EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 13th April 2016, commencing at 09.30 am in the Lecture Theatre, Conquest

	AGENDA		**Lead:**	**Time:**
1.	a) Chair's opening remarks b) Apologies for absence c) Monthly award winner(s)		Chair	0930 – 1030
2.	Quality Walks	A	Chair	
3.	Declarations of interests		Chair	
4a.	Minutes of the Trust Board Meeting in public held on 10th February 2016	B	Chair	
4b.	Matters arising	C	Chair	
5.	Chief Executive's report (Verbal)		CEO	
6.	Board Assurance Framework	D	CSec	

QUALITY, SAFETY AND PERFORMANCE

					Time:
7.	Quality Improvement Plan	Assurance	E	CEO/DN	1030 - 1140
8.	Performance and Finance report Month 9 (December) 1. Performance 2. Finance 3. Workforce	Assurance	F	DN/MD COO HRD DF	
9.	Safe Nurse Staffing Levels report	Assurance	G	DN	
10.	Patient Experience Report	Assurance	H	DN	
11.	Mortality	Assurance	I	MD	

GOVERNANCE AND ASSURANCE

					Time:
12.	Delivering Same Sex Accommodation Annual Declaration of Compliance	Assurance	J	COO	1140 – 1205
13.	Board sub-committees: a) Audit Committee b) Finance and Investment Committee c) People & Organisational Development Committee	Assurance	K	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
14.	Use of Trust Seal	L	Chair	1205 - 1230
15.	Questions from members of the public (15 minutes maximum)		Chair	
16.	Date of Next Meeting: 0930, Wednesday, 8th June, St Mary's Boardroom, EDGH		Chair	
	To adopt the following motion: *That representatives of the press and other members of the public will be excluded from Part 2 of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest* *(Section1(2) Public Bodies (Admission to Meetings) Act 1960)*		Chair	

David Clayton-Smith

David Clayton-Smith
Chairman

14th March 2016

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

East Sussex Healthcare NHS Trust

Date of Meeting:	13th April 2016
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks January - February 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 January and February 2016.

Introduction:

Quality Walks are currently carried out by Board members and members of the Senior Management 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.

Themes for the walks are decided by the Board and the focus during January and February were:

- 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:

16 services/departments were visited as part of the Quality Walk programme during January and as detailed below

Date	Time	Service	Site	Visit by
7.1.16	1.30pm	Seaford 2 (Escalation Ward)	EDGH	Jackie Churchward-Cardiff
7.1.16	3pm	Hailsham 4 (Escalation Ward)	EDGH	Jackie Churchward-Cardiff
20.1.16	3pm	Ophthalmic Day Unit Dowling Unit	Bexhill	Barry Nealon
22.1.16	8.30am	Physiotherapy	EDGH	Monica Green
27.1.16	3pm	Jevington	EDGH	Barry Nealon
27.1.16	2.30pm	Pharmacy (PMU)	EDGH	Jackie Churchward-Cardiff

27.1.16	12pm	Folkington	EDGH	Mike Stevens
29.1.16	10.30am 11.30am	DeCham Pharmacy	Conquest	Miranda Kavanagh
3.2.16	2pm	MacDonald	Conquest	Andy Slater
4.2.16	2pm	Cuckmere	EDGH	David Hughes
8.2.16	2pm	Sovereign	EDGH	David Hughes
11.2.16	9.30am	Cardiology	Conquest	Monica Green
11.2.16		Pharmacy	EDGH	Jackie Churchward-Cardiff
26.2.16	1.30pm	Radiology	Conquest	Miranda Kavanagh

11 of these visits were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit. The further 5 were carried out as ad hoc visits so staff may or may not have been notified to expect them. (NB other ad hoc 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 11 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 January and February relating to the themes collated from the feedback forms

<u>How communication and engagement can be strengthened</u>

- A new approach to staff communications and engagement was being implemented by the physiotherapy team to ensure that all staff have briefings and are aware of what is happening within the department. They were also trialling the use of graffiti boards.
- More than one area reported that there was good communication with senior nursing staff
- On an escalation ward that was visited soon after opening, the reliance on temporary staffing and high use of agency was noted by medical staff and relatives in relation to inadequate communication and handover of care.

<u>Reporting, action and learning from incidents and risks</u>

- One area had concerns regarding the length of time it can sometimes take to transfer a patient to a specialist unit on a different site.

<u>Fundamental safety issues – cleanliness, drug security, records management</u>

- One area reported a challenge in having enough ‘low’ beds to manage the number of patients they had that were suffering from dementia.
- Storage of patient records was reported as challenging in several areas either due to lack of capacity or the absence of trolleys that were lockable
- Storage of drugs was noted to be well organised and secure.
- The VitalPac monitoring system was reported as being well embedded and it is felt that the next phase of its development would provide more significant benefits
- General cleaning scores in some areas were noted as low (70%) with the underlying cause often due to the fabric of the buildings
- On an escalation ward that was visited soon after it opened some relatives commented on the breakdown of care from shift to shift with staff being unfamiliar with patient needs or treatment plans.

- On another escalation ward relatives and a patient remarked that there was a breakdown in care on transfer to the ward, this comment was made in contrast to the excellent care they had received in the emergency department. It was noted that it was evident that Trust staff were working very hard to deliver care but lack of ward knowledge, familiarity with medical teams, and lack of staff all presented additional pressure and risk.

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 responsibility for who will be taking forward the actions is recorded.

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 any changes to the current themes of communication and engagement; learning from incidents and risks and fundamental safety issues.

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

A meeting of the Trust Board was held in public on Wednesday, 10th February 2016 at 10:00 am in the St Mary's Board Room, Eastbourne DGH

Present: Mr David Clayton-Smith, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Sue Bernhauser, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Ms Sally Herne, Improvement Director
Dr David Hughes, Medical Director
Mr David Meikle, Interim Director of Finance
Mr Richard Sunley, Acting Chief Executive
Mrs Alice Webster, Director of Nursing

In attendance:
Mrs Jackie Churchward-Cardiff, Non-Executive Director designate
Ms Monica Green, Director of Human Resources
Dr Andrew Slater, Director of Clinical Information & Strategy
Mrs Lynette Wells, Company Secretary
Ms Jan Humber, Joint Staff Side Chair
Mrs Liz Fellows, Assistant Director – Operations (for item 001/2016c)
Ms Penny Walker, Making Every Contact Count Project Lead (for item 001/2016c)
Mrs Ruth Agg, Speak Up Guardian (for item 009/2016)
Mr Pete Palmer, Assistant Company Secretary (minutes)

001/2016 **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 apologised for the fact that the meeting's location had been changed from Cooden at short notice, and explained that this was due to the Junior Doctors' Strike taking place on the same day.

He explained that he would welcome questions from members of the public on items included on the agenda prior to the meeting, in order for them to be answered during the course of the meeting. No questions were forthcoming.

Mr Sunley updated the Board on the day's Junior Doctors' strike and noted that the Trust had become more proficient at dealing with the strikes as they have continued. He explained that as a result of the day's strike 186 outpatient cases, 50 day cases and 15 inpatients had been cancelled, which was a huge improvement compared to previous strikes.

b) Apologies for Absence

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

Ms Miranda Kavanagh, Non-Executive Director
Mrs Pauline Butterworth, Acting Chief Operating Officer

Mr Clayton-Smith noted that Charles Ellis had tendered his resignation as a Non-Executive Director as of 31st January 2016, and thanked him for his contribution during his time at the Trust. He explained that Mrs Churchward-Cardiff would be changing her role from Non-Executive Director designate to become a full Non-Executive Director as a result.

c) Making Every Contact Count

Mrs Fellows explained that Making Every Contact Count (MECC) had been a very positive project for ESHT and had been undertaken in conjunction with external stakeholders. She said that the aim of MECC was to create a healthier population, and that it provided training for staff in directing the public to lead healthier lifestyles.

Ms Walker explained that MECC was fully supported and funded by Hastings and Rother CCG, working in conjunction with other stakeholders. She noted that ESHT were one of very few healthcare providers who had undertaken this project within Kent, Surrey and Sussex. She explained that any member of staff would be welcome to attend training in how to speak to patients about changing their approach to health by using open questions.

Mr Stevens asked how MECC was reaching members of the public who did not attend hospital, and Ms Walker explained that the project was being carried out throughout the community by GPs and community nurses in order to try and engage with as many people as possible. She noted that in the long term the aim of MECC was to improve the health of the local population and thereby reduce the number of hospital admissions, as well as to increase life expectancy of the local population.

The Board thanked Mrs Fellows and Ms Walker for their presentation.

d) Feedback from Quality Walks

Mrs Churchward-Cardiff reported that she had undertaken four quality walks since joining the Trust and had found them to be a pleasure. She praised the staff for the way in which they undertook contact with their patients. She noted that when she had spoken to patients about their experiences they had raised concerns about lack of communication and about low staffing levels. She reported that in all the areas she had visited patients had praised the staff that looked after them, and that in the Stroke Unit she had received universally positive feedback about

staff.

Mrs Churchward-Cardiff expressed her concerns that while staff had many good ideas about improving services, they were not able to implement these.

Mr Nealon reported on his visit to the Ophthalmology Department at Bexhill Hospital. He explained that through funding from the Friends of Bexhill Hospital, the department had moved from the Conquest Hospital to Bexhill.

He reported that the move to Bexhill had been highly effective, and that the flow of patients through the unit was very streamlined. He explained that staff morale was very high and that the workforce was very stable. He noted that there had been a never event, when an incorrect lens was used in a procedure, but that much had been learnt from the incident and that processes had been introduced to ensure that the risk of recurrence was greatly reduced.

Mr Nealon reported that he had also visited Jevington Ward at EDGH, which dealt with patients with respiratory problems. He explained that patients on the ward required support on a 24 hour a day basis. He said that he had found Matron Noon to be wonderful, and that while concerns had been raised about staffing levels on the ward plans to recruitment new staff were in place.

Mrs Webster said that she had received feedback from staff about how much they had appreciated the Quality Walks, and thanked Mrs Churchward-Cardiff and Mr Nealon.

The Board noted the report on quality walks.

002/2016 **Monthly Award Winners**

Mr Clayton-Smith reported that the Monthly Award Winner for December had been Bryony Campion, for her work in developing a service for patients with Irritable Bowel Syndrome across East Sussex.

He then presented the Monthly Award for January to Ian Phillips, Ricky Ornelas, Peter Paine, Dave Gosden and Colin Goddard for the work they had done during December's external power interruption at Eastbourne.

003/2016 **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. He reported that whilst he had not formally competed a disclosure of interests to the Trust that he had no conflicts of interest to declare.

004/2016 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 2nd December 2015 were considered. Three revisions were noted and agreed as an accurate account of the discussions held.

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

b) Matters Arising

102/2015 - Report required on proposed transfer of Crowborough Maternity Unit to Maidstone and Tunbridge Wells
This item is to be discussed as item 14 on the agenda.

106/2015 – Forecast Outturn to be included in finance paper
This item is to be discussed as item 10 on the agenda.

109/2015 - Deep dive review on mortality to be included in Board seminar programme.
Dr Hughes reported that this had been added to the agenda for the Board Seminar on 16th March 2016.

110/2015 - End of Life Care – written report required for Feb meeting
This item is to be discussed as item 10 on the agenda.

113/2015 – Health Records
It was noted that a full report on Health Records would be brought before the Board in April 2016.

005/2016 **Acting Chief Executive's Report (verbal)**

Mr Sunley said that he wished to place on record his thanks for all the hard work that staff within the Trust had done during the periods of winter pressure.

Mr Stevens said that he felt that the Chief Executive's report should be presented to the Board in writing, rather than as a verbal report. Mr Clayton-Smith said that he broadly agreed with Mr Stevens' proposal and would discuss it with Mr Sunley.

006/2016 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework (BAF) had been considered at the Quality and Standards and Audit Committees and that the changes noted were self-explanatory. She highlighted that three areas within the Board Assurance Framework (BAF) were rated red – health records, the reconfiguration of the A&E departments on both

sites, pending a capital bid to the TDA and assurance in respect of financial controls.

She reported that provision of the Trust's patient transport had been put out to tender and that a new provider would be taking over the service from 10th April 2016.

Mr Stevens highlighted that the number, and quality, of clinical audits being carried out within the Trust had been discussed at the Audit Committee meeting on 20th January 2016, and that Dr Hughes had taken the lead in resolving these issues. Dr Hughes noted that he had met with Clinical Unit leads in order to discuss the situation.

Mr Clayton-Smith said that he felt that it was important that the organisation continued to make improvements in quality governance, and that these improvements were implemented in a connected fashion.

Mr Sunley reported that Capsticks had undertaken a review of the Trust's governance processes, and would guide the Trust in ensuring that improvement plans were appropriate.

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

007/2016 **Quality Improvement Plan**

Mrs Webster presented a highlight report outlining progress since the last meeting. She reported that Prederi were no longer working with the Trust on the Quality Improvement Plan (QIP) and that QIP work was now being undertaken by the Trust's Project Management Office.

Mrs Webster said that an Assurance Day had been organised on 1st March 2016 in order for a review of the progress the Trust was making against CQC warning notices to take place, and to ensure that changes that had been implemented were embedded within the organisation.

She noted that a CQC warning notice remained in place around consultant staffing levels within the A&E departments, and that the Trust had met with the CQC in order to discuss the fact that they were unable to comply with the notice. She explained that the CQC were satisfied with the plans the Trust had put in place. Dr Hughes reported that a review of the A&E departments would be undertaken by the Royal College of Emergency Medicine in order to provide help in resolving the issues being faced by the Trust.

Mr Clayton-Smith asked about actions the Trust were taking in order to attract A&E consultants during the current national shortage of A&E

doctors. Ms Green replied that current staffing levels made existing A&E doctors' rotas unattractive, and that work was being undertaken to look at the way in which the A&E departments were set up and at the way in which they delivered services. Dr Hughes noted that a safe solution to the national shortage of doctors was being sought in order to make the Trust a more attractive proposition for A&E doctors.

008/2016 **Quality Improvement Director's Report (verbal)**

Ms Herne explained that she had taken over the role of Improvement Director for ESHT from Maggie Oldham in December 2015 and that since starting in the Trust she had been made to feel very welcome. She explained that she had been undertaking meetings with staff and external groups and that she had found them to be very honest about the Trust's situation.

Ms Herne reported that additional funding to help with quality improvements within the Trust had been approved by the Trust Development Authority. She said that positive feedback had been received from the Trust's stakeholders during a meeting the previous day and that further work would need to be undertaken on improving assurance and engagement throughout the organisation.

Mr Clayton-Smith said that the Trust was focussing on providing safe, high quality care immediately, whilst also ensuring that coherent long terms plans were developed. Ms Herne noted that work was being undertaken to improve governance within the organisation, to develop improved capacity and that the CCG had been very supportive in helping the Trust in developing an improvement culture.

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

009/2016 **Speak Up Guardian's Report (verbal)**

Ms Agg explained that she had begun her new role as the Trust's Speak Up Guardian in December 2015 following 20 years of working for the Trust. She said that the Speak Up Guardian's position was introduced nationally following the Francis Report, and that a national Speak Up Guardian had recently been appointed by the CQC. She reported that her position and role had been widely advertised to staff throughout the Trust and that staff could contact her in order to raise any concerns that they may wish to raise.

Ms Agg reported that she had undertaken visits to clinical areas where she had been warmly welcomed by staff. She explained that concerns had been made known to her by staff, and that some of these had already been resolved. Ms Agg noted that she held weekly meetings with the Chief Executive, and that feedback was provided to staff about their concerns using 'You Said, We Did'.

Ms Green explained that the role of Speak Up Guardian was vital in giving staff a different channel through which to raise their concerns. She noted that the role was intentionally positioned slightly outside the management structure of the Trust to ensure that it remained independent, but that Ms Agg also had access to HR and Staff Side support if she considered this appropriate.

Mrs Churchward-Cardiff said that she hoped the Ms Agg would be able to help to identify existing organisational blocks and concerns in order for them to be resolved.

The Board noted the Speak Up Guardian's verbal report.

010/2016 **Integrated Performance Reports – December 2015 (Month 9)**

i) Patient Safety & Clinical Effectiveness

Mrs Webster reported that four never events had been reported during November and December and that investigations into these would be discussed with the TDA. She explained that the Trust had maintained its focus on Serious Incidents and had seen an increase in the clinical reporting of incidents as a result.

Mrs Webster reported that 38 incidents of clostridium difficile had been reported during the period and that an external inspection of infection control processes had been commissioned for the Conquest Hospital. She said that the level of reporting of falls within the Trust had increased, but that the level of major/catastrophic incidents reported had been reduced.

Dr Hughes reported that the Trust had asked the TDA for help with resolving the issues faced in improving mortality, and that the TDA would be making a presentation on mortality to the Clinical Units and the Board at March's Board Seminar.

Mr Nealon asked whether the mortality data indicated a need to investigate whether the issues were clinical in nature. Dr Hughes replied that the Trust had already made changes to their clinical processes following review. He explained that the Trust now planned to work alongside CHKS and the TDA in order to identify areas for continuing improvement.

Ms Herne explained that she felt that the way mortality data was currently presented to the Board raised more questions than it answered. Mr Clayton-Smith agreed that getting this data correct was of vital importance.

ii) Access, Responsiveness & Community

Mr Sunley reported that A&E performance was at 89.4% for the year to date and that pressures felt during the busy winter period had

contributed to these figures. He explained that issues with discharging medically fit patients from hospital meant that the Trust had opened 51 extra beds and that this increase in capacity was the reason for the A&E performance issues. He reported that work was being undertaken with the Trust's partners in order to try to reduce the number of patients attending A&E, but that this had not yet proved to be effective.

Mr Sunley reported that Referral to Treatment (RTT) performance had improved during January and that the issues faced by the Trust in booking radiology patients had been resolved due to the introduction of a new booking system. He explained that problems still existed in meeting 2 week cancer wait targets, but the Trust had shown an improvement in meeting this target since December. Mr Sunley reported that GPs were now explaining to patients with cancer the importance of attending their first hospital appointment within two weeks, but that issues still existed in ensuring that patients were seen within this time frame.

Mr Nealon asked why patients who voluntarily did not attend appointments within two weeks were counted against the Trust's RTT figures, and Mr Sunley explained that this was the case for all Trusts. Mrs Webster noted that occasionally patients were not aware of how urgent their appointment was, and that patients who cancelled appointments within this two week period were now called to ensure that they understood the importance of attending.

iii) Workforce

Ms Green reported that the use of temporary workforce had reduced in December, and that vacancies across the Trust had increased slightly due to an increase in establishment. She said that sickness rates had reduced for a seventh consecutive month and that appraisal and mandatory training rates had increased.

Mrs Churchward-Cardiff asked why the Trust had used 160 wte nurses more than their establishment, and Ms Green explained that this was due to increased bed usage due to operational pressures. She explained that a review of the nursing establishment would be undertaken for 2016/17.

iv) Finance

Mr Meikle reported that the Trust's deficit in December had been £4.9million against a planned deficit of £3.3million. He said that the Trust's annual deficit was projected as being £48.7million, with £26million of this being due to increased agency costs. He explained that a control group had been established, and that tight controls had been implemented, in order to review and authorise all agency spending within the Trust.

Mr Clayton-Smith asked whether the Trust was operating efficiently and Mr Meikle replied that a recent piece of work undertaken by Price

Waterhouse Cooper had identified the Trust as having a structural deficit of between £23-24million. He explained that the Lord Carter review had identified that potentially £35million could be saved if the Trust was operating with optimum efficiency, and that while he felt that not all of the recommendations made could be achieved, it was clear that there was the potential for improved efficiency within the Trust.

Mr Nealon said that he felt it was correct that the Trust considered patient safety to be more important than saving money. He noted that improving the Trust's IT infrastructure would be key in reducing inefficiencies within the organisation.

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

011/2016 **Safe Nurse & Midwifery Staffing Levels**

Mrs Webster presented the report for September-November 2015. She explained that from April 2016 the Trust should have no further need to employ agency HCAs as a full establishment of HCAs would be employed by the Trust. She reported that aims for 2016 were to embed the Enhanced Recovery Program for Surgery (ERAS) throughout the Trust, to improve Healthroster productivity throughout the organisation and to improve the amount supervisory time available for matrons. She also reported that that there would be cost implications if proposals for 7 day administrative support for nursing areas were implemented.

Mrs Webster also presented the Trust's proposed nursing establishment for 2016/17 and asked the Board for their approval. She explained that the proposed establishment was a baseline figure, and did not include increased staffing to cover escalation or specials. Mr Stevens asked whether the Trust was being ambitious enough in its proposed establishment and Mrs Webster replied that it was important to strike the correct balance to ensure that the Trust had the right people in the right place at the right time whilst avoiding over-recruitment.

The Board noted the Safe Nurse & Midwifery Staffing Levels report, and approved the Nursing Establishment for 2016/17.

012/2016 **Patient Experience Report Quarter 3 (October-December 2015)**

Mrs Webster presented the report and explained that a considerable amount of work had been undertaken to improve the Trust's responses to complaints. She explained that Healthwatch had undertaken a review of the Trust's complaints processes. Mrs Webster reported that while responses to Friends and Family Tests were good, the number of patients completing this survey remained low.

Mrs Churchward-Cardiff said that there were some instances were very

similar complaints had occurred in the same areas, and asked what was being done to prevent these recurrences. Mrs Webster replied that the report did not provide the full context of the complaints, and that the recurrences had occurred regarding cancelled appointments due to the organisation being in 'black' status. Mrs Churchward-Cardiff asked if more detailed information could be included in future reports, and Mrs Webster agreed to explore whether this was possible. **AW**

The Board noted the Patient Experience Report Quarter 3

013/2016 **End of Life Care**

Dr Hughes presented an update on End of life Care (EOLC) within the Trust, and asked for the Board's approval on an updated EOLC strategy.

Dr Hughes explained that the CQC had rated the Trust's EOLC strategy as 'Needs Improvement' and that as a result it had been updated. He noted that the Chair of the EOLC group had stepped down and that he hoped to appointed a successor soon. He reported that he hoped the revised strategy would address existing issues with data quality, monitoring, rapid discharge planning and patient experience, and that further improvements would be garnered from the Trust's ongoing EOLC education programme for staff which had now trained 40% of the Trust's staff.

Mr Stevens noted that a report on EOLC from 2015 had shown that 80% of patients undergoing EOLC wished to die in their own home, and that he couldn't see this reflected within the proposed strategy. Mrs Churchward-Cardiff explained that it would be useful for the strategy to clearly set out what EOLC standard the Trust hoped to achieve. Mrs Webster asked that timelines for achievement be included within the strategy.

Dr Hughes agreed to rewrite the EOLC strategy in light of the Board's recommendations. **DH**

The Board did not approve the updated EOLC strategy, and asked for it to be revised and presented for approval at a future Board meeting.

STRATEGY

014/2016 **High Weald Maternity Pathway**

Mr Sunley presented a proposal for the transfer of Crowborough Birthing Centre and community midwifery services within the High Weald to Maidstone and Tunbridge Wells NHS Trust. He noted that the proposal had been discussed at a recent Board Meeting in private, and was support by staff, patients and CCGs.

The Board approved the transfer of Crowborough Birthing Centre and community midwifery services within the High Weald to Maidstone and Tunbridge Wells NHS Trust

015/2016 **Business and Financial Planning 2016/17**

Mr Meikle explained that final submission of the Trust's Business and Financial Planning had to be undertaken on 11th April. He noted that the Trust Board was not scheduled to meet until 13th April and asked for permission to sign off the Trust's Business and Financial Plan for 2016/17 to be delegated to the Finance & Investment Committee, who would meet on 30th March.

Mr Clayton-Smith asked whether assumptions that had been made within the strategy had been shared with stakeholders, and Mr Meikle confirmed that the strategy had been shared with the CCG, the TDA and NHS England.

The Board approved delegation of authority to the Finance & Investment Committee to sign off the Trust's Business and Financial Plan for 2016/17.

GOVERNANCE AND ASSURANCE

016/2016 **Emergency Preparedness**

The Trust's public statement on preparedness for a major incident was presented to the Board for approval.

The Board approved the statement of preparedness for publication on the Trust's website.

017/2016 **Board Sub-Committee Reports**

a) Audit Committee

The Board noted the report.

b) Finance and Investment

Mr Nealon reported that the Trust had recently won the integrated sexual health and HIV tender and explained that this had been a very positive experience for the Trust, and that a lot of learning had been gained during the process.

The Board noted the report.

c) Quality and Standards

The Board noted the report.

d) Remuneration Committee

The Board noted the report.

e) People and Organisational Development Committee

Ms Green explained that the People and Organisational Development (POD) Committee was being introduced in order to provide oversight on the Trust's workforce and to lead on any workforce issues that may arise.

The Board approved the Terms of Reference for the People and Organisational Committee

ITEMS FOR INFORMATION

018/2016 **Use of Trust Seal**

The Board noted the use of the Trust Seal on 26th January 2016 on the transfer of Unit 5/6 Apex Way lease from NHS property services to ESHT

019/2016 **Questions from Members of the Public**

a) New Chief Executive

Mr Lindsey, a reporter from the Eastbourne Independent, asked whether any update was available on the appointment of a new Chief Executive. Mr Clayton-Smith replied that the job had been offered to a candidate, but that he was unable to name them as the process had not been completed.

b) Health Records

Mr Lindsey said that he felt that it was extraordinary that the previous Improvement Director had left the Trust at short notice. Ms Herne explained that Mrs Oldham had felt that she was unable to be responsive enough to the needs of the Trust, due to the distance she had to travel from her home. She noted that a comprehensive handover had taken place between herself and Mrs Oldham.

c) Bexhill Ophthalmology

Mrs Walke reported that she had received feedback from patients about difficulties in travelling to Bexhill to access Ophthalmology services. Mr Sunley explained that an Equality Impact assessment had been undertaken before the service had been reconfigured, but recognised the importance of being aware of the issues being faced by patients.

d) A&E Temporary Staffing

Mrs Walke asked what measures were being taken to alleviate the issues being faced with staffing in the A&E departments. Mr Sunley explained that the Trust was actively trying to recruit staff, but that there was a national shortage of A&E staff which had led to a high usage of agency staff within the department.

e) Staff Overtime

Mrs Walke asked why staff were being paid overtime rates that were lower than their regular pay. Mrs Webster replied that NHS overtime rates were subject to national terms and conditions, but that the Trust had increased the rate of pay for staff working on the Trust Bank.

f) Incident Reporting

Mrs Walke asked whether the increase in incidents being reported indicated that there was an increase in incidents within the Trust. Mrs Webster replied that staff were encouraged to report every incident, and that learning could only occur if incidents were reported. She explained that while the number of incidents reported had risen, the number of incidents of severity 4 and 5 had not increased.

g) Maternity Pathway

Mrs Walke asked whether the transfer of maternity services would decrease the number of babies born within the Trust. Mr Sunley explained that there were between120-150 births each year at Crowborough Birthing Centre. He said that the public had been consulted on the proposal to transfer services and had indicated that they supported the transfer.

h) EDGH Outpatient Department

Mr Campbell noted that screens were used in order to provide separate areas within the outpatient department at EDGH and asked who would be responsible for moving these if the department needed to be evacuated. Mr Sunley replied that the screens were on wheels, and could quickly be moved by outpatient staff in order to facilitate an evacuation from the area. He noted that the department's matron was fully aware of the evacuation procedure.

i) Trust Processes and Quality

In response to a query from Mr Campbell, Mrs Webster said that the Trust's governance processes incorporated process ownership diagrams.

Mr Campbell asked if staff could be offered a proportion of any Cost Improvement Savings that they were responsible for as an incentive for encouraging efficiency within the Trust. Mr Sunley replied that the idea had been recently discussed to assess whether it was feasible. He noted that the process had been attempted in the past.

020/2016 **Date of Next Meeting**

Wednesday, 13th April 2016, at 0930 in the Lecture Theatre, Education Centre, Conquest Hospital.

021/2016 **Closed Session Resolution**

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

Signed …….

Position ……..

Date …….

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 10th February 2016 Trust Board Meeting

Agenda item	Action	Lead	Progress
012/2016	Greater detail to be provided to Board about complaints to Trust	Director of Nursing	On Agenda
013/2016	Revised End of Life Care Strategy to be presented to Board	Medical Director	Scheduled for June 2016

East Sussex Healthcare NHS Trust

Date of Meeting:	13th April 2016
Meeting:	Trust Board
Agenda item:	4b i
Subject:	End of Life Care
Reporting Officer:	Dr David Hughes, Medical Director and Executive Lead for End of Life Care

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

Purpose:

This report aims to update on the progress of actions developed from the CQC recommendations and observations. It also reports on the National Audit for End of Life Care; Dying in Hospital, that was published on the 31st March 2016 by the Royal College of Physicians.

Introduction:

In addition to the recommendations from the CQC reports on End of Life Care there are also a number of national publications and initiatives that need to feed into the Trust End of Life Care Action Plan. The recent dates of these publications show the national emphasis that remains on ensuring that End of Life Care is delivered well. These main publications are:

Transforming end of life care in acute hospitals: The route to success 'how to' guide (Revised: NHS England 2015).
Building on the Best (Macmillan Cancer Support, the National Council for Palliative Care, NHS England and the Trust Development Authority 2015)***.***
Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020 (National Palliative and End of Life Care Partnership 2015).
NHS Five Year Forward View (NHS England 2014).
One Chance to Get it Right (Leadership Alliance for the Care of the Dying Person 2014)
NICE guidance NG31: Care of adults in the last days of life (NICE 2015).
House of Commons Health Committee, End of Life Care, Fifth Report of Session (2015)
Dying Without Dignity (Parliamentary and Health Service Ombudsman 2015)

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

Progress on the Trust action plan for End of Life Care will now be monitored weekly through the Quality Improvement Group.

Staff shortages through sickness and establishment vacancies in both the Specialist Palliative Care and End of Life Care teams within the last quarter have slightly delayed the progress of service development in order to maintain service delivery.

The National End of Life Care Audit demonstrates areas that require improvement as well as where ESHT are performing above the audit average.

Benefits:

The benefits of good end of life care are vast but some examples include:

- Recognition that people are at the end of life stage (death may occur within 12 months) and also the recognition that people have entered the last days/hours of life.
- People dying in their preferred place of death which is normally their usual place of residence.
- Emotional well-being for family members and carers through holistic assessment of their needs, adequate support and effective communication.

- Symptom management, comfort and well-being for the patient.
- Assessment and care planning co-ordinated by a senior clinician.
- Excellence in care after death.
- Reduction in unnecessary admission to acute hospitals.

Risks and Implications:
The End of Life Care Team and the Specialist Palliative Care Team have been waiting for staff to come into post which has caused some delays in progressing with developments for End of Life Care. There are now two End of Life Care Facilitators in post and the Specialist Palliative Care Nurses have now been recruited to (although some are still in train). Monthly meetings are now being arranged so that actions can continue at pace.

Assurance Provided:
Care has not been compromised despite shortages in the Specialist Palliative Care Team due to sickness and establishment vacancies as the End of Life Care Team have been supporting the ward staff and monitoring the care of patients in the last days and hours of life. There is now senior nurse corporate leadership allocated to assist in the co-ordination, facilitation and implementation of the Trust End of Life Care Action Plan. Progress against the Trust Quality Improvement Plan regarding End of Life Care will now be reported on weekly through the Quality Improvement Group. A Planning Together policy has now been developed to support shared decision making between the clinician, the patient and those most important to them.

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)**:**	
Specialist Medicine Clinical Unit Clinical Governance Meetings. Trust Nursing, Midwifery and Allied Healthcare Group (TNMAG) Medicines Management Committee (for medicine related issues) Senior Leadership Forum (as required) Trust Board	

Proposals and/or Recommendations
• That monthly End of Life Care Team meetings occur to ensure that service developments and implementation of the Trust End of Life Care Action Plan continue at pace whilst continuing to support the Specialist Palliative Care Team until they are fully established. • That the recommendations from the National End of Life Care Audit – Dying in Hospital are incorporated into the Trust End of Life Care Action Plan.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
None. High quality end of life care is available for all ESHT patients.

For further information or for any enquiries relating to this report please contact:	
Name	**Contact details:**
Angela Colosi, Assistant Director of Nursing (East)	angelacolosi@nhs.net, 07900223215/01424 755255 Ex 8102.

ESHT End of Life Care Quarter 4 Report 2016

Introduction
This report aims to provide an update on the progress of actions developed from the CQC recommendations and observations. It also reports on the National Audit for End of Life Care; Dying in Hospital, that was published on the 31st March 2016 by the Royal College of Physicians.

Following on from ESHT's commitment to the NHS Improving Quality work stream; ***Transforming End of Life Care in Acute Hospitals,*** Macmillan Cancer Support, the National Council for Palliative Care, NHS England and the Trust Development Authority have come together to form an improvement programme called ***Building on the Best.*** The programme recognises the 5 key enablers (Advance Care Planning, AMBER care bundle for patients whose recovery is uncertain, Electronic Palliative Care Co-ordination Systems (EPaCCs), Rapid Discharge and Priorities for Care in the last days of life). It has also identified 4 key priority areas which were felt to have the potential and biggest impact for quality improvement. They are:

- Outpatient Departments (large footfall and opportunities for Advance Care Planning).
- Improving pain and symptom management.
- Enabling shared decision making between the patient, family and clinician.
- Improving handover from acute to primary/community care.

Other national drivers for change include engagement with ***Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020*** (National Palliative and End of Life Care Partnership 2015). The approach taken in the Ambitions Framework is aligned to the ***NHS Five Year Forward View*** and recognises that the emphasis in today's health and social care system is on local decision-making and delivery. The Ambitions Framework sets out six ambitions to bring about that overarching vision:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Comfort and wellbeing is maximised
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help.

Following the publication of the Leadership Alliance for the Care of Dying People report ***One Chance to Get it Right***, ESHT have adopted the new approach set out by the Alliance which focuses on achieving the five 'priorities of care'. These make the dying person themselves the focus of care in the last few days and hours of life and exemplify the high-level outcomes that must be delivered for every dying person. The priorities for the care of the dying person are adopted when it is thought that a person may die within the next few days or hours. The priorities are:

1. That this possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes and these are regularly reviewed and decisions revised accordingly.
2. That sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. That the dying person and those identified as important to them are involved in decisions about treatment and care to the extent that the dying person wants.
4. That the needs of families and others identified as important to the dying person are

actively explored, respected and met as far as possible.
5. That an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

Details of these principles and how to apply them are communicated to the staff through training and the availability of purple End of Life Care resource boxes which can be found in all clinical areas.

Quality Improvement Plan for End of Life Care
Work has continued on the action plan that was formulated from the recommendations and issues raised by the CQC report (2014). Details on progress can be found within the Trust's End of Life Care action plan.

Additionally, there has been progress in areas of development that have been identified and implemented by the End of Life Care Team. They include:

- The sourcing of charitable funds for carers' "Comfort Packs" and the upgrading of relatives rooms on both sites.
- A review of McKinley Syringe Driver use, incorporating an audit of usage on wards and the number of drivers, a new syringe driver policy and a review of relevant charts and an increased emphasis on essential syringe driver training (compliance now at 79.24% for acute wards).
- An audit of the End of Life Care resource boxes to ensure that all information was present and that staff knew how to utilise this information.
- Development of an End of Life Care ESHT Strategy by the Clinical Advisory Lead for End of Life Care.

Incidents for Q4
There were 35 incidents relating to End of Life Care identified for quarter 4. Themes included:

- Pressure ulcers acquired outside of ESHT services but identified by ESHT staff (these accounted for the majority of incidents and are reported through the pressure ulcer prevention work stream).
- Inappropriate pathways (x 2).
- Transport delay (x 1).
- Delay in access to medication (x 2).
- Poor documentation of care plan.
- Poor referral to District Nursing service by GP service, acute care setting and community hospital (x 3).
- Slow response to verify death at home by other agencies.
- Unavailability of syringe driver in the community (x 2, obtained from central EDGH store).
- Faulty syringe driver, patient's symptoms remained controlled.
- Safeguarding alert raised (x 2, against relative and against care home).

No trends will be identified until more data points have been collected. In immediate response to these incidents, 20 additional syringe drivers have been ordered. Each incident will be investigated individually as the majority involve other agencies. Any learning that comes out of these investigations will be fed back across the Clinical Units and, where appropriate, to the multiagency End of Life Care Clinical Reference Group (next meeting to be held on 14th April 2016).

Complaints for Q4
Four complaints about End of Life Care were received during Q4 which did not indicate any particular themes. These are currently being managed through the Trust's complaints system.

Risks and Implications
The End of Life Team and Specialist Palliative Care Team have been waiting for staff to come into post which has caused some delay in progress. There are now two End of Life Care Facilitators in post and the Specialist Palliative Care Nurses have now been recruited to (although some are still in train). The End of Life Care Team have been instrumental in supporting the clinical staff in service delivery and so some of the action plan developments have been delayed. Monthly meetings are now being arranged so that actions can continue at pace.

National End of Life Care Audit - Dying in Hospital – ESHT Report

(Royal College of Physicians March 2016)

ESHT participated in both National End of Life Care Audits undertaken in 2013 and 2015. This latest report was published on the 31st March 2016 and was the second biennial national audit of care of the dying in hospitals in England. The first audit report, published in 2014, included data collected during 2013 from three lines of enquiry – an organisational audit of services, a case note clinical audit and a retrospective survey of bereaved carers.

The changes since 2013 included the phasing out of the Liverpool Care Pathway. This was recommended by the 2013 Neuberger review in its report *More care, less pathway*. The Leadership Alliance had also published its report *One chance to get it right*. Further influential documents that have emerged include the Parliamentary and Health Service Ombudsman's report *Dying without dignity* and the Ambitions Framework. Finally, the National Institute for Health and Care Excellence (NICE) published its guidelines on *Care of the dying adult* in December 2015.

Methodology

Organisational Element
Data was collected by ESHT medical colleagues during May 2015. The organisational element sought trust-level information from participating trusts to gain an understanding of the size, scope and environment in which care was provided, as well as structural provisions in terms of policies and procedures for the care of dying patients and those people who are important to them. This information enabled the assessment of Trust performance against key national standards and contextualised the findings from the clinical case note review.

Clinical Case Note Review Element
The case note review entailed a consecutive, anonymised clinical case note audit of all adult (i.e. aged 18 years or older) deaths occurring between 1st and 31st May 2015, where each patient had been under the care of the Trust for a minimum of 4 hours, capped at 80 deaths.

National Progress Since Last Report
There was significant concern in some sections of the palliative care community that the gap left after the Liverpool Care Pathway's withdrawal could result in a degradation of services to people in the last days and hours of life. This report demonstrates that, far from a deterioration, comparing the 2013 and 2015 audits, there have been broad improvements in nearly all aspects of care of the dying in hospitals within those trusts who participated.

ESHT Results (Appendix A)

What We Do Well (against the audit average)

- The patient was given an opportunity to have their concerns listened to *(95% against an audit average of 84%).*
- Documented evidence that in the last 24 hours of life there was a holistic assessment of the patient's needs regarding an individual plan of care *(91% against an audit average of 66%).*
- We had 1 or more End of Life Care Facilitators as of 1st May 2015 *(audit average 59%)*

What we need to improve on (against the audit average)

- The needs of the person(s) important to the patient were asked about (carers' views) *(36% against an audit average of 56%).*
- There is not a lay member on the Trust board with a responsibility/role for End of Life Care *(audit average 49%)*.
- Formal in-house training did not include/cover communication skills training for care in the last hours or days of life for medical staff, nursing staff (registered and non-registered and allied health professionals *(audit average 65%).*
- There is not access to specialist palliative care for at least 9-5 Monday-Sunday *(audit average 37%).*
- Documented evidence that a discussion regarding Cardiopulmonary Resuscitation (CPR) was undertaken by a senior doctor with the patient that was relevant to the last episode of care *(36% against an audit average of 38%).*

Organisational Developments identified in the Audit

- Locally developed programmes: Yes
- Priorities of care for the dying patient: Yes
- Advance care planning process: No
- The Rapid Discharge Home to Die Care Pathway: Yes
- SBAR tool: Yes
- Schwartz rounds: Yes
- EPaCCS: No
- AMBER: No
- Gold standard Framework: No

National Audit Key Recommendations

Clinical case note review element recommendations

- Recognition of the possibility that a patient may die should be communicated to the patient, people important to the patient and staff and documented in the case notes as early as possible. The recognition of dying should be reviewed by a senior doctor or nurse.
- When the possibility of dying is not discussed with the patient or the nominated person important to them, the reasons for this should always be documented in the case notes.
- All professionals, especially those working with people living with chronic conditions, multiple comorbidities, and in particular people for whom future loss of mental capacity is anticipated (e.g. people with dementia), should initiate and encourage advance care planning.
- Assessment of holistic needs of patients, leading to an individualised care plan, should be undertaken more frequently and uniformly once it is recognised that the patient is dying. These assessments should cover:

1. all the commonly experienced symptoms seen in dying patients
2. the possible need for Clinically Assisted Hydration (CAH)
3. the dying patient's ability and desire to eat
4. the possible need for Clinically Assisted Nutrition

- Medication prescribed for the dying patient in the last 24 hours of life should be reviewed; this review should record the degree of symptom control for each of the five key symptoms.
- There needs to be better documentation of justification for Nil by Mouth (NBM) orders and improved communication of them to patients (if they are conscious) and to those important to them. NBM orders should only be made by a senior doctor, nurse or SALT specialist.
- For patients who are unconscious or lack capacity, there should be better documentation of attempts to contact and discuss hydration and/or nutrition needs with those important to them, especially those nominated to have responsibility for decisions.
- The documentation should be improved regarding the:

1. Discussions undertaken about the dying patient's spiritual/cultural/religious/practical needs
2. Identification of the needs of the dying patient and those important to them
3. Identification of patients' concerns, and those of the people important to them
4. Recording who was present at the time of the patients death
5. Care undertaken of the patient immediately before and after death (especially if there were special religious/cultural requirements)

Organisational element recommendations

- Where trusts are not already using Electronic Palliative Care Co-ordination Systems (EPaCCS) or an equivalent system for record sharing, they should take steps to do so.
- All trusts should have access to specialist palliative care services 9am to 5pm, 7 days a week.
- All medical and nursing staff with responsibility for the care of dying people should attend communication skills training specifically on care in the last days/hours of life. Health and social care professionals should receive training or information about advance care planning (e.g. www.e-lfh.org.uk/programmes/end-of-life-care).
- There should be at least one lay member with specific responsibility for end of life care on every NHS trust board.
- Trusts should provide protocols to ensure provision of patient comfort, dignity and privacy – up to, including and after the death of the patient.
- All trusts should seek bereaved relatives' views, and results should be fed back to the trust's board as well as the public.
- Trusts should perform audits of end of life care and the results should be fed back to their boards.

	CLINICAL AUDIT							ORGANISATIONAL AUDIT						
	INDICATOR	1	2	3	4	5	6	7	8A	8B	8C	8D	9	10
	Cases in clinical audit	Is there documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days**? %YES**	Is there documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient? **%YES**	Is there documented evidence that the patient was given an opportunity to have Concerns listened to? **%YES or NO BUT**	Is there documented evidence that the needs of the person(s) important to the patient were asked about? **%YES or NO BUT**	Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care? **%YES**	Is there a lay member on the Trust board with a responsibility/role for End of Life Care?	Did your Trust seek bereaved relatives' or friends' views during the last two financial years (i.e. from 1st April 2013 to 31st March 2015)?	Between 1st April 2014 and 31st March 2015 did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for **Medical staff**	Between 1st April 2014 and 31st March 2015 did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for **Nursing (registered) staff**	Between 1st April 2014 and 31st March 2015 did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for **Nursing non-registered) staff**	Between 1st April 2014 and 31st March 2015 did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for **Allied Health professional staff**	Access to **face to face** specialist palliative care for at least 9-5 Mon-Sun	Does your trust have 1 or more End of Life Care Facilitators as of 1st May 2015?
NATIONAL RESULT (% of cases for clinical audit, % of sites for organisational audit)	9302	**83%**	**79%**	**84%**	**56%**	**66%**	49%	80%	**63%**	**71%**	**62%**	**49%**	37%	**59%**
East Sussex Healthcare NHS Trust	81	79	**77**	**95**	**36**	**91**	No	Yes	**No**	**No**	**No**	**No**	No	**Yes**

Appendix A:

National End of Life Care Audit - Dying in Hospital (Royal College of Physicians March 2016)

End of Life Care Action Plan from CQC Recommendations and Observations 2015/2016

V1 AC Nov 2015 V2 Jan 2016 V3 March 2016

DRAFT

Recent updates in mauve

	Red – Significantly
	Amber – Some
	Green – in line with
	Blue - Completed

Report no	Issue (Specific 1)	Leads (Specific 2)	Action to Date / Future Plans (Specific 3)	Key Deliverables (Measurable)	Outcome Measure (Appropriate)	Constraints (Realistic)	Completion date	Reporting Arrangements	RAG Status
	Community (must do in red)								
1	Ensure that proper and complete information about patients is available to all those involved in their end of life care by taking account of the different paper and electronic systems in use.	Head of Nursing Out of Hospital Care / Practice Educators	A process has been agreed whereby plans of care for patients at the end of life stage are kept as a hard copy in the patient's home so that other agencies e.g. hospice services are communicated with. Preferred Priorities of Care documents are now being uploaded onto SECAMB's 'IBIS' electronic system. SPC Nurses use Somerset system and have read only access to SystmOne. Read only access to Somerset has been offered to the community nursing teams so that continuity of information is ensured, this will now being implemented. Further work has been done with both of the local hospices to ensure that care plans are available to all in the patient's home.	That there is a process of communication in place regardless of organisational systems in the community setting.	Patients will receive continuity of care.	Cross agency working	31.03.16	Trust Board	
2	Regularly assess and monitor the quality of the services provided in the community for end of life care as well as the resources required to sustain the service.	Service Manager Out of Hospital Care	There has been progress made in the planning stage of community access to Optimum's Meridian Quality Review Audit system currently used in the acute hospitals. This audit tool includes End of Life Care quality indicators. The indicators are now in draft form and will be added to the meridian system.	That there is an audit programme developed and implemented. This should include both internal and external audits.	That the patients and carers will receive a high standard of end of life care and that trends can be identified and used for future improvement.	Resource	31.03.16	Trust Board	
3	Regularly seek the views and experiences of patients, their families and carers	Head of Nursing Out of Hospital Care / End of Life Care Facilitators	Staff now contact patients by telephone to receive feedback on the services provided. Questionnaires are also sent by post. There is not a process for capturing carer's views specifically around end of life issues in the community as this is an action for all ESHT community services. Process in development to capture this feedback and how it is fed back to the trust board.	There will be a process in place for 100% of carers/families to feedback on the end of life care experience.	Patient experience will contribute to service improvement.	Resource	31.03.16	Patient Experience Group Trust Board	

Report no	Issue (Specific 1)	Leads (Specific 2)	Action to Date / Future Plans (Specific 3)	Key Deliverables (Measurable)	Outcome Measure (Appropriate)	Constraints (Realistic)	Completion date	Reporting Arrangements	RAG Status
4	Ensure that support for SystmOne is readily accessible for all community staff so that staff feel confident in its effectiveness and understand the benefits of the system.	Head of Nursing Out of Hospital Care	Progress and issues concerning SystmOne is monitored by the programme group on a monthly basis. There is now a pilot using laptops in progress.	There will be reduced incidents in relation to SystmOne in respect of accessibility, buffering and networks.	ESHT staff will be able to make contemporaneous notes in the community setting.		30.06.16	Trust Board	
5	Ensure a continuous cycle of improvement embedded in the audit and monitoring systems for community staff, with leaders identifying areas for improvement and ensuring staff involvement in actions to be taken.	Head of Nursing Out of Hospital Care	When the Meridian system is set up then monthly audits can be undertaken. The results of these monthly audits will be challenged and discussed at the Nursing and Midwifery review meetings.	That there is an audit programme developed and implemented. This should include both internal and external audits.	That the organisation can monitor care delivered so that we can nationally benchmark and measure our local improvements.	Resource	31.03.16	Trust Board	
6	Monitor community team meetings to ensure that corporate information and learning is disseminated to all staff.	Head of Nursing Out of Hospital Care	The Community Practice Educators are now linked with the End of Life Care Facilitators and will disseminate learning to the individual teams. Representation by the Heads of Nursing at End of Life Care will also ensure that lessons are learned and disseminated.	Staff will be able to articulate learning from incidents and what the trust strategy is in relation ro end of life care.	The quality of end of life care will improve.	Resource	30.06.16	Trust Board	
7	**CONQUEST**								
8	Review resuscitation equipment in the outpatient departments, as it was not all fit for purpose.	Matrons in OPDs / Resuscitation Officer	4th September 2015. Resus officers have visited and given scenario training sessions. O2 and resus trolleys checked daily. "Safe to Fly" programme implemented in ENT, max fax and orthodontics OPDs as a pilot. RUST audit (R U Safe Today) is now on the Meridian system. This will be implemented trust wide following confirmation of other quality metrics on 31.03.16.	Resuscitation equipment will be safe and ready to use.	In an emergency situation patients' condition will be managed safely.		31.03.16	Trust Board	
9	Consider ways of improving the bereavement facilities.	End of Life Care Facilitators/ Estates and Facilities Manager / GMs	Individual ward areas have utilised space to create facilities for privacy. The Bereavement office also have a newly decorated room for bereaved families to meet with the team. Plans include a scoping exercise to determine what additional space may be required. Plans are to refurbish accomodation so that carers can stay overnight. This refurbishment has now taken place. Funding was agreed from charitable funds. Funding has also been secured for "Comfort Packs" for relatives and friends of patients who are dying in the acute Trust but do not want to leave the bedside. These have not been implemented.	Provision of sufficient quiet room areas for EOLC carers and relatives	Carers and patients will be treated with privacy and dignity.	Resources and space.	30.06.16	Trust Board	

Report no	Issue (Specific 1)	Leads (Specific 2)	Action to Date / Future Plans (Specific 3)	Key Deliverables (Measurable)	Outcome Measure (Appropriate)	Constraints (Realistic)	Completion date	Reporting Arrangements	RAG Status
10	Do not attempt cardio respiratory resuscitation (DNACPR) forms were not consistently completed in accordance with policy	Resuscitation Officer	Regular audit is carried out on DNACPR forms. Results to be reviewed. Audits have been reduced due to capacity issues. Last audit performed in January which showed compliance in the majority of indicators.	That 100% of DNACPR forms are consistently and accurately completed	Resuscitation attempts will be appropriate and for those where it is not, they will have dignity and respect at end of life.		31.03.16	Trust Board	
11	A true picture of end of life care incidents across the Trust was not available and learnings from these incidents did not inform improvements in the quality of care delivered to end of life patients.	End of Life Care Facilitators / Governance Team	A review of the core themes of End of Life Care complaints and incidents made to the Trust (acute and community) has commenced from the beginning of October 2015. Analysis of recurrent themes will be performed by the Lead Cancer and EoLC manager from incidents - details from datix.	That there is a robust process of incident monitoring, identification of trends and actions for improvement.	That learning is identified and shared from end of life care incidents and complaints across the clinical units so that care delivery can be improved.		30.06.16	Trust Board	
12	The daily syringe driver prescription charts had no date section and a new sheet was required daily which could easily fall out of the medical records and be lost. This introduced a level of risk into the prescribing process.	Pharmacy Lead	Syringe Driver charts have been revised to include a date section.	Review of prescription charts.	Safe prescribing and documentation of patient medication administration		31.03.16	Trust Board	
13	The Trust had 2 types of syringe drivers in use across the hospital. (NPSA/ 2010/RRR019)	Medical Device Facilitators	More McKinley T34 syringe drivers have been purchased and 70% of eligible staff have received training. Monitoring shows that only McKinley T34 syringe drivers are used for patients at end of life. End of Life Care Facilitators to reaudit.	All trust staff will use the McKinley T34 syringe driver for patients at end of life.	Continuity in the delivery of symptom control medication.		31.12.15	Trust Board	
14	**EDGH**								
15	Embed end of life care in the trust-wide training strategy and include end of life champions on every ward, with regular training for staff to develop and maintain knowledge and skills.	End of Life Care Facilitators	An audit has shown that 80% of staff are trained in the use of T34 syringe drivers. The new EoLC team are currently reviewing the 5 year training programme and ward representation. 30-40% of nursing staff in the last 3 years have received EoLC teaching. EoLC & SPC is part of the induction of all new FY1 doctors and of their subsequent education sessions. It is also part of the induction of all nurses. Still to establish an up to date champion's directory.	That the implementation of the 5 year training programme is continued and there is an End of Life Care champion identified from every ward/clinical team.	That the workforce will be competent and confident to provide excellent EoLC.	Resource.	30.06.16	Trust Board	

Report no	Issue (Specific 1)	Leads (Specific 2)	Action to Date / Future Plans (Specific 3)	Key Deliverables (Measurable)	Outcome Measure (Appropriate)	Constraints (Realistic)	Completion date	Reporting Arrangements	RAG Status
17	Include discussion of incidents at the end of life steering group and cascade learning across the trust.	End of Life Care Facilitators / Governance Team	The current End of Life Care team are reviewing the need for a trust wide steering group and whether improvement will be better achieved through End of Life Care Team progress meetings. End of Life Care remains a Trust Board agenda item. Monthly End of Life Care Team meetings now set up. Weekly end of life care report to the Quality Improvement Group.	That there is a robust process of incident monitoring, identification of trends and actions for improvement.	That learning is identified and shared from end of life care incidents and complaints across the clinical units so that care delivery can be improved.	Engagement	31.03.16	Trust Board	
18	Regularly review the quality of MCA (mental capacity act) assessments and ensure that they are clearly documented.	Assistant Director of Nursing for Safeguarding	Monthly meridian audits show 84% compliance with the completion of an initial MCA assessment in the IPD which shows an increase from February 2016.	That there is 90% compliance with MCA training and that the quality of MCA assessments are included in the audit programme.	That patients without capacity to make decisions are identified and an appropriate care plan is formulated.		31.03.17	Nursing and Midwifery Reviews	
19	Review the quality of nursing documentation to ensure it accurately reflects the care delivered with individualised care plans for end of life patients.	End of Life Care Facilitators	The new End of Life Care team are reviewing the best way of recording an individualised plan of care for patients at the end of life. An alternative to the Amber Care Bundle is also being considered.	That there is an individualised care plan for all patients at end of life.	That patients at end of life will receive compassionate and individualised care.		30.06.16	Trust Board	
20	Collect and consider the opinions of carers of patients receiving end of life care to support a continual cycle of improvement.	End of Life Care Facilitators/ Bereavement Officers	The End of Life Care Team are attending the Patient Experience Group on the 21st January to decide the best method by which to capture peoples' views. Bereavement survey now in draft to take back to the next meeting.	That there is a system by which to collect feedback and suggestions from carers.	That this data is used to improve end of life care.	Sensitivity and resource.	30.09.16	Trust Board	
21	Review the support provided to the SPC team to ensure the resources enable them to achieve their ambitions for the trust. Improved leadership and administrative support is required.	SPC Manager	A review is currently underway. JD currently with HR for job evaluation. The job will be administration support for End of Life Care and Palliative Care project support. BC to go to MacMillan in the long term for band 4 clinical support workers for Specialist Palliative Care.	There will be 7 day a week access to SPC services.	To review the SPC service, with engagement from other providers in palliative care, including GPs, hospices and community nursing teams.	Financial	30.09.16	Trust Board	
22	Consider expansion of the SPC team to enable face-to-face working seven days per week.	SPC Manager	A review is currently underway. Team will be up to establishment by the end of May. 7 day working can then be explored.	There will be 7 day a week access to SPC services.	To review the SPC service, with engagement from other providers in palliative care, including GPs, hospices and community nursing teams.	Financial and recruitment into a specialist field.	30.09.16	Trust Board	
23	Consider the introduction of an end of life care electronic alert system (to easily identify patients who attend hospital already on an end of life care pathway) across trust.	End of Life Care Faciliator / Business Intelligence	VitalPAC is to be used as a way of identifying those patients in the last days of life.	That it is possible at any time to identify patients who are within the last few days and hours of life.	Patients who are within the last few days and hours of life and their families will receive the care and symptom control that they require.		31.03.16	Trust Board	

Report no	Issue (Specific 1)	Leads (Specific 2)	Action to Date / Future Plans (Specific 3)	Key Deliverables (Measurable)	Outcome Measure (Appropriate)	Constraints (Realistic)	Completion date	Reporting Arrangements	RAG Status
24	Improve the profile of end of life care across the trust by introducing a standing trust board agenda item on end of life care and have a designated clinician as trust-wide lead for end of life care who understands what is needed and is empowered to implement policy.	Executive Lead for End of Life Care	Dr Debbie Benson is the trust-wide clinical end of life care lead. End of life care is now a regular Trust Board agenda item.	End of Life Care will be a standing agenda item for Trust Board meetings with an executive lead for end of life care who will be an advocate for the development and implementation of the trust end of life care strategy.	There will be an expectation that all health care professionals and support services will be responsible for the delivery of high quality end of life care.		31.12.15	Trust Board	
25	Implement an integrated strategy for end of life care.	End of Life Care Team	The End of Life Care team have developed a draft ESHT End of Life Care Strategy (embedded in the Board report). ESHT is guided by the Ambitions document and the 5 priorities for end of life care.	There will be a multi agency strategy as well as a trust strategy for the delivery of seamless end of life care.	Patients and their carers will receive high quality end of lfe care from primary, secondary and community care services.		30.06.16	Trust Board	
26	Requirement for spiritual and religious needs to be assessed and recorded	End of Life Care Facilitators	Meridian audits shows a mean average (since April 2015) of 64% compliance in the recording of spiritual and religious needs assessment which is an increase from February 2016.	100% of patients at the end of life will have their spiritual and religious needs assessed.	100% of patients will receive the spiritual and religious support that they require at the end of their life.		31.03.17	Trust Board	
27	A review of the Trust's participation in the Amber Care Bundle (ACB)	End of Life Care Facilitators / Medical Director	ESHT are currently considering the use of a Universal assessment tool that can be compared to the Amber Care Bundle but avoids "labelling" patients at end of life. NHS Improvement have been asked by our Clinical EoLC Lead to come and help us relaunch the Transforming Programme.	ESHT will have a clear strategy as to how to care for patients whose recovery is uncertain.	Patients whose recovery is uncertain will have a clear management plan that has been formulated in partnership between the patient, their doctor and carers.		31.09.16	Trust Board / Trust Documentation and Policy Group	
28	All SPC team members to use Somerset Cancer Register to record EoLC contacts/interventions	SPC Manager		100% of eligible clinicians to record appropriate end of life care interventions on Somerset Cancer Register	Continuity of end of life care delivery.		31.09.16	Trust Board	
30	Review complex and fast track discharge processes	End of Life Care Facilitators	Ward nurses are completing the whole Fast Track assessments. NHS mail not used. Escalation often required.	100% of patients will die in the setting of their choice.	There will be seamless and timely discharges and transfers from one environment to the other regardless of funding streams.		30.06.16	Trust Board	
31	Full communication between Morbidity & Mortality Group and the EoLC Group	Chair of Mortality Overview Group and Executive Lead for End of Life Care	Assistant Director of Nursing is now supporting end of life care development and also sits on the Mortality Review Group so can provide continuity of discussion. End of Life Care reports to go to the Mortality Review Group in addition to the Board.	There will be triangulation of data and intelligence that will enhance the work of both groups.	Patients will receive safe services from ESHT.		31.03.16	Mortality Overview Group	

Report no	Issue (Specific 1)	Leads (Specific 2)	Action to Date / Future Plans (Specific 3)	Key Deliverables (Measurable)	Outcome Measure (Appropriate)	Constraints (Realistic)	Completion date	Reporting Arrangements	RAG Status
35	Improve the direct access to out of hours community nursing services	Head of Nursing for Out of Hospital Care / hospices.	Rapid discharge project (St Michaels) to work with AAU, A&E and SAU to facilitate end of life care rapid discharge (hospice@home).	Patients and carers will have a direct telephone contact number for advice and support.	Patients and carers will receive immediate support and advice when needed.		31.09.16	Trust Board	
42	To review all end of life care policies	SPC Manager / End of Life Care Facilitators	All policies have been identified and work has begun on those that require review.	All policies will be current and in d.ate	ESHT staff will have up to date guidance by which to work to.		31.03.16	Trust Documentation and Policy Group	

East Sussex Healthcare NHS Trust

Date of Meeting:	13 April 2016
Meeting:	Board Meeting
Agenda item:	6
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

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

Introduction:

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

The BAF clearly demonstrates whether the gap in control or assurance remains unchanged, has increased or decreased since the last iteration. There are clear actions against identified gaps in control and assurance and these are individually RAG rated. Updates are clearly shown in red text.

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

The Trust Board is asked to consider whether the main inherent/residual risks have been identified and that controls are appropriate to manage and mitigate the risks. Key revisions include:

1.2.4 A new gap in assurance has been added in respect of mortality.
"Mortality levels above expected range and assurance is required that there are robust mechanisms in place to understand the metrics and implement best practice."
This is currently rated red.

1.1.2 Gap in control concerning health records has moved from red to amber.
There is greater assurance that revised processes are embedding, with the roll out of iFit and evidenced by a decreased number of clinics missing patient records.

1.2.3 Infection control assurance has moved from Green to Amber.
A single action plan and programme of work is to be developed.

1.3.1 Mandatory training moved Amber to Green.
Compliance levels continue to increase demonstrating effective controls in place.

The following gaps in control will be removed on the next iteration of the BAF:

1.2.4 There is insufficient assurance that clinical laboratory diagnostics analytical equipment will be replaced in a timely way following internal approval of the managed service contract.

Contract now signed and implementation will commence.

1.2.5 Assurance is required that plain films will be reported in a timely manner. Additional

controls are needed to reduce the backlog of plain film reporting and delay in reporting non urgent radiological investigations.

Effective controls in place and backlog significantly reduced.

2.1.1 Effective controls and engagement are required to ensure the Trust can model and respond to the potential loss of any services and reconfiguration following tender exercises.

MSK modelling now part of operational/business as usual.

Three areas are rated red:

1.2.2 Relating to reconfiguration of emergency department and capital required
1.2.4 Mortality indices
3.1.1 Financial position

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

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

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

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

Consideration by other Committees
Audit Committee 23 March 2016 Will also be considered by the Quality and Standards Committee 19 April 2016

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

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

Board Assurance Framework - March 2016

Strategic Objective 1: We will ensure safe patient care is our highest priority by delivering high quality services and clinical outcomes							
Risk 1.1 We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies							
Key controls	Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following “quality walks” and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference 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						
Positive assurances	Internal audit reports on governance systems and processes Weekly audits/peer reviews eg observations of practice Monthly reviews of data with each CU 'Quality walks' programme in place and forms part of Board objectives External visits register outcomes and actions reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors						
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	CQC reports for March inspection published Sept 15, trust in special measures. Quality Improvement (QIP) plan reviewed and revised and submitted to CQC and TDA. Improvement Director working with the Trust. Internal quality summits in progress. Jan-15 Comprehensive action plan in place. Forward trajectory of progress against actions developed and forms part of action plan. 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.	end Sep-16	◄►	DN	Q&S SLF

1.1.2	C	In order to deliver an effective service, there is a requirement to improve controls in Health Records; to encompass systems and processes, storage capacity and quality of case note folders.	Implementation of business case commencing to include storage and tracking of health records. Continued issues with record availability being monitored and actions developed. Staff Forums/meetings taking place to manage staff communication and concerns. EDM contract signed. Oct-15 iFIT starting to embed with some good results but is a rolling improvement programme. Mitigating actions continue and extended to provide daily information re availability of notes. New escalation procedure for missing notes. Project to centralise Health Records underway. Health records management structure reviewed. Dec-15 Ongoing programme of work to support effective delivery of health records service in place,monitored by SLF. Consultation taking place re health records structure. Mar 16 - iFIT and on-going review of processes in Health Records have made significant reduction in missing notes, positive feedback from clinicians and reduced incidents. Storage remains challenging but is being addressed through the development of an off-site facility, available May 16. Repairs continue but ultimate solution is the EDM programme.	end Mar-16	▲	COO	Q&S SLF

Board Assurance Framework - March 2016

Strategic Objective 1: We will ensure safe patient care is our highest priority by delivering high quality services and clinical outcomes

Risk 1.2 We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.

Key controls	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with clinical units Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Monthly audit of national cleaning standards
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG compliance.

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

Board Assurance Framework - March 2016

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

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

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

Risk 1.3 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.	
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of SLF involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings Succession Planning Mandatory training passport and e-assessments
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

Board Assurance Framework - March 2016

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.3.1	A	Assurance is required that robust controls are in place in relation to mandatory training and appraisals are effective and evidenced by improved compliance in these two areas.	Mandatory training passport and e-assessments rolled out to support competency based local training. Additional mandatory sessions and bespoke training on request, temporary resource to help develop competency assessments. Training and support for line managers provided. Reduction in compliance flagged early to Clinical Units through performance meetings. Oct 15 – Compliance for mandatory training and appraisal is improving month on month and is a continuing upward trend. Specific actions to be taken over the next few months to support areas include: Tailoring mandatory courses to meet the needs of clinical units/departments. Continued review of mandatory training and appraisal compliance at Clinical Unit Accountability meetings and facilitated drop in/team sessions. Dec 15 - Mandatory Training – Aggregate Trust compliance rate at 30 Nov 15 of 86.5%. Appraisal – Achieved overall Trust compliance as at 30 Nov 15 of 81%. Activities planned to engage managers and staff in the new process. Revised paperwork also includes the new requirements for nurse revalidation. Mar 16 - As at 31/1/16 Mandatory compliance is 86.6% and Appraisal compliance is 83.34%. This is the highest level of compliance in the Trust for some time. The Appraisal process and paperwork has been redesigned and we are aiming to launch this from 1st April 2016 along with a development programme for Appraisers. A new L&D manager started in February and one of her objectives to review all that we are doing with mandatory training, move forward the competency work and identify any further efficiences we can make. Rating moved from amber to green.	end Mar-16	▲ Mar-16	HRD	Q&S SLF

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

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

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

Strategic Objective 2: We will enhance patients' experiences by working with local partnerships to meet the needs of our local population	
Risk 2.3 We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners.	
Key controls	Development of communications strategy Governance processes support and evidence organisational learning when things go wrong Quality Governance Framework and quality dashboard. Risk assessments Complaint and incident monitoring and shared learning Robust complaints process in place that supports early local resolution External, internal and clinical audit programmes in place Equality strategy and equality impact assessments
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives. Friends and Family feedback and national benchmarking Healthwatch reviews, PLACE audits and patient surveys Dr Foster/CHKS/HSMR/SHMI/RAMI data Audit opinion and reports and external reviews eg Royal College reviews Quality framework in place and priorities agreed, for Quality Account, CQUINs

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.3.1	A	Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience.	Incidents logged, issues escalated to SECAMB /CCG. Service spec reviewed by commissioner; Trust engaging with process. Apr-15 Inpatients - Trust has access to additional vehicles via Elite. Issue remains with outpatients. . Oct-15 Tender for service to be awarded end Oct with April implementation date. Will work with CCG and new provider to support improvement. Mar-16 New provider in place, managed service contract. Working with provider to ensure effective transition from SECAMB. Effectiveness of service will be monitored.	end Apr-16	◄►	COO	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.3.2	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Further controls are required to support delivery of an efficient service and good patient experience.	Review instigated to support implementation of focussed actions. Feb-15 Central team in place and systems being monitored. Considering developing specialist teams to support areas with complex processes. Apr-15 Close liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard. Aug-15 Weekly Dashboard now in place monitored by senior management team. Accountability Reviews for Clinical Admin service being set up. Oct-15 Reviewing processes to minimise short notice clinic cancellation and ensure appropriate clinical assessment of affected patients. New call management system ordered to address technical and resource issues in the appointments centre/provide enhanced service Review of 700+ letter templates underway to improve patient communication. SOPs and specialty booking rules agreed and implemented. Following review of call reminder system significant improvement in DNA rates, more scope within the programme. Dec-15 Continued progress in implementing service improvement. Call management system introduced. March 16 – 80% referrals registered within 48hrs of receipt, scanned on to e searcher to minimise risk of paper referrals going missing. First specialty about to go live with e referral system, continued roll out through 16/17. Scheduled to undertake review of the standard operating procedures implemented in Sept 15 at end of March. 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	end May-16	◄►	COO	SLF Q&S

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.1.1	C	Require evidence to ensure achievement of the 2015/16 Financial Plan and prevent crystallisation of risks as follows: activity levels exceed baseline amount and are not paid for or paid for by CCGs/NHSE at marginal rate only; stranded costs arise from the transfer of the HWLH community contract; contractual fines and penalties are levied; activity, capacity and unplanned cost pressures arise; the CIP plan of £11.4m is not delivered; revenue costs of re-financing.	Contract arrangements incentivise both parties to reduce activity. Activity and delivery of CIPs regularly managed and monitored. Monthly accountability reviews in place and remedial action undertaken where necessary. Timely reporting of finance/activity/workforce performance in place. Regular reviews by BPSG, CLT, SLF, Finance & Investment Committee and Board. Aug15- End of Q1 run rate deficit was £0.7m adverse to Plan. There is now a TDA requirement to improve the year end deficit position by £1.8m. Oct 15 – End of Q2 run rate deficit £3.6m adverse to plan. Key drivers behind this deterioration of performance are increased spending on agency costs and CIP slippage. Recovery plan being developed to improve position. Dec 15 - run rate deficit has increased to £7.3m at the end of November 2015 as a result of increased spending on agency staff, continued use of escalation beds and slippage on CIPs. A recovery plan is being implemented that focusses on grip and control especially with regard to agency costs. Rating moved to red. Mar 16 – Run rate deficit continues to increase with increased controls offset by additional 51 beds with no supporting income from the CCGs.	Commenced and on-going review and monitoring to end Mar-16	◄►	DF	F&I

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.	Essential work prioritised within Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. The Board approved a capital programme at its meeting on 2 June 2015. Delivery of this capital plan will be reported regularly to the Finance & Investment Committee and Board. Oct 15 – At the end of Q2 capital expenditure was £5.5m (marginally behind plan). The planning margin was being maintained, however as the programme is over committed, any new capital schemes will mean a re-prioritisation of the existing projects. Dec 15 – At the end of Nov 15 capital expenditure was £6.5m (marginally behind plan). The planning margin was being maintained, however as the programme is over committed, any new capital schemes will mean a re-prioritisation of the existing projects. An application is being submitted to the ITFF for additional capital investment to support the Quality Improvement Plan. Mar 16 – the 2015/16 plan is on track and expected to achieve the Trusts CRL.	On-going review and monitoring to end Mar-16	◄►	DF	F&I

Strategic Objective 3: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.							
Risk 3.3: We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.							
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital Approvals Group and Finance and Investment Committee						
Positive assurances	Essential work prioritised with Estates, IT and medical equipment plans Capital approvals group meet monthly to review capital requirements and allocate resource accordingly Monitoring by Finance and Investment Committee						
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.3.1	C	There is a gap in control as a result of the Trust not having an aligned estates strategy in place.	Estates Strategy being developed. Progress updated presented to Board seminar in April. Substantive Head of Estates in post Aug-15 Presentation on progress to date at Board seminar in Jul-15 on track for submission to December Board. Dec-15 Estates strategy reviewed by Board, further engagement session planned. Mar-16 Estates strategy will be considered at May Board seminar.	end May-16	◄►	COO	F&I SLF

Risk 3.4 We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.	
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports
Positive assurances	Policy documents and Board reporting reflect external policy Strategic development plans reflect external policy. Board seminar programme in place Business planning team established Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.4.1	A	In order to retain and develop services the trust requires the capacity and capability to effectively respond to tenders. Specialist skills are required to support Any Qualified Provider and tendering exercises by commissioners.	Business planning team in place and supported by PMO. Ongoing review of processes and evaluation of outcomes to identify learning. Tendering support in place with coaching for those involved in the process. Evaluation and lessons learnt assessment to take place to conclude by end August 2015 Oct-15 Portfolio moved to DF and being reviewed. Dec 15 - additional external resource has been commissioned by the Trust for a limited period with a specific objective of knowledge transfer. Mar-16 as above Trust successful in Sexual Health Tender..	end Mar-16	◄►	DF	SLF

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

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.1.1	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	Nursing Skill mix review now being widened to include original out of scope areas, to be completed by end June 2015. Aug-15 Nurse staffing levels review conducted Apr 2015 finalised and reported to Aug Board. Increased commissions in Foundation Degrees and Advanced Nurse Practitioners to support skill mix and development of new roles. Oct 15 – Nursing establishment half-year review undertaken Oct 15 to go to Board in Jan Mar 16 - Further work on nursing establishments is being taken forward through the business planning and budget setting process currently underway. Skill mix reviews and work through the Lord Carter programme has identified the need to consider other/new roles to support nursing which may lead to a reduction in vacancies and this work will be taken forward by the Workforce Planning Group.	end Jan-15	◄►	HRD	SLF
			International and European Recruitment Programme. Oct 15 – Philippines recruitment delayed until Nov due to visa restrictions; candidates not likely to commence in the Trust until Apr-16. Five doctors offered in Sept but only one accepted position; recruitment commenced again in India for middle grades A&E and other specialties. Meetings arranged with CU teams to agree recruitment priorities in the next 6 months. Strategic Workforce Planning to be incorporated into Business Planning process to include the exploration of new roles and skill mix to address shortage in specific staff groups Dec 15 - 173.52 FTE nurse vacancies at end of November. 7.8% Vacancy rate. 34 FTE start date pending, 38 overseas nurses appointed and expected to be available for work in Apr-16. Further overseas and European recruitment campaigns planned for Jan and Mar. 23 Newly qualified staff due to start in February. Consultant vacancy rate 6% Middle and junior Drs 6.9% Overseas recruitment continued for Drs with little success to date and reviewing approach. Mar 16 - 192.87 fte nurse vacancies as at the end of January. 10.17% vacancy rate. Increase in January due to 30 fte increase in budget. EU Nurse recruitment undertaken, and by end of March we predict 58 additional ftes consisting of 13 EU nurses; 25 UK Nurses and 20 newly qualified nurses. Anticipate 30 overseas nurses will start in April, which will give a trajectory of 152 vacancies at end of April. Further EU recruitment undertaken in Croatia and Romania, and further recruitment trip to the Philippines planned for April. This will provide an additional 70 Nurses. 61.64 Medical and Dental vacancies with a vacancy rate of 10.86%. Overseas recruitment undertaken and new ways of working in A&E is being reviewed. Overseas recruitment also being undertaken for radiographers.	Apr-16	◄►	HRD	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.1.2	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	Value based recruitment to be incorporated into the recruitment process for all posts. Feb 15 - Implemented for newly qualified nurses. Apr 15 – Implemented for HCA's and plan being developed to extend to all staff groups as part of the R&R Strategy. Oct-15 Continuing implementation and embedding Mar 16 - Values Based recruitment is being implemented for recruitment of HCA's both substantively and for the bank	end Mar-16	◄►	HRD	SLF
4.1.3	C	Assurance is required that the Trust has effective controls in place to maintain sufficient staffing levels in A&E; recruitment difficulties in consultant, middle grade and nursing. Deanery short falls in fill rate for junior positions.	Aug-15 Business continuity plans in place to cover short term difficulties. Overseas recruitment taking place. Longer term review of staff model planned. Dec-15 Discussion taking place with commissioners as part of East Sussex Better Together. Mar-16 Recruitment taking place however short falls in staffing remains. Mitigating actions such as use of long term locums	end Sep-16	◄►	COO	SLF

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

Board Assurance Framework - March 2016

Gaps in Control (C) or Assurance (A):			R	Date/ milestone	RAG	Lead	Monitoring Group
4.2.1	A	The CQC staff surveys provide insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	Mar 16 - Medical Engagement results have been published and will be shared with the medical to develop a plan for improvement. The recent Staff Survey results have seen a small improvement in some areas. Overall engagement score has increased and staff see Patient care as our priority. Results have been shared with all clinical units and directorates for dissemination to staff and development of actions for improvement. Looking for common themes across each clinical unit and will identify 3 areas to focus on linked to the staff survey feedback. The clinical units will be supported by Staff engagement and wellbeing team in sharing best practice and providing advice and guidance. The Trust has recently commissioned a cultural review to do a deep dive into why staff don't feel engaged as well as focusing on other key areas like bullying and harassment, Stress and health and wellbeing. The review will take place in April and involve a number of focus groups to seek the views of a wide range of randomly selected staff and some of our leaders. Anticipated results should be available in May 2016. A number of workplaces are introducing different approaches to staff engagement . e.g. Pharmacy have introduced Staff suggestion boxes. The team are listening to staff ideas and implementing some of their suggestions and feedbacking to staff where things aren't possible and explaining the rationale. Out of Hospitals Clinical Unit Senior Leaders held a celebration event in February to share some of their transformational work. Feedback from the leaders who undertook the programme was that they felt valued and engaged in the whole process. The Staff forums continue to run and attendance is increasing . Staff appear to appreciate the opportunity to have an open conversation with Acting Chief executive and staff are receiving timely feedback on actions agreed at the forums. The nominations for the trust annual awards have just closed and we have had our largest number of nominations this year. The awards take place in May. We have also had over 100 nominations for our Peoples choice awards where members of the public nominate a staff member or team . We also have 5 finalists at the regional Unsung Heros Awards.	end Mar-17	◄►	HRD	Q&S SLF
4.2.2	C	Transition in executive team and inability to successfully recruit to Chief Executive and Chairman posts could impact on Board effectiveness.	Aug-15 Chief Executive left July, Director of Strategy and Director of Finance leave the Trust at the end of September. Interim CEO and Director of Finance in place. Portfolio of Director of Strategy being redistributed. Jan-16 Substantive CEO in place Mar-16 CEO appointed commences Apr-16. DoF appointed commences Jun-16. Board will then be up to full complement and development programme will commence.	end Mar-16	◄►	CEO/ Chair	Rem Comm/ Board

East Sussex Healthcare NHS Trust

Date of Meeting:	13th April 2016
Meeting:	Trust Board
Agenda item:	7
Subject:	Quality Improvement Plan
Reporting Officer:	Alice Webster

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

Purpose:

To provide a high level report on the progress against the Quality Improvement Plan for the Trust.

Introduction:

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

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

1. Programme Highlights and Milestones
2. Objective Summary Dashboard
3. Significant Risks
4. Outcomes Achieved

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 main focus since the last report to the Board has been to review, in depth, the progress against the warning notices, embed the programme team and mature the governance framework to enable streamlined reporting to all stakeholders improving floor to board information on progress.

Overall Status update:- The status update as at 31st March 2015 shows the high level progress against the programme plan made in the previous 2 months. The report specifically refers to the progress and issues against the Red Actions.

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

Benefits:

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

Risks and Implications

Non-compliance with the action plan may mean the Trust is not providing high quality care and good experience for our patients. If the recommendations are not acted upon the Trust is also at risk of not meeting the Regulations set out in the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014 and may receive sanctions. Warning notices are in place for failure to fully comply with Regulations 10, 12, 15, 16, 17 and 18. The current operational pressures on the hospital are having an impact on the management of this large programme of work.

Assurance Provided:
Weekly meetings take place, chaired by the Director of Nursing, attended by the Executive Leads and Clinical Unit representatives to update and monitor the action plan. A Programme Board has been set up and is planned for May

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)**:**	
Due to be discussed at the Quality and Standards Committee Senior leaders Forum 14.3.16	

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

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

For further information or for any enquiries relating to this report please contact:	
Name: Lesley Walton / Alice Webster	**Contact details:** 01323 417400

Overall Project Status 

Trust Board
Improvement Programme Highlight Report
13th April 2016

1. Introduction

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

2. Status

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

1. **Programme Highlights and Milestones**
2. **Objective Summary Dashboard**
3. **Significant Risks**
4. **Outcomes Achieved**

3. Programme Highlights and Milestones

The main focus since the last report to the Board has been to review, in depth, the progress against the warning notices, embed the programme team and mature the governance framework to enable streamlined reporting to all stakeholders improving floor to board information on progress

3.1 Warning Notice Deep Dive Outcome: The outcome of this work highlighted the significant progress on process and procedures to comply with the notices however, sustainability products were still on-going. The deep dive illuminated the fact that sustainability is constrained by the volume of information provided to the Clinical Unit Managers. As a result, their time is spread too thinly to effectively analyse information and attend all governance meetings. This is demonstrated in the next four slides including two specific examples for Infection Prevention Control and Complaints Management. The need for a ***Ward Improvement Project*** was recommended and agreed as a way forward to support sustainable change on the floor. Other decisions included increasing Ward Clerk cover and main site management to support the Clinical Unit Leads.

3. Programme Highlights and Milestones continued.

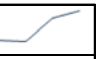
3.2 Embed the Programme Management Team: The Programme Manager has now fully transitioned to work on the Improvement Programme. Two dedicated Project Managers and a Project Support Officer are now in post as well as a dedicated Communications Lead and Change Analyst. A Business Case is in development for a further 2 project managers to be able to provide greater planning and management support to the operational leads. Also included within the Business Case are Service Improvement Leads identified as a resource required in the long term to provide education and ensure that continuous improvement is embedded across the Trust.

3.3 Maturity of the Governance Framework: A proposal from the Programme Team to streamline the reporting but instil metric rigour and project governance has been approved. This will now involve the transition to 12 key projects to increase the drive to improve with assigned Project Managers and Executive Owners. The first ***Improvement Board will be held on 9th May 2016 chaired by the CEO Adrian Bull***

Programme Highlights and Milestones

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments
SRO - Alice Webster				
Vision	04-Apr-16	Alice Webster	G	
Set Up Programme Board	31-Mar-16	Lesley Walton	C	
Programme Governance, Assurance and Terms of Reference	31-Mar-16	Lesley Walton	G	
Programme Brief	31-Mar-16	Lesley Walton	G	
Programme Plan	30-Apr-16	Lesley Walton	G	
Communications and Engagement Strategy	30-Apr-16	Suzanne Gouch	G	
Benefits Management Strategy	31-May-16	Jackie Gill	G	
Resource Management Strategy	31-May-16	Lesley Walton	G	
Risk Management and Issue Resolution Strategy	31-May-16	Lesley Walton	G	
Programme Gateway Assurance	31-May-16	Internal/External (TBC)	G	
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 framework	30-Jul-16	David Meikle	G	2 additional project managers required - business case in progress
Service Improvement Hub Established	30-Jul-16	Ashley Parrott	G	Business Case in progress
Warning Notice Compliance	1st June 2016	Alice Webster	A	Sustainability
Mortality and Morbidity Project Complete	30-Nov-16	David Hughes	R	Root Cause not fully established
Cleanliness, Infection and Prevention Control Project Complete	30-Nov-16	David Hughes	G	
Evidence Base Care Project Complete	30-Nov-16	David Hughes	G	
Medicines Management Project Complete	30-Nov-16	David Hughes	G	
Workforce Capacity Capability & Engagement Project Complete	28-Feb-17	Monica Green	A	Culture and engagement changes may take longer
Effective Relationships with External Stakeholders & the Public Project Complete	30-Nov-16	Lynette Wells	G	
Governance Project Complete	28-Feb-17	Alice Webster	G	Capsticks full Governance Review proposed
Medical Records Project Complete	30-Nov-16	Pauline Butterworth	G	
Patient Flow Project Complete	30-Nov-16	Pauline Butterworth	G	Subject to building works funded and completed
Maternity Operations Project Complete	30-Nov-16	Pauline Butterworth	G	
Secure and Safe Premises and Faculties Complete	30-Apr-16	Alice Webster	G	
Ward Improvement project Complete	31-Dec-17	Alice Webster	G	Requires Service Improvement Leads
Mock Inspection	31-May-16	Alice Webster	G	

Summary Dashboard of Objectives – Safe

SAFE		Executive Owner	Status of Action	Current Performance / Sustainability	Trend
Staffing					
14	Staff Training for staff working in Alternative Areas	Pauline Butterworth	GREEN	AMBER	WIP
12	Staff Recruitment (Vacancies)	Alice Webster	AMBER	AMBER	
48	Consultant Cover in the A&E Department	David Hughes	RED	RED	WIP
50	Support for Newly Qualified staff	Alice Webster	GREEN	AMBER	WIP
51	Monitoring Quality and Safety in relation to Staffing Levels	Alice Webster	AMBER	AMBER	WIP
52	Pathology & Histopathology Vacancies	David Hughes	AMBER	AMBER	WIP
Medicines					
25a	Integrated and Patient Focussed Pharmacy Structure	David Hughes	GREEN	AMBER	WIP
25b	Medicines Management Control Measures	David Hughes	GREEN	AMBER	WIP
25c	Centralised Medicines Management Governance Processes	David Hughes	GREEN	AMBER	WIP
43	Secure Fridge Storage at Eastbourne MLU	Alice Webster	BLUE	GREEN	WIP
44	Follow Guidance for Syntocinon	David Hughes	BLUE	BLUE	BLUE
45	Storage of IV Fluid at Conquest A&E	Alice Webster	BLUE	GREEN	WIP
46	Storage of TTA's and normal saline at nurses stations	Alice Webster	BLUE	AMBER	WIP
Incidents					
27	Medical oversight of Serious Incidents	David Hughes	AMBER	AMBER	WIP
Environment and Equipment					
40	Secure Oxygen Cylinders	Richard Sunley	BLUE	BLUE	BLUE
47	A&E department isolation in the event of lock down being required	Pauline Butterworth	BLUE	BLUE	BLUE
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards					
34	Trust Consent to Treat Policy	David Hughes	AMBER	AMBER	WIP
Mortality and Morbidity					
53	Reduce Rates to National Average (SHIMI)	David Hughes	RED	RED	
Cleanliness, Infection Control and Hygiene					
33a	Sustained and documented audiit compliance with the National Specifications for Cleanliness	Richard Sunley	GREEN	AMBER	
33b	Consistent understanding and compliance with the Trust Hand Hygiene Policy	Alice Webster	AMBER	RED	WIP
33c	Robust governance and performance processes related to infection prevention and control	Alice Webster	AMBER	RED	WIP

Summary Dashboard of Objectives – Well Led

WELL-LED		*Executive Owner*	*Status of Action*	*Current Performance / Sustainability*	*Trend*
Vision and Strategy					
2	Staff Health and Well-Being (Schwartz Rounds)	Alice Webster	GREEN	GREEN	WIP
3a	MDT Working at Conquest Hospital - Morning Board Rounds	David Hughes	RED	RED	WIP
3b	MDT Working at Conquest Hospital - Shift Handover	David Hughes	RED	RED	WIP
4	Connection between Trust Bard and staff	Monica Green	RED	AMBER	WIP
9	Relationships with the Public and Other Key Stakeholders	Lynette Wells	GREEN	AMBER	WIP
22	Leadership of Maternity Services	Pauline Butterworth	GREEN	AMBER	WIP
Leadership of the Trust					
1	Staff Engagement and Satisfaction Levels (Turnover)	Monica Green	AMBER	AMBER	
5	Staff feel able to speak up without recrimination	Richard Sunley	AMBER	AMBER	WIP
6	Harassment and Bullying of Staff	Monica Green	AMBER	RED	WIP
17	Senior Management Team Review	Richard Sunley	AMBER	AMBER	WIP
Governance, Risk Management and Quality Management					
13	Staff Sickness Absence Levels	Monica Green	GREEN	AMBER	
26	Governance and Reporting of Incidents	Alice Webster	AMBER	AMBER	
28	Learning from Incidents	Alice Webster	AMBER	AMBER	WIP
29	Governance of Service Improvement and Patient Safety Initiatives	David Hughes / Alice Webster	AMBER	AMBER	WIP
Culture Within the Trust					
15	Mandatory Training Levels	Monica Green	AMBER	AMBER	
16	Staff Appraisal Rates	Monica Green	AMBER	AMBER	

Summary Dashboard of Objectives – Responsive

RESPONSIVE	Executive Owner	Status of Action	Current Performance / Sustainability	Trend
Service Planning and Delivery to meet the needs of Local People				
11 Inform Patients of Outpatient issues in a timely manner	Pauline Butterworth	GREEN	AMBER	WIP
19 Facilities to reduce Repeated Journeys between home and Hospital	Pauline Butterworth	AMBER	AMBER	WIP
20 Define a Vision for Maternity Services	Pauline Butterworth	GREEN	AMBER	WIP
21 Information to make an informed choice about Place of Birth available	Pauline Butterworth	GREEN	GREEN	WIP
49 Women being Contacted by Midwives etc. after suffering loss	Pauline Butterworth	AMBER	AMBER	WIP
Meeting Individual Needs				
8 Translation Services	Lynette Wells	GREEN	AMBER	WIP
30 Reduced rates of Same Sex Breaches in CDU and A&E	Pauline Butterworth	GREEN	AMBER	
31 Separate Areas / Cubicles in Conquest CDU and A&E	Richard Sunley	RED	RED	WIP
32 Privacy and Dignity in Radiology and OPD	Richard Sunley	RED	RED	WIP
Review the Complaints Management Process				
7 Complaints Management Process	Alice Webster	AMBER	AMBER	
Access and Flow				
38 Ward Moves	Pauline Butterworth	GREEN	AMBER	WIP
39 Discharges Process	Pauline Butterworth	GREEN	AMBER	WIP
10a Standard Operating Procedures for Bookings	Pauline Butterworth	GREEN	GREEN	WIP
10b Outpatient Responsiveness and Flow	Pauline Butterworth	AMBER	AMBER	WIP

Summary Dashboard of Objectives – Effective and Caring

EFFECTIVE	Executive Owner	Status of Action	Current Performance / Sustainability	Trend
Evidence Based Care and Treatment				
36a Audit compliance with National Pre-Eclampsia Guidance	Alice Webster	AMBER	AMBER	WIP
36b Audit compliance with National NBM Guidance	David Hughes	AMBER	AMBER	WIP
36c Audit compliance with National End of Life Care Guidance	David Hughes	BLUE	BLUE	BLUE
37 Comply with VTE Guidance	David Hughes	GREEN	AMBER	
Access to Information				
23 Availability of Health Records	Pauline Butterworth	AMBER	AMBER	WIP
24 State of Repair of Health Records	Pauline Butterworth	AMBER	AMBER	WIP
41 CHIS System Review	David Meikle	BLUE	BLUE	BLUE
42 Children's Services KPIs Monitoring	Pauline Butterworth	BLUE	BLUE	BLUE

CARING	Executive Owner	Status of Action	Current Performance / Sustainability	Trend
Understanding and Involvement of Patients and those close to them				
18 Low Risk Birth Facilities at Conquest Hospital	Pauline Butterworth	BLUE	BLUE	BLUE

Summary Dashboard Red Actions

3a	MDT Working at Conquest Hospital - Morning Board Rounds	David Hughes	RED	RED
3b	MDT Working at Conquest Hospital - Shift Handover	David Hughes	RED	RED

- Clinical leads recently identified on both sites to accelerate progress. Review in progress of other meetings preventing attendance at MDTs and Handover.

48	Consultant Cover in the A&E Department	David Hughes	RED	RED

- Working with the CCG's to review and improve urgent care pathway – plan available by end of April 2016.
- 13 Emergency medical vacancies, recruited to 8 posts effective from May 16
- Trust is looking at the model used in Derby where they are fully staffed for middle grades, to adapt for this Trust.
- Royal College of Emergency Medicine external review Emergency dept.
- Work with Salford will also scope potential gains from moving other specialties to the front door e.g. acute medicine and care of the elderly

Summary Dashboard Red Actions cont.

53	Reduce Rates to National Average (SHIMI)	David Hughes	RED	RED

- A detailed action plan is being developed to address this. Interim measures include; established a Trust-wide weekly review of all deaths, to identify their root causes and pick up learning directly with clinicians.
- The Mortality Overview Group is to work with the clinical units to improve the quality of data they are provided to allow easier interpretation and actioning of Mortality information of reporting data
- Clinical summit planned - (likely to be end of April) to widen engagement in establishing key lines of enquiry
- Clinical Units are to ensure that regular, minuted Mortality Reviews are held and that actions and learning are followed up.

Significant Risks

Risk	Impact	Probability/Impact	Owner	Mitigation
Reviews have identified that not all the 'should do's' in the CQC reports are on the plan	May not be addressing all the requirements for CQC	15	Alice Webster	Programme Team to review and recommend additional objectives
Reviews have identified that not all the issues for Surgery are on the plan	May not be addressing all the requirements for CQC	15	Alice Webster	Programme Team to review and recommend additional objectives if required
Turnaround programme actions may impact ability to deliver improvements requiring funding	Delays to delivery of improvements	9	Alice Webster	Issues of funding and resourcing to be raised at Project Reviews for assessment

Outcomes Achieved

Staff vacancy rate reduced from 8.9% →7.9%

Increase in staff appraisal & mandatory training rates from 70.6% → 83.3%

Sickness absence reducing – 5.26% →4.45%

Increase in establishment of registered nurses by 118

New job applicants processed 20 days more quickly than in December 2014

Confidential room in CQ maternity unit for handover

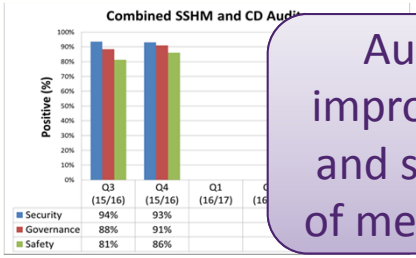
Appropriate low risk birth rooms on all sites

4x increase in unique Twitter visitors to 20,000 a month

Outcomes Achieved cont.

100% infection control audits completed

Increased hand hygiene compliance from 96.1% in 2014 to 98.03% in Feb 2016



Audits show an improvement in safe and secure handling of medicines (SSHM).

Increasing medical engagement with medical safety incidents

30% increase in reporting of patient safety incidents

East Sussex Healthcare NHS Trust

Date of Meeting:	13th April 2016
Meeting:	Trust Board
Agenda item:	8
Subject:	Integrated Performance Reports – February 2016 (Month 11)
Reporting Officers:	Finance Director Director of Human Resources Assistant Director of Performance & Delivery Associate Director for Knowledge Management

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

Purpose:

The attached document(s) provide information on the Trust's performance for the month of February 2016 (month 11).

Introduction:

The purpose of this paper is to inform the Trust Board of organisational compliance against national and local key performance metrics.

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

- RTT incompletes continue to meet the 92% standard with a final figure of 92.2%.
- Diagnostic performance did not meet the < 1% target in February. The final position was 2.44%.
- A&E performance remains challenged and under the target.
- Cancer 2 Week Wait Symptomatic standard achieved with 99.1% in February and although the 2 Week Wait standards remain challenged, it did show considerable improvement with a final position of 92.5% against a target of 93%. The 31 day standard continued to achieve.

Financial performance in month 11 was a run rate deficit of £3.9m which was £0.2m adverse to plan. This has increased the year to date deficit to £44.5m, which is £11.4m greater than plan. The impact on the forecast outturn of this deterioration in performance is currently being assessed, alongside any potential mitigation in actions that will recover the position. Any mitigation would ensure that patient safety and quality are not compromised through a Quality Impact Assessment review.

Benefits:

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

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

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

Review by other Committees/Groups (please state name and date)**:**
Finance and Investment 30th March 2016 Executive Director Meeting 5th April 2016 Trust Board 13th April 2016

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

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

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

Integrated Performance Report

M11 – FEBRUARY 2016

Presented by: Finance Director

Director of Human Resources

Assistant Director of Performance & Delivery

Associate Director for Knowledge Management

East Sussex Healthcare NHS Trust

Contents

1.0 Performance – FEBRUARY 2016

Key Issues

- Cancer performance
- Diagnostic Performance
- Mixed Sex Accommodation Breaches
- Infection Control
- Mandatory Training

Key Risks

- Failure to deliver national and local targets and trajectories for improvement
- Stranded costs post HWLH transfer
- Financial position

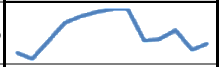
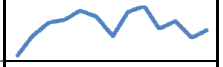
Action: The board are asked to note and accept this report.

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

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

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

1.1 Patient Safety – FEBRUARY 2016

Indicator Description	Target	Nov-15	Dec-15	Jan-16	Current Month Feb-16	Current Month Feb-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Never events - incidence rate	0	3	1	0	0	0	NA	4	0	NA	
Serious Incidents rate (per 1000 beddays)	Monitoring	2.75	2.93	2.55	2.67	2.48	7.5%	2.94	1.81	62.4%	
Medication errors causing serious harm - incidence rate	0	0	0	0	0	0	NA	0.00	0	NA	
% of Patient safety incidentscausing severe harm/death	0.50%	0.0%	0.0%	0.0%	0.0%	0.6%	-100.0%	0.2%	0.3%	-15.4%	
Patient Safety Incident Rate (Incidents/1000 Beddays)	37	35	36	33	35	29	20.4%	36	30	21%	
Patient safety incidents resulting in death or severe harm	0	0	0	0	0	4	-100.0%	22	20	10.0%	

Standards: As indicated within target column

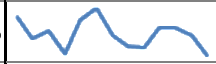
Commentary

There were no new never events in month 11. Serious harm incidents remain at zero.

The overall patient safety incident rate remains below the ceiling of 37 (NPSA reduction target). Year to date levels (to month 11), however are higher than 2014/15.

Despite a small increase from month 10, Serious Incident rate remains on an overall downward trend for the year.

1.2 Patient Safety – FEBRUARY 2016

Indicator Description	Target				Current Month			YTD			Trend
		Nov-15	Dec-15	Jan-16	Feb-16	Feb-15	Var	Curr Yr	Last Yr	Var	
Clostridium Difficile - Variance from plan	4	5	3	4	3	2	1	43	46	-3	
MRSA bactaraemias rate	0	0	0	0	0	0	0	4	0	4	
VTE Risk Assessment	95%	96.7%	96.7%	96.4%	95.7%	97.0%	-1.4%	96.4%	96.8%	-0.3%	
Number of Falls: no harm/near miss	105 p/m (1260 OT)	96	129	115	119	107.00	11.2%	1185	1295.00	-8.5%	
Number of Falls: Minor/Moderate	48 p/m (581 OT)	43	60	67	56	37.00	51%	624	615.00	1%	
Number of Falls: Major/Catastrophic	0	0	0	0	0	2	-100.0%	4	13	-69.2%	

Standards: As indicated within target column

Commentary

Reported cased of C-Diff remain in line with the plan, and below 2014/15 levels to month 11.

There were no reported cases of MRSA in month 11.

Low and medium harm falls did increase from month 10, and also remain on an upward trend from month 8. This step change is apparent in both categories and initial investigation suggests improved reporting practice is the main contributing factor.

1.3 Patient Experience – FEBRUARY 2016

Indicator Description	Target	Nov-15	Dec-15	Jan-16	Current Month Feb-16	Current Month Feb-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Inpatient Scores from Friends and Family Test % positive	96.00%	98.8%	99.0%	97.9%	98.0%	97.0%	1.0%	97.8%	96.3%	1.6%	
A&E Scores from Friends and Family Test % positive	88.00%	91.1%	90.7%	92.9%	91.0%	90.8%	0.2%	90.3%	88.7%	1.8%	
Maternity Scores from Friends and Family Test % positive	96.00%	96.6%	95.5%	95.9%	90.4%	96.6%	-6.3%	94.7%	95.2%	-0.5%	
Inpatients response rate from Friends and Family Test	45.00%	13.5%	12.9%	11.5%	13.1%	42.2%	-68.8%	16.0%	44.8%	-64.3%	
A&E response rate from Friends and Family Test	25.00%	6.8%	7.7%	8.2%	8.0%	22.0%	-63.6%	9.7%	22.2%	-56.4%	
Written Complaints - Rate	Monitoring	1.97	1.66	1.58	2.08	2.48	-16.4%	2.42	2.48	-2.2%	
Percentage of new complaints respond to (within mandatory or agreed timescales)	95.00%	95.5%	90.9%	96.2%	93.1%	97.0%	-4.0%	92.0%	97.7%	-5.8%	
Mixed Sex Accommodation Breaches	0	16	3	27	29	1	2800.1%	130	67	94.0%	

Standards:

Commentary

Inpatients and A&E scores remain above target, and also improved on previous year.

Maternity scores have declined from the previous month, and also sit below previous year's levels.

Total complaints have risen for the first time in 3 months (both rate and crude numbers). Complaints continue to be primarily from Surgery, Medicine and Urgent Care, Response rates have fallen.

1.4 Clinical Effectiveness – FEBRUARY 2016

Indicator Description	Target	Nov-15	Dec-15	Jan-16	Current Month Feb-16	Current Month Feb-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Crude Mortality Rate	1.36%	1.94%	2.03%	2.09%	1.86%	2.16%	-13.8%			#N/A	
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	Monitoring	6.49%	6.84%	7.27%	7.33%	#N/A	NA			NA	

Standards: As indicated within target column

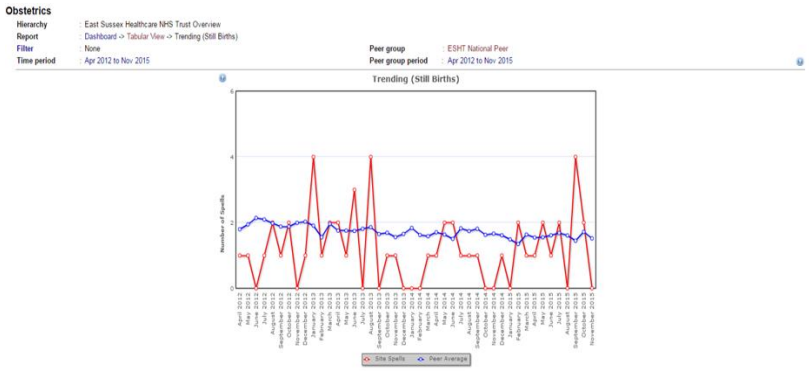
Commentary

Crude mortality reduced for the first time in 5 months. That is in line with an expected drop as the winter period comes to an end. The mortality review process continues however to ensure that the data underpinning all mortality indices is reviewed for learning and understanding.

The top 3 causes of death for 15/16 from CHKS are:
Pneumonia
Acute cerebrovascular disease
Congestive heart failure; nonhypertensive

This includes the processes behind the capture and reporting of avoidable mortality. Once finalised, these will be included in future reporting.

Current still birth rates and peer levels are below



Indicator	Still births	Trust Still births (Per 1000)	Peer Still births (Per 1000)
Single stillbirth	50	3.93	4.26
Twins - one liveborn, one stillborn	3	0.24	0.35
Twins - both stillborn	0	0.00	0.07
Other multiple births - some liveborn	0	0.00	0.02
Other multiple births - all stillborn	0	0.00	0.01

1.5 Access and Responsiveness – FEBRUARY 2016

Indicator Description	Target	Nov-15	Dec-15	Jan-16	Current Month Feb-16	Current Month Feb-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
A&E Monthly Performance (4Hr Wait) - All Types (Reported)	95%	89.4%	86.7%	85.7%	86.0%	92.5%	-6.5%	92.6%	93.99%	-1.5%	
A&E Monthly Performance (4Hr Wait)-Type 1 Only	95%	88.4%	85.6%	84.2%	84.8%	90.8%	-6.0%	89.0%	92.07%	-3.3%	
Emergency A&E >12hr to Admission	0	0	0	0	0	0	0	1	1	0	

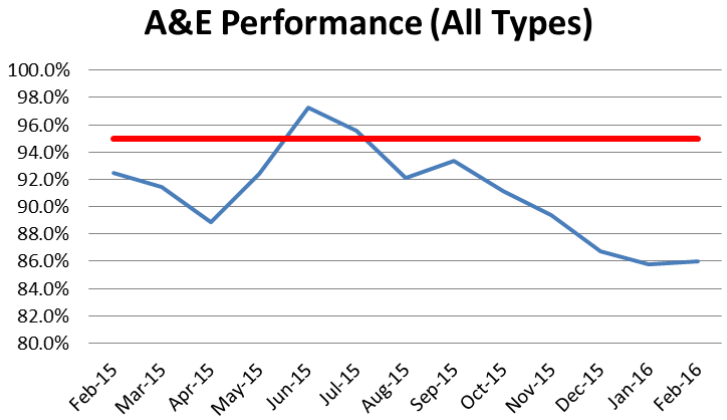
Standards:

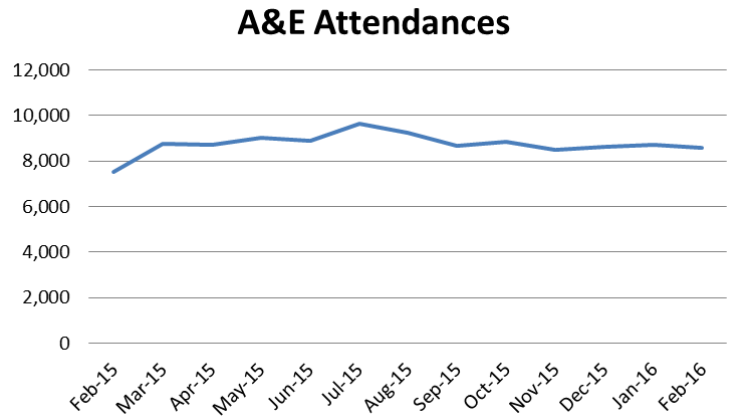
Commentary

A&E attendances have stabilised. Month 11 performance has improved slightly despite a number of challenging days in February. Future A&E performance will no longer include type 2 attendances, on account of recent changes to recording guidance.

The trust has worked jointly with commissioners to agree improvement trajectories for 2016/17. These trajectories have been underpinned by 15/16 outturn and performance. Joint work with commissioners continues to ensure agreements can be confirmed and final trajectories set.

Recruitment for posts within Urgent care is underway with interviews for Specialist registrar and Specialist Doctors to happen in April. See Appendices (P.40) for yearly comparison.





1.6 Access and Responsiveness – FEBRUARY 2016

Indicator Description	Target	Nov-15	Dec-15	Jan-16	Current Month Feb-16	Current Month Feb-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Referral to Treatment Incomplete	92%	92.76%	92.15%	92.1%	92.2%	93.64%	-1.5%	93.2%	92.49%	0.8%	
Referral to Treatment Incomplete 52+ Week Waiters	0	0	0	0	0	0	NA	0	0	NA	
Diagnostic waiting times	1.0%	0.96%	1.98%	3.81%	2.44%	0.66%	267.6%	2.00%	13.21%	-84.9%	

Standards:

Commentary

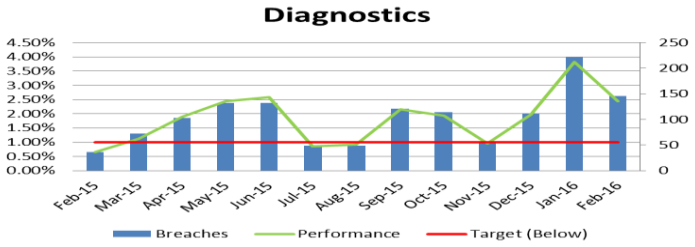
February was another challenging month which saw the trust lose elective capacity due to the Junior Doctor's Industrial Action. Pressures on bed capacity resulted in elective cancellations. RTT performance continues to achieve the 92% target.
DNA rate continues to be within median national target and continued work is in place to maintain and improve this further.

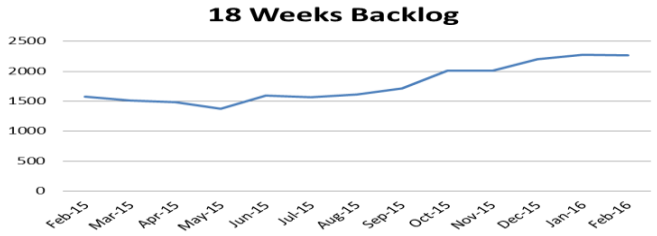
The trust has worked jointly with commissioners to agree RTT improvement trajectories for 2016/17. These Trajectories represent steady state position. Where additional capacity can be identified or alternative provider sourced for final contract sign off, trajectories will be amended to reflect.

The trust did not achieve the Diagnostic standard for February (2.44%). The majority of breaches due to endoscopy, and as a result the Trust have increased Endoscopy capacity throughout March (Medinet). In addition, endoscopy business cases for cross-site weekend capacity and an additional 3rd room at EDGH are being submitted to the Business Development Group in the coming weeks.

ESHT continues to utilise the regional independent sector PMO capacity for both diagnostics and routine elective activity.

The trust has worked jointly with commissioners to agree diagnostic improvement trajectories for 2016/17. As with RTT, these trajectories represent a steady state position.





1.7 Access and Responsiveness – January 2016

* Cancer data is always reported 1 month in arrears

Indicator Description	Target	Oct-15	Nov-15	Dec-15	Current Month Jan-16	Current Month Jan-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Two Week Wait Standard	93.0%	91.3%	89.9%	91.9%	92.5%	90.29%	2.2%	90.8%	91.14%	-0.4%	
Breast Symptom Two Week Wait Standard	93.00%	89.1%	88.5%	90.0%	99.1%	93.48%	5.6%	89.2%	89.42%	-0.2%	
31 Day Standard	96.0%	100.0%	97.4%	98.3%	96.9%	90.51%	6.4%	97.4%	95.04%	2.5%	
31 Day Subsequent Drug Standard	98.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%	100.0%	100.00%	0.0%	
31 Day Subsequent Surgery Standard	94.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%	100.0%	99.11%	0.9%	
62 Day Standard	85.0%	76.2%	75.4%	80.6%	73.0%	83.65%	-10.6%	75.2%	79.45%	-5.4%	
62 Day Screening Standard	90.0%	84.6%	54.5%	60.0%	33.3%	76.47%	-43.1%	79.1%	83.45%	-5.2%	
104 Day Waits	Monitoring	12	12	8							

Standards:

Commentary

January's Cancer performance shows improvement compared to December, with 2WW breast symptoms achieving target. Early indications for February suggest further improvement.

The live Cancer PTL implemented by the Trust earlier this year has had a significantly positive impact on the ability to focus on patients approaching target dates.

The Trust continues to work closely with CCGs to reduce the number of patients unable to attend initial 2WW appointments.

In addition, the Trust has recently engaged with support from the TDA in appointing a dedicated *Improvement Director for Cancer*, two days per week.

Recovery plans for 2016/17 have been set to reflect required changes to pathway management and interdependencies with tertiary services.

1.8 Access and Responsiveness – FEBRUARY 2016

Indicator Description	Target	Nov-15	Dec-15	Jan-16	Current Month Feb-16	Current Month Feb-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	0	0	0.0%	0	0	NA	
Proportion of patients not treated within 28 days of last minute cancellation	0.0%	0.0%	0.0%	0.0%							
Delayed Transfers of Care	3.5%	7.9%	7.5%	7.5%	10.8%	11.3%	-0.4%	7.1%	6.5%	0.5%	

Standards:

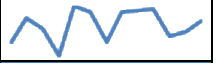
There were no urgent operations cancelled for a 2nd time in month 11.

Commentary

Final performance for January confirms that all last minute cancellations were treated within 28 days.

DTCs have risen from month 10 levels, though are less that in 2014/15. This reflects the increased non-elective length of stay seen on both sites and will require the Trust to continue to progress work with adult social care, and our own community services, to better enable placements and packages of care for patients ready for discharge.

1.9 Activity/Effectiveness – FEBRUARY 2016

Indicator Description	Target	Previous Months			Current Month			YTD			Trend
		Nov-15	Dec-15	Jan-16	Feb-16	Feb-15	Var	Curr Yr	Last Yr	Var	
Primary Referrals	Previous Yr	8,480	8,167	8,480	9,240	8,892	3.9%	96,788	96,999	-0.2%	
Cons to Cons Referrals	Previous Yr	1,466	1,217	1,262	1,246	1,514	-17.7%	15,964	17,157	-7.0%	
First OP Activity	Previous Yr	10,460	9,607	9,331	10,209	10,066	1.4%	111,966	111,386	0.5%	
Subsequent OP Activity	Previous Yr	24,329	22,220	22,549	23,417	21,670	8.1%	254,529	246,187	3.4%	

Standards:

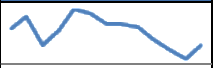
Commentary

Primary care referrals have begun to rise, though year to date levels remain slightly less than in 2014/15.

As a result, outpatient activity is also showing an increase, though levels are up significantly on 2014/15.

See Appendices (P.40) for yearly comparison.

1.10 Activity/Effectiveness – FEBRUARY 2016

Indicator Description	Target	Previous Months			Current Month			YTD			Trend
		Nov-15	Dec-15	Jan-16	Feb-16	Feb-15	Var	Curr Yr	Last Yr	Var	
Elective IP Activity	Previous Yr	621	568	512	593	687	-13.7%	7,250	8,300	-12.7%	
Elective DC Activity	Previous Yr	3,812	3,523	3,614	3,695	3,767	-1.9%	41,295	39,872	3.6%	
Non-Elective Activity	Previous Yr	3,640	3,827	3,800	3,921	3,712	5.6%	42,936	44,003	-2.4%	
A&E Attendances	Previous Yr	8,476	8,612	8,731	8,571	7,546	13.6%	97,478	94,385	3.3%	
Average LOS Elective	3.0	3.0	3.2	2.7	3.0	2.7	11.1%	3.0	2.9	4.3%	
Average LOS Non-Elective	4.6	5.7	6.2	5.7	5.9	5.8	0.9%	5.6	5.2	6.7%	

Standards:

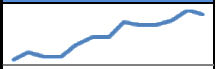
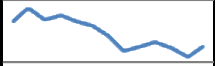
Commentary

Inpatient activity remains 13% down on the previous year. Increases in day case activity will account for a proportion of this decrease but, having only increased by 3.6% other contributing factors are in play.

Non Elective length of stay is up by almost 0.5 days year to date and almost a day month to month. This has pushed non elective occupied bed-days up, which is having a considerable impact on levels of available elective capacity.

Non elective activity is on the increase however, which suggests that discharges are increasing. If this can be sustained, it will positively impact on both DTC numbers bed capacity.

1.11 Community Services – FEBRUARY 2016

Indicator Description	Target	Previous Months			Current Month			YTD			Trend
		Nov-15	Dec-15	Jan-16	Feb-16	Feb-15	Var	Curr Yr	Last Yr	Var	
Community Nursing Referrals	Monitoring	3,391	3,578	3,971	3,764	2,118	77.7%	34,635	18,705	85.2%	
Community Nursing Total Contacts	Monitoring	32,544	34,110	34,209	32,694	30,621	6.8%	373,631	239,711	55.9%	
Community Nursing Face to Face Contacts	Monitoring	18,468	19,111	18,851	18,379	18,005	2.1%	213,778	150,632	41.9%	
% Patient Facing Time	60.00%	56.7%	56.0%	55.1%	56.2%	58.80%	-4.4%	57.2%	62.84%	-8.9%	
Community Nursing ALOS	42.00	32.3	32.7	37.4	33.3	45.73	-27.1%	40.5	42.29	-4.3%	

Standards:

Commentary

Community Nursing referrals may have stabilised following a month on month increase since April.

As a result, total contacts also appear to be stabilising, but changes to working practice within the teams are showing an increased level of indirect work.

2.0 Financial Summary – FEBRUARY 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 11.	R
Financial Sustainability Risk Ratings	The Continuity of Services Risk Rating has been enhanced and is now referred to as the Financial Sustainability Risk Rating (FSRR). The FSRR builds on the previous ratings by retaining the Liquidity Ratio and Capital Servicing Capacity, but with additional risk ratings for I&E Margin and I&E Margin Variance from Plan (see page 13). The current rating for the Trust is red.	R
Financial Summary	The Trust performance in month 11 was a run rate deficit of £3.9m with an adverse variance against plan of £0.3m. Year to date the deficit stands at £44.5m which is £11.4m worse than plan.	R
Activity & Income	Total income received during February was £0.8m above planned levels reducing the year to date variance to £1.0m below plan. Tariff-Excluded Drugs and Devices (TEDDs) income under-performed by £0.2m in month, under-performance now stands at £1.6m YTD. There is however, a corresponding underspend of £1.6m on TEDDs expenditure so therefore, this has a zero effect on the bottom line.	A
Expenditure	Operating Pay costs are above plan by £1.4m in month and are cumulatively £10.4m above plan. This is mainly due to high agency expenditure covering escalation beds and clinical vacancies. Operating Non Pay costs are £0.3m above plan in month and are £1.4m above plan cumulatively. Total costs are now £10.6m overspent year to date.	R
CIP plans	The CIP achievement year to date was £8.2m which was below the plan of £10.2m.	R
Forecast Outturn	The forecast outturn reported to the TDA has now been revised to £48.0m deficit. This is £12.8m above the revised plan	R
Balance Sheet	DH loans have increased year to date to £34.9m as a result of the drawdown of the single currency interim revenue support facility which has replaced the revolving working capital facility (RWCF). The £35.2m single currency interim revenue support loan facility is repayable in February 2019.	G
Cash Flow	The cash position of the Trust remains extremely challenging as a result of the revenue financial deficit. This is resulting in increasing creditor values and poor performance against the Better Payments Practice Code.	A
Capital Programme	After 11 months, capital expenditure has increased to £8.8m. The capital approvals group continue to monitor the capital programme on a biweekly basis until the end of the financial year in order to ensure a balanced capital position at 31st March 2016.	G

2.1 Income & Expenditure – February 2016

Headlines

- Total income in the month was £29.6m against a plan of £28.7m, a favourable variance of £0.8m and brings the YTD position to £1.0m below plan.
- Total costs in the month were £33.3m; this was £0.9m above plan. The YTD position is now £10.6m above plan.
- The £44.5m year to date deficit against plan was an adverse variance of £11.4m.
- Cost improvement plans of £11.4m have been developed for 2015/16 with a year to date achievement of £8.2m against a plan of £10.2m. The forecast delivery for the year is £9.2m.
- Operating pay costs in the month, including ad hoc costs, were £1.4m above plan and are now £10.4m above plan YTD.
- Operating Non Pay costs, including 3rd party costs, were £0.3m above plan in the month and are £1.4m above plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	22,976	23,796	820	262,395	263,289	894	287,872
Tariff-Excluded Drugs & Devices	2,704	2,525	-179	29,741	28,119	-1,622	31,453
Private Patient/ ICR	324	165	-159	3,560	2,410	-1,150	4,284
Trading Income	441	511	70	4,844	5,345	501	5,220
Other Non Clinical Income	2,295	2,568	273	25,229	25,613	384	27,180
Total Income	**28,740**	**29,565**	**825**	**325,769**	**324,776**	**-993**	**356,009**
Pay Costs	-20,326	-21,703	-1,377	-225,693	-235,632	-9,939	-245,992
Ad hoc Costs	0	-44	-44	0	-472	-472	0
Non Pay Costs	-7,667	-7,730	-63	-84,678	-86,904	-2,226	-93,424
Tariff-Excluded Drugs & Devices	-2,704	-2,564	140	-29,741	-28,158	1,583	-31,453
3rd Party Costs	-3	-259	-256	-159	-1,087	-928	-42
Other	125	50	-75	1,375	1,500	125	1,500
Total Operating Costs	**-30,575**	**-32,250**	**-1,675**	**-338,896**	**-350,753**	**-11,857**	**-369,411**
Surplus/- Deficit from Operations	**-1,835**	**-2,685**	**-850**	**-13,127**	**-25,977**	**-12,850**	**-13,402**
P/L on Asset Disposal	0	0	0	0	15	15	0
Depreciation	-1,090	-987	103	-11,985	-11,670	315	-13,075
Impairment	0	0	0	0	0	0	0
PDC Dividend	-647	-376	271	-7,116	-6,430	686	-7,763
Interest	-82	277	359	-896	-678	218	-978
Total Non Operating Costs	**-1,819**	**-1,086**	**733**	**-19,997**	**-18,763**	**1,234**	**-21,816**
Total Costs	**-32,394**	**-33,336**	**-942**	**-358,893**	**-369,516**	**-10,623**	**-391,227**
Net Surplus/-Deficit	**-3,654**	**-3,771**	**-117**	**-33,124**	**-44,740**	**-11,616**	**-35,218**
Donated Asset/Impairment Adjustment	0	-142	-142	0	199	199	0
Adjusted Net Surplus/-Deficit	**-3,654**	**-3,913**	**-259**	**-33,124**	**-44,541**	**-11,417**	**-35,218**

2.2 Cash Flow – FEBRUARY 2016

Headlines

- The cash balance at the end of the last financial year was £1.0m and the Trust is planning for a £2.1m cash balance at year-end as required by the Department of Health.
- Agreement has been reached with the TDA to replace the existing interim revolving working capital support facility (RWCF) with an interim single currency revenue support loan of £35.2m.
- The RWCF drawn down of £31.4m was repaid in February and the first drawdown of £34.9m was made against the approved new interim single currency revenue support loan of £35.2m. This new loan is repayable in February 2019.

Cash Flow Statement April 2015 to March 2016

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2016	Feb	Mar
Cash Flow from Operations												
Operating Surplus/(Deficit)	-2,181	-2,346	-3,580	-1,092	-3,148	-3,715	-4,789	-4,977	-4,878	-3,269	-3,672	-1,094
Depreciation and Amortisation	1,095	1,095	1,108	1,108	1,109	1,093	1,093	1,019	1,017	945	987	987
Impairments												
Interest Paid	-81	-81	-81	-31	-89	-92	-113	-121	131	-120	274	-296
Dividend (Paid)/Refunded	0					-4,247						-3,311
(Increase)/Decrease in Inventories	136	168	-68	103	90	-89	-28	589	-1,103	183	153	18
(Increase)/Decrease in Trade and Other Receivables	-637	-371	-6	-1,836	-2,340	1,254	1,531	2,750	5,277	-1,784	-1,388	838
Increase/(Decrease) in Trade and Other Payables	2,859	1,725	434	-53	3,628	652	6,848	306	-5,056	4,087	1,841	-3,128
Provisions Utilised	-59	-10	0	33	10	-138	-98	8	10	-48	10	-201
Net Cash Inflow/(Outflow) from Operating Activities	**1,132**	**180**	**-2,193**	**-1,768**	**-740**	**-5,282**	**4,444**	**-426**	**-4,602**	**-6**	**-1,795**	**-6,187**
Cash Flows from Investing Activities:												
Interest Received	3	3	2	2	3	2	2	2	3	2	3	2
(Payments) for Property, Plant and Equipment	-1,817	-2,232	-1,567	-1,453	-1,365	-1,250	-1,441	-1,163	-838	-1,137	-1,182	-500
(Payments) for Intangible Assets	-42	-32	-40	-17	-28	-30	-29	-29	-62	-32	-9	-32
Net Cash Inflow/(Outflow) from Investing Activities	**-1,856**	**-2,261**	**-1,605**	**-1,468**	**-1,390**	**-1,278**	**-1,468**	**-1,190**	**-897**	**-1,167**	**-1,188**	**-530**
Net Cash Inflow/(Outflow) before Financing	**-724**	**-2,081**	**-3,798**	**-3,236**	**-2,130**	**-6,560**	**2,976**	**-1,616**	**-5,499**	**-1,173**	**-2,983**	**-6,717**
New Temporary PDC	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Revenue Support Loan	0	0	0	0	0	0	0	0	0	0	0	0
Revenue Support Loan	7,440	936	4,039	3,000	2,000	2,000	2,000	2,000	6,000	2,000	-31,415	
New interim revenue support facility	0	0	0	0	0	0	0	0	0	0	34,915	303
New Capital Loan	0	0	441	0	0	0	0	0	0	0	0	0
Loans and Finance Lease repaid	-40	-16	-28	-28	-28	-241	-28	-28	-28	-347	0	-214
Net Cash Inflow/(Outflow) from Financing Activities	**7,400**	**920**	**4,452**	**2,972**	**1,972**	**1,759**	**1,972**	**1,972**	**5,972**	**1,653**	**3,500**	**89**
Net Increase/(Decrease) in Cash	**6,676**	**-1,161**	**654**	**-264**	**-158**	**-4,801**	**4,948**	**356**	**473**	**480**	**517**	**-6,628**
Opening balance	1,008	7,684	6,523	7,177	6,913	6,755	1,954	6,902	7,258	7,731	8,211	8,728
Closing balance	7,684	6,523	7,177	6,913	6,755	1,954	6,902	7,258	7,731	8,211	8,728	2,100

2.3 Balance Sheet – FEBRUARY 2016

Headlines

- The overall value of property, plant & equipment has reduced due to the transfer of the High Weald, Lewes & Havens (HWLH) properties to NHS Property Services on 1st November 2015.
- A further review of asset values is currently being conducted with the District Valuer and a further estimated reduction in non-current asset land values has been reflected in the forecast year end balance sheet.
- The year to date increase in non-current borrowings is in respect of the interim single currency revenue support loan which has replaced the existing interim revolving working capital support facility (RWCF) the working capital support facility. This 35.2m interim single currency revenue support facility is repayable in February 2019.

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast March 2016
Non Current Assets			
Property plant and equipment	271,373	239,477	232,929
Intangilble Assets	1,293	1,638	2,539
Trade and other Receivables	1,184	1,292	1,292
	273,850	**242,407**	**236,760**
Current Assets			
Inventories	6,599	6,464	6,803
Trade receivables	12,637	4,950	12,275
Other receivables	6,800	10,337	7,015
Other current assets	0	0	0
Cash and cash equivalents	1,008	8,728	2,100
	27,044	**30,479**	**28,193**
Current Liabilities			
Trade payables	-6,972	-17,264	-12,203
Other payables	-20,535	-21,972	-21,354
DH Capital Investment Loan	-383	-427	-427
DH Working Capital Loan	0	0	0
Other Financial Liabilities	-335	0	0
Provisions	-591	-288	-568
	-28,816	**-39,951**	**-34,552**
Non Current Liabilities			
DH Capital Investment Loan	-3,583	-3,767	-3,553
Borrow ings - Revenue Support Facility	0	-34,915	-35,218
DH Working Capital Loan	0		
Other Financial Liabilities	-263	0	0
Provisions	-2,588	-2,607	-2,778
	-6,434	**-41,289**	**-41,549**
Total Assets Employed	**265,644**	**191,646**	**188,852**
Financed by:			
Public Dividend Capital (PDC)	-153,530	-153,530	-153,562
Revaluation Reserve	-119,711	-109,697	-101,593
Retained Earnings Reserve	7,597	71,581	66,303
Total Taxpayers' Equity	**-265,644**	**-191,646**	**-188,852**

2.4 Receivables, Payables & Better Payments Practice Code Performance – FEBRUARY 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, year to date 80% of trade invoices has been achieved and 86% of NHS invoices.
- The Aged Debt (over 90 days) KPI is measured as a percentage of the total level of debt. The target is for this to be no more than 5%.
- The current Aged Debt KPI has reduced from 37% at 30th June to 17.7% at 29th February 2016.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	1,159	994	3,228	2,400
31 - 60 Days	356	444	254	807
61 -90 Days	208	211	374	541
91 - 120 Days	127	141	333	560
> 120 Days	773	777	761	359
Total	2,623	2,567	4,950	4,667

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	6,553	5,746	6,638	6,105
31 - 60 Days	6,492	5,747	6,467	6,265
61 -90 Days	888	591	1,103	999
91 - 120 Days	330	332	658	1,827
> 120 Days	916	701	2,398	1,065
Total	15,179	13,117	17,264	16,261

Better Payments Practice Code	Month Number of Invoices	Month By Value	YTD Number of Invoices	YTD By Value
Trade invoices paid within contract or 30 days of receipt	68.37%	65.25%	78.27%	80.32%
NHS invoices paid within contract or 30 days of receipt	34.74%	30.13%	68.15%	86.14%

2.5 Key Performance Indicators – FEBRUARY 2016

TDA Finance Risk Assessment Criteria

- The TDA has set out its reporting requirements in the latest accountability framework.
- The finance metrics have been revised by the TDA to ensure that they focus on in year delivery against plan and the individual indicators are set out in the adjacent table.
- Although the majority of risk criteria are green, the bottom-line I&E assessment (1a) has an overriding effect on the overall Trust rating. As the Trust has set a deficit plan this rating is red and under the revised TDA criteria, the overall Trust rating is red.

Monitor Financial Sustainability Risk Ratings

- The Trust has a liquidity ratio rating of 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 Payments Practice Code (BPPC)

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

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

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

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	80	95
BPPC – NHS Invoices by value (%)	86	95

2.6 Activity & Contract Income – FEBRUARY 2016

Headlines

- Re-admission fines have been accrued based on planning assumptions in line with the 'cap & collar' contract.
- CQUIN performance is based on ESHT achieving more than 75% which provides 100% of agreed targets.
- A provision has been made against MSK contract performance but this is within the planned provision.
- Block contract income in the month includes £1.8m from commissioners to support the Trust's Quality Improvement Plan. The full year projected value is £2.0m.

	Current Month			YTD		
Activity	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,278	3,246	-32	37,145	40,331	3,186
Elective Inpatients	797	667	-130	9,029	7,178	-1,851
Emergency Inpatients	3,451	3,774	323	39,864	38,841	-1,023
Total Inpatients	**7,526**	**7,687**	**161**	**86,038**	**86,350**	**312**
Excess Bed Days	2,070	2,652	582	23,913	24,547	634
Total Excess Bed Days	**2,070**	**2,652**	**582**	**23,913**	**24,547**	**634**
Consultant First Attendances	7,441	7,716	275	84,217	86,064	1,847
Consultant Follow Ups	11,925	11,875	-50	129,514	136,002	6,488
OP Procedures	4,166	3,982	-184	48,827	47,814	-1,013
Other Outpatients inc WA & Nurse l	12,684	12,649	-35	139,050	134,321	-4,729
Community Specialist	273	157	-116	2,509	1,880	-629
Total Outpatients	**36,489**	**36,379**	**-110**	**404,117**	**406,081**	**1,964**
Chemotherapy Unbundled HRGs	520	778	258	6,090	7,017	927
Antenatal Pathw ays	310	319	9	3,518	3,396	-122
Post-natal Pathw ays	261	345	84	3,187	3,235	48
A&E Attendances (excluding type 2	7,481	8,809	1,328	84,744	98,633	13,889
ITU Bed Days	467	534	67	5,294	5,498	204
SCBU Bed Days	213	216	3	2,899	3,189	290
Cardiology - Direct Access	38	94	56	544	766	222
Radiology - Direct Access	4,184	5,382	1,198	49,955	55,813	5,858
Pathology - Direct Access	286,555	299,293	12,738	3,040,815	3,040,536	-279
Therapies - Direct Access	1,412	2,407	995	17,751	29,811	12,060
Audiology	261	908	647	7,707	10,985	3,278
Midw ifery	9	6	-3	119	131	12

	Current Month			YTD		
Income £000's	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,191	3,788	-403	49,037	43,063	-5,974
Inpatients - Emergency	5,449	6,326	877	67,334	65,510	-1,824
Excess Bed Days	406	574	168	5,140	5,340	200
Outpatients	3,806	3,906	100	42,370	43,301	931
Other Acute based Activity	2,332	2,673	341	26,024	28,657	2,633
Direct Access	681	797	116	7,750	8,421	671
Block / Other	4,764	5,049	285	53,764	63,715	9,951
Re-admissions	0	148	148	0	-810	-810
CQUIN	535	535	0	6,092	6,092	0
Subtotal	22,164	23,796	1,632	257,511	263,289	5,778
Exclusions	2,704	2,525	-179	29,741	28,119	-1,622
GRAND TOTAL	**24,868**	**26,321**	**1,453**	**287,252**	**291,408**	**4,156**

2.7 Clinical Unit, Commercial & Corporate Performance (budgets) – FEBRUARY 2016

Headlines

Trust wide

Total Pay reported £1.4m overspend against the TDA plan in the month. £23.1m has been spent on agency in the first eleven months of the year compared to £10.3m for the same period last year. Cumulatively pay was £10.4m overspent.

Clinical Units (CUs)

The overall clinical unit performance was £2.3m overspend in February against plan and £18.0m cumulatively.

The adverse position is mainly due to continued agency usage covering medical and nursing vacancies, and escalation beds (£0.3m per month). A shortfall on CIP savings also contributed to the adverse variance (£2m year to date).

Non contract Income reported £1.1m under delivered, mainly on ICR and Donated Asset income. The loss of HWLH services is shown under contract income, offset by funding to support QIP/CQC recommendations.

Tariff-excluded drugs and devices reported £1.6m underspend against plan, offset by under delivery on Contract Income so overall has a neutral impact.

Estates and Facilities Directorate

£0.5m overspend YTD due to £0.5m under delivery on CIP and continued agency usage in portering, housekeeping and laundry.

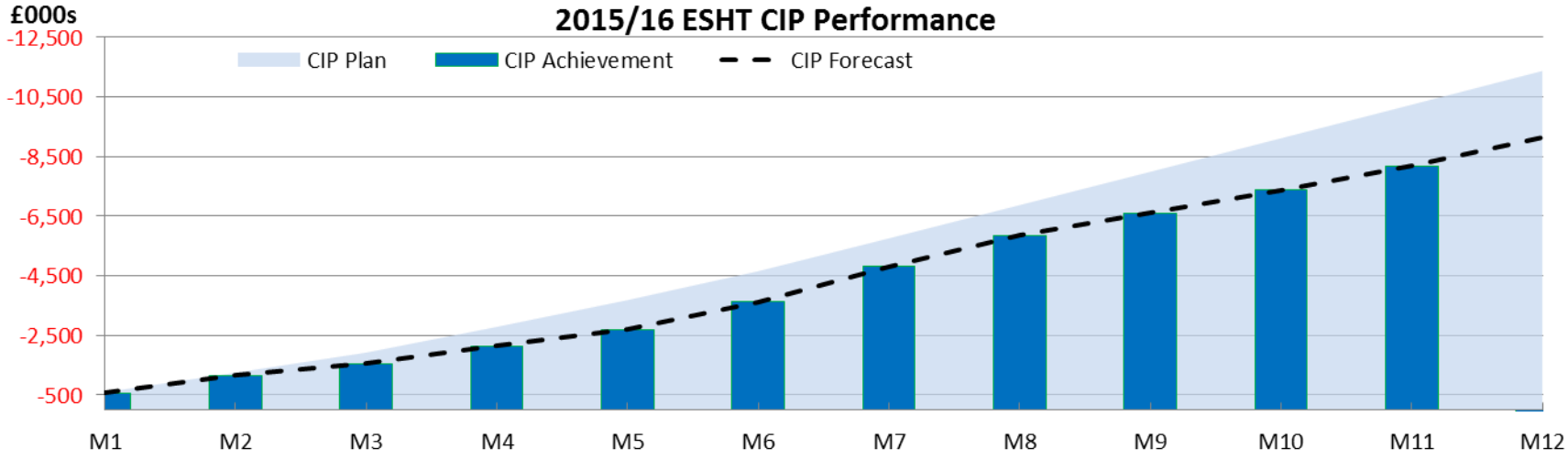
Corporate Services

Corporate Services reports £1.2m off plan cumulatively, partly due to continued interim arrangements, clinical coding agency and under delivery on CIP.

Income & Expenditure Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Urgent Care	-2,138	-2,877	-739	-22,868	-27,851	-4,983
Specialist Medicine	-1,622	-1,733	-111	-18,121	-19,637	-1,516
Cardiovascular	-1,198	-1,477	-279	-12,306	-15,039	-2,733
Surgery	-3,210	-3,807	-597	-36,133	-39,099	-2,966
Women & Children	-2,437	-2,506	-69	-26,994	-27,349	-355
Out of Hospital Care	-2,106	-2,149	-43	-28,174	-29,271	-1,097
Clinical Support	-6,167	-6,575	-408	-68,753	-73,644	-4,891
Tariff-Excluded Drugs & Devices	-2,704	-2,564	140	-29,741	-28,158	1,583
COO Operations	-930	-1,075	-145	-10,491	-11,527	-1,036
Total Clinical Units	**-22,512**	**-24,763**	**-2,251**	**-253,581**	**-271,575**	**-17,994**
Estates & Facilities	-2,118	-2,258	-140	-23,380	-23,916	-536
Corporate Services	-2,190	-2,357	-167	-24,662	-25,840	-1,178
Central Items	-2,790	-1,018	1,772	-26,674	-16,754	9,920
Total Central Areas	**-7,098**	**-5,633**	**1,465**	**-74,716**	**-66,510**	**8,206**
Contract Income	25,680	26,321	641	292,136	291,408	-728
Income	276	304	28	3,037	1,937	-1,100
Donated Asset/Impairment Adjustment	0	-142	-142	0	199	199
Adjusted Net Surplus/- Deficit	**-3,654**	**-3,913**	**-259**	**-33,124**	**-44,541**	**-11,417**

Workforce Plan FTE	Workforce Actual FTE	Pay Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
554	713	Urgent Care	-2,035	-2,739	-704	-21,748	-26,489	-4,741
432	429	Specialist Medicine	-1,522	-1,546	-24	-16,858	-17,582	-724
300	336	Cardiovascular	-1,132	-1,316	-184	-11,524	-13,774	-2,250
725	786	Surgery	-2,833	-3,212	-379	-31,705	-34,405	-2,700
590	591	Women & Children	-2,271	-2,377	-106	-25,105	-25,732	-627
721	708	Out of Hospital Care	-1,914	-2,083	-169	-25,233	-26,076	-843
1,101	1,107	Clinical Support	-4,050	-4,363	-313	-44,869	-46,914	-2,045
360	385	COO Operations	-871	-968	-97	-9,828	-10,431	-603
4,783	**5,055**	**Total Clinical Units**	**-16,628**	**-18,604**	**-1,976**	**-186,870**	**-201,403**	**-14,533**
690	713	Estates & Facilities	-1,374	-1,460	-86	-15,285	-15,690	-405
585	566	Corporate Services	-1,665	-1,765	-100	-18,473	-19,054	-581
1,275	**1,280**	**Total Non-Clinical Divisions**	**-3,039**	**-3,225**	**-186**	**-33,758**	**-34,744**	**-986**
0	**0**	Central Items	-659	82	741	-5,065	43	5,108
6,057	**6,335**	**Total Pay Analysis**	**-20,326**	**-21,747**	**-1,421**	**-225,693**	**-236,104**	**-10,411**

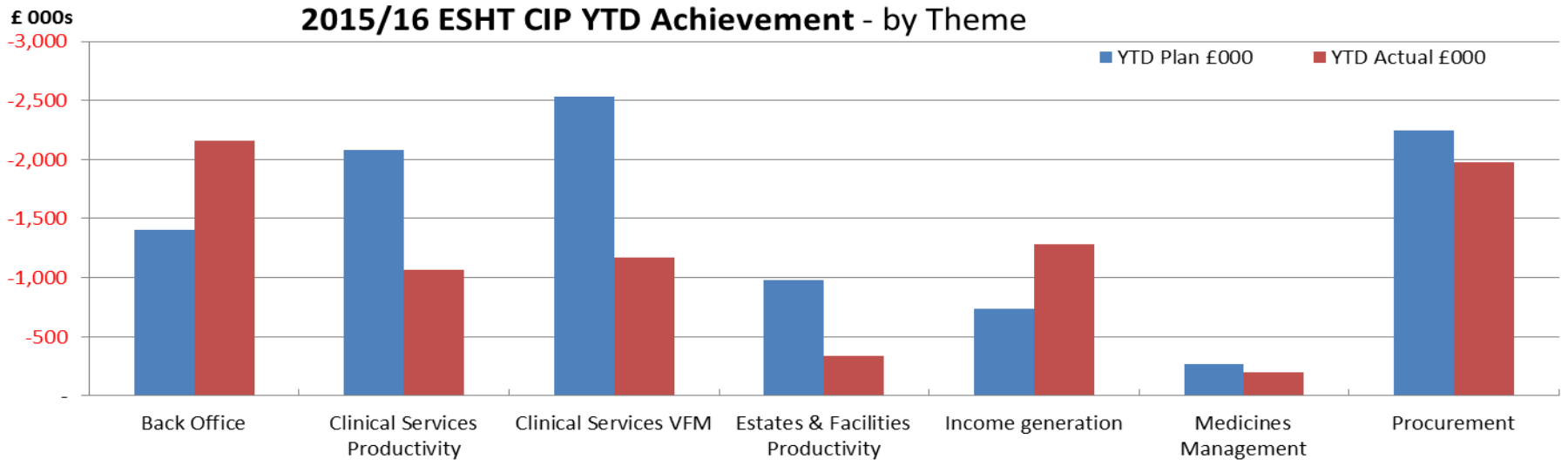
2.8 2015/16 ESHT CIP Performance to date – February 2016



	In Month			Year to Date			Forecast		
Clinical Unit	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast mth 10 £000	Variance FOT £000
Cardiovascular Medicine	-83	-73	-10	-777	-873	97	-859	-966	107
Estates and Facilities	-172	-125	-47	-1,413	-911	-502	-1,585	-1,042	-543
Corporate	-210	-210	-0	-2,070	-2,106	35	-2,281	-2,299	18
Specialist Medicine	-35	-13	-22	-368	-253	-116	-403	-265	-139
Surgery	-140	-15	-125	-1,363	-524	-839	-1,504	-572	-932
Trustwide	-13	-	-13	179	-	179	161	-131	292
Urgent Care	-35	-13	-22	-285	-167	-119	-320	-180	-140
Womens Health & Childrens Services	-62	-93	31	-599	-844	245	-660	-919	259
Contract Income	-42	-42	-	-458	-458	-	-500	-500	-
Out of Hospital Care	-53	-7	-46	-581	-138	-443	-633	-144	-489
Clinical Support	-282	-222	-60	-2,507	-1,921	-586	-2,790	-2,143	-646
Total	**-1,126**	**-812**	**-314**	**-10,243**	**-8,194**	**-2,049**	**-11,375**	**-9,161**	**-2,214**

2.9 2015/16 ESHT CIP Performance by Theme – February 2016

TDA Theme	In Month			Year to Date			Forecast		
	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast £000	Variance FOT £000
Back Office	-139	-219	80	-1,408	-2,161	753	-1,547	-2,356	809
Clinical Services Productivity	-235	-58	-177	-2,080	-1,068	-1,012	-2,319	-1,149	-1,170
Clinical Services VFM	-274	-104	-170	-2,531	-1,169	-1,362	-2,805	-1,280	-1,525
Estates & Facilities Productivity	-127	-10	-117	-976	-332	-644	-1,105	-348	-757
Income generation	-67	-180	113	-733	-1,282	549	-800	-1,464	664
Medicines Management	-28	-25	-3	-265	-202	-63	-293	-227	-66
Procurement	-256	-216	-40	-2,250	-1,980	-270	-2,506	-2,337	-169
Total	**-1,126**	**-812**	**-314**	**-10,243**	**-8,194**	**-2,049**	**-11,375**	**-9,161**	**-2,214**



2.10 Year on Year Comparisons – FEBRUARY 2016

Activity	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
Day Cases	40,331	39,256	1,075	2.7%
Elective Inpatients	7,178	8167	-989	-12.1%
Emergency Inpatients	38,841	39,422	-581	-1.5%
Total Inpatients	**86,350**	**86,845**	**-495**	**-0.6%**
Elective Excess Bed Days	1,674	1,754	-80	-4.6%
Non elective Excess Bed Days	22,873	19,887	2,986	15.0%
Total Excess Bed Days	**24,547**	**21,641**	**2,906**	**13.4%**
Consultant First Attendances	86,064	84,968	1,096	1.3%
Consultant Follow Ups	136,002	131,272	4,730	3.6%
OP Procedures	47,814	49,198	-1,384	-2.8%
Other Outpatients (WA & Nurse Led)	134,321	133,193	1,128	0.8%
Community Specialist	1,880	1,944	-64	-3.3%
Total Outpatients	**406,081**	**400,575**	**5,506**	**1.4%**
Chemotherapy Unbundled HRGs	7,017	5,924	1,093	18.5%
Antenatal Pathways	3,396	3,438	-42	-1.2%
Post-natal Pathways	3,235	3,083	152	4.9%
A&E Attendances (excluding type 2's)	98,633	95,056	3,577	3.8%
ITU Bed Days	5,498	5,316	182	3.4%
SCBU Bed Days	3,189	2,921	268	9.2%
Cardiology - Direct Access	766	680	86	12.6%
Radiology - Direct Access	55,813	51,667	4,146	8.0%
Pathology - Direct Access	3,040,536	2,962,832	77,704	2.6%
Therapies - Direct Access	29,811	34,523	-4,712	-13.6%
Audiology	10,985	15,061	-4,076	-27.1%
Midwifery	131	120	11	9.2%

£000s	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	291,408	317,857	-26,449	-8.3%
Private Patient/ RTA	2,410	2,924	-514	-17.6%
Trading Income	5,345	4,851	494	10.2%
Other Non Clinical Income	25,613	25,914	-301	-1.2%
Total Income	**324,776**	**351,546**	**-26,770**	**-7.6%**
Pay Costs	-236,104	-224,504	-11,600	-5.2%
Non Pay Costs	-116,149	-111,821	-4,328	-3.9%
Other	1,500	2,017	-517	25.6%
Total Direct Costs	-350,753	-334,308	-16,445	-4.9%
Surplus/-Deficit from Operations	**-26,977**	**17,238**	**-43,216**	**250.7%**
Profit/Loss on Asset Disposal	15	26	-11	
Depreciation	-11,670	-11,233	-437	-3.9%
Impairment	0	0	0	
PDC Dividend	-6,430	-7,175	745	10.4%
Interest	-678	-196	-482	-245.9%
Total Indirect Costs	-18,763	-18,578	-185	-1.0%
Total Costs	**-369,516**	**-352,886**	**-16,630**	**-4.7%**
Net Surplus/-Deficit	**-44,740**	**-1,340**	**-43,400**	**-3238.8%**
Donated Asset / Other Adjustment	199	383	-184	48.0%
Normalised Net Surplus/-Deficit	**-44,541**	**-957**	**-43,584**	**-4554.2%**

Headlines
• Total Inpatient activity to date is 0.6% lower than last year's level. • Total outpatients are 1.4% higher than last year although outpatient procedures are 2.8% down • Total A&E attendances are 3.8% higher than last year. • Total income is £26.8m (7.6%) down on the same period last year, this includes £16.5m (4.7%) of the £18.0m commissioner support in 2014/15 that is not available in the current year. • Total expenditure is £16.6m (4.7%) up on the same period last year.

2.11 Capital Programme – FEBRUARY 2016

Headlines

Year to Date Performance:-

After eleven months of the financial year, capital expenditure has increased to £8.8m. The most significant areas of year to date expenditure being in respect of the Pevensey Ward redevelopment, medical equipment purchase and minor capital schemes.

Commitments entered into at 29th February 2016 amount to £11.9m compared to the total capital resource of £11.8m. The current over planning margin has increased to £2.3m which is considered manageable, in light of the current level of commitments and forecast slippage anticipated within the capital programme.

The Capital Approvals Group (CAG) will continue to monitor the capital programme on a biweekly basis during the remainder of the financial year, paying particular attention to the on-going risks associated with limited capital resource.

Capital Investment Programme £000s	2015/16 Capital Programme	Expenditure at Month 11	Forecast Outturn
Capital Resources			
Depreciation	11,820		
DH Maternity Equipment Funding	32		
Additional Capital Loan - Health Records Storage	441		
League of Friends Support	1,121		
Cap Investment Loan Principal Repayment	-427		
Gross Capital Resource	12,987		
Less Donated Income	-1,121		
Capital Resource Limit (CRL)	**11,866**	-	-
Capital Investment			
Medical Equipment	2,140	1,376	1,911
IT Systems	1,028	598	859
Electronic Document Management	835	340	382
Child Health Information System	673	243	349
PAS Upgrade	373	342	425
Backlog Maintenance	1,547	378	1,329
Infrastructure Improvements - Modernisation of Inpatient Environment and Facilities	798	540	762
Pevensey Ward	2,055	2,138	2,138
Minor Capital Schemes	2,000	1,500	2,000
Health Records	881	557	569
Other various	1,810	804	1,142
Sub Total	**14,140**	**8,816**	**11,866**
Donated Asset Purchases	1,121	838	1,058
Donated Asset Funding	-1,121	-838	-1,058
Net Donated Assets	**0**	0	0
Sub Total Capital Schemes	**14,140**	**8,816**	**11,866**
Overplanning Margin (-) Underplanning (+)	-2,274	0	0
Net Capital Charge against the CRL	**11,866**	**8,816**	**11,866**

2.12 Financial Sustainability Risk Ratings – FEBRUARY 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 -15 days, a rating of 1.
  - The capital servicing capacity ratio of -0.68 results in a rating of 1.
  - The I&E margin of -13.8% results in a rating of 1.
  - The variance in I&E margin is -3.6%, a rating of 1.
  - As a result the overall Trust rating is 1.

Liquidity Ratio (days) £000s	2014/15 Outturn	2015/16 YTD
Opening Current Assets	27,044	30,479
Opening Current Liabilities	-28,815	-39,951
Net Current Assets/Liabilities	-1,771	-9,472
Inventories	-6,599	-6,464
Adj Net Current Assets/Liabilities	**-8,370**	**-15,936**
Divided by:		
Total costs in year	364,471	350,753
Multiply by (days)	360	330
Liquidity Ratio	**-8**	**-15**

Capital Servicing Capacity (times) £000s	2014/15 Outturn Actual	2015/16 YTD Plan	2015/16 YTD Actual
Net Surplus / Deficit (-) After Tax	473	-33,124	-44,740
Less:			
Donated Asset Income Adjustment	-1,107	-1,150	-839
Interest Expense	235	919	704
Profit/Loss on Sale of Assets	-29	0	-15
Depreciation & Amortisation	12,265	11,985	11,670
Impairments	-629	0	0
PDC Dividend	8,073	7,116	6,430
Revenue Available for Debt Service	**19,281**	**-14,254**	**-26,790**
Interest Expense	235	919	704
PDC Dividend	8,073	7,116	6,430
Temporary PDC repayment			
Working capital loan repayment	18,171	213	31,628
Capital loan repayment	320	306	598
	26,799	8,554	39,360
Capital Serving Capacity	**0.72**	**-1.67**	**-0.68**

Financial Efficiency £000s	2014/15 Outurn Actual	2015/16 YTD Plan	2015/16 YTD Actual	2015/16 YTD Variance
Normalised Net surplus/ deficit	88	-33,124	-44,740	
Less fixed asset impairments/disposals	-29	0	-15	
	59	-33,124	-44,755	
Divided by:				
Total Income (excl donated assets)	383,768	-324,619	-323,937	
I&E Margin	**0.0%**	**-10.2%**	**-13.8%**	**-3.6%**

2.13 Financial Risks & Mitigating Actions – FEBRUARY 2016

Summary	
RISKS:-	
The following areas of risk have been identified in achieving the projected year end £48.0m deficit.	
1) Increased activity and capacity cost pressures, e.g. Junior Doctor strike, RTT pressures, Escalation Wards, Radiology capacity	
2 Unplanned operational cost pressures, e.g. recruitment delays and continued high use of agency staff.	
MITIGATING ACTIONS:-	
The following mitigations have been identified to offset the risks identified above.	
1) Reduction in expenditure through discretionary spend controls and additional cost improvement schemes.	
2) Tighter controls on authorisation of Agency expenditure.	

3.0 Workforce Executive Summary – Key Points – FEBRUARY 2016

Headlines
• Actual workforce usage of staff in February was 6334.88 full time equivalents (ftes), 277.52 above budget. That is 51.99 ftes higher than last month. • Temporary staff expenditure was £3,843K in February (17.67% of total pay expenditure). This comprises £1,326K bank expenditure, £2,463K agency expenditure and £53K overtime. This is an increase of £102K overall compared to January • There were 422.43 fte vacancies (a vacancy factor of 7.16%). This is 42.28 ftes lower than the figure for January. • Annual turnover was 11.28% which represents 594.58 fte leavers in the last year • Monthly sickness was 5.10%, an increase of 0.65% from January. Annual sickness was 4.53%, a reduction of 0.01% • Mandatory training rates have all increased this month, with the exception of Information Governance, which is slightly lower. • Appraisal compliance increased by 1.95% to 85.29%

3.1 Trust Overview – FEBRUARY 2016

TRUST	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Trend line
WORKFORCE CAPACITY													
Budgeted fte	6135.58	6173.71	6221.89	6197.01	6233.56	6239.90	6244.41	6240.44	6028.97	6059.16	6057.38	6057.36	
Total fte usage	6149.97	6185.06	6116.05	6181.61	6216.76	6243.02	6237.90	6281.08	6236.91	6226.53	6282.89	6334.88	
Variance	-14.39	-11.35	105.84	15.4	16.8	-3.12	6.51	-40.64	-207.94	-167.37	-225.51	-277.52	
Permanent vacancies	369.29	524.43	536.35	520.61	556.18	542.99	542.14	514.02	479.35	479.90	464.71	422.43	
Fill rate	93.79%	91.36%	91.15%	91.43%	90.84%	91.07%	91.09%	91.55%	91.83%	91.87%	92.12%	92.84%	
Bank fte usage (as % total fte usage)	6.31%	6.77%	5.77%	6.07%	6.15%	6.42%	6.34%	6.34%	6.75%	6.68%	6.27%	6.65%	
Agency fte usage (as % total fte usage)	3.38%	4.11%	4.25%	4.53%	5.64%	5.33%	5.08%	5.30%	6.94%	6.45%	7.35%	7.06%	
WORKFORCE EFFICIENCY													
Annual sickness rate	4.94%	4.99%	4.99%	4.97%	4.94%	4.91%	4.86%	4.77%	4.72%	4.61%	4.54%	4.53%	
Monthly sickness rate (%)	4.77%	4.65%	4.24%	4.30%	4.21%	4.26%	4.36%	4.51%	4.60%	4.48%	4.45%	5.10%	
Turnover rate	11.98%	12.42%	12.30%	12.12%	12.26%	12.20%	11.77%	12.24%	12.07%	11.97%	11.79%	11.28%	
TRAINING & APPRAISALS													
Appraisal rate	74.68%	75.22%	74.88%	74.54%	75.03%	73.69%	77.60%	77.93%	81.83%	81.85%	83.34%	85.29%	
Fire	83.22%	81.52%	82.47%	82.82%	83.78%	83.03%	82.90%	82.77%	84.49%	83.49%	83.96%	85.07%	
Moving & Handling	81.08%	79.84%	82.97%	84.59%	85.44%	84.21%	85.24%	85.02%	85.81%	85.76%	86.93%	88.09%	
Induction	94.47%	95.16%	93.32%	93.64%	94.62%	90.95%	92.53%	91.89%	93.66%	90.95%	91.97%	92.79%	
Infec Control	86.41%	86.32%	86.27%	84.85%	85.78%	84.58%	85.82%	85.81%	86.83%	86.53%	86.99%	87.86%	
Info Gov	77.06%	75.99%	77.26%	81.89%	82.57%	82.38%	82.25%	83.41%	87.40%	86.42%	86.81%	86.23%	
Health & Safety	67.04%	68.79%	71.18%	73.36%	74.80%	75.47%	78.16%	80.03%	82.88%	83.67%	84.42%	85.35%	
MCA	92.36%	92.31%	92.48%	92.63%	93.02%	92.80%	93.18%	92.84%	93.39%	93.36%	93.10%	93.40%	
DoLs	89.09%	89.03%	89.64%	90.11%	90.88%	90.82%	91.44%	91.31%	91.81%	92.29%	92.78%	93.29%	
Safeguarding Vulnerable Adults	85.98%	72.98%	73.24%	74.38%	75.08%	74.62%	76.05%	76.05%	77.64%	78.06%	78.28%	79.06%	
Safeguarding Children Level 2	78.12%	77.90%	79.61%	79.87%	80.13%	79.19%	80.59%	80.40%	81.42%	80.75%	81.45%	82.46%	

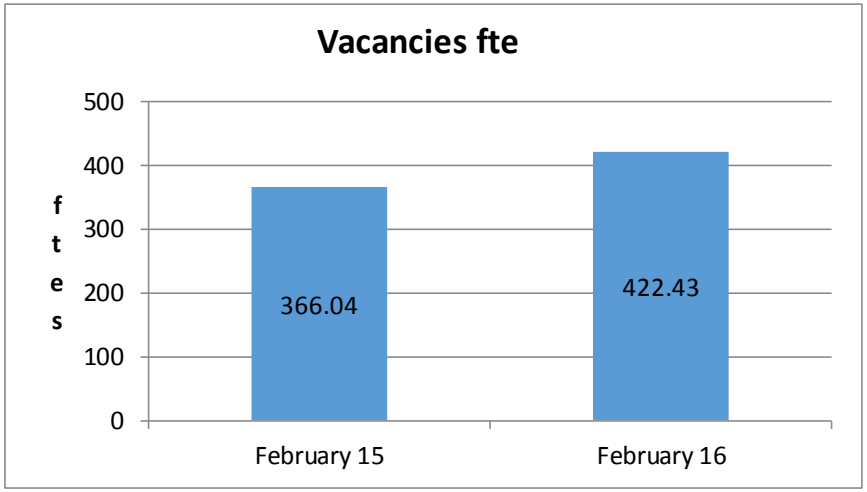
3.2 Trust Overview – Clinical Units – FEBRUARY 2016

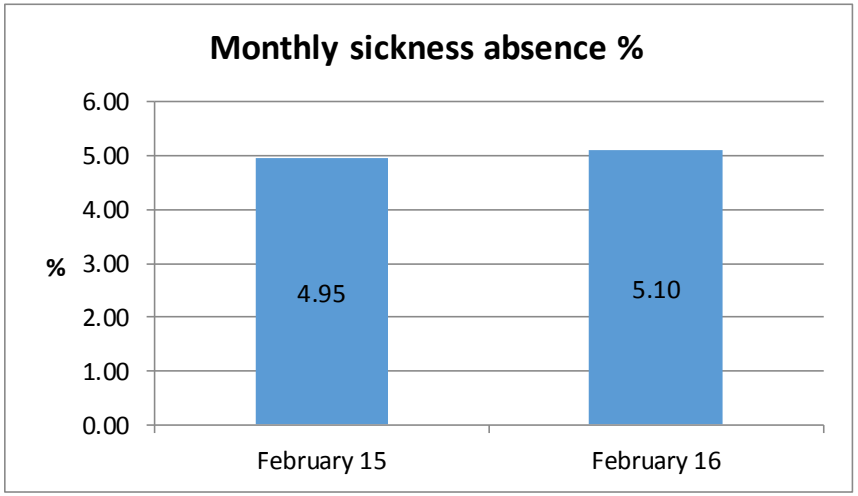
Feb-16	Budg estab fte	Actual worked fte	Vacancies fte	Vacancy trend since last month	Fill rate %	Monthly sickness %	Annual sickness %	Turnover	Temp staff expenditure	Appraised /exempt in last yr	Appraisal trend since last month
Theatres & Clinical Support	1,086.56	1,054.92	65.67	↓	93.92%	5.16%	4.52%	8.99%	£647,828	86.59%	↑
Cardiovascular Medicine	300.16	336.90	22.21	↓	92.60%	3.72%	3.68%	8.86%	£318,396	92.76%	↑
Urgent Care	553.92	698.55	37.72	↓	93.19%	6.22%	5.04%	11.82%	£1,052,611	82.83%	↑
Specialist Medicine	431.81	423.10	36.46	↓	91.56%	4.96%	4.17%	10.26%	£217,296	90.00%	↑
Out of Hospital Care	721.20	691.44	51.55	↓	92.85%	5.60%	5.20%	18.07%	£184,754	87.90%	↑
Surgery	725.16	805.95	69.74	↑	90.38%	3.93%	3.55%	9.36%	£697,047	87.71%	↑
Womens & Childrens	590.28	590.42	21.34	↑	96.38%	5.74%	4.72%	10.99%	£257,699	79.66%	↑
COO Operations	373.60	405.11	18.78	↓	94.78%	3.94%	4.32%	10.21%	£101,074	86.47%	↑
Estates & Facilities	687.94	727.62	60.12	↓	90.66%	6.65%	5.84%	8.44%	£239,838	71.68%	↑
Corporate	498.79	485.16	38.84	↓	92.11%	4.50%	3.97%	12.46%	£126,251	92.21%	↓
TRUST	6057.36	6334.88	422.43	↓	92.84%	5.10%	4.53%	11.28%	£3,842,794	85.29%	↑

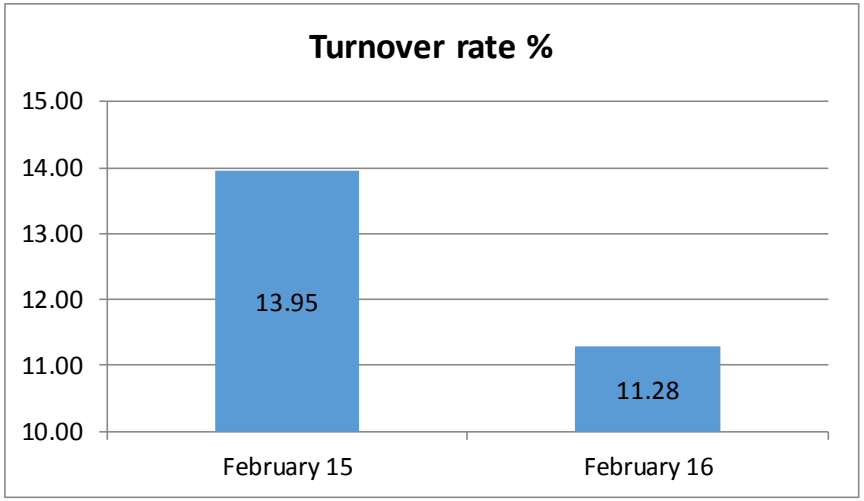
3.3 Trust Overview – Staff Groups – FEBRUARY 2016

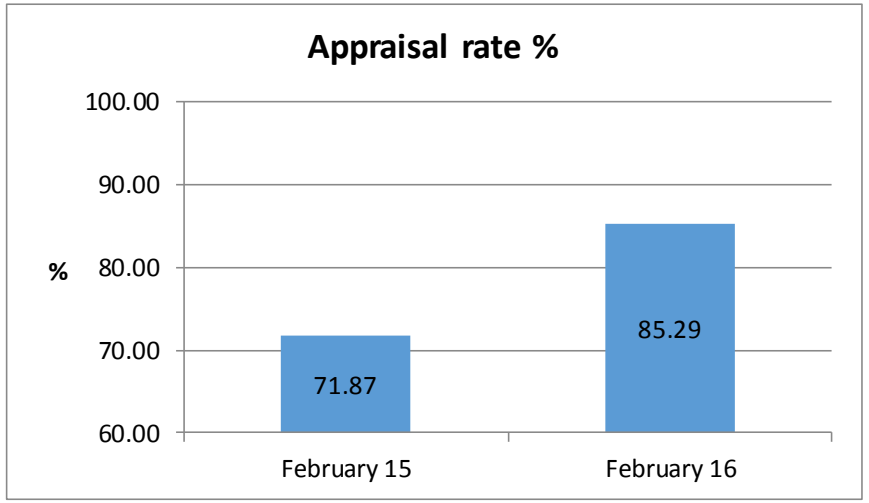
STAFF GROUPS	Budg estab fte	Actual worked fte	Vacancies fte	Fill rate %	Monthly pay budget (£000s)	Monthly pay expend. (£000s)	Monthly sickness %	Turnover %	Appraised/ exempt in last yr
MEDICAL & DENTAL	583.92	600.87	66.05	88.37%	£4,689,651	£5,136,741	1.16%	11.53%	93.58%
NURSING & MIDWIFERY REGISTERED	1930.43	2048.15	181.20	90.45%	£6,793,310	£7,476,785	5.23%	10.38%	84.40%
SCIENTIFIC, THERAP & TECH	938.43	889.07	84.92	90.94%	£2,851,887	£2,923,984	4.03%	14.25%	88.26%
ADDITIONAL CLINICAL SERVICES	757.37	884.85	-5.70	100.78%	£1,609,822	£1,864,659	7.01%	13.02%	87.40%
ADMINISTRATIVE & CLERICAL	1165.27	1188.17	65.11	94.29%	£3,033,132	£3,011,766	4.91%	10.76%	85.82%
ESTATES & ANCILLARY	681.94	723.77	30.85	95.07%	£1,347,964	£1,332,566	7.03%	8.57%	75.15%
TRUST	6057.36	6334.88	422.43	92.84%	£20,325,766	£21,746,500	5.10%	11.28%	85.29%

3.4 12 Month Comparisons – FEBRUARY 2016

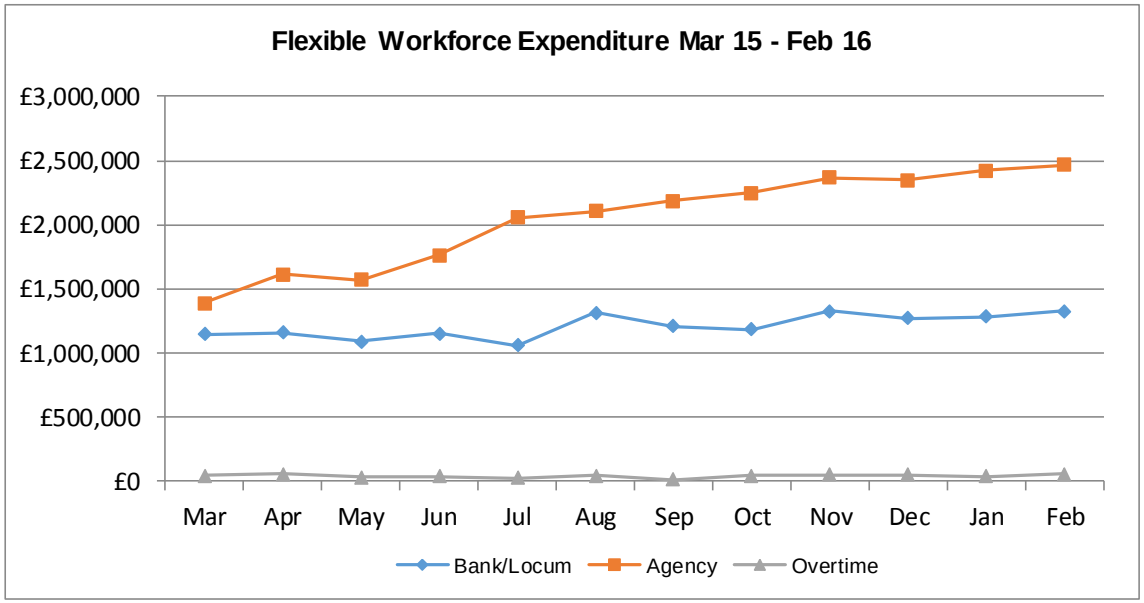


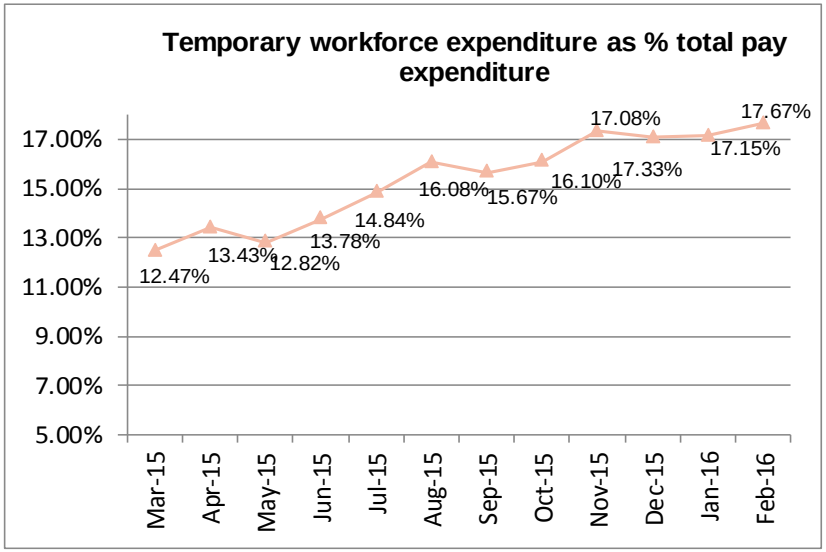


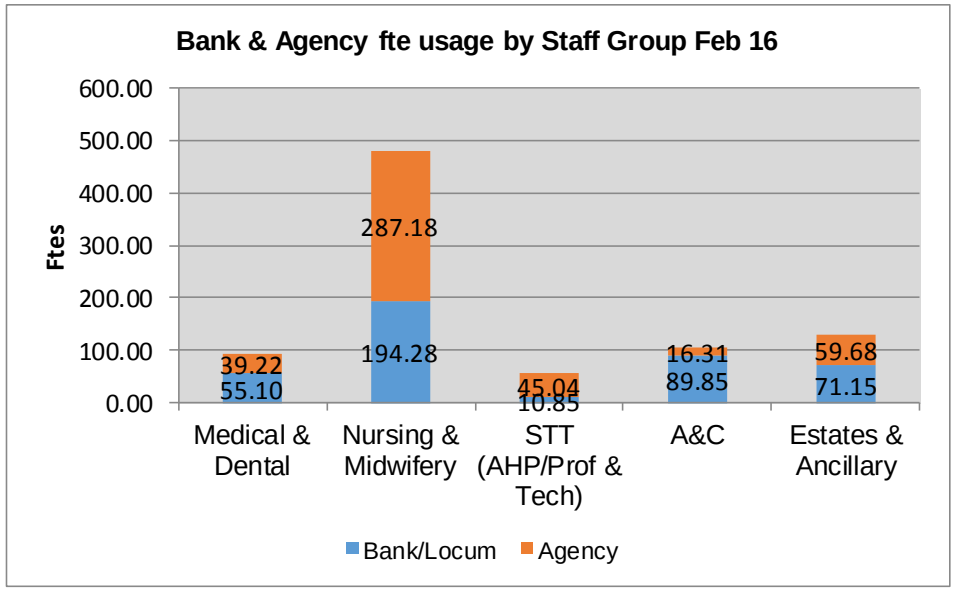


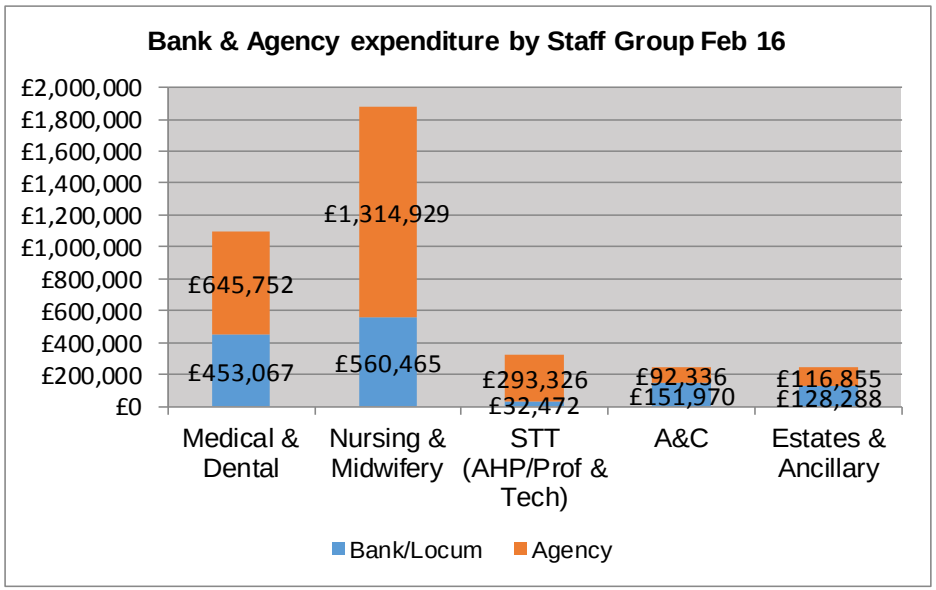


3.5 Workforce Usage – FEBRUARY 2016







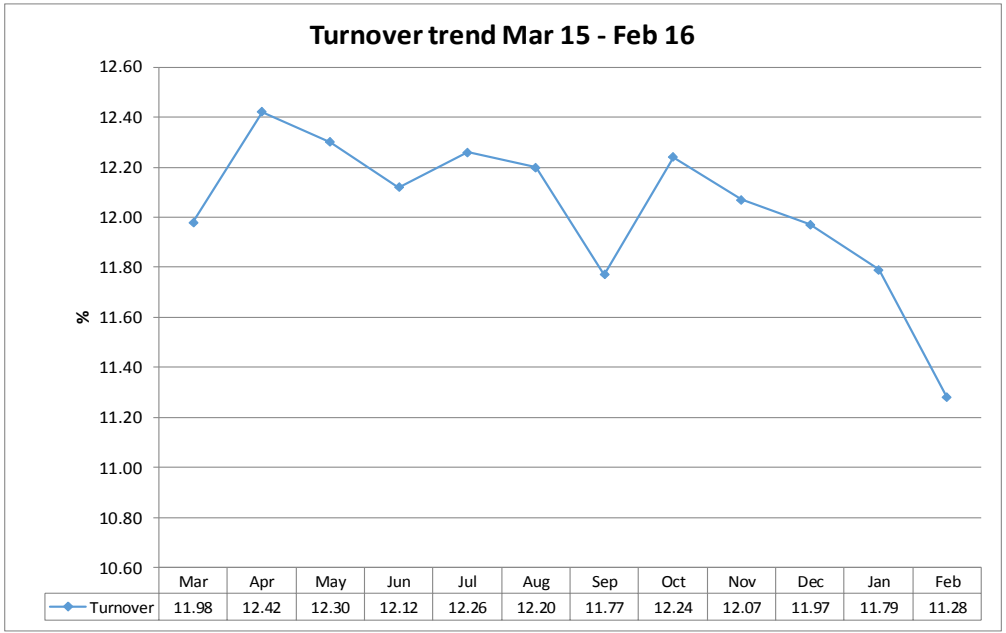


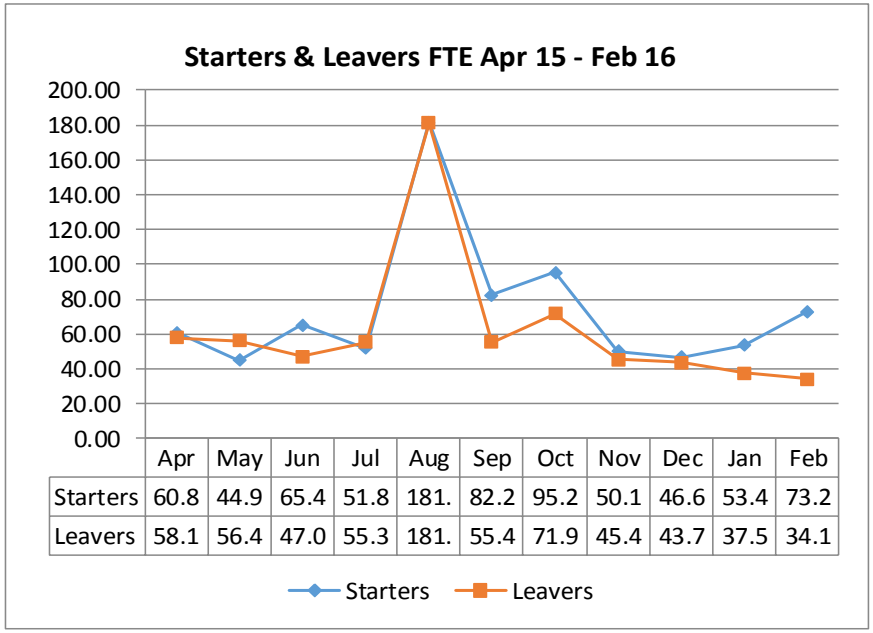
Permanent staff numbers continue to increase, by a further 41 ftes this month, following successful recruitment, yet bank, agency and overtime expenditure have all increased. Overall, temporary workforce expenditure increased by £102K compared to January at £3,843K in total for the month. Bank expenditure was up by £45K, agency increased by £42K and overtime by £15K.

The increase in temporary workforce expenditure was due to a number of factors. A&E CDU was open throughout the month and there was increased short term sickness in A&E. A new agency stroke consultant started in February and there was higher use of paediatric medical agency and Obstetrics & Gynaecology consultant agency due to vacancies. Additional beds were in use in Surgery, covering medical patients and there was increased use of specialling, particularly on De Cham and Egerton wards. There was also increased activity in Theatres resulting in additional temporary workforce usage. In addition, there was a catch up of agency invoices in Pharmacy and Transport in February which boosted expenditure in month. Additional administrative overtime was used in support of 18 weeks targets and Outpatients and Cardiology booking.

Overtime has been approved in some areas as an alternative to expenditure on agency. Reductions in agency expenditure, compared to last month, were achieved in Specialist Medicine (-£32K), Surgery (-£16K), Out of Hospital (-£28K), Estates & Facilities (-£33K) and Corporate areas (-£9K).

3.6 Turnover & Vacancies – FEBRUARY 2016





Starters & Leavers (not inc Employee Transfers)	Apr-15		May-15		Jun-15		Jul-15		Aug-15		Sep-15		Oct-15		Nov-15		Dec-15		Jan-16		Feb-16	
STAFF GROUP	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr
Add Prof Scientific and Technic	1.00	1.80	0.00	1.00	0.64	2.80	0.73	1.20	0.00	1.40	3.60	1.00	0.00	2.00	0.20	1.00	3.00	0.00	5.43	2.40	1.40	0.00
Additional Clinical Services	15.51	8.02	9.82	12.33	16.28	7.24	17.75	9.77	11.01	18.02	19.67	9.30	5.01	8.43	19.50	9.02	17.67	8.17	20.51	8.45	36.38	6.61
Administrative and Clerical	8.13	11.80	14.31	11.44	22.41	8.09	13.31	4.79	5.40	11.75	8.12	12.55	10.56	10.03	8.40	10.44	1.49	6.53	12.05	7.15	12.44	8.12
Allied Health Professionals	3.40	2.88	3.60	2.00	5.00	7.00	4.40	9.00	11.10	6.50	4.79	5.48	5.77	3.67	4.00	2.00	0.00	3.91	4.00	0.69	0.85	2.00
Estates and Ancillary	3.73	4.88	0.00	4.76	2.07	2.07	4.00	3.76	4.00	3.00	4.00	2.11	3.27	5.08	2.00	6.85	5.04	2.36	0.43	3.87	1.00	3.10
Healthcare Scientists	2.00	0.60	3.00	1.00	4.00	0.00	2.00	4.00	2.00	3.00	4.00	1.00	0.00	0.00	0.85	4.00	2.00	1.00	2.00	1.00	0.00	0.00
Medical and Dental	10.05	9.60	5.60	9.00	4.00	5.60	3.50	5.49	139.93	116.33	19.90	14.55	37.20	27.10	6.30	1.60	10.80	7.80	2.00	1.60	6.80	6.70
Nursing and Midwifery Registered	16.99	18.52	8.59	14.88	11.03	14.27	6.16	16.36	8.17	19.26	13.72	9.43	33.48	15.60	8.93	10.51	6.61	13.02	7.00	12.40	14.35	7.63
Students	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	2.00	4.50	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00
Grand Total	**60.80**	**58.10**	**44.92**	**56.41**	**65.43**	**47.06**	**51.85**	**55.37**	**181.61**	**181.26**	**82.29**	**55.42**	**95.29**	**71.91**	**50.19**	**45.42**	**46.61**	**43.79**	**53.42**	**37.56**	**73.22**	**34.16**

Trust fte vacancies reduced by a further 42.28 ftes in February and the Trust vacancy rate reduced by 0.72% to 7.16%. The medical vacancy rate was 11.63% (66.05 fte vacancies), for registered nursing & midwives, it was 9.55% (181.20 ftes) whilst unqualified nurses have now been recruited to above establishment -0.78% vacancy rate (5.70 additional ftes).

Month on month, there has been a small increase in the numbers of external nurses joining the Trust but still not to a point where UK recruited starters match the number of leavers. Thus the Trust needs to continue to supplement them with international recruitment. 7 nurses recruited from the EU will start on 18 March with a further 7 in April, 2 in May and 2 in June confirmed. A recent recruitment trip to Croatia resulted in 21 offers, with anticipated start dates in May. 13 Philippine nurses will join the Trust on 6 April with a further 23 to start, anticipated in May. Further interviews for EU nurses, via Skype, are planned for March with 20 candidates lined up. There are also further planned visits to Croatia on 10 May with 30 candidates and a second trip to the Philippines is planned for the end of April to recruit 40+ nurses.

20 newly qualified nurses started in February and there will be a further 2 cohorts of 28 nurses in September 2016 and February 2017.

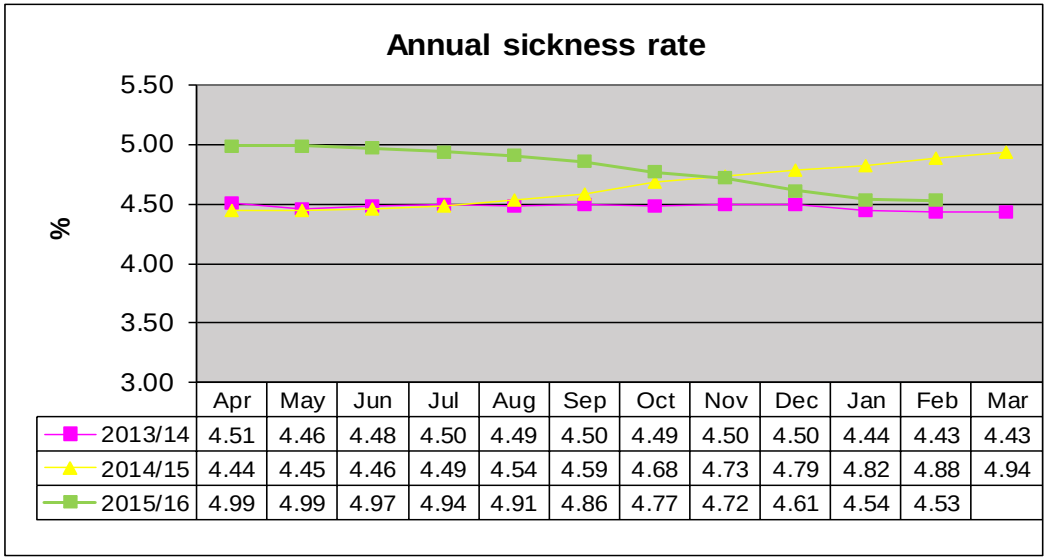
We currently have 16.15 fte vacancies for midwives following a recent increase in the establishment in February 2016, 6.88 ftes have been appointed and the remainder of the vacancies are in the recruitment process.

It remains difficult to fill medical posts for all grades in Emergency Medicine & Anaesthetics and Consultant posts in Histopathology, Elderly Care and Ophthalmology. The Trust is investigating a successful project carried out by a Trust in Derbyshire, which has resulted in them achieving full recruitment to middle grade A&E doctors from within the UK, to see if this is a model which can be adapted to address the recruitment difficulties experienced in this area.

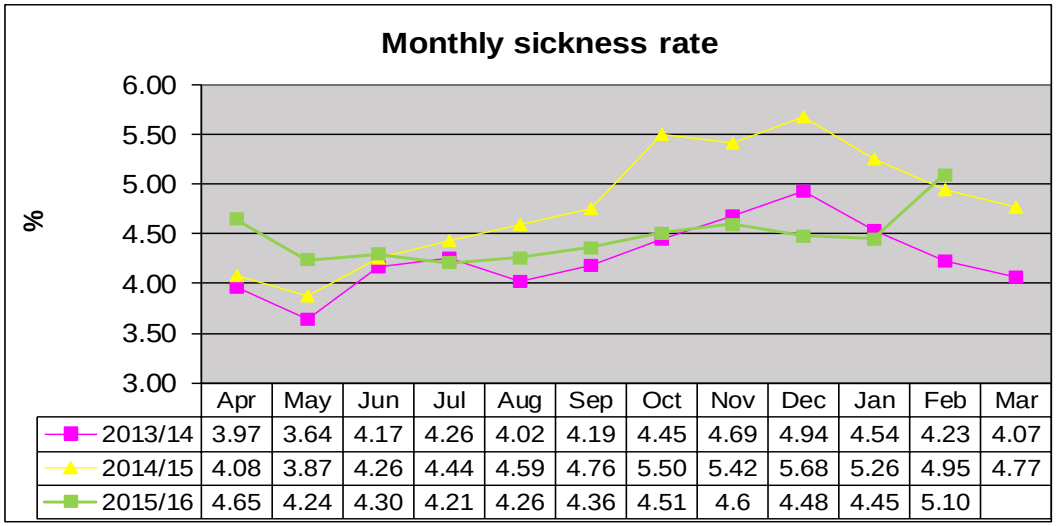
As mentioned above, unqualified nurses have been filled to slightly above establishment. Those currently in the pipeline will be offered posts on the bank if substantive posts are not available and use of healthcare assistant agency should reduce. There is also still significant use of unbudgeted workforce for escalation areas and for specialling of patients.

The Trust turnover rate continues to fall. The latest available comparative information from the Health & Social Care Information Centre shows turnover for the year to November 15 as 8.74% for NHS Trusts. For large acute Trusts it was 7.64% and for Community Trusts 17.96%. At that time our turnover was 12.07%.

3.7 Sickness – FEBRUARY 2016



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14	4.51	4.46	4.48	4.50	4.49	4.50	4.49	4.50	4.50	4.44	4.43	4.43
2014/15	4.44	4.45	4.46	4.49	4.54	4.59	4.68	4.73	4.79	4.82	4.88	4.94
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77	4.72	4.61	4.54	4.53	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14	3.97	3.64	4.17	4.26	4.02	4.19	4.45	4.69	4.94	4.54	4.23	4.07
2014/15	4.08	3.87	4.26	4.44	4.59	4.76	5.50	5.42	5.68	5.26	4.95	4.77
2015/16	4.65	4.24	4.30	4.21	4.26	4.36	4.51	4.6	4.48	4.45	5.10	

Monthly sickness has increased this month by 0.65% to 5.10%. This seems to be partly due to seasonal factors with a 39% increase, month on month, in absences due to cold/cough/flu and a 31% increase in chest & respiratory illnesses. On a positive note, absences due to stress/anxiety are down by 13%.

The annual sickness rate has still fallen marginally by 0.01% to 4.53% as the overall trend is down.

Sickness was highest in February amongst Estates and Ancillary staff at 7.03% and Additional Clinical Services staff (i.e. mostly unqualified nurses and therapy helpers) at 7.01%.

The latest available comparative figures from the Health & Social Care Information Centre show the monthly sickness rates for NHS Trusts, in November 15, at 4.45%, at a time when our rate was 4.60%. The rate for large Acute Trusts was also 4.45% and for Community Trusts it was 4.71**%**.

HR are focussing on sickness hotspots within the Trust and reducing the numbers of staff on long term sickness.

As part of the 2016/17 business planning process, funding is being reviewed to support health and wellbeing initiatives.

3.8 Training & Appraisals – FEBRUARY 2016

Mandatory Training – Six Month Trend

Mandatory training course	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	6 month trend
Induction %	92.53	91.89	93.66	90.95	91.97	92.79	
Fire %	82.90	82.77	84.49	83.49	83.96	85.07	
Manual Handling %	85.24	85.02	85.81	85.76	86.93	88.09	
Infection Control %	85.82	85.81	86.83	86.53	86.99	87.86	
Info Gov %	82.25	83.41	87.40	86.42	86.81	86.23	
Health & Safety %	78.16	80.03	82.88	83.67	84.42	85.35	
Mental Capacity Act %	93.18	92.84	93.39	93.36	93.10	93.40	
Depriv of Liberties %	91.44	91.31	91.81	92.29	92.78	93.29	
Safeguard Vuln Adults	76.05	76.05	77.64	78.06	78.28	79.06	
Safeguard Child Level 2	80.59	80.40	81.42	80.75	81.45	82.46	

Clinical Unit Mandatory Training & Appraisals

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Appraisal compliance
Theatres & Clinical Support	85.17%	87.59%	92.94%	86.01%	84.51%	87.59%	95.20%	92.18%	81.55%	84.26%	86.59%
Cardiovascular Medicine	86.89%	91.48%	90.70%	87.21%	84.59%	78.36%	89.18%	92.73%	71.27%	72.01%	92.76%
Urgent Care	80.30%	85.50%	93.40%	83.27%	76.95%	79.00%	85.98%	87.13%	68.70%	71.95%	82.83%
Specialist Medicine	85.61%	87.01%	92.06%	83.53%	81.67%	83.53%	92.74%	89.81%	81.72%	79.78%	90.00%
Out of Hospital Care	87.93%	88.06%	97.10%	91.08%	89.11%	84.78%	96.72%	97.99%	83.05%	85.04%	87.90%
Surgery	85.53%	88.82%	91.82%	86.97%	90.26%	90.39%	95.15%	94.43%	83.03%	80.61%	87.71%
Womens & Childrens	86.32%	89.92%	95.00%	88.87%	84.06%	83.16%	94.06%	92.73%	77.24%	93.05%	79.66%
COO Operations	80.71%	91.39%	73.68%	83.68%	95.55%	66.77%	n/a	n/a	n/a	n/a	86.47%
Estates & Facilities	78.73%	79.47%	84.38%	90.40%	83.01%	90.69%	100.00%	100.00%	100.00%	100.00%	71.68%
Corporate	92.83%	96.23%	100.00%	94.91%	94.72%	94.15%	94.32%	100.00%	81.82%	92.08%	92.21%
TRUST	**85.07%**	**88.09%**	**92.79%**	**87.86%**	**86.23%**	**85.35%**	**93.40%**	**93.29%**	**79.06%**	**82.46%**	**85.29%**

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

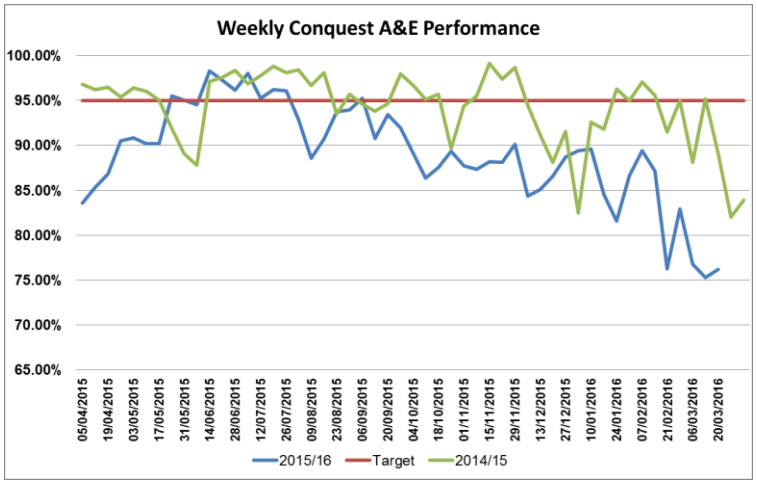
The continued efforts of the mandatory trainers, the Learning & Development team, and the Clinical Units has resulted in the majority of mandatory topics achieving over 85% compliance this month but this needs to be sustained and improved upon.

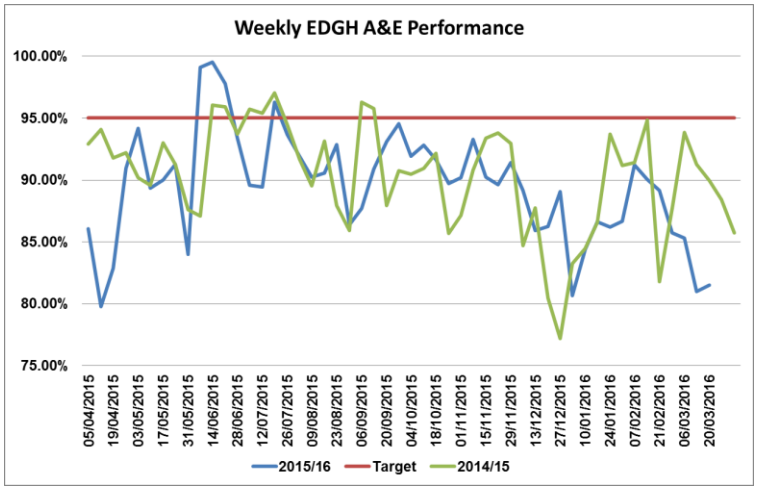
Particular emphasis will be placed on increasing compliance rates for Safeguarding Adults and Children training through the promotion of workbooks through the Clinical Unit Leads as well as making these available on Mandatory Update days. The deadline for renewal of Information Governance training is 31st March 2016 and Clinical Unit Leads will be encouraged to chase up staff who are out of date

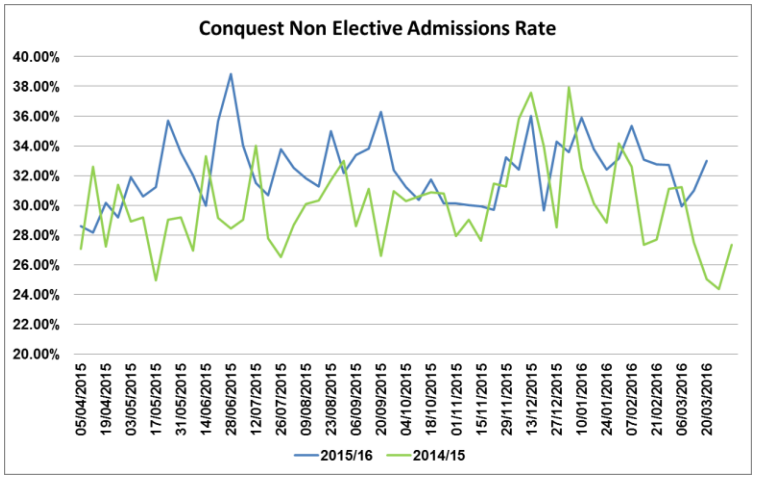
The appraisal rate continues to improve, up by a further 1.95% this month to 85.29% which is, again, the highest rate yet recorded for the Trust.

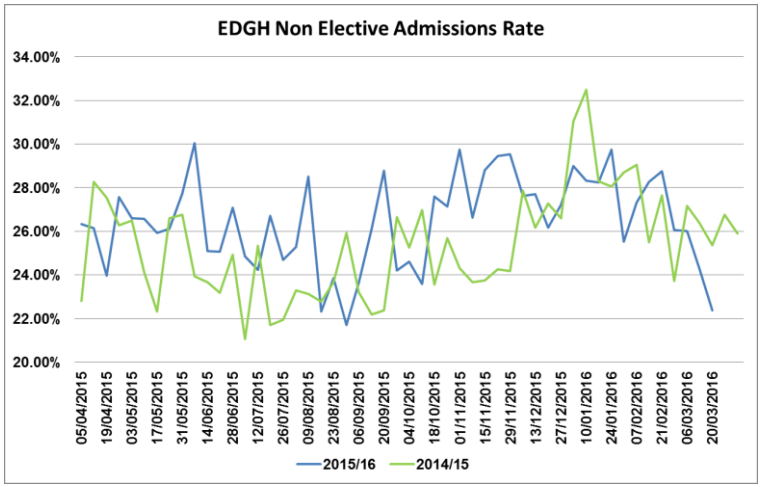
4.0 Appendices – FEBRUARY 2016

4.1 Appendix 1: A&E Performance Graphics

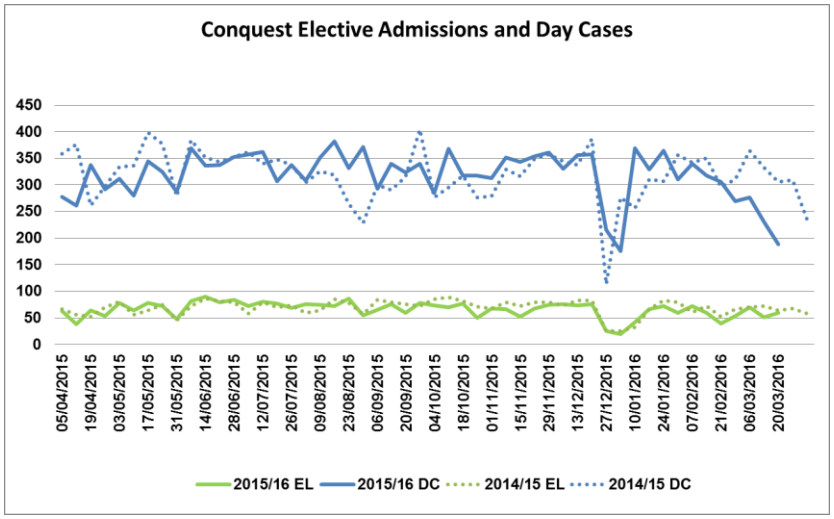


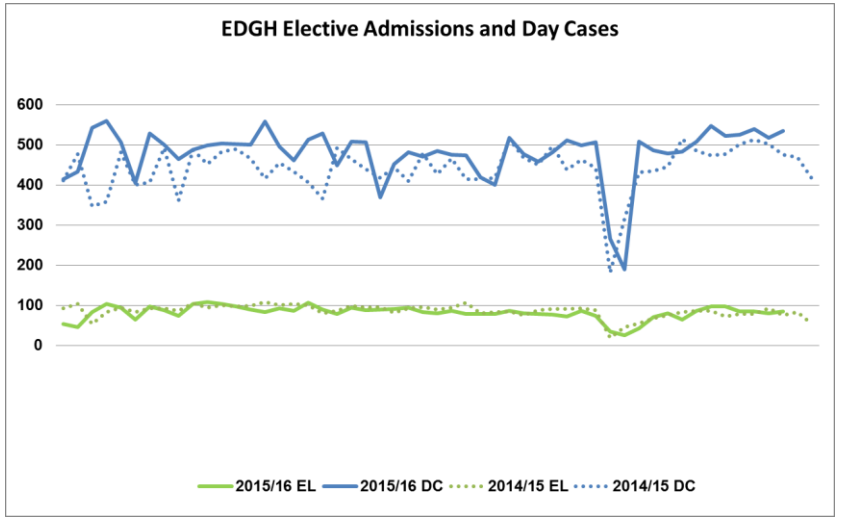


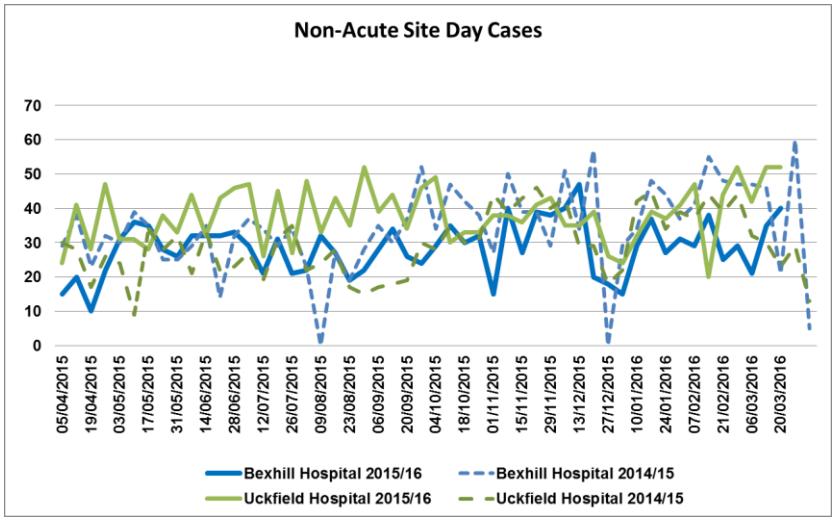


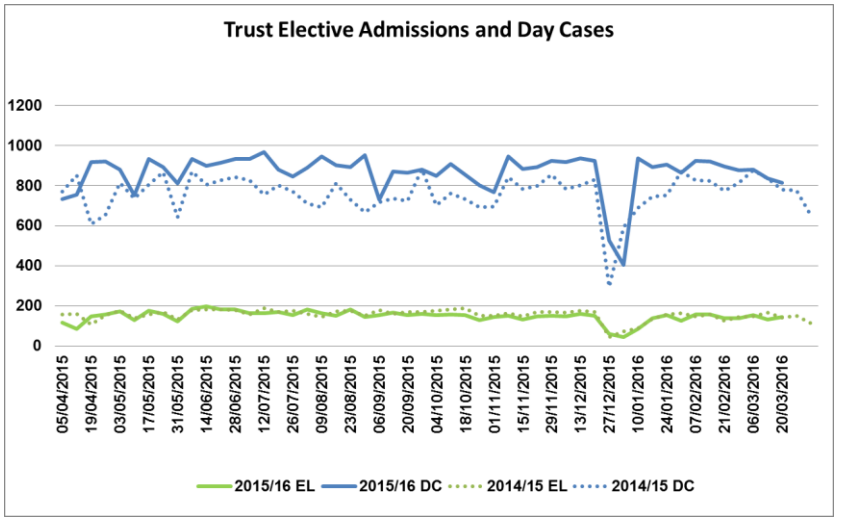


4.2 Appendix 2: Inpatient Performance Graphics – FEBRUARY 2016









East Sussex Healthcare NHS Trust

Date of Meeting:	10th February 2016
Meeting:	Trust Board
Agenda item:	9
Subject:	Safe Nurse & Midwifery Staffing Levels, December 2015 - – February 2016
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

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

Introduction:

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

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

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

Benefits:

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

Risks and Implications

- It is acknowledged that these figures are an average across the month but the breakdown of this information is available at http://www.esht.nhs.uk/nursing/staffing-levels/
- The quality figures cannot be considered as a measure of performance without significant validation and correlation with other dashboards and measures.
- This report does not negate the challenges of recruiting and maintaining a workforce that is robust and sustainable, without resorting to agency support.

Assurance Provided:

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

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)**:**

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

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

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

East Sussex Healthcare NHS Trust

SAFE NURSE & MIDWIFERY STAFFING LEVELS

1. Introduction

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

The current mandated reporting requirements also include the following inpatient areas: Paediatrics, Midwifery and Community Hospitals. The guidance does not require escalation areas to be included however given the recent decision to retain an escalation area on each main site within ESHT they are included from February 2016.

2. Background

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

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

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

3. Current Report – December 15 to February 16

3.1 The dashboards in Appendix 1, 2 & 3 have been prepared to reflect the above requirements for December 2015 through February 2016.

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

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

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

3.5 It is not possible to make a monthly comparison of the data due to changes in the report e.g. the community sites that transferred to Sussex Community Trust.

3.6 All these quality areas are monitored through respective steering groups, the safety thermometer and the trust nursing and midwifery reviews. The reviews utilises data from the nursing dashboard.

Conclusion/Recommendation

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

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

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

Alice Webster
Director of Nursing

Elizabeth Fellows
Assistant Director of Operations

Appendix 1

Dec-15	CCU	Average fill day rate - registered nurses/midwives (%	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	98.60%	114.00%	100.40%	96.90%	3	2	2
CCU EDGH	Cardiovascular Clinical Unit	95.00%	100.00%	91.10%	100.00%	2	1	1
James CCU	Cardiovascular Clinical Unit	104.00%	93.30%	94.70%	100.00%	1	1	1
Michelham	Cardiovascular Clinical Unit	84.10%	90.40%	98.40%	95.40%		2	
Stroke Unit EDGH	Cardiovascular Clinical Unit	96.60%	101.20%	95.00%	96.70%	1	9	2
	Cardiovascular Clinical Unit Total					7	15	6
Irvine Unit	Out of Hospital	89.20%	114.80%	102.50%	108.00%	2	7	2
Rye Intermediate Care Beds	Out of Hospital	110.50%	103.50%	113.30%	93.30%		5	
	Out of Hospital Total					2	12	2
Cuckmere	Specialist Medicine	119.00%	91.10%	100.00%	102.60%	2	2	3
Jevington	Specialist Medicine	99.60%	105.00%	103.30%	92.90%		4	
Pevensey	Specialist Medicine	100.20%	100.00%	100.00%	96.70%			
	Specialist Medicine Total					2	6	3
Benson Trauma	Surgery	94.70%	106.40%	98.30%	116.70%		8	1
Cookson Devas Elective	Surgery	92.10%	84.60%	86.70%	112.80%		3	1
De Cham	Surgery	88.30%	106.70%	90.00%	97.80%		4	
Egerton Trauma	Surgery	91.30%	96.70%	85.40%	138.40%		3	1
Gardner	Surgery	87.60%	90.00%	81.10%	136.70%		3	3
Hailsham 3 (Orthopaedic Elective)	Surgery	96.70%	106.00%	95.10%	89.70%		1	2
Hailsham 4	Surgery	85.00%	85.10%	110.50%	81.10%	2	3	
RT SAU	Surgery	85.50%	97.90%	90.30%	108.90%	1	1	1
Seaford 4 Urology	Surgery	99.10%	96.60%	109.80%	89.20%	1	3	2
	Surgery Total					4	29	11
Cookson Attenborough - Surgical short Stay	Theatres and Clinical Support	98.10%	100.60%	93.30%	104.80%		2	
ITU/HDU Conquest	Theatres and Clinical Support	88.20%	100.00%	92.80%	90.00%		3	1
ITU/HDU EDGH	Theatres and Clinical Support	94.40%	90.60%	80.00%	100.00%			4
	Theatres and Clinical Support Total					0	5	5
AAU Conquest	Urgent Care	93.30%	100.40%	114.40%	105.00%		6	1
Baird MAU	Urgent Care	88.60%	105.80%	101.10%	123.30%	2	2	1
MacDonald	Urgent Care	101.50%	106.80%	84.40%	108.00%		4	
Newington	Urgent Care	85.60%	112.50%	95.00%	91.30%	1	3	2
Seaford 1	Urgent Care	90.40%	86.90%	92.00%	94.70%			
Seaford 2/MSSU	Urgent Care							
	Urgent Care Total					3	15	4
Crowborough Birthing Unit	Women and Children	95.90%	82.20%	93.90%	100.90%			
EMU	Women and Children	92.20%	83.60%	100.00%	86.70%			
Frank Shaw	Women and Children	104.00%	105.80%	92.30%	91.10%			
Kipling	Women and Children	101.70%	97.30%	86.80%	90.80%			2
Mirrlees	Women and Children	98.10%	103.40%	101.00%	80.40%	1		
SCBU	Women and Children	91.30%	100.00%	92.80%	86.70%			
	Women and Children Total					1	0	2
	Grand Total					19	82	33

Appendix 2

Jan-16	CCU	Average fill day rate - registered nurses/midwives (%	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	84.62%	127.86%	97.52%	145.09%			
CCU EDGH	Cardiovascular Clinical Unit	88.64%	100.00%	103.23%	100.00%	1		
James CCU	Cardiovascular Clinical Unit	97.14%	98.50%	91.02%	100.00%		5	
Michelham	Cardiovascular Clinical Unit	107.74%	98.32%	100.07%	101.61%		1	2
Stroke Unit EDGH	Cardiovascular Clinical Unit	97.77%	109.19%	99.44%	100.19%	1	7	1
	Cardiovascular Clinical Unit Total					2	13	3
Irvine Unit	Out of Hospital	101.51%	104.91%	107.74%	96.98%		17	1
Rye Intermediate Care Beds	Out of Hospital	113.50%	124.44%	129.03%	111.29%			1
	Out of Hospital Total					0	17	2
Cuckmere	Specialist Medicine	98.39%	117.98%	99.89%	117.74%		5	1
Jevington	Specialist Medicine	118.92%	114.95%	103.89%	103.23%		2	3
Pevensey	Specialist Medicine	91.95%	100.00%	100.00%	100.00%		1	
Wellington	Specialist Medicine	104.63%	78.16%	95.48%	96.77%	1	4	2
	Specialist Medicine Total					1	12	6
Benson Trauma	Surgery	84.27%	109.15%	98.74%	106.45%	3	6	2
Cookson Devas Elective	Surgery	91.44%	82.75%	87.10%	106.45%		1	
De Cham	Surgery	90.87%	106.35%	93.55%	110.86%		3	
Egerton Trauma	Surgery	79.48%	90.60%	96.77%	91.40%	2	2	4
Gardner	Surgery	105.01%	97.04%	87.10%	94.58%		3	
Hailsham 3 (Orthopaedic Elective)	Surgery	103.33%	99.00%	97.00%	107.57%	2	8	3
Hailsham 4	Surgery							
RT SAU	Surgery	102.27%	100.12%	95.53%	91.55%		2	3
Seaford 4 Urology	Surgery							
	Surgery Total					7	25	12
Cookson Attenborough - Surgical short Stay	Theatres and Clinical Support	97.22%	88.41%	94.18%	113.22%	1	2	1
ITU/HDU Conquest	Theatres and Clinical Support	92.55%	104.56%	98.64%	93.55%	1		
ITU/HDU EDGH	Theatres and Clinical Support	105.91%	82.12%	90.95%	-			1
	Theatres and Clinical Support Total					2	2	2
AAU Conquest	Urgent Care	80.04%	101.54%	90.22%	104.30%			1
Baird MAU	Urgent Care	86.68%	99.81%	100.00%	107.53%	3	6	3
MacDonald	Urgent Care	101.01%	99.60%	87.10%	103.96%	2	7	
Newington	Urgent Care	91.02%	103.31%	89.71%	114.46%	2	8	1
Seaford 1	Urgent Care	84.83%	110.06%	90.27%	93.49%			
Seaford 2/MSSU	Urgent Care							
	Urgent Care Total					7	21	5
Crowborough Birthing Unit	Women and Children	91.75%	85.76%	96.21%	97.05%			
EMU	Women and Children	100.00%	100.00%	100.00%	100.00%			
Frank Shaw	Women and Children	101.47%	87.61%	94.79%	96.91%			1
Kipling	Women and Children	102.77%	100.00%	88.94%	84.60%		1	2
Mirrlees	Women and Children	105.65%	100.77%	101.26%	100.40%		1	
SCBU	Women and Children	97.20%	100.00%	79.03%	80.65%			
	Women and Children Total					0	2	3
	Grand Total					19	92	33

Appendix 3

Feb-16	CCU	Average fill day rate - registered nurses/midwives (%	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick Ward	Cardiovascular	84.10%	127.90%	93.20%	132.30%	2	3	2
CCU - Eastbourne DGH	Cardiovascular	87.40%	100.00%	92.00%	100.00%		1	
James/CCU Ward	Cardiovascular	96.70%	99.50%	93.50%	94.30%	1	5	2
Michelham	Cardiovascular	111.90%	96.20%	99.80%	97.20%	1	2	1
Stroke Unit EDGH	Cardiovascular	95.50%	101.60%	113.80%	105.50%	0	7	3
	Cardiovascular Clinical Unit Total					4	18	8
Irvine Unit	Out of Hospital Care	81.90%	95.60%	115.00%	97.70%	1	11	1
Rye Intermediate Care Beds	Out of Hospital Care	82.00%	108.50%	100.00%	108.60%		3	1
	Out of Hospital Total					1	14	2
Cuckmere Ward	Specialist Medicine (Loc)	89.60%	93.40%	80.00%	97.40%	2	5	
Folkington	Specialist Medicine (Loc)	111.40%	98.40%	96.70%	101.70%	1	3	
Jevington Ward	Specialist Medicine (Loc)	106.60%	104.70%	112.60%	95.40%	3		1
Wellington Ward	Specialist Medicine (Loc)	92.60%	87.60%	81.40%	90.80%		5	1
Pevensey Unit	Specialist Medicine (Loc)	100.90%	-	100.00%	86.20%		1	2
	Specialist Medicine Total					6	14	4
Benson Trauma Ward	Surgery	89.40%	96.90%	100.00%	99.50%	1	8	2
Cookson Devas Elective Ward	Surgery	91.50%	93.00%	89.20%	106.90%			
De Cham	Surgery	92.00%	101.70%	88.50%	120.60%		4	3
Egerton Trauma Ward	Surgery	88.20%	85.60%	80.00%	90.80%	3	7	4
Gardner	Surgery	86.90%	98.60%	84.10%	115.50%	2	3	1
Hailsham 3 Ward	Surgery	107.80%	107.00%	92.80%	81.60%	1	9	
Hailsham 4 - Urology Ward	Surgery	93.60%	97.40%	87.70%	81.90%	1	1	
Richard Ticehurst SAU	Surgery	90.90%	101.90%	90.40%	94.60%		3	1
Seaford 2 Escalation	Surgery					1	1	2
Seaford 4 - Mixed Surgery ward	Surgery	96.20%	83.30%	111.70%	96.90%		2	1
	Surgery Total					9	38	14
Cookson Attenborough Surgical short Stay	Theatres and Clinical Support	93.60%	100.40%	99.90%	97.90%		4	2
ITU / HDU (Conq)	Theatres and Clinical Support	81.80%	100.00%	92.50%	99.90%			4
ITU / HDU (EDGH)	Theatres and Clinical Support	99.80%	83.10%	88.00%	-			2
	Theatres and Clinical Support Total					0	4	8
Acute Admissions Unit (AAU) Conquest	Urgent Care	87.50%	95.30%	94.00%	104.60%	1	5	2
Baird MAU Ward	Urgent Care	84.80%	91.60%	99.90%	96.10%	2	2	
Newington Ward	Urgent Care	90.40%	93.90%	92.10%	109.40%	1	9	4
MacDonald	Urgent Care	82.90%	90.50%	84.30%	104.90%		3	
Seaford 1 (Medical Assessment) Unit	Urgent Care	81.10%	89.80%	88.50%	94.70%			
Tressell Ward	Urgent Care	84.90%	100.80%	86.20%	123.70%	3	6	1
	Urgent Care Total					7	25	7
Crowborough Birthing Unit	Women and Children	100.90%	100.00%	102.80%	90.40%			
Eastbourne Midwifery Unit (EMU)	Women and Children	103.00%	100.00%	89.70%	100.00%			
Frank Shaw	Women and Children	91.90%	83.50%	87.30%	95.80%			
Kipling Ward	Women and Children	90.00%	91.50%	84.90%	86.50%	1	1	1
Mirrlees	Women and Children	111.20%	95.30%	101.80%	97.20%		1	
Special Care Baby Unit (SCBU) Conquest	Women and Children	87.40%	90.40%	103.40%	86.20%			
	Women and Children Total					1	2	1
	Grand Total					28	115	44

East Sussex Healthcare NHS Trust

Date of Meeting:	13th April 2016
Meeting:	Trust Board
Agenda item:	10
Subject:	Patient Experience Report including themes from Never Events
Reporting Officer:	Alice Webster

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

Purpose:

- To provide assurance to the Board that the Trust is taking appropriate, proactive and robust measures in addressing gaps and concerns from patient experience, complaints and Never Events.

Introduction:

- This report confirms the fact that the Trust is committed to exploring data on patient experience gleaned through surveys, questionnaires, interviews and complaints in robustly addressing patient concerns and generating lessons for shared learning and preventing recurrence. The Trust is firmly committed to ensuring robust staff training, mentoring and more compelling staff and patient engagement as tools for improving patient care, Friends and Family Test (FFT) response rate and enhancing patient experience.

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

- This report notes a low response rate to patient FFT and while indicating that this is a common problem faced by most Trusts, it argues that the Trust's use of multiple tools in gathering FFT data and better patient engagement will improve response. The Trust is also exploring the possibility of using mobile text messages in improving FFT response rate.

- The Trust is committed to using patient complaints and Never Events as a pool of intelligence in proactively addressing patient concerns and generating, sharing and embedding lessons learnt in continuously improving clinical practice and patient care.

Benefits:

- This report provides assurance and informs the Board on what is being done by the Trust in continuously improving patient experience and transforming patient journey.

Risks and Implications

- No risks have been identified.

Assurance Provided:

- Yes, it demonstrates and confirms that the Trust takes prompt and robust actions in addressing concerns emanating from patient FFT; complaints and Never Events.

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)**:**	
N/A	

Proposals and/or Recommendations
• The Board is requested to note this report and gain assurance that the Trust is robustly addressing and learning from patient FFT, complaints and Never Events.

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: David Tita	**Contact details:** 01424755255 Ext 14 8106

East Sussex Healthcare NHS Trust

Patient Experience Report for Trust Board

1. **Introduction**:
The Trust is committed to exploring and learning from patient Friends and Family Test (FFT) data, complaints and Never Events in continuously improving the quality of patient care, enhancing patient safety, positive patient experience and fostering its culture of safer care.

1.1. **Background:**
The Trust gleans data on patient experience through tools such as patient feedbacks, questionnaires, surveys, FFT and complaints. Such data is then analysed and triangulated in providing a wealth of intelligence on patient perceptions of the quality of care, signposting staff to gaps in patient care and driving up improvements in care.

2. **Patient FFT data:**
The following table depicts our Trust-wide patient Friends and Family Test (FFT) score from 1st January to 23rd March 2016 (current date of report writing):

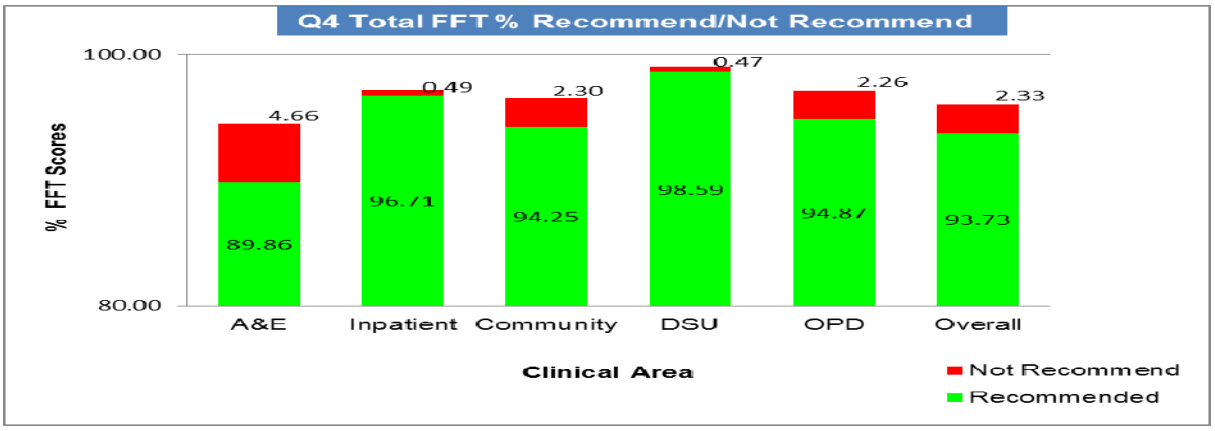


Figure 1: Bar Chart showing FFT % Recommend/Not Recommend.

The Trust has attempted to increase FFT response rates in a variety of ways, including collecting responses on paper or on electronic tablets. Link champions have been identified on wards to help to increase patient, carer and family engagement in completing FFT. The Trust is also in discussion with a company, with whom we already have existing outpatient support, who specialise in improving response rates of FFT through the use of text messaging. Multiple data sources will also be used in improving response rates and energising patient engagement.

2.1. **Patient Complaints:**

A total of 178 complaints were received by our complaints department between 1st January to 23rd March 2016 which can be broken down into four main themes: - quality of care, patient safety, communication and poor patient experience.

Distribution of complaints by Clinical Units: 1st January – 23rd March 2016

No	Clinical Unit	Number of complaints for Q4	Trends of complaints in numbers previous quarters	
			Q3	Q2
1	Cardiovascular	16 ↑	11 ↑	7
2	Urgent Care	42 ↑	23 ↓	37
3	Ad Hoc	9 ↑	5 ↓	43
4	Out of Hospital	11	11 ↑	15
5	Specialist Medicine	34	34 ↑	41
6	Surgery	40 ↓	42 ↓	52
7	Theatres & Clinical Support	12 ↑	11 ↑	10
8	Women & Children	14 ↓	20 ↑	18
	Total	178 ↓	157 ↑	223

Figure 2: A breakdown of complaints by Clinical Units indicating trends

The above table also shows that whilst Surgery indicates a downward trend, they have recorded the highest number of complaints throughout the three quarters. Cardiovascular recorded the fewest complaints across the last 3 quarters.

The numbers of complaints received by Ad Hoc has reduced from 43 Q2 to 9 in Q4. The large number of complaints related to the information governance breach that occurred within the trust and the reduction will be monitored to ensure that this was the only reason and that the reduction in complaints is sustained. Evidence from the above table demonstrates that whilst there has been a reduction in the numbers of complaints since Q2 a significant percentage of this reduction will relate to the reduction in the Ad Hoc numbers. Further interrogation of the full year data will be made available to the Quality and Standards committee

All the CUs are working extremely hard to ensure greater patient engagement and satisfaction as well as continuously delivering high quality patient care as mechanisms for mitigating complaints. CUs are also implementing complaint action plans aimed at promptly learning from complaints, embedding best practice and driving improvements by robustly addressing the specific concerns raised by complainants.

3.0 Some themes from Never Events:

The Trust is emphasising its zero tolerance to Never Events by constantly ensuring that all newly recruited staff complete the Trust induction programme, that all staff undertake mandatory training and are constantly supported and mentored by more experienced managers. The Trust also fosters a culture of openness and transparency through promoting prompt reporting and ensuring that lessons learned from Never Events are shared and embedded throughout the Trust in order to improve patient care and to prevent recurrences.

The following themes can be identified from the four Never Events that have occurred during 2015/16:

No	Main theme	Explanation of themes from our Never Events
1.	Poor Patient Experience	Never Events often deliver poor patient experience hence; staff at ESHT are constantly supported and encouraged to prevent their occurrence in the provision of patient-led safer care.
2.	Patient Harm	Never Events usually end up in discomfort and distress for the patient, their carer's and families; the Trust is committed to `Zero Never Events` through better staff training and prevention.
3.	Human Error	This is a predominant theme that runs through all the Never Events explored for this report. Two out of the four Never events resulted from lack of effective checks during or after surgical procedure. This error was due to weak systems i.e. lack of formalised swab count checking, poor procedure pack preparation and poor final WHO form checking by staff, highlighting the importance of completing an effective WHO safer surgery checklist. These have been addressed through training, clarity and strengthening of our systems and processes.

Figure 3: Main themes from Never Events

3.0 Conclusion:

The Trust is committed to ensuring that robust learning is generated from patient FFT data, complaints and Never Events in order to continuously improve the quality of patient care, to enhance patient experience and to drive up clinical standards. As part of our commitment to the Duty of Candour, our staff are encouraged to always say sorry or apologise to patients or complainants when errors occur rather than defend the indefensible.

4.0 Recommendations:

The Board is requested to note this report and gain assurance that the Trust is robustly addressing and learning from patient experience.

Name of Author: David Tita
Title of Author: Head of Governance
Date: 29/03/16

East Sussex Healthcare NHS Trust

Date of Meeting:	13th April 2016
Meeting:	Trust Board
Agenda item:	12
Subject:	Eliminating Mixed Sex Accommodation Declaration
Reporting Officer:	Pauline Butterworth, Acting Chief Operating Officer

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

Purpose:

The NHS Operating Framework 2012/13 requires all providers of NHS funded care to confirm whether they are compliant with the national definition to eliminate mixed sex accommodation except whether it is in the overall best interests of the patient, or reflects their patient choice. The Trust is required to routinely report breaches of sleeping accommodation and declare each year that they are compliant.

Introduction:

The Operating Framework 2012/13 states that:

All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/320.

From April 2011, all providers of NHS funded care were required to routinely report breaches of sleeping accommodation, as set out in national guidance, and will attract contract sanctions in respect of each patient affected. Each year, on or by 1 April, all such organisations must declare that they are compliant with the national definition or face financial penalties.

In respect of the above requirements the Trust Board has received details of any breaches as part of its performance reporting and this practice will continue.

The Trust Board is asked to declare compliance and ratify the declaration (attached) to continue to be displayed on the Trust website

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

As outlined above

Benefits:

Single sex accommodation supports the provision of privacy and dignity for patients.

Risks and Implications

Non-compliance could result in poor patient experience and a financial penalty.

Assurance Provided:

Performance reported to the Board on a monthly basis.

Proposals and/or Recommendations
The Board is asked to note the requirements and ratify the declaration for display on the Trust website.

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: Pauline Butterworth, Acting Chief Operating Officer	**Contact details:** pauline.butterworth@nhs.net

Declaration of compliance

We are proud to confirm that our hospitals are compliant with the requirements of same sex accommodation. We are committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

Patients who are admitted to any of our hospitals will only share the room where they are cared for with members of the same sex. In addition same sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen by exception based on the best interests of the person e.g. where specialist skills or equipment are needed such as critical care units.

What does this mean for patients?

Patients admitted to our hospitals can expect to be provided with accommodation in each room that only accommodates people of the same sex. There will be same sex toilet and wash facilities nearby.

If you need help to use the toilet or take a bath (eg you need a hoist or special bath) then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you to ensure your privacy is maintained.

It is possible that there will be both men and women patients on the ward, but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through opposite-sex areas.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital e.g. on your way to an x ray.

It is probable that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting each other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

The NHS will not turn patients away just because a "right-sex" bed is not immediately available.

How will we measure success?

Every day we will make an assessment of all our hospitals and review any incident where same sex accommodation has not been provided. Should this occur it will be rectified as soon as possible. This information will be reported to and monitored by senior management and Trust Board in conjunction with feedback from patient experience surveys.

Future plans

To date the Trust has invested in a number of projects to enhance privacy and dignity across it sites. Most recently we have redeveloped a ward on the Eastbourne site to increase the number of single rooms with en suite facilities. Following evaluation of the design it is our intention to expand this project on a rolling programme across both acute sites.

What do you do if you think you are in mixed sex accommodation?

If you have any concerns or queries please feel free to discuss this with the nurse in charge of your area or our Patient Advice and Liaison team.

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 20th January 2016 at 10.00am in the Committee Room, Conquest

Present: Mr Mike Stevens, Non-Executive Director (Chair)
Mr Barry Nealon, Non-Executive Director

In attendance

Ms Janine Combrinck, BDO
Ms Jenny Darwood, General Manager, Urgent Care (for item 4b)
Mr Stephen Hoaen, Head of Financial Services
Dr David Hughes, Medical Director
Mr David Meikle, Director of Finance
Mr Adrian Mills, Audit Manager, TIAA
Mr Mike Townsend, Regional Managing Director, TIAA
Mrs Lynette Wells, Company Secretary
Mr Steffan Wilkinson, Counter Fraud Manager, TIAA
Mr Keith Wilshire, Interim Clinical Effectiveness Lead
Mr Pete Palmer, Assistant Company Secretary (minutes)

Observing: Mr Moosa Patel, Consultant, Capsticks
Ms Janice Smith, Consultant, Capsticks

Action

001/16 Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions were made. He welcomed Capsticks who were observing the meeting as part of the Corporate Governance Review.

Apologies for absence were received from:

Mrs Sue Bernhauser, Non-Executive Director
Mr Richard Sunley, Acting Chief Executive
Mrs Alice Webster, Director of Nursing

002/16 Minutes of the meeting held on 4th November 2015

i) The minutes of the meeting were reviewed and minor changes were noted on pages 6 and 7. They were otherwise agreed as an accurate record.

ii) Matters Arising

The following verbal updates were provided:

Review of Clinical Audit Guidance

This was discussed as item 5 on the agenda of the meeting.

Out of Date Trust Policies

Mrs Wells reported that the policy group was currently without an administrator and as a result they had not been able to produce a list of out of date Trust policies. She said that she would email the list to Mr Stevens as soon as it was available. **LW**

Clinical Audit Update on the Forward Plan

This was discussed as item 6 on the agenda of the meeting.

IT Equipment not attached to Trust's network

Mr Meikle reported that computers within the Trust that were not attached to the Trust's network held no patient identifiable information, and therefore the data protection risks associated with these devices were considered to be extremely low.

IT Continuity Plans

Mr Meikle reported that work was progressing on building resilience into the Trust's IT infrastructure through a process of transferring equipment to the new server room in St Anne's House. He explained that this process was regularly tested, and had undergone audit.

Mr Nealon explained that he was concerned about the Trust's IT strategy and asked if the head of IT could present to a future meeting ofthe Audit Committee to provide assurance about the Trust's strategy. Mr Meikle agreed that he would arrange for this to take place. **DM**

Review of Declarations of Interest Process

Mr Palmer confirmed that revised declaration forms would be sent to staff at the end of the financial year. **PP**

003/16 Board Assurance Framework and High Level Risk Register

Mrs Wells presented the Board Assurance Framework (BAF) and High Level Risk Register.

She noted that the Trust was due to be over-recruited for HCAs by 1st March 2016, which should reduce the agency spending on HCAs.

Mrs Wells reported that the transfer of community services to HWLH had been completed in November 2015, and that from a strategy and HR perspective the move had gone well. She noted that the Trust had been left with stranded costs following the transfer.

She reported that the assurance in respect of the Trust's financial controls had been moved from amber to red.

Mrs Wells explained that she expected a number of risks around estates to be added to the High Level Risk Register in the near future as evaluation work was being undertaken within the Trust. She noted that the scores attached to any risks would be carefully reviewed prior to any addition to the Risk Register.

Mr Stevens explained that he was concerned about progress being made in resolving items included on the Risk Register and Mrs Wells replied that the Clinical Units were well sighted on the issues and were working through all of the risks in order to mitigate them.

The Committee reviewed and noted the revised High Level Risk Register and Board Assurance Framework and were of the view that the main inherent/residual risks had been identified and that actions were appropriate to manage the risks.

004/16 Clinical Unit Clinical Audit & Risk Register Review

a) Cardiovascular

Ms Connors was unable to attend the meeting, so this item was postponed for a future Audit Committee meeting.

d) Urgent Care

Ms Darwood presented the Urgent Care Clinical Unit's (CU) Audit and Risk Register review to the Committee.

Audit

Ms Darwood reported that the CU was currently undertaking three Royal College of Nursing audits, which were all voluntary. The first of these was a Venous Thromboembolism audit, which had been completed.

The second audit concerned Sedation in Adults, and she noted that the CU were struggling to audit sufficient patients and had liaised with the Royal College of Nursing to discuss the issue. She explained that steps were being taken to ensure that the audit was

completed, with doctors now filling out information on paper rather than directly on to a database in order to reduce the amount of time they had to spend completing the data collection. Ms Darwood said that she was confident that the CU would be able to complete the audit.

The third audit being undertaken by the CU concerned Vital Signs in Children, and Ms Darwood noted her confidence that this would also be completed.

Risks

Ms Darwood reported that there were 10 risks on the CU's risk register, and that no new risks had been added since she had last presented to the Audit Committee. She reported that she expected two new risks to be added to the register in the near future, concerning NCEPOD compliance with geriatric assessments and financial performance.

Vacancies in A&E Departments

Ms Darwood reported that the main risk faced by the CU concerned staffing in the Accident & Emergency Department, and that there was an unprecedented vacancy level amongst middle grade doctors. She advised that it was likely that the recently introduced government cap on locum fees could exacerbate the issue. Mr Meikle explained that the Trust was able to break the expenditure cap if there was any risk to patient safety. Dr Hughes reported that the Trust was working to recruit more doctors to the A&E departments, and that the College of Emergency Medicine had agreed to conduct a review of the A&E departments in order to provide help in resolving the issues being faced by the Trust.

Nursing Staff in Medical Assessment Unit (MAU)

Ms Darwood reported that there were currently 11 WTE vacancies in the MAU, and that recruitment was being undertaken via NHS jobs.

Mr Nealon asked if it was possible for the Trust to comply with the CQCs recommendations for inducting agency staff on the MAU, given the large numbers of agency staff that were being employed. Ms Darwood replied that the Unit had systems in place that ensured permanent staff were focussed on caring for patients and on inducting agency staff. She explained that non-nursing tasks were carried out as much as possible by staff that weren't permanent in order to mitigate any risks.

Lack of Privacy and Dignity

Ms Darwood reported that issues concerning privacy and dignity for

patients were being addressed as part of the Trust's Estates Strategy, and that funding was being sought from the TDA to resolve the issues as part of the Trust's Quality Improvement Plan.

005/16 ESHT Benchmarking Against Revised Guidelines and Standards for Clinical Audit

Mr Wilshire explained that the Health Quality Improvement Partnership (HQIP) and the Good Governance Institute (GGi) had revised their national standards for clinical audit in July 2015 and that he had carried out a benchmarking exercise to ascertain how well the Trust was meeting these revised criteria. He reported that the standards set out 10 principles for good audit that Trusts should follow, and that each principle had a progress level from 1-6 that the Trust was rated against.

Mr Stevens noted that it was clear form the report that the Trust was registering too many clinical audits and as a result not undertaking these as well as it could. He reported that Mr Townsend had undertaken a comparison of clinical audits carried out by similar Trusts and that the average number carried out was 321 compared to ESHT's 423. Mr Stevens said that it was clear that more control needed to be exerted during planning of Clinical Audits in order to reduce the number of audits being carried out, and that this would have to be undertaken with the backing of Dr Hughes. He said that he felt that the Trust's clinical audit policy and procedures would also need to be reviewed to reflect the current best practice in the NHS.

Mr Nealon asked if audits could be carried out in a more efficient fashion so that consultants were able to contribute on a greater level than they currently were able to. Mr Wilshire replied that the review of patients' notes by a consultant was a mandatory requirement for some national audits, and that as a result there was no way of streamlining the processes.

He explained that the Trust was unable to complete the National Diabetes audit, as they did not have the specific software needed to collect data. He noted that the cost of the software was around £50,000 and that the Board had decided that this was not the best use of funds. Mrs Wells explained that commissioners and the CQC had been informed of this decision.

Mr Wilshire said that work was being undertaken with the CUs to ensure that their forward audit plans were rationalised and realistic. He reported that centralised administrative resources were being put in place with a priority on mandated audits.

Mr Wilshire asked the Committee if they had a view on which of the 10 principles should be prioritised by the Trust during 2016/17, as he

felt that trying to immediately make all of the principles a priority would not be feasible. Mr Stevens replied that he would like Mr Wilshire to write a Clinical Audit Strategy for the Trust, and present it to the Audit Committee. **KW**

006/16 Clinical Audit Forward Plan 2015/16 Report

Mr Wilshire explained that further progress had been made since he had written the report he presented to the Audit Committee, and updated the Committee on this progress. He reported that he had been unable to establish who the Trust's lead clinician was for the Blood Transfusion audit, and could find no evidence that this was being undertaken. He noted that the Blood Transfusion audit might not be considered mandatory, but that the deadline for undertaking the audit in 2014/15 had been missed.

Dr Hughes noted no consultant lead had been identified within the Trust for the national blood transfusion audit, and that as a result this audit had not been completed during 2014/15. He said that a consultant lead would be identified for 2015/16 to ensure that this was completed.

Mr Nealon asked what risks existed if mandatory audits were not carried out, and what actions the Audit Committee could take to help resolve any issues. Mr Wilshire replied that if the Trust failed to complete any Priority 1 audits then this would be considered as a breach of contract, and would have to be reported to the CQC. He explained that every audit the Trust registered should have an identified lead, who would be responsible for ensuring that the audit was appropriately completed and at present this was not always the case.

The Committee noted the Clinical Audit Forward Plan 2015/16 Report

007/16 Internal Audit

<u>Progress Report</u>

Mr Townsend reported that three final audit reports had been issued. He said that the audit reports into Performance Management, Referral to Treatment and Infection Control had received reasonable assurance and that the audit into Performance Data Quality of Venous Thromboembolism (VTE) had been given limited assurance.

He noted that since the progress report had been written, an Information Governance Toolkit audit had been completed, and that a draft audit report had been issued on child healthcare systems. Mr Townsend reported that audit reports on business support ICT and nursing rosters were shortly due to be issued to the Trust, and that

tiaa would also now be undertaking an audit of the Trust's Whistleblowing policy.

Mr Stevens asked for further detail about why limited assurance had been given to the Trust in regard to the audit of complaints. Mr Mills replied that when the audit was undertaken, the Trust's new complaints manager was new in post, and as a result complaints procedures had not been updated, new staff had not been employed and ward buy in to complaints procedures was limited. He explained that he was very happy with the measures that had been taken in improving the complaints department and processes following completion of the audit, and that he expected to see significant improvement reflected in tiaa's follow up audit.

Mr Nealon asked whether Serious Incidents (SIs) were being audited to ensure that they were properly managed by the Trust. Mr Townsend replied that SIs had been audited in the past, but that they had not been audited in 2015/16. He suggested that this could be added to the work plan for 2016/17.

Mrs Wells noted that a new process had been introduced within the Trust for responding to SIs, as a result of the introduction of duty of candour. She explained patients were told verbally if any harm was caused to them and then this was followed up in writing by the Trust. She said that this revised process was valuable in ensuring that the Trust was compliant with best practice and statutory requirements..

Mr Townsend reported that a short survey had been undertaken by tiaa on the Trust's compliance with duty of candour legislation and that he expected the results to be available within the next month.

Mrs Wells commented that the results of the VTE audit had concerned the CQC as the system currently in place within the Trust was largely paper based. She noted that the Trust was exploring the possibility of recording these results on their existing VitalPAC system. Dr Hughes explained that currently 96% of VTE results were being recorded, but that this was not being carried out in real time. He explained that recording the results on VitalPAC would allow the Trust to respond to any issues and to track genuine non-compliance.

Mr Townsend reported that that internal audit team were happy with the Action Plan produced by the Trust following the Information Governance audit, and that this would be subject to a follow up audit in February 2016.

The Committee noted the Internal Audit Progress Report.

008/16 Local Counter Fraud Service Progress Report

Mr Wilkinson provided an update on tiaa's reactive work to the Committee.

Mr Stevens asked whether work was being undertaken by the counterfraud team to support whistleblowing procedures within the Trust, and whether staff could contact counterfraud directly as an alternative route for whistleblowing. Mr Wilkinson replied that campaigns had been undertaken in order to inform staff about ways in which to contact them, and that a whistleblowing survey was due to be undertaken.

The Committee noted the Local Counter Fraud Service Investigations Update.

009/16 External Audit Progress Report

Ms Combrinck reported that BDO's full audit plan would be brought before March's Audit Committee meeting.

She noted that there had been a change in Value for Money (VfM) guidance, and that there was now a single overall criterion looking at informed decision making to achieve sustained financial outcomes. Ms Combrink explained that this would affect the Trust's VfM conclusion and that discussions about this would be taking place with Mr Meikle.

The Committee noted the External Audit Progress Report.

010/16 Tenders & Waivers Report

Mr Meikle presented the Tenders & Waivers Report. Mr Stevens noted that 9 of the 12 waivers reported were assigned to the Corporate division, and Mr Hoaen explained that this was a result of where authorisation was given for the waiver rather than where the waiver was applied.

Mr Stevens explained that he was not assured by the brief explanations provided on page 3 of the report as to why waivers had been granted. He asked that the Tenders and Waivers Report presented to the Committee in the future included greater detail as to why waivers had been approved.

The Committee noted the Tenders and Waivers Report.

011/16 Information Governance Toolkit Update

Mrs Wells provided an overview of the current status of the Information Governance Toolkit (IGT). She explained that in line with best practice, ESHT set its evidence base for the IGT back to

zero every year, which ensured that evidence collected was accurate, but also made the process of collecting the data harder. She noted that the governance team had found collecting evidence to be challenging in 2015/16, but that she was confident that the Trust would achieve level 2 compliance.

Mrs Wells reported that there had been a spike in IG incidents reported in September 2015, probably as a result of increased awareness of IG due to the well-publicised loss of a data stick. She explained that three incidents had been escalated to the Information Commissioner's Office (ICO) and that two of these had been closed without penalty. She noted that the third incident was still being investigated by ICO.

The Committee noted the Information Governance Toolkit Update.

012/16 Losses & Special Payments Review

Mr Meikle presented the quarterly report on Losses and Special Payments. He noted that the Trust was concentrating on improving its methods of receiving payments for treatment from overseas visitors, and that credit card machines had been introduced to facilitate this.

Mr Stevens asked why the number of NHS Vehicle Accidents was reported as zero within the report, as he didn't think that this could be accurate. Mr Hoaen said that he would investigate this and report back to the Audit Committee. **SH**

The Committee noted the Losses & Special Payments Review

013/16 Date of Next Meeting

The next meeting of the Audit Committee will be held on:

Wednesday, 23rd March 2016, at 10.00 am in the St Mary's Board Room, EDGH.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 16th December 2015 at 9.30am – 11.30am, in St Mary's Board Room, Eastbourne DGH

Present

Mr Barry Nealon, Non-Executive Director (chair)
Ms Jackie Churchward-Cardiff, Non-Executive Director
Mr David Meikle, Interim Director of Finance
Mr Philip Astell, Deputy Director of Finance
Mr Richard Sunley, Acting Chief Executive
Mrs Pauline Butterworth, Acting Chief Operating Officer
Dr David Hughes, Medical Director

In attendance

Mrs Sue Bernhauser, Acting Chair
Mrs Maggie Oldham, Improvement Director
Mrs Lesley Walton, Programme Manager (for item 3)
Mrs Alex Graham, Head of Financial Management (for item 5)
Mrs Jo Brandt, Head of Planning & Performance (for item 8 & 9)
Mr Ajay Channana, Head of Procurement (for item 12)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to meeting and, in particular, welcomed Ms Jackie Churchward-Cardiff to her first meeting of the Finance & Investment Committee. Apologies were received from Mr Mike Stephens.	**Action**
2.	**Minutes of Meeting of 25 November 2015** The minutes of the meeting held on 25 November 2015 were agreed as an accurate record.	
3.	**Matters Arising** (i) Estates & Facilities CIP The Committee received an update report on the position around the CIP programme within Estates and Facilities. It was reported that the CIPs for FY 16/17 were being developed in advance of FY 16/17 and that expenditure in the current financial year was being closely	

	managed. The Committee felt there should be much tighter controls around the accountability of the CIP programmes. Mr Meikle reported the CIP programme is managed through the Accountability Reviews and that these will be discussed at the new Productivity and Efficiency Group. <u>(ii) ITFF Application and LTFM</u> It was noted that the final ITFF application letter and LTFM was presented to the Trust Board for formal agreement at its meeting on 2 December 2015. <u>(iii) Recruitment Trajectory</u> This was discussed under item 6 below. <u>(iv) Community Rebasing Project</u> This was discussed under item 7 below. <u>(v) PMO Project Update</u> Mrs Walton presented an update report providing more detail and further information on the Pathology Managed Equipment, Vital PAC and the Community & Child Health project as requested at the November Finance & Investment committee meeting. The Chairman asked for a more detailed update on Pathology for the January 2016 meeting. Mrs Walton provided further information on the benefits of Vital PAC. It was agreed that Mrs Butterworth would liaise with Dr Slater outside the meeting to assure the benefits of Vital PAC were fully communicated to all the Trust staff. <u>(vi) Procurement Update</u> Mr Astell reported that a new Efficiency Improvement Group was being set up and a meeting to discuss this was scheduled for January. The Group would have Non Executive Director representation. The Chairman reported that the Board was interested in receiving feedback on the Lord Carter report. It was agreed that a Lord Carter report update would be presented to the January 2016 Finance & Investment Committee meeting. <u>(vii) HWLH Community Transition Update</u>	**LW** **PB** **PA**

	Mr Meikle circulated a summary of the PWC impact assessment on ESHT loss of Community Services Contract for information. The full report will be emailed to the Group following the meeting. A more detailed report on Stranded Costs would also be presented at the next meeting.	**DM**
4(i)	**Integrated Performance Report – Month 8** Mrs Butterworth gave a brief performance update at month 8. Due to the timing of the Committee a full Integrated Performance report was not available for this meeting. It was noted that A&E has been significantly challenged around achieving 4 hour standard. However the Trust continues to meet its RTT incomplete target and will achieve diagnostics and breast 2 week wait alongside the 31 day standard. **Action** **The Committee noted the Performance update at month 8.**	
4(ii)	**Flash Report - Month 8** The Committee received a flash report providing an update on the financial position as at month 8. Due to the timing of the Finance & Investment Committee, a full finance report was not available. In month, income had underachieved and expenditure had overspent. The year to date run rate was a deficit of £31.6m which was £7.3m worse than the revised plan. The Committee challenged the reasons behind the deteriorating position and asked that a report on grip and control measures be presented to the next meeting. **Action** **The Committee noted the month 8 position.**	**DM**
5.	**2015/16 Forecast Outturn & Downside Case (deep dive) Presentation and Discussion** Mr Meikle presented a briefing on the financial performance for 2015/16 and highlighted the following key messages: • In month 8 (November 2015) the Trust generated a £5.8m deficit, £2.3m greater than plan • This had increased the year to date deficit to £31.6m, £7.3m greater than plan • Key drivers of the deterioration performance were: increasing agency costs, escalation beds, quality improvement plan implementation costs and CIP slippage	

	• A number of scenarios exist regarding the forecast outturn. Due to volatility in the cost base and the uncertainty in potential income streams, further time is needed in order to determine the year end position. When the month 9 position is reported, a definitive forecast outcome scenarios will be presented. The Committee received information on the forecast outturn scenarios, and detailed information of agency spend by clinical unit. Mr Meikle highlighted the following recovery actions were in place: • Establishment of a Temporary Workforce Review Group with a wide remit to review all aspects of temporary workforce spending including deep dives into specific areas of concern • Compliance with the recommended actions in the agency cost reduction tool • Compliance with the recommended actions in the Grip and Control Checklist which will increase review of all discretionary spending • Continued discussions with the commissioners re: additional income (Healthy Hastings, QIP support, stranded cost support, Winter Funding) • Review of possible service/activity reductions in Q4 It was noted that Mr Meikle had attended the Start the Week Meeting to re-inforce control measures. Mrs Butterworth explained how the temporary workforce is managed on a day to day service and stressed that there were very clear control measures in place. Mr Meikle circulated information to the Committee on agency costs, including a diagnostic tool received from Monitor on how to reduce the use of agency staff. The Committee also received a copy of a grip and control document issued by the TDA. **Action** **The Committee noted the report.**	**DM**
6.	**Recruitment Trajectory** Mr Meikle presented a report updating the Committee on vacancies and recruitment plans across the Clinical Units of the Trust. The reduction of the Trust's temporary workforce is a key objective as the Trust strives to increase quality and reduce costs. A robust recruitment plan with specific actions and timelines linked to a reduction in temporary staff is critical in giving the Board assurance that this objective is being implemented.	

	It was noted that the next stage would be to map these plans against permanent workforce turnover projections and temporary workforce projections in order to measure and monitor progress; highlighting risks and opportunities. The Committee received assurance that workforce plans were in place and were being implemented. It was agreed that this item would be reviewed by the Committee on a Quarterly basis. **Action** **The Committee noted the report.**	**CK**
7.	**Community Rebasing Project** Mr Astell reported that the initial phase of this project had been successful in achieving an additional £4m of CCG funding for community services in 2014/15. The project was discontinued earlier this year but was now being restarted in order to ensure that the further potential benefits can be delivered. It was noted that the schedule of costs (rebasing matrix) would need to be to be updated and the Trust would need to look at the allocation of overheads including the reallocation of the 'stranded' overheads from the loss of the HWLH community contract In parallel with the costing work the service specifications are being re-drawn and discussed with the commissioners to ensure that there is a proper alignment between the resources employed and the services and specifications being agreed to. The commissioners have agreed to engage in the process on the basis that this is cost neutral overall and have agreed to an independent review of the outcome. It was noted that the Community Rebasing project will help to drive the data quality agenda. A further update will be provided at the March 2016 Finance & Investment Committee. **Action:** **This Committee noted the Community Rebasing Project update.**	**PA**
8.	**EBITDA Quarterly Report - Q2** Mrs Brandt presented the Committee with the 2015-2016 Q2 EBITDA statement, the 2015-2016 quarterly EBITDA comparison statement and the Patient Cost Benchmarking opportunity cost statement. Mrs Brandt summarised the top 5 specialities that were highlighted as	

	a concern due to the EBITDA deficit. The Committee noted: - The 2015-2016 Q2 EBITDA deficit position for the clinical units - The number of service lines that have negative EBITDA - The 2015-2016 quarterly EBITDA variances. - The effect on the 2015-16 EBITDA of using Patient Cost Benchmarking average unit costs when applied to ESHT inpatient activity for top 5 specialties only. Fines & Penalties were not included within the Q2 EBITDA and the 2015-2016 Q2 EBITDA statement had been reconciled to the Trust's finance report. A Urology deep dive will be presented at the January 2016 meeting. **Action:** **The Committee noted the EBITDA statement position and recommended that the Committee continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews, and to return at a subsequent meeting to update on their progress.**	**JB**
9.	**2014-15 Reference Costs RCI** Mrs Brandt presented the published 2014-15 reference cost index. She explained that reference costs are the average unit cost to the NHS of providing defined services in a given financial year to NHS patients in England and are collected annually by the Department of Health. The accuracy of the data has improved year on year due to refinements in the guidance and the collection process. The reference cost index (RCI) is the measure of the relative efficiency of NHS trusts which shows the actual cost of a trust's casemix delivered at national average cost. The committee noted the 2014-15 reference cost index of 101, an improvement on the 2013-14 reference cost index which was 104. It was noted that the Trust had reconciled the 2014-15 reference cost return to the 2014-15 final financial accounts, to ensure that all relevant costs were reported. Mrs Brandt updated the Committee on a recent mandated reference cost audit undertaken by PWC on behalf of Monitor and provided some detail around the areas involved. It was noted that overall it was a good audit, however there were some issues around coding resource. Mr Meikle explained the plans in place to address some of	

	these issues. It was agreed that Mrs Brandt would provide an update on the issues arising from this audit and the actions taken at the March 2016 Finance & Investment Committee. It was also agreed that issues relating to coding would be flagged on the risk register. It was noted that the reference costs guidance for 2015/16 had recently been issued and was more prescriptive than that of last year. **Action:** **The Committee noted the reference cost index and recommended that the Trust use Department of Health reference costs benchmarking software as an enabler to identify CIP schemes, and consider the reference cost index when considering service change.**	**JB** **DM**
10.	**Tenders Schedule and Business Cases** The Committee received a schedule providing up update on current tenders as at 8 December 2015. The schedule is monitored by the Business Development Group (BDG) on a fortnightly basis. Any new Pre-Qualification Questionnaire (PQQ) or tender proposals are considered by the Corporate Leadership Team (CLT) to determine whether a potential bid by the Trust would meet a number of key criteria. The Committee noted the position of the following PQQ/tenders in the pipeline: • Community Diabetes Service for Brighton & Hove and High Weald Lewes & Havens CCGs • Integrated Sexual Health and HIV Service • Non-Invasive Ventilation Service It was noted that the Trust had been notified on 14 December 2015 that it had won the tender on the Integrated Sexual Health and HIV Service. **Action** **The Committee noted the update on tenders and service developments.**	
11.	**Job Planning – Quarterly Update** Dr Hughes gave an update on the Job planning position. The Trust had introduced a more rigorous and robust method of job planning this year to ensure that consultant activity was fully aligned	

	with Trust plans and there is the most productive use of consultant time and clinical facilities. Monthly scrutiny meetings have been undertaken with each CU from August 2014 through to March 2015. Regular contact with them continues by the Assistant Medical Director – Workforce and the revalidation and job planning team to ensure progress continues to be made and that the job plans reflect the workload and activity the Trust needs to undertake. All consultants have job plans that are being reviewed annually aiming to achieve standards based on the new job planning guidance. The Committee received an update on job planning compliance and their trajectories provided by each Clinical Unit. **Action** **The Committee recommended that this work continues.**	
12.	**Business Cases for Review** **Managed Print Solution Project (Enterprise Printing) Update** Mr Meikle presented an update on the progress on the Managed Print Solution (Enterprise Printing) project. The Committee noted that the Trust uses a multitude of network printers and photocopiers. Operational costs are currently running at approximately £640k per annum to support this service across the two acute hospitals. Recent audit of the assets across the two sites have identified 948 devices (equating to a ratio of printers to staff of 1:6). Mr Channana provided the Committee with an update on the Procurement options that the trust had been looking at, and summarised the benefits to rationalising the number of aging printers/ photocopiers and scanners on the two acute sites; replacing them with modern devices with a fully managed enterprise wide print solution from single supplier. A draft Full Business Case will be presented to the F&I Committee in January 2016 to ask for approval to proceed with the tender process to secure an appropriate supplier with a view to roll-out completed to the two acute sites by the end of December 2016. **Action** **The Committee noted the update on the project and the draft FBC will be presented to the meeting in January 2016.**	**DM**
13.	**2015/16 Work Programme**	

	The 2015/16 work programme was reviewed. It was agreed that the following items would be added to the work programme: Lord Carter update – January 2016 Enterprise Printing Draft FBC - January 2016 Capital Programme and 5 year plan – February 2016 Community Rebasing - March 2016 Recruitment Trajectory – March 2016 Update on issues arising from Reference Cost Audit - March 2016 **Action** **The Committee noted the work programme and update.**	
14.	**Date of Next Meeting** The next meeting will take place on Wednesday 27 January 2016 at 9.30am – 11.30am in the Princess Alice Room, Eastbourne DGH	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 27th January 2016 at 9.30am – 11.30am, in Princess Alice Room, Eastbourne DGH

Present	Mr Barry Nealon, Non-Executive Director (chair) Mr Mike Stephens, Non-Executive Director Ms Jackie Churchward-Cardiff, Non-Executive Director Mr David Meikle, Interim Director of Finance Mr Philip Astell, Deputy Director of Finance Mrs Pauline Butterworth, Acting Chief Operating Officer Dr David Hughes, Medical Director
In attendance	Mrs Jo Brandt, Head of Planning & Performance (for item 9) Mr Steve Garnett, Clinical Lead for Urology (for item 9) Mr Matt Hardwick, General Manager for Urology (for item 9) Mr Stephen Hoaen, Head of Financial Services (for items 10 – 12) Ms Janice Smith, Capsticks (observing) Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee. Apologies were received from Mr Richard Sunley and Mr Garry East. Ms Janice Smith from Capsticks was present as an observer at the meeting.	**Action**
2.	**Minutes of Meeting of 16 December 2015** The minutes of the meeting held on 16 December 2015 were agreed as an accurate record.	
3.	**Matters Arising** <u>(i) PMO Project Update</u> The Committee received a progress report on the proposed implementation of the key projects due to be implemented in 2015/16	

	and a status position for each project. Mr Meikle clarified some of the issues raised by the Committee on the following projects: • Vital PAC • Community & Child Health • Digital Medical Record Tracking • Pathology Managed Equipment & Rationalisation – Estates costs • GS1 Programme It was noted that the GS1 Programme was on hold until the year end as project management resource had been redirected to the quality improvement plan. The Committee asked for assurance that this would not be put on hold indefinitely and asked for a further update at the next meeting. The Committee received a detailed report on the Pathology project as requested at the last meeting. It was noted that the contract agreement had been agreed in principle and that the contract was due to be signed on 12 February 2016. The Chairman asked for an update on what the contract costs were, confirmation that all the approvals were now through, and queried whether the Trust was on track for signature on 12 February. It was agreed to invite Mrs Walton to the February meeting to clarify some of these issues. <u>(ii) Procurement Update</u> A Lord Carter report update was provided under agenda item 13 below. <u>(iii) HWLH Community Transition Update</u> It was noted that information from PWC on the impact assessment of the loss of the Community Services contract had been circulated to Committee members following the last meeting. <u>(iv) Flash Report – Month 8</u> A report on the grip and control measures was discussed under agenda item 7 below. <u>(v) 2015/16 Forecast Outturn and Downside Case</u> A definitive forecast outcome scenarios was presented under agenda item 5 below. <u>(vi) Recruitment Trajectory</u>	**LW** **LW**

	It was confirmed that this item had been added to the work programme as quarterly item. (vii) Community Rebasing Project It was noted that a Community Rebasing Project update would be presented to the March 2016 meeting. (viii) EBITDA Quarterly Report – Q2 The Urology deep dive was presented under agenda item 9 below. (ix) 2014-15 Reference Costs RCI An update on issues arising from the Reference Costs audit will be presented to the March 2016 meeting. It was noted that the issues relating to coding had been flagged on the risk register. (x) Managed Print Solution Project (Enterprise Printing) update The procurement option appraisal for the Managed Print Solution Project was discussed under agenda item 15 below.	
4(i)	**Integrated Performance Report – Month 8 and 9** Mrs Butterworth presented the Committee with the Integrated Performance Report for month 9 (December 2015). The month 8 report was included for reference and assurance. The following key highlights were noted: • RTT incompletes continue to meet the 92% standard with a final figure of 92.1%. • Diagnostic performance did not meet the < 1% target in December. The final position was 1.98% and was mainly due to capacity within Endoscopy. • A&E performance remains challenged and under the target. • Cancer targets remain challenged with only the 31 day standard being achieved although December showed improvement on November's position. • The levels of falls have increased against the previous month. Mr Meikle presented the Finance Report at month 9. It was noted that the Trust financial performance at month 9 was a run rate deficit of £4.9m which was £1.5m adverse to plan. This had increased the year to date deficit to £36.5m, which was £8.8m greater than plan. The impact on the forecast outturn of this deterioration in performance was currently being assessed, alongside any potential mitigation in actions that would recover the position. Any mitigation would ensure	

	that patient safety and quality were not compromised through a Quality Impact Assessment review. The CIP achievement year to date was £6.6m which was below the plan of £8.0m. The forecast outturn reported to the Trust Development Authority had been revised to £48.7m deficit which was £13.5m above the revised plan. Mrs Butterworth gave an update a brief workforce update. **Action** **The Committee noted the Performance, Finance and Workforce update at month 9.**	
5.	**2015/16 Forecast Outturn & Downside Case (deep dive) Presentation and Discussion** Mr Meikle presented a briefing on the financial performance for 2015/16 and highlighted the following key messages: • In month 9 (December 2015) the Trust generated a £4.9m deficit, £1.5m greater than plan. • This had increased the year to date deficit to £36.5m, £8.8m greater than plan. • Key drivers of the deteriorating performance were: increasing agency costs, escalation beds, quality improvement plan implementation costs and CIP slippage • Forecast outturn was no projected at £48.7m The Committee received information on the forecast outturn scenarios. Mr Meikle highlighted the following recovery actions were in place: • Establishment of a Temporary Workforce Review Group with a wide remit to review all aspects of temporary workforce spending including deep dives into specific areas of concern • Compliance with the recommended actions in the agency cost reduction tool • Compliance with the recommended actions in the Grip and Control checklist which will increase review of all discretionary spending • Continued discussions with the commissioners re additional income (Healthy Hastings, QIP support, stranded cost support, Winter funding) • Review of possible service / activity reductions in Q4 • TDA Turnaround checklist Q4	

	Action **The Committee noted the 2015/16 Forecast Outturn & Downside Case**	
6.	**HWLH Stranded Costs** The Committee received an update on the latest position of the stranded costs facing the Trust in relation to the transfer of Community Services to Sussex Community Trust. Mr Meikle reported that this was currently work in progress. The report presented summarised the current impact of the transfer of High Weald, Lewes and Havens Community Services to the new provider, Sussex Community NHS Trust in relation to stranded costs. The Committee noted the following key issues: • The level of stranded costs • The current mitigations proposed • Current negotiations with the CCG It was noted that work was continuing to review the level of stranded costs and to understand the savings required to mitigate further. It was agreed that more detailed analysis of what had been done to minimise the impact would be presented to the next meeting. **Action** **The Committee noted the HWLH update on Stranded costs.**	**DM**
7.	**Grip and Control Measures** Mr Meikle presented the Committee with the “Grip and Control” framework focusing on the short term actions to implement in a turnaround process and as such provides the Trust with an effective tool in order to enhance and improve on the existing control environment. The objective of the framework is to establish immediate control over the organisation with a focus on: • Cash and treasury management • Short term stabilisation • Identification of areas for income acceleration and cost reduction It was noted that the Trust was implementing and monitoring the detailed actions through the Productivity and Efficiency Group. Progress to date has been focussed on the following areas:	

	• Cash, cash-flow and debtors
	• Balance sheet issues – provisions and inventory
	• Income generation
	• Cost and expenditure
	  - Finance related controls
	  - Procurement related controls
	  - Estates related controls
	  - Other controls
	• CIPs and PMO arrangements
	• Business cases and capital controls
	• Programme Governance
	• Performance management
	• Workforce planning
	• Operational grip
	
	It was agreed that the Committee would receive a regular update on progress on the implementation of the actions.
	
	Action:
	This Committee noted the Grip and control Framework being used in the Trust and progress made to 31 December 2015. It was agreed that the Committee would receive a regular update on progress on the implementation of the actions.
		DM

8.	**Business Planning Update 2016/17** The Committee received an update on progress on the business planning process. The main planning guidance document Delivering the Forward View: NHS planning guidance 2016/17 to 2020/21 sets out the planning assumptions and priorities for the NHS for the coming year and beyond, reflecting both the government's Mandate to NHS England for 2016/17 and the on-going implementation of the Five Year Forward View. It requires NHS commissioners and providers to submit two separate but interconnected plans in 2016: • A strategic, local health and care system Sustainability and Transformation Plan (STP), covering the period October 2016 to March 2021; • An operational plan by each organisation for 2016/17, that should be consistent with the emerging local strategy and completed in time to enable contract sign-off by the end of March 2016.	

	This report provided gave details on the operational plan and progress towards its submission. It was noted that a robust timetable was in place to meet the tight deadlines on plan submissions and that the clinical units were working towards their business plans. A Business Planning away day took place on 26 January. The first draft submission is due to be submitted on 8 February 2016. This will be signed off by the Executive Directors at the Senior Leaders Forum on 2 February 2016. Mr Meikle circulated a letter received from Monitor and the TDA regarding next year's control total The Committee asked to be updated prior to the submission on 8 February 2016. The Committee was asked to note: • the progress to date on the business planning timetable, • the risks and mitigations in providing a robust and credible plan • the governance arrangements to sign off the plan **Action:** **The Committee noted the above.**	**DM**
9.	**Urology Service Review** Mrs Brandt presented the Urology Service Review which was initiated following the positive response to similar service reviews in other specialties. Urology had been chosen because it had an adverse Qtr 2 2015-2016 EBITDA variance of -29% and a net deficit of £1.8m. Urology had been asked to present the findings from the planned Service Line Reporting deep dive into their business. The 2014-2015 reference costs index for Urology was 121, indicating that costs were 21% above the average. The deficit position relates predominantly to elective inpatient work, with a loss of £911k as at Qtr 2 2015-16. It was noted that the EBITDA in 2015/16 had significantly deteriorated when compared to 2014/15. This was due to a reduction in the level of activity and subsequent income whilst the cost base had remained the same. Approximately 50% of the deterioration in income had been caused by the outpatient coding issue where outpatient procedures were being coded to outpatient attendances. Urology were working with outpatients to further improve the process.	

	Mr Garnett expressed his concerns over ongoing admin issues and that the coding forms being used were not fit for purpose. Following discussion, the Committee agreed to take a decision to change the form. It was agreed that Mr Garnett would send the form to Mrs Butterworth to instigate this action. Mrs Brandt reported that this was an issue that was raised in the reference cost audit. It was agreed that an item on Coding (specifically outpatients) would be discussed at the next meeting. Mrs Brandt summarised the next steps for Urology, and proposed that they come back to a future meeting to present the actions taken since the presentation. Mr Garnett presented Mrs Butterworth with a list of immediate actions required for Urology. It was agreed that Mrs Butterworth and Mr Hardwick would work with Mr Garnett and Mr Meikle to look at specific issues. **Action:** **The Committee noted of the Urology EBITDA statement position. It was recommended that Urology follow the next steps highlighted in the Urology Service Review paper, and that they be invited back to present the actions taken since their presentation. The Committee will continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews.**	**PB** **DM** **PB**
10.	**Quarterly Review of Aged Debts** Mr Hoaen gave an update on the current level of aged debt at the end of December 2015, split between NHS and non NHS and segmented into operational categories. It was noted that overall levels of debt over 90 days old had continued to reduce, from £1.974m at the end of September to £592k at the end of December. The percentage of over 90 day debt to the total debt has reduced from 29% at 30th September 2015 to 14% as 31st December 2015. The Committee noted the collection of the debt reported last quarter from NHS Property Services. The target remains 5%, so although progress continues to be made, the Trust is not yet in compliance with this KPI. **Action:** **Committee noted the current aged debt position.**	
11.	**Review of Capital Programme Outcome**	

	The Committee received an update on the outcomes of live capital business cases considered by the Capital Approvals Group (CAG) and also by the Finance & Investment Committee 2015/16 year to date, which are being progressed as part of the 2015/16 capital programme. This included: • Electronic Document Management • Oasis PAS Upgrade, including clinic manager implementation. • Health Records - Introduction of a bar coding identification system & improved physical storage. • Infrastructure Improvements – Modernisation of inpatient environment and facilities • Pevensey Development • Windows 7 Office 2010 Migration It was noted that these were all on track. The Chairman asked if the approved capital budget and spend could be included in future reports. **Action:** **The Committee noted the current position on live capital business cases approved during 2014/15 and the current financial year.**	**SH**
12.	**Capital Programme Quarterly Report** The committee received an update on the 2015/16 capital programme as at 31st December 2015. This reflected the recommendations made at the December Capital Approvals Group (CAG) meeting. It was noted that the capital pressures the Trust was facing were very significant with back log pressures on maintenance, medical equipment and IT at a time when it is also under pressure on its revenue performance. The capital review paper updated the committee on:- • The current performance of the capital programme. • The revised capital plan approved by the CAG in order to manage the capital plan within the capital resource limit (CRL). The Trust continues to face risks in relation to the total value of capital resource available to meet the capital needs of the Trust. In summary the risks are in respect of:- • Backlog maintenance of the trust's estate • Backlog medical equipment replacement	

	• Costs arising from IM&T backlog and infrastructure pressures Mr Meikle reported that in order to ensure a balanced capital position as at 31 March, the CAG was reviewing and monitoring the capital programme on a biweekly basis during the remainder of the financial year, paying particular attention to the risks associated with limited capital. The Chairman asked if an update could be provided at the next meeting. The Committee was asked to • Note the current performance of the capital programme • Note the significant risks arising from the deferral of capital schemes in order to bring the capital programme into balance • Note the revision of the capital programme will be required by the Capital Approvals Group in order that the Trust does not breach its capital resource limit (CLR) as 31 March 2016. **Action:** **The Committee noted the above.**	**DM**
13.	**Lord Carter Update** Mr Astell provided the Committee with an update on progress to date on the NHS Procurement and Efficiency Programme (NHS PEP - frequently referred to as the Lord Carter review) that is being driven by the Department of Health (DH). The report provided described the Trust's engagement in the project and the steps being taken to ensure that the Trust validates and exploits the true potential efficiency improvement opportunities that are identified. It was noted that the Trust had received reports from the NHS PEP that provide indicative savings opportunities based on the metrics developed as part of the programme; The indicative data and methodology contained a number of flaws and the Trust was liaising with the Lord Carter team to arrange for these to be corrected Mr Astell reported that the Trust had established an Efficiency Improvement Group (EIG), whose work would include the development of a co-ordinated response to NHS PEP outputs It was noted that the NHS PEP will transfer from DH to NHS Improvement from April 2016. **Action** **The Committee noted the contents of the report and the further**	

	assurance provided.	
14.	**Tenders Schedule and Business Cases** The Committee received a schedule providing up update on current tenders as at 14 January 2016. The schedule is monitored by the Business Development Group (BDG) on a fortnightly basis. No business cases had been approved by SLF since the last report. The Trust had now entered the annual business plan process and therefore only cases relating directly to patient safety, or those already in process will be reviewed. **Action** **The Committee noted the update on tenders and business cases.**	
15.	**Managed Print Solution (MPS) Project – Procurement Options Appraisal** The Committee received a report providing assurance that the Managed Print Solution project was following due process with regard to the procurement of a supplier of a managed print service. The report indicated that there were benefits to rationalising the number of aging printers/photocopiers and scanners on the two acute sites; replacing them with modern devices with a fully managed enterprise wide print solution from single supplier. In order to progress the procurement of a supplier it is necessary to decide on the most appropriate procurement route: • Competitive dialogue • Innovation Partnerships • Open Procedure • Restricted Procedure • Framework agreements A Procurement options appraisal paper had been discussed at the Managed Print Solution Project Board and their decision on the most appropriate procurement route will be confirmed at the next Project Board on 8th February. The draft Full Business Case will be presented to the February 2016 meeting. **Action:** **The Committee noted the Managed Print Solution project was following due process with regards to entering into the most appropriate procurement route to secure the services of a managed print solution provider.**	**DM**

16.	**Business Cases for Review** There were no Business Cases for review **Action** **There were no Business Cases for review.**	
17.	**2015/16 Work Programme** The updated 2015/16 work programme was noted. **Action** **The Committee noted the work programme and update.**	
18.	**Date of Next Meeting** The next meeting will take place on Wednesday 24 February 2016 at ***9.30am – 12pm*** in St Mary's Board Room, Eastbourne DGH.	

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the People and Organisational Development Committee meeting held on Tuesday 8 March 2016 at 2.30pm in the Sara Hampson Room, Post Graduate Centre, Eastbourne DGH

Present: Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director (JCC)
Mrs Edel Cousins, Asst. Director of HR – Workforce Development (EC)
Ms Monica Green, Director of HR (MG)
Dr David Hughes, Medical Director (DH)
Mrs Jan Humber, Staff Side Chair (JH)
Ms Kim Novis, Equality & Human Rights Lead (KN)
Mrs Moira Tenney, Deputy Director of HR (MT)
Mrs Lynette Wells, Company Secretary (LW)
Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)

In attendance: Mrs Lorraine Mason, Head of Staff Engagement & Wellbeing (LM)
Miss Sarah Gilbert, PA to the Director of HR (SG) - Minutes

No.	Item	Action
1)	**Welcome, introductions and apologies for absence**	

The Chair welcomed all members to the first meeting of the People and Organisational Development Committee (POD) and introductions were made.

Apologies for absence were received from:

Mrs Pauline Butterworth, Acting Chief Operating Officer (PB)
Mrs Alice Webster, Director of Nursing (AW)

2) Agree Terms of Reference

The Terms of Reference were reviewed. The Committee discussed its remit and whether it would wish to see work on culture and values. MG commented that the draft Organisational Development Strategy would be presented at a future meeting and work around embedding values would also be presented at a later date.

JCC highlighted that the Committee duties appeared more HR focused at present and considered that the OD element ought to be increased.

Action: JCC agreed to send some suggestions for amendments to the Terms of Reference. **JCC**

MG asked whether any of the HR reports currently presented at

Quality & Standards Committee, could be circulated to the POD Committee for information as the trends in disciplinaries and grievances would alert the Committee to risks to the organisation. The Chair agreed such reports could come to the Committee for information, however highlighted that the Committee should maintain a strategic focus.

LW and Ms Novis queried whether the Workforce Race Equality Standard (WRES) and Equality Diversity Standard 2 (EDS2) should come to the Committee for review. All agreed this would require annual review.

Action: The quarterly HR incident report and statutory mandatory training and appraisal reports to be circulated to the committee for information. The WRES/EDS2 to be presented to the POD Committee annually. **MT** **KN**

Membership of the Committee was reviewed. All agreed the current membership was appropriate, however, this would require review in due course and further members may be added.

The Terms of Reference were agreed subject to the following amendments:

- Section 6: Inclusion of additional OD related duties
- Section 7: Include sentence "The minutes of the meetings will be provided to Trust Board for information".
- Section 8: "HR Quality & Standards meeting" to be removed and replaced with "Workforce Planning Group"

Action: The updated Terms of Reference to be circulated to the Committee with the minutes **SG**

3) National Context

MG provided a verbal update to the Committee highlighting key national workforce related changes.

The Trust Development Authority and Monitor have recently merged to form NHS Improvement. The NHS Improvement Five year Forward View paper has recently been published and contains a number of workforce-related focuses including capability and capacity, workforce productivity linked to the Carter Review, maintaining a motivated and skilled workforce, leadership, retention of staff, workforce remodelling and health and wellbeing of staff.

MG also outlined the new Junior Doctors' Contract to be introduced shortly and highlighted the challenges related to implementing this. The Consultant Contract will also be looked at nationally along with the Terms and Conditions of Agenda for Change Staff. The Committee felt this would be appropriate to review further progress on this further at a future meeting.

Action: Consultant Contract and Agenda for Change Terms and Conditions to be added as an agenda item for September or December meeting. **SG**

Further national changes were highlighted. A pension cap of £1million has been introduced and this is impacting high-earners who may be thinking about retiring or taking their pension. The NHS Pay Review Bodies have announced a 1% pay rise for Agenda for Change and Consultant Medical and Dental Staff, payable from 1 April 2016.

JCC suggested, and all agreed, that it would be useful for the organisation to be proactive towards the national changes.
Action: The Chair agreed to raise this with Trust Board. **MK**

4) Staff Survey

LM outlined the results of the 2015 ESHT Staff Survey and provided some background information.

Despite extensive promotion of the survey in September 2015, a slightly lower response rate had been achieved. Highlights in the results included slight increases in the staff engagement score, care of patients and service users, ESHT being recommended as a place to work, standard of care and treatment at ESHT and staff being aware of Trust Values.

Areas of concern for ESHT were around patient and service user feedback, reporting of errors and near-misses, good communication between management and staff and support from immediate managers.

LM highlighted Quality Health Management's key recommendations/improvements including; development of communication skills of managers, improvement of feedback from staff, addressing deterioration and stress at work, handling of errors, near misses and incidents, raising concerns, focus on harassment and bullying, quality of training, patient experience data and understanding of why some staff would not recommend the organisation as a place to work or would not be happy with the standard of care received.

LM outlined some of the actions being taken to address the recommendations, and listed three key priorities: addressing bullying and harassment, health and wellbeing of staff and to ensure ESHT is recommended by staff as a good place to work and to receive care and treatment.

Following a discussion the Committee agreed the three key priorities for ESHT:

- Health and wellbeing of staff
- Addressing bullying and harassment
- Communications to staff, feedback from staff ensuring an outcome that staff feel valued

LM advised that monthly feedback surveys would be introduced

shortly which would link back to these priorities to test whether there is any improvement in the responses.

Action: Analysis of feedback surveys to be presented at the next meeting. **LM**

LM agreed to revisit the other recommendations made by Quality Health around quality of training and patient experience data to see if this could be linked in to the priorities. With regard to errors and near misses LM also agreed to review whether the recent improvements to the Datix reporting and feedback processes were having an impact.

Action: Other recommendations by Quality Health to be re-visited. **LM**

The Committee thanked LM for her presentation and acknowledged the huge amount of staff engagement work being undertaken in the Trust.

5) Focus on Recruitment

MT presented a paper on recruitment and retention and provided the local and national context. She reported on national skill shortages for certain key staff groups and difficulties in obtaining certificates of sponsorship and visas for overseas workers. The latter has been resolved temporarily to allow for recruitment of overseas nurses into the NHS. With regard to local issues, the Trust is situated close to Brighton Trust which offers specialist teaching. There are also issues with poor infrastructure at ESHT and reputation.

MT outlined key sections of the report and highlighted the vacancy rates for the different staff groups at the Trust and actions being undertaken to address and fill vacancies. She also outlined actions to also improve promotion of the Trust as a good place to work including use of social media, improvements to Trust website, branding etc.

JCC asked whether there were any roles that could be reinvented to address shortages in some areas. EC said that there were some new roles being looked at including Assistant Theatre Practitioners, Physicians Associates and Surgical Assistants in order to address the shortages. This was being included in the workforce plan for the Trust. EC also outlined areas where training was being funded for staff in certain areas to improve retention and fill vacancies.

Action: Workforce Plan to be presented at June meeting. **EC**

LW commented that there were actions being undertaken to improve the Trust Website and branding, and a recruitment video is also being developed by the Director of Nursing.

A question was raised whether the Trust had done well in terms of recruitment and retention in comparison with other Trusts in the region. MT outlined that Portsmouth Hospital have 45 nursing vacancies currently and Yeovil Trust have also made improvements

with regard to their vacancies. It was suggested that a visit could be undertaken to Portsmouth to understand the actions they have taken to reduce their vacancies.

Action: Consider undertaking a visit to Portsmouth Trust. **MT**

MT also outlined a piece of work being undertaken around retention of staff which will be presented at a future POD Committee.

Action: Retention of staff report to be presented at June meeting. **MT**

The Committee thanked MT for the report and noted the actions being taken to address skill shortages, vacancies and retention of staff.

6) Focus on Engagement

LM introduced the report. She provided some background and context, advising that the Trust's focus was on a coordinated approach for staff engagement and wellbeing and this has become a regular item on the Trust Board agenda. LM advised she was seeking the Committee's agreement for the future work plans for 2016-17 and to highlight any issues and risks to the Committee around staff engagement.

LM referred to the future work plans outlined in the Staff Engagement Update paper circulated to the Committee, which include developing leaders and collective leadership, acting on results from the cultural review and medical engagement scale work, health and wellbeing initiatives, positive promotion of the Trust and celebrating successes. She also outlined the actions already being undertaken in the Staff Engagement Action Plan.

The Committee discussed the priorities and agreed that these were acceptable to progress for 2016-17.

A suggestion was made around adopting shared learning/successes across other areas and help with publishing success stories for areas/departments. JCC commented that communications needed to be a priority.

The Committee thanked LM for her report.

7) Forward Plan

The Chair asked the Committee for future agenda items and the following were agreed for the next meeting on 1 June: **SG**

- Workforce Plan – to include recruitment initiatives, education commissions and new roles
- Draft OD Strategy
- Medical Education Scale results and actions
- Feedback from Pulse Surveys

Future business for forthcoming meetings would be detailed on a

Forward Plan to be drafted by the Chair and MG and circulated to the Committee. Review of membership would be included on this.

Action: Forward plan draft proposal to be circulated to Committee. **MK/MG**

8) Any Other Business

8.1 – Issues arising from Sub-Committees

It was agreed by the Committee for the latest minutes of each of the Sub-Committee to be circulated for information.

Action: Latest minutes from each Sub-Committee to be circulated to the Committee with the minutes of this meeting. **SG**

8.2 – Communications Message

A suggestion was made to circulate a message to all staff regarding the POD Committee meeting to detail items discussed and ask staff whether they would be interested in this and attending the Committee. MG agreed to draft a communications message.

Action: Communications message to be drafted and circulated to staff. **MG**

9) Items by correspondence

9.1 – Workforce Report – January 2016

Item noted for information.

9.2 – Workforce Profile

Item noted for information.

10) Date of Next Meeting

The next meeting of the Committee will be held on:

Wednesday 1 June 2016, 2.00 – 4.00pm in Room 3, Education Centre, Conquest Hospital and Princess Alice Room, Eastbourne DGH via video-link.

Signed: ……..

Date: ……

East Sussex Healthcare NHS Trust

Date of Meeting:	13th April 2016
Meeting:	Trust Board
Agenda item:	15
Subject:	Use of Trust Seal
Reporting Officer:	David Clayton-Smith, Chair

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

Purpose:

To keep the Board informed of the use of the Trust Seal since the last Board meeting.

Introduction:

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

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

Use of Trust Seal

11th March 2016 – Agreement between ESHT and ROSCH to provide pathology managed services for seven years.

Proposals and/or Recommendations

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

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

Name:	**Contact details:**
Lynette Wells, Company Secretary	lynette.wells2@nhs.net