Pan-Sussex training sessions for MCA "Are you Confident" e-Learning package developed in house, is now available for access via ESHT intranet. Suitable for clinicians and senior staff.
PREVENT Duty moved to a Statutory Footing in July 2015, ESHT to implement	ESHT represented at the Prevent Board Key staff trained through NHS England to deliver standardised Prevent sessions. Prevent training included in the Level 2 induction and update sessions Prevent Leaflet disseminated to all staff during training Targeted, extended training sessions, to

	ancillary staff(security/porters/Domestic staff).
Continue to Improve communication during discharge planning	Use of SBAR tool has seen a marked reduction in safeguarding adults' referrals. in patient transport issues are being addressed corporately Electronic discharge letters to GP's now standard for ESHT Review of Integrated patient documentation (IPD) completed, new IPD 5 printed in August 2016 Handover tool review in progress Safety huddles are currently being introduced within ESHT
Safeguarding of patients property and valuables remains a concern	Practice has improved at ward level. Correct agencies are being notified of incidents in a timely manner. Reviewed Disclaimer included in IPD 5
Improving staff awareness of Domestic Violence	Training continues with access for ESHT Staff to multiagency training delivered jointly by ESHT & ASC staff. Brief overview included in Trust mandatory Adult and Child Safeguarding training
Improving staff awareness of Self-Neglect	Training delivered jointly by ESHT & ASC, available to both Managers and front line staff
Development of Clinical Supervision to include Safeguarding issues	Small group supervision sessions held at ward/department level to develop awareness and a lessons learned approach, supported by the safeguarding teams. Review of the Trusts clinical supervision has been completed, policy updated and training for staff advertised for 16/17 A clinical supervision review has been completed of all clinical areas. Safety huddles are being introduced within clinical areas to include daily supervision and support

8.1 Mental Capacity Act/ Deprivation of Liberty Safeguards (DoLS)

Following the cases P vs Cheshire County Council and M&M vs Surrey County Council, the Supreme Court Judges ruled In March 2014, that to be deprived of one's liberty

- The person must be under continuous supervision and control. All three elements must be present AND

- Is the person free to leave?
- I.e. how would staff react if the person did try to leave or if relatives/friends tried to remove them?

This is now widely applied across ESHT. Please see an overview table of DoLS applications, Urgent and Standard, throughout 15/16 with comparative data for 14/15. Please note that when an Urgent authorisation is raised by ESHT, it is routine to make a standard application, however many people recover prior to requiring a standard authorisation, there is also increasing pressure placed on the DoLS team within Adult Social Care. The Assistant Director of Nursing attends quarterly DoLs strategic meeting, where it is noted that all applications made during 15/16 for DoLS applications were appropriate.

Authorisations by Quarter 2014/15	**2014/15**	**2015/16**
1 Urgent	13	26
1Standard	6	5
2 Urgent	17	24
2 Standard	4	3
3 Urgent	29	19
3 Standard	11	1
4 Urgent	15	16
4 Standard	3	0
Total		
Urgent	**74**	**85**
Standard	**24**	**9**

8.2 Mental Health Act

Sussex Partnership Foundation Trust oversees training and regulatory function in relation to the Mental Health Act for ESHT. A separate annual report is in appendix 1

8.3 Deprivation of Liberty Safeguards

The Law Commission's review of the deprivation of liberty safeguards ("DoLS") began in 2014. The Law Commission's consultation paper on deprivation of liberty was published in July 2015. It set out a comprehensive replacement scheme for the DoLS, wider in scope, which they called "protective care". The public consultation ran until November 2015.

An interim statement updated stakeholders on the key issues that have emerged at consultation and some of our initial conclusions. The Law Commission have concluded that legislative change is the only satisfactory way forward. They propose to recommend a more straightforward, streamlined and flexible scheme for authorising a DoLS. The responsibility for establishing the case for a deprivation of liberty will be shifted onto the commissioning body (such as the NHS or local authority) that is arranging the relevant care or treatment, and away from the care provider. This should provide greater clarity, since the body directly responsible for the proposed deprivation of liberty would need to provide evidence to support its case. In preparation for this change two key staff have received training as Best Interest Assessors within ESHT.

DoLS process is part of the Trust's safeguarding process, where a patient lacks capacity the Mental Capacity Act (MCA) care planning tools are used. DoLS training is available for relevant staff. Statutory notification of all DoLS applications and outcomes are reported quarterly to the CQC. At ward level specific care plans exist for patients who lack or have fluctuating capacity. An annual audit will be undertaken in July 2016.

8.4 Duty of Candour

ESHT have in place a Being Open policy. This policy is used where ESHT undertake a safeguarding concern. Currently all Safeguarding concerns are initiated through a planning meeting, ESHT agree with ASC, which agency will ensure clear communication with the adult affected during the process, this includes a follow up letter outlining all issues and action discussed.
Duty of Candour training is in place for all ESHT staff.

CCG Update

Deprivation of Liberty Safeguards (DoLS) applications have been managed through Adult Social Care since April 2013, a review of the DoLS process is currently underway

Governance

The updated Pan Sussex Adult Safeguarding policy is available in a downloadable format at website: http://sussexsafeguardingadults.procedures.org.uk

1. **sussexsafeguardingadults**.**procedures**.org.uk

The 2015 Multi-Agency audit is now complete, findings included;

- Improved strengths in practice compared to the 2014 audit
- Evidence of proportionality of response and application of procedures
- Positive partnership working
- Improvement in the involvement of families and 'persons alleged responsible'
- Focus on the quality of Mental Capacity assessment and making it Decision Specific.
- Issues relating to the response time of Police involvement

There were no specific recommendations for ESHT.

ESHT continue to work in partnership with the Multi Agency Professionals of East Sussex to safeguard vulnerable adults.

Adult Social Care (ASC) is the lead organisation for Adult Safeguarding. They are accountable to and responsible for coordinating all adult safeguarding investigations.

ESHT has jointly agreed and signed up to the Sussex Multi Agency Policy for Adults at Risk, this policy sets out the process for safeguarding adults.

ESHT updated its internal Trust policy for safeguarding adults at risk in May 2015 in line with agreed procedures and protocol.

The Director of Nursing is the Executive representative for ESHT at the Multi Agency Safeguarding Adults Board (SAAB). The Assistant Director of Nursing for Safeguarding Adults & Children deputises as required.

The Safeguarding Adults Team within ESHT is led by the Assistant Director of Nursing for Safeguarding and two nurses deliver safeguarding operational function including Mental Capacity Act and the Deprivation of Liberty Safeguards. One of these nurses delivers the Designated Adult Safeguarding Manager (DASM) function.

An ESHT Safeguarding Strategic Group meets quarterly which reviews jointly Adults and Children safeguarding, this is chaired by the Director of Nursing.

The ESHT Safeguarding Adults Operational meeting meets Bi-monthly to discuss all operational issues.

ASC is a permanent invitee to the strategic meetings. An annual Adult Safeguarding audit is completed within ESHT which is reported as Safeguarding Adults Board.

11.0 Reporting arrangements

The more detailed arrangements for Adult safeguarding is a monthly operational meeting which oversees all alerts, from the point of receiving the alert to the implementation of actions where required. This is a multidisciplinary meeting with Health and Adult Social Care which allows for regular update and senior management support for safeguarding processes within the Trust. There are 3 multi-agency operational sub-groups which meet quarterly: Operational, training and audit, ESHT have representation on all sub-groups to audit and improve the safeguarding process and practice.

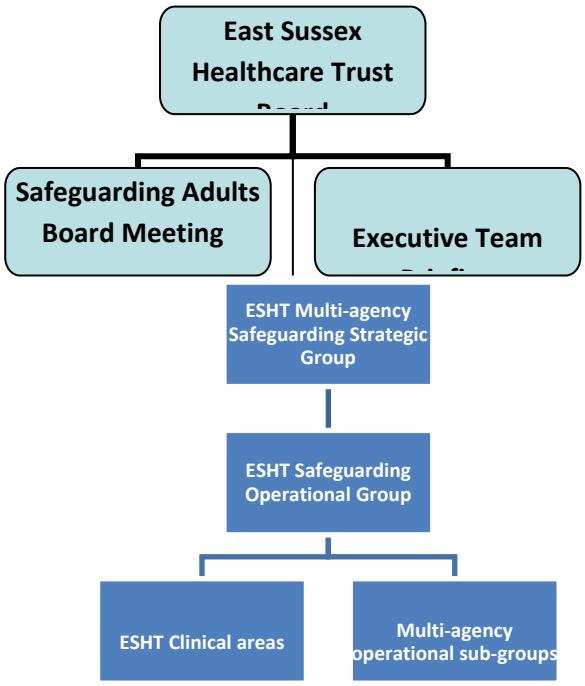
The Trust monthly operational meetings review trends and monitors actions that are in place as a result of substantiated safeguarding alerts.

DoLS process is part of ESHT's safeguarding process, where a patient lacks capacity the use of the Mental Capacity Act (MCA) care planning tools are used. DOLS training is available for relevant staff. Statutory notification of all DOLS applications and outcomes are reported quarterly to the CQC.

At ward level personalised care plans exist for patients who lack or have fluctuating capacity.
ESHT has a clear reporting structure for Safeguarding Adults. The flowchart below outlines the key elements of the structure, outlining that there are 4 steps between Safeguarding vulnerable adult activity and the Board of Directors.

Safeguarding information is provided on a fortnightly basis the Senior Leadership Forum (SLF). Quarterly reports outlining on-going activity are provided as required, Bi-monthly reports are provided to the CCG. These reports outline on-going activity and relevant actions taken to mitigate risk within ESHT.

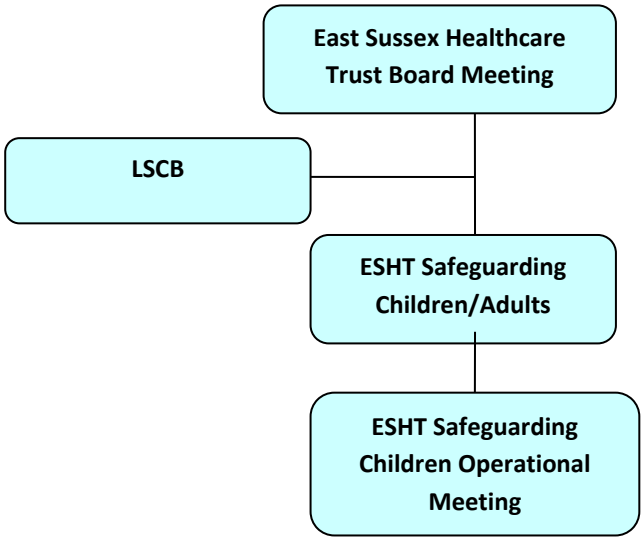
12.0 Safeguarding Adults Meeting structure:



12.1 Safeguarding Children

Safeguarding Children and Adult Strategic Group Meetings are combined, held quarterly and chaired by the Director of Nursing. Safeguarding Children Operational Group Meetings are held monthly.

12.2 ESHT safeguarding Meeting structure:



Conclusion

ESHT continue to provide a robust Adult safeguarding service throughout all areas, with on-going awareness raising to staff of Adult Safeguarding process, in line with the Care Act 2014. The latest CQC report published in April 2015 stated:

Safeguarding

- Staff knew how to report safeguarding issues.

- The process of safeguarding was both understood and followed.

The CQC report fits with evidence obtained through monitoring mandatory training and reviewing all safeguards which are raised against the Trust. There has been a continuing decline in substantiated alerts between 2012 and 2016, with effective action planning and delivery, including prevention planning for the future. Actions are identified and training packages implemented in order to mitigate against issues raised, ensuring lessons are learned preventing repeated similar safeguards.

Name of Author: Brenda Lynes-O'Meara
Title of Author: Assistant Director of Nursing for Professional Practice and Standards

Date July 2016

Sussex Partnership NHS Foundation Trust | East Sussex Healthcare NHS Trust

Mental Health Act Administration and Training - Activity Progress Report 1 April 2015 – 31 March 2016

Summary

Organisation and contact details

Organisation name	East Sussex Healthcare NHS Trust (ESHT)
Contact person name	(1) Alice Webster (2) Brenda Lynes-O'Meara
Contact person position	(1) Director of Nursing (2) Assistant Director of Nursing
Contact person phone	(1) 01323 417400 extension 3161 (2) 07900680616
Contact person email	**(1)** Alice.webster@esht.nhs.uk **(2)** B.lynes-omeara@esht.nhs.uk

Activity information

Activity Title	Provision of Mental Health Act 1983 ("MHA") Administration and MHA training services to ESHT
Goal	To ensure detentions to ESHT are lawful and compliant with the MHA 1983 and associated Code of Practice.
Intended outcomes	• Robust MHA governance procedures in place • ESHT staff trained on requirements of MHA 1998 • Detentions to ESHT lawfully processed and monitored.

Funding arrangement information

Funding arrangement start and end dates	• £52,000 1 April 2015 – 31 March 2016
Total cost	£52,000 per annum
Reporting period	1 September 2014 – 31 August 2015

Progress report preparation

Prepared by	Ellen Lim, Head of Practice Quality, Sussex Partnership NHS Foundation Trust
Others consulted	Alison Naylor, MHA Information and Quality Manager, SPFT Edward Lepper, Practice Development Officer, SPFT

Key Conclusions and Necessary Actions

In the reporting period SPFT have provided MHA Administration for patients detained to Eastbourne District General Hospital and the Conquest Hospital. Overview training on the MHA 1983 has been offered to all ESHT staff including bespoke and targeted training to specific staff groups. The contract for MHA Services ensures ESHT are able to accurately monitor detention under the MHA 1983. Governance arrangements are firmly in place between the Mental health liaison teams, ESHT trust staff and SPFT MHA Offices to ensure all detentions under the MHA are reported and appropriately monitored.

The current contract for services terminates on 31 March 2017. To continue providing MHA Administration and training services beyond this period an extension to the current contract must be agreed. To ensure stability and continuity of service a three year provision has previously been proposed, however ESHT have preferred to opt for annual renewal.

To ensure there is sufficient time to plan an exit strategy, there needs to be an agreement to renew the contract for services by September 2016. A six month exit strategy is allowed of in the current contract. In the event ESHT decide not to proceed with the current contractual arrangements, this will allow sufficient time for SPFT to withdraw current services.

Acute Trust Responsibilities - Summary

All Acute Trusts who assess and treat patients under the MHA 1983 must be specifically registered to do so; their registration must allow them to undertake regulated activity 6: ‘assessment or medical treatment for persons detained under MHA 1983’. The detention of a patient under the MHA 1983 by a hospital that is not registered to undertake this activity will be a breach of that hospital's compliance with their own registration requirements, and may call the legality of the detention into question.

Acute Trusts who are registered to assess and treat detained patients must ensure they are fully compliant with the MHA 1983 and the code of practice. In brief, this will include:

- Robust processes in place for the receipt, scrutiny, amendment, retention and monitoring of applications to detain and other detention papers (e.g. s17 forms, s19 transfer forms, CTO papers);
- governance structures in place to ensure the acute trust's hospital managers are aware of their responsibilities under MHA;
- a cohort of appointed Associate Hospital Managers who exercise the delegated powers of non-executive directors to review detentions and hear appeals;
- a suite of policies which support MHA Administration and compliance with the MHA 1983 and associated code of practice.

- processes in place to ensure the rights of the patient are safeguarded (s132, consent to treatment processes);

- A rolling programme of training for ward staff to ensure an understanding of the MHA and also for doctors who must know how to appropriately exercise their holding powers under MHA;

- a system in place for the monitoring of detentions to be reported to the Board, provide verification data to CQC and to feed into the Department of Health KP90 return;

- An agreed contract with an Independent Mental Health Advocate (IMHA) Provider to ensure detained patients have regular access to advice and support.

Review of Progress in the Reporting Period

Progress against agreed workplan and budget

The service specification is delivered for the agreed contract price of £52,000 per annum. The contract price was agreed in consideration of the following projections on detention activity and training required by ESHT staff:

1. Up to 30-35 detentions per year (and associated activity)
2. Robust governance processes in place for the reporting and monitoring of MHA detentions
3. 12 half day MHA training sessions
4. 6 half day MCA training sessions
5. As additional 8 half days training sessions to be used for either MHA or MCA as required.

Within the reporting episode, covering a one year period, there have been 36 detentions to ESHT (an over performance on the contract), established workflow processes have been embedded and SPFT has scheduled and delivered 20 training sessions in total (an over performance on the contract).

Detention Activity

Appendix A – Detention Activity

Under the current contract for services all detentions to ESHT are recorded and monitored through SPFT's MARACIS system. The system is licensed, developed and accessed by SPFT and has been updated to reflect ESHT's sites and wards to allow for more accurate reporting. Effective from 1 April 2016, SPFT are migrating to Carenotes. ESHT detentions will be recorded and monitored through the new system by SPFT's MHA team.

In the reporting period (1 April 2015 – 31 March 2016) 36 detentions to ESHT were recorded:

- 20 detentions under section 2
- two detentions under section 3 of the MHA 1983

- 13 detentions under section 5(2)
- One detention under section 5(4)

This recorded activity does not include those patients who are detained to another detaining authority and transferred to the WSHFT for medical treatment under section 17 leave arrangements.

A comparison on the same period in the previous two years is provided below:

Period (1 April 2015 – 31 March 2016)	Number of Detentions	% +/-
2012/2013	30	
2013/2014	37	+23%
2014/2015	31	-16%
2015/2016	36	+16%

Training Provided

Appendix B – Training Schedule

Under paragraph 2.7 of the contract for services SPFT agreed to provide educational training and awareness sessions for ESHT staff to ensure practice was fully compliant with the MHA 1983 and the associated Code of Practice.

Between 1 April 2015 and 31 March 2016 28 training sessions have been scheduled and of these 20 training sessions have been delivered to ESHT across Eastbourne and Conquest sites.

Based on current figures, on average SPFT is scheduling at least one - two training sessions for ESHT staff per month.

SPFT are committed to delivering MHA awareness training, process training and junior doctor training to ESHT staff. Sessions will only be cancelled if there are less than five confirmed delegates.

To ensure ESHT staff are aware of their responsibilities under the MHA 1983, SPFT have not counted cancellations by ESHT as planned training sessions to enable the full 18 sessions to be delivered, and 8 half days as required.

Governance Framework

SPFT has provided advice and guidance on implementation of an appropriate governance framework around the detention and treatment of patients under the MHA 1983. Work completed or in progress is detailed below:

- A comprehensive suite of MHA statutory forms, guidance and flowcharts installed in each A&E and with the MH Liaison teams
- Regular monitoring of detention activity by SPFT's MHA Offices who, under the contract for services, hold responsibility for the processing of all detentions on behalf of ESHT.
- Advice and support on CQC MHA Monitoring visits and supporting completion of the Provider Action Statement
- Monitoring of detention activity and provision of annual report to ESHT Trust Board
- Provision of an appropriate cohort of Associate Hospital Managers who represent ESHT Trust Board in the review of detentions under the MHA 1983.
- Offer of the provision of data, information and materials for a MHA Page on the Trust intranet, including patient information leaflets and statutory forms. SPFT have also offered to provide a comprehensive suite of MHA policies specific to Acute Trusts.
- An open invite to MHA and MCA events staged by SPFT to facilitate shared learning.

Changes to Activity Context in the Reporting Period

Care Quality Commission Monitoring

The last CQC MHA Monitoring visit was conducted in November 2013. The CQC have increased their focus on MHA Activity in Acute trusts and an inspection programme focusing on MHA compliance in Acute Trusts is expected to be implemented in 2016. Inspections may also be duplicated across sites and MHA Monitoring visits should therefore be anticipated across both Hastings and Eastbourne sites. Any Service Specification for the provision of MHA Administration and training is reviewed by the CQC MHA Commissioners as part of the inspection process.

Training of ESHT Staff

SPFT have been unable to gain consistent commitment to attend scheduled training, particularly MCA training which is routinely scheduled and then cancelled by ESHT. Whilst training has been scheduled, attendance at scheduled sessions is often low.

Updates Required to Service Specification and/or Contract for Services

Advice

SPFT MHA Coordinators will continue to provide day to day advice on the administration of the MHA 1983, and will also offer advice on Deprivation of Liberty Safeguards where required. SPFT have provided in hours contact information and agreed to the publication of contact details on any MHA pages of ESHT's intranet.

Transition or Exit Planning

It will be necessary to update the contract for services with an agreed notice period for transition or termination of the contract. A six month notice period for termination or transition (by both provider and purchaser) is proposed to allow for appropriate exit planning.

Submitted By

ELLEN LIM	**HEAD OF PRACTICE QUALITY, SPFT**
Full Name	**Title / Organisation**
	**23 June 2016**
Signature	**Date**

Appendices

Appendix A: Detention Activity

Appendix B: Training Schedule

Appendix B

Detention Activity

1 September 2014 – 31 August 2015

Maracis ID	Sex	Patient DOB	Section	History	Section Start Date	Section End Date	End Details	Ward	Hospital
2015000794	M	22/12/1974	5(2)	Inf to 5(2)	18/08/2015 16:25	19/08/2015 12:00	Informal	Tressell Ward	Conquest Hospital, Hastings
2015000806	F	03/08/1966	2	Adm 2	21/08/2015 16:45	08/09/2015 12:30	To informal	AAU	Conquest Hospital, Hastings
2015000781	F	06/07/1938	3	Inf to 3	10/09/2015 12:20	21/10/2015 16:00	To informal	Newington Ward	Conquest Hospital, Hastings
2011000399	M	27/06/1975	2	Adm 2	19/09/2015 01:00	09/10/2015 12:15	To Informal	MAU	Eastbourne DGH
2015000996	F	03/03/1935	2	Adm 2	07/10/2015 18:00	29/10/2015 14:30	To Informal	Macdonald Ward	Conquest Hospital, Hastings
2011000154	F	10/06/1985	5(2)	Inf to 5(2)	24/10/2015 00:00	26/10/2015 00:00	Invalid	Egerton Ward	Conquest Hospital, Hastings
2015001068	M	10/06/1985	5(2)	Inf to 5(2)	30/10/2015 20:40	31/10/2015 11:30	Informal	High Dependency Unit	Conquest Hospital, Hastings
2013001181	M	10/06/1990	2	Adm 2	02/11/2015 17:20	06/11/2015 16:25	To Informal	MAU	Eastbourne DGH
2015000808	F	26/06/2000	2	Inf to 2	06/11/2015 17:00	Not known	To Informal	Kipling Ward	Conquest Hospital,.

									Hastings
2014000772	M	01/05/1999	2	Adm 2	12/11/2015 16:30	24/11/2015 14:00	To Informal	CDU	Conquest Hospital, Hastings
2015001122	M	24/10/1963	5(2)	Inf to 5(2)	20/11/2015 01:23	23/11/2015 01:23	Invalid	Wellington Ward	Conquest Hospital, Hastings
2015001119	F	05/05/1929	2	Adm 2	23/11/2015 14:15	17/12/2015 12:07	Sec 3	Seaford 3	Eastbourne DGH
2015001134	F	05/02/1938	2	Adm 2	26/11/2015 12:30	22/12/2015 11:00	To Informal	MAU	Eastbourne DGH
2016000099	M	15/12/1962	2	Adm 2	15/01/2016 17:40	26/01/2016 12:30	To Informal	AAU	Conquest Hospital,. Hastings
2016000127	F	15/01/1934	2	Inf to 2	18/01/2016 16:30	14/02/2016 12:00	Sec 3	Benson Ward	Conquest Hospital,. Hastings
2016000138	M	01/02/1955	2	Adm 2	25/01/2016 17:20	Lapsed	To Informal	AAU	Conquest Hospital Hastings
2016000158	M	08/01/1978	5(2)	Inf to 5(2)	30/01/2016 14:50	02/02/2016 14:50	Lapsed	MAU	Eastbourne DGH
2016000163	M	04/04/1935	2	Inf to 2	03/02/2016 13:30	23/02/2016 13:20	To Informal	Newington Ward	Conquest Hospital, Hastings
2016000127	F	15/01/1934	3	2 to 3	14/02/2016 12:00	03/03/2016 13:00	Informal	Benson Ward	Conquest Hospital, Hastings

2016000202	M	24/12/1997	5(4)	Inf to 5(4)	21/02/2016 19:05	21/02/2016 19:25	To 5(2)	MAU	EDGH
2016000202	M	24/12/1997	5(2)	Inf to 5(2)	21/02/2016 19:05	24/02/2016	Informal	MAU	EDGH

Appendix B – ESHT Training Scheduled from 1 April 2015 until 31 March 2016

Date	Training	Site	Comment
6 May 2015	x3 2 hour MHA Training for Band 7 nurses, ward managers, A&E staff and MIU	Conquest	Cancelled due to trainer's compassionate leave
3 June 2015, 9 -12pm	3 hour MHA Training for Band 8+ site managers, senior clinicians and Specialist Doctors	Eastbourne	10 attendees
3 June 2015, 1-4pm	3 hour MHA Training for Band 8+ site managers, senior clinicians and Specialist Doctors	Eastbourne	Cancelled by ESHT
23 June 2015	MHA training for Urology Band 8 staff	Eastbourne	10 attendees
1 July 2015, 6 – 7.30pm	MHA process and statutory forms training for sire managers	Conquest	Intended use of video conferencing across Conquest and DGH sites. VC not available on the day. 3 attendees
27 July 2015 AM	3 hour MHA Training for Band 8+ site managers, senior clinicians and Specialist Doctors	Conquest	4 attendees
27 July 2015 PM	3 hour MHA Training for Band 8+ site managers, senior clinicians and Specialist Doctors	Eastbourne	Cancelled by ESHT
30 July 2015, 9-11am	2 hour MHA training for Band 7 staff	Eastbourne	12 attendees
30 July 2015, 11.30 – 1.30pm	2 hour MHA training for Band 7 staff	Eastbourne	6 attendees
20 July 2015, 2.00 – 4.00pm	2 hour MHA training for Band 7 staff	Eastbourne	Cancelled by ESHT
1 September 2015	MHA training for FY1 doctors	Eastbourne	10 attendees
2 September 2015	MHA training for FY2 doctors	Eastbourne	21 attendees
3 September 2015	MHA training for FY2 doctors	Conquest	25 attendees
25 September 2015 AM	3 hour MHA Training for Band 8+ site managers, senior clinicians and Specialist Doctors	Conquest	
25 September 2015 PM	3 hour MHA Training for Band 8+ site managers, senior clinicians and Specialist Doctors	Conquest	
29 September 2015	3.5 hour MCA and DOLS training for ESHT staff	Conquest	10 attendees

14 October 2015	MHA training for FY1s, including capacity and consent to treatment	Conquest	15 attendees
15 October 2015	MCA training for ESHT staff	Eastbourne	Cancelled by ESHT
27 October 2015	MCA training open to all ESHT staff	Eastbourne	30 attendees
12 November 2015, 9 – 11am	MHA training for Band 7 nurses, matrons, A&E staff and MIU	Eastbourne	12 attendees
12 November 2015, 11.30 – 1.30pm	MHA training for Band 7 nurses, matrons, A&E staff and MIU	Eastbourne	5 attendees
4 December 2015	MCA training for ESHT staff	Venue TBC	Cancelled by ESHT
9 December 2015	MHA training to be delivered to Matrons meeting	Conquest	Cancelled by ESHT
11 December 2015, 9-11am	MHA training open to all ESHT staff	Conquest	4 attendees
11 December 2015, 11.15 – 1.15pm	MHA training open to all ESHT staff	Conquest	7 attendees
14 December 2015	MCA training open to all ESHT staff	Conquest	Cancelled by ESHT
8 January 2016	MCA training open to all ESHT staff (pm)	Eastbourne DGH	Cancelled by ESHT due to low numbers
22 January 2016	MCA training open to all ESHT staff 9.30 – 12.30	Conquest	4 attendees

Information Update: Launch of Edition 3 of Sussex Safeguarding Adults Policy and Procedures (4th July 2016):

Edition 3 is available from 4th July 2016 via the following link:

http://sussexsafeguardingadults.procedures.org.uk

This edition includes changes required following revision of the Care and Support Statutory Guidance (CSSG) published in March 2016 to ensure compliance with this.

Please note these changes, and ensure arrangements are in place in your agency / organisation to implement these.

Summary of key changes:

- Types of abuse and possible signs of abuse (Section 2.5): this section has been replaced by *'What constitutes abuse and neglect'*. This includes a number of changes to this section including: the description of self neglect and information regarding domestic abuse and financial abuse
- A new paragraph reinforces the local authority's Powers to undertake an enquiry where there is not a duty to do so if this will enable promotion of the persons wellbeing and will support a preventative agenda (Section 3.1)
- Allegations against people in positions of trust: is a new and substantial addition to Section 3.5
- Appendix 2: Roles and Responsibilities, Safeguarding Adults Board functions and Safeguarding Adults Reviews - updates include:
  - Designated Adults Safeguarding Manager: the need to have a DASM has been removed, however the focus on the roles and responsibilities that were included under this title continue
  - An additional section on 'Practice Leadership' emphasising the role of Principal Social Worker alongside the expertise and professional leadership of all agencies and organisations

NB: re-printed hard copies will not be available for Edition 3. If you require further information please print the relevant section from the online procedures or download the updated PDF version at http://sussexsafeguardingadults.procedures.org.uk

East Sussex Healthcare NHS Trust

Date of Meeting:	12th October 2016
Meeting:	Trust Board
Agenda item:	19d
Subject:	Annual Fire Safety Report
Reporting Officer:	Pauline Butterworth, Acting Chief Operating Officer

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

Purpose:

The purpose of this report is to:

- Present the Annual Fire Safety Report (AFSR) for the period of 1st April 2015 to 31st March 2016

Introduction:

The AFSR for the period of 1st April 2015 to 31st March 2016 has been prepared by the Trust Senior Fire Safety Advisor to provide statutory information to the Trust Board and report risks with subsequent recommendations relating to Trust Fire Safety Management arrangements.

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

It is noted that the Trust has in place the appropriately qualified and experienced fire safety advisors, systems, training and fire safety risk assessments according to the requirements of HTM 05-01 (2013). Clinical units continue to attend the mandatory training sessions for fire safety and the attendance has been steadily increasing post April 2016.

The level and number of risks should decrease over the next 5 years through investment arising from the 2016-2021 Capital Plan, albeit the Trust will have in place a degree of risk related to fire safety during this period.

Benefits:

Assurance through the annual fire safety report in terms of compliance with HTM 05-01 (2013)

Risks and Implications

The level and number of risks will decrease over the next 5 years through investment arising from the 2016-2021 Capital Plan, albeit the Trust will have in place a degree of risk

related to fire safety during this period.

Assurance Provided:

- We have in place the appropriately qualified and experienced fire safety advisors, systems, training and fire safety risk assessments according to the requirements of HTM 05-01 (2013).
- The 5 year 2016-2021 capital plan is in place which is based upon a risk based approach and within this plan, any capital/refurbishment scheme will automatically take into consideration any works required to fire compartmentation, emergency lighting, fire alarm etc. works
- Within the maintenance backlog part of the 5 year 2016-2021 capital plan, there are specific sums allocated mainly to engineering and associated systems that are directly associated with addressing fire risks. Within FY16/17, £230K of the maintenance backlog funding has been specifically earmarked for various dedicated fire related works.

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
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.	X

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

None

Proposals and/or Recommendations

That the Board note this 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

For further information or for any enquiries relating to this report please contact:	
Name: Chris Hodgson Associate Director of Estates and Facilities	**Contact details:** (13) 4175

East Sussex Healthcare NHS
NHS Trust

Annual Fire Safety Report

1st April 2015 – 31st March 2016

In accordance with HTM 05-01 2013 “Managing Health Care Fire Safety”, the role of Fire Safety Manager is undertaken by Pauline Butterworth, Acting Chief Operating Officer.

Compiled and completed by
Norman (Jan) Ingram
Senior Fire Advisor
Property Management

Annual Fire Safety Report

April 1st 2015 – 31st March 2016

CONTENTS

Annual Fire Safety Report

April 1st 2015 – 31st March 2016

EXECUTIVE SUMMARY

The Annual Fire Safety Report (AFSR) for the period of 1st April 2015 to 31st March 2016 has been prepared by the Trust Senior Fire Safety Advisor to provide statutory information to the Trust Board and report risks with subsequent recommendations relating to Trust Fire Safety Management arrangements.

The Trust is currently carrying risks in relation patient and staff safety, Statutory Duty (enforcement) and service interruption, due to historic under investment in the Estate (summary and details of these risks are contained in Appendix A and B). Significant investment over the next 0 – 10 years will be required for statutory fire compliance at ESHT Sites.

The 2013 **Fire Policy** ratified in 2014 reflects the new national guidelines included in Hospital Technical Memorandum (HTM) 05-01 2013 Second edition. The Policy will be reviewed in June 2016.

Fire **Safety Protocols** are being developed for all aspects of Fire Safety Management identified in HTM 05-01. It is the intention to complete the remaining documentation by the 31st December 2016.

An Authorising Engineer has been appointed to provide fire engineering advice on request and to audit the Fire Safety Management system for assurance purposes.

Mandatory Fire Training is at **89%** (as at April 2017) of Trust Staff trained, which has increased steadily from 62% (February 2012). Increases have been due to close liaison with Learning and Development and completion of an annual training needs analysis, ensuring continuous improvement
The content of the mandatory training is reviewed annually and the new content delivered from April each year.

442 Staff have participated in **Fire Drills.**

Annual Fire Safety Report

April 1st 2015 – 31st March 2016

54 **Fire Wardens and Fire Team members** have received bespoke training in their workplace with the 3 yearly Trust wide training sessions organised for 2016/17.

The Regulatory Reform (Fire Safety) Order 2005 (RRO) focuses on the requirement for all premises to have a suitable and sufficient current **Fire Safety Risk Assessment**.

100% of the 164 **Acute** Hospital areas have been subject to risk assessments in the past 12 months.

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

All fire doors on Trust sites have been surveyed in line with the Estates and Facilities Alert – December 2015 to ensure they do not close too quickly and injure vulnerable persons. Any defects have been reported.

Any issues that arise from the various site visits to undertake the formal risk assessment are dealt with in person by the Fire Safety Manager at the time, either with the local clinical teams on fire “housekeeping” type issues and for estates matters, directly reported to the maintenance help line, with rectification being monitored for completion.

*Lewes, Crowborough and Uckfield sites transferred to NHS Property Services Ltd in 2016 which means the “Building” fire risk Assessments are no longer required.
Visits will be required to audit ESHT Staff areas.

Annual Fire Safety Report

April 1st 2015 – 31st March 2016

1.0 PURPOSE

The purpose of this report is to confirm assurance and report risks with subsequent recommendations relating to Trust Fire Safety Management arrangements for the period 1/4/15-31/3/16. .

1.1 Context

The key challenge for the Trust is to ensure a dynamic healthcare environment compliant with all relevant fire safety legislation.

Effective Management of Fire Safety is an essential to preserve life, lower the impact of any fire on business continuity and care.

Effective Fire Safety Management is also a legal requirement under the auspices of the Regulatory Reform (Fire Safety) Order 2005 and recommendations found within the Health Technical Memorandum (HTM) 05-01 managing healthcare fire safety second edition April 2013.

To ensure the continuing identification and appreciation of on-going Fire Safety risks, monthly fire reports are forwarded to the Fire Safety Manager and quarterly fire reports forwarded into the Health and Safety Steering Group (HSSG).

1.2 Legal background

The Regulatory Reform (Fire Safety Order) 2005 came into effect on 1 October 2006 and applies to England and Wales. The Fire Safety Order replaces previous fire safety legislation.

2.0 FIRE SAFETY POLICY & PROTOCOLS

2.1 Fire Policy

The 2013 Fire Policy ratified in 2014 reflects the new national guidelines included in Hospital Technical Memorandum (HTM) 05-01 2013 Second edition. The Policy is due to be reviewed in June 2016.

2.2 Fire Safety Management Plan (FSMP)

A FSMP has been developed based on the Plan, Do, Check, Act (PDCA) approach. This achieves a balance between the systems and behavioural aspects of management. It also treats Fire Safety management as an integral part of good management generally, rather than as a stand-alone system.

2.3 Fire Safety Protocols

As identified in the Fire Safety Policy, new Fire Safety Protocols are being developed for all aspects of Fire Safety management identified in HTM 05-01.

Personal Emergency Evacuation Plan (PEEP)	Ratified
Risk Assessments	Ratified
Fire Safety Training	Ratified
Normal Operating Procedures	Ratified
Emergency Action Plans	Ratified
Fire Prevention	Ratified
Fire Extinguishers	Ratified
Normal Operating & Emergency Procedures	Ratified
Fire Strategies	EFM SMT
Emergency Planning	EFM SMT
Fire Detection and Alarm Systems	EFM SMT
False Alarms and Unwanted Fire Signals	EFM SMT
Arson	EFM SMT
Construction and Refurbishments	EFM SMT

It is the intention to complete the remaining Fire Safety Protocols by the 31st December 2016.

Security
Hot Works
Maintenance of Fire Equipment.

3.0 FIRE TRAINING

The current level of mandatory Fire Training is 89%, which has increased from 62% (February 2012).

Spaces have been allocated to accommodate over 100% (6077) of Trust Staff for 2015/16 to maintain and improve on this level of compliance. Managers should be reminded to ensure staff take advantage of these sessions.

The annual training needs analysis has been completed and the training presentation content amended accordingly.

The training figures for the past three years are shown below for comparison.

Year	2012/13	2013/14	2014/15
Number of ESHT Staff	6727	6285	6077
Number of ESHT Staff in date	5415	5342	5408
Percentage	80.50%	86%	89%
Non ESHT Staff trained Volunteers, Sussex University and Doctors Surgery Staff)	564	701	492

3.1 Fire Warden Training and Fire Team Training

Carried out by the Fire Team with 54 Fire wardens being trained.

These Fire Wardens are additional to those trained during the 3 training yearly cycle and concentrate on their "workplace" risks and duties.

3.2 Practical Evacuation Exercises and Fire Drills

Fire Drills are organised and carried out by Fire Team in the Trust premises with 442 Staff trained.

4.0 INCIDENT REPORTS

4.1 Fire Systems

Any incident involving a fire or the operation of the fire system can now be reported on the Datix Web system.

All reports are investigated and feedback provided. Trends are recorded and measures put in place to reduce those incidents.

4.2 Alarm Activations

Alarm activations are within national guide Lines.

Of the 155 false alarms the Fire and Rescue Service were called 22 times with the majority of those incidents involving the Residencies.

Sussex Partnership Trust, who have been responsible for a large number of unwanted fire calls in previous years, have changed their support procedures and will not be connected to our switchboard from 31st March 2016.

4.2 Fires

There were 3 fires during 2015/16 with no injuries reported:

Conquest Hospital, Refuse bin set alight accidentally by a discarded cigarette.

Conquest Hospital, Richard Ticehurst Ward - Patient ignited papers.

Lewes Victoria Hospital-Day Surgery Recovery- Dishwasher.

A table and analysis of Fire Calls is attached at **Appendix C.**

5.0 RISK

5.1 Risk Assessment

The Regulatory Reform (Fire Safety) Order 2005 (RRO) focuses on the requirement for all premises to have a suitable and sufficient current Fire Safety Risk Assessment. The suitability being assessed against a series of guidance notes specific to the accommodation type.

5.1.1 100% of the 164 Acute Hospital areas have been subject to risk assessments in the past 12 months*.

*Lewes, Crowborough and Uckfield sites have transferred to NHS Property Services Ltd in 2016 which means the "Building" fire risk Assessments are no longer required. Visits will be required to audit ESHT Staff areas.

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

36% of the "undocumented" properties occupied by ESHT in the community have been assessed and a strategy has been devised to ensure full completion by April 2017.

100% of all properties owned by NHS Property Company Ltd in East Sussex, covered by the current service level agreement, have been subject to risk assessments in the past 12 months. This agreement ends on 31st March 2016. "Building" fire risk Assessments are no longer required however visits will be required to audit ESHT Staff areas in those buildings.

Any issues that arise from the various site visits to undertake the formal risk assessment are dealt with in person by the Fire Safety Manager at the time, either with the local clinical

teams on fire "housekeeping" type issues and for estates matters, directly reported to the maintenance help line, with rectification being monitored for completion.

5.1.2 Infrastructure Risks

The Trust is currently carrying risk in relation patient and staff safety, Statutory Duty (enforcement) and service interruption, due to historic under investment in the Estate (summary and details of these risks are contained in Appendix A and B). Significant investment over the next 0 – 10 years will be required for statutory fire compliance at ESHT Sites.

Oasthouse close residencies on the Conquest Hospital Site have been taken back from Orbit housing and are now a Trust responsibility. We will be reviewing the risks associated with this transfer in 2016/17 Q3.

A list of infrastructure risks has been identified from the outcome of Fire Risk Assessment findings and the requirements of the local enforcing authority. A summary is provided in **Appendix A** and Details in **Appendix B.**

Continued investment to resolve those risks will demonstrate that the Trust has a responsible and proactive approach to dealing with fire safety issues and compliance requirements. This investment has been recognised through the approved 5yr capital plan, 2016-2021.

5.1.3 Operational Maintenance

Operational maintenance includes the day to day maintenance of the both active and passive fire related equipment; including fire alarms, fire dampers, fire extinguishers, fire doors and emergency lighting systems.

Planned preventative maintenance of that fire related equipment is increasing in nature as systems expand and national guidance is changed. Annual inspections are now required to fire dampers (Conquest has approximately 500 and EDGH 700). The replacement of Conquest's fire alarm increased the number of devices from 1500 to

approximately 5000, all of which require testing. Modern systems often assist the maintenance function making testing less onerous, but their increasing scope providing enhanced cover, more than negates any savings made by technology. Statutory tests are being undertaken as required at the Conquest Residencies (see 5.1.2).

Consideration must be given to increase capital outlay and increase revenue budgets to meet these and other statutory requirements.

A summary is provided in **Appendix A**

6.0 AUDIT AND REVIEW

7.1 An Audit of Trust Fire Safety Management systems will be undertaken by an external Authorised Engineer in the 2016 Q3.

7.2 A Fire Safety Management Group (FSMG) has been established which reviews Compliance against Legal and Trust requirements each quarter which includes the Fire AE to provide Independent assurance and advice.

7.0 LEGISLATION UPDATES SINCE THE PREVIOUS REPORT

7.1 The HTM Managing Healthcare Fire Safety has been scrutinised by the Fire Safety group. All new guidance and amendments from the previous HTM 05-01 have been considered and where necessary amended.

7.2 Estates and Facilities Alert EFA DH-2014-003 issued concerning Fire Damper Testing and Fire Stopping.

7.3 Estates and Facilities Alert EFA DH-2015-006 issued concerning fire door closers.

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8.0 INSPECTIONS BY EAST SUSSEX FIRE AND RESCUE SERVICE AUTHORITY.

EDGH Visit: 3rd March 2016

Conquest Visit: 3rd March 2016

N Ingram

Senior Fire Safety Advisor

Appendix A – Infrastructure Risk Summary

ITEM	Reference Number	Description of Risk	RISK ASSESSMENT		ACTION required Insert actions required to reduce/eliminate risk	COST					COMMENTS
			RR	Risk Phrase		Year					
						2014/15	2015/16	2016/17	2017/18	2018/19	
Fire - Physical Environment	**1410**	There are a number of risks related to the physical building/engineering including: Fire Safety (Compartmentation) Risk of Enforcement Notice. Subject to clarification with East Sussex Fire & rescue Service - July 2014 Failure of smoke and fire dampers due to lack of maintenance.	**16**	Extreme	1. Record drawing of ductwork being provided & updated. Damper positions identified and non-critical dampers possibly removed from PPM 2. Fire Engineer engaged to survey fire compartments 3. Trust survey of fire compartment 4. Works commencing in phase 2. Replacement of 60 minutes fire doors 5. First year monies allocated and spent. 6. Project team Identifying next stage of works	**250K**	**250K**	**250K**	**250K**	**250K**	1.Non-invasive risk assessment of fire dampers to ascertain current condition and function. Full survey of all fire dampers required - funding needed. Damper testing carried out 3 yearly. 2. In progress review July 2017. 3. Completed. 4. Year one of works 60% completed. 5. Completed 6. Ongoing, falling behind on scheduled programme.

Emergency Lighting - Central Battery System. Conquest	**1432**	The Conquest Hospital does not comply with British Standard for emergency lighting. The Building consists of five separate central systems linked together by a central controller. Due to the age of the system replacement parts cannot be sourced either new or second-hand. No other maintenance support is available, system test reports cannot be accessed and there is a risk of whole or part failure of the system at any time.	**15**	Extreme	Undertake technical survey	**-**	**-**	**425K**	**450K**	**275K**	Not yet commissioned, review in FY16/17 Q3

Emergency Lighting Conquest. Frank Shaw/Mirleess/SCBU and general Maternity area.	**1433**	The Frank Shaw Ward and Maternity areas of the Conquest Hospital do not comply with BS 5266 for Emergency Lighting. The above mentioned areas were omitted from the central system installation and have been upgraded on an Adhoc basis for many years, however parts remain deficient. A survey of the area is recommended	**15**	Extreme	1. Undertake Technical Survey 2. Review previous tender and update costings 3. Review commercial risk assessment and add to the Estates 5 year Capital Plan Risk Assessment	**-**	**-**	**45K**	**-**		1. Completed August 2015 2. Up to date costs obtained and available 3. Entered on the Estates 5 year Capital Plan Risk Assessment
Compartmentation Conquest	**907**	Fire Safety Compartmentation	**9**	High	1. Test Fire Dampers every three years and record 2. Complete L1 installation (18 months) 3. The alarm system must not produce sounds which are so different to current mechanical sounders. 4. Ensure all fire doors close fully 5. Ensure compartments & Sub compartment lines are intact with no unsealed penetrations 6. Ensure that wet risers / mains are tested annually and inspected monthly 7. Ratify Trust Fire Policy 8. Upgrade Fire Detection System to BS5839:2013 L1. 9. Ensure cylinders are controlled in all areas. 10. Ensure a procedure is put in place in order to effectively manage building works 11. Ensure that 'Hospital Street' is kept clear of all combustibles and flammables.	**-**	**-**	**25K**	**175K**		1. Superseeded Estates Alert EFA DH-2014-003 Fire Damper provision. 2. Completed. 3. Completed. 4. Ongoing. 5. See action 18. 6. Completed. 7. Completed. 8. Completed. 9. Completed 10. Completed 11. Ongoing. 12. Ongoing 13. Trained staff at

					12. Provide copies of all Fire Risk Significant findings once produced. 13. Ensure all staff are provided with annual fire safety refresher training. 14. Provide a 'fire folder' to be used by the Site/Duty Manager and the Fire Service. 15. Ensure glazing in 60 min fire doors are also 60 min and not 30 min Georgian wired 16. Fire compartmentation 17. Investigate and prioritise under Capital Funds 2016/17 *UNDER CONSTANT REVIEW”						86% 14. Completed 15. Not required. Following Fire Engineers Survey. 16. Funding allocated to areas under the Ward refurbishment programme. 17. Following the survey, works will be carried out to repair (fire proof) breaches.

Appendix B Infrastructure Risk details

1.0 Fire Damper Testing and Maintenance
Estates and Facilities Alert EFA DH-2014-003

1.1 EDGH:

The recent sample testing of Fire Dampers at EDGH has identified deficiencies in Damper Maintenance.

A programme of Maintenance and testing should be introduced and supported through revenue.

1.2 Conquest:

Fire dampers are tested every 3 years, however the legal requirements is now annually and would require additional revenue support.

1.3 Bexhill and the Irvine Unit:

Fire Damper testing at Bexhill and the Irvine Unit, is being carried out funded from the ventilation budget.

2.0 Fire Compartmentation EDGH:
Estates and Facilities Alert EFA DH-2014-003

Parts of the EDGH were built with “crown immunity” and not covered by the Fire Precautions Act 1971. Sixty minute Fire Compartments were not properly established also alterations over time have caused breaches in the established fire compartments.

East Sussex Fire and Rescue visited in 2010 and 2012 regarding this issue. Their instruction dated 10/2/2012 on the “Record of Inspection SF21” was a requirement to plan, identify and upgrade all identified 60 minute fire compartments.

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A comprehensive compartmentation report was commissioned on the 3rd of July 2013 and the report received from the Fire Protection Association on the 1st November 2013. Subsequently a full intrusive survey of the EDGH has been carried out. The original 4 year programme of remedial works identified may well extend to 8 years

East Sussex Fire and Rescue Service are in agreement with the Trusts commitment of £250k per year to resolve the issue. Regular meetings are scheduled in order to maintain relationships and update progress of the Project.
A revised programme is being constructed to send to ESFRS in 2016.

Year 1 (2014/2015)

Progress with the upgrade to the buildings Phase 2 fire 60 minute fire resisting doors:

- £250K Committed
- Orders issued for 69 single and double 60 minute door sets
- Third Party Accredited contractors installed the door sets on a rolling programme between October 2014 and 31st March 2015.
- Each door set installed is issued with a certificate of conformity.

Year 2 (2015/2016)

- £250k Committed
- During installation unexpected structural issues have occurred.
- Suspended ceilings will have to be replaced after their removal as will general emergency lighting during 2016/17.
- Orders issued for 34 single and double 60 minute door sets
- Phase 1 towers (stairways) in the Hailsham /Seaford areas have been upgraded to provide safe egress and protected ingress for fire fighting operations.
- Third Party Accredited contractors installed the door sets on a rolling programme during March 2016 and April 2016.
- Each door set installed is issued with a certificate of conformity.

Year 3 (2016/2017)

- £250k Committed
- Suspended ceilings, lighting. emergency lighting and smoke detection to be replaced after the ceilings removal to in-fill fire breaches along Hospital Streets.
- All doors and walls in the lift stairwells are to be upgraded.

3.0 Fire Compartmentation Conquest:

Estates and Facilities Alert EFA DH-2014-003
When the Conquest Hospital was built Building and Firecode regulations applied however, alterations to the building have occurred causing breaches in 60 minute fire boundaries. The breaches are not assessed as high a risk compared to EDGH.

East Sussex Fire and Rescue Service visited in 2012 regarding this issue. Their instruction dated 27/2/2012 on the “Record of Inspection SF21” was a requirement to plan, identify and upgrade all breaches identified in 60 minute fire boundaries.

A comprehensive compartmentation report was commissioned, identifying existing boundaries.

General glazing requirements have been rectified and as Wards have been refurbished, fire compartmentation has been improved.

4.0 Emergency Lighting Conquest:

There are two risks.

1- The Maternity areas are not provided with sufficient emergency lighting to BS5266Part1. This was omitted on installation of the central emergency lighting system, which only covers passageways.

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April 1st 2015 – 31st March 2016

This is an entry on the Trust risk register. Costs and designs have been sourced and small areas improved during Ward refurbishments. No other progress made.

2- The Conquest consists of five separate central systems linked together by a central controller.

Due to the age of the system replacement parts cannot be sourced either new or second hand. No other maintenance support is available, system test reports cannot be accessed and there is a risk of whole or part failure of the system at any time.

East Sussex Fire and Rescue Service have instructed the Trust to have a suitable replacement plan in place by April 2015. This is an entry on the Trust risk register and this risk will reviewed in FY16/17 Q3.

Appendix C Analysis of Fire Calls

Call Type	SPT	Conquest	EDGH	Residencies	Bexhill& ABC	Lewes
Fires.	0	2**	0	0	0	1++
False Alarms	39	31	30	46	9	0
Fire Service attended	6	4+	7+	0	4	1

**** Bin Fire and Papers set alight.**

+ includes Residencies

++ Lewes transferred to NHS Property Services Ltd in January 2016.

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 20th July 2016 at 10.00am in the St Marys Boardroom, EDGH

Present: Mr Mike Stevens, Non-Executive Director
Mrs Sue Bernhauser, Non-Executive Director

In attendance Mr Jonathan Reid, Director of Finance
Mrs Lynette Wells, Director of Corporate Affairs
Ms Janine Combrinck, Director, BDO
Ms Jo Brandt, Head of Planning and Performance
Mr Andy Bissenden, Associate Director of IT
Mrs Angela Colosi, Assistant Director of Nursing
Ms Sally Herne, Improvement Director
Mr Stephen Hoaen, Head of Financial Services
Mr Chris Lovegrove, Counter Fraud Manager, tiaa
Mr Adrian Mills, Internal Audit Manager, tiaa
Mr Mike Townsend, Regional Managing Director, tiaa
Dr David Hughes, Medical Director
Mrs Karen Salt, PA to Director of Nursing (minutes)

Action

035/16 Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions and apologies were undertaken.

Apologies for absence had been received from:

Dr Adrian Bull, Chief Executive
Ms Miranda Kavanagh, Non-Executive Director
Mrs Alice Webster, Director of Nursing
Mr Jody Etherington, Audit Manager, BDO
Ms Emma Moore, Clinical Effectiveness Lead
Mr Peter Palmer, Assistant Company Secretary

036/16 Minutes

i) The minutes of the meeting held on 1st June 2016 were reviewed. An amendment was noted on page 4 out of 358, third paragraph, looking at systems and integrity, this should be changed to say that the upgrade being reviewed could reduce technical issues, not would.

ii) Under the heading of transfer of community services, the end of the first paragraph, discussing the change in contract should be revised to this financial year 2016-2017.

iii) An amendment to last page of minutes, 6 out of 358, it was noted that this should be amended to Head of Internal Audit limited assurance for 2015-2016.

The minutes were otherwise agreed as a correct record.

ii) Matters Arising

The following updates were provided:

Internal Audit – Progress Report
There has been considerable effort to follow up on outstanding actions and progress has now been made.

Internal Audit – Internal Audit Plan for 2016/17
Noted that an audit on quality of appraisals would be undertaken based on survey feedback. Outcomes should be provided at the next meeting.

Local Counter Fraud Service – Work Plan for 2016/17
Having an all staff 'code of conduct' was discussed. Mr Reid updated he had explored this with Mrs Green, and advised it is not uncommon for a Trust not to have a Code of Conduct for all staff. Expected behaviour is contractual and the Trust does have its values. This is an area that is felt that should be explored and Mr Reid would discuss with Mrs Green.

Changes in Accounting Policies
District valuer report provided to show the methodology used behind this to use an alternative for future reporting.

037/16 Board Assurance Framework and High Level Risk Register

a) Board Assurance Framework

Mrs Wells presented the Board Assurance Framework advising that the format had changed following the Board Seminar. She highlighted that a new gap in assurance on Clinical Leadership had been added and outlined the proposal to move mortality from red to amber.

Mr Stevens asked if the committee approved the change in rating of the mortality gap in control. Ms Herne thought not, as she hadn't had sight of a granular plan, although improvements were in train. Mrs Wells clarified this wasn't being changed to green and that there were far more controls in place than before. Mrs Bernhauser added that there were significant changes to patient pathways, but they had yet to see the evidence behind this.

Mr Reid suggested there be a timetable used to identify the

timescales on mortality becoming amber, with an action plan to bolster the position and drive the process. Mr Stevens agreed with Mr Reid and asked if Ms Herne would be happy with this. Mrs Herne specified she was in post on behalf of the regulator and not the Trust, and that the Trust controlled how they should provide assurance of improvements.

Mrs Colosi indicated the all the areas discussed had in fact been picked up by PMO, but she was unsure of timescales. Mr Stevens stated that he was happy with the plans in place, although he hadn't actually seen them or the results. It was agreed to leave the rating as red until further assurance was obtained.

b) High Level Risk Register

Mrs Wells gave an update on the work with Capsticks who were providing support on the scoring and consistency of the risk register with staff. Training was also being provided.

038/16 Surgery Risk Register & Clinical Audit

Surgery Risk Register

This report will be tabled at September's Audit Committee.

039/16 2014/15 Reference Costs Audit

Ms Brandt presented the 2014/2015 reference costs audit which was in accordance with the monitor costings guidance to provide assurance. ESHT was selected for audit as the Trust had not been audited for two years and Mrs Brandt stated they were not due to be audited again until the year after next. The work had been carried out by PWC. The Trust was not compliant due to cumulative cost quantum errors.

Issues that PWC were concerned about were policies and procedures, as there wasn't a flow chart to describe the process. Resourcing issues in coding were noted and were being addressed, as they were vacancies.

The Committee were assured that a significant amount of work had been undertaken by Mrs Brandt and her team following the audit and a robust action plan was in place; this was being monitored by the Finance and Investment Committee.

040/16 Trust IT Strategy Update

The update was received and the positive work noted. Mr Stevens commented that the Committee was seeking assurance on governance systems and processes.

Mr Reid suggested any issues could be picked up in the re-profiling of the capital programme.

041/16 Clinical Audit – Forward Plan 2016/17

Mr Hughes gave an update on the Clinical Audit Plan. The Trust remained non-compliant on one national clinical audit due to a software requirement and this was being explored.

Mr Stevens suggested within forward planning that too many priority 3's and 4's hadn't been followed through, and asked for Dr Hughes to follow up with Dr James Wilkinson, to ensure this was signed off. **DH**

042/16 Internal Audit

a) Progress Report

Mr Mills stated that the last update on progress was in March and that page 164 of 358 of the Committee papers provided a summary of reports that had been finalised and reports that had been submitted as drafts.

Mr Stevens raised concerns as to whether the Trust was doing enough to address areas highlighted. Mr Mills stated there had been lots of improvements, and the results were starting to materialise.

Mr Reid suggested that some findings should involve the Executive team to help pin down some of these areas, which would include QIA's. Mr Stevens raised concerns that external resources where used previously for CIPs that had a negative impact.

Mr Stevens asked if all issues were being addressed and Mr Reid and Mr Mills confirmed they were.

The 2015/2016 plan had been finalised and work on 2016/2017 was being progressed.

b) Audit Recommendations Tracker

The tracker was presented in three parts; green for closure, the second section where audit were not being satisfied with the outcome of actions following the audit, and the third part comprised of actions not yet due.

Mr Reid confirmed that he wanted to go through the report with Mr Mills and potentially have a refresh to ensure areas were being addressed.

Mr Mills confirmed the staff survey was due to go out but that the distribution list was being finalised with HR, to ensure coverage where pockets of people were missed due to not having access to email.

Mr Mills confirmed to Ms Herne and Mrs Wells that the handover audit was being scheduled, but Mrs Wells stated that one person would not have the capacity to be able to do this over two sites from 7.30am-7.30pm. The auditors would consider this.

043/16 Local Counter Fraud Service

a) Annual Report
Mr Lovegrove update on the final risk assessment and stated that this was completed but was awaiting a meeting with Mr Reid to go through the results.

b) Reactive Work
Mr Lovegrove updated on reactive work which included the ID scan on induction day for Junior Doctors. Mr Lovegrove suggested that the ID and HR checks be carried out on a different day, so passports could be used to verify identities.

c) Staff Counter fraud Survey Results
Mr Lovegrove updated on a small response from the staff survey, although he would like to take a different approach next year a focus on specific departments via the line manager or department heads.

Mr Stevens queried if there had been any kickbacks from senior staff and Mrs Wells confirmed that the declarations of interest report had been changed previously after Mr Stevens previous concerns were highlighted. Mrs Wells confirmed that she would bring the report to a future meeting after the Declaration Group had met. **LW**

d) Overpayments Protocol
Mr Lovegrove confirmed the draft was attached to the report and in train awaiting Mr Reid to sign off the document. Standards of providers and commissioners had been provided for the Committee's reference.

044/16 External Audit

a) Annual Audit Letter
Ms Combrinck verbally updated on the Annual Audit Letter and stated that the annual letter was a summary of the report that came to the last meeting.

Ms Combrinck stated that the report highlighted the value for money commentary and the committee noted this.

b) Quality Account review
The Quality Account audit was reviewed and actions noted. The management response was to be completed as there was a timing issue due to the submission date for audit papers.

Mrs Wells expressed frustration at the late timing of the audit, which did not commence until after the annual accounts audit. This made it rushed in being able to respond to queries. This was noted by BDO and would be reviewed for the next audit.

045/16 Information Governance

a) Annual Report 2015/16
The Committee reviewed and noted the Annual IG Report.

b) Information Governance Toolkit 2016/17 Update
Mrs Wells confirmed that the Trust IG was submitted on time and that a level 2 was achieved. An early planning meeting for the current year had already taken place with IGT leads.

The number of IG incidents had increased, this was largely to do with raised awareness of incident reporting.

Mrs Wells confirmed the Data Protection EU regulation would come into force in 2018. Requirements were significant and would impact on IG, and this would include resource for a privacy officer and impact officer.

c) Annual Legal Services Report
Mrs Wells updated on the Legal Services report and highlighted the duration of some cases was down to the area of the claim i.e. maternity, SCBU take some time to be agreed as quantum was not established until the child reaches a certain age. Mrs Wells stated that Mr Reid and herself authorise claims that exceed a certain amount.

Mr Stevens asked for a summary of cost and reasons behind it to appear within this report and said that it should also include ex-gratia payments and any trends. Mrs Wells advised that the NHSLA produce a report but she had not received this yet. Mr Lovegrove also offered assistance within any false claims.

046/16 Tenders and Waivers report

Mr. Stevens wanted confirmation that waivers were being appropriately applied. Mr Reid confirmed these were scrutinized by the procurement team and escalated if required. He outlined that waivers were generally raised due to the specialist nature of a service or legacy equipment when there were no alternative suppliers, but this should be picked up and highlighted in the report.

Mr. Mills confirmed as part of the audit, they were due to undertake work on the tenders and waivers area. Mr. Reid suggested that Mr. Mills had a discussion with himself and Philip Astell (Deputy Director of Finance) when this work is started.

047/16 Local Procurement of External Auditors

Auditors left the meeting. The procurement exercise was noted and timetable agreed.

048/16 Date of Next Meeting

Wednesday, 23rd November 2016, at 10.00am, St Marys Boardroom, Eastbourne.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 29th June 2016 at 9.30am – 11.30am, in St Mary's Board Room, Eastbourne DGH

Present

Mr Barry Nealon, Non-Executive Director (Chair)
Mr Mike Stevens, Non-Executive Director
Mrs Churchward-Cardiff, Non-Executive Director
Dr Adrian Bull, Chief Executive
Mr Jonathan Reid, Director of Finance
Mr Philip Astell, Acting Director of Finance

In attendance

Mrs Lynette Wells, Director of Corporate Affairs
Mr Chris Hodgson, Associate Director of Estates & Facilities (for minute 038/16)
Mrs Jo Brandt, Head of Performance & Planning (for minute 039/16 and 040/16)
Dr Nik Patel, Clinical Unit Lead – Cardiovascular (for minute 040/16)
Mrs Sandra Field, General Manager – Cardiovascular (for minute 040/16)
Mr Andy Bissenden, Associate Director of IT (for minute 043/16)
Mr Andy Slater, Director of Strategy (for minute 043/16)
Ms Gemma Lawrence, Programme Manager, PMO (for Minute 044/16)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

033/16	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee and, in particular, Mr Jonathan Reid to his first meeting of the Finance & Investment Committee. Apologies were received from Dr David Hughes and Mrs Pauline Butterworth.	**Action**
034/16	**Financial Planning and Sustainability** Mr Nealon introduced the meeting by asking Mr Reid to give a brief overview on Financial Planning and Sustainability. Mr Reid reported that few organisations come out of special measures with an improvement in their financial run rate but that this	

	should remain the Trust's aspiration. Delivering financial improvement at the same time as quality improvement is about how finance is discussed and how financial information is used in every day decision–making and should be an integral part of conversation about quality improvement. The Committee noted the following three components: • Key narrative and positive story around finance • Clear information and good financial governance • Support for delivery It was noted that the key priority over the next two months will be putting arrangements in place to support each of these issues. The Committee received information on the main areas of strengths and weaknesses. Mr Nealon said he would like to have a session on what the strategic role of the Finance & Investment Committee is in this, and what the key objectives are, and how the Board can help to achieve these goals. Dr Bull said that this Committee should look at how the Trust manages its finances as well as how it is moving towards the financial strategy of the organisation. It was noted that the overview of how it manages its finances should be available by the end of July. It was noted that there was a piece of work that needed to be done by the Executive Team on the Financial Strategy.	**JR**
035/16	**Minutes of Meeting of 25 May 2016** The minutes of the meeting held on 25 May 2016 were agreed as an accurate record.	
036/16	**Matters Arising** <u>(i) Community Rebasing Project</u> It was noted that the draft terms of reference for the Community Rebasing Project were presented to the Senior Leaders Forum on 13 June 2016. There was a slight change in that Abi Turner, General Manager for Out of Hospital were now leading that Project. <u>(ii) Rationalised Governance Structures</u> The Rationalised Governance Structures were reviewed and agreed by the Trust Board. The Terms of Reference and Work Programmes	

	are now being reviewed. (iii) Lord Carter update An update was presented under minute item 045/16 below. (iv) 'Specialing' The issue of specialing was discussed in the monthly clinical unit performance reviews. The Trust is reviewing its operational policy on specialing since the current practice is not consistent and the policy is outdated. The revised policy will be brought to the Senior Leaders Forum. (v) Integrated Performance Report Dr Bull confirmed that the issue raised at the last meeting on the CCU exempt area was being addressed. (vi) PbR – improvement margin at CU level Mr Reid confirmed that he had discussed this with Mr Astell and further discussions were due to take place both within the Finance Team and within the Clinical Units on how to use this to drive the improved contribution. (vii) 5 Year Capital Strategy This was discussed under minute 038/16 below. (viii) Underspend at M10 It was noted that Mr Meikle had sent Mr Nealon the information requested at the last meeting on how the £2m underspend identified at M10 in last year's capital programme had been spent by March 2016. (ix) Procurement update At the last meeting, the Committee had requested an update on how much stock the Trust held and what was being done to minimise stock. The Committee received an Inventory update from Mr Channana, Head of Procurement, which explained what was being done to reduce inventory levels. It was noted that Mr Reid and Mr Astell would be reviewing the inventory outside the meeting and will bring something back to this Committee.	

	(x) Quality Impact Assessments for Procurement Mr Channana provided an update which indicated that Procurement Hubs and Crown Commercial Service carry out Quality Impact Assessment as part of their tendering process prior to awarding framework contracts. As majority of Trust contracts are awarded through use of frameworks the requirement for undertaking QIA is implicitly addressed. Mr Channana's update indicated that procurement would be working closely with end user stakeholders to ensure QIA is carried out for projects which are tendered or awarded directly by the Trust without using any framework. Mr Reid reported that the QIA process in Procurement needed to be strengthened and that this would be included as part of the plan to get on top of Financial Governance. (xi) Coding Review An update was provided under minute item 041/16 below.	**JR/PA**
037/16	**Finance Report – Month 2** Mr Reid updated the Committee on the financial position and performance of the Trust as at the end of month 2. The Committee noted that in month 2 the Trust incurred a net deficit of £6.0m, which was £1.0m worse than the planned deficit of £5.0m. The cumulative deficit after two months of £11.2m was £1.5m adrift of plan. The total income in the month of £28.8m was £0.1m short of plan in the month; this was also the year to date shortfall as income was in line with plan in month 1. Total expenditure, including capital charges of £1.4m, was £34.7m in the month, £0.8m adverse to plan. After two months total expenditure of £69.1m was £1.4m in excess of plan. Cost improvements of £0.2m were achieved in the month compared to a plan of £0.3m. After two months achievement is £0.5m compared to £0.6m. Cost improvement targets were weighted towards the back end of the year reflecting the timing and lack of maturity of schemes; an equal twelfths apportionment for two months would have been more than three times the profiled plan. Cash held at the end of the month was £4.8m (4.6 days' operating costs). Pay expenditure in the month of £21.8m was £0.1m below plan, which is also the favourable variance to date.	

	Agency spend fell again in month 2, continuing the reversal of the upward trend seen throughout 2015/16. This has been due to a combination of recruitment to vacancies and successful negotiation of capped rates for most nursing agency staff. Expenditure in month 2 was £1.8m, compared to £1.9m in April and £2.5m in March. This is below the planned trajectory, which targets further significant reductions in agency costs over the rest of the year. Non-pay operating expenditure in the month of £11.3m was £1.0m above plan. This included a £0.3m shortfall on TEDDs, which was mirrored by a favourable variance on income. Cumulatively, the overspend was £1.5m, of which £0.3m was TEDDs. There were two main reasons for the non-pay overspend in the two-month period; £0.2m for the continued use of Medinet to provide additional endoscopy capacity and £0.5m of elective work outsourced to independent providers. Cost improvements of £0.2m were achieved in the month, £0.1m below plan. After two months achievement was £0.5m, which was also £0.1m below plan. Depreciation in the month of £1.0m and PDC dividend of £0.4m were both in line with plan. These costs are also on plan cumulatively, at £2.1m and £0.8m respectively. The Committee received a summary of the potential mitigations against the financial risks. In summary, after two months the Trust's financial performance had fallen £1.5m short of plan and urgent measures were required to manage the risks and recover the position over the remainder of the financial year. Mr Reid reported that the Trust had been offered, and had provisionally accepted, an improved financial settlement from NHS Improvement. **Action** **The Committee noted the Trust's financial performance for month 2.**	
038/16	**5 Year Capital Strategy 2016/17 – 2020/21** Mr Hodgson presented the Committee with the draft 5 year capital plan for 2016-2021. This considered how the Trust may bid for capital funds to help support the full implementation of the clinical strategy. The Committee received an update on the fund for Clinical Units to bid against which would improve/enhance the patient/staff experience	

It was noted that at the May 2016 Trust Board meeting, there was discussions around the estates strategy, the 5yr capital plan and how the CQC capital estates works was being coordinated within the overall capital program. The Board asked for a paper to be put together that contained a coherent 5yr capital plan that encompassed estates (including CQC works and backlog maintenance), IT and Medical equipment.

The Estates Strategy, 2016-2021, was presented to the December 2015 Board meeting and the principles contained therein was approved, with the proviso that the Estates Strategy would be reviewed when the Clinical Strategy was refreshed (completion likely to be at in FY16/47 Q3).

It is acknowledged that the Estates Strategy contained a significant number of capital projects that the Clinical Units (CU's) had requested when the Estates Strategy was being compiled. Whilst the future direction of the Clinical Strategy might change some of the CU priorities and align them into an overarching delivery plan, it is anticipated that a significant proportion of these CU's projects that were found at the consultation phase of the Estate Strategy will still relevant to the business and all of the project are contained within this 5 year plan.

Prioritisation of capital resources had been made as noted within the main report. Without additional sources of capital funding above and beyond its "normal" limits the Trust cannot transform its services to meet its clinical strategy.

The Trust will seek to submit a business case in latter part of Quarter 3 of FY16/17 for additional capital for construction schemes, medical equipment and IT equipment that support the clinical strategy and improve and enhance where appropriate the clinical environment.

In deriving the 5 year 2016-2021 capital plan the following assumptions were acknowledged:

- The clinical strategy will need to be completed and then all schemes contained with this program be reviewed for relevance and costs updated accordingly,
- All costs based upon 2016 prices and will need to be adjusted for inflation for the relevant time period,
- FY2017/18 capex program currently over committed by £1.047m and this will require further review to ensure we meet our CRL,
- Medical equipment will be managed by the Clinical Equipment Replacement & Procurement Group and any replacement will be reviewed for both conventional capex and lease options,
- Radiology equipment; strategy required on the replacement

	program and future options. • Bid for NHSi capital funds could be a lengthy and time hungry process (with consequential costs) It was noted that the 5 year 2016-2021 capital plan was in place and based upon a risk based approach and that the Trust will be integrating its future clinical strategy into the 5 year 2016-2021 capital plan. **Action** **The Committee approved the 5 year capital plan as proposed, supported in principal bid to NHSi for capital funds to help support the full implementation of the clinical strategy and noted the £120,000 from central funds for Clinical Units to bid against which will improve/enhance the patient/staff experience**	
039/16	**EBITDA Quarterly Report – Q4** Mrs Brandt presented the 2015-2016 Q4 EBITDA statement, the 2015-2016 quarterly EBITDA comparison statement and the impact on the EBITDA should the top 5 Lord Carter potential savings opportunities be realised. The Committee noted the 2015-2016 Q4 EBITDA deficit position for the clinical units, the number of service lines that had negative EBITDAs (30 of 43), the 2015-2016 quarterly EBITDA variances and the effect on the 2015-16 EBITDA if the Lord Carter top 5 PSO specialties realise their CIP target. Winter funding was included within the EBITDA statement however Fines & Penalties were excluded. The minor schemes revenue to capital transfer was also excluded from the EBITDA statement as was the support from the CCGs Mrs Brandt explained that HWLH stranded costs continue to cause a pressure on expenditure. Mr Stevens asked what was being done to reduce the stranded costs. Dr Bull agreed that this must be acted upon and reviewed. **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. HWLH stranded costs must be reviewed and an action plan agreed to reduce where possible.**	**JR**

040/16	**Cardiology Deep Dive** Mrs Brandt presented the findings of the recent Cardiology Service Review. It was noted that the Clinical Lead, General Manager and Service Manager for Cardiology had worked alongside the Performance & Planning team to undertake this piece of work. Cardiology is the specialty with largest potential saving opportunity (£4.1m) in ESHT according to the model hospital data provided by Lord Carter (NHSI), It is also the first specialty where the Trust is working jointly with the Commissioners on the collaborative development of a system wide clinical strategy. The following key issues were noted: • Qtr 4 2015-16 EBITDA % is -14.13%, a net deficit of £2.8m • 2014-15 Reference Cost Index = 125 • The net deficit relates predominantly to non-elective inpatients and outpatients. • Compared to PCB (Patient Cost Benchmarking) the ESHT average unit cost for non-elective inpatient Cardiology activity was £1.3k higher than the PCB average and average length of stay 1.4days higher than the PCB • The main cost outliers for ESHT compared to PCB are medical staffing, wards, other diagnostics and prostheses/implants & devices. • Lord Carter analysis suggests a PSO of £4.1m, £1.6m relates to non-elective inpatient activity. • Analysis on pacemaker activity found an issue with the coding of renewal pacemakers, resulting in a reduced tariff being received and consequent loss of income • Cardiology Physiology business case currently being drafted. It was noted that a previous service review was undertaken in March 2015 and the Committee reviewed the summary of findings. The Committee noted that actions that the Cardiology unit had put in place to improve its EBITDA statement position, at the same time trying to improve the quality of the care provided. The Clinical Unit were continuing to work on the focus points highlighted in the Cardiology Service Review presentation. The Clinical Unit explained that they were working jointly with commissioners to develop the system wide strategy for Cardiology by September 16. The first joint meeting was to be held today It was noted that the Efficiency Improvement Group (EIG) was	

	responsible for monitoring the progress made on the focus points actions. The Clinical Unit explained how it could turn the opportunities that were identified in the review into an action plan which would result in a recovery of income and reduction in costs, and what support they would require from the organisation. It was noted that the action plan would be included on the agenda for the Integrated Performance Reviews and an update would be provided to the Finance & Investment Committee in six months time. **Action** **The Committee noted the actions that Cardiology had put in place to improve its EBITDA statement position and improve and agreed that Cardiology continues to work on the focus points highlighted in the report. It was noted that the Efficiency Improvement Group (EIG) is responsible for monitoring the progress made on the focus points actions. Where support is required to Cardiology from members of the EIG to enable the actions to progress, it is given. The Committee 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.**	
041/16	**Interim Clinical Coding Review Report** The Committee received an update on the recent external review of Clinical Coding within East Sussex Healthcare NHS Trust. The Trust had recently commissioned an external review of the clinical coding function. The review was requested following a period of challenges over the previous 12-18 month and a concern that processes within the team may adversely be affecting trust data. The draft report from the external review had been received and this was currently being finalised. The report noted that the quality of coding has remained high despite the challenges faced, citing the achievement of level 2 of the Information Governance Toolkit. It also states that there were no significant problems with the depth of coding identified. The draft report contained a number of recommendations broken down across the following key areas: • Environment • Data Quality • Clinical Engagement • Governance	

	Although the report was still in draft, the Trust had started to move forwards on a number of the recommendations and will provide a full update on these. The final report together with an action plan will be presented to the Senior Leaders Forum and the Finance & Investment Committee. **Action:** **The Committee noted the update on the recent external review of Clinical Coding within the Trust.**	**JR**
042/16	**Tender Schedule & Business Cases Approved by SLF** The Committee received a schedule providing up update on current tenders as at 22 June 2016. The schedule is monitored by the Business Development Group (BDG) on a fortnightly basis. The Committee noted the position of the following PQQ/tenders: • Non-Invasive Ventilation Service – currently at clarification stage with responses submitted on 24 June 2016 • Direct Access Hearing Services AQP – has been submitted • Elective Service AQP – has been submitted • Non-Obstetric Ultrasound AQP - submission due June 2016 **Action** **The Committee noted the update on tenders.**	
043/16	**IT Investment – Five Year Investment Plan** Mr Bissenden and Dr Slater attended the Committee to provide assurance on last year's investments and to give an overview of the investment in IM&T over the next five years and how this supports the Trusts strategy and the digital five year forward plan. It was noted that investment priorities in the last financial year were directed towards resolving the significant risks on the departments risk register removing many single points of failure that had resulted from the underinvestment in previous years. Additionally substantial improvements were made to ensure that there was a fit for purpose and fit for the future IT infrastructure to start to meet the needs of EDM and the PACS reconsolidation program on a reliable, resilient available platform. Key to success of last year's development was working with all the programmes e.g. the PAS upgrade, EDM and the IT capital allocation to deliver a single investment in IT, not the piecemeal and silo project investment that has happened to date. The Committee received a detailed description of the work carried out	

	in 2015/16. It was reported that the IT strategy and work will continue over the next five years with partners in the Sussex Local Digital Roadmap and the East Sussex Better Together to deliver a paperless NHS by 2020 in a co-ordinated programme. Priority will be given to those elements which deliver clinical quality, safety and patient experience benefits or are needed to ensure further developments can occur on a robust IT infrastructure. The Committee received details of upgrades of existing systems and new developments over this period and costed within the 5 year capital plan. These included details on: • Electronic Document • PAS • Further VitalPAC Modules • GS1 • Telephony • Rolling hardware refreshment programme • Managed printing • Community SystmOne • E-Prescribing • VNA (Vendor Neutral Archive) • Integration and data warehouse • Cyber Security • E-learning • Other BAU The Committee noted the current five year capital program proposed to the IM&T steering. This will ensure that the IT investment is sufficient to meet the demands for the immediate and future of the service. It was acknowledged that IT had not been as linked in to the core strategies of the organisation is it should have been and that it should be given a much better support and platform in which it should be run. Dr Bull reported that Mr Bissenden will now be joining the Senior Leaders Forum and he was thinking through some other means by which the Trust can ensure that this key programme of work is much more closely linked in to the other initiatives. Mr Reid said that a further piece of additional work which was required was the benefits realisation in terms of pulling together the financial operation plan for the Trust for the next 5 years. The Committee agreed that Mr Bissenden had done a terrific job over the past year and felt re-assured by the report provided.	**JR**

	Action **An update would be provided at the June Committee meeting.**	
044/16	**Improvement Programme & Project Update** Ms Lawrence presented the Committee with a progress update on the proposed implementation of the following key Trust projects: • Community and Child Health - Phase 1 • Community and Child Health - Phase 2 • Electronic Document Management and Clinical Portal Project • Clinical Correspondence 2015/16 • Clinical Correspondence 2016/17 • Managed Print Service • Pathology Managed Equipment and Rationalisation • Health Records Service Improvement • OASIS PAS Hardware Upgrade • GS1 Programme • Philips PACS Remediation • ESHT 2020 Improvement Programme The ESHT 2020 Improvement Programme which contains 12 projects is reviewed at the Quality & Safety Committee and therefore detailed information on each project was not included within this report, this was however, available on request. All core projects and programmes are being facilitated by the Trust's PMO which is tasked with implementing these projects on behalf of the Trust. Each Project Board is chaired and led by a senior officer within the Trust. Each project has been designed to support the delivery of the Trust's Clinical Strategy and is in line with the IT and IM Strategies. **Action** **The Committee noted the progress with projects.**	
045/16	**Carter Implementation Group** Mr Reid reported that the work undertaken in the Cardiology Service Review demonstrated that the Trust had the potential to make substantial savings. However, there was a deliverability challenge and the Trust would need to look at ways to support clinicians and operational managers in driving out savings. Mr Reid noted that the current link between Carter and the in-year savings programme was not necessarily driving the pace of efficiency delivery that was required.	

	The Committee asked to see some detail on progress against CIPS. It was noted that a plan will be brought back to the Committee by the end of July that brings this all together in a more robust way. **Action** **The Committee noted the Carter Implementation Update.**	**PA**
046/16	**Business Cases** There were no business cases for review this month	
047/16	**Annual Review of Committee Effectiveness** The Committee received a report on the Annual Review of the Finance and Investment Committee. It is considered good practice for every committee of the Trust to conduct an annual self-assessment review. The report provided set out the outcome of the review which was conducted via a questionnaire to all Committee members in May/June 2016. There was a good response rate to the questionnaire. Members agreed that the number of Committee meetings held had been sufficient and appropriately structured to support the effective discharge of responsibilities. Members felt, on balance, that the volume of Committee business could be reduced, and that the number of papers considered could be streamlined to ensure more effective scrutiny and support. Matters considered and decisions made by the Committee were taken on an informed basis and members agreed these decisions were understood, owned and properly recorded and would bear scrutiny; subsequent implementation of decisions and progress had been reported back to the Committee as required. Overall the Committee was considered to be effective. Some minor changes to current Terms of Reference were suggested and agreed. **Action** **The Committee noted the report and agreed to the revised Terms of Reference (minor changes only).**	**JR**
048/16	**Changes to the Work Programme** The Committee received an update on the changes to the work programme. A review of the Trust's governance processes by Capsticks had	

	prompted a review of the Finance & Investment Committee work programme. The Committee Chair, Barry Nealon, met with Lynnette Wells, Philip Astell and Chris Kyprianou on 1 June 2016 to discuss changes to strengthen and streamline the Committee's programme. The Committee reviewed these changes, however it was agreed that the Integrated Performance Report would remain on the agenda each month, and that the Committee would focus on the finance section of the report. It was also agreed that the Long Term Financial Model should also be included on the work programme. Mrs Wells said she felt that the Committee should review what was actually being presented to this Committee as some of the reports, such as the deep dives, were more operational. Mr Reid said that the Executive Directors should perhaps be meeting directly with the specialties and that this Committee should receive assurance that the process is taking place. **Action** **The Committee noted the changes reflected in the revised work programme and agreed that the full Integrated Performance Report should be on the agenda each month.**	**JR** **JR**
049/16	**Date of Next Meeting** The next meeting will take place on Wednesday 27 July 2016 at 9.30am – 11.30am in the Committee Room, Conquest.	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 27 July 2016 at 9.30am – 11.30am, in The Committee Room, Conquest Hospital

Present
Mr Barry Nealon, Non-Executive Director (Chair)
Mr Mike Stevens, Non-Executive Director
Mrs Churchward-Cardiff, Non-Executive Director
Dr Adrian Bull, Chief Executive
Mr Jonathan Reid, Director of Finance
Mrs Pauline Butterworth, Deputy Chief Operating Officer

In attendance
Mr David Clayton-Smith, Trust Chairman
Ms Sally Herne, Improvement Director
Mr Chris Hodgson, Associate Director of Estates & Facilities (for minute 062/16 and 063/16)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

050/16	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee. There were no apologies for absence.	**Action**
051/16	**Minutes of Meeting of 29 June 2016** The minutes of the meeting held on 29 June 2016 were agreed as an accurate record subject to the paragraph on Specialing (under matters arising, item 036/16 iv) being replaced with the following paragraph: "The issue of specialing was discussed in the monthly clinical unit performance reviews. The Trust is reviewing its operational policy on specialing since the current practice is not consistent and the policy is outdated. The revised policy will be brought to the Senior Leaders Forum".	
052/16	**Matters Arising** (i) Financial Planning and sustainability This item was discussed under minute item 055/16 below. (ii) QIA Process in Procurement	

	It was recognised that there was a need to strengthen the QIP process and to ensure that all CIPs and major service changes or significant new contracts have a QIA process. This was included as part of the report on strengthening financial governance, discussed under minute item 055/16 below. A timetable for that had been agreed through the Quality Improvement Plan and will be monitored by the Programme Management Office. (iii) Stranded Costs It was noted that the Director of Finance and the Head of Financial Management were meeting with all General Managers for budget reset discussions. This would include agreeing the next steps for stranded costs. An update will be given at the August Finance and Investment Committee meeting. (iv) Coding Review The action plan was presented to the July Senior Leaders Forum and discussed under minute item 058/16 below. (v) IT Investment It was noted that the additional piece of work required on benefits realisation, in terms of pulling together the financial operation plan for the next 5 years, was continuing and would be available in August. (vi) Carter Implementation Group This was discussed under agenda item 061/16 below. It was noted that the Trust was on target and making good progress and that there would be further detail on all of the CIPs in August. (vii) Terms of Reference The Committee received a copy of the revised Terms of Reference for information. These were agreed subject to the updating the 'Director or Strategic Development and Assurance' to the 'Director of Strategy, Innovation and Planning'. It was agreed that Mr Nealon would review the Quorum of the Committee with the Director of Corporate Affairs. (viii) Work Programme It was noted that the Integrated Performance Report had been added back onto the work programme. As agreed, the LTFM had also been added.	**JR** **JR** **JR** **BN**
053/16	**Changes to the NHS Financial Framework – July 2016** The Committee noted that NHSI and NHS England had released a	

	new financial framework for NHS bodies in July 2016, both for Trusts and CCGs. Mr Reid presented a paper setting out the key implications for the Trust and describing how the Trust was addressing each component of the regime. It was noted that the level of scrutiny on finance, and the interrelationship between finance and operational performance against national standards had both increased. **Action** **The Committee noted the changes in the financial regime for Trusts and the actions required by the Trust.**	
054/16	**Integrated Performance Report – Month 3** The Committee reviewed the Integrated Performance Report for Month 3. It was noted that there had been some significant improvements in some of the quality and safety metrics. Mrs Butterworth confirmed that • All cancer standards with the exception of the 62 days were achieved. 62 days exceeded the trajectory but failed to meet the standard. The Trust did not improve in four key areas: • Diagnostic performance did not meet the < 1% target in March. • RTT incompletes did not meet the 92% standard • A&E performance remains challenged and under the target. • Cancer 62 Day waits remains below the target Mrs Butterworth explained that there were plans in place to get back onto trajectory. **Finance Report – Month 3** Mr Reid updated the Committee on the financial position of the Trust as at the end of month 3. The Committee noted that the Trust had agreed a new financial plan with NHS Improvement. This was based on a deficit plan 'control total' of £31.3m, replacing the original planned deficit of £48.0m. This is to be achieved by the Trust delivering further financial improvements of £6.3m and receiving a contribution from the national Strategic Transformation Fund (STF) of £10.4m. The revised plan sets an enhanced cost improvement target of £14.5m, compared to the original plan of £10.8m. The STF funding is contingent on meeting key financial and operational targets and the plan assumes these will be met in full. The Trust performance in month 3 was a run rate deficit of £2.4m with	

	a favourable variance against plan of £1.5m. Sustainability and Transformation Funding (STF) of £10.4m has been agreed for 2016/17 and £2.6m of this has been factored into the month 3 position. Year to date the deficit now stands at £13.6m which is in line with plan. Total income received during June was £3.0m above planned levels of which £2.6m related to STF. The year to date variance is now £2.9m above plan. Tariff-Excluded Drugs and Devices (TEDDs) income over-performed by £0.2m in month, over-performance now stands at £0.5m YTD. There is however, a corresponding overspend of £0.5m on TEDDs expenditure so therefore, this has a zero effect on the bottom line. Operating Pay costs are above plan by £0.6m in month and are cumulatively £0.5m above plan. Operating Non Pay costs are £1.1m above plan in month and are £2.6m above plan cumulatively. Total costs are now £2.8m overspent year to date. The CIP plan for 2016/17 had been increased to £14.5m. CIP achievement year to date was £0.9m which was marginally below the plan. The forecast outturn position is anticipated to be in line with the revised £31.3m deficit plan. The cash position of the Trust remains extremely challenging as a result of the revenue financial deficit. This continues to result in increasing creditor values and poor performance against the Better Payments Practice Code. Mr Stevens queried the proportion of trade invoices that had been achieved in month against the 95% target, compared to the proportion of NHS invoices. Mr Reid undertook to review this point and report back to the Committee. Discussion took place on agency usage and Mr Reid confirmed that the trust was holding the line on agency spend. However there were a small number of areas of non compliance. **Action** **The Committee noted the Trust's financial performance for month 3.**	**JR**
055/16	**Delivery of Financial Plan 2016/17** Mr Reid presented the Committee with an overview of the actions in train to ensure delivery of the 2016/17 financial plan, reflecting the position at Month 3.	

	The Executive Team were continuing to develop detailed plans for delivery, and were sourcing additional support to ensure that the leaders are empowered to deliver the changes required. Mr Reid explained that there were three significant risks to delivery of the financial plan for the Trust for 2016/17. • Operational Delivery • Agency spend • Cost Improvements The report presented to the Committee, set out further detail on each of these risks, and the actions in train to address these. It was noted that a detailed recovery plan was in development, and would be reviewed by the Executive Team and presented to the August Finance & Investment Committee. Immediate actions, agreed by the Executive Directors, to support the development of a more detailed recovery plan included : • Weekly review of progress against financial recovery plan at Executive Directors • Move Efficiency and Temporary Resourcing Review groups to weekly and strengthen the 'grip and control' measures – more rigorous and focused support for operational managers and budget-holders • Secure an immediate increase in capacity for delivery– strengthening operations, finance and HR, and seek to secure further support for NHS • Review commitment and competence - Director of Finance and Head of Financial Management to meet all General Managers in August, and monthly thereafter, supported by Finance Business Partners meeting all Service Managers on a monthly basis, alongside an immediate programme of training for budget-holders and refresh of financial governance It was noted that the level of financial risk in the Trust's financial plans was significant, but there were extensive opportunities for delivery of increased efficiencies and improvement. If the Trust does not deliver the financial plan for 2016/17, it is likely to enter the financial special measures regime, but more significantly, it will not have the capacity to deliver the plans for service development and quality improvement which exist across the organisation. Discussion took place on the delays in filling vacancies due to the admin delays on TRAC. Dr Bull said that there was a key metric that was tracking this. It was noted that this was something that could be reviewed at the Temporary Workforce Group. Dr Sally Herne also suggested that the Trust track efficiency in the permanent recruitment process ie length of time from identifying the need to recruit to having	**JR**

	a person in post to look for opportunities to reduce the length of the process and hence the time agency may need to cover the position. The Committee requested further assurance on the implementation of the above measures, with a much more detailed plan with a trajectory, to be presented to the next Finance & Investment Committee. **Action** **The Committee noted the ongoing work to secure delivery of the 2016/17 financial plan.**	**JR**
056/16	**Capital Programme Quarterly Report** The Committee received an update on the performance of the capital programme after the first three months of the financial year. At the end of month 3 the year to date capital expenditure amounted to £1.6m and the capital programme had an over planning margin of £0.95m which was considered acceptable at this stage of the financial year. The Capital Resource Group (CRG) will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital. The Trust continued to face a number of risks in relation to the total value of capital resource available to meet the capital needs of the Trust. **Action** **The Committee noted the current performance of the capital programme, the risks associated with limited capital and the need for a business case to be submitted for the £5m capital loan request in the current year.**	
057/16	**2014/15 Reference Cost Collection Audit – Action Plan** In line with the NHS Improvement (NHSI) requirement, the Committee received a report summarising the agreed findings and overall conclusion of the 2014-15 Reference Cost Collection submitted by the Trust. The detailed findings section on the PWC audit report summarised areas identified that were not compliant with the Costing Guidance. It also summarised areas for further improvement in processes and governance arrangements supporting completion of the reference cost return. The Committee received a paper summarising the progress against	

	each of the key actions. PWC's assessment confirmed that all actions plans were adequate in addressing the findings. The Audit Committee had considered the plan and indicated that scrutiny around delivery should take place through this Committee. It was agreed that updates would be provided on a quarterly basis. The Committee were pleased to note that an action plan was in place and that progress was being made. Mrs Churchward-Cardiff queried whether the right leadership was in place to deliver the action plan. Mr Reid certainly felt that the correct leadership team was in place as the team concerned had fought hard for compliance and were fully engaged in reference costs and the rest of the team were fully supportive of them. Dr Bull confirmed that, having gone through this in detail with the Head of Planning and Performance, he was absolutely confident that the team were more on top of this than a lot of other organisations. **Action** **The Committee noted the findings and recommendations, and agreed that the action plan will be implemented through the Committee.**	**JR**
058/16	**Clinical Coding Review Report – Action Plan Update** The Trust had commissioned an external review of the clinical coding function following a period of challenges over the previous 12-18 months and a concern that processes within the team may adversely be affecting trust data. A summary of the recommendations were shared with the Committee at the June Finance & Investment Committee Meeting. The final report had now been received and had been developed into an action plan for delivery and improvement. The Committee reviewed the action plan and noted that this was reviewed on a regular basis. It was noted that the Trust had already started moving forwards on a number of the recommendations and will provide an update on these and the action plan at future Finance & Investment Committee meetings. Mr Nealon reported that he had attended the opening of Apex Way and commented on how impressed he was with the new environment. He reported that the team that had moved there were extremely enthusiastic and he had fed back his comments to the team. It was agreed that a formal note of thanks would be sent to Liz Fellows from	**BN**

	the Committee for all her hard work. Mr Nealon asked if he could report this as a quality walk so that he could provide an update to the Trust Board. **Action:** **The Committee noted that the final report along with the recommendations had been developed into an action plan for delivery and improvement.**	
059/16	**STP & ESBT Financial Plans – Impact on ESHT** The STP remains an important work in progress and the Trust's financial plan needs to be aligned with both this and East Sussex Better Together. Mr Reid committed to keep the Committee updated as the STP financial plans evolve. **Action:** **The Committee noted the update.**	
060/16	**Tender Schedule & Business Cases Approved** The Committee received a schedule providing up update on current tenders as at 19 July 2016. The schedule is monitored by the Business Development Group (BDG) on a fortnightly basis. The Committee noted the position of the following PQQ/tenders in the pipeline: • Non-Invasive Ventilation Service submitted - Decision pending • Direct Access Hearing Services AQP has been submitted - Decision pending • Elective Service AQP has been submitted -- Decision pending • Non-Obstetric Ultra Sound AQP, submitted - Decision pending. • Integrated Community MSK for Hastings and Rother CCG – approach to market date is 16.09.2016 The Executive Directors meeting considers business cases for service developments to ensure that these are picked up in the annual business planning process. **Action** **The Committee noted the update on tenders and business cases.**	
061/16	**ESHT Carter Programme** Mr Reid presented the Committee with a slide on the Implementation of the Lord Carter Review which described the current and the future status of the Carter Programme.	

	It was noted the Trust was planning to move, over the next few weeks, to having a much more specific Carter Programme which is the medium term efficiency plan and in-year efficiency programme. A further detailed update will be provided at the September Finance & Investment Committee meeting. **Action** **The Committee noted the position on the implementation of the Lord Carter Review.**	**JR**
062/16	**Retail Options – EDGH and Conquest** Mr Hodgson presented the Committee with an update on the outcome of the retail procurement process for the Trust. The procurement process was now complete and the Trust was ready to appoint bidders. The Committee received drawings for the remodelled entrances and retail areas, and noted the both the financial benefits and benefits to patients in providing better catering facilities and redesigning the entrances. The Committee were asked to approve the decision to move forward with the 2 successful bidders; It was noted that this would be presented to the Trust Board in August. **Action** **The Committee approved the decision to move forward with the 2 successful bidders.**	
063/16	**Laundry Service** Mr Hodgson presented the Committee with a report on the current financial position of the Laundry Service. The Committee requested exploration of further options and a further update at the October meeting. **Action** **The Committee asked Mr Hodgson to explore further options and a further update will be given at the October Committee meeting.**	**CH**
064/16	**Replacement CT Scanner (GE Optima 660)** The Committee received a Business Case seeking approval for a replacement CT scanner (GE Optima 660). On the single siting of the Stroke Service at EDGH in July 2013, the Trust purchased a reconditioned scanner as a backup to support	

	diagnostic imaging. The required standard is for imaging to take place within 45 minutes from arrival in A&E. The demand for diagnostic imaging has increased year on year, putting additional pressures on current equipment and leading to increased down time of the main scanner. In accordance with the estates strategy the replacement for the current scanner will be located in the former Theatre 12 at EDGH. A decision on this Business Case will enable the Estates team to go out to tender for the works to commence with the conversion of Theatre 12 to a designated imaging suite. It is planned for this to be operational by April/May 2017. Approval of this business cases was required in order to define and allow progression of the estates work, which was planned within the capital programme. The Committee noted the benefits of the proposal, and received assurance that service, quality and value for money issues had been evaluated as part of the process. **Action** **The Committee approved the business case for the replacement CT Scanner (GE Optima 660) and recommended further approval by the Board of Directors.**	
065/16	**Replacement CT Scanner (GE Revolution)** The Committee received a Business Case seeking approval for a replacement CT scanner (GE Revolution The main CT scanner at EDGH is located in the area of the hospital leased to InHealth. InHealth gave notice to the Trust approximately 12 months ago of its intention to have this scanner removed to facilitate improved access to an upgraded MRI scanner at EDGH. The MRI is currently located at the front of EDGH. The current CT scanner was initially leased for a 5 year period. The lease was extended by 3 years about 18 months ago. The demand on diagnostic imaging has increased year on year, putting additional pressure on current equipment and leading to increased down time. In accordance with the estates strategy and capital programme the new CT scanner will be located in a newly-refurbished CT suite on the location of the former Theatre 12 at EDGH. Approval of this business case and the separate case for a GE Optima scanner will enable the estates team to go out to tender for the works. The two business cases are independent, except that the machines will be co-located in the new CT suite. It is planned for this to be operational by April/May 2017.	

	The Friends of EDGH have pledged to raise and contribute £500k towards the cost of the new scanner. It was noted that approval of this business cases was required in order to define and allow progression of the estates work, which was planned within the capital programme. It was agreed that it would be a good opportunity to review and improve the contract with InHealth. The Committee noted the key benefits of the proposal for services at Eastbourne DGH and received assurance that service, quality and value for money issues had been evaluated as part of the process. The Committee sought assurance from Mr Reid that the Trust had properly tested the capital comparison. It was agreed that Mr Reid would send the committee further clarification on the comparison of capital cost versus revenue cost. **Action** **The Committee approved the business case for the replacement CT Scanner (GE Revolution) and recommended further approval by the Board of Directors subject to further clarification.**	**JR**
066/16	**Capex Business Case** Dr Bull reported that discussions had taken place with NHSI on the potential £5m bid for capital funding. It was noted that there was prioritisation and this was being linked to CQC issues. It was noted that the target for submission was the end of August. **Action** **The Committee note the update on the Capex Business Case**	
067/16	**2016/17 Revised Work Programme** The Committee noted the changes to the revised work programme. It was agreed that the agenda for the August meeting would be restricted to allow time for discussion on the Medium plan business case, and that the meeting will be extended by an extra half hour, therefore starting at 9am and finishing at 11.30am. The Committee said they were pleased with the new revised layout of the agenda. **Action** **The Committee noted the revised Work Programme.**	

068/16	**Date of Next Meeting** The next meeting will take place on Wednesday 31 August 2016 at 9am – 11.30am, in St Mary's Board Room at Eastbourne DGH.	

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the People and Organisational Development (POD) Committee meeting held on Thursday 15th September 2016, 10.00am – 12.00pm Room 1, Education Centre, Conquest v/c to Princess Alice Room, EDGH

Present: Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director (JCC)
Ms Monica Green, Director of HR (MG)
Mrs Kim Novis, Equality & Human Rights Lead (KN)
Mrs Moira Tenney, Deputy Director of HR (MT)
Dr David Walker, Medical Director (DW)
Mrs Lynette Wells, Company Secretary (LW)

In attendance: Mrs Lorraine Mason, Head of Staff Engagement & Wellbeing (LM)
Miss Sarah Gilbert, PA to Director of HR (SG) - Minutes
Mrs Mel Adams, Pharmacy Governance Manager (MA) - Observer

No.	Item	Action
1)	**Welcome, introductions and apologies for absence** The Chair welcomed all members to the meeting and introductions were made. The Chair welcomed Mel Adams (MA) who was in attendance as an observer. Apologies for absence were received from: Mrs Pauline Butterworth, Acting Chief Operating Officer (PB) Mrs Edel Cousins, Asst. Director of HR – Workforce Development (EC) Dr Sally Herne, Improvement Director (SH) Mrs Jan Humber, Staff Side Chair (JH) Mrs Alice Webster, Director of Nursing (AW) Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)	
2)	**2.1 Minutes of the last meeting held on 1 June 2016** The minutes were reviewed and agreed as an accurate reflection of the meeting. **2.2 Matters Arising and review of Action Tracker:** The Action Tracker reviewed and the following updates noted: <u>Healthroster</u> – MG outlined some upcoming changes around the introduction of Safecare safer staffing module and use of a Cloud. EC/PB to provide a further update at the next meeting. Rating to be changed to "Amber".	**EC/PB**
	<u>Business planning</u> – MT outlined a business planning/workforce summit being arranged for all Clinical Units on 21 November 2016 which would focus on developing workforce plans for each CU, including recruitment and new roles. Rating to be changed to	

"amber".

Nurse Associate role – MT advised this role was on hold across Sussex at present as the curriculum was not yet ready and the Job Description had not been finalised. EC to be asked to provide a further update at the next meeting. **EC**

All completed actions to be marked "green" and updated action tracker would be circulated with the minutes of the meeting. **SG**

3) Feedback from sub-groups of HR Senior Leaders Meeting:

3.1 – Staff Engagement Ops Group
LM provided an update. She advised the group is currently being refreshed to include OD as well as staff engagement.

LM outlined the ESHT Vine champions' initiative launched last month which aims to improve communication with staff. Over 300 champions were now in place and would be communicating and reinforcing key messages such as the "Theme of the week" to staff via their informal and formal network channels.

ESHT Mentor of the year awards were held last night which recognised and celebrated nursing and preceptorship amongst nurses and AHPs across the Trust.

3.2 – Education Steering Group
MG presented a written paper and outlined key points of note. A recent appointment had been made of an Education Business Manager to integrate education, working in conjunction with HEE.

Education funding reduction continues to be of concern. Changes to funding for nurse training and AHPs are also planned and further detail will be available shortly. EC to provide an update at the next meeting. **EC**

The Doctors' Assistant role was agreed at Senior Leaders Forum earlier this week and the role would assist doctors with basic admin tasks.

The Trust is now required to employ around 100 apprentices per year and marketing has been undertaken to encourage recruitment and employment of these within the Trust, as well as offering this as a training programme for existing staff. EC to provide further information around apprenticeships for the December meeting. **EC**

SG to circulate the terms of reference for each of the sub-groups reporting into the Committee with the minutes of the meeting. **SG**

3.3 – Workforce Resourcing Group
MT advised this group was previously the Workforce Planning Group. The terms of reference had been refreshed and the launch of this group would start with the Workforce Summit planned for 21

November 2016, to be attended by CU leads, general managers and heads of nursing.

The group would also be looking at new roles including Doctors' Assistants and also Matrons' Assistants which are currently being recruited. A paper was also approved at the Senior Leaders Forum meeting earlier this week regarding the introduction of an Associate Consultant role, similar to the disestablished Associate Specialist role, which would aim to bridge the gap between specialist and consultant level and encourage retention of staff. This role would be introduced in A&E and other hard to fill areas.

MT outlined work being undertaken to recruit to vacancies. 100+ bank HCAs would be recruited shortly to help with winter pressures. Open days for Estates and facilities are being held to recruit further staff. Approximately 60 EU nurses have been recruited this year, along with 37 nurses from the Philippines, with further overseas recruitment planned for later in the year. A number of head-hunter firms had also been engaged to assist with recruitment for hard to fill consultant medical vacancies.

DW raised an issue of medical locum requests being escalated to the Medical Director for sign-off. The Committee considered this and felt the locum sign-off process warranted review to consider whether some decision-making responsibility could be made at Clinical Unit level. DW agreed to discuss with the Director of Finance. **DW**

3.4 – HR Quality & Standards Group

MG outlined this was an internal HR group whose remit is to regularly review the workforce related items on the Board Assurance Framework, HR risk register, Trust wide workforce risks and Datix incidents relating to staffing. JCC commented that she felt it would be appropriate for the Committee to have assurance that the Trust has the right HR setup in place. The Committee agreed it would be useful to regularly review HR metrics. MG agreed to provide a paper detailing relevant HR metrics at the December meeting. **MG**

4) 4.1 - Staff Survey Action Plan

LM provided an update on progress and key actions for the three priorities identified from the staff survey results:

Communications/Feedback

- Workshops/training for communications skills undertaken and were well received.
- Back to essentials programme being developed for all staff to outline the Trust's expectations of managers.
- Communications toolkit being implemented.

Bullying & Harassment

- Speak up guardian appointment
- Embedding values workshops
- Professional and Cultural Transformation Programme (PACT)

being developed for all staff.

Health & Wellbeing

- Dedicated team in place, currently undertaking a survey amongst staff to identify what they see as important.
- CQUIN target and response plan in place.
- Staff health checks being implemented for staff over 40.
- Recruitment of Specialist physiotherapist to department to help support staff with MSK problems.
- Schwartz Rounds – evaluation now available and to be shared at a future meeting.

In addition, Clinical Unit action plans have been developed and "You Said We Did" feedback is being shared within Clinical Units. LM agreed to share the overarching CU action plan with the minutes of the meeting. **LM**

4.2 - Pulse Surveys

Regular pulse surveys had been introduced to all staff to measure certain aspects of staff survey key findings since the 2015 staff survey to see if there has been any change. It was noted that the latest results show an improvement in communications between senior managers and staff.

The latest results vary greatly across the Clinical Units with Cardiovascular noted to be an area of concern. DW commented staff engagement over the Trust has improved, however, many admin teams still do not feel working lives have improved day to day as yet and there is further work to be done. The Committee noted the culture of an organisation would take time to change. LM highlighted work being undertaken by the Staff Engagement Team with leaders and managers in areas with perceived low staff engagement to provide support to staff, listen to concerns and take forward actions.

4.3 - 2016 Staff Survey

The national 2016 Staff Survey would be launched in October 2016. The Chair asked what measures the Trust would be undertaking to encourage more staff to complete the survey. LM advised an intensive communication campaign would be undertaken, and has already started engaging with CUs to promote this to their staff, and consider providing protected time. There are also plans to incentivise filling in the survey with prizes available. MG reiterated the need for Trust Board and senior management to encourage staff to complete the survey. **ALL**

5) Organisational Development Strategy Outline

LM outlined the key points of the draft Organisational Development (OD) Strategy, which would feed into the overarching ESHT 2020 improvement plan. It was noted there would be a number of strategies developed to support the OD strategy covering recruitment, education and health & wellbeing.

JCC raised the need for the strategy to include a priority around empowering managers and staff to make decisions and also providing staff with tools they would need to make changes. The Chair commented that STP and ESBT external strategies also need to be mentioned in the strategy. LM agreed to make the suggested amendments to the strategy. **LM**

The Chair agreed to present the OD Strategy at a future Board Seminar. It was agreed that progress with the OD Strategy would be reviewed at the first Committee meeting in 2017. **MK** **SG**

6) Workforce Strategy and Plan

MG outlined further revisions had been made to the Workforce Strategy and this had now been approved at Trust Board. DW commented that although the number of doctors has increased in the strategy, the number of AHPs had decreased. MG agreed to provide further information around AHP numbers as part of a deep dive at the next meeting. **MG**

It was highlighted that the Workforce Race Equality Standard (WRES) needed to be mentioned in the Workforce Strategy and MG agreed to feed this back to EC. **MG/EC**

JCC noted short term sickness had improved over the last year and MG confirmed this had been supported by work undertaken in HR. JCC asked how long term sickness is supported. MT agreed further detail around HR support for managers in relation to long term sickness would be provided at the next meeting. **MT**

It was agreed the Workforce Strategy would be reviewed at the first Committee meeting in 2017. **SG**

7) Update on new contract for Junior Doctors

MT provided an update. The first doctors in the Trust to be on the new contract start on 5th October in Obs & Gynae and the rotas have been finalised. The next implementation would be in December when all FY1s and FY2s would be on the new contract. The rotas were being updated to ensure compliance with the terms of the new contract. MT outlined costings involved with implementing the contract and advised that this would be added to the Risk Register in terms of its potential impact on finance, quality and safety. **MT**

A temporary guardian of safe working has been appointed with the interviews for the substantive post later in the year. MT reported issues with the software to implement rotas and for exception reporting and that work was ongoing with finance and IT to implement a solution. Operational briefings for managers in the Trust would be undertaken to ensure full awareness of the impact of the new contract. The next junior doctors strike is planned for the weekdays between 5th until 11th October.

MT raised whether the 7 day working group ought to be re-established as this was part of the rationale behind the

implementation of the new Junior Doctors contract by the Government. MG and DW agreed to raise this at the Executive Directors' Meeting. **MG/DW**

8) Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES)

KN provided an outline of the EDS2 report and highlighted the equal pay audit which had identified a pay gap between male and female staff across some of the higher graded staff groups in the Trust, particularly doctors. MG commented that this may be due to the length of time in post of staff in certain staff groups and also impacted by female doctors returning from maternity leave that may not want to undertake on-call, rather than a gender pay divide. KN agreed to undertake further analysis of this for bands 8c and above and provide an update at the next meeting. **KN**

KN provided some background to the WRES report which required the percentage of BME staff at the Trust within bands 1-9 broken down by clinical and non-clinical roles. It was noted that several bands were underrepresented, particularly non-clinical bands 4-6. KN advised a BME engagement group was being set up and an action plan would be developed by the group to look at what can be done to encourage more BME recruitment and appointments.

JCC queried about BME applicant shortlisting outcomes and appointments. MT advised this is being looked at and will provide a more detailed breakdown in conjunction with KN at the next meeting. **MT/KN**

9) Items for Information:

9.1 - HR Incident Report

The report was not yet available, however MT advised this would be circulated at the end of September to the Committee. MT outlined a reduction in the number of cases reported to HR in the last 6 months when compared to the previous 6 months before that. A new HR case management system was currently being procured which would provide reporting functionality. **MT**

9.2 - Workforce Report

The Committee noted the report.

10) Any other business

No items were raised.

11) The next meeting of the Committee will take place on:

Thursday 15th December 2016 from 10.00am – 12.00 pm in Sara Hampson Room, Post Grad, EDGH video conferenced to Committee Room, Conquest

2017 dates to be published in October 2016.

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.

The Committee will consider cultural development within the Trust to align behaviours with strategic objectives to promote a learning and supporting work environment. This would encompass consideration of staff development, career progression and managerial culture.

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.

6. Duties

To monitor and advise on:

- Organisational response and fit with strategic objectives
- Promotion of Trust vision and goals as part of staff development
- Learning and best practice propagation opportunities and uptake across the Trust.
- 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. The minutes of the meetings will be provided to Trust Board for information.

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

HR Senior Leaders Meeting – Verbal updates.

East Sussex Healthcare NHS
NHS Trust

Quality and Safety Committee

Minutes of the Quality and Safety Committee Meeting

Thursday 20 July 2016
St Mary's Boardroom, EDGH

Present: Mrs Sue Bernhauser, Chair
Dr David Hughes, Medical Director
Mrs Lynette Wells, Company Secretary
Mrs Sara Songhurst, Deputy Director of Nursing (for Alice Webster)
Mr Ashley Parrott, Associate Director of Governance
Ms Kim Novis, Equality and Human Rights Lead

In attendance: Mrs Lesley Smith – for Item (Infection Control)
Mrs Moira Tenney, Assistant Director of HR
Mrs Eileen Weeks, Patient Experience Manager – for Item 2.0 (Patient Story)
Mr Stuart Crichton and partner – for Item 2.0 (Patient Story)
Mrs Sandy Crichton – for Item 2.0 (Patient Story)
Mrs Karen Salt, PA to Director of Nursing (minutes)

1.0 Welcome and Apologies for Absence

Sue Bernhauser welcomed participants to the Quality and Standards Committee meeting and confirmed that the Committee was quorate.

Sue Bernhauser noted apologies for absence had been received from:

Mrs Alice Webster, Director of Nursing
Dr Adrian Bull, Chief Executive
Mrs Jackie Churchward-Cardiff, Non- Executive Director
Dr James Wilkinson, Assistant Medical Director, Quality
Mrs Anne Wilson – Director of Infection Prevention and Control
Mrs Edel Cousins – Assistant Director, Workforce Development
Mrs Pauline Butterworth – Acting Chief Operating Officer
Mrs Janet Colvert, Ex-Officio Committee Member

2.0 Patient Story

Mr Stuart Crichton gave a presentation that highlighted issues with the end of life care that his late father received at East Sussex Healthcare Trust. Mr Crichton confirmed that he was happy for his presentation to be retained by the Trust and used for information and training purposes.

3.0 Minutes of the Previous Meeting

The minutes of the 2 June meeting were agreed to be an accurate record of the meeting.

3.2 **Matters Arising and Action Log**

Action Log

QSC 1 (12 Jan 16) – the investigation was still with the CCG and so it was agreed to keep the action open until the September meeting. Action remained open.

David Hughes noted that the General Medical Council was keen to have information regarding Never Events, and any associated activity and learning. Ashley Parrott confirmed that a record of activity was available.

QSC 2 (12 Jan 16) – Miranda Kavanagh had been invited for a Deep Dive later in the year once the People and Organisational Development Group was underway. Action closed.

QSC 4 (14 Apr 16) – Ashley Parrott advised that resource had been obtained to work on the High Level Risk Register. Working with the Risk Lead and two facilitators, they had met with pharmacy and estates. More work and clarity was needed on how risks were escalated from local to corporate risk registers. Action to remain open for an update at the September meeting. .

QSC 5 (14 Apr 16) – It was confirmed that a column had been added to highlight the rise and lowering of risk. Action closed.

QSC 7 (14 Apr 16) - There had been a very good Maternity presentation at the Quality Improvement Programme meeting on 19 July 16. It was agreed that Maternity should be the Deep Dive topic at the next Quality and Safety Committee Meeting.

Action – Karen Salt to invite the Maternity Team to present a Deep Dive to the September meeting.

QSC 10 (2 Jun 16) – Action complete and closed.

QSC 11 (2 Jun 16) – The change of name had had tacit approval and was due to be submitted to the next Trust Board meeting for formal approval in August 2016. Action closed.

QSC 12 (2 Jun 16) - The amended Terms of Reference were noted and would be presented to the next Trust Board meeting for formal approval in August 2016. Action closed.

QSC 13 (2 Jun 16) – Action completed and closed.

QSC 14 (2 Jun 16) – This was a work in progress. Action remained open.

QSC 15 (2 Jun 16) – This was work in progress with additional resource required to support. Action remained open.

QSC 16 (2 Jun 16) – Action confirmed as complete. Action closed.

QSC 17 (2 Jun 16) – Action confirmed as complete. Action closed.

QSC 18 (2 Jun 16) – Letter sent to CCG and copied to members of the QSC. No response had been received. Ashley Parrott reported that the number of reported incidents was decreasing but it was not clear if this was due to improvement or reporting fatigue. The CCG had invited ESHT to join an incident group to monitor. It was noted that the Outpatient Departments were still being impacted. Action remained open.

QSC 19 (2 Jun 16) – Action completed and closed.

QSC 20 and 21 (2 Jun 16) – Actions confirmed as complete. Actions closed.

QSC 22 (2 Jun 16) – Update not available. Action remained open.

QSC 23 (2 Jun 16) – Action completed and closed.

QSC 24 (2 Jun 16) – Noted that update from Improvement Sub Committee on Mortality had not been included this time but Deep Dives had gone to the NHS I and the Quality Improvement Programme meetings. James Wilkinson to provide an update for the next meeting in September 2016. Action remained open.

QSC 25, 26 & 27 (2 Jun 16) – Actions completed and closed.

There was a discussion about how to evidence that what the Trust was doing was working. It was noted that in relation to the BAF, when elements changed from red to amber it could be because controls had been put in place or it could be because numbers had gone down due to interventions.

4.1 **Board Assurance Framework and High Level Risk Register**

A control had been added. It was noted that 3 areas were showing red:
Emergency Department reconfiguration
Patient Transport Services
Finance

Mortality was noted to be going back to red.

High Level Risk Register

Ashley Parrott noted that the trajectory was missing from the circulated version of the High Level Risk Register but confirmed that it was on the original document. .

4.2 **Legal and Claims – Annual Report**

Lynette Wells presented the Legal and Claims Annual Report which had already been to the Audit Committee and was being presented to the the Quality and Safety Committee for a quality oversight. It was noted that more detail and depth on themes and trends would be useful for the Committee to see
Action – Lynette Wells to follow up and establish whether or not a more detailed report could be produced.

Claims were noted to be up on 2015/16 with 65 clinical claims reported. It was noted that while helpful to have information on previous years' claims it would be difficult to obtain a trajectory due to the unpredictable nature of claims.

It was felt that key team leaders in the Trust Key should be made aware of the costs of claims through a short seminar. This could highlight how improvement in the area of claims could lead to a drop in premiums. Lynette Wells confirmed that process had been strengthened with issues picked up earlier having been identified through incident reporting.

Ashley Parrott explained that the triangulation of incidents through the new Patient Safety and Quality Group should allow better monitoring and the highlighting of changes in practice.

4.3 **Duty of Candour Re-Audit**

Ashley Parrott presented the Duty of Candour Re-Audit noting that the previous audit had lacked evidence that the Trust was fulfilling Duty of Candour obligations.

A new process had been introduced in April 2016 and a re-audit had been done.

The Audit had looked at the first two stages – verbal Duty of Candour where a patient was initially informed and then the written Duty of Candour letter. The Weekly Patient Safety Summit tracked all DoC activity. Compliance was improving as noted in the report. Standard letter templates had been produced and a flow chart was being produced to improve on use of these. The quality of letters was also improving.

The next part of the process was the sharing of information with families and the April to July report would highlight how well that was working.

Amber reports (internal investigations) were not of a quality that would be appropriate to share with families yet but the quality of Serious Incident reports was improving following discussions with Heads of Nursing.

It was noted that during the recent Mock Inspection some staff had shown a lack of familiarity with the Duty of Candour process but it was also noted that the lack of familiarity was most likely with the name of the process rather than with the process itself. Lynette Wells explained that a plan was in place to address this.

The Policy for Duty of Candour was in the process of being updated.

The Committee noted the report and the improved compliance with Duty of Candour.

4.4 **External Visits Report**

Lynette Wells presented the External Visits report noting that it summarized the 13 visits the Trust had received from January to March 2016 with updates on the actions in place. It was noted that not all external visits were on the report including a recent, very positive visit by the Supervisor of Midwives on 19 July.

External visits were followed up on to ensure that actions were followed up and embedded in the organisation memory. It was confirmed that the Capsticks review would appear on the next report.

4.5 **Quality Improvement Programme (including ESHT 2020)**

Lesley Walton presented the ESHT 2020 Improvement Programme report which was for assurance and an update from the last meeting. The Committee was asked to review and note the progress of the Improvement Programme .

The Quality Improvement Programme had been put into a formal programme earlier in 2016 and an Improvement Sub-Committee had been set up to monitor the progress of 11 projects, 2 of which were due to close and some of which would expand beyond CQC improvements. KPIs were still being developed for some of the projects.

Key highlights were noted as follows:

Medicines Management had closed. A new Chief Pharmacist was in post. Pharmacy was due to be inspected in the upcoming Mock Inspection. Any remaining issues would be addressed through 'business as usual'. There remained some medicines management issues on the wards but these were being looked at by the Head of Nursing for Clinical Practice (Sue Allen). CREWS reviews were feeding back and a clinical facilitator was being recruited. There would be a focus over the next few months on what wards needed.

Health Records Project – would be recommended to close following achievement of objectives. The state of repair of records remained an ongoing issue but issues were expected to be resolved with the roll out of the Electronic Document Management system due to go live in November 2016. Sue Allen, Head of Nursing (Clinical Practice) would be addressing remaining security issues identified in a TIAA audit.

Single Sex Accommodation. No breaches reported post 22.00 and daytime breaches were reported on Datix. Gill Hooper had done some work to update the policy. Work needed to be done regarding Datix reporting and follow up. The Trust policy of point prevalence was in line with national policy. The Trust Board received this national reporting but was not being made aware of daytime breaches. It was confirmed that mixed sex breaches were escalated to Executive On Call Directors.

Hospital @ Night group had been formed and was looking at day time work that was being handed over to night staff. .

Mortality - a full time Project Manager would be taking things forward, looking at Sepsis and governance processes around mortality. A workshop scheduled for August would map the current position and establish the future direction of the project..

Evidence based care - A nil by mouth audit at EDGH in June 16 would inform improvements required. A consent audit in February 16 had shown that form 4 was

not being used for patients with Mental Health Capacity issues. A further audit was due to take place.

Environmental Cleanliness and Infection Prevention and Control Project - restructure relating to improvements to Estates had cause some disruption and staff issues but these were settling down.

Governance Project - Significant work had been done and the aim was to see the Friends and Family Test become a better tool to test improvements.

Workforce Capacity, Capability and Engagement Project – The Improvement Sub Committee had ask that the PMO ocus more on patient flow with a resulting impact on work that could take place on this project.

Patient Flow Project - successful review of the plan had shown that it was working well.

Maternity - had seen good improvements and a deep dive had been presented to the Quality Improvement Programme meeting. Brenda Lynes-O'Meara had taken on the role of General Manager. There was a plan to focus on Maternity.

Effective Relationships with External Stakeholders and the Public - this was progressing towards business as usual.

Sue Bernhauser noted that at the recent mock inspection one of the reviewers had wanted to sit in on a safety huddle and had been informed that they weren't yet taking place. Sue Allen had talked about safety huddles at the CQC readiness meeting noting that they needed support. A similar initiative at Guys and St Thomas' had taken 4 years to work properly despite a team working on it.

4.6 **Health and Safety Annual report**

Ashley Parrott presented the Health and Safety Annual Report noting that it had been to the Health and Safety Committee. Staff incidents had increased – with more work needed on moving and handling. There were no other comments.

5.1 **Infection Control**

Lesley Smith presented the Infection Control Action Plan update a number of action plans had been incorporated into an integrated action plan to make it a more manageable process. The plan was RAG rated with completed actions noted in blue.

The Action Plan was broken down into 5 headings. And the aim was to incorporate it into the Annual Programme of Work. Anything new would then go into the headings and become a work plan.

A few items had been taken out, either because they had been repeated or sat with a different area (Estates and Facilities). The new, clearer action plan aimed to be clear, help the way that colleagues worked and support the year ahead.

It was noted that actions from Serious Incidents and Audits were not in the Action

Plan as they were being monitored elsewhere.

There was a discussion about RAG ratings and noted that one of the actions was Amber but appeared to be six months overdue. It was agreed that Lesley Smith would work on a solution for actions that were partly complete and consider adding a column for comments.

Action – Lesley Smith to work on a system for partly completed actions, consistent with other Committee Action Logs.

5.2 **Governance Quality Report**

Ashley Parrott presented the Governance Quality Report which aimed to provide an overview of the progress and challenges for the three quality domains of Patient Safety, Patient Experience and Clinical Effectiveness.

The key challenges were:

Serious Incident backlog – efforts were being made to clear the backlog by the end of August with the team working on new incidents while trying to clear the historical incidents.

Complaints backlog – Ongoing issue of complaints not being dealt with within timeframes. A long term sickness absence had hindered progress but additional support was due to be recruited help maintain momentum.

Risk register – Required further work needed to ensure clarity between local and corporate risk.

Friends and Family Test – response rates were still low and an analysis had been presented to the Patient Experience Steering Group in July 16. A plan was in place to adapt a system of tokens into the use of postcards which was hoped to improve response rates. Further work needed to be done on inpatient wards.

The Draft Terms of Reference of the Patient Safety and Quality Group had been issued and the first meeting was due to take place on 11 August 2016. The Terms of Reference contained detail of the duties of the Clinical Outcomes Group and the Clinical Effectiveness Group. These duties would in turn feature in the Terms of Reference for those groups. Membership of the PSQG would be strategic.

It was noted that the Trust was legally required to report on Equality and Diversity and that membership of the group would allow Kim Novis to engage on this.

Action – Kim Novis to be added to the membership of the Patient Safety and Quality Group.

Ashley Parrott then introduced a Committee summary sheet – which aimed to be a method of highlighting workplans, activity progress and issues that needed to be escalated from other committees, The summary sheet would take the place of meeting minutes and aimed to give an overview of the work of each of those committees.

5.3 **Clinical Governance Report – Capsticks**

Lynette Wells presented the report. The report had been commissioned by the Chair of the Trust and while a draft had been submitted to this meeting a final version, unchanged, had subsequently issued.

It was important to look at the recommendations and decide which ones needed to be taken forward. It was agreed that Lynette Wells and Ashley Parrott would work up a response for the next meeting in September 2016.

Action – Lynette Wells and Ashley Parrott to present a report to the next meeting highlighting which recommendations needed to be taken forward and actioned.

5.4 **ESD2 – Annual Report**

Kim Novis presented the Equality and Diversity System (ESD2) annual report and asked the Committee to confirm that the grades for each outcome were a fair reflection of the outcome.

NHS England set the framework. The report was due to go to the Equality Steering Group but the last two meetings had had to be cancelled and the report needed to be presented to the Quality and Safety Committee before the final report issued. A few elements of data were awaited.

It was noted that EDS2 Goal 2 was rated as red (undeveloped). This related to the lack of data available regarding complaints made by those with protected characteristics.

It was further noted that the report would in future be produced on a calendar year basis so that it would be issued in February and not at the same time as the Annual Account.

The Committee confirmed that the grades for each outcome were fair and that the report should move on to the next stage prior to publication on the Trust website.

5.5 **Hospital @ Night**

Meetings had taken place with a view to engaging all and getting good representation (consultants, junior doctors, registrars, senior nurses and site managers) at the Hospital @ Night meetings which aimed to take forward the Hospital @ Night model. The last meeting had shown improved attendance.

The Hospital @ Night policy had been reviewed to harmonise across the sites and would be ratified in August 2016.

It was noted that learning from a Serious Incident was due to be incorporated into the Hospital @ Night policy. Sara Songhurst confirmed that she was working on the attendance and handover template and that an electronic solution would ensure that historical data was available and would allow learning to be captured.

The Committee noted the progress of the Hospital @ Night model of working.

5.6 **Integrated Performance Report**

The Committee noted the quality elements of the Integrated Performance Report with no comments.

6.1 **Deep Dive – Policies**

Ashley Parrott presented the Policies Deep Dive noting that all policies had been uploaded to the Trust database. A lot of work had been undertaken by Clinical Units and Directorates to review and update or archive documentation. There were a number of HR policies that needed review and policies for clinical areas needed ownership and dates for review.

The database had limitations and there were some documents needed to be withdrawn. A new member of staff would be looking at all the documents to separate policies (within control of the Trust) from guidelines (advisory).

Kim Novis advised that there was a legal requirement to have equality impact assessments on policies. It was important not to allow old policies to roll over without checking that equality impact assessments had been done. Assessments would need to be added to ensure that the Trust was fully compliant. The Trust Policy Group was checking this as documentation was presented for ratification.

6.2 It was agreed that the September Deep Dive would be Maternity/Midwifery.

7.0 There was no other business raised.

8.0 There were no comments on the Sub Committee minutes.

9.0 **Date of the Next Meeting**

21 September 2016, Committee Room, Conquest.