EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 26th March 2014, commencing at 10.00 am in the Ashdown Room, Uckfield Civic Centre

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 29th January 2014	Ai	Chair
4b.	Matters arising	Aii	Chair
5.	Chief Executive's report (verbal)		CEO
6.	Board Assurance Framework	B	CSec

QUALITY, SAFETY AND PERFORMANCE

7.	Quality Governance Strategy (item deferred to the next meeting)	Assurance	C	DN
8.	Quality Improvement Priorities 2014/15	Approval	D	DN
9.	Performance Reports: a) Quality Month 10 (January) b) Finance Month 11 (February) c) Cancer Waiting Times 2013/14 d) Patient Experience Quarter 3 e) Nurse Staffing levels	Assurance	E	DN/ MDCG/ COO/ HRD/ DF

STRATEGY

10.	Market Testing Programme	Approval	F	DSA
11.	2 Year – 2014-16 Financial Planning Update	Approval	G	DF

GOVERNANCE & ASSURANCE

12.	Risk Management Strategy Annual Review	Approval	H	CoSec
13.	Same Sex Accommodation - annual declaration of compliance	Assurance	I	CoSec
14.	VitalPAC Business Case	Ratification	J	COO
15.	Board sub-committees: Committee reports and Trust Board seminar notes: a) Audit Committee 08.01.04 b) Finance and Investment Committee 11.12.13 c) Quality and Standards Committee 07.01.14 d) Trust Board seminar notes 13.11.13	Assurance	K	Comm Chairs
16.	Themes for Quality Walks	Assurance		Chair

ITEMS FOR INFORMATION

17.	Chairman's Briefing	Assurance	L	Chair
18.	Questions from members of the public (15 minutes maximum)			Chair
19.	Date of Next Meeting: Tuesday, 3rd June 2014, commencing at 10.00 am in the Oak Room, Hastings Centre, The Ridge, Hastings, TN34 2SA			Chair
20.	**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)*		M	Chair

STUART WELLING
Chairman

20th March 2014

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
CSec	Company Secretary
DF	Director of Finance
DN	Director of Nursing
DSA	Director of Strategic Development and Assurance
HRD	Director of Human Resources
MDCG	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:	26th March 2014
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks January/February 2014
Reporting Officer:	Amanda Harrison, Director of Strategic Development and Assurance

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

Purpose:

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

Introduction:

Quality Walks are carried out by Board members and members of the Senior Management Team and are either planned or carried out on an ad hoc basis. They are intended to enable quality improvement actions to be identified and addressed from a variety of sources, and provide assurance to the Board of the quality of care across the services and locations throughout the Trust.

Themes for the walks are decided by the Board and the focus during January and February was as follows:

- General Surgery;
- Management of end of life care;
- Quality of Patient notes
- District Nursing;
- Impact of turnaround and financial recovery

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

23 services/departments were visited as part of the Quality Walk programme during January and February as detailed in the attached schedule and in addition the Medical Director and Chief Operating Officer visited all areas of Lewes Victoria Hospital. All of the visits were arranged by the Assurance Manager or the Chief Executive's Office and the Ward or Unit Manager was notified in advance to expect the visit. Other ad-hoc visits may have taken place but reports have not yet been received.

Feedback forms have been received to date relating to 20 of the visits, and a copy has been passed on to the relevant department/service managers.

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

<u>General Surgery</u>

Patient flow and problems with medical outliers were reported as concerns, along with low team morale due to service changes, staff vacancies, bed pressures and doctor availability for decision making particularly at weekends.

SAU noted a backlog of CT scanning and lack of availability of ultrasound at weekends. Nutrition and Dietetics reported that there was more complexity and volume of work at the Conquest as a result of the relocation of General Surgery and they had shifted resources to match this.

Management of end of life care
This was not completed on the majority of feedback forms as it was not necessarily applicable to the areas being visited, however where relevant it was noted that care was reviewed with the palliative care team to ensure patients can exercise choices. Pharmacy reported that there was an ongoing project to improve the speed of dispensing of medication for discharge and that a review of syringe drivers and the production of new monitoring charts were underway.

Quality of Patient notes
There was little noted under this theme, however the Health Records departments visited reported enthusiasm regarding the implementation of Systmone, and pharmacy reported that a new drug chart was being introduced.

District Nursing
There were no issues reported by other services but the District Nursing team visited had some concerns about the usability of tablets to access and capture patient data when using Systmone. They also had concerns about the growing workload and unfilled vacancies which meant that the teams were often very stretched. This shortage of staffing was the team's major concern.

Impact of turnaround and financial recovery
Health Records reported a loss of bank staff on which they had previously relied, and District Nursing raised concerns that some vacancies have not been filled contributing to the staffing issues identified above.

Other key issues
The following concerns were noted as follows with the number of times raised:
Insufficient storage space within the clinical area (1); Uncertainty and concern regarding clinical service and organisational changes (1); linen shortages, (1); Equipment problems which had an impact on patient flow and length of stay. (1) The Health Visiting team stated that 'call to action' is resulting in large numbers of students in the work place, and although the prospect is good regarding increasing workforce, this has caused a level of anxiety and stress in the teams in having the ability to manage the students to the level they would wish to supervise.

Patient feedback
Comments included the following statements:
'Staff are kind and helpful but short staffed so sometimes have to wait'; 'Cleaning programme is good'; 'Good communication – all staff explain what is going on'; 'Have felt informed'; 'Food fine, varied and appetising, always a choice'; 'Water jug always at bedside and within reach'; 'When called, nurse not always able to attend promptly'; 'Very caring nurses and auxiliary staff'; 'Felt involved in care'; 'Observed very good hand hygiene'.

Benefits:

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

Risks and Implications

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

Assurance Provided:

Any actions identified at a Quality Walk are agreed at the time and it is noted who will be responsible for taking forward the action. These are logged and monitored by the Assurance Manager (Compliance) to ensure that actions are implemented.

Further visits are scheduled to take place in March and April as detailed on the attached schedule.

It was agreed at the January Board meeting that the previous themes would continue with the addition of 'Maternity and Paediatrics', and 'Aspects of Community Services feeling divorced from current issues'.

Proposals and/or Recommendations
The Board are asked to note the report.

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

For further information or for any enquiries relating to this report please contact:	
Name: Hilary White, Assurance Manager (Compliance)	**Contact details:** Hilary.white2@nhs.net

Quality Walks January - February 2014				
DATE	**TIME**	**SERVICE**	**SITE**	**Visit by**
Jan				
7.1.14	7pm	ITU	Conquest	James O'Sullivan
7.1.14	1.30pm	Littlington	EDGH	Stuart Welling
8.1.14	3.30pm	SAU	Conquest	Stuart Welling
8.1.14	5pm	Cookson Devas	Conquest	Stuart Welling
24.1.14	11am	Health Records - Adults and Children's	Apex Way Hailsham	James O'Sullivan
27.1.14	3pm	Cardiology / CCU	EDGH	Vanessa Harris
Feb				
3.2.14	9am	All wards and departments	Lewes Victoria Hospital	David Hughes Richard Sunley
10.2.14	2pm	Sleep Studies	Conquest	Darren Grayson
10.2.14	2pm	Health Visiting / School Nursing	East Hastings Childrens Centre	Alice Webster
10.2.14	4.30pm	Ophthalmology	Dowling Unit	Amanda Harrison
11.2.14	2pm	Cuckmere	EDGH	Amanda Harrison
11.2.14	2pm	Pharmacy	EDGH	Vanessa Harris
13.2.14	9.30am	James Ward	Conquest	James O'Sullivan
13.2.14	9am	Interventional Radiography, Macdonald Ward, SAU	Conquest	Stuart Welling
21.2.14	4.30pm	Irvine Unit	Bexhill	Vanessa Harris
25.2.14	9am	TVN	EDGH	Monica Green
26.2.14	3pm	DSU, Theatres, ITU	EDGH	Darren Grayson
27.2.14	11am	Berwick	EDGH	Darren Grayson
28.2.14	9.30am	Nutrition and Dietetics	CQ	Vanessa Harris
28.2.14	4pm	DN's	Bexhill HC	James O'Sullivan
Quality Walks Scheduled for March - April 2014				
March				
3.3.14	5pm	Sexual Health	Station Plaza	Vanessa Harris
6.3.14	11am	Cuckmere	EDGH	Darren Grayson
10.3.14	2pm	Benson	CQ	Darren Grayson
10.3.14	3pm	Cookson Devas	CQ	Darren Grayson
17.3.14	10.30am	Health Visitors	West Hastings Childrens Centre	Alice Webster
19.3.14	2pm	School Nurses	Ore Clinic	Amanda Harrison
20.3..14	2pm	Radiology	Crowborough	James O'Sullivan
28.3.14	11am	Electro Medical Engineering (EME)	CQ	Monica Green
28.3.14	10am	MaxFax OPD	CQ	Darren Grayson
31.3.14	10.30am	Dental Services	Ian Gow Centre	James O'Sullivan
31.3.14	10.30	SaLT	EDGH	Monica Green
April				
3.4.14	9.30pm	Macdonald	Conquest	James O'Sullivan
7.4.14	9am	All wards and departments	Rye Hospital	David Hughes Richard Sunley
7.4.14	10am	MIU, Radiology	LVH	Amanda Harrison
7.4.14	11am	Baird Ward	Conquest	Vanessa Harris
8.4.14	3pm	JCRS	Firwood	Alice Webster
14.4.14	2.30pm	James Ward	Conquest	Darren Grayson
17.4.14	4pm	School Nurses	Bexhill Health Centre	Vanessa Harris
25.4.14	9.30am	Community Respiratory Nurse	CQ	Monica Green
28.4.14	4pm	Jubilee	EDGH	Darren Grayson
29.4.14	11am	Occupational Health	Conquest	James O'Sullivan
30.4.14	10.30am	Hailsham 4	EDGH	Monica Green

To be Rearranged

Date should have happened	Time	Ward / Service	Location	Director
17.12.13	9.30am	James Ward and CCU	Conquest	James O'Sullivan
	3pm	Podiatry	EDGH	Alice Webster
		Pain Clinic (Burton Unit)	CQ	Monica Green
3.2.14		Podiatry	LVH	
21.2.14	10.30am	TVN's	CQ	Monica Green
19.2.14	9am	Community Paediatric Team	EDGH	Monica Green
11.3.14	2pm	Chiddingly	EDGH	Vanessa Harris

Contact						
Silin Cornelius						
Neil Simonite	07.1.14		17.1.14			
Dr J Lethbridge/Bob Lott	6.1.14		14.1.14			
Brenda Davey						
Deirdre Connors	6.2.14		14.2.14			
Louise Pike	5.2.14	11.2.14	11.2.14			
Minette Farne-Elliot	24.2.14		4.3.14			

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday 29th January 2014 at 10.00 am in the St Mary's Board Room, Eastbourne DGH

Present: Mr Stuart Welling, Chairman
Mrs Sue Bernhauser, Non-Executive Director Designate
Mr Charles Ellis, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mr Barry Nealon, Non-Executive Director
Mr James O'Sullivan, Non-Executive Director
Mr Darren Grayson, Chief Executive
Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Joint Medical Director – Clinical Governance
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Dr Andy Slater, Joint Medical Director - Strategy
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
Mr Mark Inman, Head of Contracting
Ms Paula Smith, Acting Associate Director – Women and Children
Ms Lindsey Stevens, Assistant Director of Nursing – Women and Children
Mrs Trish Richardson, Corporate Governance Manager (minutes)

001/2014 **Welcome and Apologies for Absence** **Action**

a) Chairman's Opening Remarks

Mr Welling welcomed everyone to the meeting and announced that Professor Jon Cohen and Mrs Bernhauser had been appointed to the Board as the new Non-Executive Director and Non-Executive Director designate with effect from 13th January 2014 and welcomed Mrs Bernhauser to her first meeting.

He welcomed Mr Inman who had been selected for the Nye Bevan Fellowship and as part of that course would be observing the Board meeting.

He congratulated Mrs Webster who had been awarded the Florence Nightingale Leadership Scholarship.

He reported that the Trust had recently undertaken a review of its provision of Board papers to ensure that it was an efficient and cost effective as possible and it had been decided that hard copies of the Board papers would no longer be supplied to external partners and members of the public.

Mr Ash requested that this decision be reconsidered due to the cost of printing the papers and Mr Welling noted his comments.

b) Apologies for Absence

He noted that apologies for absence had been received from Professor Jon Cohen and Lynette Wells, Company Secretary.

c) Monthly Award winner

Mr Welling announced that the monthly award winner was Sister Catherine Watsham who worked in outpatients and had been nominated for the hard work and motivation she gave to the outpatients team. She had also recently received her qualification in undertaking skin biopsies and was now running a successful nurse led skin biopsy service. She was a well respected senior nurse and was a skilled and informative resource to team and also provided calm, committed and supportive deputy cover to the outpatients matron, especially with the recent surgical move and the outpatients clinic reshuffle which had put extra demands on the team leadership.

d) Feedback from Quality Walks

Mr Nealon reported on his three walks to the Pharmacy Manufacturing Unit, the new Endoscopy Unit and the acute general surgical unit at the Conquest. In relation to the Endoscopy Unit the patients were pleased with the service although there were concerns about the capacity in terms of waits at the present time. He noted that a plan to address this was being developed.

Ms Green reported that she had visited theatres, occupational therapy, and pathology and these were support services that were important in supporting the patient pathway. She reported that in the theatres a lot of work had been undertaken to absorb the impact of moving acute surgery to the Conquest site including new rotas, new ways of working, staff transferring and they were now working on developing the productive operating series which focused on no delays, teams ready and equipment in place.

She reported that occupational therapy were adapting their working patterns to accommodate patients and their carers and the service played an important role linking into care in the community when patients no longer required acute care.

She reported that the pathology service was coping with the impact of the clinical strategy moves and the main issues were around equipment replacement. Mr Sunley reported that the Trust was in the process of procuring a managed service contract for the procurement of pathology equipment and he anticipated that the contract would be awarded in the next few months.

Mr Grayson reported that the Pharmacy Manufacturing Unit had been reviewed in terms of outsourcing but a proposal would be coming to the Trust Board in March that the PMU be retained in-house as it made a financial contribution to the Trust.

Mrs Harrs reported that some areas had commented on feeling under pressure as a result of turnaround but reassured the Board that all schemes implemented in reducing the use of agency and temporary staff underwent a robust quality impact assessment.

The Board noted the report on quality walks.

002/2014 **Declarations of Interest**

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

003/2014 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 27th November and 11th December 2013 were considered and approved as an accurate record.

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

b) Matters Arising

The matters arising log was noted and there were no further actions to report.

004/2014 **Chief Executive's Report**

a) Quality and Safety

Mr Grayson reported that emergency and high risk surgery had been successfully centralised to the Conquest Hospital on 14th/15th December 2013. Contrary to the view that it could and would never happen, it had been achieved and in particular he thanked Mr Sunley, Dr Slater and Ms Donnellan, the Clinical Unit lead, and their teams in achieving the move. He also thanked the ambulance service, Brighton and Sussex University Hospitals Trust and Maidstone and Tunbridge Wells Trust for their support.

He reported that the Trust's unrelenting commitment to quality and safety was shown in the very comprehensive quality report on the agenda and the Board had spent some time in seminar session reviewing how the report could be further improved.

Mr Grayson reported that the stroke service was beginning to demonstrate a really improved performance and in December had delivered all five of the high level performance metrics and was in a good place to sustain this performance.

He reported that in the Trust's unrelenting commitment to transparency and openness it had published the reports from the Royal College of Obstetrics and Gynaecology (RCOG) and the Royal College of Paediatrics and Child Health (RCPCH) following their review of the maternity and paediatrics services which had been requested by the Trust. He highlighted the comment in the RCOG report that "interim arrangements for obstetric and neonatal services at the Conquest hospital had had positive outcomes for clinical governance" and the Board could take considerable assurance that the services were safer.

Performance

Mr Grayson advised that A&E performance remained strong and the Trust had delivered its quarter 3 target and, although there were ongoing pressures so meeting the target was tough, the Trust was well placed to deliver the final quarter. He advised that there was particular pressure in elective services which was building on the 18 weeks position but overall the Trust remained in a strong position.

Finance

Mr Grayson reported that the financial position remained a pressing concern but there were some early signs of better performance emerging. The Trust was working positively with the Clinical Commissioning Groups, the Local Area Teams and the Trust Development Authority to achieve the best result in terms of financial performance.

Strategy

He advised that the public consultation on the future of maternity and paediatric services was underway and would last for 12 weeks. The Trust would be responding as an organisation to the consultation and would be engaging with staff in the formulation of the response.

He advised that the Full Business Case for Shaping our Future had been sent to the Trust Development Authority following Board approval in mid December and details of the process at the TDA was awaited.

He reported that planning had commenced for the next two years in detail and next five years in less detail and the report circulated with the agenda outlined the Trust's internal planning process. Discussions with commissioners were at an early stage but it was clear that the scale of financial and healthcare challenge across the health economy would require radical changes across pathways of care.

Mr Ellis commented that he welcomed the two reports on the maternity and paediatric services that contained both positive and negative comments.

The Board noted the report.

005/2014 **Board Assurance Framework**

Dr Harrison presented the report and advised that updates were marked in red. The report had been considered by the Audit Committee at its meeting on 7th January and Ms Kennett reported that there were no specific issues of note.

Mr Welling highlight that the risks around the elective vascular elective service had not featured and Dr Harrison advised that any risks identified would be added to the relevant service risk register and would progress through the risk system.

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.

006/2014 **Quality Improvement Plan**

Mrs Webster reported that the plan was being developed to address the recommendations of all the national reviews ensuring they were contained in one clinical improvement plan and ensuring continuing quality improvement. The Board had already approved the quality governance plan in March 2012 and the quality improvement plan would build on this document. She outlined the timescales for formulation of the plan which would be driven by clinicians and would be reviewed through the Quality and Standards Committee before coming to the March Board meeting for approval. **AW**

Mr Grayson suggested that this should be an item for discussion at the Clinical Leaders Forum and that front-line staff were engaged through a Listening into Action conversation. Mrs Webster advised that there would also be clinical engagement through the Patient Safety and Clinical Improvement Group.

Mr Sunley queried whether nurse staffing levels would feature in the plan as part of assurance to the Board and Mrs Webster advised that the plan was concentrating more on clinical improvements and there would be a separate report on nurse staffing levels as part of performance reporting.

Mrs Harris commented that the Francis report had recorded that the Mid Staffordshire Trust had lost sight of its staffing levels in the drive to achieving financial savings and asked Mrs Webster how the Trust assessed and assured itself around nurse staffing levels.

Mrs Webster advised that nurse staffing levels were reviewed three times a day seven days a week by a Head of Nursing and, if there was a requirement for temporary workforce, they managed the process. In addition, medical staffing levels were also reviewed on a daily basis.

Mr Ellis reported that he was working with Mrs Webster and Ms Green to ensure that the report on nurse staffing levels would be presented in a format that was clear, unambiguous and easily understood.

The Board noted the report and supported the development of an integrated approach to quality improvement through a measurable Quality Improvement/Quality Governance Plan.

007/2014 **Performance Reports**

a) Quality Report including Performance, Activity and Workforce – November 2013 (Month 8)

i) Quality

Mrs Webster reported that at month 8 the Trust had reported 31 Clostridium Difficile (C Diff) cases against the annual limit of 25 cases and there had been a significant amount of work at all levels across the organisation on addressing infection. The Trust continued to work with the Trust Development Authority infection control lead.

Dr Slater commented that the C Diff target was always going to be a difficult one to achieve and asked whether other Trusts were experiencing similar difficulties in meeting their targets. Mrs Webster stated that it was nationally recognised as an issue and some other Trusts were facing challenges. Dr Hughes agreed and noted that the work undertaken by Mrs Webster and the infection control team to address the challenges had been recognised as positive by the TDA. Mrs Webster reported that 7 cases had been classified as avoidable in the year which was a reduction on number of avoidable cases in the comparable period in 2012/13.

Mr Grayson reported that, whilst the target was very exacting, the Trust was breaching the limit by a significant number with a total as at today's date of 36 cases. Close attention continued to be paid to this area and the Trust had received significant assurance from the TDA on the actions being taken to improve compliance.

Mr Grayson suggested that the Board should consider the issues in a seminar session before the close of the year to ensure the action plan had been fully implemented. **AW**

Mrs Webster advised that there had been a spike in mixed sex breaches for November but, following interim work, the number had subsequently reduced in December.

She reported that the Friends and Family Test (FFT) remained a focus for the organisation and progress had been made in collection across the areas. In high flow areas such as A&E, alternative methods of collection were being developed including using volunteers to conduct telephone surveys.

She highlighted that a new audit tool had been put in place which was providing real time data on patient centred care planning.

She reported that there had been a decrease in the numbers of patient safety incidents reported in November. There had been five Severe Harm incidents in November and the number of Severe Harm incidents in October had reduced from eleven to six as five incidents had been downgraded.

Mrs Webster reported that the number of falls assessments undertaken had decreased but the on-going work with staff was making an impact as the number of falls had decreased. Mr Grayson queried the deterioration in falls assessment and Mrs Webster reported that the position had improved in December and noted that the metric covered both assessment and re-assessment.

Performance

Mr Sunley stated that the Board report covered performance in November and that he was pleased the Trust had achieved the A&E standard for both November and December and consequently quarter 3. He was extremely proud of staff at all levels and in all parts of the organisation who had helped to deliver the target by ensuring that the plans to support and maintain a good throughput of patients through the organisation had been implemented and the winter funding available had been used to provide extra ambulance cover, discharge lounges and extra ward rounds.

He reported that the Trust was in a good position in terms of delivery of the 18 week target but a backlog was building up as the Trust ensured that patients continued to be treated in turn. He anticipated that performance was likely to dip in the next quarter until the Trust was able to achieve a sustainable position.

He advised that the Trust had not achieved the standard for diagnostic waits in November and this related mainly to endoscopy where ad-hoc lists had previously been used to ensure 2 week and 6 week waits were achieved whilst capacity was built up. The decision had been taken to stop some of the lists due to financial pressures but it had now been agreed to reinstate these.

He reported that the breast two week wait target had been breached with 8 patients not being able to attend their appointments in a timely fashion. The Trust was continuing to work with GPs and others to ensure patients were encouraged to take up their appointments within the two weeks.

Mr Sunley reported that in relation to the 62 day screening and urgent referral targets these involved small number of patients and mainly related to urology where a consultant had been on sick leave. He proposed to bring an updated cancer action plan to the March board meeting. **RS**

He advised that there was a continued improvement in achieving the stroke targets and, although the December performance had yet to be validated, the early indications were that all standards were green.

Mr Welling commented that the Board shared the pride and appreciation of the hard work of the staff throughout the organisation in sustaining the A&E target. He noted that there would be a dip in performance in relation to 18 weeks and further discussions were taking place with the TDA on this issue.

He highlighted that the position on diagnostics continued to be a challenge and needed to be reviewed and agreed that the Board should review the cancer recovery plan at its next meeting.

He commented that it was reassuring for the organisation that Mr Sunley and his team fully understood and were addressing the issues around performance and thanked him and his team for their hard work.

Workforce

Ms Green stated that the November Board report demonstrated a trend of reducing reliance on temporary workforce. This had been continued into December with pay below the average of the first eight months of the year, with particular reductions in nurse agency expenditure.

She reported that there had been a marginal increase in sickness which was a seasonal trend. She advised that over the Christmas period a scheme had been introduced that all staff sick for a day or more would be required to produce a sickness certificate and this had resulted in some reductions in sickness compared to the same period the previous year. In addition, a pilot scheme was being carried out with district nursing on the reporting pathway and return to work interviews which if successful would be implemented throughout the Trust.

She reported that there had been a marginal increase in compliance with training and anticipated further improvement with the introduction of a new appraisal scheme in April.

She reported that the Trust had recruited 40 trained nurses since October and had also been able to offer places to all the newly qualified nurses who had trained in the Trust. In addition, the recruitment department had been able to reduce the time required to undertake checks with the national Disclosure and Barring Service to 48 hours from a number of weeks.

Dr Harrison asked if there were any benchmarks that could be used to understand what would be appropriate in relation to closing the gap between permanent employees and the number of budgeted FTEs and Miss Green advised that there would always be a need for flexible nurse staffing to cover short term sickness and the level had almost been reached where it could not be reduced. She noted that there was still work required to reduce medical agency expenditure. Mrs Webster commented that there was a significant use of temporary workforce in the commercial services and Dr Harrison stated that it would be useful to see a breakdown of the gap between permanent employees and budgeted establishment for each of the services. **MG**

Mr Ellis expressed concern at the appraisal rates for cardiovascular, complex and acute medicine and Ms Green explained by breaking down the figures into clinical unit areas this demonstrated where resources needed to be targeted.

Mr Welling asked what efforts were being made to improve compliance with training and Ms Green advised the requirements for mandatory training and its content were being reviewed. In addition, the Trust was participating in a pilot with other Trusts in Kent, Surrey, Sussex and South London over the introduction of a mandatory training passport.

Mrs Webster noted that there was an issue with manual handling training in commercial services and Mr Grayson reported that this would be picked up by the executive team.

Dr Hughes reported that medical revalidation compliance continued to improve and his team was in the process of following up those doctors who were still not compliant. Mr Welling congratulated Dr Hughes on the positive position.

The Board noted the quality report for November 2013.

b) Finance (month 9)

Mrs Harris reported that the year to date position was a £22.3 million deficit but at present the Trust was still aiming to deliver a £19.4 million deficit at the year end. She advised that it had been anticipated that the position would worsen before it improved and the in month position was £0.7 million worse than should have been against the in year financial recovery plan.

She reported that the total expenditure in December was £31.4 million and for the first time in the year the Trust was on plan against its financial recovery plan for expenditure. This was as a result of pay being £800,000 less than the month 1-8 average.

She advised that December income, although above original plan, was under the financial recovery plan trajectory and this mainly related to fines and penalties.

Mrs Harris reported that she was in discussion with the Clinical Commissioning Groups regarding fines and penalties and they were understanding of the investment the Trust had made in certain areas to improve its position.

She reported that there would be an in-depth review of the month 10 position and, depending on the outcome, it might be necessary to move the forecast outturn.

She highlighted that good progress was being made with the delivery and reduction in costs, agency and adhoc expenditure and against the original target a saving of £17.5 million would be achieved.

She reported that cash remained an issue but a further £5 million of temporary cash had been drawn down and in addition the Trust had submitted a bid of £5 million for additional capital funding which would enable it to implement a number of invest to save schemes.

Mrs Harris advised that the remaining financial risks were agreement of income, unexpected costs arising from winter pressures and any additional costs in relation to the delivery of 18 weeks.

Mr Nealon reported that the Finance and Investment Committee was confident that the current cost base was being addressed without prejudicing clinical performance and the efficiencies were sustainable. In addition, the Committee had approved significant capital investment in IT systems which would have a positive impact for patients.

Mr Grayson reported that if the Trust did achieve the £17.5 million savings this would be 5% of its budget and would be a creditable performance in undertaking cost improvement whilst maintaining the safety and quality of services.

The Board noted the finance report for December 2013

008/2014 **Response to the External Reviews of the Maternity and Paediatric Services**

Dr Slater presented the two reports and highlighted the organisation's willingness to seek help and assurance that internal processes were providing a high quality service.

He explained that the two reports had different terms of reference with the report from the Royal College of Obstetrics and Gynaecology (RCOG), being commissioned following the risk summit in February 2013 when it was agreed that the supported by the Royal College of Paediatrics and Child Health (RCPCH), would visit the organisation to review clinical risk management and governance surrounding obstetrics.

Dr Slater advised that the RCPCH report was commissioned by the Trust following the temporary single siting of paediatrics to the Conquest site to review the operational policy to ensure it was robust, safe and whether any further improvements could be made.

Dr Slater advised that it was important to understand that the RCPCH found the service to be safe but there were areas where safety could be improved as outlined in their recommendations. Both reports had been shared with the Clinical Units, the recommendations taken on board and action plans developed to address them. These were appended to the reports.

Dr Harrison pointed out that a number of the recommendations within the reports were contingent on a final decision being made on the future configuration of the maternity and paediatric services and this was identified in the action plans.

Ms Stevens reported that the action plan in relation to the combined RCOG and RCPCH report had been developed through meetings internally and with the Clinical Commissioning Group leads and that some of the actions had been completed since the action plans had been circulated to the Board.

Mrs Smith reported that in relation to the RCPCH report Dr Slater was taking forward reviewing the operational policy with paediatric colleagues, the unit was working closely with the Emergency Department to address the recommendations in that area and Dr Slater was the Board lead for paediatrics within the Trust.

Dr Slater reported on progress with rebuilding working relationships within the paediatric team and that he had been impressed with how the paediatric consultants from both sites had started working together in order to create a robust operational policy fit for the future whatever the final configuration of paediatric services would be.

Mr Grayson highlighted the RCOG report reference to the possible provision of a level 2 Special Care Baby Unit (SCBU) and Ms Stevens advised that this would be a decision made by commissioners following the final decision on the configuration of the service. Commissioners would take a decision based on the requirements across Sussex and would be advised by the neonatal. Her personal view was that it would bring the Trust in line with other units around the area and would enable mothers and babies to stay in local surroundings. Dr Slater noted that a different set of clinical skills would be required before a level two unit could be provided and this would need to be commissioned.

Dr Harrison advised that in relation to the public consultation the Trust would need to decide which option(s) would best deliver the recommendations in the reports and propose models of care going forward that addressed the recommendations.

She advised that the Trust's response could include a view on whether including the provision of a level 2 SCBU in the future model of care would be appropriate.

Mr Nealon asked if there had been any issues in relation to travel since the temporary single siting and Ms Stevens reported that there had been two babies born before arrival en route to the Conquest but this was similar to data from previous years. There had not been any more risk issues in relation to the interim changes and, having consolidated the service on to one site, had improved the ability to provide a safe service.

Mr Welling thanked the staff of both services for their hard work in such a challenging time.

The Board noted the progress made and agreed that there should be an update at the June Board meeting.

009/2014 **Planning Process 2014/15 to 2018/19**

Dr Harrison reported that the steering group had met for the first time the day previously and reviewed the timetable and proposed that the Board seminar on 12th March would be a whole day session for clinical unit prioritised presentations, following which the 2 year plan would be signed off at the March Trust Board meeting. There would be a further review of the five year plan at the Trust Board seminar on 16th April and Finance and Investment Committee on 30th April prior to submission to the Trust Development Authority on 6th May.

Mr O'Sullivan highlighted the tight timescale and requested that there was sufficient time built in for the Finance and Investment Committee to review the plans in detail and provide adequate assurance. It was agreed that Mr Nealon and Mrs Harris would agree how to ensure that adequate time was provided.

Mr Welling commented that transformational change was a whole system process and the Clinical Commissioning Groups were leading on this important work through the 2020 vision and Green Triangle strategies which were aiming to transform services over the next five years.

The Board noted the report and signed-off the planning process.

010/2014 **Board Sub-Committee reports and Trust Board Seminar Notes**

a) <u>Audit Committee</u>

Mr O'Sullivan presented the report on the Audit Committee meeting held on 6th January 2014 and noted the good progress made on the payroll controls project.

b) Finance and Investment Committee

Mr Nealon reported that the issues had already been discussed earlier in the meeting.

c) Quality and Standards Committee

Mr Ellis presented the report on the Quality and Standards Committee meeting held on 7th January 2014 and the assurance that the Trust was learning from Serious Incidents and other experiences had improved over the last eighteen months.

Mr Welling noted that there would be a formal proposal coming forward on how the Committee and the Patient Safety and Clinical Improvement Group would work from April onwards. **CE/AW**

d) Trust Board Seminar Notes

The notes of the seminar session held 13th November 2013 were noted.

011/2014 **Themes for Quality Walks**

Mr Welling reported that the themes agreed at the last meeting were still relevant but requested that two further areas be included:

- certain aspects of community services feeling divorced from current issues within the Trust, and
- maternity and paediatric services.

These were agreed by the Board.

012/2014 **Chairman's Briefing**

Mr Welling presented his briefing and drew the Board's attention to the correspondence with Mr Lloyd, MP for Eastbourne, and noted that the position remained unchanged in his refusal to have discussions.

013/2014 **Questions from members of the public**

a) Maternity and Paediatric Services Public Consultation

Mrs Walke noted the reports from the Royal College of Obstetrics and Gynaecology and the Royal College of Paediatrics and Child Health and now understood the seriousness of the situation and understood why the Trust had taken the action to initiate the temporary move of maternity and paediatric services.

She requested that the consultation gave consideration to the travel time, as had been considered by the Independent Review Panel, and possible delays in treatment. Mr Welling stated that it would be the role of the Clinical Commissioning Groups to weigh up the issues around safety, quality and access.

b) Satellite Renal Dialysis Unit

Mr Ash asked when the satellite renal dialysis unit would be opened and Mr Grayson advised that the service was provided by Brighton and Sussex University Hospitals NHS Trust and the Trust did not have that information.

Mr Welling commented that he was disappointed that it had not been possible to provide the unit at Eastbourne DGH but understood the reasons why it had not been possible.

c) Foundation Trust Status

Mr Ash asked if there was an update on the Trust's Foundation Trust status and Mr Grayson reported that the Trust had been focused on ensuring that it was providing safe, high performing services within the funding available and was in discussion with the commissioners and the Trust Development Authority on a timeframe for its Foundation Trust application and this would be brought to a future Board meeting.

014/2014 **Date of Next Meeting**

Wednesday, 26th March 2014, at 10.00 am in the Ashdown Room, Uckfield Civic Centre, TN22 1AE

015/2014 **Closed Session Resolution**

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

Signed …….

Position ……...

Date …….

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 29.01.14 Trust Board Meeting

Agenda Item	Action	Actioned By	When	Progress
006/2014 Quality Improvement Plan	The plan would come to the March Board meeting for approval.	Director of Nursing	26.03.14	On agenda.
007/2014ai) - Quality Report	HCAI issues to be considered in seminar session before the year end.	Director of Nursing	26.03.14	Agreed that this would be picked up through the Quality and Standards Committee and the LiA conversations around safety.
007/2014 aii) – Performance Report	Updated cancer action plan to be presented to March Board meeting.	Chief Operating Officer	26.03.14	On agenda.
007/2014 aiii) – Workforce Report	Breakdown of gap between permanent employees and budgeted establishment to be provided in the report for each of the services.	Director of Human Resources	26.03.14	To be incorporated into the new performance report.
010/2014 c) – Quality and Standards Committee	Formal proposal on how the committee would work in future to be considered as part of the review of the committee structure at the May Board seminar	Chair, Quality and Standards Committee/Director of Nursing	14.05.14	On agenda for May Board seminar.

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	6
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

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

Introduction:

Risks to achieving the Trust's strategic objectives have been agreed by the Board at a Risk Seminar as follows:

- 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

- 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.

- There is a lack of leadership capability and capacity to lead ongoing performance improvement and build a high performing organisation.

- 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.

- We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.

- 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.

- 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. In setting a deficit budget for 2013/14 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.

- We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.

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

- We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.

- We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change

The Assurance Framework has been reviewed and updated since the last meeting of the Trust Board. There are clear actions against identified gaps in control and assurance and these are individually RAG rated and any changes are marked. Updates are provided in red italics.

All items on the Trust Board agenda are reviewed to ensure they are aligned to the Trust's strategic objectives and risks outlined on the Assurance Framework.

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

The Trust Board is asked to consider whether the main inherent/residual risks have been identified and that controls are appropriate to manage and mitigate the risks. Updates and revisions are shown in red. Assurance has increased against four of the actions:

- Need to develop clinical engagement
- Vacancies and recruitment
- Trust cash holding
- Achievement of financial plans

There are currently no red rated areas.

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.

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

Audit Committee – 5th March 2014
Quality and Standards – 3rd March 2014

Proposals and/or Recommendations

The Trust Board is asked to review and note the revised Board Assurance Framework and consider whether the main inherent/residual risks have been identified with any gaps in assurance or control and that actions are appropriate to manage the risks.

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

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

None identified.

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

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

BOARD ASSURANCE FRAMEWORK

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

Key:

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

↔ Status of risk unchanged

↓ Risk reduced

↑ Risk increased

Board Assurance Framework - Feb14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
Risk 1.1: We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies									
1.1	Risk management processes in place; reviewed locally and at Board sub committees. Robust CQC action plan in place, monitored at Board level. Feedback and implementation of action following "quality walks" and assurance visits. Provider Compliance Assessments (PCA) training. Reinforcement of required standards of patient documentation Accountability agreed and known eg ADN, ward matrons, clinical leads. Implementation of quality governance framework and ongoing work to embed learning and review sources of assurance Health and Safety risk assessments	Outcome of CQC inspections Internal reviews inc/board level 'Quality Walks' CQC intelligent monitoring Board and Committee minutes Patient and Staff Surveys Health and Safety Executive IG Toolkit HR processes External accreditation/peer reviews	CQC reports following inspections Provider Compliance Assessments completed at ward level and gaps reviewed. Internal audit report on CQC compliance Weekly audits and reviews eg observations of practice Monthly reviews of data with each CU 'Quality walks' programme in place and forms part of Board objectives External visits register outcomes and actions reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors	Documented audit trail not always available eg declaration of serious incidents, discussions re DNAR.		Ward/department visits to continue involving assurance team and peer reviews. Focus on specific outcomes eg consent paperwork, medical devices checks. Incomplete DNARs being logged as incidents and escalated for action. Jan-13 Weekly DNAR spot checks by Resus team escalated to senior management. Trust wide audit took place Feb, compliance improving but agreed that Resus policy and audit methodology to be reviewed. Aug-13 Resuscitation policy tabled at Clinical Management Executive and will be updated with group's comments. Oct-13 Compliance with policies reviewed at Policy Group and paper drafted for CME (Nov-13) *Feb-14 Board reviewing and agreeing revisions to performance and quality metrics reports*	April 2012 ongoing audit throughout 2013/14 Oct-13 Apr-14	↔	MD

Board Assurance Framework - Feb14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued - Risk 1.1: We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies									
1.1				Revision to CQC compliance and inspection regime to be reviewed and impact on organisational compliance considered		Oct-13 Trust reviewing changes in CQC compliance regime including new surveillance model Dec-13 Reviewing CQC inspections reports published for other Trusts recently inspected under new model *Feb-14 Continued review and monitoring; developing process to ensure Trust is prepared for inspection and has continued evidence of regulatory compliance.*	Mar-14 ongoing	↔	DSDA

Board Assurance Framework - Feb14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Datixweb incidents are not 'finally approved' and a backlog has built up. This could impact export to NRLS and benchmarking reports against other similar organisations may not be a true reflection of the Trust incident profile.		Proposal for sustainable management of incidents and achievement of timely incident agreed with divisions. Dec-13 Quality checks and significant reduction in backlog achieved for Nov export to NRLS. Continued focus on incident management across Clinical Units. *Feb-14 Datix working group established to review issues, development and support effectiveness of system.*	end Jan-14 end Apr-14	↔	DSDA

Board Assurance Framework - Feb14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.									
1.2	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with divisions Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) monitoring Regular audit of cleaning standards	Performance indicators Benchmarking and Dr Foster data Accreditation visits/Peer Reviews National Cleaning Standards Audit Group established HOSC Healthwatch External Audit Internal Audit Clinical Audit Clinical Commissioning Groups Regulatory bodies eg CQC, HSE Information Governance Toolkit	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review National benchmarking by WM Quality Observatory Dr Foster HSMR/SHMI data Low HCAI and SSA breaches Performance delivery plan in place	Demand and patient choice impacts ability to deliver cancer metrics.		Sep-12 Cancer network discussions re urology capacity/expectations. Mar 13 - Review of pathways/clock pause criteria. Co-ordinators working outside normal hours to facilitate patient contact. GP referral issues highlighted to CCGs. May-13 Developed patient info leaflet. Diagnostic urologist joins June; training chichester and brighton consultants in complexes cases. Sep-13 Somerset info system implemented. Reviewing DH benchmarks/engaging with regional centres. Dec-13 General surgery move expected to improve colorectal screening response, meeting screening service Jan to review pathway or transfer treatment option to BSUH *Feb-14 Ongoing discussion with BSUH, action plan to Board Mar.*	end Apr-13 Sept-13	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**									
1.2	Business Continuity and Major Incident Plans Training to develop service level BC plans Reviewing and responding to national reports such as Francis, Keogh and Berwick.		Cancer - all tumour groups implementing actions following peer review of IOG compliance. Major incident testing debrief indicated plan is effective. Trust Board reviewed analysis of Keogh, Berwick et al and actions will be agreed and monitored through Quality and Standards Committee.	Inability to meet national screening standards for diabetic retinopathy due to increasing demand and limited capacity.		Recovery Plan and prioritisation in place. Exploratory meetings with BSUH to discuss possible Sussex wide service. Escalated to specialist commissioners - advised no additional funding available, service provision being reviewed. Oct-13 Follow up waits currently at 17 months - discussion ongoing with Brighton re joint working. *Feb-14 Issues reviewed at programme board. Developed recovery plan, training screeners but capacity means will not meet national screening standards continued escalation of issues.*	01/06/2013 end Nov-13	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Jan-13 Demand on emergency services, impacting patient assessment and treatment time and subsequent discharge to other specialist/bed areas		Action plan in place to enhance patient flow. Meet SECAMB monthly to review issues. May-13 Identified number of options to improve ambulance flows - being explored Sep-13 Ambulance flows improved. Focussed work to be undertaken on further improvement to minimise risk of handover fines. Oct-13 Discharge/ admission lounges on both sites,escalation plan in place for winter pressures *Feb-14 Clinical site team in place to maintain and enhance patient flow. Escalation process to whole organisation to ensure clinical and professional standards of care and review are met.*	end Nov-13	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**									
1.2				June-13 Inability to achieve reduced Cdiff trajectory. Risk register identifies concerns with weekly multi-disciplinary reviews and failure to meet national cleaning standards		June-13 Gastroenterology Consultants have an agreed job plan that ensures senior representation at the weekly ward round. Monthly audits of National Cleaning Standards (NCS) are undertaken and any failures identified and actioned. Oct-13 26 Cdiff cases ytd, RCA of all cases to identify actions and share learning. TDA supporting and action plan developed. Dec-13 Review and monitoring ongoing as outlined above *Feb-13 Only 1 case of CDiff in Jan 2014. Continued reduction in HCAIs will be QIP for 2014/15*	Ongoing review and audit throughout 2013/14	↔	DN/MD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Clinical laboratory diagnostics analytical equipment requires replacement. Heavily used equipment becomes prone to breakdown and possible loss of service.		Agreed that replacement should be undertaken via a managed services contract. Further input required from procurement and estates. TDA funding approval will be required. Sep-13 Business case being developed; equipment risks continue to be monitored and mitigating actions agreed. Oct-13 Temporary bio chemistry equipment to be installed in next month. Managed Service Contract being progressed. Dec-13 Managed Service Contract ITT planned for Jan anticipated contract award will be Jun'14	end Nov-13 Jun-14	↔	COO

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

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

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 2.1: We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.**									
2.1	Clinical Strategy engagement Communications Strategy and map of stakeholders Regular meetings with League of Friends		Trust participates in Sussex wide networks eg stroke, cardio, pathology. Monthly performance meetings with CC and TDA. Working with clinical commissioning exec via Sussex Together to identify priorities/strategic aims. Board to Board meetings with CCGs, SECAMB and other bodies.	Marketing strategy not yet developed, therefore assurance cannot be provided that the Trust is actively and effectively participating in the local market or developing and responding to market opportunities.	Risk that during the period of dissolution of the SHA/PCT to Local Area Teams and CCGs there is a loss of organisational memory and focus on the key issues affecting the Trust.	Mar 13: Stakeholder engagement strategy to be reviewed and further developed Aug 13 - Trust participating in CCG led 'large scale change' programme. Trust engaged in CCG process for public engagement, development of the case for change, model of care and options for delivering agreed service standards for Maternity, Paediatric and Gynaecology services Oct 13 - Trust fully engaged with CCGs on developing PCBC for Maternity and Paediatrics *Feb-14 - Trust will actively engage in work commissioned through NHSE and TDA to support strategic planning across local healthcare economy*	Commenced and ongoing through 2013/14 end Sep 13	↔	DSDA

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

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3	Develop and embed Patient and Public Involvement Strategy Governance processes support and evidence organisational learning when things go wrong Quality Governance Framework and quality dashboard. Risk assessments Complaint and incident monitoring and shared learning.	CQC patient and staff surveys and inspection reports SHA benchmarking PROMs Clinical quality & safety reports reviewed through Trust Committee structure Dr Foster/CHKS metrics	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives.	Insufficient triangulation of clinical governance information and impact on patient outcomes.		Quality governance framework approved and quality dashboard implemented but to be fully embedded . May-13 Information Management Review finalised and structure changes being implemented. Sep-13 - BI restructure implemented. Redefining organisation's information requirements in collaboration with the TDA. Dec-13 Ongoing work to triangulate information and identify areas of focus	end Jun- 13 end Dec-13 end Mar-14	↔	DN/ COO

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

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

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3 continued: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3				Mandatory training rates and completion of appraisal levels below expected levels.		Embed revised policy and compliance monitoring systems. Jun-13 - IT currently sourcing e-learning solutions. Aug 13 - e-learning content issue resolved agreed with Kent & Medway to utilise their server. All modules now loaded and working. Oct 13 - Work continuing to develop mandatory training staff passport across the region; will focus on 10 key areas of mandatory training. Other training will be role related. Developing competency assessment process for some mandatory training to reduce need for staff to attend training. *Feb-14 Staff Passport and competency assessments to be introduced Apr-14. Review compliance at year end and revise risk to focus on high risk areas of Mandatory training.*	Improved performanc e by Aug-12 ongoing throughout 2013 Work is ongoing but aim to complete passport and competency work by April 2014	↔	HRD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
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. In setting a deficit budget for 2013/14 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.									
3.1	Clinical strategy development informed by commissioning intentions, with involvement of PCT and consortia QIPP delivery managed through Urgent, Planned and Integrated Care divisional governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work.	Activity plan Workforce planning Clinical Strategy Divisional governance structure and performance meetings Joint audacious goal meeting with commissioners Monthly KPIs monitored PMO office in place	Trust participates in Sussex wide networks eg stroke, cardio, pathology. Written reports to CME on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored.		Require robust controls to ensure achievement of 2013/14 financial plan and prevent crystalisation of identified risks eg fines, penalties, slippage on CIP programme, achievement of CQUINs, capacity and operational cost pressures	May-13 Impact of fines and penalties being assessed on monthly basis and actions taken to mitigate income loss. Monitoring QIPP schemes and CQUIN delivery. Activity monitored against plan Aug-13 In-year Financial Recovery Plan being developed to ensure delivery of planned deficit budget. Oct/Dec-13 FRP in place, Turnaround Director appointed, focussing on cost base reduction. Progress on FRP delivery reported to F&I committee and Board. *Feb-14 Risks mitigated as much as possible and Turnaround supporting reduction of cost base whilst maintaining quality and safety. Forecast outturn £23.1m deficit.*	Commenced and ongoing review and monitoring to end Mar-14	↓	DF/DT

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
		Monthly review by Finance and Investment Committee	Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)	Increased pressure on Trust cash holding will impact ability to generate required surplus of cash to make payments.		Aug-13 Daily monitoring of cash balances, weekly meeting re managing cashflow and assessing risks. £15m cash funding loan received from TDA. Oct-13 Application for PDC Finance submitted to TDA to be considered at Jan ITFF meeting *Feb-14 PDC application granted which, together with other planned cash receipts, has enabled payment of 30+ day creditors in Feb.*	Controls implemented ongoing review throughout financial year	↓	DF

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.1 continued: We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity. In setting a deficit budget for 2013/14 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.									
				OPD referrals have reduced but not in line with original demand management expectations and there are some capacity constraints, especially in Trauma and Orthopaedics (T&O) and gastroenterology		OPD review undertaken of planned activity against capacity. Whole system recovery plans being discussed with commissioners	end Mar 2014	↔	COO
						T&O to model impact of loss of MSK contract. Sept-12: Service is being monitored to analyse impact ongoing May-13 Concerns with service to be escalated through Service Quality Review meeting Sep-13 Ongoing monitoring with commissioners. Oct -13 T&O referrals increased back to previous levels - being monitored. Dec-13 Focus on reducing RTT times in line with Trust Policy, Board Nov 2013 *Feb-14 Working with IST/TDA to finalise action plan for RTT by mid Feb.*	end Jun-12 with ongoing monitoring to end of Mar 2014	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.2: We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.									
3.2	Development of workforce strategy: - to align workforce plans with strategic direction and other delivery plans; - to ensure a link between workforce planning and quality measures Workforce assurance group disbanded and will be re-formed in line with CCG requirements which are still to be advised. Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data. Rolling recruitment programme	NHS Sussex workforce assurance process Staff utilisation reports. Integrated performance report. CQC staff survey	Training and resources for staff development CQC maternity report DGH Jul-13	Final workforce strategy will be developed once plans for clinical strategy and financial recovery/market testing further defined.		Further develop workforce strategy aligned to clinical strategy. *Feb-14 Ongoing review of establishment. Currently recruiting to all vacant clinical posts.*	Mar-14	↔	HRD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
3.2				Inability to recruit to some specialties and significant vacancies in some areas . Some areas have identified that there could be shortages in the future due to ageing workforce and changes in education provision. Also national shortages in some areas eg cardiac physiologists, ODPs and anaesthetic staff Currently significant nursing and therapy vacancies - Oct 2013		Reviewed vacancies/ difficult to recruit to posts, establishment review -escalation for hospital at night team and cardiology rotas. Aug -13 Action plan to reduce staff absence. Oct-13 Recruitment campaign in local and national press. Dec13 appointed 40 Nurses. Disclosure & barring check times avg reduced from 4 wks to 48 hrs supports expedited recruitment. 40 newly qualified nurses interviewed expected start Feb'14 Ongoing therapy recruitment. *Feb-14 Participated in Speciality Fill Rate Review Project across SE Region, submitted bid for funding to implement marketing strategy to attract applicants.*	Ongoing throughout financial year - end of Mar-14	↓	HRD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.2 continued: We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.									
3.2				Maternity and paediatric inpatient services cannot provide a consistent quality of service so for some patients some of the time we do not meet the expected and required standards.	Dependency on mitigating actions is such that the risk of service failure is increased to an unacceptable level The delivery of a safe service becomes rapidly unsustainable in the short to medium term leaving us little time to implement mitigating actions	Daily monitoring/senior review. External NCAT review. Mar-13: NCAT report received.Board considered safety of services; resolved that temporarily consultant led obstetric service, neonatal service (inc SCBU) in-patient paediatric service and emergency gynaecology service be based at Conquest only and stand alone midwifery led maternity unit be established alongside enhanced ambulatory paediatric care at DGH. May-13 Temp. reconfiguration implemented and being monitored. Sep-13 CCG seeking views to shape options for future consultation. Dec-13 CCG Board reviewed and agreed options for future consultation. Consultation commencing Jan'14 *Feb-14 Trust engaged with CCG consultation, anticipate decision Jun-14*	end Mar-13 Jun-14	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.3: We are unable to develop and implement effective cultural change programmes that lead to improvements in organisational capability and staff morale.									
3.3	Leading for Success Programme Listening in Action Programme Feedback and implementation of action following "quality walks". PAPs clinically led with staff engagement Developing organisation values	CQC Staff Survey results Quality walks and assurance visits	Positive relationship with JSC Weekly CEO message to staff well received Effective clinical leadership of clinical units		CQC staff survey improved but in some areas the Trust is still in the bottom 20%	Implementing LiA programme/developing values. Conversations held and key themes developed. Taking forward quick wins, enabling projects and clinically led team projects to deliver improvements against themes. Aug-13 Participation in year two of LIA programme confirmed. Oct-13 Plans in place to work with Optimise in applying framework to multi-faceted challenges. Over 20 wards/teams working on improvement projects for first half of phase 2. *Feb-14 Draft values developed, being progressed.*	01/01/2013 Phase 2 to commence Jul-13	↔	CEO

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

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.4: We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.									
3.4	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey to obtain core estate information, to include community hospitals; £300k secured invitation & award of service contract; survey with written report.	External company, T&T, produced six facet estate survey	Draft assessment of current estate alignment to PAPs produced	Lack of an appropriate estates strategy and backlog maintenance plan		Develop estates strategy content framework and align estate survey with clinical delivery options. Estates Strategy Board presentation and approval. Dec-13 A number of backlog maintenance issues on the high level risk register being reviewed, monitored and prioritised. *Feb-14 Some of ITFF funding allocated to capital works - being prioritised.*	end Nov-2013	↔	CD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
	Capital funding programme and development control plan			Delay/failure of national IT programme means that the Trust cannot support the effective development of electronic records that support new models of clinical care.		Draft IT strategy presented to May Bd seminar; further stakeholder consultation being undertaken. Aug-13 Community and Child Health (CCH) system FBC approved by Board/TDA. Project initiated 2Jul-13. Dec 13- Implementation of CCH project ongoing. Confirmed readiness to participate in procurement of EDMS and Clinical Portal as part of the Sussex Collaboration. Board approved OBCOct-2012. *Feb-14 Trust bid to Safer Hospitals, Safer Wards Technology Fund successful. Introducing VitalPAC, hand-held mobile technology that enables collection of vital signs observations to support early recognition of deteriorating patient.*	end Sep-2013	↔	DF

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.5: We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change									
3.5	Horizon scanning by Executive team and Board. Board seminars Board development programme. Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports	Minutes of Board seminars Attendance at FTN/NHS Confed events Developed and implemented effective marketing strategy	Policy documents and Board reporting reflect external policy. Strategic development plans reflect external policy. Board seminar programme in place	Trust has limited success in tender exercises. Specialist skills required to support Any Qualified Provider and tendering exercises by commissioners		Agreed method for handling tender opportunities and AQP which includes allocating an exec lead. Aug-13 Contract team strengthened to support AQP process. Ongoing monitoring of AQP and tenders. Oct-13 New MSK tender identified need to further increase leadership and skills of tendering team. Dec-13 Reviewing best practice in tendering - meeting with Hempson Jan 2014 *Feb-14 Future responses to service tenders to be co-ordinated by DSDA. Standardised approach and process to be developed*	end Nov 13	↔	COO

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

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	8
Subject:	Quality Improvement Priorities 2014-15
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

To inform the Board of the agreed Quality Improvement Priorities (QIP) for 2014-15 for 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 2013-2014 must include the Trust's priorities for quality improvement in 2014-15. 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 9 suggestions put forward for 2014-15 and gives detail of the 5 that were agreed by the Clinical Leadership Team in January, however 1 of these is currently being reviewed. There is a requirement that at least one is allocated to each of the following domains: Patient Safety; Clinical Effectiveness and Patient Experience.
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 2014-2015 or to produce and submit a set of Quality Accounts by the 30th June 2014 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 2014.

Review by other Committees/Groups (please state name and date)**:**
Clinical Management Executive – Feb 2014 Quality and Standards Committee/Patient Safety and Clinical Improvement Group 3.3.14

Proposals and/or Recommendations
The Trust Board is asked to note the contents of this report, specifically the quality improvement priorities selected and the timetable for the production of the Quality Account.

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

East Sussex Healthcare NHS Trust

Quality Improvement Priorities 2014/15

1. Introduction

1.1 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.

1.2 The Trust's Quality Account for 2013-2014 must include the organisations priorities for quality improvement in 2014-15. These priorities should have a significant, measurable impact, be feasible to achieve within the timescale and support the change programme and performance requirements of the Trust.

2. Current Quality Improvement Priorities

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

Patient Safety

- Patient Safety Thermometer (maintaining harm free care at 90% and above)
- Releasing Time to Care: The Productive Community Series

Clinical Effectiveness

- Cardiology – Improve the patient experience of those diagnosed with heart failure

Patient Experience

- Implementation of the Patient Experience Strategy
- Supporting young children and young people with long term conditions and disability to stay at home

3. Quality Account Improvement Priorities Proposals 2014/15

The following 9 quality account priorities were proposed for 2014/15:

1. Maximise our efforts to reduce healthcare acquired infections;

2. Improve Sharing of Learning and Spreading Good Practice;

3. Early recognition and action to support the care of the deteriorating patient (linking to Vitalpac);

4. Maximise the benefits from the reconfiguration of General Surgery;

5. Continue to develop our stroke services to ensure we are a high performing, centre of excellence;

6. Increase effectiveness of correspondence to GPs through e-correspondence;

7. Realise the benefits from the implementation of the Community Health Care System;

8. Continue to Implement the Patient Experience Strategy;

9. Ensure that we provide optimal care for patients in our care who have mental health disorders;

These were developed following consideration from patient and staff feedback, themes from complaints and incidents and by reviewing the priorities of the Trust for the forthcoming year.

4. Agreed Quality Improvement Priorities

Following a review by the Clinical Leadership Team on 28th January 2014 the following 5 Quality Improvement Priorities were agreed. They reflect our integrated organisation and the three quality improvement categories: Patient Safety; Clinical Effectiveness; Patient Experience.

4.1 Patient Safety

Freedom from healthcare associated, preventable harm

- Maximise our efforts to reduce healthcare acquired infections

4.2 Clinical Effectiveness

Doing the right thing, in the right way, for the right patient, at the right time

- Early recognition and action to support the care of the deteriorating patient – linking to Vitalpac

- Realise the benefits from the implementation of the Community Health Care System - ***this priority has now been withdrawn as the system is being implemented in 2014-15 and the benefits will not be fully realised until the following year. Alternative community based priorities are currently being considered.***

4.3 Patient Experience

Ensuring patients are treated with dignity and respect and that they are informed, supported and listened to so that they can make meaningful decisions and choices about their care.

- Continue to Implement the Patient Experience Strategy

- Ensure that we provide optimal care for patients in our care who have mental health disorders

5. Measurement

For each indicator we will state why we have chosen it, how we will monitor it and what outcomes we expect and where will we report upon our progress and achievements.

6. 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. The layout of the document is also mandatory.

7. Timetable

March 2014	Prepare the draft Quality Account
7 April 2014	Draft Quality Account circulated to members of the Trust Board, Quality and Standards Committee (QSC) and Clinical Management Executive (CME) for comment, feedback is required – the draft version may be missing information that is published after the end of the financial year.
30 April 2014	Draft Quality Account circulated to the Health Overview Scrutiny Committee (HOSC), the Clinical Commissioning Groups (CCGs) and Healthwatch for comment within 30 days – there still may be some data missing at this stage.
End of May 2014	Comments to be added from feedback, all data to be gathered ready for internal audit regarding the data quality.
May 2014	Present the final Quality Account to CME, QSC, Audit Committee – no data should be missing at this stage.
June 2014	Present the final Quality Account to the Trust Board for final comment and ratification. Chair's action may be required.
By 30 June 2014	Publish the Quality Account on NHS Choices website and forward a copy to the Secretary of State.

8. Recommendation

The Trust Board is asked to note the contents of this report, specifically the quality improvement priorities selected and the timetable for the production of the Quality Account.

Lynette Wells
Company Secretary

7th March 2014

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	9a) and b)
Subject:	Performance Report – Month 10 (January 2014) Finance Report – Month 11 (February 2014)
Reporting Officer:	Alice Webster, Director of Nursing David Hughes, Medical Director – Clinical Governance Richard Sunley, Chief Operating Officer Monica Green, Director of Human Resources Vanessa Harris, Director of Finance

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

Purpose:

The attached reports provide information on the Trust's performance for the month of January 2013/14, against quality, performance, workforce and financial indicators.

Introduction:

The monthly Quality report details ESHT's in month performance for January 2014 against the National Performance Framework metrics as described in the National Operating Plan for 2013/14. This report also details performance against other key trust metrics as well as activity and workforce indicators. It also sets out financial performance for February 2014 (M11) together with the year to date financial performance.

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

Quality Report for January 2014 (month 10)

Month 10 performance fell below the required standard and the Trust remained in "Under-Performing" Status.

Admitted and Non-Admitted Elective Referral To Treatment targets did not achieve target and 15 specialties failed to achieve.

Final month 9 Cancer performance shows the trust failing against the 62 day referral (from screening service) target.

There was 1 C-Difficile case reported in month 10. Current outturn to month 10 is 36 against a target outturn limit of 25.

There was 1 incident and 2 breaches of mixed sex accommodation in month 10, causing the Trust to fall below threshold.

The Trust achieved all Accelerating Stroke Improvement Metrics for the second consecutive month.

Finance Report for February 2014 (month 11)

The Month 11 in month position is a net deficit of £1.0 million against an original planned deficit of £2.2 million, a favourable variance of £1.2 million.

Compared to the In-year Recovery Plan (IRP) profile of £0.4 million deficit in the month the Trust has underachieved by £0.6 million. Year to date the deficit is £22.2 million. Following a review at Month 10 the Trust revised its outturn and revised the forecast outturn to a £23.1 million deficit. It is on plan to achieve this.

The Turnaround Programme is now fully embedded within the organisation. Paybill costs in February were £0.6 million below the average for the first six months of the financial year. Non-pay operating expenditure in the month of £8.3 million was £0.7m below plan. Third party costs were just £47,000 in the month. For the year to date non-pay costs of £103.3 million, including £0.8 million for third party, is now £0.7 million better than plan.

Benefits:
The report provides assurance that the Trust is monitoring performance standards and provides detail of where standards are not being met. The Board is aware of the month 11 financial position and the likely year end outturn.

Risks and Implications
The Trust is underperforming against some of the targets. An 18 week recovery plan is in place to address non achievement of RTT.

Assurance Provided:
This report details the key performance measures for the Trust against its annual business plan and as measured by external partners and the Department of Health reflecting centrally reported and audited metrics. The financial position at M11 is a deficit of is forecast to be a £23.1m deficit

Review by other Committees/Groups (please state name and date)**:**
Finance and Investment Committee 20 March 2014

Proposals and/or Recommendations
The Board is asked to note the report and the actions being taken.

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

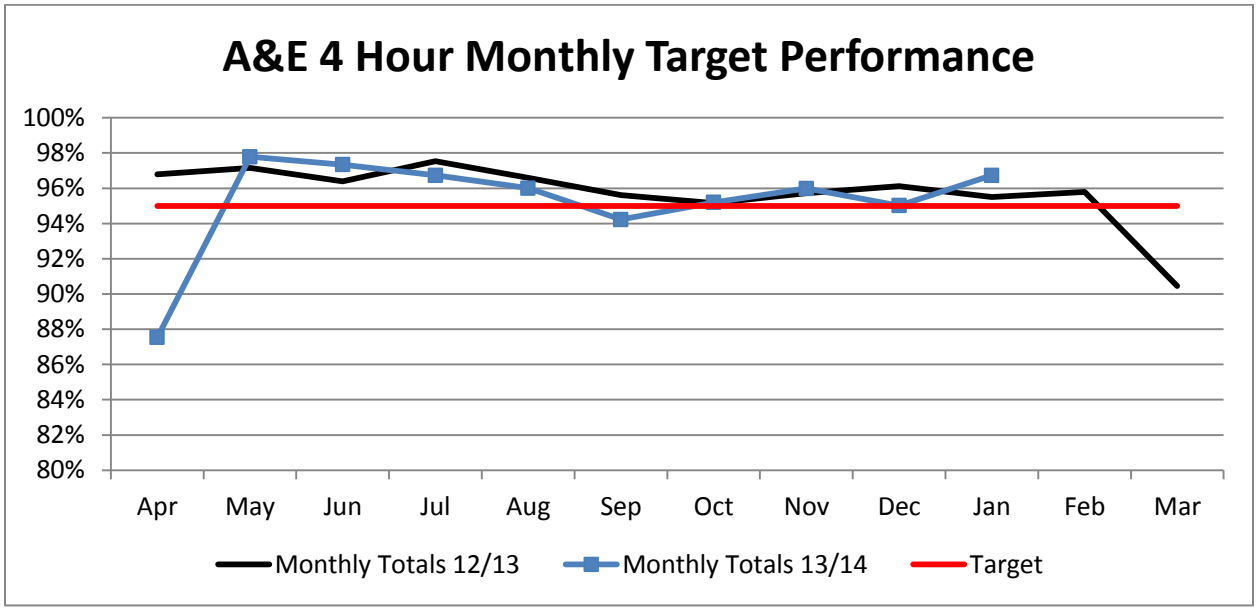
For further information or for any enquiries relating to this report please contact:	
Name: Andy Bailey, Business Intelligence Analyst	**Contact details:** andybailey@nhs.net

Report Overview
Quality, Performance and Activity

National Performance Framework (NPF)

A&E performance

- Performance remained above target in January at 96.73%. Cumulative year to date (95.28%) and Quarter 4 (95.86%) Performance was also above target.



RTT performance

- RTT Performance failed against Admitted targets and Non-Admitted Targets. There were 15 specialty failures in January (compared to 15 in November). Detail as follows
    - Admitted pathways (Trust performance was 73.66% against a 90% Target):
        - T&O (152 breaches away from target), Urology (9), Ophthalmology (112), Oral Surgery (38), General Surgery (6) and Gynaecology (31) were below target.
    - Non-Admitted pathways (Trust performance was 94.42% against a 95% Target):
        - T&O (35), Urology (4), Ophthalmology (47), Oral Surgery (15), Gastroenterology (14) and Rheumatology (33) were below target.
    - Incomplete pathways (Trust performance was 92.71% against a 90% Target): :
        - T&O (192), Gastroenterology (26) and Rheumatology (195) were below target.

An RTT recovery plan has been developed in liaison with the Intensive Support Team. It is anticipated that this will be signed off by the IST in early March. In addition to this and to ensure robust assurance is given, the Trust is undertaking to have weekly telephone conferences with the Trust Development Authority.

C-Difficile

During month 10, total CDiff cases increased to 36, and above the annual ceiling of 25. The trust has revised its internal trajectory to 45 as an aspirational ceiling for C-Difficile cases.

Cancer Performance

Month 10 Cancer Performance is based on an early preview report. Final cancer performance for December will be available during the first week of March. As it stands, the trust is failing against *2 Week Wait from Urgent GP referral*, *2WW with Breast Symptoms* and *Subsequent Treatment (Surgery) within 31 Days*.

The cancer team continue to work to ensure that tertiary communication is of the highest priority to enable the patient pathway to be as efficient as possible. Work is also ongoing to monitor patients transferring to a different tumour site and a formal process has been cascaded amongst the patient pathway co-ordinators. It is anticipated that this will reduce delays and ensure a smooth transition between tumour sites.

Mixed Sex Accommodation Breaches

There was 1 breach incident affecting 2 patients in the month (this compares to 9 patients in December). The breaches remain located in the conquest A&E Observation wards. As an interim measure minor works have been undertaken to partition the current CDU to eliminate breaches in this area. Long term, the Trust is working with external partners (Balfour Beatty) to explore building work that needs to be undertaken to support the long term changes required for the clinical strategy.

Diagnostics; % Patients seen < 6 weeks

Diagnostic Performance declined further in January due to breaches in Endoscopy (214), Audiology (4) and Radiology (24). The number of breaches for Endoscopy has increased week on week since November 2013 due to the fact that additional Endoscopy lists ceased. Endoscopy profiling shows demand is higher than current capacity. Plans have been agreed to address the capacity gap. However, in the meantime it has been agreed to carry out additional Endoscopy weekend sessions to reduce the backlog.

Stroke

All 5 ASI Metrics were achieved in January for the second consecutive month.

Enhancing Quality of Life for People with Long Term Conditions

Unplanned Hospitalisations

The rate of unplanned hospitalisation for chronic ambulatory care conditions has reduced slightly, and remains below 12/13 baseline. The rate of unplanned hospitalisation for specific conditions in U19s increased slightly in January but remains below the 12/13 baseline.

Helping People to recover from episodes of ill health or following injury

Emergency Admissions

Emergency admissions for acute conditions not usually requiring admission remains on a downward trend, in line with plan. Emergency Admissions for Children with lower respiratory tract infections decreased significantly in January in line with previous years patterns.

Emergency Re-Admissions

The rate of Emergency Re-Admissions within 28 days decreased slightly in month to 9.49% but remains below the ceiling target of 10%. Work continues that will detail all readmissions at clinical unit level to identify common themes in discharging practice that will help eliminate avoidable emergency re-admissions in the second part of the year.

Ensuring that People have a positive experience of care

On the Day Cancellations of Elective Surgery per 1000 Procedures

There was a significant decrease in Month 10 (3.47 compared to 4.96 in month 9).

MUST

MUST performance stands at 89%, but it should be noted that the new data capture mechanism has been fully implemented. Data against this indicator is now captured via a *Meridian* (3rd party also supplying the Trusts FFT solution) which enables greater sophistication and ability to capture all relevant information electronically. This ensures that wards maximise their ability to record MUST assessments undertaken. Thus, comparison against months prior to January 2014 is not possible.

Friends and Family Questionnaire

The trust achieved a 17.35% response rate in January. The highest response rate was within EDGH Inpatient Wards (32.55%) and the lowest within EDGH A&E (10.9%). The team continue to utilise volunteer services to telephone survey recent A&E attendees. This has so far proved successful in raising the response rate in this area. The Trusts Combined Unify Net Promotor Score (NPS) increased in January to 60.

Patient Centred Care Planning

The trust ensures that all patients have an integrated patient document which is personalised to their needs and requirements. The indicator has been affected by wards not completing the audit. This will be improved with the implementation of a new audit tool, due to be rolled out shortly. Due to be rolled out in the later part of quarter 3, early quarter 4.

Treating and caring for people in a safe environment and protecting them from avoidable harm

Patient Safety Incidents

There was a slight increase in reported patient safety incidents in January, in line with Trust Baseline. The trust promotes a culture of incident reporting to ensure that key themes can be constantly identified and actions taken to reduce risks and maintain the safety of patients.

Severe Harm Incidents

There were 8 Severe Harm Incidents in Categorised as follows:

- Falls: 3 Incidents
- Labour/Birth: 1 incident
- Treatment: 2 Incidents
- Admission (Inappropriate): 1 Incident
- Pressure Sore: 1 Incident

At least 95% of patients to have a falls assessment on admission

As with the MUST assessments, falls assessments are now captured via a Meridian supplied solution, electronically. As such, comparison against previous months is not possible. Performance stands at 91%.

Organisational Context

GP Referrals & Outpatient Activity

GP Referrals increased from December figures as expected (significantly less working days in December) but also rose to the second highest level this year. Increases were seen in T&O and Rheumatology. In line with this Outpatient Activity also increase significantly (both new and follow up) which will have supported the trusts plan to reduce RTT backlogs but also (as planned and expected) contributed to the reduced performance against non-admitted RTT targets.

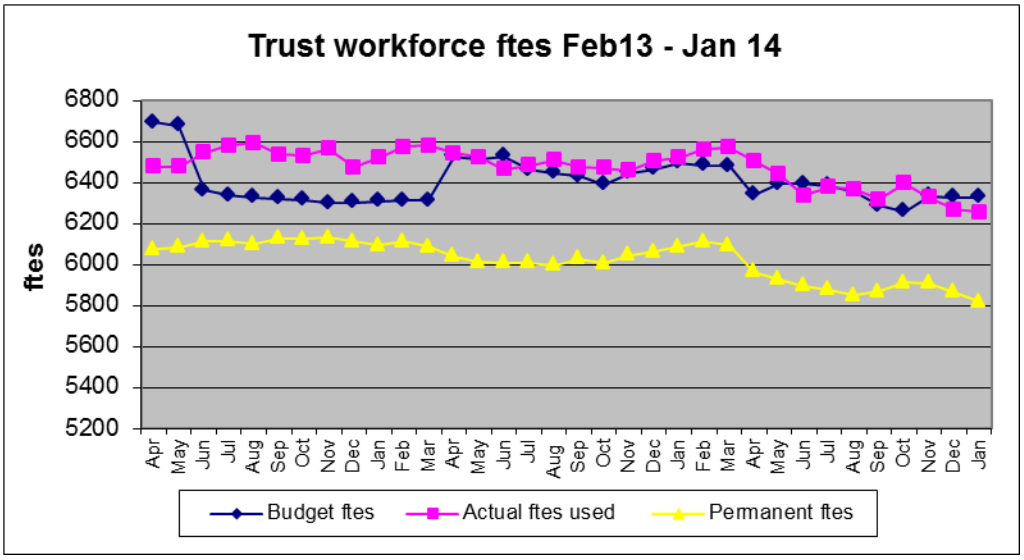
Elective Activity

Elective activity showed a significant increase from December in line with working days. As with OP activity, this increase will have supported plans to reduce RTT backlogs but will in turn reduce performance against Admitted RTT targets.

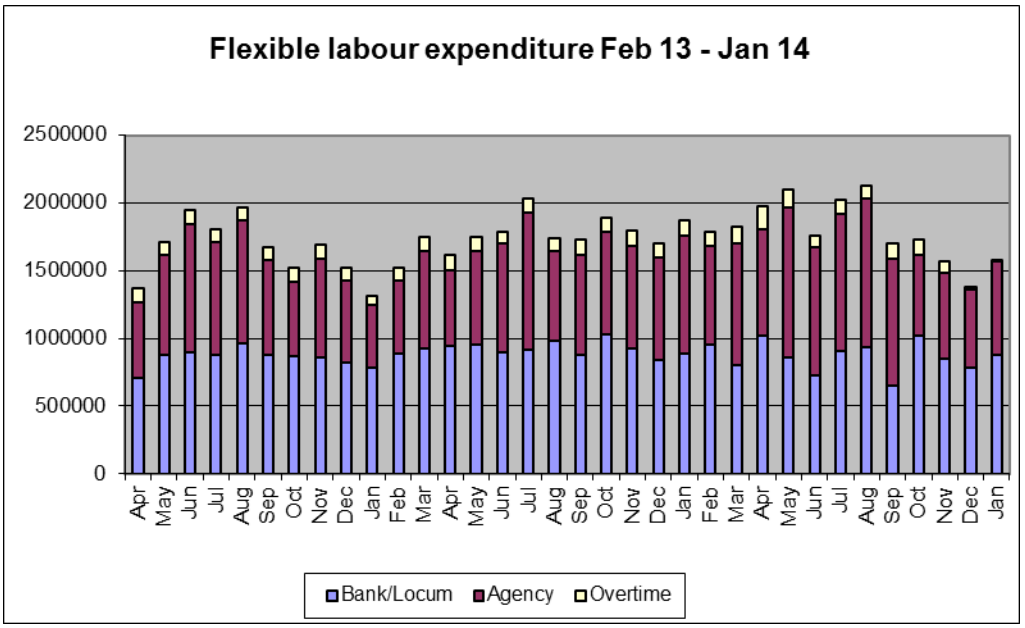
Non Elective Activity

Non-Elective Activity has settled into a fairly stable linear trend but is significantly higher than trust baseline.

Workforce



	Year to Date	
	Target	Actual
WTE in post (actual worked)	6325.78	6256.7
Paybill (£m)	204.98	212.24
Staff turnover	10%	11.8%
% of Bank, agency and overtime spend		8.44%



Actual ftes used in January were down by 10.50 compared to last month, with reductions in substantive ftes and a continued reduction in overtime partly offset by a small increase in bank usage and a 31.56 fte increase in agency usage.

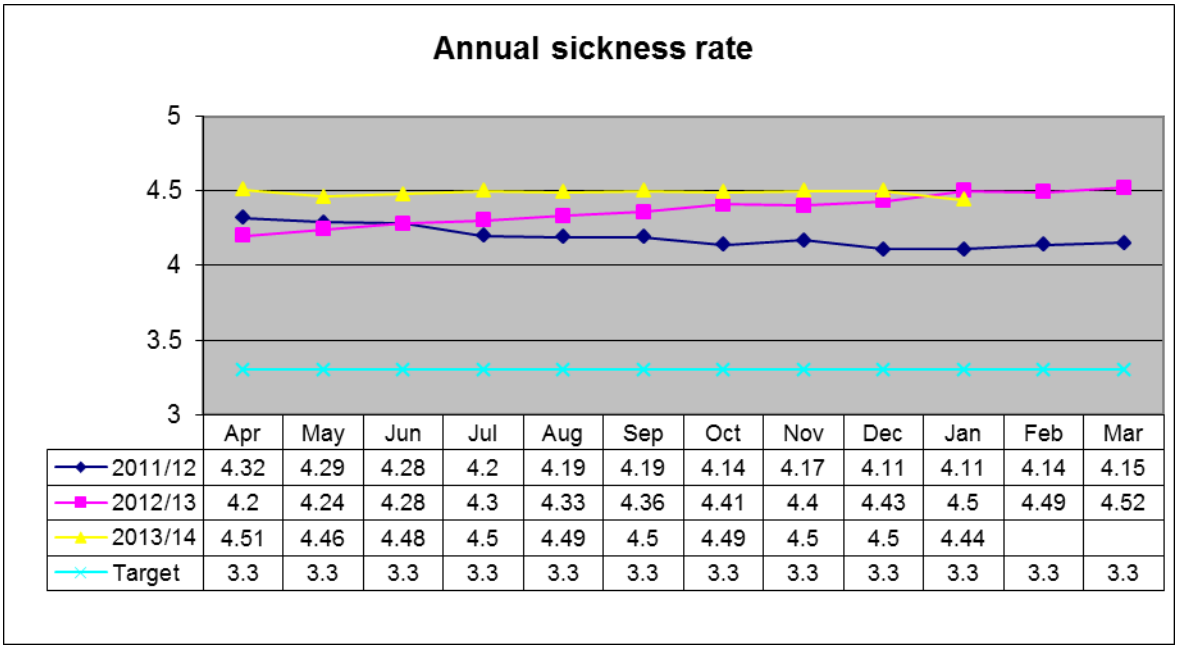
Pay expenditure was £335K above budget, with bank expenditure £76K higher than December and agency expenditure £107K higher. The increase in bank expenditure is largely due to the agreement that was made to pay Band 5 bank nurses (and Band 6 Theatre Nurses and ODPs), who have a substantive job, at their substantive rate rather than a lower fixed pay point, with arrears paid in this month. This was in order to encourage them to work on the bank rather than on the agency.

Medical agency expenditure was £76K higher this month, partly as a result of Christmas holiday cover (paid in January). In addition, there was a slight increase in nursing agency usage due to winter pressures on the Irvine Unit and in Crowborough Intermediate Care. Estates & Ancillary agency expenditure has also increased since last month due to the relaxation of the agency restrictions in the Commercial Directorate as it was demonstrated that agency rates, in this

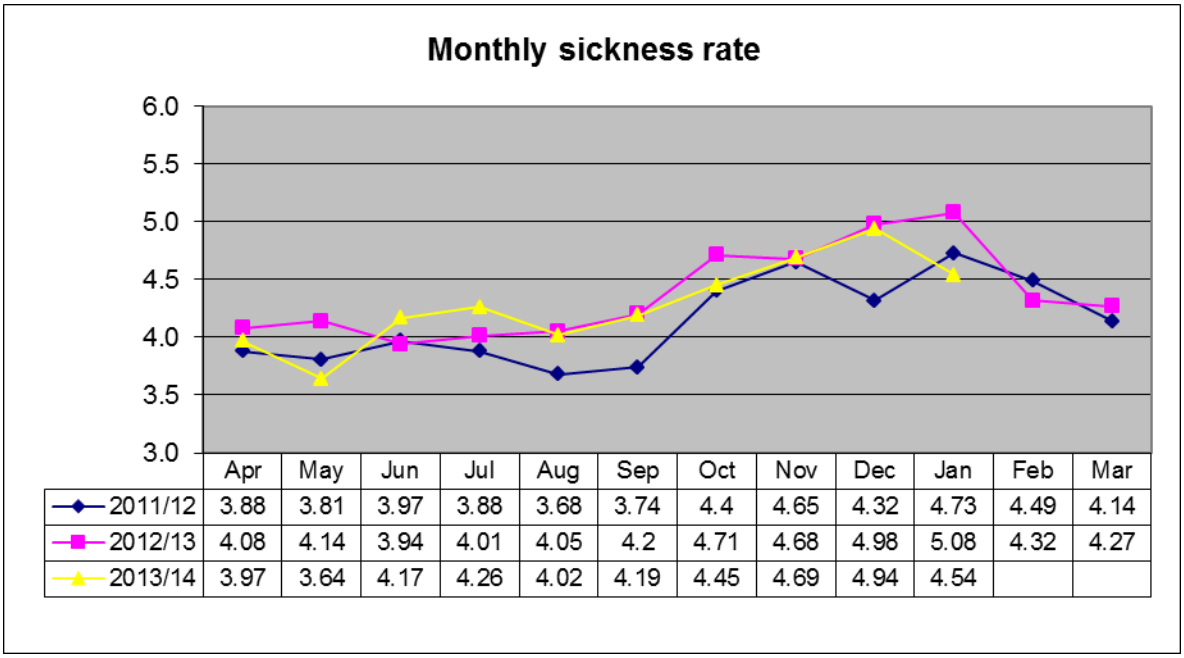
area, are actually lower than the hourly rates for substantive or bank staff. There were also some delayed agency invoices for PMU.

Overtime has continued to fall, more than halving since December to a new low of £8,105. This compares to expenditure of £116,493 in January 2013.

Sickness



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	4.32	4.29	4.28	4.2	4.19	4.19	4.14	4.17	4.11	4.11	4.14	4.15
2012/13	4.2	4.24	4.28	4.3	4.33	4.36	4.41	4.4	4.43	4.5	4.49	4.52
2013/14	4.51	4.46	4.48	4.5	4.49	4.5	4.49	4.5	4.5	4.44		
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
2011/12	3.88	3.81	3.97	3.88	3.68	3.74	4.4	4.65	4.32	4.73	4.49	4.14
2012/13	4.08	4.14	3.94	4.01	4.05	4.2	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		

Monthly sickness fell by 0.40% in January to 4.54%. This rate was 0.54% lower than the rate for January 2013 (when we experienced a Norovirus outbreak) and thus the annual sickness rate has also shown a drop, for the first time in three months, down by 0.06% to 4.44%. The Staff Groups with the highest sickness rates were Additional Clinical Services (unqualified nurses and therapy helpers) at 6.59% (down 0.77% on last month) and Nursing & Midwifery staff at 5.63% (down by 0.29%).

Work to manage long term sickness has resulted in a drop in the proportion of long term absence in most Clinical Units, this month. The overall Trust percentage of long term sickness has fallen from 47% to 41%.

Training and Appraisals (incl. Divisional Summary)

Mandatory training figures have improved slightly again this month, except for marginal decreases in Manual Handling and Infection Control. The former is partly due to absence amongst the Manual Handling training team. Appraisals compliance also continues to improve, up by a further 1.13% to 61.93%.

Clinical Unit/Directorate	Annual sickness	Monthly sickness	Short term sickness <28 days	Long Term sickness >=28 days	Cumulative pay expenditure v budget (£000s)	Appraised/ exempt in last yr	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Mental Capacity Act training	Depriv of Liberties training
Trauma & Orthopaedic	2.86%	3.74%	71.46%	28.54%	£20	65.80%	79.37%	78.03%	90.91%	84.75%	64.57%	92.51%	86.08%
Urol, Gen & Vasc Surg	3.61%	5.00%	70.87%	29.13%	£856	75.94%	80.07%	75.68%	95.24%	83.11%	71.28%	94.44%	91.23%
Theatres Anaes & Crit Care	5.03%	5.64%	62.74%	37.26%	£226	73.88%	83.28%	75.26%	93.02%	83.62%	76.31%	91.30%	88.19%
Head & Neck Surg	3.66%	3.75%	71.36%	28.64%	£888	71.31%	85.94%	86.75%	96.88%	89.96%	83.13%	90.21%	88.89%
Planned Med & Adult OPD	4.61%	4.70%	63.73%	36.27%	£726	57.14%	84.63%	79.02%	95.65%	88.05%	79.02%	89.25%	75.68%
Cardiovasc Medicine	4.09%	3.13%	53.94%	46.06%	£0	44.62%	72.89%	74.36%	96.97%	80.59%	58.24%	82.27%	80.72%
Specialist Medicine	4.55%	4.54%	67.43%	32.57%	£599	67.17%	84.51%	74.65%	91.30%	84.15%	73.94%	89.71%	87.50%
Complex Medicine	5.62%	6.74%	62.78%	37.22%	£850	42.90%	67.25%	66.93%	93.10%	73.58%	63.45%	89.50%	85.99%
Acute Medicine	5.43%	5.39%	58.03%	41.97%	£1,953	49.21%	70.42%	65.28%	95.45%	71.39%	52.57%	80.70%	75.52%
Clinical Support	3.14%	3.21%	78.27%	21.73%	-£501	61.03%	86.58%	79.60%	100.00%	83.09%	81.07%	72.73%	52.27%
Children & Young People	4.99%	4.24%	60.11%	39.89%	£956	60.89%	79.95%	75.89%	96.97%	76.37%	69.69%	80.92%	74.87%
Womens & Sexual Health	5.62%	6.62%	58.61%	41.39%	-£44	60.48%	82.75%	79.82%	100.00%	72.81%	64.33%	85.95%	65.74%
Therapy Services	3.78%	4.64%	59.34%	40.66%	£104	65.03%	84.58%	77.29%	98.70%	73.96%	72.29%	94.63%	88.26%
Commercial	4.97%	3.76%	33.21%	66.79%	-£763	64.57%	79.02%	51.98%	93.24%	90.74%	80.25%	73.91%	87.50%
Corporate	3.04%	3.19%	37.95%	62.05%	-£661	73.17%	88.43%	90.17%	100.00%	87.99%	82.53%	90.67%	81.03%
TRUST	**4.44%**	**4.54%**	**59.01%**	**40.99%**	**£7,260**	**61.93%**	**80.24%**	**72.80%**	**95.67%**	**82.08%**	**72.74%**	**87.74%**	**80.73%**

Medical Appraisal Compliance Status January 2014					
	Number of doctors	Compliant	Percentage Compliant	Total expected to be compliant by 31/03/14	Percentage expected to be compliant by 31/03/14
Consultants (including honorary contract holders)	221	214	**97%**	217	**98%**
Staff grade, associate specialist, speciality doctor (including hospital practitioners / clinical assistants who do not have a prescribed connection elsewhere)	114	108	**96%**	110	**96%**
Total	335	322	**96%**	327	**98%**

The total number of doctors in the Trust are those doctors with a prescribed connection to the Responsible Officer. Doctors who are compliant with medical appraisals are those who have either had an appraisal in the last 12 months and/or have been in the Trust for less than 12 months and/or have a valid reason for absence (e.g. long term sickness or maternity leave). Doctors who are expected to be compliant by 31/03/14 are doctors who have informed the medical revalidation team of their planned and imminent medical appraisal date and the name of their medical appraiser.

All appraisals should now take place between April and December each year. The Responsible Officer has granted an amnesty to those doctors who still need to have an annual appraisal before the end of the financial year but these doctors will be expected to have a further annual appraisal before 31 December 2014 in order to comply with Trust Policy.

Doctors are being asked to nominate their preferred medical appraiser for 2014 (maximum of three), and the intended month of their 2014 appraisal, by the end of February 2014. Those who do not do this will be allocated an appraiser and a month for their next appraisal by the medical revalidation team. Doctors who do not engage in the medical appraisal process will be sent a letter to their home address reminding them of their obligations. This forms part of a staged process of non-engagement culminating in a report of non-engagement to the GMC who have the right to remove a doctor's licence to practise.

East Sussex Healthcare Trust
Service Performance for 2013/14

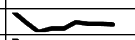
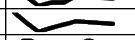
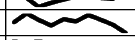
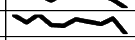
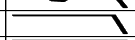
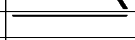
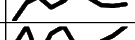
Performance Indicator	Thresholds		MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6	MONTH 7	MONTH 8	MONTH 9	MONTH 10	MONTH 11	MONTH 12
	Performing	Under-performing	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total time in A&E - 95% of patients should be seen within four hours	95%	94%	87.53%	97.78%	97.34%	96.74%	96.01%	94.22%	95.19%	95.98%	95.01%	96.73%		
MRSA	0	>1SD	0	0	0	0	0	0	0	0	1	1		
C Diff	0	>1SD	4	10	11	14	18	23	27	31	35.0	36.0		
RTT - admitted - 90% in 18 weeks	90%	85%	84.62%	82.97%	76.78%	92.81%	92.43%	91.79%	91.41%	90.03%	80.50%	73.66%		
RTT - non-admitted - 95% in 18 weeks	95%	90%	96.57%	96.85%	96.60%	96.91%	96.79%	95.42%	95.77%	95.06%	94.65%	94.42%		
RTT - incomplete 92% in 18 weeks	92%	87%	94.81%	94.99%	95.50%	94.86%	94.24%	93.86%	92.42%	92.40%	92.13%	92.71%		
RTT delivery in all specialties	0	>20	11	9	11	4	5	6	9	9	16	15		
Diagnostic Test Waiting Times	<1%	5%	0.77%	0.13%	0.47%	0.35%	2.11%	0.71%	0.75%	1.62%	4.70%	5.78%		
Cancer 2 Week Wait	93%	88%	93.91%	96.49%	94.69%	93.05%	94.95%	94.22%	95.95%	94.74%	93.41%	91.09%		
Cancer 2 week wait - Breast	93%	88%	96.30%	93.00%	96.74%	91.61%	91.23%	94.38%	93.14%	92.19%	94.95%	87.40%		
Cancer 31 day - Subsequent Surgery	94%	89%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	92.86%		
Cancer 31 day - Subsequent Chemo	98%	93%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
Cancer 31 day - Diagnosis to Treatment.	96%	91%	96.11%	97.95%	98.58%	97.50%	98.13%	99.38%	98.52%	97.69%	97.62%	97.84%		
Cancer 62 Day Screening Service	90%	85%	77.78%	100.00%	66.67%	91.67%	100.00%	77.78%	73.68%	83.33%	89.47%	100.00%		
Cancer 62 Day Urgent Referral	85%	80%	85.71%	85.23%	82.21%	89.91%	77.68%	79.90%	81.19%	79.67%	88.71%	88.99%		
Delayed transfers of care	3.5%	5.0%	0.60%	0.68%	0.68%	0.63%	0.47%	0.61%	0.69%	0.57%	0.46%	0.64%		
Mixed Sex Accommodation Breaches	0.0%	0.5%	0.00%	0.00%	0.11%	0.15%	0.91%	0.48%	0.31%	0.16%	0.17%	0.04%		
VTE Risk Assessment	95.0%	80.0%	95.26%	96.75%	96.28%	97.16%	96.44%	97.04%	96.91%	97.13%	96.99%	97.92%		
		NPF SCORE	2.38	2.71	2.56	2.89	2.71	2.64	2.56	2.38	2.09	1.82		

Performance figures that are coloured grey have not yet been fully validated and are only indicative. Where inreference to cancer targets, figs will be taken from a preview and updated/fixed the following month. Where in reference to RTT, figs will be taken from the live tracking system and updated/fixed in line with the national timetable

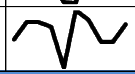
R
A
G

Clinical Effectiveness

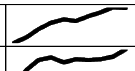
1. Preventing people from dying prematurely

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
RAMI (Risk Adjusted Mortality Index)	100	100	NA		118	100	85	90	90	101.0	99.0	98.0	97.0			
SHMI (In Hospital) Sourced from CHKS			TBC		91	76	63	69.0	73.0	78.0	77.0	76.0	75.0			
Cancer waits 2 week	93%	88%	93.96%		93.91%	96.49%	94.69%	93.05%	94.95%	94.22%	95.95%	94.74%	93.41%	91.09%		
Cancer waits 2 week – Breast	93%	88%	93.84%		96.30%	93.00%	96.74%	91.61%	91.23%	94.38%	93.14%	92.19%	94.95%	87.40%		
Cancer 31 day – subsequent surgery	94%	89%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	92.86%		
Cancer 31 day – chemo	98%	93%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
Cancer waits 31 days diagnosis to treatment	96%	91%	96.45%		96.11%	97.95%	98.58%	97.50%	98.13%	99.38%	98.52%	97.69%	97.62%	97.84%		
Cancer waits 62 days > from urgent GP	90%	85%	83.28%		77.78%	100.00%	66.67%	91.67%	100.00%	77.78%	73.68%	83.33%	89.47%	100.00%		
Cancer waits 62 days > from screening service	85%	80%	83.08%		85.71%	85.23%	82.21%	89.91%	77.68%	79.90%	81.19%	79.67%	88.71%	88.99%		
Cancer waits 62 days > from consultant upgrade	No OS	No OS	NEW		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		

2. Enhancing quality of life for people with long term conditions

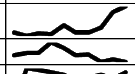
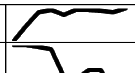
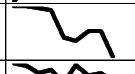
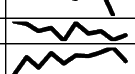
Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Reduction in Unplanned hospitalisation for chronic ambulatory care conditions (adults)	Reduction	N/A	295		282	300	297	275	255	254	294	307	298	296		
Reduction in Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Reduction	N/A	27		18	25	25	23	6	30	26	17	17	24		

3. Helping people to recover from episodes of ill health or following injury

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Emergency admissions for acute conditions which should not usually require hospital admission	RO	RO	422		464	396	334	367	428	364	409	417	404	324		
Emergency admissions for children with lower respiratory tract infections	RO	RO	TBC		21	10	8	5	5	8	10	18	108	45		
% Emergency Readmissions within 28 days	RO	11.00%	10.00%		10.44%	12.21%	11.48%	12.84%	11.78%	12.41%	11.02%	10.54%	9.46%	9.79%		
ASI 1: Preventable stroke	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
ASI 2: Direct Admission to Stroke Unit	90.00%	90.00%	83.20%		65.12%	69.23%	75.86%	81.03%	83.67%	82.35%	86.27%	89.36%	93.33%	92.45%		
ASI 3: 90% Acute Stroke Care	80.00%	80.00%	78.80%		61.11%	76.25%	86.76%	89.71%	83.67%	87.18%	86.89%	87.27%	90.24%	98.36%		
ASI 4a: Access to Brain Imaging (1H)	50.00%	50.00%	57.60%		42.86%	59.38%	61.82%	52.54%	71.74%	86.21%	76.00%	77.78%	83.33%	81.13%		
ASI 4b: Access to Brain Imaging (24H)	100.00%	100.00%	98.50%		95.24%	100.00%	98.21%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
ASI 5: High Risk TIA	60.00%	60.00%	72.50%		71.43%	80.00%	82.76%	67.44%	81.40%	78.26%	78.13%	74.07%	66.67%	75.68%		
The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
% MUST nutritional assessments undertaken					97.00%	94.00%	94.00%	99.00%	71.00%	70.00%	77.00%	62.00%	53.00%	89.00%		

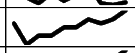
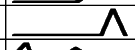
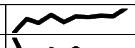
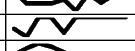
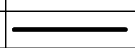
Patient Experience

4. Ensuring that people have a positive experience of care

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Diagnostics - % of patients waiting > 5 wks	1%	5%	0.42%		0.77%	0.13%	0.47%	0.35%	2.11%	0.71%	0.75%	1.62%	4.70%	5.78%		
A&E Attendances	RO	RO	11292		11605	11963	11944	13324	12577	11631	11732	10803	11093	10818		
Total time in A&E - 95% of patients should be seen within four hours	95%	94%	95.66%		87.53%	97.78%	97.34%	96.74%	96.01%	94.22%	95.19%	95.98%	95.01%	96.73%		
Mixed sex accommodation breaches	0.00%	0.50%	0.02%		0.00%	0.00%	0.11%	0.15%	0.91%	0.48%	0.31%	0.16%	0.17%	0.04%		
On the day cancellations of elective surgery per 1000 procedures for non-clinical reasons			TBC		4.43	4.09	3.04	5.68	2.63	2.09	8.57	4.48	4.96	3.47		
Responsiveness to inpatient personal needs	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
Peoples experience of integrated care	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
% Complaints responded to within timescales	100%	95%	55.00%		54.24%	71.21%	85.71%	89.09%	83.02%	88.89%	89.36%	88.33%	86.54%	90.74%		
Patient centred care plans, responsive to individual preferences, needs and values - %					99.00%	99.00%	98.00%	96.00%	74.00%	71.00%	79.00%	79.00%	58.00%			
Adult – BADS Efficiency Score	85%	75%	78.80%		57.79%	55.69%	50.18%	52.50%	42.23%	56.79%	48.00%	50.15%	42.86%	46.77%		
Paediatric – BADS Efficiency Score	85%	75%	78.80%		55.56%	80.00%	65.00%	85.19%	70.83%	82.61%	81.48%	86.36%	93.33%	73.91%		
FFT Response Rate	15%	13%	NEW		10.04%	11.46%	16.38%	17.48%	15.19%	17.66%	18.48%	22.85%	16.69%	17.35%		
FFT NET Promotor Score			NEW		60.00%	65.00%	62.00%	63.00%	59.00%	61.00%	55.00%	50.00%	56.00%	60.00%		

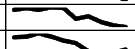
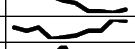
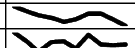
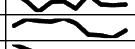
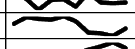
Patient Safety

5. Treating and caring for people in a safe environment and protecting them from avoidable harm

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Patient safety incidents reported	RO	RO	675		779	732	665	783	694	762	878	665	647	674		
Safety incidents involving severe harm or death	0	0	7		5	0	2	2	4	4	6	5	6	8		
Incidence of hospital-related venous thromboembolism (VTE)	RO	RO	46.0		0	0	0	0	0	0	1	2	3	4		
Incidence of healthcare associated MRSA infection	0	0	0		0	0	0	0	0	0	0	0	1	0		
Incidence of healthcare associated *C. difficile* infection	2	2	4		4	6	1	3	4	5	4	4	4	1		
Incidence of all category 2,3 and 4 pressure ulcers reported by ESHT	RO	RO	58		33	23	29	18	30	30	40	33	30	23		
Incidence of medication errors causing serious harm	RO	RO	0		0	0	0	0	0	0	0	0	0	0		
Admission of full-term babies to neonatal care	RO	RO	TBC		12	5	12	8	10	11	12	11	10	12		
Incidence of harm to children due to 'failure to monitor'	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
% of patients with VTE assessment	95.00%	85.00%	93.31%		95.26%	96.75%	96.28%	97.16%	96.44%	97.04%	96.91%	97.13%	96.99%	97.92%		
Reduction in the outturn number of falls by at least 10%	178	178	198		241	175	176	212	194	214	193	173	187	201		
At least 95% of patients to have a falls assessment on admission	95.00%	90.00%	TBC		96.00%	97.00%	97.00%	96.00%	71.00%	73.00%	74.00%	64.00%	58.00%	91.00%		
Number of new serious incidents	RO	RO	15.0		21	12	12	12	15	7	19	13	18	21		
% Submitted within timescale (month)	90%	85%	TBC		90.48%	83.33%	100.00%	100.00%	86.67%	100.00%	100.00%	100.00%	100.00%	100.00%		
Serious Incidents Open	RO	RO	30.0		57	68	77	71	61	54	53	44	44	42		
Nice Technology Appraisal compliance	95%	95%	73%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
Number of CAS alerts breaching timescales	0.0	0.0	TBC		0	0	0	0	0	0	0	0	0	0		
Number of substantiated Safeguarding alerts	RO	RO	TBC		2	1	0	1	0	0	0	0	#N/A	#N/A		
Compliance with cleaning standards	86%	80%	95.03%		93.89%	94.03%	93.19%	94.16%	89.45%	89.06%	90.32%	93.41%	#N/A	95.71%		

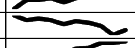
Organisational Context

6. Organisational Context

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Non elective FFCEs	RO	RO	3315		3,844	4,089	3,894	4,101	4,097	3,963	4,395	4,113	4,125	4,137		
GP Referrals to hospital	RO	RO	7238		7,588	7,837	7,352	8,221	7,109	7,191	8,194	7,667	6,896	8,053		
Other referrals for First OP appointment	RO	RO	3522		3,499	3,878	3,566	3,906	3,788	3,670	3,725	3,379	3,087	3,440		
First OP attendances following GP referral	RO	RO	6927		6,371	6,770	6,518	7,418	6,065	6,514	7,226	6,747	6,052	7,012		
All First OP attendances	RO	RO	10475		10,048	10,538	10,389	11,559	9,802	10,410	11,308	10,487	9,382	10,775		
All subsequent OP attendances	RO	RO	23048		25,387	24,598	23,848	26,337	23,076	24,450	25,810	25,011	21,044	25,489		
Elective FFCEs	RO	RO	799		730	772	846	787	760	790	822	868	700	833		
RTT – admitted – 90% in 18 weeks	90%	85%	90%		84.62%	82.97%	76.78%	92.81%	92.43%	91.79%	91.41%	90.03%	80.50%	73.66%		
RTT – non-admitted – 95% in 18 weeks	95%	90%	96%		96.57%	96.85%	96.60%	96.91%	96.79%	95.42%	95.77%	95.06%	94.65%	94.42%		
RTT – incomplete 92% in 18 weeks	92%	87%	96%		94.81%	94.99%	95.50%	94.86%	94.24%	93.86%	92.42%	92.40%	92.13%	92.71%		
RTT - Specialty Compliance	0	20	8		11	9	11	4	5	6	9	9	16	15		
% Uncoded Spells	RO	RO	TBC		0.04%	0.04%	0.05%	0.04%	0.09%	0.02%	0.03%	0.06%	0.06%	0.04%		

WorkForce

7. Workforce

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Permanent FTE	RO	RO	6,048		5,964	5,926	5,895	5,877	5,848	5,868	5,911	5,909	5,864	5,819		
Bank FTE	RO	RO	341		397	338	272	334	337	293	378	319	313	316		
Agency FTE	RO	RO	181		145	175	168	167	180	158	105	101	90	122		
% Permanent FTE	RO	RO	92.05%		91.67%	91.10%	90.62%	90.34%	89.90%	90.20%	90.87%	90.83%	90.14%	89.45%		
% Bank FTE	RO	RO	5.19%		6.10%	5.20%	4.17%	5.14%	5.19%	4.50%	5.82%	4.90%	4.82%	4.85%		
% Agency FTE	RO	RO	2.76%		2.23%	2.69%	2.58%	2.56%	2.77%	2.43%	1.61%	1.55%	1.39%	1.87%		
Monthly Sickness	3.30%	3.80%	4.52%		3.97%	3.64%	4.17%	4.26%	4.02%	4.19%	4.45%	4.69%	4.94%	4.54%		
Annual Sickness	3.30%	3.80%	4.52%		4.51%	4.46%	4.48%	4.50%	4.49%	4.50%	4.49%	4.50%	4.50%	4.44%		
Induction Uptake	90.00%	75.00%	90.31%		91.10%	94.60%	95.30%	95.09%	95.22%	95.08%	93.62%	94.06%	94.48%	95.67%		
Fire Training Uptake	90.00%	75.00%	75.10%		74.27%	76.18%	77.57%	75.12%	77.85%	78.87%	79.49%	80.50%	79.56%	80.24%		
Manual Handling uptake	90.00%	75.00%	70.40%		70.83%	71.89%	71.69%	72.32%	71.50%	73.70%	73.06%	72.90%	73.10%	72.80%		
Infection Control Training Uptake	90.00%	75.00%	78.73%		78.43%	80.24%	80.33%	80.75%	79.74%	80.71%	81.19%	82.32%	82.59%	82.08%		
Information Governance Training Uptake	90.00%	75.00%	81.53%		79.04%	76.83%	77.53%	76.91%	75.34%	76.56%	75.77%	74.43%	70.75%	72.74%		
MCA Training Uptake	90.00%	75.00%	80.56%		84.67%	84.86%	84.53%	84.93%	85.60%	86.56%	86.69%	87.45%	87.48%	87.74%		
Deprivation of Liberty Training Uptake	90.00%	75.00%	72.60%		75.71%	76.19%	76.46%	77.15%	76.12%	78.29%	78.22%	79.40%	80.07%	80.73%		
Appraisal Compliance	90.00%	75.00%	64.75%		63.68%	62.36%	62.12%	62.58%	60.12%	58.60%	57.76%	59.15%	60.80%	61.93%		

East Sussex Healthcare NHS
NHS Trust

FINANCE REPORT – February 2014

Vanessa Harris – March 2014

East Sussex Healthcare NHS
NHS Trust

Financial Summary – February 2014

Key Issue	Summary	YTD
Key Performance Indicators	Measured against Monitor criteria the year to date position at the end of February remains a red rating of 1.	R
Financial Summary	In February the Trust made a net deficit of £1.0m against a planned deficit of £2.2m, a favourable variance of £1.2m. The Trust performance for the year to date was a deficit of £22.2m, an adverse variance against original plan of £3.5m. Income was £3.6m above original plan and total costs, excluding impairments of £10m, were £7.4m over original plan. Compared to the In-year Recovery Plan (IRP) profile of £0.4m deficit in the month the Trust has underachieved by £0.6m but the Trust is on plan to achieve the forecast outturn of £23.1m.	R
Activity & Income	Total income was £1.7m better than plan in the month, improving the cumulative favourable position to £3.6m. This position takes into account the agreement reached with commissioners over the value of fines and penalties to be applied/reinvested.	G
Expenditure	Pay costs YTD are above original plan by £8.0m, which includes £12.0m of costs in respect of agency staff, overtime and ad-hoc payments. Total costs for February were £31.3m, which is £1.0m below the average (excluding impairments) for the first six months of the year. February pay expenditure is £0.6m below the average for the first six months of the financial year. Non-pay operating expenditure in the month of £8.3m was £0.7m below plan. Third party costs were just £47k in the month. For the year to date non-pay costs of £103.3m, including £0.8m for third party, is now £0.7m better than plan.	R
CIP plans	CIP achievement YTD, including turnaround CIPs, increased to £14.4m, 82% achievement, an underachievement of £3.3m.	R
Balance Sheet	The balance sheet is IFRS compliant and includes the value of properties transferred from the former PCTs.	G
Cash Flow	The cash balance at the end of February was just below £4.0m (4 days' operating costs). The Trust received permanent revenue PDC in the month and this together with other receipts allowed the Trust to reduce its trade creditors by £19.3m.	G
Capital Programme	Following the approval of the additional capital resource from the Safer Hospitals Safer Wards Technology Fund & the Nurse Technology Fund bids the total 2013/14 capital resource limit (CRL) has increased to £16.0m. The Trust remains on track to achieve a break even at 31st March 2014 against this revised CRL.	G
Risk Summary	The overall Trust rating is a red rating of 1.	R

Income & Expenditure – February 2014

Headlines

• Total expenditure in the month, including capital charges of £2.0m but excluding impairment, was £31.3m. This was £0.6m above plan but £0.3m below month 10. Cumulatively, total expenditure excluding impairment is £353.0m, which is £7.4m or 2.1% above plan.

• Cumulatively, the deficit is £22.2m against the original plan of £18.7m, resulting in a shortfall YTD against original plan of £3.5m.

• Cost improvements of £14.4m have been achieved after eleven months, £3.3m behind the year to date plan.

•Total income in the month was £30.3m against a plan of £28.5m, producing a favourable variance of £1.7m. Cumulatively, income is now £330.5m, which is £3.6m favourable to plan.

• Pay costs in the month, including ad hoc costs, were £0.8m above plan. Cumulatively, pay is £8.0m ahead of plan with ad hoc costs of £2.1m and agency costs of £9.1m.

• Non Pay costs, including 3rd party costs, are £0.7m below plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	25,639	27,499	1,860	294,944	299,275	4,331	321,943
Private Patient/ ICR	354	374	20	3,745	2,621	-1,124	3,519
Trading Income	406	358	-48	4,464	4,145	-319	5,201
Education	713	688	-25	7,991	7,849	-142	8,420
Other Non Clinical Income	1,429	1,373	-56	15,771	16,651	880	17,739
Total Income	**28,541**	**30,292**	**1,751**	**326,915**	**330,541**	**3,626**	**356,822**
Pay Costs	-20,060	-20,746	-686	-224,624	-231,044	-6,420	-244,546
Ad hoc Costs	-41	-111	-70	-458	-2,054	-1,596	-500
Non Pay Costs	-9,044	-9,048	-4	-103,496	-104,978	-1,482	-112,530
3rd Party Costs	-125	-47	78	-1,377	-843	534	-1,500
Other	83	688	605	917	2,563	1,646	1,000
Total Direct Costs	**-29,187**	**-29,264**	**-77**	**-329,038**	**-336,356**	**-7,318**	**-358,076**
Surplus/- Deficit from Operations	**-646**	**1,028**	**1,674**	**-2,123**	**-5,815**	**-3,692**	**-1,254**
P/L on Asset Disposal	0	6	6	0	7	7	0
Depreciation	-987	-972	15	-10,858	-10,540	318	-11,845
Impairment	0	0	0	0	-10,018	-10,018	0
PDC Dividend	-485	-1,003	-518	-5,338	-5,856	-518	-5,823
Interest	-36	-33	3	-402	-269	133	-439
Total Indirect Costs	**-1,508**	**-2,002**	**-494**	**-16,598**	**-26,676**	**-10,078**	**-18,107**
Total Costs	**-30,695**	**-31,266**	**-571**	**-345,636**	**-363,032**	**-17,396**	**-376,183**
Net Surplus/-Deficit	**-2,154**	**-974**	**1,180**	**-18,721**	**-32,491**	**-13,770**	**-19,361**
Donated Asset/Impairment Adjustment	0	-1	-1	0	10,260	10,260	0
Adjusted Net Surplus/-Deficit	**-2,154**	**-975**	**1,179**	**-18,721**	**-22,231**	**-3,510**	**-19,361**

Surplus/- Deficit from Operations	**-646**	**1,028**	**1,674**	**-2,123**	**-5,815**	**-3,692**	**-1,254**
Debtors	-241	6,767	7,008	601	-11,295	-11,896	453
Creditors	-148	-10,005	-9,857	-2,144	142	2,286	-2,023
Other	15	36	21	-96	-1,168	-1,072	580
CF from Operations	**-1,020**	**-2,174**	**-1,154**	**-3,762**	**-18,136**	**-14,374**	**-2,244**
CAPEX	-2,487	-3,911	-1,424	-21,493	-13,944	7,549	-22,041
Proceeds from Asset Sales	0	0	0	0	0	0	0
Interest Rec'd/Paid	2	2	0	-440	20	460	-539
Temporary Borrowing	0	8,118	8,118	0	37,118	37,118	0
Net movement in loans	0	0	0	33,163	-837	-34,000	31,341
PDC	0	0	0	-2,912	-3,082	-170	-5,823
Other	-29	54	83	-575	687	1,262	-694
Net Cash Inflow/Outflow	**-3,534**	**2,089**	**5,623**	**3,981**	**1,826**	**-2,155**	**0**

Balance Sheet – February 2014

Headlines

• The cash balance at the end of February was just below £4.0m (4 days' operating costs). The Trust received £34.4m permanent revenue PDC in the month, enabling it to repay the £29.0m temporary PDC. In addition, the £2.7m balance (of the total £5m) of permanent capital PDC was drawn down in the month. This injection of funds together with other receipts allowed the Trust to reduce its trade creditors by £19.3m.

•This significantly improved liquidity will also result in improved 'Better Payment Practice Code' statistics and will reduce the negative impacts on supplier relations.

• Delivery of the FRP remains a critical element in achieving sustainable levels of liquidity in the long term.

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual
Non Current Assets		
Property plant and equipment	202,953	249,922
Intangilble Assets	285	639
Trade and other Receivables	898	647
	204,136	**251,208**
Current Assets		
Inventories	6,869	6,723
Trade and other receivables	14,051	25,597
Other current assets	107	0
Cash and cash equivalents	2,250	3,969
	23,277	**36,289**
Current Liabilities		
Trade and other payables	-33,044	-32,328
DoH Loan	-1,674	-1,674
Borrow ings - Finance Leases	-308	-308
Provisions	-475	-470
	-35,501	**-34,780**
Non Current Liabilities		
DoH Loan	-5,209	-4,372
Borrow ings - Finance Leases	-916	-611
Provisions	-2,672	-2,515
	-8,797	**-7,498**
Total Assets Employed	**183,115**	**245,219**
Financed by		
Public Dividend Capital (PDC)	111,969	149,840
Revaluation Reserve	82,175	102,565
Income & Expenditure Reserve	-11,029	-7,186
Total Tax Payers Equity	**183,115**	**245,219**

Key Performance Indicators – February 2014

Headlines

KPIs

• The Trust has a planned annual deficit budget of £19.4m.

• The EBITDA Margin for the year to date was negative 2.1% compared to the planned negative 1.0% resulting in a red risk rating of 1.

• The EBITDA achieved as a percentage of plan is a risk rating of 1.

• The I&E surplus margin is a red rating of 1.

• The liquidity ratio, including the Working Capital Facility (WCF), now stands at 24 days, a risk rating of 3. Excluding the WCF the liquidity days would be -5 days.

•The overall KPI rating remains a red rating of 1.

KPIs	Previous YTD	YTD Actual	YTD Plan
EBITDA Margin (%)	-2.6	-2.1	-1.0
EBITDA Achieved (% of plan)	305.6	207.3	100.0
Net Return After Financing (%)	-10.2	-10.6	-9.0
I&E surplus margin (%)	-7.1	-6.7	-5.7
Liquidity Ratio (days)	19	24	20
Overall Monitor Risk Rating	1	1	1

National & Local Measures	Previous YTD	YTD Actual	YTD Plan
Income v Plan (£m)	300.2	330.5	326.9
Expenditure (before financing costs) v Plan (£m)	307.1	336.4	329.0
CRES Plans (£m)	12.0	14.4	17.6
BPPC – Trade invoices by value (%)	37.1	37.6	95
BPPC – NHS Invoices by value (%)	38.9	51.2	95

Monitor Ratings	YTD Risk Rating
EBITDA Margin	1
EBITDA % Achieved	1
Net Return After Financing	1
I&E Surplus Margin	1
Liquidity Ratio	3
Overall Risk Rating	1

Activity & Contract Income – February 2014

Headlines

•Headline contract activity income is £1.5m favourable to plan year to date, excluding high cost drugs and device exclusions.

•High cost drugs and device exclusions income has a neutral impact on ESHT as they are offset by expenditure. After allowing for these areas, total contract income is £4.3m above planned levels.

•The month 11 year to date position reflects the agreement with commissioners in respect of the 2013/14 fines & penalties to be applied/reinvested and 100% overall achievement of CQUIN.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,284	3,537	253	39,422	39,125	-297
Elective Inpatients	772	792	20	9,265	8,624	-641
Emergency Inpatients	3,006	3,323	317	35,855	39,945	4,090
Total Inpatients	**7,062**	**7,652**	**590**	**84,542**	**87,694**	**3,152**
Excess Bed Days	2,168	2,924	756	25,864	28,180	2,316
Total Excess Bed Days	**2,168**	**2,924**	**756**	**25,864**	**28,180**	**2,316**
Consultant First Attendances	7,350	7,436	86	88,231	84,417	-3,814
Consultant Follow Ups	11,378	11,988	611	136,579	134,733	-1,845
OP Procedures	3,666	4,774	1,108	44,005	50,780	6,775
Other Outpatients inc WA & Nurse Led	7,855	9,862	2,007	93,719	111,929	18,210
Community Specialist	222	366	144	2,666	2,724	58
Total Outpatients	**30,471**	**34,427**	**3,955**	**365,200**	**384,584**	**19,384**
Chemotherapy Unbundled HRGs	431	477	46	5,173	5,483	310
Antenatal Pathways	303	370	66	3,643	3,699	56
Post-natal Pathways	303	350	46	3,643	3,820	177
A&E Attendances (excluding type 2's)	7,497	7,473	-24	95,253	92,888	-2,365
ITU Bed Days	619	538	-81	5,844	5,640	-204
SCBU Bed Days	292	96	-197	2,911	2,677	-235
Cardiology - Direct Access	63	56	-7	759	768	9
Radiology - Direct Access	3,677	4,349	672	44,135	50,763	6,628
Pathology - Direct Access	247,047	287,068	40,021	2,965,528	3,080,179	114,651
Therapies - Direct Access	3,376	3,772	396	40,526	36,767	-3,759

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,337	4,909	572	52,069	51,255	-814
Inpatients - Emergency	5,740	5,612	-128	68,467	72,336	3,869
Excess Bed Days	504	665	161	6,007	6,508	501
Outpatients	3,552	3,958	406	42,361	44,005	1,644
Other Acute based Activity	2,493	2,290	-203	27,963	27,349	-614
Direct Access	720	778	58	8,651	8,593	-58
Block Contract	5,716	5,830	114	63,071	63,271	200
Mandatory Fines & Penalties	-308	1,234	1,542	-3,394	-4,189	-795
Other	531	87	-444	3,521	1,128	-2,393
CQUIN	586	586	0	6,785	6,785	0
Subtotal	23,871	25,949	2,078	275,501	277,041	1,540
Exclusions	1,768	1,550	-218	19,443	22,234	2,791
GRAND TOTAL	**25,639**	**27,499**	**1,860**	**294,944**	**299,275**	**4,331**

Divisional Performance (budgets) – February 2014

Headlines

Planned Care

The division over spent by £285k in the month increasing the year to date (YTD) overspend to £10,951k. Income is currently £1,854k below plan. YTD pay is overspent by £5,659k due to agency, ad-hocs early in the year & unidentified CIP . Non-pay is overspent by £3,438k due to theatres non pay & undelivered CIP.

Urgent Care

An underspend of £396k in the month, has decreased the year to date overspend to £3,161k. The YTD pay overspend of £4,433k is mainly in respect of agency costs. Non pay is cumulatively £2,089k overspent and income is cumulatively over-achieved by £3,361k.

Integrated Care

The division overspent by £264k in the month increasing the YTD overspend ing to £4,043k. Pay underspent in the month by £123k reducing the YTD overspend to £420k. Non pay overspent by £586k in the month and is overspent YTD by £3,649k. Income over achieved in month by £199k.

Commercial Directorate

The directorate overspent in February by £286k. This was in respect of underachieved divisional income. Pay remains under spent, mainly in Facilities Housekeeping & Estates. YTD the division overspending is £1,713k.

Corporate Services

The Directorate overspent in February by £216k. This has increased the YTD overspending to £1,177k.

Divisional 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
Planned Care	3,322	3,037	-285	40,513	29,562	-10,951
Urgent Care	1,467	1,863	396	20,037	16,876	-3,161
Integrated Care	-2,918	-3,182	-264	-37,309	-41,352	-4,043
Total Clinical Divisions	**1,871**	**1,718**	**-153**	**23,241**	**5,086**	**-18,155**
Commercial Directorate	-2,260	-2,546	-286	-25,230	-26,943	-1,713
Corporate Services	-2,429	-2,645	-216	-25,793	-26,970	-1,177
Central Items	-2,778	-1,328	1,450	-27,089	-24,266	2,823
	-7,467	**-6,519**	**948**	**-78,112**	**-78,179**	**-67**
Income	3,442	3,827	385	36,150	40,602	4,452
Donated Asset/Impairment Adjustment	0	-1	-1	0	10,260	10,260
Total	**-2,154**	**-975**	**1,179**	**-18,721**	**-22,231**	**-3,510**

Workforce Plan FTE	Workforce Actual FTE	Divisions Pay Analysis	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
1,604	1,693	Planned Care	-5,926	-6,487	-561	-66,472	-72,131	-5,659
1,479	1,536	Urgent Care	-4,882	-5,262	-380	-53,920	-58,353	-4,433
1,657	1,557	Integrated Care	-5,655	-5,532	123	-62,252	-62,672	-420
4,741	**4,786**	**Total Clinical Divisions**	**-16,463**	**-17,281**	**-818**	**-182,644**	**-193,156**	**-10,512**
1,065	1,001	Commercial Directorate	-2,110	-1,978	132	-23,151	-22,255	896
520	490	Corporate Services	-1,663	-1,584	79	-18,280	-17,534	746
1,585	**1,491**	**Total Non-Clinical Divisions**	**-3,773**	**-3,562**	**211**	**-41,431**	**-39,789**	**1,642**
		Central Items	135	-14	-149	-1,007	-153	854
6,326	**6,277**	**Total Pay Analysis**	**-20,101**	**-20,857**	**-756**	**-225,082**	**-233,098**	**-8,016**

Divisional Performance (budgets) Planned Care Division – February 2014

Headlines

Pay

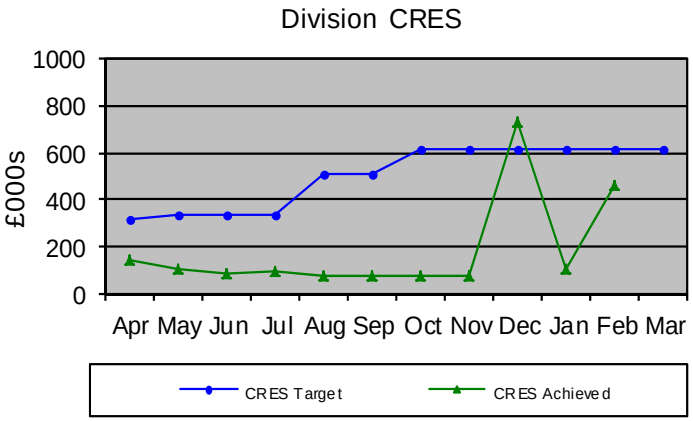
Pay overspent by £561k in the month, bringing the YTD pay overspending to £5,659k. This is due to ad hoc activity, agency, bureau & locum costs for acuity, maternity & sick leave which have been partly offset by vacancy savings. Month 11 agency spend was £296k which remains above the required level for the FRP. This was lower than the levels incurred in November and December.

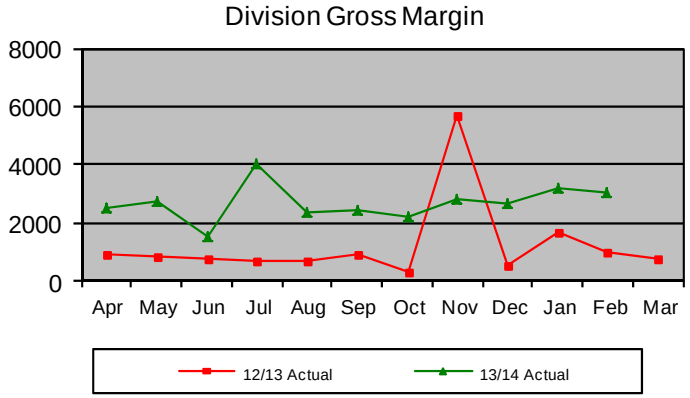
Non Pay

Non-pay was overspent by £442k in the month, bringing the YTD overspending to £3,438k. The overspending in the month was due to undelivered CIPs, high expenditure on prosthesis, orthopaedic consumables and general supplies.

Income

Contract income was £722k above plan in month and is now cumulatively £1,749k below plan.





Workforce Plan FTE	Workforce Actual FTE	Planned 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	10,454	11,176	722	121,475	119,726	-1,749
		Other Income	242	238	-4	2,659	2,554	-105
		Total Income	**10,696**	**11,414**	**718**	**124,134**	**122,280**	**-1,854**
1,604	1,693	Pay	-5,926	-6,487	-561	-66,472	-72,131	-5,659
		Non pay	-1,448	-1,890	-442	-17,149	-20,587	-3,438
1,604	**1,693**	**Total Expenditure**	**-7,374**	**-8,377**	**-1,003**	**-83,621**	**-92,718**	**-9,097**
1,604	**1,693**	**Gross Margin**	**3,322**	**3,037**	**-285**	**40,513**	**29,562**	**-10,951**

Divisional Performance (budgets) Urgent Care Division – February 2014

Headlines

Pay

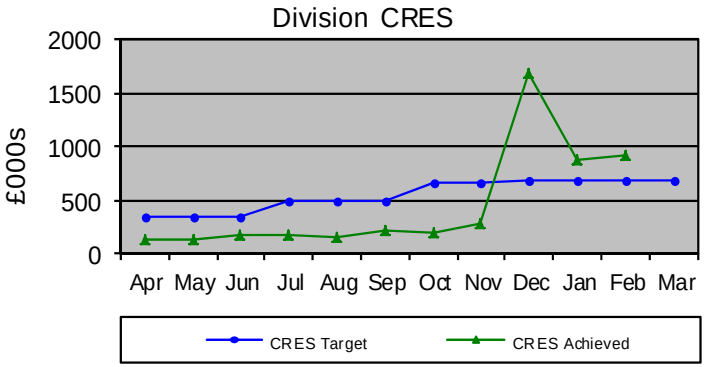
Pay overspent in the month by £380k due to underachieving CIP schemes. Agency costs amounted to £212k in month and are at the same level incurred in January. Medical agency pressures remain within A&E and Diabetes /Endocrinology.

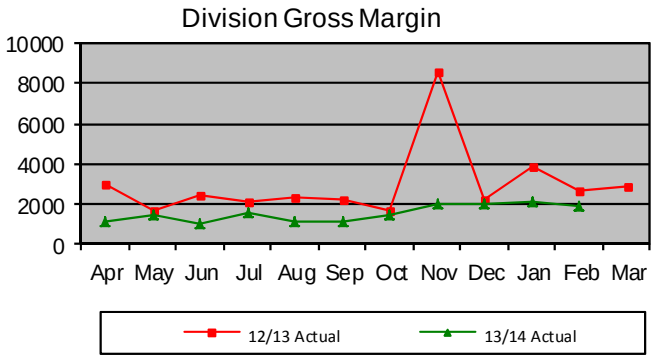
Non Pay

Non pay over spent by £96k in month. This was due to underachieving CIP schemes offset by a revised radiology maintenance costs . The YTD non pay position is now £2,089k above plan.

Income

Income over achieved by £872k in the month. YTD income has over achieved by £3,361k.





Workforce Plan FTE	Workforce Actual FTE	Urgent Care	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	7,071	7,943	872	83,628	86,862	3,234
		Other Income	29	29	0	317	444	127
		Total Income	**7,100**	**7,972**	**872**	**83,945**	**87,306**	**3,361**
1,479	1,536	Pay	-4,882	-5,262	-380	-53,920	-58,353	-4,433
		Non pay	-751	-847	-96	-9,988	-12,077	-2,089
1,479	**1,536**	**Total Expenditure**	**-5,633**	**-6,109**	**-476**	**-63,908**	**-70,430**	**-6,522**
1,479	**1,536**	**Gross Margin**	**1,467**	**1,863**	**396**	**20,037**	**16,876**	**-3,161**

Divisional Performance (budgets) Integrated Care Division – February 2014

Headlines

Pay

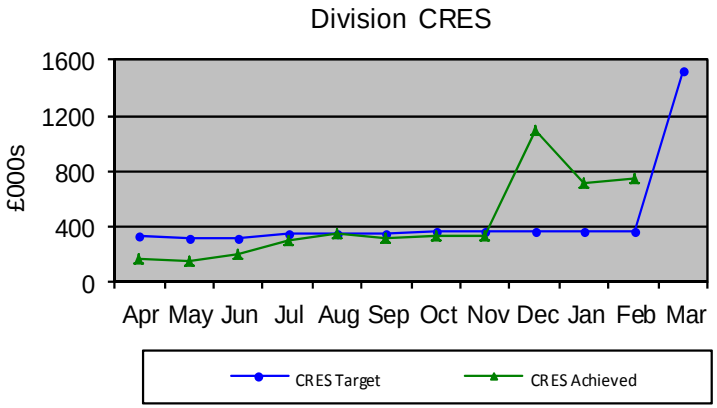
In Month 11, pay underspent by £123k which has reduced the YTD overspending to £420k. The in month under spend is a result of vacancies, tighter agency control and no ad-hocs, mitigating increased spends across paediatric locums. The YTD overspending is principally in respect of Children & Young persons medical paediatric cover supporting A&E.

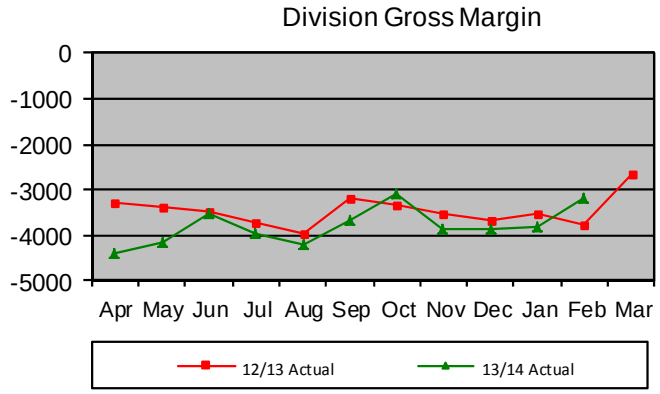
Non Pay

In month the division reported a non pay overspend of £586k which has increased the YTD overspending to £3,649k. The adverse position is due to third party expenditure, mobile scanning & out of hours costs across radiology, together with activity driven clinical chemistry expenditure and slippage against the CIP target.

Income

Income overachieved in the month by £199k. YTD Contract income is an adverse variance of £450k, whilst non contract income is £476k above plan.





Workforce Plan FTE	Workforce Actual FTE	Integrated 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	5,458	5,583	125	62,595	62,145	-450
		Other Income	232	306	74	2,559	3,035	476
		Total Income	**5,690**	**5,889**	**199**	**65,154**	**65,180**	**26**
1,657	1,557	Pay	-5,655	-5,532	123	-62,252	-62,672	-420
		Non pay	-2,953	-3,539	-586	-40,211	-43,860	-3,649
1,657	**1,557**	**Total Expenditure**	**-8,608**	**-9,071**	**-463**	**-102,463**	**-106,532**	**-4,069**
1,657	**1,557**	**Gross Margin**	**-2,918**	**-3,182**	**-264**	**-37,309**	**-41,352**	**-4,043**

Divisional Performance (budgets) Commercial Directorate – February 2014

Headlines

Pay

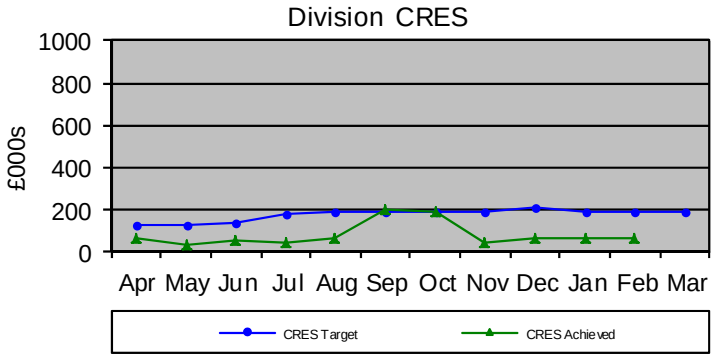
Pay underspent by £132k in February as a result of continued under spending within hotel services (mainly housekeeping), property services management & design team vacancies.

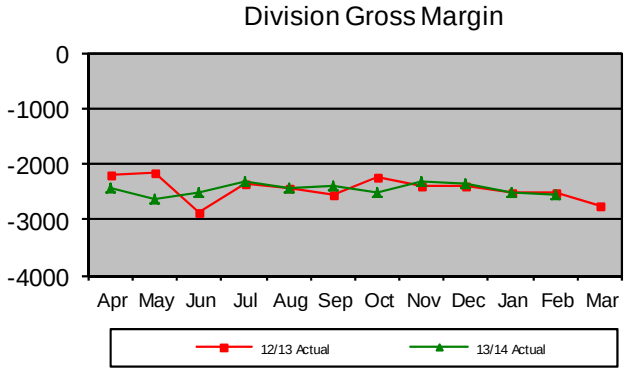
Non Pay

Non pay was £204k overspent in month. The main factor being slippage against CIP delivery, EHS drugs & internal recharges

Income

Income underachieved in the month by £214k taking the YTD variance to £1,364k below plan. Underachievement was in respect of EHS external income, car parking, accommodation, restaurant income & Michelham PP income.





Workforce Plan FTE	Workforce Actual FTE	Commercial Directorate	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	1,176	962	-214	12,808	11,444	-1,364
		Total Income	**1,176**	**962**	**-214**	**12,808**	**11,444**	**-1,364**
1,065	1,001	Pay	-2,110	-1,978	132	-23,151	-22,255	896
		Non pay	-1,326	-1,530	-204	-14,887	-16,132	-1,245
1,065	**1,001**	**Total Expenditure**	**-3,436**	**-3,508**	**-72**	**-38,038**	**-38,387**	**-349**
1,065	**1,001**	**Gross Margin**	**-2,260**	**-2,546**	**-286**	**-25,230**	**-26,943**	**-1,713**

Divisional Performance (budgets) Corporate Services – February 2014

Headlines

Pay

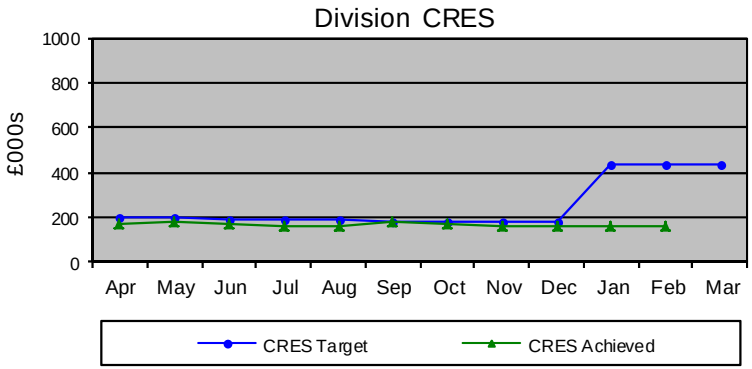
Corporate pay underspent in February by £79k increasing the cumulative under spending to £746k. The under-spending is principally due to vacancies within Finance, Strategic Development , Director of Nursing & Human Resources.

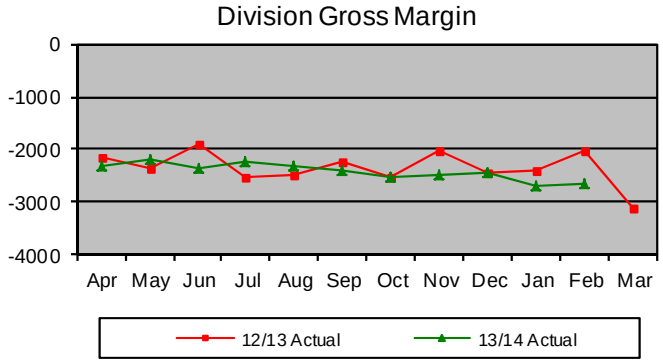
Non Pay

Corporate non pay overspent by £85k in February which increased the YTD overspending to £928k. This overspending is due to hosted funds, settlement payments and CIPs delivery.

Income

Income underachieved by £210k in the month, increasing the YTD under achievement to £995k. This underachievement is in respect of child health, occupational health & University of Brighton Library/Education Centre income.





Workforce Plan FTE	Workforce Actual FTE	Corporate Services	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	438	228	-210	4,724	3,729	-995
		Total Income	**438**	**228**	**-210**	**4,724**	**3,729**	**-995**
520	490	Pay	-1,663	-1,584	79	-18,280	-17,534	746
		Non pay	-1,204	-1,289	-85	-12,237	-13,165	-928
520	**490**	**Total Expenditure**	**-2,867**	**-2,873**	**-6**	**-30,517**	**-30,699**	**-182**
520	**490**	**Gross Margin**	**-2,429**	**-2,645**	**-216**	**-25,793**	**-26,970**	**-1,177**

CIP Plans – February 2014

Headlines

• The total initial Trust CRES target for 2013/14 was £20.0m. In addition, QIPP related savings total £0.95m. The initial divisional CRES targets of £22.0m included an over-planning margin of £2.0m.

• In month CRES achievement of £2.4m including turnaround CIPs, was £0.1m below the initial plan CIP target. YTD total achievement of £14.4m was £3.2m below target.

• The profile of plans indicates the continued risk of a shortfall against the target for the full year.

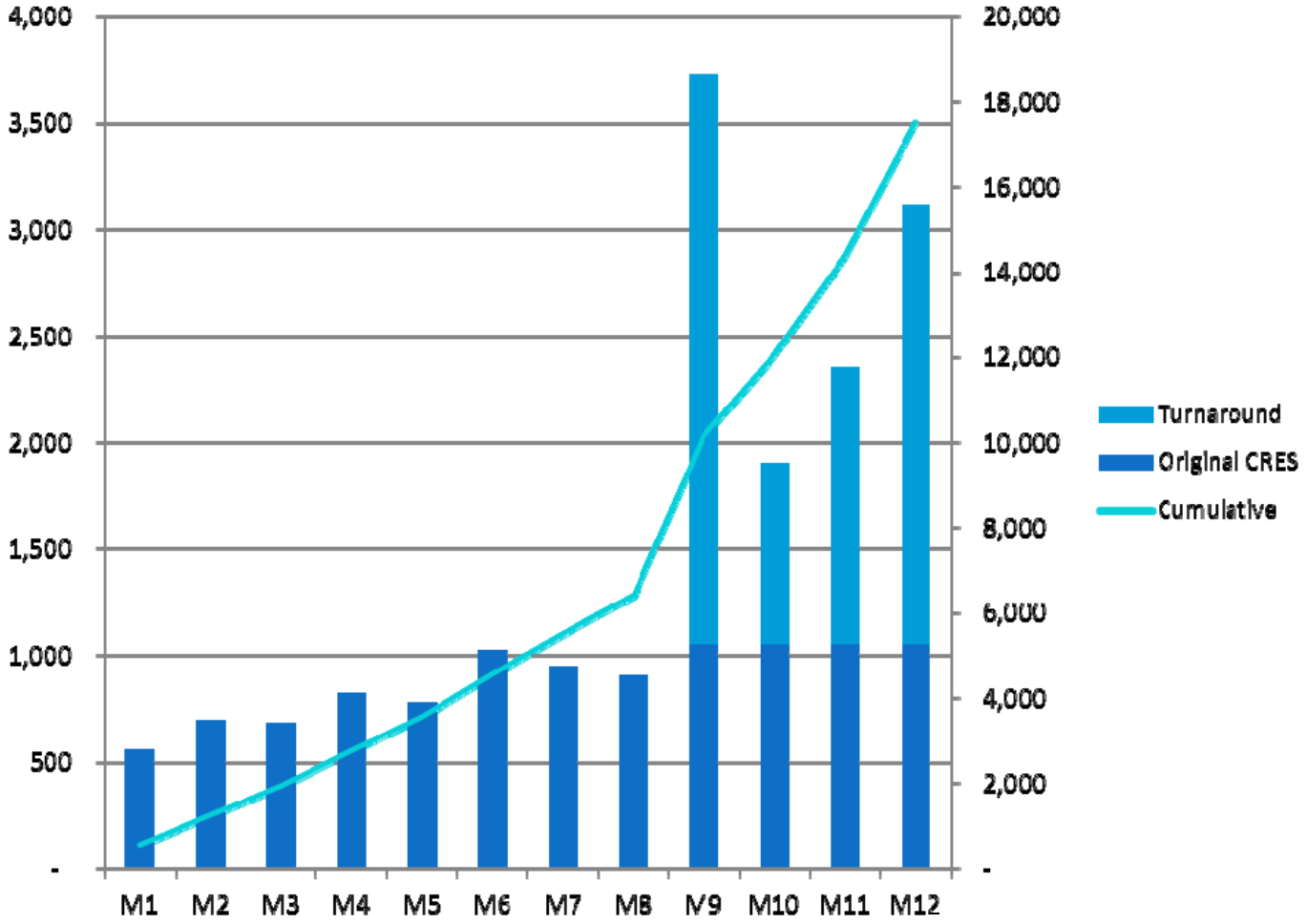
Division	2013/14 Target £000s	2013/14 In-year identified target £000s	2013/14 Target to forecast gap £000s	Red £000s	Amber £000s	Green £000s
Planned Care	6,010	6,010	0	3,508	1,479	1,023
Urgent Care	6,580	6,580	0	737	1,278	4,565
Integrated Care	5,300	6,295	995	0	2,743	3,552
Corporate Services	2,970	2,970	0	1,005	0	1,965
Commercial Directorate	2,090	2,090	0	1,158	0	932
Sub Total Divisions	22,950	23,945	995	6,408	5,500	12,037
QIPP Related Savings	-950	-950	0	-950		
Sub Total Divisions	22,000	22,995	995	5,458	5,500	12,037
Overplanning Margin	-1,963	-2,958	-995	-2,958	0	0
Total	**20,037**	**20,037**	**0**	**2,500**	**5,500**	**12,037**

Division	In-month CRES Target £000s	In-month CRES achieved £000s	In-month CRES variance £000s	YTD CRES Target £000s	YTD CRES achieved £000s	YTD CRES variance £000s
Planned Care	592	458	-134	4,675	2,035	-2,640
Urgent Care	666	920	254	5,077	4,923	-154
Integrated Care	433	754	321	4,028	4,750	722
Corporate Services	287	156	-131	2,212	1,809	-403
Commercial Directorate	266	62	-204	1,639	870	-769
Sub Total Divisions	2,244	2,350	106	17,631	14,387	-3,244
Overplanning Margin			0			0
Total	**2,244**	**2,350**	**106**	**17,631**	**14,387**	**-3,244**

Cost Improvement Forecast – February 2014

Headlines

- The original plan is profiled to deliver £10.6m at year end.
- Actual delivery in M11 includes turnaround actions in Mth 7-11.
- The Turnaround plan is forecast to deliver £6.9m additional cost improvements
- Year end delivery is forecast to be £17.5m, £2.5m short of the original plan.



Year on Year Comparisons – February 2014

Headlines

- YTD total Inpatients were 0.5% higher than last year.
- YTD outpatients were 6.4% lower than last year.
- YTD A&E attendances were 0.1% lower than last year.
- NHS patient income is 7.1% lower than last year due to tariff reductions and the non availability of non-recurrent income support received in previous years.
- Total costs, excluding impairments, are below last years levels.

Activity	2013/14 YTD Actual	2012/13 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Planned Same Day	39,125	39,693	-568	-1.4%
Elective Inpatients	8,624	9038	-414	-4.6%
Emergency Inpatients	39,945	38,498	1,447	3.8%
Total Inpatients	**87,694**	**87,229**	**465**	**0.5%**
Elective Excess Bed Days	1,895	1,504	391	26.0%
Non elective Excess Bed Days	26,285	23,278	3,007	12.9%
Total Excess Bed Days	**28,180**	**24,782**	**3,398**	**13.7%**
Consultant First Attendances	84,417	91,201	-6,784	-7.4%
Consultant Follow Ups	134,733	146,521	-11,788	-8.0%
OP Procedures	50,780	41,888	8,892	21.2%
Other Outpatients (WA & Nurse Led)	111,929	128,764	-16,835	-13.1%
Community Specialist	2724	2513	211	8.4%
Total Outpatients	**384,584**	**410,887**	**-26,303**	**-6.4%**
A&E Attendances	92,888	92,969	-81	-0.1%
ITU Bed Days	5,640	6,163	-523	-8.5%
SCBU Bed Days	2,677	3,250	-573	-17.6%
Cardiology - Direct Access	768	768	0	0.0%
Radiology - Direct Access	50,763	49,619	1,144	2.3%
Pathology - Direct Access	3,080,179	2,881,567	198,612	6.9%
Therapies - Direct Access	36,767	31,144	5,623	18.1%

£000s	2013/14 YTD Actual	2012/13 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	299,275	322,078	-22,803	-7.1%
Private Patient/ RTA	2,621	2,934	-313	-10.7%
Trading Income	4,145	4,333	-188	-4.3%
Education	7,849	7,013	836	11.9%
Other Non Clinical Income	16,651	17,071	-420	-2.5%
Total Income	**330,541**	**353,429**	**-22,888**	**-6.5%**
Pay Costs	-233,098	-234,259	1,161	-0.5%
Non Pay Costs	-105,821	-105,450	-371	0.4%
Other	2,563	1,386	1,177	84.9%
Total Direct Costs	-336,356	-338,323	1,967	-0.6%
Surplus/-Deficit from Operations	**-5,815**	**15,106**	**-20,921**	**-138.5%**
Profit/Loss on Asset Disposal	7	22	-15	
Depreciation	-10,540	-9,210	-1,330	14.4%
Impairment	-10,018		-10,018	
PDC Dividend	-5,856	-5,752	-104	1.8%
Interest	-269	-323	54	-16.7%
Total Indirect Costs	-26,676	-15,263	-11,413	74.8%
Total Costs	**-363,032**	**-353,586**	**-9,446**	**2.7%**
Net Surplus/-Deficit	**-32,491**	**-157**	**-32,334**	**20594.9%**
Donated Asset / Other Adjustment	10,260	182	10,078	5537.4%
Normalised Net Surplus/-Deficit	**-22,231**	**25**	**-22,256**	**-89024.0%**

Capital Programme – February 2014

Headlines

- At the end of month 11 the year to date capital expenditure amounted to £11.5m.
- Following the approval of the additional capital resource from the Safer Hospitals Safer Wards Technology Fund & the Nurse Technology Fund the total 2013/14 capital resource limit (CRL) has increased to £16.0m.
- Commitments entered into totalled £13.2m at 28th February 2014 and further forecast commitments increase the potential total capital commitment to £15.9m compared to the Trust total capital resource of £16m.
- This forecast capital programme under commitment of £0.1m will be managed to ensure the CRL is fully utilised but not breached at 31st March 2014.

Capital Investment Programme £000s	2013/14 Capital Programme	2013/14 Forecast Commitment	Expenditure to Month 11
Capital Resources			
Depreciation	10,545		
Additional Capital Funding	5,000		
Additional Capital - VitalPak	822		
Additional Capital - Technology Fund	186		
League of Friends Support	1,243		
Cap Investmnt Loan Principal Repayment	-540		
Gross Capital Resource	17,256		
Less Donated Income	-1,243		
Capital Resource Limit (CRL)	**16,013**		-
Capital Investment			
Clinical Strategy - Capital Loan	252	252	252
Clinical Strategy - Trust Programme	594	615	504
Medical Equipment	3,246	3,258	2,343
Information Systems	1,222	1,109	313
Electronic Document Management	200	200	154
Child Health Information System	260	190	127
Endoscopy Development	1,360	1,367	1,367
Backlog Maintenance/Ward Deep Clean	1,714	1,600	823
Minor Capital Schemes	3,250	3,250	3,146
Maternity	497	497	490
Pathology CLD Estate costs	198	163	72
PACS.RIS	221	221	75
Safer Hospitals/Nurse Technology Fund	1,008	1,008	0
Other	909	869	649
Brought Forward Schemes	1,275	1,299	1,218
Sub Total	**16,207**	**15,898**	**11,533**
Donated Asset Purchases	1,243	1,107	949
Donated Asset Funding	-1,243	-1,107	-949
Net Donated Assets	**0**	**0**	0
Sub Total Capital Schemes	**16,207**	**15,898**	**11,533**
Overplanning Margin (-) Underplanning (+)	-194	115	
Net Capital Charge against the CRL	**16,013**	**16,013**	**11,533**

Key Performance Indicators & Reserves – February 2014

Headlines

• The EBITDA achieved YTD was -£6.8m compared to the planned value of -£3.3m. This has resulted in a -10.6% Net Return after Financing excluding impairment.

• The liquidity ratio, including the Working Capital Facility(WCF), stands at 24 days following the draw down of the temporary loans. Without the WCF the liquidity days would have been -5 days.

Underlying Performance	2012/13 Outturn	2013/14 Plan	2013/14 YTD
Surplus/-Deficit from Operations	17,057	-2,123	-5,815
Donated Asset Income Adjustment	-939	-1,139	-948
EBITDA	16,118	-3,262	-6,763
Divided by:			
Total Income	387,400	326,915	330,541
Donated Asset Income Adjustment	-939	-1,139	-948
EBITDA Margin	**4.2%**	**-1.0%**	**-2.1%**
EBITDA % Achieved			
Actual EBITDA	16,118	-3,262	-6,763
Divided by:			
Budgeted EBITDA	18,880	-3,262	-3,262
EBITDA % Achieved	**85.4%**	**100.0%**	**207.3%**

Liquidity £000s	2012/13 Outturn	2013/14 YTD
Opening Current Assets	23,294	36,289
Opening Current Liabilities	-35,518	-34,780
Net Current Assets/Liabilities	-12,224	1,509
Inventories	-6,869	-6,723
Adj Net Current Assets/Liabilitie	-19,093	-5,214
In year working capital facility	30,439	30,159
	11,346	**24,945**
Divided by:		
Total costs in yr x-1	370,343	336,356
Multiply by (days)	360	330
Liquidity Ratio	**11**	**24**

Financial Efficiency £000s	2012/13 Outturn Actual	2013/14 YTD Plan	2013/14 YTD Actual
Surplus / Deficit(-) from Operations	17,057	-2,123	-5,815
Less:			
Donated Asset Income Adjustment	-939	-1,139	-948
Interest Expense	-368	-402	-269
Depreciation & Amortisation	-10,040	-10,858	-10,540
PDC Dividend	-6,224	-5,338	-5,856
Net Return	-514	-19,860	-23,428
Total Debt	-6,883	-6,046	-6,046
Finance Leases & Borrowings	-1,224	-919	-919
Taxpayers Equity	-183,115	-245,219	-245,219
Balance Sheet Financing	-191,222	-252,184	-252,184
B/fwd Debt	-8,557	-6,883	-6,883
Finance Leases & Borrowings	-1,514	-1,224	-1,224
Taxpayers Equity	-186,312	-183,115	-183,115
Balance Sheet Financing	-196,383	-191,222	-191,222
Net Return after Financing Score %	**-0.3%**	**-9.0%**	**-10.6%**
Net surplus/ deficit	472	-18,721	-32,491
Less fixed asset impairments/disposals	-22	0	10,260
	450	-18,721	-22,231
Divided by:			
Total Income	387,400	325,776	329,593
I&E surplus margin	**0.1%**	**-5.7%**	**-6.7%**

Reserves £000s	Opening Reserves	Issued	Closing Reserves
Wage Award	2,491	-2,409	82
CQUIN	2,162	-2,008	155
High Cost Drugs	18,994	-17,411	1,583
Device Exclusions	2,216	-2,031	185
Contingency	3,626	-3,328	298
	29,489	**-27,186**	**2,303**

Financial Risks & Mitigating Actions – February 2014

Summary	
RISKS:-	
With just one month remaining to year end the level of risk to the full year forecast is not as high as in earlier months. Contract settlement with CCGs remains an area of uncertainty despite the level of fines and penalties having already been agreed. However, negotiations with CCGs have indicated that the risk of a material adverse movement on the Trust's income projections is low. Other remaining areas of risk are:- • Pressure to incur premium costs in meeting the RTT. • Loss of control over agency and other premium pay costs. • Year-end adjustments including stocktaking	

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	9c
Subject:	Cancer Waiting Times 2013/14
Reporting Officer:	Richard Sunley, Deputy CEO/ Chief Operating Officer

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

Purpose:

This paper outlines actions to improve performance in relation to cancer targets and identifies the Trust's position in relation to the recent "Immediate Review of Cancer Services at Colchester Hospital."

Introduction:

Performance issues in relation to cancer targets have resulted in a reorganisation and refocus of resources to achieve improvement and sustainability. At the same time, in light of concerns raised by the Care Quality Commission (CQC) at Colchester Hospital, ESHT's has reviewed its processes for managing cancer services.

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

Key to service improvement is a review of cancer pathways and the accountability for managing patients on these pathways.

Benefits:

When implemented the action plan attached and actions discussed in relation to outcomes from Colchester will deliver an improved service.

Risks and Implications

These are RAG rated in the attached plan.

Assurance Provided:

This review has identified the key issues and progress towards resolution.

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

This report will be overseen by the Cancer Board.

Proposals and/or Recommendations

In summary these issues are:

- Focus Patient Tracker (PPC) resources backed by the "Somerset" Cancer data system.
- Improved diagnostic responsiveness.
- Recognition of the specialist urology service.
- Improved patient communication in relation to choice.

- Pathway review, particularly for screening the tertiary services.
- Improved organisation and accountability of Multi-Disciplinary Meetings (MDMs).

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: Richard Sunley, Deputy Chief Executive/ Chief Operating Officer	**Contact details:** Ext: 4343

East Sussex Healthcare NHS Trust

Implications for ESHT of the 'Colchester' Report for ESHT

1. Introduction

1.1 The ESHT Cancer Advisory Team (CAT) has recently taken over the cancer waiting times function and the management of the associated staff and processes. With this change an opportunity has been presented to review processes and functions. The CAT and Executive Lead for Cancer are keen that any review of processes is carried out in line with currently recommended best practice as detailed in Version 8.0 of Cancer Waiting Times Guidance and the recently published Colchester Report.

2. Background

2.1 A report into the Immediate Review of Cancer Services at Colchester Hospital University Foundation NHS Trust ('The Colchester Report') was published by NHS England in December 2013 following a Care Quality Commission (CQC) report which identified a number of failings in cancer services at Colchester.

2.2 Assurance has previously been provided to the ESHT Board, following the initial Colchester CQC Report publicity, around the robustness of the processes in place at ESHT. This identified that all cancer patients are tracked appropriately and in line with national Waiting Times Guidance, thus ensuring that patients are treated within the most rapid timescales possible and that all waiting times are both validated and accurate.

2.3 The purpose of this paper is to advise the Board of the findings of the NHS England Review and to set those findings in context for ESHT and identify areas where our processes could be altered to reflect absolute best practice whilst adopting recommendations for improving cancer waiting times performance.

3. The Colchester Report

3.1 The Colchester Report details in depth the review of processes and practices that were in place within that Trust which led to unwarranted delays to diagnosis and treatment.

3.2 Much of the report concentrates on recommendations for change that are already in place and well established in ESHT. This includes the use of an established Cancer Pathway Management Tool; within ESHT the Somerset Cancer Registry (SCR) is well established and is used for the collection of all mandatory national clinical audits and for the tracking of all cancer patients subject to cancer waiting times. Additionally, the role of patient trackers (PPCs) is long established at ESHT and a robust validation and reporting assurance process is in place. Clinical leadership is identified as a key feature of highly functional services and ESHT has benefited from exemplary Cancer Clinical leads in the current incumbent, Dr David Sallomi, and in his predecessor, the late Dr Judy Beard.

3.3 Of the recommendations made at Colchester a number of actions have been identified by the CAT which would be of use in developing and refining existing processes to provide additional assurance and which will assist in improving performance around cancer waits. Many actions are detailed in the attached Cancer Waiting Times Action Plan but those actions which are explicitly recommended in the Colchester Report are indicated below under Item 4.

4. Conclusion/Recommendation

4.1 Cancer Pathways: It is recommended for Colchester that a review of all cancer pathways is carried out. The ESHT CAT had already identified this as an aim of the year ahead in view of the dissolution of the Sussex Cancer Network. This work is now underway with existing pathways being reviewed to clarify fitness for purpose, appropriateness in terms of timelines for investigations and treatments and suitability for patients. All pathways are currently being revisited with Cancer Patient Pathway Co-ordinators and then will be shared with Multi-Disclipinary Team (MDT) Leads and finally signed off by the tumour site specific MDT at their AGM for inclusion in their operational policies. Where bottlenecks are identified which slow down patient pathways, service improvement work will be co-ordinated jointly by the MDTs and the CAT.

4.2 Upgrade Processes: There is a well established process in place for the upgrading of patients with a suspected cancer who have not been referred in via the Two Week Wait scheme. This process will be re-launched across the Trust as there are variations in take up from MDT to MDT. This will act as a failsafe to ensure that all patients with a suspected cancer are managed on the same pathways and actively tracked by the dedicated tracking team.

4.3 Inter MDT Transfer/Inter Trust Transfer: Processes vary between MDTs and different tertiary centres and although most of them are highly functional the CAT are working on a uniform process for all MDTs. Not only will this mitigate risk around this process but it also gives the opportunity to review timelines for referral as the interfaces between MDTs and Trusts have locally been identified as one of the principle causes of delay.

4.4 Tracking Function: Within ESHT Patient Pathway Co-ordinators (PPCs) carry out the role of proactively tracking cancer patients, organising the team's Multi Disciplinary Meetings (MDMs) and co-ordinating the MDT's Peer Review function. In other organisations this role may be referred to as MDT Co-ordinators or similar. This team is well established but it will be timely to review the structure of the team and the role description in order to ensure that the highest levels of functionality from the team are being achieved. These staff are key to effective and timely diagnostics and intervention and thus to high quality care for cancer patients.

4.5 Accountability: The accountability for cancer waiting times breaches has been historically fed through the Cancer Priority Treatment List (PTL) meeting. The CAT has identified that accountability must be broadened to the MDTs and the Clinical Units whilst retaining and refining the responsiveness of the Cancer PTL meeting.

A new Cancer PTL Report has been developed by Business Intelligence which will be launched in March 2014 to identify patients at risk of breaching waiting times standards at a much earlier point in the pathway. The feedback to the Clinical Units and the MDTs can then be further refined to ensure timely highlighting of issues.

A refining of the function of the Cancer Delivery Group would also be beneficial and this action is being taken forward jointly by the CAT, the Interim Medicine Clinical Unit General Manager and the Chief Operating Officer.

4.6 All these actions have been fed into the Cancer Waiting Times Action Plan which will be monitored and updated on a monthly basis.

Dee Daly
Lead Cancer Manager

14th February 2014

Waiting Times – Cancer Performance:

Performance Indicator	Thresholds		MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6	MONTH 7	MONTH 8	MONTH 9	MONTH 10	MONTH 11	MONTH 12
	Performing	Under-performing	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cancer 2 Week Wait	93%	88%	93.91%	96.49%	94.69%	93.05%	94.95%	94.22%	95.95%	94.74%	93.41%			
Cancer 2 week wait - Breast	93%	88%	96.30%	93.00%	96.74%	91.61%	91.23%	94.38%	93.14%	92.19%	94.95%			
Cancer 31 day - Subsequent Surgery	94%	89%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
Cancer 31 day - Subsequent Chemo	98%	93%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
Cancer 31 day - Diagnosis to Treatment.	96%	91%	96.11%	97.95%	98.58%	97.50%	98.13%	99.38%	98.52%	97.69%	97.53%			
Cancer 62 Day Screening Service	90%	85%	77.78%	100.00%	66.67%	91.67%	100.00%	77.78%	73.68%	83.33%	89.47%			
Cancer 62 Day Urgent Referral	85%	80%	85.71%	85.23%	82.21%	89.91%	77.68%	79.90%	81.19%	79.67%	89.27%			

ESHT Cancer Waiting Times Action Plan v.1 (04-02-14)

Dee Daly (Lead Cancer Manager) / Mel Kayne (Lead PPC)

Gap / Risk	Action Required	By Whom	Expected Outcome of Action	RAG Rating Deadline date	Progress Update
PPC Tracking: there is an uneven work distribution and the current departmental structure is not the most efficient overall. PPCs currently have to undertake general administration duties and have focused on MDMs instead of prioritising tracking. Due to the cross site nature of the departmental structure some PPCs have to attend MDMs as support which are unrelated to their individual workload taking up valuable tracking time.	Immediate departmental restructure and launch of new PPC role with duties, responsibilities and accountability clearly outlined with tracking as the main focus. Within the new structure there will be clear accountability laid out with 1:1 meetings with GMs timetabled for each PPC on a regular basis. Additional closer working relationships between PPCs and CNSs will be made explicit.	Lead Cancer Manager / Lead Tracker / Human Resources	Even workload distribution with support staff in place to provide administrative support to PPCs to release time to dedicate to proactive tracking thus reducing breaches.	Apr-14	Restructure paper completed and with Finance for costing. Appointment sought with HR to commence restructure process as a matter of urgency.
Cancer PTL Meeting: currently the only patients discussed are those which are raised by the PPCs and therefore does not provide a real time picture of the amount of patients on the PTL.	Launch of new PTL meeting with a revised format to incorporate patient level reporting to facilitate a patient by patient discussion (to influence 62 day pathways). Regular attendance by all PPCs / General Managers / Diagnostics Managers	Lead Cancer Manager / Lead Tracker	More proactive discussion of patients enabling earlier highlighting of problems resulting in active monitoring of Cancer PTL, reduction in breaches and individual accountability.	Apr-14	Information team completed new PTL report on 04/02/14. This will be populated with patients at a fixed day in their pathway initially with a more sophisticated approach being developed over time. New report to be trialled with three PPCs from the meeting on 10/02/14
Endoscopy Capacity (Two Week Wait): Reduced capacity in Endoscopy has a negative impact on the start of the patient pathway (straight to test) if they are unable to be seen within the 14 day target resulting in a knock on effect.	Extra Saturday lists have been reinstated and a recovery plan has been developed to reduce reliance on ad hocs by flexing existing capacity.	General Manager (Specialist Medicine)	Reduction in two week wai breaches and reduction in reliance on ad hocs.	Mar-14	Extra lists have been reinstated from 27/01/14

Endoscopy Capacity (62 Day target). Reduced capacity in Endoscopy has a negative impact on the 62 day target due to delays encountered in the diagnostic element of the pathway. The impact of these delays is that the diagnosis is achieved later in the pathway resulting in a reduced amount of time left for review / MDM discussion / staging / treatment planning.	Extra Saturday lists have been reinstated and a recovery plan has been developed to reduce reliance on ad hocs by flexing existing capacity.	General Manager (Specialist Medicine)	Reduction in waiting times for diagnostics and resultant reduction in breaches and reliance upon ad hocs.	Mar-14	Extra lists have been reinstated from 27/01/14
Urology Prostate Pathway (62 Day): The current prostate diagnostic that is followed is that once histological confirmation has been achieved the patient requires a staging MRI scan at Eastbourne followed by a Specialist MDM discussion prior to an appointment for treatment planning. Currently the MRI is not requested until the patient has been seen at a breaking bad news OPA which results in pathway delays.	Proposal to pre warn patients that an MRI may be required at their initial OPA or TRUS appointment. Generic letter could be sent to patients informing them that an MRI is required prior to an appointment for treatment planning. MRI could then be requested as soon a histological confirmation is obtained.	General Manager (Breast/Colorectal/ Urology) / MDM Lead Clinician	More efficient use of time on the pathway as the patient could be seen for a bad news appointment and given an MRI date or be seen after the MRI is performed resulting in a reduction in breaches. RISK: If this is not handled appropriately it could cause unnecessary alarm or worry to the patient.	Apr-14	For discussion with MDT and General Manager (Breast / Colorectal / Urology)

Patient Choice (TWW): Patients declining appointments for their initial consultation resulting in significant delays and TWW breaches.	Continued communication with GPs to highlight referred patients that are unavailable within the 14 day period. Additional communication to go out to GPs via CCGs to re-emphasise the importance of timely referral and advising patients of the reason for urgent referral and therefore the importance of accepting any appointments offered. An audit of UTAs will also be carried out to ensure that patients are not just being offered short notice appointments. TWW clerk will also need to collate details of patients referred in who are unable to attend appointments within the two week period because of holidays and feed back to Lead Cancer Manager who will feed back to named CCG contact.	Lead Cancer Manager / CCG Cancer Leads	Highlighting the importance of the TWW pathways, reduction in patient UTAs and resultant reduction in breaches.	Apr-14	GP referrals for those patients who are not available until after the 14 day period are now highlighted to the CCG for discussion and action.
Patient Choice (62 Day, Screening, 31 Day); Patient choice delays after first seen with regards to diagnostic and treatment planning section of the pathway.	GP and patient education with regards to firstly highlighting to patients what a TWW referral is and secondarily providing emphasis on the importance of ensuring that the patients attend any appointments offered / diagnostics along the pathway and discouraging extended holidays during this time.	Lead Cancer Manager / CCG Cancer Leads	Highlight importance of TWW pathways and expectations. Reduction in patient UTS due to holidays and therefore reduction in breaches.	Apr-14	

Radiology - MRI Scans (62 Day, Screening, 31 Day): Delays with arranging and performing MRI scans at EDGH via private provider resulting in a lack of ownership of the issue with Radiology management. PPCs are unable to successfully expedite imaging due to a lack of Radiology management support. MRI scans are not electronically booked onto the CRIS system.	A dedicated Radiology contact that is able to respond to requests to expedite appointments. Electronic booking of MRI scans.	Lead Cancer Manager / General Manager (Radiology) / Chief Operating Officer	More streamlined tracking process enabling easier access to expediting appointments and retrieving appointment details. A more responsive service will result in a reduction in delays.	Mar-14	Request forwarded to General manager (Radiology) for senior attendance at Cancer PTL in order that these issues are picked up regularly, not on a piecemeal basis.
Bowel Screening: Patient choice delays with regards to first seen and colonoscopy dates causing delays at the beginning of the pathway.	Improved education for patients with regards to the importance of attending the first offered appointments.	Screening Manager / Trust Screening Lead / Lead Cancer Manager / General Manager (Breast / Colorectal / Urology)	Fewer delayed pathways if patients accept appointments that are initially offered, resulting in adequate time on the rest of the pathway after diagnosis has been achieved.	Mar-14	
Breast Screening: Delays inherent in the pathway back from BSUH (Screening Hub). The number of patients referred in via this route is very small so therefore any breaches impact significantly on our performance.	A number of proposals are being discussed to identify courses of action that can be taken to improve this pathway including the possibility of returning patients to ESHT at an earlier point in their pathway and the possibility of surgery being offered at different sites.	Lead Cancer Manager (ESHT) / Deputy COO (ESHT)	Patients need to be received at an earlier point in the pathway resulting in more time for staging and treatment; extra co-ordination will be required to ensure that ESHT have all the relevant information required for treatment planning.	Apr-14	Meeting held on 03-02-14 between BSUH and ESHT. Additional research being carried out by BSUH regarding Screening requirements and discussions needed with ESHT surgeons to seek agreement to pathway changes.

First Seen Delays (62 day target): Patients who are first seen within the 14 day period but who are not seen before day 10 lose extra days at the start of the pathway which would be beneficial further on. The long term aim would be to achieve a "One Week Wait".	Review OP slots to achieve a first seen appointment before Day 10.	Lead Cancer Manager / General manager (Specialist Medicine) / Lead PPC	Patients will be seen sooner at the beginning of the pathway allowing for more time on the remainder of the 62 day pathway.	Aug-14	
Need for Pathway Review: many cancer pathways were developed some years ago, there is an urgent need to review these to ensure that they reflect actual practice and to apply rigorous targets times to each stage to address waiting times breaches. This review is also in line with recommendations in the Colchester Review.	Review of all existing pathways required, to be carried out by CAT Service Facilitator working with PPCs. Once pathways are drawn out they will be confirmed with the MDT Lead and clinical team.	CAT Service Facilitator / Lead PPC / Lead Cancer Manager / Lead Cancer Clinician / Lead Cancer Nurse (Macmillan)	Accurate timelines can be applied to pathways and bottlenecks identified.	Apr-14	Pathway review commenced 04-02-14
Tertiary Treatments and Referrals (62 Day target): many breaches result from bottlenecks around referrals out to tertiary providers and late referrals in the ESHT as the Specialist Urology tertiary provider. Work around these interfaces are required.	Root cause analysis of all breaches relating to tertiary referrals and specialist Urology referrals in is required to identify issues that can be addressed.	Lead PPC / CAT Service Facilitator / Lead cancer Manager	Improvements in interfaces between providers reducing numbers of shared breaches.	Apr-14	Pathway review commenced 04-02-14
MDM Functionality (All targets): To provide assurance that all possible actions are being taken to avoid breaches MDMs must function efficiently and MDTs must be accountable for all breaches within the tumour site. This would also be in line with the recommendations of the Colchester Review.	A review of the functionality of all MDMs to establish that processes are as smooth and non-hierarchical as possible is required.	CAT Sevice Facilitator / Lead PPC / Lead Cancer Manager / Lead Cancer Clinician / Lead Cancer Nurse (Macmillan)	Improvements in the functionality of MDMs and MDT level accountability for waiting times performance.	Aug-14	

Increased understanding and accountability for Cancer Waiting Times compliance.	A complete Root Cause Analysis (RCA) to be completed for every breach and half breach. All RCAs to be discussed both at the Cancer PTL and the relevant MDM(s)	Lead PPC / Lead Cancer Manager / General manager (Specialist Medicine)	More detailed identification of causes of breaches with associated action planning to avoid repetition.	Mar-14	To commence with January waiting times report.
All targets. Benchmarking of processes and functions against recommendations in the Colchester Report is required to provide absolute assurance of appropriate governance processes.	Benchmarking paper to be prepared for Trust Board.	Lead Cancer Manager	Assurance.	Mar-14	Paper commenced, for presentation to Exec Cancer Lead (COO) by February 14th.

RAG Rating

Action implemented	Green
On target for implementation	Amber
Deadline missed	Red

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	9d
Subject:	Patient Experience Quarter 3 2013/14
Reporting Officer:	Alice Webster, Director of Nursing

Action: This paper is for					
Assurance	√	**Approval**		**Decision**	

Purpose:

This report summarises complaints activity and performance of PALS contacts and complaints, including lessons learnt and performance against Patient Experience.

Introduction:

East Sussex Healthcare Trust has "Improving the patient experience" as its top priority and recognises the value of the patient feedback received in order to continually drive forward and improve the services provided. The Trust is committed to promoting an open culture of feedback and improvement. Complaints and concerns (informal complaints) are a valuable source of feedback and should be used to inform learning and improvements in the experience of our patients.

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

- FFT continues to meet the nationally required objective – however further work is to be undertaken
- Complaints response times continue to be maintained
- The Patient Champion Programme continues to flourish across the whole organisation

Benefits:

The paper offers an update on the patient experience work within the Trust for quarter 3.

Risks and Implications

Failure to learn form complaints and poor patient experience could cause harm to patients

Assurance Provided:

The management of complaints and patient feedback continues to make progress.

Proposals and/or Recommendations

The Trust Board is requested to discuss the contents of this report and offer any comments and feedback in relation to the issues arising.

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

What risk to equality & human rights (if any) has been identified from the impact assessment?

Not applicable.

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

Name:	**Contact details:**
Alice Webster, Director of Nursing	01424 755255

East Sussex Healthcare NHS Trust

PATIENT EXPERIENCE REPORT QUARTER 3

1. Patient Experience

1.1 This report includes high level analysis of PALS contacts and complaints, including lessons learnt and performance against Patient Experience.

1.2 East Sussex Healthcare Trust has "Improving the patient experience" as our top priority and recognises the value of the patient feedback received in order to continually drive forward and improve the services provided. This essential element in improving the quality of the service the Trust provides is currently supported by each ward/department having a Patient experience champion who promotes within their areas what they have heard patients tell us and then most importantly what action was taken from that feedback.

1.3 The Trust is committed to promoting an open culture of feedback and improvement. Complaints and concerns (informal complaints) are a valuable source of feedback and should be used to inform learning and improvements in the experience of our patients.

2. Patient Experience Champions

2.1 There are now over 100 Patient Experience Champions within the Trust who are active role models for all members of staff in continuously looking at ways in which we can improve the patient experience. They have been encouraged to be aware of feedback within their areas and act upon it. This includes feedback from patient surveys, PALS, complaints and media sites such as NHS Choices and Patient Opinion. Templates for displaying "you said, we did" have been delivered to all wards and departments to demonstrate our commitment to listening to patient feedback. Over the coming weeks, people visiting the trust will see the displays and the huge amount of work being completed in response to feedback.

2.2 Recent meetings with Champions have included an important session on how we address people and the language we use. This is strengthening our commitment to being patient centred. Often, without realizing it, staff can refer to patients inappropriately leading onto labelling and stereotyping. Patient Champions have been encouraged to be aware of this and to listen out for inappropriate language in their respective areas. A short workbook is available for champions to complete.

2.3 The 8 commitments with the Patient Experience Strategy is a core element of being a Patient Experience Champion. This is the focus for all of the Champion meetings. Champions are encouraged to reflect upon how they can promote these commitments in their own areas and across the Trust.

2.4 On February 7th the Patient Experience Champions were involved in setting up displays all around the Trust to promote national Dignity day. A lot of work went into the displays and they were well received by visitors to the Trust.

2.5 On 11th April, there is a focus group with staff and service users to evaluate ways to display feedback around the Trust. This is to understand what is important to service users and staff when they see displays and what they regard as useful information.

3. Complaints Summary

Total number of spells by discharge month, financial year 2012/13

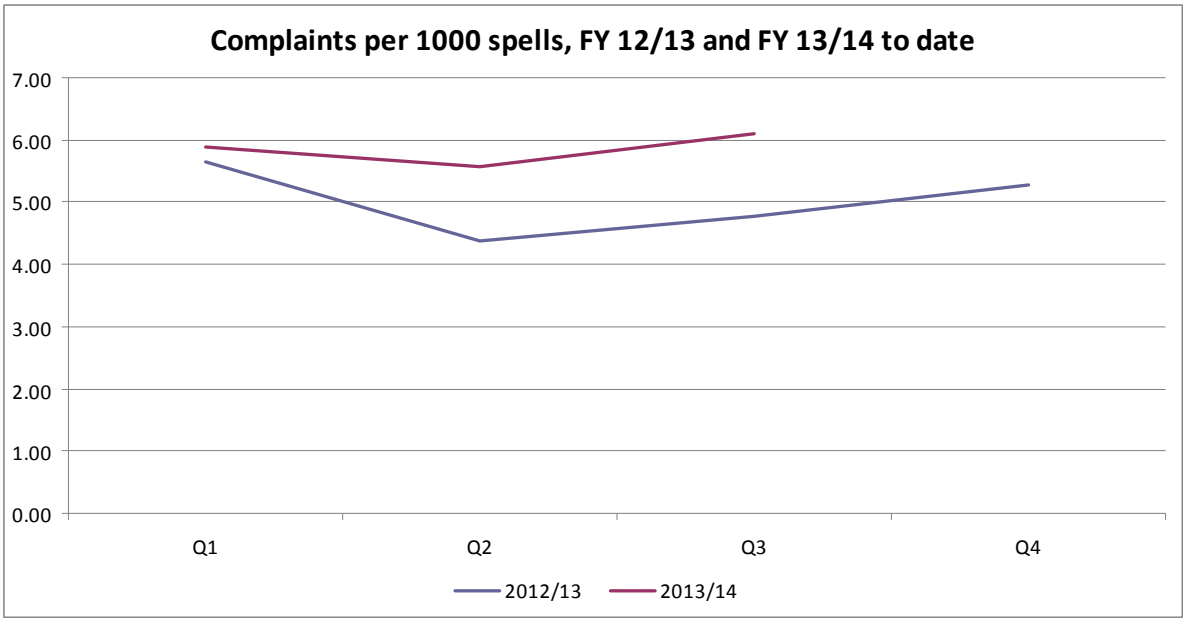
Indicator	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Number of new complaints received	55	48	38	49	28	33	39	60	23	44	39	44
Total number of spells	7889	9068	8029	8664	8476	7988	8929	8716	7866	8649	7660	7808

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of new complaints received	141	110	122	127
Total number of spells	24986	25128	25511	24117
Rate of complaints per 1000 spells	**5.64**	**4.38**	**4.78**	**5.27**

Total number of spells by discharge month, financial year 2013/14 to date

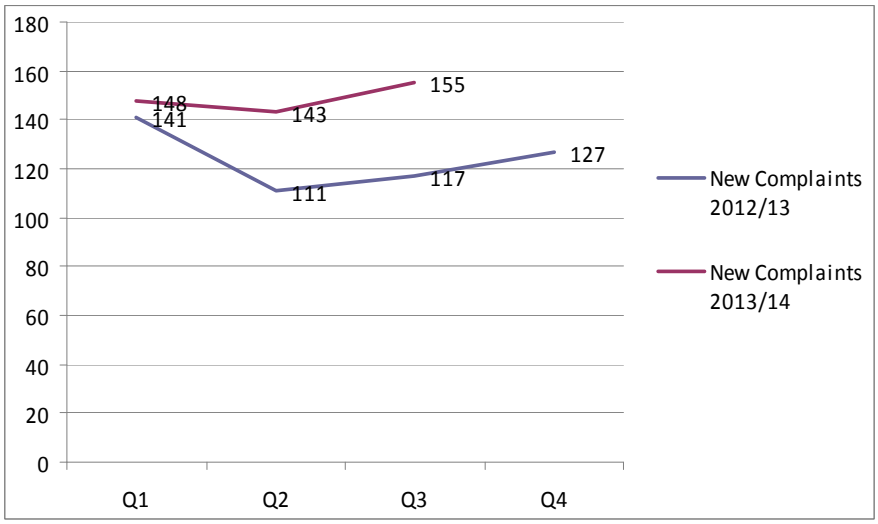
Indicator	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Number of new complaints received	45	49	54	59	41	43	59	47	49			
Total number of spells	8163	8667	8262	8874	8440	8329	8931	8497	8035			

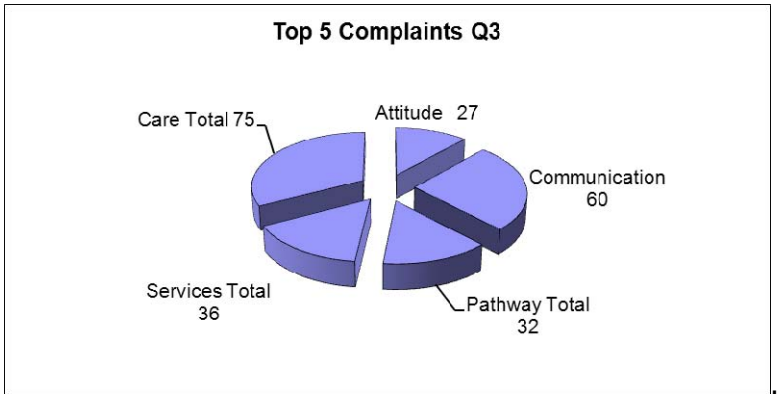
Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of new complaints received	148	143	155	
Total number of spells	25092	25643	25463	
Rate of complaints per 1000 spells	**5.90**	**5.58**	**6.09**	



3.1 New Complaints by Quarter 2012/13 - 2013/14

Compliance with 3 working days to acknowledge complaints is at 100% and has been maintained throughout Quarter 3. The number of overdue complaints rose slightly during Quarter 3. The overdue complaints rose from 16 at the end of Quarter 2 to 18 at the end of Quarter 3. 88% of complaints were responded to within timescale.





Of those identified as the top 5 key areas action plans have been put into place to ensure that these areas are improved. As with most issues that are raised there is a complexity in the complaint which may be multifaceted.

Under the current 4 C's policy the emphasis is on resolving complaints locally and this has been achieved, with the majority of these 137 resolved through the Trust's first response 23 complaints were resolved through further local resolution, either by writing again to the complainants, or by meeting with them.

3.2 Learning form complaints

Complaints should be used as drivers for improvement to the service. Complaints information is reviewed at Directorate quality/governance meetings and the actions taken as a result of complaints are also monitored.

3.3 Shared Learning in Practice example

A member of the public with learning difficulties, whom is a frequent service user, was recently in for a specific procedure. Their intervention was delayed due to the deterioration of another patient. They became increasingly frightened and upset during the wait, particularly as they could see the equipment from their sitting position. The treatment room door cannot be shut until the patient is ready for the procedure to commence.

The complaint stated that there was a lack of kind or appropriate communication and care given to the patient and the attitude of staff towards a patient with learning disabilities. Our written response acknowledged the complaint and the way in which we had made the individual feel and we offered sincere apologies if they found any of our staff's comments or actions upsetting.

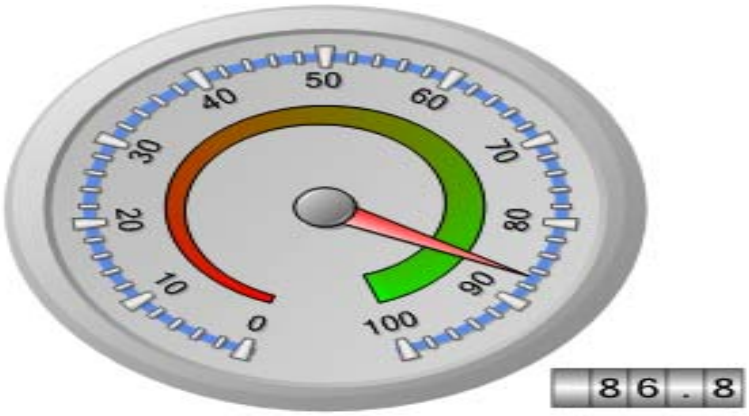
As a result of the complaint, there has been a review of how patients with learning disabilities can be supported prior to admission, and the need for information to be provided early into the treatment. Information is now stored on the computer system JOE as well as in the records.

In addition, staff are asking individuals at a preoperative stage if there are any concerns or anxieties as part of the admission process. There has also been discussion with staff about communicating sensitively and with dignity whilst maintaining an individual's privacy.

3.4 Referral to Ombudsman

6 of our complainants were not happy with our local responses and referred their complaint to the Parliamentary and Health Service Ombudsman for an independent review. The Ombudsman decided to investigate 6 complaints. 2 Complaints were rejected by the Ombudsman as properly resolved by the Trust. In 2 cases the papers have been supplied to the Ombudsman and we are awaiting their decision.

4. Q3 Patient Experience: One Stop Summary



The dial above shows the overall satisfaction score of all patients surveyed during Quarter 3 2013/14. This demonstrates that 86.8% of all patients who used our services were satisfied (8821 responses). This has decreased slightly from Quarter 2, the number of responders also decreased from 9045 responses in Quarter 2 to 8821 in Quarter 3. There is current activity to improve response rates during Quarter 4 2013/14.

4.1 Patient Experience Indicators linked to Strategy

Indicator	ESHT commitment	April	May	June	July	Aug	Sept	Oct	Nov	Dec
We will make sure you have the support and advice you need before being discharged from our care	3	80	81	85	84	83	85	84	84	83
We will give you clear high quality information about your condition, treatment and our services	3	88	89	88	91	89	92	90	90	89
We will treat you as an individual, listen to your views and respect your privacy and dignity	2 5	92	94	94	95	94	96	93	93	93
We will provide you with nutritious and appetising food, with as much support as you need, whilst in our care	3	74	76	74	75	73	75	73	74	72

Indicator	ESHT commitment	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Whilst you are an inpatient we will keep noise from staff at night to a minimum so that you can get the rest you need	2	84	81	82	90	82	81	78	80	77
Overall patient experience satisfaction	1	87	87	88	89	88	90	87	87	87
Responses		450	512	572	617	593	575	554	572	476

Bench mark - <59 – red <70 – amber <=100 green

As a result of the information and the previous feedbacks concern had been expressed re patient food provision. The facilities directorate and catering team have implemented the following actions in order to consistently improve the standard of food services provided to patients. Each week visits are made to a number of ward areas by the catering management team. The aim of these meetings are to:

- Speak to ward staff to discuss any concerns regarding food that they may have
- Speak to patients and gather feedback
- Observe meal services and offer support and advice
- Ensure that correct information is available at ward level for both patients and staff
- Identify areas of best practice.

Each visit will be summarised into a report and action plans devised as appropriate. The catering team are able to provide training for ward staff in food services and ensure that each ward has information on what support/services can be obtained. eg special diet request, snack boxes, etc. Follow up visits will be made to wards and hopefully through improved communications the standard and patients perception of the food services will improve further. During February 2014 Steamplicity was introduced throughout ESHT In-Patient services, results in response to this change will be available during quarter 4.

5. Q3 Patient Feedback: Friends and Family Test (FFT)

5.1 The FFT has been mandatory from April 2013 with a compliance level of initially 15% which has now been increased to 20% submissions for all discharge patients from January 2014. The FFT was initially started in emergency departments and inpatient settings. ESHT then collected patient feedback from MIUs and community hospitals. This is a simple question “How likely are you to recommend us”. This provides a benchmark figure; the Net Promoter Score (NPS). The NPS is calculated between -100 and + 100. The NPS for ESHT for Quarter 2 was 67 and for Quarter 3 62.

Q3	Total number of responses for each department	Total number of people eligible to respond	Response rate for each A&E department
CONQ	1461	7524	19.41%
EDGH	402	7686	5.23%
ESHT	1863	15210	12.24%
ESHT Inpatient total figures	1398	5384	25.97%

88% of inpatients were either likely or extremely likely to recommend us (based on 1687 responses)

81% of patients who attended our emergency departments were either likely or extremely likely to recommend us (based on 4008 responses in Q3)

5.2 Whilst ward movements has given differing challenges various methodologies have been used to support staff in meeting the increased target compliance supported by hardcopies, Ipads and the introduction of a counter or card voting system similar to a national supermarket.

5.3 Maternity services commenced the FFT in October 2013, expectant and new mums are offered the FFT at 3 stages of their pregnancy and post natal care.

5.4 The roll out for FFT is expected for all services by 2015 through a staged implementation. However, many services are so keen they have already commenced offering their patients the FFT which is supported.

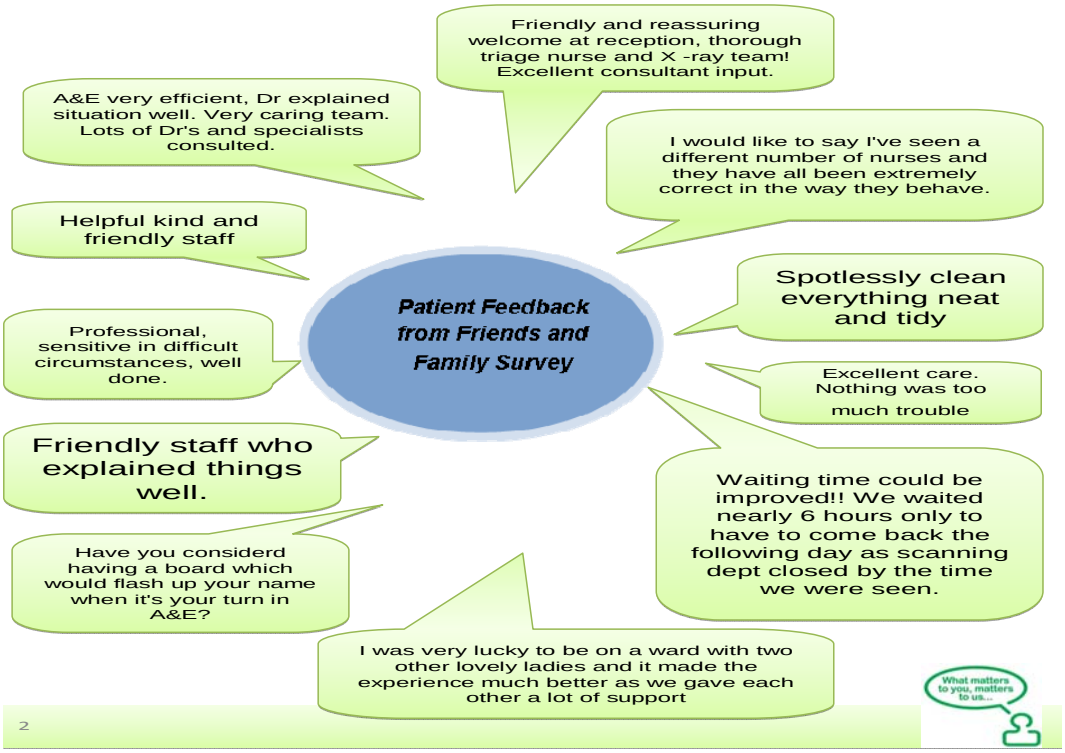
5.5 We have achieved all targets set by the Department of Health for Quarters 1-3. The table below shows the responses from A & E departments across both acute sites which has been the most problematic area as supported by low submissions across the UK.

Q3	Total number of responses for each A&E department	Total number of people eligible to respond	Response rate for each A&E department
CONQ	1578	7745	20.37%
EDGH	895	7900	11.33%
ESHT	2473	15645	15.81%

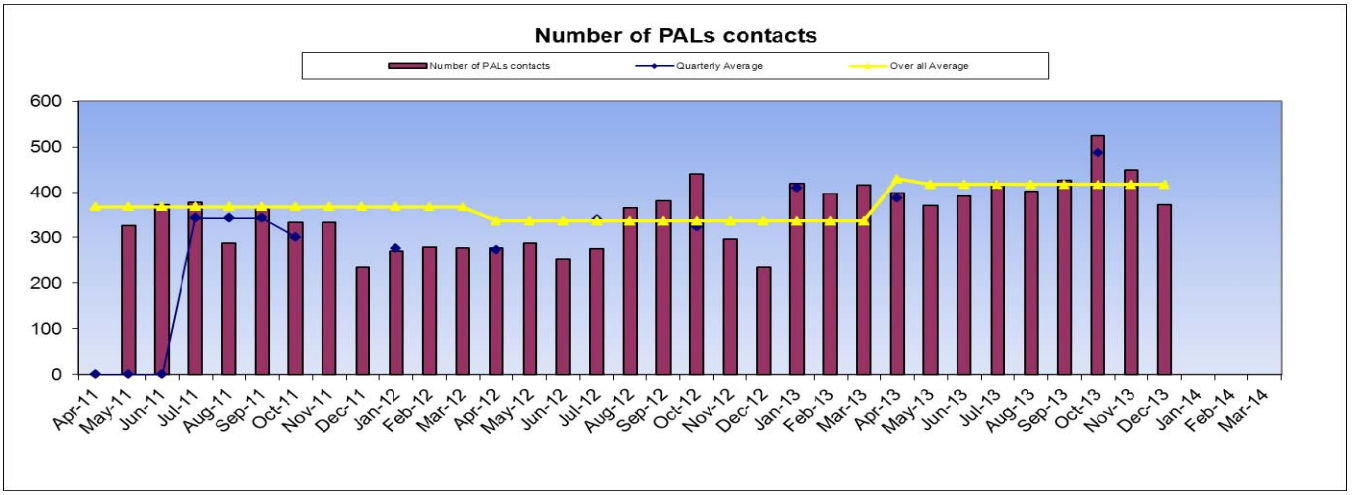
5.6 ESHT is working towards a display of this data including the showing that improvement plans are in place for implementing changes to be made to the patient experience process.

5.7 All areas are also being given a target for completion which will be monitored.

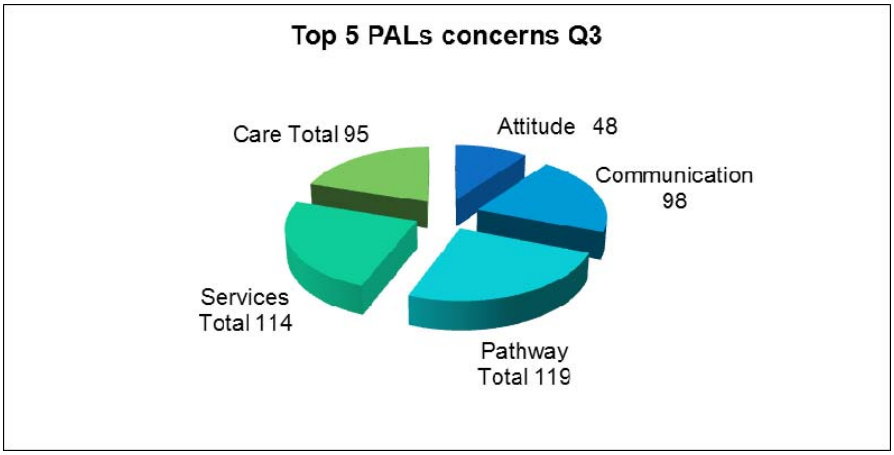
5.8 An example of recent Patient feedback from the Friends and Family test system



6. Q3 Patient Advice and Liaison Service (PALs) Summary



6.1 PALs are continuing to provide a rapid access point of contact for patients and the public with 92% of concerns being responded to within 2 working days, despite the evidenced rise in contacts.



6.2 The number of concerns increased slightly this quarter. Planned Care account for 46% of all concerns. These concerns relate specifically to communication and patient pathway issues, which are broken down into sub subjects. The number of concerns relating to communication has fallen from 139 in Quarter 2 to 98 in Quarter 3.

6.3 It is important to note that the top 5 PALs contacts mirror the top 5 complaints total.

7. Conclusion

ESHT continues to make progress and talk with and learns from patient experience issues in order to constantly improve patient experience. All inpatient and A&E areas have access to real-time patient feedback from our service users. This data is used at ward/service level in conjunction with local quality data to provide both an overview and a summary of local improvement to date.

There is a considerable amount of work being developed within the clinical areas relating to patient experience. Further developments in quarter 4 will look at the display of data for patients and increasing the returns for FFT.

Complaints management will be reviewed as a Trust and ensuring that the recommendations of the Clwyd-Hart review have been noted and action taken.

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	9e
Subject:	Nurse Staffing Levels
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

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

Introduction:

The report is presented to give an update on the process of how the trust has implemented the recommendations of the publication "How to ensure the right people, with the right skills are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability" by the National Quality Board. This has provided much needed guidance and clarity on expectations of provider and commissioner organisations on setting safe staffing levels. The review fitted in with the Trusts overall programme to promote the quality of its service and the productivity and efficiency of its service models and workforce.

The aims of the review were to:

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

The work plan of the review is being undertaken in 5 key phases.

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

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

Benefits:

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

Risks and Implications

Increased risk to patient safety
Reduction in positive patient outcomes

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

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

Proposals and/or Recommendations

The Board is asked to agree the following recommendations:-

- 1 registered nurse to every 8 patients as a minimum in acute wards
- Nurse staffing levels are assessed 3 times each day by Head of Nursing
- Biannual review of nurse staffing level reporting March and October
- Any service change requires a staffing review, the board is asked to support in principle initial changes to establishment numbers that such reviews may identify at the time, to ensure safer care is delivered reactively, whilst waiting for the next formal review
- Staff boards on display in all wards
- Nurse staffing levels published annually on website
- Absence cover is equally applied to all budgets for 18% with a 3 % cost held centrally
- 0.5% wte supervisory time for the ward matron*
- Staffing levels are agreed as per appendix 2:-
  Total increase in RN 22.5 HCA 4 : per 24 hours across ESHT
  (the increase funding for this has been agreed)

In future a full staffing review report will be presented to the Quality and Standards Committee and the Trust Board.

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:**
Alice Webster, Director of Nursing	01424 7552550 ext 6302

East Sussex Healthcare NHS Trust

NURSE STAFFING LEVELS

1. Background

1.1 Determining nursing, midwifery and care staffing requirements is a complex process, requiring input from all levels within the nursing and midwifery staffing structure. Using an evidenced-based tool is a critical part of making staffing decisions, and will ensure that these decisions are based on patient care needs and expert professional opinion. *Compassion in Practice*[1] emphasised the importance of getting this right, and the publication of the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry[2] and more recently reviews by Professor Sir Bruce Keogh into 14 trusts with elevated mortality rates[3], Don Berwick's review into patient safety[4], and the Cavendish review into the role of healthcare assistants and support workers[5] also highlighted the risks to patients of not taking this issue seriously.

1.2 In November 2013 "How to ensure the right people, with the right skills, are in the right place at the right time. *A guide to nursing, midwifery and care staffing capacity and capability* "[6] was published.

1.3 In addition to providing appropriate numbers of staff it is also necessary in line with action area 5 of Compassion in Practice (2013), the Chief Nursing Officer's vision for nurses, midwives and care givers, to ensure that the "right staff with the right skills are in the right place." Hence while this staffing review focuses on ensuring that our numbers and ratios of staff are safe and appropriate, further work on supporting our nursing staff to have the right skills, education and training must continue.

1.4 There are several nurse staffing tools in existence, many of which are based on acuity and dependency measurement and whilst there is no absolutely objective tool, the importance of setting staffing levels supported by such tools was recognised by the Keogh report (2013); Ambition 6 - "Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards". This is further supported by the aforementioned Compassion in Practice (2013) which specifically asks Trusts to use such evidence based tools and to publish through Trust Boards staffing levels and their impact on care on a six monthly basis.

1.5 More detailed guidance is provided by the Royal College of Nursing and Safe Staffing Alliance who recognise the impact that registered nurse:bed ratios can have on quality and safety of care.

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[1] *Compassion in Practice,* NHS England, December 2012. Available at http://www.england.nhs.uk/wpcontent/uploads/2012/12/compassion-in-practice.pdf

[2] *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry,* The Mid-Staffordshire NHS FoundationTrust Public Inquiry, February 2013. Available at http://www.midstaffspublicinquiry.com/

[3] *Review into the quality of care provided by 14 hospital trusts in England: overview report*, Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keoghreview/ Documents/outcomes/keogh-review-final-report.pdf

[4] *A promise to learn, a commitment to act: improving the safety of patients in England*, Don Berwick, Department of Health, August 2013. Available at: https://www.gov.uk/government/publications/berwickreview- into-patient-safety

[5] *The Cavendish review: an independent review into healthcare assistants and support workers,* CamillaCavendish, Department of Health, July 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

[6] How to ensure the right people, with the right skills, are in the right place at the right time. *A guide to nursing, midwifery and care staffing capacity and capability National Quality Board 2013 http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf*

1.6 Analysis of the RN4CAST data for the UK shows that this relationship holds for both general medical and surgical wards after accounting for differences in other staff groups[7] . For example, hospitals with an average 1:8 ratio would expect to see approximately 2% more deaths per year among surgical patients and 1% for medical patients when compared to the best staffed 20% of hospitals. This equates to approximately 20 deaths per year in an average hospital. Lower nurse patient ratios are associated with more 'excess' deaths.

1.7 These sorts of relationships are borne out in many international studies[8] and the effect has been demonstrated when staffing on individual shifts falls below planned levels[9]. The odds of registered nurses being unable to complete some necessary care are reduced by 66% in the best staffed wards compared to the worst [10]. A ratio of 1 RN to 8 patients identifies the level at which significant harm is more likely to occur. It does not represent a safe staffing level. Mandatory day time minimum staffing levels, where they are set, are calibrated for different settings, and typically range from 1:4 to 1:6[11].

1.8 The publication on 20th November 2013 of the paper "How to ensure the right people, with the right skills are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability" by the National Quality Board has provided much needed guidance and clarity on expectations of provider and commissioner organisations on setting safe staffing levels. The report sets out 10 clear expectations and contains explicit information regarding the roles and responsibilities of boards in ensuring firstly that safe staffing levels are set and consequently that appropriate staff are in place to meet these levels. Considerable additional requirements focus on areas such as assurance, transparency, workforce planning and supporting our staff to ensure that we are continuously striving to improve the quality of safe care provided within the organisation. The Trust's actions against this plan can be seen in Appendix 1.

1.9 ESHT, inline with this guidance, has used an approach where an evidence based model (The Hurst Model) is used alongside professional judgement, to form a basis for skill mix and numbers, involving the ward matrons and Heads of Nursing. However evidence based models are not available for all areas of the acute trust and very limited in the community. For this reason it is not possible to apply one model to all areas. During 2013 there have been staffing reviews of all of the areas involved with the clinical strategy. Completed as part of the process for a case for change, with the importance being assurance that there are correct numbers and skills of nurses looking after patients within the Trust.

1.10 Whilst there has not previously been a formal timetable for presentation of staffing data there has always been a link within the reports to either the ESHT Trust Board or the Quality and Standards Committee, details of workforce metrics - for example data on vacancies (short and long-term), sickness / absence, staff turnover, use of temporary staffing solutions (split by bank / agency / extra hours and over-time); and information against key quality and outcome measures - ie data on: safety thermometer, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience/ satisfaction and staff experience / satisfaction, has been an integrated part of, the performance report.

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[7] Griffiths, P., Ball J., Rafferty, A.M., Murrells, T.M., Jones, S. 'Nurse, care assistant and medical staffing: the relationship with mortality in English Acute Hospitals' RCN research conference March 2013.

[8] Kane, R.L., et al., The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systematic Review and Meta-Analysis. Medical Care, 2007. 45(12): p. 1195-1204 10.1097/MLR.0b013e3181468ca3.

[9] Needleman, J., et al., Nurse staffing and inpatient hospital mortality. N Engl J Med, 2011. 364(11): p. 1037-45.

[10] Ball, J., Murrells T., Rafferty A.M., Morrow E., Griffiths P., "'Care left undone' by nurses in English National Health Service (NHS) hospitals; the association with staffing levels, perceived quality and safety of nursing care" BMJ Quality & Safety., in press.

[11] Ball, J., Pike G., Griffiths P., Rafferty A.M., Murrells T., RN4CAST Nurse Survey in England. 2012, King's College: London.

Due to the density of metrics and the complexity of the reporting structures from ward to board the development of a robust process and reporting structure which is meaningful and accessible to all our staff and service users which facilitates a strong line of communication from ward to Board, and Board to ward.

2. Methodology

2.1 This review has taken into account a variety of recommended methods for reviewing and setting safe staffing levels all of which have influenced the recommendations in this paper, namely:

- Use of the Hurst Model
- Nurse sensitive indicators
- Registered Nurse:bed ratio modelling
- Benchmarking
- Literature review
- Professional scrutiny
- Registered Nurse:HCA ratio

2.2 The wider group of senior nurses within the Trust have had input and influence throughout this review via the Heads of Nursing for the clinical units. Quality dashboards have been transferred onto an electronic system having been developed across all inpatient, outpatient and speciality areas which triangulate a wide variety of nurse sensitive indicators including those recommended by the Safer Nursing Care Tool. Dashboards will also include workforce metrics such as appraisal rates and sickness absence in order to enable mapping of quality performance against workforce factors.

2.3 By triangulating the many layers of information and evidence above alongside professional scrutiny and organisational knowledge, all adult inpatient nurse staffing templates have been revised and proposals for change detailed below.

2.4 The review fitted in with the Trusts overall programme to promote the quality of its service and the productivity and efficiency of its service models and workforce.

2.5 The aims of the review were to:

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

2.6 The work plan of the review is being undertaken in 5 key phases:

Phase 1
The aim was to present a clear picture of the existing situation in relation to the current workforce and service. Data was collected and analysed as follows:

- The nursing budget and worked WTE by pay band for each ward and unit;
- The workload for each inpatient ward and unit: i.e. case mix, available and occupied beds, clinical activity i.e. theatre sessions and emergency attendances.

Phase 2
This phase reviewed the productivity and skill mix in each ward area and developed an overview of the scope for change in productivity and skill mix.

Phase 3
Development of projections for the future workforce. During this stage “bottom up” projections for the future workforce were developed in discussion with the ward matrons,

Heads of Nursing and operational managers. Projections were developed looking at the following:

- The nursing numbers per shift
- Skill mix per shift
- Shift hours
- Supervisory time for the ward manager and any other additional posts
- Absence cover
- Training and development requirements

Phase 4
The agreed data sets from Phase 3 to be presented to a panel, Assistant Director of Nursing, Director of Nursing, Turnaround Director, HR Lead and NED for Quality and Standards by the Ward Matron and Head of Nursing.

Phase 5
Agreed establishments to be assessed and ESHT wide numbers agreed with clinical & managerial staff. Following this a review and assessment (both internal and with external validation) will be presented back to the Quality and Standards committee.
Following the review recommendations will be made in relation to monitoring of nursing workforce and key risks.
Further work will be undertaken to scope the development of a WTE Supervisory Ward Matron Role

3. Findings

3.1 The Director of Nursing has undertaken a discussion with each inpatient ward to understand their actual nurse: patient ratios. An excessive number of patients per RN is associated with a higher than expected mortality rate and other harms. A ratio of more than 8 patients per RN significantly increases the risk of harm and constitutes a breach in patient safety which should be escalated by RNs for investigation. [12]

3.2 The staffing ratios may be appropriate with the current case mix of patients but each ward will need to have ongoing reviews. For nurses to provide compassionate care which treats patients with dignity and respect, higher levels may be needed and these need to be determined by our front line staff who are both encouraged and supported to inform senior nurses and managers when they regard staffing as unsafe, at whatever level.

3.3 The nurse staffing levels and ratios will be adjusted daily if the acuity of the patients necessitates additional staff.

4. Uplift to nursing pay budgets

4.1 *Absence cover:-*

In the existing establishment there is no agreed and equally applied 'up lift' to allow for absence cover, this includes annual leave, bank holidays, training, sick and carer leave.

[12] Rafferty, A.M., Clarke, S.P., Coles, J., Ball, J., James, P., McKee, M. & Aiken, L.H. Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records. International Journal of Nursing Studies, 44(2): 175-182.

Royal College of Nursing, Policy Briefing: Mandatory Nurse Staffing levels. 2012, RCN: London

Although this is recommended as guidance by the Royal College of Nursing, a benchmarking exercise across other acute organisations showed that uplift varied from 19 – 23% to cover:-

- Annual leave
- Sick leave
- Maternity Leave
- Study leave

Due to the high proportion of staff having longer periods of service they are therefore entitled to the maximum period of annual leave which may exceed the current funded amount. In addition to this as acuity and dependency increases along with the evidence base for care, training requirements for nursing staff have increased significantly. In order to be able to release staff for quality and safety related training and ensure that leave entitlement is given it is recommended that this approach is taken in the future. Uplifts will be applied equitably across nursing budgets and the suggested model is as follows:-

18% Annual leave
Short Term Absence
Study leave

3% Central funding to ensure equitable distribution
Long term Sick Leave
Maternity leave

3% of the whole clinical inpatient budget is placed into a 'ring fenced fund' to cover long term leave and maternity leave. The ward matrons will place a request for this and this will be managed through a process led by the director of nursing. The rationale for this is that whilst the uplift budget is applied into the bottom line, some areas need more for cover than others.

4.2 *Supervisory status of Ward Matrons*

In addition to providing safe staffing levels it is essential to also have the right clinical leadership in place and supported with time to fulfil this critical role. The Trust does not currently have a consistent approach to supervisory time for all Ward Matrons this having been reviewed within the divisions in the restructuring. Many reports including Francis and the recent National Quality Board report have highlighted the need for supervisory status for 'Ward Managers' which enables closer monitoring and scrutiny of quality and safety in the ward area.

> *…..a realistic assessment of the time required by the lead sister / charge nurse or team leader to assume supervisory status. Many trusts have supported these staff to be supervisory full time. The NHS Trust Development Authority provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow – and they expect that the lead sister, charge nurse or team leader should spend a minimum of two shifts per week assuming supervisory status.*

It is essential for nurse leaders to maintain clinical skills and work within the ward template at times to ensure an accurate understanding of ward culture and to demonstrate positive leadership behaviours.

It is recommended that the supervisory status of Ward Matrons is allocated at 0.5% of their time.

4.3 *Finance*

The proposed increase to staffing establishment represents an investment in nursing establishments.

Future work will be completed in order to quantify savings from improvements in quality that may result from improved staffing levels. It is anticipated that with recruitment to the proposed establishment, coupled with improved structure around financial management that the current spend on temporary workforce shows a significant reduction once vacancies are filled.

This review does not include escalation areas from a funding perspective, any additional beds being opened for any significant period of time will need to have extra funding made available. Evidently, whilst this is a significant requirement for investment proposed at a time of financial challenge, the recommendations of this are that this is a sustainable method of providing safe staffing levels and reducing temporary staffing spends.

Robust processes of accountability will be embedded to ensure that absolute clarity is provided for Ward Matrons around nursing pay budget management and that this is followed to ensure a sustainable position is maintained for nursing pay moving forward. Improvements proposed in this area will not only cover improvements to nurse staffing levels but also support robust and supportive financial management of pay budgets in a sustainable way to ensure financial as well as clinical maturity in relation to delivering excellent nursing care.

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

5. Conclusions

5.1 Nursing & Midwifery staffing is being reviewed using an effective evidence based methodology, (Hurst Modelling) with professional judgement in line with the NQB.

5.2 Nursing numbers are flexed in line with the bed base & dependency of the patients. However, given increasing pressures on urgent care, an older demographic, acuity & frailty of particularly vulnerable older patients there has been increasing demand placed on our complex medical care wards & Trauma Orthopaedics. Staffing numbers may have to be increased in response to this and any resulting business cases to support this on a recurrent basis will need to be developed.

5.3 The impact of the surgical move to single site in line with the clinical strategy has left the clinical unit short of staff in post, however this is within the existing vacancy rate not in lack of the established posts. Work is underway to ensure that this recruitment achieves the required number of staff.

5.4 The opportunity to review the impact of the supervisory role of Ward Matrons will inform future Nursing & Midwifery staffing reviews.

5.5 The Trust will consider the emerging evidence base to inform its twice yearly review of nursing & midwifery staffing, with the potential of using a tool which measures patient dependency to calculate the safe establishment.

5.6 Further work to include areas currently out of scope within the trust will need to be considered.

6. Recommendations

6.1 The Board is asked to agree the following recommendations:-

- 1 registered nurse to every 8 patients as a minimum in acute wards*
- Nurse staffing levels assessed 3 times each day by Head of Nursing
- Biannual review of nurse staffing level reporting March and October
- Any service change requires a staffing review and the board is asked to support in principle initial changes to establishment numbers that such reviews may identify at the time to ensure safer care is delivered reactively, whilst waiting for the next formal review
- Staff boards on display in all wards
- Nurse staffing levels published annually on website
- Absence cover is equally applied to all budgets for 18% with a 3 % cost held centrally *
- 0.5% wte supervisory time for the ward matron*

* *These have been assessed by the Turnaround Director as having limited financial impact currently on the ward budgets due to changes in the structures and ward developments and changes within the trust as a result of the clinical strategy.* Any negative cost implication will be presented in a business plan

6.2 In future a full staffing review report to be presented to the Quality and Standards Committee and the Trust Board to include:-

- The difference between current establishment and recommendations following the use of evidence based tool
- Evidence of triangulation between the use of tools and professional judgement and scrutiny
- Details of any plans to finance any additional staff required
- The difference between the current staff in post and current establishment and
- Details of how this gap is being covered and resourced.

Alice Webster
Director of Nursing

March 2014

Appendix 1

Progress against The National Quality Board (Department of Health) 'How to ensure the right people, with the right skills, are in place at the right time: a guide to nursing, midwifery and care staffing capacity and capability'.

The National Quality Board (Department of Health) published in November 2013 a paper called 'How to ensure the right people, with the right skills, are in place at the right time: a guide to nursing, midwifery and care staffing capacity and capability'. This paper sets out the expectations of providers to provide staffing to meet
the needs of patients, taking lessons from the various recent published reviews (Compassion in Practice 1; Mid-Staffordshire NHS Foundations Trust Public Inquiry2; Professor Sir Bruce Keogh review3, Don Berwick's review into patient safety4, Cavendish review of healthcare assistants).

The following outlines the expectation and ESHT review in response.

Expectation 1: Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing and capability.

- Summary of expectation for boards to assure in place and are actively involved in:
- Agreeing staffing levels.
- Consider impact of initiatives (such as cost improvement plans, reconfiguration of services).
- Monitoring of staffing levels, planned and actual.
- Receive and discuss regular reports on staffing related outcome measures (recruitment, retention, and training).
- Give authority to the Director of nursing to oversee and report on nursing, midwifery and care staffing capacity and capability and be assured robust systems are in place to enable the reporting upon this.

ESHT meets the requirements of expectation 1, evidenced by:

- A process is in place to review staffing levels, following nationally recognized methodology
- Quality impact assessment and risk assessment processes in place for any cost improvement plans, or service reconfiguration
- Process in place to monitor vacancies and staffing levels through performance reviews and workforce reporting
- Integrated performance report to the board includes workforce reports on recruitment and retention. In addition staffing workforce statistics are reviewed at the quality performance reviews.
- Director of Nursing (DoN) holds a board level responsibility as a voting Executive board member with full authority to oversee and report on nursing, midwifery and care staffing capacity and capability

Expectation 2: Processes are in place to enable staffing establishments to be met on a shift-to shift basis.

Summary of expectation for the Executive team is:

- Policies and systems in place, such as E-Rostering and escalation policies to support expectation.
- DoN and their team monitor shift-by-shift staffing levels, including temporary staffing and any trends.
- Where staffing shortages are identified staff can refer to escalation policies.

ESHT meets the requirement of expectation 2, evidence by:

- E-Rostering and escalation policies through good roster guidance and duty matron support in place.
- Assistant Director of Nursing / Heads of Nursing in place to oversee and monitor shift-by-shift staffing levels and trends, providing reports and escalation of any issues.
- Clear escalation of any staffing concerns in core hours through the senior nursing structure and out of hours through the duty manager rota.

Expectation 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.

Summary of expectation is:

- ESHT meets the requirement of expectation 3, evidence by:
- Evidence-based tools are used in conjunction with professional judgement and scrutiny to inform staffing requirements, as part of the wider workforce planning.
- Senior Nurses actively seek data to inform staffing decisions and are trained in the use of evidence based tools.

ESHT meets the requirement of expectation 3, evidence by:

- Methodology used to review staffing is based on latest evidence-based tools (e.g. Hurst Model, AUKUH and RCN safer staffing tool, midwifery guidance on birth to midwife ratios).
- All senior nurses are updated each year on the latest guidance and training provided as required to senior leaders within teams.

Expectation 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.

Summary of expectation is:

- Organization supports and enables staff to deliver compassionate care.
- Staff work in well-structured teams, enabled to practice effectively.
- Staff have supporting infrastructure in place, including IT, ward clerks and supportive line management.
- Nursing, midwifery and care staff have a professional duty to raise concerns, supported by managers
- ensuring processes are in place for them to do so.

ESHT partly meets this expectation, evidenced by:

- Trust values, which support the patient at the centre of everything the Trust does.
- Team structures in place and reviewed alongside any reconfiguration.
- All wards have ward clerks, although a gap in some areas to the level of cover – gap in meeting requirement.
- IT hardware gap in some areas, currently under the remit of the IT strategy – gap in meeting requirement.
- All care staff have clear line management and processes in place to encourage any raising of concerns
- (e.g. incident reporting, whistle blowing policy)

Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.

Summary of expectation is:

- DoN leads the process of reviewing staffing requirements, which involve ward Matrons, Heads of Nursing / Assistant Directors of Nursing.

- DoN work closely with Medical Director, Directors of Finance, Workforce and Operations, recognizing the interdependencies, with staffing papers presented to the board are the result of team working.

ESHT meet this expectation, evidenced by:

- Methodology of staffing includes professional judgement involving Ward Matrons, Heads of Nursing / Assistant Directors of Nursing.
- DoN works closely with all executive colleagues to agree and finalize staffing recommendations to the board. Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.

Expectation 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.

Summary of expectation is:

- Staffing establishments enable care staff time to undertake continuous professional development (CPD) to fulfil mentorship and supervision roles.
- Planned/unplanned leave realistic estimations are incorporated into staff establishments.
- Staffing establishments enable ward senior sisters/charge nurses supervisory time, which is monitored
- and reviewed locally.

ESHT meet this expectation, evidence by:

- Staffing establishments incorporate additional requirements for CPD to enable the fulfilment of mentorship and supervision roles.
- Leave cover is incorporated into the baseline establishment as part of the methodology applied in reviewing staffing levels.
- All senior ward leader roles have an element of supervisory time; with a clear strategy to monitor this and increase as required in key areas

Expectation 7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.

Summary of expectation is:

- Boards receive monthly updates on workforce, including the number of actual staff on duty compared to plan over the last month, the reason for gaps, actions to address gaps and any impact of gaps on quality.
- Boards receive every six months an establishment review, which should be at the public section of the board.
- Staffing information will form part of the Care Quality Commission (CQC) and Intelligent Monitoring of NHS provider organisations

ESHT currently do not meet this requirement and will need to put in place actions to meet this.

- To date monthly updates exist on workforce but not the detail of staffing establishment reports.
- There will be a paper presented to board with this data captured within the report.

Expectation 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.

Summary of expectation is:

- Information should be made available for patients/ public that outlines which staff are present and what their role is.

- Information should be displayed so that it is visible, clear, accurate and include the full range of staff available on the ward for each shift.

ESHT currently do not fully meet this requirement.

- The 'safety crosses' from the are currently displayed to in public areas on the wards, noting staffing levels from a broad perspective. Therefore a new process will need to be implemented to demonstrate this and enable reporting to the board.

Expectation 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements.

Summary of expectation is:

- NHS service providers must ensure robust systems in place to recruit, retain and develop all staff.
- Organizations must share staffing needs and annual service plans with Local Education and Training Boards (LETBs) to help determine future workforce requirements, in addition to sharing this with their regulators for assurance.
- Providers to work in partnership with Clinical Commissioning Groups (CCGs) and NHS England area teams to provide future workforce forecast, which LETBs will use to inform education commissions and the workforce plan for Health Education England (HEE).

ESHT partly meets this by:

- Robust recruitment, retention and development processes in place for nurses, midwives and care staff with clear reporting and monitoring of any future gaps and strategies to address these.
- ESHT shares and discusses its workforce needs with LETBs, including reviewing of commissions.
- Workforce planning forecast has not been fully shared with CCGs however this is an area for further development

Expectation 10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.

Summary of this expectation:

- Commissioners to be specific in contracts the outcomes and quality standards they require and actively seek assurance that sufficient nursing, midwifery and care staff capacity and capability are in place to meet these.
- Commissioners monitor quality and outcomes closely and where appropriate use contractual levers to bring about improvements if required.
- Commissioners recognize they have a contribution to make in addressing staffing-related quality issues, where these have been driven by the configuration of local services or setting

ESHT works closely with the CCGs and reports on all quality and outcome metrics as required. ESHT recognizes that reporting on specific nursing, midwifery and care staff workforce outside of the current reporting arrangements maybe required and has worked closely with CCGs to ensure the required information is provided as appropriate.

Ward	Beds /Spaces		Day		Night		Proposed		Night		Variance	Variance	Rationale
			RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
A&E Department			9	3	6	2	10	4	7	3	2	2	EDGH and CQ
MAU (Medical Assessment)	31		8	3	5	3	7	4	5	3	-1	1	Changes to skill mix
SSU (Short Stay Unit)	17		2	2	2	1	2	3	2	1	0	1	
Seaford 3 (Trauma Ortho)	29		4	4	2	2	5	4	3	2	2	0	Increased staffing at night required
UAU /Seaford 4 (Urology)	27		5	4	3	2	5	4	3	2	0	0	
Michelham Private Patients	Beds flexed		2	3	2	1	4	3	2	2	2	1	Agreed outside of the process
ICU/ HDU (Critical Care)	5+3		8	1	8	0	8	1	8	0	0	0	
Hailsham 3 (Elective Ortho)	23 (17)		4	2	2	1	3	3	2	1 (Twilight	-1	1	Changes to the way in which the team operates and a change in activity as part of the clinical strategy
Hailsham 4 (Surgery) **Weekend**	19	(6)	3	3	2	2	1	2	1	1	-1	-3	Multi speciality surgical ward with elective activity combining Chiddingly, Hailsham 4 and Glynde
Weekdays		(28)	3	3	3	4	4	3	2	2	1`	-1	As above

TW = twilight
*Twilight shifts are not full shifts ( ) = new bed numbers

Ward	Beds /Spaces	Day		Night		Proposed		Night		Variance	Variance	Rationale
		RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
Berwick (Cardiology /Medicine	28	4	4	2	2	4	4	3	2	1	0	Increased staffing nocte
Cuckmere (Gastro /Isolation)	21	4	3	2	2	4	4	3	2	1	1	Increased staffing nocte
Sovereign /East Dean (Stroke Unit)	23/10 (32)	5	6	4	3	6	7	5	4	2	2	environmental changes – high dependency staffing required due to speciality
CCU (Cardiology)	6+5 (11 + Cath Lab)	4	4	3	2	8	1	2	1	3	-4	‘‘PCI Take’ affects staffing levels alternate weeks
Pevensey (Haem /Oncology)	17	4	1	2	1	4	1	2	1	0	0	
Jevington (Respiratory)	27	4	4	3	2	4	4	3	2	0	0	
Folkington (Diabetes /Endocrine)	27	4	3	2	3	4	4	3	2	1	0	
Judy Beard (Day Unit)		6	2									Not in previous establishment reviews
Pevensey (Day Unit)		6.5	1									Not in previous establishment reviews
SSPAU		2.5	1									Not in previous establishment reviews
AAU (Short Stay /Assessment Unit)		5	3	3	3		4	4	3	-1	1	

TW = twilight *Twilight shifts are not full shifts ( ) = new bed numbers

Ward	Beds /Spaces	Day		Night		Proposed		Night		Variance	Variance	Rationale
		RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
DeCham (Surgery)	28	4	4	2+Tw	3	5	3	3	2	1	-2	Clinical Strategy changes
Gardner (Surgery)	28	4	4	2+Tw	3	5	3	3	2	1	-2	Clinical Strategy changes
Critical Care	11	10	1	9	1	10	1	9	1	0	0	
Cookson Devas	25(20)	3	2	2	2	3	3	2	2	0	1	Clinical Strategy changes
SAU Emergency Surgery	24(30)	5+AP	2	4+AP	1	6	2	5	2	0	1	Clinical Strategy changes
Maternity		10 (Thur – Sun 9+3))	3	10 (Thur – Sun 9+3)	3	10 9+3)	3	10 (Thur – Sun 9+3)	3	0	0	High risk care currently on a single site, changes to staffing realte to theatre activity
SCBU	12	4	1	4	0	4	1	4	1	0	1	Increased number of cots on Scbu
Mirlees (Women's Health)	6	2	1	1	1	2	1	1	1	0	0	
MacDonald (Complex Elderly)	28	3	5	2	4	4	5	3	3	2	-1	

TW = twilight
*Twilight shifts are not full shifts ( ) = new bed numbers

Ward	Beds /Spaces	Day		Night		Proposed Day		Proposed Night		Variance	Variance	Rationale
		RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
Kipling	21 max 25	6	2	3	1	6	2	4	2	1	1	
Benson Trauma	28	3	3	2	2	4	4	3	2	2	1	
Tressell (Respiratory Med)	28	3	3	2	2	4	4	3	2	2	1	
Wellington (Diabetes /Isolation)	20	3	3	2	2	3	3	3	2	1	0	
James /CCU (Cardiology)	23(22)	4	3	4	1	4	3	3.5	1	-0.5	0	'PCI Take' affects staffing levels alternate weeks
Baird MAU (Emergency Med)	28	4	4	3	2	5	3.5	3	2.5	1	0	
Newington (Gastro)	28	4	3	2	2	4	4	3	2	1	1	
Lewes	28	5	4	3	3	4	4	3	3	-1	0	Review of activity
Rye	15	2	2	2	1	2	2	2	1	0	0	Review of activity
Uckfield	14	2	2	2	1	2	2	2	1	0	0	Review of activity
Crowborough	15	2	2	2	1	2	2	2	1	0	0	
Irvine Unit	42	5	6	4	5	6	6	4	5	1	0	Additional resource of therapy Rehab support workers used
TOTAL										**22.5**	**4**	

TW = twilight
*Twilight shifts are not full shifts ( ) = new bed numbers

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	10
Subject:	Market Testing Programme
Reporting Officers:	Dr Amanda Harrison, Director of Strategic Development and Assurance Andy Horne, Programme Director

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

Purpose:

This paper updates the Board on progress following the approval of the market testing outline business case (OBC) at its September 2013 meeting and seeks approval for market testing the first three services following production of their transformation plans.

Introduction:

The Trust developed a market testing strategy and outline business case (OBC) which it approved at a board meeting held on 25th September 2013. The approval of the OBC set in motion the development of a programme initiation document and the on-going development of a number of full pre-procurement business cases covering the commercial and support services. These plans include:

1. Review of procurement routes, to identify 'quick wins'.
2. Development of service specifications / service level agreements for every commercial and support service as part of developing a transformation plan.
3. Following production of the service specifications, the Trust to reconfirm for each service:
   - to transform internally;
   - to market test (to test the service cost, quality and activity against the market);
   - to outsource (on the basis that this is not a core service it wishes to directly provide);
4. Agreement on type, length and conditions of contract for each service based on legal and procurement advice.
5. Review of each proposed market testing bundle and niche service to ensure best value for money and specified quality and performance will be produced.
6. Approach to managing staff implications such as TUPE and redundancy costs.
7. Production of a pre-procurement full business case for each bundle and niche service.
8. Development of a comprehensive communication plan to keep staff informed and engaged and to offer support during this process.
9. Management of risk in relation to the above.

<u>Progress and decisions</u>

Procurement quick wins:
Discussions have taken place with West Sussex County Council and Kings Healthcare, both have used a procurement process which would allow NHS Trusts in the South East Coast to use their framework agreements. Advantages of using these frameworks would be reduced procurement costs and achieving any savings at an earlier point. Quality and improved Key Performance Indicators (KPIs) are also a major part in the considerations. Disadvantages include the absence of choice (single supplier) and less flexibility on changes to specification. The Board may wish to consider a separate discussion on this.

Occupational Health:
A transformation plan has been produced which provides an improvement in efficiency but does not meet the Trust's 5 year efficiency target and the resultant cost is still above the NHS benchmarking club 'average' cost. The benchmarking club is producing a more comprehensive analysis in 2014 which may provide improved comparisons. All committees have recommended that the service is market tested. This will give the Trust the opportunity of comparing the in-house cost and quality, with costs and quality supplied from the market, on a menu basis, so that the best value for money and quality option can be considered.

A draft service specification has been developed based on the work undertaken by NHS Employers. This has been produced on a 'menu' basis with 'optional' service elements available, such as the ability and/or criteria for staff to make self-referrals, criteria for rapid access to physiotherapy and counselling services, and healthy staff promotions. This will be subject to user input and a quality impact assessment signed off in the normal manner for any agreed changes.

Pharmacy Manufacturing Unit (PMU):
A transformation plan has been produced which provides an improvement in efficiency but does not meet the Trust's 5 year efficiency target. As part of this process it has been agreed that the cancer chemotherapy preparation service based at EDGH will transfer from Commercial services to Pharmacy and (subject to another business case) be merged with a similar service based at the Conquest and already run by Pharmacy; this will also simplify the registration of this service and further efficiencies will be possible.

The remaining PMU service is mainly providing services to other organisations and therefore the main test is whether a surplus is made (taking into account all costs and overheads) and that any risks over the next 5 years can be managed to ensure a surplus can be maintained, if not improved. This service is not considered to be wholly suitable for market testing given the nature of this service is based on a high volume of small, one-off orders for other providers. Less than 10% of the business can be guaranteed in-house, and currently other services have the internal capacity to take on this work. However the Quality Control process is recommended to be market tested.

All committees have concluded that this is not a core service. However, given this service makes a net contribution to the Trust, and the cost of closing the service is material (e.g. redundancies and loss of surplus and contribution) it is recommended the transformation plan is accepted for implementation. It will be kept under review and if the annual net surplus drops below 10%, or the income level reduces to below £1.5m, the service will be referred back to the Finance and Investment committee for a further decision on any action required which would include an option of closure. Local management are also tasked with minimising staffing risks.

Crèche
This service is provided at EDGH and Conquest (CQ) sites and is primarily funded via fees by staff whose children use this service. The transformation plan provides options for significant improvement in efficiency. There is no 'do minimum' option as the CQ nursery building is already beyond its useful life and therefore needs to be closed. The Trust has previously been made aware of the applicable Health & Safety report. The existing crèche site at the CQ has also been identified as potentially needed to meet the clinical strategy expectations, although an alternative site has been identified. All options would involve costs; either through the cost of redundancy, the cost of a replacement building at the CQ or renting a suitable building offsite.

A replacement Crèche facility is recommended on the CQ site, this could be delivered through a traditional or modular build, delivered by the Trust or a 'partner'. Alternatively, the renting of existing facilities located at a convenient distance from the Conquest may be considered. In financial terms, the most improvement is found in option 2; replacing or rebuilding the CQ nursery which would involve increasing the number of places available to meet demand.

All committees have concluded that this is not a core service and therefore not a priority for scarce Trust capital resources and therefore a partnership approach is being proposed to encourage private sector investment and provision across both sites so that the benefits to staff continue to be available.

The plans referred to above have been circulated to the Board in confidence as to release them in the public domain could prejudice the commercial interests of the Trust.

Market Testing other services

The market testing programme plan is slipping behind schedule, mainly due to management and capacity issues in Commercial Services. The consequences are the potential delay to delivering the benefits within the originally planned timescale.

A new fixed term procurement specialist has been appointed to move forward with developing the service specifications, of which the largest element is commercial services.

It has been agreed that the development of the financial services specification and business transformation plan will be placed on hold due to pressures on the finance department from turnaround and budget setting activity.

Communications:
Regular Trust wide communications continue on progress with market testing. Meetings to explain and discuss the market testing programme have been held with a large number of departments.

Analysis of Key Issues and Discussion Points Raised by the Report

The OBC proposed a change of direction for commercial and support services. Rather than direct provision of the majority of its support services, this has now offered the opportunity for:

- Clarity around the exact requirements based on a zero based approach and affordability built into new service specifications;
- Testing of our service costs and quality against the market to ensure value for money and quality achieved;
- Identification of core and non-core support services;
- Decision on outsourcing.

By undertaking this process the Trust is investing in the production of service specifications and the business cases.

There is a general risk of impact on provision of support services due to staff uncertainty and higher turnover.

Access to capital for investment is likely to be a major issue.

There are opportunity costs for management time.

Benefits:

The benefits of this work will be to ensure the Trust can continue to improve quality and reduce costs associated with its support services through either internal transformation or via market testing.

These departments have produced a transformation plan that have made progress towards delivering the Trust's efficiency requirements:

- Occupational Health: - Annual run rate improvement of £119k and budget improvement of £15k.
- PMU: - Annual run rate improvement of £233k and budget improvement of £138k.
- Crèche:- An in house funded development would have improved the run rate by £156k. A partnership approach with private sector capital investment would limit this improvement to £67k. Budget Improvements are to a similar level. This ignores the impact of employer savings on national insurance and superannuation costs which is currently subject to new legislation.

Further improvements may be possible following market testing.

Risks and Implications

The clinical strategy is helping the Trust to ensure it has the correct scope of services to meet the needs of local people. This process will ensure that support services improve their effectiveness in supporting clinical services and that the maximum resource is spent on core services.

- Risks will include the Trust's capacity and capability of delivering huge change in core and support services at the same time within a suitable timescale.
- Financial risk of costs being higher than forecast in delivering the strategy / business case.
- Risk that the strategy takes longer than anticipated.
- Risk that the savings from market testing are less than forecast.
- Risk that the savings from in house provision are less than forecast.
- Risk in supporting staffing through a process with an uncertain conclusion, leading to increased staff turnover and/or poor recruitment.
- Risk of staff opposition.
- Risk of disruption to the provision of support services from all the above.

Assurance Provided:

A steering group was set up including non-executive and executive directors which has reported regularly to the Finance and Investment Committee (FIC), Clinical Management Executive (CME) and Corporate Leadership Team (CLT) on progress and for decisions.

This should assure the Board that progress is being made with this element of its Turnaround / CRES programme aimed at delivering financial stability.

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

The Programme Initiation Document was approved at FIC on 23rd October, CLT on 22nd October and CME on 28th October 2013.

The Occupational Health Service transformation plan was approved at FIC on 11th December and CME on 9th December 2013.

The Pharmacy Manufacturing Service transformation plan was approved at FIC on 22nd January 2014 and CME on 13th January 2014.

The Crèche transformation plan was approved by FIC on 26th February 2014 and CME on 24th February 2014.

The proposal and progress is also regularly discussed at the Joint Staff Committee.

Proposals and/or Recommendations

The Board is requested to discuss and approve the transformation plans as follows:

Occupational Health:

- to implement the transformational plan,
- to further develop a 'menu' for the service specification and quality impact assessments,
- to market test,
- to produce a final full business case, post receipt of tenders to decide on outsourcing.

Pharmacy Manufacturing Unit:

- to implement the transformation plan,
- to market test the quality control process / service ,
- to ask for a further paper on potential options including closure to F&I committee, if forecast surplus drops below 10% or income drops below £1.5m pa,

Crèche:

- to implement the transformation plan,

- to agree that this is a service where a partnership approach is preferred to encourage private

sector investment and the continuance of the service on both sites for Trust staff
- to seek a partner to invest and provide these services

To consider whether it wishes a further discussion paper on market testing procurement options.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
This has been identified as part of the review of both services, following consultation with the Head of Equality and Human Rights

For further information or for any enquiries relating to this report please contact:	
Name: Andy Horne, Programme Director	**Contact details:** andyhorne@nhs.net

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	11
Subject:	2 year- 2014/16 Financial Planning Update
Reporting Officer:	Vanessa Harris, Director of Finance

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

Purpose:

1. To provide an update on business planning and assumptions
2. To provide information about the overall plan within the 2 year planning context
   To advise the Trust Board on the financial outlook for 2014/15 and 2015/16 and seek approval for a recommendation to the Board to set a provisional budget for 2014/15.

Introduction:

This report is being brought to the Trust Board for the approval of a year 1 provisional working 2014/15 budget.

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

The budget for 2014/15 is under significant pressure at a time of national financial challenge and when the organisation is beginning to implement its clinical strategy. ESHT needs to jointly manage demand with all its commissioners as well as deliver a level of internal efficiency commensurate with national planning expectations.

An initial budget assessment has resulted in a deficit of £18.5m for 2014/15 after application of the internal cost improvement programme of £20.4m and after providing for known cost pressures and inflationary increases. Currently £2m of CCG Commissioner QIPP impact has been factored into the Plan but it is known that CCG Commissioners demand management expectations exceed this value. Work is ongoing to develop joint QIPP plans which will release cash savings and minimise stranded costs or underutilised capacity. The contract with specialist commissioners is also yet to be finalised and may represent a further financial risk.

Discussion is ongoing within the local health economy on the 2014/15 plan. The Board will be updated with progress at its meeting on 26 March. Meanwhile, the proposal is to issue a provisional working budget for 2014/15 recognising there is currently still a gap to bridge as set out above, this will enable budget holders to proceed with the operational management of the Trust, pending agreement of the final 2014/15 plan.

Benefits:

Budgets are set for clinical units and other areas and therefore emphasis can be moved to delivering the required savings from 1 April 2014.

Risks and Implications

As set out in the attached report – section 14.

Assurance Provided:
The 2014/15 planning process has been extremely robust with plans developed by clinical units being assessed for quality impacts by senior clinical and other ESHT directors as well as scrutiny by the Board at a whole day Scrutiny and Review event on 12 March 2014. Cost improvement targets have been developed within clinical units who own and understand the assumptions made.

Review by other Committees/Groups (please state name and date)**:**
Finance and Investment Committee - 26 February 2014 Finance and Investment Committee – 19 March 2014 Quality Impact assessment Group Board Seminar Review of clinical unit plans - 12 March 2014

Proposals and/or Recommendations
The Trust Board is recommended to: • Agree the high level outline Plan for the 2 years 2014/16. • Note the financial outlook for the 2 years 2014/16 based on the current planning assumptions. • Note that a fully developed budget is not yet available for Board approval. In the interim agree the issue of a provisional 2014/15 working budget, to enable budget holders to proceed with the operational management of the Trust, pending issue of a final budget to be agreed at the next meeting of the Board on 4 June 2014.

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

For further information or for any enquiries relating to this report please contact:	
Name: Vanessa Harris, Director of Finance	**Contact details:** Vanessa.harris2@nhs.net

East Sussex Healthcare NHS Trust

Summary of two Year Plan 2014/15 to 2015/16

1. Summary

1.1 This report which is set in the context of a 2 year planning period sets out the provisional financial plan and underlying assumptions for the forthcoming year, including cost improvement plans, together with an initial allocation of budgets. This is a provisional report pending finalisation of discussions within the Local Health Economy with all main commissioners (CCG and specialist) about the 2014/15 annual contracts for the provision of services.

1.2 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 have been submitted to the TDA (Trust Development Authority) in January and March and this paper summarises the most recent draft plan submitted to the TDA on 5 March 2014. This is not the final plan for 2014/15 and a number of key planning assumptions remain under review. The final plan is due to be submitted to the TDA by 4 April 2014.

1.3 The two year plan will form the basis of a revised 5-year longer term plan that will need to be submitted to the TDA in June.

1.4 Ahead of the final plan being finalised the Board is asked to agree that provisional 2014/15 budgets are issued to clinical units based on the assumptions set out in sections 8-15 below.

2. Background

2.1 East Sussex Healthcare Trust (ESHT) is currently three years into a five year improvement journey to improved clinical sustainability and financial viability. In close collaboration with key stakeholders in East Sussex the Trust has agreed the framework for its Clinical Strategy: Shaping our Future in 2011 against the strategic objectives the Board have agreed for the organisation

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

2.2 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 are 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

2.3 The conclusions reached about the future configuration and design of the above eight services has defined the business model for the Trust as 'one hospital on two acute sites'. This currently requires redesigned 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 is planned for 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 pending the outcome of a consultation on the long term future of these services which is currently being undertaken by the three local Clinical Commissioning Groups.

2.4 The full business case in support of the capital investment required to realise the full benefits of the clinical strategy has been developed and approved by the Trust Board and is currently awaiting consideration by the Trust Development Authority (TDA).

3. Plans for 2014/15 and 2015/16

3.1 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, ensure the prevention of inappropriate admissions and 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.

3.2 In the light of those priorities and in order to address the continuing financial challenges in the East Sussex health economy the clinical units have developed an ambitious £20.4m programme of cost improvement plans for 2014/15.

These have all been assessed for Quality Impacts by a team from within the Trust including the Operational, Medical and Nursing Directors and reviewed and scrutinised by the whole Board during a day of presentations held on 12 March 2014.

3.3 As part of the multidisciplinary review of all cost improvement plans a risk assessment of the deliverability of the plan has been undertaken. The key risks to deliverability and quality have been identified which has been fed into the financial analysis of the plan.

3.4 Cost improvement plans are being developed for 2015/16 at a total value of £20m. Further work will be undertaken over the next few weeks to finalise the detail to support these.

4. Quality Improvement Plan

4.1 For 2013/14 the Trust agreed the following priorities after a series of stakeholder engagement events across East Sussex aimed at developing the Trust's Quality Account: Progress on these is reported to the Board on a quarterly basis and will form the basis of the next Quality Account

- To maintain Harm Free Care at 90% and above through implementation of the Patient Safety Thermometer
- To implement 'Releasing Time to Care: The Productive Community Series
- To improve the patient experience of those diagnosed with heart failure.
- To implement the Patient Experience Strategy
- To support young children and young people with long term conditions and disability to stay at home.

4.2 Improvements in the five CQC domains of quality in the medium term include:

- Safety: Improvements in service safety have been delivered in line with the Clinical Strategy including the centralisation onto either Eastbourne or Hastings acute sites as described above. In addition the Trust has used the safety thermometer indicators to drive improvements in safety at ward level. An increased focus on the review of mortality within the Trust has been led by the Medical Director for governance and this will be further strengthened to ensure that Mortality and Morbidity at clinical unit and specialty level identify key risks and appropriate actions. The introduction of VitalPAC, an electronic bedside monitoring system, in 2014/15 will enhance this work.

- Caring: The Patient Experience Strategy is being implemented which includes acting on real time information from the Friends and Family Test and improving our approach to managing complaints. Our Listening into Action work is engaging staff and empowering them to make changes to the way they deliver services to improve dignity and respect.

- Effective: The development of the Clinical Strategy included a review of all eight services against best practice and national guidelines and ensured that the models of care developed and now being delivered addressed gaps in effectiveness. The Trust has a well developed system for identifying and managing clinical audit and intends to publish clinical audit results against key specialties in 2014/15. .

- Responsive: The Business case which supports the implementation of the clinical strategy 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.

- Well Led: The Trust is currently reviewing and strengthening its Quality Governance arrangements which restate the roles and responsibilities of all staff and describe the governance structure which supports this. This will be supported by a review of these arrangements against the Quality Governance Assurance Framework which will take place in 2014/15. Discussions are taking place with clinical units about quality improvement plans for the next two years in line with the Clinical Strategy. The Trust Board is ultimately accountable for the delivery of high quality care through the implementation of the Clinical Strategy and the Quality Governance Strategy and has a statutory duty of quality. The Trust receives an Integrated Performance Report at each of its formal meetings of which Quality is a key element. Performance indicators for 2014/15 are currently being developed with the Board to ensure that they are sighted on the key issues and are able to monitor quality standards and outcomes effectively.

5. Service Capacity and Developments

5.1 The Trust as part of the challenged East Sussex health economy will be working with local partners to agree the longer term plan for achieving clinical, operational and financial sustainability.

6. Delivery of operational performance standards

6.1 The Clinical Strategy sets out in detail how performance in the key specialties of acute medicine, A and E and cardiology will be improved. These plans stand alongside the improvements planned in stroke, emergency and high risk surgery and emergency and high risk trauma and orthopaedics.

6.2 Delivery of operational performance standards in 2014/15 will be based on the need to make identified improvements in efficiency and the ongoing development and implementation of the Clinical Strategy. The Trust has clear processes in place to identify areas of underperformance and risks to future achievements and these have informed the development of 2014/15 and 2015/16 plans. Plans have also been informed by reviews of best practice evidence and the evidence on optimum models of care. The Trust has been working with the Intensive Support teams for acute medicine and planned care to identify areas where workflow and processes can be improved to drive efficiency and deliver more effective and efficient outcomes for patients.

6.3 In October 2013 the Trust commenced a major turnaround programme, as part of which a bed management review has been completed and actions that will reduce length of stay and delayed discharges have been identified and incorporated into 2014/15 and 2015/16 plans.

Surgical specialities have been required to plan for improving the use of theatres through more effective and targeted list management, booking and preoperative assessment to reduce cancellations and Did Not Attends (DNAs). Staff working patterns have also been reviewed and rationalised to ensure they are matched to demand.

6.4 Seven day working is being introduced in support services including therapies to improve throughput and the patient experience by reducing length of stay in hospital and a new medical model is being introduced to provide senior expertise at the front door of the hospital seven days a week. A review of the utilistion of outpatient services is being undertaken to reduce DNAs and future care pathways will be based on a review of outpatient services and diagnostics that has identified improvements that can be delivered by applying lean methodology. A demand and capacity plan has been drawn up which will reduce the need for ad hoc clinics and outsourcing to third party suppliers.

7. Workforce Plans

7.1 Workforce Planning and Service Redesign for ESHT in 2014/2015 and beyond are aligned with the implementation of the clinical strategy and the cost improvement plan. The reductions in total workforce numbers will be achieved through skill mix reviews and increased productivity through continuous improvement in job planning and rota reviews.

8. Financial and Investment Strategy

8.1 This is a financially challenging period for the NHS, the tight fiscal position coupled with rising patient expectations and set against a changed NHS infrastructure is creating a demanding backdrop. The Trust set a planned deficit in the current financial year of £19.4 million. This deficit was based on delivery of a cost improvement programme of £20 million. Slippage on the savings programme of £2.5 million and cost pressures of £1.2 million mean that the forecast outturn is a deficit of £23.1 million. The Trust now needs to move, in the shortest time possible, to a surplus position so that it can demonstrate that it can continue to provide high quality services in a financially sustainable way.

8.2 The 5 March submission is a two year plan that shows deficits of £18.5 million for 2014/15 and £14.0 million for 2015/16. At this stage the Trust's view of its contract income for the next two years has not been reconciled with those of its main commissioners (CCG and specialist). Income levels for 2014/15 are based on forecast outturn activity levels with modest growth (population and demand) which are broadly in line with commissioner assumptions. However, the Trust is aware that CCG commissioners are planning for a level of QIPP beyond that which the Trust has built into its planned position. The Trust has provided for readmission penalties at a similar level to those agreed with CCG commissioners for the current year. No other fines and penalties have been assumed. CQUINs are assumed to be delivered in full.

8.3 The Trust faces a number of significant cost pressures, both national and local. These include:-

- Loss of income through QIPP plans (£2.0 million assumed)
- Loss of Health & Wellbeing income stream (net £0.5 million assumed)
- CNST increase (£0.7 million in 2014/15)

8.4 Expenditure budgets have been set following detailed, zero-based reviews with each clinical unit. To meet the various financial pressures and achieve the planned deficits the Trust has set itself cost improvement targets of £20.4 million (5.1% of baseline expenditure) in 2014/15 and £20.0 million (5.1%) in 2015/16. These values are net of cost pressures. A contingency of 1% of turnover has been set aside in both years. The Trust will require additional Public Dividend Capital funding to cover the cash shortfalls arising from its deficit plans. An application will be made to the Independent Trust Financing Facility via the TDA in due course.

9. Provisional Financial Outlook

9.1 Based on the above the financial outlook for 2014/15 as per the TDA submission on 5 March is summarised below.

Summary Income & Expenditure Statement	£m
Income	361.8
Pay Costs	(256.5)
Non pay Costs	(123.3)
Depreciation/PDC/Interest	(20.9)
Sub Total	(38.9)
CIP	20.4
Net Deficit	**(18.5)**

9.2 A detailed budget book, setting out expenditure plans and workforce numbers for all clinical units along with planned activity assumptions, will be issued following approval of the provisional budget.

10. Activity and Income

10.1 Activity plans are yet to be finalised with the Clinical Commissioning Groups (CCGs). The Trust has currently recognised £2 million of CCG QIPP schemes income projections and budget setting. Further detail is awaited from CCGs around other QIPP schemes.

10.2 No allowance has been made for the imposition of mandatory or local penalties or marginal rate reductions for emergency activity above threshold. An amount of £2 million has been assumed for the application of non-payment for readmissions. These areas pose a significant income risk to ESHT and will need to be tightly managed. Any financial exposure would need to be covered from contingency.

10.3 The 5 March submission was based on historic activity performance. Baseline activity, the tariff deflator and demographic growth assumptions have been largely agreed with commissioners. However, there remain a number of outstanding issues that remain to be resolved around the baseline position and the contract for 2014/15 with CCG and specialist services commissioners.

11. Cost Improvement Plans for 2014/15

11.1 In line with the rest of the public sector the East Sussex Healthcare Trust and the local health economy face a considerable financial challenge over the next five years.

As part of this, and in order to gradually reduce the Trust deficit, cost reduction measures of around £20 million will be required each year for the next two to three years. A plan has been developed to deliver £40 million of improvements over the next two years from April 2014. This section outlines the year one plan.

- Cost improvements have been identified in line with the national 'Quality, Innovation, Productivity and Prevention (QIPP) agenda.

- There are plans in place to deliver the full £20.4 million of savings in 2014/15. These vary in terms of difficulty, complexity and risk. Contingency plans will be developed over the coming months to off-set any slippage which occurs.

- The Board can be assured that :

    - Robust performance management and governance arrangement are in place to ensure delivery
    - The plans have been rigorously tested both in terms of deliverability and any potential adverse quality impact
    - There are appropriately detailed plans in place for all initiatives.
    - There is complete synchronicity with budget setting.

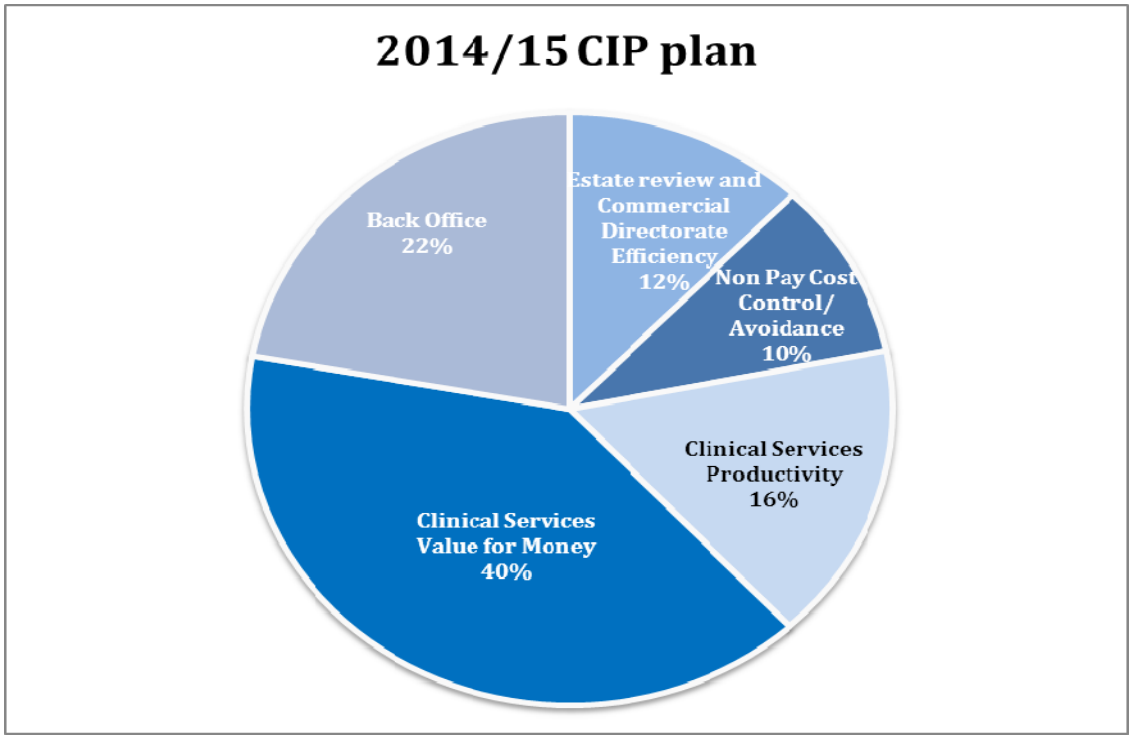
11.2 The unprecedented productivity challenges facing the Trust and the wider NHS highlight the need for a clear framework for delivery. The Trust has developed a stratified cost improvement programme based on 5 key themes to ensure substantial cost savings and efficiencies can be delivered over the next two financial years, 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.

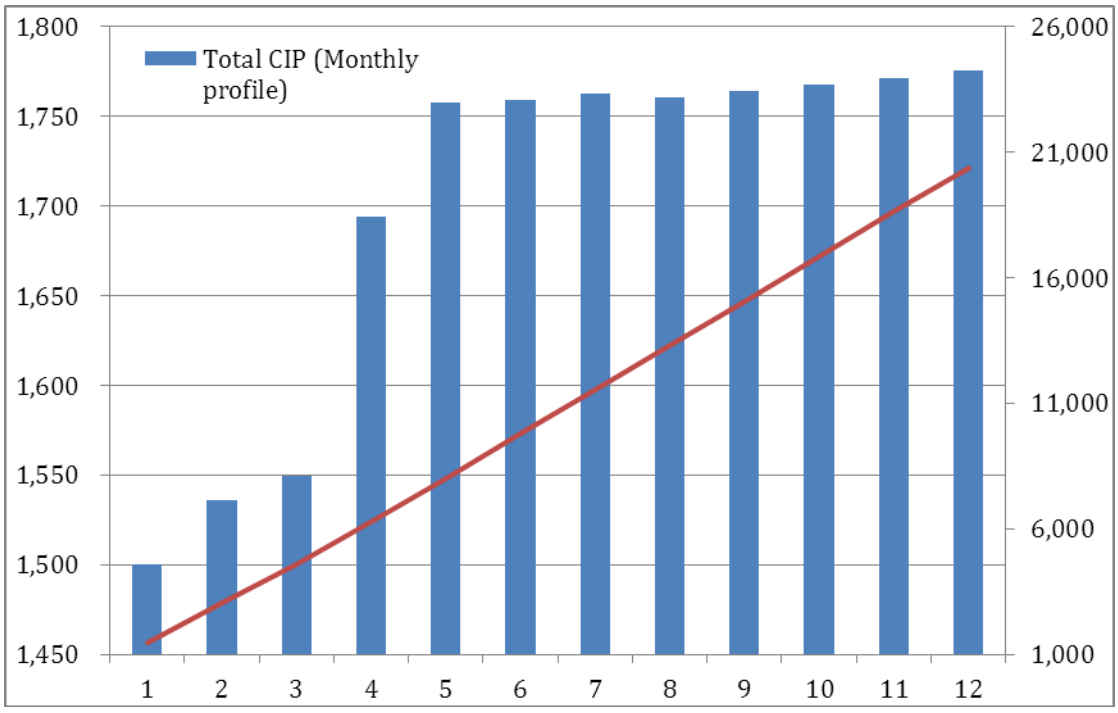
11.3 A matrix approach to developing initiatives was adopted where corporate areas and clinical business units were asked to generate ideas around the following themes and areas:

- Clinical Services Value for Money – Nursing, Medical, AHPs
- Clinical Services Productivity – Beds, Theatres, Adhoc payments
- Back office – Management, Corporate & Clinical Administration
- Non pay Cost Control/Avoidance – Procurement, Blood products, Medicines Management
- Estate review and Commercial Directorate Efficiency

11.4 The Clinical Units have developed plans to deliver a total of £20.4 million savings against these overall themes as shown in the chart below:



11.5 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:



12. Capital Programme

12.1 The provisional 2014/15 capital programme is attached at Appendix 1. It has been discussed and agreed by the Capital Approvals Group (CAG) and the Finance & Investment Committee. 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.

12.2 In setting the 2014/15 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:

- The Trust's routine replacement capital programme is planned within the limit of depreciation.

- Significant capital expenditure is 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 an external prudential borrowing loan with the drawdown phased 2014/15 £17.4 million; and 2015/16 £11.6 million.

- The cost of upgrading and improving Pevensey Ward on the DGH site is included in the £30m Shaping Our Future Clinical Strategy Full Business Case which is currently with the Trust Development Authority for approval. Should there be an unexpected delay with this approval the contingency position around this important project is that the Trust will ensure the necessary work is carried out in 2014/15 to progress the scheme. The project is estimated to have a total cost of £1.7 million and the timing and profile of payments means that the cost will fall across two financial years, this is reflected appropriately in forward capital plans.

- It is planned that medical equipment will be replaced through capital purchase rather than leasing in 2014/15.

- The minor improvements budget has been set at £2.2 million in 2014/15.

- The over planning margin has been set at a level deemed appropriate given the proposed content of the capital programme and this will be kept under review throughout the year.

- In addition, based on historic levels, significant donated funds, principally from the Friends of the Hospitals, are anticipated to be available to the Trust during the financial year.

13. Capital Risks

13.1 The Trust is facing a number of risks in relation to the total value of capital resource available in 2014/15 to meet the capital needs of the Trust. In summary the risks are:-

- The Commercial Division has identified the requirement for significant capital backlog maintenance, infrastructure improvements and electrical supply issues expenditure. The 2014/15 provisional capital programme includes £3.1m for backlog maintenance, infrastructure and supply expenditure.

Expenditure of £2.8 million will also be required for the remainder of the 5 year planning period and beyond in order to reduce the backlog maintenance risk.

- Whilst the additional £5 million capital resource approved by the Independent Trust Financing Facility (ITFF) in 2013/14 has enabled some additional medical equipment replacement, a review of medical equipment has identified there is a need for significant on-going investment to address backlog requirements. In order to remain within the available 2014/15 capital resources the medical equipment replacement group is prioritising the equipment replacement programme. In addition, a 5 year replacement programme is being further refined in order to ensure the sustained delivery of quality services. The CAG will review these priorities and also assess the longer term overall Trust risk arising from the demands for capital expenditure against the available resources.

- The IM&T strategy being developed is also likely to require significant resources over the five year planning period.

14. Financial Risks

14.1 The main risks to delivering the plan for 2014/2015 are as follows:-

- Fines and penalties exceeding planned levels
- Commissioners' QIPP plans yet to be reflected in the plan being more successful than assumed by the Trust leaving the Trust with unused capacity and potentially stranded costs
- Failure to achieve cost improvement targets
- Failure to absorb increases in demographic growth activity through assumed improvements in productivity
- Additional unplanned cost pressures including premium cost delivery
- CQUIN targets not being achieved

15. Conclusion and Recommendation

15.1 The Trust's plans to reduce deficits over the next two years are extremely challenging and will require sustained focus.

15.2 The Board is asked to:

- Agree the overall plan within the 2 year planning context
- Note the financial outlook for 2014/15 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.
- Agree, in the interim, that a provisional working budget is issued to enable budget holders to proceed with the operational management of the Trust, pending issue of a final budget to be approved at the Board meeting on 4 June 2014.
- Provisionally adopt the one year capital programme

Vanessa Harris
Director of Finance

14 March 2014

East Sussex Healthcare NHS Trust

Appendix 1

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Capital Resources	2014/15 £000
Capital Resources:	
Depreciation	11,285
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Provisional Summary Income & Expenditure Forecast Outturn & Plan 2013/14 - 2014/15

Appendix 2

Summary Income & Expenditure Statement	**2013/14 Forecast Outturn £000's**	**2014/15 Provisional Plan £000s**
NHS Patient Income	330,102	327,497
Private Patient/ ICR	3,178	4,139
Trading Income	4,521	4,628
Education	8,563	8,383
Other Non Clinical Income	17,926	17,193
Total Income	**364,290**	**361,840**
Pay Costs	-251,995	-256,595
Ad hoc Costs	-2,139	0
Non Pay Costs	-114,215	-123,266
3rd Party Costs	-900	0
CIP		20,417
Total Direct Costs	**-369,249**	**-359,444**
Surplus/-Deficit from Operations	**-4,959**	**2,396**
Less: Donated Asset Income	*-1,243*	*-1,300*
EBITDA	***-6,202***	***1,096***
Profit/Loss on Asset Disposal	7	0
Depreciation	-11,448	-12,585
Impairment	-10,018	0
PDC Dividend	-6,400	-8,112
Interest	-302	-211
Total Indirect Costs	**-28,161**	**-20,908**
Total Costs	**-397,410**	**-380,352**
Net Surplus/-Deficit	**-33,120**	**-18,512**
Donated Asset / Impairment Adjustment	10,018	0
Normalised Net Surplus/-Deficit	**-23,102**	**-18,512**

East Sussex Healthcare NHS Trust
CIP Summary

Appendix 3
£'000

Back Office (Including Clinical Administration)	3,630
Theatres productivity	850
Medical Agency and Ad-Hocs	3,181
Commercial Directorate Efficiency	2,340
Full Year effect of 2013/14 ward reconfiguration	1,497
2014/15 ward reconfiguration	1,824
Clinical unit non pay	1,079
Medicines Management & Blood Products	662
Trauma move	698
Vacancy control	2,023
Other clinical unit initiatives	2,626
Total	**20,410**

East Sussex Healthcare NHS Trust

Annex E Planning Checklist

1. Introduction

1.1 As part of the planning process set out in the Trust Development Authority (TDA) guidelines Securing *Sustainability,* the Trust has completed a planning checklist to demonstrate compliance with key regulatory requirements. This is in line with the way Foundation Trusts self-certify their compliance with Monitor.

1.2 The checklist comprises the following sections:

- Quality and workforce
- Finance
- Quality, Innovation, Productivity and Prevention (QIPP)
- Innovation
- Sustainability

2. Annexe E Submission – 5th March 2014

The full submission made on 5 March is available although further amendments may be made as part of the final submission on 4 April. The following is a summary of the key areas covered:

2.2 **Quality and Workforce**

1. **Supporting safe services**
   - Early warning systems for deteriorating patients
   - Mortality and morbidity reviews
   - Patient safety thermometer
   - Review of Serious Incidents and Never Events
   - Workforce planning
   - Quality Impact Assessments
   - Nursing review
   - Infection Control
   - Medicine Management and Optimisation

2. **Supporting Effective Services**
   - Clinical Audit
   - Adherence to NICE guidance
   - Arrangements for 7 day working
   - Access for people with mental health issues

3. **Supporting Caring Services**
   - Named consultants and nurses
   - Friends and Family Test
   - Measuring patient experience
   - End of Life Care

4. **Supporting Responsive Services**

- Waiting times
- A and E target
- Cancer targets
- MRSA targets
- C Diff trajectory
- E referrals
- Data quality
- Complaints management
- Adult and child safeguarding
- Recommendations of the children and young people's Forum
- Winterbourne Concordat
- Equality and Diversity

5. **Supporting a Well Led Organisation on Quality**
   - Quality Governance Framework
   - Staff Survey
   - Staff Appraisal
   - Medical Revalidation
   - Nursing Revalidation
   - Quality Account
   - Information Governance Toolkit
   - Quality reporting
   - Engagement strategy for patients staff and stakeholders

2.3 **Finance**

1. Financial planning
2. Pricing
3. CQUIN
4. Operational standards
5. NHS Standard Contract
6. Risk management
7. Capital
8. Triangulation with activity and workforce
9. Strategy

2.4 **QIPP**

1. Planning with commissioners
2. Consultation
3. KPIs and monitoring
4. Risk share

2.5 **Innovation**

1. NICE technology appraisals
2. Innovation Health and Wealth
3. Better Procurement Better Care strategy
4. Research plan
5. Innovation Strategy

2.6 **Sustainability**

1. FT application
2. Clinical and financial sustainability
3. Integrated business planning
4. Long term financial Model
5. Development Plan

2.7 In some areas actions have been identified to strengthen our compliance and these will be taken forward, where appropriate, in the 2014/15 business plan.

JANE RENNIE
Associate Director – Planning and Business Development

14th March 2014

East Sussex Healthcare NHS Trust

Date of Meeting:	26 March 2014
Meeting:	Trust Board
Agenda item:	12
Subject:	Annual Review of the Trust Risk Management Strategy
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

To provide the Trust Board with the updated version (V1.3) of the Trust Risk Management Strategy following its annual review.

Introduction:

The Risk Management Strategy enables the organisation to identify, analyse, evaluate, treat monitor and share learning outcomes from actual or potential risks that may have adverse consequences on the organisation. In addition it provides a framework for the management of risks which will support the Trust to become a risk enabled organisation whereby risk management and internal controls are fully embedded within the organisation.

The Risk Management Strategy was ratified by the Trust Board in January 2012 and reviewed in January 2013. Attached is V1.3 following annual review.

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

The Risk Management Strategy has been subject to annual review and the following changes made:

- Removal of reference to NHSLA assessment / standards (throughout)
- Replacement of Trust Strategic Objectives (page 6)
- Replacement of Statement of Internal Control with Annual Governance Statement (page 14)
- Removal of reference to Divisions (throughout)

Changes are shown in red text for ease of viewing.

Benefits:

By ensuring a robust risk management system is in place within the Trust, risks can be identified, analysed, recorded, managed and reported effectively and escalated where necessary.
Identifying, controlling and mitigating risks to the organisation supports the Trust in achieving its strategic aims and objectives.

Risks and Implications

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

Assurance Provided:
Risk Management Strategy, Risk Management Policy and Procedure and systems are in place although further work is required to update risks in line with recent interim organisational changes.

Review by other Committees/Groups (please state name and date)**:**
Combined Quality and Standards Committee / Patient Safety Clinical Improvement Group on 03.03.14. Amendments requested at this meeting have been made.

Proposals and/or Recommendations
The Board is asked to approve V1.3 of the Risk Management Strategy.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
As documented in the Strategy – point 11 on page 18.

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

East Sussex Healthcare NHS
NHS Trust

Risk Management Strategy

Version:	V1.3
Ratified by:	Clinical Management Executive/Trust Board, Chair Policies Group
Date ratified:	25 January 2012, 20.1.13
Name of author and title:	Emily Keeble, Head of Assurance
Date Written:	January 2012 Reviewed and updated February 2014
Name of responsible committee/individual:	Trust Board
Date issued:	21/01/13
Issue number:	2013034
Review date:	January 2015
Target audience:	All staff
Compliance with CQC outcome	Outcome 16
Compliance with any other external requirements (e.g. Information Governance)	Information Governance Toolkit 301, 302 and 307

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0 2012038	January 2012	Margaret England	New organisation	Full revision
V1.1 2012179	August 2012	Emily Keeble	Organisational change and to meet compliance requirements	Altered to reflect changes in group structures including terms of reference many of which have been updated. Inclusion of patient safety group and divisional quality groups. Development of the monitoring arrangements.
V1.2	January 2013	Emily Keeble	Changes post-NHSLA inspection	Revised monitoring table
V1.3	February 2014	Emily Keeble/Lynette Wells	Annual Review	Removal of reference to NHSLA Replacement of Trust Strategic Objectives Replaced SIC with Annual Governance Statement Removal of reference to Divisions

Consultation Table

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

Name of Individual or group	Title	Date
Amanda Harrison	Director of Strategy and Assurance	Summer 2012

Table of Contents

1. Statement of Intent

East Sussex Healthcare NHS Trust is committed to continuously improving the outcomes for its patients and achieving excellence in patient care. It recognises that it has a statutory and regulatory duty to ensure that systems of control are in place to reduce the impact of any risks that could potentially affect the organisation.

The Risk Management Strategy enables the organisation to identify, analyse, evaluate, treat monitor and share learning outcomes from actual or potential risks that may have adverse consequences on the organisation. In addition it provides a framework for the management of risks which will support the Trust to become a risk enabled organisation whereby risk management and internal controls are fully embedded within the organisation and risk management:

- Systems are in place which works and is understood by staff
- Is a key component in operational and management processes
- Supports the governance processes of the Trust
- Is firmly embedded within the culture of the organisation

2. Introduction

Definition of Risk Management:

'Risk management involves managing to achieve an appropriate balance between realising opportunities for gains while minimising losses. It is an integral part of good management practice and an essential element of good corporate governance. It is an iterative process consisting of steps that, when undertaken in sequence, enable continuous improvement in decision-making and facilitate continuous improvement in performance.'
(Australian Standard, Risk Management AS/NZS 4360:2004).

Risk Management is the term applied to a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process, in a way that will enable organisations to minimise losses and maximise opportunities. It is as much about identifying opportunities as avoiding or mitigating losses.

Risk can be defined as 'the possibility of incurring misfortune or loss,' (Oxford English Dictionary) for example through an unexpected event happening that may either cause harm or have an impact upon patients, staff, visitors, partner organisations, strategic objectives, assets and/or reputation. In particular:

- Any element which has the potential to damage or threaten the achievement of the objectives, programmes or service delivery of the organisation,

- Anything that could damage the reputation of the organisation and undermine the public's confidence in it

- Failure to guard against impropriety, malpractice, waste or poor value for money

- Failure to comply with regulations such as those covering Health and Safety and the environment and the Care Quality Commission (CQC) 'Essential standards of quality and safety'.

- An inability to respond to or manage changed circumstances in a way that prevents or minimises adverse effects on the delivery of services.

East Sussex Healthcare NHS Trust has an expectation that risk management is embedded into all areas of the organisation's operation and an absence of risk is not considered to be positive.

3. Trust Board Commitment

The Trust Board recognises that risk management is integral to good governance and management practice and is committed to ensuring this is firmly embedded within the culture of the organisation. As such, the Risk Management Strategy must be implemented throughout all levels of the organisation.

Risk Management is fundamental to the Trust Board's role in governing the organisation. The governance of the organisation is directed and controlled in order to achieve organisational objectives and the Trust Board are firmly committed to ensuring that good governance and risk management practices are in place.

4. Strategic Objectives

There should be a holistic approach to risk management across the organisation which embraces financial, organisational, clinical and non-clinical risks and in which all parts of the organisation should be involved. The key objective of the Strategy is to take all reasonable steps in the management of risk with the overall objective of protecting patients, staff, the public and assets. A primary concern is the provision of safer, risk free environments together with working policies and practices, which take into account assessed risks. In order to achieve this objective, the Trust will adopt a pro-active approach with a programme of risk management, which aims to preserve its assets and reputation and to provide protection against preventable injury and loss to employees, patients and the general public.

There are three key strategic objectives which the Trust Board uses for assessing and managing risks through the Assurance Framework:

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.

Trust objectives for risk management are to identify and manage risks:

- to the quality of services provided and the safety of patients, their carers and visitors.
- to staff and subsequent risks to service quality.
- to people who use, work or visit the service(s).
- of failing to meet national and local priority targets.

- to the financing and efficiency of services.
- to the reputation of the Trust.

5. Board and Committee Responsibilities and Accountabilities

5.1. Board

The Board is accountable for ensuring the effectiveness of the risk management systems and internal controls within the Trust. The Audit Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and (compliance with CQC registration standards.) The Board is required to gain assurance that all risks have been identified and are being appropriately managed and the Board Assurance Framework appears on the Board agenda bi monthly.

5.2. Audit Committee

The Audit Committee reviews the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In relation to its role in risk management the Committee will review the adequacy and effectiveness of:

- The Board Assurance Framework, risk management system, Annual Governance Statement together with an accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the Annual Governance Statement.

- The Committee shall report issues in relation to audit, risk or internal control to the Board of Directors on an exception basis in addition to an annual report focused on the effectiveness of the Committee in exercising these duties

5.3. Quality and Standards Committee

The Quality and Standards Committee ensure, on behalf of the Board, that taking account of best practice, there are effective structures and systems in place that support the continuous improvement of quality services, safeguard high standards of patient care and evidence effective risk management.

In relation to its role in risk management, the Committee will:

- Review quarterly the principal risks in the Assurance Framework to ensure that they remain fit for purpose, and to make recommendations for revisions to the Trust Board.

- Review and monitor the high level Risk Register for the organisation, ensure that a robust process for the identification of risk is in place, and to ensure that risks

are identified and deployed appropriately at every level throughout the organisation.

- Consider in depth any specific risks that the committee would like further assurance on.

5.4. Finance and Investment Committee

In relation to its role in risk management the Finance and Investment Committee will provide recommendations and assurance to the Board on:

- The future financial risks of the organisation
- The integrity of the Trust's financial structure

The Committees' duties include understanding the business risk environment the organisation is operating within, and helping the Board to agree an appropriate risk appetite for the Trust and where the Board delegates to the Committee the authority to agree specific investment decisions over and above the annual financial plan, they must ensure that the amended plans do not adversely affect the strategic risk facing the Trust

5.5. Clinical Management Executive

The Clinical Management Executive (CME) ensures that the organisation is able to plan and undertake the actions required to effectively deliver its strategic objectives. It ensures the business of the organisation is run effectively, efficiently and in accordance with relevant statutory obligations. Executives have responsibility for ensuring that policies set by the Board are implemented throughout the organisation. They are also responsible for ensuring that the Risk Management Strategy is relevant to the Trusts' strategic context and their goals and objectives, and that it is understood, implemented and maintained at all levels within the organisation.

The CME is the principle body through which the Chief Executive exercises their statutory accountability for the organisation. It is not a formally delegated Committee of the Board and therefore cannot carry out any of the duties of the Board. The Board and the Chief Executive are ultimately responsible for the work of the Trust and CME exists to support the Board and the CEO in delivering the Trust's vision, values and objectives.

The CME meet fortnightly and at each meeting a Clinical Unit or Corporate Function will present their entire Risk Register for review and scrutiny. The High Level Risk Register will be received by the CME every six weeks.

5.6. Patient Safety and Clinical Improvement Group

The Patient Safety and Clinical Improvement Group provides assurance to the Trust Board on matters relating to patient safety. It monitors potential and actual risks to patient safety and as such receives and reviews patient safety entries on the Trust Risk Register in order to monitor the mitigation of these risks. The Clinical Units provide reports from their Quality and Governance (incorporating risk) meetings to the Patient Safety and Clinical Improvement Group. The Patient Safety and Clinical Improvement Group reports into the Clinical Management Executive and has joint meetings with the Quality and Standards Committee.

5.7. Clinical Unit Quality and Governance Meetings

Each Clinical Unit meets monthly to discuss and oversee Quality and Governance matters including risks and issues arising from incidents. A summary of these meetings is submitted to the Patient Safety and Clinical Improvement Group.

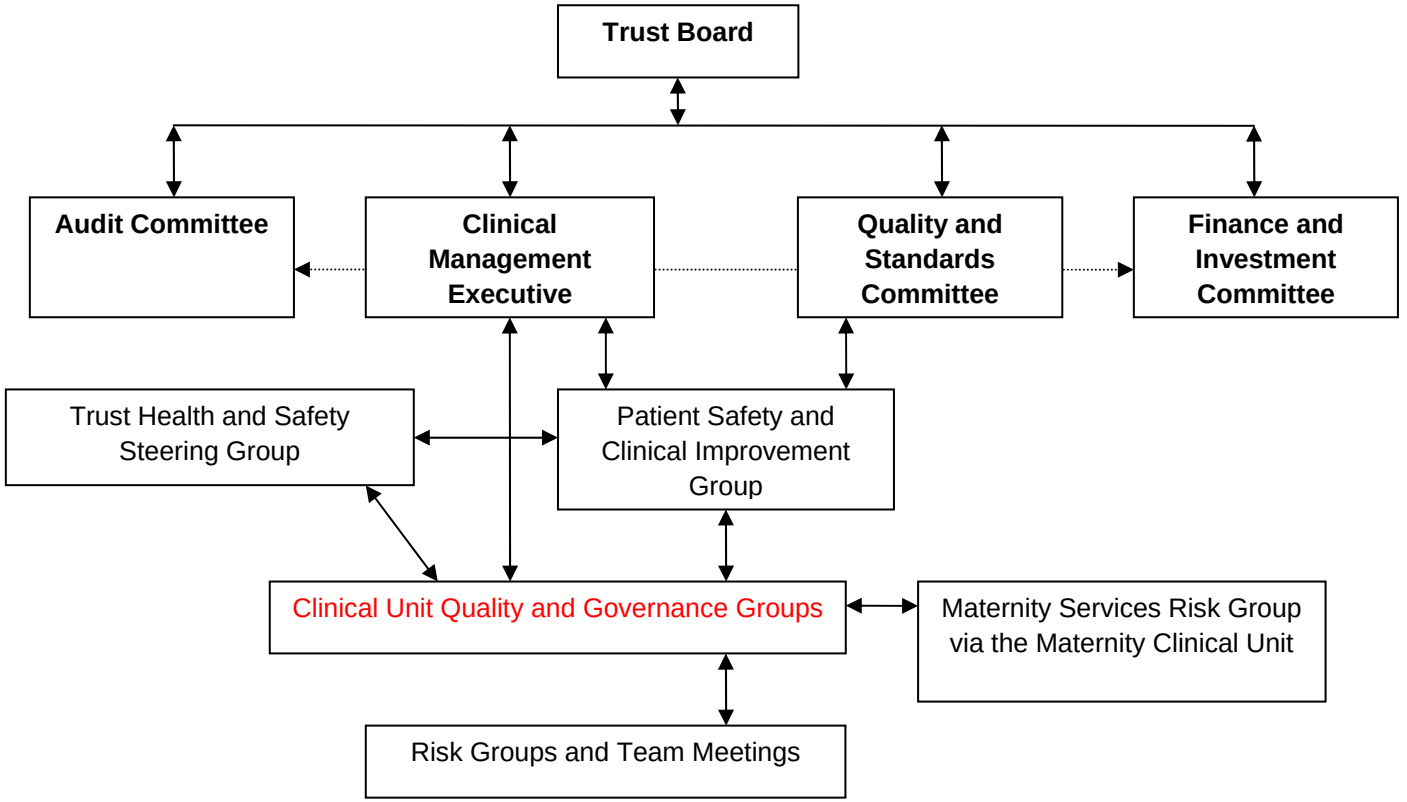
5.8. Corporate Functions – Team Meetings

Within Corporate services for example, Finance, Human Resources, Assurance and Strategy and Operations, functions will hold team meetings at which risks and their risk registers are discussed and reviewed.

5.9. Relationships between Committees

In order to ensure a co-ordinated and holistic approach to the management of risk, there is cross membership between the above committees. All of the above committees are responsible for ensuring that risks in the area of responsibility are managed and reported to the Board appropriately.

Figure 1: Organisational Risk Management Structure



6. Duties of Key Individuals

6.1. Chief Executive

The Chief Executive has overall responsibility for ensuring that an effective risk management system and a system of internal control is in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance. As Accountable Officer, the Chief Executive is, through review of internal control systems, responsible for completing the Annual Governance Statement. The Chief Executive will ensure that the responsibilities for the management and co-ordination of risk are clear and that the structure for risk management outlined in this document are maintained. The Chief Executive has delegated responsibility for the strategic management of risk to the Director of Strategic Development and Assurance. However, in order to fulfil the responsibilities of Accountable Officer the Chief Executive will discuss issues and progress in respect of risk management with the Director of Strategic Development and Assurance, the Medical Director and the Director of Nursing.

6.2. Medical Director/Director of Nursing

The Medical Director and the Director of Nursing have delegated responsibility for ensuring and overseeing the implementation of clinical risk management and clinical governance. They will provide the leadership to ensure the Trust undertakes this function in accordance with best practice, legal and statutory duties and will lead the Trust's approach on achieving compliance with standards relating to patient safety and compliance with CQC standards.

6.3. Director of Strategic Development and Assurance

The Director of Strategic Development and Assurance has delegated responsibility for leading the strategic direction for the organisation, which includes the development and maintenance of appropriate governance systems including those for risk management that ensure effective delivery against Trust business plan targets, Care Quality Commission registration standards and requirements of other regulators and is the lead Director for communications, equality and diversity, Freedom of Information and legal issues.

In addition the Director of Strategic Development and Assurance will ensure:

- The development of relevant Trust strategies, policies and frameworks to support risk management and legal services and monitor their application through the lead managers.
- The convergence of all aspects of risk management by working with Clinical Units to achieve this approach.
- The Trust Board receives regular risk management information as outlined in the Board's information schedule and the Chief Executive and Board are kept abreast of changes in requirements.

6.4. Director of Finance

The Director of Finance has delegated responsibility for ensuring the implementation of financial risk management. Working with the Medical Director, also takes responsibility

for the financial management aspects of assurance processes including those related to risk management.

6.5. Company Secretary

The Company Secretary leads on the development and management of the Board Assurance Framework and ensures that the organisation keeps abreast of best practice, legal and statutory requirements and national guidance.

6.6. Head of Assurance

The Head of Assurance is the Trust lead for Assurance and is responsible for the central assurance team which provides specialist support and advice on the implementation of the Risk Management Strategy and Policy and Procedure.

6.7. Assurance Manager (Risk and Patient Safety)

The Assurance Manager for Risk and Patient Safety will act as a source of specialist expertise and advice and will work with clinical units to ensure that risks are identified, scrutinised and managed effectively.

6.8. Assurance Manager (Health and Safety)

The Assurance Manager for Health and Safety will act as a source of specialist expertise and advice and provide strategic and operational management of the health and safety function for the Trust, working with clinical units to ensure Health and Safety risks are identified, assessed and managed.

6.9. Clinical Unit Leads / Heads of Nursing

Clinical Unit leads and Heads of Nursing are responsible for the implementation of the Trust's relevant strategies and policies which support its risk management approach. They will:

- Ensure that risk management forums are maintained within the clinical units and encourage the integration of risk management and co-ordination of risk assessments, incident reporting, and investigation of incidents/near misses and the management of risks.
- Ensure there is a system for monitoring the application of risk management within the clinical units and that risks are actioned, managed and escalated in accordance with NPSA risk grading guidance and the Trust Risk Management Policy and Procedure.
- Ensure all staff attend relevant mandatory and local training programmes relating to risk management.
- Ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting.
- Ensure the specific responsibilities of managers and staff in relation to risk management, clinical governance and compliance with CQC Standards are identified within the job descriptions for the post and those key objectives are reflected in the individual performance review/staff appraisal process.

6.10. Clinical Governance Managers / Facilitators

Clinical Governance Managers and Facilitators are responsible for implementing the policies of the Trust within the area of their span of control and for ensuring that staff understand and apply the Trust strategy in relation to risk management. This includes ensuring that staff attend all relevant mandatory training. These roles play a key part in the application of the Trust's risk management system and must ensure that risks are identified and managed in accordance with that system by placing them on the risk register. This must be undertaken in accordance with the Trust's risk management policy and procedure.

6.11. Datix Team Manager

The Datix Team Manager has responsibility for the Trust's Datix integrated risk management system, which holds data related to incidents, risks, complaints, claims and PALS contacts and will ensure that the Trust's approach to incident and risk management is compliant with good practice, national and regulatory requirements, legislation, and national standards.

6.12. Emergency Planning Officer

The Emergency Planning Officer, is accountable to the Chief Operating Officer and co-ordinates all emergency and major incident plans and responses, including pandemics, business continuity management, exercises, training and dissemination of relevant documentation and highlights any risks associated with these via the risk management process.

6.13. Information Governance Manager

The Information Governance Manager is accountable to the Head of Legal Services and ultimately the Senior Information Risk Owner (SIRO) and will ensure that the Information Governance Steering Group will review and advise on information risk. The Information Governance Manager will also liaise with other members of the Assurance Team to ensure that risk management elements of the Information Governance Toolkit are compliant.

6.14. All Managers

All levels of management must understand and implement the Trust's Risk Management Strategy and supporting processes and ensure that they have adequate knowledge and / or access to all legislation relevant to their area and as advised by appropriate experts ensure that compliance to such legislation is maintained. They must ensure that adequate resources are made available to provide safe systems of work; this will include making provision for risk assessments, appropriate control measures, raising outstanding concerns, ensuring safe working procedures / practices and continued monitoring and revision of these. They will promote risk management and health and safety awareness among all staff by example and ensure that staff are appropriately trained and competent for assessing risks and determining adequate control measures within the working environment.

Managers must be fully conversant with the Trust's approach to risk management and support the application of this strategy and its related processes and participate in the monitoring and auditing process.

All Managers are authorised to:

- Ensure that appropriate and effective risk management processes are in place within their area of responsibility and that all staff are aware of the risks within their working environment.
- Ensure all necessary risk assessments are carried out within their department.
- Implement and monitor any identified risk management control measures within their scope of responsibility.
- Review a summary of all incidents and risks within their teams and disseminating this information to ensure that appropriate learning takes place.
- Communicate risk management within their departments.

6.15. All staff

All members of staff have an individual responsibility for the management of risk and will:

- Be aware of the Trust's Risk Management Strategy and Policy and Procedure and comply with them.
- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Trust's business.
- Comply with the Incident Reporting and Management Policy by reporting all types of incidents and near misses through the appropriate processes.
- Be responsible for attending any mandatory and relevant education and training events.
- Participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed.
- Report risks to their manager as soon as they are aware of them, and where necessary complete the risk entry form.
- Provide safe clinical practice in diagnosis and treatment
- Comply with all the Trust's rules, regulations and instructions to protect health, safety and welfare of anyone affected by the Trust business.
- Neither intentionally or recklessly, interfere with nor misuse any equipment provided for the protection of health and safety.
- Be aware of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures appertaining to their particular division /unit location

7. Fair Blame Culture

The Trust supports a 'fair blame' culture. Staff reporting or directly involved in incidents, are assured that any investigation will be carried out fairly, without prejudice and with the aim of identifying and correcting the underlying causes of the incident to prevent recurrence.

They will not be subject to disciplinary action or suffer any material loss or disadvantage unless they have been negligent in their acts or omissions or wilfully failed to comply with professional standards and or codes of practice.

8. Annual Governance Statement

Each year the Board is required to produce an Annual Governance Statement which is signed off by the Chief Executive as the Accountable Officer. The Governance Statement records the stewardship of the organisation to supplement the accounts. The document outlines how successfully the organisation has coped with the challenges it faces and of how vulnerable the organisation's performance is or might be. This statement draws together position statements and evidence on governance, risk management and control, to provide a

coherent and consistent reporting mechanism. The Board is required to provide evidence that the principle risks to achieving trust objectives have been identified and are being managed. As such the risk register supports the Assurance Framework in driving the Board agenda.

9. Implementation of the Risk Management Strategy

9.1. Risk Register

The Trust's risk register is maintained as part of the Datix Integrated Risk Management System and is at the centre of the risk management process. A detailed description of the operational implementation of the risk management strategy can be found in the Risk Management Policy and Procedure. It is a dynamic document which changes continually to reflect the nature of risk and the Trust's management of it. Each risk register entry on Datix must record a minimum dataset including the description of the risk, the risk score, a summary risk treatment plan, a date for review and a residual risk rating.

9.2. How Risk is Managed

Risk Registers are held at Clinical Unit level. Clinical Governance Managers / nominated Governance Leads hold risk register entry forms which are to be used when identifying new risks for entry on the risk register (Datix). Clinical Units / Teams / Directorates will review their Risk Registers monthly at their Quality Meetings and the CME receive Divisional/directorate Risk Registers on a cyclical basis. The CME meet fortnightly and at each meeting a Division or directorate will present their entire Risk Register for review and scrutiny. The Trust High Level Risk Register will be received by the CME every six weeks. The Clinical Units / Teams / Directorates are accountable for the assessment, communication and management of risks within their area of responsibility and for providing regular updates Datix in order for the risk register to be kept up to date.

9.3. How the High Level Risk Committees Review the Organisation-Wide Risk Register

The Quality and Standards Committee and the Audit Committee receive the Trust Risk Register on a Quarterly basis. The Trust Risk Register contains all risks with a current score of 15 and above from across the organisation. In addition, the Audit Committee will also request local risk registers for assurance/scrutiny as required. Both the Quality and Standards Committee and the Audit Committee report directly into the Board following meetings escalating risks and issues as necessary. The Board Assurance Framework is also received by the Quality and Standards Committee and the Audit Committee to ensure that it adequately reflects the risks identified on the risk register.

9.4. Risk Management Training

The Trust Board remains committed to the education and development of all staff and recognise its legal and ethical responsibility to create and maintain a work environment that will ensure the welfare, health and safety of staff, patients and the public. A programme of education relating to its application for all levels of staff supports the Risk Management Strategy and its related documents. Targeted education for those staff with specific responsibilities for risk management and health and safety is also undertaken.

The Learning and Development Strategy includes a policy for induction, mandatory training and on-going risk management training. The Strategy makes clear the responsibilities of managers and all staff in meeting the requirements of key training

programmes. The Assurance Manager (Patient Safety and Risk) works with the Learning and Development Department on risk management education and training which supports specific service needs and the sharing of lessons learned from the risk management process. Specialist training advisors in health and safety and moving and handling and medical equipment training also contribute to the high profile placed upon and the commitment to comprehensive risk management training.

9.5. Board Assurance Framework

The Board Assurance Framework is a strategic risk management tool used by the Trust to identify key risks to the achievement of its aims and objectives. The Board Assurance Framework is used by the Trust Board to ensure that all identified risks are focused upon and that effective controls are in place thus providing assurance that a robust risk management system underpins the delivery of the organisation's principal aims and objectives. It highlights gaps in the effectiveness of controls or of assurance and informs the Board of the areas where it should be scrutinising the controls the organisation has in place to manage the principle risks.

9.6. Communication

Following ratification this Strategy is placed on the Trust's Intranet and all staff notified by email. Managers are responsible for ensuring that all staff develop an awareness of risk. All directors, heads of clinical units and managers are responsible for ensuring that all staff are aware of the document. On notification of a revised version of the procedural document, managers are responsible for the destruction of the superseded paper based version if one exists in their area. Further supporting information is available on the Risk Management pages of the Trust Intranet.

10. Performance Monitoring

Compliance with the minimum requirements set out below will be monitored within the Trust's Assurance Team.

Performance Monitoring Table:

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
1.1c) How risk is managed locally	Assurance Manager – Patient Safety and Risk	Detailed audit and examination of 5 risks (one per Division / Directorate) from identification through the process every 3 months.	Quarterly	Clinical Management Executive Audit Committee	Clinical Unit Lead Head of Nursing	Clinical Unit Risk Groups

11. Equality and Human Rights Statement

An equality impact assessment has been carried out in order to establish that this policy does not discriminate or have a detrimental impact upon employees or service users on the grounds of disability, age, race, gender, sexual orientation, religion or belief. The issues to note are:

1) To ensure equal access to risk management staff training
2) To consider equality, discrimination and human rights related risks for inclusion on risk registers
3) To recognise the Equality and Human Rights Commission as an external inspector
4) To consider the Equality and Human Rights Analyses (EHRA) when assessing relevant risks

12. Copy Available

An electronic copy of this document is available on the Trust Intranet page under 'document search'.
Stakeholders can access a copy through the Trust website.

13. Strategy Review Arrangements

This Strategy is ratified by the Trust Board and will be reviewed annually in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of the Trust.

14. Supporting and Related Documents

The Risk Management Strategy should be read in conjunction with:

ESHT Risk Assessment (General) Policy
ESHT Health and Safety Policy
ESHT Incident Reporting and Management Policy
ESHT Risk Management Policy and Procedure
ESHT Learning and Development Strategy and Policy
ESHT Mandatory Training Policy

15. Useful References

Public Interest Disclosure Act 1998 (Department of Health circular HSC 1999/198)
NHSLA Risk Management Standards 2011/12
Health and Safety at Work Act 1974
Governance in the NHS (HSC2000/005) NHS Executive (February 2001)
Governance in the NHS Statement on Internal Control 2001/2002 and Beyond (including supplementary guidance) of 2002/2003 NHS Executive (March 2002)
NPSA 'Healthcare risk assessment made easy' (March 2007)
Australian Standard, Risk Management AS/NZS 4360:2004

Appendix A – Staff Feedback Form

Please complete this form if you would like to make a comment on the procedural document you have just read. Your feedback will be held by the Assurance Manager and your views will be taken into account at the next review date of the document.

Title of the procedural document:	
Date of next review:	
Your name (optional):	
Date today:	
Your comments:	

Thank-you for your feedback

Please forward this form to: **Assurance Manager (NHSLA)**

East Sussex Healthcare NHS Trust

Date of Meeting:	26 March 2014
Meeting:	Trust Board
Agenda item:	13
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: Richard Sunley, Chief Operating Officer	**Contact details:** 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 ea 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

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	14
Subject:	Bedside Monitoring (VitalPAC) Business Case
Reporting Officer:	Richard Sunley, Deputy Chief Executive/Chief Operating Officer

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

Purpose:

The VitalPAC business case was approved by the Chairman following recommendation by the Finance and Investment Committee in order to meet Trust Development Authority deadlines and requires Board ratification of the Chairman's decision.

Introduction:

The Trust has been successful in a bid to The Safer Hospitals, Safer Wards Technology Fund and has secured central funding of £821,601. The fund supports rapid progression from paper-based systems to integrated digital care records (IDCRs).

The Trust was successful in the two-stage assessment process culminating in a panel interview in London. The process involved a high level of financial scrutiny of the project by NHS England and the Treasury.

VitalPAC is a medical system using hand-held mobile technology that enables nurses to collect vital signs observations on admission and throughout an inpatient stay. Combined with data from Patient Administration, pathology, microbiology and radiology systems, VitalPAC identifies high risk and deteriorating patients and immediately alerts the relevant doctor on their mobile device.

VitalPAC addresses the fundamental question of "who, where and how is my patient?" so that interventions can be started earlier, reducing complications and unnecessary mortality. Doctors' actions are recorded on mobile devices and made available anywhere on the hospital network, providing assurance of compliance with protocol.

Consultants and senior nurses can therefore check, at any time, that their patients are being monitored appropriately and their care promptly escalated when needed. Key benefits are: fewer deaths; shorter length of stay; fewer ICU admissions; fewer cardiac arrests; and fewer outbreaks of infection.

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

The business case was reviewed in detail by the Finance and Investment Committee on 22nd January 2014 and was recommended for Chairman's approval due to the requirement to meet the Trust Development Authority deadlines. Copies of the business case are available for Board members on request from the Corporate Governance Manager.

Proposals and/or Recommendations

The Board is asked to ratify the Chairman's approval of the business case.

For further information or for any enquiries relating to this report please contact:	
Name: Richard Sunley, Deputy Chief Executive/Chief Operating Officer	**Contact details:** r.sunley@nhs.net

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	15
Subject:	Board Sub-committee Reports and Trust Board Seminar Notes
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

The attached report provides a summary of the meetings of the Board sub-committees and the notes of Trust Board seminars held since the last meeting.

Introduction:

The following committees have been established as formal sub-committees of the Board.

- Audit Committee
- Finance and Investment Committee
- Quality and Standards Committee
- Remuneration and Appointments Committee

It is best practice for each Committee to summarise key points from their meetings and share these with the Board along with formal minutes of the meeting. The Board has also agreed that notes of the Trust Board Seminars will be circulated with the Trust Board agenda papers.

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

The attached reports provide a summary of the key discussion points at each of the sub-committee meetings that have taken place since the Board last met.

Benefits:

This practice will increase Board awareness of key issues being considered by its sub-committees.

Risks and Implications

Failure to implement the arrangement effectively may result in Board members being unaware of key issues within the Trust.

Assurance Provided:

This report provides the Board with assurance that effective governance arrangements are in place.

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

Not applicable.

Proposals and/or Recommendations

The Board is asked to review and note the documents.

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

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Lynette Wells, Company Secretary	(13) 4278

East Sussex Healthcare NHS Trust

AUDIT COMMITTEE

1. Introduction

1.1 Since the last Board meeting an Audit Committee meeting has been held on 5th March 2014 and a summary of the matters discussed at this meeting is provided below.

1.2 The minutes of the meeting held on 8th January 2014 are attached at Appendix 1.

2. Board Assurance Framework and High Level Risk Register

2.1 The Company Secretary presented the Board Assurance Framework (BAF) and it was reviewed and discussed by the Committee.

3. Clinical Audit

3.1 The Head of Assurance presented an update report and the Committee noted the significant process that had been made in relation to the clinical audit process which was supported by a significant assurance opinion from a recent internal audit review. It was agreed that the next steps were to provide a process that informed the Audit Committee of the assurances provided by those audits, the risks identified and how they were being addressed.

4. Review of Integrated Care Clinical Audit Forward Plan and Risk Register

4.1 The Committee received an update on the integrated care clinical units' progress with their clinical audits and undertook an in-depth review of its risk register.

5. Local Counter Fraud Service

5.1 The Committee received the progress report and noted the actions being taken in respect of on-going investigations.

6. Local Counter Fraud Service Tender

6.1 The Committee noted the appointment of TiAA as providers of local counter fraud services with effect from April 2014 and were assured of the process undertaken in awarding the tender.

7. Internal Audit

7.1 The Committee received the progress report and noted that four audits had been completed since the last meeting and reviewed their conclusions.

7.2 The Committee received the first draft of the internal audit plan for 2014/15 and noted that this would be discussed with executive directors and the final version would come to the next meeting for approval.

7.3 The Committee reviewed the audit recommendations tracker and noted the good progress being made in completing audit recommendations.

8. External Audit

12.1 The external auditor presented the external audit plan for 2013/14 and updated on progress against the plan.

12.1 He also presented the planning letter for 2014/15 which was noted by the Committee.

9. Payroll Authorisation Project

9.1 The Director of Finance advised that the project had now been concluded and noted that 100% compliance had been achieved on the bi-annual exercise to verify that all staff were on the payroll and their correct hours noted.

10. Annual Governance Statement

10.1 The Company Secretary presented the first draft of the Annual Governance Statement for 2013/14 and noted that data was still awaited which would not be available until after the year end.

11. Information Governance Toolkit Submission

11.1 The Committee approved the year-end submission at a minimum of 69% and noted that there were four standards at level 3.

12. Internal Reports

12.1 The Committee received reports on the following areas:

- Changes in Accounting Policies
- Tenders and Waivers
- Review of declarations of interests, gifts, hospitality, sponsorship and ex gratia payments

James O'Sullivan
Audit Committee Chairman

18th March 2014

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 8th January 2014 at 9.30 am in the Committee Room, Conquest Hospital

Present: Mr James O'Sullivan, Non-Executive Director (Chairman) (for item 5 onwards)
Ms Stephanie Kennett, Non-Executive Director (acting Chairman for items 1-4)
Mr Barry Nealon, Non-Executive Director

In attendance Mrs Vanessa Harris, Director of Finance
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary
Mr Leigh Lloyd-Thomas, BDO
Mr Mick Fyfe, South Coast Audit
Mr Mike Townsend, South Coast Audit (item 4 onwards)
Mr Alex Hughes, Deloitte
Mr Steve Hoaen, Head of Financial Management (item 5 onwards)
Dr Janet McGowan, Associate Director – Clinical Governance (for item 4)
Mrs Linda Eades, Payroll Manager (for item 9)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

Action

1. Welcome and Apologies for Absence

The Chairman opened the meeting and noted that a quorum was present.

Apologies for absence had been received from Dr David Hughes, Medical Director – Clinical Governance, Richard Sunley, Deputy Chief Executive/Chief Operating Officer and Dr Amanda Harrison, Director of Strategic Development and Assurance.

2. Minutes

i) The minutes of the meeting held on the 6th November 2013 were reviewed and agreed as a correct record.

Mrs Wells advised that a minor revision had been made to the Standing Financial Instructions (considered at Nov Board) page 29 to reflect current Equality Act legislation and the revised document had been uploaded to the Trust intranet.

ii) Matters Arising

Tenders and Waivers

Mrs Wells reported that she had asked Mr Binks to provide an update on the companies involved in the waivers but he had not provided this information. She would ask him to provide this information for all future reports. **LW**

3. Board Assurance Framework & High Level Risk Register

Mrs Wells presented the report and noted that it had been reviewed at the Quality and Standards Committee earlier in the week alongside the Patient Safety Risk Register.

She advised that there were two red risks on the Board Assurance Framework relating to finance and recruitment.

Mrs Wells reported that she had reviewed those risks on the high level Risk Register where it appeared that they had not been updated for a period of time. She advised that updates had been provided and dated but managers needed to update the review date box on the Datix system to show that it had been updated and they would be reminded to do this.

Mrs Webster queried the details in relation to the new risk in respect of a corroding fire escape including its location and whether remedial works had been carried out to ensure it was safe to use in the interim. Mrs Wells would ask Mr Paice to provide an update which she would circulate once received. **LW**

Mrs Harris queried those risks where the assessment for adequacy of controls was uncontrolled and suggested that these should be reviewed to understand the measures required to ensure that the adequacy was controlled. Mrs Wells agreed to follow this up. **LW**

The Committee noted the Board Assurance Framework and the High Level Risk Register.

4. Clinical Audit Forward Plan Update

Dr McGowan presented the report and acknowledged the work undertaken by Ms Keeble to progress clinical audit to this point.

She reported that a number of the outstanding audits from previous years had either been abandoned or there were valid reasons for incompletion which were outlined on the Forward Plan. She reported that the Trust was mandated to undertake priority 1 audits and for 2012/13 there were just over 20 such audits outstanding.

Dr McGowan reported that analysis showed that approximately half were NCEOPD audits and, whilst the data collection had been undertaken, the national report was awaited. The other half related to NICE guidance and colleagues were being encouraged to complete these.

She advised that there were a large number of incomplete audits for this year but anticipated that a reasonable number would be completed by March and noted that a number of audits started later in the year would not be completed by March and would go forward into the next year.

Dr McGowan reported that Ms Keeble had devised a format to map audit progress month by month and Clinical Units were being asked to regulate audits times to enable audits to be completed.

Ms Kennett asked why a number of new audits being registered were not necessarily on the audit plan. Dr McGowan explained that these were usually priority 4 audits initiated by trainee doctors and did not require any audit facilitator resources.

Mr Nealon asked if penalties or fines were applied if audits were not completed and Mrs Wells stated that there were no penalties or fines, unless CCGs invoked these through contractual mechanisms, but the risk was reputational in relation to priority 1 audits. She highlighted that there was one national audit which the Trust would not be complying with as it did not have the software required for completion, this had previously been highlighted to the Committee and the Clinical Commissioning Groups notified.

Mrs Harris queried why one of the priority 1 audits had no audit lead and Dr McGowan advised that the original audit lead had left the Trust and another doctor was being sought to take it forward.

Dr McGowan advised that steady pressure was being applied to the clinical units to be proactive with audit management.

She reported that Ms Keeble would be starting work on the 2014/15 forward plan shortly.

The Committee noted the update on the Clinical Audit Forward Plan.

5. Internal Audit

a) <u>Progress Report</u>

Mr Fyfe reported that three final audit reports had been issued -

Business continuity – significant assurance
Infection control – limited assurance
Pay health check review – significant assurance

and seven audits were currently in progress.

He reported that the infection control audit had been presented to the December Infection Control Steering Group and it had been agreed to formulate one C Diff action plan encompassing the actions from the Trust action plan, the TDA report and the South Coast Audit report. Mrs Webster reported that Mrs Lloyd had advised her that the action plan would be completed by the end of the week. Mr Fyfe advised that the issues identified by internal audit mostly related to quality of record keeping in the patient records.

Mrs Webster advised that the action plan would be monitored through the Infection Control Steering Group which reported to the Clinical Management Executive but also through the Patient Safety Group and the Quality and Standards Committee.

Mr Fyfe reported that there had been a marked improvement in the quality of payroll controls although there were still issues in relation to locums to be resolved. Mrs Harris was pleased that a significant assurance opinion had been provided for payroll authorisation and assured the Committee that there were plans to address and strengthen controls around locums which internal audit would be asked to retest and provide further assurance.

Mr Fyfe reported that the audit plan was on target and advised that the scope and objectives of the capital expenditure audit had been agreed and it would start at the end of the month. Mrs Harris reported that internal audit would be also be liaising with estates in relation to the audit.

Mr Fyfe reported that the Cost Improvement Programme audit would include linen expenditure and controls within the Trust.

The Committee noted the South Coast Audit progress report.

b) <u>Audit Recommendations Tracker</u>

Mrs Wells reported that there were 44 outstanding actions from South Coast Audit reports, of which 6 were rated red, and 5 from BDO reports.

Mrs Harris queried whether the older recommendations where no progress had been recorded for some time could be reviewed and a decision made on whether they would be addressed or not. Mrs Wells agreed to take this forward. **LW**

Mr Nealon queried how the impact of the turnaround projects were being tracked in terms of audit and Mrs Harris advised that the projects focused on reducing usage of temporary workforce, ad-hocs and 3rd party sendaways. These areas would be included within the scope of Cost Improvement Programme audit.

Mrs Webster reported that the projects had a quality impact assessment agreed before they went live and then were reviewed at various stages for any unintended consequences.

The Committee were assured of the progress made in recording and implementing audit actions.

6. Local Counter Fraud Service

a) Progress Report and Investigations Update

Mr Hughes reported that Deloitte was in the process of being sold to new accounting firm of Mazars at 31st January but assured the Committee that there would be no change to the delivery of the service and the key contacts would remain the same.

Mr Hughes advised that he had agreed with Mrs Harris additional proactive work around tendering and procurement and outlined how this would be completed.

He reported that as at 20th December 60 proactive counter fraud days had been delivered against a total of 85 and 21 investigation days had been delivered. Two referrals had been received relating to right to work visas but in both cases no concerns were identified.

He reported on the 3 proactive exercises undertaken:

Falsely claimed expenses – some higher than expected claims had been identified and further testing was being undertaken and he would provide an update at the next meeting. A new expenses policy was in the final stage of review and he would work with the Trust on publicising this and Mrs Harris stated that this would include reminding staff of the mileage calculator available.

Right to work status – no exceptions had been identified but a recommendation had been raised in respect of two employees to ensure that the Trust had the appropriate information to verify the validity of their visas.

Individuals working elsewhere on sick leave – information identified during the exercise had been passed to the HR department for further consideration.

Mr Hughes advised that he was in the final stage of the proactive exercise in respect of budget holders.

He presented an update on the referrals received since the last meeting and the progress being made with investigations.

The Committee noted the progress report and investigations update.

7. External Audit

a) Progress Report

Mr Lloyd-Thomas reported that for 2013/14 Trusts were required to consider the need to consolidate charitable accounts within their main accounts.

He advised that guidance was awaited from the Department of Health and, if the Trust decided not to consolidate the charitable accounts through the grounds of materiality, it would need to put a disclosure to this effect in the main accounts.

He confirmed that the draft financial statements would need to be submitted to the Department of Health by 23rd April and the audited statements by noon on Monday, 9th June.

He anticipated that in relation to use of resources he would probably be issuing a qualified opinion again for 2013/14 due to the Trust's challenging financial position.

Mr Lloyd-Thomas outlined how the review of stock counts were undertaken and Mrs Harris identified that the Trust needed to provide a strengthened finance presence at the stocktakes for departments holding high value items.

The Committee noted the external auditor's progress report.

8. Audit Fees for 2014/15

Mrs Harris reported that Mr Lloyd-Thomas would provide a report to the next meeting on the external audit fee which was set by the Audit Commission.

She advised in relation to the internal audit service she had received written assurance from Sussex Community Trust in relation to the contingent liability and the contract had been extended for one more year under waiver. The draft internal audit plan and associated fee would come to the March meeting for approval.

Mrs Harris reported that the Trust had gone out to tender for the counter fraud service on 31st December 2013 and a decision would be made on 12th February.

9. Tenders and Waivers Report

Mrs Wells presented the report and would provide the further information required on waivers outside the meeting and ensure that it was included in future reports. **LW**

She advised that 5 contracts had been awarded against tenders totalling £1.929 million.

The Committee noted the report.

10. Review of Aged Debts

Mr Hoaen reported that the NHS provided the majority of the Trust's debt and, due to its current cash position, the Trust was tending to prioritise payments to non-NHS organisations, and other NHS organisations were taking a similar approach. .

Mr O'Sullivan queried how the public sector sundries of £500,000 were made up and Mr Hoaen would provide this detail outside of the meeting. **SH**

The Committee noted the report on aged debts.

11. Review of Losses and Special Payments

Mr Hoaen presented the report and noted that there had been a significant write-off of pharmacy stock which covered items such as out of date medication.

Mr Nealon asked what happened if money was outstanding and Mr Hoaen explained the Trust would make a bad debt provision. For some areas this was set down in law, eg Injury Cost Recovery (RTA) income – 15%, and in relation to general bad debts it was identified if material values were at risk. Mr Lloyd-Thomas advised that this covered areas such as overseas patients.

The Committee noted the review of losses and special payments report.

12. Information Governance Toolkit (IGT) Update

Mrs Wells advised that the report covered two aspects – compliance with the IGT and a summary of information governance (IG) incidents.

She reported that the Trust was reporting 57% compliance with the IGT and aiming for a year end target of 67%. She advised that internal audit had audited 15 of the requirements and their report was awaited but she was confident that the Trust would achieve the year end target.

She reported that there had been 35 IG incidents reported with 34 graded as 'negligible/none' and 1 as 'low/minor'. She had asked the IG Manager to benchmark the Trust's position against other NHS organisations and report back to the next Information Governance Steering Group.

The Committee noted progress with the IGT Submission.

13. Payroll Authorisation Project

a) Payroll Review

Mrs Harris reported that as part of the payroll authorisation project the bi-annual exercise had been undertaken to verify that all staff were on the payroll and had their correct hours recorded.

Mrs Eades reported that there had been 88% compliance with the exercise and 12 areas (855 members of staff) were still outstanding. Mrs Harris would be personally following up non-compliance with the individual managers and, if they did not comply, would ask them to attend the next Audit Committee meeting to explain their reasons for non-compliance. **VH**

Mrs Eades reported that one overpayment in terms of excess hours for a member of staff had been identified which had stemmed from the introduction of Agenda for Change and the individual had not increased their hours. The overpayment totalled approximately £1,000 over 5/6 years.

Mr O'Sullivan was pleased to see the progress made and asked whether this now addressed the issues raised by BDO. Mrs Harris noted that there were still issues in relation to locums but these would be tracked through as an audit recommendation.

Mrs Eades reported that it was planned to standardise the procedure for the request of locums which would require one authorised signatory and be monitored by the Temporary Workforce Service team.

Mr Lloyd-Thomas noted from the internal audit report that the majority of overpayments related to bank and ad-hoc claims rather than permanent payroll.

Mrs Eades reported that the roll-out of e-rostering to nursing and midwifery staff had reduced the number of overpayments in this respect and the lists of authorisations were being matched with the e-roster database.

Mrs Harris reported that Mr Hughes would be undertaking a sample of returns made as part of the pro-active counter fraud work.

b) Healthroster project update

Mrs Harris reported that all nursing and midwifery areas had now been implemented and the next areas would be the Temporary Workforce Service and Facilities which would take until the summer and the decision would then need to be taken as to whether to move ahead with the corporate areas.

The Committee noted the reports on payroll authorisation and the good progress made and the update on the roll-out of e-rostering.

14. Date of Next Meeting

Wednesday, 5th March 2014, at 9.30 am in the St Mary's Board Room, Eastbourne DGH

Signed: ……..

Date: ……

East Sussex Healthcare NHS Trust

Finance and Investment Committee

1. Introduction

1.1 Since the Board last met a Finance and Investment Committee has been held on 26 February 2014. A summary of the items discussed at the meeting is set out below.

2. Performance Report – Month 9

2.1 The Committee received the month 9 Performance Report which detailed the Trust's in month performance against the National Performance Framework metrics as described in the National Operating Plan for 2013/14.

2.2 It was noted that Month 9 performance fell below the required standard moving the Trust into "Under-Performing" Status for the first time. This was primarily due to a single MRSA breach and under performance in Referral to Treatment (RTT) due to planned backlog clearance.

3. Finance Update –Month 10

3.1 Mrs Harris provided the Committee with an update on the month 10 financial position and the change in forecast outturn.

3.2 It was noted that there was an in month surplus of £1 million which was £300,000 better than the expected recovery trajectory of £700,000. Cumulatively the deficit had decreased to £21.3 million but was £1.4 million adrift from the expected recovery trajectory of £19.9 million.

3.3 As signalled at M9 the forecast outturn position had been reviewed in detail at M10 and the deficit is now expected to be £23.1 million.

3.4 The committee received a detailed commentary on the M10 financial position.

3.5 The income position had improved in month after taking into account agreement reached with commissioners over the value of fines and penalties to be applied/reinvested. Expenditure in Month 10 had slightly improved over M9 and there was a continued reduction against M1-6 average.

3.6 The background to the impairment recorded in M10 and its impact was explained.

4. PDC (Public Dividend Capital) Application

4.1 Mrs Harris reported that the Trust's application for 2013/14 cash in the form of non-repayable Public Dividend Capital (PDC) had been successfully concluded.

5. Cash Update

5.1 Mrs Harris updated the Committee on the cash position at 18 February 2014.

5.2 It was noted that the cash position has been very difficult throughout the financial year because of the planned deficit and historically high level of creditors.

£34.4 million of permanent PDC and £2.718 million of Emergency Capital PDC was received on the 17 January 2014. A further £2.282 million of Emergency Capital PDC will be received on the 3 March 2014. £29 million of temporary borrowing was repaid on the 17 January 2014. Accrued contract income was also received in February. The cash received had relieved the pressure on supplier payments which should allow the Trust to meet the Better Payment Practice Code (BPPC) targets for March.

5.3 The Committee received a snapshot of the trade creditor position at 18 February 2014 which showed a much improved position compared with that at M10.

6. Turnaround Update

6.1 Progress was being made as demonstrated by the M10 financial results (see above).

7. Financial Planning 2014/16

7.1 Mrs Harris made a presentation on Business Planning 2014/16. A two year Plan submission was due to be filed at the Trust Development Authority (TDA) on 5 March 2014. A final two year plan was due on 4 April 2014.

7.2 Every clinical unit with support from their respective director, finance and turnaround had been involved in preparing their 2014/16 plans over the last few weeks. A ward establishment review had also been carried out at the same time and planned staffing levels adjusted accordingly. This rigorous approach had ensured all units understood and owned their financial plans.

7.3 The income and expenditure position of the Trust over the next two years was described and noted. A deficit position was planned in both years. The 2014/15 position had worsened from a £14.9 million deficit as at the initial submission date of 13 January 2014 to a £18.5 million deficit. The reasons for this were explained. The two year positions did not include the impact of commissioner QIPP plans as no detail in respect of these plans had yet been received. In the meantime a provisional amount of £2 million had been included as QIPP in ESHT's plans.

7.4 Mr Murphy explained that the Cost Improvement Plans (CIPs) were themed around five areas: Clinical Services value for money; clinical services productivity; back office; non-pay cost control/avoidance and estate review and commercial directorate efficiency. Current plans totalled £20.4 million in 2014/15 and £20 million in 2015/16. They represented 5.6% of turnover.

7.5 Mr Murphy and Mrs Harris explained the key assumptions and issues within the plans. These would be discussed further at the Board scrutiny day with clinical units scheduled for 12 March 2014.

7.6 Mr Murphy outlined the key clinical investments totalling £3.4m in quality/safety/operational delivery that had been agreed as part of the clinical unit/ward establishment reviews and 2014/16 budget setting.

7.7 The Executive Plan approval process was noted. In addition to quality and safety sign off at clinical unit level, an all-day Quality Impact Assessment workshop was scheduled for 4 March. Clinical units would present their detailed budgets to the Board on 12 March 2014.

8. Community Rebasing Project

8.1 Mr Astell gave a progress update on the Community Rebasing Project.

8.2 Initial work on the identification of costs by individual community service and the appropriate alignment of funding by commissioner had been completed and shared with the relevant Clinical Commissioning Groups (CCGs). The two engagement meetings held to date had helped to strengthen the draft funding matrix, although there remained a small number of material queries.

9. EBITDA – Gynaecology Review Follow up

9.1 A deep dive into the Gynaecology Qtr 4 2012-13 was undertaken and presented at the September 2013 Finance & Investment Committee. Attendees at the meeting gave an update on the follow up work that Gynaecology had undertaken since this presentation with comparisons to Qtr 2 2013-14.

10. Market Testing Programme –Crèche Transformation Plan

10.1 The Committee received the Crèche transformation plan which provided an improvement in efficiency and a number of options for consideration.

10.2 The transformation plan was discussed at the Corporate Leadership Team (CLT) and the Clinical Management Executive (CME) in February 2014. The recommendation is:

- to agree that crèche is not a core service but a highly valued one
- to note a 5% increase in average fees from April 2014
- to agree that, if possible, crèche provision should continue on both sites
- to agree that this is a service where a partnership approach is preferred to encourage private sector investment and the continuance of the service for Trust staff.

11. IM&T Update

11.1 Mr Deal presented a progress report on the proposed implementation of the key IM&T projects due to be implemented in 2013/14 & into 2014/15. The report provided a summary status position for each of the following projects:

- Community and Child Health system
- NHS Mail Migration
- Southern Acute Programme - Electronic Document Management and Clinical Portal
- Electronic clinical correspondence
- Acute PAS re-procurement and PAS upgrade project
- VitalPac patient bedside monitoring
- Psuedonymisation
- Windows 7 / Office 2010 migration
- Philips PACS / RIS

12. Work Programme

12.1 The revised 2014 draft work programme was reviewed.

13. Conclusions

13.1 The Trust Board to note:

- The Committee reviewed the Performance Report for month 9 and the Finance Report for month 10
- The satisfactory conclusion of the PDC (Public Dividend Capital) application
- The cash update and improved creditor position

- Turnaround progress
- The Committee reviewed and noted the update on the financial planning process for 2014/16
- The Committee noted the further progress made on the Community Rebasing Project
- The Committee noted the Gynaecology follow up position and noted that they continue to strive to improve their EBITDA position whilst improving patient care
- The recommendation on the Crèche Transformation Plan
- The IT Projects Update
- The Committee reviewed the 2014 work programme

Barry Nealon
Chair of Finance and Investment Committee

4th March 2014

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 11th December 2013 at 2pm in the John Cook Room, EDGH

Present
Mr Barry Nealon, Non Executive Director (chair)
Mr James O'Sullivan, Non Executive Director
Mrs Vanessa Harris, Director of Finance
Mr Philip Astell, Interim Deputy Director of Finance
Mr Stuart Welling, Chairman (part)
Mr Richard Sunley, Deputy Chief Executive/Chief Operating officer

In attendance
Mrs Jo Brandt, Head of SLR (for items 5 and 6)
Mr Andrew Murphy, Turnaround Director (for item 7)
Ms Lesley Walton, IT Programme Manager (for item 9)
Mr Andy Horne, Market Testing Programme Director (for item 10)
Mr Christian Lippiatt , General Manager for Occupational Health (for item 10)
Mrs Paula Hunt, Clinical Lead for Occupational Health (for item 10)
Miss Chris Kyprianou, PA to Finance Director (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee. Apologies were received from Stephanie Kennett, Darren Grayson and David Hughes.	**Action**
2.	**Minutes of Meeting of 20 November 2013** The minutes of the meeting of 20 November 2013 were agreed as an accurate record.	
3.	**Matters Arising** (i) Finance Update - Month 7 Following a query at the last meeting Mr Astell confirmed that the line showing high cost drugs had been removed from both income and expenditure and was shown on a separate line for the M8 internal report, however it was noted that it would not be appropriate to remove this line in the published accounts that are presented to the Board.	

	(ii) Update on CRES Position Mr Murphy provided an update as part of agenda item 7 (below) (iii) SLR Report on T&O It was noted that T&O had been added to the work programme for January 2014.	
4(i)	**Performance Report – Month 7** The Committee received the month 7 Performance Report which detailed the Trust's in month performance against the National Performance Framework metrics as described in the National Operating Plan for 2013/14. The main indicators had been reviewed by the Board in private session on 27 November 2013. **Action** **The Committee noted the Performance Report for month 7.**	
4(ii)	**Finance Update – Provisional Month 8 Flash Report** Mrs Harris provided the Committee with an update on the month 8 financial position. There was an in month deficit of £1.2m. Compared to the original TDA plan the Trust was overspent by £8m ytd at month 8. The Trust had over achieved by £.9m compared to the in year FRP planned in month deficit of £2.1m. M8 income was better than Plan but expenditure remained above Plan. However, it was noted that pay costs had reduced in month. Mr Astell shared a M8 income analysis with the Committee. There had been an improvement within the month as both income from non-elective and elective activity had increased. The Committee also reviewed the M8 expenditure in more detail and noted the comparison to the previous monthly average. High costs drugs had been removed from the comparison so as not to distort the key messages. Total pay expenditure had reduced by £464k from the previous average. There had been a significant reduction in nurse agency expenditure. Non pay costs had increased by £235k but a significant part of this variance related to activity related costs. Overall there was an improving trend in the results. However, there was still much more to be done. The Finance and Turnaround Teams are currently working on the M8 results together with relevant clinical units, to forecast the year end position as well as identify any further savings opportunities. **Action** **The Committee noted the month 8 position**	

4(iii)	**PDC (Public Dividend Capital) Application** Mrs Harris provided an update on the Trust's application for cash in the form of non-repayable Public Dividend Capital. It was noted that the Trust had received £24m in the current year from the Department of Health in the form of a temporary borrowing facility (TBL). This borrowing was based on support of £19m to cover the cash pressure arising from the Trust's planned deficit for the current year and a further £5m to manage the additional pressure from a historically high level of creditors. The Trust is not able to service repayments on this level of borrowing and is in need of an alternative source of financing to repay the TBL and to meet any further short term cash pressures it faces. The Trust has submitted an application to the Trust Development Authority (TDA) for cash support in the form of permanent PDC for the £24m as well as urgent capital of £4m, interim costs of the clinical strategy £1m and a further creditor amount of £10m. The application is for consideration by the Independent Trust Financing Facility (ITFF). It was noted that the ITFF was meeting to consider the Trust's application in January. There is a risk that cash pressures may continue to build before a longer term solution can be found. There is further risk that the capital funding decision will be made too late in the year for the expenditure to be made. **Action** **The Committee noted the latest position and the associated risks**	
4(iv)	**Cash Update at Month 8** Mrs Harris updated the Committee on the cash position at the end of Month 8. It was noted that the cash position had been very difficult throughout the financial year because of the planned deficit and historically high level of creditors. £24m of temporary borrowing has already been received in year. The current PDC application with the TDA includes £15m for creditor payments of which £5m had already been received as part of the £24m. Unless the position changes significantly in December, a further temporary loan would be needed in January. Cash receipts are sufficient to cover payroll costs and maintain payment runs at current levels. Payments were being prioritised to ensure that vital supplies are maintained.	

	The Committee asked how many suppliers are represented in the total of Non NHS creditors. Mrs Harris undertook to provide this number. The Committee noted the value of NHS creditors over 120 days with concern. **Action** **The Committee noted the cash position at the end of month 8.**	**VH**
5.	**EBITDA Quarterly Report – Q2** Mrs Brandt gave an update on the 2013/14 Quarter 2 EBITDA statement which had been reconciled to the Trust's finance report. The service lines that had a positive and negative EBITDA were highlighted to the Committee. It was noted that there had been an improvement in T&O, Head & Neck, Acute Medicine and Cardiovascular, and, in particular, Gynae. There were concerns around Urology, General Surgery and Vascular which had shown some deterioration since the last quarter. However the SLR team were working with the General Manager to try to address these issues. The following areas had also deteriorated: Planned medicine, Neurology, Dermatology and Gastro, and in Complex Medicine, Geriatrics. It was noted that a deep dive EBITDA review for Geriatric Medicine would be undertaken and presented to the Committee in March 2014. In the meantime, it was noted that progress against the deep dive action plans would be presented in January for T&O and in February for Gynaecology. **Action** **The Committee noted the EBITDA statement position and agreed that it would continue to invite individual clinical specialities to attend the Committee to present the outcome of their deep dive reviews.**	
6.	**Reference Costs** Mrs Brandt updated the Committee on the published 2012-13 reference cost index (RCI). The Committee noted the 2012-13 reference cost index of 105 for the Trust. It was noted that the Department of Health/Monitor had changed the methodology for calculating the RCI this year, in addition to including activity that was previously excluded from the calculation. Mrs Brandt explained that if the same methodology had been used as for the 2011-12 calculation then the Trust 2012-13 RCI would have been 104	

	which was comparable to the published RCI for 2011-12 of 103. Mrs Brandt highlighted a table which showed the comparison against other trusts over a 5 year period. **Action** **The Committee noted the reference cost index.**	
7.	**Turnaround Update** Mr Murphy reported on Turnaround progress at M8. As a result of new substantive nursing appointments having been made and rigorous controls being put in place, nurse agency expenditure had reduced without compromising quality and safety. However medical agency costs remained high and needed further review. The Committee noted there had been an increase in Scientific and Therapeutic pay costs in M8 and Mr Murphy undertook to investigate this. Manpower planning was raised as a potential issue but Mr Murphy replied that clinical unit leaders were being very responsible about arranging staff cover so as to prevent unnecessary temporary workforce costs. Mr Murphy advised the Committee that it was taking longer to reduce ad hoc expenditure and some other costs than he had anticipated but progress was being made. It will be imperative that the last few months of the year, especially M12, show a reducing run rate. The Committee asked if operational performance would be maintained. Mr Murphy and Mr Sunley confirmed that they were working together to ensure performance targets were delivered. Mr Murphy reported that the Forecast Outturn meetings were progressing (see 4ii) as it was important to understand the year end forecast. He would also be taking a role in the 2014/15 financial planning. **Action** **The Committee noted progress to date**	**AM**
8.	**Policy & Procedure for the Submission, Evaluation and Approval of Business Cases** Mr Astell presented the Policy and Procedure for Submission, Evaluation and Approval of Business Cases. The Policy explained the key principles involved in putting forward proposals requiring investment. Its purpose was to ensure that the Trust adopted a robust and consistent approach to the preparation and consideration of business cases. It was noted that the business case process would become an integral element of the annual and strategic planning of the Trust.	

	The policy ensures that: • Business cases are rigorously tested and challenged before funds are approved • Proposals support the delivery of the Trusts strategic and operating objectives • Proposals are affordable and represent value for money The CME reviewed and approved an interim policy in July 2013. The Trust Policy Group reviewed and approved the draft policy, subject to the changes now incorporated in the policy, at their meeting on 29 November 2013. The policy was amended and considered by the CME at its meeting on 9 December 2013. The Finance & Investment Committee approved the Policy and Procedure for implementation throughout the Trust. It was noted that Mrs Harris would check whether this would need to be presented to the Board. **Action** **The Committee approved the Policy and Procedure for the Submission, Evaluation and Approval of Business Cases for implementation throughout the Trust.**	**VH**
9.	**Business Case to replace the current PAS (Patient Administration System/Service) System** Mrs Walton presented the full business case on the PAS Managed Service. It was noted that the current PAS system provided under a Contract between the Trust and Siemens Business Services (SBS) would reach the end of its contractual term in March 2014. The Trust was required, under Public Contracts Regulations 2006/2009, to re-tender the Contract. The tender process had concluded and the business case recommended Award of Contract to a contractor to provide a service from 1 April 2014 for a minimum period of 5 years up to a maximum of 10 years. The successful bidder from the procurement project was Oasis Medical Solutions (OMS), the incumbent supplier. The business case showed that there were £1.5m revenue cost savings to be made over 5 years from the recommended investment comparable to the current costs for the service over 5 years providing all existing functionality but also including additional functionality to improve services, increase income and reduce cost.	

	It was recommended that the Committee accept the outcome of the procurement and proceed to recommend a Chairman's action in the absence of a Trust Board in December to ensure TDA approval as soon as possible to assure contract sign-off for Oasis PAS V16 with OMS. The Business Case was agreed and it was agreed that in the absence of a Trust Board in December, Mrs Walton would liaise with Mrs Richardson to recommend a Chairman's action. **Action** **The Committee accepted the outcome of the procurement and recommended a Chairman's action in the absence of a Trust Board in December to ensure TDA approval as soon as possible.**	**LW**
10.	**Market Testing Update - Occupational Health Business Case & Pharmacy Manufacturing Unit (PMU)** Following Board approval of the market testing outline business case (OBC) in September 2013 and the project initiation document (PID) in October 2013, Mr Horne presented the Committee with an update on the first two services being taken through the programme. It was noted that the Trust Board had emphasised that internal departments should be given every opportunity to transform to deliver the financial improvements required before any decision was made to market test/outsource. A transformational plan on Occupational Health was presented which required a decision on whether to proceed to market testing. This provided an improvement in efficiency but did not meet the Trust's 5 year efficiency target, and the resultant cost was still above the NHS benchmarking club 'average' cost. The Service Managers highlighted some of the delivery issues that the service faces and some of the reasons why budgeted income was not being achieved. It was noted that there might be an opportunity to market test jointly with other NHS organisations. An update was provided on the PMU service. It was noted that the Steering Group had requested further development of the transformational plan which currently provided an improvement in efficiency but did not meet the Trust's 5 year efficiency target. The Committee agreed the following recommendations from the market testing steering group and the CME meeting of 9 December 2013: Occupational Health: • To implement the transformational plan	

	• To further develop a 'menu' for the service specification and quality impact assessments • To market test • To produce a final full business case, post receipt of tenders to decide on outsourcing Pharmacy Manufacturing Unit: • To note the update given in the report • To request the transformational plan at its next meeting **Action** **The Committee agreed the above recommendations.**	
11.	**Community & Child Health Project Update** The Committee received an update on progress of the Community & Child Health System (SystmOne) project. The report indicated that Phase one Child Health data migration activities had been completed and were due to be signed off on 18 December 2013. The second phase was due to begin soon after this date with a sign off due in March 2014 prior to final data production. It was noted that Non Executive representation was through Stephanie Kennett who is a Project Board Member. **Action** **The Committee noted the Community & Child Health System update.**	
12.	**Capital Programme Quarterly Report** Mrs Harris presented the Committee with a review of the 2013/14 capital programme at 30 November 2014 together with a forward look over the next four years until 2017/18. The report highlighted that the demand for capital expenditure continued to place the capital programme under significant financial pressure at a time when the overall capital resources available in 2014/15 remained uncertain. 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 were in respect of: • Backlog maintenance of the Trust's estate • Backlog medical equipment replacement • IM&T costs arising from backlog pressures and the developing strategy.	

	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 would be required by the Capital Approval Group (CAG) in order that the Trust does not breach its capital resource limit (CRL) at 31 March 2014 • Noted the 5 year capital programme which was the subject of ongoing development to meet the changing needs of the Trust. A Capital Approvals Group was scheduled for 12 December 2013. **Action** **The Committee noted the update on the 5 year capital programme and the ongoing development to meet the changing needs of the Trust.**	
12.	**Work Programme** The 2014 draft work programme was reviewed and updated. **Action** **The Committee noted the revised work programme**	
13.	**AOB** **Schneider Business Case** The Chairman asked what was happening with the Schneider Business Case. Mrs Harris explained that there was a new Estates & Facilities Advisor in place, Ian Humphries, who was reviewing some of the Estates & Facilities issues including the Schneider project. It was noted that there was further work which needed to be done on the Business Case for this project.	
14.	**Date of Next Meeting** The next meeting will take place on Wednesday 22 January 2014 at 9.30am – 11.30 am in the Princess Alice Room, Eastbourne DGH.	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 22 January 2014 at 9.30am in the Princess Alice Room, EDGH

Present

Mr Barry Nealon, Non Executive Director (chair)
Mr James O'Sullivan, Non Executive Director
Mr Jon Cohen, Non Executive Director
Mr Darren Grayson, Chief Executive
Mr Stuart Welling, Chairman
Mrs Vanessa Harris, Director of Finance
Mr Philip Astell, Interim Deputy Director of Finance
Dr David Hughes, Medical Director
Mr Richard Sunley, Deputy Chief Executive/Chief Operating officer

In attendance

Mr Andrew Murphy, Turnaround Director (for item 5)
Mrs Jo Brandt, Head of SLR (for item 8)
Mrs Jan Brewer, General Manager for T&O (for item 8)
Mrs Katey Edmundson, Head of Nursing,T&O (for item 8)
Mr Andy Horne, Market Testing Programme Director (for item 11)
Mr Paul Keen, Interim General Manager - PMU (for item 11)
Mrs Vicki Rose, Assistant Commercial Director, (EHS) (for item 11)
Mrs Jane Darling, Deputy COO (working with Medical Director – Governance) (for item 13)
Miss Chris Kyprianou, PA to Finance Director (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed Jon Cohen to his first meeting of the Finance & Investment Committee and introductions were made. Apologies were received from Stephanie Kennett.	**Action**
2.	**Minutes of Meeting of 11 December 2013** The minutes of the meeting of 11 December 2013 were agreed as an accurate record.	
3.	**Matters Arising** <u>(i) Cash Update at Month 7</u> A query was raised at the last meeting about the number of suppliers that were represented in the total of Non NHS creditors.	

	Mr Astell confirmed that this number was around 1100. (ii) Turnaround Update Mr Astell confirmed that they were still looking into increase in Scientific and Therapeutic pay costs in M8. This showed a similar level at month 9. (iii) Policy & Procedure for the Submission, Evaluation and Approval of Business Cases Mrs Harris reported that that she had checked with the Company Secretary who confirmed that the Policy and Procedure for Submission, Evaluation and Approval of Business Cases did not need to be presented to the Board. (iv) Business Case to replace the Current PAS (Patient Administration System/Service) System Mr Welling confirmed that in the absence of a Trust Board in December, he took the Board Chairman's action necessary to ensure this went through to the TDA. An amended version of the Business Case is presented under item 10 (below).	**PA**
4(i)	**Performance Report – Month 8** The Committee received the month 8 Performance Report which detailed the Trust's in month performance against the National Performance Framework metrics as described in the National Operating Plan for 2013/14. Areas of concern around achievement of cancer targets were noted. The Committee was also briefed about the 18 week waiting times which have been exceeded in some specialties. This would adversely impact the December target. The position would recover at year end. It was agreed that a balance should be struck between performance/quality/finance and the interests of patients must remain paramount. **Action** **The Committee noted the Performance Report for month 8.**	
4(ii)	**Finance Update – Provisional Month 9 Flash Report** Mrs Harris provided the Committee with an update on the month 9 financial position. There was an in month deficit of £1.7m which compared unfavourably against the expected recovery trajectory of £1m deficit.	

	Cumulatively, the deficit has reached £22.3m, and is £1.7m adrift from the expected recovery trajectory of £20.6m. Income was above original Plan but below the expected recovery trajectory. However, expenditure totalling £31.4m was equal to the expected recovery trajectory. Paybill costs continue to reduce and in M9 were £0.8m below the average for the first 8 months of the year. The report provides an early snapshot of the M9 financial position allowing the Finance and Investment Committee to understand the risks to delivery of the year-end Plan position. The Commentary provided a more detailed review of the financial position. Mr Astell gave a high level commentary on the latest financial position and highlighted the key issues and risks that may impact on the delivery of the Trust's financial plan. M9 costs were compared to the Month 1-6 average and the impact of Turnaround noted in particular the improvement in pay expenditure. Drugs (excluding High Cost Drugs) expenditure in M9 had risen and was being investigated. **Action** **The Committee noted the month 9 position**	**PA**
4(iii)	**PDC (Public Dividend Capital) Application** Mrs Harris provided an update on the Trust's application for cash in the form of non-repayable Public Dividend Capital. The Trust had received £29m in the current year from the Department of Health in the form of a temporary borrowing facility (TBL). £15m was received in June 2013, £9m in October 2013 and a further £5m in early January. This borrowing is based on support of £19m to cover the cash pressure arising from the Trust's planned deficit for the current year and a further £10m to manage the additional pressure from a historically high level of creditors. The Trust is not able to service repayments on this level of borrowing and is in need of an alternative source of financing to repay the TBL and to meet any further short-term cash pressures that it faces. Following further feedback and guidance from the TDA the Trust has submitted an application for 'permanent' PDC for consideration by the Independent Trust Financing Facility (ITFF) at its 17 January meeting. The following is a summary of the request:- • Current year deficit £19.4m. • Urgent capital of £4m as per the earlier application. • Interim capital costs of the clinical strategy £1m. • Payment of creditors £15m. • Total requirement £39.4m (capital PDC of £5m and working capital PDC of £34.4m).	

	The Finance & Investment Committee was appraised on the rigorous process being followed to secure the finance required by the Trust. The ITFF had recently met and would be recommending issue of PDC to the DH. **Action** **The Committee noted the latest position and the associated risks**	
4(iv)	**Cash Update at Month 9** Mrs Harris updated the Committee on the cash position. It was noted that the position has been very difficult throughout the financial year because of the planned deficit and historically high level of creditors. £29m of temporary borrowing has now been received in year of which £5m was received on 6 Jan 2014.The current PDC application with the TDA includes £15m for creditor payments of which £10m has already been received as part of the £29m. The report presented was a snapshot of the trade creditor position at 13 January 2014 and showed that the position was similar to that at Month 8. Payment runs were being prioritised to ensure vital supplies were maintained. **Action** **The Committee noted the cash position and that £5m of further temporary cash was received in January 2014.**	
5.	**Turnaround Update** Mr Murphy reported on Turnaround progress at M9. Nurse agency expenditure had continued to reduce without compromising quality and safety. However medical agency costs remained high and needed further review. Mr O'Sullivan asked if the progress and improvements made to the cost base were sustainable. Mr Murphy explained that change was being embedded in the 2014/15 planning exercise and he expected progress to be maintained. At M9 the current estimate is that £17.5m of CIP/Turnaround savings will be delivered in 2013/14. This represents 4.9% of planned turnover. The Committee discussed the level of savings that might be needed in 2014/15. Currently the Plan expectation is for £20m. It was noted that a Mutually Agreed Resignation Scheme (MARS) was being launched within the Trust. The scheme is designed to provide flexibility and support to NHS Trusts in periods of rapid change and re-design.	

	The launch of MARS forms part of the plan to reduce pay costs in 2014/15 and sits alongside other measures which are already in place including: controls on recruitment and reduction of bank and agency use. **Action** **The Committee noted progress to date**	
6.	**Financial Planning 2014/15** Mrs Harris provided an update on the financial planning process for 2014/15 to 2018/19. It was noted that the Trust Development Authority (TDA) had issued its 5 year planning guidance in December 2013. Mrs Harris presented a paper which was discussed and agreed at the Board seminar on 15 January 2014 setting out ESHT's planning process for 2014/15 to 2018/19. As part of the TDA planning timetable requirement a high level 1 year financial and workforce plan was submitted to the TDA on 13 January 2014. A slide pack was presented which was also shared at the Board seminar setting out a summary of that submission. The submission reflected the second year planned deficit as set out in the Medium Term Financial Plan and Long Term Financial Model and as previously agreed by the Finance and Investment Committee. Various aspects of the submission were discussed including impact on workforce and alignment with the Clinical Strategy Business Case. It was noted that alignment with CCG's financial plans would be needed over the next few weeks. Mr Nealon requested that where, exceptionally, submissions such as this are made outside of its meeting schedule, it would be useful for an electronic circulation to be made. Mrs Harris gave an update on the proposed 2014/15 National Tariff Payment System which was originally submitted to the Committee in November. Following a consultation period Monitor issued final guidance in December 2013. **Action** **The Committee noted the update on the financial planning process for 2014/15 to 2018/19.**	**VH**
7.	**Community Rebasing Project Briefing** Mr Astell gave a progress update on the Community Rebasing Project. He explained that the project was initiated within the Trust in May 2013 with a view to improving the alignment of funding for community services.	

	The purpose of the project was to ensure that the Trust was appropriately reimbursed by each of the new commissioning bodies for the work it undertakes and to help inform decisions (by both the Trust and its commissioners) about the future provision and commissioning of individual community services. It was noted that initial work on the identification of costs and the appropriate alignment of funding by commissioner had been completed. The apportionment of costs and income to individual commissioners had proved challenging as the quality of patient level activity by service was variable. The first engagement meeting with commissioners had taken place and this identified the need to further refine the apportionment of costs between commissioners. The following benefits of the exercise were noted: • a robust matrix of funding and cost agreed with commissioners; • a reduced risk that decisions about the future of individual community services will be based on incorrect or misleading information; and • establishing a basis for dialogue with commissioners about the appropriate funding of community services. Mr Cohen emphasised that this was an important area for rebalancing costs and that the Trust needed to concentrate resource on this work. It was agreed that a further update, including numbers, would be provided at the February Finance & Investment Committee meeting. **Action** **The Committee noted the progress on the community rebasing project and requested a further update for the February meeting.**	**PA**
8.	**EBITDA – T&O Service Review Follow Up** A deep dive into T&O Qtr 4 2012-13 was presented to the Finance & Committee in June 2013. Mrs Brandt gave an update on the follow up work that T&O had undertaken since this presentation with comparisons to Qtr 2 2013-14. It was noted that T&O EBITDA returned a deficit position for Qtr 4 2012-13 of - 3.69% and at Qtr 2 2013-14 this was - 4.92%. Total expenditure had reduced when pro-rated to a full year as had total income. The deficit position continued to relate solely to inpatients, with non-elective inpatients being the main contributory factor. Conversely elective inpatients had moved into a surplus position. Within non-elective inpatients one HRG in particular continues to return a deficit. Further work had been done to analyse the reasons for this and the information was discussed.	

	It was noted that the specialty had made, and continued to make operational changes to improve the position and the quality of care for the patient. It was reported that Physiotherapy and Occupational Therapy staff are not always available due to staff shortages but this was being followed up. Dr Hughes agreed to follow this up and report back to the next Committee. Mrs Brewer reported that the main thing that would make a difference would be ring fencing of beds. This would ensure throughput, of patients and avoid cancellations. Mr O Sullivan asked if the Clinical Unit felt that the review had been helpful. Mrs Brewer said that they had found this very helpful and, in particular, the benchmarking information. She confirmed that she had met with Mrs Brandt on a regular basis since June 2013 to review the position and to see what further changes could be made. Mr Welling queried whether the information was being shared with the other Consultants. Mr Grayson said that the focus of the reviews was to help Clinical Units to develop a plan to get into a sustainable and profitable position. He stated that the Committee would like to see, as part of next year's planning, detail on operational, workforce and pathway changes. **Action** **The Committee noted the T&O EBITDA statement position and noted that T&O continue to strive to improve their EBITDA position whilst improving patient care. The Committee would continue to invite individual clinical specialties to attend the Committee, to present the outcome of their deep dive reviews.**	**DH**
9.	**Bedside Monitoring (VitalPAC)** Mr Sunley presented the VitalPAC Business Case. He explained that this was a medical system using hand-held mobile technology that enables clinical staff to collect vital signs observations on admission and throughout an inpatient stay. Combined with data from Patient Administration, pathology, microbiology and radiology systems, VitalPAC identifies high risk and deteriorating patients and immediately alerts the relevant doctor on their mobile device. It was reported that the Trust had been successful in a bid to The Safer Hospitals, Safer Ward Technology Fund and had secured central funding of £821,601. The fund supports rapid progression from paper-based systems to integrated digital care records.	

	The Trust was successful in the two-stage assessment process culminating in a panel interview in London which involved a high level of financial scrutiny of the project by NHS England and the Treasury. It was noted that VitalPAC would require a one off licensing fee for the user software and additional project management costs would be absorbed within the existing resources. The cash releasing annual savings associated with VitalPAC were highlighted. In addition productivity improvements from the adoption of VitalPAC were significant. **Action** **The Committee approved Trust funding required for the VitalPAC project whilst recognising that there was a direct cost to the Trust. The Committee recommended a Chairman's action to approve the case on behalf of the Board to enable the case to be forwarded for TDA approval. It was noted that a summarised version of the Business Case would be presented to the March Board.**	**RS**
10.	**Business Case to replace the current PAS (Patient Administration System/Service) System** Mrs Harris presented an amended version of the Full Business Case to replace the current PAS System that was presented and approved at the Finance & Investment Committee on 11 December 2013. Mrs Harris reported that this was agreed at the TDA this week and will be presented to the Board (Part 2 as commercially confidential) on 29 January 2014. **Action** **The Committee noted the amended version of the Full Business Case which had been agreed by the TDA and will be presented to the January Board (Part 2).**	**VH**
11.	**Market Testing Programme - Pharmacy Manufacturing Unit (PMU)** The Committee received the PMU transformation plan which provided an improvement in efficiency but did not meet the Trust's 5 year efficiency target. It was recommended that part of this service, the cancer chemotherapy preparation service based at EDGH should transfer to Pharmacy and, subject to another business case, be merged with a similar service based at the Conquest and already run by Pharmacy. It was noted that the remaining PMU service was mainly providing services to other organisations.	

	However the Quality Control process was recommended to be market tested. The reports were discussed at the Clinical Management Executive on 13 January 2014 and agreed the following recommendation from the Steering Group: Pharmacy Manufacturing Unit: • To transfer chemotherapy preparation service to Pharmacy (note – this has been agreed locally between Pharmacy and PMU). Cost neutral with efficiencies expected at a later stage. • To implement the transformation plan and to market test the quality control process/service. These changes provide a budget improvement of £138k pa and run rate improvement of £233k pa. • To ask for a further paper on potential options, if forecast surplus drops below 10% or income drops below £1.5m pa. **Action** **The Committee agreed the above recommendations.**	
12.	**Community & Child Health Project Update** The Committee received an update on progress of the Community & Child Health System (SystmOne) project. It was noted that Specialist Nurses had been taken out of phase 1 and an additional phase had been added to accommodate this due to a number of issues, including the availability of support staff to recruit into the project. However this was not expected to impact the overall timescales of the project. **Action** **The Committee noted the Community & Child Health System update.**	
13.	**Consultant and SAS (Staff & Associate Specialist) doctor Job Planning Review** Mrs Darling updated the Committee on the progress relating to the review of the Trust's job planning processes, and the linkage to the Trust Business Planning. It was noted that Job Planning was a contractual duty for all Consultants and SAS doctors, whether working under the 2003 Consultant Contract (2008 for SAS) or 'old contracts'. Only a small number of Consultants were still on the old contract. The initial guidance within ESHT was developed in 2011, in collaboration with the LNC and BMA.	

	At the usual two years review date, the documentation and process relating to job planning needed to be reviewed now. This review is aiming to ensure the process embeds into Trust business, and to ensure that Clinical Unit leads are given as much guidance and support as necessary to ensure they are able to match all resources available to them with the demand on their services. Job planning compliance improved in 2013, but there was more to do to embed annual job planning in the Trust's business planning processes, to develop transparency, and the link into medical professional management, revalidation and appraisal. The Committee noted the following key issues: • A re-launch of job planning guidance and processes. • The process to be followed by CU management teams will be supported by clearer guidance, supporting personnel, and through tracking and monitoring • To support the Medical Director – Governance, an Associate Medical Director (Maintaining Standards) post is in place, Senior Manager support has been provided from within the Trust, and short term external HR expertise is being used. The Trust resource must be provided in an on-going manner to ensure this process is tracked, monitored and managed by CUs. • Links to revalidation and appraisal were being established • The job planning will develop further to support Trust business planning, Trust objectives and strategic direction. • The Consultant/SAS doctor basic contract of 10 PAs needs to be more clearly managed through job planning and additional PAs (APAs) accounted for through 'fixed term' contracts for APAs, properly reviewed at agreed intervals. • The maximum 12 PAs for EWTD compliance must be adhered to and managed within the Trust. The Chairman reminded the Committee that Mr Murphy had previously stated that job planning was a critical element in Turnaround and would contribute to meeting the financial targets for future years. **Action** **The Committee supported the proposed changes and timescales, and recognised the supporting mechanisms required to embed new processes.**	
14.	**Clinical Strategy** There was no update on the Clinical Strategy.	

15.	**Work Programme** The 2014 draft work programme was reviewed and updated. **Action** **The Committee noted the revised work programme**	
16.	**Date of Next Meeting** The next meeting will take place on Wednesday 26 February 2014 at 9.30am – 11.30 am in the Princess Alice Room, Eastbourne DGH.	

East Sussex Healthcare NHS Trust

QUALITY AND STANDARDS COMMITTEE

1. Introduction

1.1 Since the last Board meeting a combined Quality and Standards Committee /Patient Safety Clinical Improvement Group meeting has been held on 3 March 2014. A summary of the issues discussed at the meeting is provided below.

1.2 The minutes of the meeting held on 7 January 2014 are attached at Appendix 1.

2. Issues discussed at 3 March Meeting

2.1 Shared Learning in Practice (SliP)

A presentation was made regarding a serious incident that had occurred and been fully investigated. The Committee listened to the presentation of the case and the findings, along with the lessons learnt. Discussion also took place as to the 'journey' those involved had made and what changes to practice had occurred.

2.2 Board Assurance Framework

The assurance framework was received and the detail noted. Discussion took place around the establishment of the DatixWeb working group and the reduced backlog. The Committee requested an update at the next meeting.

2.3 Integrated Quality Report

An update was presented on the status of the information held by the Trust and discussion took place around how to bring this together and provide an integrated report to include the most beneficial indicators and identify key themes and trends.. The Committee was encouraged by the work undertaken so far.

2.4 Mandatory Training and Appraisal Compliance Report

This was presented and discussed with particular consideration around e-learning, the different ways of accessing mandatory training available to staff and focussing resources where they need to be delivered.

2.5 Schwartz Centre Rounds® Update

Occupational Health proposed the Schwartz Round structure as a means for staff to cope better with the challenging psychosocial and emotional issues that arise in caring for patients and to help them spend more time focussed on caring for patients in a compassionate way. The Committee approved for this proposal to move forward and be implemented within the Trust.

2.6 Quality Governance Strategy

The Committee noted receipt of the Quality Governance Strategy as an overarching strategy that outlines the framework for the delivery of quality governance at East Sussex Healthcare NHS Trust (ESHT) and supports the provision of high quality services for patients.

2.7 Nursing Staffing Establishments

Discussion took place on the paper presented which included the analysis of the methodology and the final inpatient levels. Further discussion was had over the relationship of ESHT staffing levels to the national staffing levels and the future workforce issues.

3 Conclusion

3.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meeting held on 3 March 2014 and the minutes of the meeting held on 7 January 2014.

Charles Ellis
Quality and Standards Committee Chairman

4 March 2014

East Sussex Healthcare NHS Trust (ESHT)

Quality and Standards Committee /Patient Safety and Clinical Improvement Group

Minutes of the Combined Quality and Standards Committee /Patient Safety and Clinical Improvement Group Meeting (PSCIG)

Tuesday, 7 January 2014
St Mary's Room, Eastbourne District General Hospital

Present:
Mrs Alice Webster, Director of Nursing, (Chair)
Mr Ian Bourns, Director of Pharmacy
Mr Kevin Burns, Data Quality Manager
Mrs Angela Colosi, Nurse Consultant for Advanced Practice
Mrs Janet Colvert, Ex-Officio Committee Member
Mrs Nicky Creasey, Assurance Manager, Health and Safety
Mrs Margaret England, Assurance Manager – Patient Safety and Risk
Mrs Liz Fellows, Assistant Director of Nursing, Planned Care
Ms Katharine Horner, Deputy Clinical Governance Manager, Integrated Care
Miss Emily Keeble, Head of Assurance
Ms Stephanie Kennett, Non-Executive Director
Miss Éanna McKnight, Head of Legal Services
Ms Michelle Parsons, Head of Nursing, Michelham Unit
Miss Abi Turner, Allied Health Professional Lead
Ms Anne Watt, Clinical Governance Manager, Integrated Care, from item 9
Mrs Lynette Wells, Company Secretary
Mrs Hilary White, Assurance Manager, Compliance

In attendance:
Mrs Mia Cruttenden, Head of Nursing, Complex Intermediate and Community Care for item two only
Mrs Edel Cousins, Assistant Director Human Resources from item 6, obo Mrs Moira Tenney
Mr James O'Sullivan, Non-Executive Director
Mrs Susan Cambell, PA to Director of Nursing (minutes)

1 Welcome and Apologies for Absence

Mrs Webster welcomed everyone to the combined Quality and Standards Committee /Patient Safety Improvement Group meeting and confirmed that the Committee was quorate.

Mrs Webster noted that apologies for absence had been received from :

Mrs Deidre Connors, Head of Nursing, Specialist Medicine
Mrs Christine Craven, Deputy Director of Nursing

Mr Charles Ellis, Non-Executive Director
Ms Sarah Goldsack, Associate Director of Knowledge Management
Dr Peter Greene, Ex-Officio Committee Member
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr David Hughes, Medical Director Governance
Mrs Paula Hunt, Senior Clinical Nurse, Occupational Health
Ms Tina Lloyd, Assistant Director of Infection Prevention and Control
Ms Brenda Lynes O'Meara, Assistant Director of Nursing Professional Practice and Standards
Mr John Kirk, Facilities and Security Manager
Dr Janet McGowan, Trust Clinical Governance Lead
Ms Linda Piper, Divisional Clinical Governance Manager
Ms Emma Tate, Clinical Outcome Improvement Manager
Dr James Wilkinson, Associate Medical Director
Dr Jamal Zaidi, Associate Medical Director

2 Shared Learning in Practice /Patient Story

The Quality and Standards Committee /Patient Safety Clinical Improvement Group (PSCIG) noted receipt of the supporting papers regarding a serious incident (SI) case review. Mrs Cruttenden presented an update on the case of an 85 year old female patient who had been admitted to the winter escalation ward over the Easter holiday period of 2013 for investigation following falls. Unfortunately the patient had a further un-witnessed fall on 1 April 2013.

Mrs Cruttenden reported that in terms of nursing assessment, an initial assessment of the patient had been undertaken as per Trust policy and the patient did not appear to have had any physical injuries.

Mrs Cruttenden confirmed that the nurses had discussed the case with the on-call First Year Doctor (FY1), who had requested two hourly observations to be undertaken. Mrs Cruttenden explained that the patient had deteriorated over the next four hours and subsequent reviews showed that the patient had sustained a neck fracture. Mrs Cruttenden confirmed that the patient sadly died on 2 April 2013.

Mrs Cruttenden explained that the subsequent SI review had benefited from multi-disciplinary clinical input. She stated that an inquest on 10 December 2013 had recorded a verdict of accidental death, but had noted that the patient died from a neck fracture. Mrs Cruttenden highlighted the care and service delivery problems, contributory factors experienced, and the root causes. Mrs Cruttenden confirmed that an action plan was in place and the falls management Policy had been revised although Mrs Cruttenden felt the anomalies between the falls management and observations policy were still open to misinterpretation and should be reviewed.

Mrs Cruttenden hoped to take forward the use of a national flash card system for high priority and high risk areas such as pressure area damage /care, falls risk and infection control which could be used as a quick reference guides for staff.

Mrs Cruttenden stated that the Coroner had thanked the Trust for its honesty and the root cause analysis (RCA) undertaken and that the Trust had identified its own points for learning. Mrs Webster thanked the team and those that were involved and stated that the Trust's openness, honesty and transparency had been evident.

Mrs Creasey confirmed she awaited a response from the Health and Safety Executive as to whether the incident was Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) reportable.

3 Minutes of the Previous Meetings

3.1 Minutes of the combined Quality and Standards Committee /PSCIG meeting held on 12 November 2013 were considered and agreed as an accurate record.

3.2 Minutes of the 6 December 2013 combined PSCIG /Essential Compliance Group (ECG) meeting were considered and agreed as an accurate record.

4 Matters Arising

The action log from the combined Quality and Standards Committee /PSCIG /ECG meetings was updated and would be circulated with the minutes.

5 Patient Safety Risk Register

Miss Keeble presented the latest high level patient safety risk register which showed risks that had been categorised as having a patient safety implication rating of 15 or above.

Mrs Wells queried if there had been an update regarding the Datix ID 971, Premises at Sturton Place risk and Miss Turner agreed to check if formal notice had been given to the Trust and she would update Mrs Fellows accordingly. **AT**

Mrs Webster noted that the review dates of some items showed as having been outstanding for a considerable amount of time. Mrs Wells explained that it was possible that this was the result of Datix fields not being correctly completed.

6 Developing an Integrated Quality Report

Miss Keeble presented an update regarding the plan to provide a comprehensive integrated quality report. Miss Keeble explained that it remained a complex issue to provide the required data as in addition to the individual reports currently provided, the clinical units also populated and provided quality dashboards at various timeframes. Miss Keeble suggested that agreement from the Committee was required as to what the integrated report should include, who could provide the information and at what level the information was required at.

Mr Burns confirmed that work had previously been undertaken in this area. Mr Bourns raised the difficulty of not simply collecting the data available, but of the need to address patient issues and provide assurance as an organisation going forward. Ms Horner stated that initially a core set of data had been in place, but this had become 'separated' with the need to accommodate all clinical units. Mrs Fellows suggested that a consistent core of data was required for patient facing services, but 'added value' services may require a different set of measures.

Mrs Wells highlighted the need for meaningful data ensuring that 'hot spot' areas, key themes and trends were identified. Mr O'Sullivan agreed and added that data should remain 'digestible' and be 'by exception' for the purpose of this meeting.

The Committee agreed that a working group should be set up and would include Ms Horner, Mrs Fellows, Mr Bourns, Mrs Colosi, Mr Burns, Mrs Creasey and Miss Keeble and would provide a draft plan for the 3 March 2014 meeting. **KH/LF/IB /KB/AC/ NC/EK**

7 Patient Safety Incident Report for November 2013

Mrs England presented the incident report for November 2013 and confirmed that there had been a total of 708 patient safety incidents reported. She stated that falls remained the highest category for the number of incidents reported by the Trust, but was pleased to note that this continued to reduce and confirmed that funding had been agreed for a pilot project around the provision of slipper socks.

Mrs Webster requested that further to page 4, 3.1.1, Top Five Reporting Locations for Falls of the report, the ward type was given for context purposes. **ME**

Mrs England confirmed that she continued to seek an update and the risk entry number relating to Health Records risk register entry and specifically the transfer of stored records. **ME**

Mrs Webster requested more detailed information regarding the 'top five' patient safety incidents reported to enable trends to be monitored and Mrs England agreed to provide this in future reports. Mrs England confirmed that there had been relatively low numbers of prescribing errors reported, five at the Conquest site and two at the Eastbourne site; she also stated that there had been five administration errors at the Conquest site and six at the Eastbourne site. Mrs England stated that typically, the severity for these incidents had been reported as low and Mr Bourns confirmed that he routinely monitored medication error incidents and had not identified a pattern with regards to staff or location. Mrs England said that those responsible for errors were monitored by Ward Matrons although monitoring medical staff had been more challenging and Mrs Fellows confirmed that where nursing concerns had been raised the information had been shared.

Mrs Colosi highlighted the slight discrepancy in the number of pressure ulcers reported was due to her validating data and that DatixWeb reported on a broad range of categories.

9 **Serious Incidents Monthly Report for December 2013**

Miss Keeble presented the report which provided an overview of the serious incidents (SI) reported in December 2013. Miss Keeble stated that subject to requests for downgrading, the total number of new SIs for the month may reduce to 15.

Miss Keeble highlighted that the Trust compliance to report SIs within two working days had significantly increased but was balanced with a quarter of the SIs raised being subject to downgrade requests. Miss Keeble stated that she would query the correct percentage for compliance as this was not currently clear as to whether it was from when the incident occurred or when the Trust became aware that the incident was an SI. **EK**

Miss Keeble confirmed that a further meeting with the 'divisions' has been scheduled for 20 January 2014 to discuss processes and present evidence regarding the implementation of actions and shared learning.

Miss Keeble confirmed that Jo Thomas, Head of Quality (Hastings, Rother CCG and Eastbourne, Hailsham Seaford CCG) continued to attend and feedback at the Serious Incident Review Group (SIRG) meetings. Miss Keeble reported two SIs remained open from 2012 and this was a significant improvement on previous years.

She confirmed a reconciliation meeting with the CCGs was scheduled and would ensure that data held by the CCG, Strategic Executive Information System (STEIS) and the Assurance team was compatible.

Mrs Fellows queried if the role of the ADN could assist with the timely raising of SIs and Mrs Webster confirmed that grade four and five incidences were alerted to ADNs within 24 hours of being reported.

Mrs Webster commended everyone involved with work around reporting and closing of SIs which reflected openness and transparency throughout the Trust.

9 **Quarterly Legal Report**

Miss McKnight presented the report which provided an overview of the number of legal claims received, both clinical and non-clinical during the second quarter of the year, July to September 2013.

Miss McKnight confirmed that currently there were 90 active clinical claims which had been referred to the National Health Service Litigation Authority (NHSLA) along with 31 non-clinical claims. She confirmed that currently 32 inquests were being managed by the legal department.

Miss McKnight reported no particular risk issues or trends had been identified through new claims or inquests. Mr Bourns sought comparison with other Trusts regarding the number and costs of claims and Miss McKnight agreed to investigate this further. Mrs Wells confirmed that the NHSLA premiums for the Trust had increased. She mentioned that the time it took to settle claims remained a factor as even though policies and practices may have changed; years could have passed before claims went through the system. **EMc**

Miss McKnight explained that due to the changes in inquest procedures, the timescale for completion and the number of those outstanding had reduced.

10 **Deprivation of Liberties Service (DoLS) and Adult and Children Safeguarding Report**

Mrs Webster presented the combined report on behalf of Ms Lynes O'Meara and noted the downward trend in the number of alerts raised during 2013/14 compared to 2012/13, with a further reduction in the number of substantiated alerts for the same timeframe, and Mrs Webster confirmed that preventative work continued locally in the community and in care homes.

Mrs Webster stated that training for both adult and children's safeguarding remained an issue and reiterated that every staff member was required to complete training at some level.

Mrs Webster reported that one of the two recent serious case reviews had identified learning points for the Trust and these pertained to community issues whilst there were no recommendations for health following the second serious case review.

Mrs Colvert sought assurance that a support system was in place for staff that dealt with both child and adult safeguarding issues and Mrs Webster commented that supervision was mandatory regarding child issues and was offered to all those working with safeguarding. Mrs Fellows confirmed that a policy was in place to support staff involved in any sort of incident but acknowledged that the Trust needed to ensure that support was offered in a way that could be accessed by staff.

11 Audit of the Learning from Grade 2 Serious Incidents (SI)

The Committee noted receipt of the six monthly Audit of the Learning from Grade 2 Serious Incidents and Miss Keeble explained that the audit had been carried out as part of the monitoring function of the Assurance team and ensured that actions identified had been implemented.

Miss Keeble assured the Committee that, in general, actions had been embedded and implemented; however, further recommendations had been identified by the audit. Miss Keeble stated that improved communication generally regarding feedback from SIs was necessary and this should be via a formal mechanism.

Mrs Colvert complimented the team on the report.

12 Quality Account Timetable 2013-14

Mrs Wells presented the timetable for producing the mandatory Trust Quality Account 2013-14 document. She reiterated that it was a requirement that the account be submitted to the Secretary for State by 30 June 2014, and would require review by Stakeholder colleagues prior to this.

Mrs Wells confirmed that a Quality Engagement event had been organised in Eastbourne and had been well attended by members of the public who provided feedback around quality improvement priorities and further events would be undertaken. Mrs Colvert stated that event details should be given wide publicity and voluntary organisations should be encouraged to attend.

Mrs Wells highlighted some of the quality improvement priorities that had been undertaken this year which included Safety Thermometer and suggested that if clinical units had any future ideas, these should be forwarded to Mrs White as a matter of urgency due to the fixed deadline.

Ms Horner queried if any improvements identified would attract priority funding and Mrs Wells stated that there was a commitment by the organisation to deliver improvement priorities and some are aligned to initiatives such as CQUINs.

Mrs Colvert clarified that for future reference, the LiNKs organisation had become Healthwatch.

Mr O'Sullivan requested that information regarding target achievement against the current year's quality improvement priorities be presented at Trust Board, and Mrs Wells stated that a report would be pulled together. Mrs Colosi confirmed that Safety Thermometer updates could be accessed via the internet site www.safetythermometer.nhs.uk

13 **Morbidity and Mortality Update**

Mrs Webster clarified that this item should appear quarterly on the agenda and will therefore be discussed at the next Committee meeting.

14 **NHS Safety Thermometer**

Mrs Colosi provided a quarterly summary report on the NHS Safety Thermometer which gave assurance that the organisation had shown improvement in reducing harm against patients and stated that the Trust remained below the trajectory during November and December 2013 for reducing the total number of pressure ulcers, both community and hospital acquired.

Mrs Colosi stated that the Safety Thermometer falls data showed a downward trend and commented that the report had been triangulated with information from DatixWeb for the first time. Mrs Colosi assured the Committee that the number of new harms acquired under ESHT care had reduced.

Mrs Colosi explained that the risk remained that the CQUIN improvement target would not be achieved as this included the number of pressure ulcers sustained outside of ESHT care. To mitigate this, patient information leaflets were now widely available for staff to give out in the community. To further raise awareness, Mrs Colosi stated that Prevention of Pressure Ulcer leaflets would be distributed to all staff with January 2014 payslips and there were national and Listening into Action events planned in March 2014.

15 **Health Care Acquired Infection (HCAI) Half Year Report 2013/14**

Mrs Webster presented the first half year report on behalf of Ms Lloyd.

She stated that subsequent to the report, 35 cases of *Clostridium Difficile* infection (CDI) had been reported as at the end of December 2013 and one case of Meticillin resistant *staphylococcus aureus* (MRSA) bacteraemia had been identified. She also confirmed that areas across the Trust had been affected by Norovirus. A robust action plan in place to support the Trust in reducing HCAIs.

16 **Gentamicin Audit August to November 2013**

Mr Bourns presented the Committee with the second report from the rolling audit and gave assurance that significant improvement and compliance had been identified, and the risk around the use of Gentamicin had reduced. Mr Bourns stated that in order to ensure improvement continued, more training would be offered to all staff involved in the use of Gentamicin along with focussed support from clinical pharmacists at ward level. Mr Bourns stated that the implementation of a new drug chart following a successful pilot would be rolled out by area and he commented that although some documentation replication was inevitable, it would be kept to a minimum.

Mr Bourns reiterated that the audit showed a beneficial clinical risk reduction impact and Gentamicin was now only used where absolutely essential.

17 **ESHT Medicines Optimisation Strategy and Action Plan**

Mr Bourns presented and sought approval from the Committee for the Trust Medicines Optimisation Strategy and action plan. Mr Bourns stated that there had been a change in the national approach to the use of medicines in the NHS with a shift from process based Medicines Management to the patient focused Medicines Optimisation.

Mr Bourns confirmed that the Trust Development Agency (TDA) had provided a self assessment tool which the Trust had used to provide gap analysis and this had identified a need for a clear Trust Medicines Optimisation Strategy. Mr Bourns assured the Committee that work was underway that demonstrated the Trust were moving forward with Medicines Optimisation particularly around leadership, strategy, reduction in harm and the implementation of the national five - year antimicrobial strategy.

Mrs Webster stated the Medicines Optimisation Strategy paper required management at an operational level and should be submitted to the Clinical Management Executive (CME), at the next available meeting. Mrs Wells requested Mr Bourns present the information at a Trust Board seminar in February 2014. **IB**

18 **Board Assurance Framework /Higher Level Risk Register**

Mrs Wells presented the updated Board Assurance Framework (BAF) which brought together Trust strategic priorities and objectives, the assessment of their risks and associated actions. Mrs Wells also presented the High Level Risk Register which documented those risks that scored 15 and above.

Mrs Wells queried if the annual DNAR audit would be undertaken and Mrs Fellows suggested that a six-monthly update had recently been presented to CME. Mrs Wells agreed to follow this up with Steve Rochester, Resuscitation Lead.

Mrs Colvert sought assurance around the Therapy Service vacancy factor and Miss Turner confirmed that currently this was at 10-12%, which was typical for the service. She reported that gaps had been identified in specialist areas and plans were in place to improve this. Miss Turner agreed to provide an updated narrative for the BAF to Mrs Wells. **AT**

Mr Bourns updated the Committee regarding reference 1.2, page 8, of the BAF and stated that ITT for Pathology had moved forward.

18 **For Information**

No documents had been presented for information.

19 **Any Other Business**

(i) Mrs Webster confirmed that the Schwartz Rounds remained an ongoing development and following discussions with Occupational Health, further information would be available at the next meeting.

(ii) Mrs Webster confirmed that she has met with Mrs Colosi and Miss Keeble to discuss a clinical improvement strategy to measure against and link in with patient safety and quality assurance thus ensuring a robust system was in place.

(iii) Mr Bourns requested that VTE be discussed at the next PSCIG /Essential Compliance Group meeting.

20. **Date of the Next Meeting**

(i) Patient Safety and Clinical Improvement Group /Essential Compliance Group
Friday, 7 February 2014, 9.00am – 10.30am, via video conference between Princess Alice Room Eastbourne District General Hospital and Chairman's, Conquest Hospital.

(ii) Quality and Standards Committee /Patient Safety and Clinical Improvement Group
Monday, 3 March 2014, 14.30 - 16.30hrs, Committee Room, Conquest Hospital

East Sussex Healthcare NHS Trust

Remuneration and Appointments Committee Annual Report 2013/14

1. Introduction

The Remuneration and Appointments Committee is a non-executive sub committee of the Board and oversees the appointments of the Chief Executive and Executive Directors and agrees the parameters for the senior appointments process. The Committee agrees and reviews the Trust policies on the reward, performance, retention and pension matters for the executive team and any relevant matters of policy that affect all staff for example agreement of the Mutually Agreed Resignation Scheme.

2. Authority and Duties

Under delegated authority from the Trust Board, the Committee determines the appropriate remuneration and terms of service for the Chief Executive and Executive Directors having proper regard to national arrangements and guidance.

The Committee also advises on, and oversees, the appropriate contractual arrangements with Chief Executive and Executive Directors, including the proper calculation and scrutiny of termination payments, taking account of national guidance as appropriate.

The remuneration rates are determined by taking into account national benchmarking and guidance in order to ensure fairness and proper regard to affordability and public scrutiny. The remuneration of the Chief Executive and Executive Directors are set at base salary only without any performance related pay. The appointment and remuneration of the Chairman and Non Executive Directors are undertaken nationally by the Trust Development Authority.

The Remuneration and Appointments Committee monitors the performance of Chief Executive and Executive Directors based on their agreed performance objectives.

3. Membership

The Committee is chaired by the Chairman of the Trust and has three Non Executive Directors as members who are appointed by the Chairman. Due to changes in Non Executive Directors during the year membership of the Committee comprised two Non Executive Directors between July 2013 and February 2014. It now has a full complement of members. The Chief Executive, Human Resources Director and Company Secretary attend meetings in an advisory capacity except when issues relating to their own performance, remuneration or terms of conditions are being discussed.

Quoracy for the meeting is three members of which one must be the Chairman. The Committee met five times between April 2013 and March 2014 and all but one meeting was quorate.

4. Annual review of terms of reference and work plan

The Committee's Terms of Reference and Annual Work Programme were reviewed in February 2014. It was proposed that the requirement for the annual review of the Terms of Reference under point 8 be revised so that it is undertaken by the Committee with any amendments being submitted to the Board for consideration.

Matters considered in 2013/14 included:

- Chief Executive's report on individual directors' performance and objectives and half yearly update of Director's performance against annual objectives.
- Chairman's report on the Chief Executive and Executive Directors appraisals and objectives
- Annual performance review for Chief Executive and Chairman's half yearly update of Chief Executive performance against annual objectives.
- HMT Review of Senior Public Sector Tax Arrangements
- Review of Senior NHS Salaries and Redundancy Arrangements
- Approval of relevant appointments and terminations
- Clinical Excellence Awards
- Approval of Mutually Agreed Resignation Scheme

5. Annual Self Assessment of Effectiveness

In February 2014 the Committee undertook an annual self assessment of its effectiveness. Members agreed that the number of Committee meetings held had been sufficient and agendas appropriately structured to support the effective discharge of responsibilities. It was noted that succession planning and an understanding of medical responsibility payments were timetabled.

Matters considered and decisions made by the Committee were taken on an informed basis and members agreed these decisions were understood, owned and properly recorded and would bear scrutiny; subsequent implementation of decisions and progress had been reported back to the Committee as required. Previous concerns that the Committee were requested to rubber stamp matters after the event had been addressed.

6. Reporting

Due to nature of the business conducted Committee minutes are considered confidential and are not in the public domain. The Chair of the Committee draws to the Board's attention to any issues that require disclosure to the full Board or require Executive action.

EAST SUSSEX HEALTHCARE NHS TRUST

Notes of the Trust Board Seminar held on 15th January 2014 at 10.15 am in the St Mary's Board Room, Eastbourne DGH

Present:
Mr Stuart Welling, Chairman
Mr Charles Ellis, Non-Executive Director
Mr Barry Nealon, Non-Executive Director
Mrs Sue Bernhauser, Non-Executive Director Designate
Mr Darren Grayson, Chief Executive
Ms Monica Green, Director of Human Resources
Mrs Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development & Assurance
Dr David Hughes, Medical Director (Governance) (for items 1-3)
Dr Andy Slater, Medical Director (Strategy)
Mrs Alice Webster, Director of Nursing
Ms Lynette Wells, Company Secretary

In Attendance:
Ms Sarah Goldsack, Associate Director – Business Intelligence (for item 2)
Dr Debbie Benson, Consultant in Palliative Care (for item 3)
Mrs Jane Rennie, Associate Director – Business Planning (for item 4)
Mrs Trish Richardson, Corporate Governance Manager (notes)

ACTION

1. Apologies for Absence and Confidential Notes of the Seminar meeting held on 11th December 2013

a) Apologies for absence were received from:

Ms Stephanie Kennett, Non-Executive Director
Mr James O'Sullivan, Non-Executive Director
Professor Jon Cohen, Non-Executive Director
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer

Mr Welling welcomed Mrs Bernhauser to her first meeting as the Trust's new Non-Executive Director designate.

b) The confidential notes of the seminar meeting held on 11th December 2013 were agreed as a correct record.

2. Update on Current Issues

a) <u>Maternity and Paediatric Services</u>

Mr Grayson reported that the CCGs' consultation on the future of the above services commenced on 12th January 2014 and he had circulated an electronic copy of the consultation document.

Dr Harrison reported that a number of market place and mini-market place events were taking place and Mrs Richardson would circulate the link to the Better Beginnings consultation website which would display the dates. The Trust would be providing clinical input into the larger events with the expectation that there would be clinical representation from the CCGs as well. **TR**

She advised that the proposed model of care was awaited from the CCGs, following which the Trust would be able to formulate its response on which option it preferred. Mr Grayson advised that there would be an internal process to develop the Trust's response and there would be an opportunity for the Board to consider the details in seminar session with the clinical teams before approving the formal response at a public Board meeting.

It was noted that there would be purdah period following the close of the consultation period due to the council elections in Hastings and the CCGs would not make their decision until June, following which it would be submitted to HOSC for approval in July.

b) A&E

Mr Grayson reported that the Trust had delivered the A&E target for quarter 3 and made a good start to quarter 4. This had been achieved by good management of the patient flow with detailed attention on this throughout the hospitals.

c) Month 9 Flash Finance Report

Mrs Harris presented the December (month 9) flash finance report and reported that there had been £1.7 million deficit for the month which was better than originally planned but underachieved by £700,000 against the in year financial recovery plan.

She reported that there had been a better than anticipated performance in activity although there had been only 18 working days in the month and this increased performance needed to be carried forward and improved in the final quarter of the year. The expenditure run rate had reduced in the month to £31.4 million due to reductions in bank, agency and overtime.

She advised that year to date the deficit was £22.3 million against the planned deficit of £20.5 million.

She reported that the cash position remained an issue and a further £5 million temporary loan had been received at the beginning of January.

She advised that the application for public dividend capital would be going forward to the ITFF panel this week and she anticipated that she would be advised the following week if the application had been successful.

d) Meeting with Lewes, High Weald and Havens CCG

Mr Welling and Mr Grayson updated on the meeting held with Dr Elizabeth Gill and Frank Sims and noted that discussions covered Crowborough, the benefits of acute and community integration, the CCG strategy and the temporary closure of the Minor Injury Unit.

2. Performance Reporting 2014/15

Discussion took place on the Board reporting requirements for 2014/15 and it was agreed that these should be framed around the Trust's strategic objectives with a set of indicators for each objective. It was agreed that a working group would be set up to further develop this in readiness for a shadow report to be presented to the March Trust Board. The group would consist of Mr Welling, chairs of the Board sub-committees – Mr Ellis, Mr Nealon and Mr O'Sullivan, Ms Green, Mrs Harris, Dr Harrison and Dr Hughes.

3. Specialist Palliative Care Services

Dr Benson outlined how specialist palliative care services integrated with the general biomedical services provided by the Trust and adopted a holistic approach aimed at providing an improved quality of life for those patients suffering chronic conditions and/or nearing the end of life in both acute and community settings. Specialist palliative care service were provided by multi-disciplinary teams, e.g. Drs, nurses, social workers, chaplain, OTs, physiotherapists, administration.

She demonstrated how the service was funded within the Trust, how it worked alongside the services provided by the two hospices in Eastbourne and Hastings and how the provision differed across the two areas. She expressed concern that the appointment to a vacant nurse post in the acute service had been put on hold and Mr Grayson agreed to follow this up to ensure that the appointment was progressed. **DG**

She highlighted how the provision of palliative care services improved the quality of life for patients and provided savings in terms of reduction in the number and length of hospital stays.

Dr Benson referred to the PEACE project which had been set up within the Trust by Dr Mucci and herself and outlined the benefits that it provided for patients.

Mr Welling reported that he and Dr Benson had met previously to discuss issues around how the service was delivered in East Sussex and it was agreed that it would be beneficial to have a high level meeting of partners involved in delivering the service to explore how the delivery of the palliative care service could be improved across East Sussex and Dr Hughes agreed to set this up. **DH**

Mr Welling thanked Dr Benson for her presentation.

4. Planning Process 2014/15 to 2018/19

Dr Harrison reported that the TDA had issued planning guidance on 23rd December 2013 to Trust Boards entitled Securing Sustainability which set out the planning requirements for 2014/15 to 2018/19.

She outlined the internal planning process which would be undertaken within the Trust to meet the TDA requirements of a 2 year plan and a 5 year plan. The process would build on the steps already undertaken to develop the clinical strategy and previous years' business, cost improvement and turnaround plans, and would adopt a risk based approach to ensure the risks to sustainability and improvement opportunities were identified and informed planning priorities informed from both a clinical unit and a top down level. The clinical units were developing specific service plans including identifying service risks and developing transformation plans. The plans would undergo a quality impact assessment by the Director of Nursing, the Chief Operating Officer and the Medical Directors and these would inform the executive led challenge process which further review and refine the plans.

She advised that the Board would be fully informed and sighted on the process which would include the relevant Clinical Units presenting the plans with the most significant risks to the Board at a session on 12th March.

Mrs Harris outlined the allocations being provided to the CCGs over the next two years and noted that these had been developed in a new format based on population size, deprivation and tackling health inequalities. All CCGs would receive an inflation increase of 2.14% in 2014/15 and 1.7% for 2015/16 and she outlined how the transfer to Better Care funding would impact on the local CCGs in 2015/16.

She reported that the TDA guidance required all Trusts in recovery to return to financial balance by the start of 2016/17 and the Trust's medium term financial recovery plan also planned for this.

Mrs Harris reported that a high level one year plan had been submitted to the TDA on 13th January based on the forecast outturn position for the current year and she outlined the assumptions and risks to the plan.

5. Date and Time of Next Meeting

Wednesday, 12th February 2014, 10am to 2pm, in the St Mary's Board Room, EDGH

East Sussex Healthcare NHS Trust

Date of Meeting:	26th March 2014
Meeting:	Trust Board
Agenda item:	17
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:

Meeting attended in February and March included:

- Public Quality Engagement Event - Hastings
- LiA Medical Staff Conversation
- Meeting with Chairs of Eastbourne,Hailsham and Seaford and Hastings and Rother CCGs
- Health & Overview Scrutiny Committee
- League of Friends Chairs Meeting
- Opening of new League of Friends Shop – Eastbourne DGH
- Musicians in residence – certificate awards – Conquest Hospital
- Various quality walks

The following correspondence is attached to the report:

NHS Fast Track Executive Programme
17 Feb letter from Jeremy Hunt re

Ensuring an Open NHS Culture/Whistleblowing Procedures
15 Feb letter from Jeremy Hunt
5 Mar letter from Jeremy Hunt

Support Project
17 Feb letter from Robert Alexander, Director of Finance, NHS Trust Development Authority, Paul Baumann, Chief Financial Officer, NHS England and Stephen Hay, Managing Director Provider Regulation, Monitor
Joint support project press release
Copy of letter to MPs

Letters to Stephen Lloyd, MP

Use of Trust Seal
The following documents have been sealed since the last Board meeting:

PAS Managed Service Contract
VitalPAC Solution 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: Stuart Welling, Chairman	**Contact details:** s.welling@nhs.net

Department of Health

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

To: Foundation Trust and NHS Trust Chairs

17 FEB 2014

Dear Colleagues,

I am delighted to write to you and all Foundation Trust and NHS Trust Chairs in England to draw your attention to the recently launched NHS Fast-Track Executive Programme – an important initiative that will bring together some of the country's best clinicians and exceptional business leaders and support them to take on executive-level careers in the NHS.

This intensive development and training experience, tailored to the needs of both candidate groups, represents one of the many actions being taken forward in response to the Francis Inquiry and is aimed at attracting and enabling new talent to join and further enrich the NHS' already excellent leadership talent pool. The programme will be run by the NHS Leadership Academy in collaboration with Harvard Kennedy School and Harvard School of Public Health, and will complement the significant work already underway by the Academy to develop the leadership skills and behaviours of a full range of staff at every tier of the NHS.

Starting on 2 June 2014, the programme will include eight weeks' international experience and education in Boston; one week in an international healthcare leadership experience (co-ordinated by KPMG's Global Healthcare practice); an executive education in the UK (including master classes, learning sets, conferences, workshops and seminars with experts in their field); and a six-month placement within the executive team of an NHS organisation, leading a major change project alongside the sponsoring Chief Executive.

At the end of the ten-month programme candidates will be supported to move into a senior executive role, where they can:

- Share their new skills and insights
- Work on tough challenges and decisions
- Have high-level influence over staff and budgets

- Maintain national networks to lead changes in the field
- Move from a clinical leader to a strategic leader

For those clinicians involved, the programme is designed to harness their talent as experts in the delivery of care and enable them to increase their influence on the design and development of NHS services - working alongside the talented leaders already in the NHS to bring to bear fresh ideas, perspectives and thinking. Many NHS clinicians will already be aware of this initiative through the marketing of the NHS Leadership Academy, so **if you have senior, experienced and patient-focused clinicians in your trust who you think would be perfect candidates for the programme, I would encourage you to remind them that we are in the final few weeks of the application process for this exciting opportunity (applications close 26th February 2014).**

It is vital to ensure that any application to the Fast-Track Executive programme is authorised and supported by whoever is responsible for candidates' NHS contract, and the sponsoring Chief Executive.

More information about the programme is available at www.leadershipacademy.nhs.uk/fast-track or by contacting Karen Lynas, Deputy Managing Director of the NHS Leadership Academy (karen.lynas@leadershipacademy.nhs.uk).

Yours sincerely

Jeremy Hunt

JEREMY HUNT

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

TO:
All Chairs in NHS Trusts in England
All Chairs in NHS Foundation Trusts in England

CC:
Monitor
NHS Trust Development Authority

15 FEB 2013

Dear Colleague,

ENSURING AN OPEN NHS CULTURE

In his report last week into the appalling events that occurred at Mid Staffordshire NHS Foundation Trust, Robert Francis highlighted the critical importance of fostering and sustaining an open culture in which concerns about care can be raised, investigated and acted upon. He said:

"*Insufficient openness, transparency and candour lead to delays in victims learning the truth, obstruct the learning process, deter disclosure of information about concerns, and cause regulation and commissioning to be undertaken on inaccurate information and understanding. This Inquiry has shown that, desirable though the principle of openness, transparency and candour may be, it is frequently not observed. This has had serious consequences.*"

You will all have seen the media coverage this week of allegations of some NHS bodies using legal processes apparently to frustrate the efforts of staff to ensure that problems are properly aired and action taken to ensure safe, effective and compassionate care for patients.

Last year, Sir David Nicholson wrote to every organisation in the NHS reminding them of their legal responsibilities in this respect and the Department's long-standing guidance on "gagging clauses" and the need for genuine consideration of concerns when they are raised (attached).

I know that many NHS organisations follow not just the letter but the spirit of that guidance. Fostering a culture of openness and transparency is essential if we are to ensure we never repeat the mistakes of Mid Staffs - which means creating a climate where it is easy for staff, present and former, to come forward with any concerns they have relating to patient safety.

For those working in the many organisations that do exactly that, I would like to thank you and commend you for your efforts. But others may recognise in their own behaviour an element of the institutional self-defence that prevents honest acknowledgement of failure followed by swift corrective action to put things right.

So I would ask you to check that the confidentiality clauses in your contracts (and compromise agreements with departing employees) do indeed embrace the *spirit* of this guidance. I would also ask you to pay very serious heed to the warning from Mid Staffordshire that a culture which is legalistic and defensive in responding to reasonable challenges and concerns can all too easily permit the persistence of poor and unacceptable care.

Raising concerns can be a brave thing to do, even in an open culture, so when our staff have the courage and professional integrity to raise concerns in the patient interest, we need to recognise and celebrate that behaviour, listen to their concerns and take action to ensure any problems are properly addressed. I know many organisations already have such an approach, but I would ask you to work with colleagues across the system to ensure this happens consistently across the NHS.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

Department of Health

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

TO:

All Chairs in NHS Trusts in England
All Cahirs in NHS Foundation Trusts in England

CC:

Monitor
NHS Trust Development Authority

- 5 MAR 2014

Dear Colleague,

You will recall that I wrote to you last year following Robert Francis QC's landmark report on Mid Staffordshire NHS Foundation Trust in order to highlight the vital importance of fostering a culture of openness and transparency in the NHS, in which concerns about care can be raised, investigated and acted upon (please see attached).

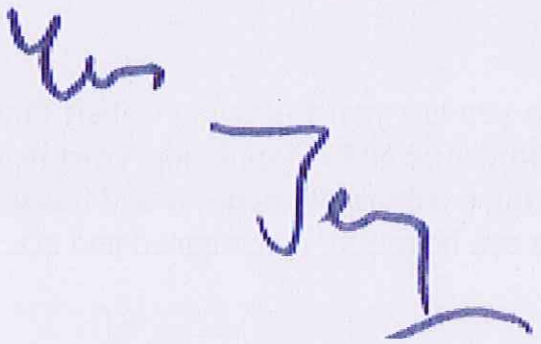
In light of recent media reports in which staff have raised concerns about whistleblowing procedures, I thought that it would be timely to reiterate how strongly I feel about staff – present and former - being able to come forward with any concerns they have regarding patient care or safety.

I believe that we have taken significant strides on furthering the ambition to create a more open culture in the NHS in the last few years. For instance, we have ensured that whistleblowing rights are included in the contracts of all NHS staff and made guidance available to employers on best practice in support of whistleblowers; whistleblowing is being embraced by the Care Quality Commission as part of their new inspection methodology; and the NHS Constitution has been amended to highlight the rights and responsibilities of NHS staff and their employers in respect of whistleblowing. Of course, we are also legislating to introduce a statutory duty of candour on organisations, and professional regulators are consulting on a new professional duty of candour for staff. I believe that this will help us to create one of the most transparent and open healthcare systems in the world.

I would like to thank you and all NHS staff for all that you have done to help us on this journey.

In a system as large and complex as the NHS, culture change will not happen overnight. It is clear that embedding an open culture across every single part of the NHS will require sustained and determined leadership from us all. Recent concerns that have been raised about whistleblowing procedures highlight the continued need for us all to speak and behave in a way that is not only consistent with the law, but which fosters trust and confidence in staff that when they speak up - because that is the right thing to do - their concerns will be heard and their actions welcomed.

As I said in my letter last year, fostering a culture of openness and transparency is essential if we are to ensure we never repeat the mistakes of Mid Staffs. I know you will all want to join me in creating an environment in which people with legitimate concerns about poor care are welcomed both as champions of patient interests, and as the true servants of NHS values.



JEREMY HUNT

17 February 2014

Sent by email to:
Darren Grayson – Chief Executive
East Sussex Healthcare NHS Trust
darrengrayson@nhs.net

Stuart Welling – Chair
East Sussex Healthcare NHS Trust
s.welling@nhs.net

Dear Darren and Stuart,

NHS England, Monitor and NHS Trust Development Authority (the national partners) are committed to working together with local health systems to secure high quality care services for patients and financial sustainability for the long term future. As part of the co-ordinated planning guidance requesting commissioners and providers to develop five year strategic plans by June 2014, we have identified 11 health economies where we believe additional support from external advisers will add the most value to the planning process.

Your organisation is one of those within the 11 health economies selected to gain additional support. Jim Lusby, Portfolio Director, will be in touch with you to explain the process further and answer any questions. The objective of this work will be to provide support at local health economy level that:

- Enables commissioners and providers in the local health economy to submit robust and deliverable strategic plans in June which clearly set out how the anticipated challenges will be met.
- Facilitates commissioners and providers to develop full implementation plans for the change that is required.

- Provides the national partners with confidence that the capacity is in place to deliver the plans, and outlines any areas of risk or where further support may be required.

We must be absolutely clear that it is still your responsibility to deliver robust strategic plans aligned across the health economy. The appointed adviser will provide additional capacity, creating analysis and insights into the major local challenges and possible solutions. They will also act as a critical friend, bringing together local health economy organisations (both commissioners and providers) to test whether your organisations are addressing your long term strategic planning in the right way.

Together, the national partners undertook a three step exercise to identify those health economies which will most benefit from this targeted support. Each national partner individually carried out analysis using a set of criteria (quantitative and qualitative analysis on finances, governance and quality) to determine a long list of proposed health economies. A workshop with regional directors from each partner organisation was held to discuss each economy on the long list in detail and determine the prioritisation of the final joint list. Follow up meetings with senior input from each of the three partners agreed the final joint list.

By investing resources to support you and your colleagues across the health economy in the planning process at this point, the national partners are attempting to avoid costly and potentially disruptive regulatory action further down the line. We have identified the areas where we believe focussed support now will result in significant positive benefits to patients in the future.

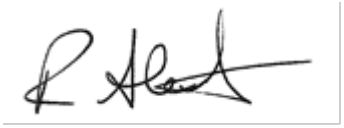
The advisers will be appointed at the end of March and will begin a programme of work of around 10 weeks across four workstreams (subject to the needs of each economy):

- A diagnosis of supply and demand;
- Solutions development and options analysis,
- Plan development; and
- Critical friend input/facilitation of implementation plan development.

We know that in some local health economies, existing work is already underway or has taken place recently. We have made clear in the outline of the work that where this is the case, any additional support should build upon and support that work. External advisers are clear that there should be no duplication of existing work.

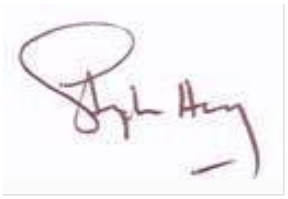
We will write to you again once the adviser has been appointed. The national partners are investing a significant amount in providing this support, but it will only have meaningful impact if you work closely in partnership with the external advisers to develop robust and effective plans together.

Yours sincerely,



Robert Alexander,
Director of Finance, NHS Trust Development Authority

Paul Baumann,
Chief Financial Officer, NHS England



Stephen Hay,
Managing Director Provider Regulation, Monitor

Address of MP

17 February 2014

Dear xxxxxxxxxx

Monitor, NHS England and the NHS Trust Development Authority (the national partners) are committed to working together to secure high quality care services for patients for the long term future. As part of that commitment, the partners have agreed to fund a series of projects to help commissioners and providers work together to develop integrated five-year plans addressing the particular local challenges they face in delivering high quality patient-focused care.

The projects will focus on eleven areas of the country, one of which, XXXXXXXXXXX, includes your constituency. The areas have been chosen on the basis that they will most benefit from external support in the first few weeks of the new financial year. The objective of this work will be to provide dedicated, specialist support at local health economy level that:

- Enables commissioners and providers in the local health economy to submit strategic plans in June that are robust, deliverable and clearly set out how the anticipated challenges will be met.
- Facilitates commissioners and providers to develop full implementation plans for the change that is required to deliver the best possible patient-centred care.
- Provides the national partners with confidence that the capacity is in place to deliver the plans, and outlines any areas of risk or where further support may be required.

As I am sure you are aware, as part of the annual planning round, all NHS organisations are being urged to plan over a five-year period in future as part of a concerted effort to tackle the long-term financial and operational challenges facing the system.

The appointed experts will act as a critical friend, seeking to bring together all partners in the health economy and testing whether the organisations are undertaking that strategic five-

year planning in the most effective way. As part of the tender, we have specifically highlighted the requirement for the expert advisors to ensure commissioners and providers engage patient groups in the planning process. They will also provide additional capacity, providing analysis and insights into the major local challenges and possible solutions.

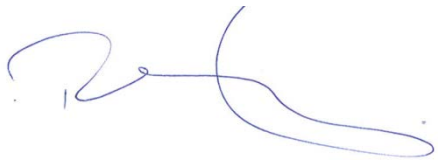
The advisers will be appointed at the end of March and will begin a programme of work of around 10 weeks across four workstreams, subject to the needs of each economy:

- A diagnosis of patient need against the provision of services;
- Development of solutions and the options available,
- Plan development;
- Implementation.

While NHS commissioners and providers in your constituency have already been informed of the projects, the partners will also be informing all local MPs, Healthwatch and health and wellbeing boards in the eleven economies.

If you need any further information, then please contact my colleague Liz Sillitoe on 020 3747 0222 or by email Elizabeth.sillitoe@monitor.gov.uk.

Yours sincerely



Toby Lambert, Director of Strategy and Policy
Sent on behalf of Partners

SW/ajp

East Sussex Healthcare NHS
NHS Trust

3rd February 2014

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 Stephen

I am disappointed that you have not responded to my letter of the 16 December repeating my suggestion that a 1:1 meeting between us would be of benefit.

The need for this has again been highlighted following your comments to the media last week about matters relating to the Trust on which you had not made any effort to discuss with either Darren or myself.

I would again extend the invitation to meet with me which must surely be of benefit if your intention is to demonstrate you genuinely have the best interests of the DGH and of those who use its services at heart.

Yours sincerely

STUART WELLING
Chairman

cc Darren Grayson, Chief Executive

East Sussex Healthcare NHS
NHS Trust

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 01323 415653

SW/JM

20th February 2014

Stephen Lloyd MP
100 Seaside Road
Eastbourne
BN21 3PF

Dear Stephen

I have viewed the evidence you gave to HOSC on Monday and read the joint press release you issued with Liz Walke. I am again concerned that you have continued to be very critical of the Trust without any prior discussion with either me or Darren to clarify the facts.

I am confident that the current public consultation process will ensure that all interested parties will have an opportunity to give their views and that the consultation includes a number of opportunities for our staff to have an input. These include staff sessions run by the CCG, feedback through the consultation website and through the form included in the consultation document. The Trust has never sought to restrict staff from raising their concerns. You may recall that staff attended the meeting of the CCGs' Governing Bodies when they agreed the case for undertaking the current consultation and freely expressed their views on the changes proposed. Indeed I would be very concerned if this was not the case. If you have any evidence contrary to this I would be very pleased to discuss it with you and with the members of staff concerned because this would be totally contrary to the way the Trust wishes to operate.

In respect of the evidence Liz Walke gave unfortunately despite the fact that she regularly attends trust Board meetings where the Board Assurance Framework (BAF) is discussed she has fundamentally misunderstood its purpose. In common with NHS organisations across the country we use our BAF as part of our governance to highlight those things which, if they happened, would mean we are not able to achieve our organisation's objectives. The red, amber and green ratings in the BAF are used to highlight to the Board areas where further action is required to prevent the risk from happening. If an area is rated green then it is removed from the BAF. The Board receives regular assurance on all areas identified in the BAF. For example in relation to patient safety in maternity services following the temporary changes we have received evidence that patient safety has improved with significantly fewer serious incidents occurring.

I have repeatedly asked you to meet with me so that we can discuss these and other issues in detail and I hope you will reflect on this and agree to a 1:1 meeting.

Yours sincerely

Stuart Welling
Chairman
East Sussex Healthcare NHS Trust
email:s.welling@nhs.net
Tel: 01323 435653

Cc Trust Board
Dr Stephen Dunn NHS TDA
Mr Michael Ensor Chairman HOSC

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PRIVATE

A meeting of East Sussex Healthcare NHS Trust Board will be held in private on Wednesday, 26th March 2014, following the public Trust Board meeting In the Ashdown Room, Uckfield Civic Centre

		Lead
1.	Apologies for Absence	Chair
2.	Declarations of Interest	Chair
3.	Minutes of the meeting held on 29th January 2014 (attached)	Chair
4.	Update on Current Issues	CEO
5.	Public Dividend Capital Application Update	DF
6.	Business Planning	DSA/ DF

STUART WELLING
Chairman

20th March 2014