EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 25th March 2015, commencing at 09.30 am in the St Peter's Community Centre, Bexhill-on-Sea

	AGENDA	**Lead:**
1.	a) Chairman's opening remarks b) Apologies for absence c) Quality Walks	Chair
2.	Monthly award winner(s)	Chair
3.	Declarations of interests	Chair
4a.	Minutes of the meeting held on 4th February 2015	Chair
4b.	Matters arising	Chair
5.	Chief Executive's report (verbal)	CEO
6.	Board Assurance Framework	DSA

QUALITY, SAFETY AND PERFORMANCE

7.	Performance report month 10 (January) and Finance report month 11 (February)	Assurance	ALL
8.	Quality Improvement Priorities 2015/16	Assurance	DN
9.	Staff Survey	Assurance	HRD
10.	Research and Development Report	Assurance	MDS

STRATEGY

11.	HOSC Report on Maternity	Assurance	DSA

DELIVERY

12.	Annual Business Plan 2014/15 Quarter 4	Assurance	DSA
13.	Annual Business Plan and Budget 2015/16 Progress Report (due before 18th March)	Assurance	DSA/DF

14.	Capital Programme 2015/16	Assurance	DF

GOVERNANCE AND ASSURANCE

15.	Same Sex Accommodation – annual declaration of compliance	Assurance	COO
16.	Board Sub-Committees: a) Audit Committee 07.01.15 b) Finance and Investment Committee 17.12.14 c) Quality and Standards Committee 02.03.15	Assurance	Comm Chairs

ITEMS FOR INFORMATION

17.	Letter from Jeremy Hunt re Francis Enquiry		Chair
18.	Chairman's Briefing		Chair
19.	Questions from members of the public (15 minutes maximum)		Chair
20.	Date of Next Meeting: Tuesday, 2nd June 2015 at 10.00 am in the Lecture Theatre, Education Centre, Conquest Hospital		Chair
21.	**To adopt the following motion:** *That representatives of the press and other members of the public will be excluded from Part 2 of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest* *(Section1(2) Public Bodies (Admission to Meetings) Act 1960)*		Chair

STUART WELLING
Chairman

10th March 2015

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:	25th March 2015
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks January/February 2015
Reporting Officer:	Amanda Harrison

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

Purpose:

This paper provides a summary of Quality Walks that have taken place during January and February 2015.

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 January and February has continued as previously. These were:

- 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:

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

Date	Time	Service	Site	Visit by
7.1.15	2-4pm	Physiotherapy	EDGH	Monica Green
8.1.15	2pm	Birthing Centre	Crowborough	Sue Bernhauser
16.1.15	9am	Dental Services	Ian Gow Centre Eastbourne	Vanessa Harris
23.1.15	1pm	District Nurses	Arthur Blackman Clinic	Sue Bernhauser
26.1.15	2pm	Podiatry	EDGH	Vanessa Harris
29.1.15	2pm	Day Surgery/OPD/Radiology	Lewes Victoria Hospital	Amanda Harrison
30.1.15	2pm	Day Surgery	Uckfield Hospital	Darren Grayson
2.2.15	12midday	Urology Investigation Suite	EDGH	Darren Grayson
2.2.15	1pm	SSPAU &OPD	EDGH	Darren Grayson
5.2.15	9am	Occupational Therapy	EDGH	Monica Green
9.2.15	3pm	Michelham	EDGH	Stuart Welling
6.2.15	1.45pm	Maternity	Conquest	Darren Grayson

9.2.15	3pm	Infection Control Team	EDGH	Amanda Harrison
9.2.15	3pm	A&E	Conquest	Sue Bernhauser
12.2.15	10am	Orthopaedic Outpatients	Conquest	Darren Grayson
Date	**Time**	**Service**	**Site**	**Visit by**
12.2.14	2pm	In patient ward	Rye Hospital	Darren Grayson
16.2.15	2pm	Occupational Health	Conquest	Amanda Harrison
19.2.15	4pm	Health Visitors Safeguarding Team	Hailsham Health Centre	Vanessa Harris
26.2.15	10am	Firle Unit	EDGH	Darren Grayson
26.2.15		CCU/Cath lab	EDGH	Darren Grayson
27.2.15	12 midday	Estates	Conquest	Sue Bernhauser
27.2.15	10am	EMU	EDGH	Darren Grayson

23 of these were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit. The remainder was carried out as an ad hoc visit 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).
At the time of writing the report feedback forms had been received relating to 17 of the visits to individual services or departments, copies of which have been passed on to the relevant managers for information.

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

Service Reconfiguration
In one of the community teams visited it was noted that the closure of beds within the acute hospitals had led to an increase in the number, complexity and dependency of the patients they cared for. The team stated that they were willing to take on additional roles but felt they could do no more without an increase in staffing levels.
At Crowborough Birthing Unit some concerns were raised about the extent to which 'local mothers' wish to go to the Conquest Hospital if complications arise during labour as at least 60% of the women using the unit come from the Pembury/Tunbridge Wells CCG area, staff also raised concerns about the viability of the unit should staffing issues continue.
In one of the community hospitals there were still ongoing concerns raised by staff regarding the outpatient administration review, staff in other areas were also worried about the possible outcome of the forthcoming community tender.
A therapy team within the acute setting were feeling the impact at the time of the continuing 'black' status on the department, as patients were often spread around the hospital on different wards for operational reasons.
In dental services the staff requested some clarity about the future plans for their service and raised concern that the team would not be able to influence further development of the service.
A podiatry team stated that changes to vascular services as part of the general surgery move had impacted on service need but staff had adapted well to meet this activity pressure.
It was noted that the short stay paediatric assessment Unit was working well and only transferring the expected number of patients, however staff were still missing not having inpatient to care for.

Information Technology (VitalPAC, SystmOne)
Community staff continued to give positive feedback about SystmOne, they felt it had improved their cross team working and enhanced the care they were able to provide, but noted that there had been some teething problems. They also felt that an increase in the number of desk top computers available to them at their base would both enhance their work and make scheduling mandatory training easier.
There were no issues or comments raised about VitalPAC during these visits

Staff Survey
One community team visited stated that all the staff present had completed the staff survey as they

saw it as a good way to make their views heard. In contrast another team stated that they felt there is always a low response rate to the survey because staff "don't think it makes any difference".

Other key issues

A therapy team reported that morale in their department had increased, but that they had some recruitment issues as a number of band 5s had left, however all the posts had been advertised.
Some excellent quality initiatives were also being introduced e.g. work around seven day services and shift working for the staff for which there is a consultation ongoing and also work around trauma unit status and what this involves.
One feedback report commented on how impressed the Director was with the open style of management and leadership demonstrated by a community team leader who clearly supported her staff, and acted as a mentor and role model to them.
In the Day surgery unit at Uckfield there had been some good work established around embedding the Trust values

Patient feedback

There was little patient feedback noted on the reports during the recent visits but one patient using the dental service stated that felt she was able to manage her treatment because the staff helped her by taking things step by step and explained everything thoroughly which reduced her anxiety.

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 Head of Compliance to ensure that actions are implemented. Further visits are being scheduled to take place in March and April.

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?
N/A

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

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday, 4th February at 10.00 am in the St. Mary's Board Room, EastbourneDistrictGeneralHospital

Present: Mr Stuart Welling, Chairman
Mrs Sue Bernhauser, Non-Executive Director
Prof. Jon Cohen, Non-Executive Director
Mr Darren Grayson, Chief Executive
Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Joint Medical Director - Clinical Governance (item 010/2015 onwards)
Mr Barry Nealon, Non-Executive Director
Dr Andy Slater, Joint Medical Director – Strategy
Mr Mike Stevens, Non-Executive Director
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Mrs Alice Webster, Director of Nursing

In attendance:
Ms Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development and Assurance
Ms Jan Humber, Joint Staff Side Chairman
Mrs Lynette Wells, Company Secretary
Mr Peter Palmer, Assistant Company Secretary (minutes)

For specific items:
MissSarah Davies, Project SEARCH Programme Co-ordinator, (item 1d)
MrsJeanette Williams,Listening into Action Lead, (item 1d)
MrsLiz Still, Research and Development Manager, (item 10)

001/2015 **Welcome and Apologies for Absence**

a) Chairman's Opening Remarks

Mr Welling welcomed everyone to the public part of the main Board meeting. He commented that this was the first meeting to be held in 2015 and that the operational pressures on the Trust over the last 2-3 months had been enormous. He thanked all of the Trust's staff for their hard work in maintaining diligence and patient safety during this busy period.

Mr Welling welcomed Jeanette Williams, Listening into Action Lead,and Sarah Davies, Project SEARCH Programme Co-ordinator, who were attending the Board in order to present on Project Search.

b) Apologies for Absence

Mr Welling reported that apologies for absence had been received from Mr Charles Ellis, Non-Executive Director

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

c) Feedback from Quality Walks

Mrs Harris reported on two visits she had undertaken and advised that she had also undertaken three further visits, to Ian Gow Memorial Health Centre in Eastbourne, to Podiatry on the Eastbourne DGH site and to the Special Care Dental Service since the Quality Walks report had been produced.

Mrs Harris noted that on every Quality Walk she always felt welcomed, that staff were proud of the services that they provided and that they were keen to show those services off. She always made a point of speaking to patients during visits and in every area patients commented on the excellent standards of cleanliness. All the feedback that Mrs Harris had received from patients had been positive, and they had commented on the good standards of care they had received.

She commented that some areas she had visited had encountered difficulties with recruitment, despite their best efforts to rectify this issue. She said that she found a large variance in whether there was sufficient storage space, but that in some areas changes had already been made to improve this. Mrs Harris had spoken to staff about the Staff Survey and had found that completion of this was variable. A common message she had heard was that staff did not see the point of completing the survey. She reported that she had also seen issues with old computers and with internet speeds, although the latter was a recognised national issue.

Mrs Harris said that she had written an article on her last two Quality Walks that had been published in the Trust Magazine “Connect”.

Mr Grayson provided an overview of his Quality Walks and it was noted that his last three Quality Walks had taken place since the report on Quality Walks was produced for the Board Meeting. These had been at UckfieldCommunityHospital, the Urology Investigation Suite at Eastbourne DGH and the Short Stay Paediatric Assessment Unit (SSPAU) at Eastbourne DGH.

He reported on his visit to UckfieldCommunityHospital, saying that it was a large community hospital, valued by the local community. He found it to have a good quality environment, and modern equipment when he was shown round by Matron Heather Green. Mr Grayson said that dental x-ray services had moved from UckfieldCommunityHospitalto

Eastbourne DGH some months ago, and that the League of Friends had purchased an x-ray machine for this service at UckfieldCommunityHospital. After discussion with the League of Friends, this machine would now be transferred to Eastbourne DGH in order to continue to be used by the service.

Mr Grayson said that the operating theatres at UckfieldCommunityHospital were heavily used, with patients coming from across East Sussex for operations. He found that the hospital had a positive atmosphere. He also spent some time on Harland inpatient ward, and discovered that there were staffing issues in this area, but that these were being resolved.

The Board noted the report on quality walks.

d) Project SEARCH

Mrs Williams and Miss Davies presented a report on Project SEARCH; a supported employment initiative for young people with learning difficulties and disabilities aged between 18-24. The Trust is undertaking this project in partnership with SussexDownsCollege and other local groups.

A short video about the initiative was played to the Board.

Mr Welling enquired about what happened when the interns had finished the project and MissDavies replied that the interns were placed in three different jobs during their year long programme, and could then apply for a job with the Trust or another employer. A 'Job Developer' is associated with the project to support the interns with their job search. The aspiration was to ensure that the interns were employable when they have finished they have completed their year within the project and that every intern would get a job.

Miss Davies explained that the interns had recently finished their first job rotation and that the extent to which their confidence had improved was noticeable. They required less support than they had previously needed.

Mr Welling asked if a further report could be made to the Trust Board when the project was completed, and Miss Davies agreed to do this.

The Board noted the report and success of Project SEARCH.

002/2015 **Monthly Award Winners**

Mr Welling reported that the winner for December was Tina Plumb, Staff Nurse on Pevensey Ward, who had been nominated for her tremendous work in raising over £3,400 over the last four years for the Pevensey Ward Appeal.

He reported that winners for January were Michelle Clements, Facilities

Manager, and Emma Watson, Night Data Input Clerk,who received the award for dealing with an acute emergency situation, when the switchboard at Eastbourne DGH went down overnight.He said that he would be presenting the award to them the following week.

003/2015 **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.

004/2015 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 26th November 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

It was noted that all matters arising had been discharged or would be considered during the business of the meeting.

005/2015 **Chief Executive's Report**

Mr Grayson reported that the Trust had, and continued to have, the most intense pressure on front of house services that he had ever experienced. A small number of routine elective procedures had to be rearranged in order for the Trust to cope with the unprecedented demand. During this period, the 95% A&E standard was narrowly missed but patient safety was maintained. Mr Grayson extended his thanks to staff for all their hard work, but noted that the pressure on services remained.

He announced that draft CQC reports had been received, and that comments regarding the factual accuracy of these reports had been sent back to the CQC. A response was awaited from the CQC.

Mr Grayson said that the High Weald, Lewes and Havens CCG tender process for their community services was now underway, and that an informative Q&A session had taken place the previous week..

He advised that the outline business case to provide satellite radiotherapy services at the DGH, being undertaken in conjunction with Brighton and Sussex University Hospitals NHS Trust, had been approved by the TDA. Two sites were being considered for this service, one would involve a new build and the second was for the service to be

based in the currently empty lower floor of the new Endoscopy Unit at Eastbourne DGH. The second of these was current the preferred option, and it was hoped that, subject to TDA final approval, this project would be finalised by the end of the next financial year.

Mr Grayson reported that the work on Pevensey Ward would go ahead, subject to final TDA approval. He also reported that there was good progress with completing the Trust's 2015/16 business plan, and that he felt that the Trust was very close to delivering a plan that everyone could be very proud of.

The Board noted the Chief Executive's report.

006/2015 **Board Assurance Framework**

Mrs Wells presented the Board Assurance Framework..She reported that the Quality and Standards Committee had undertaken a deep dive on Health Records. She advised that a new risk had been added to Framework concerning the national problems with the NHS N3 Internet Gateway and this had been discussed at the Audit Committee. Areas of the Board Assurance Framework that had been revised since the previous meeting were highlighted with red text.

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.

QUALITY, SAFETY AND PERFORMANCE

007/2015 **Performance Reports**

a) Performance Report – December 2014 (Month 9)

i) Responsiveness Domain

Mr Sunley reported that winter plans had been in place to open up 40 additional beds in order to deliver extra capacity when it was required. Due to the extraordinary demand during December and January an extra 120 beds had been needed in order to manage across both sites. Extra staff had been required in order to support these additional beds. He said that both the ambulance and social care teams had attended daily bed meetings to ensure that the service remained as robust as possible. Mr Sunley said that patient safety had been maintained throughout this period.

He noted that there had been a number of mixed sex accommodation breaches in December which all related to Critical Care patients who had been fit to leave the units, but who had not had beds available on other wards. A breach is counted in these circumstances if a patient is fit to be discharged, but is unable to be moved.

Mr Sunley spoke about Delayed Transfers of Care during December and stated that there had been problems with getting the number of social care package placements that were needed in order to discharge patients. He felt that this was likely to be an ongoing problem as winter had not yet ended. He explained that the Director of Social Care was shortly due to undertake Challenge Rounds in the Trust, in order to better understand the impact caused by the inability to access social care packages.

Mrs Bernhauser advised that on one of her recent Quality Walks she had visited MacDonald Ward and noted they had a dedicated social worker placed on the ward. She asked whether this was a solution that helped to expedite the problems around delayed discharges. Mr Sunley responded that he felt that this was a good model of care, and that he has held conversations about expanding this model to more areas in the Trust.

Mrs Bernhauser askedhow prevalent it was that patients' relations refused to take responsibility for them when they could be discharged from hospital, thus delaying their discharge. Mr Sunley said that it did happen and a great deal of planning takes place with the family to co-ordinate an appropriate discharge. The Trust tried to maintain interim placements for patients if these situations occurred.

Mr Nealon said that he had visited A&E to personally thank staff after the recent 'Black' period had ended. He was surprised to learn that the major growth in patients being admitted during this period had been elderly patients who had respiratory problems, and asked how the Trust was responding to this problem. Mr Sunley said that clinicians had to make a clinical decision based on patient safety, and that during periods of extreme pressure the admission criteria for these patients may be reviewed. Dr Slater added that East Sussex Better Together was undertaking work on this problem as it was almost inevitable that if an elderly patient with respiratory problems was brought into hospital during the evening then they would be admitted to hospital on safety grounds. There was a need for social care input in A&E throughout the evening, and perhaps during the night too.

Mr Welling enquired whether the new Clinical Decisions Unit (CDU) at the Conquest had a positive impact during the period of pressure. Mr Sunley replied that he had yet to see any figures relating to this, but that the CDU has created more space within A&E at the Conquest, and that the Conquest dealt with the recent pressures better than Eastbourne DGH had done. The CDU had also helped with delayed transfers at the Conquest. Mr Welling asked that figures were made available in time for the next Board meeting. **RS**

Mr Welling asked about how confident Mr Sunley was that Social Services were trying to put more social care packages in place. Mr Sunley responded that he was seeking assurances from Social Services

that they were doing all they could to secure provision of social care packages.

Mr Sunley reported that diagnostic waiting times mirrored those from the previous month. There had been issues regarding access to endoscopy, and a lot of work was being undertaken to improve this.He expected waiting times to improve throughout February. He added that cancer targets had been difficult to achieve in December as there had been bank holidays and patients were often unwilling to come in at short notice during the festive period. There was continued work with GP practices to raise awareness with patients and a plan in place to get these targets back on track.

Mr Sunley said that a new computer system had been introduced in order to aid with tracking patients on the 62 day cancer pathway. He also explained that he expected Clinical Nurse Specialists to have greater involvement in the management of cancer patients.

Mr Sunley explained that the Trust had met the Referral to Treatment (RTT) target for December. He did not expect that the RTT targets would be met for January and February due to the pressure on the Trust during that period, and explained that the Trust had secured contracts in the private sector in order to help with reducing any backlog of patients that built up during that period. Mr Sunley expected the RTT target to be achieved by March 2015.

ii) Effectiveness Domain

Dr Slater reported that the Trust's figures for the Hospital Standardised Mortality Ratio (HSMR) were currently rated green and that the rating for deaths in low risk conditions had improved considerably. He said that the Trust was looking at ways of reducing re-admissions of patients to hospital.

Prof. Cohen said that he felt the mortality data was very encouraging and asked to what extent becoming a community based Trust had help with improving readmission rates. Dr Slater replied that he did not feel that this had had a great effect.

iii) Safe Domain

Mrs Webster explained that there had been an increase in Clostridium Difficile cases over the preceding three months, and that the Root Cause Analysis had not identified a common theme that could account for this increase.

Prof. Cohen said that he worried that the increase in Clostridium Difficile cases may be an indication of wider underlying issues, such as a lack of nursing staff. Mrs Webster advised that this factor was considered when undertaking the Root Cause Analysis and there did not appear to be an underlying association.

Mrs Webster also said that there had been two MRSA cases reported between August and November, which had both been thoroughly investigated. One of these was a caused by a contaminant and one by a bacteraemia.

iv) Caring Domain

Mr Sunley reported that he had held discussions with High Weald, Lewes and Havens (HWLH) CCG and had increased the number of beds at Crowborough as a result. The impact of this change had not been felt by the Trust, but had a positive impact for Maidstone and Tunbridge Wells NHS Trust.

He explained that therapy wards have shown good progress over the last few months, despite having to contend with 40% staffing vacancies in speech and language services which was a trend reflected nationally. This had meant long waiting times for the service and had led to discussions with the commissioners and also an attempt to find more creative ways to recruit to these vacant positions.

Mr Sunley explained that the waiting lists for the community paediatric service were a source of great concern for the Trust and that the CCG were reviewing the referral criteria to the service in order to better manage demand. A plan is in place to increase the number of patients being seen, and 71 of the outstanding 105 patients had been seen by the end of January. A discussion has been held with the CCG, who are supportive of the Trust's efforts to reduce the waiting list. Mr Grayson explained that the CCG recognise that they do not have an up to date and evidence based specification for the community paediatric service.

Mrs Harris updated on the implementation of the community based IT system, SystmOne. This has improved the quality and reporting of data. There are now over 500 staff using the system, and the roll out of the system was to continue to specialist nursing and nursing therapy areas.

Mrs Bernhauser said that she had visited community nursing teams who were generally delighted with the system, but that they found that on occasions it froze, sometimes for up to one and a half hours on mobile devices. Mrs Harris replied that the mobile version of the system was quite new, and that the Trust was currently working through the problems with the provider of SystmOne.

v) Well Led Domain

Ms Green reported that workforce spend had increased during the recent busy period. She said that there are nationwide recruitment problems, but that there had been lots of progress with recruiting in nursing, midwifery and of HCAs. There was a need, Trustwide, to recruit 20 nurses a month just to keep staff numbers stable. The Trust was considering overseas recruitment, but needed to make sure that this

desire for recruitment was looked at in conjunction with the Clinical Units to ensure that service demands were being met.

Ms Green said that staff sickness had increased during December and was at a higher level than in previous years. She explained that in an effort to improve staff sickness a number of different measures were being implemented. The Trust's absence policy had been revised and the intervention trigger had been changed; work was being undertaken with Occupational Health to improve reviews of staff who were away from work due to long term sickness; compliance with return to work interviews was being reviewed; resilience work and work around a mentally healthy workplace was being undertaken to provide more support for staff with issues outside of work. Ms Green said that staff working in nursing, midwifery, estates and ancillary had the highest sickness rates in the Trust.

Ms Green explained that although significant progress had been made in meeting mandatory training targets the 85% target was still not being met. Mr Welling said that he had particular concerns around appraisals and that he didn't feel that good progress was being made around achieving appraisal targets. Ms Green said a traffic light system was in place to alert managers so that they knew when appraisals needed to be undertaken. She advised that she had spoken to managers who had told her that they clinical pressures were impacting on their ability to undertake appraisals.

Mrs Harris said that she didn't feel that it was good enough to set targets and then to miss them. She felt that sanctions should be made to those that didn't meet the expected levels of appraisal. Mr Welling agreed with Mrs Harris and wondered if managers were receiving adequate training in appraising staff to ensure that they took place, and that when they did so that they were meaningful.

Mr Sunley said that appraisal figures were reviewed with the Clinical Units during regular accountability meetings. Mr Grayson explained that he felt that the expectations around appraisal should be made clearly to the Clinical Units. Ms Humber agreed with this and explained that she felt that the appraisal process should be a positive experience for staff, and that managers who were not compliant should be performance managed.

The Board noted the performance report for December 2014.

b) <u>Finance Report – December 2014 (month 9)</u>

Mrs Harris reported that the Trust's overall RAG rating was green, and that itwas forecasting a very small surplus by the end of the year. She advised that £13.5 million of the £18 million deficit funding had been recognised in the month 9 position.

It was noted that there were currently two areas with amber RAG

ratings. The first was expenditure, due to pay costs being above plan, a position which would continue and which did not include additional costs associated with the busy period in December. The second was the Cost Improvement Programme which was currently £633,000 below the expected year to date figure. Mrs Harris explained that December's results had demonstrated that the Trust's financial position was not significantly off plan; she expected the Trust to meet its year end targets if everything proceeded as planned.

She reported that the Better Payment Practice Code showed that 99% of the Trust's trade invoices were paid within 30 days during December and that she thought this was a record for the Trust.

Mrs Harris said that activity was lower than it had been in the previous year, although attendances to A&E had increased. She said that she had no new financial risks to report. Risks remained around agreeing a year end position with NHS England, and the extra costs involved around the pressures in month 10.

Mr Nealon extended his congratulations to the Executive Team for their efforts in getting the Trust's finances into shape, but expressed concerns that the large number of recent changes within the Trust had had an adverse affect on morale. He further expressed concerns that the changes that would have to take place in the next financial year would affect morale further. Mr Welling acknowledged that the challenges facing the Trust in the next financial year made those faced over the current year look relatively simple.

The Board noted the finance report for December 2014.

008/2015 **Safe Nurse Staffing Levels**

Mrs Webster explained that the report had been produced in response to the requirements of the National Quality Board and NICE guidance on "Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals". Staffing levels had been reviewed using NICE guidance along with the Kingsgate Establishment Model and professional judgement. Staffing levels had been agreed using a web based tool that had been set up with input from the matrons and Clinical Units. Mrs Webster said that the process had not been suitable for all areas in the Trust. A further review was due to be completed over the course of a month in March 2015, and work was being undertaken to look at nursing for patients with specific needs.

Mrs Harris said that changes to the nursing establishment would have an impact on budget setting and enquired whether it would be possible to recruit enough nurses to fulfil the new nursing requirements. She said that during turnaround, the aim had been for nurses to be recruited to 110% of the establishment which helped reduce reliance on temporary staffing levels and the higher costs associated with this and asked if it was possible to get back to this level. Mrs Webster acknowledged that

there were issues around recruitment, but didn't see this as a reason not to try to get staffing back up to that level. She advised that job roles were being reviewed in an effort to alleviate the issues.

Mrs Bernhauser said that she felt that early recruitment of newly qualified nurses was key. Students expected to get jobs in the area that they wanted to work in, and would go elsewhere to find a position if they could not do so. She felt that this was a potential barrier to recruitment. She also stated that when she had visited community nurses, they had expressed that they would like to expand their roles and that they would welcome the opportunity that this review would give them. Mrs Webster confirmed that a review of community staff was planned for March,

Mr Nealon asked if nurses on the wards were supportive of the changes brought about by the review. Mrs Webster said that many of the matrons had brought nurses into the review meetings with them, and had requested feedback from staff about the proposals.

Mr Grayson asked if he could take assurance that, following the establishment review, wards were adequately staffed. Mrs Webster gave assurance that this was the case.

Mrs Webster reported that NICE guidance on A&E staffing levels had been published in January 2015, and the Clinical Unit were confident that this guidance would be met. The guidance is still in draft form, so the final guidance may vary. A&E staffing levels will also be reviewed in March.

Mr Welling asked if the review of staff in March would tie in to the Business Planning process for 2015/16. Mrs Webster said that she would be reviewing nurse staffing levels throughout March for the whole Trust. This process would inform Business Planning for 2016/17, but would not be ready for the 2015/16 plans.

Mr Welling asked whether there would be provision in the community nursing establishment to cover annual leave and sickness.Mrs Webster said that she had discussed this with the Clinical Unit and she was currently unsure whether there was contingency for cover planned for 2015/16. Mr Grayson said that there was no plan to make an investment in this, and raised concerns about the appropriateness of applying hospital procedures to community services.

Mrs Harris explained that SystmOne in some cases had brought about a reported 10% efficiency gain in community nursing, so this would need to be looked at alongside the nursing establishment review and reported back to the Board.

Dr. Harrison asked how professional judgement used in the process was bench marked or peer reviewed. Mrs Webster said that links had been set up with Buckinghamshire Healthcare NHS Trust and Northern Devon Healthcare NHS Trust, which were Trusts of a similar size and with

similar services. The Trusts would be reviewing each others' establishment figures to validate good professional judgement.

The Board noted report on Nurse Staffing Levels.

009/2015 **Patient Experience Report**

Mrs Webster said that the table included under 2.2 on page 1 of the Patient Experience Report, Quarter 3, was incorrect and that she would revise it.

Mrs Webster reported that it was a challenge to get patients to complete the Friends and Family test after having been to A&E. However, of those patients who had completed the test, a satisfaction rating of 83.28% was recorded.

She explained that the NHS choices website was a medium for patients to leave feedback on their experiences in hospital, and that the Trust responded to every piece of feedback left, as well as inviting those patients who were not happy to get in touch to discuss their experiences.

Mrs Webster reported that there were currently a number of overdue complaints, and that the Trust was working hard to achieve the trajectory for responding. Prof. Cohen remarked that he felt only responding to two thirds of complaints received within the expected time frame was a great distance away from the expected response rate of 100%. Mrs Webster advised that each Clinical Unit was aware of how many overdue complaints they had to respond to, and meetings were being held with the complaints manager on a weekly basis in order to help with the problem. The number of overdue complaints had been reduced since the report was produced. Mrs Webster said that she would produce figures and a timeline, for when she anticipated complaints responses would return to 100%, for the next Board Meeting. **AW**
Mrs Bernhauser said that she had Non-Executive Director overview on complaints, and that she would meet with Mrs Webster to try to help resolve the issue.

Mrs Webster assured the Board that Patient Experience was taken very seriously, and said that regular meetings were held with HealthWatch who were reporting an increase in the number of positive responses the Trust was receiving from patients.

Mr Nealon said that he was aware from discussions that concerns had been raised about the quality of discharge information provided by the Trust. Mr Sunley replied that this information was monitored, and was part of CQUINS. He anticipated that all discharge summaries would be sent electronically to GPs by the end of 2015. Currently two thirds of the specialities within the Trust were doing this. Mr Grayson said that he was unsure whether there was a mechanism for finding out if discharge information was effective, and that this needed to be reviewed and

considered.

Mrs Harris asked how the recently introduced “Hello my name is…” initiative was progressing. Mrs Webster responded that the initiative had only been running for three days, but press releases had been made and radio interviews carried out.

The Board noted the Patient Experience Report for Quarter 3.

010/2015 **Research and Development Report**

Mrs Still presented the Research and Development report, which highlighted progress in relation to the Trust’s Research and Development strategy. She said that it was important to note that the Trust did not have a research facility, but was a site for national or multinational research. Patients were not brought into hospital in order to be involved in research and they never occupied beds specifically to enable research.

She reported that the work around amending outpatient letters, to include reference to research, was still ongoing as this involved changing hundreds of templates. The Trust’s ongoing commitment to research was being added to the job descriptions of staff. Mrs Still advised that an Annual Scientific Meeting was being held on 20th March.

Mrs Still reported that there were issues with accessing NIHR IT systems which were not supported under the Trust’s current IT infrastructure. This issue was being resolved by buying laptops unconnected to the Trust’snetworks for staff so that they were able to enter web based data.

She explained that Research and Development had undergone changes since April in order to try to further engage clinical areas and clinicians. Kent Surrey and Sussex Clinical Research Network (KSS CRN) had given the Trust research recruitment targets, but Mrs Still didn’t think that these would be achieved by the end of the financial year. The Trust had met 73% of the local CRN research recruitment targets with two months of the financial year to go. Mrs Still said that she expected targets to be increased for the following year, and hoped that the Trust would be able to exceed any target given. If more commercial research could be undertaken then the system would become self funding.

Prof. Cohen said that there were many reasons to encourage staff to become involved in Research and Development. He pointed out that there were a number of studies where it would be easier to recruit patients and these would improve the recruitment figures, Mrs Still said that the Trust worked closely with pharmaceutical companies in order to try to recruit patients.

Mr Welling asked how many Clinical Unit Research Champions there

were, and Dr Hughes replied that this was an aspiration for the Trust as there were currently none, but this would become a reality once Clinical Unit appointments had been confirmed.

The Board noted the Research and Development report.

DELIVERY

011/2015 **Annual Business Plan 2014/15 Quarter 3**

Dr. Harrison presented the report which provided an overview and progress against delivery of the actions in place for the Annual Business Plan.

The Board noted the Annual Business Plan 2014/15 Quarter 3.

GOVERNANCE & ASSURANCE

012/2015 **Health and Safety Policy**

Mrs Webster presented the policy and reported that it had been reviewed and agreed by both the Health and Safety Group and CME.

The Board ratified the policy.

013/2015 **Fit and Proper Persons Directors' Requirements**

Mrs Wells presented the papers for the Board's information and assurance that there were effective processes in place to meet the Fit and Proper Persons requirements.

The Board noted the Fit and Proper Persons Directors' Requirements and actions in place to support compliance.

014/2015 **Board Sub-Committee reports and Trust Board Seminar Notes**

a) Audit Committee

Mr Stevens presented the report and noted that the Audit Committee were due to meet with the Trust's external audit partner soon. .

The Board noted the report.

b) Finance and Investment Committee

Mr Nealon presented the report and noted that recruitment was a key initiative, and that he was confident that there would be key benefits to the following year's budget brought about via recruitment.

The Board noted the report.

c) Quality and Standards Committee

Mrs Bernhauser presented the report and noted the minutes of 13th January 2015 should not have 'draft' written on them.

The Board noted the report, and approved the revised Terms of Reference.

d) Trust Board Seminar Notes

The Board adopted the notes of the Trust Board Seminar held on 5th November 2014.

e) Charitable Funds Committee

The Board approved the Terms of Reference.

015/2015 **Chairman's Briefing**

Mr Welling presented the briefing which was self explanatory.

016/2015 **Questions from members of the public**

Clash of Meetings

Mrs Walke (and via email to the Trust from Mr Ash) said that the Trust Board meeting of 25th March clashed with Eastbourne CCG's meeting and asked if it was possible for the Trust Board meeting to be moved. Mrs Wells replied that the Trust set the dates of their meetings early, and sent them to the CCG, in order to try to avoid clashes. She said that unfortunately it was not possible to change the date of the meeting as this would affect associated meetings, and an external venue had been booked in Bexhill for the meeting which couldn't be changed. Mr Welling said that he would try to ensure that meetings didn't clash in the future but that he could give no assurance that this would be possible and that he would speak to the CCG about the problem.

017/2015 **Date of Next Meeting**

Wednesday, 25th March 2015, at 10.00 am in the St Peter's Community Centre, Bexhill-on-Sea

018/2015 **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.

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 04.02.15 Trust Board Meeting

Agenda Item	Action	Actioned By	When	Progress
007/2015 a) i) Performance Report - Responsiveness Domain	Figures to show effectiveness of CDU to be presented at next meeting.	Chief Operating Officer	25.03.15	Chief Operating Officer to provide update to Public Trust Board
009/2015 Patient Experience Report	Figures and timeline to show progress against returning complaints compliance to 100% to be presented at next meeting.	Director of Nursing	25.03.15	Director of Nursing to provide update to Public Trust Board

East Sussex Healthcare NHS Trust

Date of Meeting:	25th March 2015
Meeting:	Trust Board
Agenda item:	6
Subject:	Board Assurance Framework
Reporting Officer:	Amanda Harrison, Director of Strategy and Assurance

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

Purpose:

Attached is the 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.

Three areas remain at red relate to Mandatory Training, the Estates Strategy and the Internet Gateway. The Health Records gap in control has moved to Amber. An additional gap in control has been added from the high level risk register regarding community consultant paediatrician waiting times. This is currently rated amber and the Quality and Standards Committee is seeking further assurance on the actions.

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

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

Benefits:

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

Risks and Implications

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

Assurance Provided:

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

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

our local population and improve and enhance patients' experiences	
Strategic Objective 3 - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	√

Review by other Committees/Groups (please state name and date):
Quality and Standards Committee 2nd March 2015 Audit Committee 4th March 2015

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

Assurance Framework - Key

RAG RATING:

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

Status:

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

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

Committee:	
Finance and Investment Committee	F&I
Quality and Standards Committee	Q&S
Audit Committee	AC
Clinical Management Executive	CME

C indicated Gap in control
A indicates Gap in assurance

Board Assurance Framework - Feb 2015

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**
Key controls	Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference
Positive assurances	CQC reports following inspections Provider Compliance Assessments completed to ward level and gaps reviewed Internal audit report on CQC compliance Weekly audits/peer reviews eg observations of practice Monthly reviews of data with each CU 'Quality walks' programme in place and forms part of Board objectives External visits register outcomes and actions reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	C	There is a gap in control due to the number of policies that require review and updating.	Schedule of out of date policies produced and circulated to CU leads.Process in place for reviewing and updating policies to meet Mar milestone. Monitoring through CME.	end Mar 15	◄►	DN/COO	CME
1.1.2	A	The Board cannot be fully assured in respect of compliance with CQC outcomes until the regulator has issued the September inspection report.	Project Group in place and action plan to be developed. Feb-15 Draft reports received and factual accuracy response returned to CQC.	end Mar 15	◄►	DN	Q&S CME
1.1.3	C	There is a requirement to improve controls in Health Records service; to encompass systems and processes, storage capacity and quality of case note folders.	Review of Health Records commissioned and business case funded. Feb-15 Business case being implemented to include storage and tracking of health records. Building work being agreed with NHS Property services, start date May-15. Bar coding out to tender for Feb, contract award planned March.	end May-15	▲	COO	F&I CME

Strategic Objective 1:	
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.**

Board Assurance Framework - Feb 2015

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.2.1	C	Gap in control in delivery of cancer metrics and ability to respond to demand and patient choice.	Focussed management and actions in place. Cancer network discussion re urology capacity/ expectations. Capacity and demand review of gastro and endoscopy being completed. Feb-15 Proactive management continuing, with weekly review to improve compliance. Engagement with GPs in relation to 2WW and patient education. New pathways with milestones introduced with support of cancer nurse specialists.	end Mar 15	◄►	COO	CME

Strategic Objective 1:	**Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority**
Risk 1.2 Continued	**We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**

Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

1.2.2	C	Further controls required in emergency services as demand is impacting patient assessment-treatment time and subsequent discharge to other specialist/bed areas	Meet SECAMB monthly to review issues. Action plan and escalation process in place Feb-15 Capital bid with TDA to support expansion. Capital bid outcome awaited, planning permission being sought in advance. SECAmb discussions and actions to review at CLT	Feb-15	◄►	COO	CME
1.2.3	C	Effective controls are required to minimise the risk to achievement of referral to treatment timescales, particularly the admitted pathway.	Action plan developed with support from National Intensive Support team and TDA, monitored by Trust Board. Revised trajectory agreed - admitted to be delivered in Dec-14, sustainability from Feb-15. Non-admitted to be delivered from Feb-15. National change in emphasis to focus on backlog patients. Delivery of targets now Mar-15.	end Feb-15	◄►	COO	CME
1.2.4	A	Assurance is required that there are systems in place to develop and evidence shared learning from infection control incidents	Root Cause Analysis undertaken for all outbreaks and SIs and shared learning through governance structure, CU and nurse meetings. Cleaning controls in place and hand hygiene audited. Feb-15 Pevensey Ward separation of Day Unit from inpatients as interim measure until purpose built unit in place.	end Mar 15	◄►	DN	Q&S
1.2.5	A	There is insufficient assurance that clinical laboratory diagnostics analytical equipment will be replaced in a timely way following internal approval of the managed service contract.	Agreed to replace via managed services contract. FBC to Finance and Investment Committee meeting approved then to TDA Feb-15 FBC still with TDA	end Mar 15	◄►	COO	F&I CME

Strategic Objective 1:	**Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority**
Risk 1.2 Continued	**We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**

Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

1.2.6	C	Additional controls are needed to reduce the backlog of plain film reporting and delay in reporting non urgent radiological investigations.	Process in place to reduce plain film backlog and patients being contacted. CCG appraised of position and comms sent to GPs. Prioritisation process for urgent MRI/CT scans.	end Mar 15	◄►	COO/ MD(G)	CME
1.2.7	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 Action plan in place to reduce waiting list and working in partnership with commissioners to develop service specification and care pathways	end Mar 15	**NEW**	COO	CME/Q&S

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 on-going performance improvement and build a high performing organisation.**
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of CME involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership Programmes First Line Managers programme Regular leadership meetings

Board Assurance Framework - Feb 2015

Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. On-going monitoring of safety and performance of reconfigured services to identify unintended consequences Personal Development Plans in place

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.3.1	A	Assurance is required that the controls in place in relation to mandatory training and appraisals are effective and are improving levels of mandatory training and completion of appraisals.	Initiatives such as mandatory training passport being rolled out and developing e-assessments to support competency based local training. Robust actions planned to improve compliance by the end of the year. Including additional mandatory sessions, temporary resource to help develop competency assessments. Compliance increased at end of Dec-14 but further focus required in some areas. Feb 15 - Additional group sessions will continue until April 2015	end Apr-15	◄►	HRD	Q&S CME

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.**
Key controls	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 and stakeholders

Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Monthly performance and senior management meetings with CCG and TDA. Working with clinical commissioning exec via Better Together and Challenged Health Economy to identify priorities/strategic aims. Board to Board meetings with CCGs, SECAMB and other bodies. Membership of local Health Economy Boards – UCN, Elective, Integrated. Participant in emergency clinical senates

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls and engagement are required to ensure the Trust can model and respond to the potential loss of any services and reconfiguration following tender exercises.	Trust proceeded to dialogue phase of tender process, on-going risk assessment being undertaken as CCG requirement becomes clearer. Final tender evaluation scheduled end May.	end May15	◄►	DSDA	F&I CME
			Working with prime provider to facilitate implementation of MSK model of care. Impact on current service configuration being determined.	end Mar 15	◄►	COO	CME

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.**
Key controls	Develop and embed key strategies that underpin the Integrated Business Plan (IBP): Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Membership Strategy Effective business planning process
Positive assurances	Two year integrated business plan in place Stakeholder engagement in developing plans Finalising service delivery model for maternity and paediatrics

Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

2.2.1	A	There is insufficient assurance that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work on-going. Trust submitting 15/16 plans in line with TDA requirements	end Mar 15	◄►	DSDA	F&I CME

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 2.3	**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.**
Key controls	Embedding 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 Robust complaints process in place that supports early local resolution Clinical audit plan Equality strategy and equality impact assessments
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives. Friends and Family feedback and national benchmarking Patient surveys Dr Foster/CHKS/HSMR data Audit opinion and reports Quality framework in place and priorities agreed e.g. for Quality Account, CQUINs

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.3.1	A	Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience.	Incidents logged and issues escalated to SECAMB and commissioners. Service specification being reviewed by commissioners and Trust engaging with process.	end Mar 15	◄►	COO	CME
2.3.3	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Further controls are required to support delivery of an efficient service and good patient experience.	Immediate action taken and full review instigated to understand activity and processes to support implementation of focussed actions. Feb-15 Central team in place and systems being monitored and reviewed. Consideration being given to developing a couple of specialist teams to support areas with complex processes.	end Mar 15	◄►	COO	CME

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.**
Key controls	Clinical strategy development informed by commissioning intentions, with involvement of CCGs and stakeholders QIPP delivery managed through Trust governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work Modelling of impact of service changes and consequences Monthly monitoring of income and expenditure Turnaround progress in place
Positive assurances	Trust participates in Sussex wide networks e.g. 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)

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.1.1	C	Require evidence of robust controls to ensure achievement of 2014/15 financial plan and prevent crystallisation 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.	Monthly monitoring and review of income and expenditure. Additional savings identified and further controls in place to close gap. Feb-15 M10 position is a year to date adverse variance of £313k. Forecast outturn is to achieve year end position.	Commenced and on-going review and monitoring to end Mar-15	◄►	DF	F&I

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 3.2	**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.**
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Monitoring by F&I Committee
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that following approval of the FBC funding will be available to support the required investment in estate infrastructure, IT and medical equipment. There is a significant over planning margin over the 5 year planning period and a risk that essential works may not be affordable.	Business case submitted to TDA for early release of first tranche of FBC funds. Two applications made for emergency in year capital. £400k received for Conquest CDU improvements. Other application still pending. Capital Approvals Group is overseeing 2014/15 capital programme and ensuring essential expenditure is prioritised and is making regular reports to Finance and Investment Committee. Feb-15 Emergency capital PDC agreed for Conquest Emergency Department and application for medical records improvement project recommended by ITFF to DH for approval.	On-going review and monitoring to end Mar-15	◄►	DF	F&I

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 3.3	**We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements**
Key controls	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 Development of Recruitment and Retention Strategy Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data (plans to include vacancies) Rolling recruitment programme Monthly vacancy report to CLT
Positive assurances	Training and resources for staff development Workforce planning aligned to strategic development and support Workforce assurance quarterly meetings with CCGs Implementing Values Based Recruitment and supported training programme Success with some 'hard to recruit to' posts Well functioning Temporary Workforce Service. Full participation in HEKSS Education commissioning process.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.3.1	C	There is a gap in control because the final workforce strategy has been delayed as a result of market testing and service reconfigurations that have arisen or may arise from tenders. Workforce plan to be aligned with business planning.	Number based workforce plans submitted to TDA and HEKSS to support development of specific plans. 14/15 Plan submitted in June 2014 and first high level iteration of 15/16 plan to TDA on 13th January 2015. Workforce strategy is being developed for end March 2015 to incorporate: 15/16 Business Plans Learning Plan 15/16 Recruitment Strategy Staff Engagement Action Plan Feb-15 Work ongoing	end Mar-15	◄►	HRD	CME

Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

3.3.2	A	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	Development of Recruitment & Retention Strategy and associated action plan Trust-wide for all CUs which will identify hard to recruit posts and associated actions. Feb 15 - Meetings held with all CU by end of Feb-15 Recruitment and Retention Strategy to be considered at Apr Board seminar.	end Apr-15	◄►	HRD	CME
			Nursing establishment and skill mix review being undertaken again in Dec-14. To be signed off at Board in Jan-15 Feb 15 - Skill mix review undertaken.	end Mar 15	◄►	HRD	CME
			International Recruitment Programme for nurses to start in Jan-15 Feb 15 - European recruitment campaign started 4 new recruits to start Feb-15.	end Jan-15	▲	HRD	CME
			HCA local recruitment initiative to commence in Jan with aim to achieve full establishment by June-15. Feb 15 - Commenced with 23 new staff recruited Feb.	end Jun-15	◄►	HRD	CME
			Track recruitment monitoring tool to be implemented. Feb 15 - Purchased and training underway.	end Mar 15	▲	HRD	CME
			Weekly monitoring of recruitment to be implemented. Feb 15 - Weekly monitoring implemented and monthly reporting to the CLT commenced.	end Jan-15	▲	HRD	CME
			Value based recruitment to be incorporated into the recruitment process for all posts. Feb 15 - Implemented for newly qualified nurses.	end Jun-15	◄►	HRD	CME

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 3.4	**We are unable to develop and implement effective cultural change programmes that lead to improvements in organisational capability and staff morale.**

Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and agreed by Board.
Positive assurances	Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Embedding organisation values across the organisation - Values & Behaviours Implementation Plan Staff Engagement Action Plan Leadership Conversations National Leadership programmes Surveys conducted - Staff Survey/Staff FFT/GMC Survey

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.4.1	A	The CQC staff survey 2013 provided insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	Listening into Action Showcase events and continuation of the programme being mainstreamed into wider engagement work. Values launched and being embedded. Staff Engagement Ops and Exec Groups established. Involved in national OD work on culture change - linked with Portsmouth for learning. CU Lead / GM Development - being scoped. Health & Wellbeing initiatives being developed. Forward programme for Leadership conversations. Board and other committees receive regular reports and associated action plan updates on Staff/GMC surveys, Staff FFT Feb 15 - Further update once output of 2014 Staff Survey and Q4 Staff FFT are available.	end Mar 15	◄►	HRD	Q&S CME

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 3.5	**We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.**
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital Approvals Group and Finance and Investment Committee

Board Assurance Framework - Feb 2015

Positive assurances	Essential work prioritised with Estates, IT and medical equipment plans Capital approvals group meet monthly to review capital requirements and allocate resource accordingly Monitoring by Finance and Investment Committee

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.5.1	C	There is a gap in control as a result of the Trust not having an aligned estates strategy in place.	Estates Strategy to be developed. Approach to deliver Estates Strategy development, and phasing of development, to come to Board	Apr-15	◄►	COO	F&I CME
	A	Also refer to 3.2.1					
3.5.2	C	Inability to use web based applications as the N3 Internet Gateway is running at capacity between 11:00 and 15:00 daily.	Staff requested to review and minimise internet usage. Investigating possible alternative route for clinical internet traffic. National issue - CSU have raised with N3 that the next upgrade expected Summer 2015 needs to be expedited Feb-15 Escalated urgency of resolution with SE CSU.	end Mar 15	◄►	DF	CME

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 3.6	**We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change**
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports

Board Assurance Framework - Feb 2015

Positive assurances	Policy documents and Board reporting reflect external policy Strategic development plans reflect external policy. Board seminar programme in place Business planning team established Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.6.1	A	Lack of assurance in respect of capacity and capability to effectively respond to tenders. Specialist skills are required to support Any Qualified Provider and tendering exercises by commissioners.	Business planning team in place and supported by PMO. Ongoing review of processes and evaluation of outcomes to identify learning. Feb-15 Tendering support in place with coaching for those involved in the process	end Mar 15	◀▶	DSDA	CME

Clinical Unit/Service	Specialty	Risk Subtype	ID	Site	Opened	Title	Description	Rating (initial)	Manager	Review date	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Controls in place	Adequacy of controls	Action summary	Rating (Target)
Estates Operations & Maintenance Services	EME	Patient Safety	1152	TRUST	12/02/2014	Medical devices backlog	There is a risk to patient safety and compliance with legislation as the organisation is operating with equipment and medical devices that may no longer be supported in respect of ongoing maintenance and repair including a number of old Maquet operating tables	20	Simeon Beaumont	23/01/2015	5	4	20	EXTR	Risks prioritised by risk classification of all obsolete medical devices. The highest risk equipment is at the top of the replacement priority list held by EME for inclusion in capital replacement programme where funds allow. Reactive and planned maintenance. Finance Director and chair of Medical Devices Steering Group aware and regularly updated Provisional capital of £4m for 14-15 and year end of £630k secured.	Inadequate	TDA bid for further £1m capital funding. Monies given, £1m has been spent . Risk remains the same as time goes on devices are repaired/replaced, more require repair/replacement.	2
Finance	FMT	Financial	1177	TRUST	16/04/2014	Lack of availability of Capital Funding	Trust requires significant investment in estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. However 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.	20	Vanessa Harris	24/12/2014	5	4	20	EXTR	Essential work prioritised with Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. Finance & Investment Committee reviewed 2014/15 capital prioritisation at its meeting on 25 June 2014 and will keep under review. Mid year review of capital programme carried out by Boar 24/9/14. M8 capital programme review carried out by Finance & Investment Committee 17/12/14.	Adequate	Monitor Capex through Capital Approvals Group and Finance & Investment Committee. Application for interim FBC capital resource made to TDA in August 2014. Emergency capital PDC agreed for Conquest Emergency Department and application made for medical records improvement project.	5
Specialist Medicine	Haematology	Patient Safety	991	EDH	11/04/2013	Risk of further outbreak of Glycopeptide Resistant Enterococcus infection on Pevensey ward due to inadequate toilet facilities	Outbreak of Glycopeptide Resistant Enterococcus (GRE) on Pevensey ward, Eastbourne District General Hospital (EDGH). Current facilities, insufficient side room capacity and layout do not allow separation of the ward from the day unit to minimise risk of cross infection. In summary there was an outbreak of 9 patients with a specific strain (EBOU06EC-5) of GRE on Pevensey ward in December 2012 and a second outbreak in December 2013.	12	Deirdre Connors	16/01/2015	4	5	20	EXTR	Dedicated monitoring equipment allocated for patients in isolation. Strict controls with regard to equipment cleaning between patients. Disposable curtains for Pevensey ward. Application of infection control precautions at meal services. Information leaflet for Day Case patients regarding how to screen for GRE. Hand hygiene and infection control mandatory training. Separation of Day Unit: Actual separation of Day Unit from inpatients as interim measure until purpose built unit in provided.	Adequate	Outbreak situation GRE appears to have been contracted on the ward. Risk increased.	2
Strategic Development & Assurance	OTHER	Compliance	1170	TRUST	27/03/2014	Challenged Health Economy	There is a risk that the Challenged Health Economy wo does not identify a deliverable solution for sustainability for the Trust and therefore that the Trust will not be able to formulate a 5 year integrated business plan that demonstrates a sustainable clinical model and a return financial viability	16	Dr Amanda Harrison	18/12/2014	4	5	20	EXTR	CHE Programme Board in place, led by TDA and NHS England. Trust contributing to work and is member of Programme Board	Adequate	TDA meetings Work continuing on FRP (Turnaround) Representation on Programme Board	12
Urgent Care	GENMED	Patient Safety	1135	TRUST	13/01/2014	Consultant vacancies in MAU	Insufficient staff to meet the guidelines of the Royal College of Physicians which require comprehensive cover 12 hours per day, 7 days a week in an Acute Medical Unit. This will compromise senior decision making which could negatively impact the patient's pathway of care	20	Jenny Darwood	18/09/2014	4	5	20	EXTR	1 Locums 14/07/14: Conq Acute risk meeting: Middle grades; Both sites have coped with one middle grade vacancy without incident. 18/9/14 EDGH Urgent Care Governance meeting - When discussing the risk register the clinical lead enquired as to where the MAU consultant risk had gone as this is an ongoing issue. We should be providing cover 12 hours a day, 7 day a week which we do not. Therefore the group asked that the risk register entry was re-opened.	Inadequate	Post is being advertised	8
Women & Children	Paediatrics	Patient Experience	1213	TRUST	05/08/2014	Community Paediatric Consultant Vacancies	CCG commissioners have raised concerns regarding patients having to wait for at least a year before having an appointment with a community consultant paediatrician. Long term vacancies and sickness have led to capacity within the community paediatric team unable to meet the demand. Have advertised vacant posts on several occasions and have employed locum's with minimal impact, this has led to a ever growing waiting list. Referral numbers on both sites are very different in numbers, on the west it is an average of 50 per month and on the East it is an average of 15 per month	20	Annie Singer	02/01/2015	4	5	20	EXTR	Validated waiting lists East and West of the county. Advertise 2 WTE Consultant Community Paediatricians. Recruit to 2x Consultant locum to address waiting list Look at current capacity and demand and plan trajectory Commissioner external review of Community Paediatrics Work in partnership with commissioner to develop service specification and care pathways	Inadequate	Locum consultant starting on the 19th February 2015; an advert is out to cover sick leave; the cover is now in the job plans of current consultants who have been allocated one PA or their job plan for an additional clinic; Sussex Partnership Trust will help with Ouse Valley and Wealden: 50 patients have been transferred over to the them from ESHT service An ESHT employee in the community covers adults and children: A service spec will be set up for the whole service; CCGs request that the waiting list is cleared by the end of March or they will go out to tender; Saturday clinics in the community are continuing. No change to scoring at present.	8

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Cardiovascular	General Medicine	Patient Experience	1255	TRUST	12/01/2015	Escalation Wards - Staffing Issues	Inability to provide sufficient substantive trained and HCAs employed by ESHT to provide high quality, safe care. The wards are reliant on obtaining nursing staff through the Temporary Workforce Services (TWS) to enhance the numbers of staff on each shift. The quality and availability of these staff is variable and therefore there is a potential for omissions and failings in care that could impact on patient safety, potentially result in bad publicity and place the Trust's reputation at risk.	16	Paula Smith		4	4	16	EXTR	Limited core staff based on the wards, early requesting of TWS staff and block booking of known agency staff.	Inadequate	Request for further staff from wards to add to current core staff. Block booking of known agency staff	12
Cardiovascular	STROKE	Patient Safety	1128	EDH	11/12/2013	Medical Staffing - Stroke Unit	Following single-siting stroke services to EDGH and increasing the number of beds on the EDGH site, we currently have only one dedicated Stroke Consultant, and his team to support. The Clinical Strategy demonstrated the need to employ 4 WTE to support 7 day working and Best Practice Tariff.	16	Paula Smith	13/01/2015	4	4	16	EXTR	Senior Registrar locum recruited to support. New locum consultant now in post. Annual and Study Leave to be covered by Consultant Physician, Care of the Elderly. Stroke nurse team to ensure patients are reviewed and pathway followed. Collaborative working with Complex and Intermediate care escalated to support medical staffing stroke service.	Inadequate	Advert in place and interviews planned for February 2015	6
Chief Operating Officer	Medical Records	Patient Safety	540	TRUST	15/08/2005	Poor quality of patient record	Poor quality of medical case note folders (including issues surrounding general filing, training, repair, duplicate sets and dealing with backlog of filling within medical records) which increases risk of inappropriate treatments, duplication of tests and interferes with patient care.	15	Janice Horton Wood	02/01/2015	4	4	16	EXTR	Health Records Department has now formed a team to repair patient records. The repairs are carried out for minor to full case note repairs as part of the culling of Health Records stored on the racks is being reduced and this reduces the risk of damage to patient records.	Inadequate	A number of mitigating actions have been taken and good progress has been made with the reduction in duplicate records. The on-going creation of circa 2,000 records a month alongside inadequate filing prevents a reduction in risk without significant investment. A business case has been submitted to the TDA, await feedback by 17.1.15.	6
Chief Operating Officer	Out Patients	Patient Experience	1231	TRUST	01/09/2014	Outpatient Administration	Following the centralisation of notes preparation and reception services for outpatient services on the 2 acute sites a number of concerns have been identified with regard to Patient experience leading to formal and informal complaints, Ineffective use of clinical resources resulting in delays to clinics and patients missing appointments, lack of process to ensure patient outcomes are acted upon in a timely manner, Inadequat notes preparation leading to delays to clinic decisions on occasions and disruption to the 'cashing up' process in clinics which may impact income.	20	Liz Fellows	13/11/2014	4	4	16	EXTR	Recruitment of volunteers to act as 'wayfinders' and 'queue busters' at the EDGH site More robust rota management for reception staff Crib sheets to support direction of patients to clinics and appropriate re appointing Reinstatement of reception staff in remote clinic areas Recruitment of bank staff to cover vacancies in all areas and address cashing up backlog Local review in complex specialties and interim changes in administration team to stabilise the situation	Inadequate	Active recruitment, Central Team will be in place by end November 2014	4
Chief Operating Officer	OTHER	Performance	752	TRUST	23/04/2012	Risk that 18 week Referral to Treatment target and 6 week diagnostic target will not be achieved	Delivery of elective care access targets are dependent capacity being available to assess, admit and treat an agreed number of patients within 18 weeks of their referral being received.	16	Pauline Butterworth	17/07/2014	4	4	16	EXTR	(1) The management responsibility for each specialty and its targets has been clearly defined. (2) Specialty level performance targets have been set and are monitored at weekly performance meeting overseen by Head of Performance. (3) Paper presented to Corporate Leadership Team	Adequate		12
Estates Property Management	DESIGN	Compliance	908	TRUST	10/09/2012	Building and Engineering Services (From 6Facet surveys)	Risk that backlog may result in danger to staff using the buildings and the potential for enforcement action for failure of statutory duties.	25	MCH	23/01/2015	4	4	16	EXTR	Prioritisation of capital funding to repair and replace items that may result in disruption of clinical services.	Inadequate	Investigate and prioritise under Capital Funds 2014	12
Fianance	IMT	Performance	1238	TRUST	16/10/2014	Internet speed	Risk is inability to use web based applications. The N3 Internet Gateway is running at capacity between 11:00 and 15:00 daily. National issue. Investigated and checked with South East CSU. Causing mass internet slowness and issues of connection loss/unavailability.	16	Tony Deal	22/01/2015	4	4	16	EXTR	Confirmed little can be done locally. Have sent comms to trust staff advising of the issue and requesting staff limit their use of the Internet. CSU investigating possible alternative route for clinical internet traffic. CSU have raised with N3 that the next upgrade expected Summer 2015 needs to be expedited.	Adequate	Communicate with users. Escalate urgency of resolution with SE CSU.	1
Finance	IMT	Compliance	1250	TRUST	02/12/2014	Lack of fit for purpose computing facilities (data centres)	The Trust has been aware of issues within the physical infrastructure for the IT facility and has planned to reconfigure and refurbish these facilities. Internal audit have completed a review of computing Facilities (Oct 14) and this has identified several high priority areas for improvement. Historic issues have been identified but not addressed e.g. Fire Suppression.	16	Tony Deal	22/01/2015	4	4	16	EXTR	The Trust has taken immediate action to implement some of the more straight forward recommendations in the expectation that a re-audit will take place in December. Other recommendations will need to await the refurbishment work.	Adequate	Plans for refurbishment of Level 1 Conquest are in progress, awaiting quotes from Design services/ Eastbourne Electrical	2
HR Workforce Development	LD	Compliance	657	TRUST	02/09/2008	Mandatory & Statutory Training Compliance	There is a risk that if ESHT does not consistently achieve a satisfactory level of compliance (90%+) with statutory and mandatory training, it will have a negative impact on patient safety, staff safety, CQC registration and Health & Safety compliance.	12	Edel Cousins	17/07/2014	4	4	16	EXTR	Monitored through monthly Divisional performance meetings. Deploy formal performance management measures where appropriate. Worst performing areas met with Learning and Development team to agree trajectories Recovery plans in place	Adequate		4

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Medical Director	ALL	Patient Safety	1057	TRUST	03/06/2013	Failure to achieve Dementia screening CQUIN	There is a risk that the trust will fail to achieve the Dementia screening CQUIN target (2014/15) with resulting financial penalty and reputational damage. This includes the impact on the quality of patient care from failing to identify emergency admissions over 75 who may need referral to Memory Assessment Services.	12	Elaine Lindfield	04/12/2014	4	4	16	EXTR	Project plan to ensure targets are met. Monthly performance management at CU's responsibility for achieving project milestones to specialty level and performance management by divisional management team.	Adequate	Teams are reviewing areas of non-compliance. new policy document has been written reiteratin the CQUIN and individuals responsibility. ADN's the CQUIN coordinator (Strategy) and EL are working to engage all clinical teams. Discussions taking place re employing staff to support this work. The VitalPAC dementia module has also been rolled out at Conquest to support this.	4
Nursing & Clinical Governance	Nursing	Patient Safety	743	TRUST	30/03/2012	Staffing shortages	Risk to patient safety and quality of care if agreed minimum staffing establishments are not maintained when nursing bureau is unable to supply appropriate grade of staff. Ward establishments identify the agreed number of staff and skill mix for each clinical area, base on the expected acuity of the patients. There are various reasons why this may not be achieved and on occasions this can contribute to difficulties delivering the required standard of care to patients.	9	Alice Webster	01/12/2014	4	4	16	EXTR	1. Patient acuity to be reviewed daily. 2. Local revision of off duty rota. 3. E-rostering. 4. Proactive absence management. 5. Escalate for agency authorisation if bureau unable to supply grade of staff required. 6. Board report. 7. Escalation policy for staffing agreed	Adequate	Review underway December 2014. Will be repeated in March	6
Out Of Hospital	District Nursing	Reputation	854	COMM	01/04/2012	Inability to meet DN service specification	There is a risk that ESHT is unable to meet the service specification of the DN service over a prolonged period of time resulting in reduced patient experience and quality of care. The vacancy level is currently at 8% in District Nursing services against contract. There is a national shortage of suitably qualified District Nurses.	16	Debbie Cooke	09/12/2014	4	4	16	EXTR	Active recruitment plan to fill vacancies, some adverts are already out, other to follow imminently. Escalation procedure in place involving priority setting on caseload. Cascaded to CCG, GPs and Trust colleagues. Skill mix being applied. Clear understanding of where the vacancies lie. Band 6 Case Manager role has been developed	Adequate	Have recruited but not yet in post. DC will update.□ Nursing specification to be reviewed□ Nursing specification to be reviewed	4
Out Of Hospital	PHYSIO	Patient Safety	1258	TRUST	15/01/2015	High vacancy within rotational physiotherapy	Band 6 rotational physiotherapy vacancy due: 3/12/2014 This post is within acute stroke services. Band 5 rotational physiotherapists: Current vacancies and due as from: 21.10.2014 28.11.14 5.12.14 18.11.14 14.11.14 Across a range of rotations, including acute and intermediate care units. Risk 1. Increase in referral to assessment time, not meeting local or national targets. 2. Increase in waiting list numbers for acute and intermediate care units, resulting in reduction in patient flow across the trust. 3. Bigger impact than normal on winter pressures - relying on each service being fully staffed to meet the demands on acute beds, and intermediate care service bed flow. 4. Increased LOS across the acute and intermediate care settings. 5. Clinical risks: Deterioration of function/slower rehab progression/ higher risk of hospital acquired infections/ Higher risk of pressure areas/ higher risk of post-operative complications	16	Therese Ademola		4	4	16	EXTR	- Cross team cover - Priority system to ensure high risk patients seen - Use of bank staff to cover vacancies - Close contact with finance for ATR approval - Close contact with HR for recruitment to be as fast as possible once approval achieved for ATRs - Review of risks - Service manager/GM updates on risks	Adequate	Continue to highlight need for budgets to be aligned for finance approval.□ Advertise vacancies.□ Keep staff informed.□ Bank to identify staff□	9
Specialist Medicine	Patient Safety	Patient Safety	1260	EDH	20/01/2015	Patient safety on escalation areas - Seaford 2 and Hailsham 2	Potential impact on patient care/safety due to inadequate staffing numbers, skill mix competencies and clinical skills of staff from outpatient areas and agency/temporary workforce use. Linked to the number of additional beds that can be safely opened and sustained within available resources. Admission criteria have been developed but these may be challenged due to bed pressures and potentially patients admitted with needs that cannot be met within the available resources. There is a particular risk out of hours. Delays with access to relevant medical staff due to patients not being located on specific medical wards (Doctors). Limited equipment and supplies often required to "borrow" from other wards. Access to IT monitor ting and reporting systems	16	Deirdre Connors		4	4	16	EXTR	bed conference meetings take place daily to help manage outstanding issues. Daily liaison with discharge and bed teams to expedite discharges.	Inadequate		12

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Specialist Medicine	ALL	Patient Safety	1228	TRUST	29/08/2014	Staffing	There is a risk that the wards may not be appropriately staffed at establishment due to staff sickness levels above the expected Trust average of 4%. This is compounded by the bureau's inability to cover short term sickness. This is linked to risk 743	12	Deirdre Connors	16/01/2015	4	4	16	EXTR	Roster reviews daily, offers of bureau work Staff movement between wards. Absence management policies adhered to. Staff supported to return to work. Continual to try to fill staff vacancies. Agency requests Flexibility and additional hours worked by many senior staff to support ward areas Recruiting into vacancies	Inadequate	Risk to be increased to 16 as increasing problem. Bank staff are not always the correct calibre.	6
Specialist Medicine	GASTRO	Patient Safety	999	TRUST	15/04/2013	Compliance with Cancer Targets	There is a risk that the Trust does not achieve performance indicators for colorectal cancer due to dela in patient pathway	16	Sandra Field	16/01/2015	4	4	16	EXTR	The Lead Cancer Patient Pathway Co-ordinator (PPC) continues to validate all tentative breaching pathways. All PPC's continue to escalate to GM any pending breach in advance, so an action plan can be formulated. Planning of extra theatre sessions for urology cancers Ad-hoc sessions on-going for endoscopy work Admin support, for 2ww clerks - other staff working overtime and weekends. Cancer Services Improvement Plan in place Lead escalate and additional lists added Patients treated cross site	Inadequate	Discussed with cancer manager - proactive management and weekly PTL's to improve compliance.	9
Strategic Development & Assurance	ALL	Patient Safety	1212	TRUST	23/04/2014	Autovalidation of Patient Tracker List	Potential patient safety issues associated with auto validation processes applied to the patient tracker list.This has resulted in patients either not receiving a first outpatient appointment or being lost to follow up.	16	Sarah Goldsack	01/09/2014	4	4	16	EXTR	Rule 1: Patient pathways subject to auto validation of no activity on the pathway after 90 days (approximately 140,000) Rule 2: Patient subjected to auto validation no appointment linked to partial booking after 18 weeks Rule 1 turned off April 2013 Rule 2 in place with weekly report identifying all patients subject to the rule in the preceding 7 days Paper to Corporate Leadership Team setting out issues and potential consequences.	Adequate	Clinical Harm Group established under chairmanship of Medical Director and Director o Nursing to assess any potential patient harm. External company engaged to undertake validation of records Internal validation of high risk patients Data interrogation to establish high risk patient cohorts	8
Surgery	DENTAL	Patient Safety	971	OTHER	14/02/2013	Premises at Sturton Place	It is possible that the services provided from Sturton Place may need to be relocated due to lack of fitness for purpose and lease arrangements. Risk assessments fo this building have been completed in terms of its Health and Safety, Control of Infection and access which raise concern. This puts the services at risk delivered from this site: IMOS - community oral surgery Special care dentistry - learning difficulties and phobic patients Out of hours emergency dental services.	20	David Brabner	01/04/2015	4	4	16	EXTR	A brief for the re-provision of the services is being prepared Plans to address the infection control concerns in place with provisional date for the work to be completed	Inadequate	Special Care Dentistry remains - plan to relocate by end financial year	2
Surgery	Ophthalmology	Patient Safety	1187	TRUST	22/05/2014	Large Numbers of Outstanding Ophthalmology Patient Follow ups to be appointed	There are large numbers of Ophthalmology general follow up patients waiting appointing with insufficient capacity to appoint this backlog of patients. There is a risk that patients could lose vision as they will not be reviewed at the requested follow up period. This impacts on the delivery of high quality care, increase in complaints and reputation of the Trust. This is having a direct impact on staff workload as patients repeatedly make contact to identify an appointment	16	Matt Hardwick	27/01/2015	4	4	16	EXTR	Templates reviewed and additional capacity identified. Locums in place. July Audit meeting cancelled to see follow-up patients.	Inadequate	Locums in place, recruitment to fill substantive post on -going. For review end March 2015	1
Theatres & Clinical Support	Pharmacy	Compliance	1206	EDH	31/07/2014	Air temperature excursions in clinical trial room	The clinical trials room is remote from the pharmacy dispensary as stock has to be held separately from normal stock. The Trust is provided with income to support the use of clinical trials but we are closely monitored by the companies providing the drugs and subsequent funding. It is essential that the room is maintained at a temperature below 25 degrees c. each time an excursion takes place above 25 degrees C we are obliged to inform the company. Impact: This is happening on a regular basis and could lead to companies withdrawing the funding, loss of reputation for being a clinical trial site	12	Amanda Isted	05/11/2014	4	4	16	EXTR	Pharmacy are purchasing a mobile air conditioning unit. After the air conditioning has been used during the summer months, the scor can be reviewed as it is expected this mitigation will work.	Adequate	Air temperature excursions in various areas hav been addressed.	9

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Theatres & Clinical Support	Theatres	Patient Safety	733	CONQ	24/01/2012	Operating Tables in Main Theatres Conquest Hospital	Patient safety risk due to failing components on 19 year old Maquet operating tables. Risk of malfunction due to failing components. There has been one incident of unexpected tilt and collapse of the table. The tables are no longer manufactured and parts are no longer guaranteed. The service contract only extends to the parts the company can still supply.	16	Michel Elphick	12/12/2014	4	4	16	EXTR	1. All operating tables have been checked. 2. EME have extended service contract until further notice. 3. Procurement process in place for replacement tables, added to capital programme 4. Rolling programme for replacement will provide parts for remaining Maquet tables.	Adequate	Review to take place in Feb 2015. General manager and HoN to monitor.	2
Theatres & Clinical Support	Radiology	Performance	1060	EDH	11/06/2013	PACS Tape Library failure	There is a risk that when the PACS tape library fails the service is unable to retrieve historic images which mean that comparison reports cannot be produced in a timely manner. This is causing disruption to Radiology reporting services. Whilst technicians / maintenance can attend to the site within 24 hours, if replacement parts are required, this can take longer to source.	25	Nigel Youell	30/12/2014	4	4	16	EXTR	Constant monitoring of the device. Forwarding images on to the new PACS solution Batch retrieving of historical images Batch writing of images while device is in operation Technical work around applied to reduce the frequency of the errors.	Inadequate	(1) PACS risk assessment (2) CRIS Nuffield risk assessment	8
Theatres & Clinical Support	ITU	Compliance	1249	TRUST	02/12/2014	Intensive Care units are non-compliant with new building regulations HBN 04-01 (NHS ESTATES 2013).	Existing facilities do not comply with HBN 04-02 and we are advised (Core Standards for Intensive Care Units: Faculty of Intensive Care Medicine) that this needs to be recorded on the Trust Risk Register and the Trust should indicate when facilities will be upgraded. The be spaces are too small so too cramped for the necessary equipment, risk of staff injury, infection control cross contamination. Facilities are inadequate for: Patients: no toilet or washing facilities Relatives: small waiting room @ Conquest with no amenities (no tea, coffee, fridge etc). They do have use of drinks machine and hospital hot drinks machine but not adequate. Staff: Need more consulting rooms for staff to meet relatives and give updates. No office space for clinical lead. Currently manager, matron, audit sister, educator and Outreach Sister share the same small office. Storage is inadequate and does not meet current standards. There are 5 separate storage areas for equipment, 2 are outside of critical care and thus remote location which can cause issues when needed for urgent care e.g. paediatric emergency trolley (airway and cardi	20	Pauline Simes		4	4	16	EXTR	The unit environment is managed to maintain patient safety and as an efficient service as possible i.e. Bed spaces are kept as clean and clutter free as possible and storage areas are regularly checked for stock levels and adjustments made.	Inadequate		9
Theatres & Clinical Support	PATH	EFF	737	TRUST	24/02/2012	Clinical Laboratory Diagnostics Analytical Equipment Replacement	There is risk that, due to the age of the equipment, the department is unable to run a timely service. This means that results can be delayed or patients may have to return for further tests if the machine fails whilst running	16	Shinal Amin	05/08/2014	4	4	16	EXTR	Machine on lease at Eastbourne chemistry New equipment purchased in microbiology	Adequate		8
Theatres & Clinical Support	PATH	Patient Safety	1196	TRUST	03/07/2014	Pathology Haematology (including Immunology) and blood transfusion staffing	There is a risk that due to high staff turnover within the last three months and difficulty to recruit experienced biomedical scientists, a 24 hours service cannot be provided. The risk is the provision of the service out of hours including the weekend.	16	Shinal Amin	12/12/2014	4	4	16	EXTR	Locums in place. Ongoing recruitment to vacant posts. Workload prioritisation within immunology	Inadequate	Still a major concern despite recruitment process taking place.	8
Urgent Care	CAS	Patient Safety	1140	TRUST	13/01/2014	Middle grade vacancies in Emergency Medicine	There is a national shortage of suitably qualified Emergency Department Middle Grades which is compounded by insufficient training places being offered. A sustained reliance on locums has financial implications for the Clinical Unit and the Trust. In addition a transient workforce risks the quality of clinical care given to the patients. Patient safety risks are mitigated by controls in place however financial risk remains high.	20	Jenny Darwood	18/09/2014	4	4	16	EXTR	Internal Locums being used who are aware of Trust Policies to reduce risks to patients Long term agency locums also used to ensure continuity of care / governance At Conquest there is 1.5 Middle Grade vacancies as one works part time. Mitigated with locums. Staffing levels constantly reviewed by General Manager	Inadequate		8
Cardiovascular	CARDIO	Patient Safety	1245	EDH	18/11/2014	Inability to provide adequate nurses to cover patients identified as needing special observations	Inability to provide nursing staff through the Temporary Workforce Services (TWS) to nurse patients identified as needing a special observation in line with the Trusts Policy for the Introduction & Use of Special Observation. Special observation is required to maintain patient safety and patient dignity. In addition any failings in care that may occur could potentially result in bad publicity and p the Trust's reputation at risk.	15	Paula Smith	13/01/2015	3	5	15	EXTR	Risk assessments are undertaken and reviewed using the Policy for the Introduction & Use of Special Observation. The level of observation is identified and nurses to undertake special observation are requested to fulfil the needs of the policy. If the TWS are unable to fill all shifts requests are put out to the agencies	Inadequate	Accurate Risk Assessments and use of the Trust policy including reassessment□ Cohorting of patients that require close observations □ Request additional staff from the TWS and escalate early to the agency if TWS unable to fil with bank nurses	15
Estates Operations & Maintenance Services	CARDIO	Patient Safety	1117	CONQ	10/12/2013	Electrical Supplies to Heart Centre Clinical Equipment	From the design of the Heart Centre some critical clinica equipment is not supplied automatically from the sites emergency generators . Modifications to the electrical supply have been identified by Design Services but hav not attracted funding.	15	John Hinkley	23/01/2015	5	3	15	EXTR	Cardiology clinical staff are aware of the situation. Generator tests are undertaken when the centre is NOT operating. Unexpected power interruptions can a core due to external causes.	Uncontrolled	Risk is in the Capital Plan and Business Continuity Plan. Capital Programme bid submitted. Email to be drafted to the Heart Centre lead and sent on behalf of Ian Humphrie regarding sharing the risk and costing of this risk.	6
Estates Property Management	FIRE	Compliance	906	EDH	10/09/2012	Fire Safety (Compartmentation) Risk of Enforcement Notice	Fire Safety (Compartmentation) Risk of Enforcement Notice. Subject to clarification with East Sussex Fire & rescue Service - July 2014	15	Tony Humphries	23/01/2015	5	4	15	EXTR	Project group set up to manage compartmentation identification and remedial works. Fire policy, L1 alarm systems, evacuation training. Programme of work now confirmed as >20 years and therefore an alternative management strategy is being developed to mitigate risk.	Adequate	Survey and implementation necessary works	12

Clinical Unit/Service	Specialty	Risk Subtype	ID	Site	Opened	Title	Description	Rating (initial)	Manager	Review date	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Controls in place	Adequacy of controls	Action summary	Rating (Target)
Out Of Hospital	POD	Compliance	945	TRUST	22/11/2012	Inadequate level of In-patient podiatry provision at EDGH and Conquest	Increased length of stay and increase in amputation rates locally for people with Diabetes and Diabetic Foot complications, adequate In-patient foot protection teams including Podiatry will assist in reducing LoS and amputation rates. Current Podiatry in patient provision in indaequate to meet demand.	15	Abigail Turner	09/12/2014	5	3	15	EXTR	All in-patients are clinically prioritised and seen in order of need	Inadequate	No change to risk	6
Strategic Development & Assurance	ALL	Compliance	1227	TRUST	28/08/2014	Response to Tenders	There is a risk that our response to tenders will be inadequate due to lack of capacity/ loss of intelligence through restructuring.	15	Dr Amanda Harrison	18/12/2014	3	5	15	EXTR	BPSG. Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources/appointment of Assistant Director in Operations to coordinate clinical unit planning.	Adequate	Risk remains the same	9
Strategic Development & Assurance	OCP	Performance	1226	TRUST	28/08/2014	Responding to Business Opportunities	There is a risk that the Trust will lose income, following termination of services by commissioners - Notice to terminate contract - sourced from contract notice.	15	Dr Amanda Harrison	18/12/2014	3	5	15	EXTR	Identify services which require transformation and secure adequate funding. Discussions at BPSG. Confirm who is leading on specification development. Contract negotiation	Adequate	Risk remains the same	9
Surgery	Ophthalmology	Patient Safety	736	TRUST	24/02/2012	Failure to provide timely diabetic retinopathy screening within recommended time scales	Risk of people with diabetes having undetected sight threatening diabetic retinopathy and /or sight threatening diabetic retinopathy not being referred and treated in a timely manner due to inability to meet national screening standards is due to insufficient staffing establishments.	20	Emma Payne	27/01/2015	5	3	15	EXTR	1. Prioritising for screening patients who are newly diagnosed with diabetes mellitus ensuring they are seen within 3 months therefore adherin to National Standard. 2. Extending recall for annual screening from 12 monthly intervals to 15 monthly intervals. 3. Additional £89K recurrent funding has enabled the recruitment of 2 additional screeners, a failsafe officer and additional administrative support. 4. New programme manager commenced in pos 16/06/2014, 2 screeners will be in situ end July. Failsafe office commences 01/09/2014. Trust has approved a case to introduce Scribetech mail management system to the programme which will enable the existing administration resource to provide clinical administration support	Adequate	Review date now to be April 2015 and Manager to change to Emma Payne.	1
Theatres & Clinical Support	RAD	Patient Safety	1189	TRUST	23/05/2014	Reporting on Plain Film backlog	The Trust is in the process of reducing its backlog of OPD, IP A&E and plain film examinations. There is a ris that there may be clinically urgent or unexpected finding which could have been missed or misdiagnosis even though clinical evaluation of images by referrers may have been undertaken	15	Christian Kasmeridis	28/08/2014	5	3	15	EXTR	Central Point of Radiology forms being dropped off. Date stamped by Radiology Clinical Teams and Patients Call to enquire if they have not received an appointment or Results Backlog is not being added to for high risk chest and abdominal from April 2014. CQC and IRMER inspector have been formally informed of this risk	Inadequate		12
Theatres & Clinical Support	RAD	Patient Safety	965	TRUST	07/02/2013	Delay in Reporting Times for Radiological Investigations	Examinations required surpass the reporting capacity of images and therefore images are not reported in a timely manner. Capacity paper already highlighted workforce deficiency in numbers. High number of non urgent MRI and CT scans unreported at present.	15	Christian Kasmeridis	28/08/2014	3	5	15	EXTR	Ad-hoc and extra hours. Outsourcing proposal approved in August. Reporting hubs. Cost per case reporting in place to reduce risk. Prioritisin caseload - urgent cases reviewed with no delay	Inadequate		9
Urgent Care	CAS	Patient Safety	1136	CONQ	13/01/2014	Delays in off-loading patients from ambulances due to capacity in A&E Conq	Capacity issues within the department might lead to a situation in which it is not possible to offload patients from ambulances into the unit. In this situation the Trust risks the imposition of a financial penalty by SECAM (30 minutes £200, 1 hour £1,000). In addition there is a risk that the clinical care of the patient will be compromised by the delay in specialist review and commencement of treatment. Controls are in place to manage the clinical and financial risk.	12	Jenny Darwood	16/09/2014	3	5	15	EXTR	1. Escalation plan is in place. 2. SECAM screen has been put into the middle of the department so that staff are aware of incoming patients and can respond appropriately. 3. Breaches of the 4 hour wait are monitored to assess factors which prevent the untimely discharge or transfer of patients from the department 4. Agreement in place with SECAM who will cohort patients in designated area. ESHT provide senior assessment if the delay is greater than 30 minutes. 5. SECAM hospital liaison officer working with each site at times of pressure	Adequate		8
Specialist Medicine	ENDOSC	Patient Safety	523	EDH	09/06/2005	Emergency Endoscopy out of hours	Access to emergency out of hours endoscopy service not guaranteed for patients with acute GI bleeds 24 hours a day seven days a week.	15	Deirdre Connors	16/01/2015	MOD	LIKELY	12	HIGH	There are now slots held for emergency patients on each site every morning Monday to Friday between 08:30 and 09:00. At weekends there is emergency service available on alternating sites every week each morning until 12:00 both days. IR rota instituted reduces the risk to patients.	Adequate	To remain at 12 until May / June 2015 when resubmission for JAG accreditation.	10

Clinical Unit/Service	Specialty	Risk Subtype	ID	Site	Opened	Title	Description	Rating (initial)	Manager	Review date	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Controls in place	Adequacy of controls	Action summary	Rating (Target)
Theatres & Clinical Support	PHAMI	Patient Safety	1105	TRUST	29/10/2013	Acute Hospital Pharmacist Resourcing	"ESHT has a lack of pharmacist resourcing when benchmarked to comparator Trusts. Not all clinical ward areas are covered during service provision and there is a poor ratio of pharmacists to consultant teams. The organisational and team impact of this is lack of pharmacist influence in reducing a) the incidence of Serious Incidents related to drug use, b) morbidity and mortality from medicine use and c) incidents related to prescribing higher risk drugs such as anticoagulants and cytotoxics. - Lack of pharmacist led medicines reconciliation leads to poor reputation amongst commissioners. - Lack of resourcing has a negative impact on the safety at the time of discharge. - Increased stress amongst the pharmacist team. Increasing pharmacist time on wards and leadership around medicine use has a lasting benefit beyond their visit because other practitioners i.e. doctors and nurses learn from pharmacy staff that improves their own practice when pharmacy is not present. Please note this is a consolidated risk entry of several risks related to pharmacist resourcing that have a relati Please note a lack of technician resourcing is also havir *□	20	Ian Bourns	05/11/2014	MAJOR	POSS	12	HIGH	1. Pharmacy technicians have taken over technical tasks from pharmacist to improve the teams clinical focus 2. Technological enhancement through the use of robotics and eMM have decreased the need for pharmacists to be present in the pharmacy [although this is hampered by dedicated IT equipment at ward level] 3. The use of eMM allows pharmacists to provide a patient safety screen to prescriptions remotely 4. Pharmacist resources are being focused on areas with high clinical risk [howeve it must be noted that as the clinical strategy is evolving the complexity and level of specialism within areas means that all areas are losing their generalist knowledge of medicines therefore the risk of not having pharmacists are increasing] 5. Redesign of processes e.g. drug chart to mitigate risk. 6. Investment of £ 300k of additional staffing (pharmacists, technicians and assistants) granted for 2014/15 as part of Trust turn around action plan. 6. 8 pharmacists recruited in June 2014 and will be starting over the next 3 months. 7. Pharmacy restructuring plans to gain more capacity within the additiona	Inadequate		10

East Sussex Healthcare NHS Trust

Date of Meeting:	25.03.15
Meeting:	Trust Board Meeting
Agenda item:	7
Subject:	Performance ReportMonth 10 – January 2015 Finance Report Month 11 – February 2015
Reporting Officers:	Richard Sunley, Chief Operating Officer Alice Webster, Director of Nursing Dr David Hughes, Medical Director (Clinical 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 January 2014/15 against quality, financial and workforce indicatorsand finance to the end of February 2015.

Introduction:

The two reports detail 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: 2

8 out of the 17 indicators for this domain were achieved this month. Consequently the score has reduced from a 3 to a 2 this is predominately as a result of not achieving the RTT admitted standard of 90%. This indicator has a high weighting within the domain.The other indicators which were not achieved this month were:

- RTT Non Admitted
- Diagnostic Wait Times
- A&E performance
- Two Week Wait Standard

- 31 Day Standard
- 62 Day Standard
- 62 Day Standard for Screening
- Delayed Transfers of Care

Effectiveness Domain: 5
The domain remained at a5, achieving in all indicators. The latest SHMI indicator was release recently, this showed a further reduction of the trust score bringing the trust under the upper confidence limit. As such this has been rated as green.
Safe Domain: 5
The Safe domain remains at 5, achieving in all indicators with the exception of C-Difficile. There were 3 reported cases of C-Difficile during this month.

Caring Domain: 4
The Caring domain remains at 4. A&E Friends and Family scores remain below the required standard. There were 15 Mixed sex accommodation breaches.

Well Led Domain: 3
The score for the Well Led domain remains at a 3 with achievement of 4 of the 9 indicators. A&E FFT response rates fell below the required standard. Turnover, sickness, temporary costs and appraisal rates remain below the required standard, keeping the domain score to 3.

Finance Report:
Following receipt of non-recurrent deficit funding of £18m of which £16.5m has been recognised in the M11 position, the trust performance in month 11 was a year to date run rate deficit of £957k. This is a favourable variance against original deficit plan of £16,010k. The cost improvement programme achievement ytd was £18,376k which was below plan by £31k. The forecast outturn remains a small surplus of £88k. The overall TDA RAG rating remains green.

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 11 financial position.

Risks and Implications

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

At the end of Month 11 the number of financial risks has reduced and are set out on page 25 of the finance report.

Assurance Provided:
This report includes all indicators contained within the Trust Development Authority'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 TDA. As a result of the receipt of non-recurrent deficit funding the financial performance at Month 11 is significantly better than original plan and the Trust remains forecasting a small surplus at year end.

Review by other Committees/Groups (please state name and date)**:**
This report will be reviewed by the CMEand subsequently by Finance and Investment and the Trust Board.

Proposals and/or Recommendations
To review the report 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?

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

East Sussex Healthcare Trust
Integrated Performance Report

Month 10
January 2015

EAST SUSSEX HEALTHCARE NHS TRUST KNOWLEDGE MANAGEMENT

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
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10
ESHT OVERALL QUALITY SCORE (Out of 5: 1- Poor to 5-Good)	4	4	5	5	4	5	4	4	4	4
Responsiveness Domain Score	3	2	3	3	2	3	2	3	3	2
Effectiveness Domain Score	5	5	5	5	5	5	5	5	5	5
Safe Domain Score	4	5	5	5	3	5	4	3	4	5
Caring Domain Score	5	4	4	4	5	5	4	4	4	4
Well Led Domain Score	3	3	4	4	4	4	4	4	3	3

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
			DOMAIN SCORE									
Indicator	**Standard**	**Weighting**	3	2	3	3	2	3	2	3	3	3
Referral to Treatment Admitted	90.00%	10	82.68%	84.06%	85.84%	80.88%	75.60%	82.74%	85.67%	78.26%	91.18%	74.76%
Referral to TreatmentNon Admitted	95.00%	5	94.08%	94.12%	91.81%	92.66%	91.16%	89.56%	91.42%	91.49%	90.55%	87.64%
Referral to Treatment Incomplete	92.00%	5	92.37%	92.89%	92.80%	92.35%	92.22%	93.39%	92.97%	92.04%	90.20%	92.35%
Referral to Treatment Incomplete 52+ Week Waiters	0	5	4	6	4	3	1	3	2	4	2	0
Diagnostic waiting times	1.00%	5	7.32%	6.31%	0.45%	0.70%	0.97%	0.18%	0.28%	1.29%	1.29%	1.79%
A&E All Types Monthly Performance	95.00%	10	95.20%	93.60%	95.08%	97.27%	94.07%	95.00%	93.44%	95.63%	89.01%	91.82%
12 hour Trolley waits	0	10	0	0	0	0	0	0	0	0	0	0
Two Week Wait Standard	93.00%	2	89.97%	89.07%	91.78%	89.69%	90.16%	93.41%	92.80%	92.22%	91.98%	90.20%
Breast Symptom Two Week Wait Standard	93.00%	2	84.21%	92.06%	85.00%	88.89%	93.58%	80.65%	95.89%	93.75%	92.73%	93.48%
31 Day Standard	96.00%	2	97.33%	96.71%	98.35%	99.34%	95.57%	94.87%	86.14%	90.74%	96.43%	90.20%
31 Day Subsequent Surgery Standard	94.00%	2	100.00%	100.00%	94.74%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
31 Day Subsequent Drug Standard	98.00%	2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
62 Day Standard	85.00%	5	86.01%	82.08%	77.01%	75.11%	80.00%	79.15%	76.87%	75.00%	83.11%	83.68%
62 Day Screening Standard	90.00%	2	76.92%	80.00%	100.00%	83.33%	83.33%	68.75%	83.33%	83.33%	100.00%	76.47%
Urgent Ops Cancelled for 2nd time (Number)	0	2	0	0	0	0	0	0	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%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Delayed Transfers of Care	3.50%	5	4.47%	5.90%	4.23%	5.01%	3.95%	5.43%	4.63%			

Performance in this domain dropped to a 2.

2.1 RTT Performance

RTT Performance continues to align with the trajectory agreed with the TDA and local commissioners.

For Incomplete Pathways ESHT have been set an Incomplete Backlog pathways target of 1837. This is anticipated to be achieved in February.

2.2 Diagnostics

The Trust did not deliver the 6 week diagnostic waiting time target for the month of January. The total number of breaches was 87, equating to 1.79% of the total waiting list. The breakdown of breach modalities is shown below:

- Audiology: 4
- Endoscopy: 73
- Radiology: 10

The Trust was unable to secure any additional outsourcing capacity to cover an unexpected Consultant absence

The Trust expects to recover the diagnostic position in February. (New Consultant Gastroenterologist commences and with additional capacity from IS)

2.3 A&E Performance

Performance against the 4 hour A&E waiting time standard in January was 92.82%.

Whilst the Conquest has remained stable January saw shortfalls in performance across the Trust.

At the time of writing this report, cumulative year to date A&E performance stands at 94.12%. Quarter 3 performance was92.70%. Quarter 4 currently stands at 92.81%

2.4 Cancer Performance

Cancer performance for January is currently based on a preview. The final January performance will be reported next month.

The preview Cancer report for Januaryindicates that the trust will meet the Two Week Breast Symptom Standard along with the 31 Day Surgery and Drug Standards. Early indications are that the trust did not see or treat the required number of patients against Two Week Wait Standard, 31 Day Standard and 62 Day standard and screening.

The final Cancer report for December confirmed that the trust met all the standards with the exception of the2 Week Standard, Breast Symptom and 62 day standards.

The Trust is beginning to see improvement in system and process and expects to recover all but the 62 day standard in February.

2.5 Cancellations

During December there were 17 last minute cancellations. All 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

Following the identification of an issue with the data quality of the figures for the DTCs the figures for November, December and January are currently being reviewed and revalidated. As such we have not included these figures in the report.

In the meantime a number of actions have been put into place to reduce the levels include:

- Daily conference calls with ASC regarding medically fit for discharge patients
- Patient flow teams on each site undertaking daily ward rounds
- Challenge rounds in place with consultants and senior nursing staff undertaking peer reviews of wards with extended length of stay
- Long stay patients are reviewed at start the week meetings each week

- Additional nursing resource is now in place in the community to manage patient flow rounds in bed based intermediate care units

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
			DOMAIN SCORE									
Indicator	Standard	Weighting	5	5	5	5	5	5	5	5	5	5
Hospital Standardised Mortality Ratio (DFI)	103.32	5	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08
Deaths in Low Risk Conditions	1.06	5	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75
Hospital Standardised Mortality Ratio - Weekday	110.03	5	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49
Hospital Standardised Mortality Ratio - Weekend	117.35	5	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6
Summary Hospital Mortality Indicator (HSCIC)	1.114	5	1.104	1.104	1.104	1.094	1.094	1.094	1.094	1.094	1.094	1.094
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	10%	5	7.15%	7.55%	6.38%	8.49%	7.61%	7.76%	7.94%	7.81%	7.81%	6.13%

3.1 Mortality

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

The 2013/14 Mortality indicators have been released and are shown in the table above. Significantly, the trust has improved in the low risk conditions indicator to fall within the expected level. This has consequently improved the domain score to a maximum of 5.

The latest SHMI figures were released in January to show a time period up to June 2014. The Trust figure was 1.094 which is within the confidence limits (upper limit 1.114). This has therefore been adjusted on the table above.

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 considerably lower than 2013/14. Regular analysis of emergency re-admissions now takes place, involving the key clinicians within clinical units.

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
			DOMAIN SCORE									
Indicator	Standard	Weighting	4	5	5	5	3	5	4	3	5	5
Clostridium Difficile - Variance from plan	4	10	5	3	4	2	6	2	7	6	6	3
MRSA bactaraemias	0	10	0	0	0	0	1	0	0	1	0	0
Never events	0	5	0	0	0	0	0	0	0	0	0	0
Patient safety incidents that are harmful	0	5	3	4	3	1	1	0	1	3	0	0
Medication errors causing serious harm	0	5	0	0	0	0	0	0	0	0	0	0
Overdue CAS alerts	0	2	0	0	0	0	0	0	0	0	0	0
Maternal deaths	0	2	0	0	0	0	0	0	0	0	0	0
VTE Risk Assessment	95.00%	2	99.00%	97.90%	98.29%	98.15%	98.10%	97.98%	98.67%	98.21%	95.66%	96.19%
Percentage of Harm Free Care	92.00%	5	93.96%	94.07%	94.29%	93.90%	97.53%	94.60%	94.97%	97.67%	97.83%	93.66%

4.1 Healthcare Acquired Infections

There were 3 reported cases of C-Difficile in January, which is above the trust trajectory. The year to date outturn of 44 is now above the target YTD outturn of 33.

Of these, eighteen have been confirmed as due to a lapse in care. For twenty six it has been determined that there was no lapse in care.

4.2 Patient Safety

During December the Trust reported 1 harmful incident. This was reviewed and has been deemed not to meet the criteria for a harmful incident. Incidents recorded onto the system with a severity level of 4 or above, are included within this indicator but will be routinely reviewed to ensure that the severity has been appropriately assigned. In some cases this may reduce the severity of the incident and thus remove it from this line. As such, subsequent reports may show a different number.

There were no harmful incidents reported in January.

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
			DOMAIN SCORE									
Indicator	Standard	Weighting	5	4	4	4	5	5	4	4	4	4
Inpatient Scores from Friends and Family Test	60	5	66	64	68	68	65	70	64	68	68	64
A&E Scores from Friends and Family Test	46	5	49	44	37	45	54	48	45	38	38	42
Mixed Sex Accommodation Breaches	0	2	0	0	0	0	0	27	0	31	26	15
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	7.8	2	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9

5.1 Friends and Family Test (Patient Experience)

Inpatient scores remain above the required standard. A&E scores remain marginally below the standard. As such the Caring domain score remains at4.

5.2 Mixed Sex Accommodation

There were 16 reported mixed sex accommodation breaches in December. These breaches were all located within the ITU/HDU, and were due to availability of rooms for patients with complex needs.

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
			DOMAIN SCORE									
Indicator	Standard	Weighting	3	3	4	4	4	4	4	4	3	3
Inpatients response rate from Friends and Family Test	30.00%	2	46.43%	44.22%	44.01%	46.84%	39.40%	46.21%	47.94%	48.62%	46.48%	38.55%
A&E response rate from Friends and Family Test	20.00%	2	13.59%	15.76%	35.03%	24.41%	28.75%	30.40%	25.10%	20.87%	16.66%	17.55%
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%	41.00%	41.00%	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%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%
Trust turnover rate	10.00%	3	12.45%	12.89%	12.72%	12.81%	13.19%	13.41%	13.32%	13.60%	14.09%	14.03%
Trust level total sickness rate	3.30%	3	4.08%	3.87%	4.26%	4.44%	4.59%	4.76%	5.50%	5.46%	5.74%	5.33%
Total Trust vacancy rate	10.00%	3	6.04%	6.40%	5.21%	5.61%	4.72%	5.47%	5.74%	7.60%	5.58%	6.66%
Temporary costs and overtime as % of total paybill	10.00%	3	7.02%	7.29%	8.72%	9.48%	9.58%	9.48%	9.73%	9.97%	10.16%	11.14%
Percentage of staff with annual appraisal	85.00%	3	63.37%	63.84%	63.74%	62.34%	67.02%	67.54%	68.34%	70.01%	68.28%	70.64%

6.1 Friends and Family Test (Response Rate)

A&E response rates have remain below the required standard.

6.2 Workforce

Sickness rates reduced marginally, whilst Trust Turnover appears to be stabilising.Temporary costs and overtime have further increased. Appraisal rates remain below the target figure of 85%. Further detail is given in section 8.

7.0 Community Services

7.1 Intermediate Care Beds

The tables below detail the Occupancy, Average Length of Stay and Admission rates at the Trust's 6 community sites.

Indicator	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Occupancy Level	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**
Irvine Unit	98.21%	95.70%	97.44%	91.53%	90.86%	99.26%	96.24%	99.58%	96.53%	96.99%
Crowborough Hospital	90.48%	85.94%	91.90%	90.09%	87.79%	88.33%	92.63%	94.67%	94.80%	95.34%
Firwood House	88.41%	94.62%	91.11%	77.27%	77.27%	87.14%	87.71%	85.87%	88.94%	88.79%
Meadow Lodge	80.36%	68.32%	73.57%	82.26%	86.29%	82.86%	79.26%	83.21%	82.95%	85.71%
Uckfield Hospital	87.38%	88.25%	93.10%	90.78%	94.01%	86.90%	93.55%	87.86%	90.09%	95.39%
Rye Memorial Care Centre	61.19%	76.73%	80.24%	93.55%	90.55%	70.71%	93.78%	86.90%	81.11%	88.71%
Irvine Stroke Unit	95.74%	90.86%	95.93%	82.97%	64.16%	49.26%	81.18%	95.19%	100.00%	99.64%
Total Occupancy	**87.06%**	**85.30%**	**88.49%**	**86.15%**	**84.11%**	**82.06%**	**88.36%**	**90.32%**	**90.67%**	**92.74%**

Total in Month Length of Stay (Days)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Irvine Unit	37.45	21.91	25.43	25.49	19.62	28.36	19.51	19.00	26.69	21.34
Crowborough Hospital	20.47	17.94	19.76	21.31	23.74	14.67	28.23	23.85	18.52	26.93
Firwood House	23.14	27.33	25.57	26.33	26.41	26.04	27.09	20.00	24.96	21.50
Meadow Lodge	26.04	23.61	23.19	20.09	32.79	36.80	30.52	27.75	24.67	29.94
Uckfield Hospital	25.10	19.79	20.19	23.00	20.46	22.65	25.77	22.40	14.71	27.00
Rye Memorial Care Centre	31.64	21.09	24.69	24.69	22.24	24.41	24.39	19.21	22.72	17.00
Irvine Stroke Unit	42.54	34.00	39.24	25.37	22.86	21.40	20.95	31.20	44.42	35.37
Total YTD ALOS	**29.88**	**23.19**	**25.35**	**23.90**	**23.57**	**25.71**	**24.70**	**22.78**	**24.08**	**24.98**

Admissions	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Irvine Unit	32	32	28	34	28	36	41	24	28	32
Crowborough Hospital	22	17	18	17	14	20	21	17	23	28
Firwood House	24	19	24	15	25	23	24	20	21	24
Meadow Lodge	19	26	35	26	15	20	30	25	30	21
Uckfield Hospital	14	14	17	19	24	18	11	18	25	11
Rye Memorial Care Centre	12	12	16	16	14	19	18	11	21	16
Irvine Stroke Unit	12	12	18	15	18	12	20	12	14	18
Total Admissions	**135**	**132**	**156**	**142**	**138**	**148**	**165**	**127**	**162**	**150**

Step Up Admissions	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Irvine Unit	2	1	0	2	0	0	1	1	1	1
Crowborough Hospital	4	5	9	5	7	10	5	11	4	11
Firwood House	2	0	0	1	3	2	3	1	0	1
Meadow Lodge	1	3	9	5	1	7	4	1	2	4
Uckfield Hospital	8	5	14	12	19	11	7	12	12	7
Rye Memorial Care Centre	2	4	3	5	3	2	6	2	3	5
Irvine Stroke Unit	0	0	0	0	0	0	1	0	0	0
Total Step Up Admissions	**19**	**18**	**35**	**30**	**33**	**32**	**27**	**28**	**22**	**29**

Step Down Admissions	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Irvine Unit	30	31	28	32	28	36	40	23	27	31
Crowborough Hospital	18	12	9	12	7	10	16	6	19	17
Firwood House	22	19	24	14	22	21	21	19	21	23
Meadow Lodge	18	23	26	21	14	13	26	24	28	17
Uckfield Hospital	6	9	3	7	5	7	4	6	13	4
Rye Memorial Care Centre	10	8	13	11	11	17	12	9	18	11
Irvine Stroke Unit	12	12	18	15	18	12	19	12	14	18
Total Step Down Admissions	**116**	**114**	**121**	**112**	**105**	**116**	**138**	**99**	**140**	**121**

Available beds	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Irvine Unit	28	24	26	24	24	27	24	24	26	30
Crowborough Hospital	14	14	14	14	14	14	14	15	18	18
Firwood House	21	21	21	21	21	21	21	21	21	21
Meadow Lodge	28	28	28	28	28	28	28	28	28	28
Uckfield Hospital	14	14	14	14	14	14	14	14	14	14
Rye Memorial Care Centre	14	14	14	14	14	14	14	14	14	14
Irvine Stroke Unit	18	18	18	18	18	18	18	18	18	18
Total Available Beds	**137**	**133**	**135**	**133**	**133**	**136**	**133**	**134**	**139**	**143**

Occupied Bed days	**3578**	**3517**	**3584**	**3552**	**3468**	**3348**	**3643**	**3631**	**3907**	**4111**
Available Bed days	**4110**	**4123**	**4050**	**4123**	**4123**	**4080**	**4123**	**4020**	**4309**	**4433**

7.2 Community Nursing

SystmOne is now in place within the Community Nursing teams. Staff are now using mobile devices to capture information, which represents significant progress. The next step for the Project team is to review the information being extracted to ensure data integrity is of a high level.

The first extract of activity information was made available to the Trust's information management team at the beginning of November.

The data warehouse has now been configured to store this information in easily accessible data tables.

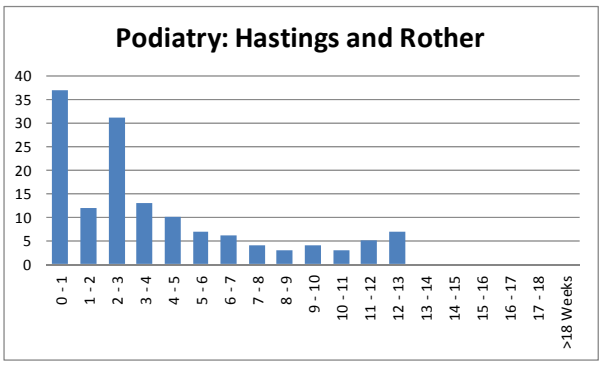
The information is being reviewed by the Information Management team to identify data quality issues. Any data quality issues identified during this process will be investigated with a view to determining their scale.

In addition to this, any training issues raised by this investigation are being cascaded to the clinical teams via the training department.

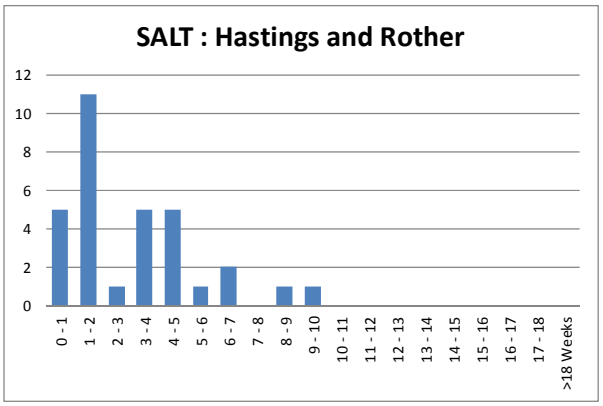
7.3 Community Therapy Waiting List Profiles

Hastings and Rother

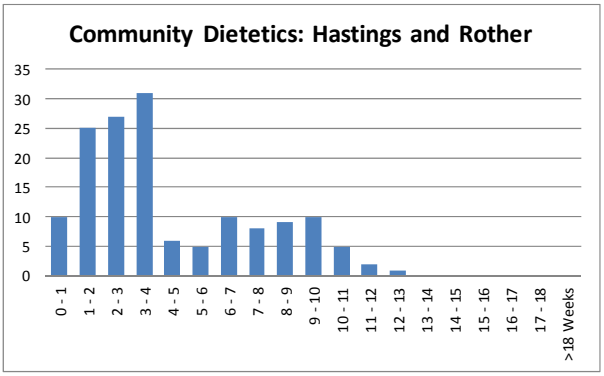
Hastings and Rother; Therapy waiting list profiles



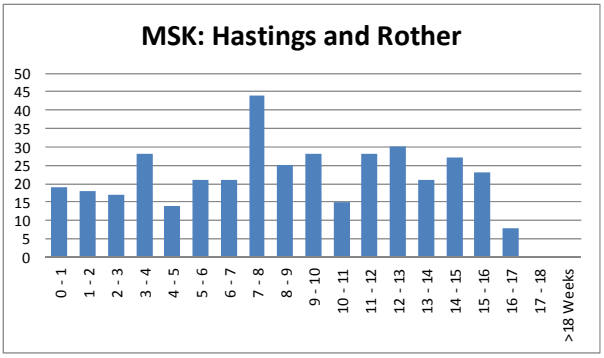
	January	December
Total Waiting List	142	250
% <13 Weeks	100%	100%



	January	December
Total Waiting List	32	44
% <13 Weeks	100%	82%



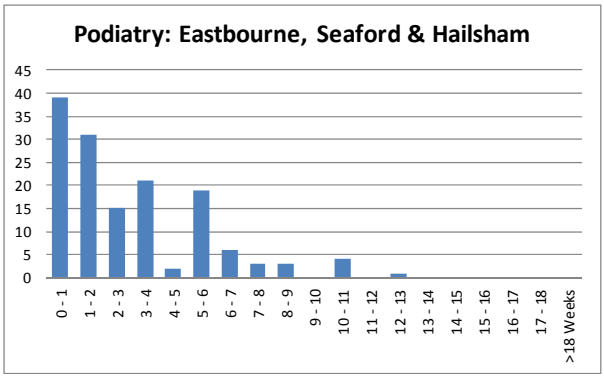
	January	December
Total Waiting List	149	123
% <13 Weeks	100%	100%



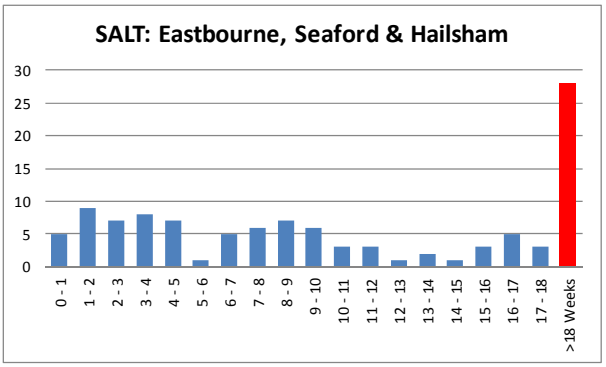
	January	December
Total Waiting List	387	317
% <13 Weeks	80%	87%

Eastbourne, Seaford and Hailsham

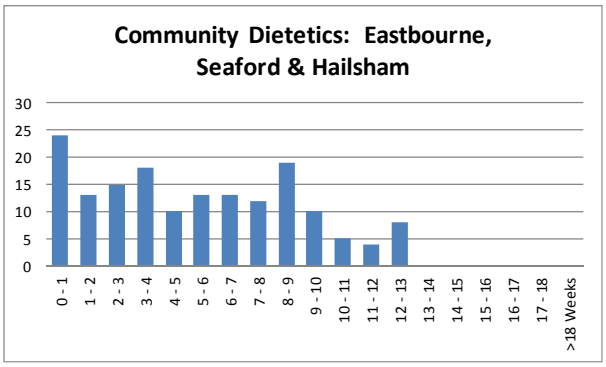
Eastbourne, Seaford and Hailsham; Therapy waiting list profiles



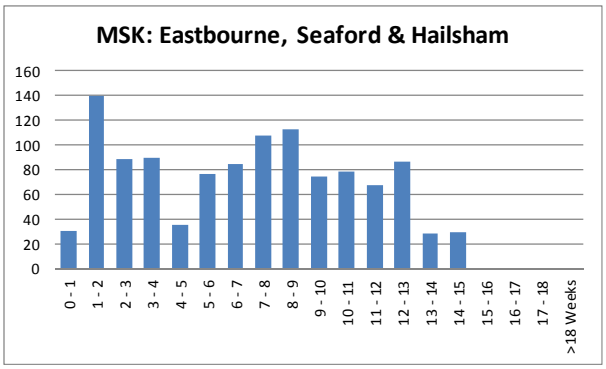
	January	December
Total Waiting List	144	101
% <13 Weeks	100%	100%



	January	December
Total Waiting List	110	109
% <13 Weeks	62%	73%

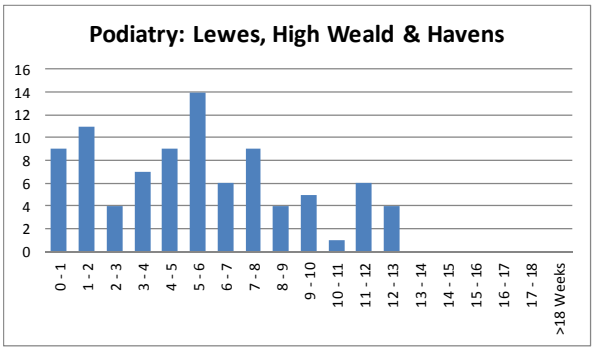


	January	December
Total Waiting List	164	22
% <13 Weeks	100%	100%

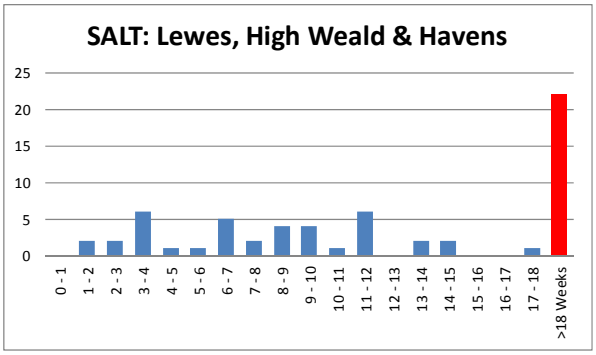


	January	December
Total Waiting List	1133	1695
% <13 Weeks	95%	93%

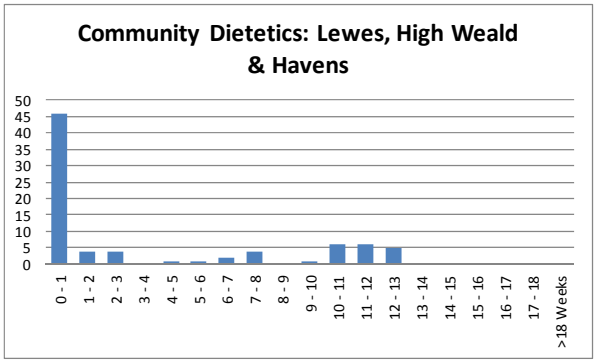
Lewes, High Weald and Havens; Therapy waiting list profiles



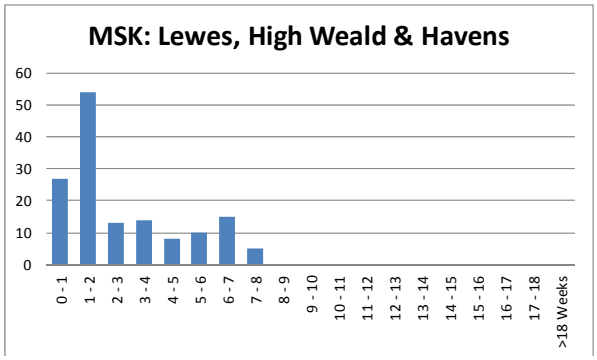
	January	December
Total Waiting List	89	97
% <13 Weeks	100%	100%



	January	December
Total Waiting List	61	105
% <13 Weeks	56%	55%



	January	December
Total Waiting List	80	109
% <13 Weeks	100%	100%



	January	December
Total Waiting List	146	188
% <13 Weeks	100%	100%

7.4 Community Paediatric Waiting List Profiles

The figures in the charts and tables below show the position for January based on the waiting list as at 16th February 2015.

It should be noted that referrals have increased and we are now able to see that whilst we have forecasted 40 new referrals per month the actual referrals were as follows:

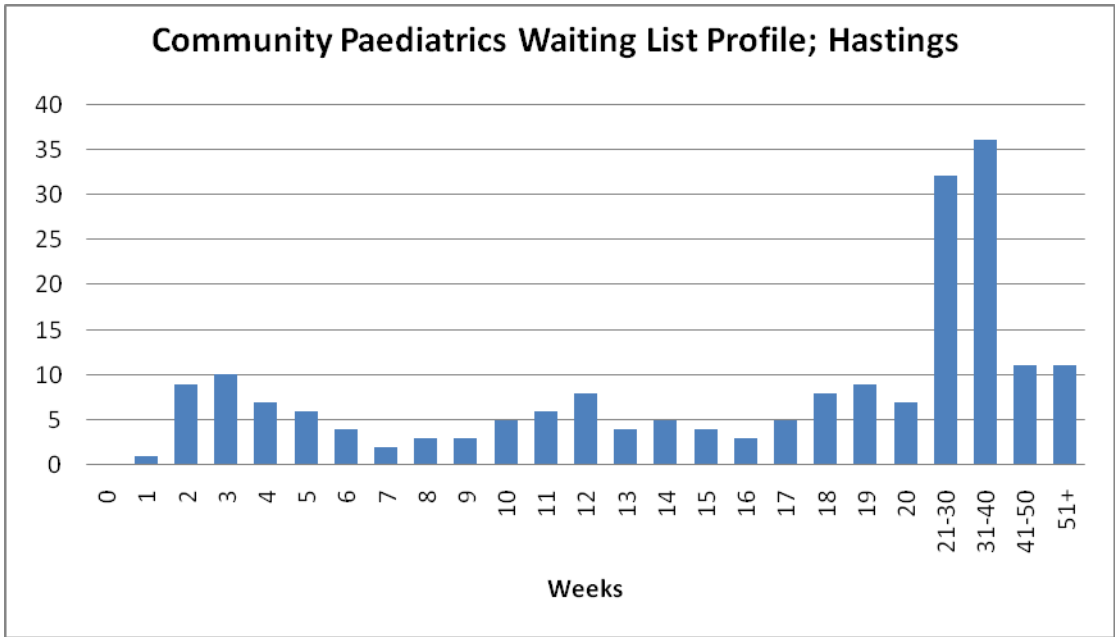
Month	Forecast	Actual
Nov 14	40	62
Dec 14	40	62
Jan 15	40	53

The increase in referrals has impacted on the proposed trajectory and to mitigate thisa professional support line has been established in order to provide rapid access to guidance and advice that might be an alternative to referral.A consultant is available twice a week for telephone discussions with referrers. This service will operate until the end of April when it will be reviewed. All GPs in East Sussex have been advised.

We will continue to seek additional mitigating actions in order to maintain the progress in reducing the waiting list.

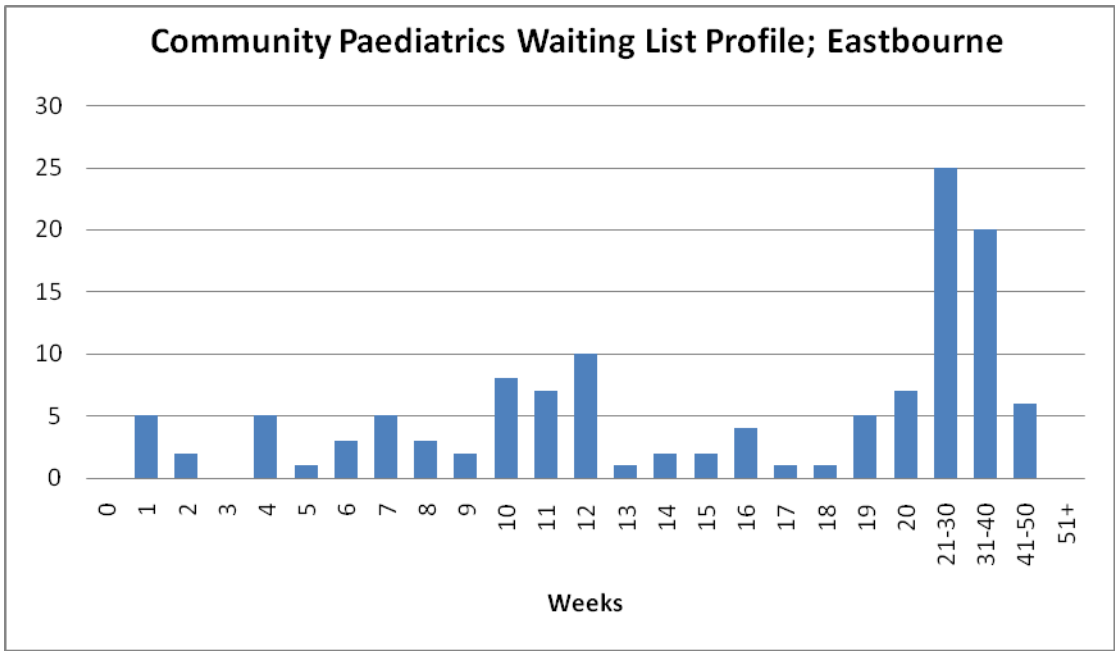
Hastings - Weeks and Number of Patients Waitings

Month	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21-30	31-40	41-50	51+	Total
November 2014	0	1	5	3	5	4	6	10	9	4	4	5	3	3	5	1	6	3	8	4	3	50	32	15	21	210
December 2014	1	0	5	4	7	5	5	3	6	4	6	7	11	8	1	6	2	3	5	1	4	61	24	18	17	214
January 2015 WL 11/02/2015	0	9	9	7	4	6	3	1	5	4	7	7	4	3	6	4	5	7	9	8	1	38	38	21	16	222
January 2015 WL 16/02/2015	0	1	9	10	7	6	4	2	3	3	5	6	8	4	5	4	3	5	8	9	7	32	36	11	11	199



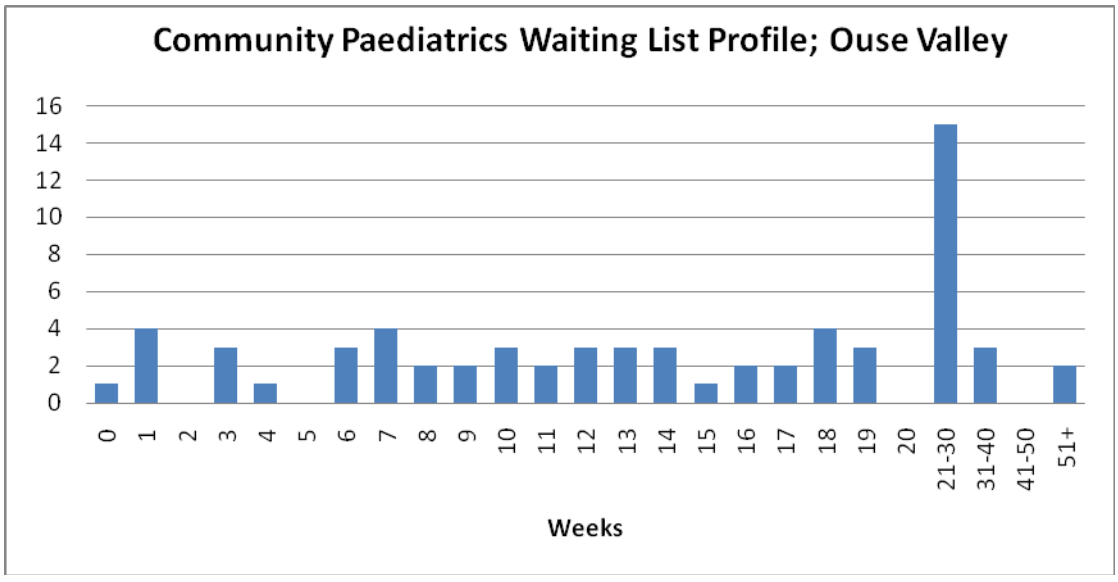
Eastbourne - Weeks and Number of Patients Waitings

Month	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21-30	31-40	41-50	51+	Total
November 2014	10	5	2	1	1	4	1	2	7	8	4	8	2	3	1	5	4	1	2	0	12	33	18	21	14	169
December 2014	3	2	3	7	6	10	3	3	0	2	3	1	6	4	8	6	5	4	1	2	6	32	23	26	17	183
January 2015 WL 11/02/2015	0	2	0	4	1	3	5	2	2	7	7	7	5	3	1	3	3	1	5	4	6	30	29	9	5	144
January 2015 WL 16/02/2015	0	5	2	0	5	1	3	5	3	2	8	7	10	1	2	2	4	1	1	5	7	25	20	6	0	125



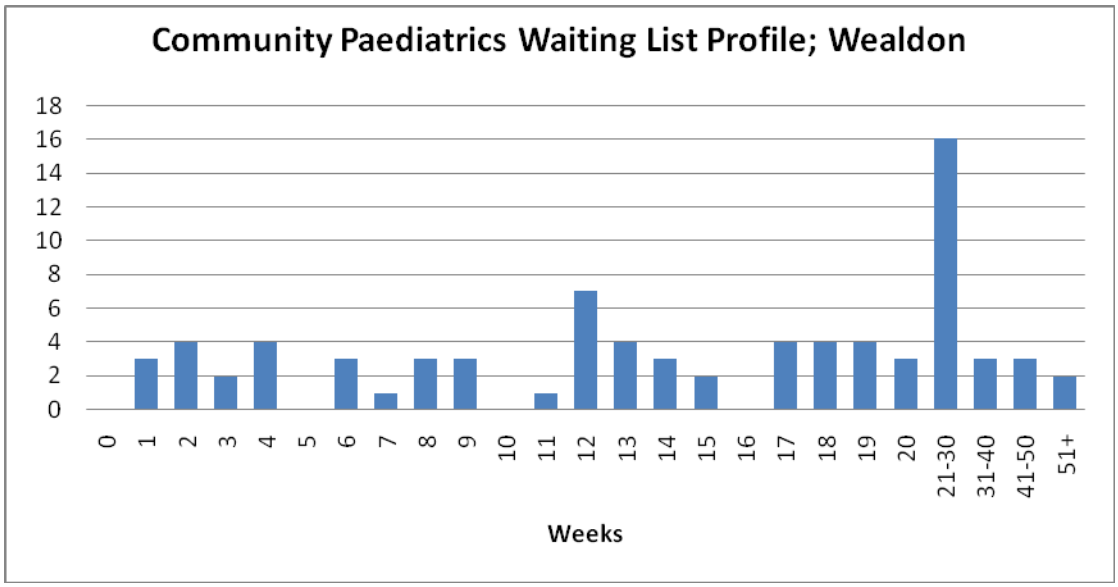
Ouse Valley - Weeks and Number of Patients Waitings

Month	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21-30	31-40	41-50	51+	Total
November 2014	4	1	4	2	1	3	3	4	5	1	2	2	1	1	2	2	1	5	2	1	5	16	16	14	12	110
December 2014	7	2	2	3	3	2	3	3	1	2	4	4	5	0	1	0	3	1	2	2	1	14	0	0	1	66
January 2015 WL 11/02/2015	0	3	3	1	0	1	6	2	2	3	3	3	2	3	1	2	3	4	5	0	1	15	3	1	0	67
January 2015 WL 16/02/2015	1	4	0	3	1	0	3	4	2	2	3	2	3	3	3	1	2	2	4	3	0	15	3	0	2	66



Wealden - Weeks and Number of Patients Waitings

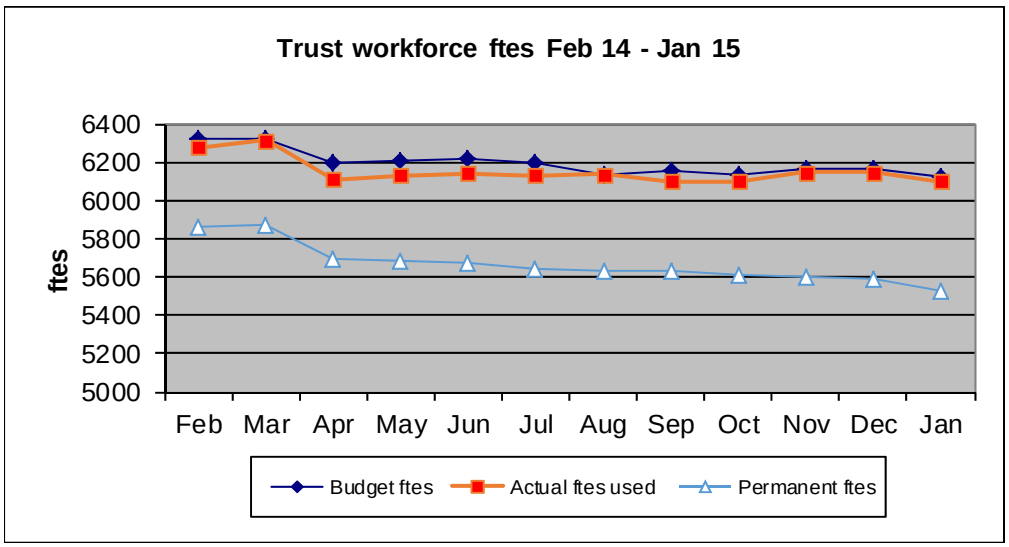
Month	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21-30	31-40	41-50	51+	Total
November 2014	7	4	5	3	2	1	6	3	3	5	4	1	3	1	3	5	1	1	0	4	2	28	22	29	27	170
December 2014	4	3	3	0	3	6	6	3	2	0	5	5	1	6	3	5	3	4	2	6	1	32	19	25	34	181
January 2015 WL 11/02/2015	1	3	2	2	2	1	3	3	3	0	3	6	6	3	2	0	5	5	2	6	2	16	4	10	7	97
January 2015 WL 16/02/2015	0	3	4	2	4	0	3	1	3	3	0	1	7	4	3	2	0	4	4	4	3	16	3	3	2	79



8.0 Workforce

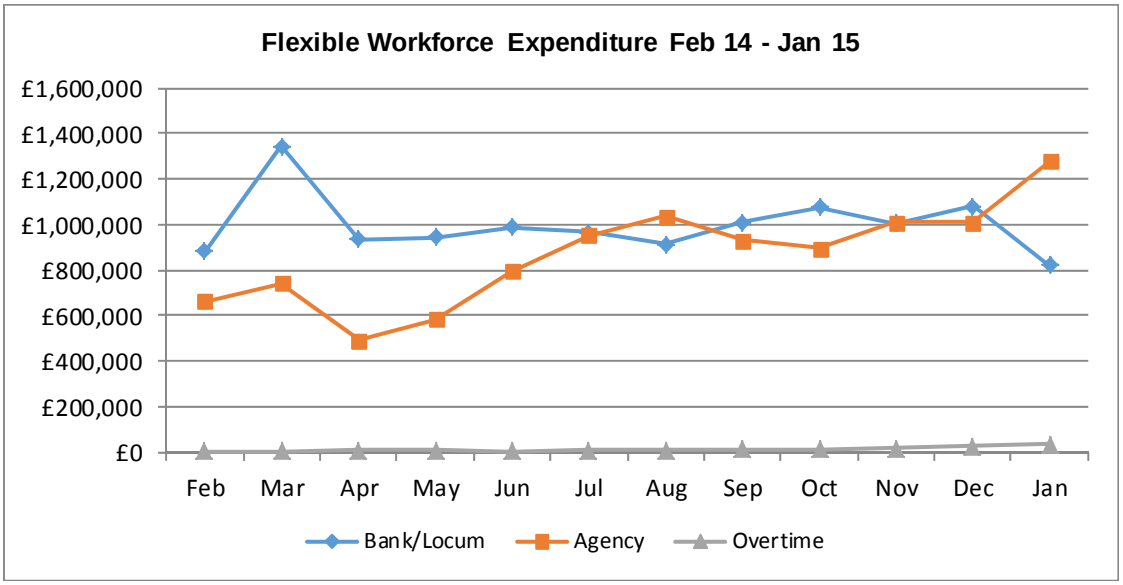
Workforce Report January 15

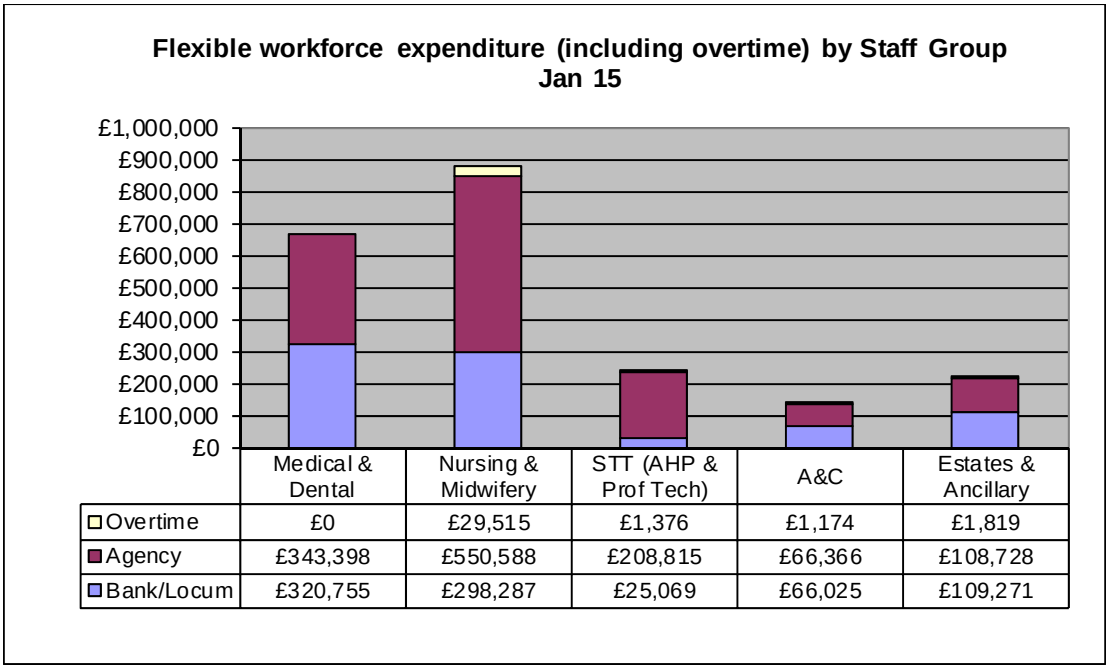
Workforce Usage



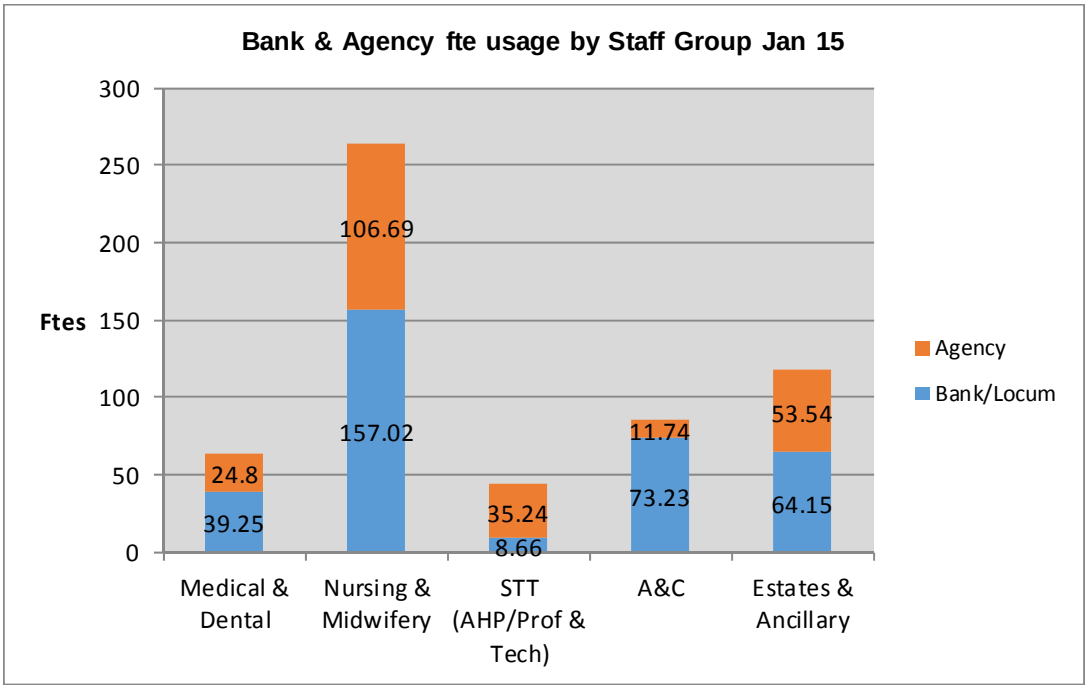
Actual usage of staff in January was 18 full time equivalents (ftes) below budget at 6101.75 ftes. The number of permanent staff has fallen to by 63 ftes to 5527.46 ftes with the balance of the workforce comprised of 342.28 fte bank staff and 232.01 fte agency. The demand for temporary workforce reflects, in part, the increased demand for services which extended into early January, resulting in a requirement for additional clinical capacity.

Flexible labour usage





	Medical & Dental	Nursing & Midwifery	STT (AHP & Prof Tech)	A&C	Estates & Ancillary
Overtime	£0	£29,515	£1,376	£1,174	£1,819
Agency	£343,398	£550,588	£208,815	£66,366	£108,728
Bank/Locum	£320,755	£298,287	£25,069	£66,025	£109,271



Pay expenditure was £296K above budget in January and is £2276K over budget for the year to date.

Although bank expenditure reduced this month by £261K (partly due to the release of previous accruals for anticipated expenditure), agency expenditure increased by £268K and overtime continued to increase, by another £8K.

The reduction in bank usage was most marked amongst nursing and midwifery staff (qualified and unqualified) with a reduction of 25.42 ftes compared to December, whilst agency usage in this group was up by 16.59 ftes. The biggest increase in agency usage was amongst Estates & Ancillary staff though this partly reflects delayed invoices received in January.

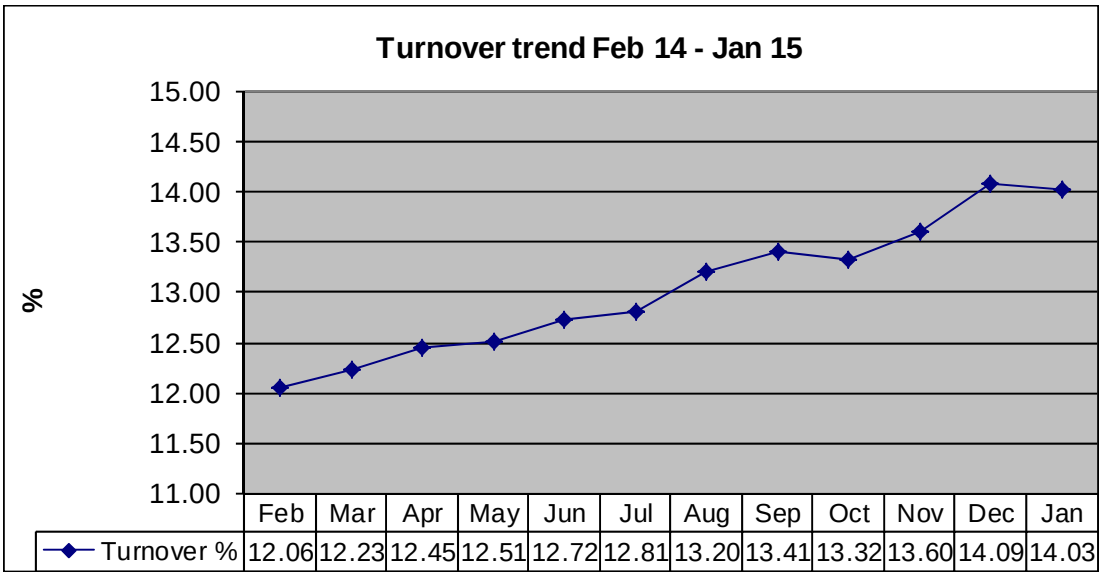
As mentioned, the increase in agency expenditure was, to some extent, due to staffing extra capacity on the Escalation wards but also includes medical agency to cover sickness and vacancies in Surgery, Womens&Childrens, Cardiovascular, Microbiology and Histopathology; nursing agency for extra beds and specialling on Hailsham 4 and, backfill for specialling of tracheostomy patients on Jevington, administrative vacancy cover in Contracting and Financial Services and delayed invoices in Housekeeping, Pathology and Radiology.

Additional overtime relates to backdated midwifery overtime claims as well as some Occupational Therapy cover in Womens and Childrens covering industrial action.

Trust vacancies by Staff Group

STAFF GROUPS	Substantive budget ftes	Substantive actual ftes	Difference	Maternity ftes	Net vacancies	Fill rate %
MEDICAL & DENTAL	556.54	515.37	41.17	3.40	37.77	93.21%
NURSING & MIDWIFERY REGISTERED	1,913.86	1,727.20	186.66	44.99	141.67	92.60%
UNQUALIFIED NURSES	774.83	696.33	69.50	22.23	56.27	92.74%
SC. THERAP & TECH (inc AHPs, Prof & Tech)	903.93	863.37	40.56	16.78	23.78	97.37%
ADMINISTRATIVE & CLERICAL	1115.35	1027.43	87.92	10.09	77.83	93.02%
ESTATES & ANCILLARY	661.10	599.71	61.39	4.17	57.22	91.34%
TRUST	5,925.61	5,429.41	496.20	101.67	394.53	93.34%

Turnover

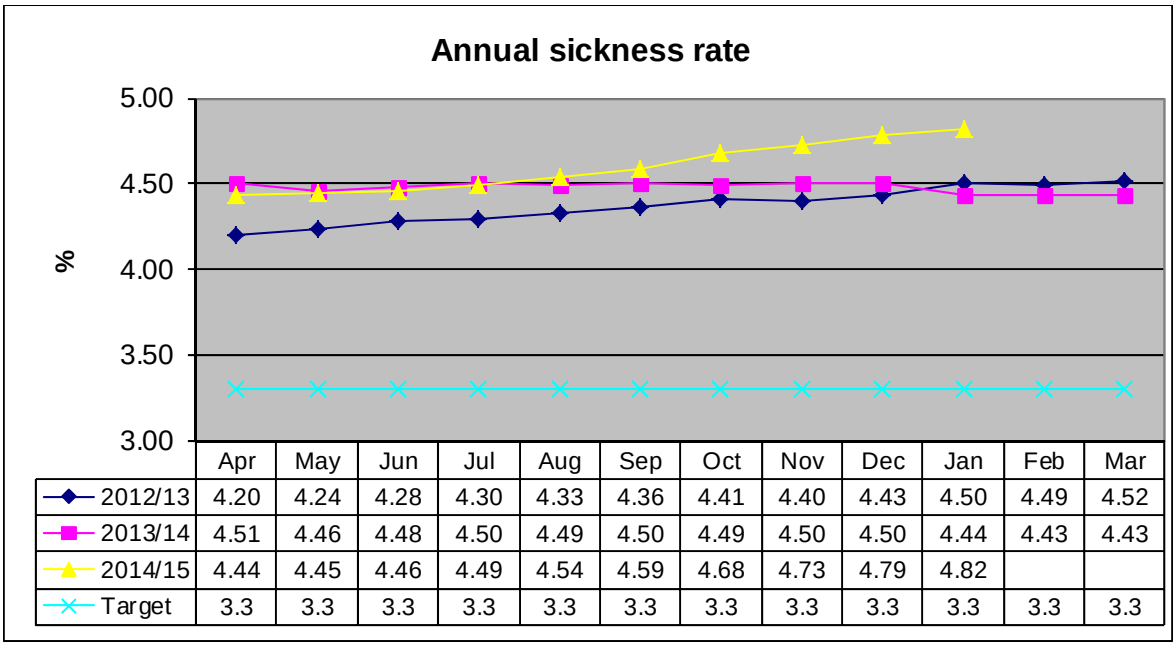


STAFF GROUPS	FTE leavers in year	Annual Turnover %
MEDICAL & DENTAL	51.22	17.15%
NURSING & MIDWIFERY REGISTERED	240.01	13.20%
ALLIED HEALTH PROFESSIONALS	70.06	18.61%
HEALTHCARE SCIENTISTS	25.60	19.92%
PROF SCIENTIFIC & TECHNICAL	27.51	16.65%
ADDITIONAL CLINICAL SERVICES	98.41	10.38%
ADMINISTRATIVE & CLERICAL	176.44	15.75%
ESTATES & ANCILLARY	78.79	12.55%
STUDENTS	11.50	16.26%
TRUST	**779.54**	**14.03%**

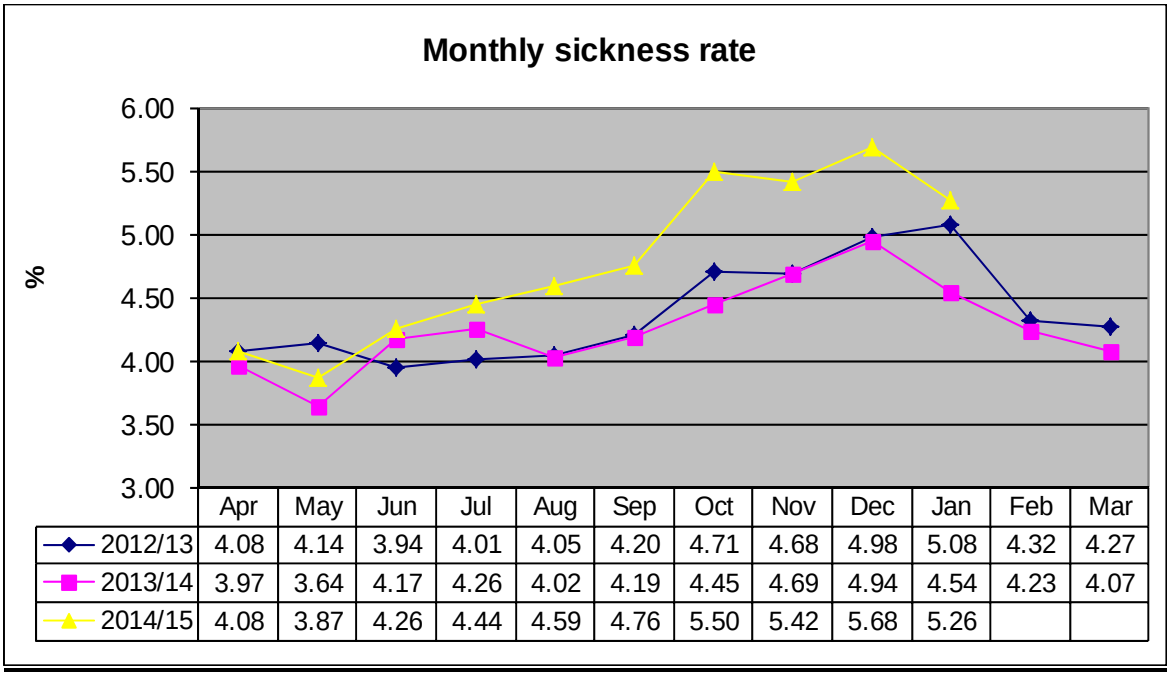
**Additional Clinical Services comprises unqualified nurses, therapy helpers and other unqualified clinical support.*

Vacancies have increased, despite recruitment activity, as turnover remains relatively high. A further 21 newly qualified nurses will be starting in February and we are actively pursuing international recruitment in Spain and Portugal and looking to collaborate as part of a Sussex wide initiative for recruitment in India and the Phillippines. Our qualified nursing vacancy rate (at 7.40%) remains relatively low compared to national estimates of around 10% (NHS Employers).
We also continue to recruit unqualified nurses through the generic recruitment campaign and clinical support administrative staff at Bands 2 & 3.

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	4.54	4.59	4.68	4.73	4.79	4.82		
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	4.59	4.76	5.50	5.42	5.68	5.26		

Clinical Unit	Annual sickness	Monthly sickness	Short term sickness <28 days	Long Term sickness >=28 days
Theatres & Clinical Support	4.89%	4.83%	61.46%	38.54%
Cardiovascular Medicine	3.79%	5.31%	65.31%	34.69%
Urgent Care	5.07%	5.33%	69.35%	30.65%
Specialist Medicine	5.14%	5.45%	51.11%	48.89%
Out of Hospital Care	5.72%	5.88%	70.21%	29.79%
Surgery	4.12%	5.37%	67.44%	32.56%
Womens & Childrens	4.49%	5.72%	68.92%	31.08%
COO Operations	4.62%	6.02%	60.89%	39.11%
Estates & Facilities	5.84%	4.42%	24.17%	75.83%
Corporate	3.76%	5.46%	55.98%	44.02%
TRUST	**4.82%**	**5.26%**	**60.53%**	**39.47%**

Monthly sickness reduced by 0.42% from December but remains high. Monthly sickness was highest in Chief Operating Officer – Operations, Out of Hospital Care and Womens&Childrens.

The top three reasons for sickness absence remain musculoskeletal (other than back injury) at 1373 full time equivalent (fte) days lost, anxiety/stress/depression at 1157 fte days and cold/cough/flu at 895 fte days.

Due to the high levels of sickness the requirement for a doctors certificate for occupational sick pay was extended after the public holidays until 12th January 2015. Analysis of the absence data is being undertaken to assess the impact of this both during and after the implementation of this initiative.

Sickness continues to be managed according to the absence management policy and there will be a focus on those areas with sickness absence rates above 10%.

Mandatory Training & Appraisals

Mandatory training – six month trend

Mandatory training course	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Trend last six months
Induction %	95.37	95.03	95.47	95.80	94.17	94.62	↓
Fire %	77.69	80.00	81.51	81.47	81.92	83.53	↑
Manual Handling %	70.88	72.29	73.63	78.25	78.95	80.33	↑
Infection Control %	79.78	82.01	83.11	85.33	86.00	86.55	↑
Info Gov %	77.11	78.33	78.87	78.92	78.49	81.03	↑
Health & Safety %	45.38	48.77	50.97	56.01	60.01	63.67	↑
Mental Capacity Act %	88.75	89.23	89.44	89.55	89.54	91.00	↑
Depriv of Liberties %	82.48	83.35	84.45	84.16	84.68	86.56	↑

(Green = 85%+, Amber= 80 – 85%, Red = <80%)

Clinical Unit mandatory training and appraisals

Clinical Unit	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
Theatres & Clinical Support	69.35%	90.10%	82.94%	98.97%	89.35%	89.35%	68.33%	92.10%	86.73%
Cardiovascular Medicine	81.18%	84.84%	77.42%	93.10%	82.90%	76.77%	51.61%	89.18%	83.81%
Urgent Care	67.79%	77.33%	67.00%	95.65%	75.51%	67.61%	55.26%	83.69%	83.95%
Specialist Medicine	84.12%	88.79%	86.21%	95.12%	88.32%	82.01%	63.55%	94.35%	88.54%
Out of Hospital Care	68.48%	85.55%	84.83%	100.00%	85.86%	89.06%	66.77%	96.16%	96.20%
Surgery	88.77%	82.83%	81.26%	89.92%	81.83%	75.68%	60.09%	90.74%	86.27%
Womens & Childrens	77.67%	87.12%	77.73%	90.57%	87.88%	83.48%	66.21%	87.13%	78.89%
COO Operations	33.49%	61.75%	82.95%	91.67%	87.33%	69.12%	44.70%	n/a	n/a
Estates & Facilities	52.85%	77.66%	69.21%	100.00%	91.69%	73.57%	63.08%	75.00%	100.00%
Corporate	86.75%	90.50%	92.56%	82.35%	90.29%	88.64%	81.99%	88.16%	86.67%
TRUST	**70.64%**	**83.53%**	**80.33%**	**94.62%**	**86.55%**	**81.03%**	**63.67%**	**91.00%**	**86.56%**

(Green = 85%+, Amber= 80 – 85%, Red = <80%)

Compliance ratescontinue to increase across the mandatory courses and is a reflection of the concerted efforts by all to maintain momentum with completion of mandatory training and appraisals. From April onwards we will be re-introducing the practical elements in courses such as Manual Handlingbut will continue to run theory sessions in the lecture theatres, which have proved successful and will maximise availability of training to staff.

East Sussex Healthcare NHS
NHS Trust

FINANCE REPORT – February 2015

Vanessa Harris – March 2015

East Sussex Healthcare NHS
NHS Trust

Financial Summary – February 2015

Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) finance risk assessment criteria are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria remains at Green in month 11.	G
Financial Summary	The Trust is in receipt of £18m of non-recurrent deficit funding, of which £16.5m YTD has been recognised in the position at month 11. The Trust performance in month 11 was a year to date run rate deficit of £957k, with a favourable variance against plan of £16,010k. Year to date, Income was £23,668k above plan whilst total costs, including the donated asset adjustment, were £7,658k overspent.	G
Activity & Income	Total income received during February was £2,225k above planned levels resulting in a year to date variance of £23,668k above plan.	G
Expenditure	Pay costs YTD are above plan by £2,648k and Non-Pay is £6,200k above plan. The Non-Pay variance is predominantly on tariff excluded drugs and devices which are recovered through income as above.	A
CIP plans	The CIP achievement YTD was £18,376k which was below plan by £31k.	A
Balance Sheet	The clinical strategy capital PDC of £17.4m has been removed from the capital resource assumptions and forecast tax payers equity.	G
Cash Flow	The Temporary revenue PDC received was repaid in February which has reduced the cash balance held at the end of month 11 to £4.9m. This cash balance will be further reduced to £1.0m at financial year end.	G
Capital Programme	The Capital Approval Group (CAG) will continue to review and monitor the capital programme in order to achieve a balanced position at 31st March 2015 paying particular attention to the risks associated with limited capital funds.	G

Income & Expenditure – February 2015

Headlines

• The Trust has received £18m of non-recurrent deficit funding of which £16.5m YTD is recognised in the month 11 position. Total income in the month was £31.2m against a plan of £29.0m, a favourable variance of £2,225k. YTD income is now £23,668k above plan.

• Total costs in the month were £31.3m. This was £158k above plan in month and brings the YTD position to £8,041k above plan.

• The run rate deficit against plan YTD was a favourable variance of £16,010k.

• Cost improvements of £18.4m have been achieved YTD month 11 which is £20k below the planned target.

• Pay costs in the month, including ad hoc costs, were £371k above plan. YTD pay is now £2,648k above plan.

• Non Pay costs, including 3rd party costs, were £70k below plan in the month and are £6,200k above plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	26,161	28,151	1,990	297,052	317,857	20,805	323,730
Private Patient/ ICR	316	52	-264	3,209	2,924	-285	4,160
Trading Income	390	446	56	4,281	4,851	570	4,421
Other Non Clinical Income	2,095	2,538	443	23,336	25,914	2,578	25,049
Total Income	**28,962**	**31,187**	**2,225**	**327,878**	**351,546**	**23,668**	**357,360**
Pay Costs	-20,004	-20,366	-362	-221,692	-224,219	-2,527	-241,875
Ad hoc Costs	-20	-29	-9	-164	-285	-121	0
Non Pay Costs	-9,353	-9,262	91	-104,932	-111,025	-6,093	-114,922
3rd Party Costs	-151	-172	-21	-689	-796	-107	-123
Other	183	183	0	2,017	2,017	0	2,200
Total Direct Costs	**-29,345**	**-29,646**	**-301**	**-325,460**	**-334,308**	**-8,848**	**-354,720**
Surplus/- Deficit from Operations	**-383**	**1,541**	**1,924**	**2,418**	**17,238**	**14,820**	**2,640**
P/L on Asset Disposal	0	4	4	0	26	26	0
Depreciation	-1,049	-911	138	-11,536	-11,233	303	-12,585
Impairment	0	0	0	0	0	0	0
PDC Dividend	-689	-652	37	-7,579	-7,175	404	-8,272
Interest	-25	-61	-36	-270	-196	74	-295
Total Indirect Costs	**-1,763**	**-1,620**	**143**	**-19,385**	**-18,578**	**807**	**-21,152**
Total Costs	**-31,108**	**-31,266**	**-158**	**-344,845**	**-352,886**	**-8,041**	**-375,872**
Net Surplus/-Deficit	**-2,146**	**-79**	**2,067**	**-16,967**	**-1,340**	**15,627**	**-18,512**
Donated Asset/Impairment Adjustment	0	-44	-44	0	383	383	0
Adjusted Net Surplus/-Deficit	**-2,146**	**-123**	**2,023**	**-16,967**	**-957**	**16,010**	**-18,512**

Cash Flow – February 2015

Headlines

- The cash balance is planned to be reduced to £1.0m at year-end.
- Temporary revenue PDC received was repaid in February from the additional £18m non-recurrent deficit funding received in January.
- The application to the Independent Trust Finance Facility (ITFF) for additional capital funding of £869k in respect of improvements in the storage and access to health records has now been approved as a 10 year capital loan. This loan will be paid to the Trust in two instalments. In 2014/15 the Trust will receive £428k in March with the remaining £421k being paid to the Trust in quarter 1 of 2015/16. Also included in the cash flow is the already approved £0.4m capital PDC for the Conquest clinical decisions unit development.
- The cash flow will remain under constant review throughout March to ensure the planned cash balance is delivered.

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	7,246	2,106	754	-23	1,470	631	942
Depreciation and Amortisation	1,031	1,031	1,031	1,033	1,035	1,028	1,030	1,033	1,034	1,035	910	1,136
Impairments												2,479
Interest Paid	-31	-31	-31	-31	-31	-31	-31	87	-16	-17	-16	-16
Dividend (Paid)/Refunded						-3,897						-3,930
(Increase)/Decrease in Inventories	-279	34	255	-174	146	-158	-21	32	-314	-144	315	36
(Increase)/Decrease in Trade and Other Receivables	1,954	2,301	-4,770	5,298	662	-11,817	1,420	-2,532	-3,064	13,854	-377	1,055
Increase/(Decrease) in Trade and Other Payables	1,719	440	1,369	-269	-1,272	4,117	-4,804	972	-127	1,025	2,302	-3,757
Provisions Utilised	125	14	16	-43	14	-106	-36	17	17	-40	136	-720
Net Cash Inflow/(Outflow) from Operating Activities	**2,799**	**2,403**	**-4,077**	**5,988**	**-751**	**-3,618**	**-336**	**363**	**-2,493**	**17,183**	**3,901**	**-2,775**
Cash Flows from Investing Activities:												
Interest Received	6	3	2	3	4	2	3	2	2	2	4	-4
(Payments) for Property, Plant and Equipment	-1,132	-1,060	-1,408	-1,423	-1,594	-1,389	-1,402	-2,496	-1,174	-1,547	-2,736	-859
(Payments) for Intangible Assets	-29	-42	-50	-37	-44	-42	-23	-41	-33	-53	-37	-52
Net Cash Inflow/(Outflow) from Investing Activities	**-1,156**	**-1,099**	**-1,456**	**-1,457**	**-1,634**	**-1,429**	**-1,422**	**-2,535**	**-1,205**	**-1,598**	**-2,769**	**-915**
Net Cash Inflow/(Outflow) before Financing	**1,644**	**1,304**	**-5,533**	**4,531**	**-2,385**	**-5,047**	**-1,758**	**-2,172**	**-3,698**	**15,585**	**1,132**	**-3,690**
New Temporary PDC	0	0	5,000	0	0	0	7,000	0	4,500	0	-16,500	0
Repayment for Temporary PDC	0	0	0	0	0	0	0	0	0	0	0	0
New Permanent PDC	0	0	0	0	0	0	0	200	0	0	0	200
New Capital Loan	0	0	0	0	0	0	0	0	0	0	0	428
Loans and Finance Lease repaid	-76	0	0	-89	0	-914	0	28	-116	9	0	-840
Net Cash Inflow/(Outflow) from Financing Activities	**-76**	**0**	**5,000**	**-89**	**0**	**-914**	**7,000**	**228**	**4,384**	**9**	**-16,500**	**-212**
Net Increase/(Decrease) in Cash	**1,568**	**1,304**	**-533**	**4,442**	**-2,385**	**-5,961**	**5,242**	**-1,944**	**686**	**15,594**	**-15,368**	**-3,902**
Opening balance	2,257	3,825	5,129	4,596	9,038	6,653	692	5,934	3,990	4,676	20,270	4,902
Closing balance	3,825	5,129	4,596	9,038	6,653	692	5,934	3,990	4,676	20,270	4,902	1,000

Balance Sheet – February 2015

Headlines

• The overall tax payer's equity is now planned to rise slightly principally due to the increase in permanent public dividend capital (PDC) in respect of the approved ITFF funding for the Conquest clinical decisions unit (£0.4m).

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Non Current Assets			
Property plant and equipment	257,258	256,189	275,662
Intangilble Assets	826	1,258	1,282
Trade and other Receivables	708	1,192	647
	258,792	**258,639**	**277,591**
Current Assets			
Inventories	6,238	6,547	6,511
Trade receivables	21,825	18,157	18,043
Other receivables	3,601	3,610	2,978
Other current assets	0	0	0
Cash and cash equivalents	2,257	4,902	1,000
	33,921	**33,216**	**28,532**
Current Liabilities			
Trade payables	-13,040	-8,566	-8,273
Other payables	-19,023	-24,822	-18,313
DoH Loan	-1,674	-1,007	-340
Borrow ings - Finance Leases	-320	-335	-335
Provisions	-462	-471	-483
	-34,519	**-35,201**	**-27,744**
Non Current Liabilities			
DoH Loan	-3,535	-3,365	-3,626
Borrow ings - Finance Leases	-598	-263	-263
Provisions	-2,632	-2,736	-2,774
	-6,765	**-6,364**	**-6,663**
Total Assets Employed	**251,429**	**250,290**	**271,716**

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Financed by			
Public Dividend Capital (PDC)	-153,130	-153,330	-153,530
Revaluation Reserve	-106,395	-106,396	-126,577
Income & Expenditure Reserve	8,096	9,436	8,391
Total Tax Payers Equity	**-251,429**	**-250,290**	**-271,716**

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

Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target, currently 95%, is for the value and volume of invoices that should be paid within 30 days.
- In month 97% of trade invoices by amount was achieved and 73% of NHS invoices by amount were paid. This has improved the year to date achievement to 91% by amount for trade invoices and 72% by amount for NHS invoices.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0- 30 Days	1,176	1,048	8,022	5,619
31 - 60 Days	323	359	3,488	4,092
61 -90 Days	180	286	3,734	660
91 - 120 Days	186	152	487	704
> 120 Days	1,173	1,177	2,426	3,698
Total	3,038	3,022	18,157	14,773

Trade Payables Aged Analysis - Purchase Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0- 30 Days	4,972	4,018	5,445	4,377
31 - 60 Days	1,790	803	1,762	1,240
61 -90 Days	366	342	493	334
91 - 120 Days	146	89	226	126
> 120 Days	404	422	640	377
Total	7,678	5,674	8,566	6,454

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	99.40%	96.73%	92.28%	91.19%
NHS invoices paid within contract or 30 days of receipt	88.29%	72.97%	63.60%	71.91%

Key Performance Indicators – February 2015

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.

• All risks are now considered "green" in the current month due to the receipt of non-recurrent deficit funding, replacing the need for PDC for liquidity purposes.

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.

Better Payments Practice Code (BPPC)
• In month performance has marginally 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 (%)	91	95
BPPC – NHS Invoices by value (%)	72	95

Activity & Contract Income – February 2015

Headlines

- Contract activity income is £2m above plan in the month, increasing the YTD performance to £20.8m 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 £16.9m (including non-recurrent deficit funding) above planned levels YTD.
- Total Elective activity is £1.5m below plan YTD this is mainly T&O and Cardiology.
- 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	3,267	3,726	459	37,163	39,256	2,093
Elective Inpatients	755	711	-44	8,605	8,167	-438
Emergency Inpatients	3,356	3,357	1	40,019	39,422	-597
Total Inpatients	**7,378**	**7,794**	**416**	**85,787**	**86,845**	**1,058**
Excess Bed Days	2,410	1,298	-1,112	28,650	21,641	-7,009
Total Excess Bed Days	**2,410**	**1,298**	**-1,112**	**28,650**	**21,641**	**-7,009**
Consultant First Attendances	6,707	7,515	808	76,228	84,968	8,740
Consultant Follow Ups	10,908	11,444	536	124,256	131,272	7,016
OP Procedures	4,463	4,375	-88	50,591	49,198	-1,393
Other Outpatients inc WA & Nurse Led	12,925	11,358	-1,567	147,330	133,193	-14,137
Community Specialist	240	190	-50	2,742	1,944	-798
Total Outpatients	**35,243**	**34,882**	**-361**	**401,147**	**400,575**	**-572**
Chemotherapy Unbundled HRGs	476	-103	-579	5,421	5,924	503
Antenatal Pathways	317	294	-23	3,611	3,438	-173
Post-natal Pathways	288	249	-39	3,287	3,083	-204
A&E Attendances (excluding type 2's)	7,717	7,604	-113	95,468	95,056	-412
ITU Bed Days	459	569	110	5,321	5,316	-5
SCBU Bed Days	237	236	-1	2,614	2,921	307
Cardiology - Direct Access	78	79	1	892	680	-212
Radiology - Direct Access	4,346	4,714	368	49,536	51,667	2,131
Pathology - Direct Access	261,974	297,396	35,422	2,986,497	2,962,832	-23,665
Therapies - Direct Access	3,263	3,061	-202	37,198	34,523	-2,675
Audiology	1,913	515	-1,398	21,807	15,061	-6,746
Midwifery	10	-2	-12	117	120	3

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,331	4,195	-136	49,323	47,855	-1,468
Inpatients - Emergency	5,955	5,956	1	70,940	67,738	-3,202
Excess Bed Days	550	299	-251	6,544	4,936	-1,608
Outpatients	3,654	3,801	147	41,556	42,690	1,134
Other Acute based Activity	2,257	2,385	128	26,568	26,914	346
Direct Access	725	786	61	8,260	8,349	89
Block Contract	5,600	5,412	-188	63,343	62,741	-602
Re-admissions	0	-197	-197	-1,667	-2,779	-1,112
Other	497	2,900	2,403	3,464	26,759	23,295
CQUIN	583	583	0	6,638	6,638	0
Subtotal	24,152	26,120	1,968	274,969	291,841	16,872
Exclusions	2,009	2,031	22	22,083	26,016	3,933
GRAND TOTAL	**26,161**	**28,151**	**1,990**	**297,052**	**317,857**	**20,805**

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

Headlines

Clinical Units (CUs)

The overall clinical unit performance was an over spending of £1.4m in the month which has resulted in a YTD over spending of £11.5m.

Commercial Directorate

The Commercial Directorate is underspent by £42k year to date with Community and Decontamination Services driving the position this month.

Corporate Services

Corporate Services was better than plan in the month and is now £717k underspent YTD.

Income & Expenditure Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Urgent Care	1,817	1,636	-181	24,560	18,231	-6,329
Specialist Medicine	362	634	272	5,003	8,330	3,327
Cardiovascular	-44	-342	-298	-285	-1,544	-1,259
Surgery	3,917	2,860	-1,057	47,487	42,841	-4,646
Women & Children	1,299	1,255	-44	14,516	13,383	-1,133
Out of Hospital Care	648	613	-35	6,690	5,732	-958
Clinical Support	-4,685	-4,507	178	-52,127	-51,767	360
Tariff-Excluded Drugs & Devices	0	0	0	0	0	0
COO Operations	-954	-1,142	-188	-10,027	-10,911	-884
Total Clinical Units	**2,360**	**1,007**	**-1,353**	**35,817**	**24,295**	**-11,522**
Commercial Directorate	-2,370	-2,340	30	-25,871	-25,829	42
Corporate Services	-1,970	-1,647	323	-20,976	-20,259	717
Central Items	-1,501	-503	998	-17,934	-15,241	2,693
Total Central Areas	**-5,841**	**-4,490**	**1,351**	**-64,781**	**-61,329**	**3,452**
Income	1,335	3,404	2,069	11,997	35,694	23,697
Donated Asset/Impairment Adjustment	0	-44	-44	0	383	383
Total	**-2,146**	**-123**	**2,023**	**-16,967**	**-957**	**16,010**

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
495	502	Urgent Care	-1,848	-1,841	7	-19,537	-19,944	-407
413	406	Specialist Medicine	-1,451	-1,558	-107	-16,513	-16,832	-319
328	373	Cardiovascular	-1,206	-1,482	-276	-13,472	-14,446	-974
674	695	Surgery	-2,787	-2,910	-123	-31,128	-31,799	-671
584	591	Women & Children	-2,182	-2,314	-132	-25,257	-25,479	-222
874	857	Out of Hospital Care	-2,425	-2,499	-74	-27,120	-27,514	-394
1,051	1,042	Clinical Support	-3,974	-4,206	-232	-44,625	-45,471	-846
421	445	COO Operations	-915	-993	-78	-9,368	-9,991	-623
4,840	**4,912**	**Total Clinical Units**	**-16,788**	**-17,803**	**-1,015**	**-187,020**	**-191,476**	**-4,456**
743	723	Commercial Directorate	-1,454	-1,433	21	-16,079	-16,122	-43
543	508	Corporate Services	-1,543	-1,600	-57	-17,280	-17,581	-301
1,286	**1,230**	**Total Non-Clinical Divisions**	**-2,997**	**-3,033**	**-36**	**-33,359**	**-33,703**	**-344**
		Central Items	-239	441	680	-1,477	675	2,152
6,126	**6,142**	**Total Pay Analysis**	**-20,024**	**-20,395**	**-371**	**-221,856**	**-224,504**	**-2,648**

Clinical Unit Performance (budgets) Urgent Care – February 2015

Headlines

Pay

Overall pay for Urgent Care underspent by £7k in the month due to reduced agency costs.

Non Pay

Non pay overspent in the month bringing the cumulative overspend to £55k.

Income

Contract income was below plan by £178k in the month and is now £5.9m 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	3,760	3,582	-178	45,147	39,281	-5,866
		Other Income	2	2	0	15	14	-1
		Total Income	**3,762**	**3,584**	**-178**	**45,162**	**39,295**	**-5,867**
495	502	Pay	-1,848	-1,841	7	-19,537	-19,944	-407
		Non pay	-97	-107	-10	-1,065	-1,120	-55
495	**502**	**Total Expenditure**	**-1,945**	**-1,948**	**-3**	**-20,602**	**-21,064**	**-462**
495	**502**	**Gross Margin**	**1,817**	**1,636**	**-181**	**24,560**	**18,231**	**-6,329**

Clinical Unit Performance (budgets) Specialist Medicine – February 2015

Headlines

Pay

Pay overspent by £107k in the month. Cumulatively pay is now an overspend of £319k YTD.

Non Pay

Non-Pay underspent by £22k in the month taking the cumulative to £5k overspend YTD.

Income

Contract income was above plan by £368k in month and is now £3.7m 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	1,966	2,334	368	22,599	26,340	3,741
		Other Income	184	173	-11	2,014	1,924	-90
		Total Income	**2,150**	**2,507**	**357**	**24,613**	**28,264**	**3,651**
413	406	Pay	-1,451	-1,558	-107	-16,513	-16,832	-319
		Non pay	-337	-315	22	-3,097	-3,102	-5
413	**406**	**Total Expenditure**	**-1,788**	**-1,873**	**-85**	**-19,610**	**-19,934**	**-324**
413	**406**	**Gross Margin**	**362**	**634**	**272**	**5,003**	**8,330**	**3,327**

Clinical Unit Performance (budgets) Cardiovascular – February 2015

Headlines

Pay

Pay overspent by £276k in the month due to increased agency costs and additional beds over plan. This brings the YTD position to £974k above plan.

Non Pay

Non pay budgets are underspent by £21k YTD and £282k cumulatively.

Income

Contract income has overachieved by £36k in month and is above plan by £675k YTD.

Other income underachieved by £79k in the month, with the YTD position being an under recovery of £678k. The Michelham Unit had occupancy during February of 20% private patients and 44% NHS patients.

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	1,286	1,322	36	14,901	15,576	675
		Other Income	263	184	-79	2,619	1,941	-678
		Total Income	**1,549**	**1,506**	**-43**	**17,520**	**17,517**	**-3**
328	373	Pay	-1,206	-1,482	-276	-13,472	-14,446	-974
		Non pay	-387	-366	21	-4,333	-4,615	-282
328	**373**	**Total Expenditure**	**-1,593**	**-1,848**	**-255**	**-17,805**	**-19,061**	**-1,256**
328	**373**	**Gross Margin**	**-44**	**-342**	**-298**	**-285**	**-1,544**	**-1,259**

Clinical Unit Performance (budgets) Surgery – February 2015

Headlines

Pay

Pay overspent by £123k in the month and is now overspent by £671k YTD. The overspending in the month was in respect of medical staffing and agency cover.

Non Pay

Non pay overspent by £18k in the month and £310k YTD.

Income

Contract income has underachieved by £914k in the month and is under plan by £3.7m YTD.

Workforce Plan FTE	Workforce Actual FTE	Surgery	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	7,202	6,288	-914	82,755	79,049	-3,706
		Other Income	46	44	-2	511	552	41
		Total Income	**7,248**	**6,332**	**-916**	**83,266**	**79,601**	**-3,665**
674	695	Pay	-2,787	-2,910	-123	-31,128	-31,799	-671
		Non pay	-544	-562	-18	-4,651	-4,961	-310
674	**695**	**Total Expenditure**	**-3,331**	**-3,472**	**-141**	**-35,779**	**-36,760**	**-981**
674	**695**	**Gross Margin**	**3,917**	**2,860**	**-1,057**	**47,487**	**42,841**	**-4,646**

Clinical Unit Performance (budgets) Women & Children – February 2015

Headlines

Pay

Pay overspent by £132k in the month and is overspent YTD by £222k.

Non Pay

Underspend of £26k in the month, non-pay now overspent by £125k YTD.

Income

Contract income overachieved by £39k in the month and is YTD £1.0m below plan.

Other income was above plan by £23k in the month.

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	3,802	3,841	39	43,128	42,148	-980
		Other Income	29	52	23	373	567	194
		Total Income	**3,831**	**3,893**	**62**	**43,501**	**42,715**	**-786**
584	591	Pay	-2,182	-2,314	-132	-25,257	-25,479	-222
		Non pay	-350	-324	26	-3,728	-3,853	-125
584	**591**	**Total Expenditure**	**-2,532**	**-2,638**	**-106**	**-28,985**	**-29,332**	**-347**
584	**591**	**Gross Margin**	**1,299**	**1,255**	**-44**	**14,516**	**13,383**	**-1,133**

Clinical Unit Performance (budgets) Out of Hospital Care – February 2015

Headlines

Pay

Pay overspent by £74k in the month due to pressure in clinical admin. Pay is now overspent YTD by £394k.

Non Pay

£46k underspent against the plan for the month and is now £42k underspent YTD.

Income

Contract income underachieved by £8k in the month, with £528k under recovered YTD.

Other income overachieved by £1k in the month.

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	3,440	3,432	-8	37,876	37,348	-528
		Other Income	110	111	1	1,209	1,131	-78
		Total Income	**3,550**	**3,543**	**-7**	**39,085**	**38,479**	**-606**
874	857	Pay	-2,425	-2,499	-74	-27,120	-27,514	-394
		Non pay	-477	-431	46	-5,275	-5,233	42
874	**857**	**Total Expenditure**	**-2,902**	**-2,930**	**-28**	**-32,395**	**-32,747**	**-352**
874	**857**	**Gross Margin**	**648**	**613**	**-35**	**6,690**	**5,732**	**-958**

Clinical Unit Performance (budgets) Clinical Support – February 2015

Headlines

Pay

Pay overspend of £232k in the month due to delayed delivery of savings. Pay is now £846k overspent YTD.

Non Pay

Non-pay expenditure was £76k over plan in month. It is now overspent by £61k YTD.

Income

Contract income was above plan by £414k YTD.

Other income was over plan by £72k in the month relating to PMU.

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	1,589	2,003	414	18,210	18,813	603
		Other Income	414	486	72	4,546	5,210	664
		Total Income	**2,003**	**2,489**	**486**	**22,756**	**24,023**	**1,267**
1,051	1,042	Pay	-3,974	-4,206	-232	-44,625	-45,471	-846
		Non pay	-2,714	-2,790	-76	-30,258	-30,319	-61
1,051	**1,042**	**Total Expenditure**	**-6,688**	**-6,996**	**-308**	**-74,883**	**-75,790**	**-907**
1,051	**1,042**	**Gross Margin**	**-4,685**	**-4,507**	**178**	**-52,127**	**-51,767**	**360**

Clinical Unit Performance (budgets) COO Operations – February 2015

Headlines

Pay

This was overspent by £78k due to clinical admin costs. Pay is now £623k overspent YTD.

Non Pay

Non pay is now £244k over plan relating to Clinical Admin.

Income

Income is £17k under plan YTD

Workforce Plan FTE	Workforce Actual FTE	COO Operations	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	9	2	-7	94	77	-17
		Total Income	**9**	**2**	**-7**	**94**	**77**	**-17**
421	445	Pay	-915	-993	-78	-9,368	-9,991	-623
		Non pay	-48	-151	-103	-753	-997	-244
421	**445**	**Total Expenditure**	**-963**	**-1,144**	**-181**	**-10,121**	**-10,988**	**-867**
421	**445**	**Gross Margin**	**-954**	**-1,142**	**-188**	**-10,027**	**-10,911**	**-884**

Divisional Performance (budgets) Commercial Directorate – February 2015

Headlines

Pay

Pay in month was £21k underspent, leaving the YTD position as £43k above plan.

Non Pay

Non pay was underspent by £15k, YTD underspend of £112k.

Divisional Income

Commercial income has underachieved by £6k in the month.

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	594	588	-6	6,531	6,504	-27
		Total Income	**594**	**588**	**-6**	**6,531**	**6,504**	**-27**
743	723	Pay	-1,454	-1,433	21	-16,079	-16,122	-43
		Non pay	-1,510	-1,495	15	-16,323	-16,211	112
743	**723**	**Total Expenditure**	**-2,964**	**-2,928**	**36**	**-32,402**	**-32,333**	**69**
743	**723**	**Gross Margin**	**-2,370**	**-2,340**	**30**	**-25,871**	**-25,829**	**42**

Divisional Performance (budgets) Corporate Services – February 2015

Headlines

Pay

Pay was overspent by £57k in the month and is £301k overspent YTD.

Non Pay

Non pay was overspent by £5k and is now £1.1m overspent YTD.

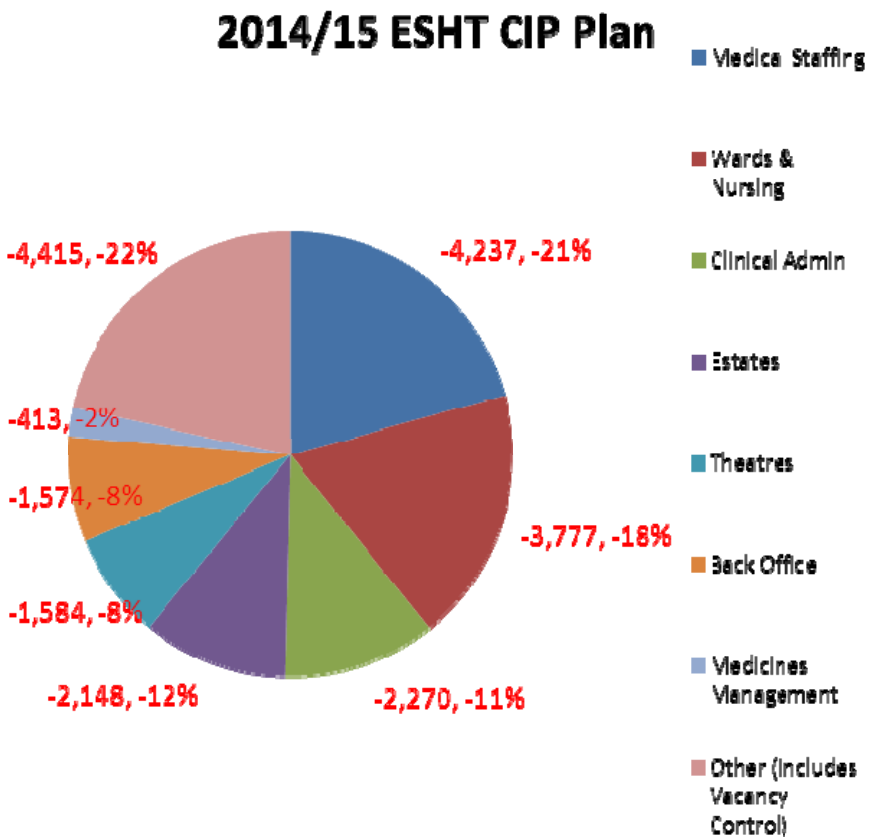
Income

£385k overachieved in month relating to additional education and training income. It is now £2.1m overachieved YTD.

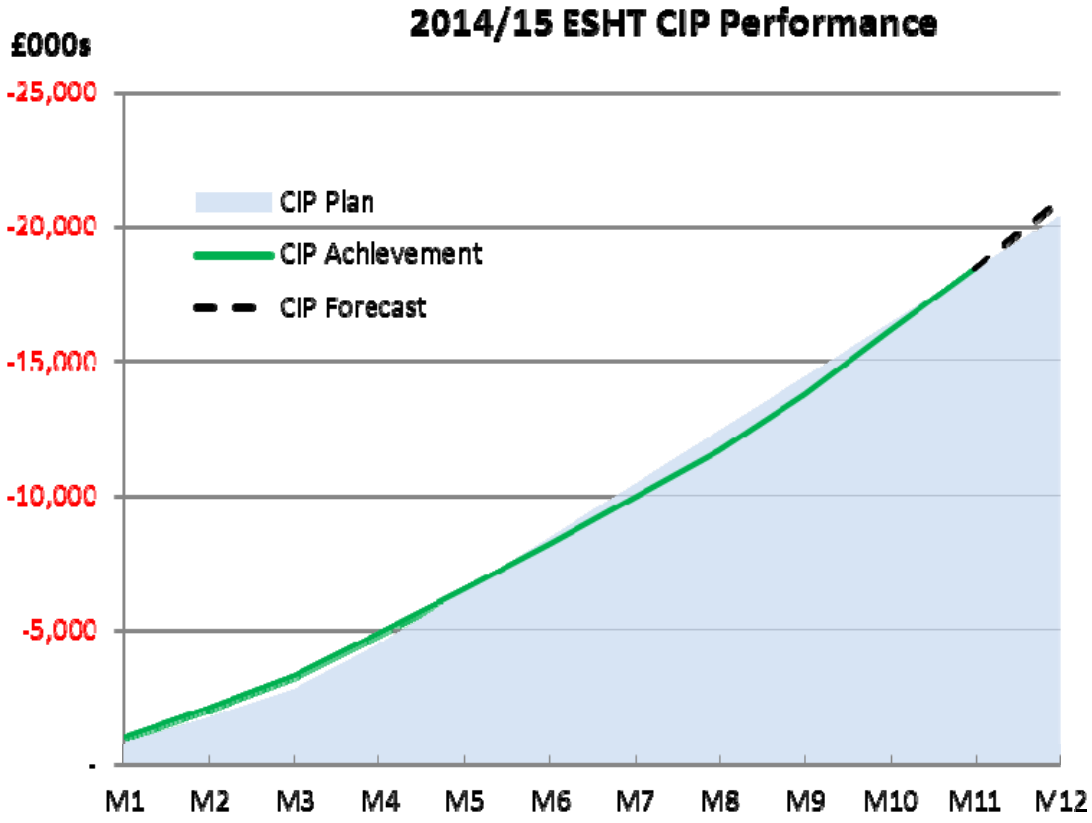
Workforce Plan FTE	Workforce Actual FTE	Corporate Services	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	2	2	0	23	23	0
		Other Income	921	1,306	385	11,249	13,336	2,087
		Total Income	**923**	**1,308**	**385**	**11,272**	**13,359**	**2,087**
543	508	Pay	-1,543	-1,600	-57	-17,280	-17,581	-301
		Non pay	-1,350	-1,355	-5	-14,968	-16,037	-1,069
543	**508**	**Total Expenditure**	**-2,893**	**-2,955**	**-62**	**-32,248**	**-33,618**	**-1,370**
543	**508**	**Gross Margin**	**-1,970**	**-1,647**	**323**	**-20,976**	**-20,259**	**717**

2014/15 ESHT CIP Plan

Themes	Full Year Plan	Key Dates	Status
Medical Staffing	-4,237	on going	
Wards & Nursing	-3,777	Oct-14	
Clinical Admin	-2,270	Oct-14	
Estates	-2,148	on going	
Theatres	-1,584	Jul-14	
Back Office	-1,574	Aug-14	
Medicines Management	-413	on going	
Other (includes Vacancy Control)	-4,415	on going	



2014/15 ESHT CIP Performance to date – Month 11

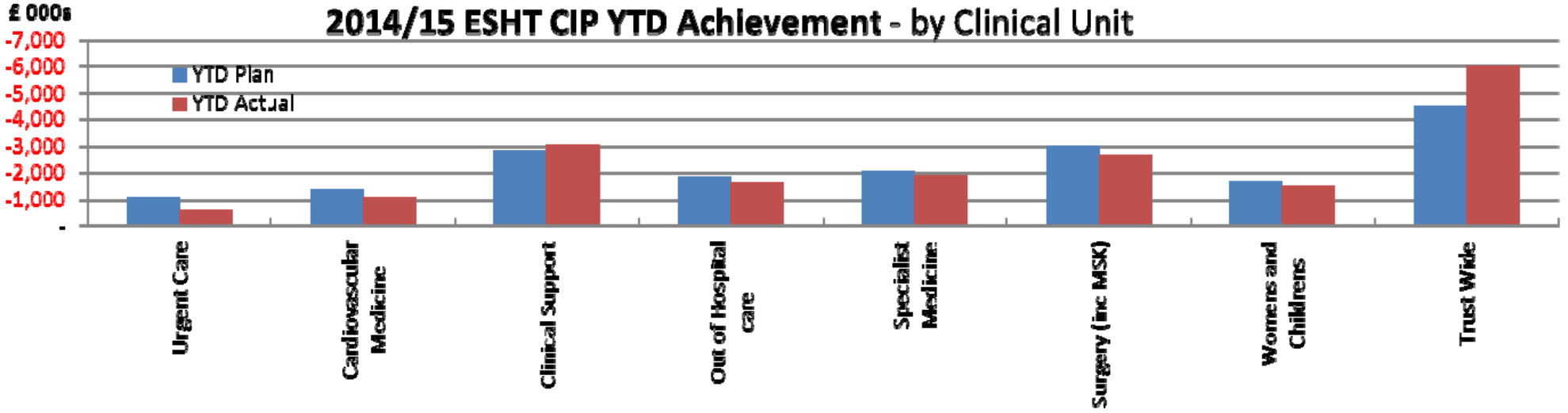


	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Plan	-799	-1,743	-2,806	-4,479	-6,432	-8,428	-10,424	-12,417	-14,408	-16,408	-18,407	-20,417
Actual	-995	-2,102	-3,272	-4,851	-6,512	-8,181	-9,888	-11,661	-13,745	-16,119	-18,376	
Forecast												-21,017

East Sussex Healthcare NHS
NHS Trust

2014/15 ESHT CIP Performance by Clinical Unit – Month 11

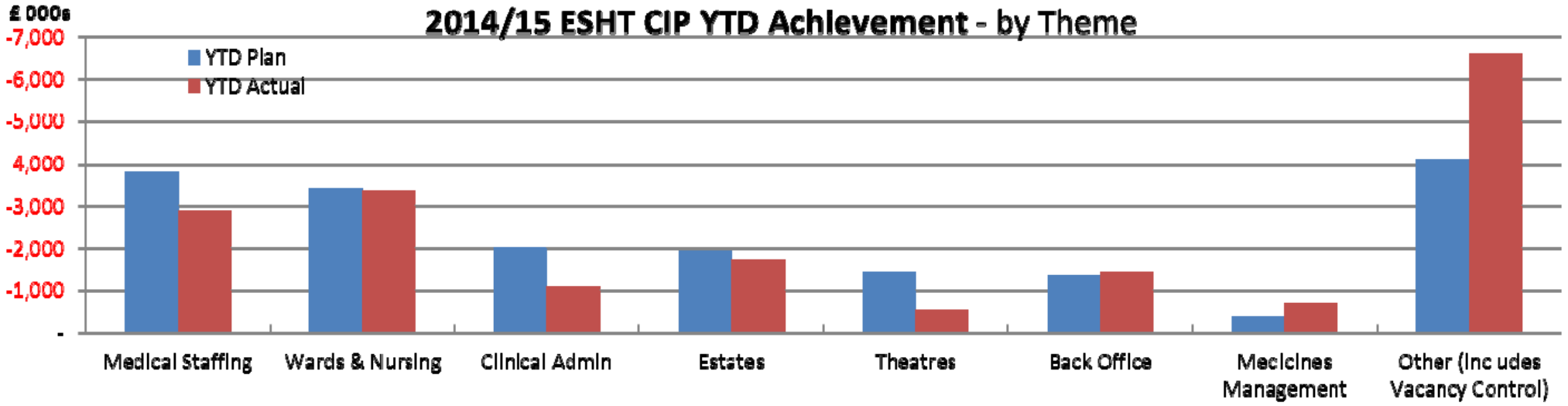
	In Month			Year to Date			Forecast		
Clinical Unit	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Full Year Plan	Full Year Forecast	Full Year Variance
Urgent Care	-117	-59	-58	-1,087	-597	-490	-1,204	-667	-536
Cardiovascular Medicine	-162	-173	11	-1,389	-1,090	-299	-1,551	-1,343	-208
Clinical Support	-319	-311	-7	-2,861	-3,061	200	-3,180	-3,399	219
Out of Hospital care	-177	-134	-43	-1,854	-1,625	-229	-2,031	-1,833	-199
Specialist Medicine	-225	-192	-32	-2,055	-1,865	-190	-2,280	-2,085	-195
Surgery (inc MSK)	-315	-245	-71	-3,022	-2,652	-370	-3,338	-2,933	-405
Womens and Childrens	-181	-77	-104	-1,673	-1,489	-183	-1,853	-1,629	-224
Trust Wide	-503	-1,065	562	-4,465	-5,997	1,531	-4,980	-7,128	2,148
Total	-1,999	-2,257	258	-18,407	-18,376	-31	-20,417	-21,017	600



East Sussex Healthcare NHS
NHS Trust

2014/15 ESHT CIP Performance by Theme – Month 11

	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	-444	-306	-137	-3,793	-2,900	-893	-4,237	-3,223	-1,015
Wards & Nursing	-375	-412	37	-3,402	-3,349	-53	-3,777	-3,785	8
Clinical Admin	-247	-80	-167	-2,015	-1,084	-931	-2,270	-1,197	-1,072
Estates	-201	-187	-13	-1,947	-1,735	-212	-2,148	-1,936	-212
Theatres	-169	-47	-122	-1,415	-548	-867	-1,584	-705	-878
Back Office	-219	-198	-21	-1,355	-1,436	81	-1,574	-1,634	60
Medicines Management	-42	-42	-	-371	-709	339	-413	-781	369
Other (includes Vacancy Control)	-303	-985	682	-4,109	-6,615	2,506	-4,415	-7,756	3,341
Total	-1,999	-2,257	258	-18,407	-18,376	-31	-20,417	-21,017	600



East Sussex Healthcare NHS
NHS Trust

Year on Year Comparisons – February 2015

Headlines

- Total Inpatients activity was 1.0% lower than last year's activity level.
- Total outpatients were 2.7% lower than last year.
- YTD A&E attendances were 2.3% 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	39,256	39,125	131	0.3%
Elective Inpatients	8,167	8623.778	-457	-5.3%
Emergency Inpatients	39,422	39,945	-523	-1.3%
Total Inpatients	**86,845**	**87,694**	**-849**	**-1.0%**
Elective Excess Bed Days	1,754	1,895	-141	-7.4%
Non elective Excess Bed Days	19,887	26,285	-6,398	-24.3%
Total Excess Bed Days	**21,641**	**28,180**	**-6,539**	**-23.2%**
Consultant First Attendances	84,968	84,417	551	0.7%
Consultant Follow Ups	131,272	134,733	-3,461	-2.6%
OP Procedures	49,198	50,780	-1,582	-3.1%
Other Outpatients (WA & Nurse Led)	133,193	139,036	-5,843	-4.2%
Community Specialist	1,944	2,724	-780	-28.6%
Total Outpatients	**400,575**	**411,690**	**-11,115**	**-2.7%**
Chemotherapy Unbundled HRGs	5,924	5,483	441	8.0%
Antenatal Pathways	3,438	3,699	-261	-7.1%
Post-natal Pathways	3,083	3,820	-737	-19.3%
A&E Attendances (excluding type 2's)	95,056	92,888	2,168	2.3%
ITU Bed Days	5,316	5,640	-324	-5.7%
SCBU Bed Days	2,921	2,677	244	9.1%
Cardiology - Direct Access	680	768	-88	-11.5%
Radiology - Direct Access	51,667	50,763	904	1.8%
Pathology - Direct Access	2,962,832	3,080,179	-117,347	-3.8%
Therapies - Direct Access	34,523	36,767	-2,244	-6.1%
Audiology	15,061	20,950	-5,889	-28.1%
Midwifery	120	114	6	5.3%

£000s	2014/15 YTD Actual	2013/14 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	317,857	299,275	18,582	6.2%
Private Patient/ RTA	2,924	2,621	303	11.6%
Trading Income	4,851	4,145	706	17.0%
Other Non Clinical Income	25,914	24,500	1,414	5.8%
Total Income	**351,546**	**330,541**	**21,005**	**6.4%**
Pay Costs	-224,504	-233,098	8,594	3.7%
Non Pay Costs	-111,821	-105,821	-6,000	-5.7%
Other	2,017	2,563	-546	21.3%
Total Direct Costs	-334,308	-336,356	2,048	0.6%
Surplus/-Deficit from Operations	**17,238**	**-5,815**	**23,053**	**396.4%**
Profit/Loss on Asset Disposal	26	7	19	271.4%
Depreciation	-11,233	-10,540	-693	-6.6%
Impairment	0	-10,018	10,018	
PDC Dividend	-7,175	-5,856	-1,319	-22.5%
Interest	-196	-269	73	27.1%
Total Indirect Costs	-18,578	-26,676	8,098	30.4%
Total Costs	**-352,886**	**-363,032**	**10,146**	**2.8%**
Net Surplus/-Deficit	**-1,340**	**-32,491**	**31,151**	**95.9%**
Donated Asset / Other Adjustment	383	10,260	-9,877	96.3%
Normalised Net Surplus/-Deficit	**-957**	**-22,231**	**21,274**	**95.7%**

Capital Programme – February 2015

Headlines

Year to Date performance:-

The Trust has now finalised the 2014/15 capital resource limit for the year with the Trust Development Authority (TDA) at £11.8m. This includes the first £428k instalment of the 10 year capital loan approved by the Independent Trust Financing Facility (ITFF) for the health records storage project. The final £441k instalment of this loan will now be included in the 2015/16 CRL.

After eleven months of the financial year capital expenditure has increased to £9.7m. The total capital programme value has now increased to £12.8m resulting in an over planning margin of £1.1m. The actual commitments entered into will be restricted to the current financial year capital resource limit (CRL) of £11.8m and the over planning items will become the first charge against the 2015/16 CRL.

As indicated by the scale of the over planning margin the capital programme remains under severe pressure as demands for capital expenditure continue to outstrip available resources and the impact on service delivery and quality will need to be carefully managed.

Capital Investment Programme £000s	2014/15 Capital Programme	Expenditure at Month 11
Capital Resources		
Depreciation	11,285	
Clinical Strategy exceptional additional PDC	0	
Additional Capital PDC - Conquest Clinical Decision	400	
Additional Capital Loan - Health Records Storage	428	
League of Friends Support	1,300	
Cap Investment Loan Principal Repayment	-340	
Gross Capital Resource	13,073	
Less Donated Income	-1,300	
Capital Resource Limit (CRL)	**11,773**	**-**
Capital Investment		
Clinical Strategy Reconfiguration	0	0
Conquest Clinical Decision Unit	400	380
Health Records Storage - Funding not yet approved.	428	428
Clinical Strategy Essential Enabling Works	250	247
Medical Equipment	2,930	2,274
Information Systems	823	530
Electronic Document Management	100	109
Child Health Information System	557	597
Backlog Maintenance	1,071	738
Infrastructure Improvements - Infection Control	630	580
Electrical Supply to DGH	540	271
Minor Capital Schemes	2,200	2,017
Pevensey Ward	300	259
Other various	1,582	558
Brought Forward Schemes	1,025	753
Sub Total	**12,836**	**9,741**
Donated Asset Purchases	1,300	853
Donated Asset Funding	-1,300	-853
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**12,836**	**9,741**
Overplanning Margin (-) Underplanning (+)	-1,063	
Net Capital Charge against the CRL	**11,773**	**9,741**

Continuity of Service Risk Ratings – February 2015

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 -8 days, a rating of 2.
- The capital servicing ratio of 0.66 results in a rating of 1.
- As a result the overall Trust rating is 2.

Liquidity Ratio (days) £000s	2013/14 Outturn	2014/15 YTD
Opening Current Assets	33,908	33,216
Opening Current Liabilities	-34,506	-35,201
Net Current Assets/Liabilities	-598	-1,985
Inventories	-6,238	-6,547
Adj Net Current Assets/Liabilities	**-6,836**	**-8,532**
Divided by:		
Total costs in year	369,719	334,308
Multiply by (days)	360	330
Liquidity Ratio	**-7**	**-8**

Capital Servicing Capacity (times) £000s	2013/14 Outturn Actual	2014/15 YTD Plan	2014/15 YTD Actual
Net Surplus / Deficit (-) After Tax	-33,412	-16,967	-1,340
Less:			
Donated Asset Income Adjustment	-999	-1,192	-854
Interest Expense	305	293	228
Profit/Loss on Sale of Assets	-9	0	-26
Depreciation & Amortisation	11,385	11,536	11,233
Impairments	10,018	0	0
PDC Dividend	6,251	7,579	7,175
Revenue Available for Debt Service	**-6,461**	**1,249**	**16,416**
Interest Expense	305	293	228
PDC Dividend	6,251	7,579	7,175
Temporary PDC repayment	29,000		
Working capital loan repayment	1,334	861	17,337
Capital loan repayment	340	160	320
	37,230	8,893	25,060
Capital Serving Capacity	**-0.17**	**0.14**	**0.66**

Financial Risks & Mitigating Actions – February 2015

Summary	
RISKS:-	
The following areas of risk remain to achieving the projected year-end FOT	
1) Further capacity and operational pressures.	
2) M12 CIP delivery.	
MITIGATING ACTIONS:-	
Mitigating actions include continued focus of CIP delivery and joint management of demand.	

East Sussex Healthcare NHS Trust

Date of Meeting:	25th March 2015
Meeting:	Trust Board
Agenda item:	8
Subject:	Quality Improvement Priorities 2015/16
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

To inform the Trust Board of the proposed Quality Improvement Priorities (QIP) 2015/16 for decision and subsequent inclusion in the Trust's Annual Quality Account.

Introduction:

Quality Accounts are annual reports to the public from NHS healthcare providers regarding the quality of services being provided; they are both retrospective and prospective in content. They allow us to provide assurances to our patients, the local public and our Commissioners in regards to the quality of care being delivered, and allow us to demonstrate our commitment to continuous, evidence-based quality improvement.

The Quality Account for 2014/15 must include the Trust's priorities for quality improvement in 2015/16. These priorities must have a significant, measurable impact, be feasible to achieve within the timescale and support the change programme and performance requirements of the Trust.

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

The attached document gives detail of the seven suggestions put forward for 2015/16. These were developed by reviewing themes for complaints and risks in addition to feedback from previous public events.

Following feedback and further suggestions from staff and public/patient groups a further two suggestions have been made.

There is a requirement that at least one is allocated to each of the following domains:

- Patient Safety;
- Clinical Effectiveness
- Patient Experience.

CME and Quality and Standards Committee have approved the suggestions made however metrics for these areas will be established. The agreement of these groups is for the following 5 QIPs:-

- Reduce the number of falls which cause significant harm by implementing a Falls reduction programme
- Improve the care patients with Dementia receive by improving their environment and access to staff with expert knowledge
- Communication QIP – # hello my name is
- Compassion QIP – to include the suggested dignity pledges

- Improving staffing by ensuring the right people with the right skills are in the right place at the right time

NB. It is a mandatory requirement to report on other quality aspects such as SHMI, participation in national clinical audits and national enquiries, research, CQUIN, and data quality.

Benefits:

The production of an annual set of Quality Accounts is mandatory for NHS provider organisations in England, as set out in the Health Act 2009. It outlines the Trust's commitment to monitoring and improving quality.

Risks and Implications

Failure to identify quality improvement priorities for 2015/16 or to produce and submit a set of Quality Accounts by the 30th June to the Secretary of State would result in non compliance with the Health Act 2009.

Assurance Provided:

The paper provides assurance that the document will be produced in line with guidance and to meet the final publish deadline of 30 June.

Proposals and / or Recommendations

The Trust Board is asked to discuss, comment and agree on the final proposed QIPs as above.

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 equality and human rights impact assessment has been conducted for this report.

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

Name: Alice Webster	**Contact details:** alice.webster@nhs.net (01323) 435855

Quality Improvement Priorities 2015/16

1. Introduction

The Trust Quality Account for 2014/15 must include the organisations priorities for quality improvement in 2015/16. These priorities must have a significant, measurable impact, be feasible to achieve within the timescale and support the change programme and performance requirements of the Trust.

Quality Accounts are annual reports to the public from NHS healthcare providers regarding the quality of services being provided; they are both retrospective and prospective in content. They allow us to provide assurances to our patients, the local public and our Commissioners in regards to the quality of care being delivered, and allow us to demonstrate our commitment to continuous, evidence-based quality improvement. Many elements of the Quality Account are mandatory, although content is generated and agreed locally.

2. Current Quality Improvement Priorities

Current quality account improvement priorities are detailed below and progress against these will be reported in this year's Quality Account.

Patient Safety

- Maximise our efforts to reduce healthcare acquired infections;

Clinical Effectiveness

- Early recognition and action to support the care of the deteriorating patient (linking to VitalPAC);

Patient Experience

- Continue to Implement the Patient Experience Strategy
- Ensure that we provide optimal care for patients in our care who have mental health disorders

3. Quality Account Improvement Priorities Proposals 2015/16

Seven Quality Improvement Priorities (QIPs) have been proposed for 2015/16 following review of complaints, risks and feedback from previous public engagement events.

These are –

Patient Safety

QIP 1 - Improved CTG interpretation within maternity to reduce adverse outcomes.

QIP 2 - Reduce the number of falls which cause significant harm by implementing a Fall's reduction programme.

Clinical Effectiveness

QIP 3 - Continue to improve the care of patients by implementing new modules and embedding the routine use of VitalPAC across the Trust.

QIP 4 - Improve the care patients with Dementia receive by improving their environment and access to staff with expert knowledge.

Patient Experience

QIP 5 - Improve communication and compassion by embracing the 'Hello my name is ' campaign.

QIP 6 - Improve the written information leaflets patients receive when they have treatment, a procedure or an operation.

QIP 7 - Continue to improve End of Life Care by enhancing the use of PEACE advanced care planning

Staff were asked to comment on these and put forward their suggestions via the extranet. Responses were received and have been taken into consideration.

Patient/Public feedback and suggestions were sought from Health Watch members and the Foundation Trust membership group via an online survey. There were 345 responses (16% response rate). All the proposed QIPs were well supported and a number of key themes emerged from the comments given around improving staffing, improving communication and privacy and dignity.

Therefore the following QIP proposals have been added for consideration and QIP 5 has been expanded.

Patient Safety

QIP 8 – Improving staffing by ensuring the right people with the right skills are in the right place at the right time.

Clinical Effectiveness

QIP 9 – Improving co-ordination of care and service for people living with complex needs in the community

Patient Experience

(QIP 5) Expand improving communication and compassion by also hosting a dignity conference to develop and implement a set of trust 'Dignity' pledges with public/patients and carers.

4. Measurement

For each QIP we will state in the Quality Account why we have chosen it, and quality metrics for these areas will be established.

5. Mandatory Information

We are required to report on a number of other quality metrics in our Quality Accounts including CQUINs, clinical audit and clinical research and performance indicators

6. Recommendation

The following were recommended by the Clinical Management Executive and Quality and Standards Committee as the identified Quality Improvement Priorities:-

Patient Safety	Reduce the number of falls which cause significant harm by implementing a Falls reduction programme
	Improving staffing by ensuring the right people with the right skills are in the right place at the right time
Clinical Effectiveness	Improve the care patients with Dementia receive by improving their environment and access to staff with expert knowledge
Patient Experience	Communication QIP – hello my name is Compassion QIP – to include the suggested dignity pledges

The Trust Board is asked to discuss, comment and agree on the final proposed Quality Improvement Priorities.

East Sussex Healthcare NHS Trust

Date of Meeting:	25.03.15
Meeting:	Trust Board
Agenda item:	9
Subject:	Staff Survey 2014 – Results Report
Reporting Officer:	Monica Green

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

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

Purpose:

The attached reports provide a summary and analysis of the 2014 staff survey results and the actions being undertaken to address issues raised.. Overall the results for 2014 are unchanged when compared with the results for 2013, apart from two key findings which have improved slightly. It is disappointing that there has not been further improvement, but this is likely to be reflective of a significant period of change within the organisation which included the single siting of some services, a management reorganisation, and a major review of clinical administration services. The purpose of the attached reports is to outline suggested key actions and outcomes to bring about improvement in staff engagement and improvements in feedback through the staff survey and staff friends and family test.

Introduction:

Attached are the following:

- The Picker Institute summary report which shows our results, how we are ranked nationally, and identifies our best and worst areas.
- An ESHT summary report drawing out the key findings from the Picker report, giving some analysis across staff groups and clinical units/departments, and suggesting actions going forward.
- A copy of the Staff Engagement Action Plan which details ongoing and future planned actions.

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

We are particularly concerned that staff don't feel involved, engaged, or communicated with. In addition we are below the national average in relation to staff feeling confident to raise concerns. These are areas we will focus on in the next 12 months.

Benefits:

The staff survey is a key mechanism to understand staff perceptions and concerns, and identify areas for action. One of the benefits of addressing these areas of concern should be an improvement in staff engagement which in turn should have a positive impact on patient experience.

Risks and Implications

The risks of not addressing staff concerns include the knock on effect on other performance

indicators, and poor staff morale which can impact on patient experience and organisational reputation.

Assurance Provided:
That there is active focus on addressing issues raised in the staff survey, supported by a Staff Engagement Operations group.

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	x
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
Strategic Objective 3 - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	x
Review by other Committees/Groups (please state name and date)**:**	

Proposals and/or Recommendations
That the Board agrees with the proposed actions to address issues arising out of the 2014 staff survey.

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

For further information or for any enquiries relating to this report please contact:	
Name: Edel Cousins	**Contact details:** Edel.cousins@nhs.net

East Sussex Healthcare NHS
NHS Trust

Staff Survey Results and Action

1. Introduction

The staff survey offers an opportunity to understand the views of staff and their experiences throughout their employment with the Trust. Although this is not the only measure that is used it does have a significant impact on our wider performance indicators for example – TDA monitoring, Quality Reports and CQC outcomes. The staff survey was conducted between October and December 2014 with the results published on 24th February 2015. The survey was conducted across all ESHT staff with a response rate of 42%. This response was higher than last year when 36% of staff responded. For 2014 the Trust is again compared with Acute Trusts as there is still no mechanism to compare with other Integrated Trusts. The questions are grouped into 28 key findings. The scores for some are straight percentages, for example the percentage of respondents who witnessed incidents; The scores for others are composites, expressed as a score out of 5, such as job satisfaction.

This report will highlight the key headlines from the survey, outline what work is already going on to address some of these issues and identify further actions required

2. Headlines from the Survey

In the main the results are similar to those reported in last years survey when which saw the culmination of a huge amount of change in the organization . This included the single siting of some services e.g. surgery, a management reorganization and a major review of our clinical administrative services.

The following outlines some of the key findings from the survey for East Sussex Healthcare:

- **Top five scores**
    - % of staff witnessing potentially harmful errors – 29% (acute trust average 34%)
    - % of staff working extra hours – 69% (acute trust average 71%)
    - % of staff experiencing physical violence from patients/relatives/public – 13% (acute trust average 14%)
    - % of staff experiencing physical violence from staff – 3% (acute trust average 3%)
    - % of staff experiencing discrimination at work – 11% (acute trust average 11

- **Bottom five scores**
  - % of staff receiving job-relevant training – 74% (acute trust average 81%)
  - % of staff agreeing that they would feel secure raising concerns about unsafe clinical practice – 56% (acute trust average 67%)
  - Fairness and effectiveness of incident reporting procedures (higher score from 1 to 5 is better) – 3.37 (acute trust average 3.54)
  - % of staff reporting good communication with senior management – 18% (acute trust average 30%)
  - Staff recommendation of the trust as a place to work or receive treatment procedures (higher score from 1 to 5 is better) – 3.27 (acute trust average3.67)
- **Overall Staff Engagement** (1 to 5 with 5 being highly engaged) – 3.46 (3.47 in 2013), in the worst 20% of acute trusts
- **Largest improvements since 2013**
  - Fairness and effectiveness of incident reporting procedures (higher score from 1 to 5 is better) – 3.37 (2013 result 3.33)
  - % of staff having equality and diversity training – 58% (2013 result 53%)

Highlights by staff group

There are a range of scores where the results are analysed by staff group:

Key Finding	Worst Staff Group	Best Staff Group	Trust Overall	National Average
% Feeling satisfied with the quality of care they are able to deliver	Nursing & Midwifery – **65%**	Additional Clinical Services – **79%**	**70%**	**77%**
Work pressure felt by staff	Allied Health Professionals – **3.37**	Additional Clinical Services – **3.06**	**3.26**	**3.07**
Effective Team Working	Estates & Ancilliary – **3.25**	Allied Health Professionals – **3.97**	**3.69**	**3.74**
% Agreeing they would feel secure raising concerns	Admin & Clerical – **43%**	Nursing & Midwifery – **66%**	**56%**	**67%**
% Reporting good	Healthcare Scientists	Additional Clinical	**18%**	**26%**

communication between senior management and staff	– **13%**	Services – **21%**		
Staff recommendation of the Trust as a place to work or receive treatment	Healthcare Scientists – **3.12**	Additional Clinical Services – **3.49**	**3.27**	**3.67**

Highlights by department

The same sample of results by directorate/clinical unit:

Key Finding	Worst CU/Directorate	Best CU/Directorate	Trust Overall	National Average
% Feeling satisfied with the quality of care they are able to deliver	Cardiovascular Medicine – **62%**	Specialist Medicine – **76%**	**70%**	**77%**
Work pressure felt by staff	Urgent Care – **3.48**	Theatres & Clinical Support – **3.11**	**3.26**	**3.07**
Effective Team Working	Commercial – **3.39**	Out Of Hospital / Womens & Childrens – **3.91**	**3.69**	**3.74**
% Agreeing they would feel secure raising concerns	Corporate – **44%**	Womens & Childrens – **67%**	**56%**	**67%**
% Reporting good communication between senior management and staff	Surgery – **15%**	Womens & Childrens – **21%**	**18%**	**26%**
Staff recommendation of the Trust as a place to work or receive treatment	Cardiovascular Medicine – **3.00**	Out of Hospital Care – **3.42**	**3.27**	**3.67**

The 2014 staff survey scores are broadly the same as the scores for 2013 except for two key findings that have improved slightly:

- KF14 – Fairness and effectiveness of reporting procedures (2013 – 3.33, 2014 – 3.37);
- KF26 - % having Equality & Diversity training in the last 12 months (2013 – 53%, 2014 – 58%)

Further to the results of the 2013 survey, the Trust continued with the Listening into Action programme in order to engage with and involve staff. Some of the main achievements included:

- Establishing a Healthcare Support Worker forum and ensuring that Healthcare Assistants are represented on the main Trust Nursing Group;

- Working with a number of clinical groups to access and fund equipment that has speeded up processes and increased patient satisfaction, eg I/V Therapy.

- Established a Staff Engagement Operations group with representation from across the Trust.

A full summary of the 2014 survey results is attached for further information.

3. Actions to secure improvement

The Trust Board has already identified that staff engagement and involvement is a key focus. During the past two years the organisation has gone through a period of significant change and it is recognized that a period of organisational stability is now required which will allow. us to implement some key actions to improve our staff engagement and involvement.

These will be included in the development of an Organisational Development strategy which is currently in draft. The strategy suggests a number of work streams which are aligned to the recent Kings Fund report on Staff engagement and the six strategic key building blocks that organizations need to have in place to ensure effective staff engagement

These are:

- Developing a compelling shared strategic direction
- Building collective and distributive Leadership
- Adopting a supportive /inclusive Leadership style
- Give staff the tools to lead service transformation
- Establishing a culture based on trust and integrity
- Placing staff engagement at the centre of the Board agenda

At an operational level a new staff engagement group has been established which includes staff representatives from frontline services who have identified some key actions that will help u improve on our staff experience and staff survey scores. The group has developed an action plan based on themes they have identified; Staff Friends and Family results and also using the NHS Employers guidance “The Engagement Star” which identifies factors that ensure excellent staff engagement. The action plan is attached and will be used as the action plan to address the five poorest scores and other key issues arising from the 2014 staff survey. Below is a quick reference guide to which section of the engagement plan will address each of the five poorest scores:

Bottom Five Scores	**Section In staff engagment Plan**
% of staff receiving job-relevant training – 74% (acute trust average 81%)	**Supporting personal development and training**
% of staff agreeing that they would feel secure raising concerns about unsafe clinical practice – 56% (acute trust average 67%)	**Ensuring every role counts**
Fairness and effectiveness of incident reporting procedures (higher score from 1 to 5 is better) – 3.37 (acute trust average 3.54)	**Enabling involvement in decision making – the listening conversations will focus on incident reporting and ensuring every role counts**
% of staff reporting good communication with senior management – 18% (acute trust average 30%)	**Delivering Great Management and Leadership**
Staff recommendation of the trust as a place to work or receive treatment procedures (higher score from 1 to 5 is better) – 3.27 (acute trust average3.67	**All sections**

It is also recommended that specific targets for improvement based on the percentage or composite scores are agreed

For example:

- % of staff receiving job-relevant training – East Sussex Score is currently at 74% and the acute trust average is 81%. For 2015/16 our suggested target for this domain is 77%

Furthermore it is recommended that to gain real ownership of the feedback from the survey it is recommended each Clinical Unit and Directorate develop local plans and targets . This will be supported by the Workforce Development Team.

The Francis report 'Freedom to Speak Up' and recommendations on raising concerns will also need to be factored into this work once we receive the national response to this.

4. Summary of key recommendations for action

- Continued focus on staff engagement at a strategic level through the organizational development strategy and feedback from ongoing staff surveys including the staff family and friends test
- Focus on the 5 lowest scores areas which clear outcomes identified and achieved through the staff engagement plan
- Clinical units/Directorates to identify specific issues to work on linked and involve staff in developing implementing and monitoring key action plans
- Implement findings from the Francis report on Raising concerns once final recommendations are published

Actions to take forward the above recommendations are detailed in the attached Staff Engagement Action Plan.

Lorraine Mason/
Edel Cousins
March 2015

2014 National NHS staff survey

Brief summary of results from East Sussex Healthcare NHS Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2014 national NHS staff survey conducted in East Sussex Healthcare NHS Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 29 Key Findings.

These sections of the report have been structured around 4 of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus three additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- Additional theme: Staff satisfaction
- Additional theme: Equality and diversity
- Additional theme: Patient experience measures

Please note that the NHS pledges were amended in 2014, however the report has been structured around 4 of the pledges which have been maintained since 2009. For more information regarding this please see the “Making Sense of Your Staff Survey Data” document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2014 survey results for East Sussex Healthcare NHS Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q12a - 12d and the un-weighted score for Key Finding 24. The percentages for Q12a – Q12d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

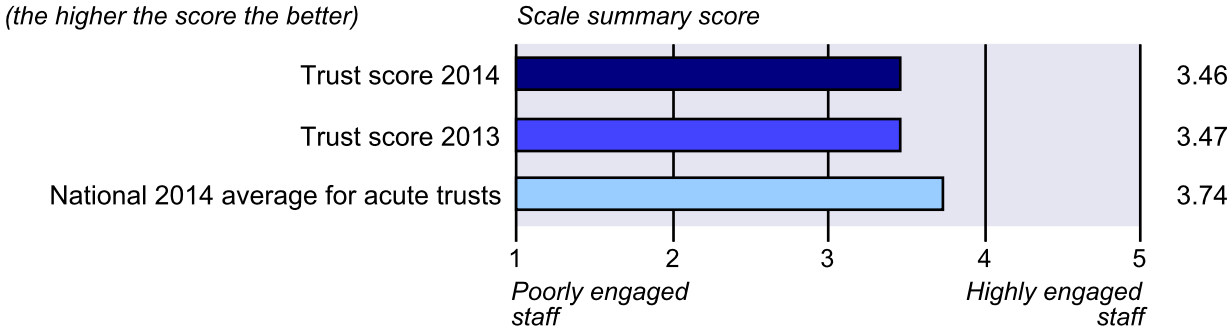
Q12a, Q12c and Q12d feed into Key Finding 24 “Staff recommendation of the trust as a place to work or receive treatment”.

		Your Trust in 2014	Average (median) for acute trusts	Your Trust in 2013
Q12a	"Care of patients / service users is my organisation's top priority"	51	70	49
Q12b	"My organisation acts on concerns raised by patients / service users"	52	71	53
Q12c	"I would recommend my organisation as a place to work"	39	58	41
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	52	65	51
KF24.	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	3.26	3.67	3.28

2. Overall indicator of staff engagement for East Sussex Healthcare NHS Trust

The figure below shows how East Sussex Healthcare NHS Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.46 was in the lowest (worst) 20% when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 22, 24 and 25. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 22); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 24); and the extent to which they feel motivated and engaged with their work (Key Finding 25).

The table below shows how East Sussex Healthcare NHS Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2013 survey.

	Change since 2013 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	! Lowest (worst) 20%
KF22. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Lowest (worst) 20%
KF24. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.)*	• No change	! Lowest (worst) 20%
KF25. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	! Lowest (worst) 20%

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2014 Key Findings for East Sussex Healthcare NHS Trust

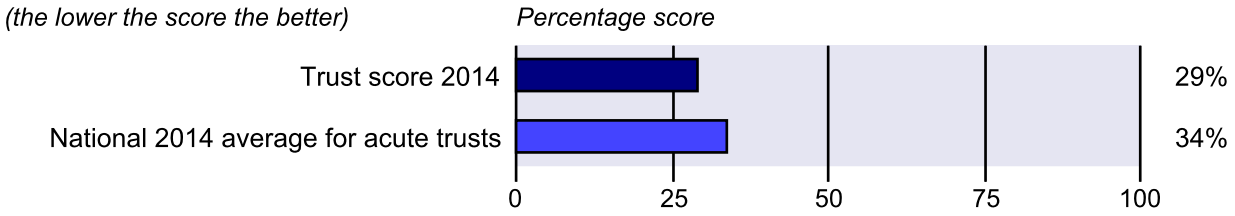
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which East Sussex Healthcare NHS Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

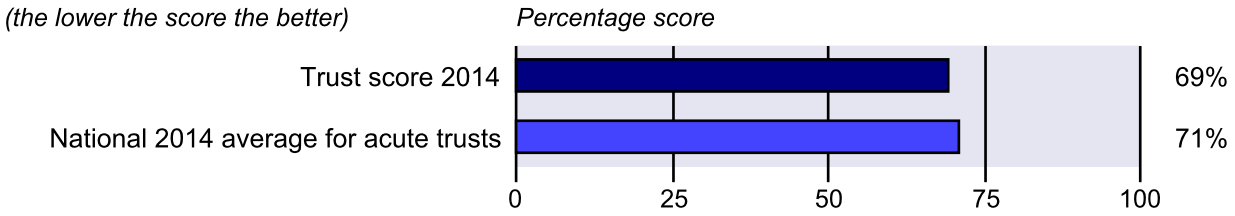
✓KF12. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



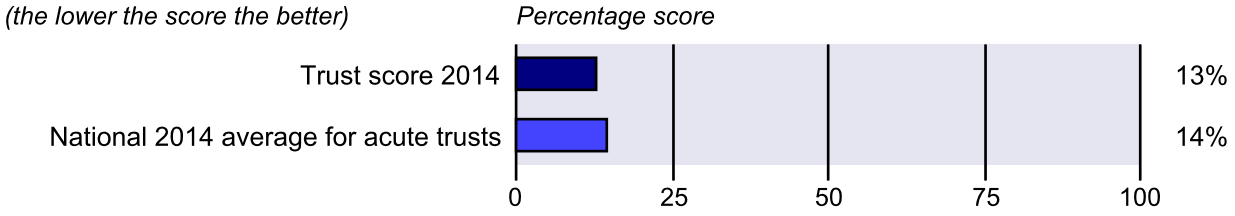
✓KF5. Percentage of staff working extra hours

(the lower the score the better)



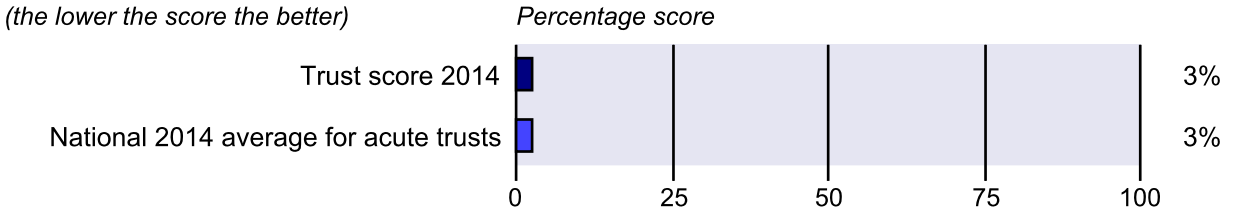
✓KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



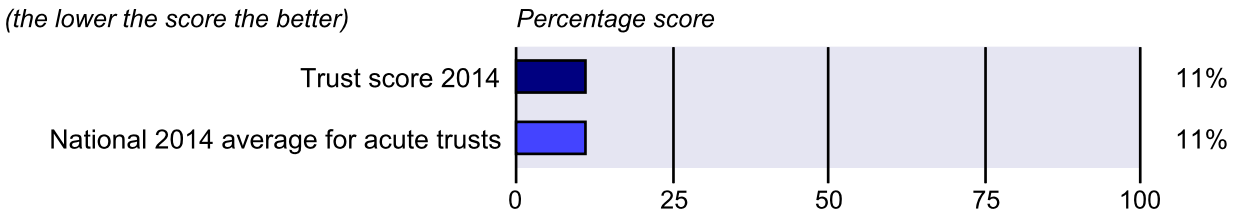
✓KF17. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



✓KF28. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)



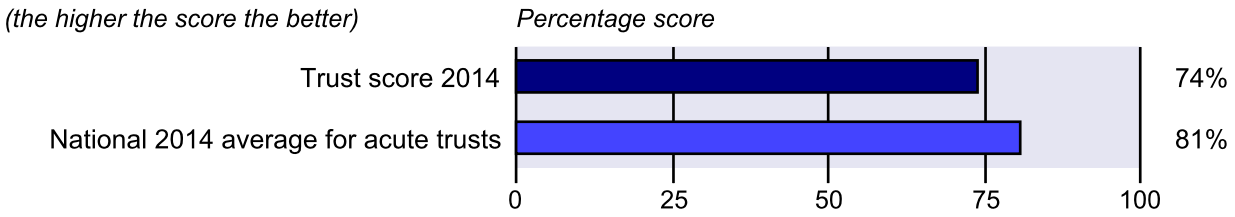
For each of the 29 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 138 (the bottom ranking score). East Sussex Healthcare NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which East Sussex Healthcare NHS Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

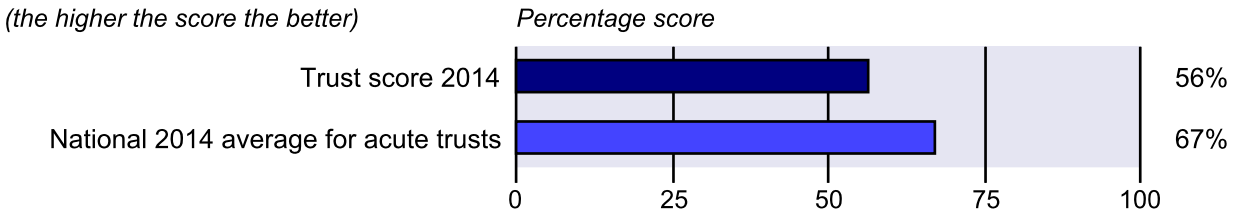
! KF6. Percentage of staff receiving job-relevant training, learning or development in last 12 months

(the higher the score the better)



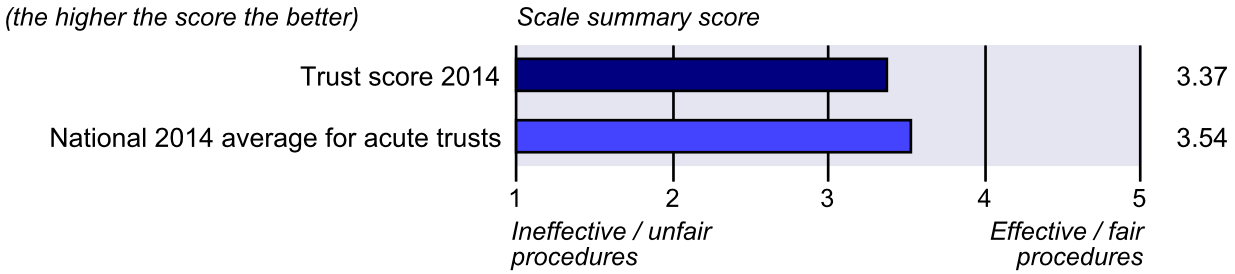
! KF15. Percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice

(the higher the score the better)



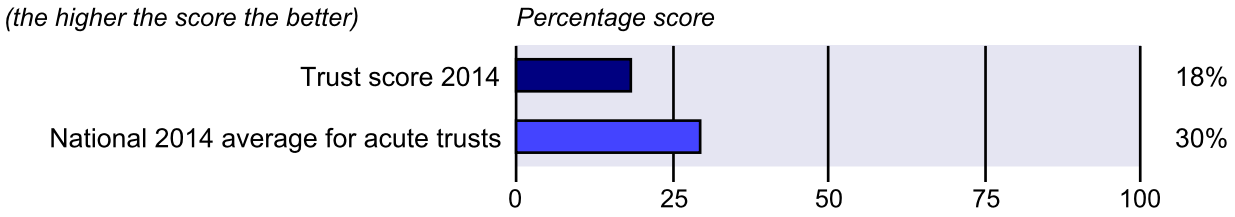
! KF14. Fairness and effectiveness of incident reporting procedures

(the higher the score the better)



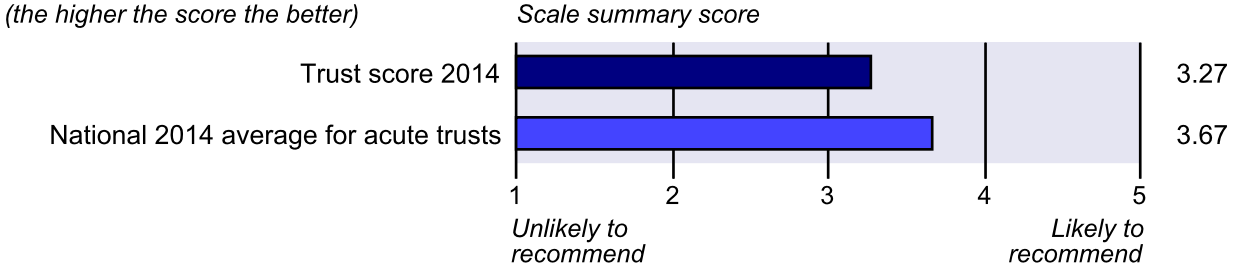
! KF21. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



! KF24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



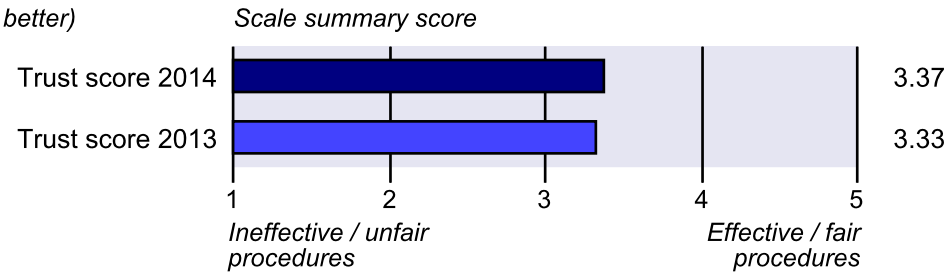
3.2 Largest Local Changes since the 2013 Survey

This page highlights the two Key Findings where staff experiences have improved at East Sussex Healthcare NHS Trust since the 2013 survey. (This is a positive local result. However, please note that, as shown in section 3.3, when compared with other acute trusts in England, the scores for Key findings KF14, and KF26 are worse than average).

WHERE STAFF EXPERIENCE HAS IMPROVED

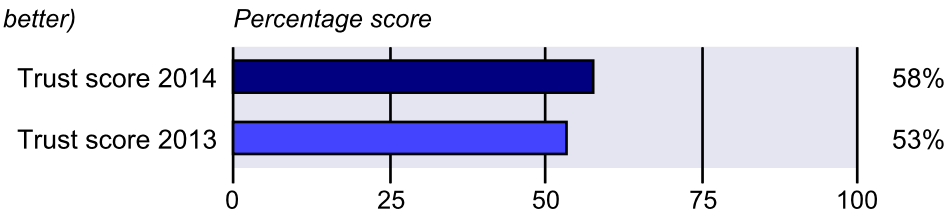
✓ KF14. Fairness and effectiveness of incident reporting procedures

(the higher the score the better)



✓ KF26. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



3.2. Summary of all Key Findings for East Sussex Healthcare NHS Trust

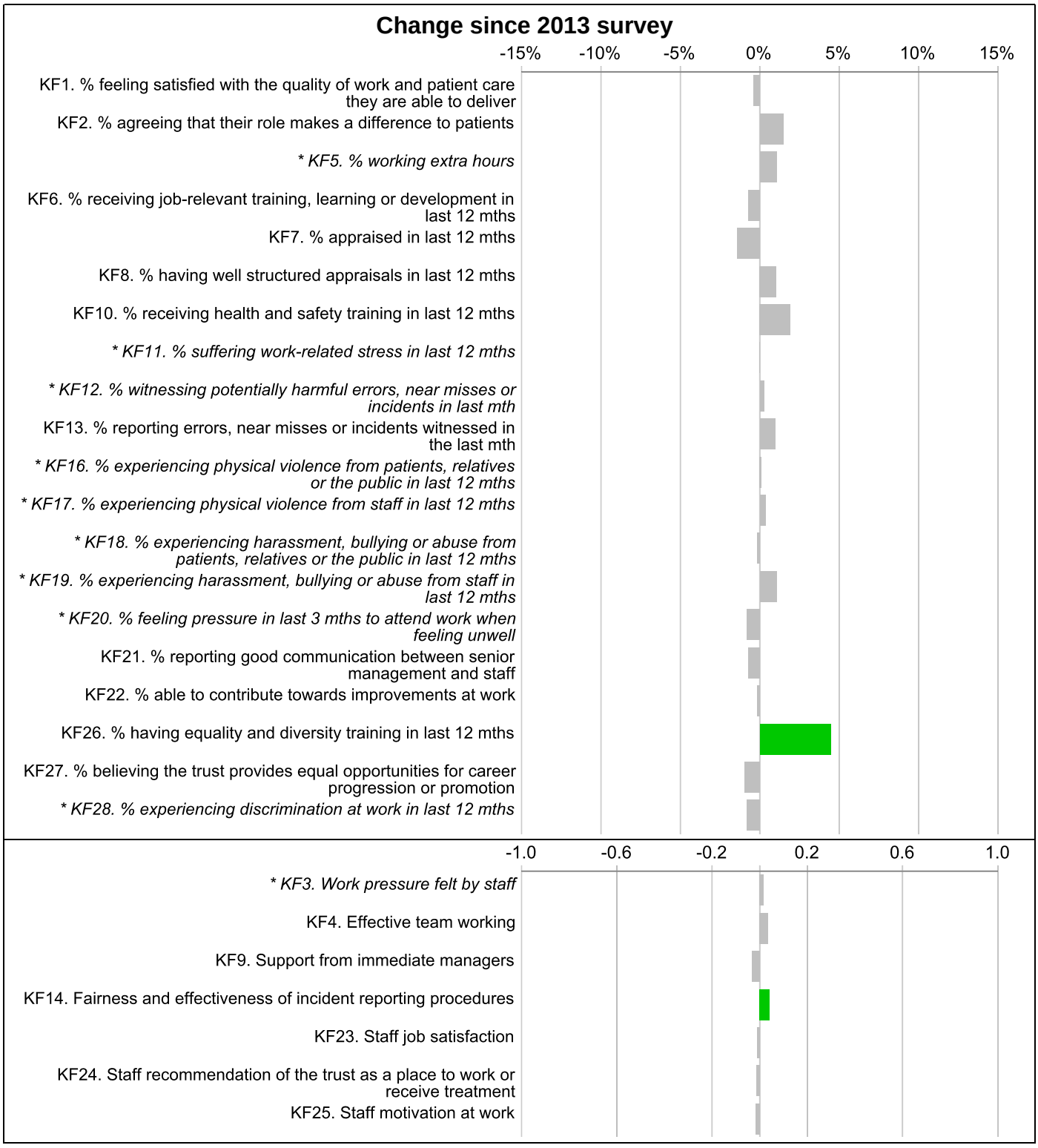
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2013 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2013 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2013 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for East Sussex Healthcare NHS Trust

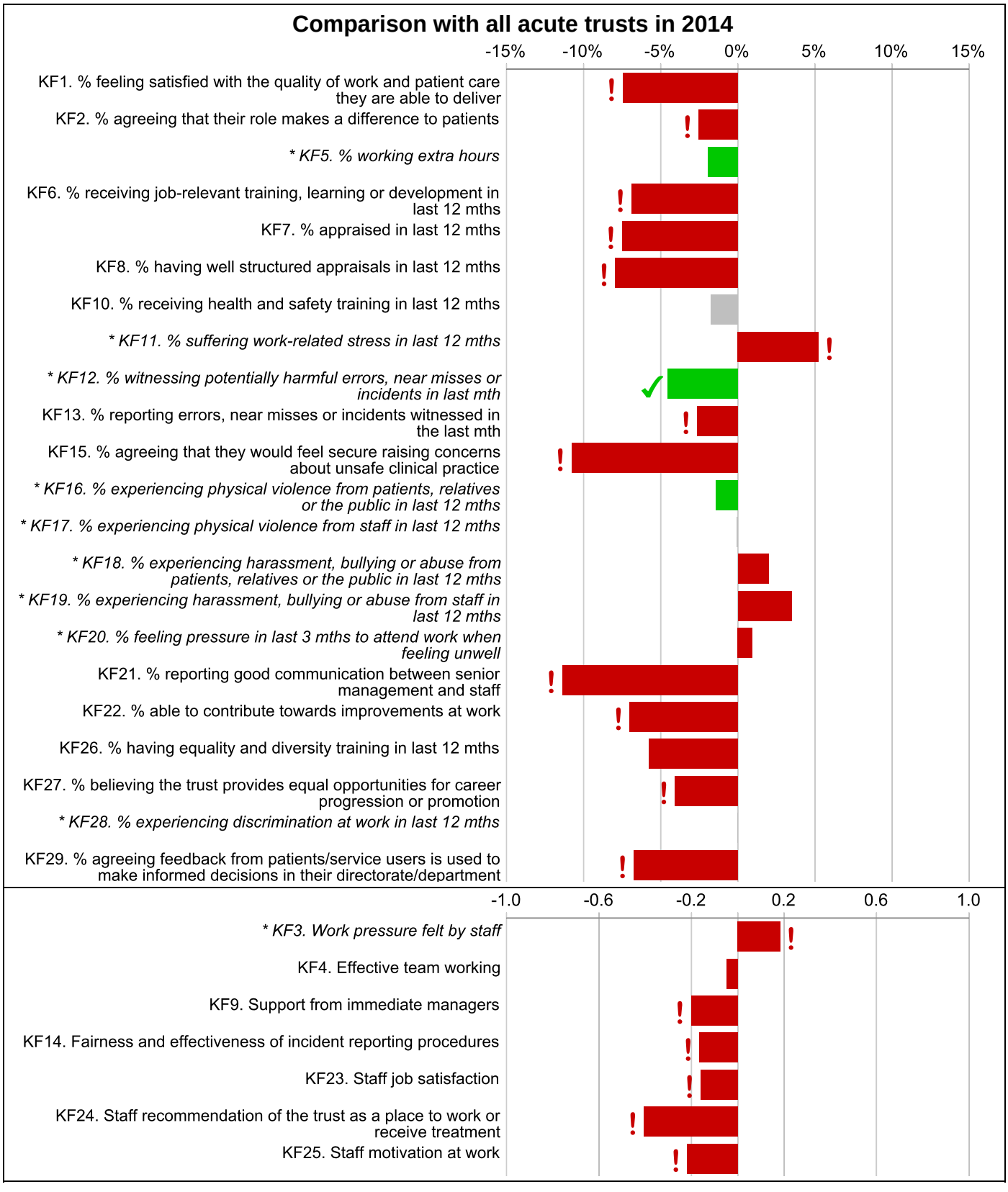
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, e.g. worse than avearge. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for East Sussex Healthcare NHS Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2013.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2013.

'Change since 2013 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2013 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2013 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.

	Change since 2013 survey	Ranking, compared with all acute trusts in 2014
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	• No change	! Lowest (worst) 20%
KF2. % agreeing that their role makes a difference to patients	• No change	! Lowest (worst) 20%
* *KF3. Work pressure felt by staff*	• No change	! Highest (worst) 20%
KF4. Effective team working	• No change	! Below (worse than) average
* *KF5. % working extra hours*	• No change	✓ Below (better than) average
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF6. % receiving job-relevant training, learning or development in last 12 mths	• No change	! Lowest (worst) 20%
KF7. % appraised in last 12 mths	• No change	! Lowest (worst) 20%
KF8. % having well structured appraisals in last 12 mths	• No change	! Lowest (worst) 20%
KF9. Support from immediate managers	• No change	! Lowest (worst) 20%
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Occupational health and safety		
KF10. % receiving health and safety training in last 12 mths	• No change	• Average
* *KF11. % suffering work-related stress in last 12 mths*	• No change	! Highest (worst) 20%
Errors and incidents		
* *KF12. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	✓ Lowest (best) 20%
KF13. % reporting errors, near misses or incidents witnessed in the last mth	• No change	! Lowest (worst) 20%
KF14. Fairness and effectiveness of incident reporting procedures	✓ Increase (better than 13)	! Lowest (worst) 20%
KF15. % agreeing that they would feel secure raising concerns about unsafe clinical practice	--	! Lowest (worst) 20%

3.3. Summary of all Key Findings for East Sussex Healthcare NHS Trust (cont)

	Change since 2013 survey	Ranking, compared with all acute trusts in 2014
Violence and harassment		
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF17. % experiencing physical violence from staff in last 12 mths*	• No change	• Average
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
Health and well-being		
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	• No change	! Above (worse than) average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF21. % reporting good communication between senior management and staff	• No change	! Lowest (worst) 20%
KF22. % able to contribute towards improvements at work	• No change	! Lowest (worst) 20%
ADDITIONAL THEME: Staff satisfaction		
KF23. Staff job satisfaction	• No change	! Lowest (worst) 20%
KF24. Staff recommendation of the trust as a place to work or receive treatment	• No change	! Lowest (worst) 20%
KF25. Staff motivation at work	• No change	! Lowest (worst) 20%
ADDITIONAL THEME: Equality and diversity		
KF26. % having equality and diversity training in last 12 mths	✓ Increase (better than 13)	! Below (worse than) average
KF27. % believing the trust provides equal opportunities for career progression or promotion	• No change	! Lowest (worst) 20%
* *KF28. % experiencing discrimination at work in last 12 mths*	• No change	• Average
ADDITIONAL THEME: Patient experience measures		
Patient/Service user experience Feedback		
KF29. % agreeing feedback from patients/service users is used to make informed decisions in their directorate/department	--	! Lowest (worst) 20%

4. Key Findings for East Sussex Healthcare NHS Trust

2660 staff at East Sussex Healthcare NHS Trust took part in this survey. This is a response rate of 42%[1] which is average for acute trusts in England, and compares with a response rate of 36% in this trust in the 2013 survey.

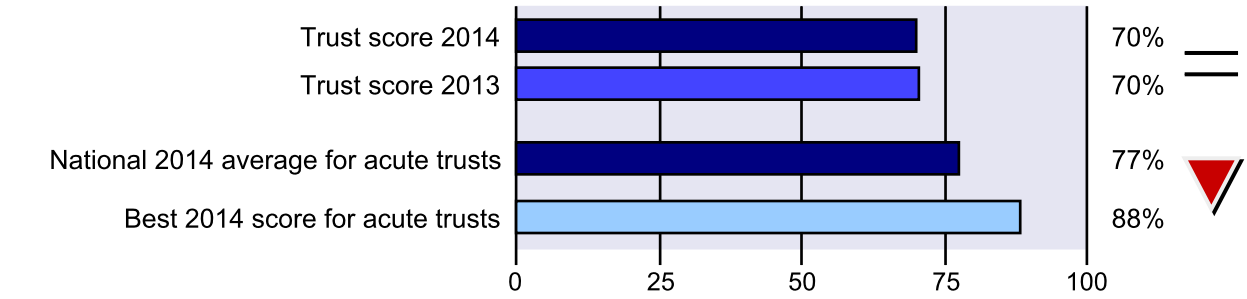
This section presents each of the 29 Key Findings, using data from the trust's 2014 survey, and compares these to other acute trusts in England and to the trust's performance in the 2013 survey. The findings are arranged under six headings – the four staff pledges from the NHS Constitution, and the three additional themes of staff satisfaction, equality and diversity and patient experience measures.

Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2013). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2013). An equals sign indicates that there has been no change.

STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

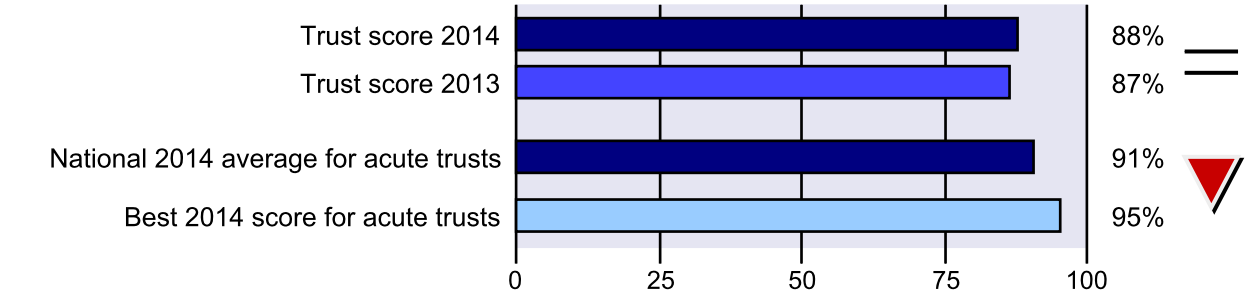
KEY FINDING 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better) *Percentage score*



KEY FINDING 2. Percentage of staff agreeing that their role makes a difference to patients

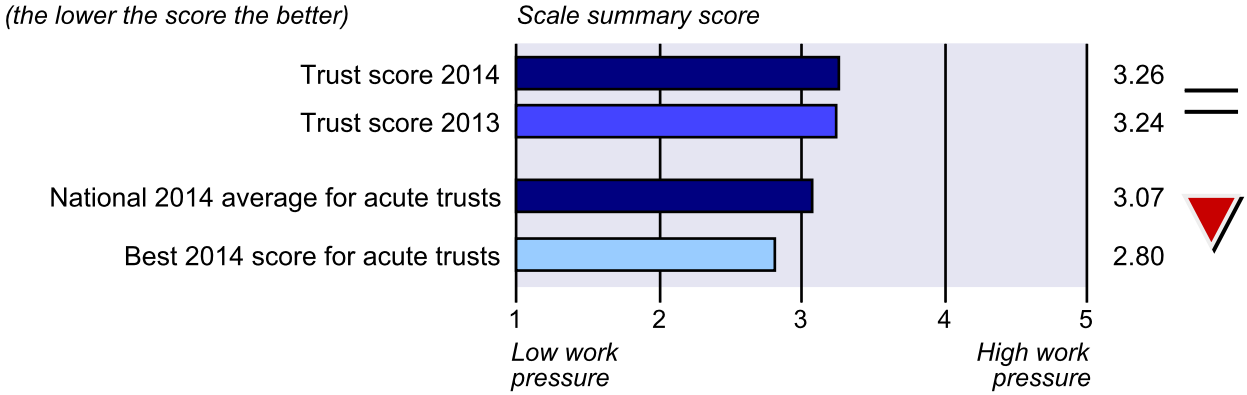
(the higher the score the better) *Percentage score*



[1]Questionnaires were sent to all 6297 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

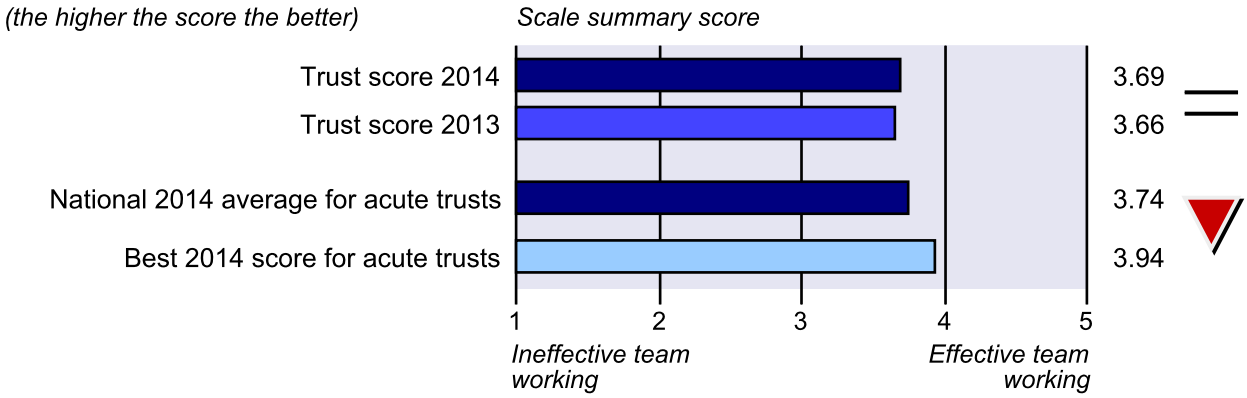
KEY FINDING 3. Work pressure felt by staff

(the lower the score the better)



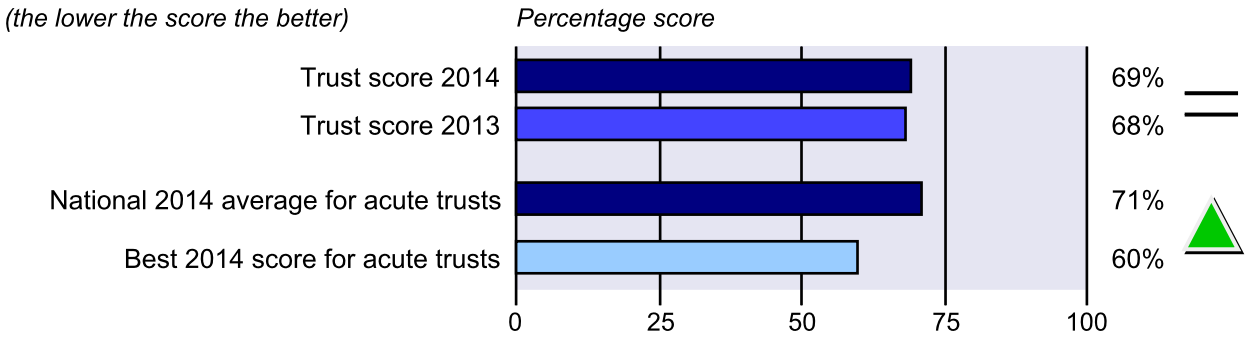
KEY FINDING 4. Effective team working

(the higher the score the better)



KEY FINDING 5. Percentage of staff working extra hours

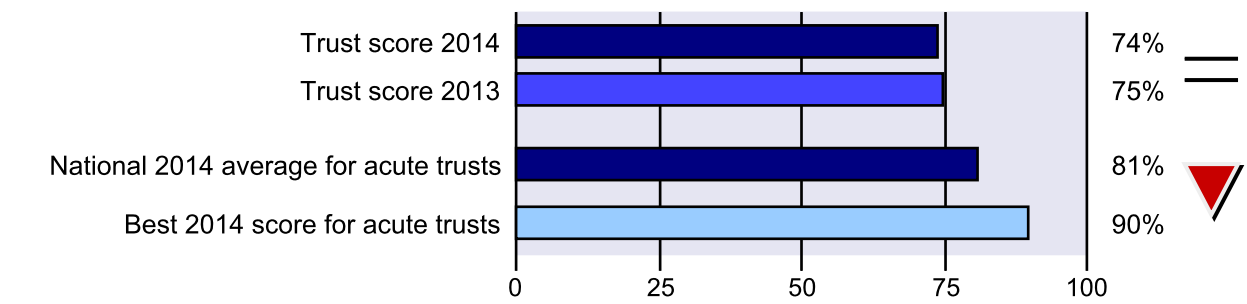
(the lower the score the better)



STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

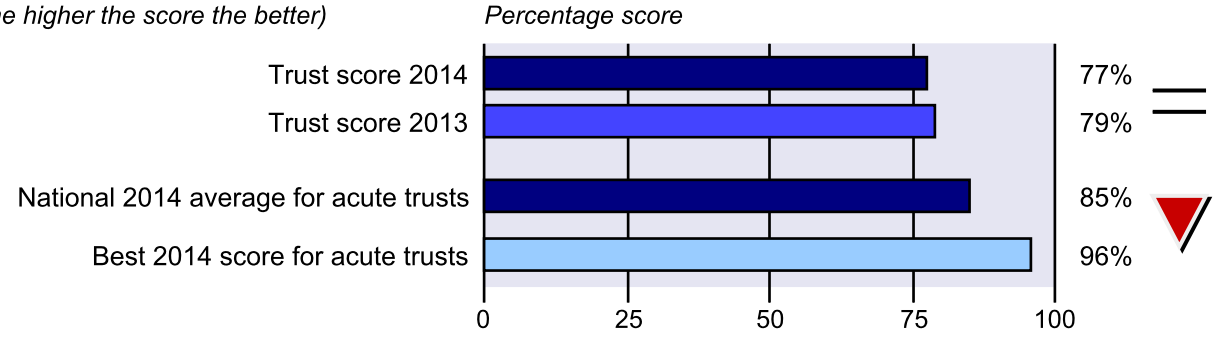
KEY FINDING 6. Percentage of staff receiving job-relevant training, learning or development in last 12 months

(the higher the score the better)



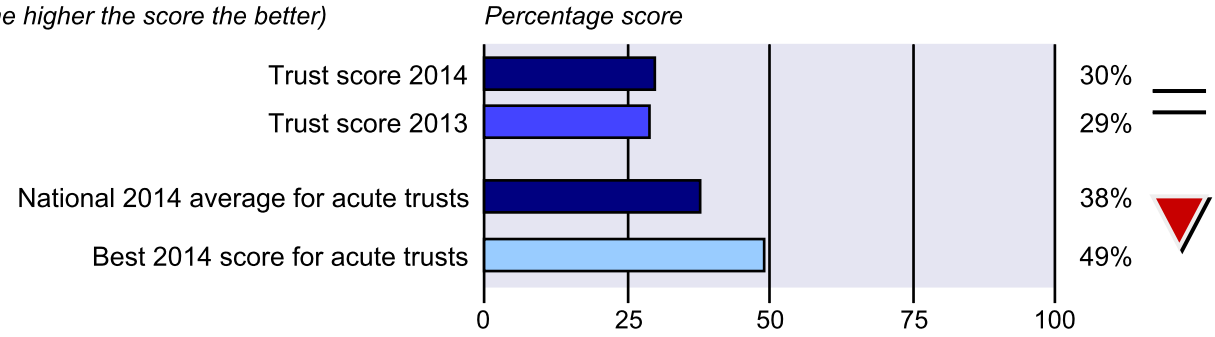
KEY FINDING 7. Percentage of staff appraised in last 12 months

(the higher the score the better)



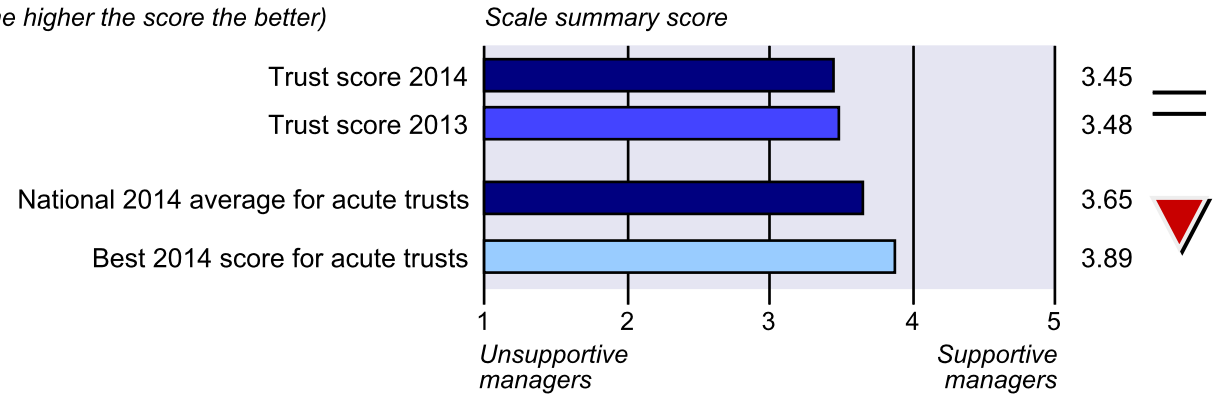
KEY FINDING 8. Percentage of staff having well structured appraisals in last 12 months

(the higher the score the better)



KEY FINDING 9. Support from immediate managers

(the higher the score the better)

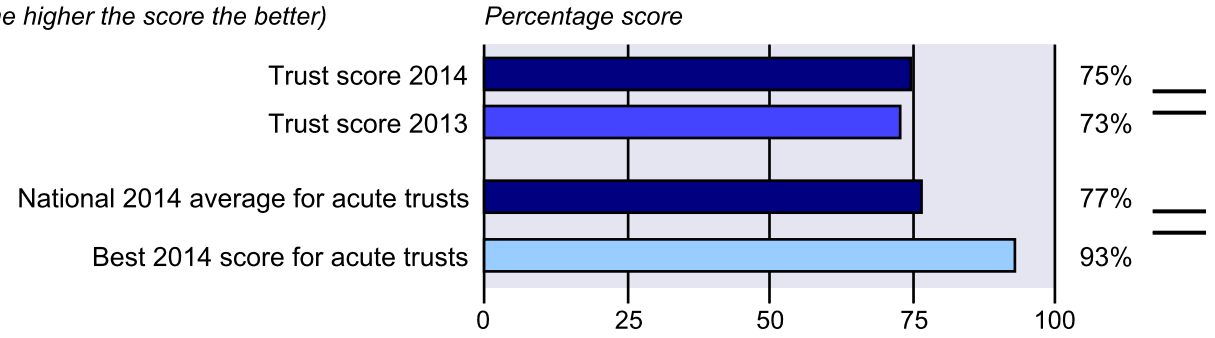


STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Occupational health and safety

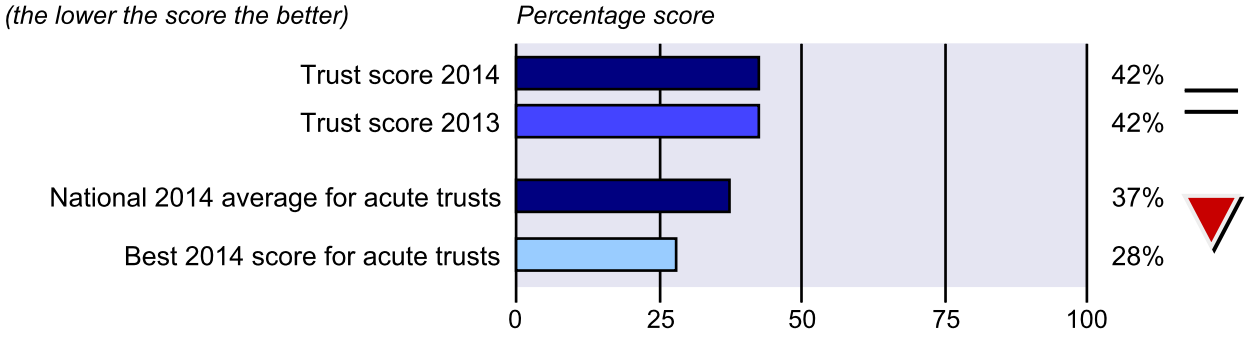
KEY FINDING 10. Percentage of staff receiving health and safety training in last 12 months

(the higher the score the better)



KEY FINDING 11. Percentage of staff suffering work-related stress in last 12 months

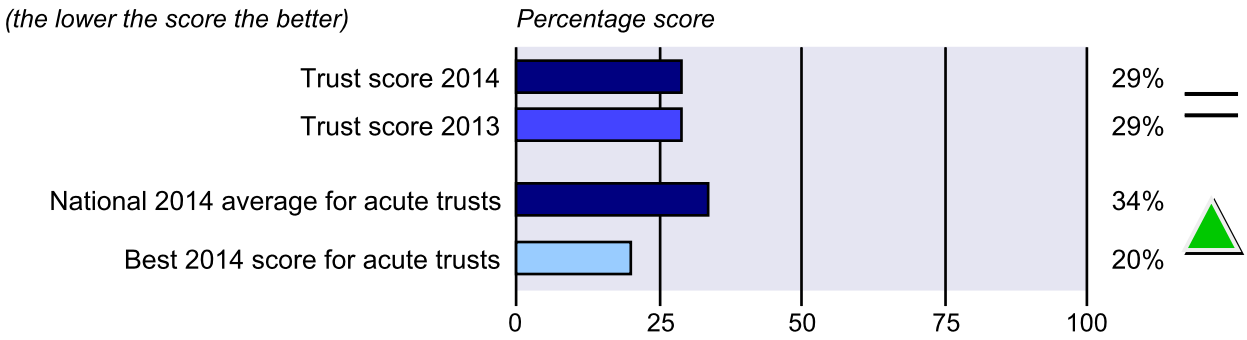
(the lower the score the better)



Errors and incidents

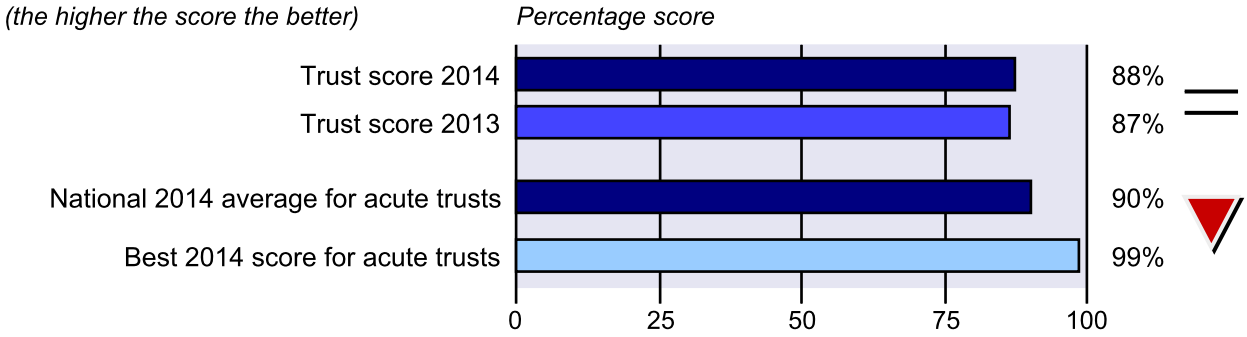
KEY FINDING 12. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



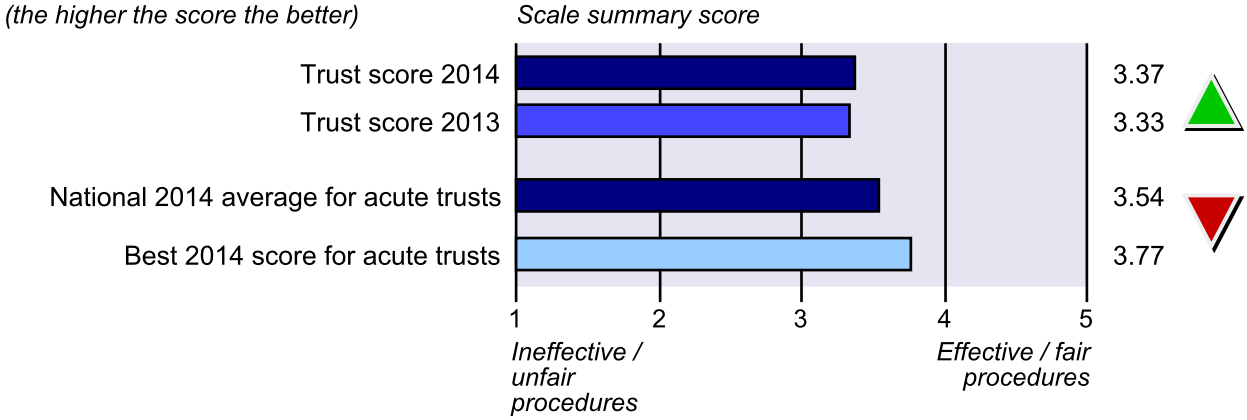
KEY FINDING 13. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



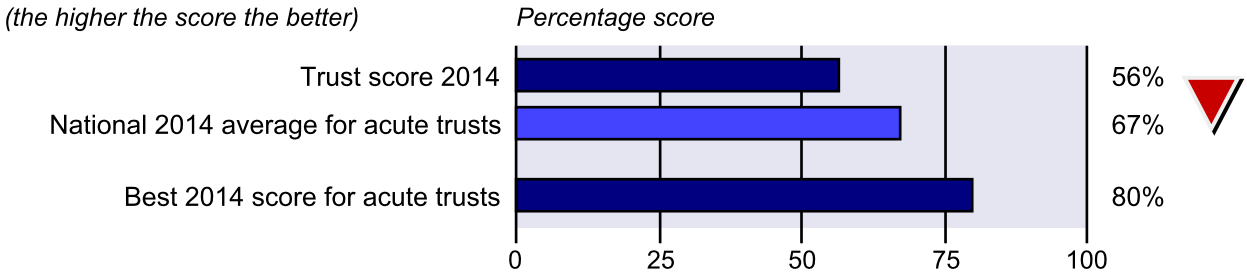
KEY FINDING 14. Fairness and effectiveness of incident reporting procedures

(the higher the score the better)



KEY FINDING 15. Percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice

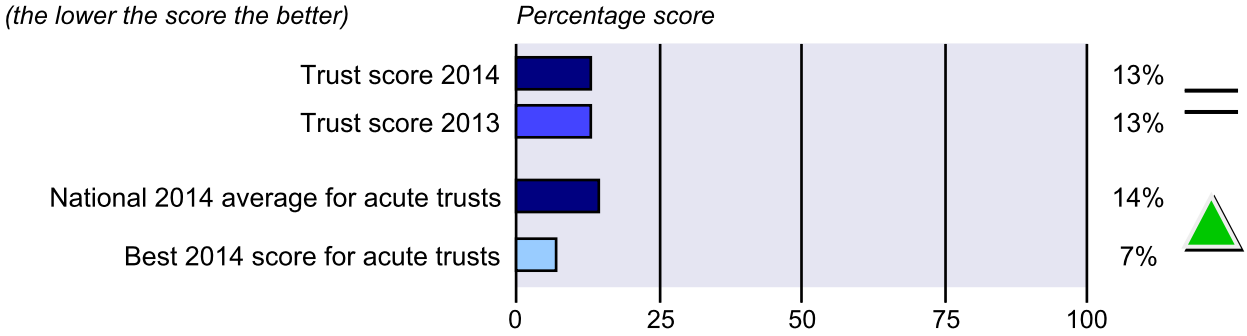
(the higher the score the better)



Violence and harassment

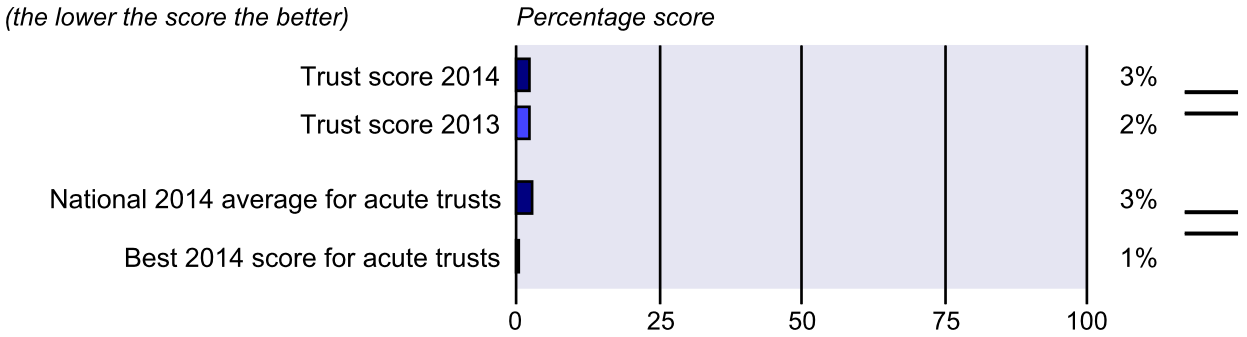
KEY FINDING 16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



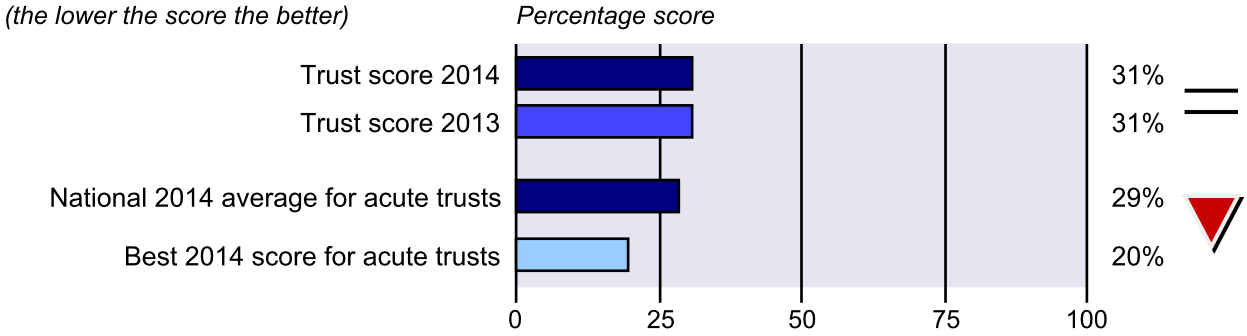
KEY FINDING 17. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



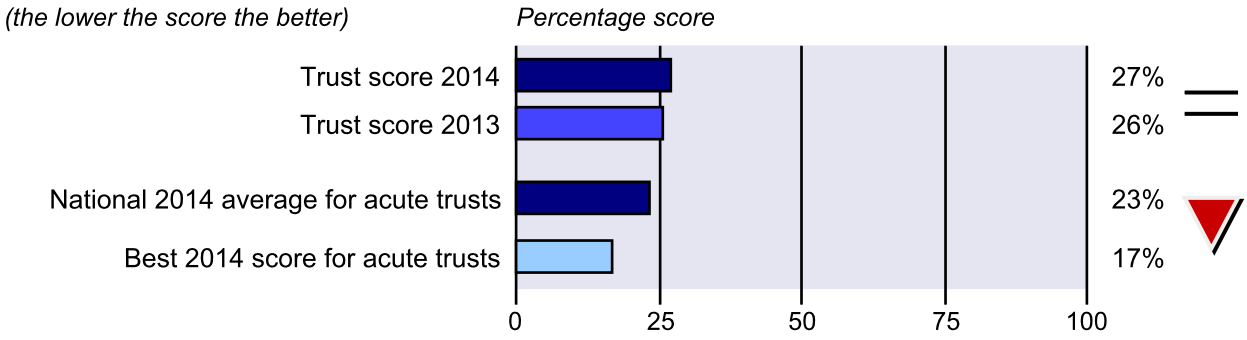
KEY FINDING 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



KEY FINDING 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

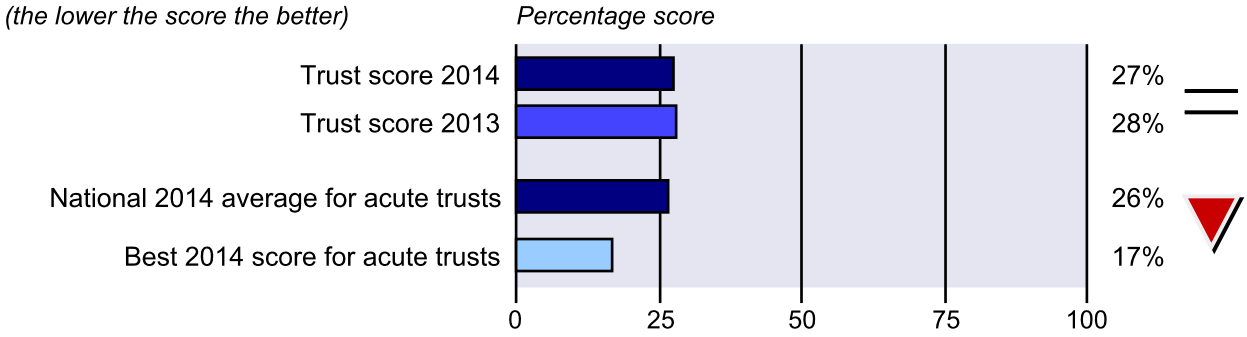
(the lower the score the better)



Health and well-being

KEY FINDING 20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell

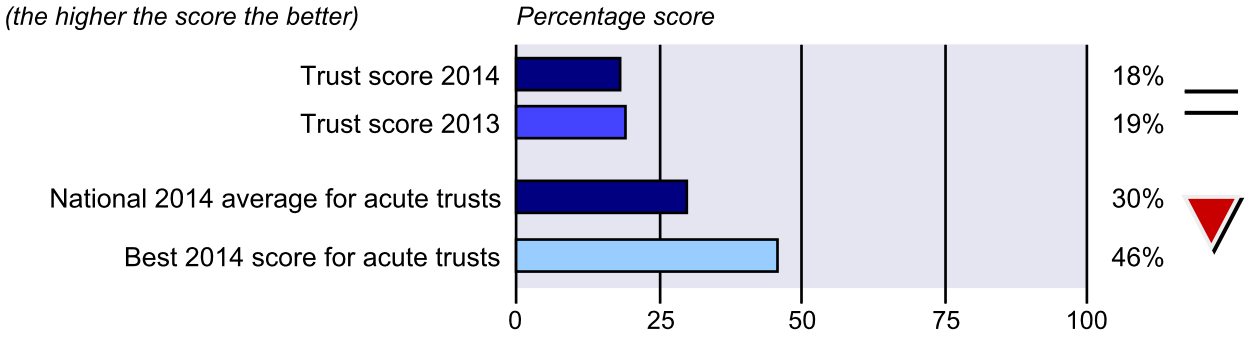
(the lower the score the better)



STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

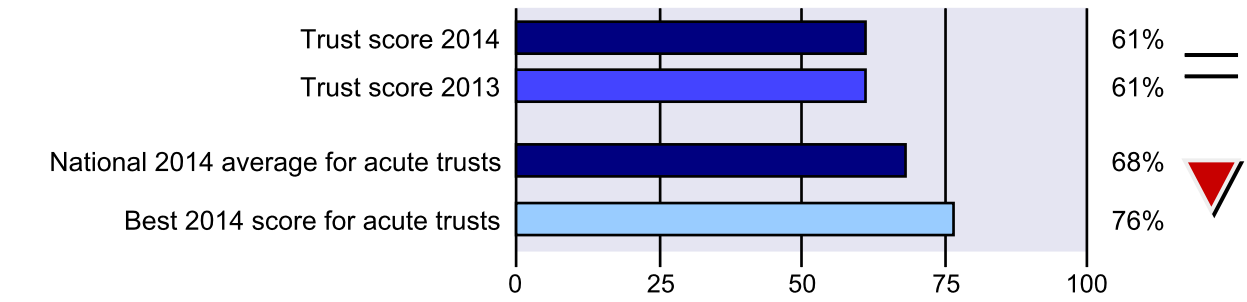
KEY FINDING 21. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 22. Percentage of staff able to contribute towards improvements at work

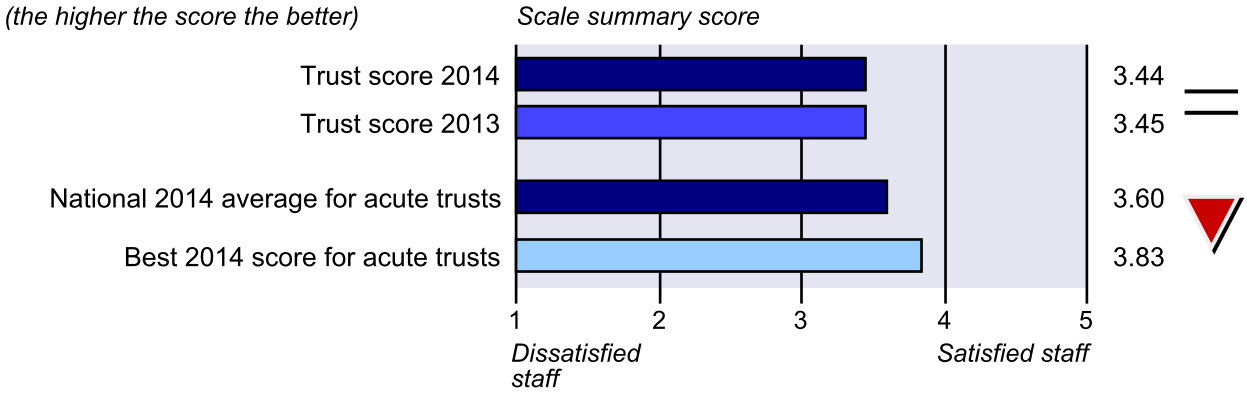
(the higher the score the better)



ADDITIONAL THEME: Staff satisfaction

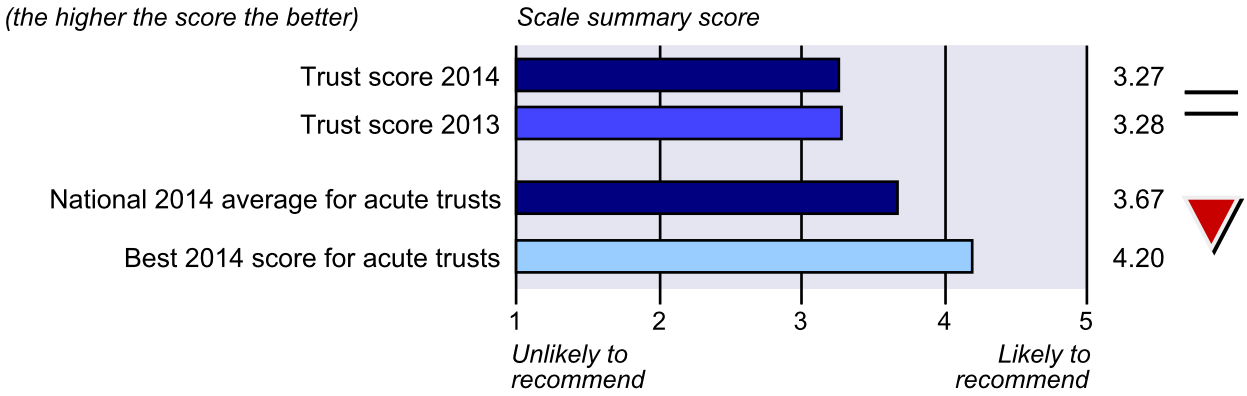
KEY FINDING 23. Staff job satisfaction

(the higher the score the better)



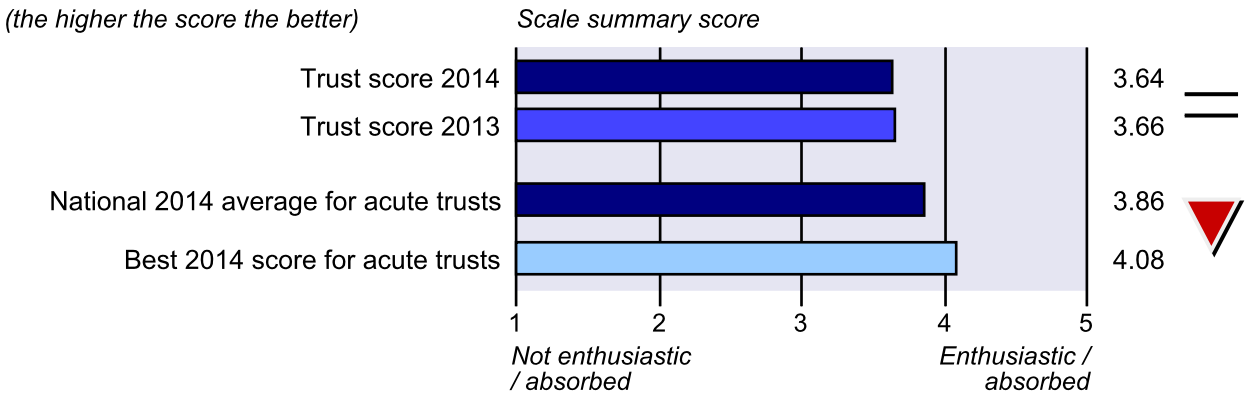
KEY FINDING 24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



KEY FINDING 25. Staff motivation at work

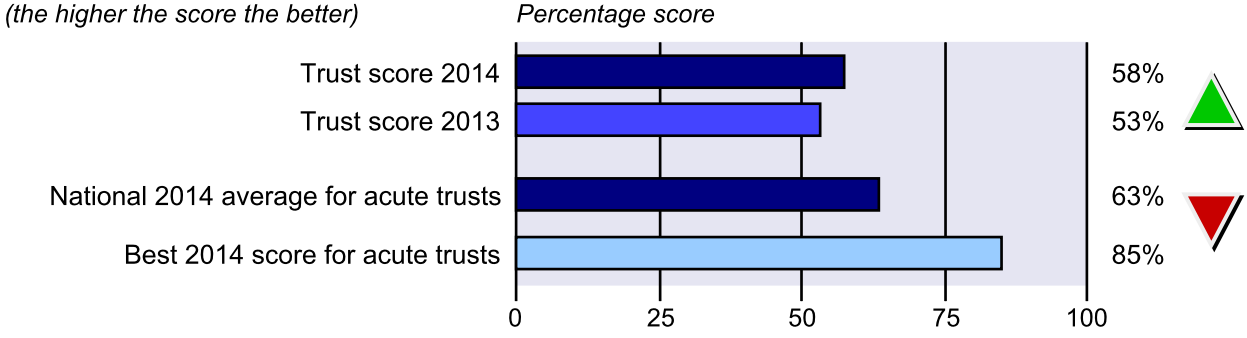
(the higher the score the better)



ADDITIONAL THEME: Equality and diversity

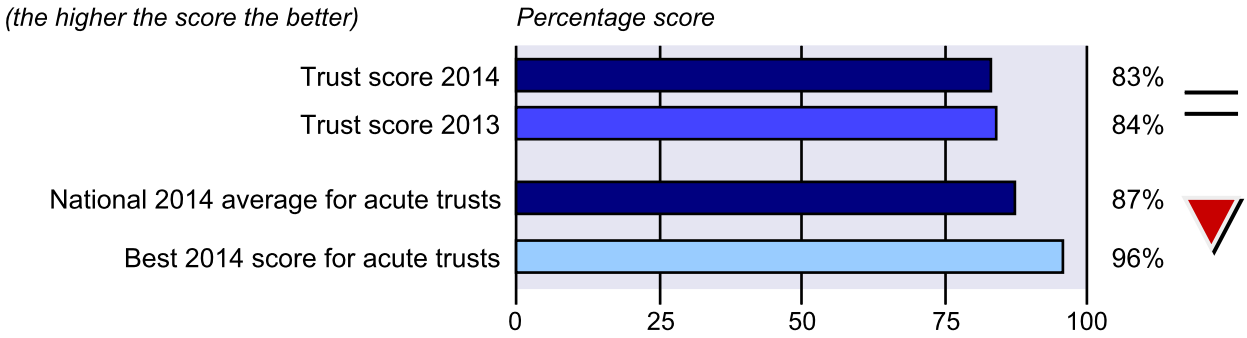
KEY FINDING 26. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



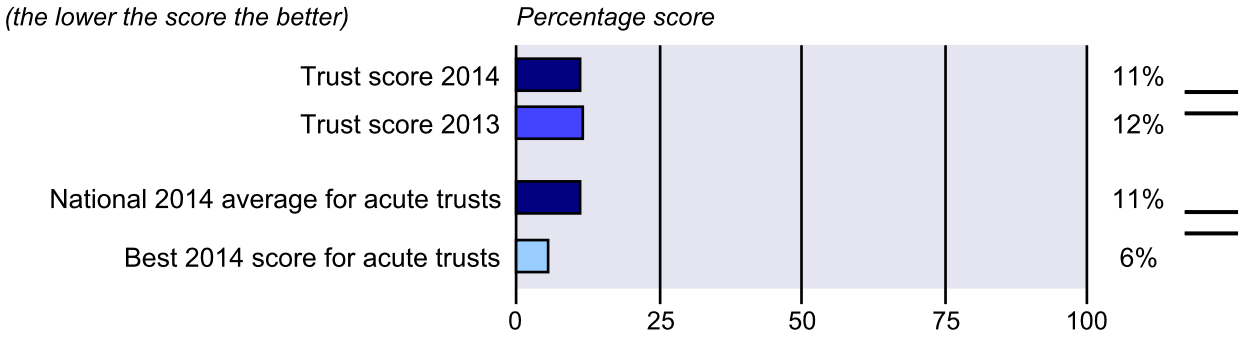
KEY FINDING 27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion

(the higher the score the better)



KEY FINDING 28. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)

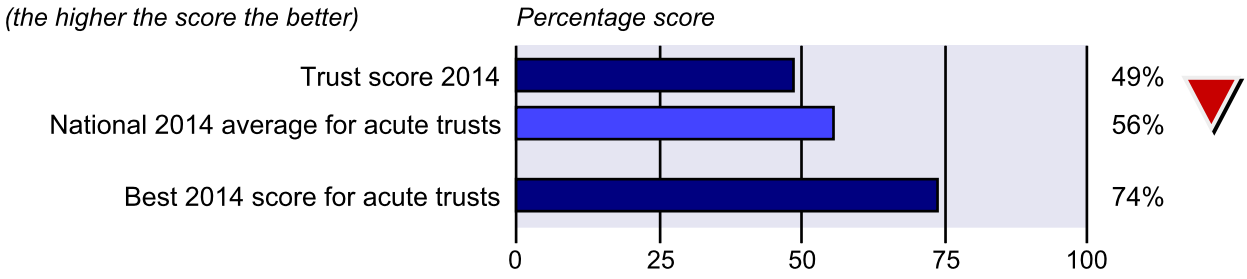


ADDITIONAL THEME: Patient experience measures

Patient/Service user experience Feedback

KEY FINDING 29. Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department

(the higher the score the better)



Staff Engagement Action Plan

Engagement Factor	Process	Lead	By When	Complete	Comments
1 Delivering great management and leadership					
	Implement Values and Behaviours Action plan.	LKM	Dec-14	✓	See separate action plan
	Develop and introduce a communication toolkit for all manager which outlines "how we do things" here at ESHT e.g. hold team meetings, know the names of all your team, back to the floor days.	JF	Mar-15		Work in progress on producing a guide for all managers about expectations. The first draft being drawn up
	Review our current process for Organisational Change with a view to introducing a more informal element to the process so that staff are consistently involved in change from the beginning	JG	Sep-15		Will discuss further with human resources in January 2015 to agree a possible date for implementation. Meeting with HR planned for February Meeting has been held with Human Resources - agreed to discuss with trade unions and a number of managers with a view to identifying the process and what additional skills managers may require
	Each manager to work with the communications team to ensure that their communication plans are in place whenever we have changes/introduce something new	SG	Apr-15		
	Introduce a mentoring programme	JW	May-15		Programme currently being advertised
	Roll out Internal first line Managers Programme	LM	Feb-15	✓	Programme currently being advertised
	Set up a multi professional sub group of the Education Steering group to develop further leadership development training- possible ideas include Leadership programme for New Consultants, Team Coaching	LM	Mar-15	✓	First meeting to be held in March 2015
2 Enabling involvement in decision-making					
	To hold staff focus groups / staff forum four times a year to triangulate data from Staff Survey and Staff Friends and Family test to identify priorities	JW	Dec-15		We need to review these staff focus groups in light of the recommendations from the communications review and themes to be given linked to FFT/Staff Survey

Engagement Factor	Process	Lead	By When	Complete	Comments
	To run Listening conversations in areas that have specific issues linked to staff survey/FFT.	JW	May-15		We have looked at the data from the staff family and friends tests and identified those staff groups who scored the highest in not recommending the trust as a place to work. We will be holding staff conversations in these areas. JW to prepare an implementation plan to feed into this, building in outcomes from staff survey and FFT and will also include Medical staff. JW targeting OOH and Clinical Admin Teams
	Publish an annual programme for Leadership Conversations and for the Leadership Conversations to be seen as a method of involving Leaders in the decision making processes.	LM	Feb-15	✓	All dates circulated
	Review whether each Clinical Unit could have a link Director(executive or non executive)who would ensure that the CU's are kept up to date with latest development and feedback relevant information to the Trust Board	MG	May-15		
3 Supporting personal development and training					
	Improve awareness of learning and development opportunities to all staff	LKM	Dec-14	✓	Met with Suzanne Gooch to discuss how to advertise more widely . Weekly e mail about learning events coming up, Learning opportunities available on the intranet via Learning and Development brochure. Going to include some articles in Connect about Learning opportunities available. Targeted e mails re bespoke pieces of training
	Continue with existing range of learning opportunities	LKM	Dec-14	✓	Achieved.
	Develop annual learning plans for each clinical unit/directorate which are a summary of all learning and development needs identified through appraisal.	LKM	Mar-15		Meetings with CU leads arranged for Jan/Feb to discuss training needs. Funds will be allocated accordingly following these meetings
	Review approach to mandatory training with a view to introducing e-assessments and therefore release some time for staff to do other job related training	LKM	Mar-15		Pilot currently taking place re Health and Safety training in Uckfield and Lewes

Engagement Factor	Process	Lead	By When	Complete	Comments
	Medical Educational Supervisors Workshop	MD	Apr-15		4x half day workshops scheduled to run late Jan to April 2015. (over 50 educational supervisors registered)
	Trainee Reps Workshops for Medical Staff	MD	Sep-14	✓	Held 29 Sept 2014 for new and continuing Reps (12 attended) co-facilitated by MD and external educational consultant. Feedback was very good to excellent. Reps email group set up as an action with regular communications to this key group of trainee doctors.
	Educator Standards and Charter of Trainer & Trainee Professional Responsibilities for Medical Staff	MD	Jan-15	✓	Documents sent to all trainers. The latter document also sent to Trainee Reps.
	To work with trade union learning reps and managers to carry out a training needs analysis for bands 1-4 and raise the profile of learning opportunities.	LM	Sep-15		First meeting due to take place in March 15 . Plan to hold some awareness events as part of Adult Learners week
	Ensure that all staff are aware of the importance of Appraisal as a key tool for valuing and supporting staff	LM	On-going		
	Review how social media can help communicate the learning and development that is available for staff	LM	Sep-14		

Engagement Factor	Process	Lead	By When	Complete	Comments
4 Ensuring every role counts					
	To develop the work we have already started, "We are proud of . . . " and ensure this is shared with other staff, patients and commissioners	LKM / JF	On-going		This work is on-going but the trust has presented at the KSS Leadership Conference in November showcasing some of the work we have done with the IV team . We have also run a Listening conversation on chronic pain that included patient representatives, GP's. The Project Search programme has gathered momentum and increased our profile in the local community. Ensure more is included from Service areas.
	To ensure staff feel both confident and empowered to raise concerns. This will include a section in the managers toolkit on how managers implement trust policy, signposting how staff can raise concerns , agreeing a mechanism for giving feedback after a concern has been raised and developing ways of sharing any learning	EK/JG	Apr-15		
	To develop the Corporate Calendar to include both internal and external awards that we can nominate staff for.	JF / SP	Mar-15		Nominations invited for staff annual awards which we will also begin to use for external awards. Increase current nominations received - staff side to help promote this
	Medical Staff Undermining and Bullying Behaviours workshop on 20th January 2015.	MD	Jan-15		Half day workshop targeted at PGME Exec Group, College Tutors Clinical Leads, General Managers and selected L&D/Corporate staff.
	GMC "Mock" Survey	MD	Feb-15		Due to be sent out to all doctors in training currently in the Trust to get intelligence on the key issues ahead of the actual Survey.
	Develop a staff forum to include looking a forum where staff can state their views(Graffiti Board)	LM	Mar-16		
	Developing citizenship across the trust so that there is a sense that we are all working together and "on the same page"	LM	Mar-17		
	Raise the profile of Staff engagement on the Trust website . Consider Reviewing the staff Room page to make it more appealing /interactive	tbc	tbc		

Engagement Factor	Process	Lead	By When	Complete	Comments
	Refresh the monthly staff awards and advertise this more frequently	SP	Apr-15		Internet page has been refreshed. Discussing how we can advertise more widely
5 Promoting a healthy & safe work environment					
	See Health and Well Being action Plan	CL	On-going		Schwarz rounds to be introduced in May 2015 . Resilience Training to be introduced targeted at high risk areas.
	Introduce Impact groups	KB	Sep-14		A pilot will be discussed at Matrons meeting on 11th March

East Sussex Healthcare NHS Trust

Date of Meeting:	25.03.15
Meeting:	Trust Board
Agenda item:	10
Subject:	Research Update - Quality, Safety and Performance
Reporting Officer:	Dr Hughes

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

Purpose:

Update Trust Board onperformance and R&D 5 year strategy outcomes to date.

Introduction:

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

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

- Awaiting Q3 performance outcomes from KSS CRN
- The R&D 5 year strategy was approved by Trust Board in September and this report seeks to update re the completed strategy outcomes.
- This report also seeks to inform the Trust Board where potential risks are evident in relation to strategy outcomes.

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.

NIHR funding will be reduced by 10% in 15/16

Assurance Provided:

Commencement of work streams to actively seek success within R&D performance and ESHT 5 year R&D strategy.
Performance for 14/15 is below requirements. However, positive feedback has been gained from performance review meeting with KSS who identify support for R&D initiatives taken to date.

Review by other Committees/Groups (please state name and date)**:**
R&D Operational Working Group

Proposals and/or Recommendations
Key objectives within the strategy require continuing high level, Trust board support to enable success.

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 – R&D Manager	**Contact details:** Liz.Still@esht.nhs.uk 01323 413880

East Sussex Healthcare NHS Trust

Research and Development - update

1. Introduction

1.1 Participating in clinical research is in the interests of ESHT, and we have an obligation to contribute. (NHS Constitution 2009)
ESHT provides opportunities to take part in multi-national and international studies by providing an integrated Clinical Research Dept that currently has studies open in 15 clinical specialties.
The studies are interventional and in general are phase III or IV clinical trials.
We also offer opportunities to take part in observational research studies

2. Background

2.1 R&D 5 year strategy was approved at September 2014 Trust Board meeting.

2.2 Performance in initiating and delivering clinical research – submission to NIHR and publication on a publicly accessible part of the Trust website are compliant.

3. Main content of the report

3.1 **R&D 5 year strategy** was approved at September 2014 Trust Board meeting.

3.1.1 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 participate in. - incomplete

3.1.2 A statement regarding commitment to research will be in all staff job descriptions.

3.1.2.1 Awaiting confirmation of completion from Director(s) of Nursing and Human Resources - Incomplete

3.1.3 Ensure appropriate and effective allocation of Supportive Professional Activity (SPA) linked to specific research activity through job planning.

3.1.3.1 Potential risk to recruitment and research participation if job planning does not include appropriate research activity SPA or withdraws them from research active clinicians.

3.1.4 The R&D Steering Group will hold an annual research meeting –20th March 2015. Applications for poster and oral presentations have been received as well as applications to attend the meeting. A total of 6 oral presentations have been selected from 11 submitted and 38 submissions to display posters. Prof Cohen will undertake the welcome address and Dr Walmsley will chair meeting.

3.2 Performance and Delivery of research

The second submission of required ESHT performance and delivery data was uploaded to NIHR by required target date – Complete.

3.2.1 Links to ESHT data on publicly accessible part of the Trust website went live on 4/11/14. http://www.esht.nhs.uk/research-and-development/ and http://www.esht.nhs.uk/research-and-development/performance/ - Complete

3.2.2 Continue to await NIHR Q3 performance confirmation. However, ESHT database suggests NIHR recruitment target will not be met. (14/15 NIHR Target set is 727. Recruitment to date is 427). This is due to several issues.

3.2.2.1 R&D Department was reconfigured April 2014 to enable research nurses to have clear line management and accountabilities within R&D. This had previously been line managed within Clinical Units with varying effect. The generic workforce required is in development. It is beginning to show improvement but work is continuing to ensure support from clinicians related to SPA activity.

3.2.2.2 There has been reliance on highly interventional studies with low recruits, but maximal time requirement. Also requiring extensive follow-up – and hinders further recruitment to studies. Observational studies are being actively sought.

3.2.2.3 Active consideration of low performing studies and whether closure is required to enable efforts to be diverted.

3.2.2.4 Improved recruitment compared to 13/14 –when 334 patients were recruited to research studies in total.

3.2.2.5 Opened studies in novel areas of research within the Trust – Anaesthetics, Neurology, Palliative care, Uro-gynaecology, and one dementia study in local care homes. This is a positive move for patients.

4. Conclusion/Recommendation

4.1 R&D Manager has met with Director of Nursing and Medical Director responsible for governance and discussed the key objectives within the strategy which require high level, Trust board support to enable success. They include the following:

- Create accountability for the strategy within Clinical Units, departments and across professional groups; performance managing their commitment to research with appropriate SPA allocation
- 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.

4.2 To underpin performance and delivery by effective use of generic research workforce supporting research active clinicians. Encouragement of research activity in novel research areas is continuing to develop and will be threatened by reduction in CRN KSS funding. This will require use of R&D capacity funding in the short term to keep staffing stable.

Name of Author **Liz Still**
Title of Author **R&D Manager**

Date **7th March 2015**


East Sussex Healthcare NHS
NHS Trust
Annual Scientific Meeting
Friday, 20th March 2015
Medical Education Centre, EDGH
Improving Patient Care through our Research
We are seeking presentations/posters and attendees from ESHT and Local Trusts.
The Research and Development department would like to invite you to join us for this annual event. This is our second meeting.
Last year we received excellent presentations from Rheumatology, Cardiology, Physiotherapy, Orthopaedics, Pain Management and Surgery. We also displayed over 50 posters as part of this inaugural event. The meeting was very well received.
This year we have chosen a theme which seeks to celebrate the impact research has on improving patient care.
This is an opportunity to exhibit the research and audit work undertaken by those working within the Trust, or completed as part of health care improvements and self-development.
This is a great opportunity to network and enhance research activity further.
Provisional Programme:
10.00- Registration
- Full programme including guest speakers:-
Professor Gordon Ferns, (Clinical Director, Kent Surrey and Sussex Clinical Research Network)
Dr Anne Mandy, Director of Post Graduate Studies, Brighton Doctoral College
plus several oral presentations (TBC)
- Buffet lunch provided - An opportunity to view poster presentations
- Session to include local Education initiatives
Everyone is welcome to join us and we look forward to welcoming you
- so please register with R&D now as places are limited.
ResearchandDevelopmentDept@esht.nhs.uk
For more information on submitting abstracts for poster and oral presentations, please contact:-
Liz Still – R&D Manager or Teresa Baumber – R&D Governance Co-ordinator, 01323 417400 (13)3042 or e-mail
Teresa.Baumber@esht.nhs.uk

East Sussex Healthcare NHS Trust

Date of Meeting:	25th March 2015
Meeting:	Trust Board
Agenda item:	11
Subject:	Progress report on Maternity and Paediatric Services following reconfiguration
Reporting Officer:	Amanda Harrison

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

Purpose:

The attached report has been compiled by the Clinical Commissioning Groups with input from the Trust to provide an update the HOSC on service improvements and progress made following the Better Beginnings consultation undertaken in 2014.

A review of the clinical evidence, and of the findings from the public consultation, resulted in the CCGs' Governing Bodies unanimously agreeing on the following configuration of services:

- Birthing services retained at all three current sites (Crowborough, Eastbourne and Hastings)
- Consultant-led maternity services provided at the ConquestHospital, Hastings
- Two midwife-led birthing units provided at Crowborough and Eastbourne
- Short-stay paediatric assessment units provided at both Eastbourne and Hastings
- Inpatient (overnight) paediatrics, the special care baby unit and emergency gynaecology co-located at the same site as the consultant-led maternity service.

Following the agreement of the configuration of services, the CCGs created a 'Better BeginningsImprovement (BBI) Board. Senior clinicians from the Trust attend this Board along with the Director of Strategic Development and Assurance. The BBI Board gathered the recommendations of the HOSC and feedback received by the public during the pre-consultation and consultation engagement activity and developed an action plan to support both the CCGs and the Trust in improving services, which the BBI Board has been overseeing through regular meetings and delegated workstreams. Progress on the action plan is included at Appendix A.

In addition to overseeing service improvements, the CCGs continue to monitor the quality andperformance of all commissioned services, including maternity and paediatrics, with a particular emphasis on gaining assurance about the on-going safety and sustainability of these services. This data is presented in Appendix B

Introduction:

The action plan compiled by the BBI Board is divided into key areas for action that have been grouped into:

- Midwifery Care Pathways
- Access to urgent paediatric care
- Communications plans to support the changes

In addition the Trust has developed an internal action plan which addresses those areas where improvements have been identified and these are within the Trust's remit to deliver without external input.

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

The Board is asked to note that work on midwifery care pathways and access to urgent paediatric care is ongoing and that this work will need to conclude before further action is taken to optimise service provision in these areas.

The report provides (in Appendix B) considerable evidence that performance has been improved and sustained against a number of quality metrics that have been subject to regular monitoring throughout the period of temporary reconfiguration and following the conclusion and decision making on permanent configuration of services

Benefits:

The report demonstrates that action has been taken following the Better Beginnings consultation to address the recommendations made by the HOSC and that the changes made to configuration of these services have resulted in improvements in service quality.

Risks and Implications

Work in two key areas is ongoing and the trust will be unable to develop full forward plans for midwifery led care and urgent paediatric care until these are concluded

Assurance Provided:

Strategic Objective 1 risk 1.1
Strategic Objective 2, risk s 2.1and 2.3

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

Proposals and/or Recommendations

The Board is asked to note the report and the assurance given 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?
N/A

For further information or for any enquiries relating to this report please contact:	
Name: Dr. Amanda Harrison, Director of Strategic Development and Assurance	**Contact details:**amanda.harrison11@nhs.net

Eastbourne, Hailsham and Seaford CCG
Hastings and Rother CCG
High Weald Lewes Havens CCG

Report: **Better Beginnings reconfiguration of maternity and paediatric services:** progress report on the implementation of the service reconfiguration

To: East Sussex Health Overview and Scrutiny Committee

From: AmandaPhilpott, Chief Officer for Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG
Wendy Carberry, Chief Officer for High Weald Lewes Havens CCG

Date: 16 March 2015

Recommendations: The HOSC is asked to note the improvements outlined in the report and the action to address recommendations made by HOSC in implementing the agreed service configuration as an outcome of Better Beginnings.

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1. Glossary

A&E	Accident and Emergency Department
BBA	Born Before Arrival / Assistance
BSUH	Brighton and Sussex University Hospitals NHS Trust
CBC	Crowborough Birthing Centre
CCG	Clinical Commissioning Group
EDGH	Eastbourne District General Hospital
EMU	Eastbourne Midwifery Unit
ESHT	East Sussex Healthcare NHS Trust
HOSC	East Sussex Health Overview and Scrutiny Committee
LOS	Length of Stay
MLU	Midwifery Led Unit
MSW	Maternity Support Worker
MTW	Maidstone and Tunbridge Wells NHS Trust
NHS	National Health Service
SSPAU	Short Stay Paediatric Assessment Unit

2. Background

2.1 Throughout 2012, the NHS Sussex Together programme reviewed maternity and paediatric services across Sussex as part of their programme of work. They concluded that there was a pressing need to change maternity services at East Sussex Healthcare NHS Trust (ESHT) to ensure that patients using these services received high quality, safe and sustainable levels of care. The “pressing need to change maternity services in ESHT“ was recommended due to particular pressures on middle grade staffing, medical trainee numbers and experience, and the number of Serious Incidents.

2.2 The CCGs in East Sussex led a review of maternity and paediatric services in the County. This included an extensive programme of clinical and public engagement which commenced in July 2013.In March 2013, ESHT took a decision to temporarily reconfigure its maternity and paediatric services on the grounds on patient safety; this was implemented in May 2013.

2.3 In 2014, the three CCGs in East Sussex held the 'Better Beginnings' public consultation on the sustainable future of maternity, inpatient paediatric and emergency gynaecology services. A review of the clinical evidence, and of the findings from the public consultation, resulted in the CCGs' Governing Bodies unanimously agreeing on the following configuration of services:

- Birthing services retained at all three current sites (Crowborough, Eastbourne and Hastings)
- 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
- Inpatient (overnight) paediatrics, the special care baby unit and emergency gynaecology co-located at the same site as the consultant-led maternity service.

2.4 This was supported by HOSC, who agreed this decision was in the best interests of local health services.

2.5 Following the agreement of the configuration of services, the CCGs created a 'Better Beginnings Improvement Board.'[1] The Board gathered the recommendations of the HOSC and feedback from the public into an action plan to support both the CCGs and the Trust in improving services, which the Improvement Board has been overseeing through regular meetings and delegated workstreams. Progress on the action plan is included at Appendix A.

2.6 In addition to overseeing service improvements, the CCGs continue to monitor the quality andperformance of all commissioned services, including maternity and paediatrics, with a particular emphasis on gaining assurance about the on-going safety and sustainability of these services.

3. Purpose

3.1 The purpose of this report is to update the HOSC on service improvements to date (most of which have now been completed), and remaining improvements that are incorporated into Trust delivery plans.

3.2 The CCGs and the Trust continue to monitor the quality and safety of services, and for the assurance of the HOSC a*Quality and Safety Report*[2]is appended.This provides summary quality information and evidence of the impact of the agreed configuration.

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[1] The Better Beginnings Improvement Board includes clinical and executive membership from each of the three CCGs in East Sussex, East Sussex Healthcare NHS Trust (ESHT) and a HOSC councillor member.
[2] Appendix A: Maternity and Paediatrics *Quality and Safety Report,* March 2015

4. Key areas for action

4.1 This section of the report is divided into key areas for action that have been grouped into:

- Midwifery Care Pathways
- Access to urgent paediatric care
- Communications plans to support the changes.

Midwifery Care Pathways

4.2 A key finding from the consultation and also a recommendation from the HOSC was that the maternity pathways for women in the North Weald should be improved to reflect women's cross-border scanning and birthing choices.

4.3 The Better Beginnings Improvement Board established a Midwifery Care Pathways Working Group[3] which hasworked with local providers to evaluate and improve midwifery care and pathways for all women in East Sussex, including a review of the care pathways for theMLUs in Eastbourne and Crowborough.

4.4 Together with providers and a patient representative, the group has designed and agreed a pathway that is intended to supportan excellent service for women in East Sussex, regardless of whether their care pathway crosses county borders.

4.5 The Group has also explored ways that the current issues might be helped in the short-term, for example improved access to sonography and clearer choices for women around ante and postnatal care or preferred place of birth.

4.6 The midwifery teams will continue to work to minimise issues with cross boundary care. Information for women and their partnershas been developed and improved, including information about the birthing options available to them and what would happen in the event of a transfer being required. A final agreement from all providers regarding the improved pathway of care is anticipated in April 2015. It is expected that the new pathway will address the key issues raised during consultation, for women in the North Weald choosing to give birth at Crowborough.

4.7 The midwifery led unit in Eastbourne is working well and there are mitigations in place to support cross-border working for both low and high risk Seaford women booked at BSUH.This includes women receiving local antenatal care from ESHT midwivesafter attending BSUH-run clinics in Peacehaven to book at the Royal Sussex County Hospital in Brighton. Routine scans are done by ESHT's sonographers, with bloods and any additional scanning undertaken by BSUH.Local scanning is already available at EDGH for women booked with

[3]The Midwifery Care Pathways Working Group is chaired by Dr David Roche (GP and Governing Body Member of High Weald Lewes Havens CCG). Membership includes patient representation and the Heads of Midwifery from ESHT, MTW and BSUH.

ESHT, and this will remain in place.Learning from this is informing progress on developing pathways between providers for women in the Crowborough area.

4.8 Other actions that were already in place, or have been implemented since the CCGs' decision include:

- risk assessments are undertaken throughout the antenatal pathway to establish preferred place of birth and birth plan in line with clinical need and women's choice
- a named midwife system is in place
- obstetric clinics continue to be provided at all three sites, unchanged from the pre-reconfiguration model
- facilities are available on all three sites to allow partners to stay overnight
- space is available where women in early labour can stay, rather than going home, where appropriate
- a workforce development plan is in place which supports the recruitment of midwifery and obstetric (and paediatric staff)
- at the Conquest there are two reserved parking slots immediately outside the delivery suite for women in labour and increased short stay bays close to the maternity entrance.

Access to Emergency Paediatrics

4.9 The Better Beginnings Programme Board established a Paediatrics Working Group[4] to review how and when patients were accessing inpatient paediatric and SSPAU services, and to consider how access could be improved in line with patients' needs.

4.10 A detailed review of the data was undertaken to test whether children were being seen in the most appropriate setting for the care that they needed. This assessment indicated that many children could be managed more comfortably by paediatric nurses in the community (e.g. those coming in for planned treatment such as IV antibiotics or wound dressings). Similarly, many children with minor conditions would be most appropriately managed in primary care or in the community, if the right services were available.

4.11 Key findings from the group's work included:

- Peak times of demand for the SSPAU tend to be between 9am and 11am and 3pm and 8pm
- The length of time children spent on the SSPAU ranged from 10 minutes to 8 hours

[4] The Paediatrics Working Group was chaired by Dr Mark Barnes (GP and Governing Body Member for Eastbourne, Hailsham and Seaford CCG). Membership includes clinical and executive representation from the CCGs and the Trust.

- The majority of children spent around 2-3 hours in the SSPAU
- Weekend activity at the SSPAU is small with an average of 8 children attending the unit over a full weekend
- On average 22 children per month are transferred from the EDGH SSPAU to the Conquest Hospital. This figure is in line with previous information provided to the HOSC
- The majority of child transfers occur towards the end of SSPAU opening times if, following treatment, overnight care is required.
- Of the children admitted to the inpatient unit, over 50% stay in hospital for under one day.

4.12 This gave rise to a wider piece of work that has been initiated to ensure that the approach incorporates how children and families access urgent services more generally, so a comprehensive pathway is developed that includes:

- enhanced GP and primary care provision
- enhanced community paediatric nursing provision
- enhanced paediatric provision in A&E

4.13 This whole model will ensure that children are treated appropriately in the right setting for their care.The work is progressing with a view to agreeing the model by the summer of 2015.

4.14 The agreed current services, including the opening hours of the SSPAU, remain unchanged in the interim and the quality and safety of the service continues to be monitored.

4.15 Other actions that were already in place, or have been implemented since the CCGs' decision include:

- a GP Education Programme on common illnesses requiring paediatric care and paediatric pathways is being rolled out across East Sussex
- a review of community paediatric nursing provision, including a review of the hours this service is available
- outreach staffin place as a point of contact between parents and hospital consultants through the children's community nursing services
- stay-over beds available as appropriate for parents with children at the inpatient unit.

Communications and Engagement

4.16 The CCGs developed a communications and engagement strategy which was supported by the HOSC. The agreed outcomes of the communications and engagement strategy have been completed, with the exception of a final wider piece of communications work which will be undertaken to inform stakeholders how the actions relating to the HOSC and consultation recommendations have been delivered, and to conclude the Better Beginnings programme.

- A birthing choices leaflet has been designed and tested with the patient group; the leaflet includes:
  - Information about birthing choices

- Information on transfer protocols, explaining what happens if a transfer is required during labour
- The promotion of normal births
- Guidance for partners on staying overnight with their partners
- Information on when to travel and early labour

- The CCGs are commissioning the development of an information app for healthcare services in East Sussex which will include appropriate information about maternity and paediatric services.

- The Trust website is under on-going review; the following updates have been made:
  - virtual tours of the maternity sites (these are also being updated)
  - breastfeeding information is up to date (the Trust has also successfully recruited a feeding specialist)
  - support regarding birth planning
  - the promotion of normal births
  - up to date information regarding paediatric services and pathways

- There is also improved communications for families and users of maternity and paediatric services, including:
  - appropriate information regarding travel to and from services
  - information about the loan of baby seats

5. High quality, safe, sustainable services

5.1 The CCGs and ESHT continue to monitor these services and agreed indicators across a range of measures are regularly reported to the CCGs' Governing Bodies and the Trust board.These quality reports demonstrate that the safety and quality of services has been sustained since the reconfiguration are publicly available on the organisations' websites. A report including the indicators agreed with HOSC can found at Appendix 2.

- end –

APPENDIX A: PROGRESS AGAINST ACTION PLAN – Updated March 2015

These actions are jointly owned by Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and High Weald Lewes CCG.

	Recommendation		Action Required	Timescale	R.A.G.	Update
1a	**Configuration of Services:** The future configuration of maternity services in East Sussex should provide for the best geographical spread of locations across the County whilst ensuring safe and sustainable services. Options 1, 2, 3 and 4 limit the choices of locations available therefore none of these four options should be selected.	1a (i)	To ensure that HOSC recommendations are available to the Governing Bodies as part of a suite of information and evidence.	25-Jun-14	Complete	HOSC recommendations were included in the Governing Bodies papers for decision making. Governing Bodies unanimously agreed on Option 6.
1b	**Configuration of Services:** The choice of service configuration should take account of a range of factors including: financial viability; population size and growth; the needs of specific population sub-groups; deprivation and associated risk factors	1b (i)	Information and evidence packs, including finance paper, health needs analysis, updated equality analysis and Options Appraisal Report are published in advance of meetings to ensure Governing Body members have enough time to read the contents	25-Jun-14	Complete	Papers for the Governing Bodies meetings on 25 June 2014 were published and provided to members one week in advance of the meetings. At the Governing Bodies meetings, following verbal presentations of the clinical case for change, the development of the options and other evidence and information, Governing Body members also took time to ask many questions regarding the evidence, several in relation to the factors highlighted by the HOSC recommendation, to assure that informed decisions were made. In addition, the options appraisal process that provided a report to the Governing Bodies considered all of the issues raised in detail as part of assessing the options against the appraisal criteria.
		1b (ii)	Governing Body demonstrate an understanding of the evidence and information provided to them, to support their decisions	25-Jun-14		
1c	**Configuration of Service:** Changes to the configuration of	1c (i)	The Better Beginnings Service Implementation Group will deliver	08/04/2014	Complete	The implementation of Option Six is supported by an investment plan,

	Recommendation		Action Required	Timescale	R.A.G.	Update
	maternity services should include upgrading and modernising facilities, with due consideration given to the number of beds required across all type and location of unit. HOSC wishes to see excellent, modern Obstetric and Gynaecological services that put the needs of women and babies at the heart of these services in East Sussex.		its agreed objectives, including - The development of an investment plan, including capital expenditure for upgrading of facilities, to be published prior to close of consultation in order to support options appraisal and decision making.			including allocated spend for upgrading and modernising of services. This investment plan was published on the Better Beginnings website, and included capital expenditure for upgrading and modernising of hospital environments. The assignment of costings to the upgrading and modernisation of facility was informed in part by feedback from staff during consultation. The provision of a modern service was a key consideration of the options appraisal panel.
			Following HOSC decision on 28/07/2014, to develop a full implementation plan, informed by Staff and Service User feedback.	31/08/2014	Complete	The Improvement Board developed a full implementation plan following the HOSC decision on 28/07/2014.
			The working group will ensure that the implementation plans for reconfiguration includes upgrading and modernising of services, and that facilities are fit for purpose.	31/08/2014	Complete	ESHT continuously monitor bed numbers and adjust as appropriate, as part of normal ESHT operational business. The CCGs continue to monitor the quality of services as part of formal commissioning mechanisms. As part of this, the CCGs actively seek assurance that - environments are fit for purpose - capacity is appropriate to demand - access is appropriate to demand The Better Beginnings Service Implementation Group delivered the

	Recommendation		Action Required	Timescale	R.A.G.	Update
						A focus group with clinicians in relation to the SSPAU was held in August 2014, with the aim of improving Paediatric services in hospital, primary care and in the community.
				Ongoing	Ongoing	Improvements have taken place within the Conquest hospital and further action that may require capital investment is included as part of usual trust investment planning (2015/16 capital plan).
			Close working with the head of engagement to ensure that the needs of women and babies are at the heart of services in East Sussex.	31/08/14	Complete	Service User and Staff feedback continues to inform the ongoing development of services. Feedback from focus groups and staff input has been fed into the working groups.

	Recommendation		Action Required	Timescale	R.A.G.	Update
2	**Maternity Services in High Weald:** The maternity care pathway for women in Crowborough and the North Weald needs to be addressed as a matter of urgency to include provision for reconnecting community midwifery with the birth choices now being made in practice by High Weald women: • Women should have the opportunity to give birth at CBC midwife-led unit with the option to go to Pembury seamlessly should an Obstetric service be required or desired • The administrative pathway barriers, such as formats of patient notes and booking arrangements operating differently in different trusts, must be resolved	2 (i)	A working group, led by a GP Governing Body Member for High Weald Lewes Havens CCG, and including clinical membership from ESHT and MTW will be established:	31/08/2014	Complete	Prior to the agreement to establish the Midwifery Care Pathway Working group, a meeting took place involving the Heads of Midwifery for ESHT and MTW, to begin discussions around the care pathway for women wishing to use maternity pathways between Crowborough Birthing Centre and Pembury. Dr David Roche, GP Governing Body Member for HWLH CCG, was identified as the Lead for the Working Group. The inaugural meeting took place in August 2014 and has met regularly since.

	Recommendation		Action Required	Timescale	R.A.G.	Update
	• Activity levels at CBC should be improved pending longer term management decisions such as reinstating Obstetric scanning services at CBC • The 'emergency transfer link' from the High Weald and Crowborough Birthing Centre (CBC) to Tunbridge Wells Hospital at Pembury must be strengthened as reflected in existing practice for women in distressed labour at CBC.		To identify, raise and resolve pathway issues and barriers (not already raised during consultation) relating to maternity services and transfer protocols in the High Weald, ensuring good clinical governance, communication and record keeping	31/8/2014	Complete	Transfer by ambulance from CBC to Pembury for women requiring 'Hot' transfer (e.g. Risk to life) has been established for many years and has proven to be robust. Women who have booked with ESHT, but decide then to travel to Pembury, can do so. These assurances will be tested as part of the CBC Working Group's objectives and are identified in the Communications Plan as information that will be used to market and promote the service. Protocols for transfer by ambulance from CBC to Pembury for women of less urgency (e.g. for pain relief) is an objective of the HWLH Maternity Care Pathway Working group Midwifery pathways that are intended to support an excellent maternity service (regardless of cross-boundary care) have been agreed by all providers.
			To ensure that the pathways for High Weald women reflect demand	31/03/2015	Ongoing	Midwifery pathways that are intended to support an excellent maternity service (regardless of cross-boundary care) have been agreed by all providers. *Ongoing work to be incorporated into High Weald Lewes Havens CCG and Trust planning.*
			To review booking processes and patient notes to improve maternity services for both providers		Ongoing	Improved liaison between providers in place. *Ongoing work to be incorporated into CCG and Trust planning.*
			To Actively promote the use of CBC, with the support of the communications and engagement		Complete	The marketing of CBC (and the EMU) was identified as an action in the Communications Strategy.The delivery of

	Recommendation		Action Required	Timescale	R.A.G.	Update
			working group and consider how activity at CBC might be improved.			the Communications and Engagement Strategy has been overseen by the Improvement Board, including the promotion of the MLUs and normal birth, and improvements to information given to mothers and partners about their birthing choices.
			Recognising that emergency transfer links, pathways and protocols are currently in place, to test that pathways are robust and known to staff		Complete	Robust transfer protocols are in place and staff are aware.
			To feed into the communications and engagement working group with regards to updates to services and pathways, so that the concerns of patients that were raised during consultation are addressed, and services are further promoted.		Complete	The Maternity Care Pathway Working Group has fed into the communications and engagement working group.
			The CBC Working Group will report into the Improvement Board, where progress against actions and milestones will be measured.	Ongoing	Complete	The Maternity Care Pathway Working Group has reported into, and been overseen, by the Better Beginnings Improvement Board
3	**Paediatric Services:** Both Eastbourne DGH and the Conquest need a Short Stay Paediatric Assessment Unit (SSPAU) that provides a level of service that is better aligned with peak periods of need than the current service. This will require :- a review of SSPAU opening hours, - consideration of how services can be provided outside normal opening hours and - a robust	3 (i)	The Better Beginnings Service Implementation Group, led by a GP Governing Body member and including senior clinicians and managers from the CCGs and ESHT, have identified the following objectives as part of their remit: - To identify, raise and resolve pathway issues and barriers (not already raised during consultation) relating to Paediatric services and	To be agreed following implementation of preferred option.	Ongoing	The Better Beginnings Service Implementation Group has completed an in-depth analysis of the activity and casemix of children using the SSPAUs. The analysis reviews current opening hours of both SSPAUs against demand. Further work is being carried out to identify the optimum opening hours and to consider how Paediatric services might be better aligned with other services, such as A&E. Through this

	Recommendation		Action Required	Timescale	R.A.G.	Update
	protocol on transfers to ensure that, for example, the intended destination is clearly communicated and agreed amongst all parties in a timely manner.		transfer protocols, ensuring good clinical governance, communication and record keeping- To analyse the activity and casemix of the SSPAUs, to better understand how the service might be developed- To be informed by the communications and engagement working group, in relation to the needs of service users and their families- To identify how Primary Care and Community pathways and services might be enhanced, supporting the development of the Paediatric service. - To meet with and be informed by Paediatric clinical staff when considering how services should be developed- To identify the different models of care for the SSPAUs that would support an excellent Paediatric service in East Sussex and to present these to the Governing Bodies for agreement- To oversee implementation of service development in the community and in the local hospitals and to work closely with GPs, with the support of the CCGs' locality engagement team, on the enhancement of Paediatric care in primary careThe Better Beginnings Service Implementation Group has been established for several months and has supported the			analysis and as part of the working group objectives, the working group has begun to develop the potential models of SSPAUs. A meeting has taken place between the GP Lead and the Paediatric clinical staff, and feedback has been captured. A second, follow-up meeting with a smaller group of consultants took place in August for some more detailed work on how the service might be developed. The working group has now completed the SSPAU assessment and is developing models of care for access to urgent paediatrics that includes GPs, community paediatric services and A&E. The CCGs' Governing Bodies will be presented with the findings of the working group, to agree on the best model of care for Access to Urgent Paediatric Care. This recommendation is expected in Summer 2015.

	Recommendation		Action Required	Timescale	R.A.G.	Update
			programme by developing an investment plan for the options, which focussed on providing a sustainable, modern service. The implementation group will continue to report into the Better Beginnings Programme Board, where progress against milestones is measured.			
4a	**Paediatric Services:** Co-locating inpatient Paediatric services with a consultant-led Obstetric unit is appropriate based on the evidence available.	4a (i)	Ensure that clinical evidence supporting the colocation of Obstetric and Inpatient Paediatric Services is available to Governing Body members.	25/06/2014	Complete	The CCGs agree with and accept this recommendation which is reflected in their final decisions.
4b	**Paediatric Services:** The operation of the Special Care Baby Unit (SCBU) should be reviewed with the strategic clinical network to see whether Level 2 services would be more appropriate in future.	4b (i)	Liaise with the Strategic Clinical Network regarding a review of the SCBU level, and inform the HOSC of the SCN Response. Work closely with the Sussex and Surrey Area Team who commission specialist services, including neonatal care, on all matters relating to the neonatal services, to ensure the needs of East Sussex are fully reflected.	28/07/2014	Complete	The response from the SCN in relation to a review of the SCBU is attached to the CCGs Report to the HOSC (28/07/2014). The response includes a description of the different levels of SCBU and what each level provides. 'The Neonatal Network has been involved throughout the East Sussex process and has consistently reviewed activity as with all services in region; at present the activity would not suggest a higher level of unit is required or sustainable.' The CCGs will continue to work closely with the Sussex and Surrey Area Team through regular meetings, during which the neonatal activity will continue to be reviewed.
5a	**Implementation**The evidence and arguments supporting the CCGs' options have failed to convince the	5a (i)	The Communications and Engagement Working group will develop a Communications	28/07/2014	Complete	A communications strategy has been developed by the Communications and Engagement Working Group, and has

	Recommendation		Action Required	Timescale	R.A.G.	Update
	campaigning organisations and many individuals of the need to change the configuration of the services. This points to the requirement, whichever option is selected, for an effective and innovative communications strategy to be in place in advance of full implementation.		strategy for Implementation. The delivery of strategy milestones will be the responsibility of the working group, but will be overseen by the Better Beginnings Improvement Board, which will build on the strategy used for consultation. The communications strategy will be shared with the HOSC and ratified by the Better Beginnings Programme Board. The plan will be initiated once the implementation of the option has been agreed. A process will be established to ensure that the outputs from the strategy (e.g. findings from service users or clinical engagement) will feed into the appropriate working groups to ensure that each workstream informs the other.			been shared with HOSC members in advance of HOSC meeting (28/07/2014). Lessons Learned from independent analysis have been incorporated into the strategy. The strategy aims to address the needs of all stakeholders, including members of the public, service users, targeted groups, GPs, providers, schools and interested bodies. The chair of the communications and engagement working group is also a member of the Better Beginnings Service Implementation Group and the Better Beginnings Programme Board. The actions outlined in the delivery plan were initiated immediately following HOSC decision on 28/07/2014, for example briefing stakeholders on the outcome of the meeting. The strategy and action plan was agreed and monitored by the Better Beginnings Improvement Board. Most actions have now been complete. Further actions on raising awareness of access to urgent paediatric care is aligned with that work stream and will be implemented upon agreement of model of care. This action is agreed as complete, with remaining actions to be incorporated as part of business planning for any further implementation of models.
5 b	The (Communications) strategy needs to be targeted particularly at future users of the service to provide clearer information and advice about:	5b (i)	Stakeholder mapping to be undertaken to ensure communications strategy is appropriately targeted, with specific	28/07/2014	Complete	The Communications Strategy, as shared with the HOSC (28/07/2014) aims to address the needs of all stakeholders, including members of the public, service

	Recommendation		Action Required	Timescale	R.A.G.	Update
	risks, safety, choices of birth location, travel and transfers; and emphasise how and why longer travel times do not necessarily equate with increased risk.		focus on the factors highlighted in the HOSC recommendation.			users, targeted groups that might be differently impacted by service change, GPs, providers, schools and other interested bodies. Many elements of the strategy are particularly focussed on ensuring that current and potential service users are informed and have knowledge of how to access services. The strategy draws out each of the factors highlighted by the HOSC and shows the communication channels that will be used to inform and address concerns. These include, for example, use of the maternity pages on ESHT website. The strategy also considers how best to inform people and address concerns, in relation to a range of groups, for example those who do not access information through internet use, and those who mainly access information via smartphones.
		5b (ii)	Delivery plan to be initiated. Various messages to media prepared in response to potential HOSC decisions.	28/07/2014	Complete	The actions outlined in the delivery plan were initiated immediately following HOSC decision on 28/07/2014, for example briefing stakeholders on the outcome of the meeting.
		5b (iii)	The strategy will be agreed by the Better Beginnings Improvement Board on 20/08/2014	20/08/2014	Complete	The strategy has been agreed and overseen by the Better Beginnings Improvement Board.
6 a	Significant importance should be attached to understanding and communicating the lessons resulting from serious incidents; such learning and resulting actions should be included in future monitoring reports	6a (i) and 6b (i)	The CCGs will continue to monitor quality of the service through regular clinical quality review meetings and through assessment of the data that is provided to the CCGs by Providers.	28/07/2014	Complete	The CCGs continue to monitor the quality of services and to analyse provider data. The CCGs and the Trust continue to monitor the quality and safety of services and have reported the ongoing

	Recommendation		Action Required	Timescale	R.A.G.	Update
	to HOSC.					improvements in quality and safety of maternity and paediatric services to the HOSC. This action is marked as complete, as this now forms part of business as usual for both the Trust and the CCGs.
6 b	A 'clinical safety champion' should be appointed for Obstetrics and Gynaecology who would liaise with the Royal Colleges and other bodies to collate clinical, safety and outcomes data and ensure that safety lessons are effectively put into practice.		A nationally agreed process is in place to enable CCGs and Trusts to follow up on lessons learned from Serious Incidents to ensure mitigating actions are put in place, where possible. Any trends identified in serious incidents will be highlighted to the HOSC, by the CCGs. The Head of Quality continues to review and report on: - BBAs - Caesarean Rates - Serious Incidents (Maternity and Paediatrics) - Induction Rates - Medical Staffing (Maternity and Paediatrics) - Midwifery Staffing - Patient Experience and Feedback (Maternity and Paediatrics) - Complaints (Maternity and Paediatrics) - Activity (Maternity and Paediatrics) - Transfers (Maternity and Paediatrics) - Information relating to other trusts The ESHT Clinical Director will continue to liaise with Royal Colleges and other bodies, and with the Head of Quality as clinical			

	Recommendation		Action Required	Timescale	R.A.G.	Update
			champion to ensure that safety lessons are effectively put into practice, using a nationally approved process. A copy of the approved process for monitoring, reporting and learning from serious incidents to be included in the report to the HOSC (28/07/2014)			
7 a	A strategy should be put in place to 'vision' a centre of excellence that will successfully attract training grade clinicians to Obstetric and Paediatric services in East Sussex.	7a (i)	The Head of Quality will monitor the improvement of clinical training and supervision, through reports from the Royal Colleges and other bodies. The Head of Quality will monitor the use of locums and temporary clinical staff as part of Quality review. The Head of Human Resources, the Clinical Director and the Head of Midwifery for ESHT will link with the Programme to ensure that any concerns around staffing are highlighted early and to identify any actions required to mitigate staffing concerns. The delivery of the communications strategy and this action plan will support ESHT in becoming the employer of choice for midwives, training grades and other Obstetric and Paediatric clinicians, including the marketing and promotion of East Sussex Healthcare Trust as a preferred employer of choice. The	As per action plans (ongoing)	Complete	The models of care for Maternity, Paediatrics and Gynaecology were developed with a focus on improving services in East Sussex, with aspirations to becoming a centre of excellence. Improvements to clinical staff training and supervision, and reductions in the use of locum and temporary medical staff, have been reported by the Royal Colleges. These improvements will continue to be reviewed and reported by the Head of Quality. The marketing of ESHT as an employer of choice has been identified as an action in the communications strategy. The Head of HR for ESHT, the Clinical Director and the Head of Midwifery are members of the Better Beginnings Implementation Group. The implementation plan for medical staffing is agreed as an objective of this group. The communications and engagement working group, and the service implementation group, are monitored in the delivery of their objectives by the Better Beginnings
7 b	Being able to retain and develop the skills of midwives is critical to providing a sustainable and safe maternity service in East Sussex. HOSC will require evidence that the significant role undertaken by midwives is given widespread recognition and especially that: • Protocols are established to ensure that midwives can make consistently accurate assessments of place for delivery and provide safe and effective antenatal risk assessments. • A strategy is put in place to ensure the effective support and retention of midwives in East Sussex.					

	Recommendation		Action Required	Timescale	R.A.G.	Update
			communication strategy will identify actions to recognise and promote the skills of midwives in East Sussex and will engage with midwives to ensure that any development to services is informed by them. Protocols for accurate assessments of place for delivery and risk levels of pregnant women are established and tested nationally.			Programme Board. ESHT midwives currently use the nationally regarded Maternity Early Warning System (MEWS) tool to assess the most appropriate place for women to deliver. Any changes to this will be made in line with national guidance. The Head of Quality monitors the quality of the maternity service. Any risks identified relating to midwife assessments will be reported and managed following the appropriate policies and procedures, and where appropriate, any trends in serious incidents will be reported to HOSC. The agreed option, which includes two standalone midwifery led units, promotes East Sussex as an innovative and desirable place for midwives to work. The trust has a workforce strategy and action plan in place of which maternity and paediatric recruitment and retention is part. The trust monitors staff satisfaction through a range of measures and acts on any findings. A review by the deanery has stated that the trust now offers much improved training opportunities.

-end-

APPENDIX B: Maternity and Paediatric Quality and Safety report: data to December 2014

1. Glossary

BBA	Born Before Arrival
BSUH	Brighton and Sussex University Hospitals NHS Trust
CBC	Crowborough Birthing Centre
CCG	Clinical Commissioning Group
CTG	Cardiotocographs
CQ	ConquestHospital
EDGH	EastbourneDistrictGeneralHospital
EMU	Eastbourne Midwifery Unit
ESHT	East Sussex Healthcare NHS Trust
HOSC	East Sussex Health Overview and Scrutiny Committee
HIE	Hypoxic Ischaemic Encephalopathy
LSCS	Lower Segment Caesarean Section
MLU	Midwifery Led Unit
MSW	Maternity Support Worker
MTW	Maidstone and Tunbridge Wells NHS Trust
NICU	Neonatal Intensive Care Unit
RCOG	RoyalCollege of Obstetricians and Gynaecologists
RSCH	RoyalSussexCountyHospital
NHS	National Health Service
SCBU	Special Care Baby Unit
SI	Serious Incident
SSPAU	Short Stay Paediatric Assessment Units
TWH	TunbridgeWellsHospital

2. Summary

2.1 Measurable safety improvements demonstrated within Trust Obstetric and Maternity services following the temporary reconfiguration of services in May 2013 and the subsequent decision post consultation have been sustained.

2.2 The Trust has reported significantly fewer maternity related Serious Incidents (SIs) following the reconfiguration of 07 May 2013 and similar incidents are not recurring.

2.3 The Trust has systems in place to undertake analysis of all incidents, and to feedback learning to all relevant staff. The quality of Serious Incident reporting has improved which provides further assurance around the Trust's ability to manage and implement learning.

2.4 The Trust has sustained a higher level of consultant presence on the labour wards (was 48hrs pre-configuration and is now 72hrs). This has translated into increased consultant involvement in decision making, increased consultant performance of operative obstetric procedures and direct supervision of junior doctors performing these procedures.

2.5 Safety has improved post reconfiguration as middle grade medical staff are now able to call upon the support and direction of the Consultant medical body in a timely manner. This is a result of the fact that these staff groups are now working on the same site. There is now a more advanced support structure for middle grade medical staff resulting in better outcomes for mothers and babies.

2.6 Reconfiguration has led to a significant decrease in the use of locum medical staff who are unfamiliar with Trust protocols, procedures and the physical environment of the maternity wards. This has led to fewer incidents, improved middle grade medical decision making and contributed to a safer environment for mothers and babies.

2.7 Maternity staffing issues such as short term sickness have occasionally affected the operational effectiveness of the midwifery led units leading to diverts and closure. Following reconfiguration the Trust is better placed to manage issues as they arise, redeploy staff and utilise assets more effectively. The Trust has demonstrated that they are able to achieve this in a safe, considered and systematic fashion.

2.8 The Trust is taking active steps to address midwifery staffing issues and has demonstrated improvements following reconfiguration in managing staff sickness.

2.9 One of the key improvements relating to maternity staffing levels is that post reconfiguration the Trust is no longer reliant upon the use of agency midwives. There is a stronger cadre of midwifery staff who are familiar with team processes, Trust protocols, guidelines and the physical environment which is crucial for providing a safe and quality service for mothers and babies.

2.10 The Trust continues to monitor both scheduled and unscheduled Lower Segment Caesarean Section (LSCS) rates and is not exceeding the national goal of 23% when measured over the year. Following the reconfiguration the middle grade medical staff decision making process and Consultant oversight has improved in relation to complications arising from Caesarean section.

2.11 The Trust continues to report babies Born Before Arrival(BBAs) when they occur. There has been no impact on mothers living in the Eastbourne area with regard to BBAs as a result of the reconfiguration. There continues to be an increase of BBAs reported in the Hastings and Rother area for mothers booked to give birth at the Conquest.

2.12 For those mothers who have experienced a BBA the Trust has confirmed that mothers and babies are triaged by a Community Midwife and if clinically indicated are advised to be transferred to the relevant maternity unit. The overwhelming majority of mothers who experienced a BBA underwent a homebirth and chose not to be admitted to hospital post-delivery. There have been no Serious Incidents post 07 May 2013 as a result of a BBA.

2.13 Patient experience continues to be reviewed and monitored by both the Trust and Commissioners in relation to both Maternity and Paediatric services. Themes and trends resulting from patient feedback are reviewed and incorporated into service provision. Analysis of patient feedback indicates no complaints related directly to the quality and safety of the maternity and paediatric configuration. This area continues to be monitored by both the Trust and Commissioners.

3. Monitoring the impact of the new configuration of services

The driver for the temporary and subsequent permanent single siting of obstetric and inpatient paediatric services was to ensure sustainably safe services. The CCGs have continued to monitor the quality and safety of the services currently being delivered, with an enhanced focus on key indicators that are most likely to be impacted by a change in service reconfiguration.

3.1 It should be noted that these form part of a wider set of indicators that continue to be monitored as part of the CCGs' clinical quality review meetings, and reported to the CCG Governing Bodies. ESHT also reports regularly to their Trust Board.

3.2 This report provides information against each of the key indicators agreed with the HOSC in January 2015.

Maternity Services

4. Serious incidents (SIs)

Position since 07 May 2013: **IMPROVED**

4.1 SIs are reported via the Trust DATIX system. All reported SIs are subjected to a full Root Cause Analysis (RCA).The Trust undertakes a review of contributory factors which have led to the occurrence of Serious Incidents.

4.2 The reduction in Serious Incidents following reconfiguration has been sustained

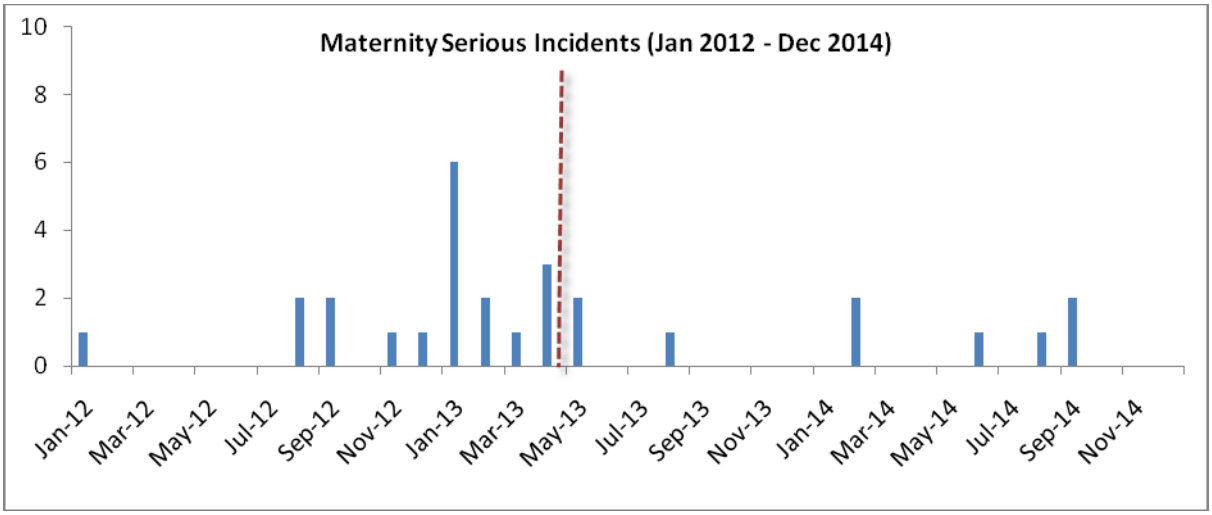
4.3 There have been no maternal deaths reported by the Trust since the reconfiguration of 07 May 2013.

4.4 There has been a decrease in babies withHypoxic Ischaemic Encephalopathy (HIE) and the maintenance of the traditionally low perinatal mortality rate.

4.5 Prior to reconfiguration a trend had been identified as a contributing factor to Serious Incidents occurring relating to the lack of substantive medical and midwifery staff. This led to an over reliance on middle grade locum doctors and agency midwives. This position has improved following reconfiguration and continues to be sustained.

4.6 Following reconfiguration there has been no key trends identified relating to medical and midwifery staffing levels

4.7 Graph 1: Maternity Serious Incidents (Jan 2012 - Dec 2014)



4.8 Table 1: Serious Incidents by month (Jan 2012 – December 2014)

January 2012 – December 2012												TOTAL
J	F	M	A	M	J	J	A	S	O	N	D	7
1	0	0	0	0	0	0	2	2	0	1	1	
January 2013 – December 2013												**TOTAL**
J	F	M	A	M*	J	J	A	S	O	N	D	12 (3*)
6	2	1	3	2	0	0	1	0	0	0	0	
January 2014 – December 2014												**TOTAL**
J	F	M	A	M	J	J	A	S	O	N	D	6
0	2	0	0	0	1	0	1	2	0	0	0	

3 reported SIs from 07 May 2013 (May to Dec 2013)

5. Lessons Learned

5.1 Learning to prevent Serious Incidents continues to be embedded within the Trust. Some examples of learning by theme are cited below:

Staffing

5.2 All incidents are reviewed and there have been no trends relating to medical staff and supervision following reconfiguration

5.3 Consultant presence on labour ward is sustained at 72 hours per week

Training

5.4 All staff undertake either K2 or the Royal College of Obstetricians and Gynaecologists(RCOG) CTG training package and this training is monitored

5.5 Additional training has been put in place for the paediatricians to support them in intubation and resuscitation of babies and discuss the details regarding preparation of babies who are to be retrieved to a Neo-natal Intensive Care Unit(NICU)

5.6 CTG training for all midwifery and medical staff is provided on a monthly basis. There is a comprehensive teaching programme for all staff who attend this session.

5.7 Monitoring of staff in terms of mandatory and additional updating is done by both midwifery supervision for midwives and by the annual appraisal for all staff

Root Cause Analysis (RCA)

5.8 Completed RCAs of Serious Incidents continue to be sent to all those involved in a case and shared with doctors and midwives at training sessions

5.9 RCAs continue to be sent to all midwifery matrons to share with their teams and discuss the learning points and recommendations

5.10 Multidisciplinary incident review meeting to discuss incidents from the previous 48-72 hours continues. This helps to ensure that if an incident is deemed to be serious it can be escalated promptly.

6. C-section rates (total, scheduled and unscheduled)[1]

Position since 07 May 2013: **NEUTRAL**

6.1 The Trust actively monitors C- Section activity in line with national guidance. The graphs below indicate the Trusts position against the:

- total C-Section rate
- scheduled C- Section rate
- unscheduled C- Section rate

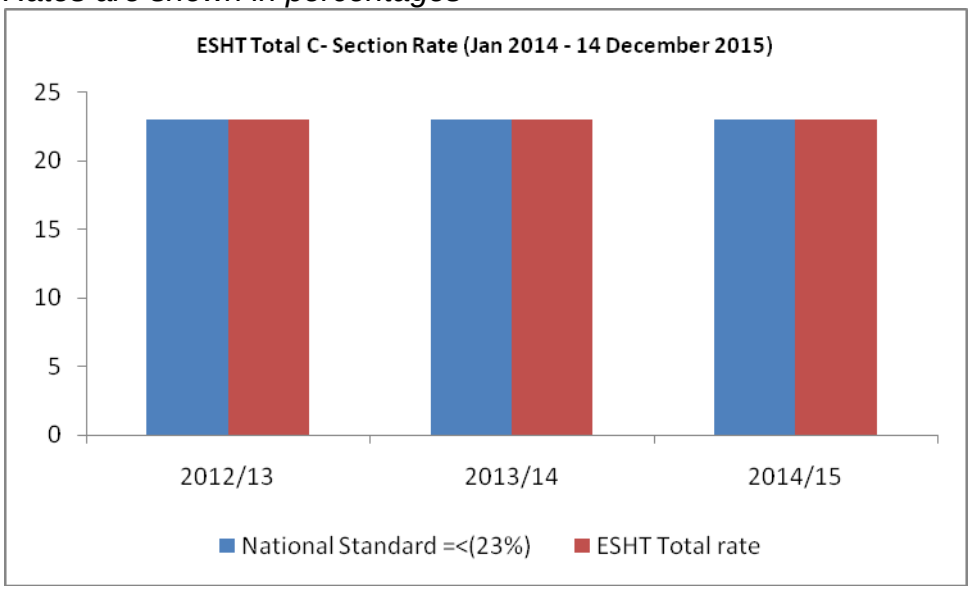
6.2 In 2012/13 and 2013/14 all three rates of total, scheduled and unscheduled were achieved at the level of the required national target standard

6.3 So far in 2014/15 for which the data is only complete up to and including November 2014 the planned rate is down by 1% and the emergency rate is up by 1%

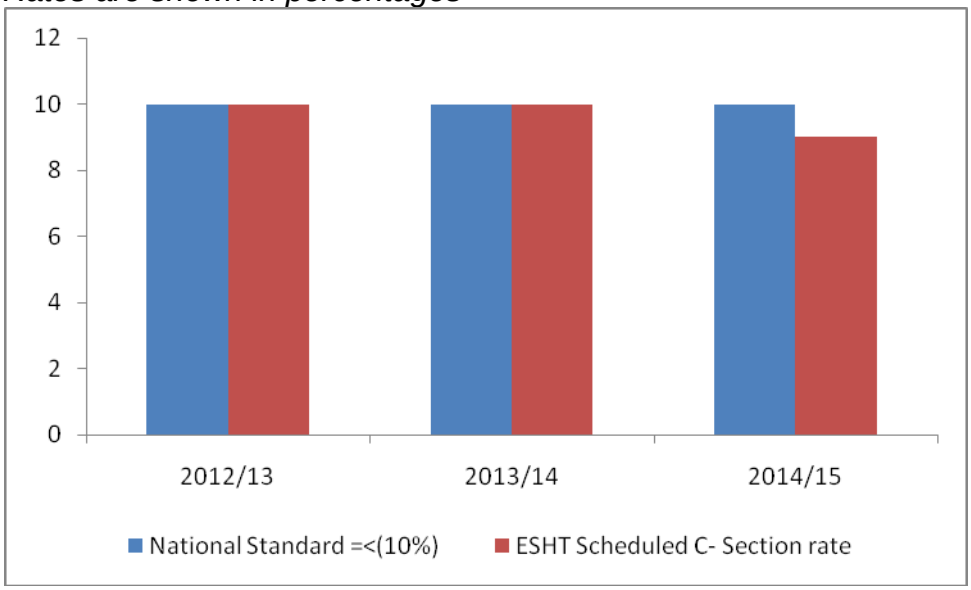
6.4 Despite an upward trend in LSCS rates throughout the country and also in ESHT prior to reconfiguration, ESHT has maintained a steady LSCS rate and within national goals of 23%. This rate has not been impacted by the reconfiguration.

[1] Source: Euroking extracts, January 2012 – 14 December 2014

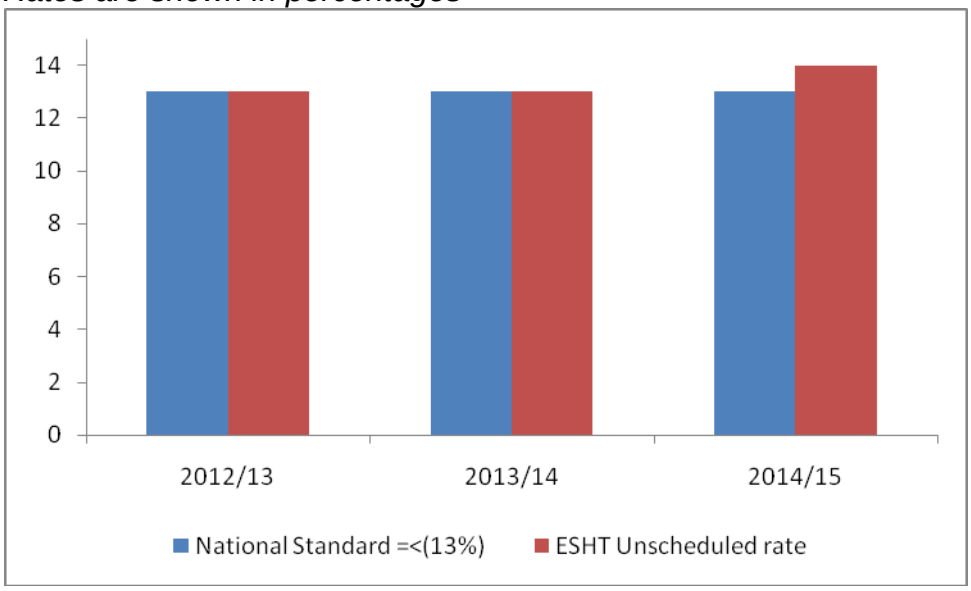
Graph 2: ESHT Total C- Section Rate (Jan 2012 - 14 December 2015)
Rates are shown in percentages



Graph 3: ESHT Scheduled C- Section rate (Jan 2012 - 14 December 2015)
Rates are shown in percentages



Graph 4: ESHT Unscheduled C- Section rate (Jan 2012 - 14 Dec 2015)
Rates are shown in percentages



7. Babies born before arrival (BBAs)[2]

Position since 07 May 2013: **NEUTRAL**

7.1 There is no nationally agreed definition for a baby born before arrival. For the purpose of this report the BBA definition refers to those babies born before the arrival of a midwife; as a result, even if a paramedic is in attendance it will still be a BBA. It should be noted this can give rise to slightly different figures being reported.

7.2 To address this the Trust has taken action to ensure that BBAs are reported in a consistent manner with sub categories of birth (for example, Born in transit in a car and Born in transit in an Ambulance), together with a conclusion as to whether the BBA was either “avoidable” or “unavoidable”. This will be fully implemented from 01 April 2015.

7.3 Following a BBA the mother and baby are reviewed by a Community Midwife.If clinically indicated both mother and baby will be transferred to the most appropriate maternity unit otherwise they remain at home.

7.4 The information below is the latest iteration of BBAs up until the end of December 2014. This information may differ slightly from the data supplied in the previous Quality update to the HOSC for the reasons cited above.

7.5 The **key headlines** in relation to BBAs are:

- No adverse outcomes for mothers or babies have been reported in relation to BBAs (some babies will have been transferred into maternity

[2]Source: ESHT Head of Midwifery records based upon Euroking extracts and DATIX entries January 2012 – 14 December 2014

units for observation checks or "warming up" in line with standard practice)

- The two key themes in relation to BBAs occurring include births taking place quicker than expected and expectant mothers not seeking advice from a midwife in good time.

- Following review the Trust has not identified proximity to a birthing unit as a significant factor in reported BBAs taking place

7.6 Table 2: Women who experienced a BBA and were booked to birth at the Crowborough Birthing Centre

	J	F	M	A	M	J	J	A	S	O	N	D	Total
2012	0	0	0	0	0	0	0	0	0	2	0	2	**4**
2013	0	1	0	1	0	0	1	1	1	0	0	0	**5**
2014	0	0	1	0	0	1	0	0	1	1	0	0	**4**

Key points:

- No adverse outcomes were seen for any of these babies

- In 2012, three woman chose to remain at home post-delivery and one was transferred into CBC

- In 2013 all sixwomen chose to remain at home post delivery

- In 2014 two women chose to remain at home post-delivery, one was transferred into CBC as was born in the car park outside CBC and three were transferred to Tunbridge Wells Hospital

7.7 Table 3: Women who experienced a BBA and were booked for birth at the EDGH/EMU

	J	F	M	A	M	J	J	A	S	O	N	D	Total
2012	2	0	1	0	4	4	0	1	0	2	2	2	**18**
2013	1	1	1	0	1	1	1	0	1	0	1	0	**8**
2014	0	3	0	1	3	0	1	0	1	3	0	3	**15**

Key points:

- No adverse outcomes were seen for any of these babies

- These figures refer mostly to women with an Eastbourne, Hailsham and Seaford (EHS) CCG postcode

- In 2012,thirteen women chose to remain at home post-delivery of which two were delivered by paramedics, one born in hospital corridor so transferred into the ward, two transferred to the Eastbourne District General Hospital (EDGH), one baby transferred to the Special Care Baby Unit(SCBU) and one baby born in transit in hospital with a paramedic

- In 2013,five chose to remain at remain at home post-delivery, twowere transferred into EDGH and one was transferred to SCBU as pre term. All women were booked to give birth at the EDGH/EMU.

- In 2014,fourteen remained at home and one was transferred to Brighton from Seaford due to maternal condition.

7.8 Table 4: Women who experienced a BBA and were booked to give birth at the Conquest Hospital

	J	F	M	A	M	J	J	A	S	O	N	D	Total
2012	1	1	2	1	3	0	3	1	2	1	1	0	**16**
2013	3	1	0	4	2	3	1	1	1	1	1	2	**20**
2014	1	1	2	3	2	2	5	1	3	0	2	4	**26**

Key points:

- No adverse outcomes were seen for any of these babies

- The majority of mothers who experienced BBAs continue to reside in the Hastings, Bexhill, St Leonards and Robertsbridge areas.

- In 2012,eight women chose to remain at home post-delivery, five transferred to Conquest, two delivered in the car so transferred into Conquest and one baby went to the SCBU

- In 2013,fivewomen chose to remain at home post-delivery, seven were transferred into Conquest, two babies went to SCBU and six babies were born in transit – three in cars,one on the door step as leaving for the hospital and two in ambulances delivered by paramedics. One out of area when William Harvey Ashford was on divert and 1 en route to Conquest

- In 2013, four out of the twenty women who experienced a BBA were from the EHS CCG area (postcode areas include Hailsham and Eastbourne). These BBAs took place from the 10 May 2013.

- In 2014, thirteen women chose to remain at home post-delivery, nine transferred into the Conquest,four mothers gave birth in transit (three in the ambulance and one in a car en route to Conquest)

- In 2014, 3 out of the twenty six women who experienced a BBA were from the EHS CCG area (postcode areas include Hailsham and Eastbourne)

8. Midwife to birth ratio

Position since 07 May 2013: **NEUTRAL**

8.1 The national standard set by Birthrate Plus is to have a ratio of 1:29 or lower and the locally agreed indicator is 1:30.

8.2 The midwife to birth ratio is measured across all sites where the Trust provides maternity services.

8.3 When broken down into site specific data, midwife to birth ratio is significantly different. This measure is similar for all Trusts that provide services across multiple MLU sites

8.4 The midwife to birth ratio will always be higher at an MLU which has to be staffed 24 hours a day to respond to intrapartum activity whenever it happens but with fewer births than at the acute site (this means the staffing levels at MLUS will be lower due to the reduced number of births)

8.5 At each of the MLUs, staff not only provide intrapartum care but also antenatal and postnatal care

8.6 At the Conquest the ratio is higher and is a consequence of staffing two MLU's with much lower birthing activity

8.7 Staffing is reviewed daily to ensure the safety of women and babies

8.8 Table 5: Midwife to birth ratio, 2012 – 2014 (National Standard – 1:29)

	2012	2013	2014
Trust Level (Average)	**1:32**	**1:27**	**1:30**
EDGH*	1:32	1:20	1:18
CBC	1:18	1:18	1:15
Conquest	1:38	1:33	1:38

** EMU from 07 May 2013*

9. Diverts and site closures

Position since 07 May 2013: **IMPROVED**

9.1 From 07 May 2013 the Conquest has not closed or gone onto divert up to and including February 2015.

9.2 The reconfiguration has ensured a sustainable, safe obstetric-led service.

9.3 In 2012 and early 2013, divert procedures were instigated on over seventy occasions between the EDGH and Conquest for the reasons related to capacity, medical or midwifery staffing.

9.4 Following reconfiguration, occasional closures and diverts continue to occur in the MLUs. A unit can be closed for a small amount of time and often no women are affected.

Table 6: Closures and Diverts (2013)[3]

2013	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CBC closed	0	0	0	1	1	3*		
No. women diverted				0	0	0		
Where to				CQ	CQ	CQ		

Key Points 2013

- All diverts were overnight except * 31/10 07.30 until 4/11/13 10.00 CBC on divert – **no women diverted**

- During these diverts the Midwife and Maternity Support Worker (MSW) on duty were re-located to Conquest.

Table 7: Closures and Diverts (2014)[4]

2014	J	F	M	A	M	J	J	A	S	O	N	D
CBC closed	1		2		2	1	2	1(*)	2		1	6($)
EMU closed	0					1			1	1		3
No. women diverted	0		0		1	0	1	3	1 from EMU	1	0	2 from CBC
Where to					EMU		TWH	EMU PRH TWH	CQ			TWH x2

Key points 2014

- All diverts were overnight except (*) 22/08 – 25/08/14 and ($) CBC diverted during the day due to staffing issues and one woman diverted to Tunbridge Wells Hospital(TWH) – **very few women (9) diverted**

- During these diverts the Midwife and Maternity Support Worker (MSW) on duty were re-located to Conquest

10. Transfers from MLUs to Obstetric Units

Position since 07 May 2013: **NEUTRAL**

10.1 No babies transferred from an MLU to an Obstetric Unit have been born en route.

10.2 The average transfer time meets the agreed standard (from making the decision to handover, to the receiving unit within our area) of 80 minutes.

10.3 The Trust has confirmed that all local transfers for first births continue to be achieved within the national average of 36%[5].

[3] Source: Euroking extracts, January 2012 – 14 December 2014
[4] Source: Euroking extracts, January 2012 – 14December 2014

11. Maternity Staffing[6]

Position since 07 May 2013: **IMPROVED**

11.1 The quality of midwifery staffing has improved with significantly less reliance on agency midwifery staffing compared with pre – 07 May 2014.

11.2 Midwife maternity leave and long term sickness and vacancies are reducing.Existing mitigations stay in place with regular bank and agency midwives who are familiar with Trust protocols and processes and ad hoc diverts enacted from the MLU's as required. Midwifery recruitment is on-going and the Head of Midwifery is investigating overseas recruitment from Europe as required.

11.3 The Trust has undertaken an analysis of midwifery staffing levels from the perspective of midwives in post against establishment for 2014. This has been undertaken for the Conquest, EMU and CBC sites. The Trust has provided commissioners with assurance that whilst the maternity led units are not always staffed to their full establishment rate there is sufficient flex within the system to maintain a safe service at the Conquest hospital by moving midwifery staff around the system as required.

12. Obstetric Medical Staffing

Position since 07 May 2013: **IMPROVED**

12.1 The Trust has demonstrated a sustained higher level of consultant presence on the labour wards than when the previous configuration was in place (was 48hrs and is now 72hrs). This has translated into increased consultant involvement in decision making, increased consultant performance of operative obstetric procedures and direct supervision of junior doctors performing these procedures. The elective caesarean lists now have a specific consultant supervisor separate from the labour ward consultant.

12.2 Safety has improved as a result of the reconfiguration as middle grade medical staff are now able to call upon the support and direction of the Consultant medical body after 1700 for direct supervision on site. This means that there is now a more advanced support structure for middle grade medical staff which has resulted in better outcomes for mothers and babies.

12.3 In line with the maternity staffing experience the reconfiguration has led to a decreased use of locum medical staff and the use of locum staff who are unfamiliar with Trust protocols, procedures and the physical environment of the maternity wards has reduced significantly.

12.4 Following reconfiguration any absence or sickness has been covered by doctors in substantive posts, in a minority of instances external known

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[5] Source: Telephone conversation between CCG Quality Manager and Trust Head of Midwifery, 17 March 2015

[6] Source: Email from ESHT Head of Midwifery to East Sussex CCGs, 11 March 2015 and Head of Midwifery Establishment vs Post figures, 11 March 2015

locums have been utilised in low-risk clinical areas with adequate supervision.

12.5 There have been less serious incidents being reported as a result with improved middle grade medical decision making and contributed to a safer environment for mothers and babies.

13. Maternity Patient Feedback[7]

Position since 07 May 2013: **IMPROVED**

13.1 The operational quality and safety forum for ensuring the review of key quality areas with the Trust is the monthly Clinical Quality Review Group where Maternity services are a regular agenda item. This meeting also reviews aspects of patient experience in relation to Trust services, including Maternity (which included the Friends and Family Test).

Key points:

- The Trust is also performing well in relation to feedback from the Friends and Family Test and has consistently scored above the minimum standard.

- Patient feedback from the Maternity Friends and Family Test include staff attitude on the antenatal wards, more affordable antenatal classes, requests for showers in baths, a request to keep the CBC open, a request to move obstetric services back to the EDGH, discharge planning and general staff attitude.

- The number ofcomplaints have reduced post reconfiguration. The same themes persist regarding standards of care and provision of services, which reflect national trends.

14. Births by site

14.1 Information relating to the number of births by site does not relate to the quality and safety of the service but does provide activity information as requested by the HOSC

14.2 The overall birth rate within ESHT has decreased by 7.1% in 2013 and a further 8.6% in 2014. This is in line with anticipated trajectories following reconfiguration.

14.3 Activity at the Conquest has increased following the single siting happened on 07 May 2013. Eastbourne data cannot be compared as EMU data has only been collected for one full calendar year.

Following the service reconfiguration of 07 May 2013 the numbers of births at the EDGH has decreased with clinically screened “high risk” pregnancies

[7] Source: Email from ESHT Head of Midwifery to East Sussex CCGs, 25 February 2015

being redirected to the Conquest as the safety of mothers and babies is the first concern for the Trust.

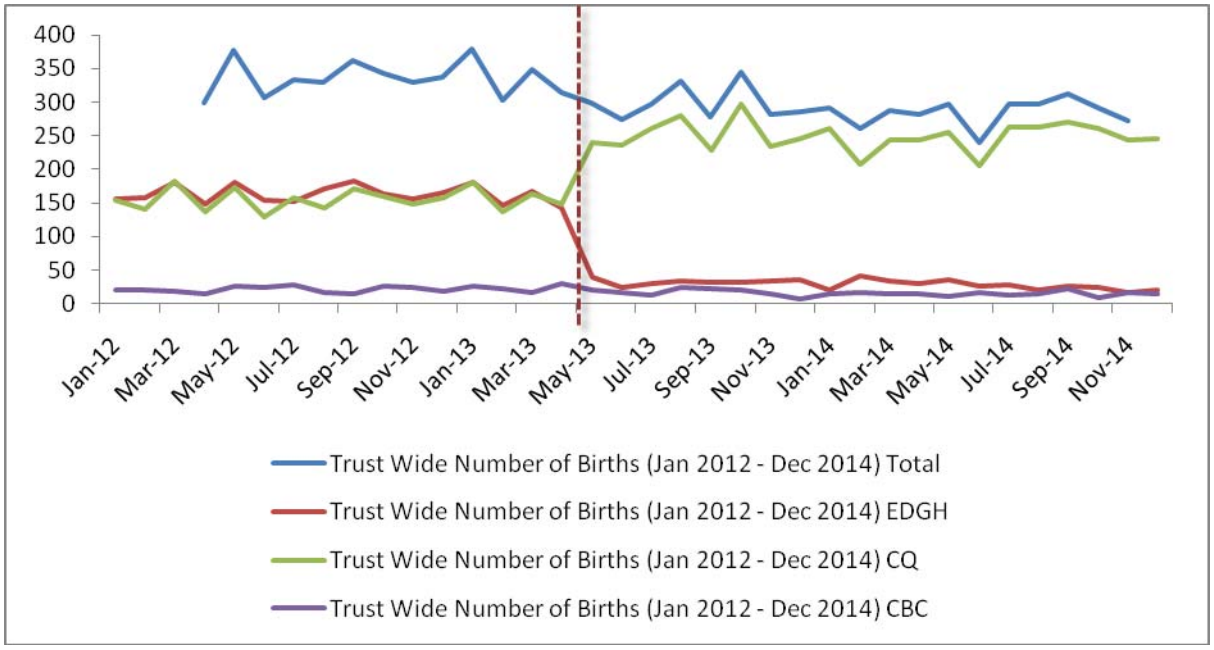
14.4 The tables below indicate the number of births by site by year for each of the three East Sussex maternity units in line with a previous request from the East Sussex HOSC.

Table 8: Births by site by year

Site	2012	2013	2014
Conquest	1860	2656	2961
Eastbourne *	1973	905	326
Crowborough Birthing Centre (CBC)	246	228	176
Total of births at ESHT	4079	3789	3463

* EMU only from 07 May 2013

Graph 5: Trust wide number of births by month (Jan 2012 - Dec 2014)



Paediatric Services

15. Paediatric Staffing[8]

Position since 07 May 2013: **IMPROVED**

[8] Source: Email from Head of Nursing, Women's and Children Clinical Unit to Children, Young People and Maternity Services Joint Commissioning Manager, 25 February 2015

15.1 The Trust has confirmed that the inpatient paediatric nursing staffing levels are in line with the required establishment.

15.2 A number of staff members made the personal decision to move to Kipling Ward at the Conquest Hospital permanently whilst others decided to work across both sites. This option has enhanced working at the Conquest Short Stay Paediatric Unit (SSPAU).

15.3 An additional clinical nurse educator role has been secured to support workforce, training and development.

15.4 Four newly qualified staff nurses joined Kipling ward in September 2014.

15.5 A healthcare assistant is currently seconded to undertake her nurse training demonstrating that the Trust is "growing their own" staff and looking forward to succession planning.

15.6 In relation to Neonatology, a Band 6 sister now has protected time in a clinical nurse educator role for one day per week to support workforce, training and development on the unit. The Trust has reported that the workforce is stable with one member of staff currently on maternity leave. A newly qualified nurse will join the team in June 2014 after an internal rotation.

16. Paediatric Serious Incidents
Position since 07 May 2013: **NEUTRAL**

16.1 There have been zero paediatricSerious Incidents reported to Commissioners as a result of the reconfigurationsince the 07 May 2013 to the time of writing this report.

16.2 There has been one paediatric Serious Incident reported since 07 May 2013 to the time of writing this report which did not relate to the safety and quality of paediatric services

17. Summary of Paediatric Service Feedback[9]
Position since 07 May 2013: **NEUTRAL**

17.1 There was an initial increase in complaints following reconfiguration related to the provision of services however these have significantly decreased during 2014(from eighteen to nine for period 07 May 2013 - 30 September 2013 and 07 May 2014 - 30 September 2014).

17.2 These complaints relate predominately to provision of services, communication, standards of care and staff attitude

[9]Source: Email from Head of Nursing, Women's and Children Clinical Unit to Children, Young People and Maternity Services Joint Commissioning Manager, 24 February 2015

18. Paediatric Transfers from EDGH to Conquest Hospital[10]

18.1 Information relating to the number of admissions by site does not relate to the quality and safety of the service but does provide activity information as requested by the HOSC.

18.2 The Trust have confirmed that between January 2014 and December 2014 a total of 6935 paediatric admissions took place at Trust level

18.3 Of this number 4608 were admitted to the Conquest Hospital and 2327 were admitted to the EDGH.

18.4 Of the 2327 EDGH total, 267 transfers took place from the EDGH SSPAU to the Conquest Hospital. This averages a monthly total of 22 and is in line with information previously reported to the HOSC where the average reported was 20.

19. Conclusion

19.1 **T**he configuration agreed by the three CCG Governing Bodies in East Sussex, and supported by the HOSC, has resulted in sustained improvements in safety and quality for maternity and paediatric services.

19.2 The CCGs and the Trust continue to monitor the safety and quality of all services as part of on-going organisational business.

March 2015

-end-

[10] Source: ESHT Business Intelligence Paediatric Activity (December 2013 to December 2014), 12 February 2015

East Sussex Healthcare NHS Trust

Date of Meeting:	25th March 2015
Meeting:	Trust Board
Agenda item:	12
Subject:	Annual Business Plan 2014-15 Quarter 4 report
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:

- The RAG rating for 2.3, 8.2, 8.4 and 8.7 have moved from amber to green and these plans are completed
- Plans 1.8 and 8.1 have improved from red to amber

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.

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	√
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	√
Strategic Objective 3 - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	√

Review by other Committees/Groups (please state name and date)**:**
Business Planning Steering Group 13.01.15

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

Strategic Objective 1:	**Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority**
ABP Objective 1:	**Ensure the organisation is able to demonstrate the quality of its services and compliance with regulatory standards**
1.7	**Respond to national plans for the revalidation of nursing staff**
Outcome Measures Plan in place to ensure that the Trust is compliant with the agreed national requirement	**Risks** Revalidation is not agreed nationally. System is complex with large numbers of staff requiring revalidation Medical revalidation system cannot be used to support the process Capital investment required

Actions:	**Date/ milestone**	**RAG**	**Lead**
Review the consultation of the draft code . Trust nurse lead for revalidation appointed IT systems reviewed in readiness for revalidation Awaiting confirmation from the NMC re exact requirements - delayed to early 2015 Discussion taking place with medical revalidation team to integrate systems. Working group formed.	Completed Completed Completed Early 2015	A ◄►	**DN**

1.8	Further strengthen Clinical Audit reporting to the Board and its Committees		
Outcome Measures Clear process in place for Clinical Audit to ensure national and local requirements are met	**Risks** Medical staff are not engaged in the process		
Actions:	**Date/ milestone**	**RAG**	**Lead**
Centralise the governance team and develop a specific Audit team – interim structure Draft consultation plan developed with HR input - due to consult April 2015. The central Clinical Effectiveness team working closely with each CU Lead to ensure a smooth transition of audit cover in interim phase. Improvements in engagement and focus already evidenced a reduction in outstanding audits from 2012/13 and 2013/14. The Clinical Audit Steering Group has been reviewed and now meets bimonthly for an hour and these meetings will be regularly interspersed with larger presentation meetings which will be held in the Lecture Theatres and open to all staff. The larger presentation meetings will provide audits of Trust-wide relevance to be presented and discussed, enabling key lessons to be shared and disseminated effectively. Clinical Audit Awards Seminar to take place at the Conquest Hospital on June 16th 2015.	Completed - Sep14 Apr15	A ▼	**MDG/DN**
ABP Objective 2:	**Ensure the organisation takes action to improve quality and outcomes for patients**		
2.1	**Implementation of mortality screening tool and review of all deaths**		
Outcome Measures Compliance with TDA guidance and achievement of CQUIN target	**Risks** Loss of CQUIN monies and lack of compliance with TDA guidance		
Actions:	**Date/ milestone**	**RAG**	**Lead**
Completion of reviews on trajectory for achievement of 90% CQUIN target Quarter 2 targets achieved Quarter 3 targets achieved and on target for Q4	Mar-15	A ◄►	**MDG**

2.2	Implementation of the Quality Improvement Programme including QUIPP and CQUIN plans		
Outcome Measures QUIPP and CQUIN programmes are developed for areas of most clinical quality concern, with a quality impact assessment completed on them with measurable performance indicators. Organisation reporting framework to ensure annual plan met by Mar 15 with regular forecasts to confirm plan on target. Impact on 2015/16 and beyond understood. Cash impact understood and managed	**Risks** Programmes are not meeting the clinical requirements and have an appropriate purposefulness QUIPP and CQUIN programmes 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		
Actions:		**Date/ milestone**	**RAG**	**Lead**
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. Monthly accountability meetings held with Clinical Units QUIP and CQUIN targets - Q2 and 3 achieved, on target for delivery for Q4. At end Jan15 savings achieved year to date below plan by £289k. Additional savings schemes have been identified to close the gap by year end		CQUIN monthly report to CME QUIP targets agreed with CCGs On-going Mar15	A ◄►	**DN/ MDG/ DF/ COO**

2.3	**Review and redesign of key specialities and sub-specialities**		
Outcome Measures Specialties and sub-specialities requiring review are prioritised. Outcomes of review fed into Annual Business Plan for 2015/6.	**Risks** 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		
Actions:		**Date/ milestone**	**RAG**	**Lead**
Specialties Identified: Gastroenterology, Cancer Services, Community Paediatrics, Rheumatology The review and redesign of these specialities have been incorporated into the relevant Clinical Unit business plans for 2015-16		Mar-16	G ▼	**COO/ DSA/ MDS**
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 3:	**Ensure opportunities and risks of the local health and social care market and of commissioning intentions are understood and responded to**		
3.1	**Implementation of a tender review and response process**		
Outcome Measures Decisions to tender for business are in line with Trust strategy and business model. Successful bids for new or existing business are clinical, operationally and financially sustainable	**Risks** 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.		
Actions:		**Date/ milestone**	**RAG**	**Lead**
The Trust has continued to develop the process learning from each tendering exercise and apply the learning to the process in place. Governance of this activity is through the Business Planning Steering Group whose role is to assess the impact and potential of tenders and approve tender responses for new and existing business.. The Associate Director of Planning and Business Development's role is to coordinate the related activities of corporate and operational staff in responding to tenders.		On-going	**A** ◄►	**DSA**

3.2	Development and implementation of a marketing and engagement strategy		
Outcome Measures Strategy agreed by the Board leading to: · clarity about key stakeholders; · roles and responsibilities within the Trust; · improved relationships with key stakeholders	**Risks** Insufficient resources for relationship management actions identified in the strategy and action plan		
Actions:	**Date/ milestone**	**RAG**	**Lead**
Work on the marketing and engagement strategy continues but is now planned to be completed in the first quarter of next year due to competing priorities generated by work on tenders.	Mar-15	**A** ◄►	**DSA**
ABP Objective 4:	**Ensure active participation in joint programmes of work to improve clinical service design and delivery**		
4.1	**Engage in the further development of the commissioner led East Sussex Better Together (ESBT) programme**		
Outcome Measures ESHT active participant in further work 5 year plan aligned to commissioning intentions Full alignment between ESBT and CHE work	**Risks** Failure to draw together ESBT and CHE work leads to misalignemnt of ESHT 5 year plan and plan for sustainability not achieved		
Actions:	**Date/ milestone**	**RAG**	**Lead**
Engagement ongoing - CCGs have 150 week implementation plan - discussions underway to ensure full Trust engagement.	Mar-15	**A** ◄►	**DSA**
Detailed plans to underpin intended impact in 2015/16 not yet available therefore not yet incorporated into CU plans	Mar-15	**R** ◄►	

4.2	Engage in the further development of the TDA/NHSE led Challenged Health Economy (CHE) programme		
Outcome Measures ESHT active participant in further work 5 year plan aligned to commissioning intentions Full alignment between ESBT and CHE work	**Risks** Failure to draw together ESBT and CHE work leads to misalignemnt of ESHT 5 year plan and plan for sustainability not achieved		
Actions:	**Date/ milestone**	**RAG**	**Lead**
PID and programme governance agreed by TDA, NHSE, CCGs and ESHT Phase 2 of programme complete - outcomes to be considered by LHE and impact on current ESBT and Trust plans to be agreed	Mar15	**A** ◄►	**DSA**

4.3	Engage in the programme of work to support the re-design of community services		
Outcome Measures Clarity on which community services support Trust strategy and business model Identification of service models which are clinically, operationally and financially sustainable	**Risks** Re-organisation may slow down work Staff engagement		
Actions:	**Date/ milestone**	**RAG**	**Lead**
Risks assessments undertaken on redesigned services. Engaged with CCGs through new management structure. Trust engaged in community service redesign through ESBT. Further work on Clinical Strategy has been outlined for agreement by Board. Trust engaged in bidding for tendered community services in HWLH. Review of community paediatric services taking place jointly with CCG - Programme Board established and increased managerial input from Trust	Oct14 Jan15 May15 May15	**A** ◄►	**MDS / COO / DSA**

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 5:	**Ensure the Trust's business model and long term strategic plan deliver clinical, operational and financial sustainability**			
5.1	**Development of an IBP and LTFM based on the outcome of ESBT and CHE programmes**			
Outcome Measures IBP and LTFM agreed by TDA 5 year plans are cascaded through the organisation and developed into CU strategic plans Receipt of capital from the TDA	**Risks** CHE work 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			
Actions:		**Date/ milestone**	**RAG**	**Lead**
Ensure engagement with stakeholders in the programmes across the economy Capital investment approved by the TDA Development of IBP and LTFM ongoing in light of ESBT and CHE work. Impact of outcomes of Five Year Forward View and Dalton review to be assessed through next steps in development of the Trust Clinical Strategy implementation plan IBP priorities feed into Annual Business Plan for 2015/16 Emergency capital applications made as appropriate		 Mar15 Mar15	**R** ◄►	**DF/ DSA**
ABP Objective 6:	**Ensure efficiency and effectiveness are improved through the implementation of the Cost Improvement Programme**			
6.1	**Act to reduce spend on medical agency**			
Outcome Measures Spend reduced and contained within total controls	**Risks** Breach in control totals			
Actions:		**Date/ milestone**	**RAG**	**Lead**
Spend being reduced but further work required to ensure local CU control totals are met CU achievement against control totals monitored through monthly accountability meetings Spend has increased from Dec14 due to winter pressures Plans to reduce spend on medical agency included within CU business plans for 2015/16		Mar-15	**A** ◄►	**MDG**

6.4	**Implementation of a revised Hospital at Night provision at EDGH**			
Outcome Measures Safe service provision	**Risks** Unable to recruit staff sufficiently skilled to provide a safe service			
Actions:		**Date/ milestone**	**RAG**	**Lead**
Plans for re-provision H@N still being revised for winter Identified clinical leads on both sites, services to be supported by next phase of Vitalpac implementation. Change manager currently working with clinical leads on both sites to scope implementation and identify issues		Mar15	**A** ◄►	**COO**
6.5	**Development and implementation of a revised medical model across the Trust**			
Outcome Measures New model implemented on both acute sites	**Risks** Unable to recruit senior clinicians to fill the rota			
Actions:		**Date/ milestone**	**RAG**	**Lead**
Agreement on new structure to allow implementation as appropriate Relevant posts have been advertised Ward redesign implemented at Conquest, EDGH to be implemented in 2015/16		Jan15	**A** ◄►	**COO/ MDS**
ABP Objective 7:	**Implement plans for the delivery of key operational requirements**			
7.1	**RTT compliance plan**			
Outcome Measures All specialities to be RTT compliant	**Risks** Insufficient capacity available to achieve compliance in all specialities			
Actions:		**Date/ milestone**	**RAG**	**Lead**
Achieve RTT compliance Extra capacity identified both internal and external funded through CCG and Local Area Team Majority of services will be RTT compliant with the exception of gastroenterology and orthopaedics by Apr15		Feb15 Apr15	**A** ◄►	**COO**

ABP Objective 8:	Develop and implement enabling strategies and programmes to ensure efficiency and effectiveness of the Trust		
8.1	**Development of an estates strategy that supports the Trust's agreed clinical services model**		
Outcome Measures New estates strategy in place	**Risks** Re-organisation of estates and operational structures that would not give sufficient time for development		
Actions:	**Date/ milestone**	**RAG**	**Lead**
Development of estates strategy in collaboration with P21 partners Currently recruiting for substantive Head of Estates (interim manager in post)- substantive Head of Estates recruited and starts Jun15 Interim Head of Estates presenting outline estates strategy to next Board Seminar	Mar15 Jun15 Apr15	**A**	**COO**
8.2	**Development of a Sustainability Management Plan**		
Outcome Measures Approved plan in place	**Risks** Development of plan delayed by corporate restructure and outsourcing of hard Facilities Management service		
Actions:	**Date/ milestone**	**RAG**	**Lead**
Production of Sustainable Management Development Plan for estates and facilities for Board approval Plan has been finalised in readiness for approval at June Board	Jun-15	**G**	**COO**

8.3	Development of an IT Strategy and delivery plan			
Outcome Measures Strategy implemented and internal transformational plan developed	**Risks** Delays in implementation Key roles not recruited to Impact of market testing TDA approval			
Actions:		**Date/ milestone**	**RAG**	**Lead**
IT Strategy approved by Board Transformation plan to be developed Complete review of market testing possibilities and report to Board		Jul14 commence Jan15 Sep15	**A** ◄► 	**DF**
8.4	**Review and further development of the Major Incident and Business Continuity Plans**			
Outcome Measures Revised plans in place	**Risks** Corporate and clinical unit restructure			
Actions:		**Date/ milestone**	**RAG**	**Lead**
Major Incident Plan reviewed and revised with new policies for EDGH and Conquest. Business continuity policy and plan revised and re-issued All are now available on Intranet and Major Incident Plan/Emergo training planned -completed		Sep14 Sep14 Mar15	**G** ▼	**COO**

8.5	Review and revision of the Workforce Plan and Trust-wide workforce risk register
Outcome Measures A plan which identifies the capacity and capability of the future workforce which meets the aims and objectives of the organisation. Specific workforce transformation plans identified and implemented Register of all identified workforce risk across the organisation, both Trust-wide and area specific	**Risks** Flexibility to respond to changing demands within the Trust Ensuring that the 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

Actions:	Date/ milestone	RAG	Lead
Revised workforce plan	Sep14	A	HRD
Development of Recruitment and Retention Strategy and Action Plan - identify hard to recruit areas and appropriate action	Jan15	◄►	
The Workforce Risks are now summarised as part of the Workforce Strategy/Plan. This document is in draft form and will be finalised by March 2015 to incorporate into business planning for 15/16.	Mar15		
Separately a meeting is planned for December with Risk leads to develop a process for HR to receive details of workforce risks. This meeting has been delayed due to long term sickness absence.	Dec14		
The workforce strategy/plan is currently being developed to final draft stage by end March/early April. This will incorporate 15/16 business planning, and April TDA returns. The strategy will go to June Board for approval.	Jun15		

8.6	Conclude implementation of the Health Roster programme		
Outcome Measures Right staff in right place at right time Reduced agency and bank usage Real time reporting of staffing numbers and absence	**Risks** System support resource not agreed System use deteriorates due to lack of support Inability to provide actual nursing numbers from Healthroster		
Actions:	**Date/ milestone**	**RAG**	**Lead**
Bexhill - Allocate were unable to resolve the issues with the timeclock fingerprints in Bexhill. Testing being carried out by supplier on a PIN number clocking in process and so far is working. The full implementation in Bexhill will now happen in January 2015 and rollout across the rest of Facilities will then take place. Once the Facilities implementation is fully underway the Healthroster support team will be able to move ahead with Corporate areas. All clinical areas now using Healthroster. Discussions taking place with Senior Nursing about a proposed nursing secondment to ensure that all clinical areas are maximising the use of Healthroster. The new PIN number system in Bexhill has been fully implemented and is working well, plans are now being developed to roll out Healthroster to the rest of Facilities. The Safer Staffing and Workforce Capacity group is now looking at the 'Safecare' module as an add on to Healthroster which will allow us to automate the process of ensuring safe staffing at ward level. Should we wish to take forward this system, a business case will be produced.	Jan-15	**A** ◄►	**HRD**

8.7	Embed programme management processes in support of delivery of Annual Business Plan			
Outcome Measures Regular project reporting to the Board Resources allocated to organisational priorities within the ABP PMO recognised as useful organisational resource	**Risks** Re-organisation of PMO may affect projects Insufficient resource to support prioritised projects			
Actions:		**Date/ milestone**	**RAG**	**Lead**
The PMO is now up and running and the governance of existing projects has been strengthened. Regular reports of key Trust wide projects are provided to CME and quarterly to the Finance and Investment Committee. Through the 2015/16 business planning process a number of Trust wide projects will be priortised to receive support from the PMO eg the theatre utilisation project which will involve several clinical units and a wide range of discplines.		Oct14 On-going Mar15	G ▼	DSA
8.9	**Implement key IM&T programmes including PAS upgrade, NHSmail, SystmOne**			
Outcome Measures IT systems implemented successful with minimal disruption	**Risks** Delays in implementation			
Actions:		**Date/ milestone**	**RAG**	**Lead**
Capital investment identified Implementation plans complete and understood		On-going	A ◄►	DF
8.10	**Development and implementation of an Innovation Strategy**			
Outcome Measures Innovation Strategy implemented	**Risks** Strategy not fully implemented			
Actions:		**Date/ milestone**	**RAG**	**Lead**
Final draft of the strategy to be produced by the Associate Medical Director - Clinical Governance by the end of March.		Mar-15	A ◄►	MDG

East Sussex Healthcare NHS Trust

Date of Meeting:	25.03.15
Meeting:	Trust Board
Agenda item:	13
Subject:	Annual Business Plan 2015/16
Reporting Officer:	Amanda Harrison

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

Purpose:

This paper is a summary of the Annual Business Plan for 2015/16 in line with guidance from the TDA about its content. The timetable for production of the plan has changed from the original one supplied to the Board In November 2014. Draft plans originally had to be with the TDA by 27th February but that date has been pushed back to 7th April. The cumulative effect is that the submission of final plans is now expected on the14th May.

Introduction:

The paper sets out the strategic context with information on our broad clinical priorities as we continue on the journey to achieve clinical operational and financial sustainability. The plan has been developed with the clinical units and corporate departments and details priorities for next year. This plan is underpinned by detailed plans at Clinical Unit and Corporate Directorate level. Progress against the delivery of the Annual Business Plan will be reported to the Board quarterly.

This report is also being brought to the F&I Committee for the approval of a provisional/draft 2014/15 expenditure budget in advance of the completion of contract negotiations and further planning submissions to the TDA.

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

The Trust should acknowledge its achievements and the progress it has made in 2014/15 The priorities for 2015/16 are provided and there are some cross cutting themes including the development of a more robust recruitment strategy to address shortages in medical and nursing staffing and reduce agency spend; continuing to engage staff through increased levels of appraisal and training. Significant projects for next year include continuing to improve the utilisation of theatres to improve patient experience and efficiency and transformation of community services.

Contract negotiations for 2015/16 with commissioners are still ongoing so in the absence of an agreed patient income budget it is proposed that the Board set an expenditure only budget. This will enable budget holders to proceed with the operational management of the Trust, pending agreement of the final 2015/16 plan.

Benefits:
Clinical units and corporate departments have been fully engaged in the process

Risks and Implications
Areas of the draft plan that are not yet confirmed or values may change Decisions affecting major areas of service which have not yet been formalised and therefore not yet adjusted for, including changes in the commissioning and provision of musculo-skeletal services, the tender for community service provision in the High Weald, Lewes and Havens Clinical Commissioning Group area and any other tenders.

Assurance Provided:
Strategic Objective 2, risk 2.2 Strategic Objective 3, risk 3.6

Review by other Committees/Groups (please state name and date)**:**
Business Planning Steering Group Finance and Investment Committee 18 March 2015

Proposals and/or Recommendations
The Board is asked to approve the draft plan and note that a fully developed budget is not yet available for Board approval. In the interim the Board is requested to agree the issue of a provisional 2015/16 expenditure working budget, to enable budget holders to proceed with the operational management of the Trust, pending issue of a final budget, expected to be agreed by the Trust Board in early May and returned to the TDA on 14 May.

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

For further information or for any enquiries relating to this report please contact:	
Name: Amanda Harrison, Director of Strategic Development & Assurance	**Contact details:** amanda.harrison11@nhs.net

East Sussex Healthcare NHS Trust
Summary of Plan for 2015/6

1. Background

East Sussex Healthcare Trust (ESHT) is currently four years into a five year improvement journey to improve clinical sustainability and financial viability. In close collaboration with key stakeholders in East Sussex the Trust agreed the strategic framework for its Clinical Strategy: Shaping our Future in 2011 against the strategic objectives the Board have agreed for the organisation

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

Based on this framework the first phase of the clinical strategy developed the business model for the Trust by defining the change required to eight key services in order that they were able to deliver the Trust's aims and objectives. These eight services that comprise about 80% of the business of the Trust are:

- Acute Medicine
- Orthopaedics
- Cardiology
- Emergency care
- Maternity
- Stroke
- Paediatrics and child health
- General Surgery

The conclusions reached about the future configuration and design of the above eight services has defined the business model for the Trust as 'emergency care, acute medicine and cardiology to be provided on both acute sites with the other five services provided differentially on each site. The model is supported by a range of community services which include those being developed to improve the management of patients with long term conditions and complex co-morbidities in community rather than acute settings. In order to implement the strategy and business model acute and hyper acute stroke services were centralised on the Eastbourne site in July 2013; emergency and high risk surgery services were centralised on the Hastings site in December 2013 and the centralisation of emergency and high risk orthopaedics at Hastings took place in May 2014.

Consultant led maternity services and in-patient paediatric services were temporarily centralised on the Hastings site in May 2013 on the grounds of safety. The three local Clinical Commissioning Groups undertook a consultation on the long term future of these services "Better Beginnings". The outcome of the consultation, published in June 2014 and ratified by the Health Overview and Scrutiny Committee in July 2014, confirmed the temporary centralisation as the permanent configuration for these services.

- Birthing services are retained at all three current sites (Conquest Eastbourne and Crowborough Hospitals)
- Consultant-led maternity services are provided at the Conquest Hospital, Hastings
- Two midwife-led birthing units are 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.

The CCGs and the Trust are currently developing the longer term model for short stay paediatrics and midwifery led care in order to fully implement this decision. The outcome of this work is expected in 2015/16 and will allow an assessment of the full capital impact of this decision and the development of a business case to support its implementation.

The full business case that supports the capital investment required to realise the full benefits of all other elements of the clinical strategy was been developed and approved by the Trust Board in 2013 and remains under consideration by the Trust Development Authority (TDA). In addition to the centralisation of services for stroke, emergency and high risk surgery and trauma and orthopaedics, the business case describes the redesigned and improved care pathways being implemented in acute medicine, emergency care and cardiac care and the infrastructure investment necessary to support this redesign. It details the improvements that will be made in patient flow and length of stay as well as the reductions that will be made in inappropriate admissions. The focus is on delivering quality improvements including increased senior decision making, improved discharge planning and infrastructure and fabric upgrades that will improve infection control.

2. Planning Objectives

Based on the Trust's Clinical Strategy the following broad clinical priorities have been identified for the planning period up until 2018/19:

- The ongoing development and implementation of a model of care for the management of frail adults across the Trust and more widely including:

  - Agreeing pathways for adult acute care which embed the model of care for frail people and support our local demography

  - Redesigning community services to realise the benefits of integrated provision and to ensure the prevention of inappropriate admissions and to facilitate timely discharge

- Developing delivery models for clinical support services including ITU, diagnostics and pathology in order to ensure alignment with optimal service configuration and that maximum efficiency and value is derived from their operation.

- Reviewing medical and surgical specialties and subspecialties against efficiency and sustainability criteria (operational, clinical and financial) to identify priorities for transformation and opportunities for differentiation followed by a review of the models of care and delivery options for the clinical services identified.

2014/15 Delivery

Table 1 sets out performance on access targets up to and including December 2014.

Responsiveness Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
			DOMAIN SCORE								
Indicator	Standard	Weighting	3	2	3	3	2	3	2	3	3
Referral to Treatment Admitted	90.00%	10	92.00%	84.09%	88.04%	88.00%	78.00%	82.74%	88.07%	78.26%	81.19%
Referral to TreatmentNon Admitted	95.00%	5	94.00%	94.12%	91.01%	93.00%	91.10%	89.00%	91.43%	91.49%	93.00%
Referral to Treatment Incomplete	92.00%	5	92.07%	92.09%	92.00%	92.00%	92.22%	92.10%	92.07%	92.04%	92.19%
Referral to Treatment Incomplete 52+ Week Waiters	0	5	4	4	4	3	1	3	2	4	0
Diagnostic waiting times	1.00%	5	7.93%	0.91%	0.48%	0.79%	0.87%	0.10%	0.28%	1.39%	1.39%
A&E All Types Monthly Performance	95.00%	10	95.20%	93.69%	95.00%	97.37%	94.07%	95.00%	93.44%	95.65%	93.61%
12 hour Trolley waits	0	10	0	0	0	0	0	0	0	0	0
Two Week Wait Standard	93.00%	2	88.87%	88.07%	91.78%	93.00%	90.16%	93.41%	92.00%	92.22%	91.90%
Breast Symptom Two Week Wait Standard	93.00%	2	94.21%	93.09%	95.00%	93.00%	93.00%	93.00%	95.00%	93.75%	93.73%
31 Day Standard	96.00%	2	97.33%	96.71%	96.95%	96.34%	96.07%	96.07%	96.14%	96.21%	96.43%
31 Day Subsequent Surgery Standard	94.00%	2	100.00%	100.00%	94.74%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
31 Day Subsequent Drug Standard	98.00%	2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
62 Day Standard	85.00%	5	86.01%	83.09%	77.09%	78.11%	80.00%	78.18%	78.07%	78.00%	83.11%
62 Day Screening Standard	90.00%	2	78.93%	88.09%	100.00%	83.33%	83.33%	88.73%	83.33%	83.33%	100.00%
Urgent Ops Cancelled for 2nd time (Number)	0	2	0	0	0	0	0	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%	0.00%	0.00%	0.00%	0.00%	0.00%
Delayed Transfers of Care	3.50%	5	4.47%	5.00%	4.23%	5.01%	5.00%	5.43%	4.80%	7.91%	12.10%

A&E 4 hour waiting standard

High demand on the Emergency Departments has resulted in the A&E standard not being met in Quarter 3 (92.70%) and with the year to date position now at risk. The Trust has experienced a high number of delayed transfers of care with medically fit for discharge patients remaining in a hospital bed.

Collaboration with partners in Social Care and through the Operational Resilience Committee continues to ensure patient delays are minimised.

RTT 18 week Standard

Performance continues to align with the trajectory agreed with the TDA and local commissioners. The focus is on reducing the longest patient pathways which continues to show improvement.

The challenged specialties of Gastroenterology and Trauma and Orthopaedics have developed plans to further improve their position.

East Sussex Healthcare NHS Trust
Summary of Plan for 2015/6

Diagnostics

The Trust met the 6 week Diagnostic targets from the months of June to October 2014 but has had capacity issues in Endoscopy following the unexpected absence of a consultant and no available support from the Independent Sector. The Trust expects to recover the position in February 2015.

The particular challenge for gastroenterology moving forward is the consequence of the extensions to national screening programs as well as the various national cancer campaigns which increases the demand on the specialty. The Trust will continue to forward plan to ensure that it has appropriate resources in place to meet these requirements.

Cancer Services

Inconsistent performance against the national cancer standards in particular the 2 week wait, 31 day and 62 day standards is expected to improve by the end of this financial year.

Improvement in the booking process and the development of a cancer PTL will ensure sustained delivery.

Table 2 sets out key quality indicators for 2014/15.

Safe Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
			DOMAIN SCORE								
Indicator	Standard	Weighting	4	5	5	5	3	5	4	3	4
Clostridium Difficile - Variance from plan	4	10	6	3	4	3	6	3	7	6	6
MRSA bacteraemias	0	10	0	0	0	0	1	0	0	1	0
Never events	0	5	0	0	0	0	0	0	0	0	0
Serious Incidents rate	TBC	5									
Patient safety incidents that are harmful	0	5	3	4	0	1	2	2	1	3	1
Medication errors causing serious harm	0	5	0	0	0	0	0	0	0	0	0
Overdue CAS alerts	0	2	0	0	0	0	0	0	0	0	0
Maternal deaths	0	2	0	0	0	0	0	0	0	0	0
VTE Risk Assessment	95.00%	2	96.00%	97.00%	96.20%	96.10%	96.10%	97.00%	96.07%	96.21%	96.00%
Percentage of Harm Free Care	92.00%	5	93.90%	94.01%	94.20%	93.90%	97.00%	94.00%	94.07%	97.07%	97.03%

There have been no grade 2 serious incidents and no Never Events in year and the percentage of VTE risk assessments is consistent.

There were 6 reported cases of C-Difficile in December, which is above the Trust trajectory. The year to date outturn of 41 is now above the target year to date outturn of 33.

Table 3 sets out key workforce indicators.

Well Led Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
			DOMAIN SCORE								
Indicator	Standard	Weighting	3	3	4	4	4	4	4	4	3
Inpatients response rate from Friends and Family Test	30.00%	2	40.40%	44.22%	44.01%	40.04%	39.40%	40.21%	47.94%	40.02%	40.40%
A&E response rate from Friends and Family Test	20.00%	2	13.89%	16.79%	36.01%	34.41%	29.70%	30.40%	35.10%	30.07%	19.00%
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%	41.00%	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	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
Data Quality of Returns to HSCIC	TBC	2									
Trust turnover rate	10.00%	3	12.48%	12.09%	12.73%	12.01%	13.19%	13.41%	13.32%	13.60%	14.09%
Trust level total sickness rate	3.30%	3	4.09%	3.87%	4.39%	4.44%	4.89%	4.79%	5.09%	5.40%	5.74%
Total Trust vacancy rate	10.00%	3	6.04%	6.40%	6.21%	5.61%	4.72%	5.47%	5.74%	7.80%	6.60%
Temporary costs and overtime as % of total payroll	10.00%	3	7.02%	7.20%	8.72%	8.40%	8.80%	8.40%	8.73%	8.87%	10.10%
Percentage of staff with annual appraisal	85.00%	3	80.37%	80.04%	80.74%	82.34%	87.02%	87.84%	88.34%	70.01%	80.39%

The Trust sickness rate is rising and this is being investigated. Staff turnover increased when the school health service transferred to a new provider. There was a higher than usual use of temporary staff over the Christmas holiday period due to high levels of demand.

39 qualified nurses have been appointed in the last month with 23 newly qualified staff in the pipeline and a further 59 anticipated in March – April. Given current turnover rates, however, we do need to replace around 20 nurse leavers a month in addition to current vacancies. Nurse recruitment is a national issue with estimated vacancy rates of 10%, according to NHS Employers (our rate is currently 6.22%). To address this, we are actively pursuing international recruitment in Spain and Portugal and looking to collaborate as part of a Sussex wide initiative for recruitment in India and the Phillippines.

We have appointed 24 new unqualified nurses, with 17 in the pipeline. We have been running a local recruitment campaign since the beginning of January as well the on-going generic recruitment and additional induction sessions have been scheduled to support new starters.

Progress towards Local Health Economy sustainability

The Trust has actively engaged in the Challenged Health Economy work and will with its partners ensure the outcome of Phase 2 of the programme, is incorporated into the East Sussex Better Together programme. The latter is a jointly agreed programme led by the three local clinical commissioning groups and the local authority. There is a 150 week implementation plan and the Trust is in discussion with its partners to ensure there is full engagement. Detailed plans for the intended impact on the Trust in 2015/16 are not yet available and are therefore not yet factored into the plans of the clinical units.

The Trust is also developing plans for further review of its service and organisational model in the light of the Dalton Review and the Five Year Forward Plan. The timetable for this is ambitious and it is envisaged that this will inform the Trust's five year integrated business plan in June and the long term financial model which underpins the strategy.

3. 2015/16 plans

a) Quality Improvement Plan

Within the course of year many patients are seen in a variety of settings and by ensuring we improve quality safeguards patients as we make our services more patient focused safer and clinically effective

The Trust will continue to focus on reducing HCAI infections in line with national guidance.

We will reduce the number of falls to serious harm. Work is progressing on the reduction of hospital acquired pressure ulcers and the Trust is working with the patient safety collaborative to ensure an integrated approach to developing and implementing preventative strategies. The trust will monitor and review the nursing and midwifery workforce in line with national guidance developing a skill mix which is appropriate to the clinical need of our patients.

Patient Experience remains a key priority for the organisation with a focus on communication and dignity for the forthcoming year. The Trust places service users at the heart of everything we do, monitoring, responding and learning from patient experience is essential.

The Trust will work with partners across the local health and social care system to develop and agree action plans that address any recommendations made by regulators including the Care Quality Commission. These actions will be fully integrated into the Trust's Quality Improvement Plan and will be monitored through the Quality and Standards Committee and the Trust Board

b) Operational Performance Plan

- **A&E 4 hour waiting standard**

A Health and Social Care debrief has taken place to ensure learning from the experiences during the winter months are captured for future planning purposes.

Variation in performance across the two main sites is the focus of particular attention with the aim of seeing consistence delivery in 2015/16.

- **RTT 18 week Standard**

2015/16 will be about maintaining steady progress and embedding best practice. The specialties of trauma and orthopaedics, particularly spinal surgery and gastroenterology, will need to continue to work to recovery plans/trajectories.

- **Diagnostics**

The Trust expects to see sustained delivery of the 6 week target moving into 2015/16.

The particular challenge for gastroenterology moving forward is the consequence of the extensions to national screening programs as well as the various national cancer campaigns which increases the demand on the specialty. The Trust will continue to forward plan to ensure that it has appropriate resources in place to meet these requirements.

- **Cancer Services**

2015/16 is about embedding best practice to achieve sustainable delivery of the cancer standards. For some tumour sites performance is dependent on other Trusts and close working relationships will continue through both the Cancer Partnership Board and Cancer Networks to ensure delays are minimised.

- **Demand and Capacity**

Our activity assumptions are based on 2014/15 forecast outturn activity plus 1.5% growth. As part of the planning process the Trust has developed a demand and capacity model which also supports the job planning process to ensure capacity is appropriate to meet demand and consultant contracts maintain and appropriate level of productivity and delivery. This work has also been supplemented with a bed capacity model, developed by the management consultants Capita, to ensure the bed compliment is appropriate in each specialty.

c) Workforce Plan

Specific areas of workforce focus during 2015/016 will continue to include:

Clinical Services:

- Ensuring recruitment to all vacant posts
- Recruitment strategy
- Improved roster management
- Enhanced role for support worker
- Improved absence management policy and process.

4. Financial and Investment Strategy

4.1 This section sets out the provisional financial plan and underlying assumptions for the forthcoming year, including cost improvement plans, together with an initial allocation of expenditure budgets. This is a provisional report pending finalisation of discussions within the Local Health Economy with all main commissioners (CCG and specialist) about the 2015/16 annual contracts for the provision of services.

4.2 From the outset of the financial year, the Trust needs to have issued budgets to clinical units, reflecting its financial plans and targets. As part of the NHS planning requirements draft financial plans were submitted to the TDA (Trust Development Authority) in January but further progress has been delayed for

resolution of the national tariff issue. This is not the final plan for 2015/16 and a number of key planning assumptions remain under discussion. The final plan (approved by the Trust Board) is due to be submitted to the TDA on 14 May 2015.

4.3 Ahead of the final plan being finalised the Board is asked to agree that provisional 2015/16 expenditure budgets are issued to clinical units based on the assumptions set out in below.

5. Financial and Investment Strategy

5.1 The wider fiscal constraint impacting on all public sector bodies coupled with rising patient and regulator expectations continues to heighten the financial challenge. This is consistent across the NHS, including foundation trusts.

5.2 The Trust set a planned deficit in the current financial year of £18.5 million. This deficit was based on delivery of a cost improvement programme (CIP) of £20 million. Following the issue of £18m of non-recurrent provider deficit funding and an increase to the CIP, the Trust is now expecting to deliver an £88k surplus. The delivery of the financial plan is based on a strategy of:

- Cash releasing savings through improved productivity and better value for money
- Tight controls on costs, particularly agency usage and enhanced pay.
- Developing collaborative relationships with commissioners to optimise our income position.

5.3 At this stage the Trust's view of its contract income for next year has not been agreed with main commissioners (CCG and specialist). This will need to be resolved and agreed over the next few weeks.

5.4 The Trust faces a number of significant cost pressures, both national and local. These include:

- Loss of income from East Sussex Better Together (ESBT) initiatives
- Potential loss of income from the new MSK Partnership arrangements
- Potential loss of HWLH Community Contract
- Loss of income re Wheelchair service
- CNST increase (£4.2m)
- Shortfall in delivering £15m CIP target (estimated £3.6m)
- Investment in Quality Improvement Programmes (£tbc)
- Marginal cost reimbursement for specialised services contract overperformance

5.5 Expenditure budgets have been set based on outturn performance, adjusted for agreed cost pressures and non-recurrent events; then adjusted downwards based on identified CIP initiatives. To meet the various financial

pressures and achieve the planned deficit the Trust has set itself cost improvement targets of £15m (3.8% of baseline expenditure); however, only £11.4m is identified. A contingency of 1% of turnover has been set (£4m). The Trust will require additional Public Dividend Capital funding to cover the cash shortfalls arising from any deficit plan.

6. Provisional Financial Outlook

6.1 Based on the above the income/expenditure outlook for 2015/16 is summarised below.

Provisional Summary Income & Expenditure Forecast Outturn & Plan 2014/15 - 2015/16

Summary Income & Expenditure Statement	2014/15 Forecast Outturn £000's	2015/16 Provisional CU Plan £000s
NHS Patient Income	348,065	TBC
Private Patient/ ICR	3,190	3,990
Trading Income	5,292	5,451
Education	10,117	10,117
Other Non Clinical Income	17,492	16,196
2015/16 Income related CIP		680
Total Income (excludes 15/16 contract income)	**384,156**	**36,434**
Pay Costs (Net of CIP)	-244,093	-242,847
Ad hoc Costs	-311	0
Non Pay Costs (Net of CIP)	-88,971	-88,280
Tariff Excluded Drugs and Devices	-29,208	-33,469
3rd Party Costs	-868	0
Contingency		-4,000
Total Direct Costs	**-363,451**	**-368,596**
Depreciation	-12,265	-12,759
PDC Dividend	-8,158	-8,974
Interest	-194	-171
Total Indirect Costs	**-20,617**	**-21,904**
Total costs	**-384,068**	**-390,500**

Memorandum; Total CIP	**21,017**	**11,375**

6.2 A budget book, setting out expenditure plans and workforce numbers for all clinical units, will be issued following approval of the provisional budget.

7. Activity and Income

7.1 Activity plans are yet to be finalised with the Clinical Commissioning Groups (CCGs). Activity plans are expected to be in line with 2014/15 outturn plus growth of 1.5%. Demand management plans arising from ESBT are yet to be agreed.

8. Cost Improvement Plans for 2014/15

8.1 In line with the rest of the public sector the East Sussex Healthcare Trust and the local health economy continue to face a considerable financial challenge to deliver cost reduction targets. The initial target for CIPs in 2015/16 was £20m (5.3%); this was reduced following the issue of the draft tariff to £15m (3.8%) to bring the Trust into line with other providers and reduce the non-delivery risk stemming from a further year of a £20m or similar target.

8.2 The unprecedented productivity challenges facing the Trust and the wider NHS highlight the need for a clear framework for delivery. The Trust has developed a stratified cost improvement programme based on seven key themes to ensure cost savings and efficiencies can be delivered, based upon the following principles:

- It is unlikely that a traditional 'salami slicing' savings programme would be successful.
- Clinical frontline services must be prioritised over non-clinical support expenditure.
- Emphasis should be placed upon making savings by reducing waste, improving productivity and enhancing value for money.
- To incorporate the lessons from the 2014/15 CIP process.

8.3 The resulting CIP initiatives have been grouped around the following themes and areas:

- Clinical Services Value for Money – e.g. reduced agency costs.
- Clinical Services Productivity – e.g. theatre utilisation.
- Medicines Management – reducing drug costs.
- Back office – e.g. reduced management consultancy.
- Estates and facilities productivity.
- Reductions in fines and penalties.
- Income generation.

8.4 There are plans in place to deliver £11.4 million of savings in 2015/16. These vary in terms of difficulty, complexity and risk. There remains a gap of £3.6m against the £15m target.

8.5 The gap arises because most areas within the Trust believe they are unable to meet their targets to reduce cost and maintain current levels of quality and access:

- There is currently limited productivity improvement in key cost driver areas i.e. the management of beds through improvements in length of stay, management of outpatients through improved utilisation.

- There is limited opportunity to materially improve productivity through single site working in key CUs (over and above what has been achieved over the past two years); namely, Specialist Medicine, Urgent Care, Surgery, Women and Children services.

- Corporate areas are unable to generate further economies of scale following the restructures completed in 2014/15.

- Outsourcing workstream has thus far not identified any savings opportunities.

- Income generation is limited in the current fiscal environment.

8.6 For the schemes developed F&I can be assured that:

- PIDs have been developed for all schemes, as appropriate.

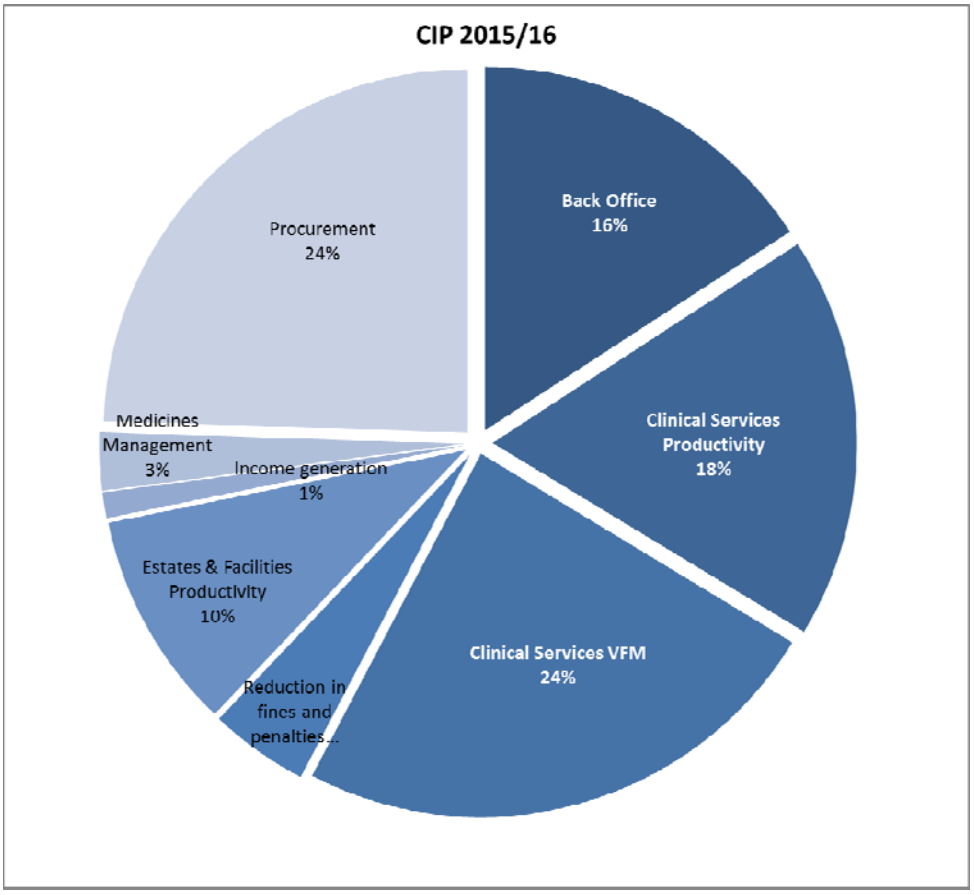
- The plans have been tested both in terms of deliverability and any potential adverse quality impact.

- The budgets are set net of identified CIPs.

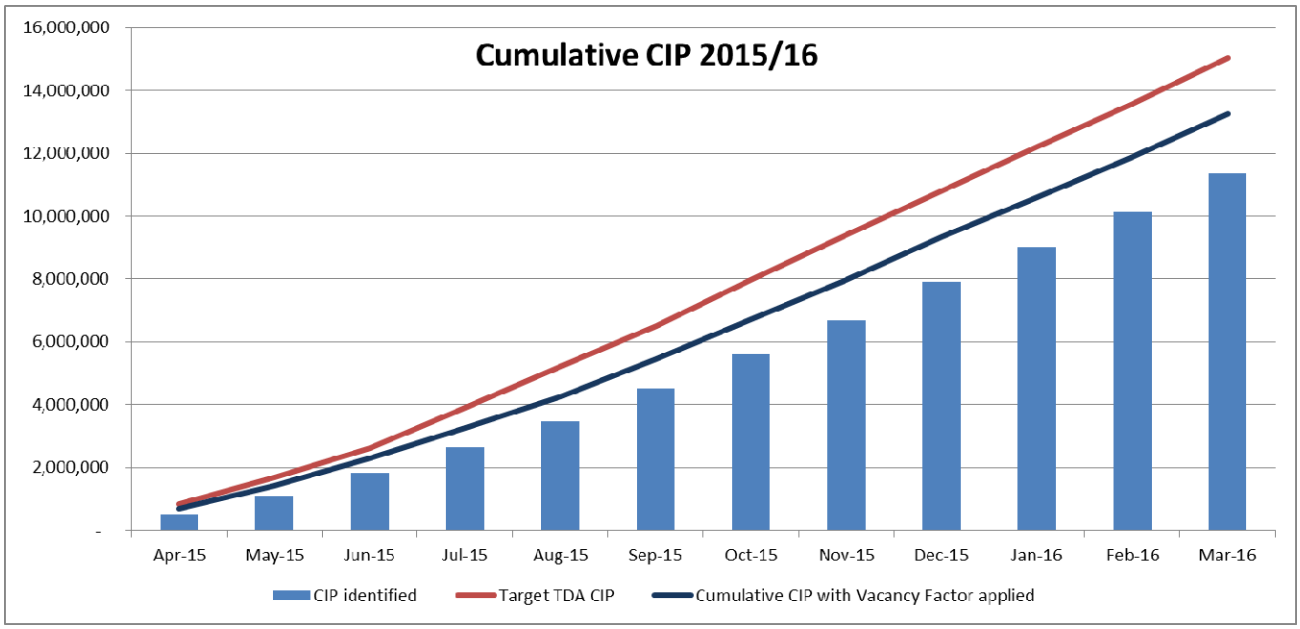
- Accountability Reviews will continue with all CUs to oversee delivery and performance management.

8.7 The plans to deliver £11.4 million savings against the overall themes are shown in the chart below:

East Sussex Healthcare NHS Trust
Summary of Plan for 2015/6



8.8 The cost improvement plan is profiled to deliver as evenly as possible across the year, and all efforts are being made to ensure that the Trust is prepared at a granular level to deliver from Month 1. The monthly and cumulative profile is shown below:



8.9 The options for closing this gap are:

- Apply a vacancy factor of 1% against all CUs and 1.5% against corporate areas not achieving their savings targets (this would reduce the gap by £1.9m).

- 7.9.2 Apply further challenge in major cost drivers e.g. further improvement in theatre utilisation, outpatient utilisation and length of stay

- 7.9.3 Apply an increase in income target from CCGs. This is considered high risk and in any case is dependent on the contract arrangements made.

9. Capital Programme

9.1 The provisional 2015/16 capital programme is attached at Annex 1. It has been discussed and agreed by the Capital Approvals Group (CAG). During the year the CAG will also keep the programme under review in order to reflect the timing of the capital requirements arising from the clinical strategy as these become clearer.

9.2 In setting the 2015/16 capital programme with an acceptable 'over planning margin' the CAG have applied the following principles in order to balance the level of capital demand to the level of available capital resources:

- Maintenance & replacement capital items are funded at the level of retained depreciation.

- Significant capital expenditure continues to be planned to deliver the clinical strategy proposals including the reconfiguration of wards to provide more single en suite rooms and to manage service rationalisations. It is planned that this capital expenditure is funded by exceptional public dividend capital (PDC) with the draw down planned as 2015/16, £17.4m and 2016/17, £11.6m.

- The upgrading and improvement of Pevensey Ward on the DGH site is planned to be completed in 2015/16. The total scheme cost being £2.5m with £0.3m being incurred in 2014/15.

- Allowance has been made for capital purchase of medical equipment at a level required to address the backlog in equipment replacement.

- The over-planning margin will be managed by slippage on schemes during the year.

- In addition, based on historic levels, significant donated funds, principally from the generous support of the Friends of the Hospitals, are anticipated to continue to be available to the Trust during the financial year.

10. Capital Risks

10.1 The Trust is facing a number of risks in relation to the total value of capital resource available in 2015/16 to meet the capital needs of the Trust. In summary the risks are:

- The decision and support for additional strategic capital from the TDA has been slow, and a high degree of uncertainty remains.

- 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 the replacement of essential equipment and a consequent increase in maintenance expenditure.

- The successful implementation of the IM&T strategy will require significant resources in future years.

11. Conclusion and Recommendation

11.1 The Trust's financial plan for 2015/16 is extremely challenging and will require sustained focus.

11.2 The Board is asked to:

- Agree the draft plan to allow provisional expenditure budgets to be set.
- Note the financial outlook for 2015/16 based on the current assumptions.
- Note that, given the on-going work to align Trust/main commissioner assumptions, a fully developed budget is not yet available for Board approval.
- Provisionally adopt the one year capital programme

Annex 1

Provisional 2015/16 capital programme

Capital Programme	2015/16 £000s
Capital Resources	
Depreciation	12,130
League of Friends Support	1,541
Exceptional Public Dividend Capital (PDC)	17,400
Interest Bearing Capital Loan – Health Records	441
Interest Bearing Capital Loan Repayment	-427
Sub Total Gross Capital Resource	31,085
Less Donated Income Support	-1,541
Total NHS Capital Financing (Capital Resource Limit)	**29,544**
Planned Capital Expenditure	
Clinical Strategy reconfiguration.	17,400
Medical Equipment	1,764
Information Systems - Core	1,577
PAS Upgrade	523
Electronic Document Management	1,010
Child Health Information Systems	510
National Barcoding Mandate GS1	200
Estates Development Plans	2,000
Estate Modernisation	
Infrastructure improvements - infection control	700
Electrical supply Issues – DGH site	100
Pevensey Ward	2,200
Minor capital	1,500
Health Records	441
Other	1,047
Sub Total	**30,972**
Donated Asset Purchases	1,541
Donated Asset Funding	-1,541
Net Donated Assets	
Sub Total Capital Schemes	**30,972**
Under commitment/Over Planning Margin	-1,428
Total CRL Capital Expenditure	**29,544**

East Sussex Healthcare NHS Trust

Date of Meeting:	25thMarch 2015
Meeting:	Trust Board
Agenda item:	14
Subject:	Capital Programme Review
Reporting Officer:	Vanessa Harris – Director of Finance

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

Purpose:

To provide the Trust Board with a review of the 2014/15 capital programme at the 31stJanuary 2015, together with a forward look over the next 5 years until 2019/20.

Introduction:

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

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

The capital programme has been under severe pressure throughout the financial year with demand for capital expenditure far out stripping available resources.

Following discussions with the Trust Development Authority (TDA) a capital application of £869k has been made for improvements in the storage and access to health records, an issue that has been on the Trust risk register for some time and was highlighted by the CQC informal feedback.

The proposed loan of £869k will be drawn down over 2 financial years. The draw down in 2014/15 is planned at £428k with the remaining balance of £441k in quarter one of 2015/16. The loan will be repayable over 10 years and the DH interest rate will be fixed on the date the loan is received. This is expected to be around the current 2.2% DH rate for a 10 year loan.

Following the approval of the additional capital resource the 2014/15total capital resource limit (CRL) will increase to £11.8m.

The forecast is for the Trust to achieve a breakeven position against its CRL at 31st March 2015.

Benefits:

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

Risks and Implications
The Trust continues to face risks in relation to the total value of capital resource available to meet the capital needs of the Trust. In summary the risks are in respect of:- • Backlog maintenance of the Trust's estate. • Backlog medical equipment replacement. • IM&T costs arising from backlog pressures and IT strategy.

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 CAGreviewed the capital programme at its meeting on 26thFebruary 2015.

Proposals and/or Recommendations
The Trust Board is asked to:- i) Note the current performance of the capital programme. ii) Note the capital loan application of £869k repayable over 10 years. iii)Note the capital programme will be managed to ensure the CRL is not breached at 31st March 2015. iv) Note the 5 year capital programme is the subject of on-going development to meet the changing needs of the Trust.

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	**Contact details:** vanessa.harris2@nhs.net

Trust Board Meeting

Capital Programme Review

Introduction:

1 This report provides the Trust Board with a review of the 2014/15 capital programme for the period ending the 31st January 2015, together with a forward look over the next 5 years until 2019/20.

2 The paper also reflects the recommendations and decisions made at the February Capital Approvals Group (CAG) meeting.

Summary

3 Thecapital programme has been under severe pressure throughout the financial year with demand for capital expenditure far out stripping available resources.

4 In order to try to address the demand and the associated risks arising in the current financial year and following discussions with the Trust Development Authority (TDA) a capital application of £869k has been made for improvements in the storage and access to health records, an issue that has been on the Trust risk register for some time and was highlighted by the CQC informal feedback.

5 Theproposed loan of £869k will be drawn down over 2 financial years. The draw down in 2014/15 is planned at £428k with the remaining balance of £441k in quarter one of 2015/16. The loan will be repayable over 10 years and the DH interest rate will be fixed on the date the loan is received. This is expected to be around the current 2.2% DH rate for a 10 year loan.

6 Following the approval of the additional capital resource the total capital resource limit (CRL) has increased to £11.8m.

7 The forecast is for the Trust to achieve a breakeven position against its CRL at 31st March 2015.

Capital Expenditure Position at Month 10 – 31stJanuary 2015.

8 At the end of month 10 the year to date capital expenditure amounted to £7.8m.

9 Commitments entered into totalled £10.4m, and further forecast commitments increase the potential total capital commitment to £11.8min line with the Trust's2014/15capital resourcelimit.

2014/15Current Capital Programme

10 Following the application for the capital loan and in order to meet the changing capital requirements of the Trust the 2014/15 capital programme has been reviewed by the CAG and the revised programme is set out below:-

2014/15 Capital Programme	2014/15 Revised Capital Programme £000s	2013/14 Forecast Commitment £000s	Expenditure Month 10 £000s
Capital Resources			
Depreciation	11,285		
League of Friends Support	1,300		
Capital Loan Application	428		
Additional Public Dividend Capital	400		
Sub Total	13,413		
Interest Bearing Capital Loan Repayment	-340		
Less Donated Income	-1,300		
Total NHS Capital Financing (Capital Resource Limit)	**11,773**		
Planned Capital Expenditure			
Clinical Strategy Reconfiguration	0	0	0
Conquest Clinical Decision Unit	400	350	331
Health Records	428	428	0
Clinical Strategy Essential Enabling Works	250	280	280
Medical Equipment	2,888	2,474	1,881
Information Systems	823	942	443
Electronic Document Management	100	100	93
Child Health Information System	557	690	565
Backlog Maintenance	1,046	1,066	434
Infrastructure Infection Control	630	688	422
Electrical Supply to the DGH	540	390	0
Minor capital	2,200	2,200	1,833
Pevensey Ward	300	300	249
Other	1,372	880	528
Brought Forward Schemes	1,025	1,010	770
Sub Total	**12,559**	**11,798**	**7,829**
Donated Asset Purchases	1,300	1,300	695
Donated Asset Funding	-1,300	-1,300	-695
Net Donated Assets	**0**	**0**	**0**
Sub Total Capital Schemes	**12,559**	**11,765**	**7,829**
Over Planning Margin (-) /Under commitment (+)	-786	-25	
Total Capital Expenditure	**11,773**	**11,773**	**7,829**

11 The forecast capital programme over commitment of £25k will be managedto ensure the CRL is not breached at 31st March 2015.

Risks.

12 Despite receiving additional capital resource in 2014/15 the Trust continues to face a considerable capital investment back log. As a result the capital programme will continue to beunder pressure as demands for capital expenditure continue toexceed available resources.

Five Year Capital Programme 2015/16 to 2019/20

13 The future year's capital programme continues to be revised and developed by the CAG through the capital planning process. The draft 5 year programme set out below reflects the current proposalsas submitted to the TDA on 13thJanuary 2015 as part of the TDA financial planning timetable.

The key issues under pinning the current draft 5 year capital programme are:-

- Maintenance & replacement capital items are funded at the level of retained depreciation.
- Significant capital expenditure continues to be planned to deliver the clinical strategy proposals including the reconfiguration of wards to provide more single en suite rooms and to manage service rationalisations. It is planned that this capital expenditure is funded by exceptional public dividend capital (PDC)with the drawdown planned as 2015/16, £17.4m and 2016/17, £11.6m.
- The upgrading and improvement of Pevensey Ward on the DGH site is planned to be completed in 2015/16. The total scheme cost being £2.5m with £0.3m being incurred in 2014/15.
- Allowance has been made for capital purchase of medical equipment in future years at a level required to address the backlog in equipment replacement.
- The over-planning margins will be managed by slippage on schemes during each year. The final level of over commitment will be set at a value that is considered a reasonable level based on past experience and the forecast content of each year'scapital programme.
- The Trust hopes to continue to benefit from the very considerable support of the Friends of the Hospitals.

Five Year Capital Programme 2015/16 to 2019/20	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s	2019/20 £000s
Capital Resources					
Depreciation	12,130	13,929	14,847	15,058	15,293
League of Friends Support	1,541	1,000	1,000	1,000	1,000
Exceptional Public Dividend Capital (PDC)	17,400	11,600			
Interest Bearing Capital Loan – Health Records	441				
Interest Bearing Capital Loan Repayment	-427	-427	-427	-436	-285
Sub Total Gross Capital Resource	31,085	26,102	15,420	15,622	16,008
Less Donated Income Support	-1,541	-1,000	-1,000	-1000	-1,000
Total NHS Capital Financing (Capital Resource Limit)	**29,544**	**25,102**	**14,420**	**14,622**	**15,008**
Planned Capital Expenditure					
Clinical Strategy reconfiguration .	17,400	11,600			
Medical Equipment	1,764	5,955	5,602	3,969	3,420
Information Systems - Core	1,577	1,140	890	865	865
PAS Upgrade	523				
Electronic Document Management	1,010	804	164	9	9
Child Health Information Systems	510				
National Barcoding Mandate GS1	200				
Estates Development Plans	2,000	5,010	4,445	4,120	4,095
Estates Modernisation		2,000	2,000		
Infrastructure improvements - infection control	700	700			
Electrical supply– DGH site	100				
Pevensey Ward	2,200				
Minor capital	1,500	1,000	1,000	1,000	1,000
Health Records	441				
Other	1,047	772	1,902	6,270	7,260
Sub Total	**30,972**	**28,981**	**16,003**	**16,233**	**16,649**
Donated Asset Purchases	1,541	1,000	1,000	1,000	1,000
Donated Asset Funding	-1,541	-1,000	-1,000	-1,000	-1,000
Net Donated Assets					
Sub Total Capital Schemes	**30,972**	**28,981**	**16,003**	**16,233**	**16,649**
Under commitment/Over Planning Margin	-1,428	-3,879	-1,583	-1,611	-1,641
Total CRL Capital Expenditure	**29,544**	**25,102**	**14,420**	**14,622**	**15,008**

Capital Pressures & Risks

14 The proposed 5 year capital programme outlined above will be subject of on-going development to meet the needs of the Trust through the capital planning process. This will include balancing risks in relation to the total value of capital resource available to meet the capital demands of the Trust. In summary the risks are:-

- **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 the 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 an additional £2.8m annually. In addition the estimated medical equipment backlog requires investment of at least an additional £3.0m per year over the planning period. The IM&T strategy is also likely to require significant resources in future years.

Recommendations

16 The Trust Board committee is asked to:-

i) Note the current performance of the capital programme.
ii) Note the capital loan application of £869k repayable over 10 years.
iii) Note the capital programme will be managed to ensure the CRL is not breached at 31st March 2015.
iv) Note the 5 year capital programme is the subject of on-going development to meet the changing needs of the Trust.

Vanessa Harris
Director of Finance

6th March 2015

East Sussex Healthcare NHS Trust

Date of Meeting:	25th March 2015
Meeting:	Trust Board
Agenda item:	15
Subject:	Eliminating Mixed Sex Accommodation Declaration
Reporting Officer:	Richard Sunley, Chief Operating Officer

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

Purpose:

The NHS Operating Framework 2013/14 requires all providers of NHS funded care to confirm whether they are compliant with the national definition to eliminate mixed sex accommodation except whether it is in the overall best interests of the patient, or reflects their patient choice. The Trust is required to routinely report breaches of sleeping accommodation and declare by 1 April each year that they are compliant.

Introduction:

The Operating Framework 2013/14 states that:

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

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

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

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

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

As outlined above

Benefits:

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

Risks and Implications

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

Assurance Provided:

Performance reported to the Board on a monthly basis.

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

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

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Richard Sunley, Chief Operating Officer	r.sunley@nhs.net

Declaration of compliance

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

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

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

What does this mean for patients?

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

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

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

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

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

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

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

How will we measure success?

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

Future plans

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

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

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

East Sussex Healthcare NHS Trust

Audit Committee

1. Introduction

Since the Board last met an Audit Committee has been held on 4th March 2015. A summary of the items discussed at the meeting is set out below.

2. Board Assurance Framework and High Level Risk Register

Head of Compliance presented the High Level Risk Register and the Board Assurance Framework and noted that it had been reviewed and updated since the previous audit committee in January.

3. Women & Children's Unit Risk Register and Clinical Audit Plan

a) Risk Register

The General Manager reported that the unit had 17 risks open, of which nine were identified as inadequate controls and related to staffing, infrastructure, issues with a new IT system and mobile phone network issues. She advised on the mitigating actions been taken in respect of these risks.

b) Clinical Audit Plan

The Risk Lead for the Women & Children's Unit presented their audit plan and advised that the Unit had a comprehensive plan for audit in place and held frequent audit meetings with regular presentations.

The Head of Nursing for the Cardiovascular Clinical Unit gave an update on the unit's Risk Register and noted that there were five open risks, of two would be removed following the unit's next risk meeting. The three remaining risks related to medical and nurse staffing.

4. Estates' Risk Register

The Facilities Manager for Estates gave an update on their Risk Register and noted that there were thirty three open risks, rated as follows:

Extreme	(15 or above)	4
High	(8-12)	26
Moderate	(4-6)	3
Low	(1-3)	0

The extreme rated risks were around hospital infrastructure, fire safety, electrical supplies to the clinical equipment in the Heart Centre and workforce.

The facilities manager reported that a four year investment plan in fire safety works had been agreed and approved with the Fire Service.

5. Clinical Audit Update

An overview was given of the clinical audit activity that had taken place across the Trust in this year and the Clinical Effectiveness Lead confirmed that all outstanding audits from 2012/13 were underway and had reduced to 5. She reported that the outstanding audits from 2013/14 had reduced to 16.

The Clinical Effectiveness Lead reported that the Clinical Audit Forward Plan had been circulated to all of the Clinical Units.

It was noted that the Trust was unable to participate in the National Adult Diabetes Audit due to the lack of a dedicated IT solution, and the Diabetic Service will put together a business plan in order to start the process of addressing this issue.

6. 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 five further audits had been finalised three with limited and two with reasonable assurance opinions.

The Committee also received, and approved, the Internal Audit Plan for 2015/16 which is due to focus on operational areas, assurance frameworks and core areas such as risk registers and the requirements of the TDA..

The updated Audit Recommendations Tracker was presented. It was noted that good progress was continuing to be made in completing actions arising from audits.

7. Local Counter Fraud Service

The Committee received the progress report and noted actions being taken on current reactive investigations. The LCFS manager also highlighted that the proactive work being taken in relation to document training by the UK Border Agency had been completed and the results were excellent. He explained that the Work Plan for 2015/16 was not yet available.

8. External Audit Progress Report

The External Auditor presented a progress report on their audits for 2014/15, and presented their audit plan for 2015/16.

9. Draft Annual Governance Statement

The Head of Compliance presented the Draft Annual Governance Statement.

10. Changes in Accounting Policies

The Deputy Director of Finance presented a report on Changes in Accounting Policies for the 2015/16 financial year.

11. Tenders and Waivers Report

The Committee noted the Tenders and Waivers report.

12. Declarations of Interest

The Committee noted the Declarations of Interest report.

13. Information Governance Toolkit Update

The Committee received an update on progress against the Information Governance Toolkit (IGT) requirements and were informed by the Head of Compliance that the Trust was likely to achieve level 2 compliance at the end of March 2015.

14. Annual Review of Effectiveness

The Committee noted the Annual Review of Effectiveness paperwork.

Mike Stevens
Chair of Audit Committee

9th March 2015

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 17 December 2014 at 9.30am in St Mary's Board Room, Eastbourne DGH

Present
Mr Barry Nealon, Non-Executive Director/Chair
Mr Michael Stevens, Non-Executive Director
Professor Jon Cohen, Non-Executive Director
Mr Stuart Welling, Chairman
Mrs Vanessa Harris, Director of Finance
Mr Gary Bryant, Deputy Director of Finance

In attendance
Ms Monica Green, HR Director (for item 4 (i)
Mr Simon Wombwell, Transformation Adviser (for Item 5)
Mr Ian Bourns, Chief Pharmacist (for item 13)
Ms Amanda Isted, Pharmacy Operations Manager (for item 13)
Miss Chris Kyprianou, PA to Finance Director (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the meeting. Apologies were received from Darren Grayson, Richard Sunley and David Hughes.	**Action**
2.	**Minutes of Meeting of 19 November 2014** The minutes of 19 November were agreed as an accurate record.	
3.	**Matters Arising** (i) Difficult to Recruit Areas It was noted that recruitment issues were being discussed at CME. A workforce update was provided under agenda item 4(i) below. (ii) Performance Report – M6 Mrs Harris reported that a revised trajectory had been submitted to the TDA that showed the Trust as being compliant for non admitted pathways by 1 February 2015. (iii) Transformation Update Mr Wombwell provided a further update under agenda item 5 below.	

	(iv) EBITDA - Cardiology The Cardiology action plan was scheduled for the February 2015 meeting. (v) OBC for East Sussex Linked Radiotherapy Unit It was noted that the full business case was still on track for the January Trust Board meeting before being submitted to the TDA for approval.	
4(i)	**Performance Report – Month 7** The Committee received the month 7 Performance Report which detailed the Trust's in month performance against key trust metrics as well as activity and workforce indicators. This report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15. It was noted that the Overall Performance Score: 4 (from a possible 5). Responsiveness Domain: 2 Decline from September. A&E performance did not achieve the 95% standard. In addition to this Cancer performance (preview data) had not achieved the 2 week wait, 31 day or 62 day standards. RTT performance continued to align with the trajectory agreed with the TDA. The aggregate position will be achieved across admitted and incomplete pathways from December 2014 and for non admitted by 1 February 2015. 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. Safe Domain: 4 Decline from September. There were 7 reported cases of C-Dificile, and 3 reported harmful incidents. Caring Domain: 4 Decline from September. A&E Friends and Family scores fell slightly below the required standard. Well Led Domain: 4 Turnover, sickness and appraisal rates remain below the required standard, holding the domain score at 4	

	The Committee noted with concern that the Trust had moved away from the cancer targets trajectory and requested that Mr Sunley attend the next meeting to reassure the Committee on the actions in place to get back on track. This should also be discussed at Quality and Standards Group. Ms Green had been invited to attend the Committee meeting to provide an update on workforce. She reported that within the month there was a slight decrease in permanent staff resulting in an increase in both agency and bank staff; however despite this, there was a reduction in costs as a result of less use of medical agency. It was reported that there were tight controls in place on use of agency. Ms Green reported that there were still ongoing recruitment issues, although in many areas this was a national problem. There was a high turnover in areas such as Allied Health Professionals and Professional & Technical staff. It was noted that within the month pay expenditure was £482k above budget and £1173k over budget for the year to date. Ms Green reported that there is typically a seasonal increase in sickness in October however this year the trust had seen the largest increase of 0.74% to a monthly high of 5.5%. Sickness was being monitored through accountability reviews. Mandatory training compliance rates had shown a steady but slow rate of increase over the last six months. A target of 85%+ compliance was set in mid October by the Clinical Management Executive on all aspects of mandatory training by 31 December 2014 (except Health & Safety). Ms Green gave an update on the Staff Friends and Family Test (SFFT) which was introduced to NHS organisations in April 2014. It was noted that the Trust response rate was very low and the results were poor. The Committee asked if Ms Green could consider how the Committee could selectively look at this further. Ms Green noted that the annual national survey results would be published early in 2015 and should provide a more robust overview. **Action** **The Committee noted the Performance Report for month 7 and noted the Trust Performance against each domain and the Workforce update.**	**RS** **MG**
4(ii)	**Finance Update – Month 8 Flash Report** Mrs Harris presented a summary of the financial performance at Month 8.	

	The report provided an early snapshot of the M8 financial position allowing the Finance and Investment Committee to understand the progress being made to deliver the year end FOT, which following the issue of non-recurrent deficit funding of £18m, had moved to a FOT of £88k surplus. Following confirmation of receipt of non-recurrent deficit funding of £18m, of which £12m (8/12) had been recognised at M8, the year to date (YTD) run rate was a deficit of £1.11m which was £11.337m better than original plan. In month there was a surplus of £91k. This position included £1.5m (1/12) of the non-recurrent £18m amount. When this is stripped out, the in-month position was a deficit of £1.409m which was unfavourable by £876k to the original plan of £533k deficit. Analysis was ongoing as to the main reasons for this variance, some of which was income related, but a part of it was due to the continuing delivery of CIPs at slightly less than planned levels. The YTD position, with the £18m stripped out, was that the Trust was £663k unfavourable to original plan. Progress was being maintained in reducing monthly costs and achieving the year end FOT position but the further identified savings initiatives would have to deliver if the year-end surplus position is to be achieved. It was agreed that to avoid confusion arising from comparison of the actual financial position to the original plan, which is pre-receipt of the non-recurrent funding, an amended I&E trajectory would be included in future reports. **Action** **The Committee noted the Month 8 financial position.**	**VH**
5.	**Transformation Update** Mr Wombwell updated the Committee on the progress and process for supporting the Trust to meet its financial targets in 2014/15 and deliver a sustainable plan for 2015/16. A review of the Month 5/August financial forecast, supported by Month 6/September results highlighted the Trust was carrying some risk to the delivery of the original £18.5m deficit financial target. F&I Committee received a summary of initiatives totalling £2m at its October Meeting and requested actions to increase this value by circa £600k to provide further comfort in the delivery of the 2014/15 plan. Following this discussion the Trust received an income adjustment from the TDA of £18m and agreed to deliver a revised break even	

	plan for 2014/15. This gave the Trust a further savings challenge of £0.6m equal to the challenge set by the Finance & Investment Committee. The key issue is the organisation's ability to deliver further actions over and above the £2m presented at the October meeting, without compromising quality of care. The previous process interrogated run rates across the organisation, with a number of initiatives rejected due to quality impact risks. The Trust is also challenged to deliver RTT targets and the A&E 4 hour target. The further challenge arising from the Trust's break even target i.e. after receiving income of only £18m against an original £18.5m deficit plan. This increases the savings requirement and, in effect, absorbs the additional £0.6m challenge set by F&I. Whilst this is not ideal, our ability to create 'headroom for comfort' from the delivery of in-year savings is compromised. The Committee sought reassurance that Quality and Safety was not being affected in the effort to secure the annual savings programme. It was noted that delivery of the savings is supported by the Transformation Adviser and monitored through the CU Accountability Reviews, which monitors metrics for safety, quality, workforce as well as financial. A significant proportion of the savings involved "tighter controls", which will need careful consideration for their quality and safety impacts, and plans would be QIA assessed before implementation. The overall programme is accountable to the Business Planning Steering Group, chaired by the Chief Executive. The Committee asked that management remain absolutely focussed on the quality/safety/finance balance and agreed that this would continue to be reviewed in all appropriate Committee meetings. **Action** **The Committee noted the Transformation update**.	
6.	**Business Planning Process** Following the submission of the annual business planning process to the Board on 26 November 2014 which included the Trust's planning timetable, further clarification had been received on dates for submission from the TDA and the Committee received an updated timetable. The Committee noted the key deadlines and how Finance and Investment Committee and Board reviews would take place within the process. In June 2014 the Trust prepared a two year business plan in line with guidance from the Trust Development Authority (TDA). The Trust has now started the process to refresh and build on this plan for 2015/16.	

	It was noted that the Trust was required to submit a two year plan which is clearly aligned to commissioning intentions; and in line with TDA guidelines to the to the TDA by the end of March 2015. **Action** **The Committee noted the updated timetable.**	
7.	**EBITDA Quarterly Report – Q2** Mr Bryant presented the 2014-2015 Q2 EBITDA statement, the 2014/2015 quarterly EBITDA comparison statement and the Patient Cost Benchmarking EBITDA statement. It was noted that 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 2014/2015 Q2 EBITDA deficit position for the clinical units and the number of service lines that had negative EBITDAs. It also noted the 2014/2015 quarterly EBITDA variances and the effect on the EBITDA of using Patient Cost Benchmarking average unit costs when applied to ESHT inpatient activity. The Committee also received information on the top 5 negative EBITDA specialties. **Action** **The Committee note of the EBITDA statement position and recommended that the Committee continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews, and to return at a subsequent meeting to update on their progress.**	
8.	**2013-14 Reference Costs** Mr Bryant presented the published 2013-14 reference cost index. The Committee noted the 2013/14 reference cost index of 104, an improvement on the 2012/13 reference cost index which was 105. It was noted that reference costs are the average unit cost to the NHS of providing defined services in a given financial year to NHS patients in England and are collected annually by the Department of Health. The accuracy of the data has improved year on year due to refinements in the guidance and the collection process.	

	This document supports the publication of 2013/14 reference costs, which give the most comprehensive picture available about how 244 NHS providers (98 NHS trusts and 146 NHS foundation trusts) spent £58.3bn delivering healthcare to patients in 2013-14. Mrs Harris reported that the Internal Auditors had audited the Trust reference cost process and had provided the trust with substantial assurance. **Action** **The Committee noted 2013/14 reference cost index of 104.**	
9.	**Capital Programme Report** Mrs Harris presented the Committee with a review of the 2014/15 capital programme at the 30th November 2014. It was noted that capital pressures the Trust was facing were very significant with back log pressures on maintenance, medical equipment and IT at a time when it is also under pressure on its revenue performance. The mid year review report updated the committee on:- • The current performance of the capital programme. • The revised capital plan approved by the CAG in order to manage the capital plan within the capital resource limit (CRL). The Trust continues to face risks in relation to the total value of capital resource available to meet the capital needs of the Trust. In summary the risks are in respect of:- • Backlog maintenance of the Trust's estate. • Backlog medical equipment replacement. • Costs arising from IM&T backlog and infrastructure pressures. The Committee received assurance on the development, management and control of the capital programme which is reviewed on a monthly basis at the Capital Approvals Group. **Action** **The Committee** - **Noted the current performance of the capital programme** - **Noted the significant risks arising from the deferral of capital schemes in order to bring the capital programme into balance** - **Noted further revision of the capital programme will be required by the Capital Approvals Group in order that the Trust does not breach its capital resource limit (CRL) at 31**	

	March 2015.	
10.	**FBC: Capital Bid update** The Full Business Case for £30m of capital expenditure to implement ESHT's clinical Strategy was approved by the Board of ESHT on 11 December and lodged with the TDA. It is still pending TDA approval. In the meantime the Trust needs to ensure that the necessary infrastructure and equipment investment can be made so that it can maintain performance and quality standards through the 2014/15 winter and beyond, on a sustainable basis. As previously reported an emergency capital public dividend application for £400k had been agreed by the Independent Trust Financing Facility (ITFF) to improve the Emergency department space at the Conquest hospital. The work on creating 8 Major cubicles in the Emergency department at the Conquest by building a new 7 bedded Clinical Decision Unit (CDU) in space currently occupied by offices was now completed. Following further discussions with the TDA a targeted capital application of £869k had now been made for improvements in the storage and access to health records, an issue that has been on the Trust risk register for some time and was highlighted by the CQC informal feedback. The application set out a proposed solution to the current issues by • An improvement in the physical storage space • The introduction of a bar code identification system. The work would also be a precursor to launching the Trust's future scanning and EDM programme moving towards fully electronic records for the Trust. The Committee requested that a Health Records Strategy be developed so that the longer term aim of the Trust in this respect could be clearly demonstrated. **Action** **The Committee noted and approved the application for emergency capital to the ITFF**	**LS**
11.	**Making Better Use of Government Resource Services Procurement & Service Delivery Platforms** Mrs Harris updated the Committee on progress with the Department of Health (DH) invitation to take part in 1) a review of Government	

	support services and delivery platforms and 2) the Lord Carter review of efficiency and productivity metrics as outlined at previous Committee meetings. A Project Steering Group had been formed to oversee the projects. This was not a decision making body but was expected to reach conclusions and make recommendations to the Finance and Investment Committee where any formal decisions will be taken. Terms of Reference had been prepared and are available upon request. It was requested that these be made available with the minutes at the next meeting. A Non-Executive Director was part of the group membership; this is Barry Nealon, Chair of the Finance and Investment Committee and Non-Executive champion for procurement. The first meeting of the Project Steering Group was held on 24 September 2014 and minutes were submitted to the October Finance and Investment Committee meeting. The second meeting was held on 8 December 2014 (minutes not yet available). Templates had been submitted to the DH by the Trust which should allow SBS and NHSP to complete their diagnostic and costing exercise. The Plan was now to meet with each of SBS and NHSP to initiate a work programme. An exploratory meeting with SBS took has taken place. In addition and as reported through the market testing update at a previous Committee meeting, the DH had provided some soft FM expertise to ESHT with a view to looking at any potential efficiency in this area. This last area of work is under the leadership of Andy Horne, Programme Manager. Mrs Harris reported that she had attended a cluster meeting of College of Experts in early December to review the progress made on the "Lord Carter metrics" which were currently at a very early stage. The meeting was designed so that expert guidance could be offered on the first draft meeting thus enabling the project team to proceed to the next milestone. **Action** **The Committee noted the progress on these two projects to date and noted that under the Terms of Reference any recommendations will be brought to this Committee where any formal decisions will be taken.**	**CK**
12.	**Tender & Service Development Schedule** The Committee received a schedule which provided an update on current tenders and service developments. It was noted that the tender and service development schedule was updated on a weekly basis and monitored by the Business Planning Steering Group (BPSG) at its weekly meetings.	

	All new Pre Qualification Questionnaire (PQQ) or tender proposals were considered by the BPSG to determine whether a potential bid by the Trust will meet a number of key criteria including : • meets the strategic direction of the Trust, • is part of the core business of the Trust, or • fits with the business model. If a decision is made to consider a bid, a working group comprising the relevant clinical, operational and corporate services undertake a risk assessment and report back to the BPSG, following which a decision is taken as to whether to proceed with a bid. The BPSG also considers business cases for service developments to ensure that these are picked up in the annual business planning process. The Committee noted the position of the following PQQ/tenders in the pipeline: • Fracture Liaison Service • Non –invasive Ventilation Service • High Weld Lewes and Havens (HWLH) community services It was noted that the BPSG had agreed a specification for tendering support at its meeting on 2 December 2014 which would allow the Trust to learn by doing. The intention was to use the current tender for community services as an opportunity for developing key skills and processes. Key personnel will be taken through the tendering process including writing skills required to finalise a future value generating contract. The Committee requested that further information about the HWLH tender be discussed at the next Board seminar. **Action** **The Committee noted the update on tenders and service developments.**	**SW**
13.	**Application for Nurse Technology Fund – Automated Storage of Medicines** Mr Bourns presented a paper providing awareness of a £970,000 bid for Nurse Technology Fund capital for roll out of automated ward medicines storage equipment and of the benefits for ESHT of such a project. The storage and security of medicines at ward level did not meet	

national guidance. In addition a significant amount of nursing time is spent looking for keys and checking availability of stock in areas that do not receive a pharmacy top up service. The use of automated systems at ward level ensures compliance with national guidelines.

As part of financial turnaround work funding for a proof of concept pilot of automated ward medicines storage had been provided. The implementation of that pilot had now finished and 3 month data from some locations was available. This showed significant benefits that were providing local validation of benefits found in other Trusts. It had also demonstrated significant support amongst nursing staff in the pilot locations as they and their patients gain the greatest benefit from this equipment

The cabinets used in this project provide:

- secure, audited, keyless access to medicines for ward staff.
- restricted access just to the required drug, minimising risk of product selection errors,
- an active stock balance
- electronic linkage to the pharmacy computer and robotics so stock top up can be provided without staff input
- an electronic Controlled Drug Register and discrepancy reporting system.

All these free up nurse time from more rapid access to medicines, stop the need for their active input to drug stock ordering and allow pharmacy staff to be redeployed to put new stock into the cabinets. The nurse capacity gained provides more time for patient care and may reduce the needs for agency use.

There was national guidance related to the safe and secure handling of medicines in hospitals. The Trust has an obligation to comply with the guidance that requires medicines to be stored under lock and key with some low risk exceptions where rapid access is needed.

It was noted that earlier in the year the Trust had invested capital to introduce automated ward drug storage in 7 areas of the Trust as a proof of concept. These units have been in use since August 2014 and have already realised a number of benefits:

- Improved stock control, including financial controls and audit.
- Improved management of controlled drugs
- Improved, fast and secure access to medicines
- Release of nursing staff time to care for patients
- Ownership of medicines at ward level
- Compliance with CQC standards and legislation
- A decrease in the cost per patient

Action

	The Committee supported and approved the bid to the Nurse Technology Fund. Should the bid fail it was proposed that the business be considered again at a future F&I Committee to determine if it should gain internal capital funding.	
14.	**Work Programme** The 2015 work programme was reviewed. The Chair asked members to review the work programme and feed back on any issues. **Action** **The Committee noted the revised work programme.**	
15.	**Date of Next Meeting** The next meeting will take place on Wednesday 28 January 2015 at 9am – 11am, in the Committee Room, Conquest. A request was made to change the venue of this meeting to the DGH but unfortunately this has not proved possible due to lack of available rooms. If the situation changes a switch will be made.	

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

Dear colleagues,

I know that in the coming weeks we will all be reflecting on the findings of the Francis report into what happened at Mid Staffordshire NHS Foundation Trust. I am determined that this will not be another report to Government that creates a lot of short-term noise but no long-term change. We need to seize this moment and ensure that the legacy of Mid Staffs is a safer, more open and compassionate NHS.

Robert Francis has been clear that to achieve this, significant cultural change is required. We all know how hard this will be – and that it depends on us finding ways to talk about things that may be uncomfortable. This is a moment of truth for the whole system and we must not shy away from it.

I know that Sir David Nicholson, NHS CE, has written to all Chief Executives in the NHS today to ask them to consider the report carefully in a public board meeting, and to work with us as we take forward our response.

We know that staff who feel engaged, supported, involved and listened to are able to provide more compassionate care to patients. We must care for staff to care for patients. The first step in engagement is listening. To prevent another Mid Staffs, I believe that we need to start by really listening, to patients and families, and to all the dedicated NHS staff working on the frontline in the NHS whatever their seniority or experience.

Many organisations already provide absolutely brilliant care. But I know this is becoming ever more difficult as the NHS gets busier and the needs

of patients more complex, so I want to thank you for your continuing effort and commitment.

If you are not already doing so I would like to ask you to hold internal events to listen to staff and ask them not just what we can learn from Francis, but also how, in an ever busier NHS, we can make sure that we provide every patient with a service that stays true to our core values of care and compassion. I believe this needs to be a conversation in every team, in every ward of every hospital, to ask ourselves if we really are listening to our patients and giving them the care we would want for our own loved ones. Many wards - indeed I am sure the majority - already do this, but for all of us there is a great deal to learn from this challenging moment for the NHS.

Along with my Ministerial team and the most senior NHS leaders, I really want to hear the insights from your discussions, and we will be visiting hospitals up and down the country over the next year, to listen and understand what more needs to be done to make a lasting difference for staff and, most importantly, patients.

I also ask you to set out for your local community the ways in which you are listening to staff and patients, to rebuild public confidence in the safety and quality of NHS care. I hope that we can find ways to tell people the kinds of inspiring and moving stories, which I hear about care every time I visit an NHS hospital, and which remind people of the meaning and the challenging reality of the work that NHS staff do every day.

JEREMY HUNT

on the day BRIEFING

the association of foundation trusts and trusts NHS providers

FREEDOM TO SPEAK UP AND GOVERNMENT'S UPDATE ON LEARNING FROM THE FRANCIS INQUIRIES

Sir Robert Francis QC has today published *Freedom To Speak Up* , an independent review into creating an open and honest reporting culture in the NHS. The Secretary of State also made a statement setting out the government's response to the review. It has accepted all Sir Robert's recommendations in principle and will consult on a package of measures to implement them.

The government has also published, *Culture Change in the NHS: applying the lessons of the Francis inquiries* – which includes a high level response to today's report on whistleblowing and documents progress in meeting the recommendations within the Francis Public Inquiry, since the commitments made in 'Hard Truths' (November 2013). An update on progress against each of the 290 recommendations contained in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry is included as an appendix.

This briefing is therefore in two parts:

- firstly, it summarises the key recommendations and actions suggested in *Freedom To Speak Up*, and the package of announcements in the government's response. The majority of these will have direct implications for NHS providers and their boards so we would also encourage you to read the full report;
- secondly, it summarises key elements of the government's response and its wider update on progress in implementing the recommendations of the Francis Inquiry.

FREEDOM TO SPEAK UP: AN INDEPENDENT REVIEW INTO CREATING OPEN AND HONEST REPORTING CULTURES IN THE NHS

In an opening letter to the Secretary of State, Sir Robert acknowledges that the NHS is working hard to promote a more open and honest culture. He recognised that the handling of concerns is difficult for employers, particularly in distinguishing between genuine and dubious concerns, and there are significant challenges in finding the time and resources to deal sensitively with such issues given competing pressures. He also acknowledges that not all concerns are raised in good faith, and that the plight of other staff involved should not be ignored – that staff have a responsibility to raise concerns in a way that are sensitive to impacts on colleagues. However, the evidence he received during the review has confirmed that there is "an urgent need for system-wide action" to build a stronger NHS culture that encourages openness and makes staff feel safe to raise concerns. There are two main recommendations:

Recommendation 1: All organisations which provide NHS healthcare and regulators should implement the Principles and Actions set out in this report in line with the good practice described in this report.

Contact: Cassandra Cameron, Policy Advisor, cassandra.cameron@nhsproviders.org

Recommendation 2: The Secretary of State should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to Parliament.

The report then sets out **20 Principles with associated Actions** that aim to create better conditions for NHS staff to raise concerns about patient safety and care, to build knowledge sharing across the NHS and to improve standards of complaints handling across organisations and provide appropriate redress when errors occur. **He recommends these be implemented in the context of the significant policy and regulatory change and associated actions that NHS organisations have already undertaken to improve openness and transparency around concerns and complaints, and with scope for flexibility for organisations to adapt them to their own circumstances.** Chapters 1 to 4 provide the introduction including the legal and policy context, review the evidence received during the inquiry and set out the key themes identified from the evidence. The 20 Principles with associated Actions are then introduced thematically, with case study examples of good practice. We have summarised these below - please note that we have abridged the text where possible for brevity.

Culture

PRINCIPLE 1: Culture of Safety: Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning in which all staff feel safe to raise concerns.
Action 1.1: Boards should ensure that progress towards this is measured, monitored and published regularly
Action 1.2: System regulators should factor this into their assessment of whether an organisation is 'well led'.

PRINCIPLE 2: Culture of raising concerns: Raising concerns should be a part of the normal routine business of any well-led NHS organisation.
Action 2.1: All NHS organisations should have an integrated policy and common procedure for employees to formally report incidents or raise concerns.
Action 2.2: NHS England, TDA and Monitor should produce the standard integrated policy to support Action 2.1.

PRINCIPLE 3: Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
Action 3.1: All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns.
Action 3.2: Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well-led.
Action 3.3: Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.

PRINCIPLE 4: Culture of visible leadership: All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.
Action 4.1: Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.
PRINCIPLE 5: Culture of valuing staff: Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to issues.
Action 5.1: Boards should consider and implement ways in which the raising of concerns can be publicly celebrated.

PRINCIPLE 6: Culture of reflective practice: There should be opportunities for all staff to engage in regular reflection of concerns in their work.
Action 6.1: All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.

Improved handling of cases

PRINCIPLE 7: Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.
Action 7.1: Staff should be encouraged to raise concerns informally and work with colleagues to find solutions.
Action 7.2: All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with good practice.

PRINCIPLE 8: Investigations: When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
Action 8.1 All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice.

PRINCIPLE 9: Mediation and dispute resolution: Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.
Action 9.1: All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to: address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern; and, repair trust and build constructive relationships.

Measures to support good practice

PRINCIPLE 10: Training: Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
Action 10.1: Every NHS organisation should provide training compliant with national standards, based on a curriculum devised by HEE and NHS England in consultation with stakeholders in accordance with good practice.

PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.
Action 11.1: Boards of NHS organisations should ensure their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including:

a) an independent person (a 'Freedom to Speak Up Guardian') appointed by the chief executive
b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports to the Board
c) at least one nominated executive director to receive and handle concerns
d) at least one nominated manager in each department to receive reports of concerns
e) a nominated independent external organisation (such as the Whistleblowing Helpline) for staff

Action 11.2: All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern.
Action 11.3: NHS England, TDA and Monitor should issue joint guidance setting out the support required for staff who have raised a concern and others involved.

PRINCIPLE 12: Support to find alternative employment in the NHS: Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should offer support.
Action 12.1: NHS England, TDA and Monitor should jointly devise and establish a support scheme for NHS workers and former NHS workers whose performance is sound who can demonstrate that they are having difficulty finding employment in the NHS as a result of having made protected disclosures.
Action 12.1: All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS.

PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
Action 13.1: Quality Accounts should include quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.
Action 13.2: All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.
Action 13.3: a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest.
b) All such settlement agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is well-led.
c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case.
d) TDA and Monitor should consider whether their role of reviewing such agreements should be delegated to the Independent National Officer recommended under Principle 15.

PRINCIPLE 14: Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:

- poor practice in relation to encouraging the raising of concerns and responding to them
- the victimisation of workers for making public interest disclosures
- raising false concerns in bad faith or for personal benefit
- acting with disrespect or other unreasonable behaviour when raising or responding to concerns
- inappropriate use of confidentiality clauses.

Action 14.1: Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.

Action 14.2: Trust boards, CQC, Monitor and TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.
Action 14.3: All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.

PRINCIPLE 15: External review: There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to:

- review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up, where there is evidence that this has not been in accordance with good practice
- advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect
- act as a support for Freedom to Speak Up Guardians
- provide national leadership on issues relating to raising concerns by NHS workers
- offer guidance on good practice about handling concerns
- publish reports on the activities of this office.

Action 15.1: CQC, Monitor, TDA, and NHS England should consider and consult on how such a post might jointly be created and resourced and submit proposals to the Secretary of State, as to how it might carry out these functions in respect of ongoing and future concerns.

PRINCIPLE 16: Coordinated regulatory action: to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.
Action 16.1: CQC, Monitor, NHS TDA in consultation with the Department of Health should work together to agree procedures and define the roles to be played by each in protecting workers who raise concerns in relation to regulated activity. Where necessary they should seek amendment of the regulations to enable this to happen.
Action 16.2: Healthcare professional regulators should review their procedures and processes to ensure compliance with the good practice set out in this report and with this Principle.

PRINCIPLE 17: Recognition of organisations: CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
Action 17.1: CQC should consider the good practice set out in this report when assessing how organisations handle staff concerns. Good practice should be viewed as a positive factor contributing to a good or outstanding rating as part of their well-led domain.

Particular measures for vulnerable groups

PRINCIPLE 18: Students and trainees: All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
Action 18.1: Professional regulators and Royal Colleges in conjunction with Health Education England should ensure that all students and trainees have access to policies, procedure and support compatible with the principles.
Action 18.2: All training for students and trainees should include training on raising and handling concerns.

PRINCIPLE 19: Primary Care: All principles should apply with necessary adaptations in primary care.
Actions 19.1 – 19.3: [these compel NHS England and all commissioned primary care services to implement policies and actions consistent with the Principles and actions in this report, adapted for primary care settings].

Extending legal protection

PRINCIPLE 20: Legal protection should be enhanced.
Action 20.1: The government should review the protection afforded to those who make protected disclosures, with a view to including discrimination in recruitment by employers (other than those to whom the disclosure relates) on grounds of having made that disclosure as a breach of either the Employment Rights Act 1996 or Equality Act 2010.
Action 20.2 : The list of persons prescribed under the Employment Rights Act 1996 should be extended to include all relevant national oversight, commissioning, scrutiny and training bodies [named].
Action 20.3: The proposal should widen the scope of the protection to include all healthcare students.

NHS PROVIDERS' RESPONSE

We welcome Sir Robert's recognition that NHS providers and their boards have made significant progress to improve the support and assistance provided to their staff to raise concerns about patient safety and quality and to demonstrate effective and early action in response. We recognise that many of our members already meet the standards suggested in the report and can provide examples of good practice.

Increased regulation and national requirements can unintentionally work against the improvements that providers and the wider NHS are setting out to achieve, and NHS Providers has consistently emphasised the need for provider boards to retain autonomy and flexibility to develop strong cultures of openness and transparency within their organisation and amongst their staff. To this end we welcome the report's focus on culture rather than further regulatory safeguards as the primary means by which this is most effectively achieved.

We also appreciate the suggestion that any government response to these proposals should take account of the significant measures and regulatory interventions already introduced to increase transparency and responsiveness to staff concerns. We are pleased that the review takes account of our reservations about the creation an additional centralised body to adjudicate whistleblowing cases. However we have some reservations about the capacity of the proposed, single Independent National Officer to carry out the proposed functions in Principle 15.

We particularly welcome Sir Robert's recognition of the complexity and diversity of whistleblowing cases and of the need to avoid using the term as a simplistic 'catch all'. Guidance for NHS organisations should certainly reflect the accountability of all staff, including those making complaints, to adopt fair, honest and open behaviours and practices, as recommended in Principle 14.

We would be happy to work with our members and the central bodies to ensure that any new measures introduced as a result of today's report do not unduly add additional administrative and regulatory burden on providers, and to share good practice across our membership with regard to empowering staff, developing cultures of transparency and distilling the learning from all feedback, complaints and concerns.

Press statement from NHS Providers

Today, Chris Hopson, chief executive, NHS Providers, said:

"The recommendations in the Freedom to Speak Up review are a welcome contribution to supporting NHS providers to deliver safe, transparent and compassionate patient care and we are particularly pleased to hear Sir Robert Francis QC commend the progress that has been made since his last inquiry. These recommendations ensure that patients, their families, service users and staff have a robust framework within which to raise their concerns. Our members recognise there is always scope for further improvement but it's crucial that this report is placed in context.

"The NHS frontline treats a million patients every 36 hours – it exists to provide the best possible care 24 hours a day 365 days a year. Ninety-six per cent of staff told the most recent NHS staff survey that the last time they saw an error, near miss or incident that could have hurt staff or patients/service users either they or a colleague reported it; and 85 per cent of staff agreed that their organisation encourages them to report errors, near misses or incidents. The CQC inpatient survey of 60,000 patients had 82% of patients rating their experience either 7, 8, 9 or 10 on a 0 - 10 scale; and 82 per cent of patients who had not complained said they would complain if they felt they had received a poor quality of care. The NHS was also rated the safest advanced economy healthcare system by the independent Commonwealth Fund in its latest report. So whilst there is always room for improvement we need to recognise that the NHS is one of the safest healthcare systems in the world, its patients are very happy with the quality of care they receive and NHS staff are strongly focused on spotting and reporting poor care should it occur.

"Today's guidance also highlights just how complex whistleblowing is, and that it cannot be used as a 'catch all' term to imply that the whistleblower is always right. Cases range from whistleblowers who have been treated inappropriately by trusts through to staff pursuing illegitimate grievances against the trust leadership or colleagues, despite having lost an employment tribunal case. NHS providers need to be able to investigate cases flexibly, so that often complex cases can be judged fairly and appropriately. The public, patients and staff, whether subject to or making a complaint, need a process that is supported by a fair and transparent framework. But whistleblowing needs to be seen in its proper context - these cases are exceptional and we must all work together to make sure that they remain so".

CULTURE CHANGE IN THE NHS: APPLYING THE LESSONS OF THE FRANCIS INQUIRIES

The second part of this briefing highlights key developments which are flagged within the government's response with relevance for members including a dedicated focus on whistleblowing upfront. The remainder of the briefing is structured around the chapters within the publication itself.

Related measures announced today include:

- a consultation on financial sanctions for NHS bodies who do not comply with the duty of candour;
- plans for expanding and improving data transparency on MyNHS;
- a consultation on updating the NHS Constitution to make transparency and safety more explicit;
- a new complaints guide to help patients raise concerns about care.

GOVERNMENT'S RESPONSE ON WHISTLEBLOWING

The government accepted all of Sir Robert's recommendations on whistleblowing in principle, including proposing new legislation to protect whistleblowers who are applying for NHS jobs from discrimination by prospective employers. Consultations on the following will follow:

- a new National Whistleblowing Guardian to protect those who speak up
- practical help through Monitor, TDA and NHS England to help whistleblowers find alternative employment
- a local whistleblowing guardian in every NHS organisation, reporting to the chief executive
- training for staff on how to raise concerns and protect others who do so.

PREVENTING PROBLEMS

This chapter reflects on safeguards within the national system, including a renewed focus on safety both locally and nationally, which members will be familiar with. This includes:

- The new leadership at the Care Quality Commission (CQC), its developing regulatory approach and strengthened independence. Half of trusts have been inspected under the new regime to date, and the regulator is on track to complete all inspections by the end of the year
- The focus on transparency since the Francis Inquiry, including the introduction of the statutory duty of candour and the recent consultation on the professional duty of candour, the use of 'named clinicians' for patients, the publication of staffing data at ward level, the launch of the MyNHS website and the sector led publication of performance data in a number of surgical specialties
- The national patient safety alerting system; the 'sign up to safety' initiative led by Sir David Dalton, chief executive, Salford Royal NHS FT which aims to halve avoidable harm and save 6,000 lives by 2017; the development of 'safety fellows' to help drive improvement (supported by the Health Foundation); the existing support offered by the NHS Litigation Authority for 'safety improvement plans'; and ongoing work by Health Education England (HEE) and Local Education and Training Boards (LETBs) to incorporate considerations of safety appropriately into all training.

Contact: Cassandra Cameron, Policy Advisor, cassandra.cameron@nhsproviders.org

In terms of next steps, the report highlights:

- The need to address variation in quality of care across the system highlighted in CQC's 'state of care' report
- A national renewed focus on tackling sepsis
- A consultation on changes to the NHS Constitution to reflect the principles of safety and transparency more explicitly. A consultation will also be launched into how the NHS Litigation Scheme could 'incentivise' transparency through the reimbursement it offers for claimants
- Proposals for a new measure of 'avoidable death' to be based on an annual audit of a representative number of case study files. Little detail is provided in the report, but there is a suggestion that any new measure of avoidable death could be adjusted for risk on a trust by trust basis, and incorporated into CQC's regulatory regime. DH will also commission work to develop similar measures for out of hospital settings and work with professional organisations to identify five areas of clinical care where reducing measurable avoidable mortality is deemed to be most critical. NHS Providers will ensure full engagement with members in the development of these measures, and our feedback on the proposals
- The report also acknowledges it would be 'sensible to consolidate national expertise and capability on safety' into a single organisation. It seems likely that this may lead to NHS England relinquishing its existing role for patient safety however the report does not go any further than to flag the need for consolidation.

DETECTING PROBLEMS QUICKLY

This chapter focuses on the core importance of ensuring appropriate cultural behaviours from the centre, and within individual organisations. Progress documented includes:

- The CQC's focus on complaints handling within their inspections, new DH/NHS England guide for patients on feedback and complaints following the Clywd, Hart Review of Complaints Handing, and the publication of a new 'vision' for complaints handling by the Parliamentary Health Service Ombudsman (PHSO) – both of which NHS Providers has been pleased to contribute to on members' behalf
- The launch of the friends and family test which, according to an NHS England survey, 85% trusts report 'using to improve patient experience' and 78% 'report that it has increased emphasis on patient experience. With over 5 million responses collected in a short time, it demonstrates considerable investment of resource and commitment by NHS providers at the frontline
- The 'connecting' initiative in which colleagues from DH and the central bodies spend more time experiencing the frontline.

The report flags a sustained national focus on complaints handling, and advocacy services. A review of complaints advocacy will be carried out by spring 2015, and government intends to fund local authorities to provide advocacy services.

TAKING ACTION PROMPTY AND ENSURING ROBUST ACCOUNTABILITY

The focus of this chapter is predominately on revisions to the national system, rather than on the local accountabilities. It includes an update on:

- The role of CQC and the development of quality regulation across secondary, primary and social care, the introduction of new fundamental standards, and the role of ratings including as a further 'benchmark' for attaining FT status

- The introduction of new and tougher duties including the offence of wilful neglect, potential for organisations to be prosecuted for failing to meet the fundamental standards, and the fit and proper persons test for directors
- The special measures process which has involved 19 trusts to date with six trusts successfully leaving the regime. The report also explicitly acknowledges the additional investment NHS providers are making in additional staffing to meet quality requirements. Those trusts in special measures alone have recruited 1,805 extra nurses and nursing support staff, and 109 more doctors. The report cites 129 changes in board level leadership since the establishment of the special measures regime.
- A sustained national policy focus on the role of 'accountable clinicians' including highlighting the development of guidance on the role of the responsible clinician in out of hospital settings by the Academy of Royal Colleges (building on their 2014 guidance for in hospital settings). CCGs will also be asked to publish what percentage of their patient populations are living with long term conditions and receiving support in line with the definitions set out in this guidance.

ENSURING STAFF ARE TRAINED AND MOTIVATED

This chapter focuses on the value of leadership within the NHS including:

- The 'well led' domain within CQC's approach; the NHS Leadership's fast track programme, and the Rose Review due to be published shortly
- The introduction of the 'friends and family' test for staff as a means to encourage greater feedback
- HEE's work to recruit, train and plan for the workforce needs of the present day and the future
- Introduction of the Care Certificate for healthcare assistants and social care support workers from 1 April.

The report reiterates the need to sustain a shared focus on supporting and empowering staff to raise concerns, and to sustain and protect the core values of the NHS.

NHS PROVIDERS' VIEW

We welcome the government's commitment to feeding back transparently on the progress which the NHS has made, both nationally and locally, against the recommendations made in Sir Robert Francis' Public Inquiry, and their timely response to today's Review of Whistleblowing in the NHS.

This report is focussed predominately on changes to the national system, and it is disappointing not to see a greater reflection of the work which provider boards and frontline staff have undertaken to learn the lessons of the Francis Inquiry and invest in building the cultures required to drive continual improvement in quality of care. We would have welcomed more case studies and shared learning throughout the text.

We also note that the section on accountability within the report is heavily focussed on national structures and it is important to remember that foundation trusts rightly operate within a balance of accountabilities to the regulators and parliament, and critically to their local communities through governors and members. In fact, all of our members invest considerably in maintaining constructive relationships with commissioners and partners across the health and care system in their local health economy – and this sense of a collective endeavour across a diverse system seems regrettably somewhat absence from the report itself.

NHS Providers has consistently argued that the central focus within the Francis Inquiry on building appropriate cultures throughout the system, and on developing leadership capability became overshadowed compared to the regulatory response to the issues raised. While our members are supportive of the risk based approach which CQC is seeking to develop, we have consistently raised concerns about the cumulative impact and burden of the number of new statutory and regulatory duties which have been imposed on the sector in response to the Francis Report. Many of these have only recently come into effect, or take effect from April 2015 and we will continue to monitor their impact in partnership with DH colleagues and our members.

We also note the focus on the special measures regime within the report. While this process has supported a number of trusts in difficulty to improve, there remains a need to align expectations of quality and finance for NHS providers with spend on meeting staffing ratios one clear driver of increasing financial pressure. We also strongly believe in the importance of autonomous provider boards retaining responsibility for the quality of care their trust provides is essential. The number of board appointments impacted by regulatory intervention is disappointing and we will continue to work with the national bodies, and our members to avoid an unintended 'chilling effect' on board recruitment and to ensure sufficient support is in place for director level appointees, particularly chairs and non executive directors.

We look forward to working with colleagues in DH and the national bodies, and with our members, to gain full clarity on new proposals set out today to strengthen the NHS Constitution and to introduce a new measure of avoidable mortality. We remain committed to working with members to share good practice with regard to empowering and supporting staff and patients, building transparent cultures and creating the local and national conditions for continuous improvement.

East Sussex Healthcare NHS Trust

Date of Meeting:	25th March 2015
Meeting:	Trust Board
Agenda item:	18
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:

Key external meetings attended in February and March:

- 6th February 2015 — Member of Parliament for Bexhill & Battle
- 19th February 2015 — South Chair Networking Event
- 9th March 2015 — Sussex Non-Executive Director's Meeting
- 23rd March 2015 — Conservative Parliamentary Candidate for Eastbourne

The following correspondence is attached to the report:

- 20th February 2015 — Letter to Stephen Lloyd, MP for Eastbourne

Use of Trust Seal

The following documents have been sealed since the last Board meeting:

Pevensey Ward Refurbishment Contract

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

SW/ajp

East Sussex Healthcare NHS
NHS Trust

20th February 2015

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 01323 417400
Website: www.esht.nhs.uk

Stephen Lloyd MP
100 Seaside Road
Eastbourne
East Sussex

Dear Mr Lloyd

Once again I am writing to you because you continue to make allegations that staff at the Trust are prevented from raising concerns about the quality of the care and services we provide.

We are committed to addressing concerns raised by patients and staff so that improvements can be made for the benefit of all local people.

On a number of occasions over the last two years I have written to you setting out the routes through which staff and patients can raise concerns. We have provided you with information about how any concerns including those of staff can be raised confidentially through our Senior Independent Director. You are also aware of a number of external bodies including the local Healthwatch that exist to ensure concerns can and are raised with the Trust.

I remain perplexed that you appear not to consider it your public duty to ensure that the Trust is aware of the concerns you say you are party to and that you are not prepared to raise these on behalf of your constituents. It would appear that you are of the view that you have concerning information about the services we provide that the Board is not party to but you are not prepared to provide us with the information we need in order to act to improve our services. As I have previously stated our responsibility is to provide the best possible services for the population of East Sussex and to ensure that safety and quality of care is our highest priority. I would once again encourage you to raise your concerns through any of the above routes in order to support the trust to further improve its services

Yours sincerely

Stuart Welling
Chairman