EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 24th September 2014, commencing at 10.45 am in the St Mary's Board Room, Eastbourne DGH

AGENDA

			Lead:
1.	a) Chairman's opening remarks b) Apologies for absence c) Quality Walks July/August 2014		Chair
2.	Monthly award winner(s)		Chair
3.	Declarations of interests		Chair
4a.	Minutes of the meeting held on 30th July 2014	Ai	Chair
4b.	Matters arising	Aii	Chair
5.	Appointment of Vice Chair		Chair
6.	Chief Executive's report (verbal)		CEO
7.	Board Assurance Framework	B	CSec

QUALITY, SAFETY AND PERFORMANCE

8.	a) Performance report month 4 (July) and Finance report month 5 (August) b) Safe Nurse Staffing Levels report July 2014	Assurance	C	ALL DN
9.	Research and Development Strategy 2014/19	Approval	D	MDG
10.	Infection Control Annual Report 2013/14 and Annual Work Programme 2014/15	Approval	E	DN/ MDG
11.	Health and Safety Annual Report 2013/14	Approval	F	DN

DELIVERY

12.	Annual Business Plan 2014-15 Quarter 2 Update	Assurance	G	DSA
13.	Capital Programme Mid Year Review	Assurance/ Approval	H	DF
14.	Operational Resilience and Capacity Plan 2014/15	Assurance	I	COO

GOVERNANCE AND ASSURANCE

15.	Board sub-committees: a) Audit Committee 03.09.14 b) Finance and Investment Committee 27.08.14 c) Quality and Standards Committee 02.09.14 d) Trust Board seminar notes 16.07.14	Assurance	J	Comm Chairs

ITEMS FOR INFORMATION

16.	Chairman's Briefing	Assurance	K	Chair
17.	Questions from members of the public (15 minutes maximum)			Chair
18.	Date of Next Meeting: Wednesday, 26th November 2014 at 10.00 am in the Oak Room, Hastings Centre			Chair
19.	**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)*		L	Chair

STUART WELLING
Chairman

18th September 2014

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
CSec	Company Secretary
DF	Director of Finance
DN	Director of Nursing
DSA	Director of Strategic Development and Assurance
HRD	Director of Human Resources
MDG	Medical Director (Clinical Governance)
MDS	Medical Director (Strategy)
AC	Audit Committee
FIC	Finance and Investment Committee
QSC	Quality and Standards Committee

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks July/August 2014
Reporting Officer:	Amanda Harrison, Director of Strategic Development and Assurance

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

Purpose:

This paper provides a summary of Quality Walks that have taken place during July and August 2014.

Introduction:

Quality Walks are 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 enable quality improvement actions to be identified and addressed from a variety of sources, and 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 July and August was as follows:

- Service Reconfiguration (Obstetrics and Paediatrics, Trauma and Orthopaedics, General Surgery)
- Information Technology (VitalPAC, SystmOne)
- Staff Survey

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

40 services/departments were visited as part of the Quality Walk programme during July and August as detailed in the attached. 37 of these were arranged by the Assurance Manager or the Chief Executive's Office and the Ward or Unit Manager notified in advance to expect the visit. The remainder were carried out as ad hoc visits so staff may or may not have been notified to expect them. (NB other adhoc visits may have taken place, but reports have not yet been received). In addition the Director of Nursing has carried out several night visits accompanied by other members of staff including the Chairman.

Feedback forms have been received to date relating to 27 of the visits, a copy has been passed on to the relevant department/service managers for information.

Summary of Observations and Findings relating to the themes collated from the feedback forms

<u>Service Reconfiguration</u>

One area reported a lack of information relating to their unit regarding reconfiguration and stated that they were not aware of any consultation regarding their particular team; however they reported minimal sickness and good morale but had found the changes upsetting for the team. Another ward that had moved locations felt that the ward had now settled down following the service change, that overall the change had gone well and that staff were working well together.

AAU reported that having Consultants available 7 days per week was a positive step and will help patients at weekends instead of the current 'blocking up' that can occur.

Most staff spoken to felt well supported by their General Manager and Head of Nursing

Information Technology (VitalPAC, SystmOne)
VitalPAC has now been implemented and was reported as working well, and seems to have been well embraced by staff.

SystmOne has been generally welcomed, there have been some issues which are being dealt with, but staff commented that complete wifi access would be beneficial. Staff also recognised that the project was not just about a new IT system but that it also represented a different way of working. Overall staff appeared really pleased with the new system and recognised its potential.

FFT - one ward reported that they are using the process to make changes and improvements to their area of care

Staff Survey
In discussions with some staff it was reported they felt that the low completion rate of the survey may be due to it being long and repetitive. There was a general perception that it is not filled in because staff can't see the point and some felt that it was not truly anonymous. They felt that some of the results may be due to nurses feeling 'demoralised by the press', and that 12 hour shifts weren't popular. Some also reported that it 'feels like education and training has been cut back'. It was also suggested that the distribution method might be a barrier to completion.

Other key issues
Several feedback reports recorded that the areas visited were well led. Morale was reported as low amongst District Nursing teams due to staff shortages, although this did not seem to be caused by low establishment levels but by annual leave, a mix of short and long term sickness and vacancies. One team also reported that funding issues for enhanced services e.g. rapid response had resulted in staffing being reduced but not the workload.

A very low staff morale was reported in the Health Records departments that had been visited as staff felt very undervalued, they also highlighted some environmental health and safety issues.

The staff affected by the new centralised booking system reported that they felt the new arrangements less efficient and that there was a loss of a speciality approach which may be detrimental.

Patient feedback
Patients spoken to made comments that the standard of food was good, and that drinks were always available. It was noted that if people need help with being fed that it was available. Patients also stated that the housekeeping is good and that wards are always being cleaned. They had noted that if they called for assistance there was always a response and that staff always explained what they are doing when interacting with patients. It was also noted that staff were very caring and kind.

Benefits:

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

Risks and Implications

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

Assurance Provided:
Any actions identified at a Quality Walk are agreed at the time and it is noted who will be responsible for taking forward the action. These are logged and monitored by the Assurance Manager (Compliance) to ensure that actions are implemented. Further visits are being scheduled to take place in September and October. It was agreed at the July Board meeting that the current themes will continue to be the focus of those visits.

Proposals and/or Recommendations
The Board are asked to note the 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?
Not applicable.

For further information or for any enquiries relating to this report please contact:	
Name: Hilary White, Assurance Manager (Compliance)	**Contact details:** Hilary.White@esht.nhs.uk

Quality Walks July-August 2014				
DATE	**TIME**	**SERVICE**	**SITE**	**Visit by**
July				
1.7.14	6am	Tressell	Conquest	Vanessa Harris
1.7.14	1.30 pm	Judy Beard Unit	Conquest	Darren Grayson
17.1.4	2.00 pm	A&E	Conquest	Darren Grayson
17.1.4	2.30 pm	Benson	Conquest	Darren Grayson
2.7.14	9-10.30	Day Surgery Unit Retinal Screening	Bexhill	Alice Webster
3.7.14	12.30pm	Gardner	Conquest	Darren Grayson
3.7.14	9.30am	Macdonald	Conquest	Darren Grayson
3.7.14	10am	DeCham	Conquest	Darren Grayson
3.7.14	11am	Newington	Conquest	Darren Grayson
3.7.14	11.40am	Tressell	Conquest	Darren Grayson
3.7.14	1.30pm	Theatres	Conquest	Darren Grayson
4.7.14	12	DN's	Park Practice	Darren Grayson
4.7.14	9am	Pevensey and Day Unit	EDGH	Darren Grayson
4.7.14	9.30am	Jevington	EDGH	Darren Grayson
8.7.14		Endoscopy	EDGH	Darren Grayson
8.7.14		Firle	EDGH	Darren Grayson
9.7.14		Trauma and Orthopaedics	Conquest	Darren Grayson
11.7.14	2.30 pm	Crowborough Hospital		Darren Grayson
11.7.14	3.30 pm	District Nursing	Crowborough	Darren Grayson
14.7.14		Mirlees	Conquest	Darren Grayson
14.7.14		Frank Shaw	Conquest	Darren Grayson
16.7.14	3.00 pm	Egerton	Conquest	Darren Grayson
16.7.14	3.30 pm	SCBU	Conquest	Darren Grayson
16.7.14	4.00 pm	Wellington	Conquest	Darren Grayson
17.7.14	9am	District Nurses	Station Plaza	Stuart Welling
17.7.14	2pm	Health Records	Conquest	Stuart Welling
21.7.14	10.30am	Audiology	EDGH	Monica Green
21.7.14	12 noon	EMU	EDGH	Darren Grayson
21.7.14	3.30 pm	Outpatients	EDGH	Darren Grayson
23.7.14	12-2pm	Endoscopy	EDGH	Jon Cohen
24.7.14	7.30pm	AAU	Conquest	Vanessa Harrison
29.7.14	3.00 pm	Uckfield Hospital		Darren Grayson
30.7.14	8.30am	Irvine Unit	Bexhill	Vanessa Harrison
31.7.14	9.30 am	Lewes Victoria		Darren Grayson
31.7.14	11.00 am	Health Visitors	Lewes	Darren Grayson
31.7.14	2.00 pm	Theatres	EDGH	Darren Grayson
August				
5.8.14	11.30 am	Health Records	Brampton Road	Stuart Welling
5.8.14	1pm	District Nurses	Eastbourne Park Primary Care Centre	Stuart Welling
6.8.14		Age Related Macular Degeneration out-patient clinic	Bexhill Hospital	Sue Bernhauser
7.8.14	5pm	Theatres	EDGH	Stuart Welling
8.8.14	9am	DN team (SytsmOne)	Eastbourne Park Primary Care Centre	Vanessa Harris
11.8.14	2pm	EMU	EDGH	Amanda Harrison
12.8.14	9am	DN team (SytsmOne)	Hailsham Health Centre	Vanessa Harris
14.8.14	1-3pm	Frank Shaw	CQ	Amanda Harrison
14.8.14	9.30 am	Health Records	Apex Way Hailsham	Stuart Welling
14.8.14	12 noon	Outpatients	Eastbourne DGH	Stuart Welling
14.8.14	11.30am	Gardner	Conquest	Vanessa Harris
18.8.14	1pm	District Nursing	Seaford Health Centre	Stuart Welling
19.8.14	2.30 pm	Bexhill Hospital/Irvine Unit	Bexhill	Darren Grayson
19.8.14	4-6pm	Community Paediatric Team	Bexhill	Amanda Harrison
20.8.14	2pm	Rye Hospital	Rye	Stuart Welling
21.8.14	1.30 pm	Friston	EDGH	Darren Grayson
22.8.14	10am	HV's School Nurses Fellowship of St Nicholas St Leonards	Hastings	Alice Webster
22.8.14	10.00 am	District Nursing	Peacehaven	Darren Grayson
22.8.14	12.00 noon	District Nursing	Seaford	Darren Grayson
22.8.14	2.00 pm	Occupational Therapy	EDGH	Darren Grayson
22.8.14	3.30 pm	Intensive Care	EDGH	Darren Grayson
22.8.14	4.00 pm	Hailsham wards	EDGH	Darren Grayson
27.8.14	1.30 pm	Wellington	Conquest	Darren Grayson
27.8.14	2.00 pm	Kipling	Conquest	Darren Grayson
27.8.14	2.30pm	Ward OPD	Crowborough	Alice Webster
29.8.14	9.00 am	Admissions Lounge	EDGH	Darren Grayson
29.8.14	11.30 am	Audiology	Eastbourne Park Primary Care Centre	Darren Grayson
29.8.14	2.00 pm	Crowborough Birthing Centre		Darren Grayson

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday, 30th July 2014 at 10.00 am in the Manor Barn, Bexhill-on-Sea

Present: Mr Stuart Welling, Chairman
Professor Jon Cohen, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mr Barry Nealon, Non-Executive Director
Mr Darren Grayson, Chief Executive
Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Joint Medical Director – Clinical Governance
Dr Andy Slater, Joint Medical Director – Strategy
Mr Michael Stevens, Non-Executive Director
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Mrs Alice Webster, Director of Nursing

In attendance: Mrs Sue Bernhauser, Non-Executive Director Designate
Ms Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development and Assurance
Mrs Lynette Wells, Company Secretary
Ms Jan Humber, Joint Staff Side Chairman
Mrs Trish Richardson, Corporate Governance Manager (minutes)

059/2014 **Welcome and Apologies for Absence**

a) Chairman's Opening Remarks

Mr Welling welcomed Mike Stevens, the Trust's new Non-Executive Director and Audit Chair, to his first meeting. He also welcomed members of the public.

He welcomed the decision by the East Sussex Health Overview and Scrutiny Committee on Monday to approve the recommendations of the East Sussex Clinical Commissioning Groups on maternity, gynaecology and paediatrics services and commented that this was an excellent decision for the people of East Sussex.

b) Apologies for Absence

Mr Welling reported that apologies for absence had been received from Charles Ellis, Non-Executive Director and Dr David Hughes, Medical Director.

He reminded everyone that the meeting was being recorded to ensure accuracy in the records.

c) Feedback from Quality Walks

Dr Harrison presented the report which covered the programme of walks undertaken during May, June and July and those scheduled for August.

Ms Kennett reported on her quality visit on the Spring Bank Holiday Monday to the Sovereign and East Dean stroke wards at Eastbourne DGH. She reported that the staff had informed her that there had been an issue with staffing levels at the start of the reconfiguration but the correct levels were now in place and they were very positive about their service, with all the stroke indicators now consistently being met and thrombolysis treatment improved.

She reported that the staff had concerns on the space limitations around the beds, storage space and the distance from A&E and the staff were keen to be involved in the design of the next phase of the development of service.

Ms Kennett reported that the staff were also concerned that patients transferred from the Conquest Hospital with a suspected stroke but not having a stroke were staying on the ward rather than being transferred back to the Conquest.

She also highlighted that a patient's discharge had been held up due to the Bank Holiday as the therapy service was not yet available 7 days a week and the introduction of the 7 day service would be a positive improvement in the next development of the service.

Dr Slater commented that it was a difficult balance to ensure that patients transported with a suspected stroke from the Conquest, but not having one, were then not rushed back. He would discuss this with his clinical colleagues outside of the meeting. He reported that he had recently walked around the stroke unit with the nursing staff, and he echoed the staff's views on the requirements for improvements around the estate and he assured the Board that the staff would be involved with the planning when the funding was received to implement the changes.

Mrs Bernhauser reported on her visits to Jevington ward at Eastbourne DGH and the child protection team at the Conquest. She advised that Jevington was a very busy acute medical ward and the night staff had welcomed the addition of a further trained nurse on nights. The staff had expressed their concern in relation to the turnover of newly qualified nurses on their ward and their investment in time to train them before they moved on when their first choice of post became available.

Mrs Bernhauser reported that the staff were aware that Vitalpac was being rolled across out Trust and looked forward to its implementation on their ward as it would be better than the paper records.

Mrs Bernhauser reported that staff had voiced some concerns over the mix of high and low dependency patients in bays and they were of the view that it would be better if the patients were cohorted. The staff had advised that there was no block to implementing this move and Mrs Bernhauser had encouraged them to carry it out as it would be beneficial for patient care.

She advised that the staff were concerned about the Trust's financial position and possibly being moved to the Conquest but that she had advised them that there had been no discussions about such a move. The staff had also highlighted that at night and at busy admission times there were sometimes breaches of mixed sex accommodation but these were addressed by the day staff when they came on duty.

Mrs Bernhauser reported that she had spoken with two patients on the ward who both praised the care they were receiving and were complimentary about the food.

Mrs Webster reported that Vitalpac had now been installed on Jevington and in relation to the issue re newly qualified staff consideration was being given to introducing a programme for new registrants that would involve rotation around the medical and surgical wards so that there was no onus on one particular ward in terms of training.

She advised that if there were emergency admissions at night and it ensuring patients were accommodated in a same sex bay would require disturbing two to three patients then this was not done. However, staff took steps to ensure same sex accommodation was achieved as soon as possible and patients' privacy and dignity was maintained..

Mrs Bernhauser reported that the child protection team at the Conquest had excellent links with the district nurses and health visitors across the patch and very well established working relationships with staff on Kipling ward and the lead midwife for child protection.

She advised that the team was also actively involved in training junior medical staff and this was borne out during her visit when the team was contacted by a SHO in the A&E department seeking advice.

She was of the opinion that the team were cohesive and working effectively as a multi-disciplinary team and able to manage fluctuations in their workload.

She commented that staff had raised an IT issue as their system was not compatible with the A&E system and therefore they had to access the paper records in the A&E department to gain information on children at risk passing through the department. The staff were aware that the IT systems and interface were being reviewed and were hopeful that the issue could be resolved.

Mrs Bernhauser highlighted that the staff had also raised concerns about the lack of a service for children and adolescents with mental health problems which had been recognised as a national issue. Mrs Bernhauser had encouraged the staff to engage with the Sussex Partnership Trust.

It was agreed that Mr Nealon and Mr Grayson would report on their quality visits at the next meeting. **BN/DG**

The Board noted the reports on quality walks.

060/2014 **Monthly Award Winners**

Mr Welling reported that the monthly award winner for June was Health Visitor Maria Wantling who was based at Seaford Health Centre. She had received tremendous praise from the women's refuge for her exemplary work with this vulnerable group of women. The manager of the refuge had commented that "Maria is an outstanding ambassador for the organisation, highly professional, effective, always demonstrating empathy to the women and families, and enabling them to make informed and supported choices at a time of crisis in their lives. Maria is a highly intuitive, skilled and responsive practitioner who inspires colleagues and students alike, and I would very much like her work and commitment to be recognised".

He reported that the winner for July was Mercie Martin who was housekeeper for the theatres at Conquest and had been nominated by the theatre staff as follows:

"Mercie has been our housekeeper for a number of years. Nothing is too much effort for Mercie and she always goes the extra mile to ensure everything shines. Mercie's smile and laughter is infectious and her very presence in the department lifts the mood."

Mr Welling advised that neither Maria nor Mercie were able to attend to the meeting and arrangements would be made to present their awards in the next week or so.

061/2014 **Declarations of Interest**

In accordance with the Trust's Standing Orders that directors should formally disclose any interests in terms of business at the meeting, the Chairman noted that there were no potential conflicts of interest declared.

062/2014 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 3rd June 2014 were considered and approved as an accurate record.

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

b) Matters Arising

The matters arising log was noted and the following updates provided:–

035/2014 – Feedback from Quality Walks

Mrs Webster reported that the issue in relation to the reconfiguration of the diabetic nurse specialist team had been rectified.

041/2014 – Draft Quality Account 2013/14

Mrs Webster reported that the percentage for positive experience in 2012/13 had been 66.9% compared to 66.7% for 2013/14.

She reported that it was not possible to provide a comparison of the incidence of Clostridium Difficile (C Diff) due to the size of the database but she assured the Board that the Trust was not an outlier and the south east region was one of the lowest regions for C Diff incidence in the country.

045/2014 – Research and Development Report

Mr Grayson reported that the footnote had been added to all Trust correspondence.

056/2014 – Questions from members of the public - Board Papers

Mr Welling reported that in future members of the public would be able to request a copy of the Board papers if they intended to attend the meeting, and the papers would be made available to them at the meeting.

063/2014 **Chief Executive's Report**

Mr Grayson presented his report focussing on the following areas:

a) Quality and safety

He commented that the Quality Governance Strategy and Quality Improvement Plan were important building blocks to improve the quality of services provided and would ensure that the systems and processes were thoroughly embedded with front line staff and in the culture of the organisation and providing assurance to the Board.

b) Performance

He reported that the Trust had had a reasonable first quarter and was on track to improve on those areas where performance remained an issue whilst managing the balance between meeting targets and operating within financial resources.

c) Finance

He advised that the organisation had made a good start to the year but there was more to be done with an ever increasing requirement as the year went on.

Mr Grayson said that the focus would continue on achieving the balance between delivering safety and quality of services within the resources available.

d) Strategy

He referred to the decision by the Health Overview and Scrutiny Committee to approve the Clinical Commissioning Groups' recommendations on maternity, gynaecology and paediatric services and believed the decision to be in the best interests of the population served by the Trust. He was proud of the leadership shown by the Trust and looked forward to seeing the benefits coming forward for the community it served.

He highlighted that the organisation was going through a period of very substantial change at a significant rate, for example changing the way the outpatient departments worked, changing clinical administration support services and restructuring the management and corporate services. This had resulted in a substantial and prolonged period of uncertainty and it was important to ensure that communications worked well so that staff understood and supported the changes. .

Mr Grayson welcomed the strategies for Knowledge Management and Information Technology which had been the crucial missing links of the strategic jigsaw and would move the Trust on significantly.

Professor Cohen endorsed Mr Grayson's comments on communications as he had experienced this on a quality walk the previous week where senior staff had indicated that they were too busy to hold team meetings which were important for cascading information to staff. Mr Grayson believed that it was understandable giving the scale of change staff were involved in. He also highlighted that there was a particular challenge at the Eastbourne end of the patch as the local media and some members of the public took every opportunity to view change as negative and the Trust needed to convince the staff and the community that Eastbourne DGH had a viable future which the changes were supporting and he had expressed this view in a recent weekly message.

The Board noted the Chief Executive's report.

064/2014 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework had been reviewed and updated since the last meeting and actions were clearly identified and RAG rated.

She advised that the Framework had been reviewed by the Quality and Standards and Audit Committees at their meetings at the beginning of July.

She confirmed that following the Board's annual review of the Framework at its July seminar one of the risks would be revised and a new risk added and the Framework would be updated for the next Board meeting.

She advised that the gap in control around diabetic retinopathy had been improved and consequently removed.

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

065/2014 **Quality Governance Strategy and Quality Improvement Plan**

a) Quality Governance Strategy

Mrs Webster reported that this was an overarching strategy which had been in place since early 2012, and it had been updated and reviewed by the Quality and Standards Committee, supported by staff conversations during March 2014.

She referred to the addition of the Mortality Overview Group at section 5.6 and the Clinical Unit Quality Governance meetings at section 5.10 to ensure that the clinical units had more accountability for their own governance issues and noted that this was reflected in the revised reporting structure. The duties of key individuals were outlined under section 6 and section 7 outlined how the strategy would be implemented.

Mrs Webster reported that Mr Sunley and herself would be working with the clinical units to close the loop around performance management.

Mr Welling noted that there was no reference to the Corporate Leadership Team and Dr Harrison explained that the Corporate Leadership Team was a tactical operational and advisory group in the organisation and the Clinical Management Executive had the responsibility for making operational decisions. The Clinical Management Executive was being reviewed in light of the management restructure to include more focus on governance.

The Board approved the Quality Governance Strategy.

b) Quality Improvement Plan

Mrs Webster reported that the Quality Improvement Plan was a new element of the Strategy and was a live document which would be continually reviewed and updated during the course of the year.

Mrs Webster reported that the Quality Improvement Manager had the key role to manage the process and deliver the plan and explained how the quality improvement projects listed in Appendix A had been developed. She advised that further work was taking place to develop milestones for the projects which would be reported on at the Quality and Standards Committee and the Board.

Mrs Harris noted the reference to collecting and learning from feedback of patients and carers but suggested that the mechanism for involving patients and carers at the design stage of changing services should also be included. Mrs Webster agreed to include this in the plan and for assurance provided an example to the Board of how service users had been involved in designing the 'How You Are Doing' boards on the wards along with staff.

Professor Cohen was concerned that there was a long list of projects and queried whether they were all deliverable and whether they should be prioritised in terms of deliverability. Mrs Webster commented that the matrix showed where the projects had been derived from and they all needed to be delivered and would be monitored through the Quality and Standards Committee.

Dr Harrison commented that the projects were all included in the annual business plan which the Board had already approved but more detail was included in the quality improvement plan. .

Mr Sunley advised that the plan was helpful operationally as it provided a clear focus on the quality programmes that the organisation would deliver alongside the access targets and financial cost improvement projects. The Performance Management Framework would support their delivery.

Mr Grayson requested that the text be reviewed in order that the outcomes for each project were clearly defined. He asked how the Board would be assured that these projects were being put into practice on the front line. Mrs Webster advised that through the clinical governance structure she and her colleagues would be working with the clinical units to ensure that they were implemented to provide safe and efficient services as part of the daily job. This would be monitored through performance management meetings.

Mr Stevens suggested that there should be champions for the projects and Mrs Webster advised that as part of the development of the matrix owners would be allocated to each project.

Mr Nealon supported the implementation of the Listening into Action projects as they were a practical way of improving quality.

Dr Harrison supported the plan as a useful step forward in focusing on quality and clarifying the priorities for next year's planning round which would commence in the autumn.

Dr Harrison advised that there would be clear priorities from external and internal drivers with programmes in place to deliver them and Listening into Action provided the bottom up approach.

Ms Green highlighted the importance of the link with individual objectives in cascading responsibility and awareness.

Dr Harrison reported that the Trust had been asked to sign up to the national Safety Campaign and was in the process of identifying how the delivery of these projects would contribute to that work.

The Board approved the Quality Improvement Plan subject to the textual changes.

066/2014 **Operational Performance Framework**

Mr Sunley presented the framework and advised that the majority of the meetings outlined in the framework had been in place since April.

He particularly drew the Board's attention to the key Start the Week (STW) and accountability meetings. He explained that the STW meeting looked at issues that had arisen in the previous week and then reviewed what needed to be achieved in the current week and how any issues would be addressed.

He reported that the accountability meetings had been introduced as part of the turnaround work and had been built on to move into the wider agenda with the governance lead also involved. Both were supported by data from Knowledge Management and informed the monthly Board performance report.

Dr Harrison reported that the performance metrics had now been agreed with the TDA and Knowledge Management were working to disaggregate these to a clinical unit level.

Mr Nealon asked how this framework translated into the individual objectives of staff and Mr Sunley gave an example in that the accountability meetings tracked access times to ensuring that they were delivered within resources and, if required, individual consultant lists would be amended.

Mr Sunley added that there were also meetings with theatres on a weekly basis to ensure that the speciality agreements were being delivered.

Mr Sunley confirmed that with the introduction of this framework built on the turnaround work he was much more confident that performance and access targets would be consistently met.

The Board took assurance that a robust framework was in place to ensure delivery of performance targets and goals.

067/2014 **Performance Reports**

a) Quality and Performance Report – May 2014 (Month 2)

i) Overall Performance Score

Mr Sunley reported that the new style performance report referred to the five domains in the Trust Development Authority (TDA) accountability framework - responsiveness, effectiveness, safety, caring and well led. He advised that the higher the score the better for each domain and the overall score for the Trust for May was 4. He outlined how this score was achieved and it was agreed that the TDA Accountability Framework and an illustration on how the Trust's performance was scored would be put on the Trust's website. **RS**

ii) Responsiveness Domain

Mr Sunley reported that under the responsiveness domain the Trust's score had moved from 3 in April to 2 for May and referred to the areas rated red in the table under section 2.0.

He advised that the Trust had not delivered the 18 week Referral to Treatment (RTT) targets for admitted and non-admitted patients at an aggregate level.

Mr Sunley highlighted that a number of specialities were delivering the targets but there were issues in capacity for the orthopaedic and maxillo-facial specialities.

He explained that the Trust had originally agreed a plan to deliver the targets on an aggregate basis by November but national funding was being made available to all organisations across England to bring forward delivery on RTT by September and provide more resilience over the winter period. He and Mrs Harris were about to sign off the final plans for funding to be agreed with the Clinical Commissioning Groups (CCGs) and the TDA.

He advised that there had been a slight improvement in diagnostic waits from 7% to 6% in May, against a target of no more than 1% of patients waiting more than 6 weeks.

Mr Sunley anticipated that the target would be achieved in June through the introduction of extra capacity in the private sector to reduce the backlog and through more efficient use of endoscopy and radiology services.

He reported that the A&E target of 95% had been missed in May at 94.67% but the performance had been recovered in June. However, the quarter one target would also be missed due to the May performance. The issues in May had related to a higher than anticipated number of patients transferred from home to A&E on both sites and delays in admission to mental health inpatient beds. He noted that the Trust was working closely with the Sussex Partnership Trust (SPT) to address this issue.

He reported that changes relating to the GP out of hours service were also affecting A&E in the way patients were being triaged and the Trust was in discussion with IC24 to see how this could be addressed.

He advised that the Trust had not achieved the monthly cancer targets in relation to 2 week wait standard, 2 week wait breast symptom, 62 day standard and 62 day screening standard. The Trust continued to work with the TDA and partners in reviewing the pathways, particularly with BSUH and that the national Intensive Support Team were attending the cancer performance meetings. The aim was to deliver the targets by October.

Mr Sunley highlighted a new standard in relation to delayed transfers of care (DTCs) which the Trust had not reported on previously. He advised that this was a difficult target for the Trust as provision covered both acute and community beds and the target was an acute trust target. The target required no more than 3.5% patients in beds to be identified as DTCs. He advised that the Trust was delivering the target in acute beds (1.5/1.6%) but the community beds were at 4.2% and delays related mainly to palliative care patients and those awaiting transfer to community facilities.

Dr Slater asked if the RTT funding came directly to the Trust or via the CCGs and Mr Sunley advised that the funding came via the CCGs as they had to sign off the Trust's plans. Mr Sunley added that as part of the contract agreement with the CCGs the Trust would also receive £1.5 million to support its winter plans.

Mr Grayson commented that he and Mr Sunley shared the level of discomfort around the performance for May but the June figures would show there was improvement and the Trust was on trajectory to recover the RTT position.

iii) Safe Domain

Mr Grayson noted that there had been a recent change in the guidance relating to Clostridium Difficile (C Diff) and Mrs Webster reported that each organisation would continue to have a limit but each case of C Diff would be required to be reviewed in conjunction with the CCGs to identify if there was a lapse in care. If it was agreed that there was not a lapse in care, then the case would be removed from the overall figures. She advised that discussions were taking place with the CCGs and TDA on how this guidance would be implemented.

Mr Grayson referred to the patient safety incidents which were harmful (3 for April and 4 for May) and asked what constituted such an incident and how was it dealt with. Mrs Webster reported that all incidents were graded from 1 to 5 on the Trust's incident reporting system, Datix, and any graded at 4 or 5 - serious harm - were automatically flagged and discussed within 24 hours with the clinical unit staff involved. The member of staff reporting the incident graded it on the system and, following the more senior review, the incident could be downgraded if it was felt to be less harmful.

Mrs Webster reported that the four incidents in May related to three cases of falls and one C Diff case. She reported that all pressure ulcers were reported at level 3 in line with national guidance and the Trust had a high number which was being addressed.

Mrs Webster reported that the percentage of harm free care related to those areas covered by the Safety Thermometer, ie pressure ulcers, falls, catheters and urinary tract infections and venous thromboembolism assessment, prophylaxis and treatment.

iv) Well Led Domain

Ms Green reported that the Trust was under budget in terms of workforce costs in May which was due to unfilled vacancies and there had been a slight increase in bank and agency usage to cover these vacancies.

She reported that staff turnover was currently 12.5% against a TDA target of 10% and the position across all staff groups in the organisation was very similar. The figure reflected the higher age profile in the organisation and that a large number of staff were opting to take retirement and it also did not take into account staff TUPE'd out of the organisation. She confirmed that all staff received an exit interview and the results were tracked for trends.

Ms Green reported that the monthly sickness rate had reduced slightly but was higher than May of last year and the annual sickness rate had increased slightly.

Ms Green highlighted the variance in sickness rates between the clinical units and advised that the Trust had a very detailed absence management programme including asking staff to provide sickness certificates for all sickness absence during recent holiday periods. She advised that work was taking place around absence for stress, both inside and outside of work.

She referred to the latest figures from the NHS Health and Social Care Informatics Centre for January 2014 which showed that the monthly sickness rate for all NHS organisations was 4.44%, acute 4.21% and community 4.7% and the Trust, an integrated acute and community organisation, rate was 4.5%, against a national target of 3.3%.

Ms Green referred to the mandatory training compliance percentages and noted that the Trust had to report the percentage of staff with annual appraisal under the well led domain. She reported that there had disappointing progress with compliance with mandatory training as shown in the breakdown amongst clinical units in section 7.3. Compliance with mandatory training would be picked up under the new operational performance framework and a concerted effort was taking place at improving mandatory training including look at other methods of delivering training as there had been 1,500 staff who did not attend sessions. The Trust was also reviewing what training was mandatory for all staff and what was role specific.

She reported that a new appraisal system had come into effect from 1st April and this was to ensure that the efforts being made in patient safety and care were understood by staff. In addition, national pay guidance now stated that staff eligible for incremental pay progression were required to have an appraisal but this only related to 50% of Trust staff due to the high number of staff at the top of their grades.

Mrs Bernhauser commented that for many staff their appraisal was the one opportunity to have a 1:1 meeting with their line manager and believed there could be a correlation between the low numbers of appraisals and the responses to the staff survey as staff could feel disenfranchised. Ms Green agreed that appraisals were an important part of staff engagement.

Mr Stevens asked what were the consequences for managers not performing appraisals and Ms Green advised that this was picked up by their line managers and reviewed as part of the accountability meetings.

Mr Nealon asked if the relationship between permanent and flexible staff was at its most optimal or were further increases or reductions anticipated. Ms Green advised that there were still a large number of medical vacancies being covered by agency and, if these could be filled, the agency usage would reduce. She advised that there would always be a requirement for some flexible staff to cover sickness but the aim would be to use bank staff rather than agency.

The Board noted the Quality and Performance report for May 2014 (month 2).

b) Finance Report - June 2014 (month 3)

Mrs Harris reported that the key message was that the Trust on plan at the end of quarter one with costs and income both being slightly under plan. The Trust had an overall TDA finance risk rating of red because it was operating in deficit and this would continue to the year end.

She reported that at the end of quarter 1 the Trust had a deficit of £6,944,000 against a planned deficit of £7,170,000 and pay costs were below plan by £630,000 and compared to a year ago £1 million less was being spent on agency, thereby providing better continuity of care for patients, and £700,000 less on ad-hoc sessions. She highlighted that the numbers for front-line staff remained the same following the investment in nursing staff agreed at the March Board meeting.

She reported that the Trust had over delivered on its cost improvement programme year to date. She confirmed that the Trust had drawn down the first tranche of £5 million cash.

Mrs Harris referred to the revised five criteria of the TDA finance risk assessment and highlighted that the Trust had a green rating in most areas but was rated red for number 1a) bottom line I&E and number 5 as it required cash to manage its deficit in year.

She highlighted that the graphs on page 20 showed the good progress being made with cost improvement programme delivery but noted the challenge of the step change planned for July onwards.

She reported that the risks had not changed since the plan was set and no other risks were manifesting themselves at the present time.

Mr Nealon reported that the Finance and Investment Committee was pleased with the progress being made but added a note of caution in relation to the five year plan, recently submitted to the TDA, as the Committee believed that there was a considerable challenge for the Trust to make a 4%+ saving year on year and had concerns about the level of resource available for capital investment. Mr Welling commented that the Challenged Health Economy work would feed into the five year plan.

The Board noted the finance report for June 2014.

c) Safe Nurse Staffing Levels

Mrs Webster presented the Safe Nurse Staffing Levels report and advised that the monthly report had been uploaded onto Unify for May and June. The reports had been reviewed in detail by the Quality and Standards Committee before being uploaded.

She advised that it was not possible to put a commentary on the submitted forms to explain the reasons for deviations against the agreed staffing establishment, eg if a patient requires 1:1 nursing an additional nurse is brought in and it distorts the figures for the ward above 100%. Mr Welling and Mr Grayson requested that future reports be on an exception basis for those areas where the standards were not being met, ie below 80%. Mrs Webster advised the full data set had been presented in the report submission however Lynette Wells confirmed that this had indeed been removed without the knowledge of Mrs Webster who was on leave. **AW**

Mrs Webster reported that NICE had recently published its guidance and the Trust had been part of the pilot scheme and the guidance was in line with the suggestions in the pilot. The guidance was being reviewed in detail and any issues would be brought back to the Board.

Mrs Webster referred to Appendix 1 of her report which outlined the ward level reporting of safety indicators that had been introduced to provide quality and safety data for patients and visitors. Mr Welling thought that it had been agreed that a cumulative position would be shown for pressure ulcers/falls and Mrs Webster said that the final configuration of the boards had been agreed with patient input but she would review the format with him outside of the meeting. **AW**

Mr Nealon asked if the reporting had made a difference and Mrs Webster was of the view that the exercise had led to a more formal review of staffing and recording of changes in clinical/speciality areas and there was now a clear process for reviewing staffing every six months. It had also led to staff being able to articulate the reasons for variations in levels.

Professor Cohen commented that the report was one of the most important documents at the meeting as it was important for the Board and public to be assured that the right staffing was in place.

The Board noted the report on Safe Nurse Staffing Levels.

d) <u>Complaints Report Quarter 1 (April to June 2014)</u>

Mrs Webster presented the report and to provide some context noted that during 2013/14 the Trust had received 622 complaints arising from the total number of episodes of care as detailed in the report.

She reported that there had been 175 complaints in the quarter against 148 in the previous quarter and there had been a reduction in the number of complaints responded to in time.

She highlighted that A&E and Acute Emergency Medicine had received the largest number of complaints but also received the largest number of compliments.

Mrs Webster advised that further work was planned to align the data so that complaints were responded to in a timely manner but also in an appropriate way. She noted that the number of complaints re-opened had reduced.

Mr Grayson commented that it was important for the Trust to take the learning from complaints and asked how they were triangulated with other information and how the Board could be assured that learning was being shared across the organisation. Mrs Webster advised that complaints were reviewed in the clinical unit governance meetings which were cross-site and any learning to be shared across the organisation went up the Patient Safety and Clinical Improvement Group and was disseminated to other areas including through the monthly newsletter, Sharing Learning in Practice. They were also triangulated with other information, eg Serious Incidents, and themes identified.

Mrs Webster reported that the Trust had been approached by the SEAP advocacy service to undertake a voluntary review of its processes and systems around social care and work with the Trust to improve responses and response times.

Mr Grayson commented that he signed all complaints responses and he had noticed a significant improvement in the Trust's responses to complaints, particularly complex ones.

The Board noted the Complaints Report for Quarter 1.

e) Friends and Family Test Quarter 1 (April to June 2014)

Mrs Webster presented the report and confirmed that the A&E target for quarter 1 had been 15% and the response rate had been 21.46% and for the inpatient wards the target had been 25% and the response rate had been 44%.

Mrs Webster reported that A&E had been a difficult area for data collection but results had improved through a change in the method of data collection.

She reported that the FFT had now been fully implemented in maternity services, with FFT questions being asked at four touch points within the maternity pathway and she highlighted some of the actions taken from the 'you said, we did' comments.

She commented that the net promoter score for quarter 1 had reduced and this would be carefully monitored going forward.

Ms Green reported that a full report on the staff FFT would be provided to the Quality and Standards Committee but the response rate had been quite low for the first quarter.

The Board noted the Friends and Family Test report for Quarter 1.

068/2014 **Medical Revalidation Annual Report 2013/14**

Dr Slater presented the report and complimented Dr Hughes and his team on being able to provide robust assurance to the Board that the requirements for revalidation were being met.

He drew the Board's attention to the increasing compliance rate with appraisal from 62% in 2011/12 to 98.5% in 2013/14.

Dr Slater referred to the cyclical process of revalidation and advised that 84 recommendations for revalidation had been made to the GMC against target of 54 for the year.

He noted that the appraisal process was quality controlled and appraisers were given appropriate training and had dedicated time in their job plans to carry out appraisals and the process was becoming increasingly embedded as business as usual.

The Board approved the annual report and took assurance from the robust system in place for medical revalidation and appraisal. It was noted that the Statement of Compliance would be signed by the Chairman and submitted to NHS England by 31st August 2014.

069/2014 **Knowledge Management Strategy 2014-17 and Information Management Technology Strategy 2014-19**

Mr Welling explained that these strategies had been discussed in draft form at the Board Seminar in July.

a) Knowledge Management (KM) Strategy 2014-17

Dr Harrison reported that both strategies were the key enablers of Trust business and the Information Technology strategy enabled the KM strategy to be delivered.

She explained that the KM strategy focused on how to ensure that the organisation was knowledge driven with accurate information to drive decision making. The strategy outlined how this would be achieved and appendix 2 detailed the development plan which was supported by strategies around clinical systems and clinical coding.

The Board approved the Knowledge Management Strategy for 2014-17.

b) Information Technology (IT) Strategy 2014-19

Mrs Harris reported that page 4 of the strategy set out the overarching themes of modernisation, support to staff provide better care and the elimination of paper. The strategy outlined the infrastructure required to move forward in accordance with the national direction of travel.

Mrs Harris highlighted the progress being made with the introduction of Vitalpac and SystmOne which had supplied 330 District Nurses with mobile technology and replaced the need for paper records in the community and the intention was to move towards an electronic paper record in the Trust over the next few months.

She stressed the importance of the strategy in that it underpinned the KM strategy and all the business of the Trust.

Professor Cohen asked whether front-line staff had been involved in developing these strategies and their delivery. Dr Slater advised that the Information Management and Technology steering group was clinically led and was responsible for overseeing the delivery of the strategy and the implementation of projects was supported by programme management but led by clinicians.

Dr Slater confirmed that the project group for the electronic patient record was clinician led and it would have the opportunity to design and refine the record to the organisation's requirements. He added that it was supported by a project to scan the paper records and clinicians formed the major part of that group.

Mr Nealon asked whether the resources and funding were available for the strategy and Mrs Harris advised that it would be necessary to agree the detail of the phasing of the work but funding had been set aside in the capital programme over the next five years.

Mr Stevens reported that on his visit to Uckfield Hospital one issue that had been raised by the staff was that certain Trust programmes were not consistent with other organisations that use the hospital facilities. Dr Harrison explained that incompatability between systems used within the NHS was a well known issue and that this particularly applied to GP systems. Integration engines would provide the linkage between systems at some point in the future.and in the meantime the Trust did what it cold to ensure compatibility between systems.

The Board approved the Information Technology Strategy 2014-19.

070/2014 **Radiotherapy Treatment Centre**

Mr Sunley updated the Board on the project being led by Brighton and Sussex University Hospitals Trust (BSUH) in conjunction with the Trust and Western Sussex Hospitals Trust to place radiotherapy treatment centres across Sussex and the intention was to site one treatment centre at the Eastbourne DGH site.

He reported that the Finance and Investment Committee had reviewed the Outline Business Case and had approved the Head of Terms for the proposed lease of land to BSUH to allow the development to happen.

Mr Sunley reported that the TDA had approved the investment in Brighton and work would start soon and the Trust was working with BSUH and the TDA to address a number of queries the TDA had in relation to the project at Eastbourne and the clinicians were included in this.

Mr Welling commented that the scheme had been in the pipeline for some time and it was good news for patients that it would be implemented in the next twelve months.

The Board noted progress on the project to place a Radiotherapy Treatment Centre at Eastbourne DGH.

071/2014 **Annual Business Plan 2014/15 Quarterly Update**

Dr Harrison reported that the Board had previously received the Annual Business Plan together with the supporting documents relating to the organisational performance management framework and programme management.

She advised that this was a quarterly high level report and there were detailed plans for each objective and the intention would be for future reports to provide a commentary against red areas.

Mr Welling requested that a note be circulated to the Board outside of the meeting with a commentary on the red areas from the relevant directors. **ALL**

The Board noted the quarterly update on the Annual Business Plan for 2014/15.

072/2014 **Annual Reports**

a) Emergency Planning and Business Continuity Annual Report 2013/14

Mr Sunley presented the annual report and noted that failure to develop emergency preparedness would put the Trust in breach of its statutory duties under the Civil Contingencies Act 2004 and would not meet the NHS England Core Standards for Emergency Preparedness, Response and Recovery (EPRR).

He advised that the Trust was required to have in place a number of plans including major incident, influenza, severe weather and business continuity. Work had continued during the year on developing business continuity plans across all areas following the implementation of the clinical strategy and restructure of the clinical units and corporate services and learning had been shared from business continuity incidents that had occurred during the year.

Mr Sunley reported that a quarterly communications call out took place to ensure that staff were able to respond in timely manner, particularly with regard to major incidents. In addition, the Trust had participated in a practical major incident exercise organised by Sussex Police held on the Eastbourne DGH site and the lessons arising from this exercise had formed part of the review of the major incident plan.

He advised that the management structure re-organisation and focus on delivery of access and financial targets had resulted in meetings relating to emergency planning and business continuity not having the required focus and emergency preparedness would be included as part of the re-writing of job plans and roles in the restructure.

The Board received the annual report on Emergency Preparedness.

b) Safeguarding Annual Report for Adults and Children 2013/14

Mrs Webster presented the report and noted that it detailed a summary of the activities undertaken in safeguarding for both adults and children.

She advised that the Trust fully participated in the multi-agency safeguarding processes for children and in particular the Trust had reviewed the recommendations of the Savile Review and its response was attached at Appendix 2.

She reported that the Trust had participated in two Serious Case Reviews during the year and no specific actions for the Trust had arisen from either case.

In relation to safeguarding adults, Mrs Webster reported that it was not a legal requirement at present but would be shortly. She highlighted that there had been an improvement in mandatory training but there was further work required.

She reported that 63% of all alerts against the Trust in the year were not taken forward into safeguarding by Adult Social Care compared to 50% the previous year and Adult Social Care had commented on the improved documentation to evidence the care being delivered to patients.

Mrs Webster referred to sections 8.5 and 8.6 covering the Mental Capacity Act/Deprivation of Liberty Safeguards and the Mental Health Act and noted that Sussex Partnership Trust oversaw the training and regulatory function for the Trust and their annual report was included at Appendix 1. She noted that the Board had received its training in February 2014.

Mr Welling commented that progress continued to be made but there was still further work to be undertaken.

Mrs Harris commented that she had expected to see reference to female genital mutilation in the safeguarding children section and Mrs Webster advised that it was not currently an issue within this particular area demographically but that further work would be undertaken to reflect this area of concern. Mr Grayson advised that new guidance was expected on this issue.

The Board received the Annual Safeguarding Report for Adults and Children.

c) Annual Equality Report 2013/14

Mrs Wells presented the report and noted that it outlined the Trust's progress against the three aims of the Public Sector Equality Duty and the outcomes of the NHS Equality Delivery System.

She highlighted that an action plan would be produced from the recommendations which would be monitored by the steering group led by the Chief Executive and underpinning this group were a number of sub-groups led by executive directors and feedback from these groups was shown on pages 5 and 6 of the report.

Mr Welling referred to the statistics in relation to bullying and harassment in acute medicine and Ms Green reported that a detailed report had been undertaken on the grievances in that area and no particular concerns had come to light.

Ms Humber commented that staff morale was low in the organisation due to a number of factors, both external and internal, and the need was for some stability in the organisation.

Ms Humber commented that appraisals were also a good way of raising staff morale.

The Board received the Annual Equality Report for 2013/14.

d) Fire Safety Annual Report Updated January 2013 – June 2014

Mr Sunley reported that at the last Board Meeting Mrs Webster had queried the actions being taken in relation to the section on identified risks in the report.

He advised that the Head of Estates and Facilities had met subsequently with the East Sussex Fire and Rescue Service (ESFRS) to discuss the risks and agreement had been reached on how they would be addressed with the capital funding allocated over the next four years.

Mr Sunley advised that the annual report had therefore been updated to reflect the revised risk assessments and re-issued to the Board for information.

Mr Sunley referred to the particular risk re emergency lighting and advised that following the above discussions with the ESFRS the risk rating had been revised with investments scheduled for the next two years.

The Board noted the updated Fire Safety Annual Report for January 2013 to June 2014.

073/2014 **Ratification of Employer Based Clinical Excellence Awards**

Ms Green reported that clinical excellence awards were a national scheme for consultants to recognise performance over and above normal expectations. She explained that there were 12 levels of award and levels 9-12 were awarded nationally and the lower levels were awarded locally.

She reported that the local Employer Based Awarding Panel had followed national guidance and scored applications against the criteria set out in her report.

She advised that the Trust had been allocated 33 points to award and the Panel had awarded 2 points to the highest scoring applicant in recognition of their achievements and 1 award to the next 31 highest scoring applicants. She noted that the total value of the awards was £161,191 and the awards had been ratified by the Remuneration Committee at its meeting on 3rd June 2014.

The Board noted that the Remuneration Committee had ratified the awards and endorsed the process followed.

074/2014 **Board Sub-Committee reports and Trust Board Seminar Notes**

a) Audit Committee

Mrs Harris presented the report and noted that Appendix 2 contained the minutes of the meeting held on 4th June 2014 where the year end accounts were discussed and approved and the audit certificate had been issued. The annual accounts would be presented to the Annual General Meeting in September.

b) Finance and Investment Committee

Mr Nealon presented the report and referred to a national initiative to save 10% of budget costs by way of procurement. The TDA had advised that any Trust receiving funding would be required to have a fully developed procurement strategy. He was the non-executive champion for this project and was working with Mrs Harris and the procurement team on developing the strategy and anticipated that there could be a substantial saving.

c) Quality and Standards Committee

Mrs Webster presented the report and referred to the patient story and advised that the service user would be coming in to do more work with nursing teams. In addition, Mr Ellis had highlighted the requirement for a close working relationship with the Audit Committee.

d) Trust Board Seminar Notes

The Board formally adopted the notes of the Trust Board Seminars held on 12th March, 16th April and 14th May 2014.

075/2014 **Review of Board Governance and Leadership**

The Board noted the outcome of the review and approved the revised terms of reference for the Quality and Standards Committee.

076/2014 **Themes for Quality Walks**

The following themes were agreed for August and September:

- Service reconfiguration (obstetrics and paediatrics, trauma and orthopaedics and general surgery)
- Information Technology
- Staff Survey

077/2014 **Chairman's Briefing**

Mr Welling referred to the letter from the NHS Confederation to The Guardian regarding the 2015 Challenge Declaration, to which he and Mr Grayson were signatories to.

He reported that he had received a response from Mr Lloyd to his letter of 18th July and Mr Lloyd had confirmed that he would be willing to meet staff to discuss maternity and paediatrics and arrangements were being made.

078/2014 **Questions from members of the public**

a) Board papers for members of the public

Mr Ash thanked the Chairman for his decision regarding the papers and suggested that the Trust's website be amended to reflect this and Mr Welling confirmed that this action would be taken. **TR**

Mr Ash also referred to a conference that he was organising for World Mental Health Day on 10th October and would welcome any presentations from Trust staff. Mr Welling thanked Mr Ash for the invitation.

b) SEAP Advocacy Service

Mrs Walke asked on behalf of Julie Absom from SEAP whether the Trust would be willing to engage an independent advocacy service for Trust staff to raise any concerns.

Mr Welling commented that the Trust was already in discussion with SEAP as referred to in the complaints report. Mr Grayson advised that there were a number of advocacy organisations and the Trust would need to follow a formal commercial procurement process if it wished to avail itself of such services.

c) Legal Fees

Mr Campbell asked for details on the personnel issues that had required expenditure on legal fees in the June finance report. Mr Grayson reported that at any one time the Trust could need to seek legal advice around the termination of employment and/or grievances raised by staff if they had sought legal advice. Ms Green commented that the Trust had a small number of Employment Tribunals compared to other organisations with three or so in any one year and the Trust needed to be represented by barristers and solicitors as part of the process.

d) Reduction in bed numbers

Mr Campbell asked if the proposed reduction in bed numbers would have any impact on the quality of care provided. Mr Grayson responded that all cost improvement projects went through a quality impact assessment led by the Medical Director and Director of Nursing. They reviewed all the schemes against a set of criteria to ensure that they did not impact on quality and access standards. He confirmed that the specific scheme had been through that process.

Mrs Walke asked a number of questions about issues pertaining to individual patients and Mr Welling asked her to direct these patients to raise their concerns through the appropriate Trust channels as it was not appropriate to discuss such individual concerns at a public meeting.

079/2014 **Date of Next Meeting**

Wednesday, 24th September 2014 – Annual General Meeting at10.00 am and public Trust Board meeting at 10.45 am in the St Mary's Board Room, Eastbourne DGH.

080/2014 **Closed Session Resolution**

The Chairman 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.

The proposal was seconded by Dr Slater.

Signed ……

Position ……..

Date …….

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 30.07.14 Trust Board Meeting

Agenda Item	Action	Actioned By	When	Progress
059/2014c) – Feedback from Quality Walks	Mr Nealon and Mr Grayson to feed back on the quality walks at the next meeting.	Non-Executive Director/Chief Executive	24.09.14	On agenda
067/201a)i) – Overall Performance Score	TDA Accountability Framework and an illustration of how performance was scored to be uploaded onto the Trust website.	Chief Operating Officer	Asap	In progress
067/2014c) – Safe Nurse Staffing Levels	Future reports to be on an exception basis for those areas where the standards were not being met, ie below 80%.	Director of Nursing	30.09.14	Included within report.
	Mrs Webster to advise the Chairman outside of the meeting why the cumulative position on pressure ulcers and falls had not been included on the 'How are we doing' ward boards	Director of Nursing		Completed
071/2014 - Annual Business Plan 2014/15 Quarterly Update	Note to be circulated to the Board outside of the meeting with a commentary on the red areas from the relevant directors.	Executive Directors	24.09.14	Updated report on the agenda.

Agenda Item	Action	Actioned By	When	Progress
078/2014a) – Questions from members of the public – board papers	Trust's website to be amended to reflect that members of public can request a copy of Board papers if they are to attend meeting. These papers to be made available to them at the meeting	Corporate Governance Manager	Asap	Completed.

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	7
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 Trust Board. The BAF clearly demonstrates whether the risk 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. August updates are provided in red italics. The Board is asked to review the August updates in the action column.

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. Updates and revisions are shown on the document in red.

Following review at the Board Seminar in July, the following additional risk has been added:

We are unable to invest in delivering/improving quality of care and outcomes for patients because we are operating in a challenged health economy and this impacts on our ability to make investment in infrastructure and service improvement

Since the last review by the Trust Board gaps in control or assurance have been removed or revised as follows:

- Risk 1.2 – following gap in control added:
  Backlog of plain film reporting and delay in reporting non urgent radiological investigations

- Risk 2.3 (page 15) both the Quality and Standards Committee and Audit Committee considered that assurances were insufficient and the gap in control should be rated red.

Benefits:

Identifying the principle strategic risks to the organisation provides assurance to the Committee and Trust Board that these risks are effectively controlled and mitigated which supports the Trust in achieving its strategic aims and objectives.

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

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

Review by other Committees/Groups (please state name and date):
Quality and Standards Committee 2nd September 2014 Audit Committee 3rd Septemebr 2014

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

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

Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	RAG
What control/systems we have in place to assist in securing delivery of our objective	*Where we can gain evidence that our controls/systems, on which we are placing reliance are effective*	*We have evidence that shows we are reaonably managing our risks and objectives are being delivered*	*Where we are failing to put controls or systems in place or where we are failing to make them effective*	*Where we are failing to gain evidence that our controls/systems on which which we place reliance are effective.*	*Assurance level:*
Examples: • Strategies, policies, procedures, guidance • Robust systems, programmes in place • Budgets, control, monitoring • Working groups/committees • Specific or team accountability • Planning exercises • Training (or other) needs assessments • Training completed • Objectives set and monitored • Accountability agreed and known • Frameworks in place to provide delivery • Contracts/agreements in place • Performance/quality monitoring • Action plans agreed at appropriate level and monitored • Complaint/incident monitoring • Risk assessments • National returns • Routine reporting of key targets with any necessary contingency plans	Examples: • External audit • Internal audit • Care Quality Commission • Clinical audits/reports • Performance indicators • External reviews/reports • Internal reviews/reports • Benchmarking undertaken • Patient/staff surveys • Local/national audits • Internal/local committees/groups • Management/ performance reports from contractors/ partners • Minutes of meetings	Examples: • Actual performance figures • Achieved ratings/targets • Proven progress against action plans • Clinical audits/reports • Received external audit reports • Controls that are deemed to be satisfactory and can be shown to be operating effectively in relation to the risk	Examples: • No regular reviews/performance monitoring or no review mechanisms • Poor/unknown data quality • No monitoring of reviews or done at an inappropriate level • Insufficient training for staff to be competent to support process • Gaps in taking action required/linking findings to action • Lack of ownership • Control does not cover all the objective or risk indicators/reports not sufficiently developed to cover all that is required • Incorrect assumptions being made	Examples: • No or inadequate assurance that performance figures provided are correct • No real assurance that reports/planning/action plans/frameworks are correct/effective/have been done • No assurance that strategies, policies, training are known and effective	Effective controls definitely in place and Board satisfied that appropriate assurances are available. Effective controls thought to be in place but assurance are uncertain and/or possibly insufficient. Effective controls may not be in place and/or appropriate assurances are not available to the Board

Key:

Chair - Chairman
CD - Commercial Director
COO -Chief Operating Officer
DN - Director of Nursing
DF - Director of Finance
DSDA - Director of Strategic Development and Assurance
DT - Director of Turnaround
HRD - Director of Human Resources
MD(S) - Medical Director Strategy
MD(G) - Medical Director Governance

↔ Status of risk unchanged

↓ Risk reduced

↑ Risk increased

Board Assurance Framework - Aug 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
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									
1.1	Risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external review, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Provider Compliance Assessments (PCA) training and support Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg ADN, ward matrons, clinical leads. Implementation of quality governance framework and ongoing work to embed learning and review sources of assurance	Outcome of CQC inspections Internal reviews inc/board level 'Quality Walks' CQC intelligent monitoring Board and Committee minutes Patient and Staff Surveys Health and Safety Executive IG Toolkit HR processes External accreditation/peer reviews	CQC reports following inspections Provider Compliance Assessments completed at ward level and gaps reviewed. Internal audit report on CQC compliance Weekly audits/peer reviews and 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	Documented audit trail not always available eg declaration of serious incidents, discussions re DNAR.	Need to ensure terms of refence and agendas of Board committees continue to effectively support scrutiny and assurance of patient safety, clinical effectiveness and patient experience.	Incomplete DNARs being logged as incidents and escalated for action. Weekly DNAR spot checks by Resus team escalated to senior management. Trust wide audit Feb 13, compliance improving, agreed Resus policy and audit methodology to be reviewed. Aug-13 Resus policy reviewed and updated. Oct-13 Compliance with policies reviewed at Policy Group and paper drafted for CME (Nov-13) Feb-14 Board reviewing and agreeing revisions to performance and quality metrics reports May-14 Annual review of Committee Structure to be undertaken by Board *Aug-14 Review of Committee structure and BGAF undertaken. Board undertaking Well Led Framework review mid August.* *Focus on reviewing out of date policies.*	April 2012 ongoing audit throughout 2013/14 May-14 end Jul-14	↔	MD

Board Assurance Framework - Aug 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued - 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									
1.1				Revision to CQC compliance and inspection regime to be reviewed and impact on organisational compliance considered		Oct-13 Trust reviewing changes in CQC compliance regime including new surveillance model Dec-13 Reviewing CQC inspections reports published for other Trusts recently inspected under new model Feb-14 Continued review and monitoring; developing process to ensure Trust is prepared for inspection and has continued evidence of regulatory compliance. May-14 Trust Inspection date confirmed as Sept 14, developing programme for preparation. Jun-14 Programme developed - excutive group and project group in place.	Mar-14 ongoing Sep-14	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
			May 14 - NRLS report indicates Trust in top 25% of incident reporters	Datixweb incidents are not 'finally approved' and a backlog has built up. This could impact export to NRLS and benchmarking reports against other similar organisations may not be a true reflection of the Trust incident profile.		Dec-13 Quality checks and significant reduction in backlog achieved for Nov export to NRLS. Continued focus on incident management across Clinical Units. Feb-14 Datix working group established to review issues, development and support effectiveness of system. May-14 Ongoing monitoring and review of incident review process. Need to strengthen central datix team. Jun-14 Centralisation of governance structure will strengthen management of incident review process *Aug-14 Interim governance structure in place*	end Jan-14 end Apr-14 end Jul-14	↔	DSDA

Board Assurance Framework - Aug 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
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.									
1.2	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	Performance indicators Benchmarking and CHKS data Accreditation visits/Peer Reviews National Cleaning Standards Audit Group established HOSC Healthwatch External Audit Internal Audit Clinical Audit Clinical Commissioning Groups Regulatory bodies eg CQC, HSE Information Governance Toolkit	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review National benchmarking by WM Quality Observatory Dr Foster/CHKS HSMR/SHMI/RAMI data Low HCAI and SSA breaches Performance delivery plan in place Level two of IGT	Demand and patient choice impacts ability to deliver cancer metrics.		Cancer network discussions re urology capacity/expectations. Review of pathways/clock pause criteria. Co-ordinators working outside normal hours to facilitate patient contact. GP referral issues highlighted to CCGs. Developed patient info leaflet. Diagnostic urologist appointed; training chichester and brighton consultants in complexes cases. Somerset info system implemented. Reviewing DH benchmarks/engaging with regional centres. Dec-13 General surgery move expected to improve colorectal screening response. Feb-14 meeting screening service to review pathway or transfer treatment option to BSUH. May-14 Action plan in place, reviewed Mar Board, working with commissioners/stakeholders to achieve compliance. *Aug-14 Continuing to implement action plan, reviewed by Intensive Support Team*	end Apr-13 Sept-13	↔	COO

Board Assurance Framework - Aug 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **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.**									
1.2	Business Continuity and Major Incident Plans Training to develop service level BC plans Reviewing and responding to national reports such as Francis, Keogh and Berwick.		Cancer - all tumour groups implementing actions following peer review of IOG compliance. Major incident testing debrief indicated plan is effective. Trust Board reviewed analysis of Keogh, Berwick et al and actions will be agreed and monitored through Quality and Standards Committee.	Demand on emergency services, impacting patient assessment and treatment time and subsequent discharge to other specialist/bed areas		Action plan in place to enhance patient flow. Meet SECAMB monthly to review issues. May-13 Identified number of options to improve ambulance flows - being explored Sep-13 Ambulance flows improved. Focussed work to be undertaken on further improvement to minimise risk of handover fines. Oct-13 Discharge/ admission lounges on both sites,escalation plan in place for winter pressures Feb-14 Clinical site team in place to maintain and enhance patient flow. Escalation process to whole organisation to ensure clinical and professional standards of care and review are met. *Aug-14 Capital bid with TDA to support expansion.*	end Nov-13	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **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.**									
1.2				June-13 Inability to achieve reduced Cdiff trajectory. Risk register identifies concerns with weekly multi-disciplinary reviews and failure to meet national cleaning standards		June-13 Gastroenterology Consultants have an agreed job plan that ensures senior representation at the weekly ward round. Monthly audits of National Cleaning Standards (NCS) are undertaken and any failures identified and actioned. Oct-13 26 Cdiff cases ytd, RCA of all cases to identify actions and share learning. TDA supporting and action plan developed. Dec-13 Review and monitoring ongoing as outlined above Feb-13 Only 1 case of CDiff in Jan 2014. Continued reduction in HCAIs will be QIP for 2014/15 May-14 Y/ed position CDiff 43 cases, 16% reduction year on year. Focus on reduction continuing. *Aug-14 Remain on trajectory for HCAI*	Ongoing review and audit throughout 2013/14	↔	DN/MD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **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.**									
				Clinical laboratory diagnostics analytical equipment requires replacement. Heavily used equipment becomes prone to breakdown and possible loss of service.		Agreed to replace via managed services contract. Further input required from procurement and estates. TDA funding approval required. Sep-13 Business case being developed; equipment risksmonitored and mitigating actions agreed. Oct-13 Temporary bio chemistry equipment to be installed. Dec-13 Managed Service Contract ITT planned for Jan anticipated contract award will be Jun'14 Aug-14 FBC to Finance and Investment Committee meeting 27/08/14 for	end Nov-13 Jun-14	↔	COO
				Backlog of plain film reporting and delay in reporting non urgent radiological investigations		*Aug-14 Process in place to reduce plain film backlog and patients being contacted. CCG appraised of position and comms sent to GPs. Prioritisation process for urgent MRI/CT scans.*		New	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
Risk 1.3: There is a lack of leadership capability and capacity to lead ongoing performance improvement and build a high performing organisation.									
1.3	Move to clinical unit structure and governance process support clinical ownership Clinicians engaged with clinical strategy Job planning aligned to Trust aims and objectives Joint Medical Director appointed to lead on Clinical Strategy Implementation of Organisational Development Strategy and Workforce Strategy Stakeholder Primary Access Points (PAP) groups in place Board Development Programme Leading for Success Programme	Clinical Quality and Patient Safety Reports Dr Foster/CHKS metrics Appraisal and revalidation process Pre Consultation Business Case (PCBC), National Clinical Advisory Team (NCAT) review and gateway review Stakeholder review process eg HOSC Shaping our Future Project Board	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy and PCBC PAPs identifying workforce implications. Clinical engagement events taking place Training and support for those clinicians taking part in consultation and reconfiguration. On-going monitoring of safety and performance of the temporary reconfiguration of obstetric and paediatric services and permanent reconfiguration of stroke services.	Requires demonstrable clinical leadership to take forward reconfiguration following consultation process.		Continue to operate PAP stakeholder groups throughout consultation period. Nov-2012 Consultation period finished - PAP groups to continue to develop implementation plans. Mar 13- PAP implementation group established and corporate support group in place. 30 PAP sub groups established to support delivery. Dec-13 Structure to provide ownership and accountability to clinical units. Clinical Forum being developed. Feb-14 General surgery move clinically led. Bottom up approach to developing two year business plans with Clinical Units engaged. *Aug-14 Revised CU leadership structure in place. Governance processes being developed. Leadership meeting 20 Aug*	Jul - Sept 12 ongoing review throughout 2013/14	↔	MD(S)

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 2 – Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences.									
Risk 2.1: We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.									
2.1	Develop effective relationships with CCGs Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners including ESCC and MPs	Evidence of participation in Clinical Leaders Group External reviews and reports	Membership of newly formed local Health Economy Boards – UCN, Elective, Integrated. Commissioners, GPs, Adult Social Care invited to be members of Strategy Board. Collaboration with neighbouring Trusts through networks Participant in emergency clinical senates	Transition in commissioning arrangements mean clinical networks and leaders groups under review. Relationship with HOSC now focused on implementation. Communications strategy and approach needs refocusing following consultation.		Building relationships with CCG and LAT teams.HOSC member on Shaping our Future Implementation Board. Communications strand part of implementation. Oct-13 Ensuring plans for delivery of service transformation are developed and aligned to Clinical Strategy. Meetings with CCGs re developing primary care strategy. Programme for strategic change 2020 vision instituted by EHS and HR CCG Feb-14 Fully engaged in consultation on the future configuration of Maternity, Gynaecology and Paediatric services. Participating in HOSC evidence gathering process. Trust participating in operational clinical networks across a range of areas including vascular. Jun-14 Continued engagement in networks. Values and behavious work undertaken. Board away day reflected on wider health economy	Mar-13	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 2.1: We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.**									
2.1	Clinical Strategy engagement Communications Strategy and map of stakeholders Regular meetings with League of Friends		Trust participates in Sussex wide networks eg stroke, cardio, pathology. Monthly performance meetings with CC and TDA. Working with clinical commissioning exec via Sussex Together to identify priorities/strategic aims. Board to Board meetings with CCGs, SECAMB and other bodies.	Marketing strategy not yet developed, therefore assurance cannot be provided that the Trust is actively and effectively participating in the local market or developing and responding to market opportunities.	There is a risk that we will not be able to respond to the Challenged Health Economy work in a way which enables us to formulate a 5 year integrated business plan.	Mar 13: Stakeholder engagement strategy to be reviewed and further developed Aug 13 - Trust participating in CCG led 'large scale change' programme. Eengaged in CCG process for public engagement, development of the case for change, model of care and options for delivering agreed service standards for Maternity, Paediatric and Gynaecology services Oct 13 - Trust fully engaged with CCGs on developing PCBC for Maternity and Paediatrics May-14 - Trust actively engaging in work commissioned by NHSE/TDA to support strategic planning across local healthcare economy Jun-14 - CHE and Better together work ongoing; clinical design	Commenced and ongoing through 2013/14 end Sep 13 end Jul-2014	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 2 – Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences.									
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.									
2.2	Develop and embed key strategies that underpin the Integrated Business Plan (IBP): Clinical Strategy Workforce Strategy IT Strategy Estates Strategy Membership Strategy Clinical strategy and development of full business case Effective business planning process	Stakeholder engagement in developing service plans Trust Board approves IBP and strategies Department of Health and Monitor	HOSC engagement in clinical strategy and plans for delivery at service level	Need to develop FBC to support Integrated Business Plan.		Jan 13: Developing FBC following consultation based on implementation plans for reconfiguration, redesign and efficiency/productivity across all 8 PAPs. Dec-13 FBC approved at Nov Board and will be submitted to TDA for ratification Feb-14 Anticipate this will be considered by TDA at May Board May-14 FBC with TDDA pending Challenged Health economy outcomes. IBP being reviewed and refreshed.	end Mar-13	↔	COO
				Underpinning strategies eg Estates, Membership and IT not yet fully developed.		Develop Estates Strategy (see 3.4)	end Nov - 13	↔	CD
						Aug-14 IT Strategy agreed at July Board meeting	end Jun-14	↑	DF

Board Assurance Framework - Aug 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3	Develop and embed Patient and Public Involvement 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.	CQC patient and staff surveys and inspection reports SHA benchmarking PROMs Clinical quality & safety reports reviewed through Trust Committee structure Dr Foster/CHKS metrics	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.	Insufficient triangulation of clinical governance information and impact on patient outcomes.		Quality governance framework approved and quality dashboard implemented but to be fully embedded . Sep-13 - BI restructure implemented. Redefining organisation's information requirements in collaboration with the TDA. Dec-13 Ongoing work to triangulate information and identify areas of focus May-14 Performance/quality metrics reporting being reviewed for Board and Q&S. *Aug-14 Focus on governance, triangualtion and learning to support restructure. Board reviewing well led framework.*	end Jun- 13 end Dec-13 end Mar-14 end Jun-14	↔	DN/ COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3 continued: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3	Robust complaints process in place that supports early local resolution Clinical audit plan Communications and marketing strategies developed and implemented Equality strategy and equality impact assessments Framework for delivery of mandatory training in place Appraisal policy and process in place	Internal patient experience surveys Complaints data and trends CQUINs Internal and external auditors Clinical audit FFT for Patient Experience Compliance rates for mandatory training and appraisal	Trust benchmarking by WM Quality Observatory Dr Foster/CHKS HSMR data Trust data and possible benchmarking for FFT	Change in process/contract for patient transport services having a detrimental impact on patient care and experience.		Review of Trust's SLA and KPIs with SECAMB and escalation of risks to commissioners. Incidents logged and reported monthly to SECAMB for investigation. Sep-13 SECAMB reviewed management arrangements. Ongoing review - issues escalated to commissioners. Feb-14 CSM for Whole Systems & Pt Flow attending stakeholder mtgs where timely discharge. Group trying to ascertain more accurate data from SECAMB. Problems encountered with late discharge will continue to be reported back to SECAMB. Jun-14 Service specification being reviewed and Trust engaging with process	end Nov-13 end Mar-14 with ongoing review	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Inconsistent delivery of trust guidelines, policies and best practice is not addressed leading to variations in patient care and clinical outcomes. Poor quality of medical case note folders increases risk of inappropriate treatments, duplication of tests and interferes with patient care. Electronic records sitting outside of the nursing audit programme currently.		Action plans in place if deficiencies identified eg completion of nursing records, compliance with DNAR policy. Quality walks/assurance visits target specific areas. Nov-12 Establishing sub committee of health records steering group. Service, review by south coast audit and monitoring at patient safety committee. Sep 13- Quarterly audit of health records in place for 13/14. Reviewing how electronic records monitored. Keogh review evaluated and actions being implemented. Feb-14 continued work on ensuring revisions to policies are communicated. May-14 work progressing re electronic record audit/audit of patient records agreed by HRSG *Aug-14 external review of Health Records commissioned.*	Mar-14	↔	DN/ MD(G)

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3 continued: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3				Mandatory training rates and completion of appraisal levels below expected levels.		*Aug-14 Mandatory Training is the subject of continuous review and in order to ensure the burden of releasing staff to complete training is as minimal as possible, over the past 2 years a number of initiatives have been taken forward:-* *- Full scoping exercise to fully understand the volume of training required and by who.* *- Significant increase in the number of e-learning modules and a significant increase in staff using e-learning.* *- Team based training offered and trainers providing more training sessions on community sites.* *- Participation in the development of a mandatory training passport across the HEKSS region (being rolled out during 2014/15).* *- Developing e-assessments to allow staff to have competency assessed locally rather than doing training (during 2014/15)*	Improved performanc e by Aug-12 ongoing throughout 2013 Work is ongoing but aim to complete passport and competency work by April 2014	↑	HRD

Board Assurance Framework - Aug 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
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, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity.									
3.1	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.	Activity plan Workforce planning Clinical Strategy Governance structure and performance meetings Monthly senior commissioner/provider meetings to review overall performance against 2014/15 contract Monthly KPIs monitored PMO office in place Monthly review by Finance and Investment Committee	Trust participates in Sussex wide networks eg stroke, cardio, pathology. Written reports to CME 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)		Require robust controls to ensure achievement of 2014/15 financial plan and prevent crystalisation of identified risks as follows: activity levels exceed plan, premium costs incurred to deliver 18 weeks, slippage on £20.4m savings plan, CQUIN income not received in full.	May-14 All aspects of income/expenditure monitored on a monthly basis against plan. Turnaround management remains in place. Cash requirement to cover deficit included in Plan and will be drawn down quarterly pending application to ITFF via TDA. Jun-14 First quarter cash drawn down. *Aug-14 M3 financial position on plan*.	Commenced and ongoing review and monitoring to end Mar-15	↔	DF/DT

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.1 continued: We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity.									
				OPD referrals reduced but not in line with original demand management expectations and there are some capacity constraints, especially in Trauma and Orthopaedics and gastroenterology		T&O to model impact of loss of MSK contract, ongoing monitoring and review with commissioners. May-14 CCGs tendering MSK prime provider model, impact on service to be modelled impact unlikely until 2015 at the earliest	Feb-15	↔	COO
				Risk to achievement of referral to treatment timescales, particularly the admitted pathway. Actions taken by the Trust to maintain performance and reduce adhocs resulted in an increasing backlog.		May 14: Action plan developed with support from the National Intensive Support team and tTDA to ensure organisation returns to achievement against the target in 2014/15 will be monitored by Trust Board Jun-14 Programme in place and working with TDA and CCGs to significantly improve RTT position Sep-14 *Aug-14 Revised trajectory agreed with TDA to acheive aggregate RTT performance by end of quarter two.*	Sep-14	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.2: We are unable to invest in delivering/improving quality of care and outcomes for patients because we are operating in a challenged health economy and this could impact on our ability to make investment in infrastructure and service improvement									
3.2	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey to obtain core estate information, to include community hospitals; £300k secured invitation & award of service contract; survey with written report. Capital funding programme and development control plan	External company, T&T, produced six facet estate survey	Draft assessment of current estate alignment to PAPs produced	Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.		May-14 Essential work prioritised with Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. Jun-14 Finance and Investment Committee to review Q1 position on 25 Jun *Aug-14 Business case submitted to TDA for early release of first tranche of FBC funds*	Ongoing review and monitoring to end Mar-15	↔	DF

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.3: We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.									
3.3	Development of workforce strategy: - to align workforce plans with strategic direction and other delivery plans; - to ensure a link between workforce planning and quality measures Workforce assurance group disbanded and will be re-formed in line with CCG requirements which are still to be advised. Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data. Rolling recruitment programme	NHS Sussex workforce assurance process Staff utilisation reports. Integrated performance report. CQC staff survey	Training and resources for staff development CQC maternity report DGH Jul-13 Disclosure & barring check times avg reduced from 4wks to 48 hrs	Final workforce strategy will be developed once plans for clinical strategy and financial recovery/market testing further defined.		*Aug-14 Workforce Planning aligns with Strategic Planning. Workforce plans are developed to support specific change programmes or in response to external requests (eg. Education planning). Numbers based workforce plans have been submitted to the TDA and HEKSS during June 2014, and narrative is currently being developed to describe specific plans in more details. Will be complete by Sept 2014. Workforce Assurance - Quarterly Meetings have now been established with the CCG's*	Mar-14	↔	HRD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
3.3				Inability to recruit to some specialties and significant vacancies in some areas . Some areas have identified that there could be shortages in the future due to ageing workforce and changes in education provision. Also national shortages in some areas eg cardiac physiologists, ODPs and anaesthetic staff Currently significant nursing and therapy vacancies - Oct 2013		*Aug14 Reviewed vacancies/ difficult to recruit to posts, establishment review, generic nurse recruitment, speeding up numbers of band 5 nurses into post. Newly qualified nurses implementing Values Based Recruitment and supported training programme; plan to extend to other professional staff groups following trial. Speciality fill rate below comparator hospitals and project initiated to address shortfall; Sonography RRP agreed and (Aug 2014) offering sponsored training to allow current radiographer to taring into the speciality. Online DBS system speeding up return of checks from average 4 weeks to average 48 hours - allowing us to get staff into post more quickly.*	Ongoing throughout financial year - end of Mar-14	↔	HRD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.3 continued: We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.									
3.3				Maternity and paediatric inpatient services cannot provide a consistent quality of service so for some patients some of the time we do not meet the expected and required standards.	Dependency on mitigating actions is such that the risk of service failure is increased to an unacceptable level The delivery of a safe service becomes rapidly unsustainable in the short to medium term leaving us little time to implement mitigating actions	Daily monitoring/senior review. Mar-13: External NCAT review received. Board considered safety of services; resolved that temporarily consultant led obstetric service, neonatal service (inc SCBU) in-patient paediatric service and emergency gynaecology service be based at Conquest only and stand alone midwifery led maternity unit be established alongside enhanced ambulatory paediatric care at DGH. May-13 Temp. reconfiguration implemented and being monitored. Sep-Jun 13 CCG seeking views to shape options for future consultation, consultation commencing Jan'14 Trust engaged with consultation, anticipate decision Jun-14 *Aug-14 Reconfiguration decision by HOSC agreed Jul14. Working with CCG on implementation.*	end Mar-13 Jun-14	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.4: We are unable to develop and implement effective cultural change programmes that lead to improvements in organisational capability and staff morale.									
3.4	Leading for Success Programme Listening in Action Programme Feedback and implementation of action following "quality walks". PAPs clinically led with staff engagement Developing organisation values	CQC Staff Survey results Quality walks and assurance visits	Positive relationship with JSC Weekly CEO message to staff well received Effective clinical leadership of clinical units		CQC 2013 staff survey results disappointing with a deterioration in a number of areas.	Implementing LiA programme/developing values. Conversations held, key themes developed, projects being implemented. Working with Optimise in applying framework to and over 20 wards/teams working on improvement projects for first half of phase 2. Feb-14 Developing values. Jun-14 Programme of work in place, focus on developing our story number, engagement with frontline staff, focused conversations, continuation of leadership conversations and staff FFT. *Aug-14 LiA showcase events taking place. Values to be launched*	01/01/2013 Phase 2 to commence Jul-13	↔	CEO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Need to develop clinical engagement		Working with Hay to develop Clinical Leadership Forum (CLF) Oct-13 CLF development conversations taken place. TORs and membership in development. Feb-14 CLF TOR to be approved by CME and Board in March 2014. First meeting scheduled *Aug-14 New CU lead structure in place, leadership conversation Aug-14.*	Mar-14	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.5: We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.									
3.5	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey to obtain core estate information, to include community hospitals; £300k secured invitation & award of service contract; survey with written report. Capital funding programme and development control plan	External company, T&T, produced six facet estate survey	Draft assessment of current estate alignment to PAPs produced	Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.		May-14 Essential work prioritised with Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. Jun-14 Finance and Investment Committee to review Q1 position on 25 Jun *Aug-14 An application for additional in-year capital is being discussed with the TDA*	Ongoing review and monitoring to end Mar-15	↔	DF

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.6: We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change									
3.6	Horizon scanning by Executive team and Board. Board seminars Board development programme. Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports	Minutes of Board seminars Attendance at FTN/NHS Confed events Developed and implemented effective marketing strategy	Policy documents and Board reporting reflect external policy. Strategic development plans reflect external policy. Board seminar programme in place	Trust has limited success in tender exercises. Specialist skills required to support Any Qualified Provider and tendering exercises by commissioners		Agreed method for handling tender opportunities and AQP. Aug-Dec13 Contract team strengthened to support AQP process. Ongoing monitoring of AQP and tenders. New MSK tender identified need to further increase leadership and skills of tendering team. Reviewing best practice in tendering - meeting with Hempson Jan 2014 Feb-14 Future responses to service tenders to be co-ordinated by DSDA. May-14 Standardised approach and process to for tenders developed and being communicated. *Aug-14 Business planning team established supported by PMO*	end Nov 13	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
						Commenced phase 2 to develop options for implementation of clinical strategy. Need to develop positive working relationship with new HOSC following elections. Aug-13 Steering Group and programme management established and assessment of services for inclusion underway. Oct-13 Agreed to restrict activity during intense action on FRP. Frailty work maintained as integral to successful achievement of FRP. Dec13 & Feb 14 2014-16 Business Plan development on schedule,arrangements in place for Board review. Five year strategy to be developed via NHSE/TDA commissioned process. Jun-14 Board Away Day held to review strategy including external factors	end Jul 2013	↔	DSDA

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	8a
Subject:	Performance Report Month 4 – July 2014 Finance Report Month 5 – August 2014
Reporting Officers:	Richard Sunley, Chief Operating Officer Alice Webster, Director of Nursing Dr David Hughes, Medical Director (Governance) Monica Green, Director of Human Resources Vanessa Harris, Director of Finance

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 July 2014/15 against quality and workforce indicators and to the end of August 2014 for finance.

Introduction:

The monthly Quality report details ESHT's in month performance against key Trust metrics as well as activity and workforce indicators.

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

Overall Performance Score: 4 (from a possible 5)

Responsiveness Domain: 3
No movement from the same score in June. Accident & Emergency and diagnostics performance remained above the required standards. This score is based upon preview cancer performance. The final domain score will be finalised in the August report. The Trust overall quality score will not be negatively impacted by the final cancer report and will remain at 4.

Effectiveness Domain: 4
Remains at 4. All but one indicator in this domain is sourced from the Dr Foster mortality web portal. This is only updated annually, so as it stands mortality performance appears static, as will the domain score. The TDA has been contacted regarding this.

Safe Domain: 5
Remains at 5. Only 2 reported cases of C-Difficile and a significant reduction in patient safety incidents.

Caring Domain: 4
A&E Friends and Family scoring improved from June, but remains below the required standard, holding the domain score at 4.

Well Led Domain: 4
Turnover, sickness and appraisal rates remain below the required standard, holding the domain score at 4.

Finance Report:
At the end of M5 financial performance was a year to date run rate deficit of £9,233k, which was a favourable variance against plan of £246k. Income and expenditure were both over plan. The cost improvement achievement was £6,521k which was ahead of plan by £89k. The overall TDA RAG rating for finance is red because the Trust has set a deficit plan for 2014/15.

Benefits:
The report provides assurance that the Trust continues to deliver a high quality, safe service for patients combined with a high level of accessibility, and provides detail of where standards are not being met. The Board is aware of the Month 5 financial position.

Risks and Implications
At the end of Month 5 the financial risks remain unchanged from those associated with the plan for the year.

Assurance Provided:
This report includes all indicators contained within the NTDA's Accountability Framework for 2014/15. Information contained within this report has been extracted from the Trust Data Warehouse in line with guidance supplied by the NTDA. The financial performance at Month 5 is slightly better than plan.

Review by other Committees/Groups (please state name and date)**:**
This report will be reviewed by the Clinical Leadership Team during months that the Trust Board does not meet.

Proposals and/or Recommendations
The Trust Board is asked to review the reports in full and note Trust performance against each domain.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
Not applicable.

For further information or for any enquiries relating to this report please contact:	
Name: Andy Bailey, Senior Information Analyst	**Contact details:** andybailey@nhs.net

East Sussex Healthcare Trust
Integrated Performance Report

Month 4
July 2014

EAST SUSSEX HEALTHCARE NHS TRUST KNOWLEDGE MANAGEMENT

1.0 Overall Performance Score

East Sussex Healthcare Trust; Summary Performance against TDA Accountability Framework 2014/15												
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
ESHT OVERALL QUALITY SCORE (Out of 5: 1- Poor to 5-Good)	4	4	4	4								
Responsiveness **Domain Score**	3	2	3	3								
Effectiveness **Domain Score**	4	4	4	4								
Safe **Domain Score**	4	5	5	5								
Caring **Domain Score**	5	4	4	4								
Well Led **Domain Score**	3	3	4	4								

2.0 Responsiveness Domain

Responsiveness Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
			DOMAIN SCORE											
Indicator	Standard	Weighting	3	2	3	3								
Referral to Treatment Admitted	90.00%	10	82.68%	84.06%	85.84%	80.88%								
Referral to TreatmentNon Admitted	95.00%	5	94.08%	94.12%	91.81%	92.66%								
Referral to Treatment Incomplete	92.00%	5	92.37%	92.89%	92.80%	92.35%								
Referral to Treatment Incomplete 52+ Week Waiters	0	5	4	6	4	3								
Diagnostic waiting times	1.00%	5	7.32%	6.31%	0.45%	0.70%								
A&E All Types Monthly Performance	95.00%	10	95.20%	93.60%	95.17%	96.85%								
12 hour Trolley waits	0	10	0	0	0	0								
Two Week Wait Standard	93.00%	2	89.97%	89.07%	91.78%	89.68%								
Breast Symptom Two Week Wait Standard	93.00%	2	84.21%	92.06%	85.00%	88.89%								
31 Day Standard	96.00%	2	97.33%	96.71%	98.35%	99.32%								
31 Day Subsequent Surgery Standard	94.00%	2	100.00%	100.00%	94.74%	100.00%								
31 Day Subsequent Drug Standard	98.00%	2	100.00%	100.00%	100.00%	100.00%								
62 Day Standard	85.00%	5	86.01%	82.08%	77.01%	73.97%								
62 Day Screening Standard	90.00%	2	76.92%	80.00%	100.00%	83.33%								
Urgent Ops Cancelled for 2nd time (Number)	0	2	0	0	0	0								
Proportion of patients not treated within 28 days of last minute cancellation	0.00%	2	0.00%	0.00%	0.00%	0.00%								
Delayed Transfers of Care	3.50%	5	4.17%	5.90%	4.23%	5.01%								

2.1 RTT Performance

RTT Performance continues to align with the trajectory agreed with the TDA and Local Commissioners. The Trust will continue to treat patients with the longest pathways. This will enable the waiting list to be reduced to a sustainable level. The aggregate RTT position will be achieved across Non-Admitted, Admitted and Incomplete pathways by October 2014.

2.2 Diagnostics

The Trust delivered the 6 week diagnostic waiting target for the month of July. The total number of breaches was 30, equating to 0.70% of the total waiting list. Breakdown of breach modalities is shown below:

- Radiology: 17
- Audiology: 1
- Endoscopy: 12

2.3 A&E Performance

Performance remained above target levels in July, with 96.85% of A&E attendances seen in less than 4 hours. Since 1st April 2014, the Trust has seen 95.17% of A&E attendances in less than 4 hours.

2.4 Cancer Performance

Cancer performance for July is currently based on a preview. The final July performance levels will be reported next month. This will not impact upon the Trust's overall quality score.

The final Cancer report for June confirmed that the Trust did not meet the required standards within both 2Week Wait standards and 62 Days from urgent referral.

Performance against these standards continues to be impacted by patient choice and outpatient capacity. July and August performance is historically impacted by patient choice. Higher proportions of patients during these months choose to delay appointments beyond a planned holiday, or are referred immediately prior to a planned holiday.

The cancer team continues to work with General Practitioners to improve the efficacy of the urgent referral process. This includes routine reporting to GPs of those patients choosing to delay an urgent referral, and analysis of the primary reasons.

Of equal importance is the initial communication between the GP and the patient at the point of an urgent referral. We continue to work together to ensure that this communication is as effective as it can be.

The Trust has also implemented a number of programmes that will improve outpatient capacity.

It is hoped that these actions will both improve the proportion of patients accepting the initial appointment offer as well as providing a greater choice in appointment date.

2.5 Cancellations

During July there were 42 last minute cancellations by the hospital. All of these were rebooked within 28 days.

There were no urgent operations cancelled for a second time.

2.6 Delayed Transfers of Care

DTCs are aggregated (Acute and Non-Acute combined) within the accountability framework's responsiveness domain.

During July, the combined percentage of delayed beddays increased, and remained higher than the 3.5% threshold.

The table below breaks the performance down into acute and non-acute.

The percentage of acute only delayed beddays increased from June and moved above the 3.5% threshold. There were 713 NHS related delayed beddays in July.

61% (433) were attributable to the need for further non-acute care.
24% (166) were attributable to patient or family choice.

Non-Acute performance is measured against a higher threshold than combined and acute.

Although higher than this threshold, and despite a slight increase in July, the percentage of non-acute delayed beddays is on a downward trend from April 2014. There were 197 NHS related delayed beddays in July.

32% (63) were attributable to patient or family choice.
29% (58) were attributable to the need for further non-acute care.

Delayed Transfer of Care Breakdown		Apr-14	May-14	Jun-14	Jul-14
Delayed Transfers of Care (Combined)	3.50%	4.17%	5.90%	4.23%	5.01%
Delayed Transfers of Care (Acute Only)	3.50%	2.38%	4.75%	3.28%	4.09%
Delayed Transfers of Care (Non-Acute Only)	7.50%	15.01%	12.77%	9.82%	10.11%

3.0 Effectiveness Domain

Effectiveness Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
			DOMAIN SCORE											
Indicator	Standard	Weighting	4	4	4	4								
Hospital Standardised Mortality Ratio (DFI)	100	5	99.7	99.7	99.7	99.7								
Deaths in Low Risk Conditions	Within Expected	5	1.4	1.4	1.4	1.4								
Hospital Standardised Mortality Ratio - Weekday	109.1	5	101.4	101.4	101.4	101.4								
Hospital Standardised Mortality Ratio - Weekend	116.5	5	100.6	100.6	100.6	100.6								
Summary Hospital Mortality Indicator (HSCIC)	Within Expected	5	107.7	107.7	107.7	107.7								
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	10%	5	7.15%	7.55%	6.38%	7.54%								

3.1 Mortality

TDA guidance for mortality requests that Trusts use the Dr Foster web portal to view and report their mortality performance.

The web portal currently only displays annual numbers for each trust which have remained static since the start of the financial year, hence why the above mortality indices haven't changed.

The Information Management team is in conversation with the TDA to determine a better way to report against mortality indicators.

3.2 Emergency Re-Admissions

The rate of emergency Re-Admissions within 30 days of a previous discharge continues to meet the standard. The rate in 2014/15 is significantly lower than 2013/14. Weekly notification and analysis of these re-admissions with the Service Managers now takes place and is helping to identify themes at ward and specialty level. This will help the trust to improve processes and reduce the risk of patients being re-admitted.

4.0 Safe Domain

Safe Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
			DOMAIN SCORE											
Indicator	**Standard**	**Weighting**	**4**	**5**	**5**	**5**								
Clostridium Difficile - Variance from plan	4	10	5	3	4	2								
MRSA bactaraemias	0	10	0	0	0	0								
Never events	0	5	0	0	0	0								
Serious Incidents rate	TBC	5												
Patient safety incidents that are harmful	0	5	3	4	8	3								
Medication errors causing serious harm	0	5	0	0	0	0								
Overdue CAS alerts	0	2	0	0	0	0								
Maternal deaths	0	2	0	0	0	0								
VTE Risk Assessment	95.00%	2	99.00%	97.90%	97.62%	97.74%								
Percentage of Harm Free Care	92.00%	5	94.02%	93.08%	94.29%	93.90%								

4.1 Healthcare Acquired Infections

There were 2 reported cases of C-Difficile in July, in line with the trust trajectory.

4.2 Patient Safety

There are currently 3 harmful incidents reported against July. At present this is a provisional number. Incidents recorded onto the system with a severity level of 4 or 5 are included within this indicator, but will be routinely reviewed to ensure that the severity has been correctly assigned. In some cases this review will reduce the severity of the incident and thus remove it from this line. As such, subsequent performance reports may show a lower number.

The 3 reported incidents in July were all falls related.

The Trust reviews all serious incidents and undertakes a Root Cause Analysis against each incident to ensure that lessons are learnt and processes can be redesigned where necessary to reduce or eliminate the risk of re-occurrence.

5.0 Caring Domain

Caring Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
			DOMAIN SCORE											
Indicator	**Standard**	**Weighting**	**5**	**4**	**4**	**4**								
Inpatient Scores from Friends and Family Test	60.00%	5	66.00%	64.00%	68.00%	68.00%								
A&E Scores from Friends and Family Test	46.00%	5	49.00%	44.00%	37.00%	45.00%								
Complaints	TBC	5												
Mixed Sex Accommodation Breaches	0	2	0	0	0	0								
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	7.8	2	7.9	7.9	7.9	7.9								

5.1 Friends and Family Test (Patient Experience)

Inpatient scores continue to achieve above the required standard. Accident and Emergency scores have improved from June, but remain marginally lower than the required standard.

5.2 Complaints

The TDA has not yet released the technical guidance for this indicator.

6.0 Well Led Domain

Well Led Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
			DOMAIN SCORE											
			3	3	4	4								
Indicator	Standard	Weighting												
Inpatients response rate from Friends and Family Test	30.00%	2	46.43%	44.22%	44.01%	46.84%								
A&E response rate from Friends and Family Test	20.00%	2	13.59%	15.76%	35.03%	24.41%								
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	40.70%	2	41.00%	41.00%	41.00%	41.00%								
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	42.30%	2	51.00%	51.00%	51.00%	51.00%								
Data Quality of Returns to HSCIC	TBC	2												
Trust turnover rate	10.00%	3	12.45%	12.89%	12.72%	12.81%								
Trust level total sickness rate	3.30%	3	4.08%	3.87%	4.26%	4.44%								
Total Trust vacancy rate	10.00%	3	6.04%	6.40%	5.21%	5.61%								
Temporary costs and overtime as % of total paybill	10.00%	3	7.02%	7.29%	8.72%	9.48%								
Percentage of staff with annual appraisal	85.00%	3	63.37%	63.84%	63.74%	62.34%								

6.1 Friends and Family Test (Response Rate)

In-patient and Accident & Emergency response rates continue to achieve the required standard.

6.2 Data Quality

The TDA has not yet released the technical guidance for this indicator.

7.0 Community Services

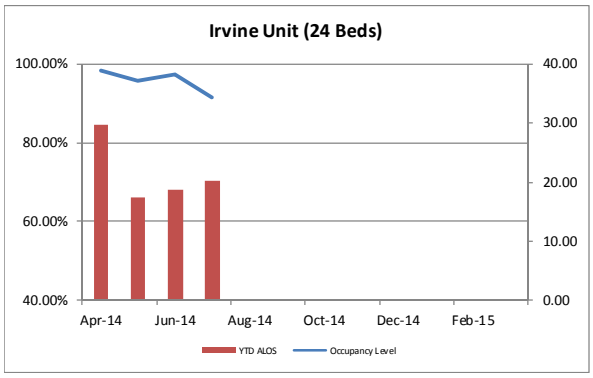
7.1 Intermediate Care Beds

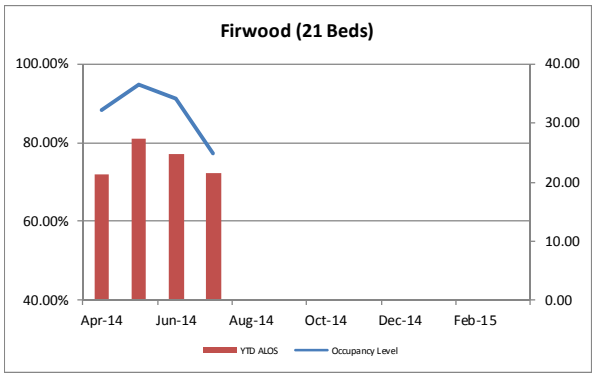
Table 1 (below) details the Occupancy, Average Length of Stay and Admission rates at the Trust's 6 community sites. Occupancy and ALOS are also represented graphically.

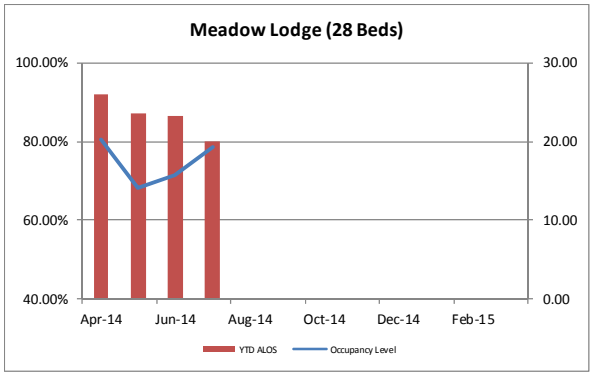
Table 1

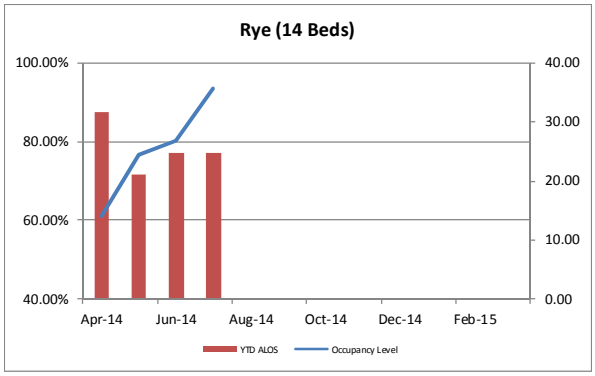
Indicator	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Occupancy Level													
Irvine Unit	98.21%	95.70%	97.44%	91.53%									
Crowborough Hospital	90.48%	85.94%	91.90%	90.09%									
Firwood House	88.41%	94.62%	91.11%	77.27%									
Meadow Lodge	80.36%	68.32%	71.31%	78.69%									
Uckfield Hospital	87.38%	88.25%	93.10%	90.78%									
Rye Memorial Care Centre	61.19%	76.73%	80.24%	93.55%									
Total Occupancy	**85.74%**	**84.43%**	**86.81%**	**85.78%**									
YTD ALOS													
Irvine Unit	29.65	17.53	18.74	20.30									
Crowborough Hospital	20.47	16.94	19.76	21.31									
Firwood House	21.21	27.33	24.69	21.58									
Meadow Lodge	26.04	23.61	23.19	20.09									
Uckfield Hospital	25.10	19.79	20.19	23.00									
Rye Memorial Care Centre	31.64	21.09	24.69	24.69									
Total YTD ALOS	**26.07**	**20.72**	**21.73**	**21.36**									
Admissions													
Irvine Unit	32	32	28	34									
Crowborough Hospital	22	17	18	17									
Firwood House	24	19	24	15									
Meadow Lodge	19	26	35	26									
Uckfield Hospital	14	14	17	19									
Rye Memorial Care Centre	12	12	16	16									
Total Admissions	**123**	**120**	**138**	**127**									
Available beds													
Irvine Unit	28	24	26	24									
Crowborough Hospital	14	14	14	14									
Firwood House	21	21	21	21									
Meadow Lodge	28	28	28	28									
Uckfield Hospital	14	14	14	14									
Rye Memorial Care Centre	14	14	14	14									
Total Available Beds	**119**	**115**	**117**	**115**									
Total Discharges	**137**	**137**	**142**	**139**									
Occupied Bed days	**3061**	**3010**	**3047**	**3058**									
Available Bed days	**3570**	**3565**	**3510**	**3565**									

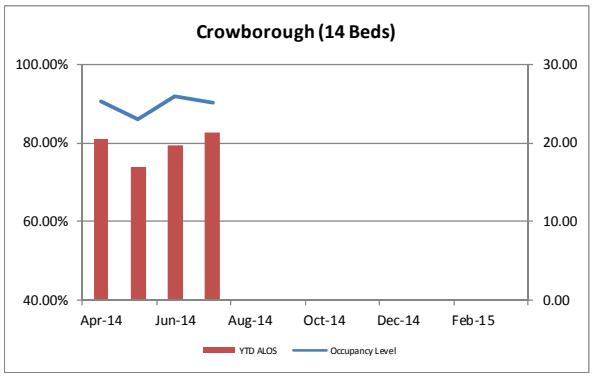
Intermediate Care Beds; Occupancy and ALOS trends

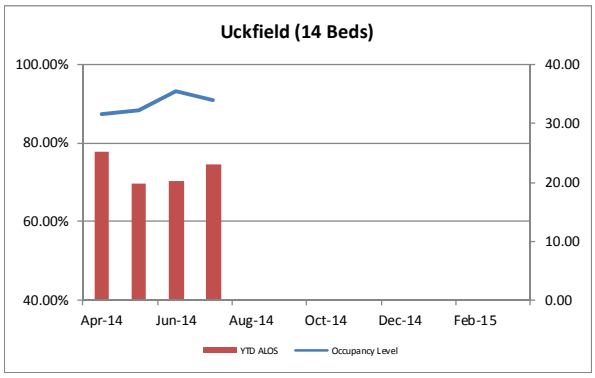

Irvine Unit (24 Beds)
100.00%
80.00%
60.00%
40.00%
40.00
30.00
20.00
10.00
0.00
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
YTD ALOS
Occupancy Level


Firwood (21 Beds)
100.00%
80.00%
60.00%
40.00%
40.00
30.00
20.00
10.00
0.00
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
YTD ALOS
Occupancy Level


Meadow Lodge (28 Beds)
100.00%
80.00%
60.00%
40.00%
30.00
20.00
10.00
0.00
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
YTD ALOS
Occupancy Level


Rye (14 Beds)
100.00%
80.00%
60.00%
40.00%
40.00
30.00
20.00
10.00
0.00
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
YTD ALOS
Occupancy Level


Crowborough (14 Beds)
100.00%
80.00%
60.00%
40.00%
30.00
20.00
10.00
0.00
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
YTD ALOS
Occupancy Level


Uckfield (14 Beds)
100.00%
80.00%
60.00%
40.00%
40.00
30.00
20.00
10.00
0.00
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
YTD ALOS
Occupancy Level

7.2 Community Nursing

The below tables detail manually captured activity across eight community nursing indicators. The information is split by Clinical Commissioning Group.

There has been a general reduction in the reported number of referrals, whilst activity (contacts/visits) has remained on an upward trend. This would support the narrative from the service that the teams that have been migrated onto the new community system, SystmOne are no longer recording referrals onto the manual collection forms, but straight into SystmOne. This is the likely explanation for the perceived drop in referrals below.

The reporting element of the SystmOne project will not be complete for some months and so the Information Management team are working with the service and the SystmOne project team to ensure key information can be extracted.

ESHT COMMUNITY NURSING SERVICE ACTIVITY

New Referrals*	Trend	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ESHT Total		4408	4618	4359	4201								
Hastings and Rother		2061	2136	2185	2081								
High Weald, Lewes and Havens		600	464	434	322								
Eastbourne, Seaford and Hailsham		1747	2018	1740	1798								

Urgent Referrals seen <2 hours	Trend	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ESHT Total		734	751	627	706								
Hastings and Rother		460	471	353	448								
High Weald, Lewes and Havens		101	92	108	88								
Eastbourne, Seaford and Hailsham		173	188	166	170								

Admission Avoidance***	Trend	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ESHT Total		468	473	264	421								
Hastings and Rother		183	199	187	283								
High Weald, Lewes and Havens		37	24	37	96								
Eastbourne, Seaford and Hailsham		248	250	40	42								

Inappropriate Referrals	Trend	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ESHT Total		97	289	95	85								
Hastings and Rother		55	252	56	54								
High Weald, Lewes and Havens		25	25	25	24								
Eastbourne, Seaford and Hailsham		17	12	14	7								

Contacts / Visits **	Trend	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ESHT Total		31588	30398	28109	30557								
Hastings and Rother		10136	10164	9740	10331								
High Weald, Lewes and Havens		7041	7110	5903	6013								
Eastbourne, Seaford and Hailsham		14411	13124	12466	14213								

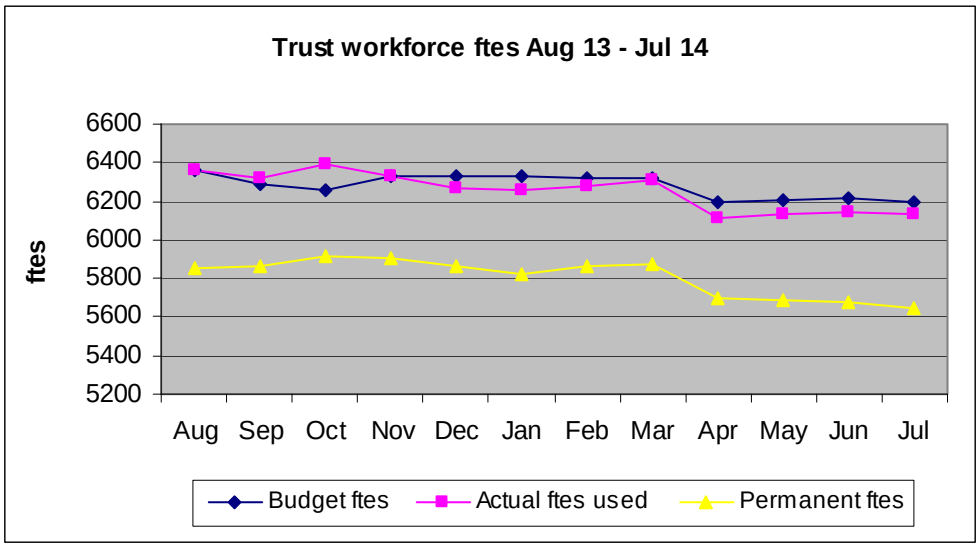
PICC's / IV's	Trend	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ESHT Total		537	546	538	552								
Hastings and Rother		392	397	404	404								
High Weald, Lewes and Havens		47	54	72	77								
Eastbourne, Seaford and Hailsham		98	95	62	71								

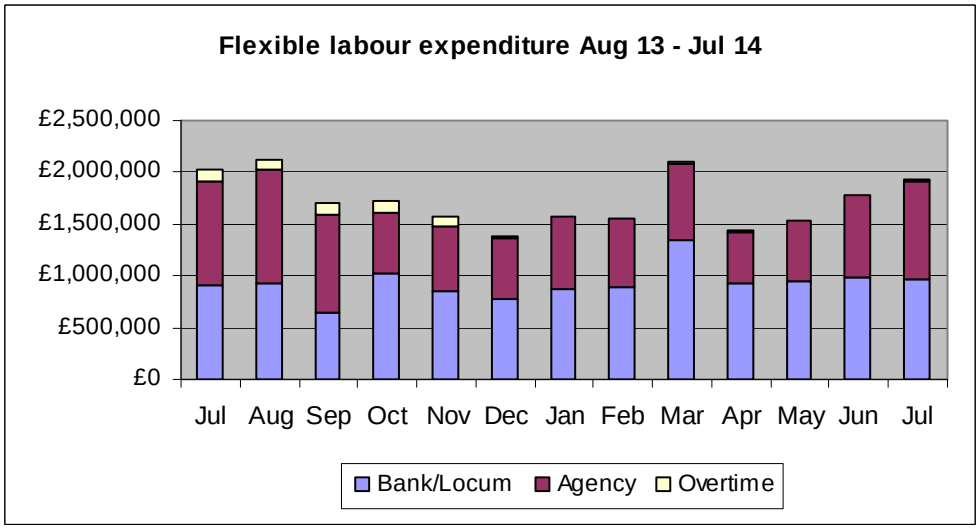
Active Caseload	Trend	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ESHT Total		4874	4615	6531	4807								
Hastings and Rother		2044	1960	3476	1814								
High Weald, Lewes and Havens		1401	927	1232	1204								
Eastbourne, Seaford and Hailsham		1429	1728	1823	1789								

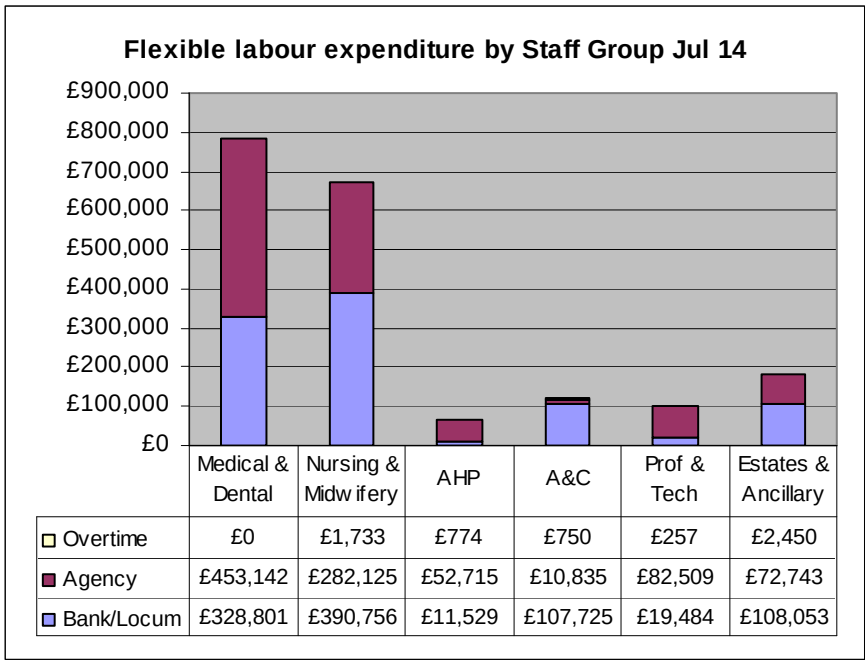
Patients Discharged	Trend	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ESHT Total		896	1087	999	854								
Hastings and Rother		361	513	503	360								
High Weald, Lewes and Havens		160	166	174	133								
Eastbourne, Seaford and Hailsham		375	408	322	361								

8.0 Workforce

Workforce Usage & Turnover



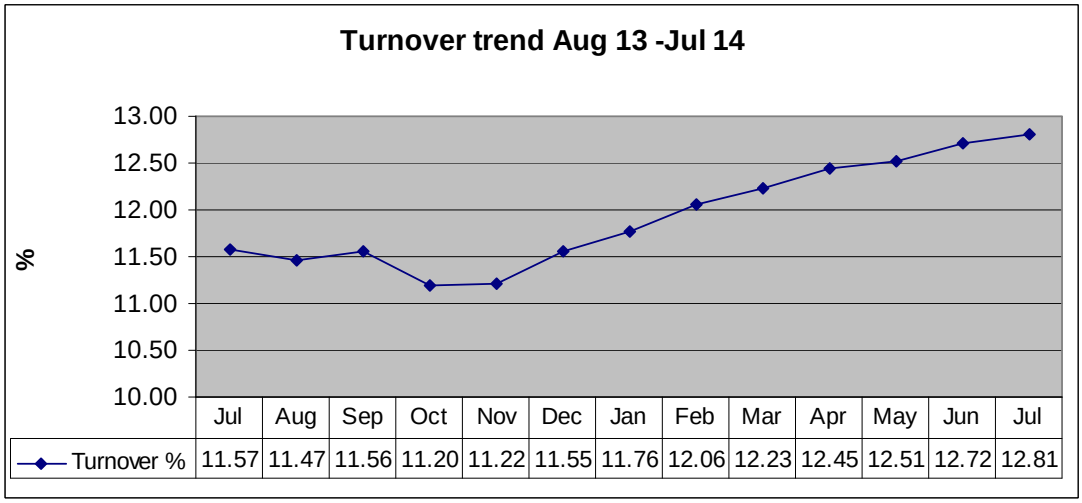




	Medical & Dental	Nursing & Midwifery	AHP	A&C	Prof & Tech	Estates & Ancillary
Overtime	£0	£1,733	£774	£750	£257	£2,450
Agency	£453,142	£282,125	£52,715	£10,835	£82,509	£72,743
Bank/Locum	£328,801	£390,756	£11,529	£107,725	£19,484	£108,053

Pay expenditure was £308K above budget at Month 4, though overall it is £321K under budget for the year to date. This monthly overspend is partly due to budget reductions in Month 4 in line with the Trust's Cost Improvement Programme although the associated planned ward closures have been slightly delayed.

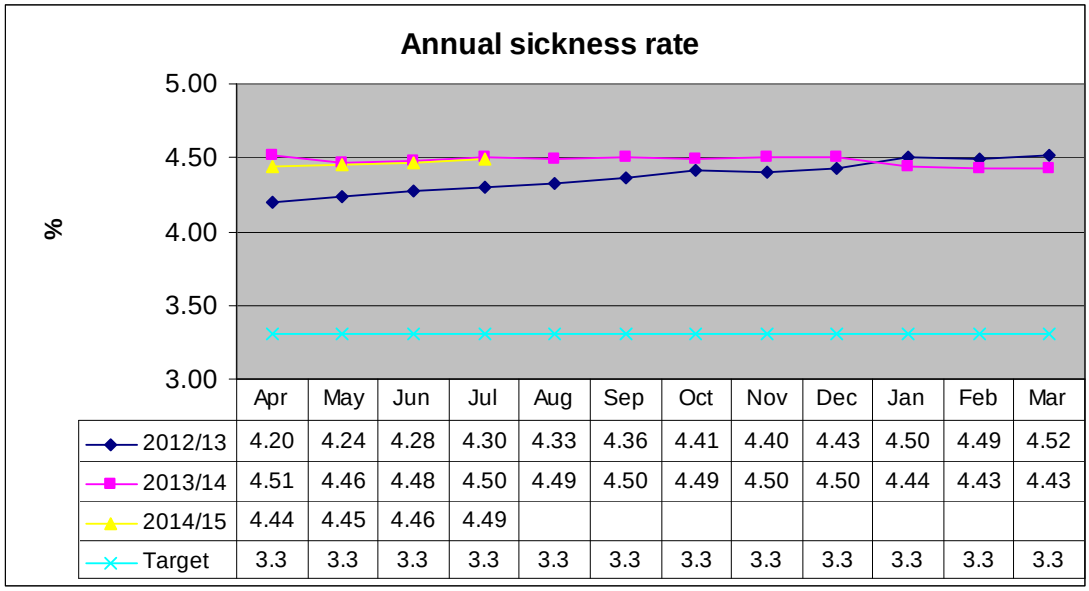
Agency expenditure has increased by £159K, compared to Month 3. This is due to additional staffing in Theatres and Surgery to meet 18 weeks targets, cover for a medical vacancy in Musculoskeletal, use of 1:1 nursing in Specialist Medicine for 3 tracheotomy patients, the use of an agency speech therapist, cover for sickness on the Irvine Unit, cover for vacancies and maternity leave in Midwifery and cover for advertised vacancies in Radiology and Pathology.



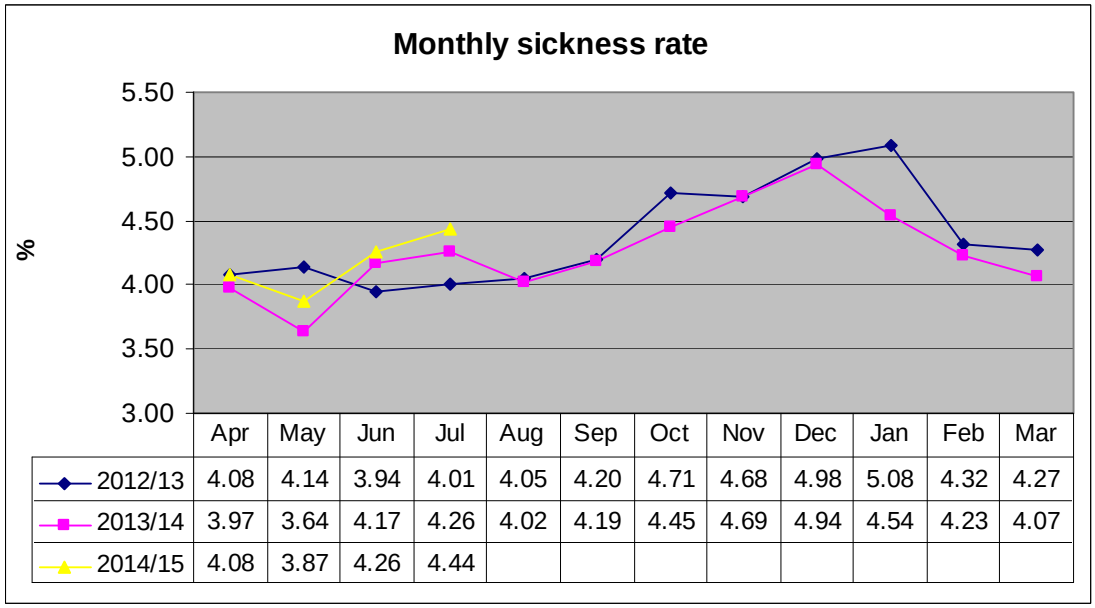
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Turnover %	11.57	11.47	11.56	11.20	11.22	11.55	11.76	12.06	12.23	12.45	12.51	12.72	12.81

Turnover continues to increase and equates to 717.85 fte leavers in the year to 31 July 2014.

Sickness



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.20	4.24	4.28	4.30	4.33	4.36	4.41	4.40	4.43	4.50	4.49	4.52
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								
Target	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.08	4.14	3.94	4.01	4.05	4.20	4.71	4.68	4.98	5.08	4.32	4.27
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								

Monthly sickness in July was up by 0.18% at 4.44%, continuing the previous trend. Annual sickness has increased to 4.49%.

The top 3 reasons for sickness this month are anxiety/stress/depression at 1465.27 fte days lost, musculoskeletal problems (other than back problems) at 1294.87 fte days and gastrointestinal problems at 649.81 fte days lost. These were also the top 3 reasons in June and the number of days lost has increased in each case.

We are planning a review of long term sickness absence to ensure that staff are being supported back to work as quickly as possible.

Clinical Unit/Directorate information

Clinical Unit/Directorate	Annual sickness	Monthly sickness	Short term sickness <28 days	Long Term sickness >=28 days	Cumulative pay expenditure v budget (£000s)	Appraised/ exempt in last yr	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training
Musculoskeletal	3.02%	2.61%	87.55%	12.45%	-£111	75.29%	72.68%	61.86%	86.67%	73.71%	62.37%	44.85%	90.11%	88.00%
Theatres, Anaes & Crit Care	5.13%	6.19%	48.32%	51.68%	-£98	68.29%	83.05%	65.16%	85.37%	83.24%	80.23%	33.52%	91.43%	87.94%
Cardiovascular Medicine	3.79%	2.95%	64.78%	35.22%	-£13	71.51%	72.11%	65.00%	93.02%	74.47%	68.68%	27.89%	89.39%	84.55%
Acute & Emergency Medicine	5.22%	4.59%	62.54%	28.07%	£47	47.34%	73.83%	54.81%	97.78%	72.35%	46.17%	45.93%	82.89%	79.71%
Specialist & Planned Medicine	4.69%	4.18%	53.11%	46.89%	£94	70.73%	84.76%	76.21%	93.88%	84.01%	71.00%	45.91%	88.71%	80.13%
Out of Hospital Care	5.37%	5.74%	51.35%	48.65%	£44	49.26%	72.76%	73.83%	96.92%	67.90%	80.35%	45.82%	93.58%	90.98%
Surgery	3.85%	4.52%	60.21%	39.79%	£84	88.34%	81.87%	70.12%	98.73%	82.27%	78.29%	52.76%	92.90%	88.58%
Clinical Support	3.35%	3.55%	37.65%	62.35%	-£172	49.21%	76.17%	75.76%	97.06%	80.86%	78.21%	49.08%	73.26%	53.49%
Womens & Childrens	4.87%	3.78%	50.74%	49.26%	-£110	62.22%	84.02%	72.95%	94.64%	78.14%	77.46%	54.23%	84.77%	72.30%
COO Operations	3.44%	4.70%	61.03%	38.97%	£70	62.63%	73.05%	81.67%	100.00%	90.30%	68.46%	31.27%	100.00%	93.75%
Commercial	5.26%	5.21%	45.71%	54.29%	£116	55.94%	68.76%	55.17%	93.75%	85.83%	71.89%	14.52%	75.00%	100.00%
Corporate	3.17%	2.43%	42.24%	57.76%	-£81	74.80%	89.69%	86.10%	88.89%	88.79%	89.01%	65.25%	89.86%	87.27%
TRUST	**4.49%**	**4.44%**	**52.77%**	**47.23%**	**-£321**	**62.34%**	**77.51%**	**69.83%**	**94.58%**	**79.69%**	**74.35%**	**41.83%**	**89.01%**	**82.32%**

Work is ongoing to provide this information against the new structures. Once complete appraisal and training rates will reflect the new operational structure.

Mandatory training compliance percentages have increased for all the Mandatory Training courses. This reflects the work that the Learning & Development team have been doing in going out to wards and departments and helping them with their recording and compliance issues.

Disappointingly, appraisal compliance is down as renewals have not kept pace with numbers expiring. Lists of staff who are showing as non-compliant are being sent out to all the Clinical Units, Commercial Division and Corporate areas to check that managers have been submitting the monitoring form after appraisals as well as actively planning to address the backlog

Medical Appraisal Status

Medical Appraisal Compliance Status July 2014					
	Number of doctors	Compliant	Percentage Compliant	Total expected to be compliant by 31/03/14	Percentage expected to be compliant by 31/03/14
Consultants (including honorary contract holders)	217	217	**100%**	**217**	**100%**
Staff grade, associate specialist, speciality doctor (including hospital practitioners / clinical assistants who do not have a prescribed connection elsewhere)	96	96	**100%**	**96**	**100%**
Locum Appointed for Service doctors	21	21	**100%**	**21**	**100%**
Total	334	334	**100%**	334	**100%**

The total number of doctors in the Trust represents those doctors with a prescribed connection to the Responsible Officer. Doctors who are compliant with medical appraisals are those who have either had an appraisal in the last 12 months and/or have been in the Trust for less than 6 months. Doctors who are expected to be compliant by 31/12/14 are doctors who have either had their appraisal since 1st April 2014 or have a planned medical appraisal date scheduled with a named medical appraiser. All appraisals should now take place between April and December each year.

All doctors are currently engaging with the medical appraisal process. It is anticipated that there will be a significant increase in the numbers of doctors having their appraisals in the third quarter of the year as their anniversary of their previous appraisal falls within this period. Over the coming years it is expected that the number of appraisals will be smoothed over the 9 month period as doctors are encouraged to have their annual appraisal within 11 months, rather than 12 months of their previous appraisal.

East Sussex Healthcare NHS
NHS Trust

FINANCE REPORT – August 2014

Vanessa Harris – September 2014

Financial Summary – August 2014

Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) has revised and reissued its finance risk assessment criteria and these are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria is Red.	R
Financial Summary	The Trust performance in month 5 was a year to date run rate deficit of £9,233k, with a favourable variance against plan of £246k. Year to date, Income was £2,149k above plan whilst total costs including the donated asset adjustment were £1,903k overspent.	R
Activity & Income	Total income received during August was £1,418k above planned levels resulting in a year to date variance of £2,149k above plan.	G
Expenditure	Pay costs YTD are above plan by £107k and Non-Pay is £2,396k above plan. The Non-Pay variance is predominantly on tariff excluded drugs and devices which are recovered through income as above.	G
CIP plans	The CIP achievement YTD was £6,521k which was ahead of plan by £89k.	G
Balance Sheet	The overall tax payer's equity is planned to rise principally due to the increase in permanent public dividend capital (PDC) being applied for to finance the revenue deficit plan and the strategic developments within the capital programme .	G
Cash Flow	Cashflow forecasting and management will remain a key task for 2014/15, whilst the deficit position is covered by the agreed draw-down of PDC this will only be accessed quarterly in arrears.	G
Capital Programme	The Capital Approval Group (CAG) will continue to review and monitor the capital programme on a monthly basis paying particular attention to the risks associated with limited capital funds.	G

Income & Expenditure – August 2014

Headlines

• Total costs in the month were £32.6m. This was £1,513k above plan and brings the YTD position to £2,292k above plan.

• The run rate deficit against plan YTD was a favourable variance of £246k.

• Cost improvements of £6.5m have been achieved YTD month 5 which is £0.1m ahead of the planned target.

• Total income in the month was £30.7m against a plan of £29.2m, a favourable variance of £1,418k. YTD income is now £2,149k above plan.

• Pay costs in the month, including ad hoc costs, were £429k above plan. YTD pay is now £107k above plan.

• Non Pay costs, including 3rd party costs, were £1,174k above plan in the month and are £2,396k above plan YTD.

• Budgets have been reallocated between Clinical Units in August to reflect the new clinical structure. This will have impacted on historic YTD variances

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	26,420	27,089	669	134,653	136,331	1,678	323,730
Private Patient/ ICR	340	322	-18	1,315	1,210	-105	4,160
Trading Income	473	387	-86	1,946	2,060	114	4,421
Other Non Clinical Income	2,001	2,854	853	10,734	11,196	462	25,049
Total Income	**29,234**	**30,652**	**1,418**	**148,648**	**150,797**	**2,149**	**357,360**
Pay Costs	-19,991	-20,410	-419	-101,883	-101,927	-44	-241,875
Ad hoc Costs	0	-10	-10	0	-63	-63	0
Non Pay Costs	-9,500	-10,675	-1,175	-48,265	-50,679	-2,414	-114,922
3rd Party Costs	-11	-10	1	-85	-67	18	-123
Other	183	183	0	917	917	0	2,200
Total Direct Costs	**-29,319**	**-30,922**	**-1,603**	**-149,316**	**-151,819**	**-2,503**	**-354,720**
Surplus/- Deficit from Operations	**-85**	**-270**	**-185**	**-668**	**-1,022**	**-354**	**2,640**
P/L on Asset Disposal	0	0	0	0	9	9	0
Depreciation	-1,049	-1,035	14	-5,244	-5,161	83	-12,585
Impairment	0	0	0	0	0	0	0
PDC Dividend	-740	-662	78	-3,444	-3,311	133	-8,272
Interest	-25	-27	-2	-123	-137	-14	-295
Total Indirect Costs	**-1,814**	**-1,724**	**90**	**-8,811**	**-8,600**	**211**	**-21,152**
Total Costs	**-31,133**	**-32,646**	**-1,513**	**-158,127**	**-160,419**	**-2,292**	**-375,872**
Net Surplus/-Deficit	**-1,899**	**-1,994**	**-95**	**-9,479**	**-9,622**	**-143**	**-18,512**
Donated Asset/Impairment Adjustment	0	115	115	0	389	389	0
Adjusted Net Surplus/-Deficit	**-1,899**	**-1,879**	**20**	**-9,479**	**-9,233**	**246**	**-18,512**

Cash Flow – August 2014

Headlines

- The cash balance is planned to be reduced to £1.0m at year-end.
- Temporary revenue PDC is planned to be received quarterly in arrears to finance the annual deficit plan.
- Clinical strategy capital PDC of £17.4m is also planned to be received during the financial year.
- The cash flow will continue to remain under constant review as the Trust is yet to be notified of a final decision on this clinical strategy funding.

Cash Flow Statement April 2014 to March 2015

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2015	Feb	Mar
Cash Flow from Operations												
Operating Surplus/(Deficit)	-1,719	-1,385	-1,948	174	-1,305	-1,583	576	181	-1,553	607	-1,432	-558
Depreciation and Amortisation	1,031	1,031	1,031	1,033	1,035	1,048	1,048	1,048	1,048	1,048	1,048	1,136
Interest Paid	-31	-31	-31	-31	-31	-5	-5	-5	-5	-5	-5	-9
Dividend (Paid)/Refunded						-4,137						-4,136
(Increase)/Decrease in Inventories	-279	34	255	-174	146							18
(Increase)/Decrease in Trade and Other Receivables	1,954	2,301	-4,770	5,298	662	265	-909	-409	-408	-909	-408	-1,741
Increase/(Decrease) in Trade and Other Payables	1,719	440	1,369	-269	-1,272	-2,555	-450	1,226	-1,401	2,602	3,531	-6,022
Provisions Utilised	125	14	16	-43	14	-18	-19	-19	-19	-19	-19	-231
Net Cash Inflow/(Outflow) from Operating Activities	**2,799**	**2,403**	**-4,077**	**5,988**	**-751**	**-6,985**	**241**	**2,022**	**-2,338**	**3,324**	**2,715**	**-11,543**
Cash Flows from Investing Activities:												
Interest Received	6	3	2	3	4	2	2	1	1	1	1	1
(Payments) for Property, Plant and Equipment	-1,132	-1,060	-1,408	-1,423	-1,594	-946	-842	-1,913	-2,669	-1,474	-4,268	-9,786
(Payments) for Intangible Assets	-29	-42	-50	-37	-44	-40	-40	-40	-40	-40	-40	-40
Net Cash Inflow/(Outflow) from Investing Activities	**-1,156**	**-1,099**	**-1,456**	**-1,457**	**-1,634**	**-984**	**-880**	**-1,952**	**-2,708**	**-1,513**	**-4,307**	**-9,825**
Net Cash Inflow/(Outflow) before Financing	**1,644**	**1,304**	**-5,533**	**4,531**	**-2,385**	**-7,969**	**-639**	**70**	**-5,046**	**1,811**	**-1,592**	**-21,368**
New Temporary PDC	0	0	5,000	0	0	4,628	0	0	4,628	0	0	4,256
Repayment for Temporary PDC	0	0	0	0	0	0	0	0	0	0	0	-18,512
New Permanent PDC	0	0	0	0	0	0	0	0	0	0	0	35,912
Loans and Finance Lease repaid	-76	0	0	-89	0	-945	0	0	0	0	0	-887
Net Cash Inflow/(Outflow) from Financing Activities	**-76**	**0**	**5,000**	**-89**	**0**	**3,683**	**0**	**0**	**4,628**	**0**	**0**	**20,769**
Net Increase/(Decrease) in Cash	**1,568**	**1,304**	**-533**	**4,442**	**-2,385**	**-4,286**	**-639**	**70**	**-418**	**1,811**	**-1,592**	**-599**
Opening balance	2,257	3,825	5,129	4,596	9,038	6,653	2,367	1,728	1,798	1,380	3,191	1,599
Closing balance	3,825	5,129	4,596	9,038	6,653	2,367	1,728	1,798	1,380	3,191	1,599	1,000

Balance Sheet – August 2014

Headlines

• The overall tax payer's equity is planned to rise principally due to the increase in permanent public dividend capital (PDC) being applied for to finance the revenue deficit plan and the capital programme strategic developments.

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Non Current Assets			
Property plant and equipment	257,258	255,411	279,286
Intangilble Assets	826	1,028	1,593
Trade and other Receivables	708	708	647
	258,792	**257,147**	**281,526**
Current Assets			
Inventories	6,238	6,257	6,511
Trade receivables	21,825	9,879	16,456
Other receivables	3,601	9,855	3,818
Other current assets	0	0	0
Cash and cash equivalents	2,257	6,653	1,000
	33,921	**32,644**	**27,785**
Current Liabilities			
Trade payables	-13,040	-8,593	-12,157
Other payables	-19,023	-25,207	-17,495
DoH Loan	-1,674	-1,674	-340
Borrow ings - Finance Leases	-320	-320	-320
Provisions	-462	-598	-483
	-34,519	**-36,392**	**-30,795**
Non Current Liabilities			
DoH Loan	-3,535	-3,535	-3,198
Borrow ings - Finance Leases	-598	-433	-282
Provisions	-2,632	-2,622	-2,435
	-6,765	**-6,590**	**-5,915**
Total Assets Employed	**251,429**	**246,809**	**272,601**

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Financed by			
Public Dividend Capital (PDC)	-153,130	-158,130	-189,042
Revaluation Reserve	-106,395	-106,396	-109,885
Income & Expenditure Reserve	8,096	17,717	26,326
Total Tax Payers Equity	**-251,429**	**-246,809**	**-272,601**

Receivables, Payables & Better Payments Practice Code Performance – August 2014

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, currently 95%, is for the value and volume of invoices that should be paid within 30 days.
- In month the target of 95% of trade invoices by amount was achieved and 92% of NHS invoices by amount were paid. This has improved the year to date achievement to 87% by amount for trade invoices and 59% by amount for NHS invoices.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	No of Invoices		Debt Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0- 30 Days	998	1,188	1,847	849
31 - 60 Days	536	470	2,187	1,120
61 -90 Days	209	204	499	4,407
91 - 120 Days	138	101	812	714
> 120 Days	1,134	1,113	4,534	3,687
Total	3,015	3,076	9,879	10,777

Trade Payables Aged Analysis - Purchase Ledger System Only	No of Invoices		Debt Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0- 30 Days	3,870	5,226	6,145	6,516
31 - 60 Days	795	883	1,479	1,087
61 -90 Days	316	354	512	411
91 - 120 Days	175	146	50	224
> 120 Days	324	298	407	430
Total	5,480	6,907	8,593	8,668

Better Payments Practice Code	Month Number of Invoices	Month By Amount	YTD Number of Invoices	YTD By Amount
Trade invoices paid within contract or 30 days of receipt	94.86%	94.97%	85.39%	86.54%
NHS invoices paid within contract or 30 days of receipt	73.03%	92.17%	42.42%	59.49%
Note: Excludes invoices awaiting payment				

Key Performance Indicators – August 2014

TDA Finance Risk Assessment Criteria.

• The TDA has reviewed its reporting requirements for 2014/15 in a new 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 1a) Bottom-line rating I&E position is the overriding rating which governs the overall Trust rating. As the Trust has set a deficit plan this rating is red and therefore under the revised TDA criteria the overall Trust rating is red.

Monitor Continuity of Service Risk Rating.

• The Trust has a liquidity ratio rating of 2 and a capital servicing ratio of 1, resulting in an overall rating of 2. This overall rating is classified by Monitor as representing a material level of financial risk.

Better Payments Practice Code (BPPC)

• In month improved performance has increased the YTD Better Payments Practice Code (BPPC) achievement for both Trade and NHS invoices.

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

Monitor Continuity of Service Risk Ratings	YTD Actual	YTD Plan
Liquidity Ratio Rating	2	2
Capital Servicing Capacity Rating	1	1
Overall Monitor Risk Rating	2	2

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	87	95
BPPC – NHS Invoices by value (%)	59	95

Activity & Contract Income – August 2014

Headlines

- Contract activity income is £669k above plan in the month and increasing the YTD performance to £1.7m above plan.
- Tariff-excluded drugs and devices income has a neutral impact on ESHT as they are offset by expenditure. After allowing for these areas, total contract income is £42k below planned levels YTD.
- Total Elective activity is £181k below plan in August this is mainly T&O, which is 185 spells below same period last year.
- Other Acute Activity underperformance is mainly Audiology, performance is now starting to improve due to staffing vacancies being filled.
- Re-admissions fines have been accrued based on agreed planning assumptions.
- CQUIN performance is based on ESHT achieving 100%.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,071	3,297	226	15,967	17,896	1,929
Elective Inpatients	760	770	10	3,954	3,835	-119
Emergency Inpatients	3,601	3,551	-50	17,772	18,167	395
Total Inpatients	**7,432**	**7,618**	**186**	**37,693**	**39,898**	**2,205**
Excess Bed Days	2,527	1,619	-908	12,520	10,095	-2,425
Total Excess Bed Days	**2,527**	**1,619**	**-908**	**12,520**	**10,095**	**-2,425**
Consultant First Attendances	5,414	7,723	2,309	28,152	38,489	10,337
Consultant Follow Ups	9,649	11,978	2,329	50,177	58,640	8,463
OP Procedures	3,961	3,940	-21	20,597	22,689	2,092
Other Outpatients inc WA & Nurse Led	13,891	11,624	-2,267	58,980	49,120	-9,860
Community Specialist	247	392	145	1,283	1,070	-213
Total Outpatients	**33,162**	**35,657**	**2,495**	**159,188**	**170,008**	**10,820**
Chemotherapy Unbundled HRGs	476	537	61	2,473	3,044	571
Antenatal Pathways	345	251	-94	1,795	1,552	-243
Post-natal Pathways	306	256	-50	1,593	1,390	-203
A&E Attendances (excluding type 2's)	9,299	8,994	-305	45,737	45,402	-335
ITU Bed Days	386	501	115	2,570	2,477	-93
SCBU Bed Days	238	142	-96	1,188	1,110	-78
Cardiology - Direct Access	78	58	-20	404	290	-114
Radiology - Direct Access	4,712	4,088	-624	24,502	23,625	-877
Pathology - Direct Access	285,378	225,699	-59,680	1,483,968	1,312,249	-171,719
Therapies - Direct Access	3,450	3,398	-52	17,941	16,674	-1,267

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,390	4,209	-181	22,800	21,649	-1,151
Inpatients - Emergency	6,271	7,012	741	30,950	32,136	1,186
Excess Bed Days	579	375	-204	2,866	2,294	-572
Outpatients	3,618	3,764	146	18,761	19,403	642
Other Acute based Activity	2,364	2,217	-147	12,718	12,294	-424
Direct Access	786	618	-168	4,086	3,720	-366
Block Contract	5,693	5,772	79	28,505	28,002	-503
Re-admissions	0	-199	-199	0	-1,279	-1,279
Other	48	256	208	539	2,964	2,425
CQUIN	587	587	0	3,007	3,007	0
Subtotal	24,336	24,611	275	124,232	124,190	-42
Exclusions	2,084	2,478	394	10,421	12,141	1,720
GRAND TOTAL	**26,420**	**27,089**	**669**	**134,653**	**136,331**	**1,678**

Clinical Unit, Commercial & Corporate Performance (budgets) – August 2014

Headlines

Clinical Units (CUs)

The overall clinical unit performance was an over spending of £315k in the month which has resulted in a YTD over spending of £1,237k.

Commercial Directorate

The Commercial Directorate is underspent by £18k year to date largely due to the receipt of a business rates rebate of £167k in the month. Under performance of income for accommodation and car parking remain issues.

Corporate Services

Corporate Services was slightly worse than plan in the month taking the overspend to £458k, principally due to the timing of income and non-pay overspends.

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	2,435	2,264	-171	11,539	9,486	-2,053
Specialist Medicine	338	594	256	1,368	3,063	1,695
Cardiovascular	-10	-198	-188	-499	-455	44
Surgery	4,236	4,299	63	21,658	21,106	-552
Women & Children	1,368	1,284	-84	6,605	6,194	-411
Out of Hospital Care	527	577	50	2,192	2,164	-28
Clinical Support	-4,836	-5,067	-231	-23,652	-23,514	138
Tariff-Excluded Drugs & Devices	0	-50	-50	0	0	0
COO Operations	-1,039	-999	40	-4,200	-4,270	-70
Total Clinical Units	**3,019**	**2,704**	**-315**	**15,011**	**13,774**	**-1,237**
Commercial Directorate	-2,340	-2,182	158	-11,650	-11,632	18
Corporate Services	-1,892	-1,904	-12	-9,127	-9,585	-458
Central Items	-1,395	-1,553	-158	-8,079	-8,154	-75
Total Central Areas	**-5,627**	**-5,639**	**-12**	**-28,856**	**-29,371**	**-515**
Income	709	941	232	4,366	5,975	1,609
Donated Asset/Impairment Adjustment	0	115	115	0	389	389
Total	**-1,899**	**-1,879**	**20**	**-9,479**	**-9,233**	**246**

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
459	473	Urgent Care	-1,675	-1,752	-77	-8,688	-8,817	-129
458	468	Specialist Medicine	-1,552	-1,688	-136	-8,280	-8,506	-226
334	342	Cardiovascular	-1,230	-1,312	-82	-6,224	-6,293	-69
667	666	Surgery	-2,820	-2,865	-45	-14,449	-14,466	-17
611	592	Women & Children	-2,274	-2,263	11	-11,750	-11,628	122
858	840	Out of Hospital Care	-2,363	-2,395	-32	-12,257	-12,334	-77
985	964	Clinical Support	-3,970	-3,918	52	-19,875	-19,552	323
420	435	COO Operations	-992	-962	30	-4,001	-4,048	-47
4,793	**4,780**	**Total Clinical Units**	**-16,876**	**-17,155**	**-279**	**-85,524**	**-85,644**	**-120**
822	838	Commercial Directorate	-1,657	-1,665	-8	-8,154	-8,280	-126
513	518	Corporate Services	-1,537	-1,587	-50	-7,835	-7,795	40
1,335	**1,356**	**Total Non-Clinical Divisions**	**-3,194**	**-3,252**	**-58**	**-15,989**	**-16,075**	**-86**
		Central Items	79	-13	-92	-370	-271	99
6,129	**6,136**	**Total Pay Analysis**	**-19,991**	**-20,420**	**-429**	**-101,883**	**-101,990**	**-107**

Clinical Unit Performance (budgets) Urgent Care – August 2014

Headlines

Pay

Overall pay for Urgent Care overspent by £77k in the month due to medical agency staff in A&E covering vacancies.

Non Pay

Non pay on plan in the month bringing the cumulative overspend to £8k.

Divisional Income

Contract income was below plan by £92k in the month and is now £1.9m below plan YTD.

Workforce Plan FTE	Workforce Actual FTE	Urgent Care	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	4,188	4,096	-92	20,694	18,784	-1,910
		Other Income	3	1	-2	12	6	-6
		Total Income	**4,191**	**4,097**	**-94**	**20,706**	**18,790**	**-1,916**
459	473	Pay	-1,675	-1,752	-77	-8,688	-8,817	-129
		Non pay	-81	-81	0	-479	-487	-8
459	**473**	**Total Expenditure**	**-1,756**	**-1,833**	**-77**	**-9,167**	**-9,304**	**-137**
459	**473**	**Gross Margin**	**2,435**	**2,264**	**-171**	**11,539**	**9,486**	**-2,053**

Clinical Unit Performance (budgets) Specialist Medicine – August 2014

Headlines

Pay

Pay overspent by £136k in the month principally due to agency expenditure. Cumulatively pay has moved to an overspend position of £226k YTD.

Non Pay

Non-Pay overspent by £34k in the month due to increased consumable costs driven by additional endoscopy and out patient clinics, taking the cumulative to an overspend position of £54k

Income

Contract income was above plan by £438k in month and is now £2.0m above plan YTD.

Workforce Plan FTE	Workforce Actual FTE	Specialist Medicine	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	1,982	2,420	438	10,159	12,159	2,000
		Other Income	181	169	-12	903	878	-25
		Total Income	**2,163**	**2,589**	**426**	**11,062**	**13,037**	**1,975**
458	468	Pay	-1,552	-1,688	-136	-8,280	-8,506	-226
		Non pay	-273	-307	-34	-1,414	-1,468	-54
458	**468**	**Total Expenditure**	**-1,825**	**-1,995**	**-170**	**-9,694**	**-9,974**	**-280**
458	**468**	**Gross Margin**	**338**	**594**	**256**	**1,368**	**3,063**	**1,695**

Clinical Unit Performance (budgets) Cardiovascular – August 2014

Headlines

Pay

Pay overspent by £82k in the month due to increased agency costs. This brings the YTD position to £69k above plan.

Non Pay

Non pay budgets are overspent by £60k YTD due to cardiology consumables.

Income

Contract income has overachieved by £36k in month and remains above plan by £328k YTD.

Other income underachieved by £95k in the month, with the YTD position being an under recovery of £155k. The Michelham Unit had 28% occupancy during August.

Workforce Plan FTE	Workforce Actual FTE	Cardiovascular	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	1,317	1,353	36	6,712	7,040	328
		Other Income	286	191	-95	1,047	892	-155
		Total Income	**1,603**	**1,544**	**-59**	**7,759**	**7,932**	**173**
334	342	Pay	-1,230	-1,312	-82	-6,224	-6,293	-69
		Non pay	-383	-430	-47	-2,034	-2,094	-60
334	**342**	**Total Expenditure**	**-1,613**	**-1,742**	**-129**	**-8,258**	**-8,387**	**-129**
334	**342**	**Gross Margin**	**-10**	**-198**	**-188**	**-499**	**-455**	**44**

Clinical Unit Performance (budgets) Surgery – August 2014

Headlines

Pay

Pay overspent by £45k in the month and is now overspent by £17k YTD. The overspending in the month was in respect of medical agency cover being partially offset by nursing vacancies.

Non Pay

Non pay overspent by £19k in the month due to purchase of ECG machines and increased spend on dressings.

Income

Contract income has overachieved by £131k in the month, but remains underachieved by £549k YTD.

Workforce Plan FTE	Workforce Actual FTE	Surgery	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	7,357	7,488	131	37,616	37,067	-549
		Other Income	49	45	-4	247	249	2
		Total Income	**7,406**	**7,533**	**127**	**37,863**	**37,316**	**-547**
667	666	Pay	-2,820	-2,865	-45	-14,449	-14,466	-17
		Non pay	-350	-369	-19	-1,756	-1,744	12
667	**666**	**Total Expenditure**	**-3,170**	**-3,234**	**-64**	**-16,205**	**-16,210**	**-5**
667	**666**	**Gross Margin**	**4,236**	**4,299**	**63**	**21,658**	**21,106**	**-552**

Clinical Unit Performance (budgets) Women & Children – August 2014

Headlines

Pay

Pay underspent in month by £11k predominantly due to midwifery vacancies. Budget is underspent YTD by £122k.

Non Pay

Underspend of £57k in the month due to the cost of HIV drugs being lower than previously estimated.

Income

Contract income underachieved by £179k in the month and is YTD £642k below plan.

Other income was above plan by £27k in the month and relates to increased Continuing Care activity.

Workforce Plan FTE	Workforce Actual FTE	Women & Children	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	3,945	3,766	-179	19,901	19,259	-642
		Other Income	36	63	27	182	262	80
		Total Income	**3,981**	**3,829**	**-152**	**20,083**	**19,521**	**-562**
611	592	Pay	-2,274	-2,263	11	-11,750	-11,628	122
		Non pay	-339	-282	57	-1,728	-1,699	29
611	**592**	**Total Expenditure**	**-2,613**	**-2,545**	**68**	**-13,478**	**-13,327**	**151**
611	**592**	**Gross Margin**	**1,368**	**1,284**	**-84**	**6,605**	**6,194**	**-411**

Clinical Unit Performance (budgets) Out of Hospital Care – August 2014

Headlines

Pay

Pay overspent by £32k in the month due to pressure in clinical admin. Pay is now overspent YTD by £77k.

Non Pay

£1k overspent against the plan for the month and is £10k underspent YTD

Income

Contract income is £96k overachieved in the month.

Other income generated a £13k variance in the month relating primarily to therapies funding.

Workforce Plan FTE	Workforce Actual FTE	Out of Hospital Care	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	3,251	3,347	96	16,273	16,333	60
		Other Income	109	96	-13	544	523	-21
		Total Income	**3,360**	**3,443**	**83**	**16,817**	**16,856**	**39**
858	840	Pay	-2,363	-2,395	-32	-12,257	-12,334	-77
		Non pay	-470	-471	-1	-2,368	-2,358	10
858	**840**	**Total Expenditure**	**-2,833**	**-2,866**	**-33**	**-14,625**	**-14,692**	**-67**
858	**840**	**Gross Margin**	**527**	**577**	**50**	**2,192**	**2,164**	**-28**

Clinical Unit Performance (budgets) Clinical Support – August 2014

Headlines

Pay

Pay underspend of £52k in the month due to vacancies across the clinical unit. Pay is now £323k underspent YTD.

Non Pay

Non-pay expenditure was £126k over plan in month. This was largely due to an increase in drug costs but remains underspent YTD.

Income

Contract income was below plan by £551k YTD.

Workforce Plan FTE	Workforce Actual FTE	Clinical Support	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	1,571	1,473	-98	8,904	8,353	-551
		Other Income	413	354	-59	1,647	1,732	85
		Total Income	**1,984**	**1,827**	**-157**	**10,551**	**10,085**	**-466**
985	964	Pay	-3,970	-3,918	52	-19,875	-19,552	323
		Non pay	-2,850	-2,976	-126	-14,328	-14,047	281
985	**964**	**Total Expenditure**	**-6,820**	**-6,894**	**-74**	**-34,203**	**-33,599**	**604**
985	**964**	**Gross Margin**	**-4,836**	**-5,067**	**-231**	**-23,652**	**-23,514**	**138**

Clinical Unit Performance (budgets) COO Operations – August 2014

Headlines

Pay

This was underspent by £30k due to clinical admin costs. Pay is now £47k overspent YTD.

Non Pay

Non pay is now £41k over plan, again relating to Clinical Admin costs.

Income

Health records and overseas visitors generated a £14k better than plan variance.

Workforce Plan FTE	Workforce Actual FTE	COO Operations	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	2	2	0	10	10	0
		Other Income	8	22	14	42	60	18
		Total Income	**10**	**24**	**14**	**52**	**70**	**18**
420	435	Pay	-992	-962	30	-4,001	-4,048	-47
		Non pay	-57	-61	-4	-251	-292	-41
420	**435**	**Total Expenditure**	**-1,049**	**-1,023**	**26**	**-4,252**	**-4,340**	**-88**
420	**435**	**Gross Margin**	**-1,039**	**-999**	**40**	**-4,200**	**-4,270**	**-70**

Divisional Performance (budgets) Commercial Directorate – August 2014

Headlines

Pay

Pay in month was £8k overspent due to use of agency in Community Facilities. The YTD position is now £126k above plan.

Non Pay

In August the non pay was underspent by £198k resulting from a business rates rebasing. YTD underspend of £216k.

Divisional Income

Commercial income has under achieved by £32k in the month due to below plan accommodation and car parking income.

Workforce Plan FTE	Workforce Actual FTE	Commercial Directorate	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Other Income	698	666	-32	3,488	3,416	-72
		Total Income	**698**	**666**	**-32**	**3,488**	**3,416**	**-72**
822	838	Pay	-1,657	-1,665	-8	-8,154	-8,280	-126
		Non pay	-1,381	-1,183	198	-6,984	-6,768	216
822	**838**	**Total Expenditure**	**-3,038**	**-2,848**	**190**	**-15,138**	**-15,048**	**90**
822	**838**	**Gross Margin**	**-2,340**	**-2,182**	**158**	**-11,650**	**-11,632**	**18**

Divisional Performance (budgets) Corporate Services – August 2014

Headlines

Pay

Pay was overspent by £50k in the month but is less that the YTD plan.

Non Pay

Non pay was overspent by £597k – this is mainly due to spend on the Child and Community Health System. This spend is matched by income.

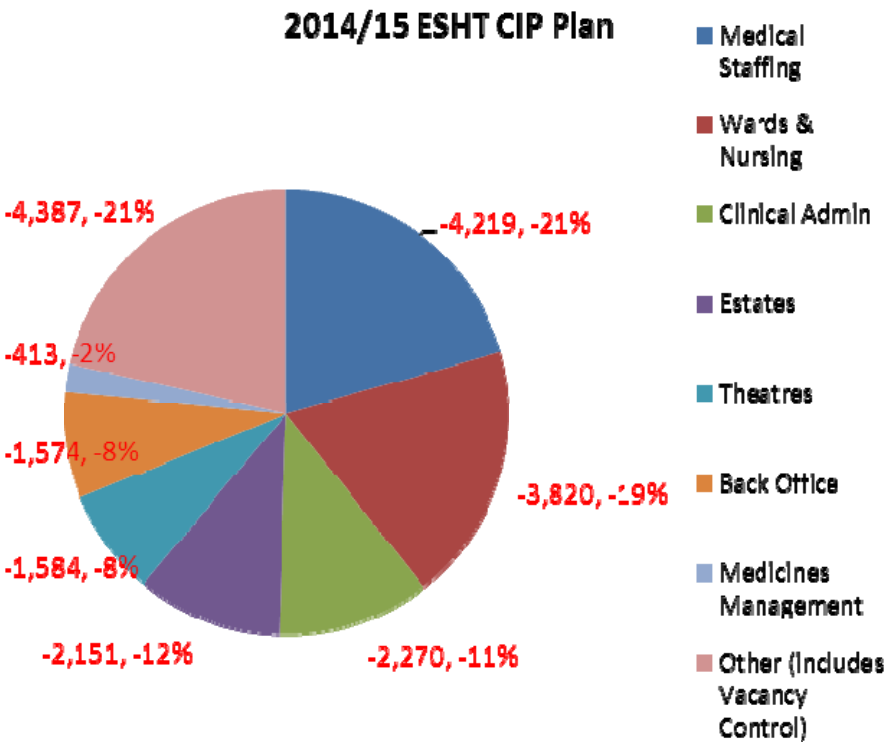
Income

£574k of income relates to the Child and Community Health System and matches non-pay spend.

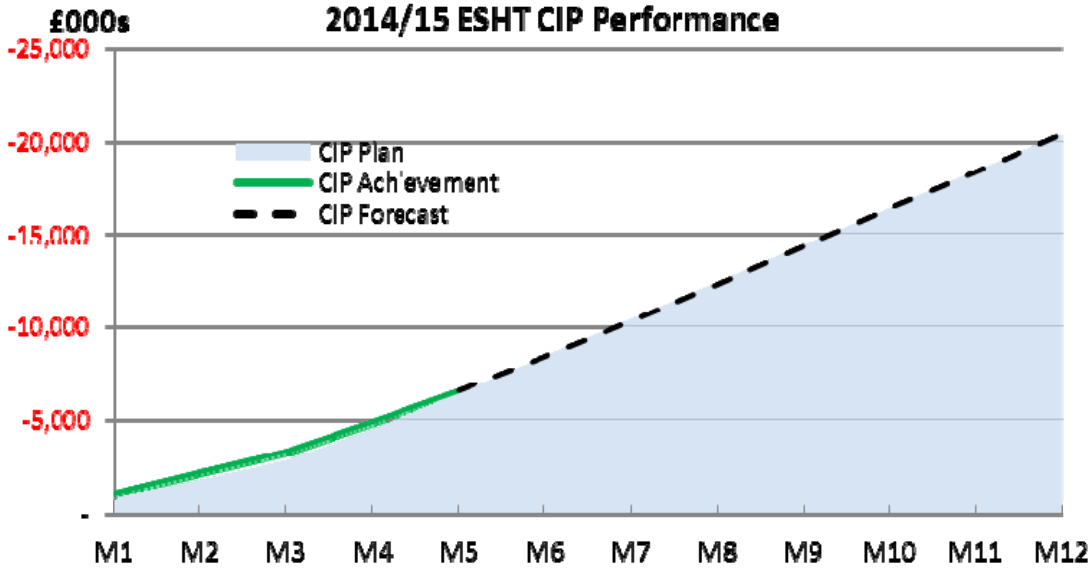
Workforce Plan FTE	Workforce Actual FTE	Corporate Services	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Other Income	1,045	1,680	635	5,480	5,657	177
		Total Income	**1,045**	**1,680**	**635**	**5,480**	**5,657**	**177**
513	518	Pay	-1,537	-1,587	-50	-7,835	-7,795	40
		Non pay	-1,400	-1,997	-597	-6,772	-7,447	-675
513	**518**	**Total Expenditure**	**-2,937**	**-3,584**	**-647**	**-14,607**	**-15,242**	**-635**
513	**518**	**Gross Margin**	**-1,892**	**-1,904**	**-12**	**-9,127**	**-9,585**	**-458**

2014/15 ESHT CIP Plan

Themes	Full Year Plan	Key Dates	Status
Medical Staffing	-4,219	on going	
Wards & Nursing	-3,820	Sep-14	
Clinical Admin	-2,270	Oct-14	
Estates	-2,151	on going	
Theatres	-1,584	Jul-14	
Back Office	-1,574	Aug-14	
Medicines Management	-413	Jun-14	
Other (includes Vacancy Control)	-4,387	on going	



2014/15 ESHT CIP Performance to date – Month 5

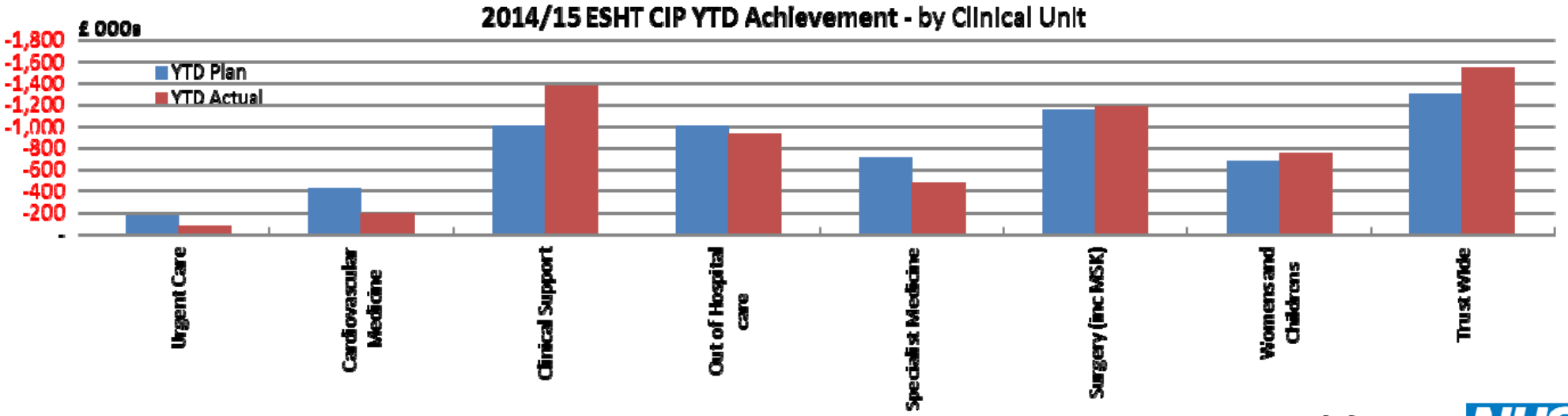


	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
	M1	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**
Plan	-799	-1,743	-2,806	-4,479	-6,432	-8,428	-10,424	-12,417	-14,408	-16,408	-18,407	-20,417
Actual	-995	-2,102	-3,272	-4,851	-6,521							
Forecast						-8,340	-10,279	-12,275	-14,298	-16,331	-18,370	-20,417

East Sussex Healthcare NHS
NHS Trust

2014/15 ESHT CIP Performance by Clinical Unit – Month 5

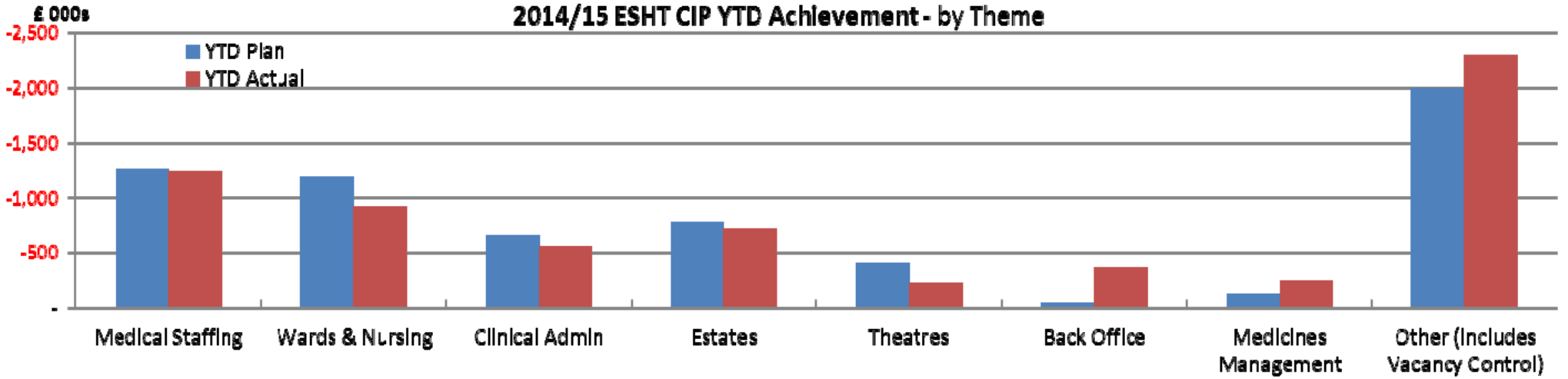
	In Month			Year to Date			Forecast		
Clinical Unit	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Full Year Plan	Full Year Forecast	Full Year Variance
Urgent Care	-73	-8	-65	-169	-74	-95	-680	-366	-315
Cardiovascular Medicine	-162	49	-211	-416	-192	-224	-1,551	-1,327	-225
Clinical Support (inc Theatres)	-284	-339	56	-1,003	-1,368	364	-3,180	-3,540	360
Out of Hospital care	-221	-200	-21	-1,010	-930	-80	-2,555	-2,475	-80
Specialist Medicine	-225	-128	-97	-707	-481	-226	-2,280	-2,054	-226
Surgery (inc MSK)	-280	-265	-15	-1,151	-1,188	36	-3,338	-3,374	36
Womens and Childrens	-136	-137	1	-674	-745	71	-1,853	-1,880	27
Trust Wide	-573	-642	69	-1,301	-1,543	242	-4,980	-5,402	422
Total	-1,953	-1,670	-283	-6,432	-6,521	89	-20,417	-20,417	-0



East Sussex Healthcare NHS
NHS Trust

2014/15 ESHT CIP Performance by Theme – M5

	In Month			Year to Date			Forecast		
Themes	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Full Year Plan	Full Year Forecast	Full Year Variance
Medical Staffing	-354	-340	-14	-1,256	-1,239	-16	-4,219	-4,105	-113
Wards & Nursing	-378	-295	-83	-1,186	-908	-278	-3,820	-3,661	-159
Clinical Admin	-188	-119	-68	-659	-552	-106	-2,270	-2,055	-215
Estates	-169	-210	41	-777	-717	-60	-2,151	-2,091	-60
Theatres	-169	-95	-73	-402	-221	-181	-1,584	-1,324	-259
Back Office	-27	-185	158	-42	-358	317	-1,574	-1,605	31
Medicines Management	-42	-59	17	-119	-239	120	-413	-567	155
Other (includes Vacancy Control)	-627	-366	-261	-1,992	-2,286	294	-4,387	-5,007	620
Total	-1,953	-1,670	-283	-6,432	-6,521	89	-20,417	-20,417	-0



East Sussex Healthcare NHS
NHS Trust

Year on Year Comparisons – August 2014

Headlines

- Total Inpatients activity was marginally higher than last year's activity level.
- Total outpatients were 2.9% lower than last year.
- YTD A&E attendances were 1.9% higher than last year.

Activity	2014/15 YTD Actual	2013/14 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	17,896	18,166	-270	-1.5%
Elective Inpatients	3,835	3855	-20	-0.5%
Emergency Inpatients	18,167	17,863	304	1.7%
Total Inpatients	**39,898**	**39,884**	**14**	**0.0%**
Elective Excess Bed Days	866	891	-25	-2.8%
Non elective Excess Bed Days	9,229	13,205	-3,976	-30.1%
Total Excess Bed Days	**10,095**	**14,096**	**-4,001**	**-28.4%**
Consultant First Attendances	38,489	38,704	-215	-0.6%
Consultant Follow Ups	58,640	61,767	-3,127	-5.1%
OP Procedures	22,689	21,872	817	3.7%
Other Outpatients (WA & Nurse Led)	49,120	51,427	-2,307	-4.5%
Community Specialist	1070	1267	-197	-15.5%
Total Outpatients	**170,008**	**175,037**	**-5,029**	**-2.9%**
Chemotherapy Unbundled HRGs	3,044	2,445	599	24.5%
Antenatal Pathways	1,552	1,706	-154	-9.0%
Post-natal Pathways	1,390	1,983	-593	-29.9%
A&E Attendances (excluding type 2's)	45,402	44,564	838	1.9%
ITU Bed Days	2,477	2,678	-201	-7.5%
SCBU Bed Days	1,110	1,341	-231	-17.2%
Cardiology - Direct Access	290	384	-94	-24.5%
Radiology - Direct Access	23,625	24,156	-531	-2.2%
Pathology - Direct Access	1,312,249	1,376,078	-63,829	-4.6%
Therapies - Direct Access	16,674	15,469	1,205	7.8%

£000s	2014/15 YTD Actual	2013/14 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	136,331	135,160	1,171	0.9%
Private Patient/ RTA	1,210	970	240	24.7%
Trading Income	2,060	1,880	180	9.6%
Other Non Clinical Income	11,196	11,016	180	1.6%
Total Income	**150,797**	**149,026**	**1,771**	**1.2%**
Pay Costs	-101,990	-107,867	5,877	5.4%
Non Pay Costs	-50,746	-47,566	-3,180	-6.7%
Other	917	417	500	-119.9%
Total Direct Costs	-151,819	-155,016	3,197	2.1%
Surplus/-Deficit from Operations	**-1,022**	**-5,990**	**4,968**	**82.9%**
Profit/Loss on Asset Disposal	9	0	9	
Depreciation	-5,161	-5,006	-155	-3.1%
Impairment	0	0	0	
PDC Dividend	-3,311	-2,426	-885	-36.5%
Interest	-137	-96	-41	-42.7%
Total Indirect Costs	-8,600	-7,528	-1,072	-14.2%
Total Costs	**-160,419**	**-162,544**	**2,125**	**1.3%**
Net Surplus/-Deficit	**-9,622**	**-13,518**	**3,896**	**28.8%**
Donated Asset / Other Adjustment	389	-142	531	373.9%
Normalised Net Surplus/-Deficit	**-9,233**	**-13,660**	**4,427**	**32.4%**

Capital Programme – August 2014

Headlines

Year to Date performance:-
After five months of the financial year capital expenditure amounts to £3.4m.

Commitments entered into total £7.2m compared to the total capital resource of £28.3m. This planned total capital resource of £28.3m includes assumed clinical strategy additional exceptional public dividend capital (PDC) of £17.4m.

While a decision is awaited from the Trust Development Authority (TDA) on the clinical strategy business case only essential planned clinical strategy enabling works are being funded from the Trust's routine capital programme.

The over planning margin has increased this month to £0.8m as additional essential Conquest A&E clinical strategy enabling works has been approved. This level of over commitment is considered acceptable at this stage of the financial year but will continue to require careful management during the remainder of the year to ensure the Trust does not exceed its capital resource limit.

The Capital Approvals Group (CAG) will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital.

Capital Investment Programme £000s	2014/15 Capital Programme	Expenditure at Month 5
Capital Resources		
Depreciation	11,285	
Clinical Strategy exceptional additional PDC	17,400	
League of Friends Support	1,300	
Cap Investment Loan Principal Repayment	-340	
Gross Capital Resource	29,645	
Less Donated Income	-1,300	
Capital Resource Limit (CRL)	**28,345**	**-**
Capital Investment		
Clinical Strategy Reconfiguration	17,400	
Clinical Strategy Essential Enabling Works	650	165
Medical Equipment	2,715	677
Information Systems	823	297
Electronic Document Management	180	127
Child Health Information System	557	200
Backlog Maintenance	964	79
Infrastructure Improvements - Infection Control	610	54
Electrical Supply to DGH	540	0
Minor Capital Schemes	2,200	917
Pevensey Ward	900	26
Other various	793	292
Brought Forward Schemes	811	516
Sub Total	**29,143**	**3,350**
Donated Asset Purchases	1,300	170
Donated Asset Funding	-1,300	-170
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**29,143**	**3,350**
Overplanning Margin (-) Underplanning (+)	-798	
Net Capital Charge against the CRL	**28,345**	**3,350**

Continuity of Service Risk Ratings – August 2014

Headlines

Continuity of Service Risk Ratings (COS):-

- Liquidity (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.
- Monitor assigns ratings between 1 and 4 to each component of the continuity of service risk ratings with 1 being the worst rating and 4 the best. The overall rating is the average of the two.
- The Trust has a liquidity ratio of -10 days, a rating of 2.
- The capital servicing ratio of -0.32 results in a rating of 1.
- As a result the overall Trust rating is 2. This rating is classified as representing a material level of financial risk.

Liquidity Ratio (days) £000s	2013/14 Outturn	2014/15 YTD
Opening Current Assets	33,908	32,644
Opening Current Liabilities	-34,506	-36,392
Net Current Assets/Liabilities	-598	-3,748
Inventories	-6,238	-6,257
Adj Net Current Assets/Liabilities	**-6,836**	**-10,005**
Divided by:		
Total costs in year	369,719	151,819
Multiply by (days)	360	150
Liquidity Ratio	**-7**	**-10**

Capital Servicing Capacity (times) £000s	2013/14 Outturn Actual	2014/15 YTD Plan	2014/15 YTD Actual
Net Surplus / Deficit (-) After Tax	-33,412	-9,479	-9,622
Less:			
Donated Asset Income Adjustment	-999	-542	-170
Interest Expense	305	133	155
Profit/Loss on Sale of Assets	-9	0	-9
Depreciation & Amortisation	11,385	5,244	5,161
Impairments	10,018	0	0
PDC Dividend	6,251	3,444	3,311
Revenue Available for Debt Service	**-6,461**	**-1,200**	**-1,174**
Interest Expense	305	133	155
PDC Dividend	6,251	3,444	3,311
Temporary PDC repayment	29,000		
Working capital loan repayment	1,334		
Capital loan repayment	340		165
	37,230	3,577	3,631
Capital Serving Capacity	**-0.17**	**-0.34**	**-0.32**

Financial Risks & Mitigating Actions – August 2014

Summary	
RISKS:-	
The following areas of risk have been identified to achieving the projected year end £18.5m deficit.	
1) Application of fines and penalties.	
2) Non-receipt of winter funds.	
3) Activity and capacity pressures.	
4) Operational cost pressures.	
5) Non delivery of CIPs .	
6) Transition costs.	
MITIGATING ACTIONS:-	
Potential mitigating actions include the development of CIP pipeline schemes, joint management of demand, continued improvement in productivity and reducing costs whilst maintaining quality & safety.	

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	8b
Subject:	Safe Nurse Staffing Levels
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

- To provide the monthly report to the Board on safe nurse staffing levels on acute inpatient 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 (NQB) (November 2013) and more recently published NICE guidance, "Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals" (July 2014), focussing on exceptions/areas of concern.

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

- There has been recent positive progress in recruitment that has supported the implementation of the new establishments agreed for 2014/15, which must be maintained.
- The variations that have occurred have been managed appropriately and indicate that safe staffing levels have been maintained

Benefits:

- The RN staffing levels are maintained at 75% or more of the agreed levels in the majority of areas, a key factor in reducing harm and poorer outcomes.
- There is no evidence that harm has been caused as a result of staffing levels.

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 recently published NICE guidance requires further review of policy and practice to ensure that best practice is met.

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.

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?
Not applicable.

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

East Sussex Healthcare NHS Trust

SAFE NURSE STAFFING LEVELS

1. Introduction

1.1 This report has been prepared in response to the requirements of the National Quality Board (NQB) (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.

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 a monthly update 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 indicators that are proven to be directly related to staffing levels i.e. falls, acquired pressure ulcers and medication errors in relation to preparation and administration.

2.3 NICE also provides evidence that there is increased harm when there is less than 75% of the agreed Registered Nurse requirement on a shift therefore this level will be used for highlighting exceptions in this report.

3. July 2014 Report

3.1 The dashboard in Appendix 1 has been prepared for July 2014 reflecting the above evidence.

It should be noted that the data for July reflects measurement against the 2014/15 establishments where recruitment has been successful however some areas that were not fully established operated on 'transitional' numbers.

The most recent analysis of vacancies in the inpatient areas demonstrates that there are 1379.26 whole time equivalent (wte) funded nursing and midwifery posts of which 53.46 wte are vacant (3.9%). There has been a significant improvement in the last month following the closure and redeployment of staff from Tressell Ward, however there is still a need to recruit additional staff to support escalation areas. It should also be noted that these figures do not reflect absence for other reasons or periods of increased acuity and activity.

3.2 Key Analysis

Four areas failed to provide 75% or more of the established RN levels:

- MAU/Seaford 1 (EDGH) fell just below this level during the daytime however the Health Care Assistant (HCA) numbers were increased to support this area.

- Rye Intermediate Care did not reach the agreed levels on 49% of the nights in July. Again there was a high level of HCAs provided to ensure that patients were safely cared for and this matter was assessed on a daily basis by the responsible senior nurse.

- Cookson Attenborough (elective orthopaedic ward) had reduced RN cover at night. It is recognised that this area delivers a high ratio of day care and therefore based on activity and professional judgment the levels of staffing are adjusted.

- Hailsham 3 (elective orthopaedic ward) had reduced RN cover during the day. Again this area has variable activity levels which are significantly reduced at weekends. As a result staffing levels are adjusted based on activity and professional judgment.

3.3 The quality indicators are monitored through the monthly nursing quality performance reviews. There were a high number of falls in three areas; however, there is no evidence that staffing levels were a contributory factor. Nor is there any evidence that quality and safety were affected by the lower levels of RNs.

4. **Conclusion/Recommendation**

The emphasis of this reporting process is not numbers but safe patient care. The data must be considered alongside operational variations and professional judgement of the relevant senior nurse.

There has been positive progress with recruitment to vacant posts to support the agreed establishments however other factors do affect the availability of staff and the Trust needs to continue with active recruitment to support winter escalation areas and reduce the requirement for temporary staff.

This overview provides assurance that the systems and processes in place allow the Trust to provide safe care in our inpatient wards. There is however further work underway to ensure that the recently published NICE Guidance is fully implemented and this will support future establishment reviews and reports.

Alice Webster
Director of Nursing

Elizabeth Fellows
Assistant Director of Operations

September 2014

Appendix 1

		Av. Fill Rate	Av. Fill Rate	Av. Fill Rate	Av. Fill Rate			
Ward/Area	**Clinical Unit**	**RNs Day**	**HCAs Day**	**RNs Night**	**HCAs Night**	**PUs**	**Falls**	**Med. Errors**
AAU Conquest	Acute Care/Medicine	81.30%	147.90%	95.70%	95.90%		3	1
Baird MAU	Acute Care/Medicine	97.10%	98.00%	77.40%	146.90%		6	
Seaford 2/MSSU	Acute Care/Medicine	106.00%	106.50%	100.30%	112.30%		4	
Seaford 1	Acute Care/Medicine	74.80%	128.60%	97.40%	105.50%			
	Acute Care/Medicine Total					0	13	1
Berwick	Cardiovascular	96.50%	94.70%	135.50%	155.00%	1	6	
CCU EDGH	Cardiovascular	117.30%		86.00%	21.00%			2
James CCU	Cardiovascular	118.10%	94.10%	92.00%	115.90%			
Michelham	Cardiovascular	97.80%	83.40%	85.50%	84.70%		1	
Stroke Unit EDGH	Cardiovascular	146.40%	124.50%	114.60%	128.70%			
	Cardiovascular Total					1	8	3
Kipling	Children and Young People	91.20%	110.50%	86.30%	66.10%			1
SCBU	Children and Young People	112.80%	81.00%	92.00%	112.90%			1
	Children and Young People Total					0	0	2
Crowborough IC Be	Out of Hospital	100.20%	97.70%	98.50%	99.90%		10	3
Irvine Unit	Out of Hospital	93.50%	126.20%	67.70%	94.00%			
Lewes Intermediate	Out of Hospital	104.80%	94.10%	86.10%	94.70%	2	13	6
Rye IC Beds	Out of Hospital	88.60%	116.10%	51.60%	196.80%		2	
Uckfield IC Beds	Out of Hospital	107.50%	98.30%	101.50%	96.50%		1	1
	Out of Hospital Total					2	26	10
Cuckmere	Specialist Medicine	110.40%	90.10%	104.60%	148.20%		6	2
Newington	Specialist Medicine	85.40%	127.50%	106.50%	134.20%	2	3	2
Folkington	Specialist Medicine	93.30%	99.30%	96.30%	135.30%	2	5	
Jevington	Specialist Medicine	129.20%	101.60%	147.20%	142.70%		4	4
MacDonald	Specialist Medicine	113.90%	86.50%	106.50%	91.10%	1	10	
Tressell	Specialist Medicine	100.60%	96.00%	101.50%	119.20%	2	2	3
Wellington	Specialist Medicine	81.90%	112.50%	93.70%	100.00%	2	6	
Pevensey	Specialist Medicine	93.00%	94.00%	100.00%	72.70%			1
	Specialist Medicine Total					7	27	8
Cookson Attenboro	Clinical Support	103.90%	107.60%	64.20%	67.70%		1	
ITU/HDU EDGH	Clinical Support	107.70%	82.40%	85.40%			1	
ITU/HDU Conquest	Clinical Support	101.10%	68.40%	82.50%	91.70%	1		
	Clinical Support Total					1	2	0
Benson Trauma	Surgery	106.00%	122.60%	93.50%	135.50%	2	8	4
Cookson Devas Elec	Surgery	96.40%	119.30%	91.90%	51.50%		5	
Egerton Trauma	Surgery	95.80%	96.50%	103.10%	133.90%	2	5	1
Hailsham 3 (Orthop	Surgery	72.70%	103.10%	80.80%	58.10%	1	2	1
Seaford 4 Urology	Surgery	116.00%	97.80%	100.20%	116.00%		1	1
De Cham	Surgery	95.80%	85.70%	79.60%	98.20%			
RT SAU	Surgery	90.80%	84.70%	78.20%	65.50%			1
Hailsham 4	Surgery	114.30%	109.90%	106.30%	86.90%		1	1
Gardner	Surgery	108.20%	80.90%	81.30%	90.80%			1
	Surgery Total					0	2	4
Crowborough BC	Women's and Reproductive Health	98.70%	99.70%	97.10%	108.60%			
EMU	Women's and Reproductive Health	88.70%	90.30%	92.30%	87.10%			
Frank Shaw	Women's and Reproductive Health	100.70%	115.60%	92.10%	95.30%			1
Mirrlees	Women's and Reproductive Health	113.40%	89.10%	113.90%	86.50%		1	
	Women's and Reproductive Health Services Total					0	1	1
	Grand Total					18	107	38

NB. Red highlight indicates less than 75% Registered Nurse agreed establishment

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	9
Subject:	Research and Development Strategy
Reporting Officer:	Dr David Hughes, Medical Director (Governance)

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

Purpose:

The purpose of this document is to state explicitly East Sussex Healthcare NHS Trust's (ESHT) commitment to Clinical Research over the next five years, and to set out our Vision of Excellence for the future. It also outlines how we expect to achieve our specific aims and become a thriving research active organisation by April 2019.

This document sets out our vision, mission and aims for 2014-2019.

Introduction:

Participating in clinical research is in the interests of ESHT, and we have an obligation to contribute. NHS Constitution 2009

The strategy will utilise our clinical potential and implement a strategic policy that will enable the Trust to achieve its research objectives, deliver a high quality and innovative clinical service for the population of East Sussex, and enhance the reputation and status of ESHT.

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

Central to the strategy is Aim 1 – to Embed research
This will bring key challenges and requires high level, Trust board support to enable success.

We want to significantly change the research culture (perceptions, attitudes, support and endeavour) amongst all staff in ESHT.

Key objectives within the strategy include the following:

- Create effective and clearly defined lines of accountability to the Trust Board for research; its management, governance, delivery and performance
- Create accountability for the strategy within Clinical Units, departments and across professional groups; performance managing their commitment to research
- Embed key research staff (eg Research Champions) as integral elements of Clinical Units, resulting in a seamless, transparent and productive integration of research and clinical delivery of services.
- Ensure appropriate and effective allocation of Supportive Professional Activity (SPA) linked to specific research activity through job planning. This will enable support of research activity within ESHT.

Other objectives contained within the strategy can and are being instigated and driven by R&D, but the objectives cited above will require particular Senior Management and Trust Board support to initiate.

Benefits:
High quality research is fundamental to our interests as an NHS care organisation. We have a duty to contribute. Our patients, staff and trainees should be given every opportunity to participate wherever possible. This reflects our core values and is an aim of the National Institute for Health Research (NIHR).

Risks and Implications
Funding for research activity via NIHR is dependent on patient recruitment to research studies. If recruitment target is not met, this risks funding. Our research portfolio and output is currently modest and much more can and should be done to increase research output in the Trust. This will pose a major challenge for the Trust with highly competitive and restricted funding opportunities.

Assurance Provided:
The strategy is intended enable the objectives set by DH, National Institute of Health Research, to be met. The strategy seeks to utilise our clinical potential and implement a strategic policy that will enable the Trust to achieve its research objectives, deliver a high quality and innovative clinical service for the population of East Sussex, and enhance the reputation and status of ESHT. With Senior Management and Trust Board support, this can be achieved.

Review by other Committees/Groups (please state name and date)**:**
Research and Development Operational Working Group - 13th June 2014 Research and Development Steering Group – 26th June 2014 Clinical Management Executive – 11th August 2014

Proposals and/or Recommendations
The Trust Board is requested to accept and approve the strategy, and support delivery of the aims contained within it.

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

For further information or for any enquiries relating to this report please contact:	
Name: Liz Still, Research and Delivery Manager	**Contact details:** 01323 413880 Liz.Still@esht.nhs.uk

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust

Research & Development Strategic Plan 2014 to 2019

- *Embedding research*
- *Developing collaboration*
- *Increasing opportunity, participation and performance*
- *Maintaining and improving standards*

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1	July 2014	Liz Still	New Document	

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Dr H Walmsley	Associate Medical Director	July 2014
Dr S Panthakalam	R&D Clinical Lead	July 2014
Dr Carol McCrum	Consultant Physiotherapist	July 2014
R&D Steering Group	R&D Steering Group	June 2014
Stuart Welling	Trust Chairman	July 2014

Table of Contents

Foreword

This new strategy is designed to translate the commitment of the Trust Board to develop our research aims and objectives into measurable deliveries and timescales. The intention is to build on the progress made to date and focus on improving our research performance to ensure the Trust provides sustainable and effective support to clinical research which potentially has direct benefits for our patients and the wider population we serve.

As an integrated acute and community trust, our success will in part be dependent on the support and joint working with our stakeholders most notably the National Institute for Health Research, the Kent Surrey & Sussex Academic Health Science Network, Kent Surrey & Sussex Clinical Research Network, Brighton & Sussex Medical School and partner providers.

My personal commitment and that of the Board to make a step change in its focus and engagement with research reflects the importance participating in clinical research has in providing high quality and innovative clinical services.

Delivering this strategy needs the committed engagement of our researchers, managers and partners. We will endeavour to work closely and support all those involved in research over the next 5 years.

Stuart Welling
Chairman
East Sussex Healthcare NHS Trust

Executive summary

East Sussex Healthcare NHS Trust identifies that participating in research is a quality driver and reflected in the NHS Constitution. The benefit of this participation has a direct impact on the quality of patient care, increases staff satisfaction and results in economic reward, which is crucial in the current climate, and raises the profile of the Trust.

The National Institute for Health Research (NIHR) recognises that there must be a strong commitment to clinical research in the UK, and the past few years have seen a significant investment and dramatic increase in research infrastructure.

Participating in clinical research is in the interests of ESHT, and we have a legal obligation to contribute. This document sets out our vision, mission and aims for 2014-2019.

Introduction

The purpose of this document is to state explicitly East Sussex Healthcare NHS Trust's (ESHT) commitment to Clinical Research over the next five years, and to set out our Vision of Excellence for the future. It also outlines how we expect to achieve our specific aims and become a thriving research active organisation by April 2019

The Trust Research Strategy will provide ESHT with a roadmap for the next five years (2014-2019), to ensure that we build on what has been achieved to date. The strategy will utilise our clinical potential and implement a strategic policy that will enable the Trust to achieve its research objectives, deliver a high quality and innovative clinical service for the population of East Sussex, and enhance the reputation and status of ESHT.

Background

The NHS Constitution (2009) states that

- "Research is a core part of the NHS. Research enables the NHS to improve the current and future health of the people it services … The NHS will do all it can to ensure that patients from every part of England are made aware of research that is of particular relevance to them."

Prof Sally Davies, Chief Medical Officer for England identified that

- "Clinical research is not just for the large teaching hospitals – it is absolutely core business for all NHS Trusts". Chief Medical Officer and Chief Scientific Advisor, Department of Health (2012)

Jonathan Sheffield OBE, Chief Executive NIHR Clinical Research Network

- "The NHS faces a challenging future. Our aging population is placing increasing demands on the health service, and we can only hope to meet these demands by

improving the effectiveness and efficiency of treatments across all therapy areas. Clinical research is the means to this end"

Research is also fundamental to the concept of NHS foundation trusts which ESHT is pursuing. The Department of Health (2005) states that

- "NHS foundation trusts will be required to provide certain essential NHS services including research."

We all need to recognise that research is an essential component of good clinical services, and that participation in research can lead to substantial improvements in service delivery and patient care, as well as significant financial saving in many cases.

There are important health-related and financial reasons for undertaking research in the NHS:

(1) Implementation of evidence-based medicine
(2) Introduction of high quality and innovative clinical services
(3) Patient access to new and improved diagnostic techniques and therapies
(4)Better access to and cost-effective use by health professionals of improvements in health technologies
(5) Cessation of ineffective treatments with major financial savings and use of nursing time
(6) Participation in clinical trials has been shown to lead to better patient outcomes and survival.

In April 2014 the structure of research organisations was changed nationally with the formation of the NIHR Clinical Research Network (CRN). Within this are 15 local CRNs. ESHT sits within the CRN Kent Surrey & Sussex (CRN:KSS). Its role is to support research within organisations with the aim of increasing research trial activity by 15% per year.
CRN KSS covers a population of just over 4.8 million people. Healthcare is provided by 12 hospital trusts, 3 mental health trusts, 2 community trusts, 1 ambulance trust, hundreds of GP surgeries and a variety of not-for-profit and commercial healthcare providers.
Whilst the general health of the population is above average, there are clear health inequalities.
We have a growing elderly and ageing population with a significant number of people aged over 85.
65,000 people in the region have dementia.

The CRN:KSS was formed in April 2014 but builds upon the previous success of the Topic and Comprehensive Research Networks. Since 2010 recruitment of patients into trials has more than doubled within KSS, and timelines for study approvals have been reduced significantly. The creation of a single research network across KSS will provide an attractive framework for clinical research. Growing research capacity and capability remains a priority.

To achieve this CRN:KSS recognises the need for further development of the research infrastructure. It is therefore essential that CRN:KSS works with local Higher Education Institutions and the Academic Health Sciences Network (AHSN) to increase access for patients to participate in research, and to increase the number of trials that are developed locally to address local health priorities. It must capture the voice of patients and carers in Kent, Surrey and Sussex.

Current Local Position

Since the introduction of the National Institute of Health Research (NIHR) and ring-fenced funding for research delivery, ESHT has increased activity, capacity and workforce significantly.

ESHT participates in clinical research which has improved significantly over the past four years, due to substantial allocation of NIHR resources, a small but committed research workforce and a small group of dedicated clinicians.

Our research portfolio and output is currently modest and much more can and should be done to increase research output in the Trust. This will pose a major challenge for the Trust with highly competitive and restricted funding opportunities.

Currently ESHT Clinical Strategy (2012) contains no reference to research activity.

Where are we now?

Research currently sits within ESHT Corporate Division and is part of the Medical Director's Executive portfolio.

An Associate Medical Director is responsible for the strategic direction of R&D.

The R&D Manager and R&D Clinical Lead are responsible for the management and governance of all research activities, with accountability for core research office staff, and the performance management of those NIHR funded Trust employees who are working on research.
From April 2014 reconfiguration of R&D has resulted in clarity of line management and support for the current research nursing delivery and administration team. (Appendix 1)

Currently 21.8 wte staff (research nurses, AHPs, pharmacists, physiologists, pathology, radiologists, administrative and clerical) are involved in delivery of clinical research studies/trials and Research Management & Governance in the Trust. Of these, 16wte are funded by NIHR with the remainder being funded from involvement in commercially funded research.

There are over 27 Clinical Consultants currently involved as either Chief Investigator (CI) or Principal Investigator (PI).
Current Research Priority areas include: Oncology, Cardiology, Rheumatology, Dermatology, Stroke, Gastroenterology, Haematology, Diabetes, Anaesthetics / Critical Care and Paediatrics.
There are 76 clinical research studies which are currently open and recruiting.

Table 1: NIHR recruitment targets and funding allocation.

	2013/14	2014/15
Recruitment Target	613	937
Funding	535K	515K
NIHR Research Nurse wte	12.09 wte	13.4 wte

The Research and Development Steering Group (R&D SG) comprises of representatives from clinical specialties, HR, financial, clinical and information support services. This group meets quarterly with a reporting structure to Trust Board via the Clinical Management Executive. Detailed reporting structure is included in R&D SG Terms of Reference.

The Research & Development Operational Working Group (R&D OWG) includes the R&D Manager, Clinical Lead for R&D, Associate Medical Director for Education & Research development, and R&D Governance Facilitator. This group meets monthly together with Directorate Accountant to manage operational issues in a timely manner. Input into operational matters also occurs through electronic communication strategies between meetings.

Moving Forward – Where we want to be?

Our Vision

The research department in ESHT aspires to be an innovative and patient-centred clinical research department within the CRN:KSS. High quality research is fundamental to our interests as an NHS care organisation. We have a duty to contribute. Our patients, staff and trainees should be given every opportunity to participate wherever possible. This reflects our core values and is an aim of the National Institute for Health Research (NIHR)

- "The NIHR is committed to working with clinicians and managers in NHS Trusts to make sure that patients are aware of opportunities to take part in research relevant to them, and have the necessary information to make informed choices on whether to participate". (Embedding Health Research 2009/10)

Mission Statement

To ensure that ESHT provides sustainable and effective research services to deliver the best possible environment to support clinical research activity that matters to the needs of our patients and the public.

- Develop a vibrant clinical research environment within the trust
- Provide our population with access to a broad portfolio of commercial and non-commercial clinical trials
- Work collaboratively with our public, private, and academic partners to grow sustainable research capability within ESHT.
- Be responsive to the health and social needs of the local population and the NHS

Who should be involved in delivering Clinical Research in ESHT?

Contributing to research is core business for East Sussex Healthcare NHS Trust and every Clinical Unit and Department should be involved in delivering our Vision.

Whilst there are individuals who may not lead research, there should be engagement and support from all staff members towards the national and local effort. This may mean undertaking specific research roles and responsibilities, or simply providing support for colleagues who are engaged in the research process; it is nevertheless our intention to ensure Trust-wide participation.

There is a need to establish a programme of training and development for all groups of staff in collaboration with CRN KSS initiatives and local academic institutes.

- "Increasingly, it is recognised that research is not just something that should concern Clinician's and that evidence-based practice should extend to management and policy making" (NIHR, 2010)

Research priority areas in the future

Dementia research is largely undertaken in Mental Health and Primary care organisations. We will seek out collaborative acute / community studies within this speciality.

Research into surgery is not currently established and we will seek to support studies in this area.

Neurology and Neuro-disability is also an area that requires support and development given the demography of the local patient population.

All projects need a research sponsor, or equivalent, which is an organisation with overall responsibility for the initiation, management and financing (or arranging the financing) of the study. Currently, ESHT R&D does not have the capacity, or sufficient expertise to fulfil the requirements of sponsorship at present.

Our Plan

We plan to create a thriving quality research culture and operational research capability, which ensures in 5 years time:

- That we are a provider of choice for research sponsors and funders
- That we can bring increased opportunities to our patients and our staff

This document sets out our 4 key strategic aims with plans on how we intend to achieve them over the next 5 years (see Figure 1).

Aim 1 – Embed research

Integration and embedding of clinical research into the clinical and administrative fabric of ESHT, thereby inducing a crucial cultural change and a paradigm shift in research support, activity and productivity in the Trust, including integration into policies and practice. We want to significantly change the research culture (perceptions, attitudes, support and endeavour) amongst all staff in ESHT.

Aim 2 – Develop Collaboration

A more focused, robust and beneficial policy of collaboration with existing NIHR research networks and academic institutions.

Aim 3 – Increase Opportunity, Participation and Performance

Maximise and sustain patient participation in high quality, funded NHS-focused research

Aim 4 – Maintain and Improve Standards

Establish effective Research Management and Governance (RM&G) Systems to ensure quality, safety and regulatory compliance.

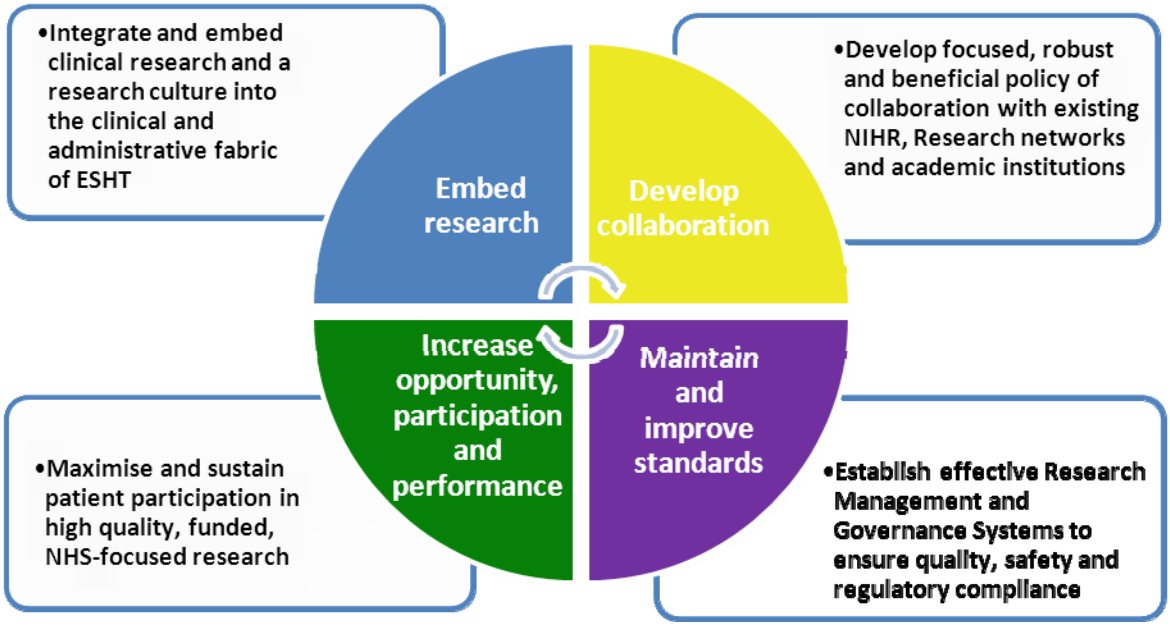


Figure 1: ESHT Research & Development Strategic Aims for 2014 to 2019

Delivering Our Aims

Aim 1: – Embed research

To achieve this, we will:

1.1 Create effective and clearly defined lines of accountability to the Trust Board for research; its management, governance, delivery and performance. Research will be part of the Trust's core business.

1.2 Ensure appropriate and effective allocation of Supportive Professional Activity (SPA) linked to specific research activity through job planning. This will enable support of research activity within ESHT. A statement regarding commitment to research will be in all staff job descriptions.

1.3 Create accountability for the strategy within Clinical Units, departments and across professional groups; performance managing their commitment to research, and key strategic initiatives against specified targets.

1.4 Ensure that Research is represented at appropriate committees and working groups across the Trust.

1.5 Develop a comprehensive communications strategy for research in ESHT and ensure that any improvements made towards our strategic goals are widely promoted across the Trust.

1.6 Ensure that clinical research activities feed and support the Trust's strategies for innovation, development and evaluation; i.e. that new innovations are researched appropriately and effectively; that innovations from research are developed and

maximised; and that new knowledge is generated and disseminated, which has an impact on clinical practice.

1.7 Embed key research staff (eg Research Champions) as integral elements of Clinical Units, resulting in a seamless, transparent and productive integration of research and clinical delivery of services.

1.8 It is unacceptable that patients do not know about research opportunities within the trust. Communication with patients is essential. A statement will be added to all Trust letters stating the trust is a research active organisation and to ask about studies they may wish to access.

In 5 years time, we will:

- Have all staff "thinking research" when considering their patient's care pathway.
- Have all departments and specialties engaged in the research process and making a Trust-wide contribution to the research effort.
- Have all professional groups participating in research as part of role and responsibilities; for example more Nurses, Midwives, Allied Health Professionals, Non-clinical staff and Managers.
- Have evidence of research engagement and support included in all job descriptions.
- Have evidence of capability in evidence-informed practice skills as part of clinical staff annual appraisals and included in job descriptions
- Have interrelated Trust policies aligned to the research plan.
- Have improved staff satisfaction through contributions to a research active organisation.
- Have clinical research fully aligned with the Trust's development strategies.
- Have an R&D award linked to the annual staff awards.
- The R&D Steering Group will hold an annual research meeting; each Clinical Unit will be expected to actively contribute to the meeting.
- The R&D group will have established a regular section in Connect within 12 months of the strategy being adopted.

Aim 2: – Develop Collaboration

2.1 To build on and develop further existing strong collaborations and research partnerships with the Kent Surrey and Sussex Clinical Research network (CRN KSS) via their six Divisional Clinical Leads and Research Delivery Managers.

2.2 To engage more effectively with the Pharmaceutical and Biotechnological industries.

2.3 To re-establish and develop strong research partnerships with the University of Brighton and other HEIs in KSS, AHSN with a view to enhancing the academic profile of ESHT, thereby, attracting to and retaining in ESHT high calibre and skilled staff.

2.4 Provide the environment and support for dual appointments between the Trust and Brighton and Sussex Medical School.

2.5 Work closely with academic partners to create opportunities for new clinical academic posts and research fellowships.

Figure 2: ESHT Research partnerships and collaborations

In 5 years time, we will:

- Have more Chief Investigators undertaking own account research activity.
- Have more 'own-account' East Sussex Healthcare Trust studies adopted onto the national NIHR portfolio.
- Have collaborative working between CI's and industry to enable appropriate sponsorship of research activity.
- Have effective collaborative working with KSS CRN Divisional clinical leads and delivery managers to increase opportunities.
- Ensure effective academic partnerships.
- Have at least 2 clinical academic posts in place

Aim 3: Increase Opportunity, Participation & Performance

3.1 Create Clinical Research Leads within specialty groups / clinical units / departments with responsibility for the promotion, development and delivery of clinical research activity amongst their peers.

3.2 Reward and recognise those staff involved in high quality clinical research and research innovations.

3.3 Formalise and structure all research roles and responsibilities across the Trust defining job descriptions / plans for those staff directly engaged in delivering high quality clinical research.

3.4 Prioritise and focus our efforts and resources on areas where there is existing capability, expertise, local need and potential performance.

3.5 Improve study set-up, opening more UKCRN portfolio and other high quality studies quickly and efficiently.

3.6 Ensure study permission times meet nationally agreed targets.

3.7 Capture, monitor and performance manage participant recruitment at all levels (monitoring against a specified target).

3.8 Identify any blocks to recruitment and facilitate their resolution.

3.9 Utilise the expertise and support of key partners in creating opportunities and driving performance. Key partners include: the NIHR Research Design Service; NIHR Divisional Clinical Leads; Clinical Trials Units; Biomedical Research Units; Academic, Commercial and Charitable Collaborators; Local NHS Organisations; Patients and the Public.

3.10 Ensure IT facilities such as a study tracker are in place to enable study teams to upload recruitment data thereby enabling interrogation of database for reliable information.

In 5 years time, we will:

- Have more patients across more specialty areas being given the opportunity to take part in NIHR Portfolio studies, and increase the numbers of patients participating in these studies
- Have more clinical departments and specialties participating in NIHR portfolio studies
- Increase Research for Patient Benefit grant applications. (RfPB funds up to £250k for applied, outcomes based health services research that will benefit patients. Applications must come from NHS trusts in consultation with a Research and Design Service (RDS) and should engage the public in the process. RfPB offers the

opportunity to collaborate in research with academia on projects that have direct relevance and potential impact on local problems).

- Have more staff with protected time for funded research duties as part of their job role or their job plan.
- Have more Principal Investigators from across professional groups and in novel speciality groups.
- Have more NIHR portfolio studies open to recruitment.
- Have more collaborative formalised, visible programmes of research with academic and other research partners.
- Have at least *80%* of our studies, which are open to recruitment, delivering to their recruitment and timeline targets.
- Have more individuals citing research opportunities as a reason for their wanting to work at East Sussex Healthcare NHS Trust.
- Other research opportunities will be fostered, including unfunded projects as part of training posts or programmes (e.g. SpR, PhD/MD and post/undergraduates) and projects funded by non-portfolio sources, for example charitable funds and successful grant applications.

Aim 4 – Maintain and Improve Standards

4.1 Review, identify and address any weaknesses in the Trust's Research Management and Governance systems, which may prevent compliance with UK regulations or recognised standards of quality and safety.

4.2 Ensure that all policies and procedures are monitored, peer-reviewed and kept up-to-date on a 2 yearly basis.

4.3 Maintain systems for the monitoring and audit of research activities; ensuring that corrective action is taken where necessary and those lessons are learned.

4.4 Ensure all RM&G systems are as effective and efficient as possible, and proportionate to risk.

4.5 Ensure that NHS permission times meet nationally agreed targets.

In 5 years time, we will:

- Have evidence of continuing improvement of standards of good practice in clinical research across the Trust.
- On-going review of systems in place which ensure the Trust remains compliant with current UK legislation governing clinical research activity for both sponsored and hosted research activities.

- Maintain confidence amongst patients, staff, research funders and sponsors with regards to the standards of clinical research in East Sussex Healthcare NHS Trust.
- Have minimised the likelihood of clinical incidents related to research.
- Have no critical findings from an MHRA inspection.
- Have minimised the likelihood of Serious Breaches related to Clinical Trials of Investigational Medicinal Products (CTIMPS).
- Have increased the numbers of staff trained in Good Clinical Practice (GCP) in research.

Conclusion

This document sets out the Research & Development Strategy for ESHT for 2014 - 2019.

It confirms the determination of the Trust to succeed in research by identifying four strategic aims, related objectives and a delivery plan that will ensure ESHT develops as a centre of research excellence.

The strategy will improve research capacity and capability by retaining and rewarding the best health professionals, improve systems of research governance and engage in research that is focused on patients and lead to improved local health and care.

The success of this research strategy relies on the support of our patients and the engagement and commitment of our staff at all levels.

This R & D strategic plan, through the dedication and efforts of the R & D Department, with support of the Trust Board, aims to foster this success across the next five years to ensure research is at the heart of the high quality and innovative clinical services the Trust provides.

References

DH Research Governance Framework for Health and Social Care, 2005

http://www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/ResearchAndDevelopmentAZ/ResearchGovernance/fs/en

DH 2005 Short guide to Foundation Trusts,
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/D H_4126013

DH White paper 2011 – see NIHR below

East Kent Hospitals NHS Trust (2013) Research Development and innovation strategy 2013 – 2016 http://www.ekhuft.nhs.uk/staff/clinical/research/

Kent and Medway NHS Trust (2009) Research and Development Strategy 2009-2012 http://www.kmpt.nhs.uk/Downloads/whats-happening/RD_strategy.pdf

Hillingdon Hospital NHS Trust (2012) Research and Development Strategy 2012 – 2014 http://www.thh.nhs.uk/documents/_Departments/Research/THH_RD_Strategy_2012-14.pdf

The NHS Constitution for England, Department of Health. March 2010.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613)

NHS England (2013) Research and Development Strategy (DRAFT) 2013-2014 http://www.england.nhs.uk/wp-content/uploads/2013/12/nhs-england-res-strat-consult.pdf

NIHR (2014) Clinical Research Network Kent Surrey and Sussex. Improving healthcare through effective partnerships. Our strategy 2014-2017 CSP069669 06/14

NIHR (2010) SDO Network Briefing Paper: Being a Good Research Partner: The Virtues and Rewards. Oct

NIHR (2009/10) Embedding Health Research
http://www.nihr.ac.uk/files/pdfs/400891_NIHR_AnnualReport2010_acc3.pdf DH White paper 2011

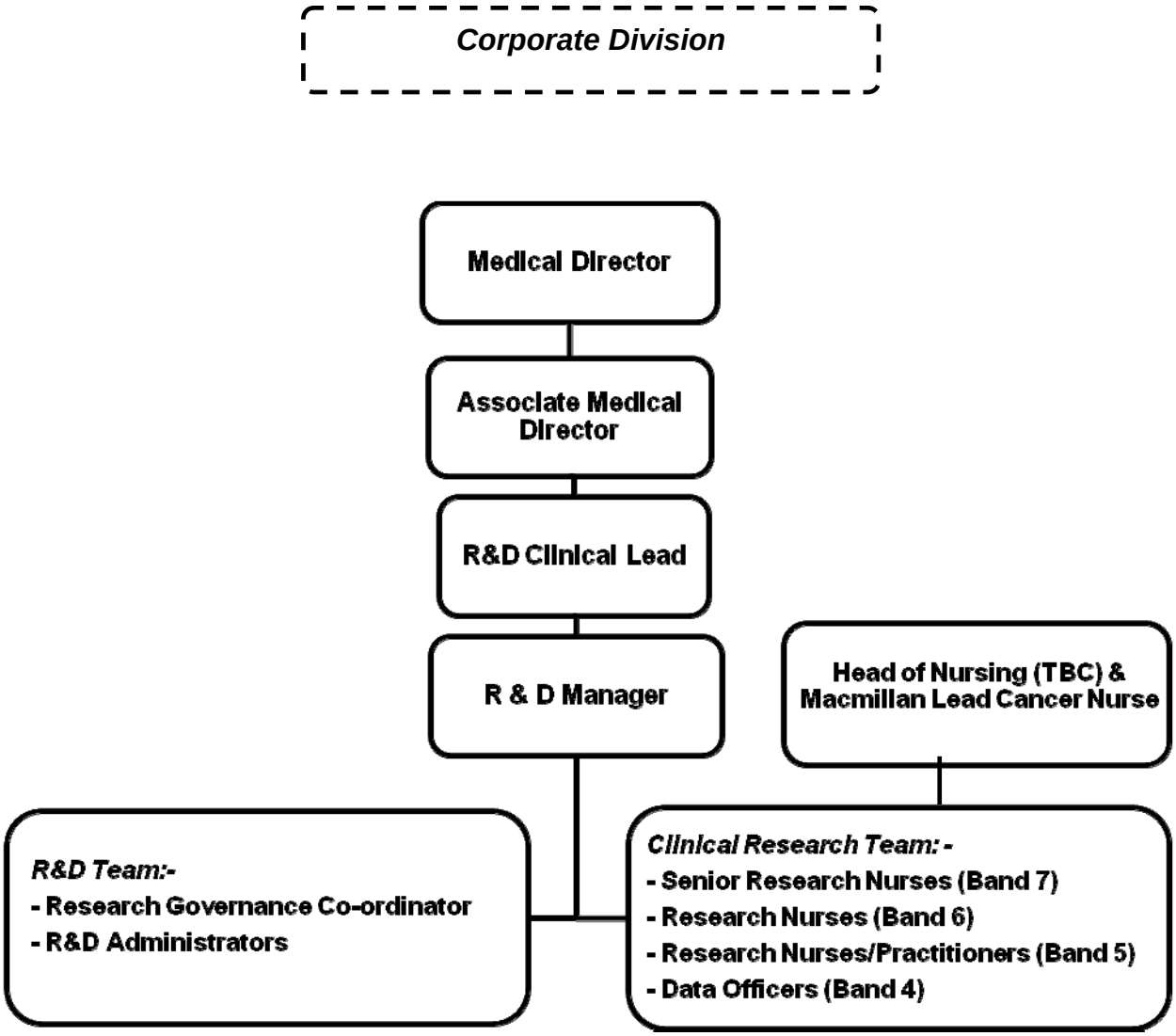
Portsmouth Hospitals NHS Trust (2011) Achieving Excellence in Clinical Research
The Way Forward. Research Strategy document
http://www.porthosp.nhs.uk/departments/Research/Research_Strategy_Jan_2011.pdf

Standards for Better Health. Healthcare Commission, 2004.
http://www.healthcarecommission.org.uk/homepage.cfm

Appendix 1

Revised staffing configuration:

The Research and Development Department is placed within Corporate Division (all in post)



East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	10
Subject:	Annual Report for Infection Prevention & Control 2013-14
Reporting Officer:	Dr David Hughes, Medical Director (Governance) Alice Webster, Director of Nursing

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

Purpose:

This paper sets out the key activities and achievements of the Trust relating to infection prevention and control during 2013-14.

Introduction:

This Annual Report has been developed in collaboration with key stakeholders in delivery of the IP&C Annual Programme of Work including Clinical Specialities and Corporate Departments. It highlights the key activities and achievements in relation to infection prevention and control during 2013-14 and provides a account of performance to enable planning of activities and managing risks going forward into 2014-15.

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

The Trust has continued to deliver reductions in both MRSA bacteraemia and *Clostridium difficile* infections. With four separate small outbreaks of CDI reported in 2013/14 however, it is recognised there is still room for improvement to reach the irreducible minimum number of cases and demonstrate evidence of no lapses in care contributing to the outcome of patients.

Investigations into the outbreaks and environmental audit reports identified areas for improvement in clinical practice, environmental condition and cleanliness and equipment cleanliness which has led to a series of actions and plans being put in place.

The Infection Prevention & Control team has had a challenging year to meet the increasing demand for a technical, clinical and service advice at a time when healthcare associated infections has remained high on the political and national healthcare agenda. The team has responded to meet these demands and expectations by prioritising the needs of the service. Within this context this has resulted in good levels of advice and support to staff and positive outcomes for patients in our care.

The Trust has demonstrated its commitment to reducing healthcare associated infections and values the specialist expertise and service provided by the team which will be expanded in 2014/15 to incorporate the National Specifications of Cleanliness audit team previously managed within the Facilities division which will enable rapid escalation of any concerns and focussed support where needed.

Benefits:

Provides a formal account of the activities and achievements in 2013-14 in relation to infection prevention and control.

Risks and Implications
Failure to improve upon measures to prevent cross infection and comply with Outcome 8 Regulation 12 “Cleanliness and Infection Control” will lead to a risk of harm to patients, inability to demonstrate compliance and increase the likelihood of adverse outcomes for the Trust.

Assurance Provided:
The Trust has demonstrated effective systems are in place to rapidly identify and manage outbreaks of infection in line with local and national guidelines. Risks identified during 2013-14 in relation to lessons learnt from outbreaks of CDI and assessment against Outcome 8 Regulation 12 were reviewed by the Trust Infection Control Group and areas for further improvement will be included in plans going forward into 2014-15.

Review by other committees / groups
Trust Infection Control Group 8th August 2014

Proposals and/or Recommendations
The Board is asked to review and approve the Annual Report for Infection Prevention & Control 2013/14 and the Annual Work Programme for 2014/15.

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

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Dr Barry Phillips, Director of Infection Prevention and Control Tina Lloyd, Assistant Director of Infection Prevention and Control	Barry.phillips@esht.nhs.uk Tina.lloyd@nhs.net

East Sussex Healthcare NHS
NHS Trust

INFECTION PREVENTION & CONTROL

ANNUAL REPORT
2013-14

CONTENTS

Executive Summary

This report outlines the activities of the Trust relating to infection prevention and control for the financial year 2013/14 and key achievements. It is presented to explain the Trust arrangements to allow early identification of patients with infections and measures taken to reduce the spread of infections to others. It also reviews the accountability arrangements, policies and procedures relating to infection control audit, surveillance and education.

Tackling infections is a key priority for the NHS and all NHS healthcare providers. Prevention and control of healthcare associated infections (HCAIs) has always been taken seriously by East Sussex Healthcare Trust which has developed programmes of activities to embrace national initiatives and reduce infection rates. Whilst the Trust employs a team of specialist nurses and support staff to advise and co-ordinate activities to prevent and control infection it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area.

The Trust reports performance and activities related to infection prevention and control regularly throughout the year to the local commissioning groups (CCGs).

The Infection Prevention & Control team works closely with other stakeholders in relation to strategies for prevention of infection including Public Health England, East Sussex County Council and Regional Specialist Laboratories and experts.

Support and guidance has been sought during 2013/14 from the Head of Infection Prevention and Control at the Trust Development Authority (TDA), London South who undertook a 2-day inspection in July 2013 followed by return visits to review progress during the year.

The Trust has continued to reduce both MRSA bacteraemia (bloodstream infections), reporting a single case in 2013/14, and *Clostridium difficile* infections (CDI) on previous years. Whilst the Trust did not meet its challenging objective for the reduction of CDI, reporting 43 cases against an objective of 25, a reduction of 8 cases (16%) was achieved from the previous year. The Department of Health has recognised that the reduction of *Clostridium difficile* in the UK has now slowed after previous successes and that the majority of cases reported in Trusts are no longer directly attributable to NHS treatment. It is more likely that they occur as a result of some people who carry C.*difficile* in their bowel who will develop symptoms due to their underlying clinical conditions or as a consequence of the antibiotics they have to take. Of the 43 cases reported by ESHT in 2013/14, six cases were found to be a result of transmission whilst in hospital. In future objectives for the reduction of CDI for NHS Trusts will be related only to those cases where a lapse in care is identified that has or might have contributed to the outcome of the patient in agreement with the CCGs.

The Infection Prevention & Control team has continued to co-ordinate the programme of activity related to infection prevention and control within the organisation, providing education and training, clinical advice and exploring new ways of engaging with clinical staff within the diverse organisation to reduce the risk of infection to patients in our care both in and out of hospital.

Tina Lloyd
Assistant Director of Infection Prevention & Control

1. Structure

The Director of Nursing is the Executive Lead for Infection Prevention & Control within the Trust.

The Deputy Chief Executive Officer is the Operational Lead for Infection Prevention & Control.

Dr Barry Phillips (Critical Care Consultant) holds the position of Trust Director of Infection Prevention & Control (DIPC) supported by Tina Lloyd, Assistant Director of Infection Prevention & Control (ADIPC).

During 2013-14 both the DIPC and the ADIPC reported to the Deputy CEO and the Director of Nursing. From the 1st April 2014 the DIPC will report directly to the Chief Executive Officer.

During the first part of 2013-14 each clinical department was grouped into 11 clinical units which reported into 3 clinical divisions (Integrated Care, Urgent Care and Planned Care). Each clinical division had a designated clinical lead for infection prevention & control with responsibilities including reporting from the Trust Infection Control Group to their divisional clinical governance meetings.

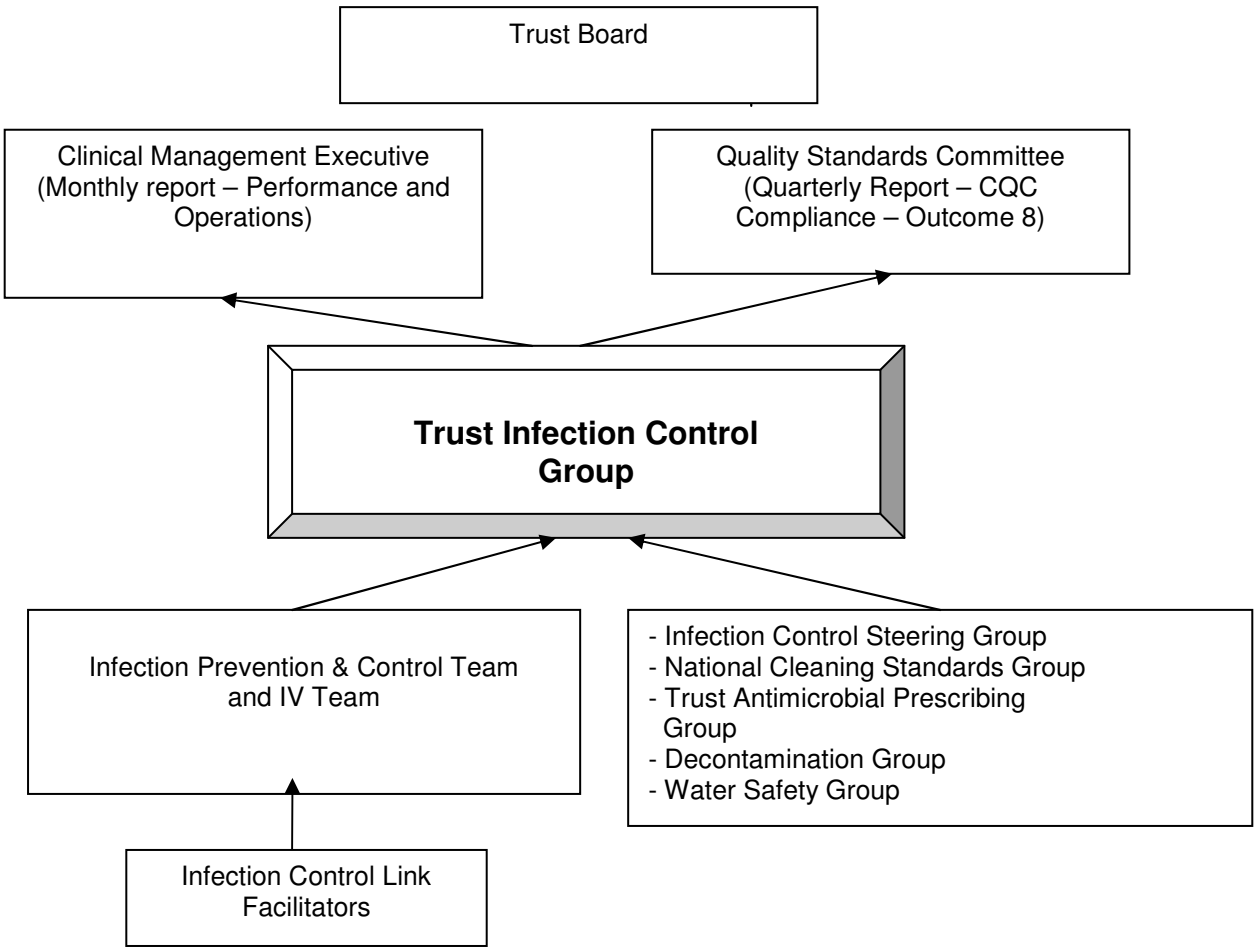
In the second half of 2013-14 the divisions were dissolved and an interim structure of 9 clinical units was put into place who report directly to the Director of Operations/Deputy CEO and Deputy Director of Operations. Each clinical unit has an appointed lead for governance and a nominated Assistant Director of Nursing (ADN) who reports on their behalf to the Trust Infection Control Group.

Clinical Matrons and Clinical Managers have the responsibility for the prevention and control of infection in their local area in line with national and local policies and guidelines. Each clinical department has appointed an Infection Control Link Facilitator who with educational support and guidance from the Infection Prevention & Control Team are responsible for cascading and monitoring compliance with infection prevention and control practices at local level.

The Trust Infection Control Group is chaired by the Director or the Assistant Director of Infection Prevention & Control. The Group meets monthly and has wide representation from throughout the Trust including from clinical units, occupational health, pharmacy, commercial division and also external membership from the local department of Public Health England (PHE). During 2013-14 the Trust Infection Control Group reported to the Trust Board via the Clinical Management Executive. From 1st April 2014 the Trust Infection Control Group will continue to report monthly to CME regarding performance and operational issues and will also report quarterly to the Quality & Standards Group regarding compliance against Outcome 8 Regulation 12 “Cleanliness and Infection Control” Health & Social Care Act 2008. (See reporting structure in 1.1)

The Terms of Reference for the Trust Infection Control Group were revised and approved in April 2014 to reflect the new reporting arrangements outlined above.

1.1 Infection Prevention & Control reporting arrangements



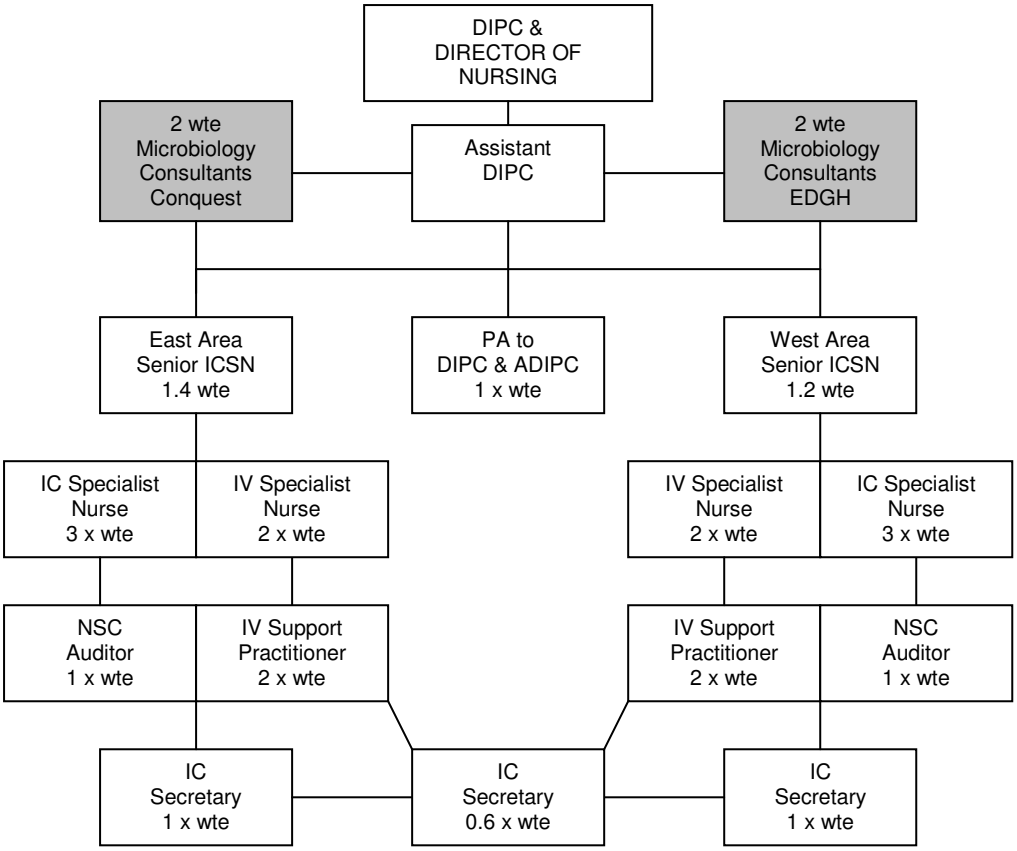
1.2 Infection Prevention & Control staffing

The Infection Prevention & Control team comprises of specialist infection control nurses, specialist intravenous (IV) therapy nurses, IV support practitioners and administrative staff and from the 1st April 2014 will also include the environmental audit team previously managed within the Facilities Department.

At the beginning of 2013-14 the infection control nurses formed three distinct teams providing services to the community areas, the Conquest Hospital and Eastbourne DGH. In addition the Trust also had service level agreements to provide a specialist dental infection control advice which terminated on 1st August 2013. The decision was made by the newly formed Local Area Team (LAT) of NHS England that this service would no longer be commissioned.

With the departure of the specialist dental post holder and a part time senior infection control nurse who led the community area team, the Trust infection prevention & control team undertook an interim restructure to ensure appropriate and adequate services and supervision of staff across the Trust. This interim structure will be reviewed in 2014-15 following the impending wider senior management organisational restructure.

Interim IP&C team structure



In addition to the IP&C team, the Trust also funds 4 x wte Consultant Microbiologist posts (2 on each acute site) based within Clinical Support CU who work closely with the IP&C team, one of whom holds the Lead Infection Control Doctor responsibility.

1 x wte Orthopaedic Surgical Site Infection Surveillance Nurse is appointed within the Musculoskeletal CU and 1 x wte Antimicrobial Prescribing Lead post is appointed within Pharmacy/Clinical Support CU.

Vacancies

During 2013-14 the IP&C team has recruited to 2 x wte IV Specialist Nurse posts and have welcomed the secondment of a Clinical Site Manager for six months to the west area team. There is currently 1 x wte vacant IC specialist nurse post pending either appointment or completion of the wider organisational restructure.

The loss of 2 x wte IC secretaries due to one post holder leaving and another on maternity had an impact on the workload of the clinical staff during 2013-14 which has resulted in them undertaking admin work in clinical time.

1.3 Infection Control Link Facilitators

At any one time there are between 80 – 100 Link Facilitators across the Trust. Infection Control Link Facilitators, with educational support and guidance from the Infection Prevention & Control Team, are responsible for cascading and monitoring compliance with infection prevention and control practices at local level. Those in high risk areas attend monthly meetings held by the Infection Control Team.

The ICLFs are provided with education and training from the specialist IP&C team and other relevant specialists. In addition the Trust also encourages and supports ICLFs to undertake further training to support them in their role. A number of ICLFs have completed a Level 7 module at Brighton University "Principles and Practice of Infection Prevention & Control".

The ICLFs are responsible for the completion of monthly hand hygiene audits, other Trustwide audits, cascade training and implementation of new policies and paperwork etc. under the guidance of the Infection Prevention & Control Team.

The results of the monthly hand hygiene compliance audits are readily available on the Trust electronic information system (EIS). Ward Matrons are required to report regularly to the Director of Nursing to provide evidence of action to improve if indicated. If repeated non-compliance by an individual member of staff is reported this is escalated to their line manager to performance manage.

1.4 Joint working across the local health economy

The Trust Infection Prevention & Control Team has worked closely with Clinical Commissioning Group (CCG) Quality Leads, East Sussex County Council Public Health Consultant and Public Health England (PHE) colleagues towards joint strategies for the reduction of healthcare associated infections which can lead to hospital admission. The Assistant DIPC reports monthly to the CCG Quality Performance Review Group (QPRG) and quarterly to the East Sussex HCAI Working Group.

The infection control specialist nurses are members of the Infection Prevention Specialists Regional Network Meeting who share and discuss local initiatives, innovations and work towards common goals across Sussex.

The Infection Prevention & Control team in collaboration with PHE, East Sussex County Council and the Network Group are focussing efforts on the reduction of catheter associated urinary tract infections. Educational events have been planned in 2014-15 to implement a catheter passport for patients with indwelling urinary catheters to promote best practice and reduce the risk of infection.

2. External Support

The Trust invited the Head of Infection Control for the Trust Development Authority (TDA South Region) to visit the Trust to review its action plan to reduce *Clostridium difficile* infection in 2013-14 and to provide additional support and advice in relation to infection control. A 2-day visit took place in July 2013 which resulted in recommendations and advice to the Trust on what more could be done to reduce the risk of infection.

The Trust developed a response document and action plan following the initial visit, progress against the plan has been monitored by the Trust Infection Control Group.

The Head of Infection Control for the TDA has continued to support the Trust throughout 2013-14 with return visits in October and December 2013 with further planned for 2014 onwards.

3. Compliance with Outcome 8 Regulation 12 "Cleanliness and Infection Control" Health & Social Care Act 2008

The Trust is required to undertake self-assessment against Care Quality Commission (CQC) standards and regulations, develop action plans for improvement if required and provide evidence of compliance, including against Outcome 8 which specifically relates to cleanliness and infection control.

During 2013-14 the responsibility for undertaking compliance against Outcome 8 was delegated to each of the Clinical Units co-ordinated by the Heads of Nursing and Governance and other departments within the Trust. Each area provided a quarterly report to the assurance team which in turn reported to the Quality & Standards Committee.

The Infection Prevention & Control Team reviewed this process along with the assurance team and senior managers and following a series of half-day education programmes with Ward Matrons, Heads of Nursing and the ICLFs a new process has been agreed and introduced from the 1st April 2014. In future wards and clinical units will be required to report compliance against Outcome 8 quarterly to the Trust Infection Control Group which will then report quarterly to the Quality & Standards Committee.

The Trust Infection Control Group now reviews and reports generic self-assessment against the whole of Outcome 8 and receives reports from local departments as evidence of compliance and assurance. The Annual Programme of Work 2014-15 will include priorities for action related to demonstrating compliance against Outcome 8.

4. Mandatory Surveillance

Some infections and micro-organisms are reported by the Trust to the Department of Heath as part of a national mandatory surveillance programme. The infections under greatest scrutiny are bloodstream infections due to Meticillin resistant *staphylococcus aureus* (MRSA bacteraemia) and diarrhoea due to *Clostridium difficile* infection (CDI).

Each NHS provider organisation is set annual objectives for the reduction of both MRSA bacteraemia and CDI.

East Sussex Healthcare Trust has shown a significant reduction in both infections over the last five years reducing MRSA bacteraemias by 95% and CDI infections by 78% since 2008/09.

It is recognised that not all cases of HCAI are avoidable hence the focus for infection prevention and control is on preventing avoidable harm. All cases of MRSA bacteraemia and CDI diagnosed and apportioned to the Trust are investigated by a root cause analysis (RCA) by a multi-disciplinary team to ensure any potential lessons learnt are acted upon and shared across the organisation.

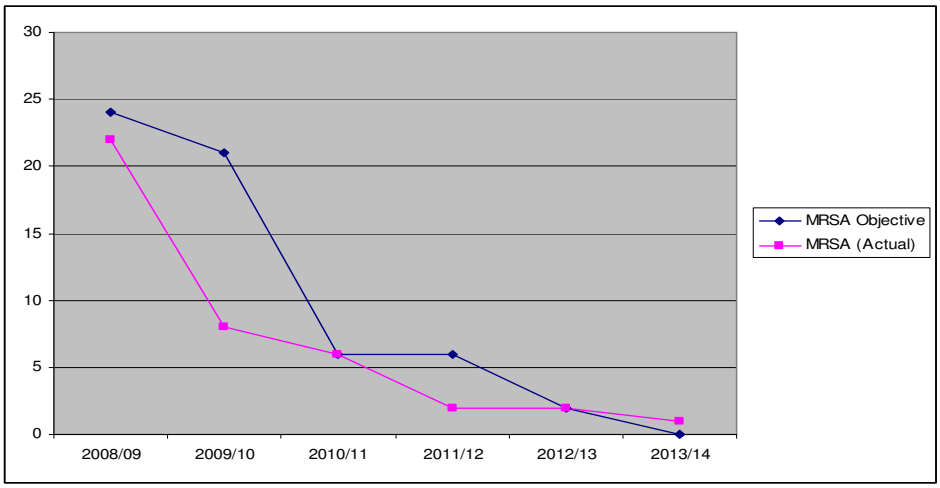
Since 2011, bloodstream infections due to meticillin sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* have been added to the national mandatory surveillance. However, these infections are more often community acquired and at the moment no hospital or Trust objectives for reduction have been set.

4.1 MRSA bacteraemia

A zero tolerance approach was given to cases of MRSA bacteraemia which could potentially be avoidable. East Sussex Healthcare Trust reported a single case of MRSA bacteraemia in 2013/14. This infection was related to a peripheral IV device used to provide essential nutrition to a patient who was unable to eat or drink. This type of IV therapy carries a risk of infection, particularly in patients with complex needs and high risk factors which can result in bacteria on the surface of the skin gaining entry into the body through the IV device.

The table below shows the number of cases of MRSA bacteraemia reported since 2008. It should be noted that prior to 2011 the data reported was for the previous acute organisation (East Sussex Hospitals NHS Trust) only.

Reduction of MRSA cases reported between 2008/09 and 2013/14



Now that the number of MRSA infections is very small the challenge for the Trust in the future is to prevent patients with MRSA colonisation of the skin developing subsequent infection when they have severe underlying conditions, poor skin or require the insertion of intravenous lines and other devices as part of their treatment. Regimes to screen all admissions and give topical antiseptics to the skin are in place for those patients with known MRSA colonisation. In 2014/15 revised Department of Health guidance is expected to be published that will recommend a move away from routine screening of all admissions for MRSA. This will result in the need to review the Trust policy for the control of MRSA and consideration of topical antiseptic regimes routinely for patients at risk and those most vulnerable rather than solely for those with known MRSA colonisation.

4.2 Clostridium difficile infection (CDI)

The number of *C.difficile* infections reported annually within the Trust is shown in the chart below. As with MRSA, the Trust has objectives for reduction in CDI. In 2013/14 the Trust reported 43 cases of CDI against a challenging objective of no more than 25. This represents a reduction of 8 cases (16%) on the previous year.

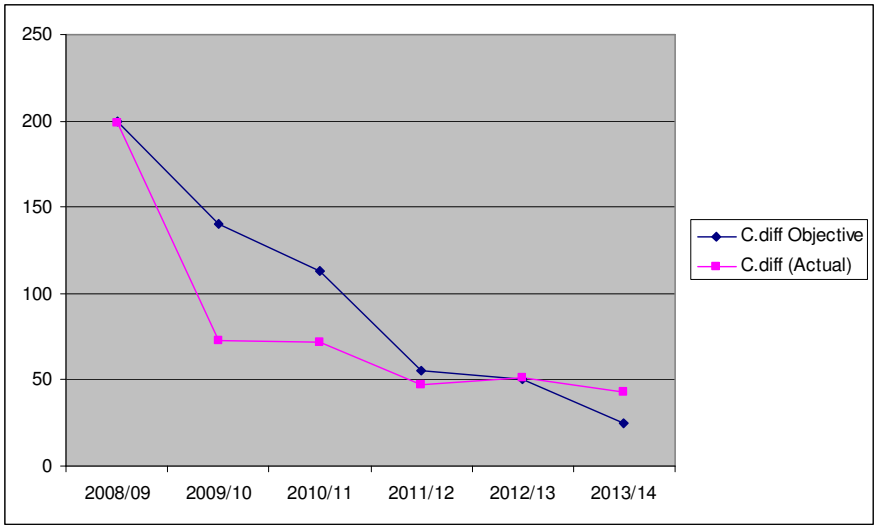
As with MRSA bacteraemia, cases of CDI are reviewed in detail. During the year, the majority of infections were sporadic. That is, there was no obvious connection between them to suggest that they were the result of transmission of CDI from one patient to another. Instead, they are more likely to have been brought into hospital at the time of admission.

In recognition of the often sporadic nature of CDI the Department of Health has revised the objectives for reduction of CDI for Trusts in 2014/15 so that where no lapses in care are identified for cases of CDI Trusts may appeal to their local commissioners for such cases not to count towards annual objectives. East Sussex Healthcare Trust is currently working with East Sussex Commissioners to agree a process and criteria for review of all such cases in future.

Where 2 or more cases were identified on the same ward, further tests were performed at a specialist reference laboratory to compare the organisms. In 6 cases there was evidence of spread on the ward which has been a cause for concern and has resulted in the Trust reporting serious incidents, focussed efforts in infection control practice and cleanliness and hygiene standards in the Trust.

The Trust deep clean programme is considered to be a major factor contributing to reduced incidence of CDI. It is likely that it also reduces the transmission of other organisms within the hospital environment. The Trust Infection Control Team continues to work with the housekeeping and operational teams to facilitate the delivery of a rolling programme of decanting wards into a vacant facility. Cleaning is more thorough when the ward is empty and hydrogen peroxide vapour (HPV) can be used to improve cleaning efficacy. Ongoing demands on bed capacity in the Trust mean that there is great pressure on wards at times when admissions increase and the deep clean programme is interrupted or postponed as a result. Nevertheless, it is still recognised to be an important component of the Trust's strategy for infection prevention and control.

Reduction of CDI cases reported between 2008/09 – 2013/14



4.3 Surgical Site Surveillance

Surgical procedures can be complicated by infection. Most commonly this is a minor infection of the surgical wound although more serious infection occasionally occurs. The risk of infection varies with the particular type and site of surgery. Therefore, surgery associated with the gastrointestinal tract, for example, has a much higher infection rate than "clean" surgery such as insertion of prosthetic hip joint.

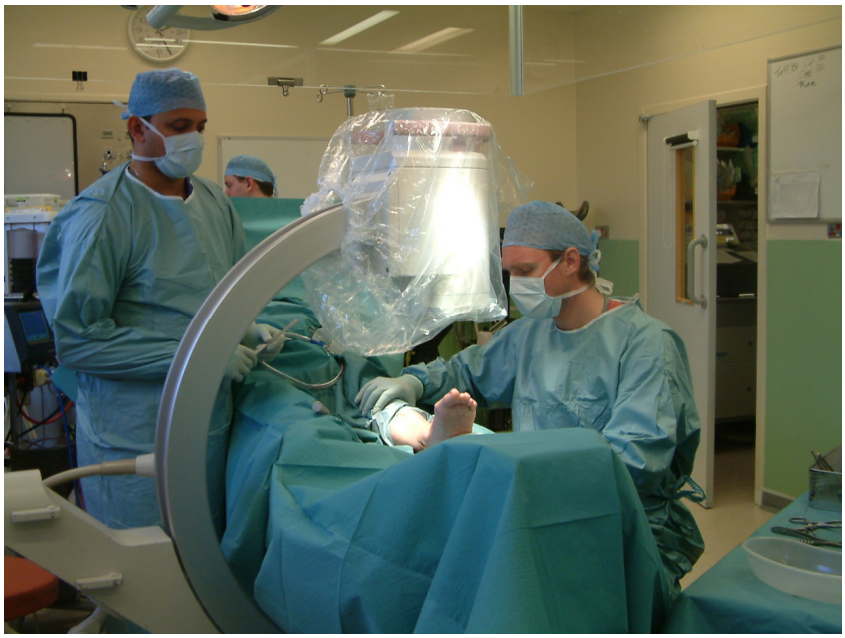
Surveillance of surgical site infections can be used as one measure of the quality of surgery, to identify where further investigations or improvements might be required. Ongoing active surveillance of hip and knee replacement surgery is a mandatory requirement of all NHS provider trusts to identify any episodes of infection up until a year after surgery. Routine standardised surveillance of SSIs enables trusts to compare their infection rates against a national benchmark, providing a means of identifying and investigating rates and causes of SSIs. The surveillance is managed by Public Health England (PHE), formerly the Health Protection Agency on behalf of the Department of Health.

Surgical site infection surveillance is required in at least 1 orthopaedic category over a minimum of 3 calendar months per year. East Sussex Healthcare Trust undertook surveillance of both hip replacement and knee replacement SSIs for 9 months during 2012/13, including any revision surgery in both categories.

The surveillance is undertaken by a dedicated surveillance nurse appointed within the orthopaedic department.

Category of surgery	Number of procedures	Number of infections	Infection rate	Mean infection rate for all participating Trusts
Total hip replacement	422	7	1.6%	0.7%
Total knee replacement	299	3	1.0%	0.6%

Surgical site infection rates for both hip surgery and knee replacement surgery were higher than the mean, even allowing for the small number of patients involved. As a result, enhanced analysis of the surveillance data has been performed locally. The infection rates for individual surgeons did not show any specific areas of concern due to the small numbers. Therefore, no specific correctable reasons for the surgical site infections were identified. However, procedures to reduce the risk of post operative infection continue to be reviewed by the musculo-skeletal clinical unit.

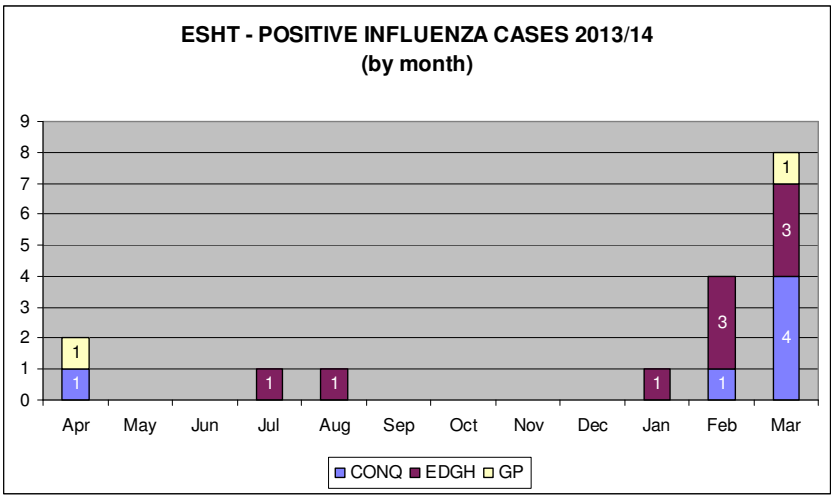


4.4 Influenza

Whilst there was no national surveillance programme for influenza all acute provider trusts were required to report on a weekly basis during the influenza season the number of cases of influenza requiring intensive care to determine the burden on critical care units nationally.

Within ESHT a total of 193 patients were tested for influenza during 2013/14 (both GP and inpatient samples), 176 resulted negative and 17 resulted positive (8.8%). Of the 17 positive cases 15 required inpatient admission and 6 required ICU admission. None of the positive cases were acquired within the healthcare setting.

The chart below shows the number of cases, location and distribution throughout the year.



5 Incidents related to infection

The Trust reports outbreaks of infection as serious incidents to the local Clinical Commissioning Groups (CCGs). These include incidents where there has been a significant impact on the running of the Trust's services (ward closures for example), or where there has been a severe impact on patient outcome.

In 2013-14 the Trust reported 7 serious incidents related to infection. These included 4 separate outbreaks of CDI resulting in 6 new cases (mentioned previously). The remaining 3 were an outbreak of Norovirus at the Conquest Hospital, Hastings, an outbreak of Glycopeptide resistant *enterococci* (GRE) amongst a high risk patient group at Eastbourne DGH and 1 patient who died as a result of CDI (diagnosed within 24hrs of admission). These 3 serious incidents are summarised below:

5.1 Norovirus outbreak (Winter vomiting disease)

Norovirus infection causes a short lived vomiting and diarrhoeal illness, which is very readily transmitted from one person to another. As a result it causes problems in hospitals, schools and other places where people congregate together and outbreaks may occur. Epidemics of infection occur throughout the country typically between October and May every year (hence the name winter vomiting disease).

Norovirus infection is seen every year in the Trust and proactive measures are taken to limit the impact of outbreaks on patients, staff and the running of the Trust services. These include, for example, awareness campaigns within the hospitals and in collaboration with the local media, limiting the number of visitors and rapidly isolating or cohorting patients with suspected symptoms to limit the risk of transmission.

In spite of these measures, outbreaks of Norovirus infection do occur and are managed according to national and local guidance.

In 2013/14, although there was a reduction in the overall burden of the number of patients and wards affected by Norovirus replicating the national picture, an outbreak at the Conquest hospital which began in late March 2014 was reported as a serious incident due to the significant impact on acute medical admission services. Three medical wards were closed temporarily to new admissions due to confirmed Norovirus and a 4th ward was partially closed and investigated at the same time. A multi-disciplinary outbreak control group was convened and enabled the outbreak to be

controlled and its duration and impact on services to be limited to the minimum possible. Services were temporarily re-provided in other areas of the Trust to minimise the impact on patients and essential services.

5.2 Glycopeptide resistant enterococci (GRE)

Glycopeptide resistant *enterococci* (GRE) is a term used to describe enterococcal species that have become resistant to the effects of the Glycopeptide group of antibiotics.

GRE bacteria usually tend to cause colonisation (harmless carriage) in humans rather than infection. However, when they cause serious infection they can be difficult to treat due to reduced treatment options. Hospital outbreaks of GRE have been reported mainly in transplant, haematology, renal dialysis and intensive care units.

Due to the risk factors in this patient group the haematology inpatient ward at EDGH has a robust and routine screening programme for all inpatient admissions to detect potential GRE carriage and possible cross infection. An outbreak was detected in December 2014 as a result of this screening programme and an outbreak control group was convened to agree an appropriate management plan and control measures in line with recommended guidelines and within current resources.

It is recognised by the Trust that the current inpatient accommodation at Eastbourne DGH requires improvement to reduce the risk of cross infection in this high risk patient group by providing separate inpatient and day care facilities and adequate isolation facilities. Due to the significant expenditure required to complete this project, a business case to provide this accommodation is awaiting approval by the national Trust Development Authority (TDA). In the interim alternative accommodation for the day care patients will be provided in a separate area from May 2014, once available.

5.3 CDI mortality

As a requirement agreed with our local CCGs, when the main cause of death is reported as CDI for any patient within ESHT, the Trust routinely reports the case as a serious incident to ensure a full investigation is undertaken into whether the patient had been diagnosed and treated appropriately and in line with local and national guidance.

One case was reported in December 2013 in a patient with a community acquired infection diagnosed within 24hrs of admission to hospital for acute medical treatment. The investigation confirmed that the patient had been diagnosed and treated appropriately once admitted to East Sussex Healthcare Trust including prompt isolation and treatment on the dedicated Gastroenterology Ward with multi-disciplinary expert advice on the management of CDI.

6 Infection Prevention Activities and Innovation

6.1 Hand Hygiene Promotion

The Trust Infection Prevention & Control Team co-ordinates an annual programme to promote effective hand hygiene throughout the organisation including;

- Monitoring of compliance by clinical staff with monthly audits.

- Award and presentation of a monthly Hand Hygiene Cup to the ward or area who has demonstrated the greatest achievement
- Monthly hand hygiene promotional posters
- Series of focussed hand hygiene promotion events for staff and patients including participation in International Hand Hygiene Day on 5th May 2013 which promotes the World Health Organisation (WHO) "5 moments of hand hygiene"
- Training of ICLFs to facilitate cascade training at local level of practical hand hygiene technique.
- Providing training of all staff on induction (joining the organisation) and at regular mandatory updates.
- Ad-hoc training when indicated for focussed improvement.
- Actively promoting hand hygiene by patients and seeking opportunities to listen to their views and respond to improve patient experience.
- In collaboration with local schools and businesses encouraged education for children and young people in hand hygiene including a hand hygiene poster colouring competition which received 402 entries, judged by the Director of Nursing.

WINNING POSTER

6.2

International Infection Prevention Week – 20th – 26th October 2013

The Trust IP&C team used the opportunity during International Infection Prevention Week to lead and influence activities to promote best practice in infection prevention and control. This included a focus on five different audits related to key areas in preventing infections in hospital, as follows;

Day 1	Equipment cleanliness
Day 2	Hand Hygiene by staff
Day 3	Isolation precautions
Day 4	Management of Intravenous (IV) devices
Day 5	Patient focus on infection control

6.3 Other audit activity

The Trust IP&C team co-ordinates a number of planned and unplanned audits throughout each year to monitor compliance with core infection prevention and control standards and any areas of risk or concern which may arise as a result of incidents. In addition to the five audits undertaken during International Infection Prevention Week the following were also undertaken;

- Monthly staff hand hygiene audits
- Ad-hoc and planned environmental audits
- *C.diff* audits
- MRSA screening audit
- Universal Precautions audit

In addition the IP&C team also support other disciplines with Trustwide audits, for example;

- National Specification of Cleanliness audits led by the Facilities team
- Audit of bed mattresses led by the Tissue Viability Team

6.4 Training and Education

The IP&C specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required. For example;

- Mandatory training on induction for all staff and volunteers
- Annual updates for clinical staff, patient facing staff, food handlers and other high risk groups
- 3-yearly updates for non-clinical, non patient facing staff
- Regular training sessions to monthly ICLF meetings for cascade
- Ad-hoc training where identified due to service need or clinical incidents (serious incidents for example)
- Induction training programme for new ICLFs

- Support other multi-disciplinary training events e.g. urinary catheter, intravenous therapy training days and other local health economy events involving independent care providers.
- Education sessions provided at Brighton University, Falmer site to support the delivery of the module related to principles and practice of infection prevention and control for healthcare professionals
- Train the trainer sessions in Hand Hygiene and Fit Testing of FFP3 masks (cascaded by ICLFs)

Compliance with attendance at mandatory induction and update sessions is monitored by the Trust along with other mandatory components of the Trust mandatory training programme.

6.5 Professional Development

All specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings.

Two members of the team attended a 3-day annual conference held by the Infection Prevention Society in London in September/October 2013. Both members of the team have used new knowledge and guidance from the conference to influence service development within the team including reviewing the way we deliver education and engage staff and looking at new ways of gaining validation of regular hand hygiene audits.

The Assistant Director of IP&C is currently being supported to undertake a Masters degree in Professional Development & Innovation including attendance at a one-week residential foundation school in professional development.

One of the Infection Control Nurses completed a Level 7 module in Principles and Practice of Infection Prevention & Control at Brighton University.

A member of the administration team has been supported to complete an Access to Nursing course and has since been offered place to commence nurse training in September 2014.

The Senior Infection Control Nurses benefitted from facilitation of Action Learning Sets by the Learning & Development team. The sets are designed to create an environment where team members are able to reflect on their learning and practice, share their experiences and explore new ways of working and solutions to any problems in the workplace.

One of the Infection & Control Nurse Specialists completed an in-house leadership course as part of her personal and professional development.

As well as utilising the in-house Learning & Development training programme team members have been supported in attending other essential specialist training required to maintain their professional practice required to provide education and training to others in the organisation including:-

- Infection Prevention Society, London South Branch development days
- Aseptic Non-touch Technique one day conference

- Reducing Surgical Site Infections conference
- Hand Hygiene Conference
- Endoscopy Decontamination
- Non-medical prescribing update
- HIV updates

6.6 Engaging Staff

One of the key concerns of patients being admitted into hospital is related to risk of infection and feeling assured they are being cared for in a safe clean environment. The IP&C team implemented a comprehensive re-training programme for all nursing and cleaning staff in collaboration with the housekeeping team of inpatient bed space cleaning. The protocol and the programme ensures that every piece of equipment and the environment surrounding each patient bed space is clean and inspected as fit for purpose before admission of each patient. When patients were asked in the patient focus audit held in October 2013 what they felt the Trust was doing well in relation to infection prevention and control, the most common positive feedback was related to the cleaning witnessed on the wards by nursing and housekeeping staff.

The IP&C team co-ordinated staff engagement conversations led by the Chief Executive and the Director of Nursing related to infection prevention and control as part of the "Listening into Action" programme (LiA). The events enabled staff from all disciplines with support of Senior Executives and Sponsors to feel empowered to implement their own local initiatives to improve infection prevention and control practice in their own teams.

Following the LiA events and learning from feedback from participants, the IP&C team held a series of half-day Infection Prevention & Control Workshops attended by Heads of Nursing, Ward Matrons and ICLFs to promote local ownership and accountability for the delivery of safe clean care and compliance with CQC standards for cleanliness and infection control. The events were supported by the Head of Person-centred Research & Practice Development. After the events participants were given the opportunity to evaluate their learning and give feedback on the sessions and on how the team could improve the infection prevention and control service to meet their needs. The evaluation and feedback from the event was extremely positive with the majority of participants reporting they felt inspired and had benefitted from the novel participatory approach to the workshops, compared to traditional conference style events held previously.

7. Intravenous Therapy Team Activities and Innovation

The IV Team is an integral component of the Infection Prevention & Control Service with specific and distinct roles and responsibilities. Management and service development is led by a Senior Infection Control Nurse. The team consists of two lead IV nurses, two specialist IV practitioners and four support staff based at Conquest Hospital and Eastbourne DGH (see Section 1.2).

The team provides a 7 day service, including Bank Holidays, from 8am – 7pm in the acute hospital sites. Long line insertions are usually undertaken Mondays – Fridays by the IV Team Lead and IV Nurse Specialist Practitioner.

The team support clinical staff in providing intravenous therapy to inpatients at ESHT and also support community based staff as requested. There are also a small number of patients who regularly access the specialist services of the team as outpatients.

7.1 Clinical Practice

The IV team undertook more than 13,000 procedures during 2013/14 to enable essential intravenous therapy for inpatients and to facilitate patients being discharged home to receive medium to long term treatment in the community, see details in the table below.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Monthly Average
Leaderflex insertion	4	4	1	3	2	5	6	9	16	15	4	11	**80**	**6.7**
Cannulations	655	672	554	539	610	503	466	483	465	462	325	482	**6216**	**518.0**
Blood tests	368	355	422	335	334	312	291	301	324	331	247	359	**3979**	**331.6**
Change of Dressings	48	142	121	138	137	111	102	110	146	137	68	109	**1369**	**114.1**
PICC Insertion	38	25	28	46	64	36	44	37	33	34	18	20	**423**	**35.3**
Midline insertion	2	12	12	12	5	10	11	10	16	5	13	12	**120**	**10.0**
Failed Attempts (bloods and cannula)	24	19	12	30	25	18	27	20	22	29	21	24	**271**	**22.6**
Troubleshooting and cvc review	62	60	55	69	21	43	59	41	59	71	21	60	**621**	**51.8**

In addition the team has also provided clinical supervision to clinical staff gaining competence in IV skills and assisted with insertion and troubleshooting of portacaths (a device inserted into patient's chest which provides a portal for long term infusions.

Cannulation (the insertion of peripheral IV devices) is the highest demand to the service which is required by many inpatients for essential treatment. The specialist skills of the team are best utilised with patients who have difficulty with cannulation. Cannulation training is also provided by the IV specialist practitioners to multi-disciplinary staff within the Trust. After initial training staff are required to demonstrate competency in practice before going on to practice cannulation independently. The IV team is working on strategies to ensure staff gain opportunities to complete their competency assessments.

General blood sampling (non blood cultures) are undertaken by other clinically trained staff and the Trust phlebotomy service. The IV team's expertise is used for more specialist tests like blood cultures. Blood culture samples require expert skill in aseptic non touch technique when collecting the sample to avoid contamination and spurious results. The IV team not only undertake blood culture collection as a routine part of the service, they also train and assess other staff competency in this procedure

The number of long line insertions varied depending on staffing within the team. A specialist nurse left the team which resulted in a vacant position for several months on the Conquest site. As an interim measure the interventional Consultant Radiologist at Conquest has supported service delivery with placing PICC lines when the IV specialist service was restricted. The numbers of lines inserted by interventional radiology is not shown in this report.

Daily routine checking of venous access documentation (VAD) is undertaken on the ward for patients with PICCs, Midline and LeaderFlex devices. The IV Team changes the dressing and assesses the line within the first 24hrs post insertion and every seven days thereafter

7.2 Training and Education of clinical staff

The IV therapy service provides a comprehensive training and education programme for Trust clinical staff related to IV insertion, line care and blood culture collection.

- Monthly Vene-cannulation training
- Blood cultures for 5th year medical students (six times a year on both acute sites)
- Formative OSCE for blood culture annually
- Blood culture and cannulation with FY1 and FY2 doctors as part of their induction
- Blood culture assessment for doctors and nurses
- Mentoring new doctors and nurses with vene-cannulation technique
- Advocating best practice with highlighting Aseptic Non-Touch Technique (ANTT) principles and adherence to infection prevention and control practices, to all healthcare workers
- Promoting vessel health preservation
- New for 2013/14: Training on Vascular Access Devices offered on both acute sites monthly to update staff on good clinical practice.
- New for 2013/14: A new programme of training for IV additives has been introduced for acute and community Trust staff to access. This training also provides an opportunity to practice ANTT.

7.3 Review of products for quality and costs saving

The team has worked with the Trust Procurement team to agree alternatives to blunt fill drawing up and blunt fill filter needles for routine use in clinical areas, which has resulted in cost savings as well as promoting best practice.

The use of Chlorhexidine (antibacterial) impregnated PICC dressings has been introduced within clinical practice for all inpatients with PICC lines to reduce the risk of infection in these specialist devices.

The IV service continuously reviews the efficacy of products used in relation to IV care to ensure the most cost effective and safest products are available to reduce the risk of infection in patients requiring IV therapy.

7.4 Professional Development

All specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings. A member of the team attended the annual ANTT conference. The newly appointed IV practitioner at the Conquest is undergoing training and competency assessment in PICC line insertion.

7.5 Service Development

Leaderflex and midline insertion already in place at Eastbourne DGH was introduced at the Conquest hospital in 2013/14. This allows greater flexibility and choice for intravenous access to meet individual patient needs whilst being cost effective for patients who require intravenous access for six weeks or less.

The team led a Listening into Action (LiA) initiative sponsored by the Deputy Chief Executive to identify ways of improving the service. As a result of this, charitable bids

submitted to the League of Friends at both Eastbourne DGH and Conquest Hospital were successful. Two *Nautilus* machines have been purchased, one for each acute site which enables the IV team to quickly locate the tip of the PICC line using ECG technology to confirm that the PICC is safe and ready to use without the need for an x-ray. The benefit to patients will be the ability for the line to be used immediately after placement, reducing any potential delays in treatment.

Two new training arms have been purchased from monies secured via Learning and Development which will enhance the ability to train medical and nursing staff on cannulation and blood culture taking. These arms can also be utilised by the IV additives training.

The IV team has relocated to offices which enables close working with the IP&C team. As part of the reorganisation, a new store room facility has been provided which has improved storage of sterile IV equipment. The room also offers the potential to accommodate some clinical interventions for ambulatory patients if service development requires.

8. Housekeeping Services

The housekeeping services for ESHT are provided by an in-house team within the Facilities Division of the Corporate Directorate. The housekeeping services and establishments have been under review during 2013/14 to standardise working practices across the localities including acute hospitals, community hospitals and various health centres and clinics.

8.1 Deep clean programme

An important part of the Housekeeping service is the annual deep clean programme to support the reduction of infections and meeting the Care Quality Commission (CQC) standard Outcome 8 Regulation 12 “Cleanliness and Infection Control” Health & Social Care Act 2008. The housekeeping team works in partnership with IP&C and operational teams to ensure delivery of the plan. This plan allows intensive cleaning and decontamination whilst areas are vacant and some remedial maintenance works to be undertaken. Communication between parties is structured and clear plans put in place at all levels to ensure the disruption to patients is minimised. The plan is often

postponed or halted due to bed capacity and service demands; however a flexible approach is required in delivery as it is recognised as an important part of the requirement of the NHS National Specifications of Cleanliness to support the reduction of infections.

8.2 Activity

The demand for housekeeping to respond to terminal cleans or deep cleans related to known or suspected infections increased during 2013/14. On average, each acute site completes 200 requests for deep cleans and 25 requests for decontamination each month. To meet this demand the housekeeping department has improved the way it responds to infection cleans in partnership with the IP&C team.

To support the delivery of the increased demand the Rapid Response Team service hours have been increased on both acute sites to 24hrs a day, 7 days a week to respond to any requests to support patient flow. The team also supports the community sites for infection deep cleans.

8.3 Service development

Twelve Hydrogen Peroxide Vapourisation (HPV) machines, which destroy organisms present in the environment, have been leased so that the housekeeping department have machines available to react to any HPV decontamination requests. These machines are portable and can be transported to any of the ESHT sites which has enabled the housekeeping department to increase the HPV treatments into all community sites within ESHT with support of a vehicle based at Eastbourne DGH.

9. Antimicrobial Stewardship Activities and Innovation

The Trust has an established Antimicrobial Stewardship Group (ASG) which has a core membership of an antimicrobial pharmacist, consultant microbiologist, medical consultant and a CCG representative. The purpose of the ASG is to support the prudent prescribing of antimicrobials to reduce antimicrobial resistance rates. It does this by:

- Developing and maintaining evidence based on antimicrobial policies and guidelines for use in secondary and primary care
- Ensuring safe and cost effective use of antimicrobials taking local, national and international bacterial resistance rates into account.
- Monitoring antimicrobial usage and compliance to policy and addressing any issues that may arise.
- Providing advice to other specialist groups/committees on use of antimicrobials
- Providing education to staff on all matters relating to prescribing and administration of antimicrobials.
- Educating patients and members of the public on antimicrobial stewardship.

During the last financial year the activities of the ASG were as follows:

9.1 Antimicrobial Prescribing Policy

The Antimicrobial Prescribing Policy for Adults and Children which contains the antimicrobial formulary of drugs was updated and revised in 2013/14. The policy contains peer-reviewed, evidence based guidelines on common infections and a large number of specialist consultants were involved. Additional chapters such as Treatment of Sepsis and Treatment of Paediatric Infections were also added. The Antimicrobial Prescribing Policy is available on the staff Extranet for easy access by staff in areas where patient related activities take place.

The Antimicrobial Prescribing Policy was also summarised and printed onto pocket sized summary cards which were then distributed to all training grade doctors for easy access to the policy at point of care (i.e. at patient's bedside).

9.2 New antibiotic introduction

The ASG successfully introduced a new antibiotic called Fidaxomicin for the treatment of recurrent *Clostridium difficile* Infection (CDI). A formulary submission (similar to a business case but for a drug) was drawn up and submitted to Medicines Management Group for approval. This antibiotic is now used for treatment of cases that fit the appropriate criteria.

9.3 Multi-disciplinary Ward Rounds

The lead antimicrobial pharmacist and consultant microbiologist participate in daily Intensive Care ward rounds and weekly *Clostridium difficile* Infection and orthopaedic infection ward rounds at both acute sites. This is in order to provide specialist input into the highest risk/most critical patients in the hospitals.

9.4 Medication Prescribing Chart

The ASG was also heavily involved in the design of a new medication prescribing chart for the trust. This was to reduce inappropriate prescribing of antimicrobials which drives patient safety, low bacterial resistance rates, reduction in CDI rates and complies with national standards. A dedicated section on the chart was also designed for Vancomycin and Gentamicin which are two antibiotics that are toxic to the kidneys and require blood levels taken regularly.

9.5 Training

The ASG has reviewed the e-learning module on antimicrobial prescribing which is an internet based programme on antimicrobial prescribing, with an assessment that all new doctors have to pass at induction and all trust doctors have to undertake every three years. There are further discussion to create a version for pharmacists and nursing staff.

9.6 Admission Avoidance Pathways

In conjunction with Commissioners and Primary Care, ASG developed Admission Avoidance Pathways which are processes developed to keep patients out of acute care and treat common infections with intravenous antibiotics at home via GP's and district nurses. These pathways will be developed as a full Outpatient Antimicrobial Treatment service which means patients can be treated at home for serious infections such as chest infections, urinary tract infections and cellulitis avoiding hospital admission.

9.7 Smartphone App

Currently the ASG is applying for funding to create a smartphone app of the antimicrobial policy so that prescribers can download it onto their smartphone and use as required instead of carrying disposable cards. This innovative approach has been taken up by a number of trusts nationally.

9.8 European Antibiotics Awareness Day

The lead antimicrobial pharmacist spearheaded a campaign on November 18th which was called European Antibiotics Awareness Day. This day was marked to educate patients and the general public on antibiotics. Activities undertaken were posters in common areas, articles in local bulletins, on the internet and handing out of leaflets.

9.9 Antibiotic prescriptions / algorithms

The lead antimicrobial pharmacist has also created algorithms for clinical pharmacists to follow when presented with antimicrobial prescriptions on their wards. These are meant to aid pharmacists query prescriptions, appropriately switch from intravenous to oral antibiotics and how to dose toxic antibiotics. This helps reduce inappropriate prescribing, switching early to oral antibiotics and reduces risk to patients from side effects, multi-resistant bacteria, hospital acquired infections.

9.10 Audits

The lead antimicrobial pharmacist also conducts monthly snapshot audits to monitor the quality of antimicrobial prescribing within the trust. This is done at ward level by clinical pharmacists and helps ascertain any issues with prescribing that is then dealt with by the ward pharmacist.

9.11 Incident reports

The lead antimicrobial pharmacist is also involved in reviewing of incident reports involving antimicrobials and also participates in root cause analysis of patients who have come to harm where antimicrobials may have directly or indirectly been involved such as RCAs of *Clostridium difficile* cases.

10. Summary and Conclusions

The Trust has continued to deliver reductions in both MRSA bacteraemia and *Clostridium difficile* infections. With four separate outbreaks of CDI reported in 2013/14, however, it is recognised there is still room for improvement to reach the irreducible minimum number of cases and demonstrate evidence of no lapses in care contributing to the outcome of patients.

The Infection Prevention & Control team has had a challenging year to meet the increasing demand for a technical, clinical and service advice at a time when healthcare associated infections has remained high on the political and national healthcare agenda. The team has responded to meet these demands and expectations by prioritising the needs of the service. Within this context this has resulted in good levels of advice and support to staff and positive outcomes for patients in our care.

The Trust has demonstrated its commitment to reducing healthcare associated infections and values the specialist expertise and service provided by the team which will be expanded in 2014/15 to incorporate the National Specifications of Cleanliness audit team previously managed within the Facilities division which will enable rapid escalation of any concerns and focussed support where needed.

The interim structure implemented to immediately address the whole service needs at the end of 2013/14 will be formally reviewed during 2014/15.

	No progress or beyond target date Immediate action required.
	Progress made or within target date. Requires further action
	Activities on schedule. No further action required.
	Completed and closed

INFECTION PREVENTION & CONTROL

ANNUAL PROGRAMME OF WORK 2014 /15

Version	Date Ratified	Name of Committee/Board/Group
V2	12/09/14	Trust Infection Control Group

Introduction

During 2013/14 huge efforts were made in tackling incidents of healthcare associated infections in our acute and community settings.

The Trust has made a commitment to deliver better health outcomes for patients by outlining its objectives to:

- Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority,
- Play a leading role in local partnerships to meet the needs of our local population and improve and enhance the patients experience,
- Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially stable.

This Annual Programme of Work has been developed in line with the Trust objectives to provide a framework of activities required during 2014/15 to demonstrate compliance against Outcome 8, Regulation 12 “Cleanliness and Infection Control” of the Health & Social Care Act 2008.

Key priorities have been identified taking into account:-

- Self assessment against Outcome 8, Regulation 12
- Acting upon lessons learnt from incidents related to infection prevention and control in 2013/14
- Reducing healthcare associated infections to meet national and local objectives

This document is formally approved and monitored by the Trust Infection Control Group (TICG) and reported to the Trust Board.

Tina Lloyd
Assistant Director of Infection Prevention & Control

Dr Barry Phillips
Director of Infection Prevention & Control

Key Priorities 2014/15

1	Demonstrate compliance with Outcome 8 Regulation 12, Health & Social Care Act 2008 'Cleanliness and Infection Control'
2	Provide a sustainable infection and control infrastructure to manage the risks related to infection prevention and control
3	Mandatory surveillance and monitoring of healthcare associated infections
4	Reduction of healthcare associated infections
5	Programme of audit of infection control practice
6	Provide and maintain a clean environment
7	Education and training programme for Trust staff
8	Antimicrobial strategy
9	Revision of infection control policies, guidelines and patient information leaflets
10	New and Emerging Threats, Policies and Guidelines
APPENDIX 1	Intravenous Therapy Service Specific Programme
APPENDIX 2	Carbapenemase-producing Enterobacteriaceae, Trust Action Plan 2014 / 2015
APPENDIX 3	Flu Action Plan

1 Demonstrate compliance with Outcome 8 Regulation 12, Health & Social Care Act 2008 'Cleanliness and Infection Control'

The Code of Practice for health and social care on the prevention and control of infections outlines what registered providers of health and social care services should do to ensure compliance with the Care Quality Commission (CQC) registration requirement for cleanliness and infection control. East Sussex Healthcare Trust must ensure systems and processes are in place to continuously monitor and demonstrate compliance to meet CQC registration requirements.

	Action	Target date	Lead responsibility
1.01	Overall Trust compliance against Outcome 8 Regulation 12 will be assessed quarterly by the Trust Infection Control Group (TICG) based on evidence provided quarterly by the Assistant Director of Infection Prevention & Control (ADIPC) compiled in collaboration with relevant speciality leads.	April 2014 July 2014 October 2014 January 2015	Tina Lloyd, ADIPC
1.02	The ADIPC will provide a report of compliance, approved on behalf of the TICG, quarterly to the Quality & Standards Committee to provide assurance and identify areas of concern or where improvement may be required for escalation to the Trust Board.	May 2014 August 2014 November 2014 February 2015	Tina Lloyd, ADIPC
1.03	Each Clinical Unit and Department within the organisation is responsible for monitoring local compliance in relation to Outcome 8 Regulation 12 'Cleanliness and Infection Control' with guidance and support of key issues from the Infection Prevention & Control Team. The governance arrangements for Infection Prevention & Control will be revised as an integral part of the Trust organisational governance restructure.	30/09/2014	Alice Webster, Director of Nursing
1.04	Develop Key Performance Indicators (KPIs) for Clinical Units and Corporate Services to monitor compliance against Outcome 8 Regulation 12 within the Trust's governance framework	30/09/2014	Tina Lloyd, ADIPC
1.05	Implement and develop robust governance and performance monitoring systems with the new organisational structure against KPIs related to Outcome 8 Regulation 12.	31/10/14	Clinical Unit Management Teams (Clinical Lead, Head of Nursing and General Manager) and Alice Webster, Director of Nursing for Corporate Services

2 Provide a sustainable infection and control infrastructure to manage the risks related to infection prevention and control

Healthcare providers must ensure that sufficient resources are available to secure effective prevention and control of infection. A review of the infection prevention and control service and structure will be required in 2014/15 to ensure it meets the needs of the organisation post restructure and the requirements of our local Clinical Commissioning Groups (CCGs)

	Action	Target date	Lead responsibility
2.01	Interim service arrangements to be implemented prior to the organisational restructure to ensure equitable service across the organisation which is able to meet the flexible needs of the service due to clinical priorities.	01/04/2014	Tina Lloyd, ADIPC
2.02	Integration of the National Specifications for Cleanliness (NSC) Audit Team following transfer from the Facilities Division of the Commercial Directorate	01/04/2014	Tina Lloyd, ADIPC
2.03	Complete a restructure of the infection prevention and control service and staffing establishment incorporating Infection Prevention & Control, Intravenous Therapy Services and NSC Audit Team, to meet the needs of the organisation.	30/11/2014	Tina Lloyd, ADIPC
2.04	Support the ongoing professional development of all team members within this specialist service including completion of annual Performance Development Reviews (PDRs) and funding for essential training including the following in 2014/15: - MSc in Professional Development and Innovation (ADIPC) - NHS Leadership Academy (Senior ICN) - Principles in Practice of Infection Prevention & Control module (ICN) - Internal Trust Leadership Programme (Band 7 staff) - National Infection Prevention Society 3 day conference (2 Team members) - National IV Therapy Conference (2 Team members) - Team Clinical Supervision (Clinical Staff) - Apprenticeship in Business Administration (Secretary) - Other specific training courses to meet individual needs -	31/03/2015	Tina Lloyd, ADIPC and Senior Infection Control Nurses
2.05	Undertake a Training Needs Analysis (TNA) for the IP&C team and integrate training needs into future service plans.	31/12/2014	Tina Lloyd, ADIPC
2.06	Work collaboratively with local CCGs to determine service needs for future commissioning of services taking into account the Trust's portfolio of services, local	31/03/2015	Tina Lloyd, ADIPC

	population, local risk factors and emerging diseases and challenges in relation to the prevention of healthcare associated infections.		
2.07	Revise the Terms of Reference for the Trust Infection Control Group and reporting groups to reflect the Trust's revised governance arrangements due to be confirmed by the end of September 2014 (See also 9.07)	31/10/14	Tina Lloyd, ADIPC

3 Mandatory Surveillance and monitoring of healthcare associated infections

The Trust is required to undertake mandatory surveillance and local monitoring programmes of healthcare associated infections to support performance monitoring, detect outbreaks and ensure appropriate control measures are in place to reduce the risk of infection. Monthly and quarterly reports produced by the Infection Prevention & Control team are provided to the Clinical Management Executive (CME) for reporting to the Trust Board. Monthly data reported on the Data Capture System requires sign-off and lock-down by the Chief Executive Officer by the 15th day of the following month.

	Action	Target date	Lead responsibility
3.01	Mandatory surveillance of MRSA bacteraemia	Monthly	Tina Lloyd, ADIPC
3.02	Mandatory surveillance of MSSA bacteraemia	Monthly	Tina Lloyd, ADIPC
3.03	Mandatory surveillance of GRE bacteraemia	Monthly	Tina Lloyd, ADIPC
3.04	Mandatory surveillance of *Clostridium difficile* infections (CDI)	Monthly	Tina Lloyd, ADIPC
3.05	Mandatory surveillance of E.coli bacteraemia	Monthly	Tina Lloyd, ADIPC
3.06	Mandatory surveillance of Orthopaedic Surgical Site Infections (minimum of 3 months per annum)	Quarterly	Sue Allen, Head of Nursing, Surgery Clinical Unit
3.07	Alert organism monitoring (including MRSA, CDI, TB, Group A Strep, Enteric infections, multiple resistant organisms including CPE)	Weekly	Senior Infection Control Nurses
3.08	National voluntary electronic surveillance reporting of Norovirus	Weekly	Senior Infection Control Nurses
3.09	Local monitoring of contaminated blood culture samples	Quarterly	IV Team Leads

4 Reduction of healthcare associated infections

The NHS Outcomes Framework for 2014/15 Domain 5 commits to NHS providers treating and caring for people in a safe environment and protecting them from "avoidable" harm. Whilst not all healthcare associated infections are "avoidable" NHS providers are set objectives for the reduction in the incidence of both MRSA bacteraemia and *Clostridium difficile* infection (CDI).

	Action	Target date	Lead responsibility
4.01	**MRSA bacteraemia** **All NHS providers are required to demonstrate a zero tolerance approach to avoidable cases of MRSA bacteraemia**		
4.01.01	A robust process is required to investigate any potential cases of MRSA bacteraemia by undertaking a Post Infection Review (PIR) in line with DH guidance (Version 2 April 2014)	Weekly reporting already in place	Tina Lloyd, ADIPC
4.01.02	The Trust policy for the Control of MRSA is overdue for review and has been postponed due to the expected publication of revised DH guidelines for the screening of patients for MRSA based on the findings of the National One Week Study (NOW Study)	December 2014	Lesley Smith, Senior ICN
4.01.03	Revise Trust Patient Information Leaflet to reflect revised Trust policy in consultation with service users.	December 2014	Lesley Smith, Senior ICN
4.01.04	Develop and deliver implementation plan for revised Trust MRSA policy to update staff on key policy changes	December 2014	Lesley Smith, Senior ICN
4.01.05	Continue ongoing monitoring of MRSA positive results received from alert organism surveillance to detect any potential outbreaks or episodes of cross infection. (See 3.07)		
4.02	***Clostridium difficile* infections (CDI)** **The Trust objective for the reduction of post 72hr cases of CDI for 2014/15 is to report no more than 44 cases. For the first time NHS providers have the opportunity to appeal to Commissioners (CCGs) for cases to NOT count against Trust objectives where it can be proven that the case is unlikely to be avoidable or related to a "lapse in care".**		

4.02.01	Agree a process for the approval of outcomes of root cause analysis investigations of all post 72hr CDI cases with local CCGs including appeal for sanctions against objective	31st August 2014	Tina Lloyd, ADIPC
4.02.02	Demonstrate shared learning and completion of actions from root cause analysis (RCA) investigations of all CDI cases.	Monthly report	Tina Lloyd, ADIPC
4.02.03	Undertake an audit of compliance with the Trust policy for the Prevention & Control of *Clostridium difficile* Infections. (See Audit Plan Section 5)		
4.02.04	Continue ongoing monitoring of CDI positive results received from alert organism surveillance to detect any potential outbreaks or episodes of cross infection. (See 3.04) Investigate any periods of increased incidence in line with national and Trust policy including application of appropriate control measures and communication with stakeholders.		

5 Programme of audit of infection control practice

NHS providers are required to have and adhere to policies designed to help to prevent and control infections. The Infection Prevention & Control Team identify a planned programme of audit of key infection control policies based on local knowledge, incidents of infection and recent lessons learnt. The planned programme of audit is outlined below. Additional local or Trustwide audits may be added to the programme during the course of the year if indicated and or recommended by the Infection Prevention & Control time.

	Action	**Target date**	**Lead responsibility**
5.01	Safer Sharps Compliance Audit	31st May 2014	Lisa Redmond, Senior ICN
5.02	Re-audit of Commode Cleanliness and Quality	31st August 2014	Lesley Smith, Senior ICN
5.03	Audit of compliance with Trust policy for Theatre hand scrubbing.	31st August 2014	Silvia Gladstone, ICN
5.04	Audit of compliance against the Trust policy for the management and control of *Clostridium difficile* infection	31st August 2014	Deborah Wood, Infection Control Nurse Specialist
5.05	Infection control facilities for domiciliary staff	31st October 2014	Amy Ellison, Infection Control Nurse Specialist
5.06	Audit related to the insertion and care of Peripheral Venous Devices	28th February 2015	IV Team
5.07	Use of individual patient urinary catheter Passport and daily assessment document (UCAM)	31st March 2015	Tina Lloyd, ADIPC
5.08	National Specification of Cleanliness (NSC) environmental audits. Monthly Trustwide reports produced and presented by the Infection Prevention & Control Team to the NSC group prior to presentation to the Trust Infection Control Group.	Monthly reports	Florence Mpofu, Senior ICN
5.09	Staff Hand Hygiene compliance audits by Infection Control Link Facilitators in clinical areas.	Monthly reports	Susanna Marsden, ICN

6 Provide and maintain a clean environment

Criterion 2 of Outcome 8 Regulation 12 'Cleanliness and Infection Control' requires East Sussex Healthcare Trust to provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. Refer also to Outcome 10, Regulation 15 Safety and Suitability of Premises contained in CQC guidance.

	Action	Target date	Lead responsibility
6.01	In order to comply with recent Choice Framework 01-01 for local policies and procedures Management and Decontamination of Surgical Instruments, the Trust needs to undertake a review of job roles and responsibilities to appoint an appropriately trained decontamination lead	30th September 2014	Richard Sunley, Deputy Chief Executive
6.02	The Trust managerial restructure scheduled for 2014/15 will need to incorporate a designated lead for environmental cleaning (previously the Assistant Director of Facilities)	12th August 2014	Richard Sunley, Deputy Chief Executive
6.03	A comprehensive housekeeping service review is required to agree revised service level agreements, frequency of cleaning with all department managers.	Dates to be confirmed	Ian Humphries, Interim Director of Estates and Facilities
6.04	The NSC Audit team currently use the Maximiser audit tool to undertake environmental audits across the organisation. This software package will no longer be supported from the end of December 2014. A procurement process is required to introduce a new software package with appropriate support from January 2015.	1st January 2015	Florence Mpofu, Senior ICN
6.05	An electronic monitoring system is being introduced to integrate all outstanding Estates and Maintenance work into one system – Computer Aided Facilities Management (CAFM).	Dates to be confirmed	Ian Humphries, Interim Director of Estates and Facilities
6.06	The NSC audit reports during 2013/14 identified a number of Estates and Maintenance jobs that remain outstanding, are out of the control of Ward Matrons and require financial investment to resolve. A report of the position and a business case for capital investment during 2014/15 will be prepared and presented for approval in collaboration with Infection Prevention & Control identification of priorities.	30th June 2014	Ian Humphries, Interim Director of Estates and Facilities
6.07	Local housekeeping manuals and cleaning schedules including task sheets, frequency of cleaning and established housekeeping hours, require revision and circulation to all areas to reflect service reviews (see 6.03)	Dates to be confirmed	Jane Gorringe, Hotel Services Manager

6.08	A new bed space cleaning protocol was introduced during 2013/14 to improve consistency and standards for cleanliness of patient bedded areas between discharge and admission of new patients. Assurance is required that the protocol is fully embedded by both nursing and housekeeping staff. Review of NSC audit results under "nursing equipment" provides regular monitoring for action where required.	Monthly reports	Each Ward Matron is required to report on a 5 week rolling programme to the Director of Nursing and the Senior Nurse Team on results of NSC Audits and any actions required and completed.
6.09	Report to be prepared and presented to the Clinical Management Executive regarding a review of the state of the built environment for consideration for investment in the Trust Capital Programme.	Completed	Ian Humphries, Interim Director of Estates and Facilities
6.10	The Trust Board approved £700k in 2014/15 as part of an overall programme of circa £2m planned for investment over 3 years to improve infrastructure and environment of a priority programme to be agreed by Infection Control	Completed	Ian Humphries, Interim Director of Estates and Facilities Tina Lloyd, ADIPC
6.11	Delivery of the priority environmental improvement programme and agreed investment 2014/15:		
6.11.01	Resolution of NCS audit defects/concerns within all hospital inpatient ward areas at Eastbourne. (Costs c £50k)	31/03/15	Ian Humphries, Interim Director of Estates and Facilities
6.11.02	Resolution of NCS audit defects/concerns within all high risk inpatient ward areas at Conquest. (Costs c £50k)	31/03/15	Ian Humphries, Interim Director of Estates and Facilities
6.11.03	Resolution of NCS audit defects / concerns within high priority non inpatient clinical areas at Eastbourne and Conquest. (Costs c £30k)	31/03/15	Ian Humphries, Interim Director of Estates and Facilities
6.11.04	Resolution of NCS audit defects/concerns within high priority community based areas. (Costs c £25k)	31/03/15	Ian Humphries, Interim Director of Estates and Facilities
6.11.05	Progression of prioritised programme of comprehensive improvements to ward based toilet and utility areas within Eastbourne and Conquest Hospitals. A detailed and agreed programme of specific locations is still to be finalised to take account of: - infection prevention risk management - Trust bed capacity requirements - Various ward closure / relocation plans - Clinical strategy - Options to undertake works while wards remain occupied Reflecting these considerations to works programme is proposed over four phases, each with costs of circa £75k (i.e. £300k in total).	31/03/15	Ian Humphries, Interim Director of Estates and Facilities

6.11.06	Many ward entrance areas have significant damage to doors and impact protection panels. A priority programme has been identified and costs will be circa £50k.	31/03/15	Ian Humphries, Interim Director of Estates and Facilities
6.11.07	Plans are prepared to allow significant improvements within Cuckmere Ward to be progressed when the ward is relocated. Costs are circa £60k.	31/03/15	Ian Humphries, Interim Director of Estates and Facilities
6.11.08	A deep clean programme is to be finalised to take account of Infection Prevention prioritisation.	31/03/15	Jane Gorringe, Hotel Services Manager
6.11.09	Proposals to establish addition 'isolation room' facilities within audit inpatient ward areas needs to be advanced. These will need to take account of risk management aspects and Trust bed capacity requirements.	31/03/15	Mike Chewter, Head of Projects, Estates Divisions *and* Tina Lloyd, ADIPC
6.12	Escalation protocols have been agreed for the supply of linen out of hours and when ward levels are insufficient. An effective monitoring and reporting system requires implementation to provide evidence of appropriate regular supply and provision of linen	31/12/14	Mark Relph, Deputy Decontamination Manager
6.13	The Trust Cleaning Strategy requires review and update	30/09/14	Jane Gorringe, Hotel Services Manager
6.14	The Trust Cleaning Manual requires review and update	30/09/14	Jane Gorringe, Hotel Services Manager
6.15	The Trust Cleaning Policy requires review and update	30/09/14	Jane Gorringe, Hotel Services Manager
6.16	The Infection Control Team is in the process of agreeing a formal process to comply with Health Building Note (HBN) 00-09 Infection Control in the Built Environment.	30/09/14	Mike Chewter, Head of Projects, Estates Divisions *and* Tina Lloyd, ADIPC
6.17	An external audit of the waste management arrangement for the Trust is scheduled for December 2014. Findings of the audit to be shared and actions/recommendations completed where indicated	31/12/14	Kevin Hodge, Assistant Facilities Manager – Logistics
6.18	Training for responsible persons in water management to be completed.	April 2014	Tony Humphries, Assistant Facilities Manager (Chair of the Water Safety Group)
6.19	Trust Water Safety Policy requires development to integrate the Trust's Legionella Policy with guidance for other water pathogens include Pseudomonas Aeruginosa to comply with Health Technical Memorandum (HTM) Water Systems 04-01	31/12/14	Tony Humphries, Assistant Facilities Manager (Chair of the Water Safety Group)
6.20	The Trust has introduced a new food service "Steamplicity". A review group	31/12/14	Michelle Clements, Facilities Manager

	recommended a revised standard operating procedure is required to outline clear roles and responsibilities for staff involved in food service to patients.		(Ancillary Services)

7 Education and training programme for Trust staff

The Trust is required to demonstrate that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection. This includes providing a programme of training on induction and updates for all employees (including volunteers). The Trust's Learning & Development policy for mandatory training outlines this programme for training and the monitoring arrangements in place to promote compliance of 95%.

This programme details the specific objectives by the IP&C service for 2014/15 to promote the learning & development programme.

	Action	Target date	Lead responsibility
7.01	Undertake annual training needs analysis (TNA) for all staff in relation to Infection Prevention & Control	January 2015	Lisa Redmond, Senior ICN
7.02	Revise Trust-wide annual mandatory update for clinical staff on an annual basis to reflect current priorities, policies and advice.	August 2014	Lisa Redmond, Senior ICN
7.03	Revise tailored training for specialist staff to reflect the infection control risks and priorities related to their service (e.g. facilities, maternity)	January 2015	Lisa Redmond, Senior ICN
7.04	Develop alternative to presentation training for non-clinical update (eLearning and / or Workbook)	December 2014	Helen Tingley, ICN Specialist
7.05	Develop and evaluate National Skills Academy (NSA) e-learning mandatory IC training for medical staff provided by Premier IT.	July 2014	Lisa Redmond, Senior ICN
7.06	Provide timely focussed training where required in response to actual or potential infection control risks to meet service needs and prioritising where required	As required	Infection Control Nurse Specialists
7.07	In addition to the mandatory training programme provided by the IP&C team all Trust Infection Control Link Facilitators are trained to provide practical hand hygiene training to staff within their own clinical area and hold local records.	Reviewed quarterly within each Clinical Area's HCAI delivery plan	Infection Control link Facilitators *and* Heads of Nursing
7.08	Trust Infection Control Team will continuously review the education and training programme for Trust staff by participation in the Trust learning & development and mandatory training group and seek innovative ideas for the delivery of training and the promotion of best practice.	Reviewed quarterly	Lisa Redmond, Senior ICN *and* Tina Lloyd ADIPC

8 Antimicrobial strategy

The Department of Health and the Department for Environment, Food and Rural Affairs published the UK Five Year Antimicrobial Resistance Strategy 2013/18 in September 2013. The Trust has an established Antimicrobial Stewardship Group with multi-disciplinary core membership which is responsible for advising the Trust Infection Control Group on what steps should be taken by the Trust to contribute to this strategy.

	Action	Target date	Lead responsibility
8.01	The Lead Antimicrobial Pharmacist post is expected to be vacant from August 2014 which will require completion of the recruitment selection process to appoint a suitable candidate. An interim plan for service delivery to be reported to the Trust Infection Control Group.	30/09/14	Jonathan Palmer, Pharmacy Manager
8.02	Introduction of a new Trust Medication Prescribing Chart to promote appropriate prescribing of antimicrobials.	30/06/14	Jonathan Palmer, Pharmacy Manager
8.03	The Antimicrobial Stewardship Group should develop a programme of work for 2014/15 and report to the Trust Infection Control Group quarterly.	Review quarterly	Lead Antimicrobial Pharmacist
8.04	Procure Smartphone App for Antimicrobial Prescribing policy for prescribers within ESHT.	31/03/14	Lead Antimicrobial Pharmacist *and* Dr Barry Phillips, DIPC
8.05	Audit of compliance with antimicrobial prescribing. The newly appointed antimicrobial prescribing lead is to review the process and methodology for audit and agree a reporting and monitoring programme in alignment with the Trust's revised governance structures post organisational restructure	31/12/14	Jonathan Palmer, Pharmacy Manager / Newly appointed Lead Antimicrobial Pharmacist
8.06	Support the Trust CDI reduction plans by attendance at weekly multi-disciplinary CDI ward rounds on the Conquest and EDGH sites and provide expert opinion around antimicrobial prescribing of individual cases during RCAs of all CDI cases.	Weekly ward rounds and fortnightly steering group meetings	Lead Antimicrobial Pharmacist / Antimicrobial Prescribing Pharmacist

9 Revision of infection control policies, guidelines and patient information leaflets

Providers are required to have and adhere to policies, designed for the individual's care that will help to prevent and control infections. The Trust Infection Control Group ratifies the infection control policies. Patient information leaflets, once approved by the TICG require ratification at the Trust Documentation Group in line with Trust policy, which requires authors to seek feedback from service users. This section details those policies and documents due for review or new development during 2014/15.

	Action	Target date	Lead responsibility
9.01	Policy for the Control of Meticillin Resistant Staphylococcus Aureus (MRSA) **Update 01/09/14: New DH guidance on screening for MRSA published in August 2014, therefore revision of Trust policy postponed until 31/12/14 due to complexity of review required.**	31/12/14	Lesley Smith, Senior ICN
9.02	Guidelines for the Control of Measles, Mumps and Rubella Infection in Hospital	31/12/2014	Lisa Redmond, Senior ICN
9.03	Revision of Hand Hygiene for Healthcare Workers Policy including update of Patient Information Leaflet.	August 2014	Susanna Marsden, ICN
9.04	Ward Closure due to Suspected or Confirmed Outbreak of Infection	September 2014	Helen Tingley, ICN Specialist
9.05	Major Outbreak Policy	October 2014	Deborah Wood, ICN Specialist
9.06	Management and Control of Viral Haemorrhagic Fever (VHF)	Completed	Dr Anne Wilson, Consultant Microbiologist
9.07	Managing the Risks Associated with Infection Prevention and Control **Update 01/09/14: Postponed due to organisational restructure and impending governance review. Revised target date for completion 31st October 2014.**	31/10/14	Tina Lloyd, ADIPC
9.08	Creutzfeldt-Jakob Disease (CJD) Policy	30/11/14	Dr S Umasankar, Consultant Microbiologist
9.09	Guidance for the Management of Animals in the Healthcare Setting	Completed	Susanna Marsden, ICN
9.10	Patient Group Directive for Administration and Supply of Mupirocin Nasal Ointment	Completed	Lesley Smith, Senior ICN
9.11	Prevention & Management of Occupational Exposure to Meningococcal Disease in Healthcare Settings	September 2014	Debbie Wood, ICN Specialist

9.12	Standard / Universal Precautions for the Prevention of Infection	31/08/14	Helen Tingley, ICN Specialist
9.13	The Decontamination of Equipment and Medical Devices	30/11/14	Florence Mpofu, Senior ICN
9.14	The Management of Hospital Linen	Completed	Silvia Gladstone, ICN
9.15	The Management of The Spillage of Bodily Fluids	30/09/14	Silvia Gladstone, ICN
9.16	Aseptic Non-Touch Technique Policy (NEW POLICY)	30/09/14	Amy Ellison, ICN Specialist
9.17	Policy for the Prevention and Control of Carbapenemase producing Enterobacteriacae (CPE) (NEW POLICY) **Update 12/09/14:** Patient Information Group have requested changes to the Patient Information Leaflet contained in this policy prior to formal ratification.	Revised target date 31/10/14	Dr Roger Springbett, Consultant Microbiologist / Lead Infection Control Doctor
9.18	Procedure for the Prevention and Control of Healthcare associated Infection for all staff working in Primary and Community Care (Non-inpatient areas only)	Completed	Florence Mpofu, Senior ICN
9.19	Water Safety Policy (See 6.19)		
9.20	*Management of Patients with Influenza including Pandemic Influenza	30/04/15	Helen Tingley, ICN Specialist
9.21	*Multi-professional practice guidelines for Peripheral Intravenous Cannulation Competency (PVC)	31/10/14	Ignacio Atillo, IV Team Lead
9.22	*The Blood Culture Collection Policy	31/10/14	Lisa Redmond, Senior ICN
9.23	*Mid-line Insertion and Care – Review of current policy	30/11/14	Sajini Davidson, IV Specialist Practitioner
9.24	*Multi-professional practice guidelines for PICC – including patient information leaflet	30/11/14	Raymund Daquiz, IV Team Lead
9.25	*Policy for the use of Urokinase (NEW POLICY)	31/01/15	Sajini Davidson, IV Specialist Practitioner
9.26	*Policy for the use of Tauralock in line sepsis (NEW POLICY)	31/01/15	Raymund Daquiz, IV Team Lead

* See also Intravenous Therapy Service specific programme (Appendix 1)

10 New and Emerging Threats, Policies and Guidelines

This section is included to encompass new requirements that may emerge during the course of the year that are not included within the self assessment against Outcome 8 Regulation 12, which is currently under review by the DH

	Action	Target date	Lead responsibility
10.01	**CARBAPENEMASE-PRODUCING ENTEROCATERIACAE (CPE)** NHS England published a Stage 2 Patient Safety Alert on 6th March 2014 to inform Trusts to instigate the development of broad level CPE management plans.		
10.01.01	CPE action plan to be developed – (See Appendix 2)	Completed	Lesley Smith, Senior ICN
10.01.02	The CPE Action Plan should be presented to the Trust Board for approval and Executive level support.	31/10/14	Tina Lloyd, ADIPC
10.01.03	Progress against the CPE Action Plan will be reported to the Trust Infection Control Group quarterly	31/10/14	Lesley Smith, Senior ICN
10.02	**FLU ACTION PLAN** The Department of Health have issued new guidance for Flu for 2014/15.		
10.02.01	A review of the latest guidance is required to identify key actions required and roles and responsibilities – (See Appendix 3).	Completed	Helen Tingley, ICN Specialist
10.02.02	Progress against the key actions identified by the Infection Control Team in relation to Flu plans for 2014/15 to be reported the Trust Infection Control Group quarterly	31/10/14	Helen Tingley, ICN Specialist
10.03	**VIRAL HAEMORRHAGIC FEVER - EBOLA** The UK Government is closely monitoring the spread of an Ebola virus in West Africa and producing guidance for NHS Provider Trusts to ensure a co-ordinated approach to the UK response in collaboration with NHS England and Public Health England (PHE)		
10.03.01	Review Trust Policy for Viral Haemorrhagic Fever (VHF) to ensure inclusion of latest guidance and advice.	Completed	Dr Anne Wilson, Consultant Microbiologist

	Update 12/09/14: Policy revised and updated as planned, however updated guidance produced in August 2014 will require further review by the new working party due to be formed to review plans to control Influenza, CPE and Ebola.	Revised target date 30/10/14	Working Party
10.03.02	Establish an Ebola working group to review guidance as it emerges and develop actions plans and processes to provide assurance of preparedness.	30/09/14	Dr Barry Phillips, DIPC
10.03.03	Report quarterly to the Trust Infection Control Group against any action plans developed.	31/10/14	Dr Barry Phillips, DIPC
10.04	**NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE)** The Institute publishes guidance and pathways regarding specific topic areas after careful consideration of evidence available. NHS providers are responsible for implementing the guidance in their local context.		
10.04.01	Undertake a GAP analysis against Public Health Guidance PH36 – Prevention and Control of Healthcare Associated Infections, and provide action plan to comply with the guidance to Trust Infection Control Group for inclusion in Annual Programme of Work 2014/15	31/10/14	Dr Barry Phillips, DIPC
10.04.02	Undertake a GAP analysis against Quality Standard QS61 – April 2014 – Infection Prevention and Control, and provide action plan to comply with the guidance to Trust Infection Control Group for inclusion in Annual Programme of Work 2014/15	31/10/14	Tina Lloyd, ADIPC
10.04.03	Undertake a GAP analysis against Quality Standard QS49 – April 2014 – Surgical site infection: prevention and treatment, and provide action plan to comply with the guidance to Trust Infection Control Group for inclusion in Annual Programme of Work 2014/15	31/10/14	Michelle Elphick, Head of Nursing, Clinical Support Clinical Unit, Sue Allen, Head of Nursing, Surgery Clinical Unit *and* Debbie Wood, ICN Specialist
10.04.04	Undertake a GAP analysis against Clinical Guidance CG74 – Surgical Site Infection, and provide action plan to comply with the guidance to Trust Infection Control Group for inclusion in Annual Programme of Work 2014/15	31/10/14	Michelle Elphick, Head of Nursing, Clinical Support Clinical Unit, Sue Allen, Head of Nursing, Surgery Clinical Unit *and* Debbie Wood, ICN Specialist

APPENDIX 1

Intravenous Therapy Service Specific Programme
(Author: Lisa Redmond, Senior Infection Control Nurse)

The IV Team consists of four specialist nurses (band 7x2, band 6x2 WTE) and four support practitioners (band 3 x4 WTE) split between two acute sites in ESHT. The team is supported by a Senior Infection Control Nurse Specialist and has been fully integrated with the Infection Control Team in the past year. The IV team provides a 7 day service including bank holidays from 08:00 – 19:00 to the acute hospitals. Long line placements are usually undertaken Mondays – Fridays by the IV Team Lead and IV Nurse Specialist Practitioners. Advice and support is provided to community staff and out-patients as required.

	Action	Target date	Lead responsibility
1	**Providing and Promoting safe IV Care**		
1.1	Work closely with clinical teams to ensure correct selection of appropriate intravenous access to support patient treatment	Daily as required	IV Team
1.2	Venecannulation, Venepuncture (difficult), blood cultures, PICCs, mid-line (removal of tunnelled lines – Conquest only). Current provision 8-7pm 7 days per week. Blocked lines and advice	May 2014	Lisa Redmond
1.3	Revise PVAD in response to findings of PVAD audit	Ongoing	Ignacio Atillo / Ray Daquiz
1.4	Undertake route cause analysis on all blood culture contaminants and produce data for quarterly HCAI Report.	Ongoing / Weekly	Ignacio Atillo / Ray Daquiz
1.5	Provide specialist support to nutritional ward rounds and microbiology	Ongoing	IV Team
1.6	Care of PICC, midlines and troubleshooting / problem solving	March 2015	Lisa Redmond
1.7	Seek dedicated areas for line insertion and treatment on both sites	Daily as required	IV Team
1.8	Support clinical staff in clinical practice achieving competency with cannulation and Venepuncture	Daily as required	IV Team
1.9	Provide advice, support and clinical input if required for patients receiving IV treatments in the community.	Daily as required	IV Team

1.20	Collaborate with community nursing team to facilitate discharge of patient requiring IV Therapy in their own homes.	May 2014	Lisa Redmond
1.21	Collaborate with Infection Control Team regarding management of patients with infections	Daily as required	IV Team
1.22	Collaborate on introduction of IV line care modules via VitalPac and re-assess its impact on use of current documentation.	Feb 2015	Lisa Redmond
2	**Training and Education of Trust Staff**		
2.1	Venecannulation training (monthly – one day study)	Ongoing	IV Team Leads
2.2	Implementation of a monitoring system for attendance at training, completion of competency assessments and due dates for updates		Ignacio Atillo IV Team Lead (EDGH)
2.3	Vascular Access Device training (care of PICC, ports, midline, leaderflex)	2 hrs session 1-2 monthly	Bands 6&7
2.4	Blood Culture training and assessment of medical students (Kings & Brighton)	Approx 6 per year (both sites)	Bands 6&7
2.5	Mock OSCEs Annually – 3 days	As per L&D programme	Bands 6&7
2.6	Blood culture training (Post Grad request) for new starters	As per L&D programme	Bands 6&7
2.7	Produce an integrated programme for IV Training for use in acute and community settings	June 2014 & evaluate March 2015	Lisa Redmond to chair Working group
3	**Policy Development**		
3.1	Blood Culture Collection	31/10/14	Lisa Redmond, Senior ICN
3.2	Mid-line Insertion and Care – Review of current policy	30/11/14	Sajini Davidson, IV Specialist Practitioner
3.3	Multi-professional Practice Guidelines for Peripheral Intravenous Cannulation Competency (PVC) Policy – including patient information.	31/10/14	Ignacio Atillo, IV Team Lead
3.4	Multi-Professional practice guidelines for PICC - including patient information leaflet.	30/11/14	Raymund Daquiz, IV Team Lead
3.5	REVIEW New clinical guidance – Use of Urokinase	31/01/15	Sajini Davidson, IV Specialist Practitioner
3.6	REVIEW New clinical guidance– Use of Tauralock in line sepsis	31/01/15	Raymund Daquiz, IV Team Lead
4	**Audit & Surveillance**		
4.1	Surveillance of all central lines of in-patients & compliance with CVAD	Daily	IV team

4.2	Re-Audit of use of Peripheral Vascular Access Document (PVAD)	February 2015	IV Team / Infection Control
5	**Review of Products for Quality and Cost Savings**		
5.1	Assess feasibility of introducing PICC and Cannula maintenance packs to encourage consistent approach to line management by staff in both in-patient and domiciliary settings.	February 2015	Ignacio Atillo & Lisa Redmond
5.2	Re- Assess impact of using “Navilist” valved PICCs	September 2013	IV Team
5.3	Seek funding for Nautilus machines for both sites.	May 2014	Lisa Redmond
6	**Team Development**		
6.1	All members of the team will have a Personal Development Review and action plan completed 2 months prior to increment date.	Ongoing	Lisa Redmond
6.2	New staff induction programme to be completed with 6 month review.	September 2014	Lisa Redmond
6.3	All band 6/7’s to be competent in insertion of PICCs	Ongoing	Ray Daquiz & Ignacio Atillo
6.4	Extend skills in placing a variety of long lines such as Mid-lines and Leaderflex	Ongoing	Ray Daquiz & Ignacio Atillo
6.5	Extend skills for band 3s with troubleshooting of PICCs, midlines and Hickman lines.	September 2014	Ray Daquiz & Ignacio Atillo
6.6	Arrange study opportunity for band 3s	December 2014	Ray Daquiz & Ignacio Atillo
6.7	Band 6 or 7 to attend IPS IV conference	November 2014	Sajini Davidson
7	**Engagement with Local Health Economy**		
7.1	Arrange further meetings of the IV working group to agree policies and processes for managing patients receiving Intravenous Treatment throughout the Trust.	TBA	Lisa Redmond
7.2	Seek opportunities to work with wider health economy such as CCG’s to identify ways to improve patient experience and ability to avoid admission and / or expedite discharge.	Ongoing	Lisa Redmond

APPENDIX 2

Carbapenemase-producing Enterobacteriacae action plan

(Author: Lesley Smith, Senior Infection Control Nurse)

1. CPE management plan development:

		Action	Target date	Lead responsibility
1.1	Preparation plan to be developed to include: Resource and capacity arrangements Staff training and update arrangements Monitoring trends Early detection and effective infection Prevention and Control practice Robust diagnositics	• Task and finish group to be formed, including, ICT, Operational leads, Consultant Microbiologist, Lead Bio Medical Scientist • Terms of reference to be developed • • Project lead to be identified	September September August	Tina Lloyd (Deputy DIPC) Tina Lloyd (Deputy DIPC) Lesley Smith (Senior Infection Control Nurse Specialist)
1.2	Implement the Carbapenemase-producing Enterobacteriaceae Management Plan immediately, with strict adherence to standard precautions; affected patients should be isolated in a single room with en suite facilities or dedicated commode	• To be approved by Trust Infection Control Group	October	Tina Lloyd (Deputy DIPC)

2. Trust engagement:

		Action	Target date	Lead responsibility
2.1	Board to make it a high priority to minimise spread and to support all infection prevention and control (IP&C) measures,	• NHS England Alert to be presented to the Board • Action plan to be presented to the board		DIPC / ADIPC

2.2	Ensure that incidents / problem related to CPE are to be raised at Board level	• CPE outbreak to be presented to the Board		DIPC / ADIPC
	Prepare a dedicated management plan (Card B.1) including infection prevention and control measures	• Review Card B.1 pages 19-23 to supports the Trusts preparation plans for the management of CPE • Completed Management plan to be presented to the Board		Tina Lloyd (Assistant DIPC)

3. Hospital wide implementation

		Action	Target date	Lead responsibility
3.1	Run awareness / training campaign for staff especially, but not exclusively, medical and nursing staff; *maintain* staff awareness of high-prevalence countries and UK problem areas	• Priority training for staff in frontline areas to identify high risk patients (refer to action card A2) and re-admissions of known CPE contacts • CPE to be include in all relevant infection control training including, medical staff and nursing staffs mandatory training • Adoc training to be delivered as required	26/09/2014	Lisa Redmond (Senior Infection Control Nurse Specialist)
3.2	On admission screen suspected cases eg previously positive cases OR history of hospitalisation abroad in last 12 months OR in a UK hospital with a known problem in last 12 months (if known)	• Process for A2, A3 & A4 of the CPE toolkit to be followed. Impact of implementation to assessed and agreed by the task and Finish group and included in Management Plan • ICT & Staff to be made aware of high prevalence countries • Identify with the support of PHE those UK hospitals with a known CPE problem (if possible)		Lesley Smith (Senior Infection Control Nurse Specialist) ICT / PHE ICT / PHE
3.3	Implement isolation strategy at triage / admission for suspected or recent laboratory-confirmed patients	• To be include in review of isolation policy • Information and training to be provided to front line areas and Operational Personnel and Site Management team		ICT ICT

3.4	Hold regular incident management team meetings to review epidemiology and IP&C strategies, including root cause analyses where applicable	• Lessons learned from Serious Incident to be clearly identified and used to inform management plan • Post outbreak meeting to be held to review management of outbreak		Helen Tingley (Infection Control Nurse Specialist) / Lesley Smith (Senior Infection Control Nurse Specialist) Lesley Smith (Senior Infection Control Nurse Specialist)
3.5	Implement communication strategy; report as a Serious Incident (SI) and inform PHE Centre if evidence of onward transmission	• Recent outbreak identified in July 2014 to be reported as a Serious Incident and PHE informed	Completed	Lesley Smith (Senior Infection Control Nurse Specialist)
3.6	Ensure that any transmission becomes a top trust priority, with leadership from board to ward	•		

4. Laboratory services

		Action	Target date	Lead responsibility
4.1	Optimise and review laboratory methods to detect producers (refer to Standard Operating Procedure)	• To be reviewed as part of the preparation plans	September 2014	Bill O'Neill (Lead bio Medical Scientist) / Consultant Microbiologist
4.2	Screen by plating rectal swabs (or faeces) and manipulated site swabs eg from skin breaks / catheter sites onto either a) proprietary chromogenic agars designed to be selective for carbapenemase-producing Enterobacteriaceae or onto b) MacConkey or CLED agar with meropenem or ertapenem discs. Examine for colonies on the selective plate or within the zone. Prior broth enrichment may be useful: use a rectal swab to inoculate 5 -10 ml broth containing a 10 µg ertapenem disc, then	• Process to be reviewed as part of the preparation plans	September 2014	Bill O'Neill (Lead bio Medical Scientist) / Consultant Microbiologist

	subculture as above			
4.3	Laboratory systems to include flagging of positive results (colonisation or infection of carbapenamsase-producing entrobacteriadeae on patient records	• Known CPE positive patients to be flagged on Laboratory System.	Completed	ICT

5. Policy development and implementation

		Action	**Target date**	**Lead responsibility**
5.1	Trust to have ratified CPE policy based on current guidelines and supported by lessons learned from outbreak management	CPE policy to be completed and ratified at the Trust Infection Control Group **Update 12/09/14:** Patient Information Group have requested changes to the Patient Information Leaflet contained in this policy prior to formal ratification.	Revised target date 31/10/14	Dr Roger Springbett, Consultant Microbiologist
5.2	CPE policy to be implemented	CPE policy to be included in Infection Control Link agenda and presented to the group for dissemination to colleagues	09/10/14	Infection Control Team / ICLFs
5.3		Audit of compliance with policy to be undertaken through the infection control link facilitators meeting.	March 2015	Infection Control Team / ICLFs

6. Infection prevention and control

		Action	**Target date**	**Lead responsibility**
6.1	Reinforce and optimise hand hygiene with soap and water or, *on visibly clean hands only*, an alcohol hand rub as an alternative	• ICLF to continue to complete monthly hand hygiene audits and report on EIS • Non compliances to continue to be challenged • Additional hand hygiene training to be delivered by ICT / ICLFs to address		

		poor practice		
6.2	Minimise spread by effective routine and terminal cleaning including all hand-contact and sanitary areas (increase frequency if evidence of spread); review procedures for effective decontamination of equipment	• Decontamination of equipment to be reviewed as part of the Management plan • Cleaning schedules, guidelines to be reviewed as part of the Management plan • Rooms from patients with known CPE are to be deep cleaned and treated with Hydrogen Peroxide Vapour treated once the room is vacated • Housekeeping capacity and allocation to be scoped to meet the demand for enhanced cleaning when required (Including the need for additional equipment)		
6.3	Designate cohort staffing depending on risk assessment, number of cases and feasibility	• To be considered as part of the Management plan		
6.4	Ensure effective incident tracking via a robust surveillance system, with an incident / outbreak management team, full epidemiological investigation, maintaining line list and epidemic curve	• Investigation, surveillance and monitoring of CPE cases to be completed as part of the outbreak management	September	ICT
6.5	Prepare a readmission, discharge and transfer strategy for affected patients and contacts	• To be considered as part of the Management plan	September	Lesley Smith (Senior Infection Control Nurse Specialist)
6.6	Plan and facilitate adequate communication to other healthcare providers (intra- and inter-regionally	• Neighbouring healthcare providers to be informed as advised by PHE and the outbreak management team	Completed	Lesley Smith (Senior Infection Control Nurse Specialist)

7. Screening				
		Action	**Target date**	**Lead responsibility**
7.1	Screen of cases to be completed as per PHE guidelines and outbreak management group	• Screen index case and case-contacts as per criteria; case find and isolate immediately; determine the extent of spread; convene an outbreak control team if spread suspected; electronically flag affected patient(s) record • Instigate weekly and discharge screening of all patient contacts (as identified) in affected units / wards for a period of 4 weeks after the last case was detected; cohort contacts if possible / feasible • Screening of staff or household members for carriage is *NOT* routinely recommended as it is unlikely to provide additional benefit to control measures, whereas promotion of strict standard precautions will		

APPENDIX 3

FLU Action Plan (Author: Helen Tingley, Infection Control Nurse Specialist)

No:	Recommendation:	Action(s) to be taken to address Root Cause:	Nominated lead(s):	Review Date:	Completion Date:	How are the actions/recommendations evidenced	Evidence of Progress and Completion
F1	Influenza Pandemic Contingency Plan policy to be updated (identify overspill areas) **Update 12/09/14:** Due to the closure of Tressell Ward at the Conquest Hospital this plan will now need to be revised ahead of the scheduled date	Policy to be updated	Ian Taylor Emergency Planning Officer	July 2015 **Revised review date Oct 2014**			Review date may need to be brought forward in light of new guidance
F2	Infection Control Management of patients with Influenza including pandemic influenza Policy to be updated (Prophylaxis needs to be included)	Policy to be updated	Dr Springbett Consultant Microbiologist / Lead Infection Control Doctor	May 2015			Review date may need to be brought forward in light of new guidance
F3	Management of a Flu Pandemic in Maternity Policy	Policy to be updated	Jenny Crowe Head of Midwifery	July 2012			
F4	Vaccination of long term high risk patients. Consultants to be aware of the need to vaccinate patients who fall into high risk categories and not vaccinated by GP	All ESHT Consultants to be emailed to make them aware	Dr Barry Phillips DIPC	October 2014			

No:	Recommendation:	Action(s) to be taken to address Root Cause:	Nominated lead(s):	Review Date:	Completion Date:	How are the actions/recommendations evidenced	Evidence of Progress and Completion
F5	Vaccination of ESHT staff (particularly front-line staff) from September 2014 & to maximise the up-take of the vaccine	Vaccination strategy to be implemented	Christian Lippiatt Manager Occupational Health	October 2014	January 2015	Staff Flu vaccination programme produced in July 2014. Delivery of flu clinics throughout the Trust	Weekly reporting internally on update by clinical service split into staff groups. Monthly reporting through inform of flu update
F6	Pregnant staff to be offered vaccination and excluded from direct care of suspected or confirmed influenza but can work on respiratory wards	All staff to be aware	Matrons Head of Nursing	October 2014			
F7	Stocks of vaccine and anti-viral medicines as per guidance	ESHT to have adequate stocks of vaccine and anti-viral medicines	Ian Bourns Pharmacy Manager	Sept 2014			
F8	Stocks of viral swabs	Microbiology to ensure adequate stocks of viral swabs	Bill O'Neill Lead BMS	October 2014			

No:	Recommendation:	Action(s) to be taken to address Root Cause:	Nominated lead(s):	Review Date:	Completion Date:	How are the actions/recommendations evidenced	Evidence of Progress and Completion
F9	To be aware of flu vaccine as part of care pathway for people in clinical risk groups particularly chronic liver disease, neurological disease, including those with learning disabilities who are at high risk of mortality from flu	To raise awareness	Clinicians, Specialist nurses, Health visitors	October 2014			
F10	Clinicians to be aware of the Flu Plan Winter 2014/2015 (DOH,PHE NHS England) The Flu Immunisation Programme 2013/2014 GOV.uk Annual Flu Programme (updated 15/07/14)	Awareness of policies/guidelines	Clinicians	October 2014			
F11	Green book Immunisation against infectious disease, Influenza chapter 19	Clinicians to be aware of chapter 19	Clinicians	October 2014			
F12	Children 2 -17 years of age at risk of flu to be vaccinated, also healthy children aged 2,3 & 4 years	Paediatricians to be aware of vaccination guidelines for children	Paediatricians	October 2014			

No:	Recommendation:	Action(s) to be taken to address Root Cause:	Nominated lead(s):	Review Date:	Completion Date:	How are the actions/recommendations evidenced	Evidence of Progress and Completion
F13	Raise awareness of flu vaccine as part of the care pathway for children	Raise awareness of flu vaccine as part of the care pathway for children in at risk groups particularly neurological diseases including learning disabilities	Paediatricians. Specialist nurses, School nurses, Health Visitors	October 2014			
F14	Two Tetra brands of vaccine are available Fluenz Tetra and Fluarix Tetra Fluarix Tetra not licensed for use in children less than three years old.	Clinicians to be aware of two Tetra brands and guidelines of its use	Ian Bourns Pharmacy Manager	Sept 2014			
F15	All children aged 2,3 & 4 (but less than 5 on 01/09/14) to be offered flu vaccine	Clinicians to be aware of immunisation programme for children	Clinicians	October 2014			
F16	7 geographical pilots of Primary School aged children started in 2013/14 will continue in England.			October 2014			

No:	Recommendation:	Action(s) to be taken to address Root Cause:	Nominated lead(s):	Review Date:	Completion Date:	How are the actions/recommendations evidenced	Evidence of Progress and Completion
F17	A minimum of 12 geographical pilots in Secondary School aged children (Years 7 & 8) 2014/2015			October 2014			
F18	PPE (surgical masks, aprons, gloves)	Clinical areas to have adequate stocks of PPE	Matrons	October 2014			
F19	FFP3 masks	ESHT to have adequate stocks of FFP3	Jenny Bungay, Materials Management	October 2014			
F20	Clinical areas that order their own FFP3 to ensure adequate stock levels	To ensure adequate stock	Matrons Endoscopy, A & E, Maternity, ITU	October 2014			
F21	Front-line areas to be fit tested by September 2014	Front line areas to ensure staff are fit tested	Matrons. Heads of Nursing	October 2014			
F22	All staff to be aware of Flu Policies and PPE required	To be discussed at ICLF meeting	ICNs	October 2014			

No:	Recommendation:	Action(s) to be taken to address Root Cause:	Nominated lead(s):	Review Date:	Completion Date:	How are the actions/recommendations evidenced	Evidence of Progress and Completion
F23	Flu & Hand Hygiene Campaign	ICNs to raise awareness of flu & Hand Hygiene	ICNs	October 2014			
F24	Flu cases to be compiled on database	Database to be kept up to date	Infection Control Team	Monthly from October 2014			

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board meeting
Agenda item:	11
Subject:	Health and Safety Annual Report 2013-14
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

This report demonstrates the progress made, acknowledges areas of development and this annual report is intended to assure the Trust Board that suitable and sufficient health and safety arrangements are in place and that health and safety is being effectively managed across the organisation.

Introduction:

This annual report highlights some of the considerable work that has been undertaken within the health and safety management at ESHT during 2013-14. The report demonstrates the organisation commitment to supporting the programme of work required and also developing a future work plan. This has been done within a three-year cycle of which the first has now been completed. Over the period of time 2011-2014 the Trust has seen a greater number of staff aware of their responsibilities within Health and Safety but has some considerable way to go.

The engagement of Clinical Units (CUs) in safety related matters and their commitment to health & safety management within their areas of work and the services they offer remains critical to the organisation being able to effectively carry out its statutory duties for health and safety and work continues to strengthen and develop the management and culture within the CUs.

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

At the commencement of the H&S three year cycle in April 2011 we needed to:

- Understand what had worked well for H&S moving into a newly integrated organisation and the potential gaps in service;
- Renew momentum to improve health and safety performance across the organisation divisions and clinical units for both clinical and non-clinical services;
- Respond to a wide range of risks that both clinical and non-clinical services experience;
- Find new and effective ways of engaging the workforce in all of the services and locations;
- Further develop the organisational and service leaders promulgating a commonsense, practical approach to H&S;
- Regain the value of the health and safety discipline and challenge its 'devaluation as a synonym' for unnecessary bureaucracy and this can be used as an excuse for not doing things and frequent disproportionate actions can occur.

Over this three year cycle the organisation and the H&S team have achieved a great deal of success, of which will be expanded upon in section 4 of this report. There are still a great deal yet to be embedded within the organisation, this will be expanded upon in section 7 and the H&S team and service gap analysis. This gap analysis will now be used to influence and inform in a logical and sequential manner the next cycle of three years for H&S in the organisation.

Benefits:

The engagement of Clinical Units (CUs) in safety related matters and their commitment to health & safety management within their areas of work and the services they offer remains critical to the organisation being able to effectively carry out its statutory duties for health and safety and work continues to strengthen and develop the management and culture within the CUs.

The corporate health and safety department continue to advice and support CUs management in meeting the many challenges encountered. The past year has been very challenging for the Corporate Health & Safety Department as the Trust Divisional structure was removed in October 2013 but not replaced with a restructure until August 2014. However ongoing work with the clinical units has maintained the focus of work. An example of this has been the introduction of the 13 week health and safety audits has been commended during 2013–14, however further work needs to be undertaken to ensure this has embedded across the Trust. The commitment to supporting health and safety is evident in the team providing support to the Trust and this has been strengthened in the governance restructure currently being developed. It is anticipated that this will support the ongoing work programme.

Whilst the picture or incidents reported across the Trust appears to be increasing this is a positive move as unless incidents are reported they cannot be learnt from. Our assurance for the Trust is that the incidents reported are reducing in the extreme category.

Risks and Implications

ESHT has specific responsibilities as an employer under various sections of the Health & Safety at Work etc. Act 1974:

- Section 2 – duties of employers to employees;
- Section 3 – duties to protect people who are not its employees from being exposed to the risks of its activities, e.g. patients, members of the public;
- Section 4 – duties as a landlord by being in control of premises.

The Management of Health and Safety at Work Regulations 1999 extends the provisions of the Health and Safety at Work etc Act 1974 and in particular the requirement to undertake suitable and sufficient risk assessments and provide adequate training and supervision.

Assurance Provided:

This annual report demonstrates how this organisation has completed its first full three year cycle for H&S since the merger in 2011 between community and acute services. Health and safety activity remains embedded within everyday working practices.

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

Health and Safety Steering Group 30th July 2014 approved this annual report
Clinical Management Executive 11th August 2014

Proposals and/or Recommendations

The Health and Safety team will continue to build on what is now established to ensure that:

- Our health and safety structure activity is measured and monitored regularly
- Development of a business case for the purchase of a centralised H&S risk management system that will capture all risk assessments and H&S audits and this in turn can be scrutinised and issues highlighted are flagged quickly and dealt with efficiently and effectively
- Working collaboratively with the named Non Executive Director (NED) and the Director of Nursing & Governance who is the named executive lead to ensure that H&S issues, lessons learnt and good practice are shared with all staff group both clinical and non clinical within the Trust

- The organisation can demonstrate a positive health and safety culture aligned to the safe behaviour and attitude of all staff
- Revitalising health and safety targets have been met and a culture of continuous improvement is measured and celebrated within our services
- The contribution to health and safety is better understood at all levels of staff within the organisation
- All levels of the organisation are regularly informed of our progress against the local and national health and safety targets
- Bench mark audit tool will become the principal tool to monitor performance and address deficiencies and this element is being developed on South East Sector.

The Trust Board is asked to approve the annual 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?
Not applicable.

For further information or for any enquiries relating to this report please contact:	
Name: Nicky Creasey, Assurance Manager Health and Safety	**Contact details:** 01424 755255 ext. 6545

East Sussex Healthcare NHS
NHS Trust

HEALTH AND SAFETY ANNUAL REPORT

April 2013 to March 2014

Complied and completed by
Trust Health and Safety Team

Nicky Creasey
Assurance Manager Health and Safety

Jennifer Newbury
Deputy Assurance Manager Health and Safety

31st July 2-14 FINAL

Contents

East Sussex Healthcare NHS Trust

Health and Safety Annual Report 2013/14

Executive summary

This annual report highlights some of the considerable work that has been undertaken within the health and safety management at ESHT during 2013-14. The report demonstrates the organisation commitment to supporting the programme of work required and also developing a future work plan. This has been done within a three-year cycle of which the first has now been completed. Over the period of time 2011-2014 the Trust has seen a greater number of staff aware of their responsibilities within Health and Safety but has some considerable way to go.

The engagement of Clinical Units (CU's) in safety related matters and their commitment to health & safety management within their areas of work and the services they offer remains critical to the organisation being able to effectively carry out its statutory duties for health and safety and work continues to strengthen and develop the management and culture within the C U's.

The corporate health and safety department continue to advice and support CU's management in meeting the many challenges encountered. The past year has been very challenging for the Corporate Health & Safety Department as the Trust Divisional structure was removed in October 2013 but not replaced with a restructure until August 2014. However ongoing work with the clinical units has maintained the focus of work. An example of this has been the introduction of the 13 week health and safety audits has been commended during 2013 – 14 however further work needs to be undertaken to ensure this has embedded across the Trust. The commitment to supporting health and safety is evident in the team providing support to the Trust and this has been strengthened in the governance restructure currently being developed. It is anticipated that this will support the ongoing work programme.

Whilst the picture or incidents reported across the Trust appears to be increasing this is a positive move as unless incidents are reported they cannot be learnt from. Our assurance for the Trust is that the incidents reported are reducing in the extreme category.

An area that the Health and Safety Steering Group has noted during the year has been the ongoing rise of Stress within the workforce. Further work is being developed to support staff and this will be a considerable part of the coming years work plan.

This report demonstrates the progress made, acknowledges areas of development and this report is intended to assure the Board that suitable and sufficient health and safety arrangements are in place and that health and safety is being effectively managed across the organisation. ***Alice Webster, Director of Nursing and H&S Trust Executive Lead***

1. Introduction

East Sussex Healthcare NHS Trust (ESHT) recognises that the effective management of health, safety and welfare supports the Trust in meeting its vision of being 'the healthcare provider of first choice for the peoples of East Sussex' and the three main strategic objectives of:

1. Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority;
2. Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences;
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.

This annual report reflects the end of a three year cycle since the integration of community and acute health care services in April 2011 and the formation of ESHT.

The H&S Team for ESHT has strived to develop, build and embed systems and processes that support staff to embrace the Health and Safety Executive (HSE) strategy for Great Britain, June 2009 mission statement:

> *"The prevention of death, injury and ill-health to those at work and those affected by work activities"*

At the commencement of our three year cycle in April 2011 we needed to:

- Understand what had worked well for H&S moving into a newly integrated organisation and the potential gaps in service;

- Renew momentum to improve health and safety performance across the organisation divisions and clinical units for both clinical and non-clinical services;
- Respond to a wide range of risks that both clinical and non-clinical services experience;
- Find new and effective ways of engaging the workforce in all of the services and locations;
- Further develop the organisational and service leaders promulgating a commonsense, practical approach to H&S;
- Regain the value of the health and safety discipline and challenge its 'devaluation as a synonym' for unnecessary bureaucracy and this can be used as an excuse for not doing things and frequent disproportionate actions can occur.

Over this three year cycle the organisation and the H&S team have achieved a great deal of success, of which will be expanded upon in section 4 of this report. There are still a great deal yet to be embedded within the organisation, this will be expanded upon in section 7 and the H&S team and service gap analysis. This gap analysis will now be used to influence and inform in a logical and sequential manner the next cycle of three years for H&S in the organisation.

2 Working Together with Trade Unions

Staff-side is made up from members of East-Sussex HealthCare NHS Trust Staff (ESHT) who are members of a Trade Union or Society, recognised by the Trust. The Staff-side members have been elected and / or appointed into their role of Health & Safety Representatives, through their Trust recognised organisations.

These staff members undergo training by their own organisations in Health & Safety, and also may undertaken further training via the Trade Union Confederation (TUC) which runs more in-depth courses which are College/University accredited. They also attend seminars & workshops in Health & Safety subjects, such as; stress, COSHH (Controls of Substances Hazardous to Health,) and RSI (Repetitive Strain Injury.)

- Staff-side Health & Safety representatives are governed by "The Safety Representatives and Safety Committees Regulations 1977".
- Staff-Side Health & Safety representatives are part of the consultation process into Health & Safety policies written by the management side of the Trust.
- Staff-side Health & Safety representatives support & represent staff, patients & visitors to the Trust.

The union members hold their own staff-side Health & Safety Committee, to which The Chair & Deputy are elected yearly into the role.

They attend the main Trust Health & Safety Steering Group (HSSG) and report hazards and findings to the management side. These meetings are every other month and minutes are taken during meetings and agreed correct at the next meeting date. The staff side chair also completes a report to the Staff-side Forum/Joint Staff Committee (JSC), so that Union & Society members elected into the role of workplace stewards are made aware of any issues which have arisen from meetings. Policies approved by staff side Health & Safety representatives are forwarded to the JSC staff-side for sign-off. This is an agreed route."

2.1 Context

ESHT has a head count of staff (excluding bank) at 31st March 2014 of 6942 (source: ESHT Workforce Department); operating over 120 sites and covers 770 square miles.

The Trust Health and Safety Steering Group (HSSG) are chaired by the Director of Nursing who is the executive named lead (see Appendix 1 ESHT H&S structure). The Group receives reports from Trust wide service, for example, Fire, Security and over see the monitoring of our service action plan, see Appendix 1 for the H&S reporting structure within the Trust.

2.2 Legal background

The key pieces of legislation and guidance are:
The Health and Safety at Work etc 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.
In particular it requires organisations to:

- Provide a health and safety policy
- Provide safe and secure working environment
- Provide safe suitable work equipment
- Provide information, instruction, training and supervision
- Provide adequate welfare facilities.

Management of Health and Safety at Work Regulations 1999 which extends the provisions of the Health and safety at Work etc 1974 in particular the requirement to undertake suitable and sufficient risk assessments.

Management for health and safety (HSG65) 2013 guidance explains the Plan, Do, Check, Act approach and shows how it can help an organisation to achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

Leading health and safety at work (INDG 417) guidance sets out an agenda for the effective leadership of health and safety; it is designed for use by all directors, governors, trustees, officers and their equivalents in the private, public and third sectors. It applies to organisations of all sizes. Protecting the health and safety of employees or members of the public who may be affected by an organisations activity is an essential part of risk management and must be led by the board. Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership. Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety. By following this guidance, it would help the organisation find the best ways to lead and promote health and safety, and therefore meet its legal obligations.

3. Achievements for 2013/2014

3.1 Action plan for 2013/14

A full copy of the action plan is available on request from the H&S team. The action plan identified 25 actions with sub sections; 17 actions were completed fully within the financial year. The remainder of the actions to be completed related to 7 policies that needed to be updated or developed by the Commercial Directorate services to maintain and ensure safe systems of work (the directorate has instigated an action plan to complete the policies). The other outstanding action relates to the development of a centralised risk assessment database for the organisation. This element had already been identified by the Trust H&S team as a gap and this was reinforced by South Coast Audit team who reviewed the health and safety provision for the Trust (Ref: Internal Audit Report ESH131406, issue date: 11th September 2013). Other than this one recommendation for a centralised database the H&S service for the Trust achieved ‘significant assurance’.

The organisation H&S team have reviewed numerous IT systems and intend to present a business case in the autumn of 2014 for implementation (if agreed) 2015/16.

3.2 Policies – Health and Safety Manual

A full copy of the manual index is available on request from the H&S Team. This document highlights that of the 36 policies, 29 policies were completed and updated.

Additionally, the H&S policies continue to be reviewed with the exception of the Young Persons at Work Policy. Due to the changes in educational requirements many young people will not become eligible for employment until they are 18. Work experience will still take place and for this reason, the requirements of the existing Young Persons at Work Policy will be incorporated into the Work Experience Policy. The overarching Health and Safety at Work Policy is under review and due to the need to have clear responsibilities in roles and accountabilities it will be delayed until the full structure is confirmed.

As policies are reviewed, a summary sheet is now embedded within the policy which will enable staff to briefly note and recognise the objectives, purpose and contents of the policy. The summary sheet will in no way remove the need to read the policy in full where required.

3.3 Training

There are 4 levels of Health and Safety training all of which require refresher training at 3 yearly intervals.

- IOSH for Senior Executives
- IOSH Managing Safely for Healthcare Professionals
- Full day Health and Safety training for team leaders, supervisors and managers
- E-Learning for staff who do not have supervisory or management responsibilities

Learning and Development provide a monthly report that identifies training compliance by clinical unit. This information is collated by HR and used to populate the scorecard that is sent to senior managers which identifies levels of compliance within the service.. Levels of health and safety training are now also included in reports to Board by Workforce Development. Work has been undertaken by both the Health and Safety department and Learning and Development to ensure that courses are aligned with the National Passport System which the Trust has signed up to. Training plans for 2014-15 include the revision of content for the current full day health and safety training and also the risk assessment. There is currently low compliance (31.24%) with health and safety training details of which are contained in the Learning and Development table, see Appendix 2.

3.4 Health and Safety Links

The database of health and safety link persons is progressing and those staff registered on the database having had suitable training receive information directly from the health and safety department to ensure that there is no miscommunication or delay of

information and that information is disseminated at an operational level quickly. Feedback during audit identifies a need for health and safety link days and these will be implemented on a trial basis during 2014/15.

3.5 Communication – Intranet and Newsletters

The intranet is continually updated with all aspects of health and safety information including links and newsletters from associated departments and regulatory bodies including the Medicines and Healthcare Regulatory Agency (MHRA). Plans in 2013/14 to ensure that a Trust wide database of commonly used substances exists as well as the associated COSHH assessments will reach fruition in 2014/15. All departments that have responsibility for trialling and approving substances for use Trust wide also have a responsibility for ensuring a Controls of Substances Hazardous to Health (COSHH) assessment is completed. It is anticipated that these assessment will be available via the Trust Health and Safety section of the intranet to avoid duplication of effort. Departments accessing and using those COSHH assessments will not be absolved from amending the COSHH assessment from use in their own department along with the requirement to retain the relevant safety data sheet where applicable.
The third edition of the Health and Safety newsletter will be published once input has been gained from the specialist Occupational Health Psychologist for the subject of Stress and Emotional Resilience.

4. Report – incidents, audits, RIDDORs

4.1 Summary

The purpose of this section is to highlight trends and key areas of risk in terms of health and safety through the identification and reporting of incidents and audit results. This group is asked to note the contents of this section and where improvement can be made; assign actions as the result of the audit findings. Key Risks were identified;

1. Low compliance with Health and Safety training
2. Failure to achieve KPI's set for Occupational Health and Safety Managements Systems (OHSMS) audits
3. Inability of the organisation to report incidents leading to 3 or more days absence from work as previously required by the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2005 as amended

4.2 Introduction

This section gives the number of health and safety related incidents and also describes the nature of Health & Safety related incidents that occurred in East Sussex Healthcare NHS Trust between 1st April 2013 and March 31st 2014 to staff and others. Full

reports are given by departments responsible for leading on the implementation of their subject matter; Moving and Handling, Security, Infection Control (Sharps incidents) and Fire.

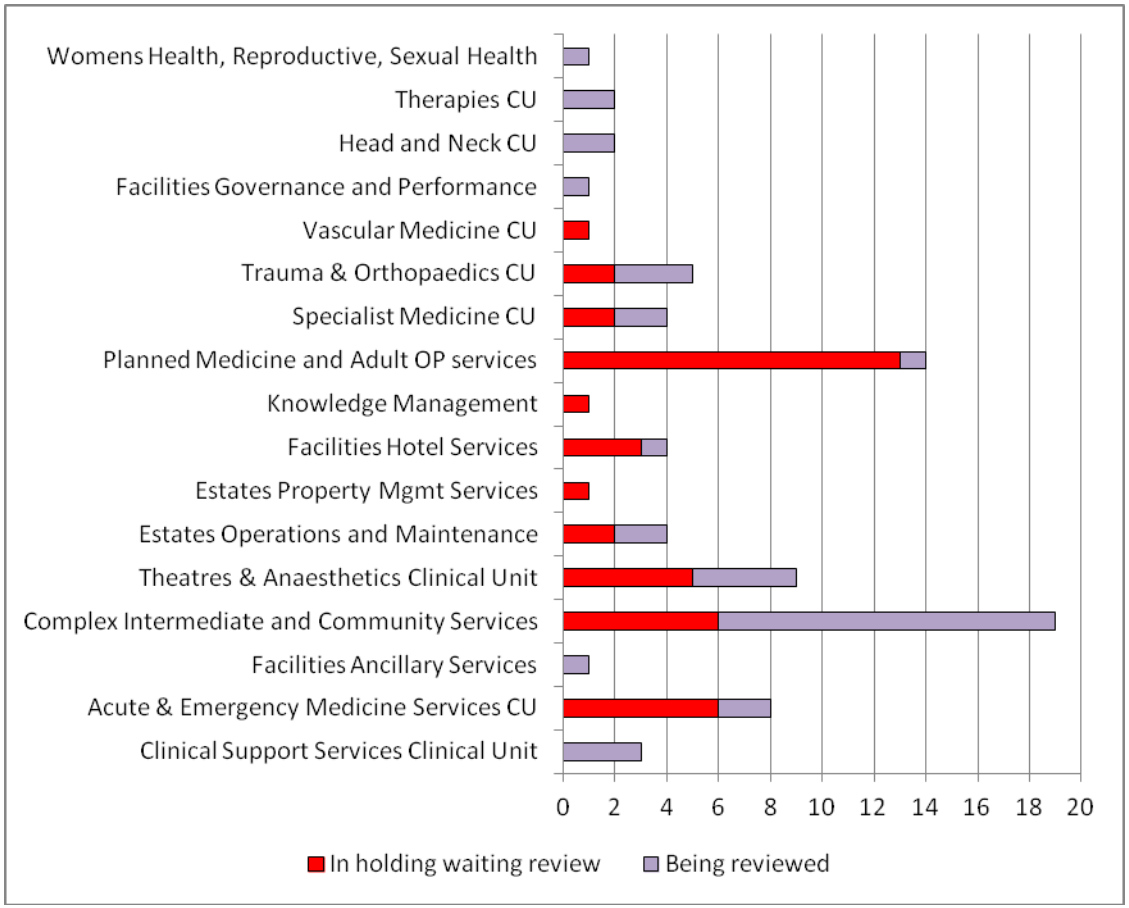
Patient Safety incidents are reported to the Patient Safety and Clinical Improvement Group & Quality and Standards Committee however, where patient incidents are defined as reportable to the Health and Safety Executive within the context of RIDDOR; these are reported to this Steering Group as well. Patient related RIDDOR's are identified in section 4.9 of this report. In addition, patient falls are reported to the Falls Steering Group.

This section also includes findings from the Occupational Health and Safety Management Systems (OHSMS) audit conducted by the Health and Safety department throughout the fiscal year and will contain activities of the Health and Safety department.

2013/14 will be the first year where full information has been able to be extracted from Datix enabling a benchmark to be set for future years. Due to the implementation of Datix web part way through the financial year 2012/13, separate incident recording systems and the amended coding requirements and grading causing difficulty with the approval process and a complete incident report for 2013/13 was not possible.

4.3 Incident Review and Closure

2013 – 2014 was the first full year of Datixweb implementation and training has taken place progressively throughout the Trust to ensure that there are sufficient managers with the knowledge to use the system. The framework for using Datixweb efficiently includes the requirement to review incidents within a specified timeframe, in line with training received and then assign or undertake investigations according to the level of incident. Handlers are automatically sent an email by the Datix programme at the time of the person reporting the incident as well as specialists.



From 1st April 2013, a total of 42 incidents have yet to be reviewed by the handler, 13 of these are within Planned Medicine and Adult Outpatient Services. 38 incidents are still in the process of being reviewed 13 of which are with Complex, Intermediate and Community Services.

The information for 2013 – 2014 analysis was extracted from Datix for the purposes of this report on 8th May 2014. The graph represents the cumulative incidents that are still outstanding for the previous year the results of which will affect the accuracy of this report. Therefore whilst every effort has been made to ensure the accuracy of the data presented in the following report, the information presented is as accurate as that which is taken from Datix at the time and relies on both timely review of the incident, the accuracy and interpretation of the trained handler.

The benefits of moving to an online reporting system are clear including;

- Greater ownership of incidents in real time by local managers
- Feedback can be sent to reporters of an incident
- Instant notification to be sent to specialists
- Reinforcement of a strong incident reporting culture
- Full audit history on every incident and subsequent investigation.

This does however require all parties to utilise the system fully with accurate information and full review.

4.4 Classification of Severity and Categories

This section includes the following categories of incident as reported;

Health and Safety

- Animal bites
- Burns and Scalds – dry or wet
- Cuts and Lacerations
- Trapped by the collapse or an overturn of an object
- Impact with static object – walking in to/ standing up
- Impact with moving, falling or flying object
- Road traffic collision
- Exposure to Hazardous Substances or clinical waste – biological, dust, chemicals, spores
- Environment - Infestation, noise, temperature, ventilation, surfaces and walkways

Slips, Trips and Falls

Moving and Handling

Needlestick and other Sharps

Security, Violence and Aggression. Theft and loss has been excluded for the purposes of this report

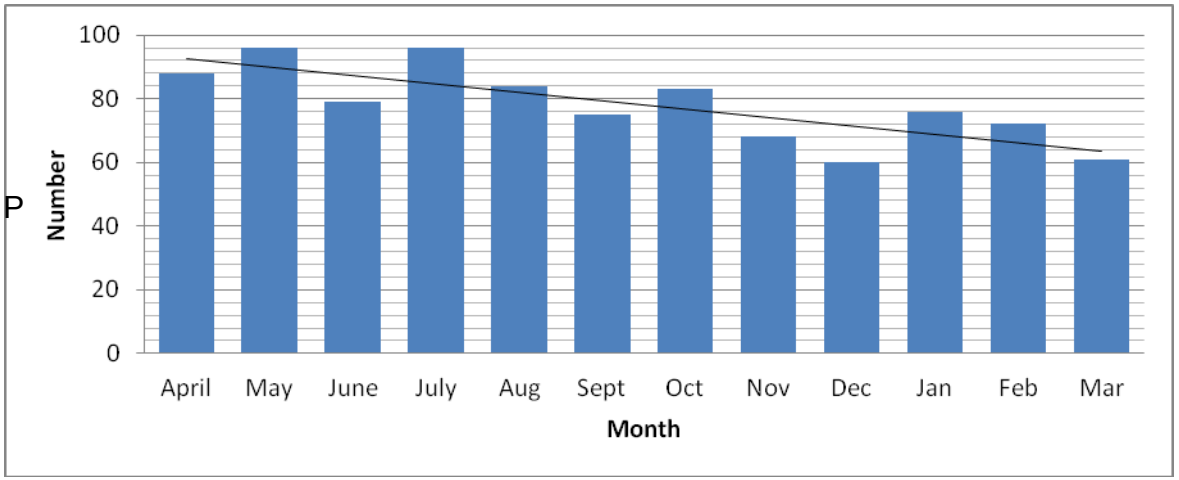
In accordance with the National Patient Safety Agency (NPSA) matrix an extract of which is below and in line with the requirements of the National Reporting and Learning System (NRLS), the report identifies those incidents according to the initial severity. It is essential that the matrix is used consistently within the organisation for both the reporting and grading of incidents and risk. Whilst there have been difficulties reported with staff using the NPSA risk matrix, the difficulty is identified as a training issue rather than the matrix itself.

NPSA Matrix

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects

4.5 Incidents reported

The graph represents the incidents reported by month for the full calendar year. There has been a general decline in reported incidents occurring in the Trust which is reinforced by the NHS staff survey 2013 indicating; 29% of staff witnessing potentially harmful errors, near misses or incidents in last month in comparison with 31% in 2012 and 33% as the 2013 national average. This is marginally tempered by key finding 14 of the staff survey: Percentage of staff reporting errors, near misses or incidents witnessed in the last month has decreased from 94% to 87%.



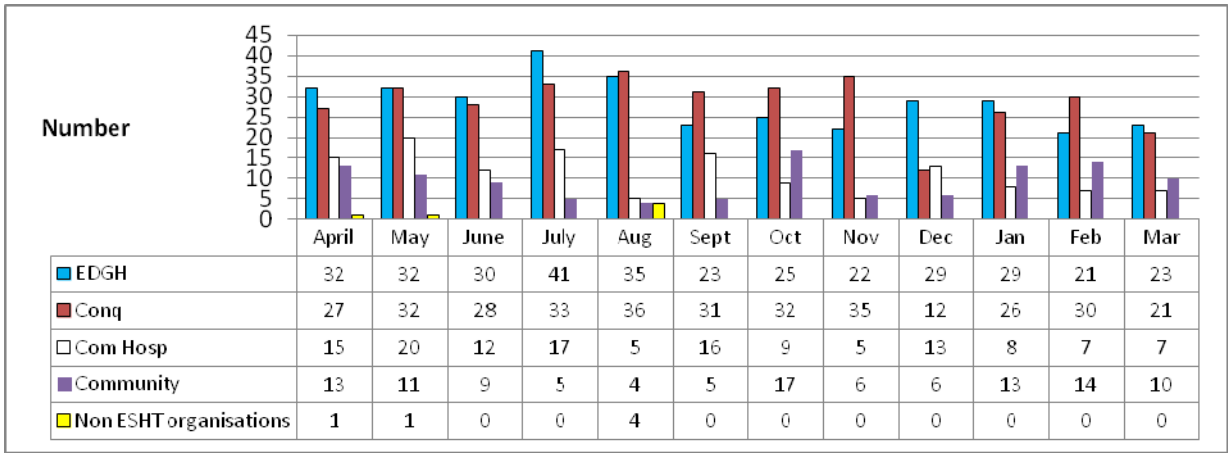
Quarter 1 263 new incidents
Quarter 2 255 new incidents
Quarter 3 211 new incidents
Quarter 4 209 new incidents

Performance indicators are being further developed to take account of the incident categories used in Datix, the

need to make the initial reporting of incidents as intuitive as possible and the reporting requirements of the NRLS.

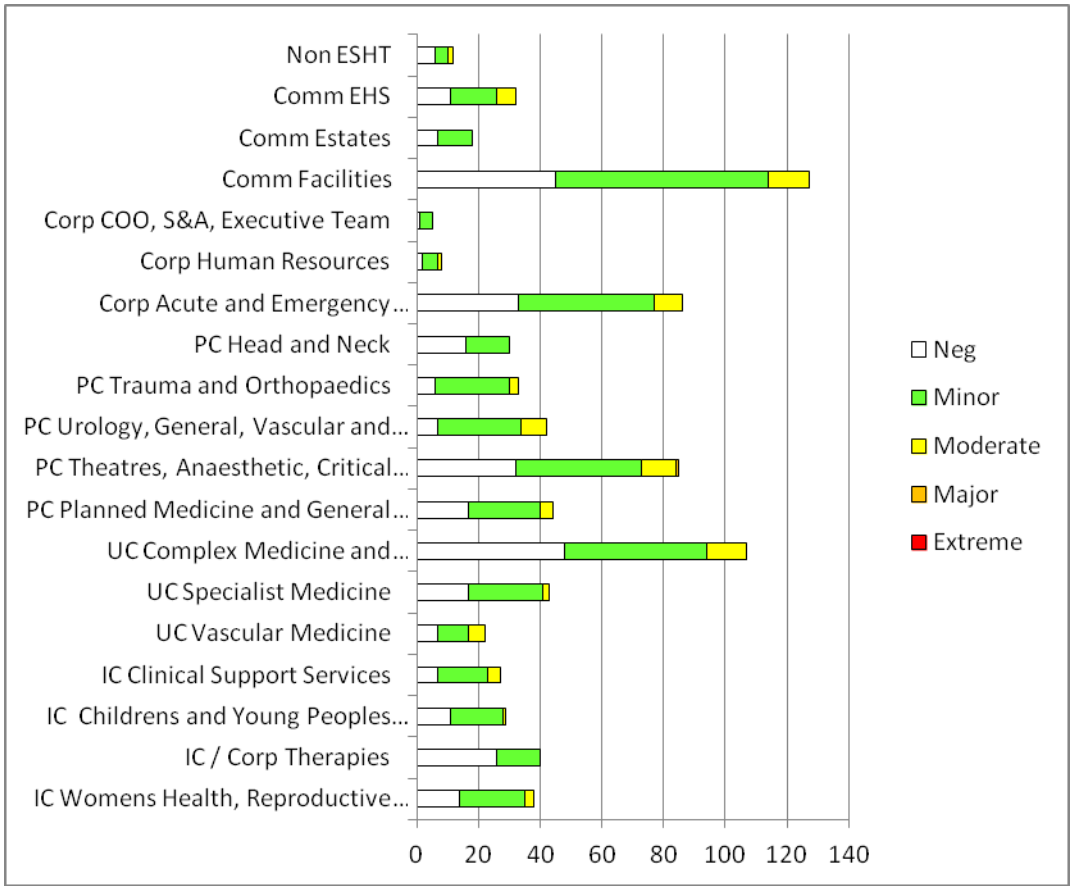
4.6 Incidents by Location

Incidents by location have been included in the annual report to enable potential identification of trends across sites and areas where services are relocated to enable preventative measures to be put in place. Community and domiciliary related incidents are generally higher coinciding with school terms peaking in late spring/ early summer. Also of note is the increase in July of incidents occurring on EDGH site followed by higher than normal incidents reported on the Conquest site. The type of incident that contributed to the increase in July was slips, trips and falls although no common factor was identifiable.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
EDGH	32	32	30	41	35	23	25	22	29	29	21	23
Conq	27	32	28	33	36	31	32	35	12	26	30	21
Com Hosp	15	20	12	17	5	16	9	5	13	8	7	7
Community	13	11	9	5	4	5	17	6	6	13	14	10
Non ESHT organisations	1	1	0	0	4	0	0	0	0	0	0	0

4.7 Health and Safety related incidents by Severity and Clinical Unit/ Division



The graph summarises all incidents to staff by severity for the full year. Each division reports on those incidents through a quarterly report presented to the Health and Safety Steering Group.

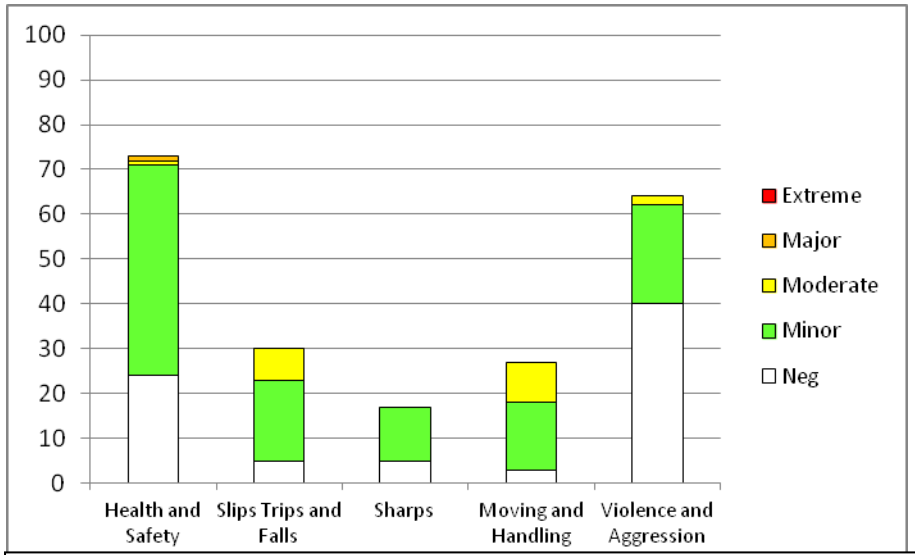
Incidents of note within this period that had the high potential to cause fatality were within the Estates department;

- A member of staff accessing the roof above radiology fell although managed to arrest the fall and avoid serious injury at Conquest Hospital
- A damaged gas pipe was as the result of a failure in the control of contractors at EDGH

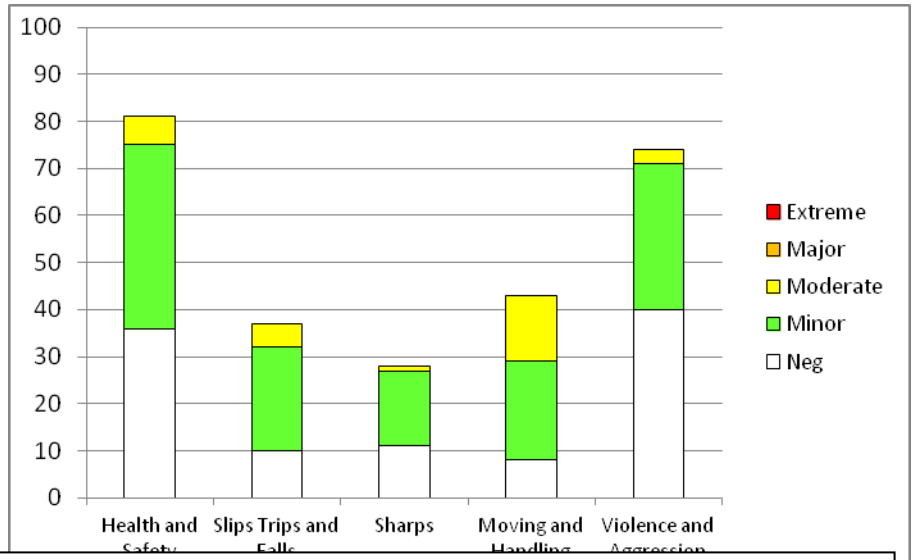
The Health and Safety Steering Group requested that both incidents were investigated and the results of those investigations were presented at the subsequent meeting.

4.8 Incident type by Quarter

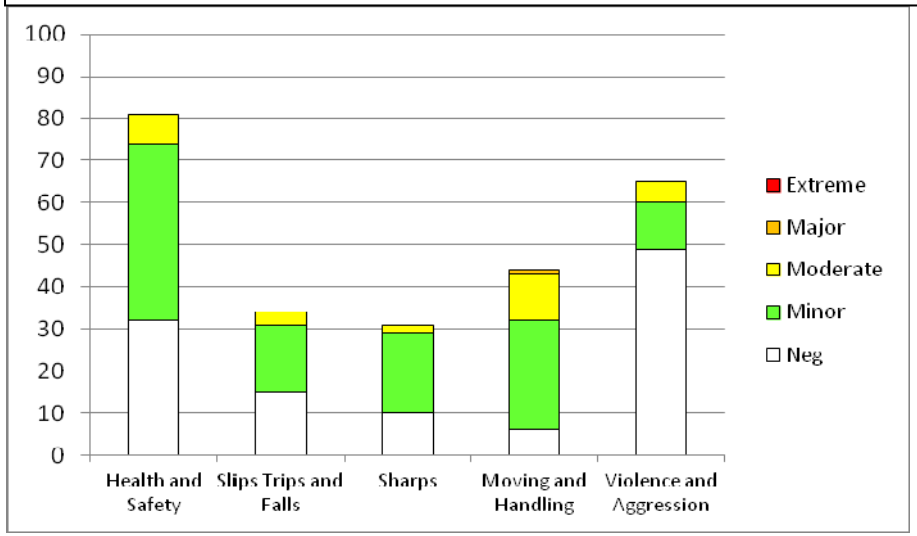
Quarter 1



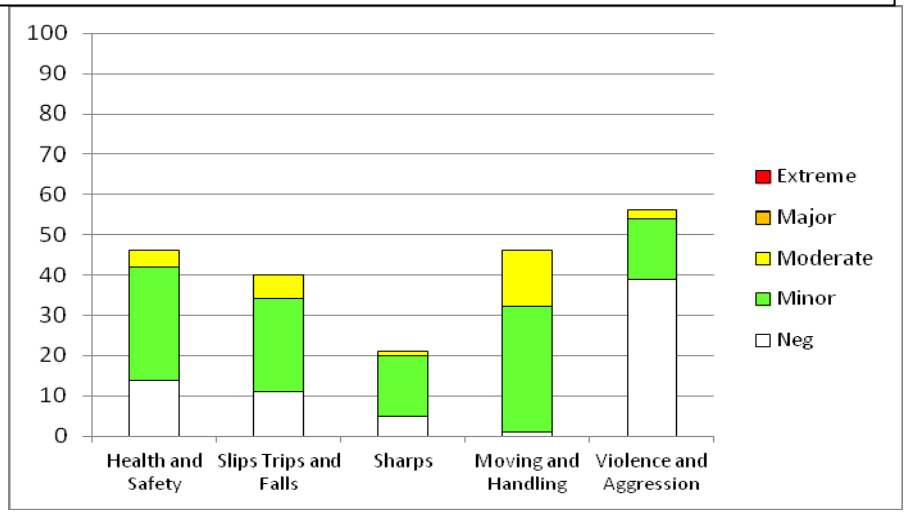
Quarter 2

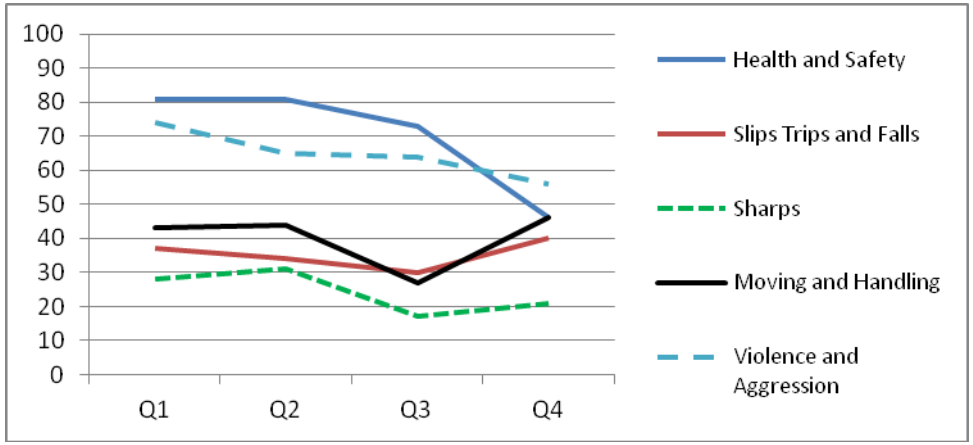


Quarter 3



Quarter 4





Incidents by quarter are indicated in the previous graphs and a summary of the full year by incident type is shown below. Both general Health and Safety incidents and Violence and Aggression indicate an overall decline throughout the year

4.9 RIDDOR events

Across the full year, a total of a total of 39 incidents defined within the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2005 (RIDDOR) were reported to the Health and Safety Executive.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Over 7 day	5	9	2	8	24
Specified Injury	1	5	4	1	
Fatality	1**	1**			
Dangerous Occurrence	1	1			

4.9.1 Over 7 day Incidents

There were 16 moving and handling incidents, 6 slip trip and fall incidents including 2 falls down steps or stairways and 2 health and safety related incidents causing staff to be absent for more than 7 days.

4.9.2 Specified Injuries

Slips, Trips and Falls resulted in 6 fractures to patients and 5 fractures to staff. 3 inpatient falls were unobserved, there was a single outpatient fall where a causal factor was stated to be the floor however a fault with the flooring was not identified and a further

inpatient fall where the patient acted against advice and mobilised independently. 3 fractures to staff occurred at Eastbourne District General Hospital (EDGH) and 2 of these involved the main staircases whilst a further happened whilst the member of staff was walking along a corridor. One community related incident involved a member of staff acting outside of their duties who fell whilst attempting to move an obstacle from the road to avoid danger to other motorists.

4.9.3 Fatalities

2 fatalities were reported to the Health and Safety Executive (HSE) which resulted in a visit from the area officer. Further in-depth investigations including the results of post mortem revealed that an omission in care had not caused the fatalities; however, the Trust has a legal duty to report the incident to the enforcing authority by the fastest available means. Whilst the report of a fatality within the Trust is unable to be amended by the HSE, they fully accept the results of the follow up reports.

4.9.4 Dangerous Occurrences

There was one single needle stick injury reported and with full involvement with Occupational Health the member of staff has successfully returned to work with no ill-effects of the potential exposure. A further incident was the identification of a failure in the buildings management system at the Containment Level (CL) CL3 laboratory Conquest during routine testing. A local prohibition was enforced by the department and remedial action identified swiftly.

4.10 Audits

Audits for Occupational Health and Safety Management Systems (OHSMS) began in June 2012, quarter 2 and have been conducted in order to benchmark the systems in place to support health and safety. The audit tool comprises 18 standards which are designed to examine;

- Structure and Roles/ Responsibilities
- Consultation, Communication and Reporting
- Documentation
- Hazard Identification, Risk Assessment and Control of Risks for routine and non-routine activities
- Hazardous Substances, Infectious Materials and control of waste.

Detailed information supports this audit report

4.10.1 Process

Elements of the OHSMS relevant to the service are objectively scored against compliance criteria – legislation and Trust policy. Evidence is required at the time of audit to support any statements;

1. Visible evidence obtained by the auditor e.g. presence of legal notices and posters, storage of PPE
2. Questions of both staff and managers
3. Records e.g. training records, risk assessments, minutes of meetings, fire inspection records

All areas audited will be subject to a further audit the frequency of which is dependent on risk rating of the preceding audit.

% Compliance	RISK RATING	Re audit
0-50	Very High	6 months
51-70	High	6 – 12 months
71-90	Medium	12 – 18 months
91-100	Low	18 – 24 months

The initial benchmark audit takes approximately 2 – 3 hours and at the end of audit and as part of the process of continual improvement in the OHSMS, the auditor will state actions necessary for areas where a need for improvement has been identified. The local manager will retain a copy of the audit and action plan. This will be further distributed to the Divisional Clinical Governance lead.

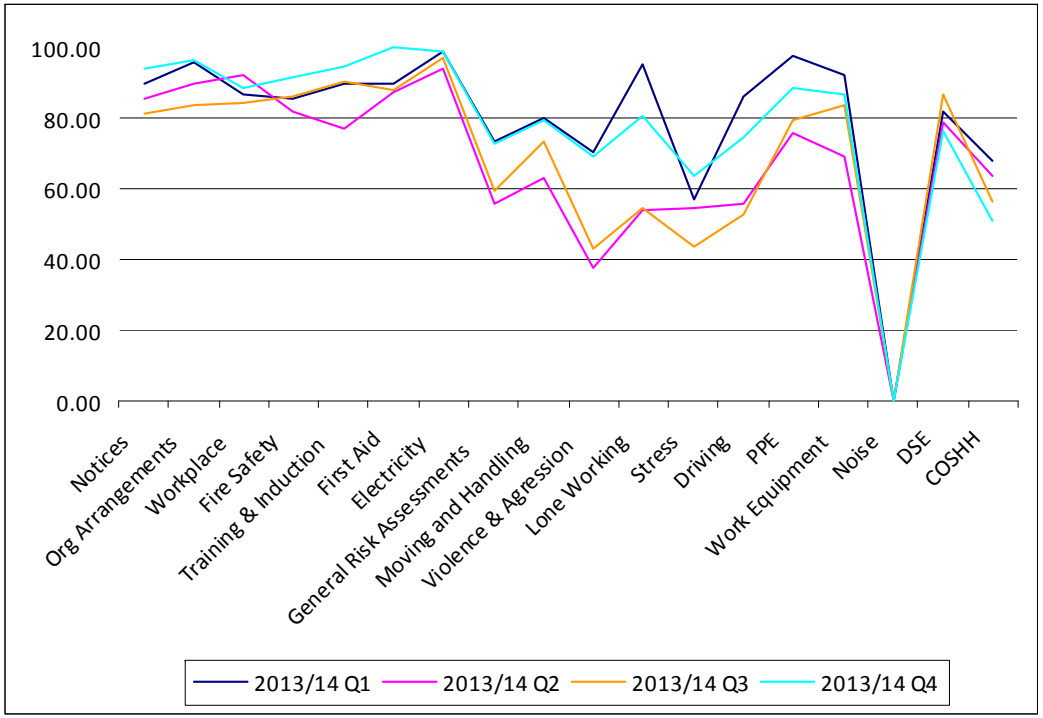
A total of 59 audits were undertaken in 2012/13 across the Trust in Community / Acute settings and 109 audits including 16 re-audits took place in 2013-14

4.10.2 Audit Findings

a) Quarterly data

The majority of audits conducted were to benchmark, the table and graph below indicates the collated results of each specific audit standard;

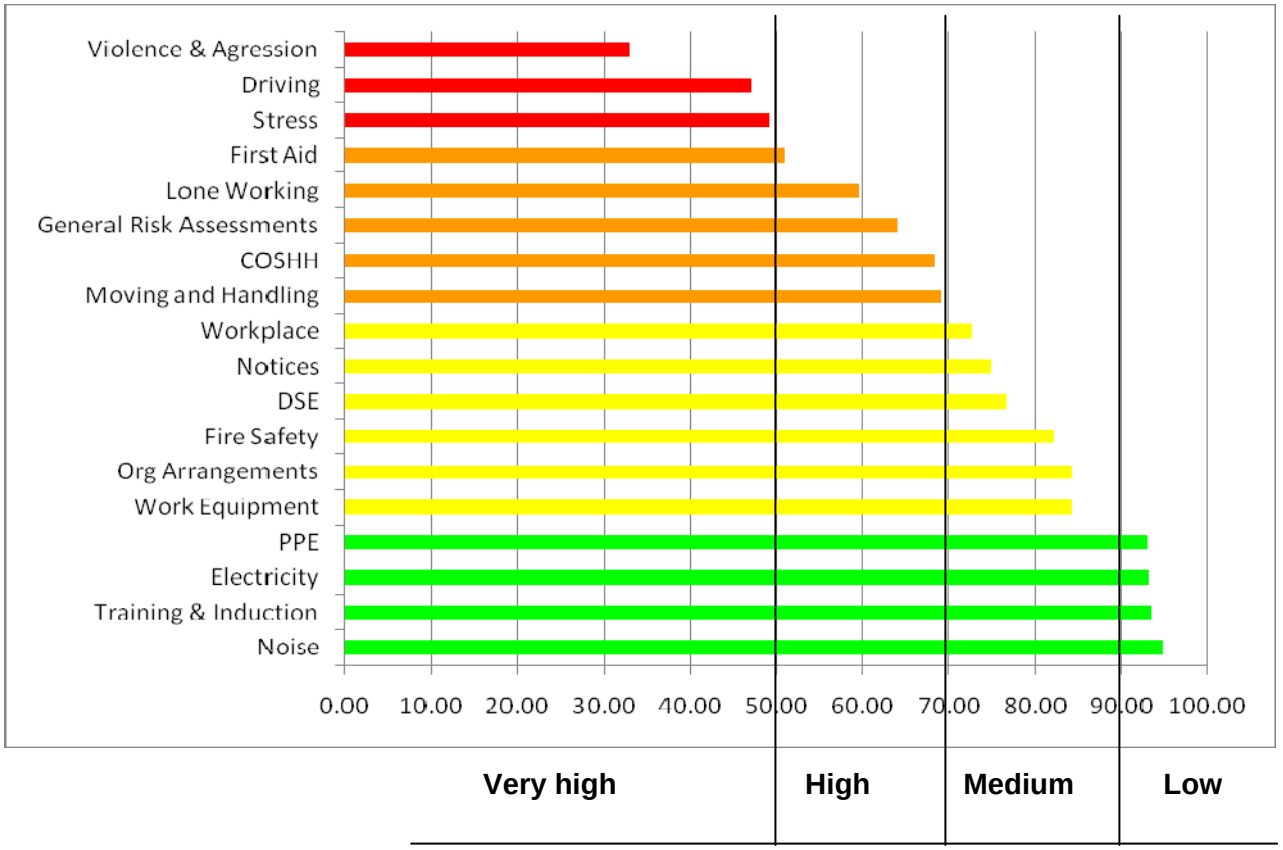
	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4
Notices	89.77	85.48	81.38	93.91
Org Arrangements	95.55	89.78	83.66	96.29
Workplace	86.62	91.91	84.51	88.76
Fire Safety	85.74	81.65	85.96	91.72
Training & Induction	89.99	77.17	90.01	94.76
First Aid	89.66	87.12	88.00	100.00
Electricity	99.09	94.08	97.14	98.62
General Risk Assessments	73.40	55.63	59.33	73.02
Moving and Handling	80.22	62.97	73.15	79.61
Violence & Aggression	70.30	37.59	43.13	69.31
Lone Working	95.27	54.12	54.63	80.67
Stress	56.74	54.60	43.62	63.62
Driving	85.92	55.60	52.59	74.55
PPE	97.72	75.56	79.68	88.70
Work Equipment	92.18	68.84	83.36	86.46
Noise	NA	0.00	0.00	0.00
DSE	81.66	78.67	86.79	76.55
COSHH	68.07	63.81	56.30	51.04



Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Lowest audit score	34.85	Lowest audit score	34.30	Lowest audit score	36.41	Lowest audit score	56.49
Highest audit score	96.62	Highest audit score	92.86	Highest audit score	100.00	Highest audit score	100.00

b) Benchmark

The annual audit report 2012/13 identified key areas of risk in terms of compliance as indicated in the graph below.



Standards that were deemed to be high risk in terms of compliance, findings included;

- Lack of assessment where the risk was significant
- Failure to check documents such as driving documentation
- Low level of awareness for the process of escalating risk

Violence and Aggression/ Security

The Policy was revised and risk assessment guidance issued by the department to clinical governance managers including a range of control and mitigation measures

Driving for Work

The meaning of driving for work was clarified at audit, attendance at local meetings and newsletters via Clinical Governance Managers

Stress

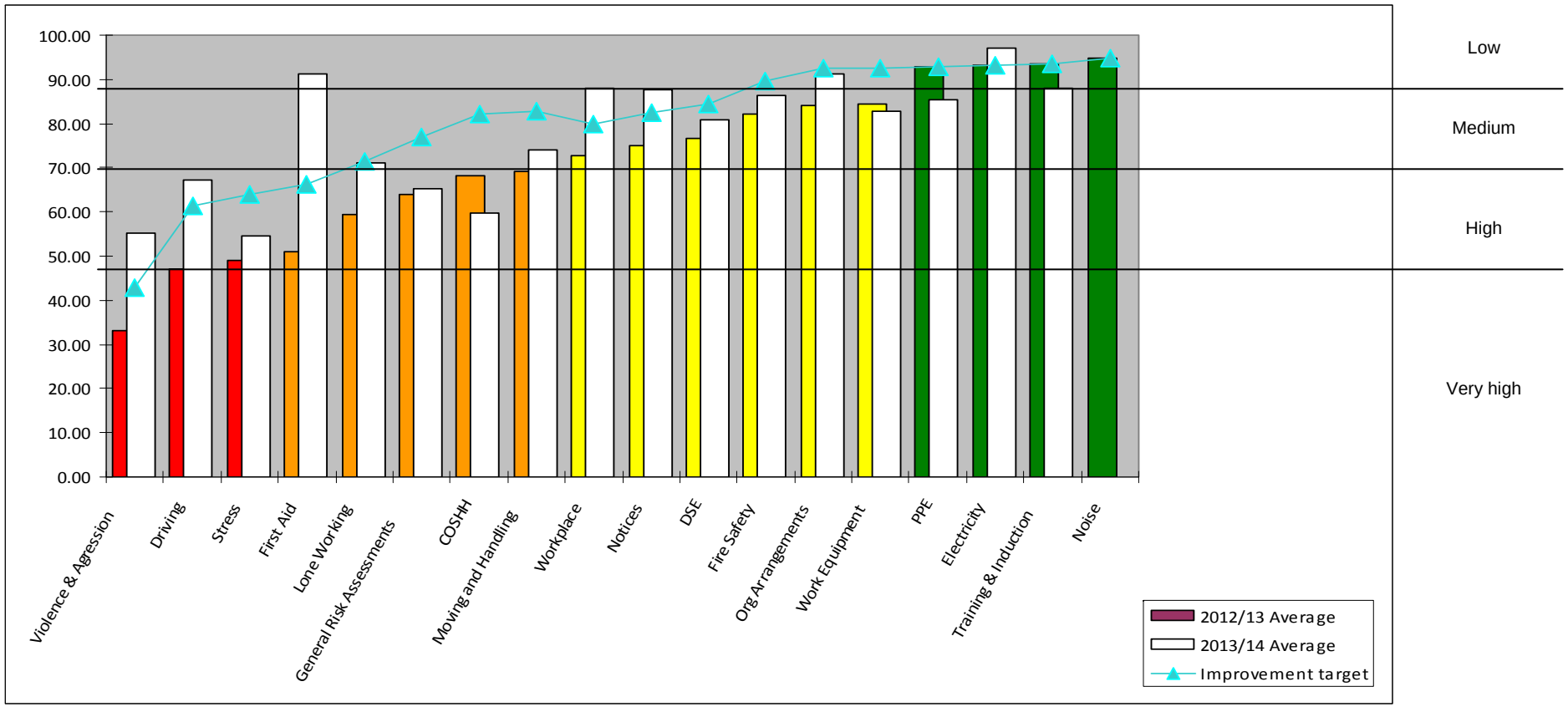
Policy revised and further information communicated through training, health and safety links and at further audit

Targets for improvement were set for 2013/ 14 based on risk:

- 30% for very high risk
- 20% for high risk
- 10% for medium risk

c) Improvements

The graph below indicates both improvements made and where further action is needed. Coloured bars represent the audit findings from 2012-13 with the respective percentages set as a target to achieve by the end of 2013 -14. Clear bars indicate the actual audit results at the end of 2013-14

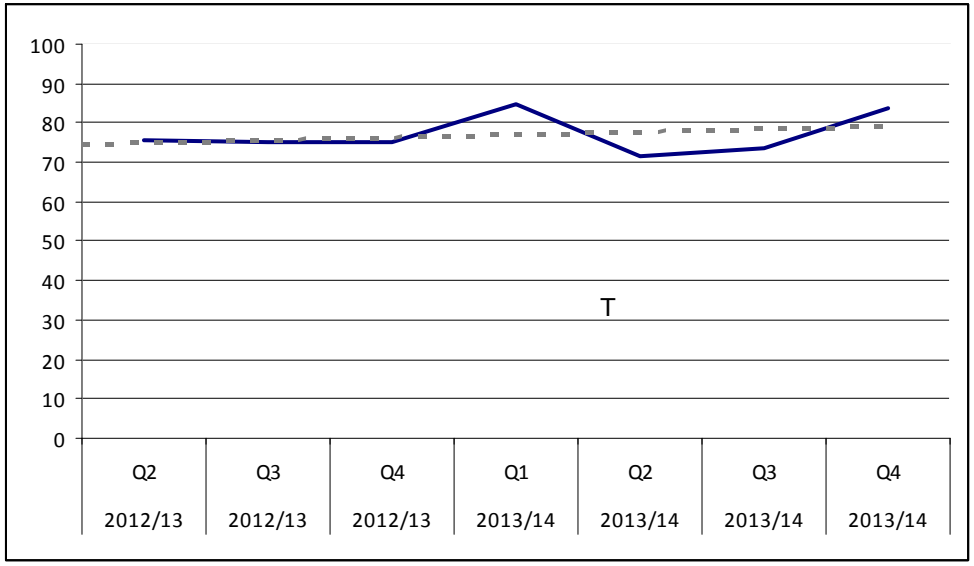


Whilst both Violence and Aggression and Driving for Work have improved and exceeded target Stress compliance is still very poor. Findings for this standard indicate that team based stress assessments are not being undertaken in some areas, staff are not aware of the individual perceived work related stress assessment or there is a lack of information on health and wellbeing in the local area.

Findings in general are still the lack of comprehensive general assessments that address the scope of risk that is presented by the work activity, specifically;

- Scoring of risk
- Limiting assessments to those that are accessed on the health and safety intranet
- Not completing COSHH assessments for hazardous substances

Plans to address this include the COSHH database for common substances in use Trust wide, revision of risk assessment and health and safety training, implementation of health and safety link days



Trust wide, the trend graph indicates the overall improvement seen since the start of OHSMS audits implemented in June 2012.

4.11 Conclusion of the data reports
Audits will continue across the Trust in 2014/15 and a target improvement of 10% has been set for medium risk and 20% for high risk, there are no longer standards that are indicating a very high risk although specific standards such as stress and risk assessment will have careful monitoring to ensure there is no regression. The audit findings indicate that the Trust is moving from high risk to a medium risk in terms of compliance

5. Moving forward over the next year
For 2014-15 H&S for the organisation has now moved into its next 3 year cycle of embedding and updating health and safety management systems. The H&S team identified in the last annual report that to ensure robust evidence base information a comprehensive gap analysis would be completed utilising the updated HSG65 of PLAN, DO, CHECK and ACT approach. This gap analysis has been completed and it is now informing 2014-15 action plan which will demonstrate the ongoing specifics of how H&S is embedded within the organisation culture, attitude and behaviour for all Trust staff.

2014-15 is the first year of the next 3 years of a H&S cycle and the Trust H&S team will endeavour to maintain a positive H&S culture aligned to safe knowledgeable behaviour and attitude of all Trust staff.

6. Conclusion
The management of H&S remains a key priority for the Trust with appropriate resources being provided to manage this within the organisation.

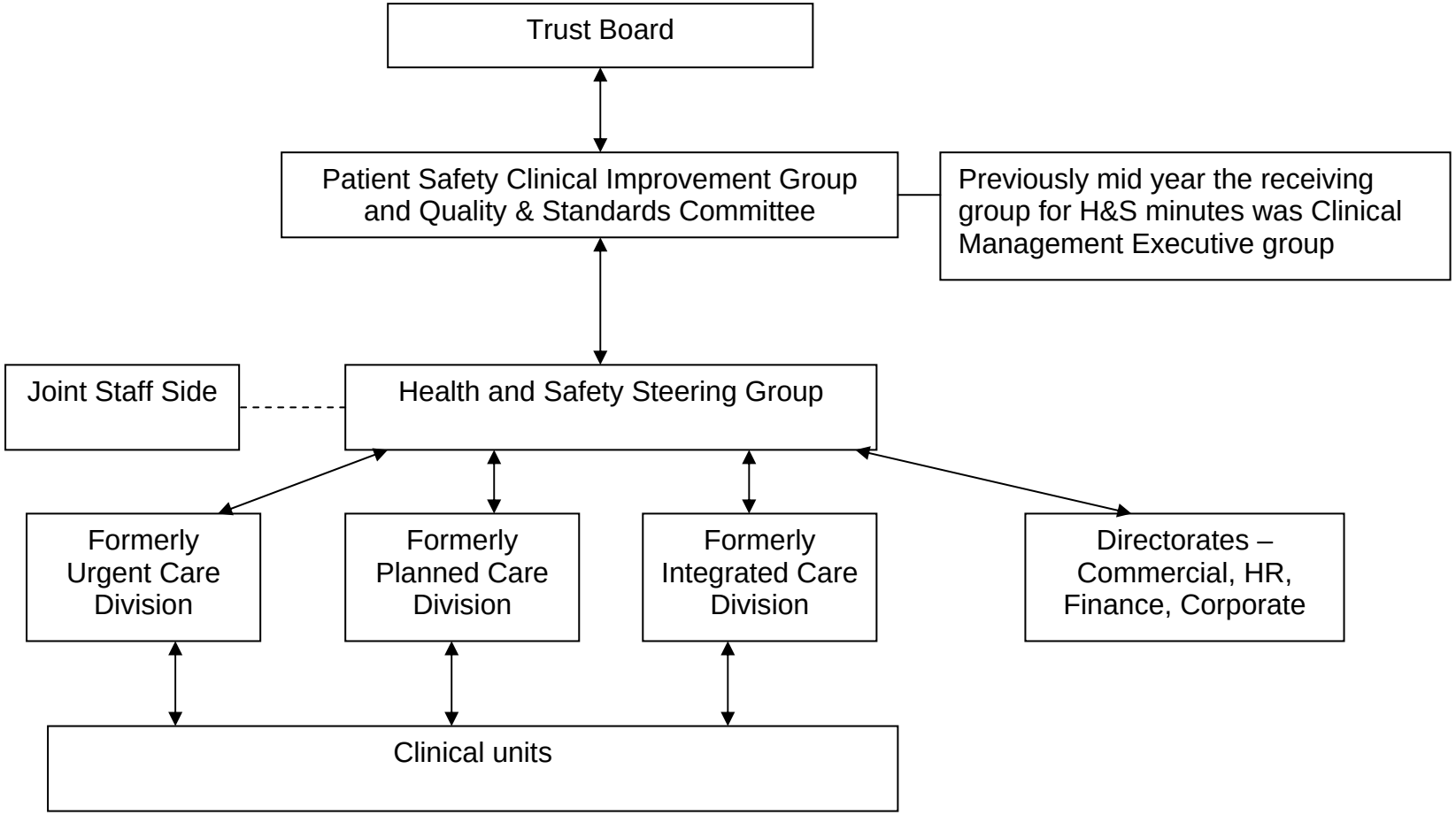
The H&S team continued through 203-14 to support clinical divisions and non-clinical directorates of Commercial, Human Resources and Corporate. Also, once the Divisional higher management triumvirate were disbanded; the named clinical units continued and the H&S team continued to offer support and an advice to ensure and be assured of on-going compliance, recognising if there were any gaps that the H&S and/or staff have identified.

The Trust maintains a positive incident reporting culture although further work and reviews to improve the processes in place are further explored by the Datix Development Group, led by the Head of Assurance and the Datix manager.

Overall the first H&S three years cycle since being a merged community and acute Trust in 2011 has been positive and as the incident and audit data demonstrates a culture and behaviour of staff is one where they feel able to seek advice and guidance without fear or feelings of apprehension.

The next H&S 3 year's cycle commencing 2014-15 will see a continued improvement.

Appendix 1 Health and Safety reporting structure



Appendix 2 Training statistics for 2013-14

Source: ESHT workforce department and learning + development of 31st March 2014

		Headcount* 31.03.14	Health & Safety non attenders	% Health & Safety
	Trauma & Orthopaedic	224	150	33.04%
	Urology, Gen & Vascular Surgical	264	185	29.92%
	Theatres Anaesthetics & Critical Care	564	447	20.74%
	Head & Neck Surgical	284	161	43.31%
	Planned Med & Adult Out Patient Department	409	278	32.03%
	Cardiovascular Medicine	273	211	22.71%
	Specialist Medicine	283	212	25.09%
	Complex Medicine	643	503	21.77%
	Acute Medicine	412	249	39.56%
	Clinical Support	528	305	42.23%
	Children & Young People	434	234	46.08%
	Women's & Sexual Health	330	211	36.06%

	Therapy Services	499	266	46.69%
Commercial		1045	932	10.81%
Chief Executive		10	5	50.00%
Chief Operating Officer		92	74	19.57%
Strategy Dev & Assurance		24	5	79.17%
(Acute) Clinical Practice		89	66	25.84%
Finance & Performance		125	45	64.00%
Human Resources		120	50	58.33%
TRUST		**6693**	**4602**	31.24%

Note: Workforce exempt staff on maternity leave, Students, those on Career Break or External Secondment and joiners in the last month (to give them a chance to get on the training). This is why the training headcount is lower than the Trust headcount.

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	12
Subject:	Annual Business Plan 2014-15 Quarter 2 update
Reporting Officer:	Dr Amanda Harrison, Director of Strategic Development and Assurance

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

Purpose:

The attached high level report outlines progress against the objectives of the Annual Business Plan for 2014/15 which was approved by the Board at its meeting on 3 June 2014. Each Director has an underpinning plan which provides milestones for delivery to achieve the corporate objectives and demonstrates progress against these milestones.

Introduction:

The Annual Business Plan has been developed in collaboration with clinical units and corporate departments. It highlights the key objectives for the organisation and highlights the key risks to delivery. To facilitate and support the delivery of the ABP objectives, the following have been developed:

- Performance Management and Accountability Framework
- A process for monitoring the impact of service changes on quality
- Programme Management arrangements.

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

- Key deliverables will come to the Board throughout the year for approval where required
- Progress on plans addressing access targets will be reported regularly through the performance report

Benefits:

There is clarity about the organisational priorities and targets for 2014/15 and the risks attached.

Risks and Implications

Failure to identify and monitor the 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 Annual Business Plan has been developed in collaboration with clinical units and corporate departments. It highlights the key objectives for the organisation and highlights the key risks to delivery.

Review by other Committees/Groups (please state name and date)**:**
Business Planning Steering Group 16.09.14

Proposals and/or Recommendations
The Board is asked to note progress on the Annual Business 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: Jane Rennie, Associate Director – Planning and Business Development	**Contact details:** Janerennie1@nhs.net

East Sussex Healthcare NHS Trust

ANNUAL BUSINESS PLAN (ABP) QUARTER 2 UPDATE

Key: Red - overdue or concern to achieving the objective ↔ Rating unchanged
Amber - no concerns to note and on plan to deliver ↓ Rating improved
Green - completed ↑ Rating worsened

Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority

ABP Objective – Ensure the organisation is able to demonstrate the quality of its services and compliance with regulatory standards						
Key Plan	**Outcome Measures**	**Risks**	**Action**	**Milestones**	**Lead**	**RAG Rating**
Completion of the Quality Governance Self Assessment/Well Led Framework	Board has self assessed its compliance against the Well Led Framework and has evidence in support of each of the four domain and actions and timeframes to support areas of development	Several new non-executives who may have insufficient knowledge to form an evidence based view on some areas of the framework. The Board has insufficient time and focus to undertake what is a significant piece of work.	Initial review of framework by Co-Sec and development of template for Board use. Board to review the ten high level questions and consider best practice examples. Board to identify evidence and areas for development. Each area to be RAG rated and actions agreed Board consideration as to timing of external review of evidence base	Completed Jul14 In progress by end Sep14 In progress by end Sep14	**DSA**	**A** **A** **A** **A** ↔
Refresh of the Board Governance Assessment Framework	BGAF has been reviewed and considered by the Board Areas identified for development have agreed actions and timeframes.	Several new non-executives who may have insufficient knowledge to form an evidence based view on some areas of the framework.	BAF refreshed and considered by the Board. RAG rating agreed and areas for development and actions identified.	Completed Jul14	**DSA**	**G** **G** ↔

Key Plan	Outcome Measures	Risks	Action	**Milestones**	**Lead**	**RAG Rating**
Development and implementation of a Knowledge Management Strategy	Approved by Board	Further development required by Board	Review by Board in Seminar and approved by Trust Board	Completed Jul14	**DSA**	**G** ↔
Publication of clinical quality measures and survival rates in line with national guidance	Patients are able to view local and national survival rates in identified specialties and compare performance with other Trusts	National guidance not met	A link has been set up to NHS Choices to provide the information	Sep 14	**MDG**	**G** ↓
Undertake Quality Impact Assessments for all programmes of service change	All service level changes have a QIA to assess against key quality indicators	Changes occur without going through the process and are in contradiction of other changes. Quality is adversely affected	Process in place to ensure that Quality Impact Assessments are completed for all services and reviewed in a timely way	1st level Aug14 - completed	**DN/MDG/ MDS**	**G** ↓
Institute a process to allow staffing at ward level to be monitored in line with national requirements	Clear robust process in place complaint with national guidance and supported by NICE guidance	Non inpatient areas have not been reviewed, ie community CIPs could be used to affect the levels of staff Recruitment and retention of staff is not maintained.	Staffing levels agreed Exception reporting bi-monthly to Trust Board Board papers 6 monthly Plans for review in late September/early October 14	Mar 14 Completed and part of the programme of work for the trust board – first paper presented in July 2014. Late Sep/ Early Oct14	**DN**	**G** ↓
Respond to national plans for the revalidation of nursing staff	Plan in place to ensure that the Trust is compliant with the agreed national requirement	Revalidation is not agreed nationally System is complex Large numbers of staff requiring revalidation Medical revalidation system cannot be used to support the process	Review the consultation of the draft code Plan developed to be compliant with the national process, when agreed Further work completed and lead identified	Aug 14 Oct 14	**DN**	**A** ↔

Key Plan	Outcome Measures	Risks	Action	Milestones	**Lead**	RAG Rating
		Capital investment required	Awaiting confirmation from the NMC re exact requirements in the autumn of 2014 Discussion and review of IT systems and programmes available to support this in line with medical revalidation			
Further strengthen Clinical Audit reporting to the Board and its Committees	Clear process in place for Clinical Audit to ensure national and local requirements are met	Medical staff are not engaged in the process	Centralise the governance team and develop a specific Audit team – interim structure Develop further the core skills of the team Interim structure in place with plans for engagement of medical staff. Audit plan monitored through Audit Committee	Sep 14	**MDG/DN**	R/A ↔

ABP Objective – Ensure the organisation takes action to improve quality and outcomes for patients						
Key Plan	**Outcome Measures**	**Risks**	**Action**	**Milestones**	**Lead**	**RAG Rating**
Implementation of mortality screening tool and review of all deaths	Compliance with TDA guidance and achievement of CQUIN target	Loss of CQUIN monies and lack of compliance with TDA guidance	Screening tool data input – 100% compliance achieved Completion of reviews on trajectory for achievement of 90% CQUIN target	Complete Mar 15	**MDG**	G ↓ **A** ↓

Key Plan	Outcome Measures	Risks	Action	Milestones	Lead	RAG Rating
Implementation of the Quality Improvement Programme including QUIPP and CQUIN plans	All QUIPP and CQUIN programmes have a quality impact completed on them with measurable performance indicators. QUIPP and CQUIN programmes are developed to areas of most clinical quality concern Organisation reporting framework Annual plan met by Mar 15 Impact on 15/16 and beyond understood. Regular forecasts confirm plan on target Cash impact understood and managed	Programmes are not meeting the clinical requirements and have an appropriate purposefulness QUIPP and CQUIN are developed without clinician involvement QUIPP and CQUIN lead sits within the COO structure and needs to be linked to the governance team In year cost pressures not covered off by contingencies or other savings plans Savings schemes slip in year Stakeholders challenge Trust's plans	Process in place to ensure a robust delivery of the key programmes with a strong focus on improving the quality and outcomes of our services Budget completed and signed off by Trust Board. CU leads agree to budget plans. Annual plan submitted to TDA and approved Monthly accountability meetings held with Clinical Units	CQUIN monthly report to CME QUIP targets agreed with CCGs Jun 14 Submitted Jun14 On-going	**DN/MDG/ DF/COO**	**A** ↔
Review and redesign of key specialities and sub-specialities	Specialties and sub-specialities requiring review are prioritised Outcomes of review fed into ABP for 2015/6	Reorganisation may mean that Clinical Units have insufficient capacity to undertake reviews The outcome of the CHE work will affect key decisions and reviews will take longer	Process in place to identify specialties and subspecialties which require review Specialties Identified: Gastroenterology Cancer Services.	Complete Jul 14 Mar 15	**COO/ DSA/ MDS**	**G** ↓ **R** ↔
Monitor and review the outcomes of service reconfiguration	Achieved target	Failure to achieve target	As agreed in CQUIN plan with CCGs		**COO/ MDS**	**G** ↔

Key Plans	Outcome Measures	Risks	Action	Milestones	**Lead**	RAG rating
Implementation of Vitalpac	Adverse patient incidents as a result of deterioration significantly reduces by the responsive management of them Patient outcomes are improved	The system is not 'rolled' out across the trust The system is not used by staff Incidents are not responded to or learnt form	Vitalpac system in place across the area and supports the responsive management of deteriorating patients Evaluation of phase one to be undertaken prior to switching on further modules.	1st module completed across all areas – Aug14	**DN/MDS/ MDG/COO**	**A** ↔

Strategic Objective 2 – Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences

ABP Objective - Ensure opportunities and risks of the local health and social care market and of commissioning intentions are understood and responded to						
Key Plan	**Outcome Measures**	**Risks**	**Action**	**Milestones**	**Lead**	**RAG Rating**
Implementation of a tender review and response process	Decisions to tender for business are in line with Trust strategy and business model Successful bids for new or existing business are clinically operationally and financially sustainable	The Trust is not able to offer services which are safe and clinically sustainable within the resources set out in tender documents Where contracts are let to other providers the Trust's overheads increase and are unsustainable	Process in place for risk assessment of services against tenders and business development opportunities Coordination of responses to tenders Review of process	Jul 14 Ongoing Dec 14	**DSA**	**G** **A** **A** ↔
Development and implementation of a marketing and engagement strategy	Strategy agreed by the Board. Clarity about key stakeholders; roles and responsibilities within the trust; improved relationships with key stakeholders	Insufficient resources for relationship management actions identified in the strategy and action plan	Develop marketing and engagement strategy Action plan agreed for 2015/16	Dec 14 Mar 15	**DSA**	**A** **A** ↔

ABP Objective - Ensure active participation in joint programmes of work to improve clinical service design and delivery						
Key Plan	**Outcome Measures**	**Risks**	**Action**	**Milestones**	**Lead**	**RAG Rating**
Engage in the further development of the commissioner led Better Together programme	ESHT active participant in further work 5year plan aligned to commissioning intentions Full alignment between ESBT and CHE work	Failure to draw together ESBT and CHE work leads to misalignment of ESHT 5 year plan and plan for sustainability not achieved	PID and programme governance agreed by TDA, NHSE, CCGs and ESHT Further analytical and pathway development work undertaken		**DSA**	**A** **R** ↔
Engage in the further development of the TDA/NHSE led Challenged Health Economy programme	ESHT active participant in further work 5year plan aligned to commissioning intentions Full alignment between ESBT and CHE work	Failure to draw together ESBT and CHE work leads to misalignment of ESHT 5 year plan and plan for sustainability not achieved	PID and programme governance agreed by TDA, NHSE, CCGs and ESHT Further analytical and pathway development work undertaken		**DSA**	**A** **A** ↔
Engage in the programme of work to support the re-design of community services	Clarity on which community services support Trust strategy and business model Identification of service models which are clinically, operationally and financially sustainable	Reorganisation may slow down this work Staff engagement	Risk assessments undertaken on community services. Risk assessments undertaken on redesigned services. Engaged with CCGs through new management structure.	Jun 14 Oct 14	**MDS/ COO/ DSA**	**A** **R** ↔
Establish the Clinical Leadership Forum as key vehicle for clinical engagement within the Trust and ensure its members are able to engage in external clinical fora as appropriate	Development of Forum to inform the strategic clinical development of the Trust	Engagement does not occur Advice not in line with Trust objectives	Approve Terms of Reference Set work plan Report to Clinical Management Executive	Sep 14	**MDS**	**A** ↔

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

ABP Objective – Ensure the Trust's business model and long term strategic plan deliver clinical, operational and financial sustainability						
Key Plan	**Outcome Measures**	**Risks**	**Action**	**Milestones**	**Lead**	**RAG Rating**
Development of an IBP and LTFM based on the outcome of the Better Together and Challenged Health Economy programmes	LTFM and IBP agreed by TDA 5 year plans are cascaded through the organisation and developed into CU strategic plans Receipt of capital from the TDA	Challenged Health Economy cannot deliver a financially sustainable model for East Sussex Current year's plans impact on future years Delay in capital investment Engagement with clinical units	Updated IBP and LTFM to TDA Ensure engagement with stakeholders in the programmes across the economy. Capital investment approved by the TDA Refresh of IBP IBP priorities feed into ABP for 2015/16	Jun 14 Dec 14 Mar 15	**DF/DSA**	**R** ↔

ABP Objective – Ensure efficiency and effectiveness are improved through the implementation of the Cost Improvement Programme						
Key Plan	**Outcome Measures**	**Risks**	**Action**	**Milestones**	**Lead**	**RAG Rating**
Act to reduce spend on medical agency	**Spend reduced and contained within control totals**	**Breach in control totals**	**Spend being reduced but further work required to ensure local CU control totals are met**	Mar 15	**MDG**	**A** ↓
Improve efficiencies in clinical administration	New service provision agreed	Communications to patients and staff Potential grievance by unions	Consultation completed and implementation plan being actioned.	Nov 14	**COO**	**G** ↔
Improve theatre utilisation and productivity	Closure of theatre sessions	Physical changes required in both theatres and outpatients at Bexhill to allow safe move	Revised Theatre time table implemented August 2014. Ongoing management of utilisation.	Complete	**COO**	**G** ↔
Implementation of a revised Hospital at Night provision at EDGH	Safe service provision	Unable to recruit staff sufficiently skilled to provide a safe service	Plans for re-provision H@N still being revised for Winter.	End Dec 14	**COO**	**R** ↔

Key Plan	Outcome Measures	Risks	Action	Milestones	**Lead**	RAG Rating
Development and implementation of a revised medical model across the Trust	New models on both acute sites	Unable to recruit senior clinicians to fill the rota	Agreement on new structure to allow implementation as appropriate	Sep 14	**COO/MDS**	**R** ↔
Delivery of the clinical correspondence programme	Achievement of CQUIN target	IT interfaces with community systems	Progress reported to CME via monthly CQUIN report	Mar 15	**COO**	**G** ↔

ABP Objective – Implement plans for the delivery of key operational requirements						
Key Plan	**Outcome Measures**	**Risks**	**Action**	**Milestones**	**Lead**	**RAG Rating**
RTT compliance plan	All specialities to be RTT compliant	Insufficient capacity available to achieve compliance in all specialities	Achieve RTT compliance	Oct 14	**COO**	**A** ↔
Diagnostic waits compliance plan	No more than 1% of patients waiting more than 6 weeks	Capacity in radiology and endoscopy and unknown impact of public health campaigns	Regular updates via Board performance report	Sustainable May14 onwards	**COO**	**G** ↔
Ambulance handover improvement plan	Improved ambulance handover times	High levels of demand at Conquest SECAmb unable to reduce conveyance, particularly from nursing and residential homes	Regular meetings between SECAmb & Trust to agree monthly performance	On-going	**COO**	**G** ↔
Cancelled operations improvement plan	Numbers of cancelled operations reduced	Theatre capacity Winter bed pressures Theatre equipment Infrastructure	Cancelled operations performance reported in Board Quality report, Start the Week meetings and Theatre Utilisation weekly meeting	On-going	**COO**	**G** ↔

ABP Objective – Develop and implement enabling strategies and programmes to ensure efficiency and effectiveness of the Trust						
Key Plan	**Outcome Measures**	**Risks**	**Action**	**Milestones**	**Lead**	**RAG Rating**
Development of an estates strategy that supports the Trust's agreed clinical services model	New estates strategy in place	Re-organisation of estates and operational structures that would not give sufficient time for development	Development of estates strategy in collaboration with P21 partners		**COO**	**A** ↑
Development of a Sustainability Management plan	Approved plan in place	Development of plan delayed by corporate restructure and outsourcing of hard Facilities Management service	Production of Sustainable Management Development Plan for estates and facilities for Board approval	Sep 14	**COO**	**A** ↑
Development of an IT Strategy and delivery plan	Strategy implemented Internal transformational plan developed	Delays in implementation Key roles not recruited to Impact of market testing TDA Approval	Strategy submitted and approved by Trust Board Complete review of market testing possibilities Approval by TDA	Jul 14 Mar 15	**DF**	**A** ↓
Review and further development of the Major Incident and Business Continuity Plans	Revised plans in place	Corporate and clinical unit restructure	Revised plans to be available Further modifications to be achieved by Mar15	Aug 14 - complete Mar 15	**COO**	**G** ↔
Review and revision of the Workforce Plan and Trust-wide workforce risk register	A plan which identifies the capacity and capability of the future work force which meets the aims and objectives of the organisations. Specific workforce transformation plans identified and implemented Register of all identified workforce risk across the organisation both Trust wide and area specific.	Flexibility to respond to changing demands within the Trust Ensuring that workforce plan reflects requirements for all areas of the Trust Engagement of the workforce Contractual Flexibility Management /HR Capacity Ensuring that all risks are identified and appropriate mitigation in place	Revised Workforce Plan Trust Workforce Risk Register ? Report to Trust Board	End Aug 14 – Due to the need to focus on CQC data requirements, this date has been moved to end Sept 14.	**HRD**	**A/R** ↔

Key Plan	Outcome Measures	Risks	Action	Milestones	**Lead**	RAG Rating
				End Aug 14 – The Trust workforce risks have been extracted from the Trust risk register and are currently being collated into a single document. Ongoing management of the separate 'workforce risk register' will need to be discussed with the wider Assurance team.		
Conclude the implementation of the Health Rostering programme	Right staff in right place at right time Reduced use of agency and bank usage Real time reporting of staffing numbers and absence	System Support resource not agreed. System use deteriorates due to lack of support. Inability to provide actual nursing numbers from Healthroster	All clinical teams rostered electronically Facilities staff rostered Decision on corporate staff E-Rostering	End Aug 14 – All clinical teams now rostered with the exception of one radiology area – this will be taken forward as part of business as usual. End Dec 14 – Facilities staff rostering has commenced in Bexhill but technical issues have caused delays. A further upgrade is being implemented in mid September and this should resolve the technical issues.	**HRD**	**A/R** ↔

Key Plan	Outcome Measures	Risks	Action	Milestones	**Lead**	RAG Rating
				Once we are confident that Bexhill is working fine, we will continue the implementation but may need to revise the end date. Sep14 – Final decision to be taken by CLT in mid Sept.		
Embed programme management processes in support of delivery of the Annual Business Plan	Regular project reporting to the Board Resources allocated to organisational priorities within the Annual Business Plan PMO recognised as useful organisational resource	Reorganisation of PMO may affect projects Insufficient resource to support prioritised projects	Programme Management Office established Key projects prioritised and resources allocated in line with protocols Review of PMO effectiveness	Aug 14 Sep 14 Mar 15	**DSA**	**A** **A** ↔
Develop and implement a Procurement Strategy	Savings delivered Procurement involved in service delivery Staff recruited to permanently Response to DH guidance agreed by Trust Board	Staff vacancies in key roles covered by interims Savings plans slip Investment may be required to implement strategy DH guidance impacts on other strategies	Strategy submitted and approved by Trust Board Procurement savings identified DH guidance when issued is understood	Sep 14 On-going Dec 14 Dec 14	**DF**	**R** ↑

Key Plan	Outcome Measures	Risks	Action	Milestones	Lead	RAG Rating
Implement key IM&T programmes including PAS upgrade, NHSMail, SystmOne	IT systems implemented successfully with minimal disruption	Delays in implementation Impact of market testing Lack of investment identified TDA approval	Capital investment identified Implementation plans complete and understood	On-going	**DF**	**A** ↔
Development and implementation of an Innovation Strategy	Innovation Strategy implemented	Strategy not fully implemented.	Associate MD Clinical Governance to draft strategy	End Nov14	**MDG**	**A** ↓

COO	Chief Operating Officer
DF	Director of Finance
DN	Director of Nursing
DSA	Director of Strategic Development and Assurance
HRD	Director of Human Resources
MDG	Medical Director – Governance
MDS	Medical Director - Strategy

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	13
Subject:	Capital Programme Mid-Year Review
Reporting Officer:	Vanessa Harris – Director of Finance

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

Purpose:

To update the Trust Board on the mid-year review of the capital programme carried out by the Capital Approvals Group (CAG).

Introduction:

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

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

The capital pressures the Trust is facing are very significant with backlog pressures on maintenance, medical equipment and IT at a time when it is also under pressure on its revenue performance.

The attached mid-year review paper updates the committee on:-

- The current performance of the capital programme.
- The revised capital plan approved by the Capital Approvals Group in order to manage the capital plan within the capital resource limit (CRL).

Benefits:

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

Risks and Implications

The internal capital budget will remain under its current pressure (Board Assurance Item 3.5).

Assurance Provided:

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

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

The mid-year review was conducted by the CAG at its meeting in August.

Proposals and/or Recommendations

The Trust Board is asked to:-

i) Note the current performance of the capital programme
ii) Note the application for additional in year capital

iii) Approve the revised capital plan in order that the Trust does not breach its capital resource limit (CRL) at 31st March 2015

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: Vanessa Harris, Director of Finance	**Contact details:** vanessa.harris2@nhs.net

East Sussex Healthcare NHS Trust

Capital Programme Mid-Year Review

1. Introduction

This report provides a mid-year review of the 2014/15 capital programme including recommendations made by the Capital Approvals Group (CAG).

2. Summary

The 2014/15 capital programme was initially planned on the assumption that the Trust would have available to it two main sources of funding :-

- Planned clinical strategy exceptional public dividend (PDC) capital £17.4m which is subject to approval by the Trust Development Authority (TDA)
- Internally generated capital funding planned within the limit of depreciation.

However, the full clinical strategy business case is still pending TDA approval. In the meantime in order to ensure that the necessary infrastructure and equipment investment can be made, so that performance and quality standards can be maintained through the 2014/15 winter and beyond on a sustainable basis, an application for in-year capital is being discussed with the TDA.

3. Capital Programme Position at Month 4 – 31st July 2014.

At the end of month 4 the year to date capital expenditure amounts to £2.4m.

Commitments entered into amount to £6.4m, and the programme is currently planned with an over commitment margin of £0.3m at the mid-year stage compared to the Trust's currently approved capital resource limit (CRL) of £10.9m, excluding planned but unapproved clinical strategy funding.

The CAG reviewed the capital programme at its August meeting and this level of over commitment is considered acceptable at this stage of the financial year but will continue to require careful management during the remainder of the financial year to ensure the Trust does not exceed its CRL.

The CAG will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital.

4. Current Capital Programme

In order to meet the changing capital requirements of the Trust the initial 2014/15 capital programme has been revised by the CAG and the current capital programme is set out below:-

2014/15 Capital Programme	2014/15 Initial Capital Programme £000s	2014/15 Revised Capital Programme £000s	Expenditure Month 4 £000s
Capital Resources			
Depreciation	11,285	11,285	
League of Friends Support	1,300	1,300	
Clinical Strategy Exceptional Additional PDC	17,400	17,400	
Interest Bearing Capital Loan Repayment	-340	-340	
Gross Capital Resource	29,645	29,645	
Less Donated Income	-1,300	-1,300	
Total NHS Capital Financing (Capital Resource Limit)	**28,345**	**28,345**	
Planned Capital Expenditure			
Clinical Strategy Reconfiguration	17,400	17,400	0
Clinical Strategy Essential Enabling Works	450	250	162
Medical Equipment	3,570	2,637	211
Information Systems	1,179	823	274
Electronic Document Management	200	180	41
Child Health Information System	619	557	158
Backlog Maintenance	1,664	964	51
Infrastructure Improvements – Infection Control	800	610	0
Electrical Supply to the EDGH	600	540	0
Minor capital	2,200	2,200	733
Pevensey Ward	1,000	900	17
Other Various	711	793	232
Brought Forward Schemes	811	811	492
Sub Total	**31,204**	**28,665**	**2,371**
Donated Asset Purchases	1,300	1,300	173
Donated Asset Funding	-1,300	-1,300	-173
Net Donated Assets	**0**	**0**	**0**
Sub Total Capital Schemes	**31,204**	**28,665**	**2,371**
Over Planning Margin	-2,859	-320	
Total Capital Expenditure	**28,345**	**28,345**	**2,371**

5. Capital Pressures & Risks

Although the 2014/15 capital programme has been balanced with a manageable over commitment the programme is under severe pressure and demands for capital expenditure continue to far outstrip available resources.

In order to achieve a balanced position demands for medical equipment have had to be restricted to available resources and the impact on service delivery and quality will need to be carefully managed.

The capital programme does not have any allowance for any unplanned urgent and equipment replacement occurring in the remainder of the financial year and any demand will require current plans to be revisited in year.

The application for additional in- year capital, which is still under discussion, includes some capital elements which have been identified as necessary to ensure delivery of winter resilience or quality and productivity improvements/requirements.

6. Long Term Pressures

The limited capital funds available to the Trust in recent years has constrained spending on backlog maintenance, medical equipment and IT infrastructure. This has resulted in delays in replacement of essential equipment and a consequent increase in maintenance expenditure. To address the current level of risk adjusted backlog and estimates of investment required to prevent further deterioration in the overall estate condition the Trust should be spending £2.8m annually. In addition the estimated medical equipment backlog requires investment of at least £3.0m per year over the 5 year planning period. The IM&T strategy being developed is likely to require significant resources in future years.

7. Recommendations

The Trust Board is asked to:-

i) Note the current performance of the capital programme.

ii) Note that an application for in year capital is being discussed with the TDA.

iii) Approve the revised capital plan in order that the Trust does not breach its capital resource limit (CRL) at 31st March 2015.

Vanessa Harris
Director of Finance

9th September 2014

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	14
Subject:	Operational Resilience and Capacity Plan 2014/15
Reporting Officer:	Richard Sunley, Chief Operating Officer

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

Purpose:

This paper is to provide assurance to the board regarding the Trust's preparedness for winter.

Introduction:

The Operational Resilience and Capacity Plan reflects the work undertaken by the Urgent Care Board and is part of a whole systems approach to managing periods of increased pressure and establishing sustainability for both urgent care and elective activity throughout the year.

Analysis of Key Issues and Discussion Points:

The aim of the Operational Resilience and Capacity Plan (ORCP) is to ensure:

- Seamless, safe & timely care is provided despite variations in demand.
- Delivery of its contracts, national and local operational quality and operational standards and targets.
- Best use of available resources internally and in the local health economy.
- Robust escalation arrangements and processes are in place and understood and embedded as part of the whole systems response to significant operational pressures.

Benefits:

Provides solutions to enable the delivery of safe capacity management and maintain organisational performance.

Risks and Implications

Failure to maintain key services and patient safety if the escalation and control processes are not followed.

Assurance Provided:

Operational Resilience and Capacity Plan 2014/15

Review by other Committees/Groups

Corporate Leadership Team – 16/08/14
Trust Board seminar – 17/09/14

Proposals and/or Recommendations

The Board is asked to note the Trust's preparedness for winter as outlined in the Operational Resilience and Capacity Plan for 2014/15.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
Impact assessment not yet completed.

For further information or for any enquiries relating to this report please contact:	
Name: Pauline Butterworth, Deputy Chief Operating Officer – Operations Directorate	**Contact details:** pauline.butterworth@esht.nhs.uk

East Sussex Healthcare NHS
NHS Trust

OPERATIONAL RESILIENCE AND CAPACITY PLAN 2014/15

Produced By :	Title/Directorate	Date:
Pauline Butterworth	Deputy Chief Operating Officer	July 2014

Person Responsible for Monitoring Compliance& Review	Richard Sunley, Chief Operating Officer
Signature& Date	August 2014

Multi-disciplinary Evaluation/Approval

Name	Title/Specialty	Date:
Corporate Leadership Team		12/08/2014

Ratification Committee

Issue Number (Administrative use only)	Date of Issue& Version	Next Review Date	Date Ratified	Name of Committee/Board/Group
		Sept 2014		Trust Board

CONTENTS

East Sussex Healthcare NHS Trust

OPERATIONAL RESILIENCE AND CAPACITY PLAN

2014/15

1. Introduction

1.1 The ESHT plan reflects the work undertaken by the Urgent Care Board and is part of a whole systems approach to managing periods of increased pressure and establishing sustainability for both urgent care and elective activity throughout the year.

This plan sets out the Trusts response to managing variations in non-elective demand whilst ensuring capacity to maintain the delivery of planned care standards.

It is accepted that these pressures may occur at any time throughout the year and this plan will be activated by the Executive Team when it is considered appropriate to the operational circumstances.

1.2 The aim of the Operational Resilience and Capacity Plan (ORCP) is to ensure:

- Seamless, safe & timely care is provided despite variations in demand.
- Delivery of its contracts, national and local operational quality and operational standards and targets.
- Best use of available resources internally and in the local health economy.
- Robust escalation arrangements and processes are in place and understood and embedded as part of the whole systems response to significant operational pressures.

2. The Plan

The operational model is a key component of the overall plan. Decisions must be made in a structured way and communication must be consistent, both internally and external to the Trust.

Capacity and escalation planning is key to understanding the steps needed to manage variations in demand and service implications. Clear guidance of the actions to be taken are laid out in both the Trust's Escalation Resource Plan (ERP) (see Appendix 1) and the Trust and Business Continuity Plans (BCPs) which can be accessed via the Trust Intranet.

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

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

3. Operational Readiness

3.1 Executive and Operational Lead

The Chief Operating Officer (COO) is the lead for developing the Trust's Operational Resilience and Capacity Plan. It is developed with engagement from all clinical and support areas within the Trust and sensitive to discussions with the wider health and social care community.

Engagements with staff in respect of ward moves, service redesigns and patient pathway changes that support operational resilience are subject to a communication plan developed by the Communication Team.

The COO or Deputy COO is responsible for leading any business continuity incident that arises from operational resilience, including infection outbreaks and inclement weather.

3.2 Managing Capacity

Trust forward planning and monitoring will be developed and managed through a senior operational group chaired by the COO.

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

The Whole Systems Task Group (WSTG) will be convened if deemed necessary by the COO or his nominated deputy (Executive Director out of hours) as per the Whole Systems Escalation process (WSEP).

The decision to open or close identified escalation beds will be agreed by the COO or his nominated deputy (or Executive Director out of hours) but only after the following action has been taken:-

- Discussion between Clinical Units at General Manager/ Head of Nursing level to ensure communication about opening additional capacity is agreed with assurances around supporting staffing plans.
- A plan for de-escalation is agreed.
- Clear review and governance arrangements throughout escalation and de-escalation are agreed and signed off by the Clinical Director/ Head of Nursing/GM.

The bed utilisation plan for next day elective admissions will be formulated in the previous day Site Meetings.

The Trust and Clinical Unit/Department BCPs will be used when adverse events occur. This is a separate process from major incident planning.

Management of infection control issues will be carried out at the bed conference calls. Representatives from the Infection Control Team will attend and work with the Site Team to place patients appropriately and give advice. In the event of an infection outbreak being declared BCPs will be applied. Clinical leadership will be provided by the Director of Infection Prevention & Control (DIPC), and operational leadership led by the COO.

The Clinical Unit for Surgery will maintain elective activity within planned care bed base (taking account of their own efficiency plans and increased use of Day Surgery resources) in order to achieve and maintain delivery of 18 week and Cancer access targets. It will also ensure it is able to manage any variation in non-elective demand, particularly trauma activity, within its own bed base.

The Clinical Unit for Medicine will manage any variation in non-elective activity by maintaining good patient flow and appropriate and timely discharge. However, it is recognised that even with very active discharge management, demand can be such that additional capacity may be required. The senior operational group will manage the opening of any additional capacity in-line with the Trust Escalations/Business Continuity Plans. This must take into account the likely need for flexing bed capacity, including the community and social care setting and managing capacity appropriately for infection outbreaks.

Additional capacity will be available in the following areas:-

CONQUEST

28 beds on Tressell Ward: to be managed by Cardiovascular Clinical Unit.

EDGH

28 beds on Folkington Ward: to be managed by Cardiovascular Clinical Unit.

The Theatres and Clinical Support Clinical Unit will manage any variation in demand on their services. They will ensure capacity is put in place to maintain good patient flow and appropriate and timely discharge and the delivery of all Trust access targets. The Clinical Unit will also support the opening of additional capacity and special measures to maintain services during periods of Infection outbreaks.

3.3 Site Management

The Site Manager at Conquest Hospital and Eastbourne DGH will coordinate elective and emergency patient flow. There will be regular meetings on each day at which senior representatives from all clinical and support services will attend. In addition, they will deal with site issues.

Staffing issues are the responsibility of the Heads of Nursing and Ward Managers within the Clinical Units during the hours of 8.00 am – 4.00 pm, and will be overseen and appropriate actions taken by the Site Team outside of these hours.

In escalation (amber onwards) there are four across site bed conference calls held at 09.30,12.00, 15.00 &17.30 hours .Operational staff use a task list (contained within the Escalation Resource Plan (ERP) which gives guidance on internal triggers & actions required at times of escalation.

The Whole System Operational Resilience Plan has been developed by the CCG which will support the Trust in its management of capacity pressures. The policy includes triggers for escalation and incorporates interventions required to support ESHT by all local partners. This will be reinforced through the Integrated and Urgent Care Networks.

In addition, to ensure a timely and consistent whole system response when levels of DTCs at the Trust reach 24 and above, the escalation to the WSTG is authorised by the COO or his deputy. Senior managers will report into the COO or Deputy COO on outcomes and seek support for further escalation as required. In the Out of Ours (OoHs) scenario this will be the responsibility of Executive Directors.

The COO or his deputy will require updates from a nominated General Manager of the Day relating to escalation issues, with assurance that the Escalation Plan has been followed. The COO or his deputy will provide support/ advice/ intervention as required. In the Out of Ours (OoHs) scenario this will be the responsibility of Executive Directors.

General communications of actions taken at the conference calls will be part of the bed report (sent out via email). The Clinical Unit representative of the Day will attend site meetings and the On Call Manager (OCM) for the day will take handover no later than 4pm. If the Trust operational status is amber or red the Executive on Call will be informed.

Actions in the bed report will be linked to the indicators and triggers in the ERP. The Site Team must communicate to all relevant staff and agencies the actions identified at the 9.30am bed conference call. This needs to take place by 10am.

General Managers and Heads of Nursing will support the Site Team by for example contacting Consultant staff, liaising with Adult Social Care and other actions as appropriate. The actions will be clear with expected outcomes and timescales for reporting back to the Site Team.

Each morning, the Site Team will produce a list of outliers (medical and surgical specialties) for distribution to the Clinical Teams. (This will ensure that the patient's location is known). The Medical Teams and Multi-Disciplinary Teams (MDTs) will manage the outliers proactively with the aim of repatriating to appropriate specialty ward as soon as possible or ensuring appropriate and timely discharge, 7 days per week.

Actions will include:

- Stroke & trauma patients are to have direct access to specialty beds (Network and SOE assurance to be included).

- Site Team to manage all admissions irrespective of 'decision to admit' point.

- Admissions areas will not be used as in-patient areas.

A daily winter situation report (SITREP) is agreed by a designated Executive Director and reported to the TDA.

3.4 Patient Flow - Additional Support

- Named Adult Social Care (ASC) workers are allocated to all Medical Wards and meet twice weekly to do Board Rounds. This will include the Lead Nurse, Discharge Nurse(s) and the named ASC worker(s). In addition, MDTs are now attended by the ASC and Discharge Nurse. This is essential to ensuring ward staff have accurate and timely information relating to discharge planning.

- Additional medical support is in place over the weekend and Bank Holidays to review in-patients and ensure appropriate and timely discharge.

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

- Extended bed conference on Friday 9.30 am will discuss plans for Weekend and Bank Holidays, including identified patients for discharge in order to maintain patient flow. (This will require support from Primary Care and ASC).

- Additional Patient Transport Service (PTS) arrangements for known periods of high demand, for example the Christmas and New Year period, will be the subject of discussion with Commissioners. This will be led by the Whole Systems Patient Flow Manager or their nominated deputy.

- As from 1st December six day therapies will be in place for the Medical wards.

- Weekly whole systems operational meetings will be held to focus on appropriate placement of patients in the community and DTC's.

- Integrated Community Access Point (ICAP) to circulate daily information of bed availability and demand, including number of patients that have been referred and those accepted. In return, providers to ensure ICAP have provider status available by 10am each morning. This will ensure patient placements can be prioritised appropriately.

3.5 Cancellation of Surgery

In the event of significant pressure on bed and theatre capacity there may be a need to cancel planned surgery. The following process will be adhered to.

Designation of beds for the next day elective activity will be considered as part of the daily Site Team meeting with the relevant General Managers present. All Clinical Units must be represented in this planning process to ensure all patients are prioritised according to clinical need and patient safety.

Decision

- The decision to cancel a scheduled operation lies with the COO or nominated deputy. The decision will be made in conjunction with the Clinical Unit Manager, the admitting Consultant and the Site Team and after the Protocol for Cancellation of Operations has been followed.

Reporting

- The cancellation(s) will be reported as per the Referral Management Administrative Guidance.

Follow up Action

- Following cancellation of any elective operation the Clinical Unit for Surgery is responsible for ensuring that the patient is given a date either on day of cancellation or within the next two working days.

- It is the responsibility of the Admissions staff to ensure that the PAS record includes details of cancellations. This information will be taken into account should further cancellations be required.

3.6 Mortuary Services

3.6.1 The Trust currently has storage capacity as follows:

Mortuary	Permanent Body Fridge Storage	Permanent Body Freezer Storage	Additional Cold Storage Capacity	Total Potential Storage Capacity
Conquest	79	4	12	95
EDGH	85	4	12	101
Total	164	8	24	196

There are 12 additional cold stores for supply to either site.

The Trust has good working relationships with the local funeral directors who have previously responded to requests for support in times of increased demand, including weekends and Bank Holidays. It is anticipated that this level of service will continue. December 27th – 31st will be deemed to be routine working days. Monitoring of the body stores will be undertaken on a daily basis and decisions to utilise the Eastbourne body store to support the Conquest site may be taken at times of peak demand.

3.7 Christmas & New Year Plans

The Trust will produce a document, by December 1st 2014, detailing service arrangements to enable smooth consistent service delivery during the Christmas and New Year holiday period.

3.8 Flu Pandemic Implementation Strategy

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

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

3.9 Major Incident Escalation

The Trust has a Major Incident Plan, with contribution in the health economy Emergency Planning Groups.

4. NHS/Social Care Joint Arrangements

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

All referrals for Intermediate Care Assessment (ICA) are dealt with by a single point of access telephone number (ICAP). The referral is considered by a clinician and appropriate action taken to ensure patients are assessed for suitability to intermediate care and for a transfer to be expedited by the team as required.

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

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

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

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

5. Critical Care Services

ESHT has the funded capacity for 11 Level 3 Critical Care beds (Conquest 6, EDGH 5) and 8 Level 2 Critical Care beds (Conquest 5: EDGH 3). This capability can be flexed to meet demand. Flexibility to manage demand peaks is available through overnight post-operative recovery services at Eastbourne DGH.

This service provides overnight Level 2 care in the Post Anaesthetic Care Unit within the Operating Department and enables complex elective surgery to go ahead irrespective of the bed state in ICU/HDU.

The Critical Care Outreach Team has been particularly successful since it was introduced in November 2004. The aim of this team is to provide support, both clinically and educationally, to the ward staff and junior doctors in order that patients may be prevented from requiring Level 2 or Level 3 support in the intensive care units. This level of support has prevented a number of admissions to the units and will continue throughout the year. It also has a crucial role in following up patients discharged from critical care and helping to avert re-admissions.

The Critical Care Delivery Group will continue to meet to steer the direction of critical care services for the Trust.

The Sussex Critical Care Network is well established. The Critical Care Units commence further bed exploration outside the transfer network for Critical Care beds once all potential 'in network placements' have been exhausted.

<u>Critical Care Reporting Arrangements</u>

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

- Cancelled operations due to lack of an ITU bed are reported through the Theatre Information System.
- Use of extra non funded beds or any change in category (from Level 2 to Level 3) are reported through the Ward Watcher System and reported by the Critical Care Audit Nurse to the Critical Care Delivery Group.
- Transfers of patients to other Critical Care Units are recorded on the Critical Care Transfer Form. The clinical matron/general manager for critical care will be informed and will in turn inform the Chief Executive via the Chief Operating Officer.

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

- Critical care level 2&3 beds are declared through Unify to SHA on a daily basis.

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

Escalation of Critical Care Services

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

- Unfunded bed(s) will be utilized in the first instance. A clinical decision will be required as to whether the existing patients or the patients requiring admission would be more appropriately managed in another critical care facility.

- Patients can be cared for and ventilated in the theatre recovery area for a limited period of time, whilst arrangements are made to either transfer a patient from critical care to a general ward, or arrange to transfer a patient to another critical care unit within ESHT.
- In the event that there are no beds within ESHT; other critical care units within the local transfer Network will be approached for a bed. If necessary, the patient will remain in theatre recovery until a bed is located.

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

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

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

6. Preventative measures

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

The staff vaccination programme will run with a series of clinics arranged across all Trust sites.

Occupational Health will prioritize over subsequent forth coming months. A variety of internal communications will be used to advertise and promote clinics.

The Trust's Communication Department co-operates with communication leads from the local CCGs and Social Services to ensure that the media relation plans for winter are agreed and in place, including the campaigns, 'The Earlier the Better'.

7. Communications

The Head of Communications will ensure that all external communications are directed at the right areas and that local communities are aware of how they can help their local NHS.

The Trust co-operates with communication leads from the local CCGs, ASC & SECAMB to ensure that the media relations plans for winter are agreed and in place. This ensures a Whole Health economy approach and a consistent message throughout East Sussex. Over previous years the pro-active media relations plan has been derived from the guidance issued by the DH 'Choose Well Campaign'.

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

The Trust provides proactive information to the TDA, CCGs and LHRP via a daily SITREP and capacity management tool. The Trust will use appropriate spokespersons including the Chief Executive, COO, Director of Nursing, Medical Director and Clinical Directors.

The Director of Strategic Development and Assurance, together with the Head of Communications, takes the lead in the event of adverse publicity about services, supported, if necessary, by the Chief Executive, COO, Chairman, the Executive Team and Board Directors.

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

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

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

East Sussex Healthcare NHS
NHS Trust

ADMINISTRATIVE GUIDANCE NOTES

Escalation Resource Plan

Written/Produced By:	Title/Directorate	Date:
Jane Darling Pauline Butterworth	Deputy Chief Operating Officer and Patient Flow Manager	November 2011

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

Multi-Disciplinary Evaluation / Approval

Name	Title/Specialty	Date:

Ratification Committee

Issue Number (Administrative use only)	Date of Issue& Version	Next Review Date	Date Ratified	Name of Committee/Board/Group
	November 2011			**CME**
	August 2014 V7			**CLT**

CONTENTS

Escalation Resource Plan

1. Background

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

2. Purpose of Guidance:

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

3. Process to Follow:

Cross site operational conference calls are held three times a day (9.30, 12.00, 15.00 and 17.30 hours). A bed report and action plan is provided immediately after each operational conference call detailing the current and predicted situation within the organisation, taking into consideration other ‘whole system’ issues.

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

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

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

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

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

4. ERP Levels

ERP Level 1- Normal service - Green

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

ERP Level 2 - Concern – Amber

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

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

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

ERP Level 3 - Severe Pressure – Red

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

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

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

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

ERP Level 4 - Potential Service failure - BLACK

Factors/Triggers at level 4 are:

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

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

- Inform Chief Executive

5. Co-ordination & Assessment of information

- The General Manager for Urgent Care or nominated deputy will chair the daily bed conference calls where the assessment of triggers will be carried out and the current operational level agreed. The Chief Operating Officer/Deputy/Exec on call will be advised when escalation to red occurs. In hours, escalation will be to the Deputy COO if the COO is not available. This is to ensure senior overview of operational pressures is maintained at all times.

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

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

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

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

ERP LEVEL1- NORMAL SERVICE				
	ACTION	**RESPONSIBLE**	**IMPACT**	**REVIEW**
ERP LEVEL 1 - NORMALSERVICE	**Staffing**		**PREVENTATIVE ACTIONS REQUIRED TO SUSTAIN PERFORMANCE AND PATIENT CARE**	**REPORT BACK TO THREE TIMES DAILY CROSS SITE CONFERENCE CALLS**
	Highlight daily staffing shortages to CM's to report back within an agreed time frame	CSM's/CM's		
	Weekend staffing cover required for forward planning, report back within an agreed timeframe	CM's/CSM's		
	Staffing cover for bank holiday period required for forward planning, report back within an agreed time frame	CM's/CSM's		
	Patient Flow, Ward Rounds, Discharges			
	Limited discharges-escalate to GM's/HONs	CSM's/CM's/GM's		
	Identify early discharges, expedite confirmed discharges using the Discharge Lounge	CSM's		
	Potential discharges- clarify plan, and action as necessary	CSM's/ Ward Teams		
	Ensure all ward rounds have commenced by 9.30am,escalate to GM's if not achieved	CSM's/GM's		
	Deliver Discharge pro forma & reinforce need for info to be available by 12pm	CSM's		
	Reinforce discharge benchmark for each ward	CSM's/ HON		
	Patient Flow-A&E			
	Monitor Pt flow at front end, liaise with A&E leads for hourly SitRep	CSM's both sites		
	Highlight all potential breaches at 2.45 hours that do not have a plan	A&E Leads/CSM's both Sites		
	Highlight all potential breaches at 3.15hours that do not have a plan	CSM's Both sites to CM		
	A&E Lead to advise CSM's if Ambulances cannot be offloaded>15 mins	A&E Leads/CSM's both Sites		
	Escalate all ambulance queuing issues to HoN/GM Urgent care, if wait times likely to exceed 30mins	CSM's Both sites/HON		
	Report >3 ambulances waiting to off load at any given time to GM	CSM's Both sites/ HON		
	Escalate all unresolved site issues to GM	CSM's Both sites/ HON		
	Critical Care Beds			
	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSM's both sites /ITU Consultants		
	Infection Control			
	ICN review of side room provision (Monday & Wednesday)	ICN both sites/CSM's		
	ICN review of specific infection control issues	ICN both sites/CSM's		
	Whole Systems			
	Weekly Operational Conference Call	GM Out of hospital DN/CM,CSD		
	Board Rounds- Mon AM/Wed PM	SM Urgent		

ERP Level1 – Normal Service - Green - Notes
1. The Trust is operating normally
2. Demand is at expected levels and being managed effectively
3. Resourcing is satisfactory therefore work is considered and acceptable
4. There are no excessive demands on the Trust due to weather, significant events NHS Capacity or technology issues
5. The Trust is meeting its key performance targets

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

ERP LEVEL 3 - CONCERN	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
	Patient Flow- A&E	**Patient Flow-A&E**		PREVENTATIVE ACTION REQUIRED TO SUSTAIN PERFORMANCE AND PATEINT CARE	REPORT BACK TO THREE TIMES DAILY CROSS SITE CONFERENCE CALL
	Over 10 confirmed A&E breaches across the site in the previous 12 hours	Monitor Pt flow at front end, liaise with A&E leads for hourly Sit Rep	CSM's both sites		
		Contact PSL/CCG(GP's),IC24: Current operational status	CSM's both Sites		
		Highlight all potential breaches at 2.45 hours that do not have a plan	A&E Leads/CSM's both Sites		
		Highlight all potential breaches at 3.00 hours that do not have a plan	CSM's Both sites		
	Up to 5 Ambulances unable to offload within 30 minutes within a defined 8 hour period(0.00Hrs- 08.00Hrs,08.00Hrs-16.00Hrs,16.00Hrs-00.00Hrs)	A&E Lead to advise CSM's if Ambulances cannot be off loaded within 15mins	A&E Leads/CSM's both Sites		
		Escalate all ambulance queuing issues to HON Urgent Care if wait times likely to exceed 30mins	CSM's Both sites to HON		
		Report>3ambulances waiting to offload at any given time to HON Urgent Care.	CSM's Both sites to CM,CSD		
		Liaise with SECamb regarding current operational status	CSM/HoN		
		Escalate all unresolved site issues to CM	CSM's Both sites to CM		
	Critical Care Beds	**Critical Care Beds**			
	<1 Level 3 critical care bed per Site	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSM's both sites liaise with ITU Consultants		
	Infection Control	**Infection Control**			
	Infection Control Issues impacting on bed capacity	ICN review of side room provision(Monday& Wednesday)	ICN both sites to CSM's		
		ICN review of specific infection control issues	ICN both sites to CSM's		
	Whole Systems	**Whole Systems**			
	DTC's across Site> 24but<30	Weekly Operational Conference Call	GM Out of Hospital		
		Board Rounds-Mon AM/ Wed PM	SMs Urgent care		

ERP Level 2 – Concern - Notes
1. Additional Attendees at cross site conference call–Assistant Director of Nursing, GM'S
2. Out of Hours-GM to chair the cross site conference calls and attend either hospital site as required. GM to remain on site till 7pm at least.

.

ERP Level 3 - Severe Pressure- Six or more of the following triggers need to be met before declaring this level:					
ERP LEVEL 3 – SEVERE PRESSURE	**TRIGGERS**	**ACTIONS**	**RESPONSIBLE**	**REVIEW**	**IMPACT**
	Staffing	**Staffing**		PREVENTATIVE ACTION REQUIRED TO SUSTAIN PERFORMANCE AND PATEINT CARE	REPORT BACK TO THREE TIMES DAILY CROSS SITE CONFERENCE CALL
	Staffing issues- >10 nursing staff per shift, per Site	Highlight daily nursing shortages to HONs to report back within an agreed time frame, review use of specialist nurses & review use of alternative staffing groups	CSM's/ HONs		
		No short notice leave to be granted<48hours/review non essential training, consider re-scheduling	Deputy COO, ADs, and ADNs		
		Weekend staffing cover required for forward planning, report back within an agreed timeframe	HON to CSM's both sites		
		Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe	HON to CSM's both sites		
	Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E>6 hours	Re-deploy medical staff to the front end	Deputy COO/ADNs/GMs		
		Medical study leave/ training sessions to be reviewed & stopped as necessary	Deputy COO/ADNs/GMs		
		Audit half days to be cancelled	Clinical Leads/GMs		
		Consider use of locums	Deputy COO/ADNs/GMs		
	Patient Flow, Discharges	**Patient Flow, Ward Rounds, Discharges**			
	No beds available on MAU Or SAU across the Site	Early discharges, utilize discharge lounge in order to create capacity in acute access points	CSM's/ Ward Teams		
	Lessthan5discharges identified per Site	Limited discharges- escalate to all GMs/HONs/ADNs	CSM's/ADNs/HONs//GM's		
		Identify early discharges, expedite confirmed discharges using the Discharge lounge	SM's both Sites		
		Potential discharges- clarify plan, and action as necessary	SM's/Ward Teams		
		Continue Grand Rounds	Clinical leads		
		Deliver Discharge preform a & reinforce benchmark, info to be available by12pm	SM's both sites		
		Reinforce discharge benchmark for each ward	SM's both sites HONs		

	TRIGGERS	ACTIONS	RESPONSIBLE	REVIEW	IMPACT
ERP LEVEL 3 – SEVERE PRESSURE	**Patient Flow**	**Patient Flow-Bed Capacity**		PREVENTATIVE ACTION REQUIRED TO SUSTAIN PERFORMANCE AND PATEINT CARE	REPORT BACK TO THREE TIMES DAILY CROSS SITE CONFERENCE CALL
	More than10 beds closed per Site	Review rationale for closed beds and report at crosssite conference call	CSM's both Sites		
	More than 20 additional beds open per the Site	Review rationale for additional open beds and report at cross site conference call	CSM's both Sites		
	TCI's cancelled on the day	Review plan going forward for TCI's except urgent and cancer stream. No cancellations without agreement of COO/Deputy COO	CSM's both Sites		
	Elective cancellations 24 hours previously				
	Patient Flow- A&E	**Patient Flow-A&E**			
	A&E flow KPIs not being met	Monitor Pt flow at front end, liaise with A&E leads for hourly Sit Rep	CSM's both sites		
	Over 20 confirmed A&E Breaches across the Site in the previous 6 hours	Contact HERMES/PCT(GP's),South East Health recurrent operational status, request alternatives pathways/admission avoidance	CSM's both Sites		
		Highlightallpotentialbreachesat2.45hoursthatdo not have a plan	A&E Leads to CSM's both Sites		
		Highlightallpotentialbreachesat3.15hoursthatdonothavea plan	CSM's Both sites/HON		
		Open additional bed capacity including day surgery & other clinical areas	CSM's both sites		
	More than 6 Ambulances unable to off load within 30 minutes within a defined 8 hour period(0.00Hrs-08.00Hrs,08.00Hrs-16.00Hrs,16.00Hrs-00.00Hrs)	A&E Lead to advise CSM's if Ambulances cannot be offloaded> 1hour,implementcohorting	A&E Leads to CSM's both Sites		
		Escalate all ambulance queuing issues to GM/HON Urgent care if wait times exceed 30mins	CSM's Both sites/HON		
		Report >3 ambulances waiting to off load at any given time to CM	CSM's Both sites/HON		
		Liaise with SECamb regarding operational status, consider Divert	COO/Deputy COO/ AD UCD		
		Escalate all unresolved site issues to GMs/HONs/Deputy COO	CSM's Both sites/ HON		

ERP LEVEL 3- SEVERE PRESSURE	TRIGGERS	ACTIONS	RESPONSIBLE	REVIEW	IMPACT
	Critical Care Beds	**Critical Care Beds**		ACTION REQUIRED TO SUSTAIN PREVENTATIVE PERFORMANCE AND PATEINT CARE	REPORT BACK TO THREE TIMES DAILY CROSSSITE CONFERENCE CALL
	No Level 3 critical care beds per site	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSM's both sites liaise with ITU Consultants		
	Infection Control	**Infection Control**			
	Infection Control Issues impacting on bed capacity	ICN review of side room provision (Monday & Wednesday)	ICN both sites to CSM's		
		ICN review of specific infection control issues	ICN both sites to CSM's		
	Whole Systems	**Whole Systems**			
	DTC's across Site>30	Increase Operational Conference Calls to daily	GM Out of Hospital with Whole System		
		Board Rounds – Mon AM/Wed PM	CM's		
		Chief Operating Officer/Deputy to inform whole systems task group	COO/Deputy COO		

Notes:
1. Additional attendees at Bed Meetings-, COO &/ or Deputy COO, ADNs Senior Facilities representation 2. Representation from A&E Leads
3. ASC & CCG Provider to be present at 9.30 hours and12.00hrs bed meetings
4. Out of Hours- GM to attend bed meeting and either Hospital Site as required. Must remain on site until 10pm at least.
5. Out of Hours-Exec on Call to chair bed meetings and attend either Hospital Site as required

ERPLevel 4–Potential Service Failure-Triggers:

1. **When the RED Triggers continue for over 72hours and are not expected to resolve within the next 24hours**.COO or deputy to Liaise with Whole Systems Task Group for consideration to elevate to Black Status:
2. Implement Business Continuity Plans due to inability of the Trust to maintain normal service delivery due to adverse events e.g severe weather conditions, infection outbreak, extraordinary depletion of resources, loss of priority fuel supplies-in these cases business continuity plans will be activated

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERP LEVEL 4 – POTENTIAL SERVICE FAILURE	**Staffing**	**Staffing**		POTENTIAL SERVICE FAILURE WHICH WILL AFFECT PERFORMANCE AND PATIENT CARE	REPORT BACK TO CROSS SITE CONFERENCE CALL
	Staffing issues- >10 nursing staff per shift, per Site	Highlight daily nursing shortages to HONs to report back within an agreed timeframe, review use of specialist nurses & review use of alternative staffing groups	CSM's/ HONs		
		No short notice leave to be granted<48hours/ review non essential training, consider re-scheduling	Deputy COO ADs/ ADN's/GMs		
		Weekend staffing cover required for forward planning, report back within an agreed timeframe	HONs to CSM's both sites		
		Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe	HONs to CSM's both sites		
	Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E>6 hours	Re-deploy medical staff to the frontend	GMs		
		Medical study leave/ training sessions to be reviewed& stopped as necessary	GMs/Clinical Leads		
		Audit half days to be cancelled	Clinical Lead		
		Consider use of agency staff	GMs		
	Patient Flow, Ward Rounds, Discharges	**Patient Flow, Ward Rounds, Discharges**			
	Less than 5 discharges identified per Site	Limited discharges – escalate to all GMs & HONs	CSM's/ HONs/GM's		
		Identify early discharges, expedite confirmed discharges using the Discharge lounge	CSM's both Sites		
		Potential discharges-clarify plan, and action as necessary	CSM's/ Ward Teams		
		Instigate Grand Rounds	Clinical Lead/GMs		
		Deliver Discharge proforma &reinforce benchmark, info to be available by12pm,reinforce discharge benchmark	CSM's both sites		
		Cancel all TCI's	COO/Deputy COO/ GMs		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERP LEVEL 4 – POTENTIAL SERVICE FAILURE	**Patient Flow**	**Patient Flow-Bed Capacity**		POTENTIAL SERVICE FAILURE WHICH WILL AFFECT PERFORMANCE AND PATIENT CARE	REPORT BACK TO CROSSSITE CONFERENCE CALL
	No beds available on MAU or SAU across the Site	Early discharges, utilize discharge lounge in order to create capacity in gateway areas	CSM's/ Ward Teams		
	Morethan10 beds closed per Site	Review rationale for closed beds and report at cross site conference call	CSM's both Sites		
	More than 20 additional beds open per the Site	Review rationale for additional open beds and report at cross site conference call	CSM's both Sites		
	TCI's cancelled on the day	Review plan going forward for TCI's except urgent and cancer stream	CSM's both Sites		
	Elective cancellations 24 hours previously				
	Patient Flow- A&E	**Patient Flow-A&E**			
	A&E performance is below 98%	Monitor flow at front end, liaise with A&E leads for hourly Sit Rep	CSM's both sites		
	Over 20 breaches across the site in the previous 6 hours, all extra capacity beds open	Highlight all potential breaches at2.45hours that do not have a plan	A&E Leads to CSM's both Sites		
		Contact CCGs (GP's),South East Healthcare: current operational status, request alternative pathways/ admission avoidance	CSM's both Sites		
		Highlight all potential breaches at 3.15hours that do not have a plan	CSM's Both sites to HoN/GM		
	More than 6 Ambulances unable to off load within 30 minutes within a defined 8 hour period (0.00Hrs-08.00Hrs, 08.00Hrs-16.00Hrs, 16.00Hrs-00.00Hrs)	Escalate all ambulance queuing issues to HON/GM urgent Care and Deputy COO if wait times exceed 30mins	CSM's Both sites to HoN/GM		
		Report >3 ambulances waiting to off load at any given time to HoN Acute medicine and patient Flow Manager.	CSM's Both sites to HoN		
		Liaise with SECamb regarding operational status, consider Divert	Chief Operating Officer/Deputy COO		
		Escalate all un-resolvable site issues to Deputy COO	GMs/HONs		
	Critical Care Beds	**Critical Care Beds**			
	No Level 3 critical care beds per site	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSM's both sites liaise with ITU Consultants		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERP LEVEL 4	**Infection Control**	**Infection Control**		POTENTIAL SERVICE FAILURE	REPORT BACK TO CROSS SITE CONFERENCE CALL
	Infection Control Issues impacting on bed capacity	ICN review of side room provision (Monday & Wednesday)	ICN both sites to CSM's		
		ICN review of specific infection control issues	ICN both sites to CSM's		
	Whole Systems	**Whole Systems**			
	DTC's across Site >30	Daily Operational Conference Call	GM Out of Hospital		
		Board Rounds-Mon AM/Wed PM-add in Friday	HoNs		
		Daily Whole Systems Task Group	Chief Operating Officer/Deputy		

Notes:

1. Additional attendees at Bed Meetings-COO/Deputy COO, ADNs /Director of Nursing
2. Facilities representation
3. Representation from A&E Leads
4. In Hours– COO/Deputy COO (AD UCD if COOs not available) **Out of Hours, Exec Director on call.**
5. Out of Hours-GM to attend bed meeting and either Hospital Site as required. Must remain on site until 10pm at least.
6. Out of Hours-Exec on Call to chair bed meetings and attend either Hospital Site as required
7. For additional actions please refer to Trust Business Continuity Plan

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	15
Subject:	Board Sub-committee Reports and Trust Board Seminar Notes
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

The attached report provides a summary of the meetings of the Board sub-committees and the notes of Trust Board seminars held since the last meeting.

Introduction:

The following committees have been established as formal sub-committees of the Board.

- Audit Committee
- Finance and Investment Committee
- Quality and Standards Committee
- Remuneration and Appointments Committee

It is best practice for each Committee to summarise key points from their meetings and share these with the Board along with formal minutes of the meeting. The Board has also agreed that notes of the Trust Board Seminars will be circulated with the Trust Board agenda papers.

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

The attached reports provide a summary of the key discussion points at each of the sub-committee meetings that have taken place since the Board last met.

Benefits:

This practice will increase Board awareness of key issues being considered by its sub-committees.

Risks and Implications

Failure to implement the arrangement effectively may result in Board members being unaware of key issues within the Trust.

Assurance Provided:

This report provides the Board with assurance that effective governance arrangements are in place.

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

Not applicable.

Proposals and/or Recommendations

The Board is asked to review and note the documents.

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:** (13) 4278

East Sussex Healthcare NHS Trust

Audit Committee

1. Introduction

Since the Board last met an Audit Committee has been held on 3 September 2014. A summary of the items discussed at the meeting is set out below.

2. Board Assurance Framework and High Level Risk Register

The Company Secretary presented the High Level Risk Register and the Board Assurance Framework and updated the Committee on gaps in control or assurance that had been removed or revised.

It was noted that a significant amount of work had been done on the high level risk register and this work was ongoing.

It was noted that a new risk had been added:

'We are unable to invest in delivering/improving quality of care and outcomes for patients because we are operating in a challenged health economy and this could impact on our ability to make investment in infrastructure and service improvement'

3. Clinical Audit Update

An overview was given of the clinical audit activity that had taken place across the Trust in this year. It highlighted some of the identified risks and improvement measures that had been implemented as a direct result of Trust wide activity.

The number and nature of open audits was reviewed. Improving clinical engagement will be a key focus in the months ahead. Within the new governance structure there would be identified clinical audit facilitators who would be working very closely with the clinical units and associated audit leads to assist in the completion of the outstanding audits, this will lead to an improvement of the RAG ratings on the Forward Plan.

It was noted that two NCAPOP audits were currently rated as red and these were National Vascular Registry (NVR) in Vascular Surgery, and the Rheumatoid & Early Inflammatory Arthritis National Audit in Rheumatology. Progress and issues with these audits was discussed and the Medical Director was asked to help with support for the second audit. A further update would be provided at the next meeting.

4. Internal Audit

The Committee received the Internal Audit Progress Report and was updated on the progress against the action plan. It was noted that since the previous update, a further three audits had been finalised.

The Internal Audit Charter was presented to the Committee. It was a requirement by the Public Sector Internal Audit Standards (PSIAS) for internal audit providers to have an agreed Internal Audit Charter in place. The Charter was agreed subject to some minor changes.

The updated Audit Recommendations Tracker was presented. It was noted that significant progress had been made with closing down many of the audit points.

5. Local Counter Fraud Service

The Committee received the progress report and noted actions being taken on new reactive investigations and one initial referral. Alongside the reactive work it was noted that that the good progress was being made with the agreed actions in the 2014/15 workplan.

The final report submitted to the Trust by NHS Protect was noted. This detailed findings from the Focused Fraud Assessment carried out by NHS Protect on 19 and 20 June 2014. Areas requiring improvement had been included in the report. It was recommended that NHS Protect meets with the Trust again in January 2015.

6. External Audit Progress Report

The external auditor presented a progress report on the external audit work for 2014/15 and highlighted the key issues. It was noted that the Use of Resources RAG rating is red given that the Trust had set a deficit budget.

7. Research Governance Annual Report

The Committee received the Research Governance Annual Report which outlined research governance and associated activities over the past year.

8. Tenders and Waivers Report

The Committee noted the Tenders and Waivers report.

9. Review of aged debts

The Committee received a report showing the current level of aged debt, split between NHS and non NHS. It was noted that overall levels of outstanding debt had increased since the last report to the Audit Committee. The increase was mainly due to NHS Sundry debt. A specific project was underway to improve collection of debt and it was agreed that in future aged debt reports would be presented to the Finance & Investment Committee rather than the Audit Committee.

10. Review of losses and special payments

The report showing the losses and special payments made during April – July 2014 was noted. There were no novel or contentious items highlighted in the report. The largest elements related to outdated pharmacy stock and employer liability claims.

11. Review of declarations of interests, gifts, hospitality, sponsorship and ex gratia payments

A report from the recent Declarations Group that met on a quarterly basis was received. It was noted that internal audit would conduct a follow up proactive audit in respect of declarations of interests.

12. Information Governance Report

The Committee received an update on progress against the Information Governance Toolkit (IGT) requirements at 31st July 2014, and summary of the IG incidents reported from April 2014 onwards.

13. Auditor Panel Regulations and Consultation

The Director of Finance presented a report on the Department of Health consultation on Health Service Bodies' Auditor Panels and their Independence which was noted. The ESHT proposed responses to the two consultation questions were agreed.

Mike Stevens
Chair of Audit Committee

5 September 2014

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 9th July 2014 at 10.00am In the Committee Room, Conquest Hospital

Present: Mr Charles Ellis, Non-Executive Director (Chair)
Mr Barry Nealon, Non-Executive Director

In attendance Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Medical Director (Governance)
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary
Mr Leigh Lloyd-Thomas, BDO
Mr Mike Townsend, TiAA
Ms Jenny Robson, Account Manager, TiAA
Mr Steffan Wilkinson, Counter Fraud Manager, TiAA
Mrs Emma Moore, Assurance Manager- Clinical Effectiveness (for item 6)
Dr Sam Panthakalam, Consultant Rheumatologist (for item 6c)
Mr John Kirk, Facilities and Security Manager (for items 3 and 4)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

Action

1. Welcome and Apologies for Absence

Mr Ellis opened the meeting and noted that a quorum was present.

Apologies for absence had been received from:

Sue Bernhauser, Non-Executive Director designate
Mike Stevens, Non-Executive Director
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr Janet McGowan, Associate Medical Director

2. Minutes

i) The minutes of the meeting held on 4th June 2014 were reviewed and agreed as a correct record subject to Mr Wilkinson's christian name being amended to Steffan on page 1 of the minutes.

ii) Matters Arising

It was noted that all the actions arising from the last meeting had been completed.

3. Commercial Risk Register

Mr Kirk presented the risk register for the Commercial division and advised that it had recently been reviewed and the majority of the risks had had their ratings reduced as capital funding had been received in order to implement action plans. There were now only three extreme risks on the register which were:

- Datix 1152 - 20 - Failure to replace obsolete Medical Devices within ESHT due to limited capital.
- Datix 908 - 16 - 6 facet survey and other condition reports identified an extreme risk range of "backlog maintenance".
- Datix 1117 – 15 – Electrical Supplies to Conquest Heart Centre. Uninterrupted power supply needed.

Mrs Webster queried whether risk 19, dating back to 2002, could be removed as it would appear that all the actions required had been completed and it was now a case of on-going monitoring. Mr Kirk reported that the appropriate policies and procedures had been put in place and capital funding had been received which had enabled the risk to be reduced to 10. He would take it back to the next divisional risk meeting for agreement that the risk could be removed from the register. **JK**

Mrs Webster queried whether a risk should be added to the register in relation to the changes in the provision of housekeeping staff on the wards as the ward matrons had raised this as an issue. Mr Kirk advised that he was not aware of this and would discuss it with Mr Humphries. **JK**

Mr Kirk advised that a number of risks relating to the fabric of the building and infection control issues had had their rating reduced as capital funding had been agreed over the next three years to address the issues.

Mr Hughes queried the description of the risk 1162 in relation to patient safety and asked whether there had been any incidents. Mr Kirk advised that he was not aware of any incidents and he would ask the EME Manager to review the wording. **JK**

Mr Nealon queried whether the extreme risks matched the funding allocated by the Capital Approvals Group to address prioritised infrastructure and equipment as had been discussed at the recent Finance and Investment Committee. Mrs Harris agreed to check this with the Capital Approvals Group. **VH**

Mr Kirk reported that the fire safety risks had been suspended from the risk register as discussions had taken place with the East Sussex Fire and Rescue Service (ESFRS) and a four year plan had been agreed to address the risks and they were waiting official confirmation from ESFRS on the plan.

Mrs Webster queried the rating for risk 908 as it was rated higher on the high level Risk Register and Mrs Wells explained that this was due to timing as she had pulled the report prior to the commercial division risk register being updated.

The Audit Committee noted the report and the actions being taken to manage the risks.

4. Annual Security Report 2013/14 and Workplan for 2014/15

Mr Kirk presented the report which had been approved by Mr Sunley as the executive lead for security in the Trust and advised that the Trust was required to produce an annual report to be sent to NHS Protect who were responsible for security management in NHS premises.

He referred to the statistical summary of incidents over the last year and highlighted that clinical assaults, which were minor assaults by a patient due to their capacity, medication or condition, had increased from 33 to 68 but physical assaults by patients had reduced to 49 from 66 and had not required any staff to be treated for harm. He highlighted that verbal abuse had increased from 86 to 123 incidents but thefts had remained the same as the previous year.

He highlighted that with the implementation of the new patient property policy he anticipated a reduction in loss property/theft incidents during the coming year and a number of audits would be undertaken to demonstrate that the policy was embedded.

Mr Kirk reported that the Trust was in the lower quartile nationally in terms of reporting crimes and there were no major concerns. He advised that the statistics and trends were monitored through the Health and Safety Steering Group and cross-site security groups.

Mr Kirk advised that for the year ahead focus would be on preserving conflict resolution training, reducing thefts and securing capital funding for access control systems.

Discussion took place on the baby tagging system and it was agreed that Mr Kirk would ask the Midwifery Manager to undertake a formal risk assessment and discuss it with the Head of Midwifery. **JK**

Mr Nealon queried the safeguards provided for lone workers and Mr Kirk explained that training was provided to staff, buddy systems were used, mobile phones provided, diaries kept and staff were provided with personal attack alarms. He advised that there had only been one serious lone worker incident in the last four years and the Trust had a lone worker group which reviewed any incidents and in the last year there had been one minor incident.

Mrs Webster asked what restraint training was provided for security staff and Mr Kirk advised that Cardinal Security provided security staff for the Trust and they received a four week induction on site and received both conflict resolution and control and restraint training.

Mrs Harris asked if there was any formal liaison between the security team and the counter fraud service and Mr Kirk advised that with the appointment of Tiaa to provide counterfraud services liaison had improved immeasurably and monthly documented meetings were taking place. Mrs Harris suggested that it would be useful to include this information in the annual report going forward. **JK**

Mrs Harris queried if the workplan had any financial consequences and Mr Kirk advised that it was mainly resources in terms of time and the team were already undertaking the a good part of the workplan.

Mrs Harris asked about the capital funding for access control and Mr Kirk explained that he had put in a bid for funding this year which had not been successful and Mrs Harris suggested that he apply for charitable funds. **JK**

The Committee noted the Annual Security report for 2013/14 and supported the Workplan for 2014/15.

5. **Board Assurance Framework and High Level Risk Register**

Mrs Wells reported that the Board Assurance Framework had not come to the June meeting of the Audit Committee meeting as it had been a single item meeting but it had been received at the Board meeting in June and therefore the Committee would be familiar with the May updates.

She advised that the June updates were in red italics and included more specific wording in terms of the Referral to Treatment risk and noted that the risk relating to diabetic retinopathy screening had been removed as there was now assurance around funding and the Trust had been able to recruit additional screeners to the service.

She reported that the high level risk register had been to the Clinical Management Executive where a number of issues had been identified around scoring, adequate description of risks and age of some of risks and the Head of Assurance was attending Clinical Unit accountability meetings to go through the risks to update them. She anticipated that by the next meeting the high level risk register would be more up-to-date.

Mrs Harris highlighted that some of the text had been lost in risk 3.3 relating to the staff survey results. Mrs Wells advised that this related to the programme of work in place including engagement with frontline staff, focused conversations, continuation of leadership

conversations and staff Friends and Family Test.

Mr Lloyd-Thomas commented that the Trust had had poor results for a number of years in its staff survey and Mrs Wells reported that a more focussed approach was being taken this year through staff engagement and this had been discussed by the Trust Board at its last meeting.

Mrs Webster commented that when she met groups of staff she did not recognise the results of the staff survey and the Trust needed to gain the views of the 63% of the staff who had not responded to the survey.

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

6. Clinical Audit

a) Annual Report 2013/14

Mrs Moore reported that at the start of 2013/14 there had been 168 new or rolling/ongoing audits, 175 from 2012/13 and 8 from 2011/12 and there had been concern at the number of audits being carried over from the previous year putting pressure on the governance resources available in the divisions at that time. By the end of the year the numbers of audits carried over from 2012/13 had reduced to 75 and from 2011/12 the number had reduced to 3. The report provided a snapshot of BRAG ratings of new audits, the majority of which were red which was mostly due to lack of updates from the audit leads. The process for abandoning audits had been tightened up during the year.

She reported that at the year end two of the nationally mandated audits –the national vascular registry audit and the national emergency laparotomy audit – had not submitted data since December 2013 for the reasons outlined in the report.

She reported that the Trust was eligible to participate in 34 NCAPOP and Quality Account audits lists during the year and it had participated in 32. It had not participated in the National Adult Diabetes Audit as it did not have the required specialist software and there had been no cases for the Paediatric Bronchiectasis audit.

Mrs Moore reported that six national clinical audit reports had been reviewed by the Trust last year and the intention was to review more this year. The national reports were discussed in clinical unit audit meetings or at the Clinical Audit Steering Group and local actions were noted and monitored through the clinical audit database.

Mrs Moore noted that 103 local clinical audits had been reviewed and the report contained a sample of recommendations from these audits.

She advised that 29% of the new audits had been completed to the required standard as per Trust policy and there were plans to improve this figure by attending induction and handing out educational material and having more involvement with the clinical units.

Dr Hughes reported that there needed to be more education for participants of the expectation of completion and resources available and Mrs Moore said that focus also needed to be on the quality of audits with an awareness of the Trust overview of audit activity and areas of focus.

Mrs Webster reported that the review being undertaken of the governance structure was to provide experts in clinical audit, rather than generalists, who would provide more support to the clinical units in this area.

Mrs Moore reported that there had been 69 re-audits registered on audit database and the intention was to encourage more re-auditing to be undertaken to provide evidence that actions had been implemented and the resultant changes in practice.

She reported that 94 audits had been abandoned, of which 55 were NHSLA/CNST audits, following notification from the NHSLA that their inspection process was to change and the Steering Group had agreed that the audits could be officially abandoned. She advised that from 2014/15 a new cycle of record keeping audits would take place with two audits being undertaken within each speciality each year. A standardised audit tool had been produced centrally to assist the clinical units with this process.

She highlighted that the process for abandoning audits had recently been tightened and it had been agreed that only the Audit Committee would decide whether a priority 1 audit could be abandoned.

Mrs Moore highlighted that attendance at the Clinical Audit Steering Group had been poor throughout the year with little clinical representation and the Group had now moved to a more outcome focused agenda and she hoped that this would encourage more clinicians to attend.

It would also be picked up through the engagement with and development of relationships with the clinical units.

Mr Nealon asked how the Trust compared to other Trusts and Mrs Moore reported that the Trust's participation in national mandated audits had been good during 2013/14 as it had participated in every

audit.

Dr Hughes commented that the issue around clinical engagement was a key one and the way to improve it was with greater clarity and explicitness through the leaders of the new clinical units.

The Committee noted the Clinical Audit Annual Report for 2013/14.

b) Clinical Audit Forward Plan 2014/15

Mrs Moore presented the Clinical Audit Forward Plan for 2014/15 and highlighted that one audit remained open from 2011/12, 22 from 2012/13 and 73 from 2013/14 and there were 160 new or on-going/rolling audits.

The Committee noted the current status of the Clinical Audit Forward Plan for 2014/15.

c) National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis

Mr Ellis welcomed Dr Panthakalam to the meeting who reported that he had signed up for the national audit for rheumatoid and early inflammatory arthritis on 3rd December 2013 and at that time he had not anticipated the staffing issues that had now arisen due to vacancies within the consultants in rheumatology. He advised that the audit took 5-10 minutes per patient which was very time consuming and every new patient with diagnosis of suspected inflammatory arthritis needed to be documented and followed up every 3 months thereafter.

He advised that due to the demands on the current consultants, who were covering both Eastbourne and Conquest sites, they were not able to meet the time commitment to upload the data. He anticipated that the situation could change once an appointment was made to the vacant post at the Conquest site by the end of 2014.

Mrs Wells reported that it was part of the Trust's contract with the commissioners that it fulfilled all national audit requirements and the Trust would have to notify them which could lead to financial consequences. It would also have reputational impact as compliance with national audits was monitored by the CQC and other national organisations.

It was agreed that Mrs Moore and Dr Panthakalam would explore whether it would be possible to use administrative support to upload the data with the consultants documenting the information in a clinic letter. Mrs Moore would report back at the next meeting. **EM**

d) National Vascular Registry Audit

Dr Hughes reported that following the vascular surgery review emergency vascular surgery had moved to Brighton and the intention had been that elective services would also move there. However, this move had been delayed for quite some time and the two ESHT surgeons, who provided part-time vascular services, had cited the demands of their general surgical responsibilities since the single siting of the services to the Conquest in not being able to provide the data to comply with the audit.

The view of the Committee was that the Trust should fulfil its commitments as if a serious incident occurred both the surgeons and the Trust could come under severe criticism in not monitoring their practice.

Mrs Wells suggested that Mrs Moore review the audit requirements to see if it could be managed with additional administrative support and report back to the next meeting. **EM**

7. Internal Audit

a) Progress Report

Mr Townsend presented the progress report and reported that three audits had been finalised since the last meeting:

- Research governance – significant assurance
- Capital programme – significant assurance
- Leaver Processing and Revocation of Access Review – limited assurance

He reported that in relation to the research governance audit all staff were complying with the process and controls.

He advised that one high priority point had been raised in relation to the capital programme audit which was to ensure that every capital project with value of over £100,000 should have a business case attached to it. Mrs Harris advised that this point related to the temporary move of consultant led maternity and paediatric services to the Conquest site and there were mitigating circumstances as an urgent decision had been required due to safety reasons.

Mr Townsend reported that limited assurance had been provided on the leaver processing and revocation of access review audit as there was a lack of procedures in relation to inactive and dormant accounts. Mrs Harris reported that the recommendations had been implemented and all inactive accounts over one year had been deleted and all inactive accounts under one year disabled.

Mr Townsend highlighted that the report also contained the overall audit plan for the year and client briefings from various sources.

Mrs Harris reported that ten copies of the new Audit Committee Handbook had been ordered.

The Committee noted the Internal Audit Progress Report.

b) Audit Recommendations Tracker

Mrs Wells reported that there were 38 Tiaa audit recommendations still active which was a considerably better position than a year ago and 5 were rated red. She would be discussing with Mr Stevens, as the new chair of the committee, whether the report should just contain red and amber actions in the future. **LW**

The Committee noted the report.

8. Counter Fraud Service

a) Progress Report and Counterfraud Workplan for 2014/15

Mr Wilkinson reported that the progress report covered activity from 1st April to 21st June 2014. He reported that there had been three referrals during the period and one was being further investigated whilst the other two had been dismissed. He updated the Committee on the details of the investigation.

He reported that Mazars would continue to take the lead on one reactive investigation as it was going forward to criminal action.

He reported that in terms of proactive activity the focus had been on raising awareness and a risk assessment process had been undertaken, the results of which had informed the workplan. He circulated copies of the fraudstop! Publication which Tiaa issued twice a year. He reported that a combined fraud awareness month was scheduled for September involving the local security force and the local police force.

The Committee noted the progress report and approved the Workplan for 2014/15.

b) Investigations Updates

The Committee noted the confidential investigation updates which included a closing report from Mazars.

c) Local Counterfraud Survey

Mr Wilkinson reported that this survey had been conducted by Mazars during 2013/14 and aspects coming out of the survey would

be built into the workplan.

The Committee noted the results of the Local Counterfraud Survey.

d) Focused Fraud Assessment

Mrs Harris provided a brief update on the Focused Fraud Assessment carried out by NHS Protect on 19th and 20th June 2014 which was a routine review of the Trust's Self Assessment Tool.

She reported that in the informal feedback NHS Protect had not supported the Trust's assessment of its performance in relation to the provision of data on the First database as not all data had been uploaded in relation to investigations which went no further than disciplinary action. Mr Wilkinson confirmed that all information would be uploaded in future.

Mrs Harris anticipated that she would receive the formal report within one month and Mr Wilkinson advised that any recommendations would be built into the workplan.

The Committee noted the update on the Focused Fraud Assessment.

9. External Audit

a) Annual Audit Letter 2013/14

Mr Lloyd-Thomas reported that this was a summary version of his report presented at the last meeting and would become a public document.

He reminded the Committee that he had issued an unqualified opinion on the financial statements but a qualified position on the use of resources.

He confirmed that the Quality Account had been submitted on time and highlighted that there had been some issues with the VTE data as outlined in the letter and suggested that there should be more smart targets for the quality improvement priorities in 2014/15 .

Mrs Harris expressed her concern at the wording on page 2 in relation to the increased deficit and the issue of impairment and Mr Lloyd-Thomas agreed to amend the sentence. **LLT**

10. Information Governance

a) Annual Report for 2013/14 and Workplan for 2014/15

Mrs Wells presented the annual report and advised that it outlined progress on information governance in the Trust and the achievement of Level 2 of the Information Governance Toolkit. She highlighted that there had been around 40 information governance incidents during the year which seemed quite low for a Trust of this size. The incidents had all been reviewed and learning disseminated through the organisation.

She advised that the key dates for 2014/15 were contained within the workplan.

The Committee noted the Annual Report for 2013/14 and the Workplan for 2014/15.

b) Information Governance Toolkit 2014/15 Update

She presented the update and advised that the Information Governance Toolkit guidance for 2014/15 had recently been received and relevant managers were in the progress of pulling evidence together for the July submission.

She complimented the work of Ruth Paine, the Information Governance manager, in leading this work.

The Committee noted the update on the Information Governance Toolkit for 2014/15.

11. Tenders and Waivers Report

Mrs Harris presented the report which covered the period from the March meeting to 23rd June 2014 and detailed all tenders and waivers awarded in that time. She highlighted that this was the busiest part of the year with contracts starting up in April. She explained that the report also listed the top ten waivers by value.

She advised the Committee that she had taken on the responsibility for the procurement function from 1st April 2014 with Mr Nealon as the non-executive champion and noted that there was a great deal of work to carry out in the procurement function in relation to strategic direction over the next couple of years.

Mr Nealon reported that he had attended the non-executive procurement conference recently and it had been clear that the Trust Development Authority expected a strategic plan for procurement especially within Trusts where funding had been received and this was being progressed within the Trust.

The Committee noted the Tenders and Waivers Report.

12. Department of Health Consultation Response on proposals for new constitutional requirements for the audit committees of NHS Trusts and Clinical Commissioning Groups

Mrs Wells reported that the consultation document had been circulated to the Audit Committee in November 2013 and it had decided as the recommendations related mainly to Clinical Commissioning Groups that the Trust would not make a response. The consultation response from the Department of Health had been circulated to the Audit Committee to note and the Trust would be allowed to nominate the audit committee to act as the auditor panel.

The Committee noted the Department of Health Consultation Response.

13. Date of Next Meeting

Wednesday, 3rd September 2014, at **10.00 am** in the St Mary's Board Room, Eastbourne DGH – please note revised start time.

Signed: ……..

Date: ……

East Sussex Healthcare NHS Trust

Finance and Investment Committee

1. Introduction

Since the Board last met a Finance and Investment Committee has been held on 27 August 2014. A summary of the items discussed at the meeting is set out below.

2. Performance Report – Month 1

The Committee received the month 3 Performance Report which detailed ESHT's in month performance against key trust metrics as well as activity and workforce indicators.

It was noted that the overall performance score was 4 from a possible 5 highlighted areas were as follows:

Responsiveness Domain: 3
Increase from a score of 2 in May, primarily due to achievements within A&E and diagnostics. This score is based upon preview cancer performance. The final domain score will be finalised in the July report. The Trust overall quality score will not be negatively impacted by the final cancer report and will remain at 4. Progress on the small number of over 52 week waiters was noted.

Effectiveness Domain: 4
Remains at 4 for 3rd consecutive month, largely due to the high proportion of mortality indicators within this domain, which are only measured quarterly.

Safe Domain: 5
Achievements within the majority of indicators within this domain ensure that a score of 5 is maintained.

Caring Domain: 4
A&E Friends and Family scores fell below standard, holding the score of 4 from May.

3. Finance Update – Month 3

Mrs Harris presented the Finance Report for Month 4 and highlighted the key issues.

In month the actual deficit was £410k which was also the planned deficit for the month. At the end of M4 financial performance was a year to date run rate deficit of £7,354k, which was a favourable variance against plan of £226k. Income and expenditure were both slightly over plan. The cost improvement achievement was £4,851k which was ahead of plan by £372k. It was noted that the overall Trust Development Authority (TDA) RAG rating for finance was red because the Trust had set a deficit plan for 2014/15.

4. Turnaround Update

Mrs Harris updated Committee on changes to Turnaround support arrangements.

5. Community Rebasing Project – Quarterly Update

The Committee received a progress update on the status of the Community Rebasing Project.

It was noted that the cost matrix for community services needed to be refreshed over the next 4 weeks to reflect outturn for 2013/14 and a more robust basis for attribution of overheads, based on the recently completed reference cost submission.

Mr Grayson updated the Committee on progress against tender submissions.

6. Overseas Visitors

Mr Knight updated the Committee on the charging of Overseas Visitors for NHS treatment where appropriate.

Mr Knight explained the procedure for identifying and charging overseas patients under the Charging Regulations. Risks had been identified and actions were in hand to improve overseas visitor's identification and payment.

7. Clinical Laboratory Diagnostics Managed Service Contract (MSC) Procurement and Full Business Case (FBC)

Ms Amin presented the Contract Award Report for the procurement of a Managed Service Contract and associated Full Business Case (FBC).

Ms Amin explained that the plan, built around the procurement of the Managed Service Contract (MSC), was to reconfigure the services by replacing old and failing equipment with new analysers. This would facilitate a streamlined service provision enabling staff skill mix efficiencies whilst providing enhanced staff work place opportunities and increased service quality and user value with reduced costs.

The Committee received a summary of the finance and technical evaluations which were combined to identify the successful bidder.

The Committee were asked to endorse the award of the managed service contract to the successful bidder and the content of the FBC for submission to Trust Board in September 2014.

Following approval by this Committee and the Trust Board in September, the FBC will be formally submitted to the TDA for approval.

8. Capital Equipment – Business Case for approval - Procurement of Anaesthetic Machines – cross site

Mr Leakey and Dr McNeillis presented the Business Case for the approval of capital funding of £950k to replace the existing anaesthetic machines within theatres. (£500k expenditure in 2014/15 and £450k expenditure in 2015/16).

The funding for this business case was included within this year's capital budget and is in accordance with the discussion at the recent Capital Approvals Group.

9. Capital Equipment – Business Case for approval - Procurement of Conquest Surgical Operating Tables/ Operative Surgical Trolleys

Mr Leakey and Dr McNeillis presented the Business Case for the approval of capital funding of £450k to replace existing surgical operating tables/operative surgical trolleys at the Conquest.

The funding for this business case was included within this year's capital budget and is in accordance with the discussion at the recent Capital Approvals Group.

10. FBC: Bid for First Tranche Funds

The Full Business Case (FBC) for £30m of capital expenditure to implement the Trust's clinical strategy had been approved by the Trust Board on 11 December 2013 and lodged with the TDA. This was still pending TDA approval.

Mrs Harris reported that following ongoing discussions with the TDA, the Trust had made an application for part of the capital included within the FBC. The Trust had yet to receive any feedback from the TDA, however this would be followed up at a meeting with the TDA on 28 August.

The application also included some capital elements which were outside the FBC but had been identified as necessary to ensure delivery of winter resilience or quality and productivity improvement/ requirements.

The Committee received a summary of the main areas included within the application.

11. Making Better Use of Government Resource Services Procurement & Service Delivery Platforms

The Committee received an update on the progress with the DH (Department of Health) invitation to take part in a review of Government support services and delivery platforms as outlined at Committee meetings on 25 June and 23 July 2014.

It was noted that two DH representatives had met the Director of Finance and other key portfolio leads on 1st July 2014 to discuss the review and a Project Steering Group was being formed. Mr Nealon would be the Non Executive Director of this Project Group.

Further updates would be brought to the Committee.

12. Job Planning for Consultant Medical staff

Dr Hughes gave an update on Job Planning process for Consultant Medical staff.

It was noted that within the current job planning round, the focus had been on the challenge to SPA time (supporting professional activity) to ensure that there are measurable outputs associated within this.

Following the restructure there is now a team allocated to this, which sits under Dr Hughes, with Jamal Zaidi as Associate Medical Director, with the new team in place the process can be accelerated. It was also noted that the General Managers would also be much more involved. In this way assurance can be provided that Consultant's objectives will be aligned to those of the clinical unit and the overarching corporate objectives resulting in alignment of clinical accountability and Trust performance.

13. IT Projects Update

The Committee received a progress report on the proposed implementation of the following IM&T projects due to be implemented in 2014/15 :

- Community and Child Health system
- NHS Mail Migration
- Southern Acute Programme - Electronic Document Management and Clinical Portal
- Electronic clinical correspondence
- Acute PAS upgrade
- VitalPac patient bedside monitoring

- Psuedonymisation
- Windows 7 / Office 2010 migration
- Euroking maternity system upgrade

Core projects were being facilitated by the IT Project Office which was tasked with implementing these projects on behalf of the Trust and each Project Board is chaired and led by a senior officer within the Trust.

14. Annual Review of Committee Effectiveness

Mr Nealon presented the report which set out the outcome of this review which was conducted via a questionnaire to all Committee members in July 2014.

Members agreed that the number of Committee meetings held had been sufficient and agendas appropriately structured to support the effective discharge of responsibilities. It was agreed that no changes to the current Terms of Reference were needed.

Matters considered and decisions made by the Committee were taken on an informed basis and members agreed these decisions were understood, owned and properly recorded and would bear scrutiny; subsequent implementation of decisions and progress had been reported back to the Committee as required. Some improvement suggestions had been made.

The Committee felt that it had effectively discharged its responsibilities throughout the year and that there was nothing it was aware of at this time that had not been disclosed appropriately.

The Committee's Terms of Reference were reviewed as part of the self-effectiveness review and they remain fit for purpose. It was noted that four non executives attend the Committee whereas the requirement in the Terms of Reference is two and this was queried. After the meeting the matter was referred to the Company Secretary and it was proposed to revise the number of non-executives to three which is in line with other Board sub-committees and gives flexibility should there be changes in non-executive directors.

15. Work Programme

The revised 2014 work programme was reviewed.

16. Conclusions

The Trust Board to note:

- The Committee reviewed the Performance Report for month 3 and noted the Trust Performance against each domain
- The Committee noted the month 4 financial position
- The Committee noted the Turnaround update
- The Committee noted the further progress on the community rebasing project and the associated opportunities, risks and challenges involved.
- The Committee noted the report on charging for overseas visitors and the recommendations that were being put in place to raise awareness and improve payment.
- The Finance and Investment Committee endorsed the award of the managed service contract to the successful bidder and the content of the Full Business Case for submission to the Trust Board in September 2014.

- The Committee approved the capital funding of £950k to replace the anaesthetic machines – cross site, £500k for 2014 and £450k in 2015/16. This Business Case will also need approval by the Trust Board.
- The Committee approved the capital funding of £450k to replace the Conquest Surgical Operating Tables/operative surgical trolleys.
- The Committee noted the bid for capital funds.
- A project scoping meeting with DH representatives took place on 1st July 2014, a Project Steering Group was being formed and that Barry Nealon is the Non Exec Director representative
- The Committee noted the Job Planning process
- The Committee noted the IT Projects update
- The Committee noted the Review of Committee Effectiveness report and suggested improvements
- The Committee noted the revised work programme

Barry Nealon
Chair of Finance and Investment Committee

1 September 2014

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 25 June 2014 at 9.30am in the Princess Alice Room at Eastbourne DGH

Present
Mr Barry Nealon, Chair
Mr Michael Stevens, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mr Darren Grayson, Chief Executive
Mr Richard Sunley, Deputy Chief Executive/COO
Mr Philip Astell, Interim Deputy Director of Finance
Dr David Hughes, Medical Director

In attendance
Mr Gary Bryant, Deputy Director of Finance
Mr Andrew Murphy, Turnaround Director (for item 5)
Mrs Jo Brandt, Head of SLR (for item 6)
Mr Dave Wells, Head of Financial Planning (for item 7)
Mr Mark Inman, Head of Contracting (for item 9)
Mr Andy Horne, Programme Director (for item 10)
Mr Tony Deal, Associate Director of IT (for items 11 & 12)
Mr Ian Bourns, Clinical Unit Lead Clinical Support Services (for item 13)
Ms Shinal Amin, Principlal Biomedical Scientist (for item 13)
Ms E Costigan, Project Manager, PMO (for item 13)
Miss Chris Kyprianou, PA to Finance Director (minutes)

1. Welcome and Apologies **Action**

Mr Nealon welcomed Mr Michael Stevens, Non Executive Director to his first meeting of the Finance & Investment Committee.

Apologies were received from Professor Jon Cohen and Mrs Vanessa Harris.

2. Minutes of Meeting of 28 May 2014

The minutes of 28 May were agreed as an accurate record.

3. Matters Arising

(i) Performance Report – Month 12

At the previous meeting the Committee had sought assurance that the rigour of financial control was not prejudicing the delivery of the Trust's operational performance.

The issue of balancing quality/safety/finance was also discussed and it was noted that this had been discussed fully at the Board Meeting on 3 June. Mr Nealon confirmed that this would be an ongoing discussion.

An update on the operational recovery plan would be given under agenda item 4(i) below.

(ii) Capital Programme

Further information on the Capital Programme would be provided under agenda item 7 below.

(iii) 5 Year Financial Plan Update

Pending the outcome of the Challenged Health Economy work a TDA submission was filed on 20 June 2014 based on the 'as is' model and the significant risks to achieving the outlined position. In particular, delivery of the level of planned savings was highlighted. This would be discussed further under item 4(iii) below.

4(i) Performance Report – Month 1

Mr Sunley presented the month 1 Performance Report which detailed the Trust's performance for the month of April 2014 against quality and workforce indicators and highlighted the key issues.

Admitted and Non-Admitted Elective Referral To Treatment (RTT) targets did not achieve target and 16 specialties failed to achieve.

Final month 1 Cancer performance showed the trust failing against 2WW and 2WW - Breast Symptoms.

Diagnostic waiters remained above the 1% ceiling for the third consecutive month.

There were 5 C-Difficile cases reported in month 1. The ceiling outturn for 2014/15 is 44.

Mr Sunley gave an update on the recovery plans that were put in place around diagnostics, A&E performance and Referral to Treatment and explained the difficulties with pressures within the system.

In terms of the Referral to treatment times, the trajectory was to deliver those targets by the end of November. However, notification had been received from the TDA that funding was being made available nationally that could enable the Trust to bring this forward to the end of September.

Mr Sunley reported that the format of the Performance Report would be changing as part of the new structure that the TDA were looking at nationally and that month 1 would be re-submitted in the new format.

Action
The Committee noted the Performance Report for month 1 and the recovery plans that have been put in place.

4(ii) Finance Update – Month 2

Mr Astell presented the Finance Report for Month 2 and highlighted the key issues. It was noted that financial performance YTD was a run rate deficit of £4.382m which was £153k favourable to plan. Income and expenditure were both slightly under plan. The cost improvement programme had achieved £2.102m of savings to date, which was ahead of plan by £359k.

Total income received during May was £111k below planned levels increasing the year to date variance to £326k below plan.

Cash at the end of month 2 was £5.2m.

Action
The Committee noted the Month 2 financial position.

4(iii) LTFM/IBP Refresh

Mr Astell reported that the Trust had submitted a 5-year Long Term Financial Model (LTFM) together with the Trust's Integrated Business Plan (IBP) to the TDA on 20 June 2014.

At its last meeting on 28 May the Finance & Investment Committee had reviewed the assumptions and modelling that supported the 5-year financial plan for the Trust. The Committee had asked that in making a submission to the TDA it should be made clear that there were significant risks to achieving the outlined position, in particular delivery of the level of planed savings. Also, that making planned predictions over a 5 year period could not be done with any accuracy bearing in mind the range of reviews being undertaken to bring about an agreed strategy for the overall Health Economy.

The risks had been highlighted in the IBP and at the routine Integrated Delivery Meeting with the TDA on 29 May. The Portfolio Director had confirmed that the 20 June 2014 submission was understood to be an 'as is' position which would, in due course, be overtaken by a Plan informed by the outcome of the Challenged Health Economy work.

The Plan showed how, in an "as is" scenario, the Trust can potentially move out of recurrent financial deficit into a sustainable surplus by 2017/18. As highlighted at the May Committee meeting the Plan was broadly similar to the LTFM which was agreed and submitted to the TDA in January 2014, the main change being the consequential effect of the 2013/14 deficit being larger than originally planned.

The following areas of risk had been identified to the delivery of the plan:

- Income could fall by more than the level assumed with the non receipt of winter funds in 2014/15 being a potential risk
- Contractual fines and penalties are a potential income risk.
- A shortfall on CIP plans could arise based on historic delivery levels.
- Operational cost pressures could exceed the assumptions, especially if the Trust finds it is unable to deliver the productivity improvements needed to deliver RTT targets using internal capacity.
- Activity and capacity pressures may be experienced.
- Additional clinical strategy transitional costs may arise.

Mr Astell reported that, in addition to the above, the IBP had placed strong emphasis on the operational risks arising from financial constraints on the capital programme and this had also been discussed with the TDA.

Action
The Committee noted that the Trust had submitted a 5-year Long Term Financial Model (LTFM) together with the Trust's Integrated Business Plan (IBP), to the TDA on 20 June 2014.

5. Turnaround Update

Mr Murphy provided an update on the Turnaround Programme, noting the successful delivery of plans in the first two months. He indicated that he expected month 3 also to be in line with plan but cautioned that there were more significant risks to delivery in the second quarter. That would be the point at which an increased level of savings was planned from bed number reductions, theatre efficiencies and the rationalisation of clinical administration. He expected there to be some slippage on the bed reductions and theatre plans. He stated that some beds would need to be kept open to meet the RTT pressures mentioned earlier. However, this could potentially be offset by the national funding being made available to help meet this target. He concluded by expressing confidence that the Trust would deliver its CIP targets across the year.

Mr Nealon asked why Out of Hospital Care was underperforming against its targets.

Mr Murphy explained that there had been an overspend on district nursing as it had not been possible to achieve its savings with the current low level of staff turnover and there were no plans to make redundancies. Mr Grayson cautioned against pushing too hard on this particular target while activity was increasing and quality had to be maintained. There needed to be improved engagement with CCGs to ensure that district nursing is appropriately resourced and funded. Mr Murphy stated that, if the CIP target for district nursing could not be met, more challenging targets would need to be set in other areas.

Action
The Committee noted the Turnaround update

6. EBITDA Quarterly Report - Q4

Mrs Brandt presented the 2013/2014 Qtr 4 EBITDA statement and the 2013-2014 quarterly EBITDA comparison statement.

Service Line Reporting measures the Trust's profitability by each of its service-lines, rather than just at an aggregated level for the whole Trust. It enables the trust to increase its productivity by providing board members, clinical leaders and managers with the necessary financial information to make informed decisions and manage performance on a regular basis.

The Committee noted the 2013/14 Q4 EBITDA deficit position for the clinical units and the number of service lines that had a negative EBITDA.

The report compared the average Q4 income to average Q3 income and showed that the income for Q4 on average was around £6m higher, mainly due to the agreement reached on fines and penalties.

Mrs Brandt highlighted the top 5 EBITDA improvements and deteriorations by quarter over the last year.

It was noted that deep dives were scheduled in for Geriatric Medicine, Breast Surgery and Cardiology. The review of Geriatric Medicine had been deferred from July to September.

The Committee felt that the movement charts were extremely helpful and it was agreed that this information would be provided within future EBITDA quarterly reports.

It was noted that there were a large amount of long length of stay elderly patients in geriatrics, some having a dementia diagnosis, which is due to our demographics. Mr Nealon asked if this had been part of the work that Mr Sunley had completed. Mr Sunley explained that it was different as that related to frail adults not dementia.

Mrs Brandt stated that that dementia in long length of stay patients was an issue worth raising as it was not only relevant to geriatrics but also respiratory and A&E. Mr Nealon said that he would like a larger discussion at a Board seminar on dementia. **DG**

Action
The Committee noted the EBITDA statement position. The Committee would 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.

7. Capital Programme Quarterly Report

Mr Wells gave an update on the performance of the capital programme as at the end of May and provided detail on the risks arising from the need to reduce capital expenditure due to limited capital resources.

It was noted that at the end of May the year to date capital expenditure amounted to £0.8m and the capital programme had an over planning margin of £0.7m.

As a result of the need to reduce capital expenditure due to limited capital resources the Capital Approvals Group (CAG) carried out a review of the capital expenditure considered high priority for 2014/15. The review looked at the key areas of high priority medical equipment, radiology equipment, IT, estates backlog maintenance and infection control (details of which were set out in the report). Following discussion with the leads for each of the key areas, who are members of the CAG, the highest priority expenditure was agreed and included in the 2014/15 Capital Programme. The leads, who are members of the CAG, will keep all areas under review and, if necessary, reprioritise and reallocate resources to meet need.

It was noted that the (CAG) will continue to review and monitor the capital programme on a monthly basis.

Mr Grayson suggested that the League of Friends be approached to assist with the replacement of some medical equipment. Mr Grayson said he would discuss the requirement of Fluoroscopy at Lewes with Mrs Webster. It was agreed that there would be a discussion at the next CAG meeting about a co-ordinated approach with the various Leagues of Friends, and also on charitable funds. **DG** **DW**

Action
The Committee noted the current performance of the capital programme. The Committee also noted the risks arising from the deferral of capital schemes in order to bring the capital programme into balance and that the Capital Approvals Group will carry out a monthly review to monitor any emerging issues

that might result in patient or other risk and if necessary reprioritise and reallocate resources to meet need.

8. Challenged Health Economy (CHE) Update

Mr Grayson provided a progress report on the work being undertaken with PwC to develop a fully aligned five-year plan.

The three local CCGs had produced a high level five-year activity plan based on projected future funding. This plan assumes that there would be no change to the funding formula and that any demographic growth in activity would be offset by commissioning intentions. Mr Grayson noted that this was an ambitious assumption as it had not been achieved before.

Mr Grayson reported that the work PwC had undertaken to assess the Trust's relative efficiency had concluded that ESHT is no less efficient than other two-site Trusts when the impact of community is stripped out. PwC had then explored how the Trust's cost base could be reduced to reflect available funding, taking account of the expected 4 per cent annual efficiency challenge. Mr Grayson noted that a number of assumptions used in the modelling were sensitive to change and this could have a significant impact on the conclusion. PwC were continuing to work on the sensitivity analysis.

Mr Grayson stated that the final meeting of the Programme Board, chaired by the NHSE/TDA, was due to take place the next day and that he would report to the next Committee meeting on progress

In response to a question from Mr Nealon, Mr Grayson stated that the best short term response is to deliver 2014/15 targets within the financial plan.

Action
The Finance and Investment Committee noted the update.

9. Specialist Contract Update

Mr Inman gave a presentation on the risks arising from the Trust's contract with NHS England (NHSE).

Mr Inman introduced his presentation by stating that there had been significant uncertainties about the funding available to NHSE for specialist commissioning. This related to disputes about the division of funding between commissioners. As a result NHSE had scaled back its contract with ESHT from £43.9m originally agreed to £42.7m.

As a result of the funding constraints NHSE has contracted for a lower level of activity/high cost exclusions than is likely to arise based on past experience.

As a consequence, it is likely that the contract will over perform in activity/exclusions (primarily drugs) terms and NHSE have advised that they will use all available contract levers to manage the overall contract value. This will include data challenges, enforcing contractual deductions ('fines and penalties'), enforcement of tariff excluded drug protocols and non-payment for any new service developments that have not been given prior approval. The planned value of CQUIN and DQUIP funding under this contract is also at risk.

The overall risk to the Trust could be up to £2m.

Mr Inman described the mitigations the Trust can used to manage the risk. This included the following:-

- Ensure that negotiated CQUIN and DQUIP targets are deliverable
- Ensure that clinicians are aware of the need to obtain prior approval for new service developments
- Resist a move towards NHSE paying the principal provider for shared care activity and monitor this carefully
- Implement the Blue Teq system for preauthorisation of tariff excluded drugs

Mr Grayson requested a report for the Corporate Team Meeting explaining what Blu Teq is, where the Trust is with implementing it and what the governance arrangements are. **VH/MI**

It was agreed that awareness of the importance of not introducing new services without prior approval should be taken through the Performance Management Framework. **RS**

Following discussion the Committee asked for further clarification as to how the reduction in the NHSE contract value had been dealt with in the plan. **VH**

Action
The Committee noted Specialist Contract Update.

10. Market Testing Update

Following discussion at the Finance & Investment Committee and the Corporate Leadership Team (CLT), it was agreed that there would be clarification regarding the pace of the services to be considered for market testing.

Mr Horne presented an update paper which had identified recommendations for the F&I committee to consider, and gave a further update on progress.

Mr Horne asked the Committee for a decision on the following three issues:

- That the market testing of hard FM services is delayed until 2015/16.
- That Corporate Directors should be given time to deliver current turnaround plans and further develop their 2015/16 proposals, which will need to incorporate efficiency savings of 10%, prior to market testing.
- That priority is given to the development of service specifications leading to the development of a transformation plan for soft FM services, where a decision can be made on market testing.

The above issues were explained in greater detail within the report.

Mr Stevens asked whether the Trust should be moving more quickly towards market testing of the relevant services as it will not know whether value for money is being achieved until it has done so. Mr Grayson said that the Trust could be accelerating this initiative but it had to be prioritised alongside the many other issues that were currently being addressed.

Action
The Committee discussed the market testing update and agreed to the above recommendations from the Corporate Lead Team (CLT)

11. Windows 7 Upgrade compatibility – Progress Report

The Committee received a progress update on the proposed migration of Trust PCs and laptops from Windows XP/Office 2003 to Windows 7/Office 2010 and the associate software application compatibility testing.

Mr Deal reported that 89 applications (approximately 85%) had been tested and 16 of these were not compliant with Windows 7. A short term solution has been developed to reduce impact while application upgrade options are put in place. The 'Joe' clinical system is not compatible with Windows 7 and poses a significant risk.

Mr Deal explained that there was a need to upgrade to Windows 7 due to licensing and support issues.

The Committee noted the risks and benefits of the proposed migration.

Action
The Committee noted the progress made on the proposed migration from Windows XP/Office 2003 to Windows 7/Office 2010 and noted the risks and benefits of the proposed migration.

12. Community & Child Health System - Project Update

The Committee received an update on progress of the Community & Child Health System (SystmOne) project.

Mr Deal explained that some of the 'go live' dates had been re-scheduled, however, the project was still on target for completion in January 2015.

Mr Nealon asked if the system could be linked with EMIS, the GP system. Mr Deal said that this is one of the options that could be explored in the future. **TD**

Action
The Committee noted the progress made on the Community & Child Health System (SystmOne) project.

13. Clinical Laboratory Diagnostics Managed Service Contract

Mr Bourns and Ms Costigan presented an update on progress in procuring the Clinical Laboratory Diagnostic Managed Service Contract. The Committee were assured that due process had been undertaken during the evaluation of the bidder submissions and the development of the associated Draft Full Business Case (FBC) in preparation for the submission of the Contract Award and final FBC to the Finance & Investment Committee and Trust Board in July 2014.

It was noted that the Operational and Finance sections of the draft FBC were still being finalised

The Committee was asked to approve the governance process, including the submission of final documentation to the TDA post approval by the Trust Board.

The report indicated that the invitation to Tender opened on 8 January 2014 and closed on 1 April 2014 (an extension was provided to ensure that all bidders had adequate time to complete work with third party suppliers). The bidders who passed the PQQ were invited to tender. Bidder presentations took place on 23 May 2014.

The Operational, Strategic and Transition sub-sections are awaiting answers to additional clarification questions.

It was noted that the evaluation of the Finance Models was underway and detailed finance clarification sessions with all bidders were held with bidders on 12 June 2014. At present, the Trust was completing a process whereby the Operational and Finance sections were being validated together to ensure that the cost of the bids is compared on a "like for like" basis.

There were outstanding queries raised with suppliers which would impact on the final outcome of the finance evaluation.

Once the comparable Finance Models have been evaluated and moderated, the outcome of the Finance evaluation process will be complete.

The Committee were asked to

- note and prepare for the submission of the contract award report and FBC to its meeting in July 2014
- endorse the approach of awarding the contract to the successful supplier immediately after the Trust Board decision on 30 July 2014 and work with the successful bidder to finalise contracts until TDA approval is forthcoming. This parallel process is also subject to TDA approval.
- review the draft FBC documentation presented raise any queries around content or process by 5pm Monday 30 June. Queries will be responded to as part of the final submission to F&I in July 2014.

Action
The Committee reviewed the draft FBC documentation, noted and prepared for the submission of the contract award report and FBC to its meeting in July and endorsed the approach of awarding the contract to the successful supplier immediately after the Trust Board decision on 30 July 2014 and work with the successful bidder to finalise contracts until TDA approval is forthcoming.

14. Making Better Use of Government Resource Services Procurement & Service Delivery Platforms

Mr Astell presented a letter from Richard Douglas at the Department of Health (DH) inviting the Trust to take part in a review process.

It was noted that the DH, led by its Commercial Division, was examining the scope for increased use by Trusts of the DH's and Cabinet Office's central support platforms that have been put in place for NHS bodies to conduct their commercial business more efficiently and more cost effectively.

As a Trust that had been in receipt of Public Dividend Capital with planned future deficits the DH had a particular interest in ensuring that the Trust had examined opportunities to maximise the use of all such support service platforms.

The first step to launching the review was for the Trust to create a time limited Task and Finish Group. This is being led by the Finance Director.

There was an expectation that the Trust will act on any recommendations contained in these reviews. Subject to the right level of Trust support the review would be completed within a four week period. There was no cost to the Trust for undertaking this review work.

Action
The Committee noted:

- **The DH request to participate in the process**
- **The establishment of a Task & Finish Group to oversee the initial review work**
- **That further reports will be brought to the Committee**

14. Work Programme

The 2014 work programme was reviewed.

It was noted that the EBITDA deep dive for Geriatric Medicine would be put back from July to September and therefore the deep dive for Breast Surgery will be brought forward to the July meeting.

Action
The Committee noted the revised work programme

15. Date of Next Meeting

The next meeting will take place on Wednesday 23 July 2014 at 3pm – 5pm in St Mary's Board Room at Eastbourne DGH.

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 23 July 2014 at 3pm in St Mary's Board Room Eastbourne DGH

Present
Mr Barry Nealon, Chair
Mr Michael Stevens, Non-Executive Director
Professor Jon Cohen, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mrs Vanessa Harris, Director of Finance
Mr Richard Sunley, Deputy Chief Executive/COO (Part)
Mr Gary Bryant, Deputy Director of Finance

In attendance
Mr Andrew Murphy, Turnaround Director (for item 5)
Mrs Lucie Jaggar, Interim Head of Procurement (for item 9)
Miss Chris Kyprianou, PA to Finance Director (minutes)

1. Welcome and Apologies **Action**

Apologies were received from Darren Grayson and David Hughes.

2. Minutes of Meeting of 25 June 2014

The minutes of 25 June were agreed as an accurate record.

3. Matters Arising

(i) EBITDA Quarterly Report – Q4

The Chair had asked for a larger discussion on dementia. It was noted that this item was being scheduled into a future Board Seminar.

(ii) Capital Programme

With regard to the use of charitable funds, Mrs Harris reported that she had presented a paper to the Corporate Team Meeting about a co-ordinated approach with the various Leagues of Friends. Professor Cohen asked how requests for capital projects were prioritised. Mrs Harris explained that the Capital Approvals Group meets monthly to review the priorities for capital funding.

(iii) Speciality Contract Update

Mrs Harris reported that a Blu Teq report was presented to CLT at its meeting on 8 July 2014.

Mrs Harris explained how the reduction in the NHSE contract value had been dealt with in plan.

(iii) Community & Child Health Project Update

Mrs Harris confirmed that SystmOne could not currently be linked to EMIS however, there were some GP practices in the High Weald and Lewes area who use SystmOne. Full integration would be an aspiration for the future.

A further update would be provided under agenda item 11.

4(i) Performance Report – Month 2

Mr Sunley presented the month 2 Performance Report which detailed ESHT's in month performance against key trust metrics as well as activity and workforce indicators.

It was noted that The Trust Development Authority had reviewed its reporting requirements for 2014/15, publishing the new Accountability Framework.

The model describes how NHS Trusts can expect to be assessed by the NHS Trust Development Authority, how they can expect to be held to account for what they have promised to deliver, and what indicators will be used to determine whether the Trust believes an organisation is delivering high quality care.

For 2014/15 it is recommended that the NTDA reports Oversight and Escalation on two parts 'quality and delivery' and 'finance and sustainability'. 'Quality and delivery' is to be sub-divided into five sections, one for each of the Chief Inspectorate of Hospitals (CIH) domains (Caring, Effective, Responsive, Safe and Well Led).

Finance and Sustainability are not part of the CIH inspection or CQC Risk Rating but are still a very important part of Oversight and Escalation and therefore will be reported as the second section of the Oversight and Escalation Model.

The NTDA will adopt a similar scoring system of the CQC where 1 is high risk and 5 is lower risk, to reduce the potential of any confusion that might arise if the NTDA was to continue with 5 being the highest risk. The NTDA will continue to use the term 'escalation levels' as opposed to 'bands' to retain the distinction between our assessment of risk and that of the CQC. There is no intention that Oversight and Escalation will attempt to replicate or estimate future CQC risk ratings.

The scorecard to support Oversight and Escalation had been re-designed to move away from one for acute, community, mental health and ambulance services, to a single scorecard as the increasing

multifaceted provision of services by Trusts mean these are increasingly artificial differentiations.

The Trust was still awaiting guidance on the definition and calculations of some indicators and therefore the attached performance report is draft pending any further clarifications and may subsequently change.

It was noted that A&E performance had improved in June following a dip in May. Compliance with the cancer targets needs to be improved and work is ongoing.

The Committee asked whether community indicators could be included in the report. The Chief Operating Officer undertook to follow this up. **RS**

Action
The Committee noted the Performance Report for month 2 and noted the Trust Performance against each domain.

4(ii) Finance Update – Month 3

Mrs Harris presented the Finance Report for Month 3 and highlighted the key issues. It was noted that at the end of M3 financial performance was a year to date run rate deficit of £6,944k, which was a favourable variance against plan of £226k. Income and expenditure were both slightly under plan. The cost improvement achievement was £3,272k which was ahead of plan by £466k.

Overall the Trust is red rated for finance. Even though many of the finance criteria on page 5 of the report are rated green the bottom line rating is governed by the in- year I&E position which is an overriding rating. As the Trust has set a deficit plan the overall Trust rating is red.

Action
The Committee noted the Month 3 financial position.

4(iii) Financial Quarterly Review

Mr Bryant provided an overview of the financial performance for the 1st Quarter of 2014/15.

During the first 3 months of the year, the Trust was marginally ahead of plan by £0.2m, with a deficit of £6.9m. All 3 months have been slightly better than plan, with pay costs currently £0.6m under-spent YTD and non-pay costs slightly overspent at £0.2m. Pay costs are £0.2m a month less than the last 3 months of last year and £1.2m below per month for the same period a year ago.

The drop in pay costs of £3.6m (year on year) has been in ad-hoc payments of £0.7m, £1m of agency costs, and the balance relates to permanent/bank staff. The reduction has been made in commercial and corporate areas.

Contract income is currently below plan before PbR excluded items (these are costs passed through to the CCGs). It is expected that this position will be recovered. PbR excluded items are £0.5m above plan, and this is mirrored in the current overspend in non-pay.

Other income is currently behind plan, with private patients and ICR income £0.2m adverse. The balance is due to the timing of actual income against the phased plan. By the year end, with the exception of private patients, other income will be at least at planned levels.

CIP plans for the year are £20.4m, £2.8m of which is the YTD target. After 3 months, ESHT is £0.5m ahead of this target, which is reflected within the overall position described above. From next month, the monthly target starts to increase, so that by month 5, the target is £2m per month. So far all areas, with the exception of estates non pay schemes, are delivering above plan.

At the end of the quarter, there was £4.6m of cash at the bank, and ESHT is currently paying the majority of creditors on time. A review of the current authorisation system and processes has highlighted areas which are affecting the ability to meet the Better Payment Practice Code (BPPC) target of 95%. Current achievement is 80.

ESHT set an overall deficit plan for the year of £18.5m, on an income level of £357.4m. Based on the performance to date, the Trust is forecasting to meet this

The Committee was assured that scrutiny was carried out on the current YTD financial position, and that each clinical unit was expected to sign off their forecast outturn, and that the current risks have been mitigated, or other plans are in place to manage back to the planned deficit of £18.5m

Action
The Committee note the updated and received assurance that the current financial performance was consistent with the overall plan for the year.

5. Turnaround Update

Mr Murphy provided an update on the Turnaround Programme, noting the successful delivery of plans in the first three months. He indicated that he expected the cumulative total at month 4 also to be in line with plan but cautioned that there were more significant risks to delivery in the second quarter due to the step up in level of CIP delivery

required. He highlighted progress with plans to reduce bed numbers, increase theatre efficiencies and rationalise clinical administration. He stated that some beds would need to be kept open to meet the RTT pressures and theatre capacity would also need to be similarly aligned. However, this could potentially be offset by the national funding being made available to help meet this target.

Action
The Committee noted the Turnaround update

6. Challenged Health Economy (CHE) Update

The Committee received a paper setting out the outcomes to date from the Challenged Health Economy programme and the summary of the discussion at the Board Awayday which was presented at the recent Board Seminar of 16 July 2014.

The documents had provided the Board with a perspective on the options for the future sustainability of the Trust and the local health economy.

Action
The Finance and Investment Committee noted the CHE work was discussed at the recent Board Seminar.

7. Clinical Laboratory Diagnostics Managed Service Contract (MSC) Procurement and Draft FBC

The Chair reported that this item had been removed from the agenda for today's meeting. Further amendments were required to be made and therefore it had been agreed to pull this item from the agenda.

Mr Stevens raised some issues on the contract which Mr Bryant agreed to investigate outside the meeting. In the meantime it was agreed to defer this item and discuss this in more detail in August. **GB**

Action
This item was removed from the agenda and will be discussed at the August Committee meeting.

8. Making Better Use of Government Resource Services Procurement & Service Delivery Platforms

Mrs Harris updated the Committee on progress with the DH (Department of Health) invitation to take part in a review of Government support services and delivery platforms as outlined at the last meeting.

Mrs Harris reported that a review process was proposed which would examine the Trust's current and potential use of support platforms.

Two DH representatives had met the Director of Finance and other key portfolio leads on 1 July to discuss the review. Discussion took place around the:

- Aims of the review
- Stages of the review
- Governance and management of the project

It was decided that given the feasibility testing stage would require working with the Trust to obtain information and access to ESHT staff this should take place after the CQC inspection to avoid any unnecessary clash of priorities. However, given the need to set out a sustainable future for the Trust's procurement function, which was currently under interim leadership arrangements, it was agreed that the Trust would start to look at options around procurement ahead of the rest of the project.

It was noted that a Project Steering Group would be formed to oversee the project. This would not be a decision making body but it was expected to reach conclusions and make recommendations to the Finance and Investment Committee. Terms of Reference were being prepared and there was an expectation that a Non-Executive Director will be part of the group membership.

Action
The Committee noted:

- **A project scoping meeting with DH representatives took place on 1st July 2014**
- **A Project Steering Group needs to be formed with Non-Executive Director participation**
- **Further reports will be brought to the Committee**

9. Procurement update

Mrs Jaggar updated the Committee on progress within the procurement function since 1 April 2014 when it moved into the Finance Directorate.

The update was part of an initiative to bring visibility to the work of the Procurement team, highlight achievements to date which make progress towards the national aim and give assurance that a robust 3 year Procurement strategy was under development.

The report focused on opportunities for the Trust to make significant cost savings and efficiency improvements through harnessing and developing the skills and expertise with in the team and more integrated work with key stakeholders.

It was noted that earlier in the year Dr Dan Poulter, Minister for Health

and David Flory, Chief Executive, NHS TDA wrote to all NHS Trusts about plans to help NHS providers deliver £1.5 – £2 billion procurement efficiency savings by the end of 2015-16. In their letter they stated that they were keen to support boards to give more attention to the management of their non-pay spend. To this end, a package of support to help Non-Executive Director (NEDs) was being developed; this included a summit for Non-Executive Directors on NHS Procurement in May. This was attended by Mr Nealon who was the procurement champion for the Trust.

It was noted that timetable to sign off the new Strategy was September 2014 with implementation in October. This fits in with the Department of Health guidance and requirement to begin executing the e-Procurement strategy.

A further procurement update would be provided in three months time.

Action
The Committee noted the requirements for developing and executing a 3 year Procurement strategy and the implications for this Trust.

10. Job Planning for Consultant Medical Staff

The Committee received an update report on consultant job planning.

The report showed that progress had been made with most services having addressed job planning and medical expenditure remaining within planned budgetary limits. However further work was needed to ensure a rigorous and robust approach is sustained and further savings were made to meet the year-end forecast.

In the absence of the Medical Director who is on annual leave, it was agreed to defer this item to the August meeting where it could be discussed in greater detail. **DH**

Action
The report was deferred to the August meeting.

11. Community & Child Health System - Project Update

Mrs Harris gave an update on progress of the Community & Child Health System (SystmOne) project.

It was noted that the system has been rolled out to District Nurses and 330 district nurses in all three CCG areas were now using the system.

The Chair reported that he had met with some of the district nurses

who said this was a fantastic system however there were a few implementation issues reported which Mrs Harris assured the Committee were being looked into.

Action
The Committee noted the progress made on the Community & Child Health System (SystmOne) project.

12. Work Programme

The 2014 work programme was noted.

It was noted that the Committee would need to consider a draft report on the Committee effectiveness at the August Committee meeting. In view of this, the Committee members would be asked some questions reflecting on the performance of the Committee over the last year. It was agreed that Mrs Harris would email the Terms of Reference and a list of questions to Committee members asking for their feedback, to enable a draft report to be presented to the August meeting. **VH**

Action
The Committee noted the revised work programme.

13. Date of Next Meeting

The next meeting will take place on Wednesday 27 August 2014 at 9.30am – 11.30am in the Committee Room, Conquest.

East Sussex Healthcare NHS Trust

QUALITY AND STANDARDS COMMITTEE

1. Introduction

1.1 Since the last Board meeting a final combined Quality and Standards Committee /Patient Safety Clinical Improvement Group meeting has been held on 2 September 2014. A summary of the issues discussed at the meeting is provided below.

1.2 The minutes of the meeting held on 7 July 2014 are attached at Appendix 1.

2. Issues discussed at 2 September Meeting

2.1 Shared Learning in Practice (SliP)

A presentation was made regarding end of life care for a patient in our care. The case presented was summarised as the main emphasis of the concern being communication between the family and the medical / nursing staff. It was very clear to those present that whilst the issue had been addressed with the family there was clearly more learning to happen across the organisation. The appropriate actions have been individually taken and the meeting discussed receiving assurance that ongoing work was in place.

2.2 Board Assurance Framework and High Level Risk Register

The assurance framework and high level risk register were received and the detail noted. Discussion took place around the SECAMB entries and it was confirmed that capital funding for extra capacity for the Emergency department had been agreed from January 2015.

2.3 NHS Litigation Authority (NHS LA) Annual Report

A summary was presented to the Committee following the recently issued annual 2013/14 review. It was confirmed that the Trust was in the process of participating in the Sign up to Safety Campaign where organisations produce robust safety plans to demonstrate how the organisation will reduce higher volume and higher value claims. It was noted that the Trust's number of claims appeared to be higher than the national average and the group requested and update on this.

2.4 HCAI Quarter 1 Performance Report

This was presented and discussed with particular consideration around the zero number of cases of MRSA bacteraemia reported, which the group felt reflected highly on good quality care.

2.5 Patient Experience Report Quarter 1

The Committee noted that the Trust had achieved the quarter 1 target for both the patient and Staff Friends and Family testing and that data had been triangulated from a number of sources obtained from service users in order to improve patient experience. It was agreed that complaints can be a very powerful patient voice and should be seen constructively as a way to help the organisation improve the services offered.

2.6 **Staff Friends and Family Test**

The Committee noted receipt of the Staff Friends and Family Test update, a requirement for all NHS Trusts which allows staff to give their feedback on how likely they are to recommend the organisation they work in to friends and family who need care or treatment and how likely staff are to recommend the organisation they work in as a place of work. It was noted that a Listening into Action event had taken place to discuss the issues raised.

2.7 **A Voice for Change: The Ombudsman's Annual Report and Accounts 2013-14**

The report, following the first year of a five-year strategy by the Ombudsman to 'deliver more impact for more people' was received by the Committee.

3 Conclusion

3.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meetings held on 2 September 2014 and the minutes of the meeting held on 7 July 2014.

Charles Ellis
Quality and Standards Committee Chairman

3 September 2014

Appendix One

Patient Safety and Quality and Standards Committee
Conquest Committee Room, 7th of July 2014

Present		Apologies	
Charles Ellis Non-Executive Director & Chair	CE	Stephanie Kennett Non-Executive Director	SK
Rae Joel Clinical Governance Manager	RJ	Christine Craven Deputy Director of Nursing	CC
Sue Bernhauser No-Executive Director	SB	Liz Fellows Assistant Director of Nursing, West	LF
Alice Webster Director of Nursing	AW	Jamal Zaidi Consultant, Obs and Gynae	JZ
Janet Colvert Patient	JC	Lindsey Stevens Assistant Director of Nursing, Maternity	LS
Lynette Wells Company Secretary	LW	Amanda Harrison Director of Strategic Development and Assurance Strategic Development and Assurance	AH
James Wilkinson Associate Medical Director	JW	Hilary White Assurance Manager Compliance Strategic Development and Assurance	HW
Stuart Welling Chairman	SW	Edel Cousins Assistant Director HR (Workforce Development Human Resources	EC
Janet McGowan Associate Medical Director	JM	Paula Hunt Nurse Consultant Occupational Health	PH
Margaret England Assurance Manager Patient Safety and Risk	ME		
Nicky Creasey Assurance Manager Health and Safety	NC		
Emily Keeble Head of Assurance	EK		
Richard Sunley Chief Operating Officer	RS		
Eanna Mcknight Head of Legal	EMc		
Abigail Turner Head of Therapies	AT		
Emma Moore	EM		
David Hughes Medical Director	DH		

Minutes **Action**

1. Welcome and Apologies for Absence.

Mr Ellis opened the meeting and covered the apologies received.

2. Minutes of Previous Meeting – 6.5.14

The minutes were agreed as a true and accurate reflection with the exception of one query raised by Mrs Colvert, Page 3 Deaths in the Community.

Mrs Webster attends the CQRG meeting which is run by the local CCG's, she confirmed that Certified cause of death was raised at the CQRG meeting as still being an issue and that this will be looked in to further.

3. Matters Arising and Action Log

Datix Web – Upload to NRLS in a timelier manner Mr Ellis sought clarity around this.

Mrs Webster confirmed that this related to cases when Datix reports were being completed late; however the process has now been revised. The time difference between NRLS and Datix can be an issue and the Datix team have worked on this. The next NRLS report is due out in September 2014 and this will show if the time delay has improved.

Action Plan updated accordingly

Dr McGowan provided an update on pain and chronic pain. This group has now been disestablished as the group was too large to continue with.

Quality Governance Strategy will be going to July 2014 Board.

Dr Walton has been working with Dr Hughes regarding the action on the log and will provide an update on this at a later stage.

4 Patient Story – Feedback by Mrs Webster

Mrs Webster spoke about a letter that she had received from a relative of a patient who had sadly died on HDU /ITU. The relative had also written to the team on HDU/ITU. The letter praised the care that had been delivered by the team the relative spoke about embarking on a nursing career themselves and how they would like to be able to deliver the same standard of care.

Mrs Webster said how touching it was to read this letter, she has also met with the team to discuss the letter with them.

Mr Ellis said that it was positive to receive these letters bearing in mind that it must have been a difficult time for the relative and it was very good to hear that the relative is going on to nurse train.

Mrs Wells spoke about how the Trust is receiving a lot more positive feedback through NHS Choices.

5 Staffing and NHS Choices

Mrs Webster spoke about the Unify return which is carried out for nursing staff as part of the Francis review however as yet it does not include Medical Staff or AHP's.

This is for the public to be able to see what staffing is available on all wards for public scrutiny.

The data for this is due to be uploaded once again this week; nationally we sit in the middle range.

Mrs Fellows is currently working on the template for staffing.

Staffing figures are looked at daily, four times per day, to ensure that no areas are under staffed. Mrs Webster went on to speak about the quality boards on the wards which also highlight the staffing requirements and any variance in staffing on the wards.

In line with guidance, staffing is looked at for in patient areas only and outpatient areas are not taken in to account as yet.

Mr Welling asked what the burden on staff is if staffing is reported four times per day, Mrs Webster explained that the HoN leads the process and in time ERostering and VitalPAc will support this.

Mr Ellis spoke about the return for EDGH in June and the difference in the staffing establishments, i.e. required and actual variances. Mrs Webster explained that this was due to the high acuity in the wards, where there may be one to one nursing care required for some patients.

Mr Ellis asked if we did anything to publicise that we now have the boards in the hospital, Mrs Webster confirmed that this was publicised via the extranet.

6 Morbidity and Mortality Report Dr Wilkinson delivered the M&M report.

Areas highlighted:

- Improving on HMSR. It appears that we will be rebased, when this takes place there is a high possibility we will be below 100.

- SHIMI – Increase in mortality, this will take time to work its way through the system and will not show until Dec this year. This relates to the step up/step down nature of community hospitals and admissions from other providers.

- Deaths in low risk conditions were reviewed and intelligent monitoring alerts no significant concerns identified, underlying condition a predominant factor. Documentation and care were good.

- NEWS scoring improving.

- Coding audit, there were some issues with coding and it appeared that there were some coding inaccuracies. Medical staff were not mentioning specific conditions in the notes which were not able to be picked up by the coders.

- Mortality meetings were now well established and these were held monthly across CU's. A Mortality review group is also held which looks at data from the meetings and reports up to the review group.

- An electronic mortality data base had been set up.

From a board perspective Stuart Welling highlighted the following:
SHIMI concerns
Coding – The way we manage and look after records
NEWS – the early warning system
He asked if Vitalpac will make a difference. Dr Wilkinson advised it is being well received and felt it would make a difference especially for HCA's. Dr Wilkinson confirmed that significant

changes on NEWS scores are being acted upon.

Mr Sunley advised that medical records requires investment, the area needs to be centralised, and currently we are working with a deficient system.

Mrs Webster spoke about ensuring that the clerical support is still in place on the wards to support record keeping and how vital this is.

7 Integrated Quality Report

Miss Keeble presented the report and advised she had met with Andy Bailey and Ms Goldsack from Business Intelligence who are currently looking at dashboards which are being produced across the Trust and will update at a future meeting.

8 Findings from provider survey of Francis Implementation

Mrs Wells confirmed that she had circulated the report for information and highlighted two items from the reports which were embedding values – staff have carried out a lot of work around the Trust through LiA in this area. The one area that we may need to concentrate on is the code of ethics.

Mrs Webster referred to page15 - Bank locum and agency staff and mandatory training. Mrs Webster confirmed that we are revising our systems so that if bank staff do not undertake mandatory training then shifts will not be made available for them.

9 9.1 Chief Inspector of Hospitals Visit – Sept

Mrs Webster advised that a project group has been established which she is chairing. The inspection will involve about 60 inspectors and will encompass the entire Trust, community and acute sites.

There will be requests for a lot of data and this will be co-ordinated by Mrs Wells and Mrs White.

Dr McGowan asked where possible could we look at specific areas that have had a lot of changes recently and concentrate on those areas.

It is important that there is effective communication and support mechanisms in place for staff.

9.2 Draft Intelligent Monitoring Report

Mrs Wells confirmed that the draft has been received and will be published on 25/07. The Trust now appears in category 1; this is due to the staff survey results. We could remain in this position for the year until the next results are published.

We have 11 risks; 6 elevated and 5 normal. All risks are reviewed to ensure actions are in place if required.

9.3 CQC Action Plan Reports
The action plan in respect of the CQC district nursing inspection was noted and is almost complete. Mrs Wells updated there are two amber areas and this is related to the implementation of SystmOne.

10 Quality Walks Reports.
Mrs Wells presented the report, summarising the quality walks carried out between March and April.

Feedback is given to teams and there are a lot of positives. It was noted that staff are understandably anxious about services going out to tender, including school nursing and MSK and it is important that there is good communication with staff who may be affected.

11. Quality Account.
Mrs Wells reported that the account was filed by the 30 June deadline.

12. Patient safety incident report – May 2014
Mrs England provided an overview of the figures from the report, there were 557 actual incidents during May. The majority of incidents raised were around falls however this was reducing, and the work being undertaken through the falls group is assisting.

The matrix for scoring had been re-sent to all matrons, and reporters. There is a Slipper Sock pilot being rolled out in three areas; reporting will begin after three months which will be August 2014.

There were a total of 62 Pressure Ulcer incidents raised.

The incidents involving Patient Discharge and Transfer were mainly related to patient transfer issues.

Mrs Bernhauser asked about the details on page 12 around incorrect administration of drugs, Mrs England confirmed that she will look in to this and report back. ME

Incorrect meds – no trends to report

There were a total of 26 patient record errors.

Mrs Sunley said the he felt that this was a very good medium for reporting incidents such as this and highlighting areas of concerns. It would be beneficial for future reports to highlight actions and learning.

Noted that Egerton discharge lounge should be included in action plan.

13 Serious Incidents June 2014.
Report delivered by Miss Keeble.

A total of 14 SI's were reported in the month.
All were reported in time to the CCG and within the current timescale. There were no never events reported in June

Two members of the CCG attended the SIRG meeting last Wednesday – the rate of closure is much improved now.
We do have a good reputation in reporting our SI's to the CCG on time, 45 days is the standard reporting time.

Mrs Webster/Mrs England/Miss Keeble met with each CU regarding SI's and actions in respect of SI's and will write a report on the outcome of this.

Shared learning – A newsletter is produced each month,
Piloting a checklist for a new process around pressure ulcers this has been refined from the CCG's.

Mr Welling asked how assured Miss Keeble was on the quality of the RCA's being received. Miss Keeble confirmed that the quality has improved and that it does help with the various levels of scrutiny that the RCA's go through. At the point of the RCA going to the CCG they have been through a rigorous evaluation process.

14. Any Other Business

None Recorded

15. Date of Next Meeting.

Patient Safety and Clinical Improvement Group/Essential Compliance Group
Tuesday 5th of August 2014, 14.30-16.30 St Marys Room EDGH

Quality and Standards Committee Meeting
Tuesday 2nd of September, St Marys Room EDGH

EAST SUSSEX HEALTHCARE NHS TRUST

Notes of the Trust Board Seminar held on Wednesday, 16th July 2014, at 10.00 am in the Committee Room, Conquest Hospital

Present: Stuart Welling, Chairman
Sue Bernhauser, Non-Executive Director Designate
Charles Ellis, Non-Executive Director
Barry Nealon, Non-Executive Director
Mike Stevens, Non-Executive Director
Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Monica Green, Director of Human Resources
Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr Andy Slater, Medical Director (Strategy)
Lynette Wells, Company Secretary

In Attendance: Tony Deal, Associate Director of IT (item 5)
Sarah Goldsack, Associate Director – Knowledge Management (item 5)
Trish Richardson, Corporate Governance Manager (notes)

ACTION

1. Welcome and Apologies for Absence

Mr Welling welcomed Mr Stevens to his first Board seminar.

a) Apologies for absence were received from:

Professor Jon Cohen, Non-Executive Director
Stephanie Kennett, Non-Executive Director
Darren Grayson, Chief Executive
Dr David Hughes, Medical Director (Clinical Governance)
Alice Webster, Director of Nursing

b) **Notes of the Seminar meeting held on 14th May 2014**

The notes of the seminar held on 14th May 2014 were agreed as a correct record.

c) **Update on Current Issues**

i) Changes in Government Ministerial Appointments

Mr Welling reported that Greg Barker had resigned from his post as Minister of State for Climate Change in the recent Ministerial reshuffle and Amber Rudd had been appointed as Parliamentary Under Secretary of State for Climate Change.

ii) Finance Flash Report M3

Mrs Harris presented the finance flash report for June and noted that the deficit was slightly better than plan for the third month in a row, with both income and expenditure being slightly down in the month.

She advised that delivery on the cost improvement programmes was on plan but noted that a step up in savings was required from July onwards. She confirmed that plans were in place but there could be some limited slippage in terms of dates but this would be managed.

Mr Nealon queried whether the cost improvement programmes were impacting on the Trust's ability to drive income but Mrs Harris explained that there had been a reduction both in patient income and non clinical income.

Mrs Harris confirmed that she had phased in one quarter of the contingency in line with the TDA plan.

iii) Operational Performance Month 3

Mr Sunley reported that the A&E targets had been delivered in June but because of the dip in performance in May it had not recovered sufficiently to achieve the quarter one targets.

He reported that in May there had been a high level of activity and outlined that this related to the change in the GP out of hours contract and accessing mental health inpatient beds and discussions were taking place with partners to resolve these issues.

He reported that diagnostic waits had been brought back in line in June and the Trust had delivered the target of no more than 1% of patients waiting for a diagnostic test.

He reported that in relation to Referral to Treatment (RTT) targets the Trust was delivering on most of the specialities apart from two which was pulling the overall score down.

He advised that funding was being made available nationally to deliver RTT targets by the end of September in order to provide more resilience over the winter period and the Trust would be submitting a bid for funding.

iv) Emergency and High risk Trauma and Orthopaedics (T&O)

Mr Sunley reported that the move had worked well and Dr Slater reported that the theatre teams were working well to manage both T&O and general surgical cases.

In relation to staffing levels Mr Sunley reported that nurse recruitment had been good and vacancies were being covered but difficulties were still being experienced in theatre staffing, both with anaesthetists and theatre practitioners, and vacancies were being covered with bank and agency staff.

Mr Sunley reported that it was still too early to quantify the impact on neighbouring organisations of the move.

v) Planning for Future Sustainability

Dr Harrison updated on the challenged health economy work and advised that the Board would have the opportunity to discuss the outputs in detail at the Board awayday on 11th June.

She reported that PWC had now completed their stage of the work and would be providing a summary report to the TDA and NHS England.

2. CQC Chief Inspector of Hospital's Visit – September 2014

Dr Harrison outlined the preparations that were taking place for the CIH visit in September and advised that weekly meetings of the project group, chaired by Mrs Webster, were taking place where progress against the action plan and operational detail were monitored.

She reported that PWC would be conducting a mock inspection the following week.

3. Board Governance and Leadership Review

3.1 Review of Board Assurance Framework (BAF)

Dr Harrison explained that the BAF was the document that gave the Board assurance that key risks were being appropriately managed and RAG rated whether controls and assurances were adequate and identified any gaps.

Discussion took place on the key risks against the three strategic objectives and the assurances and controls supporting them and whether there were any further gaps to be added.

It was agreed that the following risk should be added under strategic objective 3:

We are unable to invest in delivering/improving quality of care and outcomes for patients because we are operating in a challenged health economy and this impacts on our ability to make investment in infrastructure and service improvement.

Mrs Wells would refresh the BAF and bring a revised version to the next board meeting. **LW**

3.2 Board Governance Assurance Framework

Mrs Wells explained that the BGAF had been introduced two years ago to support Boards in their journey to Foundation Trust status and it was a two stage process with the Board self assessing itself against a set of indicators in the Board governance memorandum, ie;

- Board size and composition
- Board evaluation, development and learning
- Board insight and foresight
- Board engagement and involvement

and then moving on to the second stage of external validation.

She advised that the Board had previously undertaken the self-assessment but had not moved onto the external validation stage as its FT journey had been delayed.

The Board reviewed the previous self assessment against the indicators, focusing in particular on any red flags, and Mrs Wells noted any amendments.

3.3 Review of Committee Structure

Mr Ellis reported that the Quality and Standards Committee had not been functioning appropriately as attendance from clinical representatives had been poor and the reports received were over rich with data and facts but light on interpretation. In addition, as part of the turnaround work the committee had temporarily merged with the Patient Safety and Clinical Improvement Group with the result that it had become even more unwieldy and not achieving its aims.

Mr Ellis explained that the review of the terms of reference and membership was to form a committee that fulfilled its governance functions but was also challenging in driving the Trust forward.

Mr Ellis also emphasised the importance of the linkage between the Quality and Standards Committee and the Audit Committee.

Dr Harrison agreed that there was value in changing the terms of reference and membership and she advised that the Quality Improvement Plan would provide the Committee with a clear plan to work from to seek assurance on its implementation and outcomes. She suggested that the next meeting of the Quality and Standards Committee should articulate how it would intend to undertake that and therefore deliver against the terms of reference.

The recommendations to the terms of reference and membership were accepted and it was agreed that they would come to the Board meeting at the end of July for approval.

3.4 Review of Well Led Framework

It was agreed that this review would be conducted at the August Board Seminar.

4. Winter Preparedness

Mr Sunley reported that as previously mentioned the Trust had the opportunity to bid for national funding to ensure sustainability around RTT targets and also look at resilience and capacity planning.

He advised that the Trust was required to submit its bid by 30th July and the proposal was to build on increasing internal capacity and purchase some external activity.

He advised that there was also a discussion taking place with the CCGs, the area team and the urgent care network about funding for winter and general pressures. .

5. Draft Knowledge Management and Information Technology Strategies

Ms Goldsack reported that a review had been undertaken of the Business Intelligence department and associated areas eighteen months ago and one of the recommendations was that the Information Technology (IT) and Knowledge Management (KM) should be separated out to allow concentration on KM but both areas would continue to work closely together to achieve their objectives.

Ms Goldsack and Mr Deal highlighted a number of the issues currently facing the Trust including:

- ageing IT infrastructure
- multiple in-house systems and reliant on the knowledge of one person
- fragmented data warehouse
- systems often not interacting with each other
- ageing servers
- paper based systems still common
- limited disaster recovery plans
- multiple log-ins for medical staff access

Mr Deal referred to the Clinical Data Maturity Index (CDMI) and advised that the Trust was currently ranked 129 out of 159 Trusts in the county but the implementation of the KM and IT strategies would over a period of five years move the Trust up the table.

They advised that their aims were to provide real time, accurate and transparent data and information to support the Trust operationally and strategically, information systems to support clinicians and staff to provide safe, efficient and effective patient care and through SLAs with the clinical units and corporate departments be the hub of information and data.

Mr Deal reported that the aim of the IT strategy was to bring clinical systems back into one area and provide a clinical portal which would be a one stop shop for clinicians to gain information when required.

He advised that the key priorities were to put in the right infrastructure to deliver clinical and corporate systems to users, review and update how IT services were delivered including partnering with other organisations and driving innovation so that systems were exploited to their full potential.

Ms Goldsack outlined the priorities for Knowledge Management as to ensure that appropriately trained staff were able to deploy and utilise appropriate business intelligence tools, procured systems were able to integrate data appropriately into the warehouse and implement automated reporting where appropriate. This would include a review of all the existing clinical information systems in the Trust to ensure that there was a full understanding of what they were used for and that they were fit for purpose and appropriately used.

Mr Welling commented that milestones for delivery needed to be included and the financial requirements and this would be included in the final strategies.

The Board supported the direction of travel and Dr Harrison requested that any points of detail or clarification be sent to Ms Goldsack and Mr Deal as soon as possible in order that the strategies could be presented at the Board Meeting at the end of July for approval.

6. Date and Time of Next Meeting

Wednesday, 13th August 2014, from 10.00 am to 2.00 pm, St Mary's Board Room, Eastbourne DGH.

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	16
Subject:	Chairman's Briefing
Reporting Officer:	Stuart Welling, Chairman

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

Purpose:

To keep the Board informed of the activities undertaken by the Chairman since the last Board meeting.

Introduction:

The purpose of this paper is to provide an overview of activities undertaken and relevant correspondence received or sent by the Chairman since the last Board meeting.

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

Meetings attended in August and September:

- 26 August 2014 – Chair of Healthwatch East Sussex
- 15 September 2014 – Chair of HOSC
- Various Quality Walks to locations across the Trust

The following correspondence is attached to the report:

- Letter from Stephen Lloyd 28 July 2014 – referred to at last meeting
- Chairman's Brief

Use of Trust Seal

The following document has been sealed since the last meeting:
30 July 14 Deed of Variation relating to the Lease of the Medical Wing at Rye Memorial Centre between Rye, Winchelsea & District Memorial Hospital Ltd and ESHT.

Proposals and/or Recommendations

The Board is asked to note the activities undertaken by the Chairman since the last Board meeting.

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

Name:	**Contact details:**
Stuart Welling, Chairman	s.welling@nhs.net

HOUSE OF COMMONS
LONDON SW1A 0AA

Mr Stuart Welling
Chairman of the Board
East Sussex Healthcare NHS Trust
Eastbourne DGH
Kings Drive
Eastbourne
BN21 2UD

Reference: DGH/280714/JW

Date: 28th July 2014

Dear Mr Welling

Thank you for your letter, and for your understanding of my strongly held view that Eastbourne needs to have a fully functioning Hospital with an undiminished complement of core services.

I hope you appreciate that while I do have reservations about the direction of travel chosen by yourself and the other senior managers, I am fully supportive of all the staff members who work for ESHT. I speak regularly with a broad range of people employed at our local hospital and across the Community Health Service. I am very well aware of the excellent job that many do and indeed the views that they hold on the changes made by the Trust!

I would also like to reassure the midwives and doctors that I am wholly supportive of their work. You know the concerns I have around the lack of consultant provision at the DGH maternity unit but this does not stop my firm desire for our midwife provision to be the best in the UK. Consequently, I would be happy to meet with them over the coming month.

I should point out, I have just received information that appears to indicate a serious shortage of midwives locally. I know this is a particular issue at Crowborough, but unless something is done I am anxious the shortage of qualified midwives available may begin to impact negatively at our own hospital. I would welcome reassurance on this score. Meanwhile I would be more than happy to meet with key clinical staff at the DGH.

Rest assured I will continue to speak out on behalf of the overwhelming number of my constituents who oppose your changes, and who fear for the way they will access health provision should core services continue to be downgraded at the DGH.

I continue to remain behind the tremendous efforts made by so many of the Trust's employees, no matter which direction you take our healthcare services.

Yours sincerely

Stephen Lloyd MP
Eastbourne and Willingdon Constituency.

East Sussex Healthcare NHS
NHS Trust

Chairman's brief

Update of key issues at the Trust — 22nd July 2014

Strategy

As I mentioned in my last brief we have submitted our plans to the Trust Development Authority for a £30 million capital investment to implement the first phase of the 'Shaping our Future' Clinical Strategy and we are still awaiting their response. This funding will enable us to redevelop both the Trust's main acute hospitals (£13m on the Eastbourne DGH site and £17m on the Conquest Hospital site). It is a foundation stone in improving the quality of our services. The implementation of our clinical strategy has provided us with an important opportunity to ensure that we are able to deliver sustainable healthcare services for local people in the future. It will ensure we are able to respond to national and local requirements to improve patient safety, patient outcomes and service quality as well as meeting performance standards.

Emergency and high risk orthopaedics

In May we centralised our emergency and high risk orthopaedic services at Conquest Hospital in Hastings, to improve the quality of care we are able to offer our patients. Having all emergency and high risk orthopaedics based on one site, means we have more surgeons available to carry out planned procedures. We have also improved the care we provide to patients with orthopaedic emergencies by ensuring that there is a senior surgeon available who has no other duties so that they are dedicated to managing these patients. This means we are able to reduce the number of planned operations and clinics we have to cancel and treat people more quickly, which in turn will improve their recovery.

Emergency and high risk orthopaedic services is the third service to be centralised following the extensive Shaping our Future public consultation in 2012. In July 2013 we centralised hyper acute and acute stroke services at Eastbourne District General Hospital and increased stroke rehabilitation beds at the Irvine Unit in Bexhill from 12 to 18. In December last year emergency and high risk general surgery services moved, as planned, to the Conquest Hospital. As a result more surgeons are now available to carry out planned procedures, we are able to treat people quickly, improve recovery times and reduce the number of planned operations that we have to cancel. All the evidence indicates these moves have improved the quality of care we are able to provide to patients now and in the future in East Sussex.

Better Beginnings

You will probably be aware the East Sussex Clinical Commissioning Groups have agreed on their preferred option following the outcome of their Better Beginnings consultation on the future of local NHS maternity, paediatric and emergency gynaecology services. They approved option 6 as the best way to ensure safe and high quality services for local women and children in the long term. This option results in the following configuration of services:

- Birthing services retained at all three current sites
- Consultant-led maternity services provided at the Conquest Hospital, Hastings
- Two midwife-led birthing units provided - at Crowborough and Eastbourne
- Short-stay paediatric assessment units provided at both Eastbourne and Hastings
- In-patient (overnight) paediatrics, the special care baby unit and emergency gynaecology co-located at the same site as the consultant-led maternity service.

We are now awaiting the outcome of the HOSC meeting on 28th July when they will consider the CCGs' final conclusions and decision and consider whether it is in the best interests of the health services for the local area

Once finalised this decision will put an end to the long running issue of the provision of maternity services in East Sussex with the recognition that it is far safer and clinically sustainable to provide services from one consultant led obstetric unit. It represents the best way forward to ensure safe and high quality services for mothers, babies and children in East Sussex. We will work with our service users, commissioners, the local authority and other partners to implement this decision and ensure we can provide the best possible services under this option. This will build on the successes and learning we have developed since we introduced the current temporary configuration of services back in May 2013.

Performance

Despite the Trust achieving savings of £17.5 million in the financial year 2013/14 the final outturn deficit was £23.1 million. During the financial year we have had to make some tough decisions in order to maintain and improve the quality and safety of our services whilst receiving less income than the previous year. We put in place robust processes to ensure that delivering savings equating to five percent of our income did not impact on patient safety and the quality of our services

Like the rest of the NHS we face considerable financial challenges, this current financial year (2014/15) we plan to achieve savings of £20.4million. However, despite this level of savings we are planning to end the year with a deficit of £18.5million.

During the year 2013/14 we paid careful attention to our performance against the national standards as we know these have a significant impact on patient outcomes. It is most pleasing that our A&E departments continued to perform strongly with 95.26% of patients seen within four hours of arrival. We also focused on reducing healthcare associated infections (HCAIs) in 2013/14. This is challenging but we made good progress and the number of patients with Clostridium Difficile reduced by 16% to 43 cases. However, we were very disappointed to have one case of Methicillin Resistant Staphylococcus Aureus (MRSA) in November 2013 after 12 months without a case. We have ensured that we have identified the improvements and changes we can make following each of these cases and we expect to be able to make further improvements in 2014/15.

In 2014/5, we will focus on ensuring we meet all cancer targets and we are working with local GPs and others to address those areas where we have not been able to meet the standards we would expect. There is still more to do but we have seen some improvements in this area which is encouraging. The Trust's main focus this year will continue to be on patient safety. The year will be just as difficult as last, if not more so, with the challenge continuing to be providing services safely to a high quality within the money we have available.

Care Quality Commission

The Care Quality Commission (CQC) has announced that the Trust will be inspected in the week commencing 9th September 2014 under the new Chief Inspector of Hospitals' inspection regime. This is part of their planned programme of inspections under this new regime that will see all acute Trusts inspected by the end of 2015. When the inspection team arrives, they will see an integrated Trust that works to provide seamless care for the people of East Sussex. I know our staff work incredibly hard, day in, day out, to deliver great care to patients. I see this when I visit wards and departments, and I hear this when I speak to patients and visitors and in the complimentary letters received from patients and their relatives.

The new inspection regime is more extensive and rigorous than previous CQC inspections. It will involve a large team headed up by a senior clinician or executive including senior CQC inspectors, other professional and clinical staff and trained members of the public ('experts with experience'). The

teams will spend two to three full days at the Trust in the week of 9th September and will return for a further unannounced inspection in the following weeks. Our expectation is that they will inspect every major site that delivers acute and community services and will focus on the following acute services

- Accident and Emergency
- Intensive/critical care
- Surgery
- Maternity and family planning,
- Children's care
- Medical care (inc older people's care)
- Outpatients
- End of Life Care

As well as

- Community health services for adults
- Community health services for children
- Community health inpatient services
- End of life care in the community

The CQC will be keen to see whether we've got good plans and procedures in place, and they'll want reassurance that we've got the basics right such as infection control, privacy and dignity for our patients, and protecting them from harm. Like every other Trust in the country, we have our challenges and we know we don't get everything right all of the time, but that doesn't stop us aiming high and continually trying to improve the care we offer.

Quality Account 2013/14

We have published our Quality Account 2013/14 which is an annual report to the public from NHS provider organisations. The Quality Account is both retrospective and prospective in content, looking back at some of the achievements of the last year and looking forward at some of the priorities that have been set for the coming year. The document is available to view by clicking here.

New Paperless Clinical Monitoring System

In my last message I said that we had just started to roll out across a new paperless clinical monitoring system which uses hand held mobile technology starting at the Conquest Hospital. I am pleased to say the system is working well and last month we started to roll-out the new system in wards at Eastbourne DGH. This new system will become fully operational across both acute hospital sites by October 2014 and has been funded following a successful bid to the Safer Hospitals, Safer Wards Technology Fund for £821,000 and the Nursing Technology Fund for £186,000

The new system called VitalPAC enables nurses to record seven routine observations, such as temperature, pulse and blood pressure, and removes the requirement for a paper chart. Using a set of evidence based algorithms it also monitors and analyses patients' vital signs and gives an early indication that a patient maybe deteriorating. The system will automatically summon doctors and other senior clinical staff when the vital signs indicate the patient may be deteriorating.

Implementing this new system will improve patient safety and patient outcomes as it will identify the early signs of deterioration in a patient's vital signs and ensure quicker clinical intervention. Specialist teams such as critical care outreach, infection control and pain services will use this as a surveillance system for patients across the hospital so they can identify patients who may need proactive interventions to avoid the need for them to go into intensive care. Where the system has been implemented elsewhere it has resulted in reductions in mortality, cardiac arrests, length of stay and in improvements in patient outcomes.

New Child Health and Community System

We continue to invest in our community services with the roll out of a new patient record system called 'SystmOne' for Child Health and Community Services. This new system fully supports the NHS vision for a 'one patient, one record' model of healthcare and will be fully operational by the end of the year.

The SystmOne Community and Child Health system allows appropriate patient information to be shared electronically between healthcare professionals with the consent of the patient. This means that patients do not need to give the same information to a number of different health professionals and that those health professionals who have access to the system can get immediate access to clinical data. This will help them to work seamlessly together to deliver the best patient care. SystmOne users will include district nurses, health visitors, speech and language therapists, child health staff as well as a number of other community staff. Some GP practices will also have access to the system.

The implementation of SystmOne across the Community and Child Health services will bring about a number of changes in the way staff work including some staff being able to use security protected mobile devices, similar to a tablet to view caseloads and update the patient record whilst away from their base.

Dr David Howlett

Congratulations to Consultant Radiologist Dr David Howlett who has been awarded the title of Honorary Clinical Professor in Radiology at Brighton and Sussex Medical School by the University of Sussex. This is tremendous personal achievement and a great accolade for the Trust.

Thanks to our Volunteers

Every year we thank our Volunteers for the service they give to our patients and local hospitals at an annual Volunteers Celebration Event. At this event we presented certificates in recognition of their length of service. This year a total of 43 volunteers achieved 10 years service and 10 have achieved 20 years. Remarkably, two volunteers, Gisella Picton who volunteers at the Conquest Hospital and Jo Marchant who volunteers at Heathfield Health Centre, were recognised for 40 years service. They are the only volunteers to achieve this milestone in the last ten years.

We have around 1,200 registered volunteers in the community and at Bexhill, Conquest, Crowborough, Eastbourne, Lewes, Rye and Uckfield Hospitals working in many different areas. The volunteers give their time free for a minimum of four hours a week with many working longer hours.

We are extremely grateful for the work undertaken by the many volunteers in our hospitals. They all share one common thing - they give the precious gift of time. It is time freely given, in many cases a considerable amount of time, which all helps contribute to a better experience for our patients and visitors. The work, commitment and enthusiasm of our volunteers are a superb example to us all and a great service to the local community.

New Non Executive Director

I am delighted to announce that Michael Stevens has been appointed as Non-Executive Directors of East Sussex Healthcare NHS Trust taking up his position on 11th June 2014. Michael Stevens is a retired KPMG Partner and Fellow of the Institute of Chartered Accountants working for KPMG for 37 years. His wealth of experience will enable him to make a very valuable contribution to the Trust Board and enhance the leadership of the Trust.