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 November 2014, commencing at 10.00 am in the Oak Room, Hastings Centre

	AGENDA		**Lead:**
1.	a) Chairman's opening remarks b) Apologies for absence c) Quality Walks September/October 2014		Chair
2.	Monthly award winner(s)		Chair
3.	Declarations of interests		Chair
4a.	Minutes of the meeting held on 24th September 2014	A i	Chair
4b.	Matters arising	A ii	Chair
5.	Chief Executive's report (verbal)		CEO
6.	Board Assurance Framework	B	CSec

QUALITY, SAFETY AND PERFORMANCE

7.	a) Performance report month 6 (September) and Finance report month 7 (October) b) Current Quality Account Indicators	Assurance	C	ALL DN
8.	Safe Nurse Staffing Levels report	Assurance	D	DN
9.	Patient Experience Report Quarter 2 (July-September 2014)	Assurance	E	DN
10.	Mortality Indicators and Metrics report	Assurance	F	MDG
11.	Research and Development report	Assurance	G	MDS

STRATEGY

12.	Education Strategy 2014-17	Approval	H	HRD

13.	Procurement Strategy	Approval	I	DF
14.	Annual Business Planning Framework for 2015-16	Assurance	J	DSA

GOVERNANCE AND ASSURANCE

15.	Annual Review of Corporate Documents	Approval	K	CoSec
16.	Board sub-committees: a) Audit Committee 12.11.14 b) Finance and Investment Committee 29.10.14 c) Quality and Standards Committee 10.11.14 d) Trust Board seminar notes 13.08.14, 17.09.14 and 15.10.14	Assurance	L	Comm Chairs

ITEMS FOR INFORMATION

17.	Chairman's Briefing	M	Chair
18.	Meeting Dates for 2015	N	Chair
19.	Questions from members of the public (15 minutes maximum)		Chair
20.	Date of Next Meeting: Wednesday, 4th February 2015 at 10.00 am in the St Mary's Board Room, Eastbourne DGH		Chair
21.	**To adopt the following motion:** *That representatives of the press and other members of the public will be excluded from Part 2 of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest* *(Section1(2) Public Bodies (Admission to Meetings) Act 1960)*	O	Chair

STUART WELLING
Chairman

20th November 2014

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

East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 2014
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks September/October 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 September and October 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 September and October has continued as previously. These were:

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

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

18 services/departments were visited as part of the Quality Walk programme during September and October as detailed in the attached. 15 of these were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit. The remainder were carried out as ad hoc visits so staff may or may not have been notified to expect them. (NB other adhoc visits may have taken place, but reports have not yet been received). In addition the Director of Nursing carried out an evening/night visit at the Conquest Hospital accompanied by a Non-Executive Director.

Feedback forms have been received to date relating to 14 of the visits, copies of which have been passed on to the relevant department/service managers for information.

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

<u>Service Reconfiguration</u>

Following the closure of the Day Surgery Unit at Eastbourne at the beginning of August, the Admission Unit on Litlington Ward had seen an increase in activity. On the day of the Quality Walk the unit had admitted 47 patients in the morning – the maximum is usually around 35. With a mixture of operations, i.e. some long, some short, this has an impact on the activity of the department, however it was observed that although this is a very busy area the flow of patients was working well. Staff seemed very positive and engaged despite the levels of activity but did voice their concerns if the unit were to move again.

A visit to the surgical teams at the Conquest found that since a previous visit the staffing position had improved and although the teams were working under considerable pressure the unit was working well.
An acute ward that had recently changed its function and subsequently required 2 teams to be brought together reported that they have integrated well.
Outpatient staff were feeling the impact of the 'admin review' and reported that due to the changes they felt there was a loss of the personal touch to the patients and that pressures led to a 'factory line' type of service. There was also concern about the future noted at one of the Community Hospitals affected by the tendering process initiated by High Weald Lewes and Havens CCG.

Information Technology (VitalPAC, SystmOne)
In the areas visited SystmOne was welcomed and seen as a positive improvement but there were some concerns by one team that it did not fit that well with the needs of Health Visiting
VitalPAC appears to have been well embedded and although some areas felt that initially it was a slow process they were now positive about its impact and reported that it saves time by avoiding form filling and by self calculating News Scores. It also acts as an aide memoir for staff; however it can add a complication when carrying out monthly audits as VitalPAC does not collate everything required.
In the health records department it was reported that there are plans to use an IT platform which will interface in a paperless fashion with Vital-Pack to give point of need patient history.

Staff Survey
In some areas there was awareness that several staff had received reminder letters to complete the current staff survey but felt that time to do so was a pressure. Staff also reported that there had been a significant drive to complete mandatory training and they were being given time to do this.

Other key issues
Loss of administrative staff in a Health Visiting/School Nursing team was reported which meant that tasks had to be done by clinical staff. It was also noted that in the same team case loads were becoming more complex particularly with black minority and ethnic groups and the homeless.
Problems with accessing medical records remain an issue for the outpatient departments and the working accommodation for staff in health records remain cramped with each library full to capacity.
Medical cover at one of the Community Hospitals was reported to be an issue and it was agreed that this would be discussed with the relevant CCG.
Some acute areas reported that at times having sufficient staff to provide care for patients being 'specialed' is a challenge and there is a reliance on the Temporary Workforce Service to provide cover which cannot always be fulfilled.

Patient feedback
Community patients spoken to appeared to be very happy with their care and environment; patients in the acute setting reported good nursing care, and stated they felt informed and involved in their care however some had mixed comments about the food. Lack of storage for patient's belongings was raised as an issue in one area.

Benefits:

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

Risks and Implications

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

Assurance Provided:
Any actions identified at a Quality Walk are agreed at the time and it is noted who will be responsible for taking forward the action. These are logged and monitored by the Head of Compliance to ensure that actions are implemented. Further visits are being scheduled to take place in November and December. It has been agreed that the current themes will continue throughout November.

Link to Board Assurance Framework:
Strategic Objective 1, risk 1.1

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

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

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

Quality Walks September - October 2014				
DATE	**TIME**	**SERVICE**	**SITE**	**Visit by**
September				
3.9.14	10am	Cuckmere	EDGH	Darren Grayson
4.9.14	10am	Intermediate Care beds	Lewes Victoria Hospital	Amanda Harrison
10.9.14		Health Records	EDGH	Barry Nealon
15.9.14	10.45am	Berwick Ward Jevington Ward	EDGH	Alice Webster Susan Bernhauser David Hughes
22.9.14	1.45pm	Health Visitors and School Nurses	London Road St Leonards	Stuart Welling
25.9.14	9.30pm	All areas	Conquest	Barry Nealon Alice Webster
30.9.14	9.30am	Out Patients	EDGH	Stuart Welling
October				
1.10.14	2pm	Admissions Lounge (Litlington)	EDGH	Monica Green
6.10.14	2pm	Glynde Ward	EDGH	Jon Cohen
13.10.14	10am	Michelham Unit	EDGH	Darren Grayson
15.10.14	2.30pm	Seaford 1 MAU	EDGH	Jon Cohen
16.10.13	11am	Egerton Unit	Conquest	Amanda Harrison
20.10.14	3.30pm	Pathology	EDGH	Amanda Harrison
21.10.14	2.15pm	Tressell James SAU	Conquest	Stuart Welling
30.10.14	11.30am	Berwick	EDGH	Stuart Welling
30.10.14	10am	Firwood intermediate care beds	Eastbourne	Amanda Harrison
30.10.14	11.30am	Wellington Ward	Conquest	Monica Green
31.10.14	6am	Berwick	EDGH	Vanessa Harris

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EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday, 24th September 2014 at 10.45 am in the St Mary's Board Room, Eastbourne DGH

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

In attendance: Mrs Sue Bernhauser, Non-Executive Director Designate
Ms Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development and Assurance
Mrs Lynette Wells, Company Secretary
Ms Jan Humber, Joint Staff Side Chairman
Dr Barry Phillips, Director of Infection Prevention and Control (item 088/2014)
Mrs Tina Lloyd, Assistant Director of Infection Prevention and Control (item 088/2014)
Ms Lesley Smith, Senior Nurse Infection Control (item 088/2014)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

081/2014 **Welcome and Apologies for Absence**

a) Chairman's Opening Remarks

Mr Welling welcomed everyone to the public part of the main Board meeting.

b) Apologies for Absence

Mr Welling reported that apologies for absence had been received from Professor Jon Cohen and Charles Ellis, Non-Executive Directors.

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

c) Feedback from Quality Walks

The Board noted the summary report and Mr Welling invited Mr Grayson and Mr Nealon to feed back on the visits they had undertaken.

Mr Grayson reported that he had undertaken a large number of quality walks during July and August but wished to concentrate his report on his visits with the community nursing teams, including a half day spent with Andy Geall in Eastbourne.

Mr Grayson commented that he had never met a more highly motivated workforce who were committed towards working in the community and particularly relished the challenges of working independently but also as part of a team.

He reported that the staff provided a fantastic level of care including strong team working and he had seen the positive impact of SystmOne for staff on several occasions.

He highlighted that the level of demand and need in the community continued to grow expediently which was appreciated by the Trust and commissioners and they both needed to think about how they could enable and invest in the community services as simply shifting resources from the acute service would not work. He highlighted that there was also an issue relating to variable GP expectations and through dialogue with the commissioners agreement would be reached on the provision of and the expectations on community services.

Mr Grayson reported that another issue the Trust and the commissioners were focused on was the sustainability of the community services as it was an ageing workforce with a large number of staff approaching retirement. Mrs Webster reported that the number of training commissions had been doubled for this year and the aim was to increase this further in years to come but it would not solve the staffing gap.

Mr Nealon reported on his walks to the health records department which was based on a number of sites including the Conquest, Eastbourne DGH, Hailsham and Brampton Way.

He highlighted that the abandonment of the national IT strategy had resulted in the Trust still having a manual patient record system which consisted of 1.5 million records, with 2,000 new records being created each month into the system. This had contributed to increasingly difficult working environments and there was a high degree of long term sickness which was indicative of the poor working environments and deserved to be on the risk register.

He reported that the Trust, in combination with Western Sussex Hospitals Trust and Queen Victoria Hospital Trust, were planning to invest in an Electronic Document Management (EDM) system within the next year. This system would make it easier for clinicians to access patient records electronically and would help to provide a better working environment for the staff but also.

Mr Welling commented that he had also visited these areas and agreed with the issue of the environment not being conducive to good working. Mr Sunley thanked Mr Nealon for his useful report and noted that the Trust had identified these issues and was planning action. The areas of concern identified by the Trust had also been reflected by the CQC when they had visited this area. He highlighted the good work the staff did in the area in difficult conditions and the service had suffered from not being recognised as an issue in previous years.

It was agreed that Mr Welling and Mrs Bernhauser would report back on their quality walks at the next meeting. **SW/SB**

The Board noted the reports on quality walks.

082/2014 **Monthly Award Winners**

Mr Welling reported that the monthly award winner for August was Cardiac Rehabilitation Sister Hilary Richards who had been nominated as follows:

"I would like to nominate Hilary for her recent hard work and effort promoting our service and the hospital to the local population. She single handedly organised our regular health promotion event at Airbourne which is run jointly with the British Heart Foundation. Over 3,000 people came to the marquee for heart health checks and health promotion advice. The event was supported by members of staff from various departments who volunteered their time but Hilary's organisation and energy made it happen. Most of these efforts were in her own time including setting up and breaking down the stall and covering a day and a half of the sessions herself. I have a comment form the Area Development Manager who wanted to support her nomination for this award:

"This is the third year we have worked with Hilary, she is undeniably the cornerstone of our partnership working and sincerely believes in the promoting of good health for all of the residents and visitors to Eastbourne at the Eastbourne Airshow." Suzanna McGregor, Area Development Manager, British Heart Foundation

Hilary has been working in the cardiac rehab team for many years, she provides expert advice on cardiovascular disease and supports myself and our team with her unflagging energy and enthusiasm for her role. I would love her to have some formal recognition for her commitment to the team, her patients and Eastbourne Hospital."

Mr Welling reported that he had visited Sister Richards recently and presented her with her certificate and award.

He reported that the winner for September was Practice Educator Judith Ball who had been nominated as follows:

"Judith has been and continues to be a great source of inspiration to everyone she comes in to contact with. In her role as a Practice Educator (PE) she covers 4 areas within her CCG – The Havens, Lewes, Heathfield and Crowborough - providing support to all community staff, working with new community nurses, supporting current community nurses, supporting the Team Leads and Trust Managers in taking processes forward and taking a proactive stance with educational issues.

The PE role is multi-faceted requiring a large range of abilities. Judith is quick to offer help to her fellow PE colleagues and has been proactive in setting up and running various teaching projects both locally and strategically. Whilst working as a PE Judith has undertaken further study at the University of Brighton to achieve a Distinction in Designing, Planning and Strategic Working in Education (Masters Level).

From working with Judith I see first hand how this course has influenced her and enhanced her practice. On networking with colleagues it is evident how knowledgeable Judith is around a vast variety of clinical issues. She also explains skills/procedures in a language that anyone can relate to from pre registration student nurses to managers.

She is involved with the Listening in Action project around Values and Behaviours because she is passionate about nursing and ensuring people are recognised for all their hard work and commitment. Judith is one of those people who is quick to praise others and encourages staff to 'shout' about the work they do so now I feel it is her turn to be recognised for all the work she does."

Mr Welling reported that Ms Ball was not able to attend as she was on annual leave and arrangements would be made to present her award on her return.

083/2014 **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.

084/2014 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 30th July 2014 were considered and approved as an accurate record.

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

b) Matters Arising

The updates on the matters arising log were noted and Mr Sunley reported that an explanation of the TDA Accountability Framework was now on the Trust's website.

085/2014 **Appointment of Vice Chair**

The Board supported the appointment by the Chairman of Mr Nealon as Vice Chair.

086/2014 **Chief Executive's Report**

Mr Grayson presented his report focussing on the CQC inspection in September which was a routine planned inspection. He was of the opinion that the process went well and the feedback from the inspection team was that they had been welcomed by staff who had been universally open and freely shared their views.

He thanked all the staff for their positive response, in particular the nursing staff, and for their support on the journey the Trust was on.

He reported that the Trust continued to provide the inspection team with information – over 900 documents – and the team had also listened to the views of the local population and commissioners. He expected that the report would published around the middle of November.

He highlighted that the CQC team had said that the Trust had uniformly caring staff of whom it should be proud and none of our services had raised any major flags of concern. In addition, the feedback did not identify any significant areas of improvement that he had not shared with the inspection team in his presentation at the beginning of the visit, including healthcare records. This was Important as it demonstrated that the Board and leadership team knew the issues within the organisation, the risks and the mitigating actions being taken.

Mr Grayson emphasised that the role of the inspection team was to look at the safety and responsiveness of the services provided by the Trust and not comment or pronounce judgement on its strategy.

He commented that he was aware that the Trust had in the past seen final pronouncements in CQC reports at odds with feedback received on the day but he believed that everyone should be proud of the CQC comment relating to the caring approach of the staff and he hoped that the CQC would help the Trust on its journey to provide high quality services to the local population.

The Board noted the Chief Executive's report.

087/2014 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework been updated and reviewed since last meeting of the Board and had been to the September meetings of the Quality and Standards and Audit Committees.

Mrs Wells reported that an additional risk – 3.2 - had been added and following discussion at the Audit Committee they had recommended that the wording should be revised to:

"We are unable to …. and this could impact on our ability ….."

Mrs Wells reported that an additional gap in control had been added to risk 1.2 in relation to the backlog in plain film reporting and actions were in place to address this.

She reported that both committees had reviewed the rating for risk 2.3 in relation to mandatory training and their view was that there was not sufficient assurance at present and recommended that the RAG rating be changed to red.

She noted that part of the risk in relation to health records was captured on page 14 of the Framework.

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. It also accepted the amendment in the wording for risk 3.2 and the change in the RAG rating for risk 2.3.

088/2014 **Infection Control Annual Report 2013-14 and Annual Work Programme for 2014-15**

Mr Welling welcomed Dr Phillips, Mrs Lloyd and Ms Smith to the meeting.

Mrs Lloyd reported that the key headlines in the annual report for last year were the Trust's achievement of a continued reduction in MRSA and Clostridium Difficile infection (CDI) and the challenges related to cross infection CDI and implementing the lessons learned from such cases.

Dr Phillips commented that the report demonstrated how the team worked closely with staff to provide assistance, support and advice on addressing infections and particularly during 2013/14 when there had been quite significant structural reconfiguration taking place. He also referred to the external support provided by commissioners, the county council, Public Health England and the Trust Development Authority which assisted the Trust to ensure compliance with Outcome 8 Regulation 12 "Cleanliness and Infection Control" of the Health and

Social Care Act 2008.

Mrs Lloyd reported that the Trust had performed extremely well in reducing MRSA cases with only one case reported in 2013/14.

Mrs Lloyd highlighted the decrease in MRSA cases since 2008/09 when the Trust reported just over 20 cases.

Mrs Lloyd also highlighted that in relation to CDI the Trust had reported 43 cases in 2013/14 against a challenging target of 25 and this had represented a reduction of 8 cases on the previous year.

She reported that in recognition of the often sporadic nature of CDI the Department of Health had revised the objectives for reduction of CDI in 2014/15 and the cases would be measured through lapses in care rather than actual numbers. She highlighted that 95% of cases were due to the administration of essential therapy.

In response to a question from Mr Nealon regarding the provision of side rooms, Dr Phillips reported that as the Trust took on a lighter footprint it added to the challenge through the loss of side rooms but this was being recognised and addressed. Each clinical unit had been set a target for side rooms for each year and this would be incorporated in their planning over the next three years.

He commented that the provision of many side rooms was not considered the “holy grail” as it had been recognised that higher nursing and higher cleaning ratios were required to ensure that they were effective.

Mr Sunley referred to the higher percentage against the mean infection rate in surgical site surveillance and asked how this was being addressed. Dr Phillips reported that a root cause analysis (RCA) had been undertaken for each case and there were multiple factors contributing within the patient pathway and this had resulted in a group of orthopaedic surgeons reviewing the whole patient pathway to identify the areas where improvements could be made. Mrs Lloyd highlighted that the infection rates for individual surgeons did not show any specific areas of concern.

Mrs Lloyd reported that in light of the issues around environment the cleaning standards auditors had been moved into the infection control service resulting in the provision of better data moving forward to respond quickly to such issues.

Dr Phillips commented that the age of the buildings provided a challenge to both cleaning and nursing staff to maintain the environmental cleanliness and spending was being prioritised to improve refurbishment, roofs and the water system.

Dr Hughes welcomed the national change of focus regarding CDI and Mr Grayson reported that 22 cases of CDI had been reported so far for 2014/15, of which 8 had an element of lapse in care.

Mr Welling asked about how the incidence of community orientated infections from nursing homes was being addressed and Mrs Lloyd reported that the Trust worked collaboratively with local partners and nursing homes.

Mrs Lloyd reported that a patient passport was being introduced for patients to reduce catheter infections and the effectiveness of this project would be audited in the last quarter of the year. She highlighted the benefit following the integration with community services with improved communication.

Mrs Harris asked how the team was helping staff undertake their mandatory training and Mrs Lloyd reported that multi-faceted training was being offered, eg workbooks, on-line training, case studies for clinical staff, but she emphasised the value of local face-to-face training to provide additional training.

Mrs Lloyd reported that the key priorities of the annual programme of work for 2014/15 were outlined on page 3 of the programme but referred to the work around new emerging threats including the development of a broad level CPE management plan which required Board support.

Mr Welling and Mrs Webster thanked the team for their excellent work during the year.

The Board approved the Annual Report for 2013-14 and the Annual Work Programme for 2014-15.

089/2014 **Performance Reports**

a) Performance Report – July 2014 (Month 4)

i) Responsiveness Domain

Mr Sunley referred to the Referral to Treatment (RTT) times and reported that the Trust was on target to deliver on the aggregate level by the end of October and the backlog of patients had been reduced by 1400 cases. He highlighted that there were still challenges around gastroenterology, rheumatology and orthopaedics due to the volume of patients coming into those services.

He reported that a number of patients had been identified from the review of the backlog of patients waiting more than 18 weeks and13 patients who had waited over 52 weeks. These patients had now been or were waiting to be seen and all their cases had been reviewed by the Director of Nursing and Medical Directors and their GPs.

Mr Grayson asked if the Trust was on target to clear the 18 weeks backlog and Mr Sunley confirmed that the Trust was on trajectory and this was measured on a weekly basis by the Trust Development Authority (TDA) and commissioners.

In relation to A&E, Mr Sunley reported that the quarterly performance continued to be variable – 95.5% at Q2 - and work continued to strengthen delivery.

Mr Sunley reported that both the 2 week wait cancer standards and the 62 day wait cancer standard had not been achieved. In relation to the 2 week waits he advised that the Trust was working closely with clinical staff to ensure the right conversations were taking place with patients to encourage them to attend their appointments and also working closely with GP colleagues to identify where conversations with patients could happen within surgeries.

In relation to the 62 days wait he reported that the majority of issues related to the small numbers of urology patients where complicated pathways relied on a number of investigations and surgical interventions – some by Trust surgeons and some by external surgeons. He advised that a new partnership board had been set up as this was one of the more difficult targets to deliver involving a combination of primary and acute care to ensure that all interventions were happening in a timely manner.

Dr Harrison asked if the cancer board had a view on actions that could significantly help the Trust to achieve the targets. Mr Sunley explained that the cancer board consisted of both Trust and commissioning clinicians and it was very much of the view that conversations with patients needed to be more robust and appropriate conversations were now taking place.

Dr Harrison asked if there was an ongoing audit of referrals and Mr Sunley confirmed that this was the case and Trust surgeons were having conversations with the relevant GPs about patients not attending or also writing to individual GP practices to make them aware.

Mr Sunley reported that in relation to delayed transfers of care (DTCs) there had been some issues around the calculation and capture of data but agreement had now been reached on the patients to be counted, ie those patients medically fit and ready for discharge. There had been good engagement from social services who had their own staff based within the larger acute elements of the Trust to manage the throughput of patients to more appropriate facilities.

Mr Welling asked if there would be a further impact on DTC numbers with the reduction in social services spend and Mr Sunley reported that there was now a good focus on performance and it was helpful to have an agreed dataset to manage against and there had been a reduction in community bed DTCs.

Mr Sunley advised that social services funding was not an issue but the changeover in provision of homecare services and awaiting family decisions on where patients should go were the biggest issues.

Effectiveness Domain

Dr Hughes reported that the TDA guidance required the Trust to use the Dr Foster portal to view and report on their mortality performance and the portal only displayed annual numbers and these had remained static since the start of the year.
He was able to assure the Board that the Trust did track mortality information through CHKS on a month by month basis and a new improved process had been implemented to monitor and review the data with clinical units through the Mortality Overview Group. Mr Welling confirmed that at the Board seminar in August the Board had received a very detailed update on mortality.

Safe Domain

Mrs Webster reported that there had been 2 reported cases of CDI in July in line with Trust trajectory and there had been no Never Events in the year so far.

She referred to the patient safety incidents and advised that the ratings varied from first reporting as the cases were reviewed and the final assessment of harm undertaken.

She reported that the percentage of harm free care continued at around 94% and this was available for public record on a monthly basis.

Caring Domain

Mrs Webster reported that there had been increase in the number of Friends and Family Test (FFT) returns for the A&E departments to 46% but this remained marginally lower than the required standard.

She reported that there continued to be no mixed sex accommodation breaches for the year.

She informed the Board that as yet the TDA had not released guidance on reporting on complaints but there would be a quarterly report on complaints at the next meeting.

Well Led Domain

Mr Grayson reported that the scoring for turnover and vacancy, for which the Trust was rated red, was not as well developed as it might be as it was a comparator to acute only Trusts but at present there was no comparator for integrated Trusts.

Mr Grayson reported that the annual appraisal rate still hovered around the 60% mark although early sight of the August figures demonstrated some improvement. He encouraged staff and management to ensure that appraisals were undertaken in a timely way.

Dr Hughes commented that the impending arrival of nurse revalidation would help to push up compliance.

Mr Welling referred to the inclusion of the community nursing activity and queried the high number of inappropriate referrals for May and Mrs Webster reported that this related to a data issue and was not accurate.

Workforce Usage and Turnover

Ms Green referred to the first table on Trust workforce full-time equivalents (ftes) and advised that there would always be a gap between the substantive and totals numbers to cater for unexpected workforce needs

She reported that there had been a slight increase in temporary staff, particularly around agency and overtime, which was due to activity, sickness and vacancies in hard to recruit areas.

Ms Green reported that the monthly sickness rate had increased to 4.4% from 4.2% which was in line with the national trend and certainly within the indicators for other combined Trusts. She advised that all managers had details of sickness broken down by individual members of staff on a regular basis.

In relation to mandatory training and appraisal she reported that there had been a slight increase in figures for both areas since the report had been produced with the appraisal rate now at 67%.

Mr Stevens asked how compliance was monitored and Ms Green reported that compliance was monitored through performance meetings with clinical units and there were detailed plans to increase levels as described in the Board Assurance Framework.

Discussion took place on the turnover trend and Ms Green clarified that the data included staff who had left via the MARS scheme, staff transferred out from the Trust where services had been taken over by other providers and people retiring. She advised that no group of staff had particularly high turnover.

Mr Nealon commented that there appeared to be no material difference in the flexible labour numbers since July last year. Ms Green reported that there was higher usage of flexible labour in July due to annual leave but there had been definite reductions in nurse agency usage but this had been offset by an increase in medical agency to cover difficult to recruit posts and increased establishment.

Dr Harrison commented that the report provided a high level assessment of cost, and not numbers, and did not provide a split between the type of flexible labour being used and the same applied to the turnover figures.

Dr Hughes reported that he would be reviewing the medical revalidation report so that it provided a real time analysis of the current position within the year but highlighted that all the doctors were currently meeting their contractual obligations in relation to appraisal.

The Board noted the performance report for July 2014.

b) Finance Report – August 2014 (month 5)

Mrs Harris presented the finance report for month 5 and reported that the deficit of £1.87 million within the month was £20,000 better than planned and year to date the Trust deficit was £9.23 million against a planned deficit of £9.479 million.

She reported that there had been heavy pressures on pay in August resulting in an unfavourable variance in month and year to date.

She highlighted that the overall position was better than planned but needed close attention.

She reported that the Trust had no cash issues and in the month the Trust had achieved the standard against the Better Payment Practice Code of 95% on trade invoices and 92% on NHS invoices.

Mrs Harris referred to the comparison with the financial performance indicators on page 6 of the report but noted that the Trust's rating remained red overall as it was planning for a year end deficit.

She reported that cost improvement programme performance in August showed a slight slippage and noted that this was partly due to timing on some of the savings programmes where there had been some slippage. She reported that all programmes were being reviewed and she expected the Trust to move back on track and she was still forecasting that the Trust would achieve its savings programme at the year end.

She reported that income was slightly better than 2013/14 but pay expenditure was significantly down as well as the overall total expenditure position which indicated that the Trust was making progress in terms of managing and improving the underlying position.

Mr Nealon reported that the half year review would refocus attention on staying on plan and the rigour would continue for the result of the year through the Finance and Investment Committee. He noted that there were some very good projects coming through for capital investment.

The Board noted the finance report for August 2014.

c) Safe Nurse Staffing Levels

Mrs Webster reported that the nurse staffing levels were reviewed by the Quality and Standards Committee on a monthly basis and the nursing teams monitored the levels on a daily basis.

She referred to section 3.2 of the report which provided an analysis of those wards where 75% or more of established trained nursing levels were not achieved in line with NICE guidance.

Mrs Webster reported that where MAU and Seaford 1 fell below the 75% level in the day time the number of Healthcare Assistants (HCAs) were increased to support the area following a review of acuity and dependency

In relation to Rye Intermediate Care she reported that the levels of trained nurses at night had been reduced as there had been a reduced number of patients in the unit during the summer months.

She reported that on Cookson Attenborough it was recognised that there was a lot of activity through day cases but less trained nurse input was required at night and therefore based on activity levels and professional judgement the levels of staffing had been adjusted.

In relation to Hailsham 3 Mrs Webster advised that this area had variable levels of activity which was significantly reduced at weekends and therefore the trained nurse cover had been reduced during the year again based on activity levels and professional judgement.

She highlighted that appendix 1 attempted to provide some context to the figures being provided by showing the numbers of pressure ulcers falls and medication errors per area and it was planned to include in future staff sickness, maternity leave and training.

The Board noted the report on Safe Nurse Staffing Levels.

090/2014 **Research and Development Strategy 2014/19**

Dr Hughes reported that the ethos of the document was to make research and development (R&D) part of the Trust focus and enhance the Trust's contribution across the region.

He highlighted the four key objectives of the strategy and noted the improvements made under the leadership of Liz Still and looked forward to an improved contribution. He reported that Dr Walmsley had been appointed to lead on the strategic direction of R&D and work with key partners and a more focused approach was being taken to recruitment and completion of studies, to R&D becoming a more focal point of clinical unit understanding and R&D time would be included within consultant job plans.

Dr Hughes reported that discussions would be taking place on how nurses could contribute to studies and the intention was to seek R&D champions in each clinical unit.

Dr Hughes reported that it was planned to improve communications to increase interest and recruitment to studies and provide regular reports on progress to the Board.

Mr Stevens asked about the availability of funding from commercial organisations and Dr Hughes advised that this funding tended to focus more towards larger teaching institutions and the aim of the strategy was to Increase the Trust profile within the academic health science network and the Brighton and Sussex Medical School.
Dr Slater reported that the network was working with local and small medium enterprises to attract funding.

Mr Welling reported that Professor Cohen represented the Board on the R&D Group.

Mr Grayson welcomed the strategy and noted that an action plan was to be developed and there would be a report back within six months. -

The Board approved the Research and Development Strategy 2014/19, and supported delivery of the aims contained within it.

091/2014 **Health and Safety Annual Report 2013-14**

Mrs Webster presented the report and noted that it demonstrated the considerable progress made within the organisation in this area.

She reported that the health and safety team consisted of two people and they had an enormous challenge to ensure that staff understood and accepted that health and safety was every member of staff's responsibility.

She highlighted that whilst significant progress had been made there were still some areas which had challenges and these were identified within the report.

She reported that the number of incidents which continued to be open as not investigated had reduced as they had been incorrectly reported. There had been no extreme incidents but two major ones in the year and root cause analysis had been undertaken and presented to the Health and Safety Steering Group.

Mrs Webster advised that the report also detailed annual audits which were monitored through the Health and Safety Steering Group and an increase in staff stress had been noted and this was being addressed in the plan moving forward.

Mr Welling asked if the lessons emerging from various actions/incidents were disseminated across the organisation and Mrs Webster advised that the change in the governance structure would improve this.

Mr Grayson highlighted the unacceptably low level of training and asked what more could be done to improve this and Mrs Webster reported that workbooks and competency based training had been being rolled out in the latter half the year and senior managers were going through the IAMS training.

Mr Grayson reported that the Trust clearly had an obligation to make training as accessible and easy as possible but there was also an obligation on the employee to ensure he/she was appropriately trained.

Ms Green advised that health and safety training relevant to the staff role was provided but agreed that it was every individual's responsibility to ensure that they operated in a safe way and this would be picked up through appraisal. She highlighted that the employer also needed to ensure that staff were able to be released from the workplace in order to undertake training. Mr Grayson commented that it was important to ensure that the balance was right between what the employer has to do and what individual has to do and address if this was not correct.

The Board approved the Health and Safety Annual Report for 2013-14.

092/2014 **Annual Business Plan 2014/15 Quarter 2 Update**

Dr Harrison presented the quarter 2 update of the Annual Business Plan covering July to September 2014.

The Board reviewed those plans RAG rated red and the following updates were received:

Review and redesign of sub-specialities
Dr Harrison reported that the work was underway in relation to gastroenterology and breast services. She advised that when the Annual Business Plan was first developed the view was that phase 2 of the clinical strategy would be undertaken in a more formal way than it had actually been taken forward. Mr Sunley reported that in relation to acute medicine the front end of the hospital had been redesigned to provide 7 day week clinical cover and supporting the change in bed configuration.

East Sussex Better Together
Mr Grayson reported that this work was tied into the work of the challenged health economy and joint working was taking place between the Trust and the commissioners to try to align plans.

Redesign of community services
Dr Harrison reported that the risk assessment of the services had been undertaken and the Better Together group was designing the service models.

Implementation of a revised Hospital at Night provision at EDGH
Mr Sunley updated on progress with the revision of the Hospital at Night service including the change in the general manager on call rota so that they were site based until 11.00 pm at night and improved paediatric cover at the Eastbourne site. The rating would be revised for the next update.

Revised medical model
Mr Sunley reported that good progress was being made in re-organising job plans in order to implement the revised medical model.

Workforce Risk Register
Ms Green confirmed that the work was on track to deliver the workforce risk register.

Conclude the implementation of the Health Rostering Programme
Ms Green reported that this had been discussed by the management team and a plan was in place to conclude implementation.

P*rocurement Strategy*
Mrs Harris reported that the strategy was originally planned to come to this meeting for approval but it would now come to the November meeting.

The Board noted the quarter 2 update on the Annual Business Plan for 2014/15.

Ms Humber left the meeting.

093/2014 **Capital Programme Mid Year Review**

Mrs Harris reported that this was an update for the Board on the performance of the capital programme for the first six months of the year.

She referred to section 4 of her report which compared the original programme at April and the revised programme now in place with a reduced overplanning margin which had been tested through the Capital Approvals Group and was regularly monitored through the Finance and Investment Committee.

She highlighted that the pressures on the capital programme were referenced in the Board Assurance Framework.

The Board noted the current performance of the capital programme and the application for additional in year capital, and approved the revised capital plan to ensure that the Trust did not breach its Capital Resource Limit at the end of 2014-15.

094/2014 **Operational Resilience and Capacity Plan 2014/15**

Mr Sunley presented the operational plan detailing how the winter pressures would be handled within the Trust and noted that it linked into the local health economy plan.

Dr Harrison noted that in relation to the mortuary section additional cold storage capacity was available at Bexhill which needed to be included.

The Board noted the Trust's preparedness for winter as outlined in the Operational Resilience and Capacity Plan 2014/15.

095/2014 **Board Sub-Committee reports and Trust Board Seminar Notes**

a) Audit Committee

Mr Stevens presented the report and noted that the local counterfraud service had requested an increase its budget as there were a number of matters which required more investigation than normal and this had been agreed by the Committee for one year only.

The Board noted the report.

b) Finance and Investment Committee

Mr Nealon presented the report and highlighted the potential to increase capital investment through the implementation of managed service contracts and advised that one such contract would be implemented very shortly.

The Board noted the report.

c) Quality and Standards Committee

Mr Welling commented that the Committee had gone through a refresh and the new Terms of Reference had been approved by the Board at its last meeting.

The Board noted the report.

d) Trust Board Seminar Notes

The Board adopted the notes of the Trust Board Seminar held on 16th July 2014.

096/2014 **Chairman's Briefing**

Mr Welling commented that this briefing was self explanatory and was pleased to announce that a date had now been agreed with Mr Lloyd, MP, to meet with maternity staff in early October.

097/2014 **Questions from members of the public**

a) Turnaround

Mr Campbell asked what the end date was for the employment of Kingsgate and whether they were providing value for money. Mr Grayson confirmed that they were providing value for money and the end date on the current contract was at the end of the financial year.

b) Annual Sickness Rate

Mr Campbell asked whether the Trust would achieve the annual sickness rate target of 3.3% and Ms Green explained that the target was set nationally for acute Trusts and it was her view that the Trust would not achieve this target as it was an integrated Trust.

c) Infection Control

Mr Campbell asked whether it was possible to say whether or not the majority of infection controls cases were either due to environmental issues or individuals. Dr Hughes reported that a root cause analysis was carried out on each case and where it was an avoidable infection it would relate to one and/or both of those issues.

d) Audit Meeting

Mrs Walke queried whether there had been an audit meeting on 31st July as the minutes had not come to the Trust Board and Mrs Wells responded that she would check and would list the dates of the meetings in the minutes: **LW**

Date of Audit Committee	**Date Minutes Submitted to Trust Board**
8th January 2014	26th March 2014
5th March 2014	30th July 2014
4th June 2014	30th July 2014
9th July 2014	24th September 2014

e) Services

Mrs Walke reported that she had e-mailed a request for a breakdown of the services provided at both hospitals and as yet had not received a reply. Dr Harrison confirmed that this request was being dealt with under the Freedom of Information (FOI) Act and she would receive a response within the timescales of the Act.

Dr Harrison commented that it was best practice to deal with any such information requests under the FOI Act to ensure responses were provided within reasonable timescales.

f) Ebola Outbreak

Mr Hardwick asked whether any staff had volunteered to provide support to the countries affected by the Ebola outbreak. Mr Grayson reported that members of staff had volunteered in the past to provide support to other parts of the world but he was not aware of any staff so far. He advised that as the request had only recently come out from the Department of Health staff might volunteer over the next few weeks and this would be reflected at the next meeting. **MG**

g) Remuneration Committee

Mr Campbell asked if minutes were produced for the Remuneration Committee and whether they came to the Board. Mr Welling confirmed that high level minutes were produced. Mrs Wells advised that due to the confidential information contained within the minutes they were not circulated to the Board. However, she noted that reports from the Committee were provided to the Board and agreed to list the dates of recent reports in the minutes: **LW**

Remuneration Committee Report	**Date Reports Submitted to Trust Board**
Annual Report	26th March 2014
CEA 2013 Round	30th July 2014

097/2014 **Date of Next Meeting**

Wednesday, 26th November 2014, at 10.00 am in the Oak Room, Hastings Centre.

098/2014 **Closed Session Resolution**

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

Signed …….

Position ……...Date ……..

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 24.09.14 Trust Board Meeting

Agenda Item	Action	Actioned By	When	Progress
081/2014c) – Feedback from Quality Walks	Mr Welling and Mrs Bernhauser would report back on their quality walks at the next meeting.	Chairman/Non-Executive Director	26.11.14	On agenda
089/2014a)vi) – Performance Report – Workforce Usage and Turnover	Medical revalidation report to be reviewed to provide a real time analysis of the current position within the year.	Medical Director - Governance	26.11.14	Completed.
090/2014 – Research and Development Strategy	An update on the Research and Development strategy action plan to come back to the Board within six months.	Medical Director – Governance	26.03.15	Added to work programme
094/2014 – Operational Resilience and Capacity Plan 2014/15	Additional cold storage capacity available at Bexhill to be included in the plan.	Chief Operating Officer	Asap	Completed.
097/2014d) – Questions from members of the public – Audit Committee	Dates of the Audit Committee meetings and when the minutes were submitted to the Board to be included in the Board meeting minutes	Company Secretary	26.11.14	Completed
097/2014f) – Questions from members of the public – Ebola Outbreak	Update on whether any Trust staff had volunteered to help with the Ebola outbreak to be provided at the next meeting.	Director of Human Resources	26.11.14	Not aware of any requests to take time away from work to do so
097/2014g) – Questions from members of the public – Remuneration Committee	List of dates to be provided in the Board minutes when reports from the Remuneration Committee were provided to the Board.	Company Secretary	26.11.14	Completed

East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 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 revised format Board Assurance Framework (BAF) which brings together the strategic priorities and objectives of the organisation, with an assessment of their risks, the controls in place and details of the internal and external assurance along with associated actions.

Introduction:

The Assurance Framework has been reviewed and format updated since the last meeting of the Trust Board as outlined at the recent Board seminar. The BAF clearly demonstrates whether the risk remains unchanged, has increased or decreased since the last iteration. There are clear actions against identified gaps in control and assurance and these are individually RAG rated.

Following review by the Quality and Standards and Audit Committees two areas have moved from amber to red these relate to Health Records and the Estates Strategy. The Quality and Standards Committee will be undertaking a "deep dive" into health records at the January meeting.

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

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

Benefits:

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

Risks and Implications

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

Assurance Provided:

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

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

Board Seminar 5th November 2014
Quality and Standards Committee 10th November 2014
Audit Committee 12th November 2014

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

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

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

Assurance Framework - Key

RAG RATING:

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

Status:

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

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

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

C indicated Gap in control
A indicates Gap in assurance

Board Assurance Framework - October 2014

Strategic Objective 1:	**Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority**
Risk 1.1	**We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies**
Key controls	Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference
Positive assurances	CQC reports following inspections Provider Compliance Assessments completed to ward level and gaps reviewed Internal audit report on CQC compliance Weekly audits/peer reviews eg observations of practice Monthly reviews of data with each CU 'Quality walks' programme in place and forms part of Board objectives External visits register outcomes and actions reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	C	There is a gap in control due to the number of policies that require review and updating.	Schedule of out of date policies produced and circulated to CU leads. Considered at CME October	end Mar 15	◄►	DN/COO	CME
1.1.2	A	The Board cannot be fully assured in respect of compliance with CQC outcomes until the regulator has issued the September inspection report.	Report expected beginning of November for factual accuracy review. Project Group in place and action plan to be developed.	end Dec 14	◄►	DN	Q&S CME
1.1.3	C	There is a requirement to improve controls in Health Records service; to encompass systems and processes, storage capacity and quality of case note folders.	Review of Health Records commissioned and business case being developed.	end Dec 14	▼	COO	F&I CME

Strategic Objective 1:	**Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority**
Risk 1.2	**We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**
Key controls	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with clinical units Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Monthly audit of national cleaning standards
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Low HCAI and SSA breaches Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG compliance. Trust Board reviewed analysis of Keogh, Berwick et al; actions agreed and monitored at Q&S Committee.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.2.1	C	Gap in control in delivery of cancer metrics and ability to respond to demand and patient choice.	Focussed management and action plan in place. Discussions with cancer network discussions re urology capacity/expectations. Capacity and demand review of gastro and endoscopy being completed.	end Mar 15	◄►	COO	CME
1.2.2	C	Further controls required in emergency services as demand is impacting patient assessment-treatment time and subsequent discharge to other specialist/bed areas	Meet SECAMB monthly to review issues. Action plan and escalation process in place Capital bid with TDA to support expansion	end Dec 14	◄►	COO	CME

Strategic Objective 1:			Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority				
Risk 1.2 Continued			**We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**				
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.2.3	C	Effective controls are required to minimise the risk to achievement of referral to treatment timescales, particularly the admitted pathway.	Action plan developed with support from National Intensive Support team and TDA, monitored by Trust Board. Revised trajectory agreed to achieve aggregate RTT performance by end of Oct 14.	end Oct 14	▲	COO	CME
1.2.4	A	Assurance is required that there are systems in place to develop and evidence shared learning from infection control incidents	Root Cause Analysis undertaken for all outbreaks and SIs. Need to evidence learning.	end Mar 15	◄►	DN	Q&S
1.2.5	A	There is insufficient assurance that clinical laboratory diagnostics analytical equipment will be replaced in a timely way following internal approval of the managed service contract.	Agreed to replace via managed services contract. FBC to Finance and Investment Committee meeting approved. Oct 14- FBC with TDA.	end Dec 14	◄►	COO	F&I CME
1.2.6	C	Additional controls are required to reduce the backlog of plain film reporting and delay in reporting non urgent radiological investigations.	Process in place to reduce plain film backlog and patients being contacted. CCG appraised of position and comms sent to GPs. Prioritisation process for urgent MRI/CT scans.	end Mar 15	◄►	COO/ MD(G)	CME

Board Assurance Framework - October 2014

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.**
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of CME involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy Board Development Programme Leading for Success Programme Regular leadership meetings
Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. On-going monitoring of safety and performance of reconfigured services to identify unintended consequences

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.3.1	A	Assurance is required that the controls in place in relation to mandatory training and appraisals are effective and are improving levels of mandatory training and completion of appraisals.	Initiatives such as mandatory training passport being rolled out and developing e-assessments to support competency based local training. Robust actions planned to improve compliance by the end of the year.	end Dec 14	◄►	HRD	Q&S CME

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls and engagement are required to ensure the Trust can model and respond to the potential loss of any services and reconfiguration following tender exercises.	PQQ issued for community services by HWLH. Impact to be assessed and options evaluated for future tender.	end Dec 14	**New**	DSDA	F&I CME
			Working with prime provider to facilitate implementation of MSK model of care. Impact on current service configuration being determined.	end Mar 15	◄►	DSDA	CME

Strategic Objective 2:	**Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences**
Risk 2.2	**We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.**
Key controls	Develop and embed key strategies that underpin the Integrated Business Plan (IBP): Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Membership Strategy Effective business planning process
Positive assurances	Two year integrated business plan in place Stakeholder engagement in developing plans Finalising service delivery model for maternity and paediatrics

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.2.1	A	There is insufficient assurance that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work ongoing and clinical design group established	end Mar 15	◄►	DSDA	F&I CME

Strategic Objective 2:	**Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences**
Risk 2.3	**We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.**
Key controls	Embedding Patient and Public Involvement Strategy Governance processes support and evidence organisational learning when things go wrong Quality Governance Framework and quality dashboard. Risk assessments Complaint and incident monitoring and shared learning Robust complaints process in place that supports early local resolution Clinical audit plan Equality strategy and equality impact assessments
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives. Friends and Family feedback and national benchmarking Patient surveys Dr Foster/CHKS/HSMR data Audit opinion and reports Quality framework in place and priorities agreed eg for Quality Account, CQUINs

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

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.1.1	C	Require evidence of robust controls to ensure achievement of 2014/15 financial plan and prevent crystallisation of identified risks as follows: activity levels exceed plan, premium costs incurred to deliver 18 weeks, slippage on £20.4m savings plan, CQUIN income not received in full.	Monthly monitoring and review of income and expenditure. Financial position on plan	Commenced and ongoing review and monitoring to end Mar-15	◄►	DF	F&I

Strategic Objective 3:	**Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.**
Risk 3.2	**We are unable to invest in delivering/improving quality of care and outcomes for patients because we are operating in a challenged health economy and this could impact on our ability to make investment in infrastructure and service improvement.**
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Monitoring by F&I Committee
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that following approval of the FBC funding will be available to support the required investment in estate infrastructure, IT and medical equipment.	Business case submitted to TDA for early release of first tranche of FBC funds	Ongoing review and monitoring to end Mar-15	◄►	DF	F&I

Strategic Objective 3:	**Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.**
Risk 3.3	**We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements**
Key controls	Development of workforce strategy: - to align workforce plans with strategic direction and other delivery plans; - to ensure a link between workforce planning and quality measures 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
Positive assurances	Training and resources for staff development Disclosure & barring check times avg reduced from 4wks to 48hrs Workforce planning aligned to strategic development and support Workforce assurance quarterly meetings with CCGs Implemented Values Based Recruitment and supported training programme

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.3.1	C	There is a gap in control because the final workforce strategy has been delayed as a result of market testing and service reconfigurations that have arisen or may arise from tenders. This means that the Trust may not be able to effectively plan for its future workforce requirements	Number based workforce plans submitted to TDA and HEKSS to support development of specific plans.	end Oct 14	◄►	HRD	CME
3.3.2	A	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties eg cardiac physiologists, ODPs and anaesthetic staff.	Ongoing actions and monitoring including speeding up of DBS checks, projects initiated in respect of speciality fill rates and rolling recruitment programme for nursing	end Mar 15	◄►	HRD	CME

Strategic Objective 3:	**Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.**
Risk 3.4	**We are unable to develop and implement effective cultural change programmes that lead to improvements in organisational capability and staff morale.**
Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values
Positive assurances	Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Positive relationship with staff side committee Embedding organisation values across the organisation

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.4.1	A	The CQC staff survey 2013 provided insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	Listening into Action Showcase events and continuation of the programme Values launched and being embedded.	end Mar 15	◄►	HRD	Q&S CME

Strategic Objective 3:			**Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.**				
Risk 3.5			**We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.**				
Key controls			Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital Approvals Group and Finance and Investment Committee				
Positive assurances			Essential work prioritised with Estates, IT and medical equipment plans Capital approvals group meet monthly to review capital requirements and allocate resource accordingly Monitoring by Finance and Investment Committee				
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.5.1	C	There is a gap in control as a result of the Trust not having an aligned estates strategy in place.	Estates Strategy to be developed	end Mar 15	▼	COO	F&I CME
	A	Also refer to 3.2.1					

Strategic Objective 3:	**Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.**
Risk 3.6	**We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change**
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports
Positive assurances	Policy documents and Board reporting reflect external policy Strategic development plans reflect external policy. Board seminar programme in place Business planning team established Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources

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

East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 2014
Meeting:	Trust Board
Agenda item:	7a
Subject:	Performance Report Month 6 – September 2014 Finance Report Month 7 – October 2014
Reporting Officers:	Richard Sunley, Chief Operating Officer Alice Webster, Director of Nursing Dr David Hughes, Medical Director (Clinical Governance) Monica Green, Director of Human Resources Vanessa Harris, Director of Finance

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

Purpose:

The attached document(s) provide information on the Trust's performance for the month of September 2014 against quality and workforce indicators and to the end of October 2014 for finance.

Introduction:

The two reports details ESHT's in month performance against key Trust metrics as well as activity, workforce and finance indicators.

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

Overall Performance Score: 4 (from a possible 5)

Responsiveness Domain: 3
Improvement from August. A&E performance achieved the 95% standard. In addition to this Cancer performance (preview) achieved the 2WW standard, but did not deliver below 31 or 62 days indicators.

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

Safe Domain: 5
Remains at 5. There were 2 reported cases of C-Dificile, but no reported harmful incidents.

Caring Domain: 5
Remains at 5 due to continued achievement of A&E Friends and Family standards. There were 20 mixed sex accommodation breaches. All other standards within this domain were achieved in September.

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

Finance Report:
Following receipt of non-recurrent deficit funding of £18m of which £10.5m has been recognised in the M7 position the year to date run rate deficit is £1,201k, which is a favourable variance against plan of £10,713k. Income and expenditure were both above plan. The cost improvement achievement was £9,888k YTD which was behind plan by £536k. The Trust has increased its savings target by £600k and the forecast outturn is now a small surplus of £88k, as a result the overall TDA RAG rating for finance has moved from red to green.

Benefits:

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

The Board is aware of the Month 7 financial position.

Risks and Implications

At the end of Month 7 the financial risks remain unchanged from those associated with the plan for the year except for the addition of a financial risk relating to a NHS England QIPP issued in year, value £665k.

Assurance Provided:

This report includes all indicators contained within the NTDA's Accountability Framework for 2014/15. Information contained within this report has been extracted from the Trust Data Warehouse in line with guidance supplied by the NTDA.

Following receipt of the non-recurrent deficit funding the financial performance at Month 7 is significantly better than original plan and the Trust is now forecasting a small surplus at year end.

Board Assurance Framework:

Strategic Objective 1, risks 1.1, 1.2 and 1.3
Strategic Objective 2, risk 2.3
Strategic Objective 3, risk 3.1

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

This report will be reviewed by the Corporate Leadership Team during months that the Trust Board does not meet.

Proposals and/or Recommendations

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

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

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

Not applicable.

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

Name:	**Contact details:**
Andy Bailey, Senior Information Analyst	andybailey@nhs.net

East Sussex Healthcare Trust
Integrated Performance Report

Month 6
September 2014

EAST SUSSEX HEALTHCARE NHS TRUST KNOWLEDGE MANAGEMENT

1.0 Overall Performance Score

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

2.0 Responsiveness Domain

Responsiveness Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
			DOMAIN SCORE					
Indicator	Standard	Weighting	3	2	3	3	2	3
Referral to Treatment Admitted	90.00%	10	82.68%	84.06%	85.84%	80.88%	75.60%	82.74%
Referral to TreatmentNon Admitted	95.00%	5	94.08%	94.12%	91.81%	92.66%	91.16%	89.56%
Referral to Treatment Incomplete	92.00%	5	92.37%	92.89%	92.80%	92.35%	92.21%	93.39%
Referral to Treatment Incomplete 52+ Week Waiters	0	5	4	6	4	3	4	3
Diagnostic waiting times	1.00%	5	7.32%	6.31%	0.45%	0.70%	0.97%	0.18%
A&E All Types Monthly Performance	95.00%	10	95.20%	93.60%	95.08%	97.27%	94.08%	95.00%
12 hour Trolley waits	0	10	0	0	0	0	0	0
Two Week Wait Standard	93.00%	2	89.97%	89.07%	91.78%	89.69%	90.16%	93.41%
Breast Symptom Two Week Wait Standard	93.00%	2	84.21%	92.06%	85.00%	88.89%	93.58%	80.65%
31 Day Standard	96.00%	2	97.33%	96.71%	98.35%	99.34%	95.57%	94.87%
31 Day Subsequent Surgery Standard	94.00%	2	100.00%	100.00%	94.74%	100.00%	100.00%	100.00%
31 Day Subsequent Drug Standard	98.00%	2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
62 Day Standard	85.00%	5	86.01%	82.08%	77.01%	75.11%	80.00%	79.15%
62 Day Screening Standard	90.00%	2	76.92%	80.00%	100.00%	83.33%	83.33%	68.75%
Urgent Ops Cancelled for 2nd time (Number)	0	2	0	0	0	0	0	0
Proportion of patients not treated within 28 days of last minute cancellation	0.00%	2	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Delayed Transfers of Care	3.50%	5	4.47%	5.90%	4.23%	5.01%	3.95%	6.28%

2.1 RTT Performance

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

2.2 Diagnostics

The Trust delivered the 6 week diagnostic waiting time target for the month of September. The total number of breaches was 7, equating to 0.18% of the total waiting list. The breakdown of breach modalities is shown below:

- Radiology: 5
- Audiology: 1
- Endoscopy: 1

2.3 A&E Performance

The 4 hour A&E waiting time standard was delivered in September, with 95.00% of patients seen within 4 hours.

At the time of writing this report, cumulative year to date performance stands at 95.00%, whilst quarter 3 performance stands at 94.40%.

2.4 Cancer Performance

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

The final Cancer report for August confirmed that the trust did not meet the required standard within 2 week, 31 day and 62 day standards.

Patient choice and outpatient capacity continue to impact performance against these standards. Historically, delays due to patient choice are higher during July and August. A greater number of patients during these months are referred immediately prior to a planned holiday or choose to delay an appointment until after a planned trip.

With this in mind collaborative work with General Practitioners is vital and the Trust continues to report back to GPs on those patients that have chosen to defer urgent appointments. Additional collaborative work is aimed at ensuring that the initial communication with the patient (at the point of an urgent referral) is as effective as it can be.

Outpatient capacity is being improved on the back of a number of programmes implemented by the Trust in recent months.

The actions detailed above have been put in place to improve the proportion of patients accepting the initial appointment offer as well as providing a greater choice in appointment date.

The current September preview does show an improvement in performance against the 2 week wait standard.

2.5 Cancellations

During September there were 19 last minute cancellations. All were rebooked within 28 days. These cancellations were predominantly within Dermatology (5) and Max Fax (3).

There were no urgent operations cancelled for a second time.

2.6 Delayed Transfers of Care

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

During September the combined percentage of delayed beddays increased, and remained slightly higher than the 3.5% standard.

The table below provides a breakdown of August's performance.

Delayed Transfer of Care Breakdown		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Delayed Transfers of Care (Combined)	3.50%	4.47%	5.90%	4.23%	5.01%	4.07%	6.28%
Delayed Transfers of Care (Acute Only)	3.50%	2.38%	4.75%	3.28%	4.09%	3.14%	4.75%
Delayed Transfers of Care (Non-Acute Only)	7.50%	15.01%	12.77%	9.82%	10.11%	9.12%	13.13%

The percentage of acute delayed beddays increased from August and and performance declined to 4.75% achieving the required standard. There were 847 delayed acute beddays in September. Of these, 781 were attributable to NHS reasons.

316 were attributable to the need for further non-acute care.
317 were attributable to patient or family choice.

The non-acute standard is 7.5%. Performance declined in September, going against the downward trend seen so far this financial year. There were 475 delayed non-acute beddays in September. Of these, 366 were attributable to NHS reasons.

125 were attributable to the need for further non-acute care.
66 were attributable to the need for assessment
65 were attributable to patient or family choice
62 were attributable to residential home

3.0 Effectiveness Domain

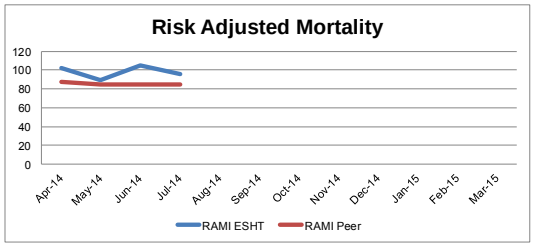
Effectiveness Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
			DOMAIN SCORE					
Indicator	Standard	Weighting	4	4	4	4	4	4
Hospital Standardised Mortality Ratio (DFI)	100	5	99.7	99.7	99.7	99.7	99.7	99.7
Deaths in Low Risk Conditions	Within Expected	5	1.4	1.4	1.4	1.4	1.4	1.4
Hospital Standardised Mortality Ratio - Weekday	109.1	5	101.4	101.4	101.4	101.4	101.4	101.4
Hospital Standardised Mortality Ratio - Weekend	116.5	5	100.6	100.6	100.6	100.6	100.6	100.6
Summary Hospital Mortality Indicator (HSCIC)	Within Expected	5	107.7	107.7	107.7	107.7	107.7	107.7
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	10%	5	7.15%	7.55%	6.38%	8.49%	7.61%	6.93%

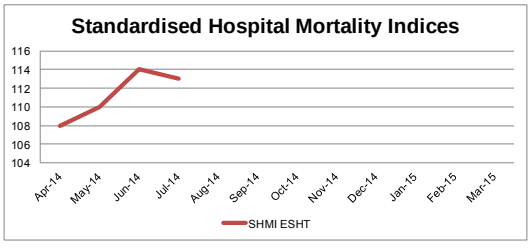
3.1 Mortality

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

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

Current performance against HSMR and SHMI source from CHKS can be seen below.





3.2 Emergency Re-Admissions

The rate of emergency re-admissions within 30 days of a previous discharge continues to meet the standard. The rate in 2014/15 is considerably lower than

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

4.0 Safe Domain

Safe Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
			DOMAIN SCORE					
Indicator	Standard	Weighting	4	5	5	5	4	5
Clostridium Difficile - Variance from plan	4	10	5	3	4	2	6	2
MRSA bactaraemias	0	10	0	0	0	0	0	0
Never events	0	5	0	0	0	0	0	0
Serious Incidents rate	TBC	5						
Patient safety incidents that are harmful	0	5	3	4	8	3	2	2
Medication errors causing serious harm	0	5	0	0	0	0	0	0
Overdue CAS alerts	0	2	0	0	0	0	0	0
Maternal deaths	0	2	0	0	0	0	0	0
VTE Risk Assessment	95.00%	2	99.00%	97.90%	98.29%	98.15%	98.09%	97.94%
Percentage of Harm Free Care	92.00%	5	93.96%	94.07%	94.29%	93.90%	97.53%	94.60%

4.1 Healthcare Acquired Infections

There were 2 reported cases of C-Difficile in September, which is below the trust trajectory. The year to date outturn remains on plan.

4.2 Patient Safety

During August the Trust reported 2 harmful incidents.

5.0 Caring Domain

Caring Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
			DOMAIN SCORE					
Indicator	Standard	Weighting	5	4	4	4	5	5
Inpatient Scores from Friends and Family Test	60.00%	5	66.00%	64.00%	68.00%	68.00%	65.00%	70.00%
A&E Scores from Friends and Family Test	46.00%	5	49.00%	44.00%	37.00%	45.00%	54.00%	48.00%
Complaints	TBC	5						
Mixed Sex Accommodation Breaches	0	2	0	0	0	0	0	20
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	7.8	2	7.9	7.9	7.9	7.9	7.9	7.9

5.1 Friends and Family Test (Patient Experience)

Inpatient score remain above the required standard, and for the first month since the start of the year, A&E scores have also achieved. This has contributed to a maximum Caring domain score of 5.

5.2 Complaints

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

5.3 Mixed Sex Accommodation

The Trust reported 20 Mixed Sex accommodation breaches in September. The breaches were all located within the Hastings acute observation unit.

6.0 Well Led Domain

Well Led Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
			DOMAIN SCORE					
Indicator	**Standard**	**Weighting**	**3**	**3**	**4**	**4**	**4**	**4**
Inpatients response rate from Friends and Family Test	30.00%	2	46.43%	44.22%	44.01%	46.84%	39.40%	46.21%
A&E response rate from Friends and Family Test	20.00%	2	13.59%	15.76%	35.03%	24.41%	28.75%	30.40%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	40.70%	2	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	42.30%	2	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%
Data Quality of Returns to HSCIC	TBC	2						
Trust turnover rate	10.00%	3	12.45%	12.89%	12.72%	12.81%	13.19%	13.41%
Trust level total sickness rate	3.30%	3	4.08%	3.87%	4.26%	4.44%	4.59%	4.76%
Total Trust vacancy rate	10.00%	3	6.04%	6.40%	5.21%	5.61%	4.72%	5.47%
Temporary costs and overtime as % of total paybill	10.00%	3	7.02%	7.29%	8.72%	9.48%	9.58%	9.48%
Percentage of staff with annual appraisal	85.00%	3	63.37%	63.84%	63.74%	62.34%	66.96%	68.23%

6.1 Friends and Family Test (Response Rate)

Inpatient and A&E response rates continue to achieve the required standard, though A&E response rates did reduce significantly in September.

6.2 Data Quality

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

6.3 Workforce

Sickness rates and Trust turnover continue on an upward trend. Further detail is given in section 8.

7.0 Community Services

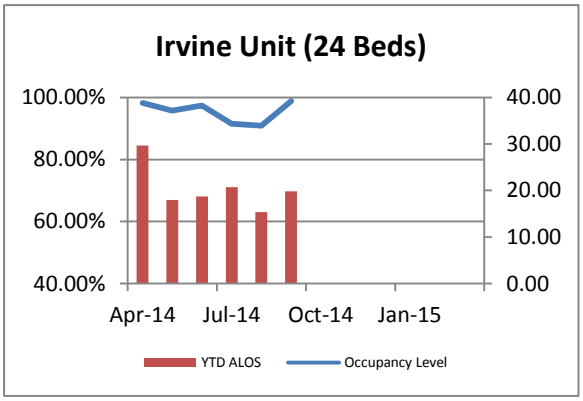
7.1 Intermediate Care Beds

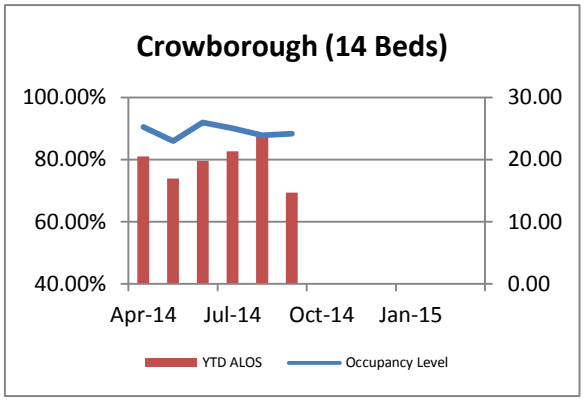
Table 1 (below) details the Occupancy, Average Length of Stay and Admission rates at the Trust's 6 community sites. Occupancy and ALOS are also represented graphically.

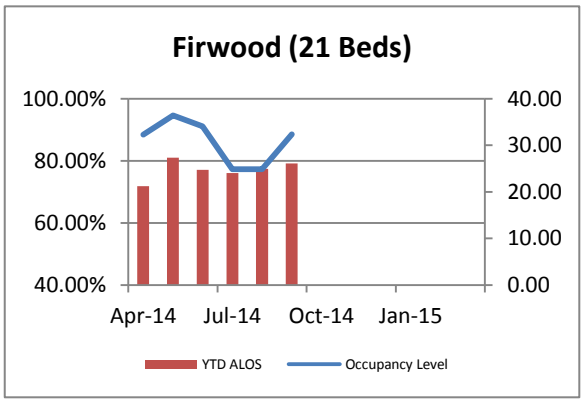
Table 1: Community occupancy and ALOS

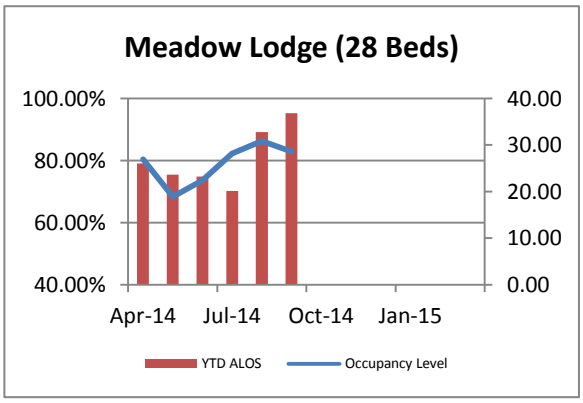
Indicator	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Occupancy Level						
Irvine Unit	98.21%	95.70%	97.44%	91.53%	90.86%	98.89%
Crowborough Hospital	90.48%	85.94%	91.90%	90.09%	87.79%	88.33%
Firwood House	88.41%	94.62%	91.11%	77.27%	77.27%	88.57%
Meadow Lodge	80.36%	68.32%	73.57%	82.26%	86.29%	82.86%
Uckfield Hospital	87.38%	88.25%	93.10%	90.78%	94.01%	86.90%
Rye Memorial Care Centre	61.19%	76.73%	80.24%	93.55%	89.86%	67.38%
Irvine Stroke Unit	95.74%	90.86%	95.93%	82.97%	64.16%	49.26%
Total Occupancy	**87.06%**	**85.30%**	**88.49%**	**86.15%**	**84.04%**	**81.86%**
YTD ALOS						
Irvine Unit	29.65	17.97	18.74	20.74	15.38	19.85
Crowborough Hospital	20.47	16.94	19.76	21.31	23.74	14.67
Firwood House	21.21	27.33	24.69	24.04	24.94	26.08
Meadow Lodge	26.04	23.61	23.19	20.09	32.79	36.80
Uckfield Hospital	25.10	19.79	20.19	23.00	20.46	22.65
Rye Memorial Care Centre	31.64	21.09	24.69	24.69	22.24	24.41
Irvine Stroke Unit	39.50	36.96	37.00	32.46	29.43	27.99
Total YTD ALOS	**26.07**	**20.87**	**21.73**	**21.93**	**22.10**	**23.90**
Admissions						
Irvine Unit	32	32	28	34	28	36
Crowborough Hospital	22	17	18	17	14	20
Firwood House	24	19	24	15	25	24
Meadow Lodge	19	26	35	26	15	20
Uckfield Hospital	14	14	17	19	24	18
Rye Memorial Care Centre	12	12	16	16	14	19
Irvine Stroke Unit	12	12	18	15	18	12
Total Admissions	**135**	**132**	**156**	**142**	**138**	**149**
Available beds						
Irvine Unit	28	24	26	24	24	27
Crowborough Hospital	14	14	14	14	14	14
Firwood House	21	21	21	21	21	21
Meadow Lodge	28	28	28	28	28	28
Uckfield Hospital	14	14	14	14	14	14
Rye Memorial Care Centre	14	14	14	14	14	14
Irvine Stroke Unit	18	18	18	18	18	18
Total Available Beds	**137**	**133**	**135**	**133**	**133**	**136**
Total Discharges	**151**	**148**	**160**	**156**	**157**	**150**
Occupied Bed days	**3578**	**3517**	**3584**	**3552**	**3465**	**3340**
Available Bed days	**4110**	**4123**	**4050**	**4123**	**4123**	**4080**

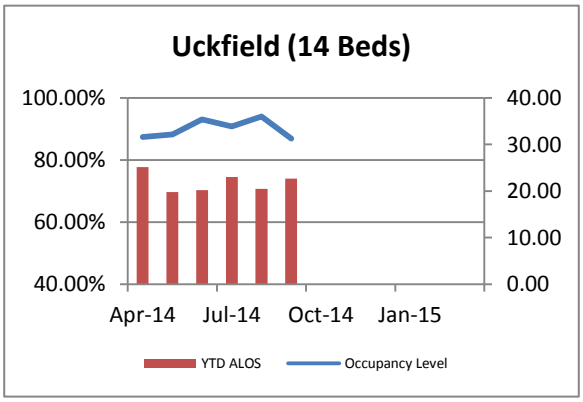
Intermediate Care Beds; Occupancy and ALOS trends

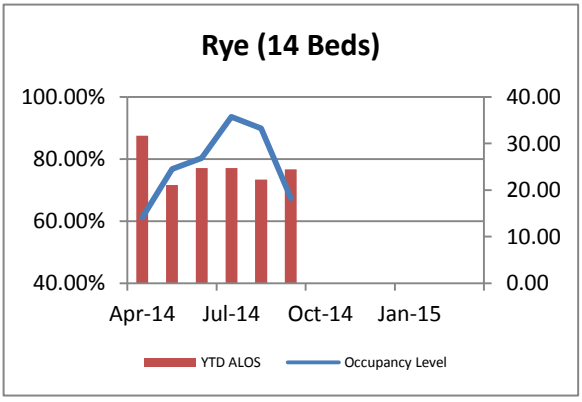












7.2 Community Nursing

The below tables detail manually captured activity across eight community nursing indicators. The information is captured manually within each team. August and September data capture has been delayed due to SystmOne implementation commitments.

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

Urgent Referrals	Trend	Apr-14	May-14	Jun-14	Jul-14
ESHT Total		734	751	627	706
Hastings and Rother		460	471	353	448
High Weald, Lewes and Havens		101	92	108	88
Eastbourne, Seaford and Hailsham		173	188	166	170

Inappropriate Referrals	Trend	Apr-14	May-14	Jun-14	Jul-14
ESHT Total		97	289	95	85
Hastings and Rother		55	252	56	54
High Weald, Lewes and Havens		25	25	25	24
Eastbourne, Seaford and Hailsham		17	12	14	7

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

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

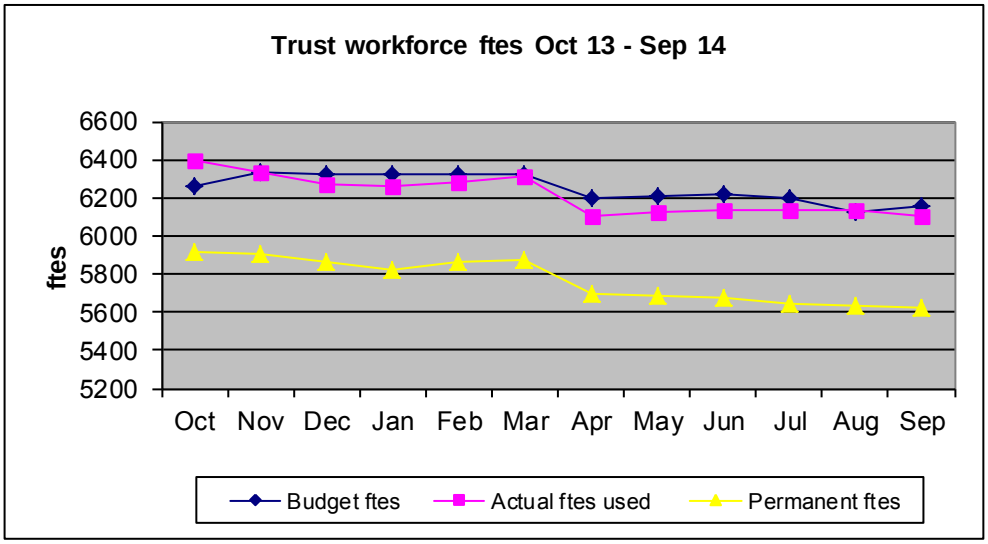
Contacts / Visits **	Trend	Apr-14	May-14	Jun-14	Jul-14
ESHT Total		31588	30398	28109	30557
Hastings and Rother		10136	10164	9740	10331
High Weald, Lewes and Havens		7041	7110	5903	6013
Eastbourne, Seaford and Hailsham		14411	13124	12466	14213

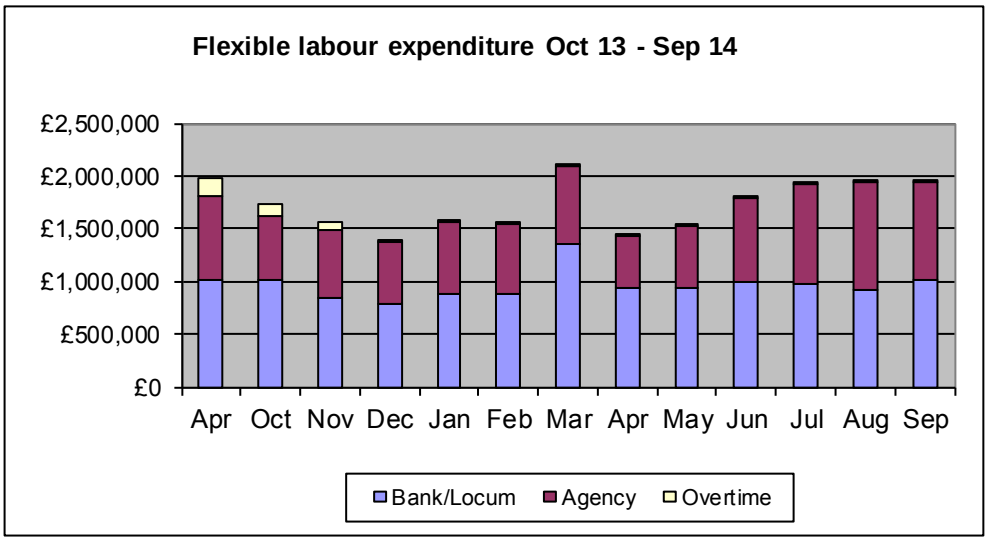
Admission Avoidance***	Trend	Apr-14	May-14	Jun-14	Jul-14
ESHT Total		468	473	264	421
Hastings and Rother		183	199	187	283
High Weald, Lewes and Havens		37	24	37	96
Eastbourne, Seaford and Hailsham		248	250	40	42

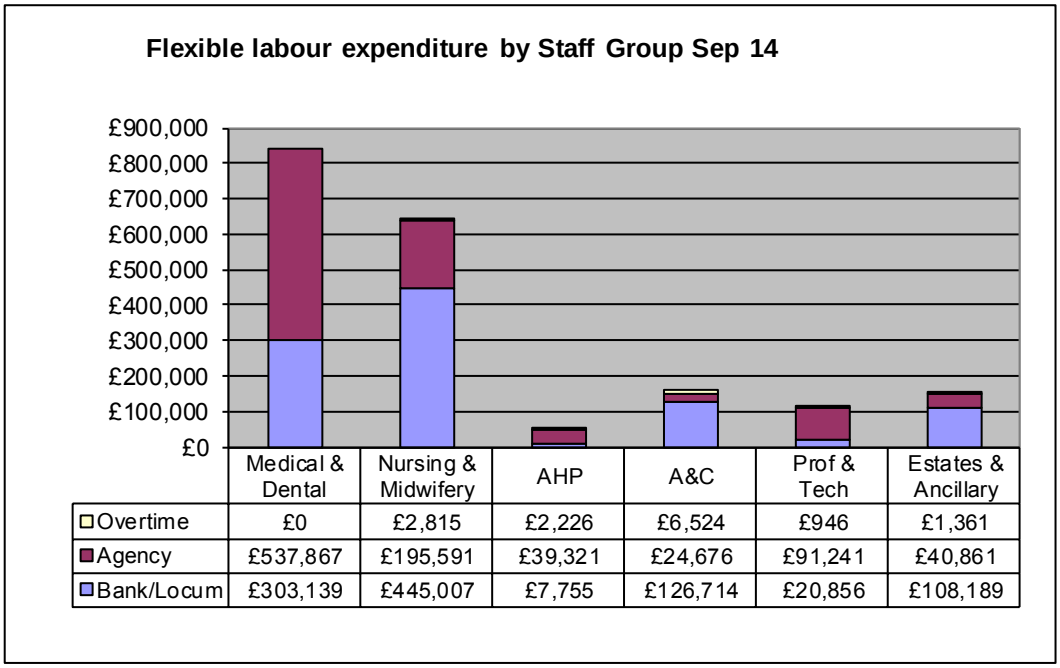
PICC's / IV's	Trend	Apr-14	May-14	Jun-14	Jul-14
ESHT Total		537	546	538	552
Hastings and Rother		392	397	404	404
High Weald, Lewes and Havens		47	54	72	77
Eastbourne, Seaford and Hailsham		98	95	62	71

8.0 Workforce

Workforce Usage & Turnover



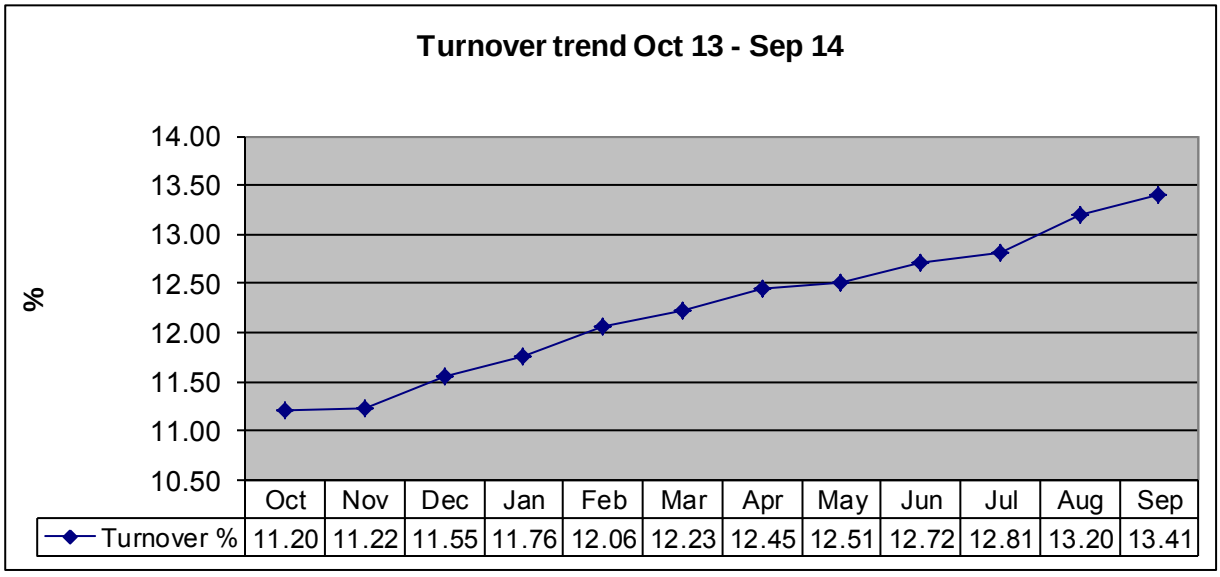




	Medical & Dental	Nursing & Midwifery	AHP	A&C	Prof & Tech	Estates & Ancillary
Overtime	£0	£2,815	£2,226	£6,524	£946	£1,361
Agency	£537,867	£195,591	£39,321	£24,676	£91,241	£40,861
Bank/Locum	£303,139	£445,007	£7,755	£126,714	£20,856	£108,189

Pay expenditure was £584K above budget in August and is £691K over budget for the year to date.

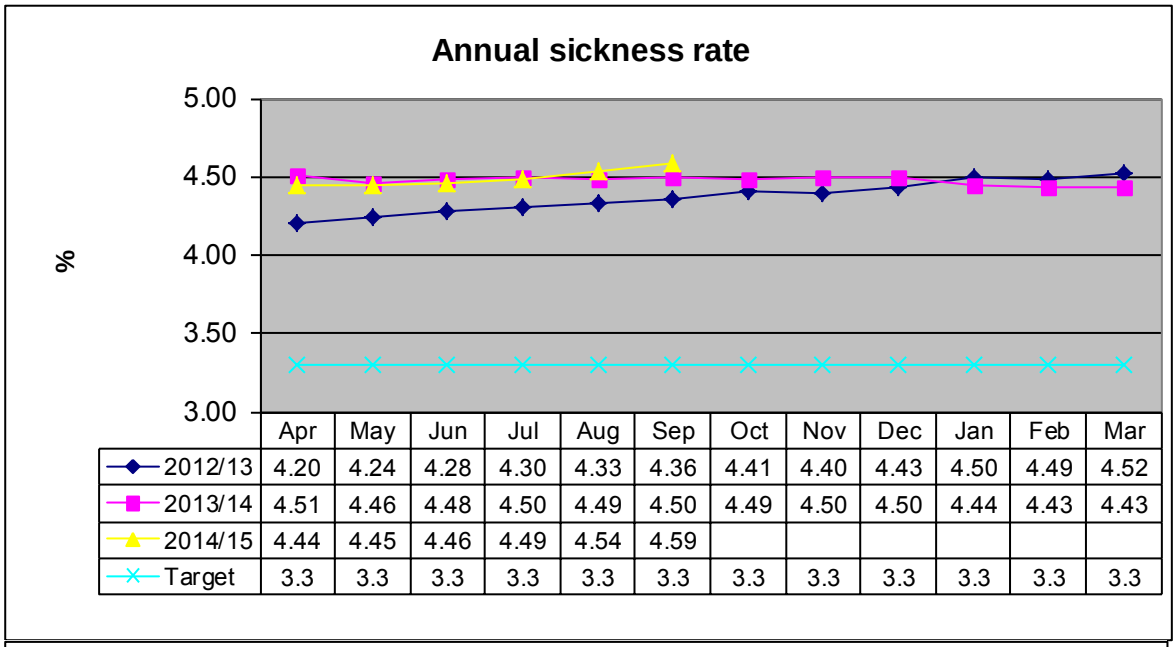
Temporary workforce expenditure has remained virtually static this month (down £432) but with a shift from agency expenditure (down by £107K) to bank expenditure (up by £99K). This increased bank usage has been largely to cover for vacancies in Clinical Units. Overtime expenditure has increased this month from £6K to £14K. This increase is due to physiotherapy support for clinics to meet the 18 weeks target in Orthopaedics and cover for vacancies and maternity leave in Finance & IT and Strategy Directorates.



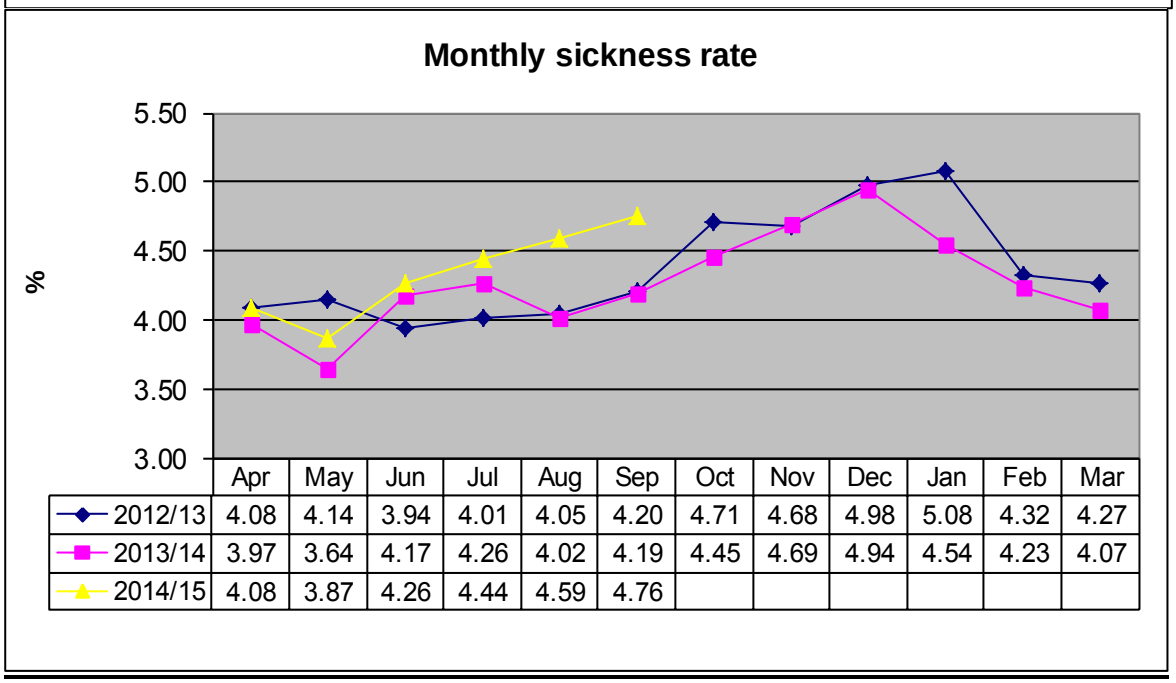
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Turnover %	11.20	11.22	11.55	11.76	12.06	12.23	12.45	12.51	12.72	12.81	13.20	13.41

Turnover has continued to increase and equates to 748.93 fte leavers in the year to 30 September 2014.

Sickness



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.20	4.24	4.28	4.30	4.33	4.36	4.41	4.40	4.43	4.50	4.49	4.52
2013/14	4.51	4.46	4.48	4.50	4.49	4.50	4.49	4.50	4.50	4.44	4.43	4.43
2014/15	4.44	4.45	4.46	4.49	4.54	4.59						
Target	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.08	4.14	3.94	4.01	4.05	4.20	4.71	4.68	4.98	5.08	4.32	4.27
2013/14	3.97	3.64	4.17	4.26	4.02	4.19	4.45	4.69	4.94	4.54	4.23	4.07
2014/15	4.08	3.87	4.26	4.44	4.59	4.76						

Monthly sickness in September increased by a further 0.17% to 4.76%. and, accordingly, annual sickness has increased by another 0.05% to 4.59%. The monthly sickness figure equates to 8225.74 fte days lost to sickness (or 274.2 fte staff off sick).

Monthly sickness was highest in Commercial Division at 6.39%, whilst Specialist Medicine, Out of Hospital Care, Theatres & Clinical Support , Cardiovascular Medicine and Chief Operating Officer – Operations all had monthly sickness rates over 5%.

A group has been set up within Estates and Facilities to review the management of all Long Term Sickness cases and this will be broadened to cover all those breaching the sickness trigger points under the Absence Management policy.

Clinical Unit/Directorate information

Clinical Unit/Directorate	Annual sickness	Monthly sickness	Short term sickness <28 days	Long Term sickness >=28 days	Cumulative pay expenditure v budget (£000s)	Appraised/exempt in last yr	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training
Theatres, Anaes & Crit Care	4.53%	5.23%	62.33%	37.67%	-£243	74.18%	84.36%	71.34%	96.92%	82.85%	83.65%	53.18%	87.33%	80.71%
Cardiovascular Medicine	3.95%	5.15%	87.94%	12.06%	£133	65.49%	78.06%	65.81%	94.29%	75.16%	78.39%	38.06%	88.89%	84.62%
Urgent Care	5.23%	4.81%	73.22%	22.78%	£240	50.59%	77.68%	60.61%	96.30%	75.27%	54.05%	48.58%	82.45%	78.99%
Specialist Medicine	4.63%	5.48%	45.21%	54.79%	£290	85.12%	83.40%	75.10%	96.77%	83.61%	73.65%	51.24%	90.58%	81.05%
Out of Hospital Care	5.53%	5.26%	61.50%	38.50%	£129	62.67%	76.58%	76.98%	99.08%	73.87%	83.08%	53.15%	94.28%	92.31%
Surgery	3.76%	3.58%	70.06%	29.94%	£86	83.57%	81.78%	69.53%	89.77%	81.34%	71.43%	55.54%	90.87%	86.81%
Womens & Childrens	4.61%	3.99%	67.46%	32.54%	-£119	68.13%	87.14%	75.52%	91.23%	81.33%	82.99%	59.75%	85.57%	75.38%
COO Operations	3.95%	5.10%	44.51%	55.49%	£90	58.44%	66.58%	82.56%	100.00%	89.43%	70.02%	36.36%	100.00%	100.00%
Commercial	5.44%	6.39%	43.17%	56.83%	£125	52.03%	72.20%	60.02%	95.74%	88.66%	81.03%	17.06%	75.00%	100.00%
Corporate	3.15%	2.68%	56.15%	43.85%	£39	76.62%	89.75%	88.52%	94.74%	90.37%	90.16%	74.39%	89.74%	81.25%
TRUST	**4.54%**	**4.59%**	**59.75%**	**40.25%**	**£691**	**67.87%**	**80.00%**	**72.29%**	**95.03%**	**82.01%**	**78.33%**	**48.77%**	**89.23%**	**83.35%**

Trust level mandatory training compliance percentages have increased this month (with the exception of a marginal decline in Trust induction) This is despite a higher than usual rate of non attenders (i.e. staff booked onto training but not attending on the day) which continues to be an issue. The Corporate Leadership Team have set a target of 85% for mandatory training compliance by 31 December 2014. To meet demand, Learning & Development have arranged additional updates through November/December and Clinical Units have been tasked with providing Recovery Plans to the Chief Executive to demonstrate how they will meet the target.

Appraisal compliance has increased by a further 0.85% this month. There are, however, 373 staff whose appraisal is due in October and will need to be renewed if the rate is not to drop. A further follow up exercise is underway whereby Clinical Units have been sent lists of those staff for whom appraisals have not been reported.

Medical Appraisal Compliance Status September 2014					
	Number of doctors	Compliant	Percentage Compliant	Total expected to be compliant by 31/03/15	Percentage expected to be compliant by 31/03/15
Consultants (including honorary contract holders)	219	219	**100%**	219	**100%**
Staff grade, associate specialist, speciality doctor (including hospital practitioners / clinical assistants who do not have a prescribed connection elsewhere)	97	97	**100%**	97	**100%**
Locum Appointed for Service doctors	14	14	**100%**	14	**100%**
Total	330	330	**100%**	330	**100%**

The compliance rating for ESHT for medical appraisals has recently been benchmarked by NHS England; the attached graph, provided by NHS England, demonstrates the success achieved in this Trust for the year 2013/14. Compared to other Trusts in the South, ESHT achieved the highest appraisal compliance rate.

We are on track to achieve 100% compliance for the year 2014/15. However, there are many challenges facing the medical revalidation and job planning team and much support needs to be provided to doctors on a regular basis in guiding them through the process. This month we have needed to follow up 20 doctors who were at risk of non-compliance but who subsequently booked their medical appraisals.

The appraisal rate is only one factor in this process. The extended appraisal, as prescribed by the GMC, is intended to be a robust appraisal interview with a heightened focus on patient safety, quality improvement and personal development. To this end, the team of 42 medical appraisers receive regular updates, training and action learning sets, facilitated by the medical revalidation and job planning team. The focus is currently on developing effective Personal Development Plans and the inclusion of Clinical Audit data in appraisals, the latter integrating Trust and personal objectives. There is also work in progress by the team to align job planning and PDP objectives.

East Sussex Healthcare NHS
NHS Trust

FINANCE REPORT – October 2014

Vanessa Harris – November 2014

Financial Summary – October 2014

Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) finance risk assessment criteria are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria has moved to Green in month 7	G
Financial Summary	The Trust is in receipt of £18m of non-recurrent deficit funding, of which £10.5m YTD has been recognised in the position at Month 7. The Trust performance in month 7 was a year to date run rate deficit of £1,201k, with a favourable variance against plan of £10,713k. Year to date, Income was £15,374k above plan whilst total costs, including the donated asset adjustment, were £4,661k overspent.	G
Activity & Income	Total income received during October was £2,899k above planned levels resulting in a year to date variance of £15,374k above plan.	G
Expenditure	Pay costs YTD are above plan by £1,169k and Non-Pay is £4,240k above plan. The Non-Pay variance is predominantly on tariff excluded drugs and devices which are recovered through income as above.	G
CIP plans	The CIP achievement YTD was £9,888k which was below plan by £536k.	G
Balance Sheet	The overall tax payer's equity is planned to rise due to the increase in permanent public dividend capital (PDC) being applied for in respect of strategic developments within the capital programme .	G
Cash Flow	Cash flow forecasting and management continues to be a key task for 2014/15.	G
Capital Programme	The Capital Approval Group (CAG) continues to review and monitor the capital programme on a monthly basis paying particular attention to the risks associated with limited capital funds.	G

Income & Expenditure – October 2014

Headlines

• The Trust has received £18m of non-recurrent deficit funding of which £10.5m YTD is recognised in the m7 position. Total income in the month was £33.8m against a plan of £30.9m, a favourable variance of £2,899k. YTD income is now £15,374k above plan

•Total costs in the month were £32.4m. This was £1,334k above plan and brings the YTD position to £5,102k above plan.

• The run rate deficit against plan YTD was a favourable variance of £10,713k.

• Cost improvements of £9.9m have been achieved YTD month 6 which is £0.5m below the planned target.

• Pay costs in the month, including ad hoc costs, were £477k above plan. YTD pay is now £1,169k above plan.

• Non Pay costs, including 3rd party costs, were £911k above plan in the month and are £4,240k above plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	28,115	30,656	2,541	188,871	203,192	14,321	323,730
Private Patient/ ICR	306	255	-51	1,930	1,892	-38	4,160
Trading Income	390	446	56	2,725	2,970	245	4,421
Other Non Clinical Income	2,109	2,462	353	14,958	15,804	846	25,049
Total Income	**30,920**	**33,819**	**2,899**	**208,484**	**223,858**	**15,374**	**357,360**
Pay Costs	-19,914	-20,390	-476	-141,834	-142,903	-1,069	-241,875
Ad hoc Costs	-26	-27	-1	-26	-126	-100	0
Non Pay Costs	-9,560	-10,472	-912	-67,256	-71,518	-4,262	-114,922
3rd Party Costs	22	23	1	-229	-207	22	-123
Other	183	183	0	1,283	1,283	0	2,200
Total Direct Costs	**-29,295**	**-30,683**	**-1,388**	**-208,062**	**-213,471**	**-5,409**	**-354,720**
Surplus/- Deficit from Operations	**1,625**	**3,136**	**1,511**	**422**	**10,387**	**9,965**	**2,640**
P/L on Asset Disposal	0	12	12	0	22	22	0
Depreciation	-1,049	-1,030	19	-7,341	-7,220	121	-12,585
Impairment	0	0	0	0	0	0	0
PDC Dividend	-689	-663	26	-4,823	-4,636	187	-8,272
Interest	-25	-28	-3	-172	-195	-23	-295
Total Indirect Costs	**-1,763**	**-1,709**	**54**	**-12,336**	**-12,029**	**307**	**-21,152**
Total Costs	**-31,058**	**-32,392**	**-1,334**	**-220,398**	**-225,500**	**-5,102**	**-375,872**
Net Surplus/-Deficit	**-138**	**1,427**	**1,565**	**-11,914**	**-1,642**	**10,272**	**-18,512**
Donated Asset/Impairment Adjustment	0	-53	-53	0	441	441	0
Adjusted Net Surplus/-Deficit	**-138**	**1,374**	**1,512**	**-11,914**	**-1,201**	**10,713**	**-18,512**

Cash Flow – October 2014

Headlines

- The cash balance is planned to be reduced to £1.0m at year-end.
- Temporary revenue PDC received to date will be repaid from the additional £18m non-recurrent deficit funding.
- Clinical strategy capital PDC of £17.4m is also planned to be received during the financial year.
- The cash flow will continue to remain under constant review.

Cash Flow Statement April 2014 to March 2015

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2015	Feb	Mar
Cash Flow from Operations												
Operating Surplus/(Deficit)	-1,719	-1,385	-1,948	174	-1,305	7,246	2,106	1,681	-53	2,107	68	942
Depreciation and Amortisation	1,031	1,031	1,031	1,033	1,035	1,028	1,030	1,048	1,048	1,048	1,048	1,136
Interest Paid	-31	-31	-31	-31	-31	-31	-31	-5	-5	-5	-5	-9
Dividend (Paid)/Refunded						-3,897						-3,897
(Increase)/Decrease in Inventories	-279	34	255	-174	146	-158	-21					18
(Increase)/Decrease in Trade and Other Receivables	1,954	2,301	-4,770	5,298	662	-11,817	1,420	-409	2,720	-1,409	92	3,000
Increase/(Decrease) in Trade and Other Payables	1,719	440	1,369	-269	-1,272	4,117	-4,804	-4,480	-1,401	1,602	1,531	2,852
Provisions Utilised	125	14	16	-43	14	-106	-36	-19	-19	-19	-19	-231
Net Cash Inflow/(Outflow) from Operating Activities	**2,799**	**2,403**	**-4,077**	**5,988**	**-751**	**-3,618**	**-336**	**-2,184**	**2,290**	**3,324**	**2,715**	**3,811**
Cash Flows from Investing Activities:												
Interest Received	6	3	2	3	4	2	3	1	1	1	1	1
(Payments) for Property, Plant and Equipment	-1,132	-1,060	-1,408	-1,423	-1,594	-1,389	-1,402	-2,313	-2,669	-1,474	-4,268	-8,859
(Payments) for Intangible Assets	-29	-42	-50	-37	-44	-42	-23	-40	-40	-40	-40	-40
Net Cash Inflow/(Outflow) from Investing Activities	**-1,156**	**-1,099**	**-1,456**	**-1,457**	**-1,634**	**-1,429**	**-1,422**	**-2,352**	**-2,708**	**-1,513**	**-4,307**	**-8,898**
Net Cash Inflow/(Outflow) before Financing	**1,644**	**1,304**	**-5,533**	**4,531**	**-2,385**	**-5,047**	**-1,758**	**-4,536**	**-418**	**1,811**	**-1,592**	**-5,087**
New Temporary PDC	0	0	5,000	0	0	0	7,000	0	0	0	0	0
Repayment for Temporary PDC	0	0	0	0	0	0	0	0	0	0	0	-12,000
New Permanent PDC	0	0	0	0	0	0	0	400	0	0	0	17,400
Loans and Finance Lease repaid	-76	0	0	-89	0	-914	0	0	0	0	0	-906
Net Cash Inflow/(Outflow) from Financing Activities	**-76**	**0**	**5,000**	**-89**	**0**	**-914**	**7,000**	**400**	**0**	**0**	**0**	**4,494**
Net Increase/(Decrease) in Cash	**1,568**	**1,304**	**-533**	**4,442**	**-2,385**	**-5,961**	**5,242**	**-4,136**	**-418**	**1,811**	**-1,592**	**-593**
Opening balance	2,257	3,825	5,129	4,596	9,038	6,653	692	5,934	1,798	1,380	3,191	1,599
Closing balance	3,825	5,129	4,596	9,038	6,653	692	5,934	1,798	1,380	3,191	1,599	1,006

Balance Sheet – October 2014

Headlines

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

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Non Current Assets			
Property plant and equipment	257,258	254,829	272,446
Intangilble Assets	826	1,093	1,184
Trade and other Receivables	708	801	647
	258,792	**256,723**	**274,277**
Current Assets			
Inventories	6,238	6,436	6,511
Trade receivables	21,825	9,366	14,806
Other receivables	3,601	20,673	3,818
Other current assets	0	0	0
Cash and cash equivalents	2,257	5,934	1,006
	33,921	**42,409**	**26,141**
Current Liabilities			
Trade payables	-13,040	-7,036	-8,166
Other payables	-19,023	-22,181	-17,495
DoH Loan	-1,674	-1,007	-343
Borrow ings - Finance Leases	-320	-320	-320
Provisions	-462	-430	-483
	-34,519	**-30,974**	**-26,807**
Non Current Liabilities			
DoH Loan	-3,535	-3,365	-3,195
Borrow ings - Finance Leases	-598	-357	-278
Provisions	-2,632	-2,648	-2,738
	-6,765	**-6,370**	**-6,211**
Total Assets Employed	**251,429**	**261,788**	**267,400**

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Financed by			
Public Dividend Capital (PDC)	-153,130	-165,130	-170,930
Revaluation Reserve	-106,395	-106,395	-106,396
Income & Expenditure Reserve	8,096	9,737	9,926
Total Tax Payers Equity	**-251,429**	**-261,788**	**-267,400**

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

Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target, currently 95%, is for the value and volume of invoices that should be paid within 30 days.
- In month 94% of trade invoices by amount was achieved and 68% of NHS invoices by amount were paid. This has improved the year to date achievement to 89% by amount for trade invoices and 65% by amount for NHS invoices.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0- 30 Days	1,069	1,254	2,542	2,328
31 - 60 Days	521	425	1,067	5,035
61 -90 Days	195	244	790	1,259
91 - 120 Days	143	146	528	437
> 120 Days	1,047	1,168	4,439	4,001
Total	2,975	3,237	9,366	13,060

Trade Payables Aged Analysis - Purchase Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0- 30 Days	2,603	6,299	3,229	8,268
31 - 60 Days	985	1,032	2,519	1,572
61 -90 Days	300	211	592	669
91 - 120 Days	136	148	269	440
> 120 Days	390	344	427	323
Total	4,414	8,034	7,036	11,272

Better Payments Practice Code	Month Number of Invoices	Month By Amount	YTD Number of Invoices	YTD By Amount
Trade invoices paid within contract or 30 days of receipt	97.90%	93.56%	88.88%	88.87%
NHS invoices paid within contract or 30 days of receipt	82.17%	67.94%	51.59%	65.03%

Key Performance Indicators – October 2014

TDA Finance Risk Assessment Criteria.

• The TDA has reviewed its reporting requirements for 2014/15 in a new accountability framework.

• The finance metrics have been revised by the TDA to ensure that they focus on in year delivery against plan and the individual indicators are set out in the adjacent table.

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

Monitor Continuity of Service Risk Rating.

• The Trust has a liquidity ratio rating of 4 and a capital servicing ratio of 2, resulting in an overall rating of 3.

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

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

Monitor Continuity of Service Risk Ratings	YTD Actual	YTD Plan
Liquidity Ratio Rating	4	3
Capital Servicing Capacity Rating	2	1
Overall Monitor Risk Rating	3	2

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	89	95
BPPC – NHS Invoices by value (%)	65	95

Activity & Contract Income – October 2014

Headlines

- Contract activity income is £2.5m above plan in the month and increasing the YTD performance to £14.3m above plan.
- Tariff-excluded drugs and devices income has a neutral impact on ESHT as they are offset by expenditure. After allowing for these areas, total contract income is £11.3mill above planned levels YTD.
- Total Elective activity is £1.4m below plan YTD this is mainly T&O and Cardiology.
- Re-admissions fines have been accrued based on agreed planning assumptions.
- CQUIN performance is based on ESHT achieving 100%.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,728	3,432	-296	24,251	24,836	585
Elective Inpatients	867	780	-87	5,621	5,480	-141
Emergency Inpatients	3,714	3,656	-58	25,640	25,333	-307
Total Inpatients	**8,309**	**7,868**	**-441**	**55,512**	**55,649**	**137**
Excess Bed Days	2,676	2,211	-465	18,382	14,540	-3,842
Total Excess Bed Days	**2,676**	**2,211**	**-465**	**18,382**	**14,540**	**-3,842**
Consultant First Attendances	7,626	8,226	600	49,707	54,577	4,870
Consultant Follow Ups	12,511	13,253	742	81,161	83,968	2,807
OP Procedures	5,023	4,784	-239	32,924	31,938	-986
Other Outpatients inc WA & Nurse Led	14,857	12,985	-1,872	96,273	86,320	-9,953
Community Specialist	276	272	-4	1,792	1,403	-389
Total Outpatients	**40,293**	**39,520**	**-773**	**261,857**	**258,206**	**-3,651**
Chemotherapy Unbundled HRGs	547	874	327	3,543	4,120	577
Antenatal Pathways	364	317	-47	2,360	2,214	-146
Post-natal Pathways	331	272	-59	2,148	2,016	-132
A&E Attendances (excluding type 2's)	8,713	8,743	30	62,782	62,670	-112
ITU Bed Days	443	436	-7	3,261	3,325	64
SCBU Bed Days	238	479	241	1,664	1,913	249
Cardiology - Direct Access	90	13	-77	583	421	-162
Radiology - Direct Access	4,997	5,031	34	32,372	33,429	1,057
Pathology - Direct Access	301,270	289,751	-11,519	1,951,702	1,907,124	-44,578
Therapies - Direct Access	3,752	3,523	-229	24,309	23,294	-1,015
Audiology	2,200	720	-1,480	14,251	11,099	-3,152
Midwifery	11	10	-1	75	84	9

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,961	4,576	-385	32,208	30,831	-1,377
Inpatients - Emergency	6,582	6,209	-373	45,448	43,847	-1,601
Excess Bed Days	611	505	-106	4,199	3,296	-903
Outpatients	4,168	3,852	-316	27,115	27,428	313
Other Acute based Activity	2,441	2,649	208	17,088	17,264	176
Direct Access	832	793	-39	5,397	5,433	36
Block Contract	5,794	6,060	266	40,451	40,251	-200
Re-admissions	-167	-292	-125	-1,167	-1,825	-658
Other	257	3,311	3,054	-139	15,389	15,528
CQUIN	629	629	0	4,219	4,219	0
Subtotal	26,108	28,292	2,184	174,819	186,133	11,314
Exclusions	2,007	2,364	357	14,052	17,059	3,007
GRAND TOTAL	**28,115**	**30,656**	**2,541**	**188,871**	**203,192**	**14,321**

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

Headlines

Clinical Units (CUs)

The overall clinical unit performance was an over spending of £1,802k in the month which has resulted in a YTD over spending of £5,196k.

Commercial Directorate

The Commercial Directorate is underspent by £26k year to date with income generation, hotel services and property services driving the position this month.

Corporate Services

Corporate Services was on plan in the month leaving the overspend at £602k,.

Income & Expenditure Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Urgent Care	2,356	2,002	-354	16,147	12,241	-3,906
Specialist Medicine	649	897	248	3,398	5,177	1,779
Cardiovascular	247	132	-115	-285	-731	-446
Surgery	5,038	4,036	-1,002	31,270	28,816	-2,454
Women & Children	1,463	1,393	-70	9,249	8,870	-379
Out of Hospital Care	666	636	-30	4,098	3,875	-223
Clinical Support	-4,606	-4,896	-290	-33,674	-32,910	764
Tariff-Excluded Drugs & Devices	0	0	0	0	0	0
COO Operations	-884	-1,073	-189	-5,989	-6,320	-331
Total Clinical Units	**4,929**	**3,127**	**-1,802**	**24,214**	**19,018**	**-5,196**
Commercial Directorate	-2,367	-2,307	60	-16,317	-16,291	26
Corporate Services	-2,017	-2,017	0	-13,129	-13,731	-602
Central Items	-1,757	-1,534	223	-11,649	-11,236	413
Total Central Areas	**-6,141**	**-5,858**	**283**	**-41,095**	**-41,258**	**-163**
Income	1,074	4,158	3,084	4,967	20,598	15,631
Donated Asset/Impairment Adjustment	0	-53	-53	0	441	441
Total	**-138**	**1,374**	**1,512**	**-11,914**	**-1,201**	**10,713**

Workforce Plan FTE	Workforce Actual FTE	Pay Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
494	511	Urgent Care	-1,734	-1,791	-57	-12,303	-12,629	-326
416	410	Specialist Medicine	-1,500	-1,471	29	-10,677	-10,910	-233
292	309	Cardiovascular	-1,082	-1,127	-45	-8,696	-8,874	-178
673	682	Surgery	-2,773	-2,863	-90	-20,023	-20,244	-221
631	617	Women & Children	-2,300	-2,399	-99	-16,361	-16,341	20
874	847	Out of Hospital Care	-2,420	-2,455	-35	-17,425	-17,588	-163
980	950	Clinical Support	-3,816	-4,034	-218	-27,660	-27,589	71
413	443	COO Operations	-827	-976	-149	-5,654	-5,893	-239
4,773	**4,767**	**Total Clinical Units**	**-16,452**	**-17,116**	**-664**	**-118,799**	**-120,068**	**-1,269**
826	823	Commercial Directorate	-1,613	-1,628	-15	-11,395	-11,536	-141
537	512	Corporate Services	-1,602	-1,665	-63	-10,964	-11,134	-170
1,363	**1,335**	**Total Non-Clinical Divisions**	**-3,215**	**-3,293**	**-78**	**-22,359**	**-22,670**	**-311**
		Central Items	-273	-8	265	-702	-291	411
6,136	**6,102**	**Total Pay Analysis**	**-19,940**	**-20,417**	**-477**	**-141,860**	**-143,029**	**-1,169**

Clinical Unit Performance (budgets) Urgent Care – October 2014

Headlines

Pay

Overall pay for Urgent Care overspent by £57k in the month due to medical and nursing agency staff in A&E covering vacancies and patients requiring specialist care.

Non Pay

Non pay overspent in the month bringing the cumulative overspend to £15k.

Divisional Income

Contract income was below plan by £285k in the month and is now £3.6m below plan YTD.

Workforce Plan FTE	Workforce Actual FTE	Urgent Care	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	4,186	3,901	-285	29,116	25,550	-3,566
		Other Income	1	3	2	10	11	1
		Total Income	**4,187**	**3,904**	**-283**	**29,126**	**25,561**	**-3,565**
494	511	Pay	-1,734	-1,791	-57	-12,303	-12,629	-326
		Non pay	-97	-111	-14	-676	-691	-15
494	**511**	**Total Expenditure**	**-1,831**	**-1,902**	**-71**	**-12,979**	**-13,320**	**-341**
494	**511**	**Gross Margin**	**2,356**	**2,002**	**-354**	**16,147**	**12,241**	**-3,906**

Clinical Unit Performance (budgets) Specialist Medicine – October 2014

Headlines

Pay

Pay underspent by £29k in the month principally due to reductions in agency expenditure. Cumulatively pay has reduced to an overspend position of £233k YTD.

Non Pay

Non-Pay overspent by £40k in the month due to general ward issues and endoscopy spend taking the cumulative to £23k overspend YTD.

Income

Contract income was above plan by £265k in month and is now £2.1m above plan YTD.

Workforce Plan FTE	Workforce Actual FTE	Specialist Medicine	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	2,223	2,488	265	14,677	16,762	2,085
		Other Income	183	177	-6	1,282	1,232	-50
		Total Income	**2,406**	**2,665**	**259**	**15,959**	**17,994**	**2,035**
416	410	Pay	-1,500	-1,471	29	-10,677	-10,910	-233
		Non pay	-257	-297	-40	-1,884	-1,907	-23
416	**410**	**Total Expenditure**	**-1,757**	**-1,768**	**-11**	**-12,561**	**-12,817**	**-256**
416	**410**	**Gross Margin**	**649**	**897**	**248**	**3,398**	**5,177**	**1,779**

Clinical Unit Performance (budgets) Cardiovascular – October 2014

Headlines

Pay

Pay overspent by £45k in the month due to increased agency costs and additional beds over plan. This brings the YTD position to £178k above plan.

Non Pay

Non pay budgets are overspent by £240k YTD due to cardiology consumables.

Income

Contract income has overachieved by £102k in month and remains above plan by £351k YTD.

Other income underachieved by £102k in the month, with the YTD position being an under recovery of £379k. The Michelham Unit had 29% occupancy during October.

Workforce Plan FTE	Workforce Actual FTE	Cardiovascular	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	1,455	1,557	102	9,662	10,013	351
		Other Income	253	151	-102	1,555	1,176	-379
		Total Income	**1,708**	**1,708**	**0**	**11,217**	**11,189**	**-28**
292	309	Pay	-1,082	-1,127	-45	-8,696	-8,874	-178
		Non pay	-379	-449	-70	-2,806	-3,046	-240
292	**309**	**Total Expenditure**	**-1,461**	**-1,576**	**-115**	**-11,502**	**-11,920**	**-418**
292	**309**	**Gross Margin**	**247**	**132**	**-115**	**-285**	**-731**	**-446**

Clinical Unit Performance (budgets) Surgery – October 2014

Headlines

Pay

Pay overspent by £90k in the month and is now overspent by £221k YTD. The overspending in the month was in respect of medical staffing and agency cover.

Non Pay

Non pay overspent by £106k in the month due to increased spend on hearing aids.

Income

Contract income has underachieved by £817k in the month and is under plan by £2.1m YTD.

Workforce Plan FTE	Workforce Actual FTE	Surgery	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	8,101	7,284	-817	53,679	51,602	-2,077
		Other Income	46	57	11	326	346	20
		Total Income	**8,147**	**7,341**	**-806**	**54,005**	**51,948**	**-2,057**
673	682	Pay	-2,773	-2,863	-90	-20,023	-20,244	-221
		Non pay	-336	-442	-106	-2,712	-2,888	-176
673	**682**	**Total Expenditure**	**-3,109**	**-3,305**	**-196**	**-22,735**	**-23,132**	**-397**
673	**682**	**Gross Margin**	**5,038**	**4,036**	**-1,002**	**31,270**	**28,816**	**-2,454**

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

Headlines

Pay

Pay overspent by £99k due to increase nursing and medical locum costs and is underspent YTD by £20k.

Non Pay

Overspend of £34k in the month due to increased spend on medical and surgical equipment.

Income

Contract income overachieved by £45k in the month and is YTD £543k below plan.

Other income was above plan by £18k in the month.

Workforce Plan FTE	Workforce Actual FTE	Women & Children	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	4,074	4,119	45	27,721	27,178	-543
		Other Income	37	55	18	254	371	117
		Total Income	**4,111**	**4,174**	**63**	**27,975**	**27,549**	**-426**
631	617	Pay	-2,300	-2,399	-99	-16,361	-16,341	20
		Non pay	-348	-382	-34	-2,365	-2,338	27
631	**617**	**Total Expenditure**	**-2,648**	**-2,781**	**-133**	**-18,726**	**-18,679**	**47**
631	**617**	**Gross Margin**	**1,463**	**1,393**	**-70**	**9,249**	**8,870**	**-379**

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

Headlines

Pay

Pay overspent by £35k in the month due to pressure in clinical admin. Pay is now overspent YTD by £163k.

Non Pay

£4k overspent against the plan for the month due to spending on wheelchairs and is now £14k overspent YTD

Income

Contract income is £6k underachieved in the month.

Other income overachieved by £15k in the month

Workforce Plan FTE	Workforce Actual FTE	Out of Hospital 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	3,453	3,447	-6	24,120	24,092	-28
		Other Income	110	125	15	770	752	-18
		Total Income	**3,563**	**3,572**	**9**	**24,890**	**24,844**	**-46**
874	847	Pay	-2,420	-2,455	-35	-17,425	-17,588	-163
		Non pay	-477	-481	-4	-3,367	-3,381	-14
874	**847**	**Total Expenditure**	**-2,897**	**-2,936**	**-39**	**-20,792**	**-20,969**	**-177**
874	**847**	**Gross Margin**	**666**	**636**	**-30**	**4,098**	**3,875**	**-223**

Clinical Unit Performance (budgets) Clinical Support – October 2014

Headlines

Pay

Pay overspend of £218k in the month due to additional sessions and payments for back-log reporting . Pay is now £71k underspent YTD.

Non Pay

Non-pay expenditure was £91k over plan in month is underspent by £294k YTD.

Income

Contract income was below plan by £57k YTD.

Other income was over plan by £76k in the month relating to PMU.

Workforce Plan FTE	Workforce Actual FTE	Clinical Support	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	1,708	1,651	-57	11,606	11,775	169
		Other Income	330	406	76	2,306	2,536	230
		Total Income	**2,038**	**2,057**	**19**	**13,912**	**14,311**	**399**
980	950	Pay	-3,816	-4,034	-218	-27,660	-27,589	71
		Non pay	-2,828	-2,919	-91	-19,926	-19,632	294
980	**950**	**Total Expenditure**	**-6,644**	**-6,953**	**-309**	**-47,586**	**-47,221**	**365**
980	**950**	**Gross Margin**	**-4,606**	**-4,896**	**-290**	**-33,674**	**-32,910**	**764**

Clinical Unit Performance (budgets) COO Operations – October 2014

Headlines

Pay

This was overspent by £149k due to clinical admin costs. Pay is now £239k overspent YTD.

Non Pay

Non pay is now £96k over plan relating to Clinical Admin.

Income

Income remains broadly on plan.

Workforce Plan FTE	Workforce Actual FTE	COO Operations	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Other Income	8	0	-8	59	63	4
		Total Income	**8**	**0**	**-8**	**59**	**63**	**4**
413	443	Pay	-827	-976	-149	-5,654	-5,893	-239
		Non pay	-65	-97	-32	-394	-490	-96
413	**443**	**Total Expenditure**	**-892**	**-1,073**	**-181**	**-6,048**	**-6,383**	**-335**
413	**443**	**Gross Margin**	**-884**	**-1,073**	**-189**	**-5,989**	**-6,320**	**-331**

Divisional Performance (budgets) Commercial Directorate – October 2014

Headlines

Pay

Pay in month was £15k overspent, leaving the YTD position as £141k above plan.

Non Pay

In October non pay was underspent by £43k with ancillary, property and hotel services being the drivers. YTD underspend of £168k.

Divisional Income

Commercial income has overachieved by £32k in the month due to EME and design team recharges.

Workforce Plan FTE	Workforce Actual FTE	Commercial Directorate	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Other Income	698	730	32	4,883	4,882	-1
		Total Income	**698**	**730**	**32**	**4,883**	**4,882**	**-1**
826	823	Pay	-1,613	-1,628	-15	-11,395	-11,536	-141
		Non pay	-1,452	-1,409	43	-9,805	-9,637	168
826	**823**	**Total Expenditure**	**-3,065**	**-3,037**	**28**	**-21,200**	**-21,173**	**27**
826	**823**	**Gross Margin**	**-2,367**	**-2,307**	**60**	**-16,317**	**-16,291**	**26**

Divisional Performance (budgets) Corporate Services – October 2014

Headlines

Pay

Pay was overspent by £63k in the month and is £170k overspent YTD.

Non Pay

Non pay was overspent by £111k due to consultancy costs.

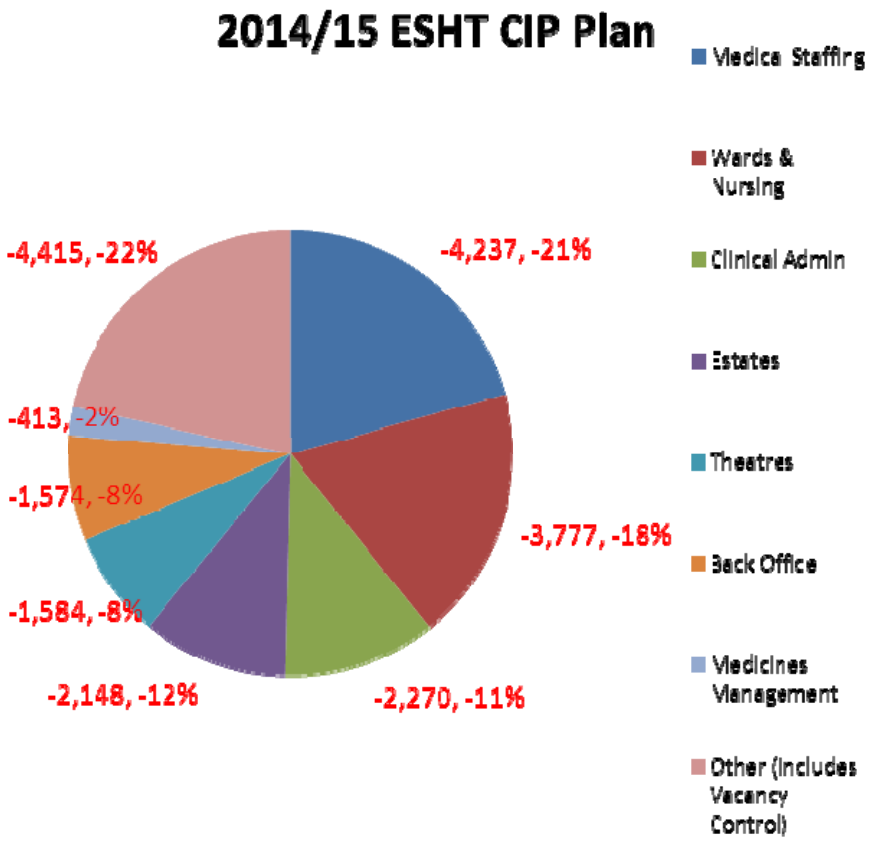
Income

£174k overachieved in month relating to MPET income.

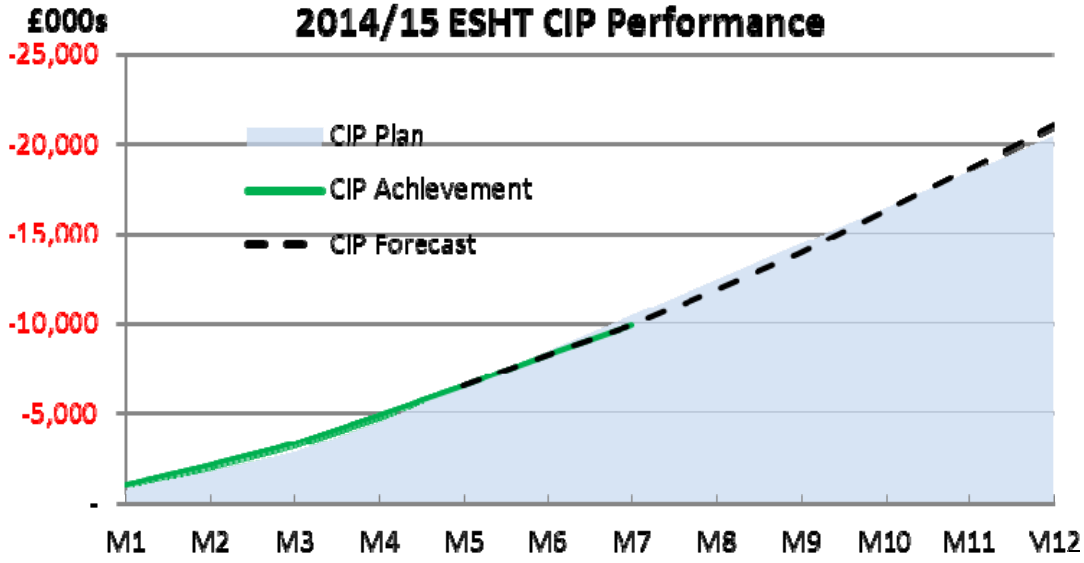
Workforce Plan FTE	Workforce Actual FTE	Corporate Services	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	2	2	0	15	15	0
		Other Income	970	1,144	174	7,424	7,844	420
		Total Income	**972**	**1,146**	**174**	**7,439**	**7,859**	**420**
537	512	Pay	-1,602	-1,665	-63	-10,964	-11,134	-170
		Non pay	-1,387	-1,498	-111	-9,604	-10,456	-852
537	**512**	**Total Expenditure**	**-2,989**	**-3,163**	**-174**	**-20,568**	**-21,590**	**-1,022**
537	**512**	**Gross Margin**	**-2,017**	**-2,017**	**0**	**-13,129**	**-13,731**	**-602**

2014/15 ESHT CIP Plan

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



2014/15 ESHT CIP Performance to date – Month 7



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Plan	-799	-1,743	-2,806	-4,479	-6,432	-8,428	-10,424	-12,417	-14,408	-16,408	-18,407	-20,417
Actual	-995	-2,102	-3,272	-4,851	-6,512	-8,181	-9,888					
Forecast								-11,786	-13,856	-16,196	-18,608	-21,020

East Sussex Healthcare NHS
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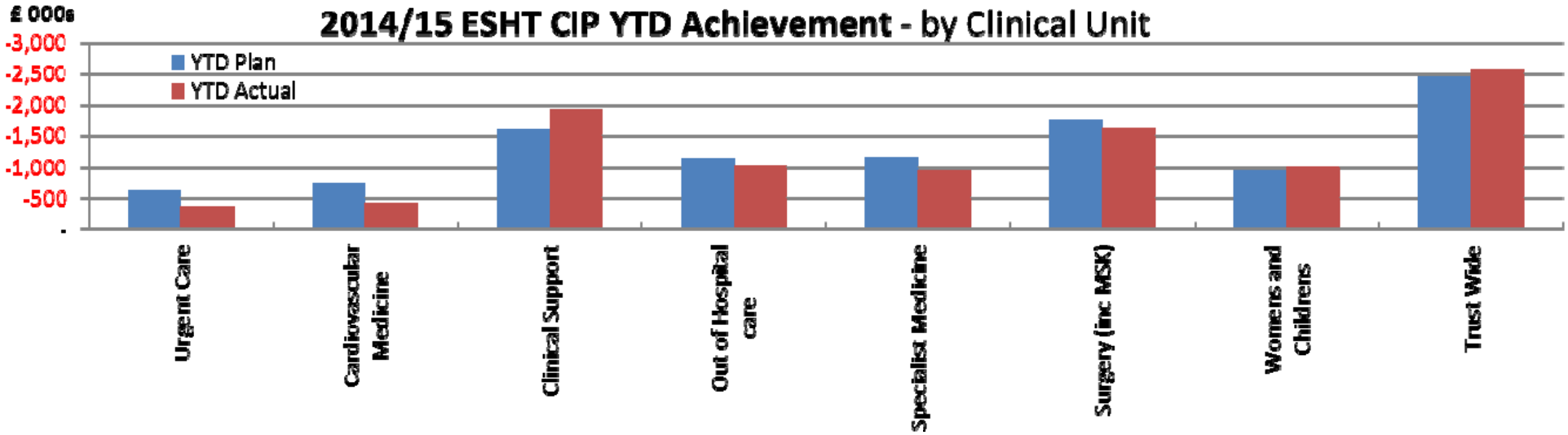
2014/15 ESHT CIP Performance by Clinical Unit – Month 7

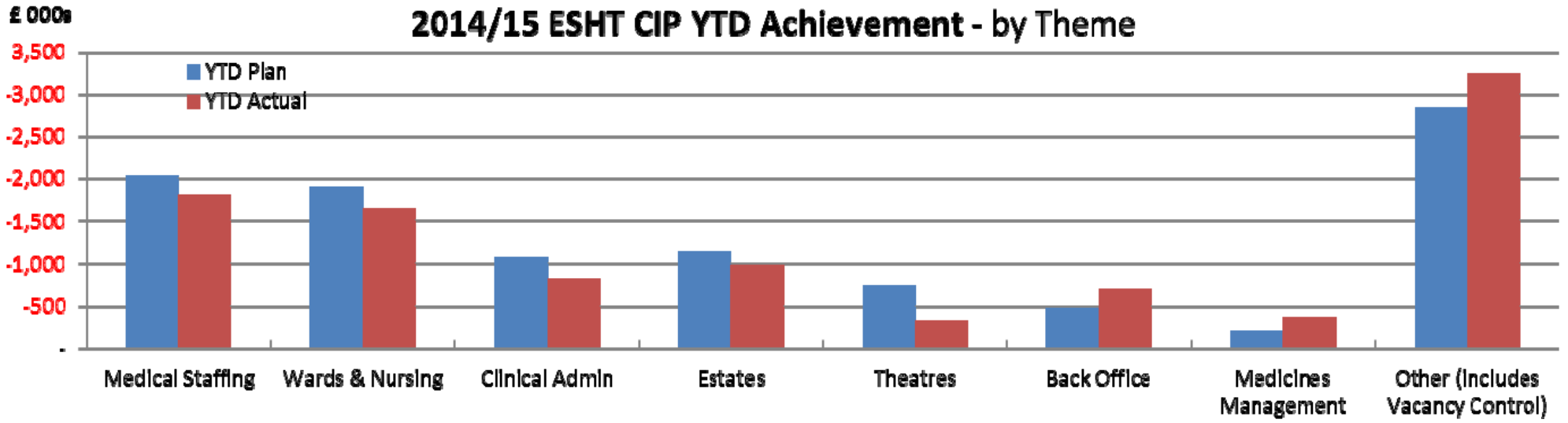
	In Month			Year to Date			Forecast		
Clinical Unit	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Full Year Plan	Full Year Forecast	Full Year Variance
Urgent Care	-117	-54	-63	-620	-375	-246	-1,204	-685	-519
Cardiovascular Medicine	-162	-137	-25	-740	-421	-319	-1,551	-1,562	10
Clinical Support	-312	-169	-143	-1,599	-1,929	330	-3,180	-3,391	211
Out of Hospital care	-177	-156	-21	-1,146	-1,031	-116	-2,031	-2,021	-10
Specialist Medicine	-225	-273	49	-1,157	-939	-218	-2,280	-2,181	-99
Surgery (inc MSK)	-315	-268	-48	-1,750	-1,624	-126	-3,338	-3,037	-301
Womens and Childrens	-152	-140	-12	-962	-1,014	52	-1,853	-1,928	75
Trust Wide	-536	-509	-27	-2,450	-2,555	106	-4,980	-6,215	1,236
Total	-1,996	-1,706	-290	-10,424	-9,888	-536	-20,417	-21,020	603



East Sussex Healthcare NHS
NHS Trust

2014/15 ESHT CIP Performance by Theme – Month 7

	In Month			Year to Date			Forecast		
Themes	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Full Year Plan	Full Year Forecast	Full Year Variance
Medical Staffing	-409	-287	-122	-2,032	-1,806	-226	-4,237	-3,579	-658
Wards & Nursing	-375	-443	68	-1,904	-1,659	-245	-3,777	-3,780	3
Clinical Admin	-213	-134	-79	-1,072	-809	-263	-2,270	-1,596	-673
Estates	-201	-154	-47	-1,145	-980	-165	-2,148	-1,982	-165
Theatres	-169	-46	-123	-739	-326	-414	-1,584	-901	-682
Back Office	-219	-173	-46	-479	-694	215	-1,574	-1,634	60
Medicines Management	-42	-42	-	-203	-373	170	-413	-733	320
Other (includes Vacancy Control)	-369	-427	58	-2,849	-3,241	392	-4,415	-6,814	2,399
Total	-1,996	-1,706	-290	-10,424	-9,888	-536	-20,417	-21,020	603



East Sussex Healthcare NHS
NHS Trust

Year on Year Comparisons – October 2014

Headlines

- Total Inpatients activity was 1.3% higher than last year's activity level.
- Total outpatients were 2.6% lower than last year.
- YTD A&E attendances were 2.3% higher than last year.

Activity	2014/15 YTD Actual	2013/14 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	24,836	25,443	-607	-2.4%
Elective Inpatients	5,480	5472	8	0.1%
Emergency Inpatients	25,333	24,014	1,319	5.5%
Total Inpatients	**55,649**	**54,929**	**720**	**1.3%**
Elective Excess Bed Days	1,135	1,054	81	7.7%
Non elective Excess Bed Days	13,405	16,698	-3,293	-19.7%
Total Excess Bed Days	**14,540**	**17,752**	**-3,212**	**-18.1%**
Consultant First Attendances	54,577	54,570	7	0.0%
Consultant Follow Ups	83,968	87,234	-3,266	-3.7%
OP Procedures	31,938	31,861	77	0.2%
Other Outpatients (WA & Nurse Led)	86,320	89,748	-3,428	-3.8%
Community Specialist	1,403	1,639	-236	-14.4%
Total Outpatients	**258,206**	**265,052**	**-6,846**	**-2.6%**
Chemotherapy Unbundled HRGs	4,120	3,360	760	22.6%
Antenatal Pathways	2,214	2,348	-134	-5.7%
Post-natal Pathways	2,016	2,574	-558	-21.7%
A&E Attendances (excluding type 2's)	62,670	61,274	1,396	2.3%
ITU Bed Days	3,325	3,430	-105	-3.1%
SCBU Bed Days	1,913	1,903	10	0.5%
Cardiology - Direct Access	421	582	-161	-27.7%
Radiology - Direct Access	33,429	34,084	-655	-1.9%
Pathology - Direct Access	1,907,124	1,970,914	-63,790	-3.2%
Therapies - Direct Access	23,294	23,406	-112	-0.5%
Audiology	11,099	14,689	-3,590	-24.4%
Midwifery	84	77	7	9.1%

£000s	2014/15 YTD Actual	2013/14 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	203,192	187,148	16,044	8.6%
Private Patient/ RTA	1,892	1,565	327	20.9%
Trading Income	2,970	2,604	366	14.1%
Other Non Clinical Income	15,804	15,467	337	2.2%
Total Income	**223,858**	**206,784**	**17,074**	**8.3%**
Pay Costs	-143,029	-149,996	6,967	4.6%
Non Pay Costs	-71,725	-66,381	-5,344	-8.1%
Other	1,283	729	554	-76.0%
Total Direct Costs	-213,471	-215,648	2,177	1.0%
Surplus/-Deficit from Operations	**10,387**	**-8,864**	**19,251**	**217.2%**
Profit/Loss on Asset Disposal	22	0	22	
Depreciation	-7,220	-7,021	-199	-2.8%
Impairment	0		0	
PDC Dividend	-4,636	-3,397	-1,239	-36.5%
Interest	-195	-132	-63	-47.7%
Total Indirect Costs	-12,029	-10,550	-1,479	-14.0%
Total Costs	**-225,500**	**-226,198**	**698**	**0.3%**
Net Surplus/-Deficit	**-1,642**	**-19,414**	**17,772**	**91.5%**
Donated Asset / Other Adjustment	441	36	405	-1125.0%
Normalised Net Surplus/-Deficit	**-1,201**	**-19,378**	**18,177**	**93.8%**

Capital Programme – October 2014

Headlines

Year to Date performance:-
After seven months of the financial year capital expenditure has increased to £4.7m.

Commitments entered into total £8.7m compared to the revised forecast total capital resource of £28.7m.

The forecast annual capital resource has increased by £0.4m following the approval in September of a funding bid submitted to the Independent Trust Financing Facility (ITFF) in respect of the Conquest clinical decision unit (CDU) development. However, a decision is still awaited from the Trust Development Authority (TDA) on the £17.4m clinical strategy business case funding. As a result only essential clinical strategy enabling works are being carried out funded from the Trust's routine capital programme.

The over planning margin has increased to £0.6m. This level of over commitment is considered acceptable at this stage of the financial year and the Capital Approvals Group (CAG) will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the uncertainty around the clinical strategy business case exceptional funding, the progress on the Pevensey development and clarification of the electrical supply requirements.

Capital Investment Programme £000s	2014/15 Capital Programme	Expenditure at Month 7
Capital Resources		
Depreciation	11,285	
Clinical Strategy exceptional additional PDC	17,400	
Additional Capital - Conquest Clinical Decision Unit	400	
League of Friends Support	1,300	
Cap Investment Loan Principal Repayment	-340	
Gross Capital Resource	30,045	
Less Donated Income	-1,300	
Capital Resource Limit (CRL)	**28,745**	**-**
Capital Investment		
Clinical Strategy Reconfiguration	17,400	0
Conquest Clinical Decision Unit	400	6
Clinical Strategy Essential Enabling Works	250	205
Medical Equipment	2,721	775
Information Systems	823	317
Electronic Document Management	180	63
Child Health Information System	557	340
Backlog Maintenance	964	173
Infrastructure Improvements - Infection Control	610	226
Electrical Supply to DGH	540	0
Minor Capital Schemes	2,200	1,283
Pevensey Ward	746	249
Other various	1,099	414
Brought Forward Schemes	811	667
Sub Total	**29,301**	**4,718**
Donated Asset Purchases	1,300	342
Donated Asset Funding	-1,300	-342
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**29,301**	**4,718**
Overplanning Margin (-) Underplanning (+)	-556	
Net Capital Charge against the CRL	**28,745**	**4,718**

Continuity of Service Risk Ratings – October 2014

Headlines

Continuity of Service Risk Ratings (COS):-

- Liquidity (days)
  - Days of operating costs held in cash or cash equivalent forms.
- Capital service capacity ratio (times)
  - The degree to which the organisation's generated income covers its financial obligations.
- Monitor assigns ratings between 1 and 4 to each component of the continuity of service risk ratings with 1 being the worst rating and 4 the best. The overall rating is the average of the two.
- The Trust has a liquidity ratio of 5 days, a rating of 4.
- The capital servicing ratio of 1.70 results in a rating of 2.
- As a result the overall Trust rating is 3.

Liquidity Ratio (days) £000s	2013/14 Outturn	2014/15 YTD
Opening Current Assets	33,908	42,409
Opening Current Liabilities	-34,506	-30,974
Net Current Assets/Liabilities	-598	11,435
Inventories	-6,238	-6,436
Adj Net Current Assets/Liabilities	**-6,836**	**4,999**
Divided by:		
Total costs in year	369,719	213,471
Multiply by (days)	360	210
Liquidity Ratio	**-7**	**5**

Capital Servicing Capacity (times) £000s	2013/14 Outturn Actual	2014/15 YTD Plan	2014/15 YTD Actual
Net Surplus / Deficit (-) After Tax	-33,412	-11,914	-1,642
Less:			
Donated Asset Income Adjustment	-999	-758	-341
Interest Expense	305	187	217
Profit/Loss on Sale of Assets	-9	0	-22
Depreciation & Amortisation	11,385	7,341	7,220
Impairments	10,018	0	0
PDC Dividend	6,251	4,823	4,636
Revenue Available for Debt Service	**-6,461**	**-321**	**10,068**
Interest Expense	305	187	217
PDC Dividend	6,251	4,823	4,636
Temporary PDC repayment	29,000		
Working capital loan repayment	1,334	861	837
Capital loan repayment	340	160	242
	37,230	6,031	5,932
Capital Serving Capacity	**-0.17**	**-0.05**	**1.70**

Financial Risks & Mitigating Actions – October 2014

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

East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 2014
Meeting:	Trust Board
Agenda item:	Current Quality Account Indicators
Subject:	7b
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

This report is provided to update the Board on the progress of the current Quality Account Indicators. The report is presented in a table, however there is further information available from the leads should this be required.

Introduction:

Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

The quality account for ESHT has previously been to the board for both approval in its development and also sign off.

Work is being developed to review the priorities for 2015/16, however this will be presented to the board at a later stage.

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

All of the current Quality Account priorities have been reviewed and are delivering as expected. Further work is required to ensure that the embedding of these initiatives is in place and that there is evidence of shared learning across the organisation.

Benefits:

Achievement of these key areas of quality improvement will ensure that the trust continues to develop its role in improving patient safety, clinical effectiveness and patient experience.

Risks and Implications

Failure to deliver this programme will not provide assurance that the organisation is a learning one, able to deliver safer care.

Assurance Provided:

All programmes are on track to deliver with a named lead being held to account for progress.

Board Assurance Framework:

Strategic Objective 1, risks 1.1 and 1.2

Review by other Committees/Groups (please state name and date)**:**
Trust Infection Control Group Vital Pac Steering Group Quality and Standards

Proposals and/or Recommendations
The Board is asked to note the contents of 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?
Nil to note

For further information or for any enquiries relating to this report please contact:	
Name Alice Webster, Director of Nursing	**Contact details:** alice.webster@nhs.net

QUALITY ACCOUNT INDICATORS UPDATE – November 2014

Priority	Action in the Quality Account	Lead	Update	Rag Status
Patient Safety				
To ensure that safety always comes first within our organisation by Maximising our efforts to reduce healthcare associated infections	We will monitor practice by undertaking a programme of key infection control audits and surveillance findings. These will be incorporated into the Trust routine audit meetings for engagement and feedback to clinical staff.	Associate Director of Infection Control	Audit programme in place	Amber
	Ward Matrons will be required to present reports every five weeks to demonstrate compliance with hand hygiene, as well as environmental and equipment cleanliness.	Associate Director of Infection Control	Process in place and being monitored through the Nursing Quality Performance meeting with the Clinical areas	Green
	All incidences of MRSA or Clostridium difficile (CDiff) will be reported as incidents and investigated. Themes and trends from incidents and complaints will be reviewed and learning shared across the organisation	Associate Director of Infection Control	Practice in place and effectiveness being monitored. Themes and trends to be a part of the reporting to trust Infection Control Group	Amber
	Compliance with the Code of Practice for Health and Adult Social Care on the Prevention & Control of Infection (Outcome 8 Regulation 12 'Cleanliness and Infection Control' of the Health & Social Care Act 2008 (regulated activities) Regulations 2010) will be assessed every 3 months.	Associate Director of Infection Control	Compliant with exceptions reported to the Trust infection Control group	Amber

Priority	Action in the Quality Account	Lead	Update	Rag Status
Clinical Effectiveness				
To consistently provide high quality patient care in line with identified best practice Early recognition and action to support the care of the deteriorating patient	The system is fully transparent and auditable allowing for an in-depth analysis of activity and performance. This will enable the Trust to target those areas where additional support and education for medical and nursing teams may be required. Weekly and monthly performance reports will be produced for every ward area detailing the full sets of observations performed on patients; these reports will allow us to determine if appropriate escalation of care for sick patients took place at the right time. This information will be readily available for both the Heads of Nursing and Ward Matrons so that progress can be monitored and any issues promptly addressed. Our future goal is to display this information in a 'traffic light format' on every ward. We also hope to clearly evidence (through the use of VitalPAC) a reduction in the number of cardiac arrest calls put out across the Trust. The introduction of this system should enable efficient, rapid escalation of sick patients through the Medical and Surgical Emergency Team calls, preventing patient deterioration into a full cardiac arrest. The Trust will be monitoring the cardiac arrest rate to evidence this.	Director of Nursing	27.10.14 Vital Pac in place across the Trust from September 2014 Reporting structure being implemented – learning clinic held October 2014 to review first set of data but only a few weeks available Staff being trained for extracting reports No progress as too early	Amber

Priority	Action in the Quality Account	Lead	Update	Rag Status
Patient Experience				
Continuing to implement the Patient Experience Strategy	Progress with achieving Patient Experience quality improvement initiatives will be monitored on a quarterly basis by the Trust Board. The Patient Experience Steering Group is the forum for reporting all patient experience activities on a monthly basis; this Group ensures that lessons are learnt widely across the Trust.	Head of Patient Experience	Patient Experience Steering Group to be instigated. Reports to board in place.	Amber
To improve our communication with patients; listening acting upon and being responsive to the feedback we receive from our patients and their carers	Patient experience will be monitored and audited through the existing Family and Friends Test; results will be analysed to determine if delays are occurring in obtaining specialist reviews for applicable patients with the aim of reducing delayed patient transfers to SPFT.	Assistant Director of Nursing (Safeguarding)	FFT continues to be audited for review of delays in relation to specialist reviews. No delays noted through the FFT.	Green
	Ensure that we provide optimal care for patients in our care who have mental health disorders	Assistant Director of Nursing (Safeguarding)	Training provided for key staff (ward manager's, site manager's, FY1 and FY2) and being arranged monthly throughout 15/16. Key support systems for staff completing documentation identified and related staff trained.	Amber
	The Trust will work with SPFT to undertake an annual audit of patients detained under the Mental Health Act to ensure compliance and identify further improvements. Regular partnership meetings will also be held between SPFT and the Trust to ensure we are informed and aware of detention activity.	Assistant Director of Nursing (Safeguarding)	Audit completed in March 2014. Full compliance noted. Regular communication now occurs between SPFT and ESHT, meetings commenced Nov 2014	Amber

Key:
Amber – Actions being implemented and evidence of good progress
Green – Actions implemented and assurance of improvement evident

East Sussex Healthcare NHS Trust

Date of Meeting:	26 November 2014
Meeting:	Trust Board
Agenda item:	8
Subject:	Safe Nurse Staffing Levels
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

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

Introduction:

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

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

- Appropriate Nurse staffing levels are critical to patient safety
- The Trust has systems in place to address and manage variations with support from senior nursing staff
- The variations that have occurred have been managed appropriately and indicate that safe staffing levels have been maintained

Benefits:

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

Risks and Implications

- It is acknowledged that these figures are an average across the month but the breakdown of this information is available at http://www.esht.nhs.uk/nursing/staffing-levels/
- The recently published NICE guidance requires further review of policy and practice to ensure that best practice is met.

Assurance Provided:

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

Board Assurance Framework:
Strategic Objective 3, risk 3.3

Review by other Committees/Groups (please state name and date)**:**
Quality and Standards Committee 10th November 2014

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

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

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

East Sussex Healthcare NHS Trust

SAFE NURSE STAFFING LEVELS

1. Introduction

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

The current mandated reporting requirements also include the following inpatient areas: Paediatrics, Midwifery and Community Hospitals.

2. Background

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

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

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

3. August 2014 Report

3.1 The dashboard in Appendix 1 has been prepared for August 2014 reflecting the above requirements.

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

- Michelham Ward is a private ward with a staffing establishment for 21 beds. It has been ring fenced to enhance opportunities for additional private activity and has been providing care to a reduced number of patients and therefore staffing levels have been adjusted to reflect the requirement.

- Lewes Intermediate Care operated on slightly less than 75% of the established RN complement at night due to vacancies. Various measures were taken to obtain the full complement of RNs at night but the situation was assessed daily by the Matron who ensured that there were no less than 2 RNs available every night and is confident that this provided a safe level of RN cover.

- Richard Ticehurst Surgical Assessment Unit fell to an average RN cover of 73.5% during the day. The unit is established to have 6 RNs on day duty, on no occasion were there less than 5 RNs available. In addition Healthcare Assistants levels were enhanced to address this deficit.

September 2014 Report

4. The dashboard in Appendix 2 has been prepared for September 2014 reflecting the NQB/NICE requirements.

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

- Michelham Ward is a private ward with a staffing establishment for 21 beds. As in August it has been providing care to a reduced number of patients and therefore staffing levels have been adjusted to reflect the requirement.

- The Irvine Unit operated on slightly less than 75% of the established RN complement at night. Various measures were taken to obtain the full complement of RNs at night but the situation was assessed daily by the Matron or Nurse in charge who ensured that there were no less than 3 RNs available every night.

- Richard Ticehurst Surgical Assessment Unit fell to an average RN cover of 71.5% during the day. The unit is established to have 6 RNs on day duty, on no occasion were there less than 5 RNs available. In addition Healthcare Assistants levels were enhanced to address this deficit.

5. **Quality Indicators**

The quality indicators are monitored through the monthly nursing quality performance reviews. There is no evidence that quality and safety were affected by the lower levels of RNs in August and September however it is essential that active recruitment and retention strategies continue to maintain a robust nursing workforce that can deliver safe care. This work is being led by the Assistant Directors of Nursing who are pursuing a number of routes from international recruitment to return to nursing programmes.

6. **Conclusion/Recommendation**

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

This overview provides assurance that the systems and processes in place allow the Trust to provide safe care in our inpatient wards. The next nursing establishment review is being planned at present and will be reported to the Trust Board in due course.

Alice Webster
Director of Nursing

Elizabeth Fellows
Assistant Director of Operations

November 2014

Appendix 1

Aug-14	Clinical Unit	Average fill rate day	Average fill rate day	Average fill rate night	Average fill rate night	PU's	Falls	Med. Errors
		RN/RM	HCA	RN/RM	HCA			
Berwick	Cardiovascular Clinical Unit	92.83%	120.36%	76.34%	177.95%		12	1
CCU EDGH	Cardiovascular Clinical Unit	116.95%		80.65%	25.32%			
Folkington	Cardiovascular Clinical Unit	88.43%	123.37%	82.26%	195.58%		9	
James CCU	Cardiovascular Clinical Unit	102.96%	91.69%	95.16%	112.62%		4	1
Michelham	Cardiovascular Clinical Unit	66.53%	78.33%	87.17%	169.49%			
Stroke Unit EDGH	Cardiovascular Clinical Unit	112.46%	105.47%	84.60%	123.70%			
Wellington	Cardiovascular Clinical Unit	86.41%	81.52%	96.49%	78.49%		2	
	Cardiovascular Clinical Unit Total					0	27	2
Crowborough Intermediate Beds	Out of Hospital	103.35%	97.09%	95.37%	109.96%		7	2
Harlands Medical	Out of Hospital							
Irvine Unit	Out of Hospital	77.14%	121.76%	75.25%	87.74%			
Lewes Intermediate care	Out of Hospital	100.00%	125.00%	74.19%	85.48%		19	6
Rye Intermediate Care Beds	Out of Hospital	98.39%	111.04%	103.23%	98.18%		1	
	Out of Hospital Total					0	27	8
Cuckmere	Specialist Medicine	94.80%	91.18%	86.02%	133.98%	2	10	
Jevington	Specialist Medicine	114.46%	100.39%	119.50%	149.65%	1	7	
Newington	Specialist Medicine	92.41%	91.39%	77.42%	115.99%	1	8	
Pevensey	Specialist Medicine	87.66%	38.92%	100.00%	74.19%			
Tressell	Specialist Medicine						4	
	Specialist Medicine Total					4	29	0
Benson Trauma	Surgery	82.77%	87.78%	93.55%	125.18%		5	
Cookson Attenborough - Surgical short Stay	Surgery	123.10%	135.45%	81.25%	93.75%			
Cookson Devas Elective	Surgery	84.67%	61.27%	85.48%	45.16%	1	2	
De Cham	Surgery	86.64%	117.16%	100.00%	149.79%	1	4	1
Egerton Trauma	Surgery	85.15%	86.18%	98.39%	113.29%	1	6	1
Gardner	Surgery	82.12%	129.22%	80.34%	139.94%	1	1	
Hailsham 3 (Orthopaedic Elective)	Surgery	91.57%	117.18%	90.43%	64.75%	1	2	1
Hailsham 4	Surgery	112.82%	119.00%	106.62%	109.02%		1	1
MacDonald	Specialist Medicine	87.98%	95.12%	112.90%	117.72%	3	9	1
RT SAU	Surgery	73.49%	119.18%	75.34%	97.97%		1	1
Seaford 4 Urology	Surgery	82.86%	94.26%	94.53%	111.29%		2	1
	Surgery Total					8	33	7
ITU/HDU Conquest	Theatres and Clinical Support	96.21%	69.78%	76.42%	81.63%			
ITU/HDU EDGH	Theatres and Clinical Support	103.85%	76.30%	89.94%				1
	Theatres and Clinical Support Total					0	0	1
AAU Conquest	Urgent Care	77.70%	106.73%	89.25%	105.84%		2	1
Baird MAU	Urgent Care	86.36%	93.79%	95.09%	100.44%		6	2
Seaford 1	Urgent Care	100.35%	94.20%	93.52%	96.91%			
Seaford 2/MSSU	Urgent Care	108.45%	69.77%	101.75%	116.13%		7	
	Urgent Care Total					0	15	3
Crowborough Birthing Unit	Women and Children	93.13%	97.62%	100.56%	100.14%			
EMU	Women and Children	93.34%	93.55%	92.01%	90.32%			
Frank Shaw	Women and Children	86.75%	98.40%	88.33%	94.76%			
Kipling	Women and Children	89.88%	123.77%	78.23%	67.74%			
Mirrlees	Women and Children	105.79%	97.19%	123.98%	77.70%			
SCBU	Women and Children	98.54%	83.87%	85.76%	83.87%			1
	Women and Children Total					0	0	1
	Grand Total					12	131	22

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

Appendix 2

Sep-14	Clinical Unit	Average fill rate day	Average fill rate day	Average fill rate night	Average fill rate night	PUs	Falls	Med Errors
		RN/RM	HCA	RN/RM	HCA			
Berwick	Cardiovascular Clinical Unit	89.90%	92.90%	115.00%	160.10%		4	
CCU EDGH	Cardiovascular Clinical Unit	78.70%	-	80.00%	-			
James CCU	Cardiovascular Clinical Unit	110.60%	84.80%	94.20%	93.30%		1	
Michelham	Cardiovascular Clinical Unit	61.30%	80.10%	78.30%	75.00%			
Stroke Unit EDGH	Cardiovascular Clinical Unit	118.20%	94.20%	105.90%	111.20%			
Wellington	Cardiovascular Clinical Unit	95.80%	81.30%	103.30%	52.10%		2	2
	Cardiovascular Clinical Unit Total					0	7	1
Crowborough Intermediate Beds	Out of Hospital	104.70%	100.10%	96.80%	100.00%	1	5	7
Irvine Unit	Out of Hospital	75.50%	127.10%	71.60%	90.50%			1
Lewes Intermediate Care	Out of Hospital	83.80%	86.10%	82.50%	89.90%	1	11	6
Rye Intermediate Care Beds	Out of Hospital	92.10%	109.10%	106.90%	96.70%			1
Uckfield Intermediate Care Beds	Out of Hospital	112.00%	117.40%	100.10%	100.10%		5	1
	Out of Hospital Total					2	21	16
Cuckmere	Specialist Medicine	92.60%	70.80%	106.70%	166.10%	1	4	1
Jevington	Specialist Medicine	104.80%	100.60%	87.80%	141.70%		1	
MacDonald	Specialist Medicine	78.00%	92.60%	97.30%	112.50%		10	
Newington	Specialist Medicine	101.80%	97.20%	84.40%	139.30%	3	9	
Pevensey	Specialist Medicine	92.60%	34.70%	100.00%	93.30%			
	Specialist Medicine Total					4	24	1
Benson Trauma	Surgery	78.90%	92.50%	95.00%	144.90%	2	1	1
Cookson Attenborough - Surgical short Stay	Surgery	131.80%	94.00%	100.00%	100.00%			
Cookson Devas Elective	Surgery	85.90%	66.20%	91.70%	40.00%			
De Cham	Surgery	87.00%	145.10%	90.70%	176.30%	1	4	1
Egerton Trauma	Surgery	96.90%	93.50%	96.70%	141.90%	3	5	3
Gardner	Surgery	107.50%	136.00%	102.80%	146.30%	1	2	
Hailsham 3 (Orthopaedic Elective)	Surgery	98.80%	77.80%	90.40%	52.10%		3	
Hailsham 4	Surgery	95.60%	93.00%	108.60%	109.80%		3	1
RT SAU	Surgery	71.70%	135.70%	77.70%	101.70%		3	
Seaford 4 Urology	Surgery	84.00%	97.00%	93.30%	106.70%			
	Surgery Total					7	21	6
ITU/HDU Conquest	Theatres and Clinical Support	99.40%	62.10%	81.50%	100.00%			6
ITU/HDU EDGH	Theatres and Clinical Support	102.80%	51.70%	85.20%	-			1
	Theatres and Clinical Support Total					0		7
AAU Conquest	Urgent Care	88.80%	112.60%	96.70%	97.90%		5	5
Baird MAU	Urgent Care	102.00%	100.40%	124.30%	95.90%	2	9	
Seaford 1	Urgent Care	103.20%	90.70%	92.70%	98.90%			
Seaford 2/MSSU	Urgent Care	112.80%	70.00%	93.30%	123.30%		1	1
	Urgent Care Total					2	15	6
Crowborough Birthing Unit	Women and Children	100.20%	90.90%	107.70%	96.80%			
EMU	Women and Children	86.90%	96.70%	85.00%	93.30%			
Frank Shaw	Women and Children	89.70%	92.40%	94.10%	93.50%			
Kipling	Women and Children	84.90%	83.80%	78.60%	56.70%			
Mirrlees	Women and Children	102.50%	94.20%	108.10%	97.00%		1	1
SCBU	Women and Children	109.90%	71.70%	85.00%	83.30%			
	Women and Children Total					0	1	1
	Grand Total					15	92	40

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

East Sussex Healthcare NHS Trust

Date of Meeting:	26 November 2014
Meeting:	Trust Board
Agenda item:	9
Subject:	Patient Experience Report Quarter 2
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

The purpose of this paper is to provide the Board with information about patient experience within Quarter 2 of this year.

Introduction:

Patient Experience provides feedback from patients and the public on their experience of the Trust.

The information in this paper outlines our position in Q2 in the following areas:

- Friends and Family Test;
- NHS Choices;
- Staff FFT;
- PALS;
- Complaints;
- Patient experience strategy commitments and practical examples.

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

FFT

The overall satisfaction score of all patients surveyed during Q2 2014/15 is that 89.4% of all patients who used our services were satisfied (12811 responses). This is an increase in both the satisfaction score and the number of responders over Q1

Overall response rates for Q2 were A&E 30.4%, with a target of 15% and Adult in-patients 46.21% with a target of 30%.

FFT has now been fully implemented within Maternity services. The overall satisfaction score of all maternity patients surveyed during Q2 2014/15 demonstrated that 86.6% of all women who used our services were satisfied (460 responses). This has decreased very slightly from Q1 from 88.08%. Response rates do fluctuate according to the birth rate.

Trust Improvement Indicators

This data is collected from a variety of sources ie patient comment cards and further questions relevent to the ward areas (ie around food and noise on the ward) asked through FFT. The attached paper demonstrates little change in patient responses across the months from April.

Ward feedback

Ward level data from each individual area is reviewed monthly and analysed. On each patient facing clinical area, data is displayed on the 'How we are Doing' board in the format of "You said, We did", for all service users to view.

Additionally this data is triangulated with other quality information gathered by each clinical area, this includes for example safety thermometer data, monthly quality review data, SI and Safeguarding data, in order to act on and improve service user experience. Examples of services changes are available in the attached paper.

NHS choices
NHS choices is a website where Service users can post comments about their experiences of using NHS services. A rating system of 1-5 is used. Whist there are some excellent examples of positive patient comments the rating system demonstrates significant room for improvement in particular around the booking system; communication and staff attitude.

Staff FFT
The staff FFT response for 2014/15 was based on one question 'How likely are you to recommend this organisation to your friends and family as a place to work. Approximately 8000 questionnaires were distributed in 2013 and the ESHT Staff FFT score was 3.28. The net promoter score for the same question in Q2 2014 was17.

PALs
Despite the increase in demand, PALs are continuing to provide a rapid access point of contact for patient's and the public with 94% of concerns being responded to within 2 working days. The response rate has risen from 74% in Q1.

Complaints
Compliance with 3 working days to acknowledge complaints has dropped during Q2. The number of overdue complaints has risen during Q2. The overdue complaints rose from 57 at the end of Q1 to 83 at the end of Q2. 65% of complaints were responded to within timescale. Compliance reduced from 72% in July to 58% in September. The overall compliance was 87% for 2013/14. The top 5 complaint themes remain unchanged from the previous quarter and are – total care, attitude, communication, services total and patient pathway.

Benefits:.

The attached report demonstrates a number of ways in which the service has listened to patient concerns and made changes to improve. The "You said; We did' initiative on the wards shows that positive actions are taken having listen to patients and relatives. Changes have also been made following the receipt of formal patient complaints.

Risks and Implications:

Quarter 1 highlighted a concern in a rise in the number of overdue complaints, unfortunately this has not improved in Quarter 2. This trend needs to be addressed and the number of complaints answered within the set time frame needs to improve significantly.

Assurance Provided:

Overall the Trust is able to demonstrate a number of positive initiatives that are in place and working very well. Engagement with patients has led to improvements in systems and care delivery.

Board Assurance Framework:

Strategic Objective 1, risk 1.1
Strategic Objective 2, risk 2.3

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

Quality and Standards Committee 10th November 2014

Proposals and/or Recommendations
The use of FFT has proven to be very helpful in monitoring patient experience – this forum for data collection could be further expanded and there are plans to research how other organisations use FFT to capture patient and relative experiences. Re-establishment of the Patient Experience Steering Group will enable better reviewing and triangulation of data at a higher level across the Trust. This group will review all feedback including information from national CQC surveys. The group will monitor action plans with clinical units where appropriate. Triangulation at a team level consists of each department, service and ward regularly reviewing their patient feedback data arising from FFT, complaints, NHS choices, PALS and Compliments. Patient Experience Champions support this process and are made aware of the different sources of feedback data. They underpin the Patient Experience Strategy by raising awareness within their teams and encouraging continuous service improvement. All Information is triangulated and reviewed at quality review meetings chaired by the Director (and Assistant Directors) of Nursing. Work will continue with our Service User Champions and with the continued FFT roll out plans the Trust will gain valuable feedback about which methodologies work and whether publications are written in a way that people can understand. The NHS Choices provide value patient feedback which the organisation will continue to disseminate to staff via the patient experience champions.

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:**
Lindsey Stevens, Deputy Director of Nursing and Midwifery	lindseystevens@nhs.net
Alice Webster, Director of Nursing	alice.webster@nhs.net

East Sussex Healthcare NHS Trust

Patient Experience Report Quarter 2 (July – September 2014)

1. Introduction

Patient Experience provides feedback from patients and the public on their experience of the Trust.

The information in this paper outlines our position in Quarter 2 (Q2) in the following areas:

- Friends and Family Test (FFT)
- NHS Choices
- Staff Friends and Family Test
- PALS
- Complaints
- Patient experience strategy commitments and practical examples
- Conclusion
- Action plan

2. Quarter 2 Friends and Family Test (FFT)

CQUIN Targets

Month	Return	Response Rate	CQUIN Target
July	A&E	24.41%	15%
	Inpatients	46.84%	30%
	Maternity	32.96%	N/A
	Trust Total	29.58%	
August	A&E	28.75%	15%
	Inpatients	39.40%	30%
	Maternity	31.71%	N/A
	Trust Total	31.11%	
September	A&E	30.40%	15%
	Inpatients	46.21%	30%
	Maternity	28.97%	N/A
	Trust Total	33.39%	

Patient feedback 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 Q1 was 58. The NPS for Q2 is also 58.

2.1 Patient Feedback: Friends and Familty Test

Q2	Total number of responses for each department	Total number of people eligible to respond	Response rate for each A&E department
Conquest A&E	2143	9047	23.69%
Eastbourne District General Hospital A&E	2725	8507	32.03%
ESHT	7017	22418	31.30%
ESHT Inpatient	2149	4864	44.18%

Inpatient areas achieved an overall satisfaction rating of 89.5%. (based on 2770 responses)

Our Emergency departments achieved an overall satisfaction rating of 86.7%. (based on 2857 responses in Q2)

The overall satisfaction score of all patients surveyed during Q2 2014/15 is that 89.4% of all patients who used our services were satisfied (12811 responses). This is an increase in both the satisfaction score and the number of responders over Q1.

2.2 Maternity: Friends and Family Test

FFT has now been fully implemented within Maternity services.

NHS England are asking that within maternity services we ask the FFT questions at 4 touch points;

Touch point 1 is at 36 weeks pregnant, touch point 2&3 labour care and immediate postnatal care and touch point 4 at the 10 day discharge to the health visitor.

Touch point 1 and 4 are collected via a web link and 2&3 mainly on iPads in all of the Midwifery units and online for homebirths.

The overall satisfaction score of all maternity patients surveyed during Q2 2014/15 demonstrated that 86.6% of all women who used our services were satisfied (460 responses). This has decreased very slightly from Q1 from 88.08%. Response rates do fluctuate according to the birth rate.

Response rates for maternity are improving slowly with some hard work from the community midwives as touch points 1 and 4 are more difficult to get users of the service to complete. Further work is being undertaken to provide eligibility data for touch point 1 and 4 from a system called viewpoint GC. The Practice Development midwife will be meeting with IT to filter the data from this system.

2.3 Trust Improvement Indicators

Please see below, ESHT improvement indicators for 2014/15, with service user satisfaction below.

Indicator	ESHT commitment	Apr	May	Jun	July	Aug	Sep
We will make sure you have the support and advice you need before being discharged from our care	3	87	84	86	86	84	87
We will give you clear high quality information about your condition, treatment and our services	3	91	89	90	91	90	92
We will treat you as an individual, listen to your views and respect your privacy and dignity	2	95	94	93	94	95	95
We will provide you with nutritious and appetising food, with as much support as you need, whilst in our care	3	78	77	79	78	79	82
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	82	79	79	80	83	82
Overall patient experience satisfaction	1	89	88	88	89	89	90
Responses		674	854	882	993	908	867

2.4 Sample Patient Feedback from Family and Friends

Everything was excellent, you kept us informed at all times. The Treatment and Staff were marvellous. I would change nothing 10/10 Carry on Very good.

The Sister (Nurse) was very helpful / communicative during procedure. Clear helpful instructions at beginning of procedure.

Lots of delays between stages: referral-consultation - mammogram - MRI - consultation/report etc., etc., Letter lost in post. Unable to speak to anyone due to Annual leave of Consultant and Secretary in separate weeks!

Appalling delay in being seen. High car parking charges, to rub salt into the wound after 4 hour wait! Hospital dirty - waiting areas and loo's. Food and liquids.

All staff were friendly, patient and quiet mannered around patients. I fully understood the process and felt cared for and reassured when I became particularly uncomfortable during the procedure.

Very much involved in the process and I was confident that the timing was driven by my needs rather than the hospital's.

2.5 Ward feedback

Ward level data from each individual area is reviewed monthly and analysed. On each patient facing clinical area, data is displayed on the 'How we are Doing' board in the format of "You said, We did", for all service users to view.

Additionally this data is triangulated with other quality information gathered by each clinical area, this includes for example safety thermometer data, monthly quality review data, Serious Incident and Safeguarding data, in order to act on and improve service user experience. Below is a sample of data displayed at ward level.

Seaford 4 - Urology ward

You said	**We did**
We weren't giving enough privacy when discussing conditions or treatment.	We have a quiet room available for confidential discussions with medical and nursing staff. We aim to give you the option to discuss sensitive information in private, where possible. We have reinforced this information with all staff on the ward.

Berwick ward

You said	**We Did**
We needed an area for private and sensitive conversation.	We have now converted an office space into a private room for patients and relatives.

CCU – EDGH

You said	**We did**
Less light at night.	We have reminded night staff to reduce lighting to a minimum and can now offer eye masks to our patients.

Benson ward

You said	**We did**
Sometimes the night staff had not always been handed over all of the information.	We have discussed this in our staff meeting and re-enforced the importance of communication between the teams. This will be monitored closely.

Midwifery

You said	**We did**
Delays in going home	ESHT are training eight midwives this year with our Paediatric colleagues under Bournemouth University to be qualified in performing the examination of the newborn which must take place within 72 hours of birth. Currently only the paediatricians and some GP's are qualified to perform the checks.

2.6 Overall Trust themes from ward and departments

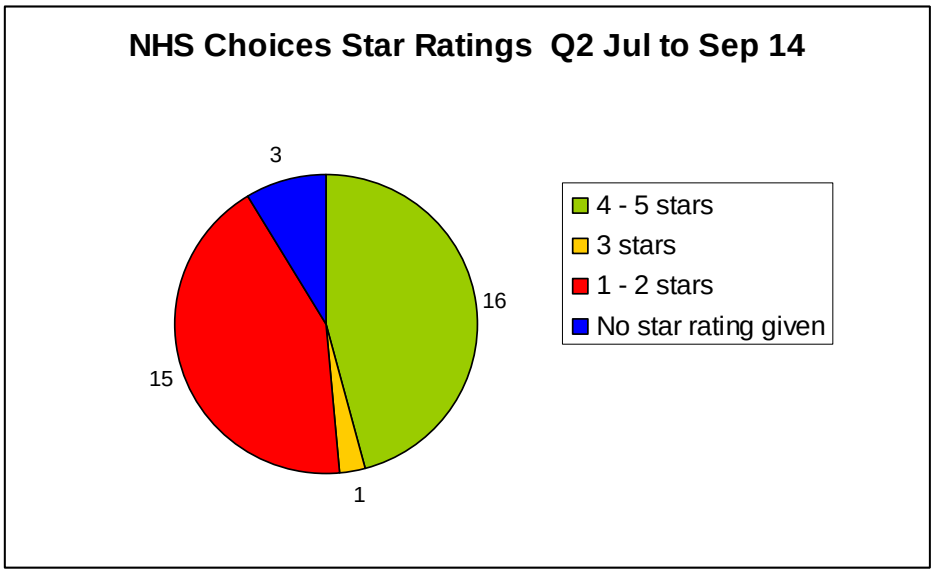
You said	**We did**
Patients from a number of wards are reporting that it can be quite noisy at night when they are trying to sleep.	Night staff are being reminded about strategies to keep noise down to a low level at night.

	Ear plugs have been made available for patients at request on a number of wards.
Some patients have said that we need more staff on duty.	Extra staff are being recruited where there are shortages.
The new booking in system for Outpatients is not an improvement.	We are monitoring the new booking in system closely and have put measures in place to.
Communication about the new central booking in system could be better.	We are in the process of reviewing that communication about the new central booking.

3. Quarter 2 NHS Choices

NHS Choices is a website where service users can post comments about their experiences of using NHS services.

There is also a facility to give the service commented on a star rating from 1 to 5 stars with 1 being a poor rating to 5 being excellent.



A total of 35 narratives were posted on NHS choices during Quarter 2, interestingly 17 during September which was almost as many as July and August combined.

The Trust regards NHS choices as a rich source of feedback information that helps us to monitor the quality of our services. The information is disseminated to all staff through the Patient Experience Champions and a monthly report is sent out to all department and ward managers.

A learning exercise has been developed to focus Patient Champions on how to share and use this information to make improvements or share good practice.

3.1 Examples of comments & responses

Comments received	Our replies
I must thank the staff of Seaford 4 for the great care and attention I received. In particular one member of staff and team leader were a huge support and provided me with an outstanding service and kindnesses. They were utterly selfless, devoted and professional.	Thank you for your posting on NHS choices expressing your appreciation of the care and attention you received from staff on Seaford 4 ward at Eastbourne DGH. It's always encouraging for staff to receive positive feedback as this reflects their hard work and commitment to providing a high quality standard of care. We will ensure that your feedback and 'thank you' is shared with staff.
Since my referral I waited 2 months before enquired to find out referral was lost by hospital. I had to continue pressing to be kept informed by email- nothing sent When 6 months later I was appalled by the way I was treated by nurse and doctor considering my cataracts Was it because I came from Bexhill I felt patronise treated as simple minded	We're deeply concerned to read about your experience with the Ophthalmology Department at Eastbourne District General Hospital. We welcome all feedback and would like to assure you that all comments are taken seriously and acted upon as part of our ongoing commitment to improving people's experience. In the first instance, your posting has been forwarded to the Head of Nursing and Clinical Lead for Ophthalmology. We are keen to speak to you to discuss your experience in more detail and we would also like the opportunity to apologise in person for the fact that your experience was poor. If you would like to do this, please make contact with our Patient Advice and Liaison Service (PALS). PALS can be contacted by phone 01323 435886, by email PALSE@esht.nhs.uk , or in person by dropping in between 9am – 4pm (Mon-Fri) to the PALS office located in the main entrance opposite the WRVS Coffee Shop
I had a prostatectomy a month ago and spend a couple of days post op on Seaford 4. The care I received couldn't be faulted-friendly efficient nursing and medical staff, responsive to any questions I had, and explaining at each stage what I could expect.	Thank you for your posting on NHS choices about the care you received from staff at Eastbourne District General Hospital. We will certainly make sure your words of appreciation and feedback is shared with staff. It means such a lot to staff to receive positive feedback reflecting their dedication, hard work and commitment to providing the best possible care for all patients. It is extremely kind of you to take the time to provide feedback and we hope that you are making a good recovery.

3.2 Themes from Quarter 2:

For excellent ratings:	**For low ratings**
Staff kindness, efficiency and caring attitude. Organisation of service.	Administration organisation and appointment delays The new booking in system was highlighted two to three times.

Good communication. Many staff praised for their standards of care.	Staff attitude. Communication.

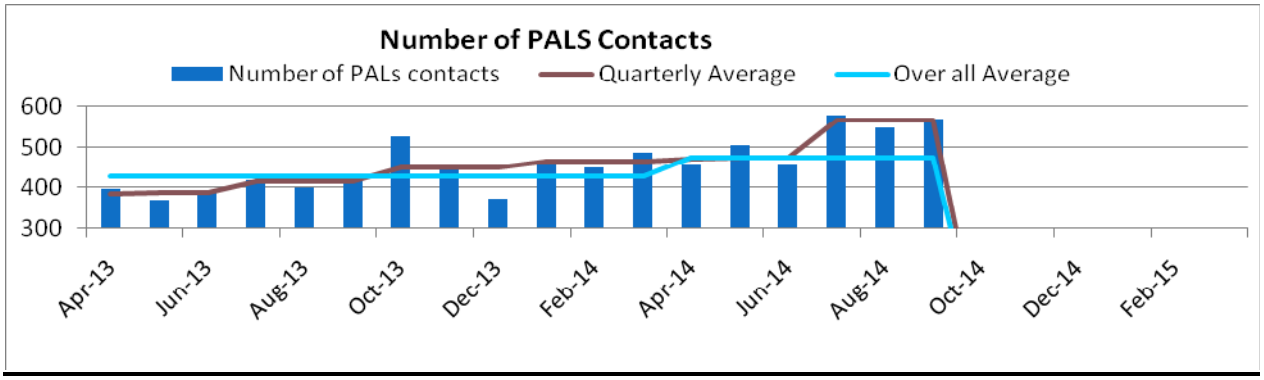
4. Quarter 2 Staff FFT

The staff FFT response for 2014/15 was based on measuring one question 'How likely are you to recommend this organisation to your friends and family as a place to work' and was asked through the annual staff questionnaire.

Approximately 8000 questionnaires were distributed in 2013. ESHT Staff FFT score in 2013 was 3.28. Two listening into action sessions took place in July 2014, where the "You said, We did" philosophy was used to both provide feedback to staff of immediate and longer term actions based on the responses received, and to offer a further opportunity to gather staff views.

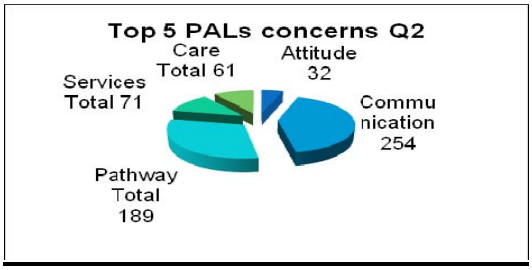
Key actions have led to a strategic staff satisfaction group commencing. Key actions are available if required.

5. Quarter 2 Patient Advice and Liaison Service Summary



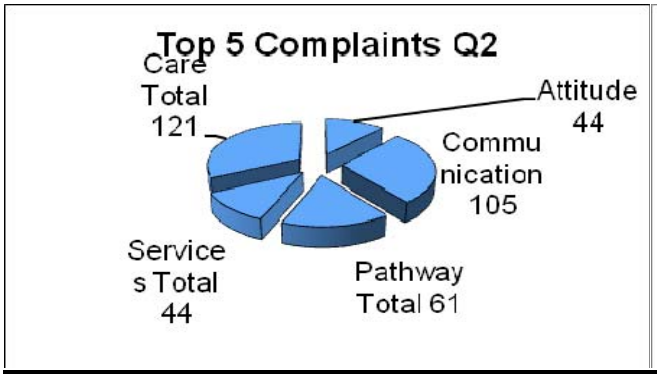
Despite the increase in demand, PALs are continuing to provide a rapid access point of contact for patients and the public with 94% of concerns being responded to within two working days. The response rate has risen from 74% in Quarter 1.

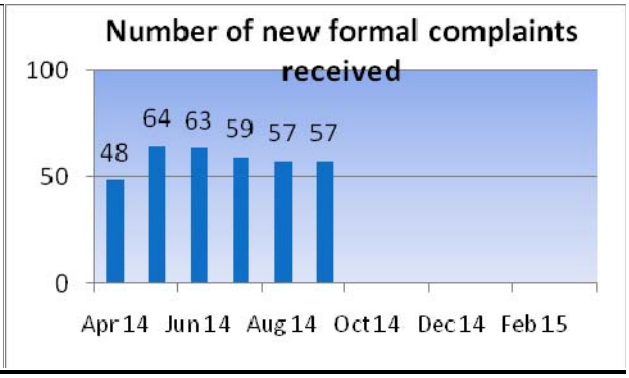
The number of concerns increased this quarter from 571 (Q1) to 748 (Q2). Head and Neck and Planned Medicine account for 46% of all concerns. Concerns relate specifically to communication and patient pathway issues, which are broken down in to sub subjects. The number of concerns relating to Communication has risen from 234 in Q1 to 254 in Q2 and concerns relating to Patient Pathway from 119 in Q1 to 189 in Q2.



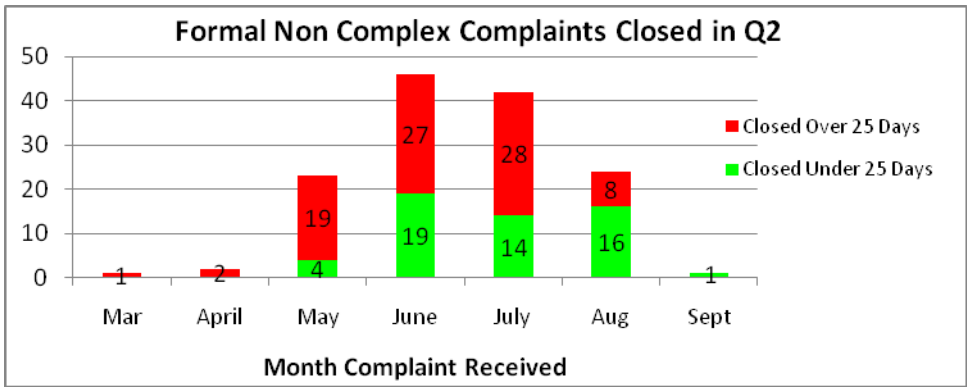
6. Quarter 2 Complaints: One Stop Summary

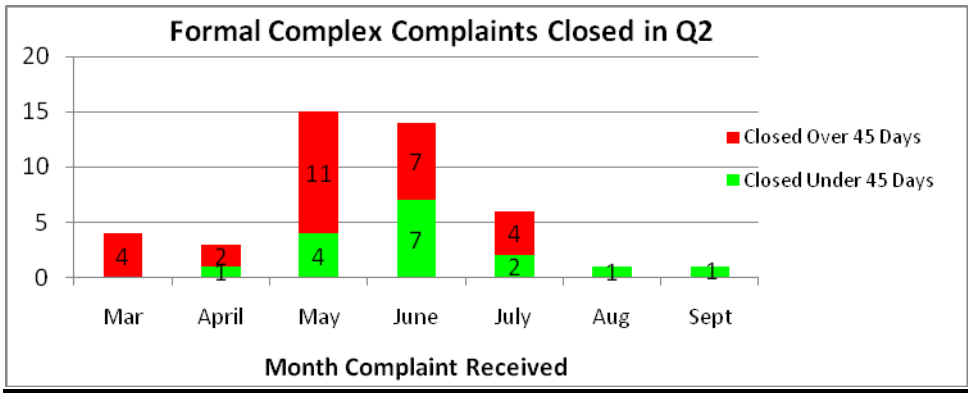
Compliance with three working days to acknowledge complaints has dropped during Q2. The number of overdue complaints has risen during Q2. The overdue complaints rose from 57 at the end of Q1 to 83 at the end of Q2. 65% of complaints were responded to within timescale. Compliance reduced from 72% in July to 58% in September. The overall compliance was 87% for 2013/14.





6.1 Closed Complaints Summary





These graphs show the number of complaints closed during Q2.

The 39% of Formal Non Complex complaints have taken longer than 25 days to close.

The 36% of Formal Complex complaints have taken longer than 45 days to close.

The Trust is currently working on strengthening the triangulation of patient experience feedback. Patient experience data is essentially triangulated through two routes; one being quality reviews at a local team level, and the other being at Trust wide level through the Patient Experience Steering Group. Membership of this group includes representatives from each clinical unit, an Assistant Director (chair), a Non-executive Director and Patient Experience Lead. The group also invites patient and service user representatives and Patient Experience Champions.

SEAP is an independent advocacy agency that is able to support patients and relatives through the complaints process.

SEAP have offered to come into the hospitals within East Sussex for one day a week to use their expertise and experience to help patients and relatives who come to PALS with complex problems and issues. It is anticipated that by using this agency we may be able to prevent these concerns from escalating to formal complaints thus saving the patients times and NHS resources by concluding on this problems swiftly and efficiently

The Patient Experience Steering Group is accountable for reviewing and triangulating data at a higher level across the trust. They review all feedback but this also extends to feedback from National CQC surveys. They discuss and determine action and monitor action plans with clinical units where appropriate. An example of change in this respect was the overall negative feedback we had been receiving about food which led to the commissioning of a new meal service called 'Steamplicity' offering a wider choice of meals.

6.2 Extract of Outcomes for Complaints Received July – September 2014

You said…	We did …
Patient unhappy with delay in ear moulds being fitted and that the department had received them some while ago.	In future, if the Audiology Department are unable to make contact with a patient by telephone to advise them to collect their ear moulds, they will make arrangements to post the ear moulds to the patient, once their address has been checked with their general practitioner (GP), as opposed to just storing them.
Patient's relative raised concern regarding the difficulties following discharge from hospital in obtaining the specialist dressings required for nephrostomies.	A patient information leaflet for the care of nephrostomies is currently being developed by one of the Specialist Nurses in Urology and will include information on the dressings required, the drain guards and the replacement of the tubes. This will also be shared with the District Nursing Team, as the dressings in particular are not those that they would regularly use.
Patient's relative raised hygiene concerns regarding urine bottle repeatedly being left on patient's food table.	Urine bottle holder racks have been ordered and each patient now has the facility to store bottles away from the tables.
Patient's relative concerned over delays in care, as patient waited for six months to have an ERCP under general anaesthetic.	A regular GA ERCP session is being developed between Endoscopy and Theatres.
Patient sustained injury on broken base of shower.	Floor in shower area been repaired.

7. Action Plan

Activity	Action	Timescale
Consider innovative forms of submission options of FFT.	Research what other Trusts use.	April 2015.

NHS Choices.	Continue to respond to comments and share practice amongst patient experience champions. Improve the rating scores and positive feedback from patients.	Review March 2015
Continue to work towards the Trust commitments set out in the Patient Experience Strategy.	Re-establish the Patient Experience Steering group.	PESG to re-commence Jan 2015.
Responding to patient complaints.	Significantly improve on the number of out of time complaints.	December 2014.

8. Analysis of Patient Experience Report

FFT returns have highlighted that discharge organisation is an issue and this is evident in discharge appearing in the top five categories for incident reporting, however it is also a theme from our complaints therefore further analysis and subsequent action will be undertaken on this point.

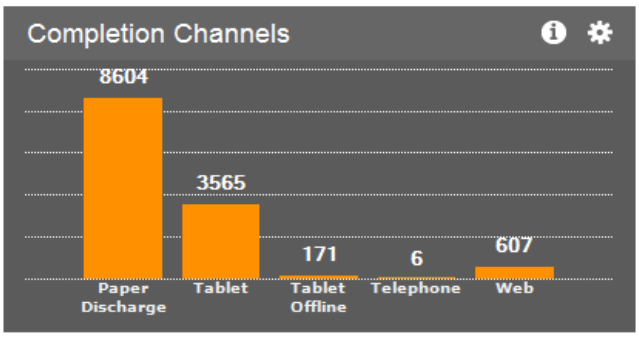
Complaints trends highlighted pathway issues and communication to be the main areas of concern which was also supported in PALS contacts. Some of the pathway issues may have been a resultant of communication however this needs a greater understanding before a conclusion is reached and action taken.

Communication is most likely to be the cause of many of these issues and as the further analysis is completed on the reporting of Q2, the current context in which the Trust operates will need to factored in. An example of this is that in Q2 there was a Trust senior restructure and a major change to the way in which outpatients was managed. If this is some of the cause of the issues then it is expected that there will be a decrease in the levels of adverse reporting. This work will be reviewed with the clinical units leads and by the Clinical Improvement lead, however this data is only just available and so will be undertaken in the coming weeks evidencing a greater thematic review and actions for the trust in all clinical setting.

9. Conclusions -

Triangulation at a team level consists of each department, service and ward regularly reviewing their patient feedback data arising from FFT, complaints, NHS choices, PALS and compliments. Patient Experience Champions support this process and are made aware of the different sources of feedback data. They underpin the Patient Experience Strategy by raising awareness within their teams and encouraging continuous service improvement. All Information is triangulated and reviewed at quality review meetings chaired by the Director (and Assistant Directors) of Nursing.

At East Sussex Healthcare NHS Trust we have collected over 13000 responses to the Friends and Family test within the last three months. We actively engage with patients and their families by offering a number of ways with which they can provide feedback as illustrated overleaf:



10. Recommendations

Re-establishment of the Patient Experience Steering Group will enable better reviewing and triangulation of data at a higher level across the Trust. This group will review all feedback including information from National CQC surveys. The groups will monitor action plans with clinical units where appropriate

Work will continue with our Service User Champions and with the continued FFT roll out plans the Trust will gain valuable feedback about which methodologies work and whether publications are written in a way that people can understand.

The NHS Choices provide value patient feedback which the organisation will continue to disseminate to staff via the patient experience champions.

East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 2014
Meeting:	Trust Board
Agenda item:	10
Subject:	Mortality Indicators and Metrics report
Reporting Officer:	Dr James Wilkinson, Assistant Medical Director, Quality and Innovation Dr David Hughes, Medical Director

Action: This paper is for

Assurance	√	Approval		Decision	

Purpose:

The purpose of this report is to:

- Provide a summary of the main mortality indicators and the differences between them.
- Identify what mortality indicators external bodies use to monitor trusts.
- Outline ESHT mortality monitoring and assurance mechanisms and progress in monitoring.
- Update the Board on the Trust's current position with respect to the main indices, new alerts from CQC or areas of concern.

Introduction:

The various mortality indices, and the main differences between them, are described in sections Board members may already be familiar with these.

Trust mortality monitoring and assurance mechanisms are explained in section 4.

The current position with respect to mortality indicators, alerts and areas of concern is highlighted in sections 5-6.

Developments to the clinical coding systems are covered in section 7.

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

- Mortality indices have continued to improve. Summary Hospital-Level Mortality Indicator (SHMI) is now within the expected range at 110.0
- Hospital Standardised Mortality Ratio (HSMR) and Risk Adjusted Mortality Index (RAMI) for the period August 2013-July 2014 remain below the levels in the previous 12 months.
- HSMR rolling 12 month average has reduced steadily from 105 in July 2013 to 91 in July 2014.
- The Trust has received no Cumulative Sum (CUSUM) alerts from CQC. The most recent alert (therapeutic endoscopic biliary tract procedures) was closed in August.
- We are now able to monitor our cumulative mortality data by condition. No major issues are apparent on the current year of data.
- Use of the electronic mortality database for recording mortality reviews is increasing, achieving CQUIN requirements in Q2 and currently on track to achieve Q3 requirement.
- The Mortality Review Group (MRG) and Mortality Overview Group (MOG) continue to monitor mortality indices monthly. Surgery, Muscoloskeletal (T&O), Urgent Care, Cardiovascular and Women & Children have presented to MOG.

- Monthly mortality scorecards remain challenging for Clinical Units (CUs).
- Work is ongoing with Clinical Commissioning Groups (CCGs) and local GPs to increase capture of community mortality data.

Benefits:
Robust monitoring and review of a wide range of mortality indicators and metrics is essential to the wider monitoring of quality at ESHT.

Risks and Implications
Without robust mechanisms for monitoring performance and challenging clinical units on mortality and patient safety indicators there is risk that early signs of developing problems may be missed and quality of care may be affected.

Assurance Provided
This paper aims to provide assurance on the robustness of the Trust's mortality review systems and the improvement in both nationally published and internally monitored mortality metrics.

Board Assurance Framework:
Strategic Objective 1, risks 1.1 and 1.2

Review by other Committees/Groups (please state name and date):
Corporate Leadership Team 18.11.14

Proposals and/or Recommendations
The Board is asked to note the progress in both nationally published and internally monitored mortality metrics and take assurance on the robustness of the Trust's mortality review systems.

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: Dr James Wilkinson, Assistant Medical Director – Quality and Innovation	**Contact details:** 01323 417400 ext 3718

East Sussex Healthcare NHS Trust

Mortality Indicators and Metrics Update
November 2014

1. Introduction

1.1 This paper provides a summary of the main mortality indicators (sections 2-3), outlines the differences between them and identifies which indicators are used by external monitoring bodies. Board members may already be familiar with these.

1.2 Trust mortality monitoring and assurance mechanisms are explained in section 4.

1.3 The current position with respect to mortality indicators, alerts and areas of concern is highlighted in sections 5-6.

1.4 Developments to the clinical coding systems are covered in section 7.

2. Mortality Indicators

2.1 There are two main ways to measure mortality rates:

- Crude death rates, which are the actual number of deaths (numerator), divided by the number of discharges (denominator) in a given period of time.

- Standardised mortality ratios (SMRs) or risk-adjusted mortality indicators, which are the actual number of deaths as a proportion of the number expected within a given period of time. The methodology uses a number of variables to adjust the data to reflect the risk of death, including, amongst others, primary diagnosis on admission, age and gender, co-morbidities, relative affluence of the area and whether the patient received palliative care. Most of this data is derived from what has been documented in the notes and coded by the clinical coders.

2.2 Although it is important to monitor crude deaths, these do not adjust for different case-mix and population profiles. SMRs attempt to do this.

2.3 There are three main national SMRs or risk-adjusted mortality indicators currently in use:

- Summary Hospital-level Mortality Indicator (SHMI) developed and published by the HSCIC.
- Hospital Standardised Mortality Ratio (HSMR) developed and published by Dr Foster Intelligence
- Risk Adjusted Mortality Indicator (RAMI) developed and published by CHKS

2.4 Though the three indicators will broadly reflect the same variations. their different methodologies do produce slightly different results. The differences in methodology and exclusions are identified in the following table:

	Summary Hospital-level Mortality Indicator (SHMI) **	Hospital Standardised Mortality Rate (HSMR)	Risk Adjusted Mortality Index (RAMI)
Observed	Number of observed in-hospital deaths plus deaths out of hospital within 30 days of discharge	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England*	Total number of observed in-hospital deaths
Expected	Expected number of deaths *Calculated using a 36-month data set to get the risk estimate*	Expected number of deaths	Expected number of deaths *Calculated using a 10-year data set (as of 2012) to get the risk estimate*
Adjustments	• Gender • Age group • Admission method • Co-morbidity • Year of dataset • Diagnosis group *Details of the categories can be referenced from the methodology specification document****	• Gender • Age in bands of five up to 90+ • Admission method • Source of admission • History of previous emergency admissions in last 12 months • Month of admission • Socio economic deprivation quintile (using Carstairs) • Primary diagnosis based on the clinical classification system • Diagnosis sub-group • Co-morbidities based on Charlson score • Palliative care • Year of discharge	• Gender • Age group • Clinical grouping (HRG) • Primary and secondary diagnosis • Primary and secondary Procedures • Hospital type • Admission method *Further detailed methodology information is included in CHKS products*****
Exclusions	• Specialist, community, mental health and independent sector hospitals. • Stillbirths • Day cases, regular day and night attenders	Excludes day cases and regular attendees	Excludes mental illness, obstetrics, babies born in or out of hospital, day cases, and patients admitted as emergencies with a zero length of stay discharged alive and spells coded as palliative care (Z515)
Whose data is being compared and how much data is used for comparison e.g. all Trusts or certain proportion etc.	All England non-specialist acute trusts except mental health, community and independent sector hospitals. Data attributed to Trust in which patient died or was discharged from	All England provider Trusts via SUS Data attributed to all Trusts within a 'super-spell' of activity that ends in death	UK database of Trust data and HES Data attributed to Trust in which patient died

** HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, and the figure of 80% is quite variable dependent on the case mix of the trust. HSMR could just as easily cover 100% of activity. It covers 80% of activity mostly for historical reasons and the fact that you get little extra value from the other 20%.*

*** The HSCIC publishes the SHMI indicator as observed, expected, denominator, value, upper control limits, lower control limits and banding. The term numerator is not used in the publication.*

**** http://www.ic.nhs.uk/services/summary-hospital-level-mortality-indicator-shmi*

***** CHKS www.chks.co.uk*

2.5 All three indicators are primarily relevant to acute hospitals. As ESHT is an integrated provider, data on which these indicators is built is taken from all activity whether that is undertaken in the two acute hospitals, step-down admissions to a community site from another acute provider, or step-up admissions to a community hospital.

2.6 SHMI, which includes deaths within 30 days of discharge from hospital, and which does not adjust for palliative care, presents a particular challenge to integrated Trusts. ESHT's configuration means that deaths post 30 days from any community site will also be included in the indictor. With the exception of Bexhill Irvine Unit, these patients are under the care of GPs. Some are step-down patients from other acute providers; predominantly BSUH and MTW.

3. External monitoring of SMR Indicators

3.1 Imperial College and CQC CUSUM Alerts

These alerts can be raised by either source. CUSUM (Cumulative Sum) alerts are related to specific diagnosis or procedure groups through HSMR methodologies and Dr Foster Intelligence.

3.2 CQC Intelligent Monitoring

This monitors both Trust level SHMI from the HSCIC and HSMR indicators at diagnosis clinical classification group and procedure level from Dr Foster Intelligence. CUSUM alerts and weekday/weekend mortality are also monitored through the HSMR methodology.

3.3 Trust Development Authority (TDA)

Recent data provided to the Trust from the TDA has been produced by the Benchmark data provider, Healthcare Evaluation Data (HED) who is able to provide data using both HSMR published methodology and SHMI methodology. This data has been presented in a number of ways to look at SMRs for Diagnosis groups, by specialty, by Elective/non elective admission type and weekend or weekday admission.

3.4 Dr Foster Hospital Guide

Publishes a number of HSMR indicators annually in addition to the SHMI for the financial year period. HSMR is also split by acute site rather than just at Trust level.

SHMI is presented as a rolling 12 month average, the indicator being published 8 months after the sample period. Their latest data, published earlier this month, covers the period January to December 2013.

HSMR is generally presented as monthly trends and year-to-date for each financial year. However, the HED and TDA have recently started looking at HSMR in the same way, as a rolling 12 month average. This irons out some short term variation, but the effects of any major variation will not work their way fully through the system for 12 months.

To add to the complexity, HSMR, using the methodology described by Dr Foster, is also calculated by CHKS and by HED, but each obtains slightly different results.

4. Monitoring and review of mortality indicators and metrics

The Trust has a developed framework to review the three main SMR indicators, crude mortality and a number of associated metrics on a monthly basis.

ESHT use CHKS as the provider of benchmarked comparative data. In addition to the RAMI indicator, which can be viewed in a number of ways, CHKS Tools also provides high level HSMR and HSMR by Diagnosis groups, with CUSUM alerting capacity against monthly variation in excess deaths. Although this is a different methodology to that of Dr Foster (and consequently Imperial and CQC CUSUM alerts), which is based on sequential deaths, CHKS have assured us that it will provide an earlier warning signal.

The benefit of using CHKS is that all the RAMI indicators, for both mortality and patient safety, which are monitored at trust level are also monitored at ESHT Clinical Unit (CU) level, specialty and sub specialty level. This enables each CU to access their own data very quickly, drill down to find out where problems may exist, be able to act on the data and provide feedback back to the Medical Director.

4.4 **Mortality Review Group (MRG)**

The monthly multi-disciplinary Mortality Review Group (MRG) focuses on the review of CHKS mortality data, triangulating a variety of information from other quality indicators and supported by the production of a high level Trust Mortality scorecard.

Areas of risk or concern are reviewed and monitored and further detailed reviews and investigation by the clinical units is requested when appropriate.

4.5 **Mortality Overview Group (MOG)**

MRG makes recommendations to the Mortality Overview Group (MOG), chaired by the Medical Director, which also meets monthly and requests Clinical Unit Leadership attend to provide explanation and assurance for mortality indicators and metrics related to their CU.

To date, Cardiovascular, Surgery, T&O, Urgent Care, Women & Children have presented. All clinical units will have attended and presented by the end of 2014.

CU monthly reporting of Mortality and patient indicator was commenced in early July 2014, and is taking some time to become embedded with the new CU teams.

4.6 **Morbidity and Mortality (M&M) Trust Policy**

The Trust M&M Policy outlines the standards/expectations for all deaths to be reviewed using a standardised template, the classification of all death to identify if there were possible avoidable factors and that each review is now captured electronically on the trust developed mortality database.

The policy has been recently updated to reflect these recent changes to the process and the additional requirement for the review of deaths and was ratified by CME on the 22nd October.

4.7 **Trust Electronic Mortality Database**

The Trust electronic mortality database records details of all ESHT deaths, including certified cause of death, post mortem and coroner referrals. This process is managed by the Trust bereavement offices. At present the database covers deaths occurring in the two acute hospitals and the Irvine Unit at Bexhill, in which patients are under the direct care of ESHT consultants and their teams.

Since April, the database has also provided a transparent record of the details of review of deaths within the acute hospitals. The proportion of mortality reviews recorded on the database is the subject of a local CQUIN for 2014/15.

4.8 **Progress in implementing the database and recording of mortality reviews**
Though uptake was initially slow, the Trust achieved the Q2 CQUIN target of 90 % of deaths recorded on the database and 40% of all deaths reviewed on it by the end of Q2, and is currently on target to achieve the Q3 target of 95% of deaths (currently 99.25%) and 60% of Q2 reviews (currently 46.17%) recorded on the database.

At present, mortality review of deaths in GP beds in community hospitals remains incomplete. A review of deaths earlier this year did not reveal any major issues of clinical care, and indicated generally good documentation, particularly by nursing staff. However, deaths of patients under GP care are not routinely reviewed. Work is ongoing with the CCGs, via CQRG, and discussions starting with the GP practices admitting patients to these hospitals, on increasing the level of review of patients dying in the community hospitals and on capturing mortality in the community following discharge from both acute and community units.

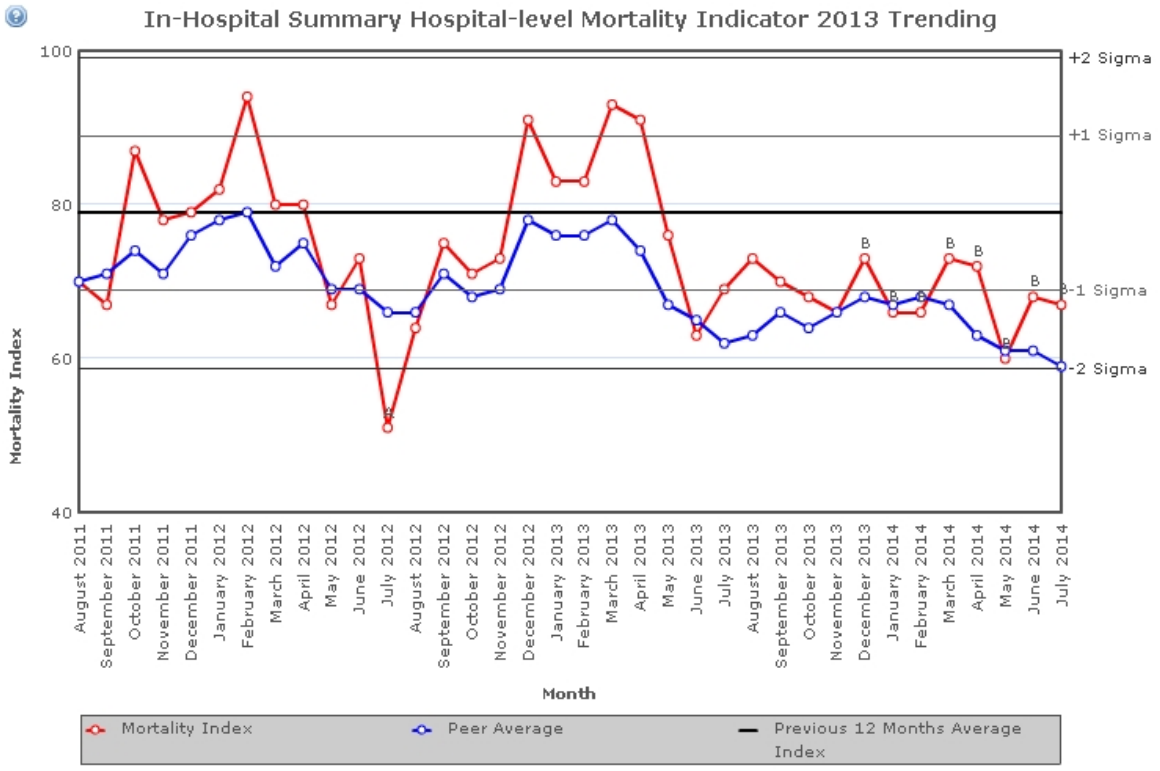
5. Current ESHT mortality indicator position

5.1 **SHMI** - Summary Hospital - level Mortality Indicator

SHMI peaked at 113.6 for the period October 2012 to September 2013 making the trust a statistical outlier for this indicator. Since then, it has reduced. The most recent data, published in October, has shown a further reduction to 110.0, with the Trust now lying within the expected range.

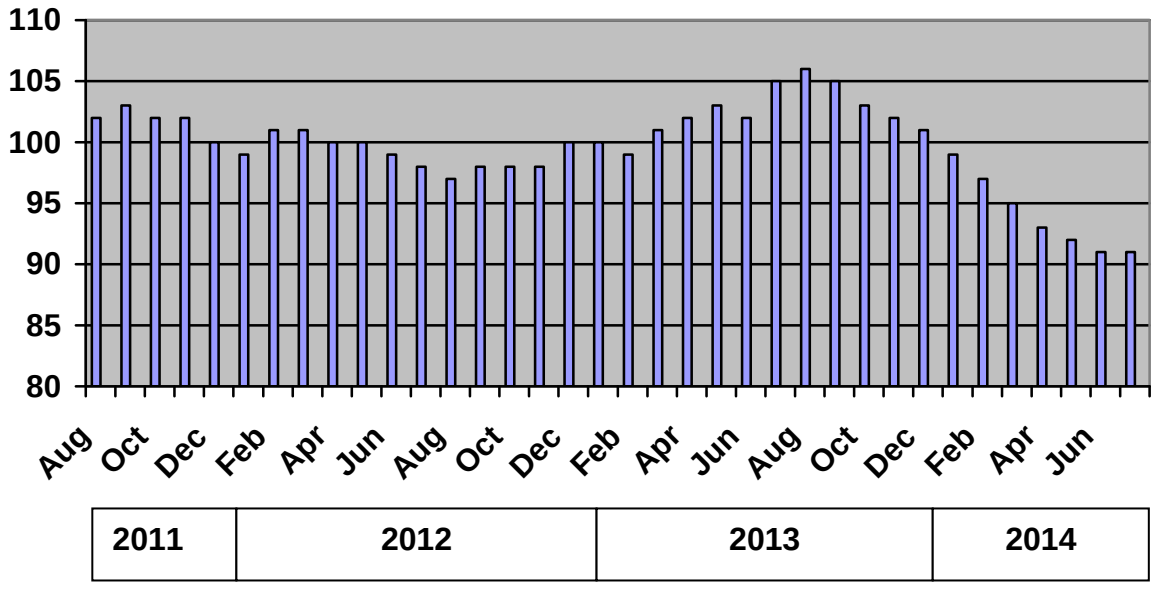
	Oct 2011 - Sep 2012	Jan 2012 - Dec 2012	Apr 2012 - Mar 2013	Jul 2012 - Jun 2013	Oct 2012 - Sept 2013	Jan 2013 - Dec 2013	Apr 2013 - Mar 2014
SHMI (12 month rolling average)	105.0	107.0	107.7	109.7	113.6	112.7	110.0

Though SHMI trending is not possible with the CHKS tool, we are able to trend our in-hospital SHMI. The variation in this corresponds with the nationally published SHMI. Following the 2012/13 winter bulge, monthly SHMI has approximated to the national average SHMI.



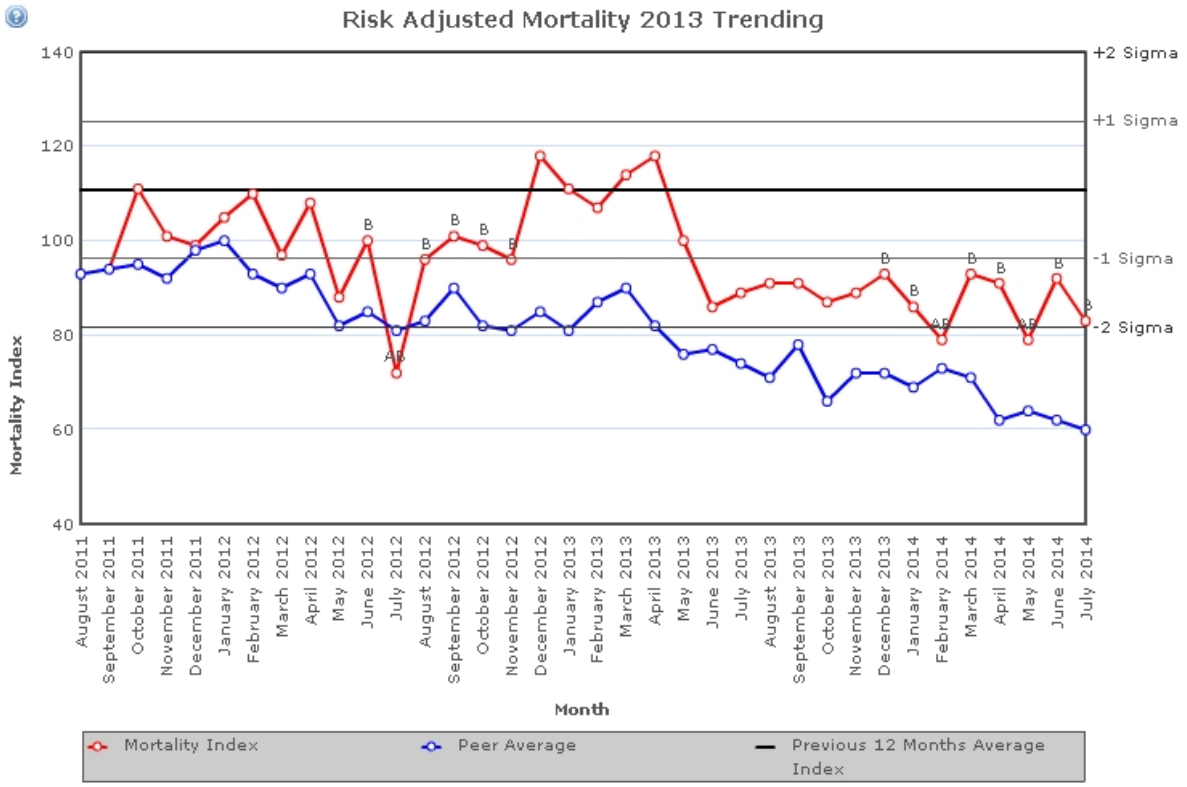
5.2 **HSMR** - Hospital Standard Mortality Ratio

Rolling 12 monthly average **HMSR** calculated by CHKS is displayed below. For the 12 months to July 2014 it was 91 (105 in July 2013)



5.3 **RAMI** - Risk Adjusted Mortality Indicator

Monthly variation in RAMI follows a similar pattern to the In-Hospital SHMI



6. CQC Intelligent Monitoring and CUSUM Alerts

The Trust has received no CUSUM alerts since the last Board update. The most recent alert, concerning therapeutic endoscopic procedures on biliary tract, was closed in August.

We are now able to monitor cumulative mortality for specific conditions using the CHKS Mortality Profiler tool, which applies CUSUM methodology. There are no specific issues arising from this over the last year of data.

7. Clinical Coding Improvements

The Trust commissioned an independent external clinical coding review of inpatient activity from April to June 2013 (2013-14 Q1) which was undertaken by Coding Solutions, an NHS Classification Service approved auditor. The report and recommendations have now been presented to the MOG and Clinical Management Executive (CME) in July and the action plan is monitored by CME.

Spell end date coding rather than episode coding has now been implemented in addition to community coders moving into the overall Trust clinical coding team as part of a number of improvements identified in March 2014.

8. Conclusions and next steps

Though the Trust continues to face challenges in each of the nationally monitored mortality measures, these are steadily improving. The effects of the sustained increase in mortality over the winter of 2012-13 are gradually working their way out of the rolling data, and the Trust is no longer an outlier in its SHMI. Further improvement is expected with the next published figures in January 2015.

No single over-riding factor has been identified for that increase in mortality, other than the effects of a severe and prolonged winter in a population with a very high proportion of extreme elderly.

Significant progress has been made in our systems for monitoring our mortality data and learning from mortality review. The current systems provide a clear framework for mortality monitoring and place accountability more clearly on the CUs but also give them, and their constituent specialties, the tools to understand their own mortality data.

8.4 The planned next steps are:

- To continue to embedding the electronic M&M database and monitor its use.
- Monitor the review of all deaths in low risk conditions at M&M meetings.
- Monthly monitoring of diagnosis group CUSUM data at MRG.
- Monitoring of completion of action plans for issues arising from M&M review.
- Supporting the use of CHKS by CUs and specialties for monitoring mortality and other quality indices and the use of the mortality dashboard across the trust
- To continue the programme of detailed discussion with individual CUs at the monthly MOG to understand variations in their mortality and action plans to address issues.
- Further work with CCGs, via CQRG, and local groups of GPs on capturing information on deaths in the community hospitals and following discharge.

Dr James Wilkinson
Assistant Medical Director – Quality and Innovation

November 2014

East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 2014
Meeting:	Trust Board
Agenda item:	11
Subject:	Research and Development Update
Reporting Officer:	Dr Hughes, Medical Director (Clinical Governance)

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

Purpose:

To update the Trust Board on Quarter 2 performance and the Research and Development (R&D) 5 year strategy outcomes to date.

Introduction:

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

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

- 2nd Quarter performance received from KSS CRN.
- The R&D 5 year strategy was approved by Trust Board in September and this report seeks to update re the completed strategy outcomes.
- This report also seeks to inform the Trust Board where potential risks are evident in relation to strategy outcomes.

Benefits:

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

Risks and Implications

Funding for research activity via NIHR is dependent on patient recruitment to research studies. If recruitment target is not met, this risks funding.

Assurance Provided:

Commencement of workstreams to actively seek success within R&D performance and ESHT 5 year R&D strategy.

Board Assurance Framework:

Strategic Objective 1, risk 1.3
Strategic Objective 2, risk 2.3

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

R&D Operational Working Group

Proposals and/or Recommendations

Key objectives within the strategy require high level, Trust board support to enable success.

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

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

East Sussex Healthcare NHS Trust

Research and Development Quarter 2 Update

1. Introduction

1.1 Participating in clinical research is in the interests of ESHT, and under the NHS Constitution 2009 the organisation has an obligation to contribute. (NHS Constitution 2009)

2. Background

2.1 The second quarter performance has been received from Kent, Surrey and Sussex Clinical Research Network (KSSCRN) (see Appendix 1)

2.2 The Research and Development (R&D) 5 year strategy was approved at the September 2014 Trust Board meeting.

2.3 Performance in initiating and delivering clinical research – submission to the National Institute for Health Research (NIHR) and publication on a publicly accessible part of the Trust website by 31st October 2014.

3. R&D Performance

3.1 The second quarter performance shows improvement from quarter one as shown in the CRN report:

- We have moved from 39% of target to 68% of target. Improvement is demonstrated.
- We have asked the teams to identify observational studies as a priority at present, as we have a large portfolio of interventional. Improvement here is demonstrated
- Number of days to approve – this demonstrates a downward trend and we are working to reduce further.
- Recruitment to time and target – the R&D Manager sent details of the missing targets at ESHT last quarter. The R&D Manager will ask CRN to supply details of those studies that have not recruited and the missing targets again.

3.2 R&D 5 year Strategy was approved at the September 2014 Trust Board meeting and the following actions agreed:

- Statement added to all Trust letters stating the Trust is a research active organisation
  Not complete due to technical issues. R&D has agreed to fund the resource required to make the additions to 100s of template letters.
- Statement regarding commitment to research to be included in staff job descriptions.
  Not complete – R&D Manager has supplied template statements – for collaboration with Director(s) of Nursing and Human Resources

- Ensure appropriate and effective allocation of Supportive Professional Activity (SPA) linked to specific research activity through job planning.
  Potential risk to recruitment and research participation if job planning does not include appropriate research activity SPA or withdraws them from research active clinicians
- R&D Steering Group to hold an annual research meeting
  Meeting booked for 20th March 2015 (flyer attached at Appendix 2).
- R&D group to establish a regular section in Connect within 12 months of the strategy being adopted
  Completed
- Improve study set-up, ensure study permission times meet nationally agreed targets
  Improvement demonstrated (see 3.1)
- Ensure that NHS permission times meet nationally agreed targets
  Improvement demonstrated (see 3.1)

3.3 Performance in initiating and delivering clinical research – Contract signed between ESHT and NIHR

- First submission of required ESHT data was uploaded to NIHR by required target date.
- Links to ESHT data on publicly accessible part of the Trust website went live on 4/11/14. http://www.esht.nhs.uk/research-and-development/ and http://www.esht.nhs.uk/research-and-development/performance/

3.4 ESHT Operational Capability Statement – details sent for publication on NIHR website.
The Department of Health expects NHS organisations to publish an operational capability statement (OCS). NHS organisations that do so make a clear statement about what they are able to offer as hosts or sponsors of health research. Sponsors and researchers can see and use the information to inform and speed up decisions about where to carry out research. Through the development of the OCS, ESHT have demonstrated that health research is a core activity within the organisation.

4. Conclusion/Recommendation

4.1 Positive outcomes have been achieved as indicated in the report. There are also several work streams which have commenced and are moving towards positive outcome.

4.2 The R&D Manager has booked appointments to meet with Director of Nursing and Medical Director responsible for governance to discuss the key objectives within the strategy which require high level, Trust board support to enable success.

4.3 The key objectives include the following:

- Create effective and clearly defined lines of accountability to the Trust Board for research; its management, governance, delivery and performance

- Create accountability for the strategy within Clinical Units, departments and across professional groups; performance managing their commitment to research
- Embed key research staff (eg Research Champions) as integral elements of Clinical Units, resulting in a seamless, transparent and productive integration of research and clinical delivery of services.

Liz Still
Research and Development Manager

7th November 2014

National Institute for Health Research

CRN: Kent, Surrey and Sussex Quarterly Report

East Sussex Healthcare NHS Trust

Data extracted 20/10/2014

Please note:
To minimise potential data quality issues stemming from delays in studies reporting their recruitment figures to the NIHR, recruitment information in this report is presented with an approximate 1 month delay.
For this report, recruitment data has been analysed with a maximum recruitment date of 28/09/2014

East Sussex Healthcare NHS Trust

Quarterly Performance Report

National Institute for Health Research
Clinical Research Network Kent, Surrey and Sussex

Recruitment by Member Organisation FY2014/5

Data is from the official NIHR recruitment database

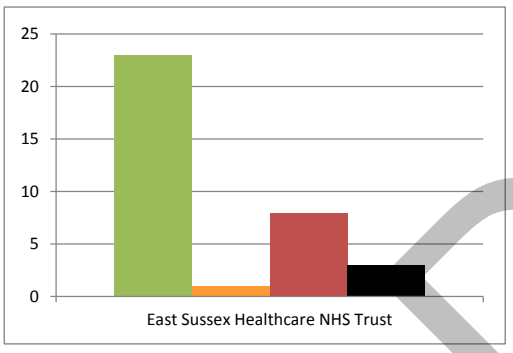
Member Organisation	Target	YTD Target **	YTD Recruits **	On Target
Ashford and St Peters Hospitals NHS FT	942	462	1300	281%
BSUH NHS Trust	2952	1448	1747	121%
Dartford and Gravesham NHS Trust	600	294	268	91%
East Kent Hospitals University NHS FT	1650	809	1150	142%
East Sussex Healthcare NHS Trust	**727**	**357**	**241**	**68%**
Frimley Park Hospital NHS FT	1887	925	853	92%
Kent Community Health NHS Trust	100	49	112	229%
KMPT	250	123	136	111%
Medway Community Healthcare	40	20	0	0%
Medway NHS FT	1037	509	2234	439%
MTW NHS Trust	1100	539	308	57%
Queen Victoria Hospital NHS FT	126	62	142	229%
Royal Surrey County Hospital NHS FT	1090	535	581	109%
SEC Ambulance	14	7	0	0%
Surrey and Borders Partnership NHS FT	362	178	123	69%
Surrey and Sussex Healthcare NHS Trust	511	251	507	202%
Sussex Community NHS Trust	545	267	311	116%
Sussex Partnership NHS FT	1747	857	542	63%
Western Sussex Hospitals NHS FT	1108	543	474	87%

**To counter delays by study teams uploading data, both targets and recruitment figures are presented with a 4 week delay

Recruitment to Time and Target

Open Studies	Green	Amber	Red	Black
East Sussex Healthcare NHS Trust	23	1	8	3

There are also 33 studies with missing targets for East Sussex Healthcare NHS Trust



vs. Expected recruitment

G	>=100%
A	>=60-99%
R	< 60%
B	No recruits

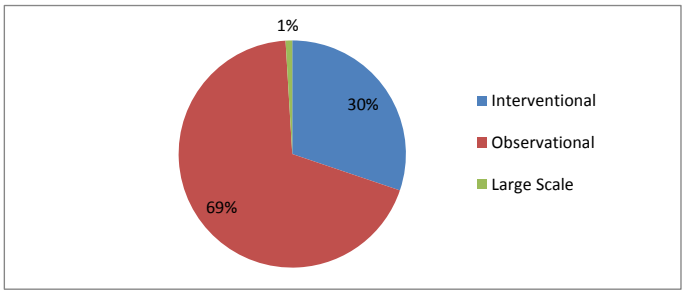
Financial Allocation 2014/5

514,004.00

East Sussex Healthcare NHS Trust

Recruitment by Study Type FY2014/5

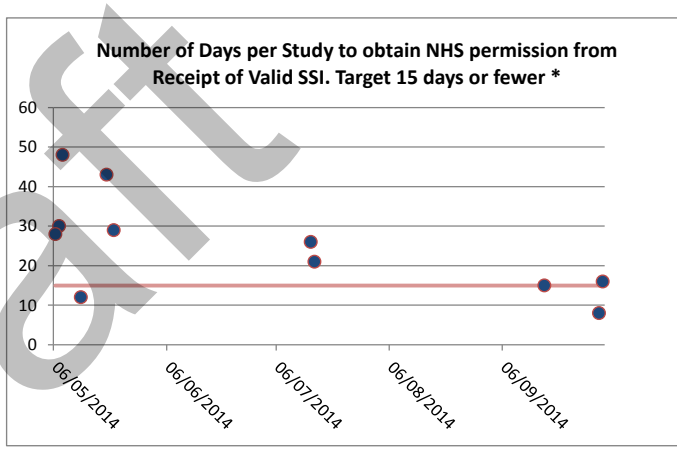
Interventional	Observational	Large Scale	Industry
64	146	2	44



Number of Industry Studies reporting Recruitment in FY2014/15

Data is from the official NIHR recruitment database

	Studies	Recruits
East Sussex Healthcare NHS Trust	11	44
All Kent Surrey and Sussex	112	2040



East Sussex Healthcare NHS Trust average permission time - 25 days
Kent Surrey and Sussex average permission time - 16 days
National average permission time - 18 days

* NB: Although achievement against this 15 day metric is not performance managed, it does support achievement against High Level Objective 4, as well as the Department of Health's Performance and Initiation on Delivery of research 70 day benchmark.
The local CRNs are expected to monitor progress and work with RM&G staff to have a plan to achieve the CSP process improvement targets for both study wide and local reviews. The change in April from a target of 30 days to 15 days means that a gradual improvement over time is expected rather than immediate.

Top 5 Recruting Studies in FY2014/5	Main Specialty	Recruits
A national survey of patient reported outcome after anaesthesia	Anaesthesia, perioperative medicine and pain management	107
Randomised comparison of iFR to FFR	Cardiovascular disease	24
CCRN 1070 (Stroke AF)	Cardiovascular disease	21
PROVENT.	Critical care	8
STROKE-INF	Stroke	8

East Sussex Healthcare NHS
NHS Trust

Annual Scientific Meeting

Friday, 20th March 2015

Medical Education Centre, EDGH

Improving Patient Care through our Research

We are seeking presentations/posters and attendees from ESHT and Local Trusts.

The Research and Development department would like to invite you to join us for this annual event. This is our second meeting.

Last year we received excellent presentations from Rheumatology, Cardiology, Physiotherapy, Orthopaedics, Pain Management and Surgery. We also displayed over 50 posters as part of this inaugural event. The meeting was very well received.

This year we have chosen a theme which seeks to celebrate the impact research has on improving patient care.

This is an opportunity to exhibit the research and audit work undertaken by those working within the Trust, or completed as part of health care improvements and self-development.

This is a great opportunity to network and enhance research activity further.

Provisional Programme:

10.00- Registration

- Full programme including guest speakers:-
  Professor Gordon Ferns, (Clinical Director, Kent Surrey and Sussex Clinical Research Network)
  Dr Anne Mandy, Director of Post Graduate Studies, Brighton Doctoral College
  plus several oral presentations (TBC)
- Buffet lunch provided - An opportunity to view poster presentations
- Session to include local Education initiatives

Everyone is welcome to join us and we look forward to welcoming you - so please register with R&D now as places are limited.

ResearchandDevelopmentDept@esht.nhs.uk

For more information on submitting abstracts for poster and oral presentations, please contact:-
Liz Still – R&D Manager or Teresa Baumber – R&D Governance Co-ordinator, 01323 417400 (13)3042 or e-mail Teresa.Baumber@esht.nhs.uk

East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 2014
Meeting:	Trust Board
Agenda item:	12
Subject:	Education Strategy 2014-17
Reporting Officer:	Dr David Hughes, Medical Director (Clinical Governance)

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

Purpose:

To set out the Trust's education priorities and how it will use its resources over the next 5 years to support education and training that will act as an enabler to deliver the Trust's objectives. Our vision is to make ESHT a centre of excellence for Education.

Introduction:

The Education Strategy sets out how ESHT will provide excellent, innovative, integrated and cost effective education to improve patient safety, experience and outcomes. Patient safety and care will be at the centre of all learning. This strategy is in line with the Trust`s overall strategic direction and ensures that learning supports this. It has been developed with input from all staff groups.

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

1) Local issues – with the reduction in trainees in many healthcare groups it is imperative that we provide education opportunities that attract and retain quality staff by making ESHT a place people wish to come to for their training. ESHT wishes to strengthen its relationships with Brighton and Sussex University Hospitals NHS Trust (BSUH) for the benefit of both organisations with the hope of joint academic appointments.

2) National issues - The Francis report emphasised the importance of learning and development as key in supporting the right culture in NHS Trusts. An increased emphasis on training in multi-professional groups enhances team working, communication and improves patient outcomes (integrated education) with an emphasis on simulation. The structure of education has changed nationally with responsibility held by Health Education England and its network of Local Education Training Boards (LETBs) who control funding.

Benefits:

1) Improvement of patient safety and care
2) Increase number of trainees wishing to join the Trust
3) Retention of current staff
4) Cultivate leaders capable of embedding education and training into practice.
5) Develop partnership working with other organisations.

Risks and Implications

The weaknesses and threats are highlighted in Appendix 2 in the paper and include poor educational facilities, silo working, the lack of understanding of education and its impact on patient care, and poor Trust Board buy in.

Assurance Provided:
The new Education Board structure will bring the different groups together and remove silo working and improve patient care.

Board Assurance Framework:
Strategic Objective 1, risk 1.3 Strategic Objective 2, risk 2.3 Strategic Objective 3, risk 3.3

Review by other Committees/Groups (please state name and date)**:**
The Education Strategy will be monitored by the new Education Board that will meet bimonthly, the first meeting having happened in October. There are 5 subgroups reporting to the Board responsible for different aspects of the strategy (Education Board Terms of Reference). Each subgroup has its own Terms of Reference. The Education Board will report to the Clinical Management Executive. Clinical Management Executive – 10/11/14.

Proposals and/or Recommendations
The Board is asked to support this strategy and the educational structure under the new Education 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: Dr Harry Walmsley, MBBS FRCA Associate Medical Director for Academia, Education and Research	**Contact details:** harrywalmsley@nhs.net

East Sussex Healthcare NHS Trust

Education Strategy 2014-2017

1. Introduction

1.1 This Education Strategy sets out how East Sussex Healthcare NHS Trust (ESHT) will provide excellent, innovative and integrated education to improve patient safety, experience and outcomes. Patient care will be kept at the centre of all learning. It aims to be ambitious in setting the strategy but will be realistic in setting goals for achievement.

1.2 The Trust values the importance of education and training both to develop its own workforce to support the delivery of high quality care on a sustainable basis, but also to play a part in the wider training of the future NHS workforce. Education and training play a crucial part in developing and retaining a high quality and motivated workforce, ensuring staff are fit and safe to practice, are as effective as possible in their roles, up to date with the latest learning and best practice, and continually developing their skills whatever their area of work or level of responsibility. This strategy sets out the Trust`s priorities and how it will use its resources over the next 4 years to support education and training that will act as an enabler to deliver the Trust`s objectives.

1.3 This educational strategy has been developed with input from various staff groups and in line with the Trusts overall strategy and ensuring that learning supports this. The implementation of this strategy will be overseen in detail by the newly formed ESHT Education Board which is accountable to the Trust Board.

1.4 It is important to understand that the activities the Trust undertakes in relation to education are largely grouped into 2 categories:

- education and training of current staff
- education of professionals in training (doctors, nurses, many other professionals).

2. Background

Local Context

2.1 The Trust is one of the largest in the country with 2 main District general hospitals, 5 community hospitals, 120 sites and over 6700 staff. It is relatively unique in being an integrated acute and community Trust and therefore employs staff with very diverse educational needs. Amongst this workforce there are staff in training positions (e.g. junior doctors) that will be part of the workforce whilst they complete professional training. The Trust also provides student placements in a number of other disciplines.

2.2 Improving patient safety is a key principle of the Trust. The Trust aims to embed the learning from patient incidents and complaints into the portfolio of training programmes. Patient safety training is a key theme within the clinical setting.

2.3 ESHT has developed a strategic direction for the organisation with a clear vision and mission. These are accompanied by a set of strategic objectives and aims.

(Figure 1)

Our promise to patients and staff

Patients come first at East Sussex Healthcare NHS Trust.

We work in partnership with commissioners, other providers, our staff and volunteers as part of a locally focused and integrated network of health and social care in the country.

Our vision it to be:
- The healthcare provider of first choice for the people of East Sussex.

Our mission is to:
- Deliver better health outcomes and an excellent experience for everyone we provide with healthcare services.

Our strategic objectives are to:
- Improve quality and clinical outcomes but 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 benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.

Our aims are that all services delivered by the Trust are:
- Safe
- Effective
- Caring
- Responsive and
- Well led

2.4 In order to achieve this ESHT as an organisation needs to further strengthen the provision of education and training of its current staff and the professionals in training.

National Context

2.5 The reports on patient safety and quality of services arising from the Mid-Staffordshire Enquiry (Francis report)1 identified learning and development as a key support for developing the right cultures within NHS organisations. Training in multi-professional groups enhances team working, communication between professional groups and improves patient outcomes and patient satisfaction.

2.6 Support for education and training has been reorganised as part of the NHS changes in 2013. Responsibility for commissioning training and development programmes for future health professionals has become the responsibility of Health Education England and its network of Local Education Training Boards (LETB).The Trust is a member of the Kent, Surrey, Sussex LETB, which is now called Health Education Kent Surrey and Sussex (HEKSS). The aim of HEKSS is to get better value from the funding available for education and training by encouraging a more integrated approach to delivery which will also lead to better patient care. There will be a closer alignment between the commissioning of training with the future workforce and development needs of providers in both secondary and primary care.

2.7 There is pressure on training budgets for efficiency savings and this is unlikely to change at least over the next few years.

2.8 Proposals are in place to re-organise medical workforce training that will direct doctors into GP training. This will reduce the number of hospital training placements. In the longer term the "Shape of Training" review has proposed increasing generalist training but these reforms are likely to take several years to be implemented. This will have an effect on postgraduate and undergraduate training.

2.9 The reduction in the number of doctors in training will need to be replaced through the development of other healthcare professional roles.

2.10 The Trust wishes to further develop its relationship with the Brighton Medical School and University which provides a unique opportunity for education and training developments for both staff and students. This will hopefully include joint academic appointments between Brighton and ESHT.

2.11 There are also other drivers for change for example as technology develops our methods of teaching and learning, we will also need to develop to include more on-line learning.

2.12 Simulation enables learning on clinical skills and team working to take place in a safe environment. There is a strong focus increasingly to train staff in multi-professional groups to improve their team communication skills. This training can be taken down to service, ward and theatre level.

2.13 Other groups of health care providers such as Healthcare Scientists are also going through changes in training which are summarised later (Appendix 3).

2.14 HEKSS has recently introduced the Quality Improvement Tool (QIT) which has replaced the Contract review process. This is a much less prescriptive method of action planning which allows providers to develop and manage their own improvement processes with regard to education and training in order to meet the desired outcomes. The QIT will enable providers to be assessed / self-assess against the seven standards below (Appendix 1). ESHT is currently in the process of finalising its QIT:

These are:

- patient safety
- Organisational culture in supporting practice education
- executive ownership of practice education
- staff in place to effectively support practice education
- physical support for practice education
- standards of service
- partnership working

2.15 There is a set of indicators for each standard together with the criteria for meeting them. A level of concern is determined based on assessment of the evidence provided. Local Education Providers (LEP) will be asked to return their QITs and action plans in advance of the meeting to sign off the Learning and Development Agreement (LDA) and the QIT. The QIT will be a living document with four monthly reviews. The old type of visit concentrating on individual medical specialties is planned to be replaced by integrated team visits of medical teams, ward teams, and others involved in the patient pathway for that specialty.

3. Components of the Education Strategy

1. Vision - to be a centre of excellence for Education

2. Mission - to provide education opportunities that attract and retain quality staff and improve outcomes for patients.

3. Aims and Objectives - meet the aims of the Trust through education by:

- providing excellent integrated and training accessible to all staff groups to improve the quality of patient care
- attracting highly motivated health care professionals by making education a core part of the job of all staff with appropriate time allocated.
- continuing to fulfil its contracts and commitments for the delivery of training placements for students and trainees to a high standard.
- developing new and enhanced roles that can help the Trust deliver more cost effective care through changes in skill mix.
- ensuring research activity is embedded into staff practice
- working in collaboration with partner organisations to develop education regionally. Play a leading role in HEKSS.
- promoting the values of ESHT through appropriate learning opportunities.
- establishing and promoting a proactive approach to education to address the values and direction of the Trust
- bringing together educational teams both physically and aspirationally to facilitate integrated learning
- creating Education and Learning centres with an atmosphere conducive to learning
- developing an Education Board to drive the consolidation of finances, Learning and development Agreement (LDA) obligations, and HEKSS and CQC quality requirements
- ensuring learning opportunities are appropriate, accessible and deliver improvements in direct patient care
- considering marketing opportunities to promote ESHT and attract highly motivated health care professionals.

4. What will this do for ESHT?

4.1 The outcomes expected from the implementation of this strategy include:

- a motivated, competent, caring and capable workforce
- improved clinical outcomes through the joint development of clinical teams.
- becoming a recognised leader in patient safety training.
- providing a sustainable workforce as a result of better fill rates for training posts and an appropriate skill mix.
- reductions in staff turnover, and the associated costs of recruitment, induction and minimising potential discontinuity within teams and services.
- improved collaboration between all healthcare provider staff groups in ESHT
- increased compliance with mandatory training requirements
- cost efficiencies by sharing, for example, educational facilities and administrative support
- the development of high quality learning environments
- the development of new training pathways

5. Key Actions

5.1 Given these drivers for change there are key actions that need to be taken over the next five years to strengthen our education provision and single us out as a highly desirable place to work and be trained.

5.2 The key actions have been developed to support the strength and opportunities and tackle the weaknesses and threats identified through a SWOT analysis (Appendix 2 – Strengths, weaknesses, opportunities and threats to the Education Strategy). Taking these actions will deliver the aims and objectives of the Educational Strategy and therefore of the Trust as a whole.

5.3 The key actions have been grouped under five main headings with specific actions detailed under each:

1) To manage education, training and development activities effectively and efficiently, based on the needs of the Trust, and in a way that supports its other strategic aims and objectives:

- A smaller Education Board (formerly the Internal Education Forum) has been set up with five subgroups to jointly plan, co-ordinate and oversee all education, training and development activities within the Trust so that they support Trust objectives and use training budgets most effectively.
- To look at changing the Local Academic Board (LAB) from a medically focused Board to one that covers all the clinical workforce.
- To evaluate training needs using appraisal data, safety and performance data, staff and patient feedback, complaints and incident data. It should be based on the requirements of the individual Clinical Units (CUs) and Trust plans and strategies.
- Changing the infrastructure of the Postgraduate Medical Centre in Eastbourne so that Learning and Development (LD), Nurse Education, and Medical Revalidation are all located there with medical education. The Centre will be renamed the Education and Learning Centre. The management offices and meeting rooms will move to Duncan House. This will allow proper integration of education, training and development. This will help meet any regulatory and Commissioner quality assurance arrangements. These moves were planned for the end of September 2014 but were halted due to organisational pressures outside education. A working group will be set up to look at this again involving the whole estate.
- To look at the possibility to re-organise the management structure of education. To have an Education manager overseeing all education allowing LD, Library services and Clinical Education (nursing education team) to move out of Workforce and Organisation Development structure into an Education management structure, including medical staff, supporting integration of education and training. This may lead to the formation of a new “Education, Training and Workforce Development Committee” and /or a new “Education and Training Committee” to oversee this. This could take on the role of the current “Education Board”.
- Maximise the utilisation of e-learning and new developments in learning technology to optimise accessibility of training, so the Trust needs to ensure that the IT infrastructure is sufficiently resourced. The IT facilities in both main Education centre lecture theatres need upgrading to meet modern day standards.
- To improve the opportunities for multidisciplinary training using the excellent simulation facilities on both main sites and take the mobile facilities for this to ward and theatre environments.
- Consistent processes for recording, monitoring and evaluating education learning and development outcomes across the range of Trust activities in this area.

2) To support continuous learning for all staff which underpins the development of the workforce and the delivery of care by staff who are supported to thrive and able to give their very best.

- Developing a co-ordinated approach to lifelong learning based on excellent appraisal and personal development processes that will support the requirements of revalidation and maintaining registration to practice.

- Promote team development through integrated learning opportunities with a team development programme and resources.
- Provide access to skills and other training, accredited programmes, continuous professional development, mandatory training and essential job skills training in response to Trust and patient needs.
- Develop new education, training and development programmes and pathways that fit with new roles and new ways of working eg enhanced practitioner roles. This may also be as a result of changes in service delivery such as the transfer of care into community settings and the need for development of new roles.
- Promote clear and equitable policies on access to education, training and development using technology such as e-learning.
- To provide and develop entry into health care education through preceptorship and apprenticeships.
- Develop career opportunities by retaining staff in post whilst they are acquiring their qualifications and developing their careers.

3) To cultivate leaders and managers capable of embedding education, training and development into practice, to support quality, safety, clinical governance, service development and a learning culture.

- Key leaders and managers to complete a leadership programme giving them the skills and attributes to lead and manage.
- Encourage the development of opportunities for multi-disciplinary learning amongst our leaders and managers.
- To share best practice models by learning from other departments and providers across the healthcare and education community.
- Develop specific service improvement projects as part of development programmes and processes for leadership development.
- Encourage a positive learning and feedback culture that expects leaders to identify their own learning needs and promotes an expectation that leaders/managers are responsible for developing their own skills as developers of people.
- Strengthen and formalise succession planning, mentoring and coaching.

4) To develop partnership working with other organisations and, where appropriate, integration with these to support the delivery of training and development that has the greatest impact and benefit and maximising opportunities for shared learning.

- Engagement by the Trust in the HEKSS Board and Partnership Council to influence the workforce training and priorities the Trust supports.
- Build a closer relationship with Brighton University and Medical School and other lead providers of medical and dental education.
- To make joint academic appointments in medical and other clinical groups between Brighton and ESHT to increase the education and research profile of ESHT. There has been agreement for a joint Senior Lecturer post in Stroke care.
- Although ESHT is an Associate Teaching Hospital with Brighton and Kings, Guys and St Thomas` the aim is to achieve “University” Hospital status through these joint academic posts.
- Develop an information site to publicise access to learning and development opportunities outside the Trust e.g. NHS Leadership academy.
- Work with schools and other education providers to raise the profile of careers in the NHS for school leavers’ and others.

- To use the training and development facilities within the Trust to bring in income from partners e.g. mandatory training for GP practices.
- To work with other organisations on apprenticeship and placement opportunities.

5) To deliver education, training and development that is continually quality assured, meets required standards, and ensures that all sources of funding are used effectively, efficiently and appropriately.

- To oversee the management and use of education funds so that they are used appropriately and equitably by all staff groups for the benefit of staff and patients.
- To develop an annual education, training and development action plan to address in year priorities.
- Review the Trust`s medical training placement support and its sustainability by specialty based on future commissioning intentions, funding, and safety and supervision required. Where necessary develop alternative approaches such as developing other staff groups to fill the gaps.
- Make use of all external funding sources, including from HEKSS, for education, training and development. Have plans available in advance.
- Make the Trust the main provider of education, training and development in the health care economy. Make opportunities to generate income.
- Draw up a framework for recording, monitoring and evaluating education, learning and development outcomes and participant feedback.
- To be actively involved in the HEKSS Quality Improvement Tool to highlight areas for improvement and the action plan to do it.

Refer to Appendix 3 – Current situation and future strategy for specific clinical areas and staff for further information.

6. Objectives for 2014-2016

- Decide on Committee format and management structure for Education, Training and Development within ESHT.
- Complete the move of LD and nurse education to the PGMC in Eastbourne.
- Understand the education resources and budgets
- Make education and training part of the core business of all employees of the Trust (added to all Job Descriptions) with appropriate time allocated in job plans for this.
- Co-ordinate in-house expertise to train
- Start the coordination of multi-disciplinary training and team development work.
- Use and optimise simulation for clinical skills training for all staff in the simulation suite and mock ward environments, and in a multi-professional way, including resuscitation.
- Link in to the appraisal and PDP process for staff development
- Continue the Leadership programme for key leaders
- Develop the Library and Knowledge Service to include modern IT facilities to allow further development of e-learning
- Design and deliver a standard course / training evaluation form
- Maximise external funding opportunities through HEKSS and a plan for income generation
- Improve compliance with mandatory training including the further development of the “passport” with the help of good high quality on-line materials. Develop a competence assessment approach.
- Continue to be active within HEKSS

- Look at specialties where medical trainee numbers may be lost, together with the Trust strategy, and the opportunity to train other health care workers to take on some of the roles.

7. Summary

The Education strategy is to support the Trust`s wider workforce and other strategies by ensuring the skills, competence and abilities of Trust staff are maximised and aligned with high quality, clinically effective and safe care and that education and training delivery is coordinated and overseen effectively on behalf of the Trust Board. It is intended that the way we deliver education, training and development will be different in that it will be truly integrated.

Dr Harry Walmsley
Associate Medical Director for Academia, Education and Research

November 2014

REFERENCES

[1] Francis Enquiry into Mid Staffordshire NHS Foundation Trust reports, Keogh mortality review, Berwick Report "A promise to learn - a commitment to act, Improving the Safety of Patients in England"

APPENDIX 1

STANDARD 1 - PATIENT SAFETY		
The responsibilities, related duties, working hours and supervision/mentorship of learners must be consistent with the delivery of high-quality, safe patient care. There must be clear procedures to address immediately any concerns from learners about patient safety.		
	Indicator	Criteria
1a	Learners provide safe and high quality care to patients.	Learners make the care of patients their first concern. The provider ensures that the principles and values of the NHS Constitution are endorsed and upheld.
1b	Learners are able to raise concerns regarding patient safety.	There must be a clear process for learners to raise concerns regarding patient safety. Learners are encouraged and enabled to raise concerns with positive outcomes.
1c	Learners only undertake appropriate tasks in which they are competent or are learning to be competent, and with adequate supervision.	Learners are never asked to work beyond the limits of their competence without appropriate support and supervision. Those supervising the clinical care provided by learners must be clearly identified; competent to supervise; and be accessible and approachable at all times while the learner is on duty.
1d	Shift and on-call rota patterns are designed so as to minimise the adverse effects of sleep deprivation.	Work patterns and intensity of work must not result in sleep deprivation, which may have adverse effects on patient safety. Learners must have adequate rest periods.
1e	Formal handover arrangements are in place, ensuring continuity of patient care.	Learners must have well organised handover arrangements, ensuring continuity of patient care at the start and end of periods of day or night duties every day of the week.
1f	(Trainee doctors only) Trainees must act in accordance with the GMC's Guidance - *Consent: patients and doctors making decisions together (2008).*	Before seeking consent both trainee and supervisor must be satisfied that the trainee understands the proposed intervention and its risks, and is prepared to answer associated questions the patient may ask. If they are unable to do so they should have access to a supervisor with the required knowledge.

STANDARD 2 - THE ORGANISATIONAL CULTURE IN SUPPORTING PRACTICE EDUCATION		
The organisation aligns its values, strategy and resources to demonstrate how it values its role as an education setting in helping learners meet the relevant curriculum requirements while encouraging and supporting individual, team and professional responsibility in delivering high quality learning environments and training opportunities.		
	Indicator	Criteria
2a	A learning culture has been created and invested in across the provider.	The provider is continuously developing as a learning organisation. Staff are enabled to consider education as an equal priority to other components of their role.
2b	Multi-professional learning opportunities are provided for learners.	Multi-professional training plan is in place and is embedded. Promotion of multi-professional learning opportunities aligned to patient care pathways.
2c	The provider is committed to continuous personal and professional development and lifelong learning.	Learners receive support and encouragement in personal and professional development and lifelong learning. Learners have regular appraisals and have development plans.
2d	Learner feedback on the placement experience and the quality of education is reviewed and aligned to local continuous quality improvement.	Learner feedback is actively sought. Learners are able to provide constructive feedback on the placement experience via a safe and supportive process. The provider has a local continuous quality improvement programme that incorporates feedback from learners. Actions are taken where necessary and the learner is informed of the actions.
2e	Enhancements in education practice within placements are disseminated across the provider, resulting in continuous quality improvement.	There are transparent and collaborative quality improvement processes to collect and disseminate notable practice and enhancements in education practice across the provider.

STANDARD 3 - EXECUTIVE OWNERSHIP OF PRACTICE EDUCATION		
The organisation provides effective senior leadership and direction demonstrating a clear commitment and accountability to the delivery of high quality education.		
	Indicator	Criteria
3a	There is Board level engagement across the organisation in workforce planning, education, training, the leadership of all staff and the financial spend involved in these areas.	An up to date education and training plan (or education strategy) linked to workforce development to meet strategic priorities. This is regularly reported and monitored at Board level. Educational governance in place to review plans and education and training standards. Demonstrate commitment to CPPD planning evidenced by demonstrable improvements to patient care. Evidence of robust workforce planning.
3b	The provider has an Executive Education Lead (EEL), who is a Board level member of staff with accountability for multi-professional education within the provider.	A multi-professional structure is in place to support education within the organisation. The EEL is a Board Level member of staff responsible for representing the organisation on the Partnership Council and speaking from a pan-workforce perspective. The EEL is responsible for the management of HEKSS allocated funds. The EEL takes overall responsibility for final sign off of the annual workforce and education commissioning submission to HEKSS and the Learning and Development Agreement (LDA) action plan and ongoing reporting requirements.
3c	The Provider has structures and systems in place to ensure the infrastructure and adequate resources are available for administering and managing training and education.	Infrastructure for administering and managing training and education is appropriate to deliver the LDA. Regular Reports to the Board and other relevant committees. Escalation process in place to inform HEKSS of any concerns or issues. There are processes in place to allocate and monitor and report the use of funding that is equitable and in line with the education and training plan: • Funding to support the learning environment (tariff). • Funding to support CPPD. • Salary support costs. • Other funding allocations for example, apprenticeships, Technology Enhanced Learning (TEL), compassion.
3d	The Provider Board considers any associated impact on health education and training when considering or implementing changes in services.	Process to ensure that the impact on education and training is discussed at Board level within the organisation. Report to HEKSS changes to service that impact on education and training, especially concerning placement capacity.

STANDARD 4 - STAFF IN PLACE TO EFFECTIVELY SUPPORT PRACTICE EDUCATION		
The organisation values staff that mentor, supervise and educate, ensuring there is appropriate workforce planning, recruitment and support, and that there are training and development opportunities to enable those staff to successfully undertake the responsibilities required in this role.		
	Indicator	Criteria
4a	The practice placement environment is properly resourced with an appropriate ratio of professionally prepared support staff to learners, ensuring education standards are met within the organisation.	Appropriate numbers of educators to learners within the organisation. Processes in place to ensure that educators are trained to the standards set out by their professional group and that they are updated annually. Annual appraisals of educators' skills and competencies as well as their values and behaviours are undertaken. Safe learner supervision that meets the standards in the Learning and Development Agreement (LDA), CQC and clinical

		governance standards. Safe learner supervision that assures adequate levels of supervision and includes inductions to placement areas, handover procedures, appropriate access to senior support and graded experience.
4b	The Provider has processes in place to ensure that there is an induction process for educators, they have job descriptions, there are mechanisms in place to support educators and there is a quality assurance process.	Induction and support systems are in place to support educators within the Provider. All educators have the specific competencies included within their job descriptions. A quality assurance process is in place for the educators within the organisation and action is taken if educators are not meeting standards.
4c	Learners in difficulty are supported and all learners receive effective feedback in a timely manner.	Learners in difficulty are supported by educators and show demonstrable improvement. Learners receive effective feedback from educators at appropriate times with support. Educators support learners in difficulty to reduce attrition rates.
4d	Appropriate staff to make improvements in pass rates and outcomes for learners.	Analysis of learner exams undertaken, reviews of competency, pass rates and outcomes.
4e	The Provider ensures that all staff are engaged in supporting learners and to provide a consistent experience with the learning environment.	All staff to provide support to all learners within the organisation. Ensure there multi-professional opportunities available to learners, e.g. placements across care pathways, hub and spoke placements.
4f	Staffing levels are adequate to provide a safe learning environment.	Evidence of use of appropriate methodology to ensure safe staffing levels. Monitoring of staffing levels and action taken to address any issues or concerns.

STANDARD 5 – PHYSICAL SUPPORT FOR PRACTICE EDUCATION		
The organisation has resources and facilities to facilitate an encouraging learning environment for learners.		
	Indicator	Criteria
5a	Enhanced learning experience supported by information technology that improves educational outcomes.	IT equipment is available to all staff 24/7 for learning activities.
5b	Improved educational outcomes through access to Library and Knowledge Services.	All learners and educators have access to Library and Knowledge Services that are at least 90% compliant with the national Library Quality Assurance Framework in accordance with the LDA.
5c	Learners achieve a better work life balance through access to accommodation.	Accommodation is available and accessible for those requiring it out of hours.
5d	Teaching resources are reviewed to ensure they are current and appropriate.	Resources mapped to curriculum.
5e	Learners benefit from training together as a team. Variety of opportunities accommodates different learning styles which improved educational outcomes.	Multi-professional Learning opportunities. Simulation. E-learning. Mobile technology.

STANDARD 6 - STANDARDS OF SERVICE		
The organisation has robust governance structures and processes in place to ensure a safe and effective environment for learners.		
	Indicator	Criteria
6a	The provider has a workforce and education strategy and plan that demonstrates working in partnership with CCGs and is shared with HEKSS to inform future investments in education and training.	The strategy and plan is agreed with commissioning CCGs and shared with HEKSS. It is complete in terms of staff groups and 5 year forecast figures. It contains a robust narrative to explain service changes and assumptions, and how safe staffing levels will be maintained. It includes education commissioning and CPD requirements. It includes risks to delivery of the plan. It is signed off at Board level.
6b	Standards and educational criteria are embedded into the curriculum and continually reviewed.	Educators and senior staff are involved in the curriculum delivery, development and assessment. The provider meets the requirements of curricula set by the Professional Standards Review Bodies (PSBR) including the NMC, GMC, HCPC, etc.
6c	Quality of the learner assessment is maintained.	The Provider has processes in place to ensure that learner assessment is appropriately moderated and there is evidence of external scrutiny of the assessment of learners. Learner assessment is moderated within the organisation. All staff to provide support to all learners within the organisation. Evidence of external scrutiny of the assessment of learners.
6d	HEKSS is made aware of any appropriate complaints and serious incidents that occur in a learning environment in a timely fashion. The actions taken and the outcomes from investigations into serious incidents / never events involving learners are communicated and lessons are learnt.	HEKSS is notified of complaints, serious incidents and never events that involve learners within 5 working days, dependent on the seriousness of the event. Actions are taken as a result with the involvement of the learner, and HEKSS is updated on any investigation. Learning from serious incidents is cascaded through the provider and improvements can be demonstrated. Refer to *Serious Incident Framework, March 2013 (NHS England) and The Never Events List; 2013/14 update (NHS England).*
6e	Learners are involved in audits and quality improvement initiatives and the outcomes are put into practice and sustained	There is clear guidance on audits and quality improvement initiatives. Learners have the opportunity to be involved in audits and quality improvement initiatives. The outcomes are implemented and evaluated.
6f	The quality of recruitment of learners is continually reviewed and reduction in attrition is demonstrated due to more appropriate applicants being recruited.	Senior staff make themselves available to be involved in the recruitment process. All mandatory pre-employment checks are carried out - Disclosure and Barring Service (DBS) agreement, independent safeguarding authority and occupational health clearance. Values based recruitment methods are used.

STANDARD 7 - PARTNERSHIP WORKING		
The organisation has effective structures and processes in place to promote and implement strong partnership arrangements, such as service planning, the sharing of information and quality improvement activities.		
	Indicator	Criteria
7a	The provider works in partnership with other organisations to ensure educational outcomes are optimised.	Rotational programmes provide the required educational outcomes. The organisation works in partnership with other providers, HEIs and HEKSS to maintain and develop educational programmes that meet the needs of service, provide value for money and produce high quality outcomes.
7b	There is an identified senior staff member within the provider who is responsible for formal liaison with the education institution, including agreement of policies and processes.	A Board level member of staff with responsibility for the management of multi-professional education and training. There is effective communication with all stakeholders.
7c	Senior staff are involved in developing quality improvement and enhancement action plans in partnership with educators as part of the quality assurance process.	Senior staff make themselves available to be involved in the quality assurance process. Senior staff develop and implement improvement plans in partnership with the educator, and are part of the monitoring process of the plans, attending relevant meetings.
7d	There is a formal joined up approach between practice and education to the preparation and allocation of practice placements.	The provider ensures that the placement is fully prepared for each learner and is supportive and enquiring of their individual learning requirements while enabling all to feel part of the team.
7e	There are robust systems in place for raising and addressing any concerns about the placement.	Learners are able to raise any concerns about the placement, and there are systems in place for addressing these concerns. There are clearly identified processes and systems of communication between the education institution, the provider and the learner during the practice placement.

APPENDIX 2

SWOT Analysis for Education Strategy

Strengths	*Weaknesses*
Development of facilities Integration of education beginning Good medical training experience Good trainers GMC survey improvements Dedicated education teams	Poor current educational facilities Lack of coordination and silo working No combined oversight Poor compliance with mandatory training Financial constraints Geography Lack of understanding of education and its impact on patient care Little learning from mistakes – incidents and governance Education team structures – disparate Two acute sites and numerous community sites Training accessibility Inconsistent processes and infrastructure
Opportunities	*Threats*
Coordinated an Integrated approach to training and reducing silo working Develop a stronger needs based approach to training Excellent simulation facilities and mobile equipment Simulation development Build on enthusiasm Consolidate education facilities and finance Share best practice training and delivery techniques (developing all trainers) Stronger evaluation measures and systematic feedback to inform measures of effectiveness Future cost efficiencies – coordination of training may deliver these Income generation Consolidate services External marketing e.g. GPs e-learning projects Enhanced roles of non-medical staff	Reduction of trainee numbers Increasing service pressures preventing release of staff for training Financial constraints – potential reduction in central education budgets Staff attrition Lack of board buy in Keeping up with quality requirements External targets Consolidate services Proximity to Brighton and transport links

APPENDIX 3

Current situation at ESHT and future strategy for specific clinical areas and staff

1. Education

1.1 **The educational environment** has been specified as essential in the government response to Francis (2013) et al. Both the PGMC at Eastbourne DGH and the Education Centre (EC) at the Conquest are substandard. The situation is worse at the PGMC where a significant area of the Centre has been lost to management offices with the Turnaround offices placed next to the PGMC admin office making the atmosphere difficult at times. Ad hoc meetings take place in seminar rooms without discussion disrupting the service the medical education team is providing. The use of the Garden Room (formerly the restaurant area) in the EC for management has reduced educational space available for booking and disrupts the educational environment. This use of teaching areas for management activities at the EC can be managed temporarily but should be avoided in future. The location of the Medical Education team on the first floor leaves them slightly isolated.

1.2 **ESHT had the lowest fill rate for medical trainees** in the South East in August 2013. Possible causes have been the uncertainty of the ESHT clinical strategy and the geographical location of the two main hospitals. Both are difficult to get to from London, and the Conquest from Brighton. It is also possible that ESHT may not be selling itself at its best in recruitment. At a time of reducing numbers of trainees ESHT needs to make itself a place trainees wish to come to.

1.3 **HEE has clearly specified that education should be integrated**. Instead of different disciplines (medicine, nursing, etc) training and working in silos they should work together. Locating medical education in the PGMC and EC, nurse education based at Bexhill, and Learning and Development in Duncan House at the EDGH site creates a barrier to integrated education at ESHT. They should be centralised to allow true integration.

1.4 **Simulation** - HEE and HEKSS see this as an important way of training to improve patient outcomes, particularly around the deteriorating patient. Simulation does occur in ESHT but mostly in the simulation suites which does not adequately replicate clinical environments or allow staff to work in a multidisciplinary way. It should be taken right down to ward level where, for example, ward rounds can be simulated. Likewise emergencies in the operating theatre environment with a full theatre team. End of Life Care is another area. To do this needs the full cooperation of all and the willingness to make it succeed. Currently there is no clear integrated leadership for simulation training within the Trust.

1.5 **Nursing** - The commissioning intentions are relatively unchanged, but some nurse commissioning may focus more on the Health Visitor programme rather than hospital nursing. The school of nursing service would be put out to tender.
There is a need to match pre-registration student numbers against workforce plans, but also commissioning the numbers that can be realistically supported within practice areas for the duration of the programme. Currently the interview process of soon to qualify nursing is being redefined to ensure a values and competency based recruitment process in line with the Francis report.

A further initiative is hopefully being introduced to develop the preceptorship programme of newly qualified nurses. This is envisaged to include a 6 month supernumerary pathway in two related clinical areas.

1.6 **Modernising Scientific Careers (Health Care Sciences)** - this includes a wide range of posts within the Trust, including staff in EME, photography, pathology, cardiology, respiratory, audiology, sleep and vision as well as some others areas. The posts are divided into 3 groups, Life (lab based), Physical (EME, wheelchair) and Physiological (cardiac sciences). Up until now all these specialties have had their own training programmes at Universities to BSc level. In 2011 these programmes all came under the umbrella of modernising scientific careers. This includes BSc Healthcare Science (Practitioner Training Programme (PTP)) provided by a small number of Universities and MSc Healthcare Science (Scientist Training Programme (STP)) provided by an even smaller number. Some specialties e.g. pathology have continued with their old BSc / training courses as some universities want to continue with their old BSc. Universities now no longer provide old BSc programmes for physiological sciences e.g. cardiology. There is already a shortage of physiologists nationally and in the short term this change in programme will make it worse. The PTP programmes are run in London, Portsmouth and Southampton and STP in Newcastle and Manchester. Brighton run none. Cardiology have an STP student starting in September which is paid for by HEKSS. There are plans to start a PTP student in 2015.

There is now no funding for the BSc programmes so it is not an option for in house training. PTP graduates come out at Band 6 and STP at Band 7 on qualification. This is higher than most current experienced practitioners creating its own problems.

There is funding for Foundation degrees from HEKSS to develop band 1-4 staff locally. However there is a limited number of Universities providing this so these staff would have to travel far and stay during their University period.

1.7 **Allied Health Professionals (AHP)** – The Trust currently has an AHP workforce of nearly 600 staff. These include podiatrists, physiotherapists, occupational therapists, speech and language therapists, dieticians along with allied staff. Currently patient care is increasingly taking place in the community and a flexible, responsive workforce is needed along with wide ranging uni and multidisciplinary CPD needs which is challenged by current austerity strategies. Fragmenting of services and plurality of providers challenges the workforce where it is essential that there is exposure to a wide range of clinical placements in order to develop robust postgraduate competencies and consolidate their knowledge. For example when the Hastings and Rother MSK pathway went to an alternative provider this led to a reduction in the accessibility of MSK physiotherapy rotations for band 5 and 6 staff. This has also limited student opportunities. Inability to provide an adequate range of training also effects ESHT`s ability to attract and retain staff.

Physiotherapy is a very research orientated department within ESHT. They successfully bid for backfill post funding whilst undertaking research. They are also applying currently for Masters in Research.

1.8 **Resuscitation and Trauma Care (ATLS)** - The Resuscitation Dept is active across the Trust and lead on a lot of the simulation work. Currently Basic Life Support (BLS) is mandatory for all staff and Immediate (ILS) and Advanced Life Support (ALS) for certain groups of clinical staff. However there is not 100% compliance.

The Advanced Trauma Life Support (ATLS) course is again run on both sites.

The Sussex Trauma Network says in its criteria for Trauma Unit (TU) status that all doctors involved in the Trauma team should have a current ATLS Provider certificate. This is not complied with. Eastbourne has the highest percentage of ATLS Instructors of any hospital in the country and Dr Walmsley has been allowed to run the Royal College of Surgeons Instructor course in Eastbourne, the only DGH allowed to do that.

1.9 **Undergraduates** - SLAs for undergraduate education are currently held between BSMS, Kings College London and ESHT on both sites. The undergraduate programmes complete the medical education model enriching the medical teams within departments and provide a focus and a reality check on patient safety. A SIFT committee has been established to monitor the governance of finance generated by delivering these programmes. It is suggested that these programmes continue within the Trust.

This link with BSMS adds a development element for education faculty within ESHT. Ensuring established medical student programmes will also assist in gaining Associate University Hospital status, a well-recognised and worthwhile status for ESHT.

2. Five Year Strategy; "Changing the culture of an organisation can take 10 years" (HEKSS correspondence).

2.1 Short Term (2014-2016)

2.1.1 Cost Collection Exercise – to establish as accurate a process as possible that will help decide the future educational tariff. If ESHT estimates the cost too low then that would threaten the financial position. If too high it could make ESHT non-competitive. This requires high level buy in to support the data collection process.

2.1.2 PGMC and EC Accommodation – In answer to the Francis report our educational facilities must be fit for purpose to support the future of integrated education. The management offices in the PGMC at the EDGH must be moved to other parts of the Trust. This will then allow nurse education, Learning and Development, and Revalidation to move into the PGMC. This would also free up Duncan House so that it could be used for management offices. These moves are planned for the last week in September 2014. All existing educational space at the EC at Conquest must be retained. A single process for e-booking of educational rooms is planned.

2.1.3 Medical trainee fill rate – ESHT has made a successful bid for £36K to facilitate review of how the Trust addresses its poor trainee fill rate and how it might better market its opportunities. This will include some market research, the development of the ESHT input to the HEKSS specialty prospectus and the creation of marketing material to encourage trainees to choose ESHT as their preferred learning Trust. The Trust must emphasise its determination to support this. The project started in June and will start by auditing reasons why trainees might not have put ESHT as their priority. Is it uncertainty over the Trust strategy, geography, or the Trust not selling itself well? Or something else.

2.1.4 Educational Committees – A review of current education structures is advised. The new Education Board (formally Internal Education Forum (IEF)) and LAB have very large agendas. It is appropriate to bring together key players from these and other committees to focus on the major actions we need to take to move the Trust to the forefront within the region. We need a small group of leaders on education from within the Trust to make a plan to drive the "must dos" forward through the Education Board and Local Academic Board.

2.1.5 Simulation – Currently simulation is run by a group of enthusiasts and mostly focuses on medical simulation. Although there is still need for Foundation doctor simulation training there needs to be the development of a multidisciplinary faculty. There is currently little integration with other clinical workforces. The Trust has bid for funding from HEKSS for a short term simulation apprentice. The Anaesthetic CU has appointed an anaesthetic simulation fellow from August. This is funded from current vacant posts. We need also to plan in SPA time for a consultant / lead clinician on each site to lead this project and bring it together. Up until now most of simulation has been run by anaesthetists. This needs to be addressed. All CUs need to take a role in simulation as do other non-medical workforce. This buy in needs initially to be driven by the senior consultants who have already been involved in simulation.

2.1.6 Job Description (JD) – Education and Research are "core business" for health care organizations. All job descriptions must reflect this with a sentence or paragraph in all JDs in the Trust to reflect a more positive approach to this. Appropriate time must be given in SPAs in consultant job plans, and job plans of other clinical staff, to support this. A commitment to education and research on Trust letters to patients is an NIHR recommendation.

2.1.7 Links with outside organisations – It is imperative that ESHT keeps up to date with developments and plans within HEKSS (by attending its Sussex Partnership Council and being part of their work streams), the AHSN, the CRN, and the Medical school and university in Brighton.
Several consultants within the Trust have contacts through committees at the Royal Colleges and other organisations which are important to build on.

2.1.8 Library services should continue to develop the mix of virtual and physical resources to meet the educational and research agenda. This includes a physical presence on both acute sites, 24/7 access and internet based resources. Recurrent funding for library services and inclusion in the developing committee infrastructure is required. It is a requirement for medical training that all Trusts have Wi-Fi access for trainees. Open access Wi-Fi is now available on both library sites.

Health Science Libraries - Ease of access to learning resources including research databases is important. 24 hour access needs to be enhanced whilst maintaining security. A bid has been accepted by HEKSS to enhance the e-learning facilities and space, to encourage more flexible use of the space for learning. These areas must not be used for meetings. The use of mobile devices for e-learning is the future and would require some work with IT and Learning and Development. The IT structure of the Trust needs resourcing e.g. Webex.

HEKSS will be visiting the library facilities very soon. Last year all standards were met and was second only to Brighton. It is possible that this year not all standards will be met because of considerable changes at the Health Science Library when the University of Brighton withdrew from co-management. The Trust is taking full management of the library which will ensure equity of service across the Trust.

2.1.9 Healthcare Sciences (HCS) - With all the changes within healthcare science in terms of training the Trust has reached the point where it needs to invest in the future of the profession by getting involved in STP and PTP training programmes. One STP is being taken on in cardiology this year with plans for a PTP student in 2015. These training programmes require that the students are placed in a variety of departments. Therefore all departments will need to work together to facilitate the training needs within each of the specialties.

The new HCS lead has met with all the different HCS specialty leads to build a Trust network to link with the Academy of Healthcare Science. The link person at HEKKS has left and it is important that that link is replaced. Placement funding needs to be obtained from HEKKS.

2.1.10 Learning and Development (LD) - the department runs many courses for a wide range of professions. Once LD move into the PGMC true multidisciplinary integrated training can happen. In order to deliver safe care all must work as a team.

2.1.11 Delivery of this agenda requires explicit board level commitment. The Board should formally consider progress in these areas regularly. The Board will need to support the use of resource to support education. It is acknowledged that resources are scarce but central funding is available for appropriate projects. The Trust performance scorecard should include specific lines related to education and research. Perhaps there should be more explicit recognition for consultants involved in Education and Research reflected in the award of CEAs.

2.2 Medium Term (2016 – 2017)

2.2.1 PGMC and EC Building – The centres need modernising, particularly the PGMC. Monies are available to be bid for from outside agencies but most require an equal Trust financial commitment to the same amount as well. The EC needs a lift between the 2 floors to meet DDA requirements. The rearrangement of offices within the Education Centre is also necessary to ensure the area is fit for purpose.

2.2.2 Joint Consultant Appointments with BSUH and BSMS – Joint appointments will greatly increase the educational and research profile of ESHT. However single posts such as the one proposed for Stroke may feel isolated, both academically and from an R and D perspective, from Brighton. On discussion with Jon Cohen it would appear to be better to start by appointing some consultants, who have an academic interest, to ESHT but with an SPA on alternate weeks at the medical school. Over the years and after a few more appointments this could move much more towards genuine joint appointments.

Many Trusts have appointed consultants to particular specialties but with a specific medical education interest. The JD of such posts could perhaps have 3 PAs allocated to teach undergraduates and postgraduates with strong links to the University and medical school.

2.2.3 Medical Trainees - with the reduction in medical trainees reduced to a minimum by the proposed short term educational strategy, there is likely to still be shortages in some specialties. HEKSS is keen to develop other staff to fill these workforce gaps, such as specialty nurses and Physicians Associates. There are some in the Trust who appear to be keen on this however training in many of these roles may take several years.

ESHT needs to be looking for areas of expertise it has to become a new provider of choice for this e.g. critical care training, in order to help recruitment.

2.2.4 New courses – with appropriate modernised educational facilities it would be important to run more courses in house to both develop staff within the Trust and income generate using internal expertise. There is a big resource of consultants, and some other staff groups, within the Trust who currently teach on courses regionally and nationally, some of whom have already expressed an interest in running some of these courses within the Trust. This could be income generating for Education but more importantly will raise the profile of the Trust.

2.2.5 Nursing - There needs to be a more overarching approach to post-registration development. In order for budgets to be spent wisely the Clinical Units need to develop workforce plans and that these are shared with the education departments in a timely way to ensure monies and contracts are focussed and aligned to the skills required by the various specialties. Therefore partner universities also must be liaised with to ensure the relevance of the programmes being delivered.

2.2.6 Healthcare Sciences - there is the need to develop in house training to include management courses. Staff need to be encouraged in new training with more cross working between specialties. L and D can help with this. Placement funding needs to be obtained from HEKSS so that PTP students don`t have to self-fund. It is hoped that other specialties, apart from cardiology, in HCS will want to start STP and PTP students in their specialties.

2.2.7 AHPs - A future educational strategy needs to develop a training plan to meet service needs and new AHP led pathways. This development of new AHP roles will lead to new educational challenges. Educational and research opportunities are a strong influence in relation to successful recruitment and retention. Strategies need to consider the importance of succession planning, competency developments and meeting associated training. Education needs to encompass in house development and training and take advantage of multi-professional training opportunities. This will need to be provided by L and D. AHP consultant roles and advanced practice roles are one area where workforce gaps in other specialties could be filled in a cost effective manner. This will require an investment in time and money as developing these roles can take 8-10 years. Physiotherapy is a very research active department.

2.2.8 Resuscitation and Trauma – With appropriate educational facilities at the PGMC the Eastbourne ATLS course could be run there and not at a local hotel as it has been for the last 20 years. It is hoped that there will be 100% compliance with those medical specialties required to do the training. The resuscitation department will still be leading on Simulation.

2.2.9 Library Services will need to develop outreach and more tailored information services to meet organisational, clinical and personal information needs. This will include the introduction of “Knowledge share”. Several projects supporting research and e-learning should be developed in the medium term, including for example the “issuing” of tablets and laptops for e-learning and more training in SPSS and survey monkey.

2.3 **Long Term (2017-1019)**

2.3.1 This will depend on many factors, not least any changes in national or regional structure and policy after the general election in 2015. It will also depend on how far the Trust has progressed with the short and medium term strategy. There is clearly a lot of work to be done in the next three years.

2.3.2 However it would be hoped that by 2017 ESHT will have become a provider of choice for education in many specialties and across professions, with an established model and structure for integrated education. With the newly introduced financial tariff the Trust will be providing integrated education for all clinical staff groups and also running more regional and nationally recognised courses, supplementing educational regional income.

East Sussex Healthcare NHS
NHS Trust

Education Board Sub-Group (e-Learning, Library & IT)

Terms of Reference *(Draft version 1.0)*

Constitution

The Subgroup for e-Learning, Library and IT is accountable to the Education Board.

Purpose & Objectives of the Sub-Group

- to explore opportunities for utilising e-Learning as part of a "blended" learning approach to education and training within the Trust
- to ensure that there is the necessary infrastructure within IT to support diverse learning platform (e.g. e-noting, e-prescribing, utilisation of YouTube and social media)
- to ensure Library Services are providing a service that reflects the current learning environment (i.e. e-journals, etc)
- to consider cost implications for any implementation projects in these areas to seek the necessary Trust approval via the authorisation mechanisms that are currently in place
- to make specific recommendations to the Education Board with reference e-Learning, Library & IT
- to review current infrastructure in these areas to evaluate whether we are in a position to deliver as per the Trust Education Strategy and requirements from external organisations such as the GMC, CQC, HE KSS, Brighton University and King's College London
- to ensure a coordinated approach to the areas identified as part of the sub-group's remit

Membership of the Sub-Group

- Medical Education Manager (Chair)
- Library Services & Education Centre (Conquest) Manager
- Learning & Development Manager
- Senior Manager, IT

Deputies - all members of the sub-group are asked to ensure that a deputy attends the meetings when they are unable to do so.

Quorum - a quorum will consist of two of the above including the Chair (or nominated Deputy)

Accountability & Reporting

The notes of the meeting shall be formerly recorded and submitted to Education Board at it scheduled meetings.

Frequency

The meetings will take place three times per year and will be no more than two hours in duration.

Authority

The sub-group is authorised by the Education Board.

Monitoring Effectiveness

The sub-group will provide reports to the Education Board via its Chair.

Review Date

The Terms of Reference will be reviewed on an annual basis.

EAST SUSSEX HEALTHCARE NHS TRUST

EDUCATION BOARD

TERMS OF REFERENCE

1. Constitution

The Education Board is accountable to the Clinical Management Executive (CME).

2. Terms of Reference

2.1 ***Purpose of the Group***

- Forum for leading development and delivery of multi-disciplinary education within ESHT
- Determine the use of new funding and oversee and monitor the use of existing Educational funds
- Manage relationships with HEKSS
- Exchange of information and learning to and from HEKSS.
- To hold to account the subgroups for delivery of their annual plans
- To identify and share notable practice

2.2 ***Objectives***

- To develop a future vision for ESHT education
- Translate the HEKSS Skills Development Strategy into local priorities and annual work plans
- Identify opportunities for the use of new education funding;
- Developing and delivering multi-disciplinary education
- Identifying future skills development needs
- Input into workforce planning from an education perspective;
- Develop the use of education facilities.
- Support and progress education throughout ESHT
- Develop and maintain links with the Academic Health Science Network

3. Membership of the Group

- Director of Human Resources
- Chief Executive
- Director of Medical Education
- Education Transformation Associate (chair)
- Assistant Director Workforce Development
- Clinical Education manager
- Medical Education Manager
- Clinical Tutors x 2
- Chairs of the 5 Education Board subgroups (see below)
- Representative from HEKSS
- Finance representative

- Non-executive director
- (trainee representatives on the 5 subgroups)

3.1 ***Deputies*** - All members of the group are required to ensure that deputies attend when they are not able to do so.

Further representatives and external stakeholders will be invited to attend for specific agenda items as and when appropriate.

3.2 ***Quorum***

A quorum will consist of six of the above including the Chair (or nominated Deputy).

4. ***Subgroups***

The work of the Education Board is divided between 5 subgroups who will produce their own Terms of Reference and annual work plan. It is expected that the subgroups will meet bimonthly to report on progress at each Education Board. Membership of the subgroups will be decided by the chair of each group. All healthcare groups will need to be represented on at least one subgroup. The 5 subgroups are:

- Delivery of Training – includes simulation and integration of education
- Library, IT and e-learning.
- Quality & Coordination of all Training
- Finance
- Marketing & Future Educational Developments – courses & roles

5. Accountability and Reporting

The notes of the Education Board meetings shall be formally recorded and submitted to the Clinical Management Executive and held by the HR Director.

6. Frequency

Meetings will take place bimonthly, and will last no more than two hours.

7 Authority

The Education Board is authorised by the Clinical Management Executive.

8. Monitoring Effectiveness

The Education Board will provide an annual report to the Clinical Management Executive and will also conduct an annual review of the effectiveness of the group – this will look at the membership, percentage of action plans completed, identification of issues for the group such as reporting framework links, sub group structures and roles etc.

9. Other Matters

The PA to the Director of HR will administer the meeting.

Minutes will be approved by the Chair before distribution to the membership.

10. Review Date

These terms of reference shall be reviewed annually.

East Sussex Healthcare NHS Trust

Date of Meeting:	26 November 2014
Meeting:	Trust Board
Agenda item:	13
Subject:	Procurement Strategy
Reporting Officer:	Vanessa Harris, Director of Finance

Action: This paper is for **(please tick)**					
Assurance		**Approval**	**X**	**Decision**	
Purpose:					
To approve the new Procurement Strategy.					

Introduction:

The strategy is based upon the premise of invest to save and seeks to give assurance to the Trust that through its execution the Trust will reduce expenditure whilst maintaining quality patient care and develop a strong commercial and 'value-based' approach across the departments. As part of the strategy development, the previous Trust Procurement strategy has been reviewed and there has been discussion and informal benchmarking with NHS peer Trust Procurement teams, the Department of Health (DoH), NHS SBS and ESHT staff.

The key areas of future delivery within this proposal are;

- cost efficiencies (cash releasing and procurement savings) of 3-5% over 3 years
- skilled resources to support the immediate delivery of savings and projects requiring change management
- consistency with DoH strategies and implementation of DoH mandated policies
- service improvements through increased use of IT systems
- long term planning flexibility to meet changes in clinical strategy
- compliance and promotion of good governance as best practice procurement is rolled out and adopted across the Trust

To deliver these benefits, we will;

- assume responsibility for the contracting of all non-pay spend excl. pharmacy where it makes sense to do so
- implement procurement product groups to ensure fully engaged clinical and department resource aligned to all projects
- restructure the existing Procurement team to ensure fully aligned resources and in-house catalogue capability; invest in current staff to increase levels of competence and capability
- review collaborative arrangements to ensure value for money
- review current just in time supplies policy and investigate benefits of bulk purchase
- provide support to the commercial bid team
- implement full catalogue management process to ensure correct ordering of products at correct prices

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

Cost efficiencies and workplan to deliver them
Procurement Leadership and capability

Benefits:
Cost efficiencies over three years Compliance, control and visibility of spend

Risks and Implications
Recruitment and stable team structure Pace and scale of savings

Assurance Provided:
Ongoing measurement through key procurement metrics and savings sign off (by clinicians and finance) of cost improvement plans Assessment of impact via QIA (Quality Impact Assessment) Panel

Board Assurance Framework:
Strategic Objective 3, risk 3.1

Review by other Committees/Groups (please state name and date)**:**
Finance & Investment Committee: 19th November 2014

Proposals and/or Recommendations
The Trust Board is asked to approve the Procurement 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?
Not applicable.

For further information or for any enquiries relating to this report please contact:	
Name: Lucie Jaggar, Head of Procurement	**Contact details:** 01323 413832

EAST SUSSEX HEALTHCARE TRUST

PROCUREMENT STRATEGY

1. Executive Summary

This strategy is based upon the premise of invest to save and seeks to give assurance to the Trust that through its execution the Trust will reduce expenditure whilst maintaining quality patient care and develop a strong commercial and 'value-based' approach across the departments. As part of the strategy development, the previous Trust Procurement strategy has been reviewed and there has been discussion and informal benchmarking with NHS peer Trust Procurement teams, the Department of Health (DoH), NHS SBS and ESHT staff.

The key areas of future delivery within this proposal are;

- cost efficiencies (cash releasing and procurement savings) over 3 yrs of between 3-5%
- skilled resources to support the immediate delivery of savings and projects requiring change management
- consistency with DoH strategies and implementation of DoH mandated policies
- service improvements through increased use of IT systems
- long term planning flexibility to meet changes in clinical strategy
- compliance and promotion of good governance as best practice procurement is rolled out and adopted across the Trust

To deliver these benefits, we will;

- assume responsibility for the contracting of all non-pay spend excl. pharmacy implement procurement product groups to ensure fully engaged clinical and department resource aligned to all projects
- restructure the existing Procurement team to ensure fully aligned resources and in-house catalogue capability; invest in current staff to increase levels of competence and capability
- continually review collaborative arrangements to ensure value for money
- review current just in time supplies policy and investigate benefits of bulk purchase
- provide support to the commercial bid team
- implement full catalogue management process to ensure correct ordering of products at correct prices

2. Introduction

This document details the Procurement Strategy for East Sussex Healthcare Trust 2014/5-2017/18. It is written at a time when the Trust, as part of a Challenged Health Economy, needs to demonstrate it is maximising all back office savings opportunities.

For Procurement this means supporting and in some areas, driving the review activity. We need to continue and increase our efforts to maximise all savings opportunities and work in tandem with trusted partners to implement a substantial and credible cost savings programme.

The Procurement team has made good inroads into the rationalisation and right-sizing of the supplier base and tendering of non-pay goods and services over the past few years but this has largely been confined to medical consumables and there remains substantial scope for cost savings through the application of best practice and high standards, collaboration and process modernisation.

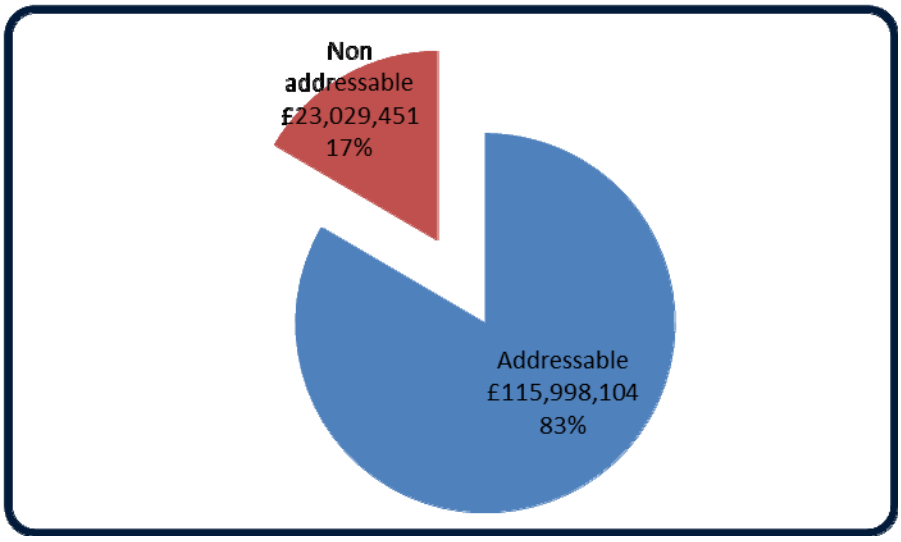
The financial challenge can only be met by a more innovative and wider spread procurement process. By harnessing relationships with key suppliers, ESHT will continue to deliver quality, value and innovation; however, it will be vital that stakeholders are responsive to creative ideas received internally from staff and externally from procurement partners and the market place.

Procurement is not an activity that is restricted to procurement professionals. Everyone involved in the end to end procurement process has the responsibility for ensuring that the products and services that are selected, bought and used represent value for money, provide the right outcome for the patient and are not wasted.

This Procurement Strategy focuses on delivering best practice procurement across the Trust that benefits both patients and staff and which meets the aims and objectives of all organisations and the local health economy. It will define the actions to continue the journey of continuous improvement in procurement over the next three years, recognising and embedding the national (DoH) strategy and standards that are considered to be best in class and deliver value into patient care.

3. Current Spend Overview

Overall Spend Profile



East Sussex Healthcare NHS Trust has a total spend of **£139m** including VAT during April 2013 to March 2014 FY 2013/14 (12 months).
83% of this has been identified as potentially addressable;
17% has been identified as non addressable.

- **Non Addressable spend** is defined as inter-trust spend, all pension and NI Contributions, the NHS Litigation spend, CRB checks, Voucher schemes, Charities, Payroll Deductions, One off Suppliers, small Miscellaneous Expenditure and County Councils.
- **Addressable spend** is defined as potential influenceable areas of spend. NB. Spend currently within contract is included in this figure and will need to be taken into account when determining specific sourcing plans within a given financial year.

Top 30 Category Spend Profile (addressable spend)

Of the addressable spend identified, Procurement currently has visibility and control of approximately 50% of the spend. This poses a challenge for the team as we are charged with ensuring best value and compliance to EU Procurement legislation across the all Trust expenditure areas. However, of the spend actively managed by the Procurement team, approximately 60% is via collaborative procurement arrangements with the NHS Hub or with local NHS Trust partners which we aim to continue and increase.

The Trust spend with NHS Supply Chain (NHSSC) is high for a Trust of this size because of the limited goods-in/storage capacity at both the acute sites, hence a just-in-time policy is operated which necessitates consolidation of deliveries via one provider rather than multiple suppliers delivering direct to the Trust. Where it has visibility and influence of spend, the Procurement team at EHST has a proven track record of delivering value for money and improving outcomes at reduced cost through clinical partnerships. A proactive approach to benchmarking and tendering each contract as it expires ensures access to competitive pricing and quality in the market place. To date, the focus has been largely on medical consumable supplies.

The Procurement team has 9 permanent roles managing an influenceable spend of c.£116m per annum and currently comprises a Head of Procurement, 3 category managers responsible for delivering sourcing projects and 5 buyers to manage the day to day requirements, ad-hoc purchase requests and product queries from the various Trust departments. The category managers are either CIPS qualified or working towards a full qualification and between them, have over 40 yrs of Healthcare Procurement and Supply chain experience, both public and private sector. The permanence and stability of the team ensures a robust supply-market knowledge and an awareness of innovation and best-practice across all areas of goods and services procured. Informal benchmarking suggest the current team organisation structure is lean compared to other NHS Trusts of similar size and that roles are more junior than the same roles at neighbouring Trusts. As such there is a tangible risk that we lose staff in the near future to other Trusts unless we can redress the balance and make the roles and the team more attractive to staff.

The team makes use of several different routes to purchase, depending on the nature of the goods and services. Collaboration with the Procurement Hubs, other local NHS Trusts and supplier partnerships are all models encouraged and currently operated which guarantee access to the whole market place rather than restricting the Trust to one route and one supplier. Tenders managed by the Procurement team are fully compliant with OJEU Directives and are regularly audited and scrutinised via a governance

process. Auditability, transparency and accountability of public money are key principles of every procurement at ESHT.

Key Procurement Themes

Consistent with the NHS Procurement Strategy 'Better Procurement Better Value Better Care' (August 2013) and the NHS Standards of Procurement (Revision 2 June 2013), the E-Procurement Strategy and NHS Procurement and Efficiency programme (November 2014) four key themes underpin the components of the new strategy. It is critical that each of these areas is invested in and developed appropriately;

LEADERSHIP
The role of procurement in delivering the organisations objectives is understood and supported at every level. This will enhance service transformation through better procurement in which our key stakeholders will participate

PARTNERSHIPS
Relationships with other NHS organisations, commissioners and procurement partners are better understood with opportunities maximised by leveraging better value through our contracts

PEOPLE
All staff in the procurement process are appropriately trained and working effectively to obtain and use the products and services to do their job and understand their role to use procurement to assist in the delivery of safe and efficient healthcare

PROCESS
All procurement systems are designed and implemented to ensure value for money is achieved to ensure that we bring a high-quality insight into our programmes of work that are benchmarked regularly against best practices

The Strategy aims to transform procurement over the next three years by delivering value for the organisation, stakeholders and patients with sustainable savings that are underpinned by compliance, controls and commercial viability. Measurement of progress against this strategy and our improvement against the NHS Standards of Procurement will be tracked quarterly and reported to the Trust Finance and Investment Committee.

4. Procurement Strategy

The Procurement Strategy has been framed around 8 key components:

i. Cost Efficiencies and Productivity Gains
ii Improving Outcomes through Clinical Procurement Partnerships
iii Integrated and Collaborative Procurement
iv Supply Chain Management and Efficiency
v Procurement Resource and Capability

vi Strengthening Procurement Governance
vii Data and Information Transparency
viii. Sustainable Procurement Policy and Practice
ix. Fair and Equitable Trading
x Corporate and Social Responsibility

To support the above, ESHT has designed its structure to align with divisional and clinical unit service lines. Our route to market will see the deployment of different commercial models and more partnership working that is underpinned by stronger commercial contract management with the supplier base.

i. Cost Efficiencies and Productivity Gains

Aim: Deliver cost efficiencies for the Trust of £6.5m over three years (2014/15 – 2017/18) through rigorous sourcing, best practice and initiatives to combat inflation. Increase contract coverage and procurement influence across all non-pay spend (see figure 1.)

- Develop strategic workplan with NHSSC and set joint cost saving target to ensure joint accountability. Implement NHSSC 'core list' as default position
- Ensure all tenders focus on the total cost of acquisition and full life costs and ensure equipment, stock, consumables are included where appropriate in supplier agreements
- Move to longer term contracts where appropriate (e.g. equipment maintenance where there is no choice of supplier) to negotiate better pricing
- Move tendering and contract renewal within IT, Estates, facilities, Wheelchairs, orthotics within the Procurement team where appropriate to increase influence over the additional spend
- Commence benchmarking review and opportunity analysis with external partner in September 2014 to identify opportunities for further cost savings and waste reduction and feed into the 2015/16 workplan
- Look to implement managed service provider models in print, medical equipment maintenance, stationery, staff bank where there is tangible benefit to the Trust
- Ensure robust process in place for both Stakeholders and Finance to approve and sign-off each savings project
- Reduce the range and variety of goods purchased through product standardisation and supplier rationalisation programmes. Identify and promote more cost effective products, service models and sources of supply
- Understand the market dynamics and conditions through strong and early signals about strategic direction and future investments.
- Develop strategies and initiatives that manage suppliers and combat inflation; report monthly on all price increases within the medical consumables category and address with key suppliers at review

meetings. Escalate details of resistant suppliers for national intervention where appropriate.
- Support the Trust to review make vs. buy business case across internal services and play lead role in project implementation team where outsource is preferred route
- Initiate early payments to suppliers where cost effective to do so
- Ensure Community stakeholders are engaged and included in spend analysis and plans to review categories; meet with Community hospitals monthly

ii. Improving Outcomes through Clinical Partnerships
Aim: Embed clinically led procurement programmes that are developed to drive out waste and unnecessary cost, whilst maintaining and improving the quality of care to our patients.

- Involvement of and leadership by clinicians to become accepted practice in setting the procurement agenda and providing input into procurement decisions. Procurement workplan to be signed off and 'owned' by relevant Clinicians at the start of the year. Procurement saving targets need to be embedded into individuals' (budget) objectives
- Harvesting ideas through joint clinical and commercial forums led by Procurement monthly
- Adopting a patient centric approach to procurement to ensure that quality and safety remain at the forefront of procurement decisions
- Clinically-led negotiations in the areas of strategic importance
- Understanding the cost of clinical variation to inform our approach to product standardisation, supplier rationalisation, savings delivery and improving safety in clinical practice. NB. All outcomes will be approved by a representative clinician before being implemented

iii. Integrated and Collaborative Procurement
Aim: Working together to consolidate purchasing requirements to drive greater cost efficiencies from the market. Target 80% of spend on sourcing projects via collaboration

- Maximise use of NHS Hubs and Crown Commercial Solutions to access national frameworks to speed up route to market. Drive Hubs to offer 'one membership' access scheme to reduce membership fees
- Share workplans with neighbouring Trusts to identify opportunities for collaboration on specific sourcing projects. Meet quarterly to review
- Harness buying power of NHSSC to engage with suppliers on rationalisation and take advantage of 'Compare and Save' initiatives where possible (see Section i). Target savings delivered via NHSSC is £200k per annum (as part of annual savings target)
- Develop better and more efficient partnerships with suppliers with the aim of reducing the cost to serve (as part of annual savings target)

iv. Supply Chain Management and Efficiency
Aim: To eradicate wastage and inefficiency in the supply chain

- Review stock levels once a year to ensure best use of space and efficient stock turnover
- Remove waste in the supply chain to drive down costs, whilst maintaining and improving clinical outcomes; ensure robust process for stock write offs/returns to suppliers
- Supply chain development to be both flexible and responsive to changes in the clinical models of care and the way in which support services are delivered
- Examine and remove inefficient supply chain methods and processes, addressing disproportionately high 'cost to serve' e.g. cost of consigned inventory, sales, technical support and instrumentation, where analysis suggests these areas collectively represent as much as 40% of the price of the product.
- Implement parcel tracking system at CQ and EDGH to ensure accountability and responsibility of parcels across the Trust
- Review use of just in time ordering methods and examine benefits of bulk purchases where appropriate
- Assess potential capacity to store bulk purchases where economically advantageous to the Trust
- Improve security to Stores at both sites to ensure appropriate levels of access
- Review use of electronic cabinets within theatre stores area to prevent errors in stocktaking and replenishment

v. Procurement resource and capability
Aim: Implement new team structure to make it fit for purpose to face future challenges (see Appendix 1)

- Re-grade Category manager roles to align to NHS standard and attract high calibre individuals into the Trust; roles to be responsible for key group of stakeholders and clinical units
- Create Data and information team to support delivery of more cost savings through in-depth spend analysis and to implement DoH e-Procurement strategy and catalogue
- Use Hubs as consultants on high value projects where there is no in-house expertise
- Create a team to support market testing across the Trust by leading supplier/market engagement and contracting process
- Improve leadership in procurement at all levels from the Trust Boards, Executive and Non-Executive Directors through to clinicians and budget holders. Procurement must be seen by the organisation(s) as a strategic priority and in doing so recognise the importance of good procurement practice to the business.
- Staff involved in procurement of non-pay and contract management across the Trust to become accountable to Head of Procurement

- Actively engage in the Department of Health 'Centre of Procurement Development Programme' to ensure at local level all relevant staff groups are equipped with the tools and techniques to deliver effective procurements and contract management.

vi. Strengthening Procurement Governance
Aim: Strengthen management, control and compliance in the purchase to pay process.

- Ensure that procurement governance is clearly defined and communicated via Intranet and Procurement Policy
- Procurement policy and processes to be clearly defined, accessible and visible to all staff.
- Produce relevant metrics to track compliance and performance.
- Provide greater visibility of the performance of our top contracts which will help to improve the management of our major suppliers and ensure that they are meeting their contractual obligations and delivering against the agreed performance indicators.
- Compliance with procurement catalogues and processes to ensure good results e.g. eradicating off contract spend and non-purchase orders.
- Minimise use of non-PO spend. Target 80% going through purchase orders

vii. Data information and transparency
Aim: Improve data, information and transparency including the adoption of DoH e-Procurement Strategy and GS1 coding standards

- Implement GHX catalogue solution in order to begin adoption of NHS e-Procurement Strategy and progress the adoption of common global standards; GS1 standards (for product coding, location coding and data synchronisation) and PEPPOL standards (for purchase order, shipping note and invoice messaging). NB. This will be a mandatory requirement from April 1st 2015
- In accordance with the Government Transparency Agenda, increase transparency by publishing all procurement data including opportunities, expenditure and contracts in Contracts Finder and other local media.
- Support internal management and governance by implementing a dashboard of the 7 core procurement metrics presented in the National Procurement Strategy, "Better Procurement Better Value Better Care". These core metrics focus on three key areas of procurement performance, namely: **enabling business continuity**, **procurement efficiency** and **mitigating risk**. See Appendix 2
- Access to non-pay spend information to be timely, and accurate and analysed on the basis of continuous improvement. Data manager will review spend reports monthly and review exceptions/variances.

viii. Sustainable Procurement
Aim: In the context of broader sustainability, maintain the balance between financial, social and environmental factors, focusing on energy efficiency, carbon reduction and recycling and to ensure social justice and equity. Integrating environmental, health, social, political and economic issues into procurement decisions to embrace the founding principle of healthcare, 'first to do no harm'.

- Produce a Sustainable Procurement Strategy and Policy that is focused on the products and services that it acquires, underpinning supply chains (to be read in conjunction with the Trusts environmental management policy)
- Lead by example by removing barriers to sustainable development, by engaging with a mix of small, medium and large businesses (where permissible within EU Procurement Directives) whilst simultaneously driving innovation, cost efficiency and responsible procurement practice

ix. Fair and Equitable Trade
Aim: To produce a policy that ensures procurement compliance with the principles of 'Fair and Equitable Trading'.

ESHT's Procurement Policy will assist in managing risk associated with labour standards, ensuring compliance with relevant legislation, fostering transparency through the supply chain, providing for due diligence in supplier approaches to managing labour standards and promoting continual improvement in this respect.

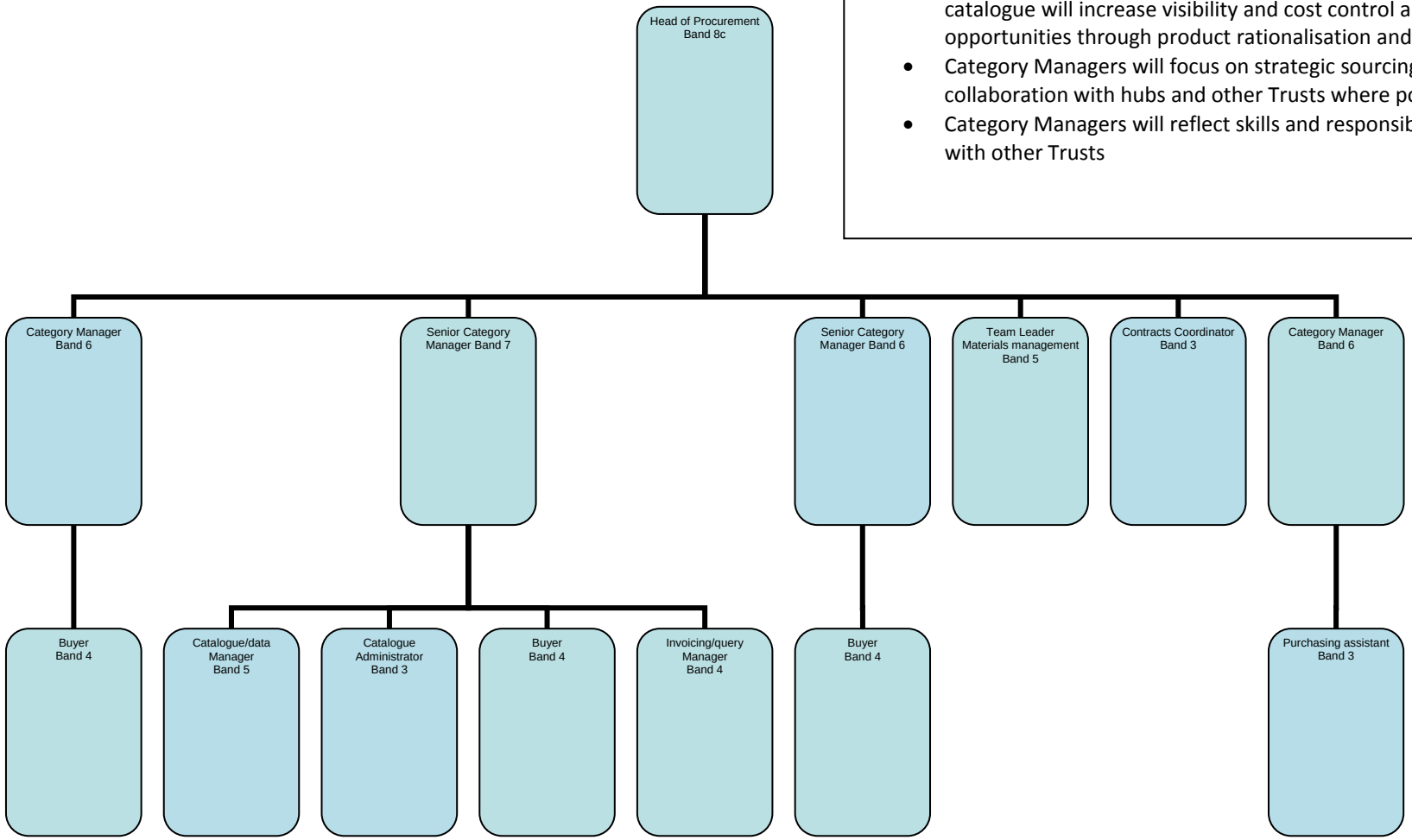
x. Corporate and Social Responsibility
Aims: To ensure all staff maintain the highest standards of personal integrity and that the business affairs of the organisation are conducted in a moral, honest manner and in full compliance with all legal requirements

- All procurement shall be non- discriminatory and will comply fully with the Equality Act 2010.
- The Standards of Business Conduct will be followed by all staff.
- Staff who work with suppliers shall act with integrity, transparency and fairness.
- Staff shall complete a 'Declaration of Interest' statement each financial year

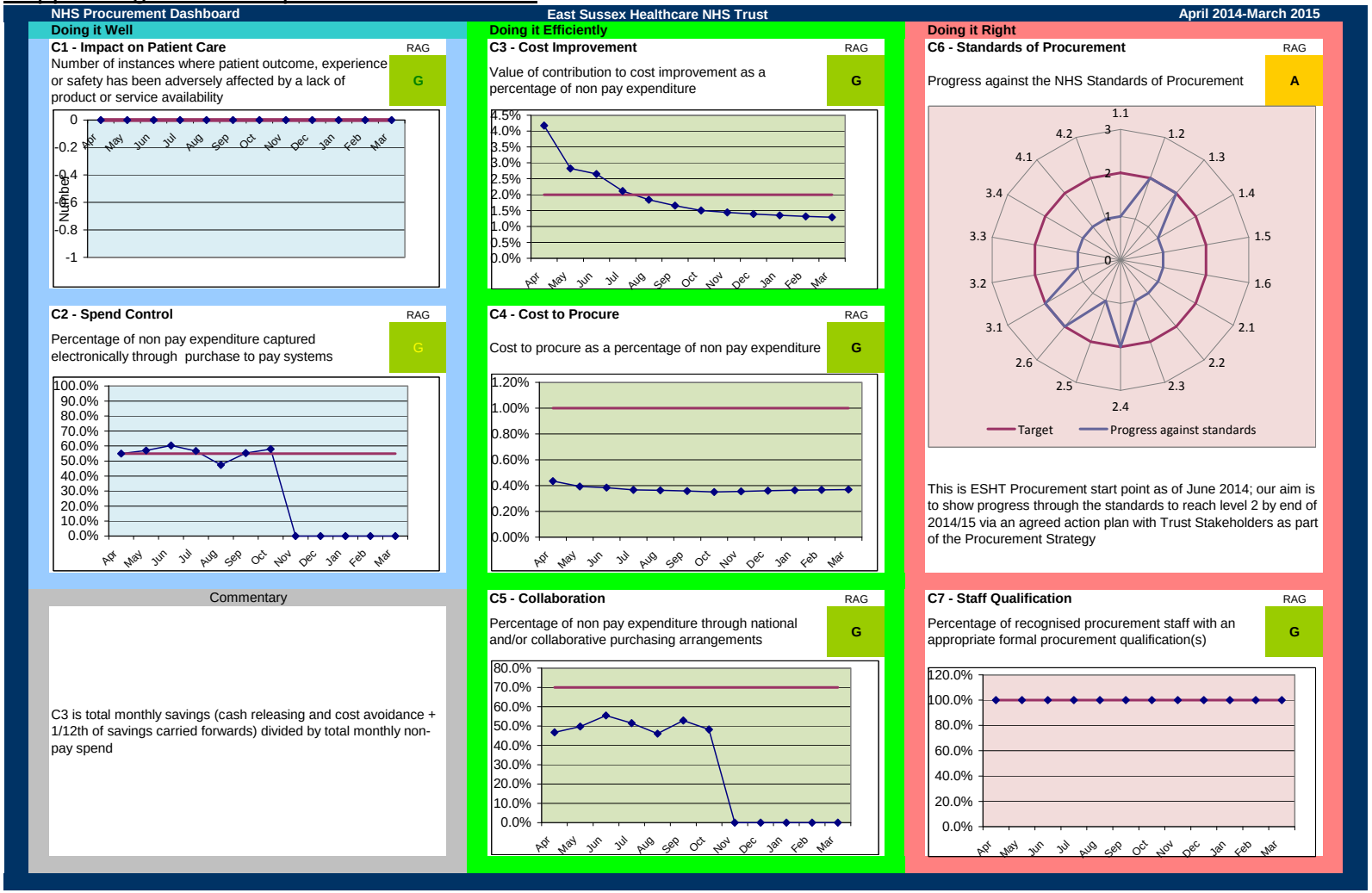
Appendix 1. Proposed new Procurement Team structure

Key principles of restructure;

- Resource dedicated to introduction and management of ESHT product catalogue will increase visibility and cost control and generate savings opportunities through product rationalisation and standardisation
- Category Managers will focus on strategic sourcing and tenders, through collaboration with hubs and other Trusts where possible
- Category Managers will reflect skills and responsibility and bring them in line with other Trusts



Appendix 2 - NHS Procurement Dashboard – current position (October 2014) East Sussex Healthcare Trust Purchasing and Supplies against the 7 published standards.



East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 2014
Meeting:	Trust Board
Agenda item:	14
Subject:	Annual Business Planning Framework for 2015-16
Reporting Officer:	Amanda Harrison, Director of Strategic Development and Assurance

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

Assurance	✓	Approval		Decision	

Purpose:

This paper provides an outline of the process the Trust has in place to develop its business plan for 2015-16

Introduction:

In June 2014 the Trust prepared a two year business plan in line with guidance from the Trust Development Authority (TDA). The Trust now needs to refresh and build on this plan for 2015-16 and 2016-17.

This report sets out the framework for developing the plan with the accompanying timetable.

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

The Trust will be required to submit a two year plan which is clearly aligned to commissioning intentions; and in line with TDA guidelines to the to the TDA by the end of March 2015 (guidance awaited on exact deadlines).

This paper sets out the planning process that will be undertaken within the Trust to develop and ratify the above plan.

Benefits:

- Integrated planning for sustainability which incorporates quality, finance, workforce and activity across the Trust
- Programme of engagement with key stakeholders

Risks and Implications

- Areas of the draft plan that are not yet confirmed or values may change
- Decisions affecting major areas of service which have not yet been formalised and therefore not yet adjusted for, eg MSK and other tenders, Obstetrics and Gynaecology.

Assurance Provided:

- External and internal drivers will be played into the planning process
- Clinical units and corporate departments will be fully engaged in the process
- Executive and Board reviews have been factored into the timetable

Board Assurance Framework:
Strategic Objective 2, risk 2.2 Strategic Objective 3, risk 3.6

Review by other Committees/Groups (please state name and date):
Business Planning Steering Group 14.10.14

Proposals and/or Recommendations
The Board are asked to note the process and the dates that have been earmarked for updates and decisions.

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: Jane Rennie, Associate Director – Planning and Business Development	**Contact details:** janerennie1@nhs.net

East Sussex Healthcare NHS Trust

Annual Business Planning Framework for 2015/16

1. Introduction

In June 2014 the Trust prepared a two year business plan in line with guidance from the NHS Trust Development Authority (TDA). We will now need to refresh and build on this plan for 2015/16 and 2016/17, details of which are at Appendix A. This paper sets out the framework for developing the plan with the accompanying timetable.

2. Key Planning Assumptions

Guidance from the TDA or NHS England (NHSE) normally comes out in late December of each year but it is unlikely to be materially different from last year with a continuing drive for financial and clinical sustainability. The three East Sussex Clinical Commissioning Groups (CCGs) have issued their commissioning intentions for 2015-16 and these can be accessed as follows:

- http://www.eastbournehailshamandseafordccg.nhs.uk/about-us/our-governing-body/meetings-in-public/?categoryesctl9764335=12606
- http://www.hastingsandrotherccg.nhs.uk/about-us/our-governing-body/meetings-in-public/?categoryesctl9887418=12329
- http://www.highwealdleweshavensccg.nhs.uk/about-us/our-governing-body/meetings-in-public/?categoryesctl9891007=12603&p=2

Our assumptions now are that:

- Developments will only take place where commissioners have agreed new investment to fund them
- Clinical Units (CUs) should plan for service reductions where indicated by commissioners
- Funding for growth in activity will be met by equal and apposite QIPP targets
- Cost pressures should be identified, ie anticipated increases in costs for which no funding is expected, but these will only be funded in exceptional circumstances, eg national directives or on grounds of safety
- Tariff deflator likely to be 1.5-2.00%
- CIP target 6% of expenditure outturn for 2014/15, ie £20 million
- Quality and safety maintained or improved – we will need to build in any recommendations from the CIH inspection. The report will not be available until January 2015.
- Better Care Fund (BCF)/East Sussex Better Together will impact on services in 2015/16

We will also need to build in any emerging NHSE plans for specialist and primary care commissioning.

3. Other Known Service Changes following Procurement exercises

The following changes will need to be modelled into our plans for 2015/16:

- The School Health and Immunisations Service to be re-provided by Kent Community from 1 January 2015
- The MSK service in Eastbourne, Hailsham and Seaford will be managed by Sussex MSK Partnership from April 2015
- The Trust is awaiting a decision on adult wheelchair services; children's wheelchairs services to be re-provided elsewhere (provider not yet known)
- Decision on new service, Fracture Liaison, is still awaited

- High Weald Lewes and Havens Clinical Commissioning Group (HWLH CCG) have now clarified the services which will be subject to tender by competitive dialogue and these will need to be quantified. We will also need to clarify the position for services where they have issued notice but have not decided not to re-tender.

The financial risks are being calculated on all of the above.

4. Process

There are some key activities which need to be undertaken as part of the business planning process:

4.1 Establish the baseline/outturn position

4.2 Agree planning assumptions - consistent across all workstreams – see a-g below

4.3 Complete templates and collate information at clinical unit and corporate level to cover:
a) Quality and Safety Improvements
b) External drivers, eg CCG intentions, BCF and 7/7 working
c) Contracting and commissioning plans
d) Activity targets
e) Finance and Cost Improvement Programme
f) Workforce projections
g) Estates and Capital

4.4 Forecast baseline position to create draft plan for 2015/16

4.5 Review and test for consistency and moderate

4.6 Impact assess the quality of the plan

4.7 Identify risks/mitigations.

5. Engagement with Corporate Departments and Clinical Units

There is a programme of organisational engagement in place with a number of awaydays planned. A representative from the Clinical Commissioning Groups is attending the 25th November event to share their expectations of the coming year.

This is an iterative process and initial plans will be refined as more information becomes available.

Clinical Units are expected to engage their staff on development of their plans and a communications plan will ensure that all staff are updated throughout the process.

6. Timetable

Subject to confirmation from the TDA on their timetables this is the provisional schedule of dates:

What	When	Notes on process and deliverables
Leadership and Planning Awayday	20 August 14	
2015-16 Business Planning Group	8 – 17 October 14	Corporate workstreams working on planning assumptions for 2015-16
CUs outline plans for 2015/16	October 14	CUs starting to work on vision for next 3 years and identifying top 3 plans for 2015-16 including risks, interdependencies, etc
Commissioning Intentions published	Beginning of November 14	To be taken into account in planning assumptions
2015/16 Business Planning Awayday	25 November 14	Corporate services to present planning assumptions for 2015-16 as basis for CUs to start developing top 3 plans for 2015/16 and 3 year vision
Planning Framework	26 November 14	Approved by Board
TDA Planning Guidance published	First week of December 14	To be taken into account in planning process
Planning/Activity and Income Assumptions determined	31 December 2014	
Publication of CIH Inspection report	January 15	Actions to be incorporated into plans
QIA Panel	6 January 15	Sign off first cut of 2 yr business plan, key risks and issues
Business Planning Steering Group	6 January 15	Sign off first cut of 2 yr business plan, key risks and issues
Clinical Management Executive	12 January 15	Sign-off of first cut of 2 yr business plan, key risks and issues
Board seminar	14 January 15	Presentation on key risks and issues, financial planning update and first cut of 2 yr business plan
Business Planning Awayday	20 January 15	CUs present on worked up plans for 2015/16, corporate services outline their 3 year vision, with top 3 plans for 2015/16
Finance and Investment Committee	21 January 15	Financial planning update and sign off of first cut of 2yr business plan, key risks and issues
TDA	21-31 January 15	Submission of first cut of 2yr business plan
Business Planning Steering Group	17 February 15	Sign-off of second cut of 2 yr business plan
Finance and Investment Committee	25 February 15	Sign-off of second cut of 2yr business plan and financial plan
Contracts signed	27 February 15	Activity, finance, etc finalised
TDA	First week March 15	Submission of second cut 2 yr business, finance, activity plan and workforce plan, updated Annexe E
Clinical units	Beginning March15	Individual CUs sign off their plans for 2015/16
QIA Panel	3 March 15	Sign off CU plans for 2015/16
Business Planning Steering Group	3 March 15	Executive challenge and sign off CU plans for 2015/16
Clinical Management Executive	9 March 15	Sign off CU plans and final draft of business plan

Board seminar	11 March 15	CUs to present summary of their plans for Board review to include analysis of key risks and quality impact of plans
Finance and Investment Committee	18 March 15	Review plan
Board Meeting	25 March 15	Approval of 2015/16 business plan and budget
TDA	1st week April 15	Submission of final 2 yr business, finance, activity plan and workforce plan, updated Annexe E
Clinical Management Executive	11 May 15	Sign-off of summary 5 year plan, IBP & LTFM
Board seminar	13 May 15	Sign-off of summary 5 year plan, IBP & LTFM
Finance and Investment Committee	27 May 15	Sign-off of summary 5 year plan, IBP & LTFM
TDA	Mid June 15	Submission of summary 5 year plan, IBP & LTFM

7. Risks

- Areas of the draft plan that are not yet confirmed or values may change
- Decisions affecting major areas of service which have not yet been formalised and therefore not yet adjusted for eg MSK and other tenders; Obstetrics and Gynaecology

8. Recommendation

The Board is asked to note the process and the dates that have been earmarked for updates and decisions.

JANE RENNIE
Associate Director – Business Planning

19th November 2014

Appendix A

East Sussex Healthcare NHS Trust

Annual Business Plan 2014/15

1. Introduction

1.1 In line with TDA guidance, *Securing Sustainability,* the Trust has prepared a two year business plan which meets national and local requirements. The first year of this plan has been developed in detail and forms the Trust's Annual Business Plan (ABP) for 2014/15. The ABP is aligned to the Trust's strategic objectives and is fully integrated setting out the projects and programmes that will deliver improvements in quality and operational and financial performance in 2014/15. It also includes the corporate workplan that will support the delivery of these improvements.

1.2 The Trust needs to ensure that the work programme is in place to secure the delivery of that plan from April 2014 and that progress on the plan is reported to the Board in a timely manner. This document sets out the key objectives of the ABP along with information about how the delivery of the plan will be managed, monitored and reported.

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 agreed the strategic framework for its Clinical Strategy: Shaping our Future in 2011 against the strategic objectives the Board have agreed for the organisation

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 were able to deliver the Trust's aims and objectives. These eight services that comprise about 80% of the business of the Trust are:

- Acute Medicine
- Orthopaedics
- Cardiology
- Emergency care
- Maternity
- Stroke
- Paediatrics and child health
- General Surgery

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 the provision of integrated community and acute care with 'one hospital on two sites'. Delivering this business model 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 also required integration with 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.

2.4 In order to implement the strategy and business model acute and hyper acute stroke services were centralised on the Eastbourne site in July 2013; emergency and high risk surgery services were centralised on the Hastings site in December 2013 and the centralisation of emergency and high risk orthopaedics at Hastings took place in May 2014.

Consultant led Maternity services and in-patient paediatric services were temporarily centralised on the Hastings site in May 2013 on the grounds of safety. A decision on the long term configuration of these services will be made by the three local Clinical Commissioning Groups (CCGs) in the summer of 2014 following a formal public consultation which concluded in April 2014. The options consulted on do not include the provision of consultant led maternity and inpatient paediatric services on both acute sites.

2.5 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). In addition to the centralisation of services for stroke; emergency and high risk surgery and trauma and orthopaedics, the business case describes the redesigned and improved care pathways being implemented in acute medicine, emergency care and cardiac care and the infrastructure investment necessary to support this redesign. It details the improvements that will be made in patient flow and length of stay as well as the reductions that will be made in inappropriate admissions. The focus is on delivering quality improvements including increased senior decision making, improved discharge planning and infrastructure and fabric upgrades that will improve infection control. Following the decision on the future configuration of maternity, paediatric and gynaecology services an analysis of the capital consequences of each of the options will inform the CCGs' decision making process.

3. Strategic Objectives

3.1 In 2013/14 the Trust Board confirmed its mission and revised and simplified its strategic objectives as follows:

Mission
Deliver better health outcomes and an excellent experience for everyone we provide with healthcare services.

Strategic Objectives

- 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 benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.

Aims
In delivering its strategic objectives the Board has stated that its aim is that all services delivered by the Trust are:

- Safe
- Effective
- Caring
- Responsive and
- Well led.

4. Plans for 2014/15 and 2015/16

4.1 The Trust has been identified as one of eleven Challenged Health Economies meaning that there are significant risks to the overall financial sustainability of providers and commissioners in the local health economy. The TDA, NHS England and Monitor have commissioned a programme of support for these economies which aims to produce evidence based proposals for delivering sustainability. This work is currently underway and the outcomes of it will be the first stage of defining the approach to securing future sustainability. The Trust will need to reflect these outcomes in its future plans and ensure that there is alignment with these outcomes and the future business model for the Trust.

4.2 Whilst the above work is underway the Trust's ABP for 2014/15 is based on the extant Clinical Strategy which identifies the following broad clinical priorities for the planning period up until 2018/19

- The ongoing development and implementation of a model of care for the management of frail adults across the Trust and more widely including:
- Agreeing pathways for adult acute care which embed the model of care for frail people and support our local demography
- Redesigning community services to realise the benefits of integrated provision and to ensure the prevention of inappropriate admissions and to facilitate timely discharge
- Developing delivery models for clinical support services including ITU, diagnostics and pathology in order to ensure alignment with optimal service configuration and that maximum efficiency and value is derived from their operation.
- Reviewing medical and surgical specialties and subspecialties against efficiency and sustainability criteria (operational, clinical and financial) to identify priorities for transformation and opportunities for differentiation followed by a review of the models of care and delivery options for the clinical services identified.

4.3 The ABP contains plans for cost improvement, quality improvement, delivery of the clinical and operational capacity required to meet key access targets and the enabling corporate workstreams that will support these plans. Further details are given in the following sections.

5. Cost Improvement

5.1 In the light of the above priorities and in order to address the continuing financial challenges in East Sussex health economy the clinical units and corporate departments have developed ambitious cost improvement plans (CIPs) for 2014/15 including:

- Implementation of a new medical model which will result in reduced lengths of stay
- Improvement in theatre productivity leading to increased efficiency
- Implementation of the agreed reconfiguration of emergency and high risk orthopaedic services
- Improved arrangements for Hospital at Night at Eastbourne District General Hospital.

6. Quality Improvement

6.1 The Trust agreed the following quality priorities through a series of stakeholder engagement events across East Sussex. These priorities have informed the development

of the Trust's Quality Account. Progress against the quality account measures is reported to the Board on a quarterly basis.

- Maximise our efforts to reduce healthcare associated infections
- Early recognition and action to support the care of the deteriorating patient
- Continue to implement our patient experience strategy
- Ensure that we provide optimal care for patients who have mental health disorders.

6.2 Further quality improvements have been identified by considering any risks to compliance with statutory and regulatory standards and to the delivery of the key recommendations as set out following the Keogh Review, Francis Report, Berwick review, Cavendish review and Clywd-Hart review and in guidance from the National Quality Board.

6.3 The quality improvement elements of the ABP are aligned to the Trust's aims for service provision and the five CQC domains of quality. A detailed Quality Improvement Plan will be developed to ensure that implementation of these aspects of the ABP are fully co-ordinated.

7. Quality Impact Assessments (QIAs)

7.1 A robust process in now in place to assess the impact of all CIPs on the quality and safety of services**.** The quality impact assessment assesses quality risks in relation to the following three quality and safety domains:

- Patient safety
- Clinical effectiveness
- Patient experience.

7.2 The assessments are undertaken by a panel comprising the Medical Directors and the Director of Nursing and recommendations are made to the Business Planning Steering Group who make the final decision to approve or reject plans. A record is kept of these decisions for audit and assurance purposes. As plans are implemented the panel is responsible for monitoring the outcome and alerting the business planning steering group about any reduction in quality or safety.

7.3 In developing the ABP and CIP all clinical units have undertaken these in line with the process outlined in detail at Appendix One of this paper.

8. Delivery of operational performance standards

8.1 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.

8.2 In October 2013 the Trust commenced a turnaround programme, as part of this programme of work 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 12015/16 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.

8.3 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.

8.4 A review of the utilisation 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.

9. Key risks

9.1 As part of the multidisciplinary review of the ABP a risk assessment of the deliverability of all elements of the plan has been undertaken. The key risks to deliverability and quality have been identified and fed into the financial analysis of the plan. The key risks identified include:

- An adverse impact on quality arising from the implementation of elements of the plan
- Non delivery of key operational requirements and NHS Constitution commitments
- Delays in the implementation of the new medical model
- Inability to define or deliver clinically and financially sustainable models of care that improve day case rates and ensure clinical standards, training and development requirements are met.for those acute surgical specialties and sub-specialties not already considered through the development of the Clinical Strategy.
- Ability to deliver changes to provision of minor injury services
- Delays in the delivery of theatre efficiency
- Adverse impact of a revised contract for community services
- Delays in the delivery of hospital at night at Eastbourne DGH
- Fines and penalties exceeding planned levels
- Impact of activity reductions beyond those assumed in plans
- Failure to absorb increases in activity through assumed improvements in productivity
- Additional unplanned cost pressures including premium cost delivery
- CQUIN targets not being achieved.

10. Supporting Plans

10.1 The above quality, cost and operational improvement plans are supported by a number of aligned plans that ensure the organisation is able to deliver key improvements. These include:

10.2 Workforce Plans

Workforce planning and service redesign for ESHT in 2014 - 2016 and beyond is aligned with the implementation of the clinical strategy and the savings plan. The reductions in total workforce numbers that are the consequence of improved efficiencies will be achieved through skill mix reviews and increased productivity through continuous improvement in job planning and rota reviews.

10.3 Specific areas of workforce focus during 2014 – 2016 include:

Clinical Services:

- Ensuring recruitment to all vacant posts
- Investment in nursing posts in areas of need – approximately an additional 40 wtes
- Improved roster management
- Enhanced role for support workers
- Full review of medical staffing requirements – review of job plans and proposed moves to team based job plans.

Productivity:

- Full review of clinical administrative support
- Reduction in Theatre lists resulting in two theatre closures
- Proposed closure of two medical wards
- 7 day working for support services including therapies in key areas described previously.

Back Office and Commercial:

- Potential market testing of some services (eg. Occupational Health, Facilities Management)
- Efficiencies in management and staffing costs
- Skill Mixing.

10.4 **Financial and Investment Plan**

The Trust has submitted a two-year plan that shows deficits of £18.5 million for 2014/15 and £14.0 million for 2015/16. The contract with CCGs for 204/15 is a standard contract which recognises the heavy burden of risk on provider and commissioner alike within the challenged local health economy and the importance of a collaborative approach. The contract value includes all contract elements except for tariff-excluded drugs and devices, which will continue on a 'pass-through' basis. The specialist contract with NHSE is also a standard contract and includes investment for areas such as Health Visiting.

10.5 The Trust faces a number of financial pressures in 2014/15. These include:-

- Loss of income through QIPP plans (£4.0 million assumed)
- Loss of Health and Wellbeing income stream (net £0.5 million assumed)
- CNST increase (£0.7 million in 2014/15).

10.6 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 £20.4m (5.2 per cent of baseline expenditure) in 2014/15 and £20.0m (5.2 per cent) in 2015/16. These values are net of cost pressures. A contingency of 1 per cent of turnover has been set aside in both years. The Trust will require additional PDC funding to cover the cash shortfalls arising from its deficit plans. Further applications will be made to the Independent Trust Financing Facility via the TDA in due course.

10.7 The Trust's capital plans include investment to support delivery of the clinical strategy at £17.4 million in 2014/15 and £11.6 million in 2015/16. In addition, the Trust is planning significant investment in the following areas:-

- Medical equipment - £2.6m in 2014/15 including new MRI
- New IT Systems and Infrastructure - £1.7m in 2014/15
- Backlog maintenance and other infrastructure improvements - £2.6m in 2014/15
- Ward redevelopment – £1.7m (net of charitable contribution) over the two years.

11. Annual Business Plan Objectives for 2014/15

11.1 The objectives have been written taking account of the following:

- The Trust's strategic objectives
- Feedback from the Trust Development Authority about the elements they expect to see in the 2014/15 Business Plan
- Key actions arising from the Cost Improvement Programme
- Completion of 2013/14 objectives.

11.2 A process is in place which will identify key milestones and deliverables as well as assigning leadership roles. This will enable the Board to be provided with a quarterly progress report.

11.3 The objectives are shown at Appendix Two.

12. Performance Management

12.1 A performance management framework has been developed to ensure that all individuals and teams within the Trust have clear accountabilities for the management of all aspects of organisational performance so that the Trust can achieve its strategic objectives to:

12.2 The purpose of the Performance Management Framework is to support the delivery of the Board's plans by ensuring alignment between the four domains of operational performance (clinical and non-clinical), activity, finance and quality to enable the Board and the Trust's clinical and non-clinical management and staff to:

- Assess current performance and performance trajectories against organisational targets and goals
- Determine what action is necessary to address performance issues and manage performance risks
- Develop and implement plans to secure the required performance
- Focus resource and attention in the required areas to maintain and where necessary improve performance.

12.3 The full framework is at Appendix Three.

13. Programme Management

13.1 Through the Programme Management Office reporting mechanisms will be in place for all key programmes which support the delivery of the Annual Business Plan. Each programme of work will have a risk and issues log which identifies mitigation.

13.2 Quarterly progress reports will be made to the Board on the Annual Business Plan which will highlight key risks.

14. Risk Management

14.1 Risk management is embedded within the Trust's processes. The Board Assurance Framework describes the key risks to delivery of the corporate objectives and outlines relevant controls and assurances, together with any further actions required to mitigate the risks. The Board Assurance Framework will be updated in the context of 2014-15 corporate objectives for Trust Board approval.

15. Planning for 2015/16

15.1 An evaluation of the 2014/15 process for developing the Trust Cost Improvement Programme has been undertaken in May 2014. The lessons learned have been used to inform the Integrated Annual Business Planning process for next year. Appendix Four sets out the programme of work required in the coming months to develop an integrated plan which will build on the work undertaken this year.

East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 2014
Meeting:	Trust Board
Agenda item:	15
Subject:	Annual Review of Standing Orders, Standing Financial Instructions and Schedule of Matters reserved to the Board and Scheme of Delegation
Reporting Officer:	Lynette Wells, Company Secretary Vanessa Harris, Director of Finance

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

Purpose:

The Trust Board is asked to review and approve the proposed revisions to the Standing Orders, Standing Financial Instructions, Schedule of Matters Reserved to the Board and Scheme of Delegation.

Introduction:

The Trust Board is required to review its Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation on an annual basis.

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

- Standing Orders cover all aspects of the conduct of the Trust, including governance, committees and their duties and responsibilities.
- The Scheme of Delegation lays down in detail the specifics of committee responsibilities and duties together with that of the executive and the officers to which delegated authority has been designated.
- The Standing Financial Instructions detail the financial conduct and governance of the Trust and requirements therein.

Proposed revisions to these three documents are outlined in the attached appendix.

The Audit Committee undertook the initial assessment of the documents on 12th November 2014 and recommended the proposed revisions for approval by the Board.

Benefits:

Annual review supports the strengthening of internal controls, recognise changes in the health care environment and ensure compliance with legislation.

Risks and Implications

None identified.

Assurance Provided:

The annual review supports the strengthening of internal controls, recognise changes in the health care environment and ensure compliance with legislation.

Board Assurance Framework:
Strategic Objective 1, risk 1.3

Review by Other Committees:
Audit Committee – 12/11/14

Proposals and/or Recommendations
The Trust Board is asked to approve the proposed changes to the Standing Orders, Standing Financial Instructions and Schedule of Matters Reserved to the Board and Scheme of Delegation.

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

Appendix A

Annual Review of Corporate Documents

Standing Financial Instructions		
Page No	**Section**	**Revision**
10	2.1.1	NHS Audit Committee Handbook *Remove:* (March 2007)
16	22.7.2	European Union Tendering Threshold values *Remove: values of supplies and service and works contracts and add link to current thresholds* *www.ojec.com/thresholds.aspx*

Schedule of Matters Reserved to the Board and Scheme of Delegation		
Page No	**Section**	**Revision**
17	7.5.3	Chief Executive – Report waivers of tendering procedures to the Board *Revise:* Director of Finance – Report waivers of tendering procedures to the Audit Committee
40	31 a)	Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy *Replace:* Commercial Director with Chief Operating Officer
41	38	Review of all statutory compliance legislation and Health and Safety requirements *Replace:* Director of Strategic Development and Assurance with Director of Nursing
41	39	Review of compliance with environmental regulations *Replace:* Commercial Director with Chief Operating Officer

Standing Orders		
Page No	Section	Revision
30	8.2	Sealing of documents *Add:* Also refer to 7.8 of standing financial instructions

East Sussex Healthcare NHS Trust

Date of Meeting:	24th September 2014
Meeting:	Trust Board
Agenda item:	16
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.

Board Assurance Framework:

Strategic Objective 1, risk 1.3

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

Since the Board last met an Audit Committee has been held on 12th November 2014. A summary of the items discussed at the meeting is set out below.

2. Board Assurance Framework and High Level Risk Register

The Company Secretary presented the High Level Risk Register and the Board Assurance Framework and noted that the format of the Board Assurance Framework had been revised.

The Committee supported the recommendation from the Quality and Standards Committee that the rating for 1.1.3 should move to red as there was not sufficient assurance around the progress in this area. It was noted that the Quality and Standards Committee would be undertaking a "deep dive" into health records at its next meeting.

The Committee also recommended that the rating for 3.5.1 be moved to red as there was not an Estates Strategy in place and there was a delay in the recruitment to a Head of Estates and Facilities for the Trust.

3. Specialist Medicine Risk Register

The Head of Nursing for the Specialist Medicine Clinical Unit gave an update on the unit's Risk Register and discussion took place on the software system used in the cancer units and it was agreed that the Company Secretary would discuss the level of scoring of this risk with the Head of Medicines Management as the Committee was concerned that it was too low.

Discussion took place on compliance with cancer targets and the Head of Nursing was requested to supply a follow up report on the action plans in relation for gastroenterology and dermatology.

4. Clinical Audit Update

An overview was given of the clinical audit activity that had taken place across the Trust in this year. It highlighted some of the identified risks and improvement measures that had been implemented as a direct result of Trust wide activity.

It was noted that the National Vascular Registry (NVR) in Vascular Surgery was still rated red and the Committee requested that the Medical Director raise the issue of non-compliance at the next executive meeting.

5. Internal Audit

The Committee received the Internal Audit Progress Report and was updated on the progress against the action plan. It was noted that since the previous update, a further three audits had been finalised.

The updated Audit Recommendations Tracker was presented. It was noted that further significant progress had been made with closing down many of the audit points.

6. Local Counter Fraud Service

The Committee received the progress report and noted actions being taken on new reactive investigations and one initial referral. Alongside the reactive work it was noted that that the good progress was being made with the agreed actions in the 2014/15 workplan.

7. External Audit Progress Report

The external auditor presented a progress report on the planning work for the financial statement and the value for money audits for 2014/15 and highlighted the key issues.

8. Tenders and Waivers Report

The Committee noted the Tenders and Waivers report.

9. Information Governance Toolkit Update

The Committee received an update on progress against the Information Governance Toolkit (IGT) requirements at 31st October 2014, and a summary of the IG incidents reported from April 2014 onwards.

10. Review of Corporate Governance Documents

The Company Secretary reported on the annual review undertaken of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation by herself and the Director of Finance and noted that there were only some minor amendments for this year.

The Audit Committee recommended that the Trust Board approve the proposed changes to the Standing Orders, Standing Financial Instructions and Schedule of Matters Reserved to the Board and Scheme of Delegation.

11. Local Audit Accountability Act Consultations – National Audit Office and Financial Reporting Council

The Director of Finance informed the Committee of the detail of the two consultations and noted that she had responded to the National Audit Office consultation in relation to the value for money conclusion audit work over the emphasis of the work being clearer for the general public.

1. Meeting Dates and Work Programme for 2015

These were agreed by the Committee.

Mike Stevens
Chair of Audit Committee

17th November 2014

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 3rd September 2014 at 10.30am In St Mary's Board Room, Eastbourne DGH

Present: Mike Stevens, Non-Executive Director (Chair)
Mr Charles Ellis, Non-Executive Director
Mrs Sue Bernhauser, Non-Executive Director designate
Mr Barry Nealon, Non-Executive Director

In attendance Mrs Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development & Assurance
Dr Janet McGowan, Associate Medical Director
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary
Mr Leigh Lloyd-Thomas, BDO
Mr Mike Townsend, TiAA
Ms Jenny Robson, Account Manager, TiAA
Mr Steffan Wilkinson, Counter Fraud Manager, TiAA
Mr Bertram Green, Interim Head of Financial Services
Mrs Emma Moore, Assurance Manager- Clinical Effectiveness (for item 4)
Miss C Kyprianou, PA to Director of Finance (minutes)

		Action
1.	**Welcome and Apologies for Absence** Mr Stevens opened the meeting and introductions were made. Apologies for absence had been received from: Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer Dr David Hughes, Medical Director It was agreed that in future full names would replace initials on the agenda and the assurance column should be removed as each paper should explain its purpose.	
2. i)	**Minutes of the meeting held on 9 July 2014** The minutes of the meeting were reviewed and agreed as an accurate record subject to the following amendments: Mrs Sue Bernhauser's name to be removed from the list of those present.	**TR**

	Under Internal Audit Progress report (item 7a) this should say: "He advised that one high priority point had been raised ...."	**TR**
ii)	Matters Arising	
a)	***Commercial Risk Register***	
	The update to have been provided by the Facilities and Security Manager in relation to matters on the risk register was deferred to the next meeting.	**JK**
b)	***Annual Security Report***	
	No updates received – to be carried forward to next meeting.	**JK**
c)	***National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis***	
	Progress given under agenda item 4 (below)	
d)	***National Vascular Registry Audit***	
	Progress report given under agenda item 4 (below)	
e)	***Audit Recommendations Tracker***	
	It was agreed that only red and ambers would be provided in the audit recommendations tracker	
f)	***Annual Audit Letter***	
	This had been amended as requested	
3.	**Board Assurance Framework and High Level Risk Register**	
	Mrs Wells presented the High Level Risk Register and the Board Assurance Framework.	
	It was noted that a significant amount of work had been done on the high level risk register and this was now much more focused. This work was ongoing.	
	With regard to the Board Assurance Framework, Mrs Wells reported that following review at the July Board Meeting, the following risk had been added:	
	'We are unable to invest in delivering/improving quality of care and outcomes for patients because we are operating in a challenged health economy and this impacts on our ability to make investment in infrastructure and service improvement'	

	It was agreed that this risk should be amended to read: *'...challenged health economy and this **could** impact ....'* Mrs Wells reported that gaps in control or assurance had been removed or revised as follows: • Risk 1.2 – following gap in control added: *'Backlog of plain film reporting and delay in reporting non urgent radiological investigations'* All other changes in the Board Assurance Process were highlighted in red and italics. Mrs Bernhauser asked if, given the issue with compliance levels, the RAG rating for mandatory training should be reviewed. This was currently amber. Mrs Wells said this had been recently changed from red to amber; however she would check the rationale behind this, and amend the RAG rating, if appropriate, prior to the report being presented to the Board. **The Committee reviewed and noted the revised High Level Risk Register and Board Assurance Framework and were of the view that the main inherent/residual risks had been identified and that actions were appropriate to manage the risks.**	**LW** **LW**
4. a)	**Clinical Audit** <u>Clinical Audit update</u> Mrs Moore gave an overview of the clinical audit activity that had taken place across the Trust this year and highlighted some of the identified risks and improvement measures that had been implemented as a direct result of Trust wide activity. It was reported that there were 179 audits on the 2014/15 forward plan, 49 remained open from the 2013/14 and 16 remained open from 2012/13; however the 2011/12 audits had now all been cleared. Mrs Moore gave an overview of the open audits. Improving clinical engagement will be a key focus in the months ahead. Within the new governance structure there would be identified clinical audit facilitators who would be working very closely with the clinical units and associated audit leads to assist in the completion of the outstanding audits, this will lead to an improvement of the RAG ratings on the Forward Plan. It was noted that two NCAPOP audits were currently rated as red and these were National Vascular Registry (NVR) in Vascular Surgery, and the Rheumatoid & Early Inflammatory Arthritis National Audit in Rheumatology.	

	It was noted that the Clinical Audit Steering Group were informed in March 2014 that the Trust had not submitted data to the (NVR) since December 2013. Non participation holds both a reputational risk to the Trust due to the reporting requirements of the Quality Account, and would breach the Trust commissioning contract. The Vascular Surgeons were invited to attend the July Audit Committee to discuss the issues behind non participation but were unable to attend. Since the July meeting, discussions had taken place and the surgical Clinical Governance Facilitator was in the process of liaising with Mr Sandison to determine what support could be provided to ensure Trust participation as soon as possible. The Trust's non participation in this audit will be added to the high level risk register if issues remain throughout September. JMcG agreed to liaise further with David Hughes to ensure Trust participation.	**JMcG**
	The Rheumatoid & Early Inflammatory Arthritis National Audit was both an NCAPOP and Quality Account study. Resource issues had caused a delay in starting the three year audit; however data can be entered retrospectively and therefore there was the potential for the Trust to 'catch up'. Dr Panthakalam had attended the July Audit Committee to discuss his concerns and it was agreed that focus would be given to initiating this study throughout September. It was reported that the audit was made up of two sections: an organisational questionnaire which has to be completed annually, and the main data review and submission. The Trust had missed the deadline for submission of the organisational questionnaire for Year 1 but had been given an extension. Dr Panthakalam had now successfully completed and submitted the questionnaire.	
	A further update on progress of the above two NCPOP audits would be provided at the next meeting.	**EM/ JMcG**
	Mrs Moore gave a summary of a recently completed audit to demonstrate how effective clinical audit can be as a tool to facilitate continuous clinical practice improvement and enable shared learning across the Trust. The audit was to assess compliance with regular pain assessment requirements, quantify the prevalence of significant pain and identify patients in whom subsequent assessment indicated that the pain was not effectively brought under control. It was agreed that Mrs Moore would send Mrs Webster a copy of the full audit.	**EM**
	Mr Stevens said he did not feel the recommendations in this audit fully addressed the issues and asked for further specific detail. It was agreed that further information would be sought from the acute pain service that undertook the audit.	**EM**
	The Committee noted the Clinical Audit update and 2014-15 forward plan	

5. a)	**Internal Audit** <u>Progress Report</u> Ms Robson presented the Internal Audit Progress Report and updated the committee on the progress against the action plan. It was noted that since the previous update, the following three finalised audits had been carried out: • Medicines management – Controlled Drugs • Employment of Locums • IT Review on the network Infrastructure Security Systems The following six additional audits were underway: • Sickness Absence Management • Ward Visits • Recruitment • Follow ups • Critical Financial Assurance • Charitable Funds Mrs Harris reported that the finalised review of the employment of locums demonstrated that there had been an improvement around payroll controls for locum staff. **The Committee noted the Internal Audit Progress Report.**	
b)	<u>Internal Audit Charter</u> Mr Townsend presented the Committee with the Internal Audit Charter. It was a requirement by the Public Sector Internal Audit Standards (PSIAS) for internal audit providers to have an agreed Internal Audit Charter in place. It was noted that the Charter provides a formal document that defines the purpose of internal audit activity, its authority and its responsibility. It also assists the Board and senior management in fulfilling their oversight responsibilities in ensuring that the purpose, authority and responsibility of internal audit activity is consistent with that set out in the standards. Mr Stevens suggested some minor changes to the charter which Mr Townsend undertook to make before sending the revised charter to Mrs Harris and Mrs Wells. **The Committee approved the Internal Audit Charter subject to the suggested changes.**	**MT**

c)	Audit Recommendations Tracker Mrs Wells presented the updated Audit Recommendations Tracker. It was noted that significant progress had been made with closing down many of these audits. There were just over 60 actions on the tracker, including 6 red areas. Mrs Wells reported that she had met with Ms Robson to discuss how to follow through some of the recommendations that were closed and how to get the assurance. It was noted that in some cases auditors were meeting with the leads to agree the actions before the audits were closed. Mrs Wells would review the report further to see what other recommendations could be closed. **The Committee noted the report.**	**LW**
6. a)	**Local Counter Fraud Service** Progress Report Mr Wilkinson presented the Local Counter Fraud Service (LCFS) progress report covering activity from 20 June to 8 August 2014. There were three new reactive investigations and one other initial referral. Mr Wilkinson provided an update on the reactive investigations. Dr Harrison said it would be helpful to have a section in the report which showed the lessons learnt. Alongside the reactive work, the LCFS had also worked on the actions listed in the Proactive part of the workplan. It was noted that that the LCFS continued to make good progress with the agreed actions in the 2014/15 workplan. The Proactive budget for the year was 87 days; so far LCFS had used 34 days. The indicative Reactive budget for the year was 41 days; so far they had used 34 days. The report recommended that the reactive budget was increased. The request for an increase in resource would be considered by the Finance Director having regard for Value for Money. Such increase should be for one year before reverting to previous activity levels. **The Committee noted the report.**	**SW** **SW/VH**
b)	Focused Fraud Assessment Mr Wilkinson presented the final report submitted to the Trust by NHS Protect, detailing their findings from the Focused Fraud Assessment carried out by NHS Protect on 19 and 20 June 2014.	

	NHS Protect were assessing the following two elements: Prevent and deter work – revised score green Hold to account work – revised score red Mr Wilkinson reported that he had discussed the areas requiring improvement with Mrs Harris, and actions agreed, and this information had been included in the report. Mr Wilkinson reported that he will recommend that NHS Protect meets with the Trust again in January 2015. **The Committee noted the update on the Focused Fraud Assessment.**	
7. a)	**External Audit** <u>Progress Report</u> Mr Lloyd Thomas presented a progress report on the external audit work for 2014/15 and highlighted the key issues. Mr Lloyd-Thomas reported that they had issued the planning letter, which was the indicative fee for the year, in February. However subsequently, in late March the Audit Commission removed the fees for the quality account pending a review of the publication and audit requirements by NHS England and Monitor. It was noted that the Use of Resources RAG rating is red given that the Trust had set a deficit budget. **The Committee noted the BDO progress report**	
8.	**Research Governance Annual Report** The Committee received the Research Governance Annual Report which outlined research governance and associated activities over the past year. The report highlighted that: • Current research governance processes were robust • The reorganisation of Research and Development had put in place a system for managing the research activity and performance • Portfolio management database would enable timely performance management and publication on Trust website	

	Mr Stevens queried whether the Capability Statement had been published on the web. Mrs Wells agreed to follow this up. **The Committee noted the Annual Report**	**LW**
9.	**Tenders and Waivers Report** Mrs Harris presented the report which covered the period 24 June – 15 August and detailed all tenders and waivers awarded in that time. It was noted that 2 contracts with a total identified contract value of £102k were awarded against ESHT tenders, framework further competitions and direct framework awards in during that period. Further (or "mini") competitions were held when the Trust Procurement Department elects to use a collaborative framework agreement of NHS Supply Chain or more commonly through the local collaborative procurement hub, NHS Commercial Solutions (NHSCS). Further tenders/mini competitions for clinical and non-clinical products were pending or nearing decision on award: • Managed Pathology service • Cardiology; pacemakers and ICDs Significant levels of cash releasing savings were anticipated for the new contracts Further or "mini" competitions against existing NHS Commercial Solutions or NHS Supply Chain framework agreements were planned for some other areas all of which were expected to release significant savings contributions to the Care Divisions' non-pay CRES and at the same time ensure both compliance with Trust SO/SFIs and public procurement regulations. It was noted that there were 17 waivers recorded during the same period with a cumulative value of £902k. Mrs Harris explained that every waiver required sign off by herself and/or the Chief Executive. Mr Stevens asked if in future reports the value of waivers could be set against the total of non-pay expenditure for the same period to contextualise the level of reporting. **The Committee noted and approved the Tenders and Waivers Report for the period 24 June 2014 – 15 August 2014.**	**LJ**

10.	**Review of aged debts** Mr Green presented a report showing the current level of aged debt, split between NHS and non NHS. The Committee received two aged debtor tables, one current, and one containing comparative information from the last Audit Committee (8 January 2014) where aged debts were reported. It was noted that overall levels of outstanding debt had increased since the last report to the Audit Committee. The increase was mainly due to NHS Sundry debt. The increase was largely due to NHS Sundry Debt but the levels of 180 day debt in most categories had increased significantly since December. There were still issues with settlement of NHS debts which was linked to the high levels of outstanding NHS creditors. The issue of clearing NHS creditor invoices continued to be tackled and in conjunction with this strategies and resources were being directed specifically to address NHS outstanding debt. However, NHS debt levels, unless disputed by the other NHS organisation, was still considered as low risk. Mr Stevens expressed his concerns over the overall level of increased debt. Mr Green assured the committee that the processes were being reviewed. Mrs Harris explained that there was some ongoing work on how the trust collects debts and any proposals to write off debts would need to go through her. Mrs Harris explained the agreement of balances process that takes place where the Trust agrees balances with its NHS partners and this was currently due to be done at month 6. It was noted that NHS debt levels were considered to represent an acceptable level of risk. It was agreed that future aged debt reports would be presented to the Finance & Investment Committee rather than Audit Committee. **The Committee noted the current aged debt position**	**VH**
11.	**Review of losses and special payments** Mrs Harris presented a report showing the losses and special payments made during April – July 2014 financial year. There were no novel or contentious items highlighted in the report. The largest elements relate to outdated pharmacy stock and employer liability claims. **The Committee noted the current position.**	

12.	**Review of declarations of interests, gifts, hospitality, sponsorship and ex gratia payments** Mrs Wells reported that a Declarations Group meets on a quarterly basis, consisting of Mrs Harris, Mr Sunley and herself, to review the declarations of interests, gifts and hospitality register, ex gratia payments and financial redress/payments made through complaints. The Committee received a copy of the minutes from the February meeting and a report from a meeting which took place on 28 August. Mrs Wells reported that 535 Declaration of Interest forms had been sent out and of these, 305 had been returned to date, containing 39 declarations. The outstanding forms were being followed up and all declarations received would be reviewed to ensure there is no potential conflict of interest. Mrs Wells reported that she was meeting with Mrs Friend, from TIAA on 4 September on the follow up proactive audit that they will undertake in respect of declarations of interests. **The Committee received the report and noted the assurance provided**	**LW**
13.	**Information Governance Report** The Committee received an update on progress against the Information Governance Toolkit (IGT) requirements at 31st July 2014, and summary of the IG incidents reported from April 2014 onwards. Between April and July, 14 IG incidents had been reported against categories used by the DoH. During the reporting period, 9 were graded as negligible, 4 as minor and 1 as medium for severity. It was noted that the Trust needs to make the year-end submission with all requirements at a minimum of Level 2 to ensure compliance with the IGT. **The Committee noted the progress against the Information Governance toolkit**	
14.	**Auditor Panel Regulations and Consultation** Mrs Harris presented a report on the Department of Health consultation on Health Service Bodies' Auditor Panels and their Independence. The consultation asks the following questions and ESHT proposed responses are shown in italics.	

	Question 1: Do you agree that auditor panel's role (regulation 5) in agreeing non-audit work is set in regulations. *Yes* Question 2: Do you have any comments on the proposed regulations? *No* The Committee was asked to note the Department of Health consultation on Health Service Bodies' Auditor Panels and their Independence and agree ESHT proposed responses to the two consultation questions. **The Committee noted the Department of Health consultation on Health Service Bodies' Auditor Panels and their Independence and agree ESHT proposed responses to the two consultation questions.**	
15.	**Date of Next Meeting** Wednesday, 12th November 2014, at 10 am in the St Mary's Board Room, Eastbourne DGH.	

Signed: ……..

Date: ……

East Sussex Healthcare NHS Trust

Finance and Investment Committee

1. Introduction

Since the Board last met a Finance and Investment Committee has been held on 29 October 2014. A summary of the items discussed at the meeting is set out below.

2. Performance Report – Month 5

The Committee received the month 5 Performance Report which detailed ESHT's in month performance against key trust metrics as well as activity and workforce indicators.

It was noted that the overall Performance Score was 4 (from a possible 5)

Responsiveness Domain: 2
A decline from July. A&E performance was below the 95% standard. In addition to this Cancer performance (preview data) was below standard within 2WW, 31 days and both 62 day indicators. The cancer team was working to improve delivery by the end of Q3.

RTT performance continues to align with the trajectory agreed with the TDA and local commissioners although there are risks in gastroenterology and rheumatology specialties. There is a recovery plan to deliver activity within existing resources. The number of over 52 week waiters was noted. The diagnostic performance had now recovered and performance had been delivered 3 months in a row. It was noted that the additional RTT and tranche 1 winter funding had not yet been received by ESHT from its commissioners.

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

Safe Domain: 5
Remains at 5. There were 6 reported cases of C-Dificile, but no reported harmful incidents.

Caring Domain: 5
An improvement from July due to A&E Friends and Family scoring reaching the required standard for the first time. All standards within this domain were achieved in August.

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

3. Finance Update – Month 6

Mrs Harris presented the Finance Report for Month 6 and highlighted the key issues.

At the end of M6 financial performance was a year to date run rate deficit of £11,575k, which was a favourable variance against plan of £201k. Income and expenditure were both over plan. The cost improvement achievement was £8,180k which was behind plan by £248k. The overall TDA RAG rating for finance is red because the Trust has set a deficit plan for 2014/15.

4. Mid Year Financial Review

Mr Bryant gave an overview of the financial performance at the end of month 6.

ESHT set an overall deficit plan for the year of £18.5m, on an income level of £357.4m. Based on the performance to date, the Trust is forecasting to meet this plan.

5. Quarterly Review of Aged Debts

The Committee received an update on the aged debt position for the Trust as at 30 September 2014 and a plan of action for addressing the level of 'over 90 day' outstanding debts.

6. Transformation Update

Mr Wombwell updated the Committee on the progress and process for supporting the Trust to meet its financial targets in 2014/15 (notably, deficit plan of £18.5m) and deliver a sustainable plan for 2015/16.

A review of the Month 5 financial forecast, supported by Month 6 results suggested the Trust was carrying some risk to the delivery of the financial target of £18.5m deficit. The proposals set out aim to address this risk through the identification and delivery of further in-year savings of £2m.

The report demonstrated that the process for identification of further savings had involved the CU management team, including clinical leaders and had sought a direct contribution from all areas. Where applicable a full quality impact assessment (QIA) of schemes would be carried out.

7. FBC: Update

The Full Business Case (FBC) for £30m of capital expenditure to implement the Trust's clinical strategy had been approved by the Trust Board on 11 December 2013 and lodged with the TDA. This was still pending TDA approval.

Mrs Harris reported that following ongoing discussions with the TDA, the Trust had made an application for an early release of part of the capital included within the FBC.

The application also included some capital elements which were outside the FBC but had been identified as necessary to ensure delivery of winter resilience or quality and productivity improvement/ requirements. Discussions were still ongoing with the TDA about progressing this.

In the meantime a small part of the early release scheme has been accelerated and the Trust had made an emergency capital public dividend application for £400k to create 8 Major cubicles in the Emergency department at the Conquest by building a new 7 bedded Clinical Decision Unit (CDU) in space currently occupied by offices. This application has been approved by the Independent Trust Financing Facility (ITFF) and work has begun.

8. PAS Project Business Case – Oasis v16 Upgrade

Mrs Goldsack gave an update on the position of the Patient Administration System/Service (PAS) which was re-tendered earlier this year.

To enable the required implementation of Clinic Manager the Trust servers would need to be upgraded as the improvements required to support these systems were not possible on the current servers due to the risk to the live environment and the potential to cause the system to be unstable.

The Committee supported the PAS upgrade. However it was agreed that evidence of clinical engagement into the Clinic Manager part of the project would need to be included in the business case that is presented to the Board.

9. OBC Managed Enterprise Printing Solution

Mr Deal presented a business case for approval to proceed to full tender for a fully managed enterprise printing solution.

The Committee agreed that this should move forward.

10. Pevensey Ward Business Case

Due to the delays in receiving a final price for this project the Business Case was not available for review at this meeting.

As this was a high priority item it was agreed that this would be circulated for virtual approval as soon as it is available.

11. Schneider Project Update

Mr Humphries presented an update on the Schneider project, the current costs and savings and proposed next steps.

The revised project proposal was reviewed and it was now proposed that the Trust seek formal independent advice on certain aspects of the proposal.

12. Making Better Use of Government Resource Services Procurement & Service Delivery Platforms

Mrs Harris gave an update on the progress with the DH (Department of Health) invitation to take part in a review of Government support services and delivery platforms. Alongside this piece of work there was also a further review by Lord Carter to look at efficiency and productivity across a range of areas

13. Market Testing Programme Update

Mr Horne gave an update on the market testing programme in particular the following areas:

Occupational Health

The specification for this service had been discussed and agreed at the evaluation panel. This process was good and allowed discussion and agreement on the service required. The specification was currently in the process of being agreed by Maidstone and Tunbridge Wells NHS Trust (MTW) who were partnering the Trust through market testing.

The proposed framework agreement would be between ESHT and the successful Supplier, with both ESHT and MTW "calling-off" separate contracts for their respective requirements. Other public sector organisations that the Trust currently provided a service to would also have separate contracts.

The Committee was invited to confirm that this approach was the most appropriate for the tender of Occupational Health services and (following agreement by MTW) to agree to move to Tender stage.

Nursery services

The Committee was asked to approve the tender for nursery services, and approve that the capital cost of planning permission, site clearance and provision of base and services at the Conquest site of circa £55k in 2015.

Corporate services and hard FM

These services were suspended from the market testing programme following the decision in June. However, the Trust had recently agreed to join a small group of NHS organisations 'supporting better resource utilisation', chaired by Lord Carter. Initially the Trust would be working with them to review parts of the finance service, procurement and soft FM services.

Soft FM services

As noted in the September update, it was agreed with the Interim Estates & Facilities advisor that an 'exemplar' Standard Service Level Specification was produced (for catering) and this was rolled out across all other commercial services departments.

It was accepted that this was an internal document to be used for their transformation plan and will need some further development to turn it into an external specification document fit for tendering purposes.

The latest plan would see the service specifications completed in November and an aim to complete the soft FM transformation plans for a decision on whether to proceed to market testing by the Board in February.

The Committee was invited to note the possible procurement route and to agree the timetable to allow the Board/Committee decision by the end of February 2015.

14. EBITDA Quarterly Report Q1

The Committee received the 2014-2015 Qtr 1 EBITDA statement and the 2014-2015 quarterly EBITDA comparison statement.

15. Capital Programme Mid Year Review

The Committee noted that as there was no Finance & Investment Committee meeting in September, this item went directly to the Board meeting on 24 September 2014.

16. Tender & Service Development Schedule

The Committee received a schedule which provided an update on current tenders and service developments.

17. Community & Child Health Project Update

The Committee received an update on progress of the Community and Child Health System (SystmOne) project.

18. Work Programme

The 2014 work programme was noted.

19. Dates of meetings for 2015

The provisional dates for 2015 meetings were agreed.

Barry Nealon
Chair of Finance and Investment Committee

31 October 2014

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 27 August 2014 at 9.30am in the Committee Room, Conquest

Present
Mr Barry Nealon, Chair
Mr Michael Stevens, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mr Darren Grayson, Chief Executive
Mrs Vanessa Harris, Director of Finance
Mr Richard Sunley, Deputy Chief Executive/COO (Part)
Dr David Hughes, Medical Director (Part)
Mr Stephen Hoaen, Head of Financial Services (for Gary Bryant, Deputy Director of Finance)

In attendance
Mr Daniel Knight, Head of Contracting & Income (for item 7)
Ms Shinal Amin, Principal Biomedical Scientist, (for item 8)
Mr Tim Leakey, Theatre Matron for Orthopaedics (for item 9)
Dr Nick McNeillis, Associate Medical Director for Clinical Operations & Consultant Anaesthetist (for item 9)
Miss Chris Kyprianou, PA to Finance Director (minutes)

1. Welcome and Apologies **Action**

Apologies were received from Professor Jon Cohen and Mr Gary Bryant.

2. Minutes of Meeting of 23 July 2014

The minutes of 23 July were agreed as an accurate record.

3. Matters Arising

(i) Performance Report – Month 2

At the last meeting the Committee had asked whether community indicators could be included in the report. It was agreed that the Chief Operating Officer would follow this up. **RS**

(ii) Clinical Laboratory diagnostics Managed Service Contract (MSC) Procurement and Draft FBC

It was noted that the issues raised at the last meeting on this item were responded to within the report. This was discussed under agenda item 8 below.

(iii) Job Planning for Consultant Medical Staff

This item was discussed under agenda item 12 below.

(iv) Annual Review of Committee Effectiveness

Mrs Harris had emailed the Committee with a list of questions and the Terms of Reference of the Committee and a report was presented under agenda item 14 below.

4(i) Performance Report – Month 3

Mr Sunley presented the month 3 Performance Report which detailed ESHT's in month performance against key trust metrics as well as activity and workforce indicators.

This report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15.

It was noted that the overall performance score was 4 from a possible 5 and these were as follows:

Responsiveness Domain: 3
Increase from a score of 2 in May, primarily due to achievements within A&E and diagnostics. This score is based upon preview cancer performance. The final domain score will be finalised in the July report. The Trust overall quality score will not be negatively impacted by the final cancer report and will remain at 4. Progress on the small number of over 52 week waiters was noted.

Effectiveness Domain: 4
Remains at 4 for 3rd consecutive month, largely due to the high proportion of mortality indicators within this domain, which are only measured quarterly.

Safe Domain: 5
Achievements within the majority of indicators within this domain ensure that a score of 5 is maintained.

Caring Domain: 4
A&E Friends and Family scores fell below standard, holding the score of 4 from May.

It was noted that the Trust Score against the responsiveness domain reduced to 2 in the month.

Mr Grayson asked if the font could be increased for future reports.

Action
The Committee noted the Performance Report for month 3 and noted the Trust Performance against each domain.

4(ii) Finance Update – Month 4

Mrs Harris presented the Finance Report for Month 4 and highlighted the key issues.

In month the actual deficit was £410k which was also the planned deficit for the month. At the end of M4 financial performance was a year to date run rate deficit of £7,354k, which was a favourable variance against plan of £226k. Income and expenditure were both slightly over plan. The cost improvement achievement was £4,851k which was ahead of plan by £372k. It was noted that the overall Trust Development Authority (TDA) RAG rating for finance was red because the Trust had set a deficit plan for 2014/15.

At the end of M4 the financial risks remain unchanged from those associated with the plan for the year.

Mr Nealon asked why there was a ytd favourable variance of £2m on the block contract income report (page 7). This relates to the fact that the detailed activity plan is still be finalised with CCGs. Pending finalisation there is an element of income included within block contracts that has not yet been attributed to other areas and therefore shows a favourable variance.

Further explanation for the favourable position on other CIP value (page 23) was sought. This is where budgets are temporarily showing higher than expected vacancies and is shown separately. On-going recruitment is expected to bring the variance back to plan at the end of the year

Action
The Committee noted the Month 4 financial position.

5. Turnaround Update

Mrs Harris updated Committee on changes to Turnaround support arrangements. It was noted that Andrew Murphy had finished at the Trust in mid-August 2014 although he would continue to provide oversight to the programme until 31 March 2015 and that Simon Wombwell will take over as Transformation Adviser from 1 September 2014. Mr Wombwell will help the Trust maintain delivery of the 2014/15 Plan and support transition out of the Turnaround programme .

Action
The Committee noted the Turnaround update

6. Community Rebasing Project – Quarterly Update

The Committee received a progress update on the status of the Community Rebasing Project.

It was noted that the cost matrix for community services needed to be refreshed over the next 4 weeks to reflect outturn for 2013/14 and a more robust basis for attribution of overheads, based on the recently completed reference cost submission.

It was noted that although good progress had been made to date this project has entered a critical phase. With strong project management, improved resourcing and more robust data quality the outputs from this next stage could help to:

- Improve the Trust's understanding of the business and facilitate efficiency improvements through the use of service line reporting;
- Improve the alignment of funding and cost, thereby ensuring that services are affordable;
- Provide information to assist with improving integration with acute services;
- Enable the Trust to respond more effectively to tender invitations
- Provide information to assist with improving integration with acute services

Mr Grayson updated the Committee on progress against tender submissions. This included the award of the MSK contract to the Sussex MSK Partnership and the award of School Health Services to Kent Community Health NHS Trust. ESHT is currently responding to the Invitation to Tender for another service. It was agreed that in future a short report should be made to every Committee meeting to update on progress against tenders.

Action
The Committee noted the further progress on this project and the associated opportunities, risks and challenges involved.

7. Overseas Visitors

Mr Knight updated the Committee on the charging of Overseas Visitors for NHS treatment where appropriate.

This item had been raised at the Audit Committee on 4 June 2014 when reviewing the Annual Accounts.

Mr Knight explained the procedure for identifying and charging overseas patients under the Charging Regulations. Risks had been identified and actions were in hand to improve overseas visitor's identification and payment.

To improve identification the following recommendations were being put in place to increase awareness:

- Programme of presentations to Clinical Areas

- Periodic All Staff email communication
- Periodic use of screensavers advertising 'the question' and Overseas Visitor Team contact details
- Overseas Visitor Team event alongside annual Counter Fraud event (main entrance and staff restaurant)

Conflict resolution training for front line nursing and admin staff would be increased.

To improve payment

- Credit card machines would be made available to the Overseas Visitors Team

It was noted that the Department of Health (DH) had issued its two year implementation plan for the Visitor and Migrant Cost Recovery Programme in July 2014. The Overseas Visitor Team was in contact with the DH implementation team and will work with new systems when they are available.

Action
This Committee noted the report on charging for overseas visitors and the recommendations that were being put in place to raise awareness and improve payment.

8. Clinical Laboratory Diagnostics Managed Service Contract (MSC) Procurement and Full Business Case (FBC)

Ms Amin presented the Contract Award Report for the procurement of a Managed Service Contract and associated Full Business Case (FBC).

Ms Amin explained that the plan, built around the procurement of the Managed Service Contract (MSC), was to reconfigure the services by replacing old and failing equipment with new analysers. This would facilitate a streamlined service provision enabling staff skill mix efficiencies whilst providing enhanced staff work place opportunities and increased service quality and user value with reduced costs.

It was noted that a preferred bidder has been selected as successful and the contract would run for 7 years initially, at a total cost of £18m over the period. As well as replacing the failing equipment with state of the art technology, the project was expected to realise a surplus of £7.6m over the 7 year lifetime of the contract.

The Committee received a summary of the finance and technical evaluations which were combined to identify the successful bidder.

The Committee were asked to endorse the award of the managed service contract to the successful bidder and the content of the FBC for submission to Trust Board in September 2014.

Following approval by this Committee and the Trust Board in September, the FBC will be formally submitted to the TDA for approval.

Mrs Harris reported that the FBC had simultaneously been submitted to the TDA in order to receive some early feedback on whether there were likely be any issues. The comments from the TDA had been/will be incorporated into the final FBC.

Action
The Finance and Investment Committee endorsed the award of the managed service contract to the successful bidder and the content of the Full Business Case for submission to Trust Board in September 2014.

9(i). Capital Equipment – Business Case for approval

- **Procurement of Anaesthetic Machines – cross site**

Mr Leakey and Dr McNeillis presented the Business Case for the approval of capital funding of £950k to replace the existing anaesthetic machines within theatres. (£500k expenditure in 2014/15 and £450k expenditure in 2015/16).

Mr Leakey explained that the existing Anaesthetic machines were in urgent need of replacement.

Mr Leakey explained that, due to the age of the machines, the ones at Conquest would be replaced first, and those at Eastbourne would be replaced the following year.

The funding for this business case was included within this year's capital budget and is in accordance with the discussion at the recent Capital Approvals Group.

Action
The Committee approved the capital funding of £950k to replace the anaesthetic machines – cross site, £500k for 2014 and £450k in 2015/16. This Business Case will also need approval by the Trust Board.

9(ii) Capital Equipment – Business Case for approval

- **Procurement of Conquest Surgical Operating Tables/ Operative Surgical Trolleys**

Mr Leakey and Dr McNeillis presented the Business Case for the approval of capital funding of £450k to replace existing surgical operating tables/operative surgical trolleys at the Conquest.

Mr Leakey explained that the existing operating tables were in urgent need of replacement as service parts were not available for the majority of tables due to their age.

The new operating tables would be integrated throughout the whole of theatres and could be used throughout a number of specialities. Replacement of these tables would also reduce maintenance costs.

Mr Leakey reported that there was an evaluation process in place, which would end in February 2015 at which point a supplier would be selected.

The funding for this business case was included within this year's capital budget and is in accordance with the discussion at the recent Capital Approvals Group.

Action
The Committee approved the capital funding of £450k to replace the Conquest Surgical Operating Tables/operative surgical trolleys.

10. FBC: Bid for Early Release of First Tranche Funds

The Full Business Case (FBC) for £30m of capital expenditure to implement the Trust's clinical strategy had been approved by the Trust Board on 11 December 2013 and lodged with the TDA. This was still pending TDA approval.

Mrs Harris reported that following ongoing discussions with the TDA, the Trust had made an application for an early release of part of the capital included within the FBC. The Trust had yet to receive any feedback from the TDA, however this would be followed up at a meeting with the TDA on 28 August.

The application, which totalled £11.665m, also included some capital elements which were outside the FBC but had been identified as necessary to ensure delivery of winter resilience or quality and productivity improvement/ requirements.

The Committee received a summary of the main areas included within the application.

Ms Stephanie Kennett questioned whether the Trust was asking for things that were not in the original application. Mrs Harris confirmed that there were items in the report that were not in the original application and these were detailed within the report. The total cost of these additional items was £3.2m.

Action
The Committee noted the bid for early release of first tranche FBC funds.

11. Making Better Use of Government Resource Services Procurement & Service Delivery Platforms

The Committee received an update on the progress with the DH (Department of Health) invitation to take part in a review of Government support services and delivery platforms as outlined at Committee meetings on 25 June and 23 July 2014.

It was noted that two DH representatives had met the Director of Finance and other key portfolio leads on 1st July 2014 to discuss the review and a Project Steering Group was being formed. Mr Nealon would be the Non Executive Direct of this Project Group.

Further updates would be brought to the Committee.

Action
The Committee noted that:

- **A project scoping meeting with DH representatives took place on 1st July 2014**
- **A Project Steering Group was being formed. The Non-Executive Director representative will be Barry Nealon.**
- **Further reports will be brought to the Committee**

12. Job Planning for Consultant Medical staff

Dr Hughes gave an update on Job Planning process for Consultant Medical staff.

It was noted that within the current job planning round, the focus had been on the challenge to SPA time (supporting professional activity) to ensure that there are measurable outputs associated within this.

Following the restructure there is now a team dedicated to this, which sits under Dr Hughes, with Jamal Zaidi as Associate Medical Director, with the new team in place the process can be accelerated. It was also noted that the General Managers would also be much more involved. In this way assurance can be provided that Consultant's objectives will be aligned to those of the clinical unit and the overarching corporate objectives resulting in alignment of clinical accountability and Trust performance.

Once the paperwork was in a standard format and agreed with the General Manager and Clinical Unit Lead, a Performance Monitoring process will take place with the Medical Director and Deputy Chief Executive/Chief Operating Officer to review the job plans.

Action
The Committee noted the Job Planning process

13. IT Projects Update

The Committee received a progress report on the proposed implementation of the following IM&T projects due to be implemented in 2014/15 :

- Community and Child Health system
- NHS Mail Migration
- Southern Acute Programme - Electronic Document Management and Clinical Portal
- Electronic clinical correspondence
- Acute PAS upgrade
- VitalPac patient bedside monitoring
- Psuedonymisation
- Windows 7 / Office 2010 migration
- Euroking maternity system upgrade

Core projects were being facilitated by the IT Project Office which was tasked with implementing these projects on behalf of the Trust and each Project Board is chaired and led by a senior officer within the Trust.

All projects are on track to deliver within the project timescales despite a number of risks to delivery mainly driven by third party and recruitment risks.

Mrs Harris reported on the progress on the Collaborative Procurement for an Electronic Document Management (EDM) system and Clinical Portal. It was noted that a Business Case for this will need to be presented to this Committee and should be added to the work programme. **CK**

Action
The Committee noted the progress on the above projects.

14. Annual Review of Committee Effectiveness

Mr Nealon presented the report which set out the outcome of this review which was conducted via a questionnaire to all Committee members in July 2014.

Members agreed that the number of Committee meetings held had been sufficient and agendas appropriately structured to support the effective discharge of responsibilities. It was agreed that no changes to the current Terms of Reference were needed.

Matters considered and decisions made by the Committee were taken on an informed basis and members agreed these decisions were understood, owned and properly recorded and would bear scrutiny; subsequent implementation of decisions and progress had been reported back to the Committee as required.

The following improvement suggestions were made:

- At the end of every meeting the Committee should reflect on the effectiveness of the meeting and agree key messages for transmission to the next Board.

- Include a Timetabled review of past decisions, to check that they have been delivered on time, and in budget within the work programme.

- More benchmarking of performance against other similar Trusts.

- Review of agenda structure and items so that meetings can always be contained within the allocated 2 hours.

The Committee felt that it had effectively discharged its responsibilities throughout the year and that there was nothing it was aware of at this time that had not been disclosed appropriately.

The Committee's Terms of Reference were reviewed as part of the self-effectiveness review and they remain fit for purpose. It was noted that four non executives attend the Committee when the requirement in the Terms of Reference is two and this was queried. After the meeting the matter was referred to the Company Secretary and it was proposed to revise the number of non-executives to three which is in line with other Board sub-committees and gives flexibility should there be changes in non-executive directors. The Annual Work Programme is set at the start of the year and is a standing agenda item so that it is reviewed at every meeting of the Committee.

Mr Stevens queried the amount of paperwork that is sent out with the agenda. Following discussion it was agreed that the more detailed reports would be distributed electronically only (and made available in paper form upon request) and that the summary of the report should continue to be included within the cover sheet.

Action
The Committee noted the report and suggested improvements.

15. Work Programme

The 2014 work programme was noted.

Action
The Committee noted the revised work programme.

16. Date of Next Meeting

The next meeting will take place on Wednesday 17 September 2014 at 9.30am – 11.30am in the Committee Room, Conquest.

East Sussex Healthcare NHS Trust

QUALITY AND STANDARDS COMMITTEE

1. Introduction

1.1 Since the last Board meeting a Quality and Standards Committee meeting has been held on 10 November 2014. A summary of the issues discussed at the meeting is provided below.

1.2 The minutes of the meeting held on 2 September 2014 are attached at Appendix 1.

2. Issues discussed at 10 November Meeting

2.1 **Shared Learning in Practice (SLiP)**
A presentation was made by a service user and Senior Clinical and Health Psychologist following treatment whilst under the care of the Trust. The case presented was summarised as a positive outcome with collaborative working between the organisation and Sussex Partnership Foundation Trust.

2.2 **Board Assurance Framework and High Level Risk Register**

The assurance framework and high level risk register were received and the detail noted. Discussion took place around the review of health records and it was agreed that a 'deep-dive' into the issues would be undertaken at the January 2015 meeting.

2.3 **Care Quality Commission (CCG) Update on Chief Inspector of Hospitals Visit**

It was noted that there had been a delay to the expected timetable for the publication of the CQC report and the ESHT Quality Summit would be postponed until January 2015.

2.4 **Integrated Quality Report**

This was presented and discussed with particular consideration around the organisational position for Quarter 2 with triangulated data from agreed quality sources. It was noted that overall the Trust was able to demonstrate a number of positive initiatives that were in place and working well and engagement with patients had led to improvements in systems and care delivery.

2.5 **Trust Infection Control Group – Self Assessment of Compliance Against Outcome 8 Regulation 12 'Cleanliness and Infection Control – Quarter 2, 2014-15**

The report which had been compiled in collaboration with key stakeholders provided evidence of current self assessment of Trust compliance. It was noted that the Trust Infection Control Group had developed an annual programme of work to address the areas where improved compliance was required as a priority, and this had been approved by the Trust Board.

2.6 **Mandatory Training and Appraisal Compliance**

The Committee noted that there had been a concerted focus on compliance with mandatory training and appraisals recently and all areas have now been set a target to achieve 90% compliance with mandatory training by end March 2015.

2.7 **Duty of Candour**

The report, outlining the requirement of the statutory Duty of Candour and providing assurance that the Trust would meet it regulatory obligations was received by the Committee.

3 Conclusion

3.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meeting held on 10 November 2014 and the minutes of the meeting held on 2 September 2014.

Sue Bernhauser
Quality and Standards Committee

11 November 2014

Appendix One

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, 2 September 2014
St Mary's Room, Eastbourne**

Present:
Mrs Sue Bernhauser, Non-Executive Director Designate
Professor Jon Cohen, Non-Executive Director
Mrs Janet Colvert, Ex-Officio Committee Member
Mrs Nicky Creasey, Assurance Manager, Health and Safety
Mr Charles Ellis, Non-Executive Director (Chair)
Mrs Margaret England, Patient Safety Lead
Miss Emily Keeble, Head of Assurance
Miss Stephanie Kennett, Non-Executive Director
Ms Tina Lloyd, Assistant Director of Nursing, Infection Prevention and Control
Mrs Lindsey Stevens, Deputy Director of Nursing
Mr Richard Sunley, Chief Operating Officer
Ms Emma Tate, Head of Clinical Improvement
Mrs Moira Tenney, Deputy Director of HR
Miss Abi Turner, Allied Health Professionals Lead
Mrs Alice Webster, Director of Nursing
Dr James Wilkinson, Assistant Medical Director, Quality

In attendance:
Mrs Susan Cambell, PA to Director of Nursing (minutes)
Ms Sally Grainger, Nursing Analyst

1.1 **Welcome and Apologies for Absence**

Mr Ellis welcomed participants to the combined Quality and Standards Committee /Patient Safety Improvement Group meeting and confirmed that the Committee was quorate.

Mr Ellis noted that apologies for absence had been received from :

Ms Denise Blackman, Head of Clinical Coding
Mr Ian Bourns, Director of Pharmacy
Mrs Angela Colosi, Assistant Director of Nursing, East
Ms Sarah Goldsack, Associate Director of Knowledge Management
Dr Amanda Harrison, Director of Strategic Development and Assurance
Mrs Paula Hunt, Nurse Consultant, Occupational Health
Ms Emma Jones-Davies, Medicines Management Nurse / VTE
Dr Janet McGowan, Trust Clinical Governance Lead
Miss Éanna McKnight, Head of Legal Services
Mr Stuart Welling, Chairman
Mrs Lynette Wells, Company Secretary
Mrs Hilary White, Assurance Manager, Compliance
Dr Jamal Zaidi, Assistant Medical Director, Workforce

1.2 **Revised Terms of Reference and Structure of Future Meetings**

Following changes to the Membership and discussion around a proactive approach of mapping reports and responsibilities, it was agreed that the Committee Terms of Reference and forward planner would be updated and presented at the next meeting for agreement. . **CE/LW/ AW**

2.1 **Shared Learning in Practice (SLiP)**

A presentation was made by a family member regarding end of life care for a patient in the care of the Trust. The case presented was summarised as the main emphasis of the concern being communication between the family members and the medical /nursing staff. It was noted that whilst the issue had been addressed with the family, more learning needed to happen across the organisation and Mrs Webster and Mrs Stevens agreed to take this forward and update the Committee. Professor Cohen sought assurance that this was not endemic across the Trust and Mrs Webster agreed that both herself and Dr Hughes would specifically look at the end of life care procedures. **AW/LS** **AW/DH**

3.1 **Minutes of the Previous Meetings**

Minutes of the combined Quality and Standards Committee /PSCIG meeting held on 7 July 2014 were considered and agreed as an accurate record.

3.2 **Matters Arising**

The updated action log from the combined Quality and Standards Committee meetings would be circulated with the minutes.

4.1 **(a) Board Assurance Framework (BAF)**

Mrs Wells presented the BAF report and the Committee noted the detail. The group sought assurance around the high number of SECAMB entries and Mr Sunley confirmed that capital funding to create extra capacity for the Emergency Department had been agreed from January 2015 and detailed plans would be drawn up.

Mrs Webster highlighted the risk of delay in reporting non-urgent radiological investigations and the backlog of plain film reporting. She requested that this issue was monitored and verbally fedback to the Committee. **RS**

Mrs Bernhauser highlighted concerns around compliance levels for appraisals and mandatory training within the Trust. Mrs Tenney confirmed that there had been a drive to address this over recent weeks and more up to date compliance figures would be available in the near future. Mrs Webster agreed to speak with Mrs Wells about making the BAF document more ‘reader friendly’. **AW/LW**

(b) High Level Risk Register

Miss Keeble presented the High Level Risk Register and stated that an earlier version had been submitted to CQC ahead of their visit and that this version had since been scrutinised at the Clinical Unit accountability meetings. Mr Ellis queried if the replacement of medical devices backlog was dependant on TDA funding.

Mr Sunley explained that the EME team assessed devices on the basis of need and these were replaced using capital funding.

Dr Wilkinson highlighted the inability to recruit Community Paediatric Consultants, despite a proactive recruitment campaign. He stated that he did not feel assured that that action plan was any different to the controls currently in place. Miss Keeble agreed to take this back to the Directorate. **EK**

4.2 **NHS Litigation Authority (NHS LA) Annual Report**

Mrs Webster presented a letter from the NHS LA which summarised the issues they faced, which included an increased number of claims. It was noted that the Trust's number of claims appeared to be higher than the national average. Professor Cohen enquired if the most frequently reported clinical negligence claims, by specialty data, reflected the national trend. Mrs Webster agreed to ask Mrs Wells for an update regarding this. **AW/LW**

Mrs Webster confirmed that the Trust were participating in the Sign up to Safety Campaign and this linked into the Clinical Improvement Plan.

4.3 **Healthcare Associated Infections (HCAI) Report June 2014 /Quarter 1**

Ms Lloyd presented the HCAI performance report and stated that she would provide the Outcome 8 compliance report at the November 2014 meeting. Ms Lloyd explained the new processes around lapses in care for reporting *Clostridium Difficile* infections (CDI). She explained that 12 cases of CDI had been diagnosed in Quarter 1, with six being reported against the Trust objective and reiterated that there was no clinical evidence of cross infection on the ward. She highlighted the actions that related to the six cases that required completion in relation to environmental and equipment cleanliness.

Professor Cohen commended the Infection Prevention and Control team and the entire nursing staff with regard to the zero number of cases of MRSA bacteraemia reported in Quarter 1 which, he said, spoke of good quality care.

4.4 **(a) Patient Safety Incident Report for July 2014**

Mrs England presented the incident report for July 2014 and confirmed that there had been a slight increase in the number patient safety incidents reported.

Mrs England confirmed that patient falls remained the highest category of reported incidents but there had been a significant reduction compared with the same period last year. Mrs England stated that a multifaceted approach to patients when they came into hospital around spectacles, footwear and medication may have accounted for the reduction. Mrs Colvert commented that the Listening into Action (LiA) event had also been a positive link. Mrs England stated that the Terms of Reference for the Patient Steering Group had been updated to reflect changes to the Clinical Units and Membership, with an emphasis on group participants sharing the lessons learnt.

Mrs Webster highlighted that a large number of falls had been reported as negligible or minor i.e. patients falling with less injury and re-iterated that it was a positive that staff members continued to report incidents, irrespective of the severity. Mrs Webster requested comparison information from the preceding year to monitor the trend and Mrs England agreed to provide this. **ME**

Ms Tate requested that the information around patient incidents, including near misses, as a percentage of occupied bed days be made available on a 12 month rolling programme and Mrs England agreed to provide an annual report at the next meeting. **ME**

Miss Keeble highlighted the new question focussed pressure ulcer investigation checklist that had been rolled out across the Trust following a successful pilot. Miss Keeble stated that the checklist, developed by the Clinical Commissioning Group (CCG), had already helped identify discrepancies over Waterlow scores and this had resulted in additional training for staff.

Ms Lloyd queried the number of pressure ulcers acquired in patients' homes, as this appeared to be high. Mrs Webster stated that as a percentage of all community setting contacts this was not the case and not all pressure ulcers reported were attributable to the Trust.

Mrs Bernhauser queried the number of incidents relating to babies being born before arrival and the reconfiguration of the maternity services. Mrs Stevens stated that numbers had increased and close scrutiny of data across the Trust had shown this was not the case for Eastbourne residents giving birth at Hastings. Mrs Stevens confirmed the situation continued to be monitored.

4.4 **(b) Serious Incidents Monthly Report August 2014**

The Committee noted receipt of the comprehensive Serious Incidents Monthly Report for August 2014.

5.1 **Patient Experience Report, Quarter 1, April – June 2014**

Mrs Webster presented the Patient Experience Quarter 1 report and was pleased to confirm the increased Friends and Family Test (FFT) response rates following the introduction of an improved collection of data system in both Emergency Departments. Mrs Webster stated adult in-patient areas had achieved 44.01% against a target of 25% and these areas used the FFT information productively.

Mrs Stevens confirmed that the FFT had now been fully implemented within the Maternity Service, with questions asked at four 'touchpoints', the final one being in a community setting.

Mrs Webster reported a significant increase in Patient Advice and Liaison Service (PALS) activity which demonstrated that patients felt able to come forward informally and discuss problems they had experienced.

Mrs Stevens confirmed that a Listening into Action (LiA) event had been planned specifically around complaint issues, enabling staff to view them as positive step forward, also the next Shared Learning in Practice (SLiP) newsletter would focus on complaints.

5.2 **Staff Friends and Family Test (SFFT)**

Mrs Tenney provided an update on the Staff Friends and Family Test which had been introduced in April 2014 which included the survey results for the first quarter.

Mrs Tenney reported a response rate of 9.3%, which had been disappointing and was due to problems with the presentation of the original email.

Staff concerns had been recognised and a LiA event had been undertaken to find out how to improve the response rate and why only 39% of those who did respond would recommend the organisation as a place to work. Mrs Tenney stated that a number of issues had been raised and discussed including, restructure, communication, implementation of changes and concerns around establishment and that these key concerns had been recognised by the Trust.

Mrs Bernhauser expressed reassurance that 66% of staff responded that they were either extremely likely, or likely to recommend the organisation to friends and family if they needed care or treatment. She suggested that in many cases the static workforce had no comparator experience of working for other organisations and this may have accounted for only 39% of staff recommending the organisation to friends and family as a place to work. Mrs Tenney agreed to explore if responses could be identified by professional background to give greater understanding of the results. **MT**

5.3 **A voice for change:**
The Ombudsman's Annual Report and Accounts 2013-14

Mrs Webster presented the annual report to the Committee which demonstrated that complaints to the Ombudsman had increased six fold over the previous year.

6.1 **For Information**

The following items were noted by the Committee;

6.1 Minutes from the Trust Health and Safety Steering Group meeting.
6.2 Minutes from the Consent and Clinical Ethics Committee meeting.
6.3 Minutes of the Policy Group.

7.1 **Any Other Business**

None noted.

8.1 **Date of the Next Meeting**

Monday, 11 November 2014, 2.30pm – 4.30pm, Committee Room, Conquest Hospital

EAST SUSSEX HEALTHCARE NHS TRUST

Notes of the Trust Board Seminar held on Wednesday, 13th August 2014, at 10.00 am in the St Mary's Board Room, Eastbourne DGH

Present: Stuart Welling, Chairman
Sue Bernhauser, Non-Executive Director Designate
Charles Ellis, Non-Executive Director
Stephanie Kennett, Non-Executive Director
Mike Stevens, Non-Executive Director
Monica Green, Director of Human Resources
Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr David Hughes, Medical Director (Governance)
Alice Webster, Director of Nursing

In Attendance: Pauline Butterworth, Deputy Chief Operating Officer (item 1c)i)
Dr James Wilkinson, Associate Medical Director (item 3)
Trish Richardson, Corporate Governance Manager (notes)

ACTION

1. Welcome and Apologies for Absence

Mr Welling welcomed

a) Apologies for absence were received from:

Professor Jon Cohen, Non-Executive Director
Barry Nealon, Non-Executive Director
Darren Grayson, Chief Executive
Dr Andy Slater, Medical Director (Strategy)
Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Lynette Wells, Company Secretary

b) **Notes of the Seminar meeting held on 16th July 2014**

The notes of the seminar held on 16th July 2014 were agreed as a correct record, subject to the amendment of the date and time of the next meeting.

c) **Update on Current Issues**

i) Month 4 Performance Update and Progress with RTT targets

Mrs Butterworth reported that the Trust was meeting the trajectory for recovery of the RTT position as agreed with the TDA.

Mrs Butterworth confirmed that patients were being treated in order and the backlog was being managed with the intention of achieving sustainability by the end of October.

She reported that the A&E and diagnostic wait targets had been delivered but due to timing issues could not verify the cancer targets. She advised that there had been no operations cancelled for the second month in a row but the Trust was not achieving the overall target for delayed transfers of care which related to delays in the community hospitals as the target was being met in the acute hospitals.

Mrs Butterworth explained the issues relating to breaches of the 2 week wait and 62 day standards for cancer in June (month 3) and the work being undertaken to address these areas.

Mr Welling asked if Mrs Butterworth was assured that all the issues relating to RTT had been uncovered and were being resolved. Mrs Butterworth believed that all current data issues were known and action was being taken to identify any clinical issues associated with this. She noted that an external validation company had been engaged to review the reporting systems and data quality and their report would be provided after a month's worth of data had been evaluated.

Mrs Butterworth reported that in relation to 6 week diagnostic waits a comprehensive demand and capacity exercise had been undertaken and additional internal capacity had been sourced and 180 procedures had been outsourced.

Dr Harrison queried the performance in relation to stroke services and Mrs Butterworth advised that the Trust was performing near the top nationally in terms of patients being scanned within one hour of arrival and admitted to a stroke ward within 4 hours – the targets it was monitored on in the previous year. However, there were still challenges in accessing therapy within 72 hours, particularly in relation to speech and language therapy.

ii) <u>Finance Flash Report M4</u>

Mrs Harris presented the report for July (month 4) and advised that there had been an actual deficit of £410,000 against a planned deficit of the same amount in the month. She noted that income had been above plan in month and that assumptions had been made in the position for July that the costs associated with the RTT recovery would be covered by national funding as agreed with the TDA.

Mr Welling commented that it was encouraging that the Trust remained on plan and he queried if there were any indications that there were slippages with any of the cost improvement plans.

Mrs Harris advised that the finance team had been through the clinical units' positions at month 3 (June) and there were some pressures coming through in the commercial directorate and this was being reviewed. In addition, there had been slippage on the two wards closures and it was anticipated that one ward would now close in August and the other in September.

Mrs Webster commented that some of slippage in the reconfiguration projects had been due to the Quality Impact Assessment Panel requesting further assurances about quality and safety before being approved.

iii) CQC Preparation

Dr Harrison reported that a turnaround approach was now being taken to the preparation which was being led by CLT through a consolidated action plan, and staff engagement events were continuing to happen across the Trust.

Mrs Webster reported that the first batch of data had been sent into the CQC and the second batch was due in at the end of the week.

Dr Harrison confirmed that she would circulate the staff briefings to Board members for information. **AH**

Mr Welling asked if the project plan was on track and Mrs Webster advised that it was being monitored weekly and turnaround support was being provided on a daily basis to ensure actions were being completed.

Mr Welling reported that the early indications were that the inspectors would only want to interview himself and Mr Ellis as Chair of the Quality and Standards Committee but he asked Board members to keep themselves available in case they were required during the actual visit.

Dr Harrison confirmed that the themes from the mock inspection feedback had been incorporated into the action planning.

iv) Clinical Strategy Full Business Case: Bid to TDA for early release of first tranche of funds

Mrs Harris reported that a bid was being made to the TDA for an early release of the first tranche of business case funding.

Mrs Harris reported that this funding would cover areas such as the expansion of A&E in readiness for winter, quality improvements and productivity improvements.

She would be submitting the detailed case to the Finance and Investment Committee the following week. **VH**

v) Management Restructure

Ms Green reported that the restructure of the clinical units had now been completed with the clinical leads, general managers, heads of nursing and service managers appointed.

She advised that a new leadership group meeting was taking place on 20th August with the intention of discussing aims and objectives and creating new leadership energy. In addition, the new Trust values would be launched at the meeting.

vi) Challenged Health Economy

Dr Harrison reported that the first phase of the work with PWC had now been completed and she would circulate the final version of the information pack received to the Board. The proposal for the next phase of the work was currently being worked up. **AH**

2. **Board Governance and Leadership Review**

2.1 Board Code of Conduct

Dr Harrison presented the internal Board code of conduct which stood apart from the external NHS Code of Conduct and Board governance codes. She reminded members that the code had been drawn up as part of the Board development work with HAY but she had circulated it again in order for new non-executive members to have the opportunity to comment on it.

Board members confirmed that they accepted the contents of the code.

2.2 Review of Well Led Framework

Dr Harrison reported that there was some overlap between the Well Led Framework and the Board Governance Assurance Framework. She advised that an external assessment would be undertaken of both frameworks as part of the Foundation Trust (FT) application and Monitor process but the Trust was not at that stage at present.

Dr Harrison explained that the intention was therefore to undertake an internal review of where the Board believed that it stood against the domains of the Well Led Framework, providing evidence to demonstrate compliance and explanation of any gaps and actions being taken to address them.

In response to a question from Mr Stevens, Dr Harrison confirmed that there had been an external review of board governance in 2012 undertaken by Capsticks.

Domains 1 and 2 were reviewed and evidence was provided and gaps and actions highlighted which were noted and would be incorporated into the updated assessment by Mrs Wells.

It was agreed that domains 3 and 4 would be reviewed at the next seminar on 17th September.

3. Mortality and Morbidity Update

Dr Wilkinson presented the report and explained that there were three main indices used to measure mortality rates and they all looked at the rates in a slightly different way:

- Hospital Standardised Mortality Ratio (HSMR) – produced nationally by Dr Foster and widely publicised
- Risk Adjusted Mortality Indicator – used by CHKS and based on Dr Foster published methodology to produce its own version of HSMR – provided basically the same information as the HSMR
- Summary Hospital Level Mortality Indicator – used by the Department of Health and included all causes of mortality, other than maternal, and included deaths within 30 days of leaving hospital.

He explained the differences between the three indicators and how they were used as flags/markers to highlight any anomalies in specialities, following which further investigations were undertaken to ensure that sub-standard clinical care was not being provided.

He referred to a bulge in the mortality rate that had taken place from December 2012 to March2013 which was thought to be due to the severe winter and the demographics of an elderly population and following patient case note review there had been no indications of any sub-standard clinical care. He advised that since May 2013 the mortality rates had steadily been reducing.

Dr Wilkinson reported that the internal annual figure for HSMR had come out at 94 but every year the HSMR was rebased and this year the rebasing was a reduction of around 8 points which

translated into 102 for the Trust which was control limits.

Dr Wilkinson outlined the areas of concern highlighted through the indicators over the last twelve months, the findings of each of the reviews and actions being to taken address any issues arising and these were detailed in section 6 of his report.

He reported that the entire Trust mortality review system had been revamped and a more rigorous framework had now been put in place to ensure that all adult deaths in hospital were entered on an electronic database with the expectation that they would be reviewed by the clinical teams within 3 months of their death. In order to promote compliance, the clinical units would be required to report monthly on the proportion of registered deaths had been reviewed within that timescale and a CQUIN target had also been agreed with the commissioners that 95% of all adult deaths would have had a timely review by the end of this financial year.

He outlined the role of the Mortality Review Group (MRG) in reviewing the mortality data and triangulating it with other quality indicators which was supported by the production of a high level Trust Mortality scorecard. The group reviewed and monitored areas of risk or concern and requested further detailed investigations if required.

He explained that the Mortality Overview Group (MOG) required clinical units to attend on a rolling basis to provide explanation and assurance on the mortality indicators and metrics related to their unit.

He reported that it was also proposed to introduce an independent quality control of mortality reviews by reviewing samples of notes which would link into the regular review processes of the two groups.

Mr Welling thanked both Dr Wilkinson, and his predecessor Dr McNeillis, on the enormous amount of work that they had undertaken to ensure that a robust process was now in place to monitor mortality within the Trust. He asked how far the process had been embedded on a routine day to day basis within the clinical unit.

Dr Wilkinson advised that this was work in progress as ownership and understanding of the system was still variable in some clinical units. He confirmed that all of the clinical units had received training in how to use the CHKS database and the new reporting structure required its use to provide the data required for the units to report to the MRG and MOG. He would also contact the new clinical unit leads to ensure that they were clear about the expectation required of them and their consultant colleagues.

Dr Hughes highlighted that the revalidation process would also help in embedding the process as mortality data would form part of this review going forward.

Mr Welling asked how the Board could support the process and Dr Wilkinson advised that the Board's support in reiterating the importance of these quality issues and on their quality walks asking medical staff about mortality reviews would help to embed the process.

Mrs Webster stated that the Patient Safety and Clinical Improvement Group and the Quality and Standards Committee would also be reviewing the process to provide assurance that it was becoming embedding and monitoring themes arising from the reviews by the two mortality groups.

Mr Stevens asked if there were independent assessments of the mortality data and Dr Wilkinson explained that the mortality review of a death was undertaken by the clinical team responsible for the patient's care but alert reviews were undertaken by independent clinicians.

Discussion took place on the understanding of the process of reviewing deaths in community hospitals as the SHMI ratio in particular included deaths within 30 days of discharge from an acute site which covered the community hospitals. Dr Wilkinson reported that a review had been undertaken of all the deaths (16) in the community hospitals in the first quarter of 2014/15. He advised that the majority were step-up patients who had been admitted by their GP for palliative care in advanced cancer, COPD and heart failure and a smaller proportion were step-down patients from other providers, predominantly Brighton but also Maidstone and Tunbridge Wells. In the majority of cases the transfer documentation was detailed, the nursing documentation was good and the death was expected.

He highlighted however that there were number of difficulties in relation to the mortality reviews and coding for community patients:

- GPs provided the care for patients in the community hospitals, apart from the Bexhill Irvine Unit, and completed the death certificates which they kept in their surgeries. Agreement had now been reached through the commissioners that GPs would advise the Trust of the cause of death.
- mortality reviews for patients admitted under other acute providers were conducted by that provider organisation, although the death was recorded under ESHT for mortality data purposes. If the admitting documentation was not detailed, this

provided a coding issue for the Trust

- GPs admitting patients were not required to undertake mortality reviews and therefore these had to be undertaken by Trust staff through a case note review as the staff did not have access to the GP notes – this was being discussed with the commissioners

He advised that it had now been agreed that the mortality review of a patient who had stepped down from an ESHT acute hospital and died in a community hospital would be undertaken by the inpatient speciality that had transferred the patient.

Mr Welling thanked Dr Wilkinson for his presentation and looked forward to further updates during the year.

4. Date and Time of Next Meeting

Wednesday, 17th September 2014, from 12 noon to 2.30 pm in the Committee Room, Conquest Hospital, followed by a Charitable Trustees meeting from 2.30 – 3.00 pm in the same venue.

EAST SUSSEX HEALTHCARE NHS TRUST

Notes of the Trust Board Seminar held on Wednesday, 17th September 2014, at 10.00 am in the Committee Room, Conquest Hospital

Present: Stuart Welling, Chairman
Sue Bernhauser, Non-Executive Director Designate
Charles Ellis, Non-Executive Director
Mike Stevens, Non-Executive Director
Darren Grayson, Chief Executive
Monica Green, Director of Human Resources
Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr David Hughes, Medical Director (Governance)
Dr Andy Slater, Medical Director (Strategy) (from 12 noon)
Alice Webster, Director of Nursing
Lynette Wells, Company Secretary

In Attendance: Trish Richardson, Corporate Governance Manager (notes)

ACTION

1. Welcome and Apologies for Absence

a) Apologies for absence were received from:

Professor Jon Cohen, Non-Executive Director
Stephanie Kennett, Non-Executive Director
Barry Nealon, Non-Executive Director
Richard Sunley, Deputy Chief Executive/Chief Operating Officer

b) **Notes of the Seminar meeting held on 13th August 2014**

The notes of the seminar held on 13th August 2014 were agreed as a correct record.

c) **Update on Current Issues**

i) <u>CQC</u>

Mr Grayson reported that the scheduled CQC inspection had taken place last week and there would be a series of follow up unannounced visits in the next couple of weeks. He advised that the process and logistics had worked well and the inspection team had particularly commended the work of Mrs Prout who had overseen the logistics.

Mr Grayson reported that the CQC would produce its report in the next 6-8 weeks, following which it would come to the Trust to check for factual accuracy and then would be published. He anticipated that this would be in the period mid November to mid December. In addition, a quality summit would be held with the Trust, CQC, TDA, NHS England, commissioners and local authority participating and the Trust would be expected to produce an action plan to address improvements required.

He gave a brief summary of the high level feedback received on the final day of the inspection and commented on how pleased and proud he was that the team had complimented the Trust on its universally caring staff and how welcoming and accommodating they had been. The team had mentioned a number of areas where they had found areas of really good practice, eg critical care outreach, children's community nursing and the Birthing Centres. They also mentioned the positive impact of the introduction of VitalPAC and SystmOne. He advised that the challenges they had reflected on were ones that the Trust had highlighted to them including the impact of the clinical administration review, issues in healthcare records, outpatient services and a need to ensure that governance processes were robust and applied in every area.

ii) Progress with RTT Targets

Mr Grayson reported that the Trust was in line with its trajectory to achieve aggregrate reporting in November and the backlog continued to be reduced. He noted that the Trust had received just under £1.7 million to achieve and sustain compliance.

Dr Harrison reported that a detailed paper would come to the next seminar updating on the data issue that had been found and the actions being taken to address it.

iii) Finance Month 5 Flash Report

Mrs Harris reported that month 5 was £20,000 better than planned and year to date the Trust deficit was £9.23 million against a planned deficit of £9.479 million.

She highlighted that there had been more income and expenditure than predicted in month 5 and this included SystmOne income and expenditure and the impact of high cost drugs and higher than planned pay costs. She noted that the cost improvement plans had under delivered by £283k in month but the Trust was still slightly ahead on these plans as it had performed well in the first quarter. The slippage was partially due to the original phasing of the closing of the two wards, one on each acute site.

Mr Welling commented that it was encouraging that the Trust was on track at month 5 but focus needed to be maintained on the cost improvement position.

iv) National Audit Office Report: Funding healthcare: Making allocations to local areas

Mrs Harris reported that 81% of the NHS England funding allocation was given to 211 Clinical Commissioning Groups (CCGs) and the report advised that the methodology used for the funding allocation was sound.

She advised that the report highlighted that there was a variance in funding across CCGs and there was slow progress in moving CCGs towards what should be their funding allocation as moving it from other CCGs would destabilise local health economies.

She advised that the allocation per patient to the Trust's local CCGs was as follows:

Eastbourne, Hailsham and Seaford	1,252	-64	-4.8
Hastings and Rother	1,363	+59	+4.5
High Weald Lewes Havens	1,121	+34	+3.1

and the allocation was used to fund acute and mental health care whilst primary care was funded from Local Area Teams.

Dr Harrison queried what the net result was of the allocation to the local CCGs and Mrs Harris agreed to provide this following the meeting.

2. **Board Governance and Leadership Review**

2.1 Well Led Framework

The Board split into three working groups and reviewed domains 2, 3 and 4 and Mrs Wells would bring an updated framework to the November seminar for the Board to review. **LW**

3. Organisational Values/Implementation Plan

Dr Harrison reported that the values had been developed through a Listening into Action (LiA) process with 2,000 staff involved. She referred to the implementation plan and the use of a diagnostic to measure the progress with implementation of the plan.

She highlighted that the values were being linked to staff induction and appraisal and increasingly being used to recruit staff in a positive way.

Mr Welling commented that this was an important piece of work and the issue was how the values would be embedded in the organisation. Dr Harrison advised that it would help if everyone took responsibility for challenging staff when their behaviour was outside of the values and recognising where values were being met.

4. Winter Preparedness

Mr Grayson reported that the Operational Resilience and Capacity policy described how the Trust would respond in the likelihood of additional demands on its services during the "winter" period.

He advised that the policy would go to the next public Board meeting for approval.

5. Date and Time of Next Meeting

Wednesday, 15th October 2014, from 10.00 am to 2.00 pm, St Mary's Board Room, Eastbourne DGH.

EAST SUSSEX HEALTHCARE NHS TRUST

Notes of the Trust Board Seminar held on Wednesday, 15th October 2014, at 10.00 am in the St Mary's Board Room, Eastbourne DGH

Present: Stuart Welling, Chairman
Sue Bernhauser, Non-Executive Director Designate
Professor Jon Cohen, Non-Executive Director
Stephanie Kennett, Non-Executive Director
Barry Nealon, Non-Executive Director
Mike Stevens, Non-Executive Director
Darren Grayson, Chief Executive
Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr David Hughes, Medical Director (Governance)
Dr Andy Slater, Medical Director (Strategy)
Alice Webster, Director of Nursing
Lynette Wells, Company Secretary

In Attendance: Mr Gary Bryant, Deputy Director of Finance
Trish Richardson, Corporate Governance Manager (notes)

ACTION

1. Welcome and Apologies for Absence

a) Apologies for absence were received from:

Charles Ellis, Non-Executive Director
Vanessa Harris, Director of Finance
Richard Sunley, Chief Operating Officer

Mr Welling announced that this was Ms Kennett's last meeting as she was stepping down from her non-executive director position to focus on the magistracy and her personal life. He formally placed on record his thanks for the time and commitment she had given to the Trust since her appointment in June 2012.

b) **Notes of the Seminar meeting held on 17th September 2014**

The notes of the seminar held on 17th September 2014 were agreed as a correct record.

c) <u>Update on current issues</u>

i) <u>Referral to Treatment (RTT) Targets</u>

Mr Grayson reported that the RTT position nationally had been steadily deteriorating and resilience funding of £250 million had been made available in the summer.

Mr Grayson advised that the aim of the funding was to move the NHS back into compliance on the aggregate position for RTT by the end of October.

He explained that the Trust had agreed a package of actions with the commissioners, although final agreement had yet to be reached on funding. The Trust was expecting to be compliant by the end of October for admitted and non-admitted patients but it would be extremely tight with the pinch points being gastroenterology, orthopaedics and rheumatology.

Mr Bryant reported that the month 6 financial position assumed additional funding would be received.

Mr Grayson confirmed that the backlog of patients continued to be reduced in line with the trajectory agreed with the TDA.

ii) Month 6 Performance Update

Mr Grayson reported that the A&E target of 95% had been delivered for both September and quarter 2 and the position was just over 95% year to date. He noted that during this period both Tressell and Folkington wards had been closed.

Professor Cohen congratulated the whole team on this achievement.

iii) Industrial Action

Mr Grayson reported that four unions - GMB, Unison, Unite and Royal College of Midwives – had taken industrial action for four hours between 7 to 11 am on 13th October. Ms Green reported that contingency measures had been put in place such as no extra annual leave and private ambulances as there had been a potential ambulance service impact. She advised that only about 30 Trust staff had taken action and there had been a minimal impact on services.

She reported that other public sector action had taken place on 14th October and on 27th October radiographers were planning to take industrial action which could have an impact on services and again contingency measures were being put in place.

iv) Finance Month 6 Flash Report

Mr Bryant reported that there had been a small deficit of £45,000 in month and a positive variance of £201,000 year to date.

Mr Bryant reported that there had been an increase in non pay due to high cost drugs and outlined the actions being taken by NHS England in this regard.

He highlighted that pay costs were starting to move away from plan although there had been a slight reduction in agency costs in September. He advised that there had also been slippage on the CIP plans and the year to date position was an under-achievement of £248,000.

Professor Cohen asked whether the medical agency costs were in relation to substantive posts or short term cover and Dr Harrison replied that a further analysis was being undertaken to identify the split and an update would be provided at the Finance and Investment Committee.

Mr Grayson commented that it was good news that the Trust was still on plan but the position was getting tougher with extra beds being opened earlier in the year than had been hoped and an additional £2 million of savings would be necessary to ensure the Trust's position at the year end.

v) CQC

Mrs Wells confirmed that all information had now been provided to the CQC and Mr Grayson advised that the draft report was expected in early November.

Mr Welling reported that the Campaign for Change Eastbourne – a group focused on elderly care - had made representations to the CQC about their concerns which they had copied to the Trust. He advised that he was arranging to meet them in the near future to discuss their concerns.

vi) Better Care Fund

Mr Grayson reported that the Better Care Fund had a high profile nationally, but not locally, and the aim of the fund was to provide more care in the community but it required the shift of planned income from acute services to community health services and was linked to the health and social care integration agenda. He advised that the commissioners' view was that the Better Care Fund was contained within the East Sussex Better Together commissioning plan.

Mr Grayson reported that the commissioners (CCGs and ESCC) proposal for delivering the BCF had been submitted to the Health and Wellbeing Board for sign-off.

Mr Grayson reported that in the provider commentary the Trust had noted that it had not seen the activity detail within the commissioning plan so was unable to confirm the numbers contained therein. He advised that the Trust would discuss the plan in the normal way with commissioning colleagues.
Mr Bryant advised that the impact for 2015/16 onwards of the Better Care Fund had not been included in ESHT's financial plan.

Mr Grayson confirmed that he did not anticipate that any more beds would be closed in the acute hospitals unless there was a significant step down in activity.

vii) Challenged Health Economy Work

Mr Grayson updated on the first stages of the Challenged Health Economy work and reported on the next steps that were being taken.

viii) Clinical Strategy FBC and Pevensey Ward Upgrade

Mr Grayson reported that the TDA had asked the Trust to reshape the FBC to reflect any themes emerging from the CQC report, once released, that required capital investment and this was being prepared in readiness for release of the report.

In relation to the Pevensey Ward upgrade, Mr Grayson reported that the intention was to start this month although discussions were still taking place on the guaranteed maximum price.

ix) High Weald Lewes and the Havens CCG Community Services

Mr Grayson reported that the CCG had signalled its intention to re-procure its community services some months ago and this had now been narrowed down to 17 services and a PQQ was to be issued in the next few days. He advised that slightly over 500 staff would be affected and the contract value was approximately £13 million.

Discussion took place on the next steps and Dr Harrison advised that once the PQQ was issued a risk assessment would be undertaken on those services being tendered, considered by the Business Planning Steering Group and brought to the Board for discussion within the timetable of the PQQ process.

x) Maternity and Paediatric Services

Mr Grayson reported that the Save the DGH campaign was considering making a legal challenge on the HOSC decision.

xi) Notification of an Inquest

Mr Grayson informed the Board that a public inquest was scheduled to be held on 26th November in relation to a patient who had died unexpectedly two and a half years ago at Eastbourne DGH.

Mr Grayson advised that the case had been reported as a Serious Incident at the time and that the Trust and the Royal College of Surgeons had conducted a thorough investigation. Mrs Wells reported that the legal claim was being handled by the NHS Litigation Authority.

2. **18 Week Referral to Treatment PTL and PAS**

Dr Harrison reported that in order for the Trust to manage patients it had a Patient Treatment List (PTL) system which it also used to manage its patient waiting list and report on the RTT targets. She advised that when RTT targets were first introduced systems were written which included a number of rules in order to ensure that patients were counted correctly these were called auto-validation rules.
She advised that it had become apparent that two auto-validation rules were leading to issues in reporting correctly. The rules application of these rules led to some patients being removed from the PTL because they was no activity on their pathway and not re-appearing on the PTL until activity was added to their pathway often after they had breached the RTT target. Specialties where there were long waits for appointments were particularly affected by the application of these rules. She reported that it had been possible to switch off one of these rules but switching off the other would have a major impact on the robustness of PTL data. Therefore a weekly report was now generated for General Managers showing the patients added to this rule each week so that they could validate these patients and where appropriate expedite patients whose pathway was in excess of 18 weeks.

Dr Harrison reported that having recognised these rules as an issue the next steps were to ensure that there had not been an adverse impact on any affected patients.

Dr Harrison advised that it was clear that the vast majority of patients had been treated and had their pathways reinstated. However, a process had been put in place to check or validate that patients had received treatment. This had been done on a risk basis meaning that those patients on high risk pathways had been reviewed these pathways included those where waiting times were long such as orthopaedics, gastroenterology and gynaecology.

Dr Harrison confirmed that this approach had been developed with the input and advice of the Intensive Support Team (IST) and the TDA. The Trust brought in an external company to undertake this validation process.

She reported that to date the validation had identified a small number of patients where there had been a delay in treatment and she anticipated that further small numbers of patients would be identified as the process was concluded. She advised that in all of these cases the investigation had taken place to understand why the patients had been auto validated off and in the majority of cases it had been due to an administrative error whilst entering the patients into the system which had led to the rules being applied. Other patients were being treated on long and complex pathways where the rules had been appropriately applied. Therefore although the application of the auto-validation rules had affected reporting it had not directly affected the management of patients. The validation exercise had however identified a number of areas of administrative practice that could be improved and these improvements were being implemented.

She reported that all patients identified as having waited over 52 weeks had been reviewed clinically through a clinical outcome group led by the Medical Director and Director of Nursing but no incidents of harm had been discovered. All patients had also had further appointments and treatments planned and these were complete in the majority of cases. She advised that the records review was continuing to take place and when it was completed the Trust would discuss with the IST about whether a further risk based review was required.

Dr Harrison expressed concern that the long waiting patients had also not been picked up in primary care by the referring clinician.

With regard to RTT reporting, she referred to the actions set out in the report that had been taken to correct the reporting and advised that the Trust no longer solely relied on the PTL but also on the information provided to General Managers for validation resulting in more confidence in the waiting lists.

She reported that the auto-validation rules been scrutinised as far as possible and when the Trust moved to the new PAS in March 2015 action was being taken to ensure that robust and uncontaminated data was taken across and the risks were outlined in the report.

Dr Harrison summarised that whilst this anomaly had caused significant issues, no harm to patients had been identified and actions for the move to the new PAS PTL and RTT reporting were being managed appropriately.

Mr Nealon asked what mitigations were in place and Dr Harrison advised that the mitigations were the individual tracking of patients on the lists and the standardisation of monitoring of the waiting lists by the General Managers and Service Managers.

Mrs Webster reported that the clinical outcome group was picking up issues in relation to primary care responsibility and learning lessons.

Dr Harrison confirmed that the anomalies had not been identified through issues being raised either by patients or their GPs.

Mr Grayson reported that the Trust had put itself in a stronger place through the actions it had taken with the external review and in being open and transparent with the TDA, commissioners and the IST and assurance was now provided that the risks going forward were being minimalised.

3. NHS Confederation: Challenge Manifesto 2015

Mr Grayson reported that the Confederation was using the challenge manifesto as a way of highlighting the financial issues of the NHS to political parties and he and Mr Welling had supported this.

Discussion took place on how the manifesto could be used in a local context and it was agreed that it would be helpful to refer to the appendix summarising the challenges and identify how the Trust was responding to them.

4. ESHT Response to Savile Report

Mrs Webster reminded the Board that an initial review of the Savile report had been included in the Safeguarding annual report.

She presented the updated action plan which was based on the six key areas of the report and contained the assurances being implemented with a RAG rating system. She highlighted that one area was rated red which related to a review of the complaints policy in light of the Clwyd/Hart review. She advised that the policy would be updated to reflect both this review and the Duty of Candour legislative requirements when published in November.

She reported that in relation to the amber ratings the interim Patient Experience Manager would address the issue of stakeholder groups and compliance with policies was included within the ESHT annual audit process.

In response to a query from Professor Cohen, Mrs Webster confirmed that safeguarding electronic updates were now in place.

Mr Welling suggested that in order to assure compliance with the policy in relation to external visitors a sample audit be carried out and Mrs Webster agreed to take this forward. **AW**

Discussion took place with regard to ex-members of staff and whether their access levels were reviewed on their departure if they continued to visit the Trust and it was agreed that Mrs Webster would discuss this with the Security Manager to ascertain whether access levels were reviewed and how often. **AW**

5. Date and Time of Next Meeting

Wednesday, 5th November 2014, from 10.00 am to 2.00 pm, St Mary's Board Room, Eastbourne DGH.

East Sussex Healthcare NHS Trust

Date of Meeting:	26th November 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:

Key external meetings attended in October and November:

- 1 October 2014 — Chairman / Chief Executive of St Michael's Hospice Quality Engagement Event re LiA
- 8 October 2014 — Sussex Non-Executive Directors meeting
- 9 October 2014 — Sussex Chairs Meeting
- 20 October 2014 — League of Friends Chairs Meeting
- 22 October 2014 — NHSTDA Integrated Delivery Meeting
- 5 November 2014 — Sussex CCGs Chairs
- 19 November 2014 — Friends of Eastbourne Hospital AGM
- 25 November 2014 — Campaign for Change Group

The following correspondence is attached to the report:

- October 2014 — Chairman's Brief
- 20th October 2014 — Letter to Stephen Lloyd, MP for Eastbourne

Use of Trust Seal

The Trust Seal has not been used since the last meeting:

Proposals and/or Recommendations

The Board is asked to note the activities undertaken by the Chairman since the last Board meeting.

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

Name:	**Contact details:**
Stuart Welling, Chairman	s.welling@nhs.net

East Sussex Healthcare NHS
NHS Trust

Chairman's brief

Update of key issues at the Trust — 16th October 2014

Strategy

I have previously mentioned that we have submitted our plans to the NHS Trust Development Authority (TDA) for a £30 million capital investment to implement the first phase of the 'Shaping our Future' Clinical Strategy. We still await a final decision on this funding which will enable us to redevelop both the Trust's main acute hospitals (£13m on the Eastbourne DGH site and £17m on the Conquest Hospital site). The Board believes that this investment is a foundation stone to improving the quality of our services. The implementation of our clinical strategy has provided us with an important opportunity to ensure that we are able to deliver sustainable healthcare services for local people in the future. It will ensure we are able to respond to national and local requirements to improve patient safety, patient outcomes and service quality as well as meeting performance standards.

I recognise that the changes that we have made over the past 18 months by reconfiguring services have had a major impact and it has been a challenging and difficult period for staff and patients. That is why we now need a period of consolidation to realise the benefits of these changes for our patients. As you would expect we will continue to review and improve the quality, effectiveness and efficiency of all our services and to work in partnership with NHS and Social care partners to deliver a sustainable service for all the people of East Sussex.

There is still a lot of inaccurate statements being made about the future of Eastbourne DGH. Unfortunately, a small number of local people have made a name for themselves saying things about the hospital that are simply untrue. Based on these untruths it seems the rumour mill goes into action leading to needless anxiety for all the patients we serve and our staff who work in the hospital. I would like to be very clear about the future of Eastbourne DGH: it will continue to provide the services most people need most often. This includes Accident and Emergency, acute medicine, cardiology, diabetes, haematology, gastroenterology, stroke services, elective surgery and day surgery. It will also provide midwifery led maternity services, paediatric assessment, outpatients, radiology and other essential support services. We continue to develop and invest in Eastbourne DGH because it is a critical part of the services we provide for the people of East Sussex. Whilst we await approval from the TDA for our £30million capital investment plans we continue to invest in equipment and the environment at Eastbourne including the recently opened state of the art endoscopy unit costing over £5m. Plans are well advanced for the new radiotherapy unit bringing this service into East Sussex for the first time ever in 2015. These are significant investments in the future of Eastbourne DGH and in better care for our patients.

Values

We have recently launched our new Trust Values under the theme of '*what matters to you matters to us all'.* The Trust is going through a period of significant change as we develop clinical services to meet the needs of the NHS in the 21st Century. Our Trust Values will be at the heart of how we behave and act as we plan for the future and continue to ensure we provide high quality, safe care to patients in the right place and at the right time.

The four core Trust Values: ***Working Together; Improvement and Development; Engagement and Involvement; and Respect and Compassion*** have been developed by our staff as part of the Listening into Action (LiA) programme. During 2013, a LiA group worked to identify and develop values which are important to staff, place the focus on patients and help the organisation to achieve its strategic aims and objectives. The LiA group actively sought staff feedback about what was important

to them. Activities included a roadshow around many of the Trust sites, attendance at team meetings, discussions with the Joint Staff Council and staff questionnaire.

Feedback was received from over two thousand staff and the LiA group then set to work identifying the four core themes by linking values and behaviours that were relevant and important to patients and staff. Our new Trust Values reflect a commitment to ensuring that the needs of our patients remain at the heart of everything we say and do. We will demonstrate them when caring for patients, communicating with their families and friends and in how we working with colleagues and partners. To be a success our Trust Values must shape our culture and be demonstrated in all aspects of our work.

Better Beginnings

Since my last Brief you will probably be aware of the decision of East Sussex Health Overview and Scrutiny Committee (HOSC) to support the changes to maternity and paediatric services agreed by the East Sussex Clinical Commissioning Groups in June. HOSC agreed that the CCGs' decision to approve option 6 was made in the best interests of the health service for local people and is the best way to ensure safe and high quality services for local women and children in the long term.

This option results in the following configuration of services:

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

Our primary concern has always been, and will continue to be, the safety of babies, mothers and children. This decision puts an end to the long running issue of the provision of maternity services in East Sussex and makes permanent the temporary configuration put in pace by the Board in May 2013 with the recognition that it is far safer and clinically sustainable to provide services from one consultant led obstetric unit. It represents the best way forward to ensure safe and high quality services for mothers, babies and children in East Sussex.

Now that a permanent decision has been made we will work with our service users, commissioners, the local authority and other partners to ensure we can provide the best possible services under this option. This will build on the learning and feedback we have had from patients and staff since we implemented the temporary configuration of services in May 2013.

Performance

Under the NHS Trust Development Authority's (TDA) Accountability Framework, the Trust's monthly performance is assessed under five domains, which are combined to give an overall quality score. The five domains are Responsiveness, Effectiveness, Safe, Caring and Well Led. Each domain is given an overall score between 1 and 5, where 1 is high risk and 5 is lower risk. The Trust's overall quality score is derived from weighting the scores across the five domains and will also be given as a figure between 1 and 5.

The full performance report gives data on the Trust's performance for July (month 4 of 2014/15) against key performance framework indicators and financial targets. Below is a summary, the full report can be viewed on-line – **click here>>**

Overall Trust score (July)	4
Responsiveness domain	3
Effectiveness domain	4
Safe domain	5
Caring domain	4
Well Led domain	4

At the end of August (month 5), the Trust had a deficit of £9.233million, against a planned deficit of £9.479million, giving a favourable variance against plan of £246,000. The Trust is still slightly ahead of plan with its Cost Improvement Programme, with £6.5million achieved to date. However in August there had been a shortfall in planned savings of £283k. It is important we maintain the momentum around achieving these savings and we are will be closely monitoring this. The Trust is currently forecasting to meet its £18.5million deficit at the end of the financial year.

Care Quality Commission

The Care Quality Commission (CQC) inspected the Trust in September 2014 under the new Chief Inspector of Hospitals' inspection regime. This was part of their planned programme of inspections under a new regime that will see all acute Trusts inspected by the end of 2015. The CQC commented on how welcoming and accommodating all our staff were and that staff were universally caring. I was very pleased and proud to hear this feedback and confirmation of what I and the Board know to be true. We all see it every day when we visit clinical and non clinical areas and hear the passion of staff for providing good care and see the evidence of their commitment to working to deliver benefits to patients what ever their role is in the organisation.

The CQC gave us a brief informal feedback session however we do not expect their full report until the end of November. Their informal feedback was brief and deliberately high level. It outlined areas where they had observed good practice and areas where we have more challenges. In addition to saying that the overall care and commitment demonstrated by our staff was impressive they also talked about a number of areas where they had seen examples of really good practice. These included Critical Care Outreach, Children's Community Nursing and the Birthing Centres. They also mentioned the positive impact of the introduction of new IT systems VitalPAC and SystmOne that support the way we deliver care. The challenges they reflected on were ones that we had highlighted to them and we either already have plans in place or are well on the way to developing plans to address these challenges.

This new inspection regime is very intensive and comprehensive and I am proud of the way we handled it. In particular, I was impressed by the effort and energy people put in to making sure they were able to communicate their pride in the things we do well, were honest about our challenges and clear about what we are doing about them. We will continue to put our energies into building on those things we do well and making improvements for our patients.

Research and Development

Historically research has in the main been the preserve of the larger University teaching hospitals, linked with medical schools, research charities and, of course, drug and technology companies. However there is an increasingly important research role for District General Hospitals, community services and mental health services.

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

We know that clinical research drives improvements in healthcare and leads to the development of more effective treatments for patients and that the government has a stated aim of encouraging health research. We also know that the NHS is facing its most difficult financial challenge in its 66-year history at a time when demand on the NHS is ever increasing and that being innovative through research and development can help improve productivity and improve efficiency. Therefore the Board is committed to providing opportunities for clinical Research and Development and to developing a research active culture

Delivering this strategy needs the committed engagement of our researchers, managers and partners. As an integrated acute and community trust, our success will in part be dependent on the support and joint working with our stakeholders most notably the National Institute for Health Research, the Kent Surrey & Sussex Academic Health Science Network, Kent Surrey & Sussex Clinical Research Network, Brighton & Sussex Medical School and partner providers. We will endeavour to work closely and support all those involved in research over the next five years.

Annual General Meeting

The Trust held its Annual General Meeting on 24th September before the Board meeting. Chief Executive Darren Grayson gave a presentation on the Trust's achievements and challenges during 2013/14 and Vanessa Harris our Director of Finance presented the Trust's financial position for the 2013/14 financial year. The Annual Report and Summary Financial Statements 2013/14 and the Quality Account 2013/14 were presented and are now available on the **Trust website>>**

Care of Cancer patients highly praised

The care we provide to cancer patients has again been highly praised in a national survey of patients who were diagnosed with the disease. The recently published National Cancer Patient Experience Survey was completed by 551 local patients. These patients rated the Trust in the top 20% of providers in the country in six areas including feeling that they were seen as soon as necessary, being given the right amount of information about their surgery and having the right post-discharge support. These aspects of care are incredibly important to patients and it is pleasing to note that despite a significant increase in referrals patients feel they are being seeing promptly and with respect and dignity.

This survey shows the excellent quality of care we deliver and the multi-disciplinary teams providing these services should be highly commended for the level of achievement. As always with these surveys, there are some areas where we will look to make improvements and we will be working closely with our Cancer Services User Group to achieve these. Overall however, the results are very positive.

Winter

Despite the very warm temperatures of recent weeks we cannot escape the fact that winter is just around the corner. The Trust Board has agreed our operational resilience and capacity plan for 2014/15. This is our plan to ensure that we have a co-ordinated and appropriate response to changes in demand for both elective and emergency activity - not just in winter, but at any time of the year. However, experience tells us winter will be an exceptionally busy period and this plan sets out how services across the Trust will be managed, ensuring the quality of our services and patient safety are not compromised at any time.

Our plans will manage focus on the need to maintain good patient flow through appropriate and timely treatment and discharge. However, we recognise that even with active management, demand can be such that additional capacity may to required, including in the community and social care setting. We therefore have made provision for additional capacity with a 28 bed escalation ward at both Conquest Hospital and Eastbourne DGH which is available to be opened when required inline with our escalation plans.

Infection control

The control of healthcare associated infections and the reduction of infection rates remains a key priority for us. We have continued to reduce both MRSA bacteraemia (bloodstream infections) and Clostridium difficile infections (CDI) in recent years. Since 2008/09 we have made a significant reduction in both infections reducing MRSA bacteraemias by 95% and CDI infections by 78%. Last

year (2013/14), we reported one case of MRSA and we had 43 cases of CDI which represented a reduction of 8 cases (16%) from the previous year.

Of these 43 cases, six cases were found to be as a result of transmission whilst in our hospitals which indicates there is still more we can do to reduce the incidence of this infection. Although our standards are high and our record on controlling and minimising infection is good I can assure you that we remain constantly vigilant when it comes to reducing healthcare acquired infections and adhering to strict infection control procedures.

Appointment of Vice Chair

I am pleased to announce that the Board has approved the appointment of Non Executive Director Barry Nealon as Vice Chair of the Board. Barry joined the Trust as a Non Executive Director designate on 1st June 2012 and become a full voting member on 15th July 2013 since joining the Trust he has made a very valuable contribution to the Trust Board and enhanced the leadership of the Trust.

East Sussex Healthcare NHS
NHS Trust

SW/ajp

20th October 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 hope that you found your meeting with our maternity and paediatric clinicians and managers helpful and beneficial. I trust that they were able to provide you with evidence and assurances about the improvements that have been made in the safety and quality of these services since they were reconfigured. I am aware that you raised the issue of transport for patients and relatives between the two sites and would like to assure you that whilst it is not the Trust's role to provide transport we are working with our commissioners and the local authority who have the responsibility for public transport provision to explore options for improving transport links. I appreciate your support in this area.

I am also aware that during the meeting you raised concerns with the staff present about the quality of elderly care provided by the Trust. I am sorry that you felt that it was appropriate and necessary to do so in this forum particularly when you will have been aware that this group of front line staff were not going to be able to respond to these concerns. I would therefore like to ask you to please raise these concerns directly with me and provide me with any evidence or information you have to substantiate them. As you know we take all concerns about the quality of care we provide seriously and will always investigate and take action where we are provided with the information that enables us to do so.

I look forward to hearing from you.

Yours sincerely

Stuart Welling
Chairman

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING DATES 2015

Wednesday 4th February	St Mary's Board Room, Eastbourne DGH	10.00 am
Wednesday 25th March	St Peter's Community Centre, Bexhill-on-Sea	10.00 am
Tuesday 2nd June	Lecture Theatre, Education Centre, Conquest Hospital	10.00 am
Wednesday 5th August	Ashdown Room, Uckfield Civic Centre	10.00 am
Wednesday 30th September AGM & Board Meeting	Lecture Theatre, Education Centre, Conquest Hospital	10.00 am
Wednesday 2nd December	St Mary's Board Room, Eastbourne DGH	10.00 am