

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

**A meeting of East Sussex Healthcare NHS Trust Board will be held on
Wednesday, 29th January 2014, commencing at 10.00 am in the
St Mary's Board Room, Eastbourne DGH**

AGENDA

AGENDA			Lead:
1.	a) Chairman's opening remarks b) Apologies for absence c) Feedback from Quality Walks		Chair
2.	Monthly award winner(s)		Chair
3.	Declarations of interests		Chair
4a.	Minutes of the meeting held on 27 th November 2013 and 11 th December 2013	Ai	Chair
4b.	Matters arising	Aii	Chair
5.	Chief Executive's report (verbal)		CEO
6.	Board Assurance Framework	B	CSec

QUALITY, SAFETY AND PERFORMANCE

7.	Quality Improvement Plan Briefing	Assurance	C	DN
8.	Performance Reports: a) Quality Month 8 (November) b) Finance Month 9 (December)	Assurance	D	DN/ MDCG/ COO/ HRD/ DF
9.	RCOG and RCPH reports and action plans	Assurance	E	MDCG/ MDS

STRATEGY

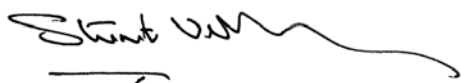
10.	Business Planning Process 2014/15 to 2018/19	Assurance	F	DSA
-----	--	-----------	---	-----

GOVERNANCE & ASSURANCE

11.	Board sub-committees: Committee reports and Trust Board seminar notes: a) Audit Committee 08.01.04 b) Finance and Investment Committee 11.12.13 c) Quality and Standards Committee 07.01.14 d) Trust Board seminar notes 13.11.13	Assurance	G	Comm Chairs
12	Themes for Quality Walks	Assurance		Chair

ITEMS FOR INFORMATION

13.	Chairman's Briefing	Assurance	H	Chair
14.	Questions from members of the public (15 minutes maximum)			Chair
15.	Date of Next Meeting: Wednesday, 26 th March 2014, commencing at 10.00 am in the Ashdown Room, The Civic Centre, Uckfield, TN22 1AE			Chair
16.	To adopt the following motion: <i>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</i> <i>(Section 1(2) Public Bodies (Admission to Meetings) Act 1960)</i>			Chair



STUART WELLING
Chairman

23rd January 2014

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

East Sussex Healthcare NHS Trust

Date of Meeting:	29 th January 2014
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks November/December 2013
Reporting Officer:	Lynette Wells, Company Secretary

Action: This paper is for (please tick)
Assurance <input checked="" type="checkbox"/> Approval <input type="checkbox"/> Decision <input type="checkbox"/>
Purpose:
This paper provides a summary of Quality Walks that have taken place during November and December 2013.

Introduction:
<p>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.</p> <p>Themes for the walks are decided by the Board and the focus during November and December was as follows:</p> <ul style="list-style-type: none"> • Friends and Family Test feedback; • Management of end of life care on wards; • Junior medical staff (Keogh and Berwick action plan); • District nursing (CQC action plan); • Maternity and paediatrics; • Financial recovery.

Analysis of Key Issues and Discussion Points Raised by the Report:
<p>20 services/departments were visited as part of the Quality Walk programme during November and December as detailed in the attached. 17 of these were arranged by the Assurance Manager or the Chief Executive's Office and the Ward or Unit Manager was notified in advance to expect the visit. 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).</p> <p>Feedback forms have been received to date relating to 18 of the visits, and a copy has been passed on to the relevant department/service managers</p>

Summary of Observations and Findings relating to the themes reported on feedback forms

Friends and Family Feedback Test

The wards felt that generally the feedback received from patients was good, one area were not aware of what feedback their department was getting and another stated their response level was low and felt this was due to patients being unable to use computer tablets.

Management of end of life care on wards

This was not completed on the majority of feedback forms as it was not applicable to the areas being visited, however where relevant it was noted that the end of life care pathway is explained to patients and relatives, that open visiting is in place and relatives can stay overnight.

Junior medical staff (Keogh and Berwick action plan)

Junior staff spoken to state that there were good opportunities for gaining skills and experience and they felt able to contact relevant Consultants out of hours for advice if necessary. One Matron stated that they had 'Good quality junior doctors who use 'the ward team approach''.

District nursing

This was not completed on the majority of feedback forms as it was not felt to be applicable to the areas being visited although it was noted by one department that 'engagement with the service can be patchy' and one ward stated that now all referrals go through ICAP (integrated care assessment process) it felt that the visiting criteria had changed which had caused some problems.

Maternity and paediatrics

Theatres stated that they had felt the impact of the changes and Pathology reported that there had been an increased demand on the blood bank at Hastings with the temporary move of Maternity & Paediatrics but plans have been implemented to respond to this.

Financial recovery

Most staff appeared to have a clear understanding of the Trust's financial position but several areas commented on feeling pressured as a result of turnaround, noting issues with staffing levels and teams often very 'stretched' with the reduction in the use of temporary staff. One community team stated that they felt divorced from the current issues within the Trust as everything feels very 'acute focused'.

Other key issues

The following concerns were noted are as follows with the number of times raised:

Lack of space (4); broken equipment not able to be replaced (3); lack of communication regarding clinical service/ward changes (2); difficulty accessing medical records (2); linen shortages, IT response time slow for urgent issues, inappropriateness of building/facilities (community) and the lack of refurbishment and estates work (1).

Benefits:	
Quality Walks are an opportunity for the views of staff, patients and visitors to be sought by the Board and help raise the profile of patient safety and compliance standards within the Trust. It enables the Board members to identify areas of excellence, identify risks and ensure Board visibility within the organisation.	
Risks and Implications	
Any risks identified are acted upon and escalated to the risk register as appropriate.	
Assurance Provided:	
Any actions identified at a Quality Walk are agreed at the time and it is noted who will be responsible for taking forward the action. These are logged and monitored by the Assurance Manager to ensure that actions are implemented.	
Further visits are scheduled to take place in January and February as detailed on the attached.	
The following themes were agreed at the November Board meeting and will be the focus for the Walks taking place in January and February:	
<ul style="list-style-type: none"> • General Surgery; • Management of end of life care; • Quality of patient notes; • District Nursing; • Impact of turnaround and financial recovery. 	
Proposals and/or Recommendations	
The Board are asked to note the report.	
Outcome of the Equality & Human Rights Impact Assessment (EHRIA)	
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?	
Not applicable.	
For further information or for any enquiries relating to this report please contact:	
Name: Hilary White, Assurance Manager (Compliance)	Contact details: Hilary.White@esht.nhs.uk

Quality Walks

Quality Walks November December 2013				
DATE	TIME	SERVICE	SITE	Visit by
November				
5.11.13	2.30pm	Folkington Ward	EDGH	Vanessa Harris
6.11.13	9.30am	Theatres	EDGH	Monica Green
11.11.13	8.30am	Occupational Therapy	EDGH	Monica Green
12.11.13	9am	Health Visiting	Princes Park Eastbourne	James O'Sullivan
14.11.13	10am	Jubilee Eye Suite	EDGH	Amanda Harrison
14.11.13	11am	Firle Unit	EDGH	Amanda Harrison
20.11.13	2.30pm	Health Visitors	Sidley Children's Centre	Alice Webster
22.11.13	11am	Pathology	Conquest	Monica Green
25.11.13	10am	Physiotherapy Department	Conquest	James O'Sullivan
29.11.13	10am	Diabetic and Endocrinology Unit	Conquest	Vanessa Harris
December				
2.12.13	2pm	Radiology	EDGH	Amanda Harrison
2.12.13	11.30am	School Nursing	Arthur Blackman Clinic	Vanessa Harris
03.12.13	9am	New Endoscopy Unit	EDGH	Barry Nealon
5.12.13	11am	District Nurses	Eastbourne Park Primary Care Centre	Darren Grayson
9.12.13	4.30pm	DeCham/SAU	Conquest	Vanessa Harris
10.12.13	2.30pm	District Nursing	Hailsham Health Centre	Alice Webster
19.12.13	2pm	Newington Ward	Conquest	Monica Green
20.12.13	9am	Continence Team	Bexhill Hospital	Vanessa Harris
20.12.13	10am	Health Records	Conquest	James O'Sullivan
21.12.13	10.30pm	Emergency Department	EDGH	James O'Sullivan
Quality Walks Scheduled for January February 2014				
January				
7.1.14	7pm	ITU	Conquest	James O'Sullivan
21.1.14	3pm	Pain Clinic (Burton Unit)	Conquest	Monica Green
24.1.14	11am	Health Records - Adults & Children's	Apex Way Hailsham	James O'Sullivan
20.1.14	2pm	Seaford 3	EDGH	Darren Grayson
20.1.14	3pm	Hailsham 3	EDGH	Darren Grayson
30.1.14	3pm	Sexual Health	Avenue House	Darren Grayson
30.1.14	9.30am	Nutrition and Dietetics	Conquest	Vanessa Harris
February				
10.2.14	2pm	Sleep Studies	Conquest	Darren Grayson
10.2.14	2pm	Health Visiting / School Nursing	East Hastings Childrens Centre	Alice Webster
11.2.14	2pm	Cuckmere	EDGH	Amanda Harrison
11.2.14	2pm	Pharmacy	EDGH	Vanessa Harris
13.2.14	9.30am	Day Surgery	Lewes Victoria Hospital	James O'Sullivan
13.2.14	10am	OPD	Lewes Victoria Hospital	James O'Sullivan
19.2.14	4.30pm	Irvine Unit	Bexhill Hospital	Vanessa Harris
19.2.14	9am	Community Paediatric Team	EDGH	Monica Green
21.2.14	10.30am	TVN's	Conquest	Monica Green
27.2.14	11am	Berwick	EDGH	Darren Grayson
28.2.14	4pm	DN's	Bexhill Health Centre	James O'Sullivan

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday 27th November 2013 at 10.00 am in the Lecture Theatre, Conquest Hospital

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

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

104/2013 **Welcome**

Action

a) Chairman's Opening Remarks

Mr Welling welcomed everyone to the meeting and noted that there were no apologies for absence.

He highlighted that the Government had now issued its response to the Francis report and the executive team and Quality and Standards Committee would be reviewing the response and updating the Trust's action plan accordingly.

He reported that he and Mr Grayson had met with members of Eastbourne Borough Council on 13th November 2013 to discuss the future of healthcare in East Sussex, particularly Eastbourne. Following the meeting the Leader of the Council had made a public statement which Mr Welling and Mr Grayson believed did not represent the meeting and this had been challenged by the Trust and a response was awaited.

He advised that the Quality Engagement Event held on 25th November had been attended by over 60 members of the public and there had been a good constructive dialogue.

He reported that the interview process for the vacant non-executive director appointments was currently taking place.

b) Feedback from Quality Walks

Mr O'Sullivan reported on two visits he had made to Rye Memorial Hospital and Conquest Outpatients. Issues highlighted had been:

- Rye Memorial Hospital - patients had been extremely complimentary about standards of care received and the only issue concerned patient transport which sometimes left less mobile patients stranded for a period of time.
- Conquest Outpatients – issues were highlighted in terms of patient records not always being available and he intended to carry out a follow up visit to the health records department to explore this further. The matron was also concerned about too many adhoc clinics but the Trust was looking to structure the work to reduce the number of clinics which was more convenient for staff and positive in savings.

Mrs Harris advised that patient transport was a recurring theme in quality walks and this needed to be addressed to ensure improved patient experience, a quicker discharge and reduced length of stay.

Dr Harrison reported on her two visits:

- Jubilee Eye Suite, Eastbourne DGH – a day case ophthalmology unit - the doctors in training had advised that they were happy with their practice and a wide variety of cases.
- Firlie unit, Eastbourne DGH – a pre-operative assessment clinic. Patient transport was highlighted as an issue as when patient transport booked it was not flexible enough to accommodate patients going to pre-operative assessment following their outpatient appointment. She had also discussed the move of high risk surgery to the Conquest and work had taken place to ensure the pre-operative assessment was co-ordinated and standardised across the Trust and those patients being referred to Conquest for high risk surgery would still have their pre-operative assessment undertaken at Eastbourne. The patients were appreciative of the flexibility in being able to have their assessment on the same day. The only negative issue had been the lack of access for administrative staff to printers and this had now been resolved.

Mr Grayson reported that he had visited Berwick ward to observe an audit of cleanliness on that ward with facilities and infection control staff. The matron for the ward had participated in the inspection and, whilst the cleanliness was very good, some equipment had not met required standards and she had taken this on board. He noted that some of the estate was also tired and, whilst functional, needed improving as it affected the overall impression of the ward. Consideration would need to be given to how capital could be used flexibly to address some of the refurbishment issues across the Trust.

105/2013 **Monthly Award Winner**

Mr Welling announced that this month's award winner was Fiona Andrews, a Health Visitor, who had been nominated by one of the mothers she looked after. She said that Fiona had helped her with both her children and she was always amazed at her ability to provide interesting and up-to-date information on the issues she was experiencing and could reference the latest research. She is highly regarded by the mothers in her area as an exceptional health visitor.

He would be presenting Ms Andrews with her award following the meeting.

106/2013 **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.

107/2013 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 25th September 2013 were considered and approved as an accurate record, subject to the amendment of the date at the top of the first page.

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

b) Matters Arising

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

108/2013 **Chief Executive's Report**

a) Quality and safety

Mr Grayson reported that the Trust had received the reports from the Royal College of Obstetrics and Gynaecology and the Royal College of Paediatrics commissioned following the changes to the provision of maternity and paediatrics earlier this year which gave further information and assurance on the safety of the services and made recommendations about their future development. Plans were being developed to implement the recommendations and the reports had been shared with clinicians, the Trust Development Authority (TDA) and other stakeholders. The reports, together with the action plans, would be brought to the Board at its meeting in January.

Mr Grayson highlighted that the Care Quality Commission (CQC) had recently published the first four reports following the introduction of a new way of inspecting hospitals led by the Chief Inspector of Hospitals Professor Sir Mike Richards that built on the reviews undertaken by Sir Bruce Keogh. He highlighted that there was a lot to learn from the reports and the Board agenda item on mortality linked into issues raised in the reports. The Dr Foster Good Hospital Guide would be published shortly and the Trust had raised with Dr Foster its concerns around how the Summary Hospital-level Mortality Indicator (SHMI) was reported in relation to Trusts providing integrated care services.

He reported that the Trust remained green overall on performance although there were some areas of difficulty. The Trust had exceeded its limit for Clostridium Difficile (C Diff) cases although it was acknowledged that the limit had been very demanding as it was half of the previous year's numbers. A Listening into Action event was being planned to explore further improvements that could be made in this area.

He reported that the Trust was continuing to achieve the 95% A&E target and there had only been a couple of weeks in September when it had been missed and he congratulated the staff in both DGHs who were working under enormous pressure to deliver good standards of care.

Finance

Mr Grayson reported that turnaround was now embedded in the organisation and all decisions being made went through a robust quality and safety assessment process to ensure that they were right for patients and operationally achievable. There had not been a great impact in October on the cost base but he expected to see a significant improvement in November.

Strategy

He advised that the move of high risk general surgery was ready to take place in December and the decision would be made at the Board today. He anticipated that the consultation on the long term future of maternity and paediatric services led by the Clinical Commissioning Groups would start in January following the Clinical Commissioning Groups Board meetings in December.

He reported that the Trust was in discussion with the Trust Development Authority (TDA) and commissioners in planning for the future, both in the medium and long term, and was committed to working with commissioners and representatives of local communities to draw up a plan to meet the needs of patients within financial resources.

109/2013 **Board Assurance Framework**

Mrs Wells presented the latest version of the Board Assurance Framework which had been reviewed in Audit Committee along with the high level Risk Register.

She advised that the amendments made were highlighted in red with some controls removed, narrative revised and a new gap in control added relating to Datixweb due to a backlog of incidents being 'finally approved'. An action plan had been agreed with the divisions to clear the backlog.

The Board noted the revised Board Assurance Framework and agreed that the main inherent/residual risks had been identified and actions were appropriate to manage risks.

110/2013 **Care Quality Commission – Avenue House**

Mrs Webster reported that a CQC inspection had taken place at Avenue House on 18th September 2013, with the report published on 1st November and the Trust was compliant with all standards assessed.

She advised that there had been a planned CQC inspection to monitor the use of the Mental Health Act 1983 and the report was awaited.

The Board noted the outcome of the report of the inspection on 18th September 2013.

111/2013 **Performance Reports**

a) Quality Report including Performance, Activity and Workforce – September 2013 (Month 6)

i) Serious Incidents

Mrs Webster advised that there had been 7 Serious Incidents reported in September in accordance with national and local guidance and the Root Cause Analyses were taking place.

She advised that the Quality and Standards Committee received a full Serious Incident and Patient Experience Report which had been reviewed in detail at the last meeting.

ii) Falls

She highlighted that there had not been a reduction in falls in the month but she anticipated that there would be an improvement in the coming months.

Mr Ellis reported that the Quality and Standards Committee had looked at falls across the organisation in depth and assured itself that the lessons learnt were being shared across the organisation.

Mrs Webster reported that there had been a Listening into Action event on the prevention of falls and a number of ideas were being taken forward relating to environment and practice.

iii) Mixed Sex Accommodation

Mrs Webster reported that there were plans in place to address the mixed sex accommodation breaches which mainly related to the A&E area in the Conquest and she anticipated that the situation should start to improve in December once building works had been completed.

iv) Friends and Family Test (FFT)

Mrs Harris noted that the lowest net promoter score for the FFT was in A&E and queried what steps were being taken to improve the rate of response. Mrs Webster reported that there was an issue nationally with the collection of data in this area and different methods of collection were being explored to try to encourage a greater response.

v) Malnutrition Universal Screening Tool (MUST)

Mr Ellis was concerned at the reduction in the percentage of MUST assessments being undertaken and Mrs Webster reported that plans were in place to address this and she anticipated that there would be an improvement by the next Board meeting.

vi) Stroke Indicators

Mr O'Sullivan commented that there had been a notable improvement in the stroke indicators apart from the direct admissions target. Mr Sunley confirmed that there had been an improvement in the stroke service since centralising on the Eastbourne DGH site and the target for direct admission to the stroke unit related to a relatively small number of patients and the Trust was working closely with the ambulance service and primary care colleagues to ensure the pathway was used appropriately and patients accessed the unit as soon as possible.

Dr Slater assured the Board that those patients who found themselves on a different hospital site to the acute stroke unit were receiving appropriate immediate medical care and then were moved to the stroke unit at the appropriate time in their treatment.

vii) A&E

Mr Sunley reported that he was disappointed that the Trust had not delivered the 4 hour target for September but was confident that it would be achieved in October. There had been challenges in September over access to inpatient beds, particularly in orthopaedics and elective surgery, as well as medical staffing issues in A&E. Since October his team had been working with the turnaround team to improve bed management and patient flow.

He commented that this was building on work already undertaken in medicine to reduce length of stay in inpatient and community beds. This had included identifying those patients who were awaiting discharge to appropriate facilities elsewhere, facilitating their discharge and enabling a ward to be closed on the Eastbourne DGH site.

Mr Sunley advised that this work had been delivered alongside achieving the A&E target and the focus was now on winter plans to ensure there was sufficient capacity available to continue to deliver the target.

viii) Referral to Treatment Waiting Times

Mr Sunley reported that the organisation had again achieved the waiting time targets at an organisational level although a number of specialities had not delivered. Work was taking place to identify how capacity could be provided internally rather than relying on additional sessions at weekends, in the evenings and in the private sector.

ix) Cancer Waiting Time Targets

He reported that the Trust was working with Brighton and Guildford in relation to the 62 day screening target to ensure that the Trust received early notification in relation to colorectal and breast cancer patients if treatment was required.

He advised that in relation to the 62 day target from urgent GP referral the key services were colorectal and urology. Agreement had been reached to appoint a new consultant urologist to ensure more surgical capacity was available and this should ensure a major improvement in delivering the urological target. The new endoscopy unit had now opened which would increase the available capacity and reduce waiting times for diagnostic tests and the new CT scanner would also increase capacity.

Mr Welling queried in terms of the overall position the confidence level that the issues associated with various cancer targets would be resolved. Mr Sunley advised that he remained confident about those areas where the Trust had direct input, ie endoscopy capacity,, but less confident in areas where there were a small volume of patients and the detail needed to be worked through with other organisations.

x) Workforce

Ms Green reported that there had been an in month reduction in budgeted workforce due to reductions in bank and agency usage, particularly in urgent care and integrated care.

She advised that there had been a slight increase in sickness in the month which followed a similar seasonal change in previous years.

Ms Green reported that generally mandatory training compliance had improved with the exception of Trust induction. She was disappointed that appraisals compliance continued to fall but a new appraisal process would be introduced in the next financial year whereby incremental progression would be linked to performance and she was confident that this would help to restore compliance.

Mr Welling queried progress with the uptake of flu vaccinations and Ms Green advised that 34% of front-line staff had received vaccinations against a target of 75%. Mr Grayson stated that the Trust's levels remained low compared to other Trusts and, whilst reasonable steps were being taken to encourage staff to have the vaccination, it was very disappointing that the uptake could not be improved beyond the mid 30%, particularly as the Secretary of State had been very clear that the allocation of future financial support for winter would be linked to achieving 75% of staff having the vaccination.

b) Finance

Mrs Harris reported that for October the Trust had a run rate deficit of £19.4 million which was equivalent to the forecast deficit for the year. She noted that the in year financial recovery plan forecast was that the position would worsen before it improved.

She advised that in comparison to the Trust's original plan submitted to the TDA the position was £8.9 million adverse and against the in year financial recovery plan £1.9 million adverse. There had been a significant under-achievement in income and pay costs in respect of agency, overtime and adhoc payments were above plan. In addition, cost improvement savings had not been delivered in the month.

Mrs Harris reported that the Trust had drawn down two temporary borrowing loans - £15 million in June and a further £9 million in October – to ease its cash flow position.

She explained that part of the reason for income being below plan was the estimated provisions made for fines and penalties as no agreement had yet been reached with the commissioners on how much would be charged.

She noted the capital expenditure position; demand continued to outstrip resources and advised that the Trust had submitted an application for an additional £4 million capital resource for this financial year and the TDA would advise the Trust whether it had been successful in January.

Mrs Harris outlined the risks that the Trust faced for the final four months of the year and summarised that performance in month 7 had not been as good as had been anticipated. She expected the position to improve in month 8 with the turnaround programme in place linked to the financial recovery plan.

She confirmed that all actions being taken in turnaround that affected patient care required a quality and safety impact assessment and the Nurse Director and the Medical Directors met on a weekly basis with the Turnaround Director to ensure that there was no reduction in quality and safety.

Mr Nealon commented that the figures for October were disappointing and the Turnaround Director was working with each Clinical Unit to reinforce the need to run as efficiently as possible within the bounds of safety.

Dr Hughes reported that the Clinical Units were identifying projects with the support of the turnaround team and these projects were reviewed against a set of metrics for maintaining safety and quality on a weekly basis by himself, Mrs Webster and from a strategic viewpoint, Dr Slater, and operationally, Mr Sunley. The quality and safety metrics had been shared with the TDA to ensure that the Trust was not missing any areas.

Mr Grayson asked Mrs Harris to clarify how the shortfall on income was made up and Mrs Harris said it comprised £4.8 million of fines and penalties, including readmissions of £1.9 million, and a fall in activity relating to elective inpatients. These patients were on the waiting list and would still need to be treated and the Trust would therefore eventually receive the income.

In response to a query from Ms Kennett, Mrs Harris stated that she would present a turnaround report at the next meeting which would set out the progress made up to month 9 and in the meantime the Finance and Investment Committee monitored progress on a monthly basis and the executive on a weekly basis.

Resolved:

The Board noted the reports and the actions being taken to deliver the key performance measures and the initiation of the in year financial recovery plan.

112/2013 Mortality Indicators and Metrics Report

Dr Hughes presented the report and noted that Sir Bruce Keogh on behalf of NHS England had recently advised that best practice should be to use these indicators and metrics as signals and alerts prompting further scrutiny.

He reported that the Trust's Hospital Standardised Mortality Ratio (HSMR) had reduced sequentially year on year and sat within the national norms. The Summary Hospital-level Mortality Indicator (SHMI) described mortality through different statistical analysis and this indicator was higher but the Trust was not an outlier. The Trust was working with the Health and Social Care Information Centre to identify and resolve any issues with the validity and comparability of the data due to the Trust being an integrated acute and community provider.

He advised that any concerns or outlying performance identified through these indicators or metrics were reviewed through case note reviews by senior clinicians. To date they had not identified any avoidable mortality underpinning these indices.

Dr Hughes reported that an improved more robust system of review at Mortality and Morbidity meetings had been introduced and all the processes were overseen by the Mortality Review Group to bring further executive focus on the indicators.

He also advised that the Trust had contracted with CHKS to provide not only HSMR and SHMI data but also Risk Adjusted Mortality Indicator (RAMI) data at a clinical unit and individual clinician level on a real time basis.

Dr Harrison commented that the right processes were in place and the data provided by CHKS would allow the Trust to drill down to individual incidents beneath the figures and reconcile them back to the mortality and morbidity reviews to understand the data.

Resolved:

The Board noted the report and the proposed next steps.

113/2013 Emergency and High Risk General Surgery

Mr Sunley reported that the proposed date to single site emergency and high risk general surgery on to the Conquest Hospital site was 14th/15th December 2013. The date had been agreed with Miss Donnellan, the Clinical Unit lead, and balanced clinical need and the practicality of managing the service during the winter/Christmas period.

Mr Welling reported that the Board had met with Miss Donnellan in seminar session to discuss the safety and quality measures taken to ensure a smooth transition of the service and understand the risks to patients if the move did not take place and the risks of the move relating to the colorectal cancer multi-disciplinary team meetings, the vascular service and the impact on Brighton and Sussex University Hospitals Trust (BSUH).

a) Colorectal Cancer Multi-disciplinary Team (MDT) Meetings

Dr Slater referred to the letter received from the colorectal surgeons at EDGH and the principal point related to compliance with the requirements of the MDT. He explained that the current position was that there were two MDTs, one on each site, and the Conquest had oncology support provided by Maidstone and Tunbridge Wells whilst the Eastbourne DGH had support from Brighton. He outlined the proposal to provide a single MDT with support from Brighton which had always been the long term plan but advised that Brighton would have difficulty in providing a job plan for their oncologists to support a single MDT in the short term.

Dr Slater outlined the interim arrangements which had been proposed and had been discussed with the cancer network who had felt that the arrangements were appropriate on a time limited basis, with a fully compliant MDT being provided from April.

Dr Slater reported that he had met with the Eastbourne colorectal surgeons who were concerned that there was the potential for Eastbourne patients not to have the benefit of a full MDT discussion of their cases with the oncologist from BSUH and following negotiation and identification of resources it had been agreed that a full MDT would continue on Eastbourne site until a Brighton oncologist was available to support the single MDT on the Conquest site. He pointed out that neither MDT as currently configured would meet the national requirements of a MDT from January as the standards had become more stringent and the expectation was that from April 2014 MDT provision would comply with the revised standards.

Mr Grayson asked if the Kent, Surrey and Sussex Cancer Network had indicated their support of the interim arrangement in writing and Dr Slater advised that this had not yet been received but would follow this up.

b) Vascular service

Dr Slater reported that BSUH supported the emergency vascular service across Sussex and would be taking over the provision of elective vascular work across Sussex but as yet a date had not been agreed for this move. The Trust's initial view was that it would not be appropriate to undertake a double move of vascular elective patients from Eastbourne to Conquest and then to Brighton but in the absence of a firmly agreed date for the transfer of the work the issue was how the elective vascular work could be sustained at the Eastbourne DGH. He would be attending a county wide meeting on 4th December to discuss the provision of the elective vascular service.

He stated that it was his view and that of Miss Donnellan that if the time period was relatively short then it would not be appropriate to move patients twice. However, if the time period was longer, then the clinical risks need to be managed and it would be more appropriate for the higher risk vascular patients to move across to the Conquest but the radiology work would stay at Eastbourne DGH with vascular surgeon cover.

Mr Grayson suggested that following the meeting on the 4th December a decision would be made on the future provision of elective vascular services based on the risks relating to the management of a relatively small number of cases a week.

c) Impact on BSUH

Mr Grayson reported that there had been detailed discussions with BSUH, MTW and the ambulance service in relation to those patients who would go to an alternative provider following the move. The original estimates in the Pre-Consultation Business Case had been 5% of patients and, having worked through the issues at a granular level this view was sustained with the number of patients going to MTW on average being estimated to be 1-2 a week which MTW had accepted.

He advised that the number for BSUH would be on average 6 a week, also in line with the PCBC, and discussions were continuing with BSUH to secure agreement that this additional work load could be managed. If this agreement could not be secured then the discussion would be escalated to Chief Executive level for resolution.

Mrs Harris reported that there would be a cost to the move of £89,000 part year effect for additional nursing staff and the small loss of income to Brighton.

She queried if the Interventional Radiology Suite would be operational from 23rd December and Dr Slater confirmed that this was the case and training for the new suite had been provided off site on similar equipment. He stated that this upgrade would provide significant quality gains.

Mrs Harris asked if the current shortfall in nursing had been addressed and Dr Slater said that recruitment was on-going. Mrs Webster advised that plans were in place to manage the process safely in the initial phase and identified that there were significant risks in relation to nurse staffing if the move did not take place.

Dr Slater confirmed that there would be senior clinicians to oversee the move in order to ensure that it ran as smoothly as possible.

Mr Sunley reported that in terms of winter pressures the ambulances would come direct to the Surgical Assessment Unit and surgeons would be on site to manage the patients straightaway which would reduce the pressure on A&E.

Resolved:

The Board authorised the move to single site emergency and high risk general surgery on the Conquest site from 14th/15th December 2013, subject to further assurances around the colorectal MDT, the elective vascular service and agreement with BSUH and delegated the Chief Executive to give the final authorisation once he was satisfied with the further assurances provided.

114/2013 **Specialist Commissioning Compliance with national service specifications and adoption of derogation plans**

Mrs Harris reported that NHS England had created a single operating model for nationally specialised services and those organisations providing such services were required to be consistent with the policies and service specifications by 1st October 2013. Where organisations were not compliant, a formal service derogation would be agreed with NHS England with a detailed action plan to achieve compliance with agreed timescales.

She explained that approximately 10% of the NHS budget was spent on specialised services and of the 196 service specifications only 8 affected the Trust directly.

Mrs Harris reported that work had taken place to assess the Trust's compliance with the eight service specifications over the summer and four had already been agreed as compliant by 1st October and four were subject to formal derogation. The two chemotherapy services were currently compliant apart from the Patient and Carer feedback and involvement domain and the deadline for compliance with this domain was the end of December. The other two services – urology cancer and vascular services – had derogations in place and the Trust had until the middle of December to confirm compliance with the variations on those.

She advised that there would be no financial impact in this change in arrangements for 2013/14 but in 2014/15 there was uncertainty on how the funding flow would be affected by the derogation exercise. In addition, there was anticipation that some services currently provided might be decommissioned in 2014/15 as they had changed the way in which they are delivered.

Mr O'Sullivan queried when the Trust would be able to confirm its compliance and Mrs Harris agreed to provide an update at the next meeting. She noted that the Clinical Commissioning Groups would provide compliance in respect of vascular services.

VH

Resolved:

The Board noted the progress to date and the assurances given internally and by the area team.

115/2013 **Annual Review of Standing Orders, Standing Financial Instructions and Schedule of Matters reserved to the Board and Scheme of Delegation**

Mrs Wells reported that the principal changes to the documents were summarised in the front sheet and reflected changes arising from the Health and Social Care Act 2012. The documents had been to the Audit Committee who had recommended that the revisions be approved.

Mr O'Sullivan reported that the documents had been thoroughly reviewed the previous year with a number of amendments and this year the amendments were largely administrative.

Mrs Harris pointed out that under the Scheme of Delegation point 13.1.2 addition f) referred to capital expenditure over £500,000.

Resolved:

The Board approved the revisions to the Standing Orders, Standing Financial Instructions and Schedule of Matters reserved to the Board and Scheme of Delegation.

116/2013 **Board Sub-Committee reports and Trust Board Seminar Notes**

a) Audit Committee

Mr O'Sullivan presented the report on the Audit Committee meeting held on 6th November 2013 and highlighted the Audit Committee's concern that South Coast Audit was only able to provide limited assurance on compliance with mandatory training and this issue had been picked up regularly in the Board performance reports.

Ms Green reported that the Assistant Director of Workforce Development was leading on a review of the level of training need in the organisation and the development of a training passport across Surrey, Sussex and Kent to enable staff to move between organisations with an accepted level of competency.

b) Finance and Investment Committee

Mr Nealon presented the report from the Finance and Investment Committee meeting held on 23rd October 2013 and highlighted the useful information being provided from service line reporting enabling deep dives to be undertaken into individual lines of activity to monitor for outliers.

c) Quality and Standards Committee

Mr Ellis presented the report for the Quality and Standards Committee held on 12th November 2013 and advised that on a temporary basis the Quality and Standards and Patient Safety and Clinical Involvement Committees had been brought together until early next year whilst a review was conducted of how the two groups worked together.

He reported that there had been a discussion on the quality of medical records and it had been agreed that this would be a subject of a deep dive at the next meeting.

d) Trust Board Seminar

The notes of the Trust Board seminars held on 14th August, 11th September and 9th October 2013 were received.

117/2013 **Quality Walks**

Discussion took on possible themes for quality walks for the next two months and the following areas were suggested:

General surgery
Impact of turnaround and financial recovery
End of life care
District nurses
Quality of patient notes

118/2013 **Board Meeting dates for 2014**

The meeting dates for 2014 were noted.

119/2013 **Questions from members of the public**

a) Stroke Services

Ms Walke reported that she had received positive feedback relating to the stroke service.

She raised the issue of a particular patient awaiting scans and she was asked to discuss this with Mrs Webster or Dr Hughes outside of the meeting.

b) Emergency and High Risk General Surgery move

Ms Walke asked if it was possible that maternity could go back to Eastbourne DGH because of the other service changes. Mr Welling advised that it was for the Clinical Commissioning Groups to decide as to where maternity and paediatric services were based for the long term. If they decided a consultant based service should be provided at both Eastbourne DGH and the Conquest, then the Trust would have to determine its capability to deliver the service.

Mr Grayson stated that the move of emergency and high risk general surgery was had been planned in the Outline Business Case and Pre-Consultation Business Case. He advised that it was possible and safe to move maternity and paediatric consultant led services to Eastbourne DGH but it was his personal view that consultant led safe maternity and paediatrics services could not be provided on both sites.

c)

Public Dividend Capital

Mr Campbell asked if it required Board approval for short term loans to be changed to Public Dividend Capital.

Mrs Harris advised that it needed both the Trust Board and Trust Development Authority approval.

d) Budget for 2014/15

Mr Campbell asked if the budget for 2014/15 could be produced without approval of the Shaping our Future Full Business Case and both Mr Grayson and Mr Welling confirmed this was the case.

e) Shaping our Future Full Business Case

Mr Campbell asked what was the final date for approval of the Full Business Case and Mr Grayson advised that it was being considered in the private part of the meeting, following which a date would be decided for an additional Board Meeting to consider the Full Business Case in public.

120/2013 **Date of Next Meeting**

Wednesday, 29th January 2014, at 10.00 am in the St Mary's Board Room, Eastbourne DGH.

121/2013 **Closed Session Resolution**

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

Signed

Position

Date

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday, 11th December 2013, at 10.00 am in the St Mary's Board Room, Eastbourne DGH

Present: Mr Stuart Welling, Chairman
Mr Charles Ellis, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mr Barry Nealon, Non-Executive Director
Mr James O'Sullivan, Non-Executive Director
Mr Darren Grayson, Chief Executive
Mrs Vanessa Harris, Director of Finance
Dr Andy Slater, Joint Medical Director
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Alice Webster, Director of Nursing

In attendance: Ms Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development and Assurance
Mrs Lynette Wells, Company Secretary
Mrs Trish Richardson, Corporate Governance Manager (minutes)

122/2013 Welcome Action

Mr Welling welcomed everyone to the additional meeting of the Trust Board and advised that this meeting and all future Board meetings would be recorded to ensure accuracy in the records.

He noted that apologies for absence had been received from Dr David Hughes, Medical Director – Clinical Governance, and Jan Humber, Staff Side Chairman.

123/2013 Declarations of Interest

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

124/2013 Clarification of Voting Members

Mr Welling confirmed that the members of the Board entitled to vote were:

Chairman, Non-Executive Directors, the Chief Executive, Deputy Chief Executive/Chief Operating Officer, Director of Nursing, Medical Director - Strategy and Director of Finance.

125/2013 **Chief Executive's report**

a) Shaping our Future Phase 1 – Emergency and High Risk General Surgery

Mr Grayson confirmed that the move of emergency and high risk general surgery would take place on 14th/15th December 2013 as planned. He reminded the Board that further assurances had been sought on the elective vascular service and the impact on Brighton and Sussex University Hospitals Trust (BSUH) of the move.

He advised that the issue in relation to the impact on Brighton and Sussex University Hospitals Trust (BSUH) had been resolved through a range of operational measures to manage the situation and he expressed his thanks to Brighton, Maidstone and Tunbridge Wells NHS Trust and the ambulance service for their co-operation.

In relation to the elective vascular service, he reminded the Board that the plan was to centralise this service to BSUH, as had already occurred with the emergency vascular service, in line with the recommendations of the review by the Vascular Society carried out on behalf of the commissioners. The Trust treated approximately 90 elective vascular patients a year, averaging two patients a week, who underwent high risk procedures with major arterial requirements and an ITU stay thereafter. It had initially been thought that BSUH would take over the elective service before the end of this calendar year but for a number of reasons this would not now happen until at least the second half of the next calendar year.

He reported that at the Clinical Management Executive the previous Monday the Vascular Lead and the Clinical Unit Lead had recommended that the elective vascular work be centralised at the Conquest Hospital with high risk general surgery and this had been approved. As vascular work was regarded as a tertiary service and a service for the Trust which was only supported by two surgeons, he had also asked Dr Slater and the Clinical Unit to consider how the service should be provided in the short to medium term until Brighton was able to provide the full elective tertiary service.

Mr Welling queried the view of the commissioning body and Mr Grayson reported that the vascular service was a specialised service commissioned by the Local Area Team for Surrey and Sussex. There was currently a derogation in place as BSUH was not yet in a position to take the full complement of the Sussex workload. The Local Area Team had been informed of the Trust's plans to centralise on safety grounds.

A&E

Mr Grayson reported that the Trust was on black due to the acuity of patients attending A&E and had been on business continuity for 24 hours.

Maternity and Paediatric Services

Mr Grayson reported that two of the local Clinical Commissioning Groups – Hastings and Rother and Eastbourne, Hailsham and Seaford – were meeting together later that day to consider the pre-consultation business case for maternity and paediatric services.

126/2013 **Phase 1 Implementation of the Shaping our Future Clinical Strategy Full Business Case (FBC)**

Mr Welling reported that the FBC had gone through a number of iterations to arrive at this final version and he wished to ensure that the Board was fully assured on all the key aspects.

Mr Grayson commented that the FBC was the case for implementing the decision made a year ago by the commissioners and the Health Overview and Scrutiny Committee on the way forward and securing the capital to support that decision.

He reminded the Board that the work on Shaping our Future began in 2010/11 when eight primary access points had been identified for review and the FBC outlined the investment required to substantially redesign emergency care, cardiology and acute medicine and reconfigure stroke, emergency and high risk surgery and emergency and high risk trauma and orthopaedics. This included investment in theatres and oncology, which included the redevelopment of the Pevensey Unit on the EDGH site, and backlog maintenance and improvement of the infrastructure. The estates element of investment would also be supplemented with the use of the Trust's own capital.

He advised that the investment would enable the Trust to improve safety quality and privacy and dignity as well as putting it in a position to respond to the future commissioning intentions of the Clinical Commissioning Groups and allow the Trust to deliver sustainable health services for the local population and respond to national requirements to deliver improved outcomes.

Mr Grayson commented that the Trust wanted to develop centres of excellence and the first step had been to centralise the stroke service in July and as a result there had been a substantial improvement in that service although there was still further to go. The changes outlined in the FBC provided the Trust with the opportunity to develop a gold standard stroke service and be an exemplar for this service.

Dr Slater reported that the current models of care were not sustainable and did not meet the ever increasing quality demands within the NHS. The Shaping our Future work had reviewed the services in terms of redesign and reconfiguration and this FBC demonstrated how the Trust would work to provide sustainable and efficient services in the future.

He commented that by providing a high quality service the length of stay of patients would be reduced within the acute hospitals, thereby reducing the number of beds required with a consequent reduction in the number of staff required. The key to reducing length of stay was to ensure that patients were treated in the right place at the right time with the appropriate degree of seniority and appropriate reablement services to ensure patients could be discharged safely. The FBC provided for a 4% annual reduction in length of stay for the next five years which was achievable but challenging.

Mrs Harris reported that the Outline Business Case approved in November 2012 set out the finances for the three services where reconfiguration was required and therefore there were different values in the FBC as it covered the six services. She highlighted that page 18 outlined how the £30 million would be invested on the two sites and how it would improve the estate infrastructure and yield quality improvements through patient experience and patient outcomes. She advised that the FBC did not necessarily address all the backlog maintenance issues because of the age of the two estates and a £2.8 million backlog clearance investment would be required going forward and this would be planned annually through the £10 million capital programme.

She advised that the methodology being used for the procurement and delivery of the project, Procure 21, was a recognised national scheme and guaranteed a maximum price for delivery. Balfour Beatty was the selected partner for the Trust and they would manage the procurement and delivery of the project.

She reported that the revenue savings were forecast to be £34.1 million after five years from the £30 million investment across the six areas and section 5 of the FBC detailed how the investment and cost reductions would be made.

Mrs Webster commented that the improvements outlined in the FBC would continue to improve patient experience.

Mr Ellis reported that the Quality and Standards Committee had reviewed an earlier draft of the FBC and were assured that quality would be maintained and enhanced across the Trust.

Mr Welling asked if there were any issues in relation to the operational implementation and Mr Sunley advised that the project office had drafted the FBC with the support of Balfour Beatty and he had no concerns at this stage.

Ms Kennett referred to the risks highlighted within the FBC and asked what would be the process if a risk materialised before the Trust Development Authority (TDA) had reached its decision on the FBC.

Mr Grayson advised that the TDA would inform the Trust of the timeline for consideration by its Board once the FBC was received. In the meantime, issues of clinical safety and performance would be dealt with on day to day basis through well developed internal operational and governance processes. If the risk related to the estate and/or infrastructure, the capital programme had £1 million set aside for backlog maintenance. The Trust's accountability remained and it would need to demonstrate that it was taking all reasonable and appropriate measures for patient safety to ensure sustainability of services in the short term.

Mr Nealon reported that the Finance and Investment Committee had reviewed the FBC in detail and tested it from an economic viewpoint. Mrs Harris reported that the financial risks were set out in section 5.19 and showed how these were mitigated.

Dr Harrison highlighted that the FBC did not cover maternity and paediatrics and the Trust would need to respond to any consultation by the Clinical Commissioning Groups on these services and detail the financial implications of any of the options being consulted on and the investment required.

Mr Grayson highlighted that the investment in the FBC was split roughly half and half between the two acute sites and was seeking to bring both hospitals up to modern standards. The £15 million planned to be invested in the Eastbourne DGH would cover A&E, wards, theatres and a range of other areas. This was the most substantial investment in the estate and in past years the great majority of investment had been spent on the Eastbourne site including £5 million on endoscopy.

Mr Grayson advised that if the Board approved the FBC, it would then be submitted to the TDA for approval at some point in the new year.

127/2013 **Matters Relating to the Report on the Agenda raised by members of the public**

Ms Walke queried the process for submission of the FBC and Mr Welling confirmed that the Board needed to approve the FBC in order for it to be submitted to the TDA.

128/2013 **Phase 1 Implementation of the Shaping our Future Clinical Strategy Full Business Case (FBC)**

Resolved:

The Board unanimously approved the Phase 1 Implementation of the Shaping our Future Clinical Strategy Full Business Case and noted that it would now be submitted to the Trust Development Authority for consideration.

129/2013 **Date of Next Meetings**

Wednesday, 29th January 2014, at 10.00 am in the St Mary's Board
Room, Eastbourne DGH

Signed

Position

Date

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 27.11.13 Trust Board Meetings

Agenda Item	Action	Actioned By	When	Progress
<i>113/2013 Emergency and High Risk General Surgery</i>	Final authorisation to be provided by Chief Executive for the move to take place on 14 th /15 th December	Chief Executive	11.12.13	Chief Executive confirmed assurances had been received and the move of emergency and high risk general surgery would take place on 14 th /15 th December
<i>114/2013) – Specialist Commissioning Compliance</i>	Update to be provided at next meeting on Trust compliance.	Director of Finance	29.01.14	ESHT has worked with the Local Area Specialist Team to progress the four outstanding derogations. Two of the four derogations have become 'commissioner led' and require development of Sussex wide solutions. One of the derogations is dependent on part of the pathway being resolved by an out of area Trust. The fourth derogation will be part compliant by 1/4/2014 and estimated to be fully compliant by 03/6/2014.

East Sussex Healthcare NHS Trust

Date of Meeting:	29 th January 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	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Decision
Purpose:				
Attached is the updated Board Assurance Framework (BAF) which brings together the strategic priorities and objectives of the organisation, with an assessment of their risks, the controls in place and details of the internal and external assurance along with associated actions.				

Introduction:
<p>Risks to achieving the Trust's strategic objectives were reviewed and agreed by the Board at a Risk Seminar as follows:</p> <ul style="list-style-type: none"> • We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies • We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties. • There is a lack of leadership capability and capacity to lead ongoing performance improvement and build a high performing organisation. • We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy. • We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability. • We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners. • We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity. In setting a deficit budget for 2013/14 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers. • We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements. • We are unable to develop and implement effective cultural change programmes that lead to improvements in organisational capability and staff morale.

- We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.
- We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change

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

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

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

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

Benefits:

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

Risks and Implications

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

Assurance Provided:

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

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

Audit Committee – 8th January 2014
Quality and Standards – 7th January 2014

Proposals and/or Recommendations

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

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

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

None identified.

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

Name: Lynette Wells, Company Secretary	Contact details: Lynette.wells@esht.nhs.uk
--	---

BOARD ASSURANCE FRAMEWORK

Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	RAG
<i>What control/systems we have in place to assist in securing delivery of our objective</i>	<i>Where we can gain evidence that our controls/systems, on which we are placing reliance are effective</i>	<i>We have evidence that shows we are reasonably managing our risks and objectives are being delivered</i>	<i>Where we are failing to put controls or systems in place or where we are failing to make them effective</i>	<i>Where we are failing to gain evidence that our controls/systems on which we place reliance are effective.</i>	Assurance level:
<p>Examples:</p> <ul style="list-style-type: none"> • Strategies, policies, procedures, guidance • Robust systems, programmes in place • Budgets, control, monitoring • Working groups/committees • Specific or team accountability • Planning exercises • Training (or other) needs assessments • Training completed • Objectives set and monitored • Accountability agreed and known • Frameworks in place to provide delivery • Contracts/agreements in place • Performance/quality monitoring • Action plans agreed at appropriate level and monitored • Complaint/incident monitoring • Risk assessments • National returns • Routine reporting of key targets with any necessary contingency plans 	<p>Examples:</p> <ul style="list-style-type: none"> • External audit • Internal audit • Care Quality Commission • Clinical audits/reports • Performance indicators • External reviews/reports • Internal reviews/reports • Benchmarking undertaken • Patient/staff surveys • Local/national audits • Internal/local committees/groups • Management/ performance reports from contractors/ partners • Minutes of meetings 	<p>Examples:</p> <ul style="list-style-type: none"> • Actual performance figures • Achieved ratings/targets • Proven progress against action plans • Clinical audits/reports • Received external audit reports • Controls that are deemed to be satisfactory and can be shown to be operating effectively in relation to the risk 	<p>Examples:</p> <ul style="list-style-type: none"> • No regular reviews/performance monitoring or no review mechanisms • Poor/unknown data quality • No monitoring of reviews or done at an inappropriate level • Insufficient training for staff to be competent to support process • Gaps in taking action required/linking findings to action • Lack of ownership • Control does not cover all the objective or risk indicators/reports not sufficiently developed to cover all that is required • Incorrect assumptions being made 	<p>Examples:</p> <ul style="list-style-type: none"> • No or inadequate assurance that performance figures provided are correct • No real assurance that reports/planning/action plans/frameworks are correct/effective/have been done • No assurance that strategies, policies, training are known and effective 	<div>Effective controls definitely in place and Board satisfied that appropriate assurances are available.</div> <div>Effective controls thought to be in place but assurance are uncertain and/or possibly insufficient.</div> <div>Effective controls may not be in place and/or appropriate assurances are not available to the Board</div>

Key:

Chair - Chairman
 CD - Commercial Director
 COO -Chief Operating Officer
 DN - Director of Nursing
 DF - Director of Finance

DSDA - Director of Strategic Development and Assurance
 DT - Director of Transformation
 HRD - Director of Human Resources
 MD - Medical Director

↔ Status of risk unchanged

↓ Risk reduced

↑ Risk increased

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
Risk 1.1: We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies									
1.1	<p>Robust CQC action plan in place, monitored at Board level.</p> <p>NHSLA project plan developed and monitored through Committee structure.</p> <p>Feedback and implementation of action following “quality walks” and assurance visits.</p> <p>Provider Compliance Assessments (PCA) training.</p> <p>Reinforcement of required standards of patient documentation</p>	<p>Outcome of CQC unannounced inspections</p> <p>NHSLA assessment</p> <p>Internal reviews inc/board level 'Quality Walks'</p> <p>CQC risk profile</p> <p>Board and Committee minutes</p> <p>Patient and Staff Surveys</p> <p>Health and Safety Executive</p> <p>IG Toolkit</p> <p>HR processes</p> <p>External accreditation/peer reviews</p>	<p>CQC reports.</p> <p>Provider Compliance Assessments being completed at ward level and gaps reviewed.</p> <p>Internal audit report on CQC compliance</p> <p>Weekly audits and reviews eg observations of practice</p> <p>Monthly reviews of data with each clinical unit</p> <p>Achievement of NHSLA level one and CNST (maternity) level two</p> <p>'Quality walks' programme in place and forms part of Board objectives</p>	<p>Documented audit trail not always available eg declaration of serious incidents, discussions re DNAR.</p>		<p>Ward/department visits to continue involving assurance team and peer reviews. Focus on specific outcomes eg consent paperwork, medical devices checks.</p> <p>Incomplete DNARs being logged as incidents and escalated for action.</p> <p>Jan-13 Weekly DNAR spot checks by Resus team escalated to senior management.</p> <p>Trust wide audit took place Feb, compliance improving but agreed that Resus policy and audit methodology to be reviewed.</p> <p>Aug-13 Resuscitation policy tabled at Clinical Management Executive and will be updated with group's comments.</p> <p>Oct-13 Compliance with policies reviewed at Policy Group and paper drafted for CME (Nov-13)</p>	<p>April 2012 ongoing audit throughout 2013/14</p> <p>Oct-13</p>	↔	MD

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued - Risk 1.1: We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies									
1.1	<p>Accountability agreed and known eg ADN, ward matrons, clinical leads.</p> <p>Implementation of quality governance framework</p> <p>Health and Safety Risk Assessments</p> <p>External visits register</p> <p>Ongoing work to embed learning and review sources of assurance</p>		<p>External visits register maintained; reviewed by Quality and Standards Committee</p> <p>Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors</p>	PCAs not fully developed at ward/department level		<p>Local PCAs have been developed and training provided. Audit of PCA self assessments undertaken. Jan-13 PCA compliance report presented to CME, focus on addressing gaps and concerns and testing evidence.</p> <p>May-13 Continued focus on addressing gaps, action plans to CME/Quality and Standards Committee</p> <p>Oct-13 Trust is reviewing changes in CQC compliance regime when published, including new surveillance model</p> <p><i>Dec-13 Reviewing CQC inspections reports published for other Trusts recently inspected under new model</i></p>	<p>Audit complete end Jan-13 ongoing development in place complete by Dec-13</p>	↔	DSDA

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Datixweb incidents are not 'finally approved' and a backlog has built up. This could impact export to NRLS and benchmarking reports against other similar organisations may not be a true reflection of the Trust incident profile.		01/09/2013 Proposal for sustainable management of incidents and achievement of timely incident agreed with divisions and working to clear backlog. <i>Dec-13 Quality checks and significant reduction in backlog achieved in time for export to NRLS end of Nov. Continued focus on incident management across Clinical Units.</i>	end Jan-14	↔	DSDA

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.									
1.2	Business Continuity and Major Incident Plans Training to develop service level BC plans Reviewing and responding to national reports such as Francis, Keogh and Berwick.	Information Governance Toolkit	Cancer - all tumour groups implementing actions following peer review of IOG compliance. Major incident testing debrief indicated plan is effective. Trust Board reviewed analysis of Keogh, Berwick et al and actions will be agreed and monitored through Quality and Standards Committee.	Inability to meet national screening standards for diabetic retinopathy due to increasing demand and limited capacity.		Recovery Plan and prioritisation in place Nov-12: Additional funding to support delivery of the Quality Standards not available - Exploratory meetings with Brighton DRSS to discuss possible Sussex wide service. Escalated to specialist commissioners who advised no additional funding, service provision being reviewed. Oct-13 Follow up waits currently at 17 months - discussion ongoing with Brighton re joint working.	01/06/2013 end Nov-13	↔	COO

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Jan-13 Demand on emergency services, impacting patient assessment and treatment time and subsequent discharge to other specialist/bed areas		<p>Action plan in place to enhance patient flow. Currently meet with SECAMB monthly to review issues and high level operational meeting planned.</p> <p>May-13 Identified number of options to improve ambulance flows - being explored</p> <p>Sep-13 Ambulance flows improved. Focussed work to be undertaken on further improvement to minimise risk of handover fines.</p> <p>Oct-13 Discharge/admission lounges on both sites and escalation plan in place for winter pressures</p>	end Nov-13	↔	COO

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 2 – Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences.									
Risk 2.1: We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.									
2.1	<p>Develop effective relationships with CCGs</p> <p>Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work.</p> <p>Relationship with and reporting to HOSC</p> <p>Programme of meetings with key partners including ESCC and MPs</p>	<p>Evidence of participation in Clinical Leaders Group</p> <p>External reviews and reports</p>	<p>Membership of newly formed local Health Economy Boards – UCN, Elective, Integrated.</p> <p>Commissioners, GPs, Adult Social Care invited to be members of Strategy Board.</p> <p>Collaboration with neighbouring Trusts through networks</p>	<p>Transition in commissioning arrangements mean clinical networks and leaders groups under review. Relationship with HOSC now focused on implementation.</p> <p>Communications strategy and approach needs refocusing following consultation.</p>		<p>Jan-13: ESHT participant in emergency clinical senate. Reinstatement of HOSC working Group. HOSC member on Shaping our Future Implementation Board. Communications strand part of implementation work. Build relationships with CCG teams and leads and emerging LAT leads. Ongoing Contract Management meetings and Single Performance Conversations.</p> <p>Oct-13 Ensuring sound plans for the delivery of Service transformation are developed and aligned to the Clinical Strategy. Meetings taking place with CCGs on development of primary care strategy. Programme for strategic change 2020 vision instituted by EHS and HR CCG</p>	Mar-13	↔	DSDA

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3 continued: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3	Robust complaints process in place that supports early local resolution	Internal patient experience surveys	Trust benchmarking by WM Quality Observatory	Change in process/contract for patient transport services having a detrimental impact on patient care and experience.		Review of Trust's SLA and KPIs with SECAMB and escalation of risks to commissioners. Incidents logged and reported monthly to SECAMB for investigation. Sep-13 SECAMB reviewed management arrangements. Ongoing review - issues escalated to commissioners.	end Nov-13	↔	COO
	Clinical audit plan Communications and marketing strategies developed and implemented Equality strategy and equality impact assessments Framework for delivery of mandatory training in place Appraisal policy and process in place	Complaints data and trends CQUINs Internal and external auditors Clinical audit FFT for Patient Experience	Dr Foster HSMR data Trust data and possible benchmarking for FFT	Inconsistent delivery of trust guidelines, policies and best practice is not addressed leading to variations in patient care and clinical outcomes. Poor quality of medical case note folders increases risk of inappropriate treatments, duplication of tests and interferes with patient care. Electronic records sitting outside of the nursing audit programme currently.		Action plans in place if deficiencies identified eg completion of nursing records, compliance with DNAR policy. Quality walks/assurance visits target specific areas. Nov-12 Establishing sub committee of health records steering group. Service, review by south coast audit and monitoring at patient safety committee. Sep 13- Quarterly audit of health records in place for 13/14. Review of how electronic records are monitored. Keogh review being evaluated and necessary actions implemented.	Mar-14		DN/ MD

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3 continued: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
				Mandatory training rates and completion of appraisal levels below expected levels.		Embed revised policy and compliance monitoring systems. Jun-13 - Discussing e-learning issue with local Trusts. IT currently sourcing solutions. Aug 13 - The e-learning content issue has been resolved by agreeing with Kent & Medway to utilise their server. All modules are now loaded and working on the K&M server. Oct 13 - Work is continuing on developing a mandatory training staff passport across the region which will focus on 10 key areas of mandatory training. All other training will be role related. For some areas of mandatory training, we are also looking to develop a competency assessment process which will reduce the need for staff to attend training.	Improved performance by Aug-12 ongoing throughout 2013 Work is ongoing but aim to complete passport and competency work by April 2014	↔	HRD

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic objective 3 – Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.									
Risk 3.1: We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity. In setting a deficit budget for 2013/14 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.									
3.1	<p>Clinical strategy development informed by commissioning intentions, with involvement of PCT and consortia</p> <p>QIPP delivery managed through Urgent, Planned and Integrated Care divisional governance structures aligned to clinical strategy.</p> <p>Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work.</p>	<p>Activity plan</p> <p>Workforce planning</p> <p>Clinical Strategy</p> <p>Divisional governance structure and performance meetings</p> <p>Joint audacious goal meeting with commissioners</p> <p>Monthly KPIs monitored</p> <p>PMO office in place</p>	<p>Trust participates in Sussex wide networks eg stroke, cardio, pathology.</p> <p>Written reports to CME on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated.</p> <p>Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored.</p>		Require robust controls to ensure achievement of 2013/14 financial plan and prevent crystallisation of identified risks eg fines, penalties, slippage on CIP programme, achievement of CQUINs, capacity and operational cost pressures	<p>May-13 Impact of fines and penalties being assessed on monthly basis and actions taken to mitigate income loss. Monitoring of QIPP schemes and CQUIN delivery. Activity being monitored against plan</p> <p>Aug-13 In-year Financial Recovery Plan being developed to ensure delivery of planned deficit budget.</p> <p><i>Oct/Dec-13 FRP in place and Turnaround Director appointed and focussing on cost base reduction. Progress on FRP delivery reported to F&I committee and Board.</i></p>	Commenced and ongoing review and monitoring to end Mar-14	↔	DF/DT

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
		Monthly review by Finance and Investment Committee	Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)	Increased pressure on Trust cash holding will impact ability to generate required surplus of cash to make payments.		<p>Aug-13 Daily monitoring of cash balances and weekly meeting re managing cashflow and assessing risks. £15m cash funding loan received from TDA,.</p> <p>Oct-13 Application for PDC Finance submitted to TDA 11th October 2013 - <i>to be considered at Jan ITFF meeting</i></p>	Controls implemented ongoing review throughout financial year	↔	DF

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.1 continued: We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity. In setting a deficit budget for 2013/14 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.									
				OPD referrals have reduced but not in line with original demand management expectations and there are some capacity constraints, especially in Trauma and Orthopaedics (T&O) and gastroenterology		OPD review undertaken of planned activity against capacity. Whole system recovery plans being discussed with commissioners	end Mar 2014	↔	COO
						T&O to model impact of loss of MSK contract. June 2012 - paper circulated to CLT for consideration. Sept-12: Service is being monitored to analyse impact ongoing May-13 Concerns with service to be escalated through Service Quality Review meeting Sep-13 Ongoing monitoring with commissioners. Oct -13 T&O referrals increased back to previous levels - being monitored. <i>Dec-13 Focus on reducing RTT times in line with Trust Policy, discussed by Board Nov 2013</i>	end Jun-12 with ongoing monitoring to end of Mar 2014	↔	COO

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.2: We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.									
3.2	Development of workforce strategy: - to align workforce plans with strategic direction and other delivery plans; - to ensure a link between workforce planning and quality measures	NHS Sussex workforce assurance process Staff utilisation reports. Integrated performance	Training and resources for staff development CQC maternity report DGH Jul-13	Final workforce strategy will be developed once plans for clinical strategy and financial recovery/market testing further defined.		Further develop workforce strategy aligned to clinical strategy	Mar-14	↔	HRD

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
	<p>measures</p> <p>Workforce assurance group disbanded and will be re-formed in line with CCG requirements which are still to be advised.</p> <p>Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data.</p> <p>Rolling recruitment programme</p>	<p>performance report.</p> <p>CQC staff survey</p>		<p>Inability to recruit to some specialties and significant vacancies in some areas . Some areas have identified that there could be shortages in the future due to ageing workforce and changes in education provision. Also national shortages in some areas eg cardiac physiologists, ODPs and anaesthetic staff</p> <p>Currently significant nursing and therapy vacancies - Oct 2013</p>		<p>Vacancies/difficult to recruit to posts reviewed.</p> <p>Jun-13: Rota and establishment review - escalation for hospital at night team and cardiology on call rotas.</p> <p>Aug -13 Action plan to support reduction in staff absence.</p> <p>Oct-13 Recruitment campaign in local and national press.</p> <p><i>Dec13 appointed 40 Nurses - 28 already started. Disclosure and barring check times reduced from average of 4 weeks to 48 hours supports expedited recruitment. 40 newly qualified nurses interviewed expected to start Feb'14 Ongoing therapy recruitment.</i></p>	<p>Ongoing throughout financial year - end of Mar-14</p>	↔	HRD

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.2 continued: We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.									
3.2				Maternity and paediatric inpatient services cannot provide a consistent quality of service so for some patients some of the time we do not meet the expected and required standards.	Dependency on mitigating actions is such that the risk of service failure is increased to an unacceptable level The delivery of a safe service becomes rapidly unsustainable in the short to medium term leaving us little time to implement mitigating actions	Daily monitoring and senior review. External NCAT review of services. Mar-13: NCAT report received. 8 Mar - Board considered safety of services; resolved that temporarily consultant led obstetric service, neonatal service (inc SCBU) in-patient paediatric service and emergency gynaecology service be based at the Conquest Hospital only and a stand alone midwifery led maternity unit be established alongside enhanced ambulatory paediatric care at DGH. May-13 Temp. reconfiguration implemented and being monitored. Sep-13 CCG seeking views to shape options for future consultation. <i>Dec-13 CCG Board reviewed and agreed options for future consultation. Consultation commencing Jan'14</i>	end Mar-13	↔	COO

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
	Capital funding programme and development control plan			Delay/failure of national IT programme means that the Trust cannot support the effective development of electronic records that support new models of clinical care.		<p>Draft IT strategy presented to May Bd seminar; further stakeholder consultation being undertaken. Aug-13 Community and Child Health (CCH) system FBC approved by Board/TDA. Project initiated 2 July 2013.</p> <p><i>Dec 13- Implementation of CCH project ongoing. Trust confirmed readiness to participate in procurement of Electronic Document Management System and Clinical Portal as part of the Sussex Collaboration. OBC approved by board Oct-2012.</i></p>	end Sep-2013	↔	DF

Board Assurance Framework - Dec13 Update

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

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
						<p>Commencing phase 2 to develop options for implementation of the clinical strategy. Need to develop positive working relationship with the new HOSC following local elections</p> <p>Aug-13 Steering Group and Programme management arrangements for Phase 2 in place. Assessment of services for inclusion underway in line with agreed methodology.</p> <p>Oct-13 Agreed to restrict activity during period of intense action on FRP.</p> <p>Work on frailty to be maintained as integral to successful achievement of FRP</p> <p><i>Dec-13 Focus on developing 2014/15 business plan</i></p>	end Jul 2013	↔	DSDA

East Sussex Healthcare NHS Trust

Date of Meeting:	29 th January 2014
Meeting:	Trust Board
Agenda item:	7
Subject:	Quality Improvement Plan Briefing
Reporting Officer:	Alice Webster, Director of Nursing David Hughes, Medical Director

Action: This paper is for				
Assurance		Approval	√	Decision
Purpose:				
The purpose of this briefing paper is to bring together the findings of a number of pieces of work to identify the common issues relevant to East Sussex Healthcare NHS Trust so that we can review the actions already taken and those under development and ensure that any additional requirements and clinical improvement is built into our strategic planning and also Quality Account priorities for 2014/15.				

Introduction:
As part of the Trust's ongoing commitment to provide high quality, safe services for patients, the quality improvement and quality plan will set out how:
<ul style="list-style-type: none"> • Patient safety is managed • Quality is improved through clinical effectiveness, and • Assurance is sought that these systems and processes are effective

Analysis of Key Issues and Discussion Points Raised by the Report:
During 2013, the Board has received updates on Improving Quality and Safety – addressing the recommendations of the reviews by Professor Sir Bruce Keogh and Professor Don Berwick. This plan will support the implementation of the action plan presented to the September 2013 meeting of the Trust Board aimed at addressing the recommendations of these published reviews.
In addition, it will use a model for improvement to consider:
<ul style="list-style-type: none"> • What is to be accomplished? • How will the Trust know that a change is an improvement? and • What change can be made that will result in improvement?

Benefits:
The paper offers a briefing and plan for the development of an integrated approach to clinical improvement.

Risks and Implications
There is a risk that failure to have robust improvement plan may result in an uncoordinated approach to quality improvement.

Assurance Provided:
Where the recommendations for Francis, Keogh and Berwick have highlighted further work for ESHT a range of work streams have already been implemented, however this work needs to be reflected in the Trust plan.

Proposals and/or Recommendations
The Trust Board is asked to note the content of the paper and support the development of an integrated approach to quality improvement through the development of a measurable Quality Improvement / Quality Governance Plan.

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

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

East Sussex Healthcare NHS Trust

QUALITY IMPROVEMENT PLAN BRIEFING

1. Introduction

- 1.1 The purpose of this briefing paper is to bring together the findings of a number of pieces of work to identify the common issues relevant to East Sussex healthcare NHS Trust so that we can review the actions already taken and those under development and ensure that any additional requirements and clinical improvement is built into our strategic planning and also Quality Account priorities for 2014/15.
- 1.2 Over the next three months members of the Trust will be working on developing a Quality Improvement/Quality Governance plan.
- 1.3 As part of the Trust's ongoing commitment to provide high quality, safe services for patients, the document will set out how:
 - Patient Safety is managed
 - Quality is improved through clinical effectiveness, and
 - Assurance is sought that these systems and processes are effective.
- 1.4 In addition, it will use a model for improvement to consider:
 - What is to be accomplished?
 - How will the Trust know that a change is an improvement?, and
 - What change can be made that will result in improvement?

2. Background

- 2.1 In March 2012, the Trust Board ratified the Quality Governance Plan which was described as an overarching plan outlining the framework for the delivery of quality governance at East Sussex Healthcare NHS Trust (ESHT) to support the provision of high quality services for patients. This new plan will build on this original document.

3. Context

- 3.1 During 2013, the Board has received updates on Improving Quality and Safety – addressing the recommendations of the reviews by Professor Sir Bruce Keogh and Professor Don Berwick. This plan will support the implementation of the action plan presented to the September 2013 meeting of the Trust Board aimed at addressing the recommendations of these published reviews.
- 3.2 Where the recommendations for Francis, Keogh and Berwick have highlighted further work for ESHT a range of work streams have already been implemented, however this work needs to be reflected in the Trust plan. It is intended that the findings of each of the three reviews will be summarised in a framework, clearly linked to the Trust's strategic objectives, where this link is not clear it is recommended that a gap analysis be completed to ensure the 'area' is not lost.

- 3.3 There are a number of recommendations which will be addressed by work being undertaken nationally by the regulatory organisations and professional bodies, which the Trust will respond as applicable.

4. Timescales

Action	Deadline	Lead
First review	17.01.2014	Head of Assurance/ Consultant Nurse for Advanced Practice
First draft to be circulated for consultation	31.01.2014	To be circulated to the Patient Safety and Clinical Improvement Group
Deadline for comments on first draft	14.02.2014	All those wishing to comment on the document. Comments to be provided to the Head of Assurance
Final first draft to be completed for submission to the March meeting of the Quality and Standards / Patient Safety and Quality Improvement Committee	19.02.2014	Head of Assurance/ Consultant Nurse for Advanced Practice
Presentation and discussion at the Quality and Standards / Patient Safety and Quality Improvement Committee	03.03.2014	Director of Nursing
To be presented to Trust Board	27.03.2014	Director of Nursing

5. Conclusions

- 5.1 Several highly relevant pieces of work have been underway within the Trust pre-dating the publication of the Francis Report. These include:
- Articulation of organisational values;
 - A clinical strategy programme designed to support the development of quality sustainable services;
 - Implementing the real-time patient experience feedback;
 - Developing the framework for the use of the FFT feedback across the Trust inpatient and outpatient areas;
 - A patient experience sub group to support the patient experience plan;
 - Learning from patient experience;
 - Measurement for quality improvement - ward quality dashboards are being developed and will be rolled out across the Trust in January 2014;
 - Listening to and supporting staff - Listening into Action is in place across the Trust.

- 5.2 It is imperative that the domains of work following Francis, Keogh, Berwick and Cavendish sit within the context of Trust Values.

6. Recommendations

- 6.1 The Trust board is asked to note the content of the paper and support the development of an integrated approach to quality improvement through the development of a measurable Quality Improvement/Quality Governance Plan.

East Sussex Healthcare NHS Trust

Date of Meeting:	29 th January 2014
Meeting:	Trust Board
Agenda item:	8
Subject:	Performance Reports – Quality Report November 2013 (month 8) Finance December 2013 (month 9)
Reporting Officers:	Vanessa Harris, Director of Finance Monica Green, Director of Human Resources Dr David Hughes, Medical Director (Clinical Governance) Richard Sunley, Chief Operating Officer Alice Webster, Director of Nursing

Action: This paper is for (please tick)			
Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>
Purpose:			
The purpose of the attached reports is to update the Board on the quality, performance, workforce and financial position of the Trust.			

Introduction:
The attached documents provide information on the Trust's performance for the month of November 2013 (month 8) against quality, performance and workforce indicators, and against finance for December 2013 (month 9), together with the year to date financial performance.

Analysis of Key Issues and Discussion Points Raised by the Report:
<p>Quality Report for November 2013 (month 8) The Trust maintained a 'performing' status against core National Performance Framework metrics.</p> <p>Elective Referral To Treatment targets remained above target but 9 specialties failed to achieve.</p> <p>Final month 7 Cancer performance shows the Trust failing against both 62 day urgent referral targets, as well as 2 week wait for Breast Symptoms.</p> <p>There were four C-Difficile cases reported in the month and the current outturn to month 8 is 31 against a target outturn limit of 25.</p> <p>There were 2 incidents and 8 breaches of mixed sex accommodation in month 8, causing the Trust to fall below threshold.</p> <p>Finance Report for December 2013 (month 9) The M9 in month position is a deficit of £1.7m which compares unfavourably against the expected recovery trajectory of £1m deficit. Cumulatively, the deficit has reached £22.3m, and is £1.7m adrift from the expected recovery trajectory of £20.6m. Income was above</p>

original Plan but below the expected recovery trajectory. However, expenditure totalling £31.4m was equal to the expected recovery trajectory. Paybill costs continue to reduce and in M9 were £0.8m below the average for the first 8 months of the year. The Turnaround Programme is now embedded within the organisation. There are significant risks to delivery of the planned deficit of £19.4m but progress is being made. The forecast outturn will be reviewed after closure of M10.

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.

The Board is aware of the month 9 financial position and the action being taken to deliver the financial plan.

Risks and Implications

The final outturn C-Difficile target of ≤ 25 cases has been breached, which will cause fines to be levied against the Trust.

Mixed Sex accommodation breaches in Month 8 will cause fines to be levied against the Trust.

ASI (Acute Stroke Improvement) indicator 2 (Direct admission to Stroke Ward) has not been achieved, which may result in commissioners withholding Trust income.

Risks to delivery of the income and expenditure plan and cash position are set out within the report. Unless the in-year recovery plan is delivered the Trust will not achieve its 2013/14 financial Plan.

Assurance Provided:

This report details the key performance measures for the Trust against its annual business plan and as measured by external partners and the Department of Health reflecting centrally reported and audited metrics.

The financial risks are being managed through the implementation of the in year financial recovery plan.

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

Clinical Management Executive 13.01.14

Finance and Investment Committee 22.01.14

Proposals and/or Recommendations

The Board is asked to note the following actions have been taken and are on-going:

- Delivery of the key performance measures
- Progress with the Turnaround programme is being made but there remain significant risks to delivery of the financial plan

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

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

None.

For further information or for any enquiries relating to this report please contact:	
Name: Andy Bailey, Business Intelligence Analyst David Wells, Head of Financial Planning	Contact details: andybailey@nhs.net david.wells6@nhs.net

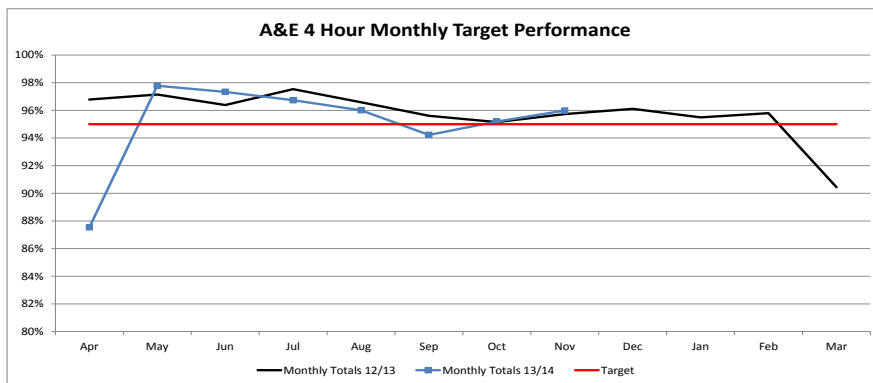
East Sussex Healthcare Trust

Quality Report (Including Performance, Activity and Workforce)

Month 8

November 2013



National Performance Framework (NPF)**-A&E performance**

Performance improved in month to to 95.98% and above the 95% target in November.

-RTT performance

RTT Performance remains above target levels at Trust Level, however there were 9 Specialties failing in month.

Within admitted pathways:

T&O (25 breaches) and Gynaecology (11) were below target.

Within Non-Admitted Pathways:

T&O (40), Oral Surgery (19), Thoracic Medicine (6) and Rheumatology (31) were below target.

Within Incomplete pathways:

T&O (260), Oral Surgery (31) and Rheumatology (97) were below target.

Actions being undertaken to address RTT performance include:

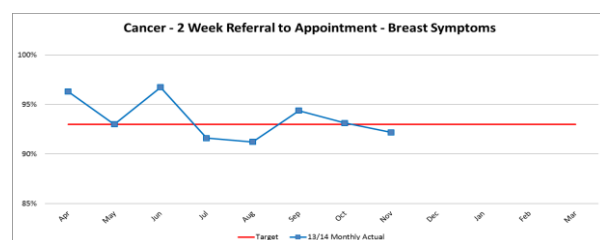
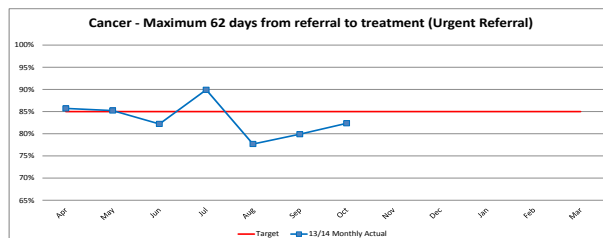
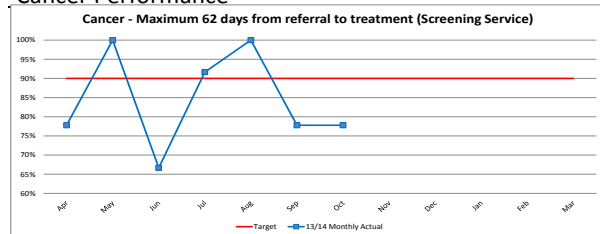
T&O: A detailed recovery plan around increased throughput for T&O is now in place. This involves converting OP sessions to theatre sessions and increasing theatre throughput and the early booking of theatre lists to identify shortages and surpluses in a timely fashion.

Ophthalmology: There will be an increase in OP ophthalmology space at Bexhill, and the approval of limited ad hoc sessions.

Rheumatology: Advertising and recruiting to key clinical posts within Rheumatology and altering clinical profiles.

-CDifficile

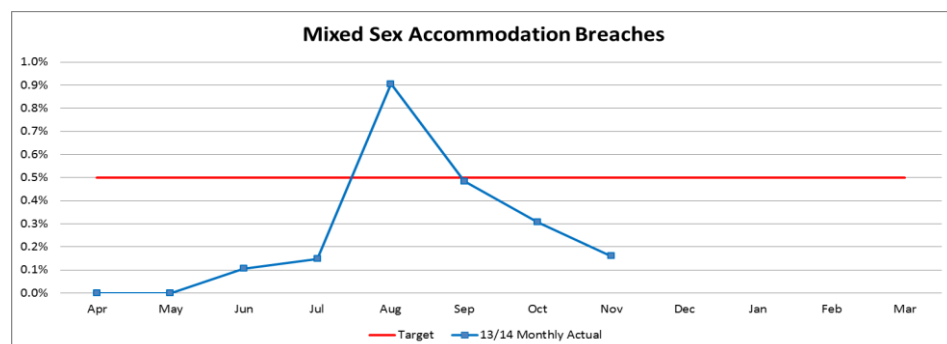
During month 8, total CDiff cases increased to 31, and above the annual ceiling of 25. The trust has revised it's internal trajectory to 45 as an aspirational ceiling for C-Difficile cases.

-Cancer Performance

Report Overview: Quality, Performance and Activity

Month 8 Cancer Performance is based on an early preview report. Final cancer performance for November will be available during the first week of January. As it stands, the trust is failing against 62 days screening referral to treatment, on account of 3 patient breaches, two of which were patient choice. The trust is also failing against the 62 day urgent referral to treatment target, on account of 16 breaches, one of which was patient choice. The Trust is also failing against 2WW Breast Symptoms on account of 10 breaches, 8 of which were patient choice.

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

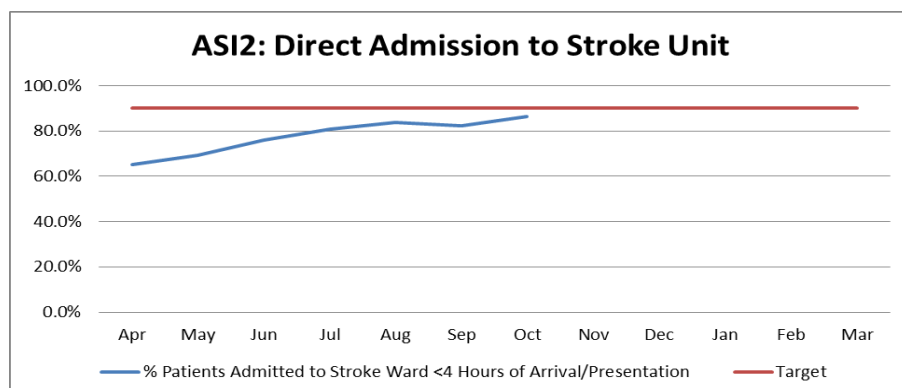


-There were 2 breach incidents affecting 8 patients in the month (this compares to 16 patients in September). The breaches remain located in the conquest A&E Observation wards. As an interim measure minor works are underway to partition the current CDU to eliminate breaches in this area. It is anticipated that this interim measure will be in place early December. Long term, the Trust is working with external partners (Balfour Beatty) to explore building work that needs to be undertaken to support the long term changes required to support the clinical strategy.

Diagnostics; % Patients seen < 6 weeks

Diagnostic Performance declined in November due to breaches in endoscopy (57) and Radiology (16). Additional clinics are being scheduled to ensure that performance returns to target in month 9.

Stroke



Stroke performance remains above target in four out of five ASI indicators. The failing target is *Percentage of Patients Admitted to a Stroke Ward within 4 hours of Presentation*. The target for this indicator is 90%. The trust has improved month on month consistently since April, but remains below target on account of a small number of breaches (5-8). These breaches now primarily fall into 2 categories; Patients taken to the conquest hospital by SECAMB in error and patients that die en route to the Stroke ward (these patients are included within the indicator tolerance and cannot be excepted). The stroke team undertakes twice weekly multi disciplinary validation meetings to ensure that all possible pathway improvements can be made. The trust continues to feedback to SECAMB the need for suspected stroke patients to be

Enhancing Quality of Life for People with Long Term Conditions

- The rate of unplanned hospitalisation for chronic ambulatory care conditions has stabilised, and remains below 12/13 baseline.
- The rate of unplanned hospitalisation for specific conditions in U19s has reduced significantly, and in line with plan.

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

- Emergency Admissions for acute conditions not usually requiring admission remains on a downward trend, in line with plan. Emergency Admissions for Children with lower respiratory tract infections have begun to rise.

-Emergency Re-Admissions

The rate of Emergency Re-Admissions within 28 days decreased slightly in month to 10.54. Work has begun to detail all readmissions at clinical unit level to identify common themes in discharging practice that will help eliminate avoidable emergency re-admissions in the second part of the year.

Ensuring that People have a positive experience of care

On the Day Cancellations of Elective Surgery per 1000 Procedures

There was a steep decrease in Month 8 (4.04 compared to 9.03 in month 7 and a YTD average of 4.32)

Friends and Family Questionnaire

The trust achieved a 22.85% response rate in October. The results this month include the new Maternity FFT submissions. The highest response rate was within Maternity (46.95%) and the lowest within EDGH A&E (9%). The team continue to utilise volunteer services to telephone survey recent A&E attendees. This has so far proved successful in raising the response rate in this area.

The Trusts Combined Unify Net Promotor Score (NPS) declined slightly in September to 50. The best clinical unit being Cardiovascular Medicine (80). The lowest NPS during the month was in Theatres (40).

Patient Centred Care Planning

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

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

-Patient Safety Incidents

There was a decrease in reported patient safety incidents in November. The trust promotes a culture of incident reporting to ensure that key themes can be constantly identified and actions taken to reduce risks and maintain the safety of patients.

-Severe Harm Incidents

There were 5 Severe Harm Incidents in November. Two (40%) of these incidents were in relation to Labour/Birth. The remainder were equally distributed between Patient Transfer (1), Treatment (1), and Infection (1). These incidents are now being investigated to determine root cause and identify any learning that can be disseminated. It should be noted that as a result of investigation and RCA, severe harm incidents reported within the month 7 report have been reduced from 11 to 6 as a result of 5 being downgraded.

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

Work has been ongoing in ensuring assessments are undertaken and whilst there has been a decrease in the achievement of this target there has been a decrease in the numbers of falls across the trust.

Organisational Context

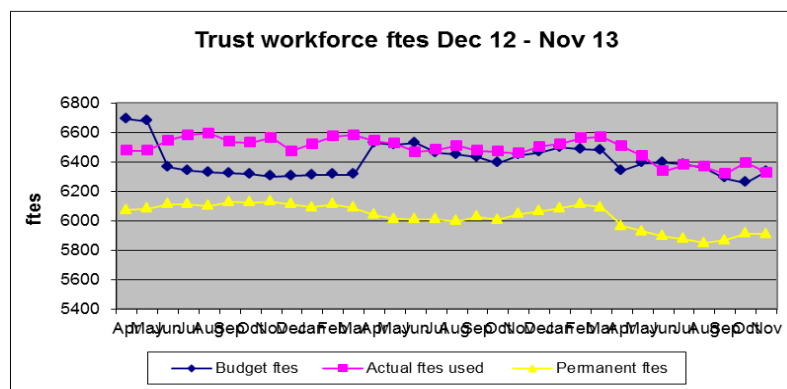
- GP Referrals decreased in November, and in line with this Outpatient Activity also decreased (both new and follow up). This increase was primarily across "Planned Care" specialties (ENT, Max-Fax, Ophthalmology, T&O)

- Other referrals were slightly below previous years average levels, but remain on an even trend for YTD.

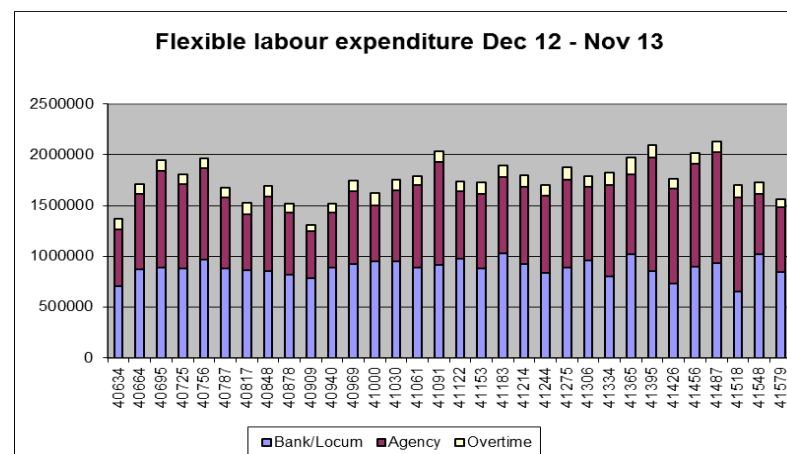
- Elective activity continues to rise (4th consecutive month) and is on an established upward trend for the YTD.

- Non-Elective Activity decreased in month but remains showing an upward linear trend year to date and above previous years levels.

Workforce Usage



	Year to Date	
	Target	Actual
WTE in post (actual worked)	6331.91	6328.5
Paybill (£m)	164.31	170.96
Staff turnover	10%	11.2%
% of Bank, agency and overtime spend		8.76%



Division/Directorate	Budgeted estab. Fte Nov 13	Actual (worked)* fte Nov 13	Variance (ftes)	Permanent fte usage (inc overtime)	Monthly bank ftes usage	Bank usage as % total usage	Monthly agency ftes usage	Agency usage as % total usage
Planned Care	1,613.94	1,722.82	108.88	1,584.34	97.24	5.64%	41.24	2.39%
Urgent Care	1,480.39	1,519.22	38.83	1,397.12	107.64	7.09%	14.46	0.95%
Integrated Care	1,652.71	1,569.38	-83.33	1,518.69	44.63	2.84%	6.06	0.39%
Commercial	1,064.59	1,009.31	-55.28	910.60	58.14	5.76%	40.57	4.02%
Corporate Services	520.28	507.74	-12.54	496.57	11.08	2.18%	0.09	0.02%
TRUST	6331.91	6328.47	-3.44	5,908.72	318.73	5.04%	101.02	1.60%

An increase in the budgeted establishment for the Winter wards, combined with a reduction of 65.69 ftes in actual ftes worked, means that actual ftes are 3.44 ftes below budget. The bulk of the reduction is in bank usage (as last month included five weeks bank usage instead of the usual four) down by 59.76 ftes.

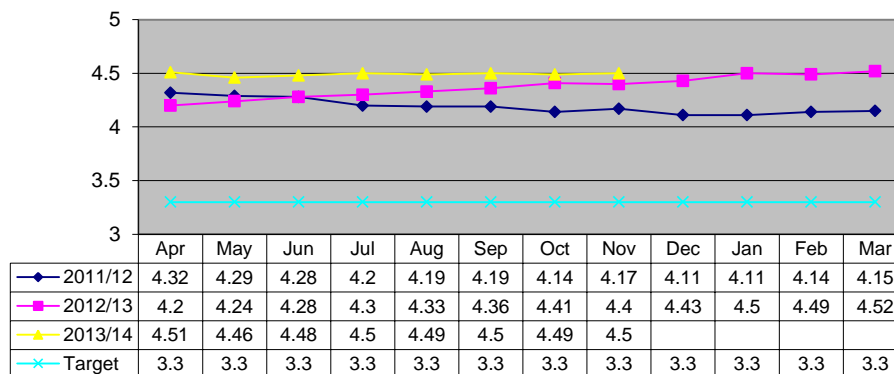
Agency usage is actually down by 41.99 ftes, 29.80 of which relates to nursing, (but this is obscured by the fact that last month there was the reduction in Urgent Care agency for unused accruals, so the net reduction, month on month, is 3.48 ftes).

Overtime expenditure is down by £29K (overtime paid in Month 8 relates to that worked in Month 7, so the full effects of the overtime ban are not yet apparent).

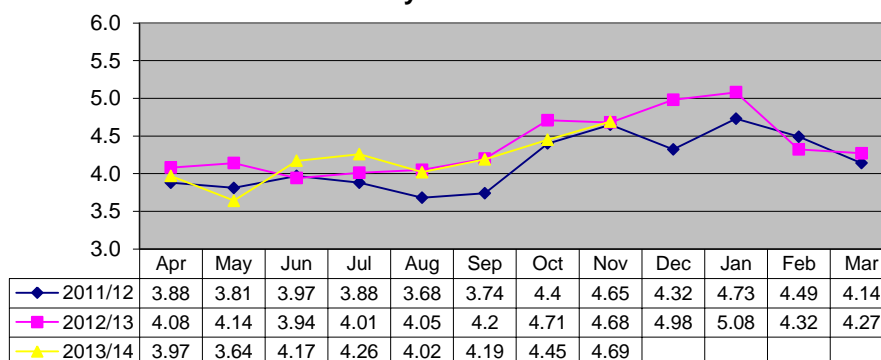
Report Overview: Workforce

Sickness

Annual sickness rate



Monthly sickness rate



Monthly sickness has increased by a further 0.24% to virtually the same level as in November 2011 and 2012. Annual sickness has shown a marginal increase to 4.50%.

Monthly sickness was highest in Womens & Sexual Health at 6.56% and Complex Medicine at 6.52%. Along with Acute Medicine (at 5.54%), they also have the highest rates for annual sickness at 5.50% and 5.59%, respectively.

Training and Appraisals (incl Divisional Summary)

Trust mandatory training compliance rates have all marginally increased since last month, except for slight decreases in Manual Handling ction and Information Governance.

Appraisals compliance has increased this month for the first time since July, up by 1.39%. It is concerning, however that Cardiovascular Medicine (40.86%), Complex Medicine (43.28%) and Acute Medicine (48.56%) all have reported PDR rates of less than 50%.

Division/ Directorate	Annual sickness	Monthly sickness	Short term sickness <28 days	Long Term sickness >=28 days	Cumulative pay expenditure v budget (£000s)	Appraised /exempt in last yr	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Mental Capacity Act training	Depriv of Liberties training
Planned Care	4.26%	4.12%	55.41%	44.59%	£3,443	62.01%	81.94%	79.56%	92.67%	84.21%	77.97%	90.82%	85.08%
Urgent Care	5.04%	5.38%	49.84%	50.16%	£3,352	49.91%	76.47%	73.83%	91.43%	78.01%	75.62%	87.33%	82.26%
Integrated Care	4.34%	5.26%	52.04%	47.96%	£864	53.15%	79.58%	75.35%	95.19%	74.31%	73.87%	80.32%	64.96%
Commercial	5.22%	3.53%	48.12%	51.88%	-£386	53.30%	77.60%	53.70%	91.78%	88.85%	73.66%	79.07%	87.50%
Corporate	2.99%	2.98%	56.38%	43.62%	-£326	79.35%	89.20%	90.80%	97.96%	93.10%	84.14%	84.21%	70.73%
TRUST	4.49%	4.45%	53.87%	46.13%	£6,048	57.76%	79.49%	73.06%	93.62%	81.19%	75.77%	86.69%	78.22%

Report Overview: Workforce

Medical Appraisal Compliance Status November 2013

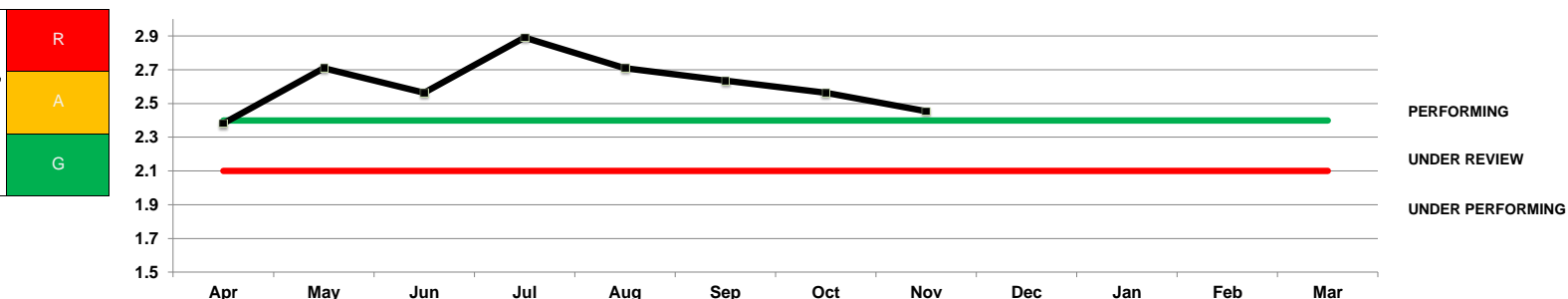
	Number of doctors	Compliant	Percentage Compliant	Total expected to be compliant by 31/12/2013	Percentage expected to be compliant by 31/12/2013
Consultants (including honorary contract holders)	218	193	89%	211	97%
Staff grade, associate specialist, speciality doctor (including hospital practitioners / clinical assistants who do not have a prescribed connection elsewhere)	113	88	78%	108	96%
Total	331	281	85%	319	96%


























The total number of doctors in the Trust are those doctors with a prescribed connection to the Responsible Officer. Doctors who are compliant with medical appraisals are those who have either had an appraisal in the last 12 months and/or have been in the Trust for less than 12 months. Doctors who are expected to be compliant by 31/12/13 are doctors who have either had their appraisal since April 2013 or informed the medical revalidation team of their planned medical appraisal date and the name of their medical appraiser. All appraisals should now take place between April and December each year. Doctors who have not yet booked their medical appraisal have been sent a letter to their home address reminding them of their obligations.













































**East Sussex Healthcare Trust
Service Performance for 2013/14**

Performance Indicator	Thresholds		MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6	MONTH 7	MONTH 8	MONTH 9	MONTH 10	MONTH 11	MONTH 12
	Performing	Under-performing	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total time in A&E - 95% of patients should be seen within four hours	95%	94%	87.53%	97.78%	97.34%	96.74%	96.01%	94.22%	95.19%	95.98%				
MRSA	0	>1SD	0	0	0	0	0	0	0	0				
C Diff	0	>1SD	4	10	11	14	18	23	27	31				
RTT - admitted - 90% in 18 weeks	90%	85%	84.62%	82.97%	76.78%	92.81%	92.43%	91.79%	91.41%	90.03%				
RTT - non-admitted - 95% in 18 weeks	95%	90%	96.57%	96.85%	96.60%	96.91%	96.79%	95.42%	95.77%	95.06%				
RTT - incomplete 92% in 18 weeks	92%	87%	94.81%	94.99%	95.50%	94.86%	94.24%	93.86%	92.42%	92.40%				
RTT delivery in all specialties	0	>20	11	9	11	4	5	6	9	9				
Diagnostic Test Waiting Times	<1%	5%	0.77%	0.13%	0.47%	0.35%	2.11%	0.71%	0.75%	1.62%				
Cancer 2 Week Wait	93%	88%	93.91%	96.49%	94.69%	93.05%	94.95%	94.22%	95.95%	94.74%				
Cancer 2 week wait - Breast	93%	88%	96.30%	93.00%	96.74%	91.61%	91.23%	94.38%	93.14%	92.19%				
Cancer 31 day - Subsequent Surgery	94%	89%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
Cancer 31 day - Subsequent Chemo	98%	93%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
Cancer 31 day - Diagnosis to Treatment.	96%	91%	96.11%	97.95%	98.58%	97.50%	98.13%	99.38%	98.52%	98.79%				
Cancer 62 Day Screening Service	90%	85%	77.78%	100.00%	66.67%	91.67%	100.00%	77.78%	73.68%	83.33%				
Cancer 62 Day Urgent Referral	85%	80%	85.71%	85.23%	82.21%	89.91%	77.68%	79.90%	81.19%	81.40%				
Delayed transfers of care	3.5%	5.0%	0.60%	0.68%	0.68%	0.63%	0.47%	0.61%	0.69%	0.57%				
Mixed Sex Accommodation Breaches	0.0%	0.5%	0.00%	0.00%	0.11%	0.15%	0.91%	0.48%	0.31%	0.16%				
VTE Risk Assessment	95.0%	80.0%	95.26%	96.75%	96.28%	97.16%	96.44%	97.04%	96.91%	96.20%				
NPF SCORE			2.38	2.71	2.56	2.89	2.71	2.64	2.56	2.45				

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



Clinical Effectiveness	1. Preventing people from dying prematurely																
	Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	RAMI (Risk Adjusted Mortality Index)	100	100	NA		118	100	85	90	90	101.0	99.0					
	SHMI (In Hospital) Sourced from CHKS			TBC		91	76	63	69.0	73.0	78.0	77.0					
	Cancer waits 2 week	93%	88%	93.96%		93.91%	96.49%	94.69%	93.05%	94.95%	94.22%	95.95%	94.74%				
	Cancer waits 2 week – Breast	93%	88%	93.84%		96.30%	93.00%	96.74%	91.61%	91.23%	94.38%	93.14%	92.19%				
	Cancer 31 day – subsequent surgery	94%	89%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
	Cancer 31 day – chemo	98%	93%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
	Cancer waits 31 days diagnosis to treatment	96%	91%	96.45%		96.11%	97.95%	98.58%	97.50%	98.13%	99.38%	98.52%	98.79%				
	Cancer waits 62 days > from urgent GP	90%	85%	83.28%		77.78%	100.00%	66.67%	91.67%	100.00%	77.78%	73.68%	83.33%				
	Cancer waits 62 days > from screening service	85%	80%	83.08%		85.71%	85.23%	82.21%	89.91%	77.68%	79.90%	81.19%	81.40%				
	Cancer waits 62 days > from consultant upgrade	No OS	No OS	NEW		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
	2. Enhancing quality of life for people with long term conditions																
	Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Reduction in Unplanned hospitalisation for chronic ambulatory care conditions (adults)	Reduction	N/A	295		282	299	296	275	255	254	293	292				
	Reduction in Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Reduction	N/A	27		18	25	25	23	6	30	26	17				
3. Helping people to recover from episodes of ill health or following injury																	
Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Emergency admissions for acute conditions which should not usually require hospital admission	RO	RO	422		464	396	335	367	426	364	403	377					
Emergency admissions for children with lower respiratory tract infections	RO	RO	TBC		21	10	8	5	5	8	10	16					
% Emergency Readmissions within 28 days	RO	11.00%	10.00%		10.44%	12.21%	11.48%	12.84%	11.78%	12.41%	11.02%	10.54%					
ASI 1: Preventable stroke					DATA CAPTURE PROCESS UNDER DEVELOPMENT												
ASI 2: Direct Admission to Stroke Unit	90.00%	90.00%	83.20%		65.12%	69.23%	75.86%	81.03%	83.67%	82.35%	86.27%	0.00%					
ASI 3: 90% Acute Stroke Care	80.00%	80.00%	78.80%		61.11%	76.25%	86.76%	89.71%	83.67%	87.18%	86.89%	0.00%					
ASI 4a: Access to Brain Imaging (1H)	50.00%	50.00%	57.60%		42.86%	59.38%	61.82%	52.54%	71.74%	86.21%	76.00%	0.00%					
ASI 4b: Access to Brain Imaging (24H)	100.00%	100.00%	98.50%		95.24%	100.00%	98.21%	100.00%	100.00%	100.00%	100.00%	0.00%					
ASI 5: High Risk TIA	60.00%	60.00%	72.50%		71.43%	80.00%	82.76%	67.44%	81.40%	78.26%	78.13%	0.00%					
The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days					DATA CAPTURE PROCESS UNDER DEVELOPMENT												
The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days					DATA CAPTURE PROCESS UNDER DEVELOPMENT												
% MUST nutritional assessments undertaken					97.00%	94.00%	94.00%	99.00%	71.00%	70.00%	77.00%	62.00%					
Patient Experience	4. Ensuring that people have a positive experience of care																
	Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Diagnostics - % of patients waiting > 5 wks	1%	5%	0.42%		0.77%	0.13%	0.47%	0.35%	2.11%	0.71%	0.75%	1.62%				
	A&E Attendances	RO	RO	11292		11605	11963	11944	13324	12577	11631	11733	10806				
	Total time in A&E - 95% of patients should be seen within four hours	95%	94%	95.66%		87.53%	97.78%	97.34%	96.74%	96.01%	94.22%	95.19%	95.98%				
	Mixed sex accommodation breaches	0.00%	0.50%	0.02%		0.00%	0.00%	0.11%	0.15%	0.91%	0.48%	0.31%	0.16%				
	On the day cancellations of elective surgery per 1000 procedures for non-clinical reasons			TBC		4.43	4.09	3.04	5.68	2.63	2.09	8.57	4.04				
	Responsiveness to inpatient personal needs					DATA CAPTURE PROCESS UNDER DEVELOPMENT											
	Peoples experience of integrated care					DATA CAPTURE PROCESS UNDER DEVELOPMENT											
	% Complaints responded to within timescales	100%	95%	55.00%		54.24%	71.21%	85.71%	89.09%	83.02%	88.89%	89.36%	88.33%				
	Patient centred care plans, responsive to individual preferences, needs and values - %					99.00%	99.00%	98.00%	96.00%	74.00%	71.00%	79.00%	79.00%				
	Adult – BADS Efficiency Score	85%	75%	78.80%		57.79%	55.69%	50.18%	52.50%	42.23%	56.79%	48.00%	50.45%				
	Paediatric – BADS Efficiency Score	85%	75%	78.80%		55.56%	80.00%	65.00%	85.19%	70.83%	82.61%	81.48%	86.36%				
	FFT Response Rate	15%	13%	NEW		10.04%	11.46%	16.38%	17.48%	15.19%	17.66%	18.48%	22.85%				
	FFT NET Promotor Score			NEW		60.00%	65.00%	62.00%	63.00%	59.00%	60.00%	54.00%	50.00%				

Patient Safety	5. Treating and caring for people in a safe environment and protecting them from avoidable harm																
	Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Patient safety incidents reported	RO	RO	675		782	735	679	787	697	770	836	651				
	Safety incidents involving severe harm or death	0	0	7		5	#N/A	2	2	3	4	6	5				
	Incidence of hospital-related venous thromboembolism (VTE)	RO	RO	46.0		0	0	0	0	0	0	1	2				
	Incidence of healthcare associated MRSA infection	0	0	0		0	0	0	0	0	0	0	0				
	Incidence of healthcare associated C. difficile infection	2	2	4		4	6	1	3	4	5	4	4				
	Incidence of all category 2,3 and 4 pressure ulcers reported by ESHT	RO	RO	58		33	23	31	18	30	32	40	32				
	Incidence of medication errors causing serious harm	RO	RO	0		0	0	0	0	0	0	0	0				
	Admission of full-term babies to neonatal care	RO	RO	TBC		12	5	12	8	10	11	12	#N/A				
	Incidence of harm to children due to 'failure to monitor'	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
	% of patients with VTE assessment	95.00%	85.00%	93.31%		95.26%	96.75%	96.28%	97.16%	96.44%	97.04%	96.91%	96.20%				
	Reduction in the outturn number of falls by at least 10%	178	178	198		241	175	176	212	194	214	191	173				
	At least 95% of patients to have a falls assessment on admission	95.00%	90.00%	TBC		96.00%	97.00%	97.00%	96.00%	71.00%	73.00%	74.00%	64.00%				
	Number of new serious incidents	RO	RO	15.0		21	12	12	12	15	7	19	13				
	% Submitted within timescale (month)	90%	85%	TBC		90.48%	83.33%	100.00%	100.00%	86.67%	100.00%	100.00%	100.00%				
	Serious Incidents Open	RO	RO	30.0		57	68	77	71	61	54	53	44				
Nice Technology Appraisal compliance	95%	95%	73%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	#N/A					
Number of CAS alerts breaching timescales	0.0	0.0	TBC		0	0	0	0	0	0	0	0					
Number of substantiated Safeguarding alerts	RO	RO	TBC		2	1	0	1	0	0	#N/A	#N/A					
Compliance with cleaning standards	86%	80%	95.03%		93.89%	94.03%	93.19%	94.16%	89.45%	89.06%	90.32%	93.41%					
Organisational Context	6. Organisational Context																
	Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Non elective FFCes	RO	RO	3315		3,844	4,089	3,894	4,100	4,097	3,962	4,395	4,101				
	GP Referrals to hospital	RO	RO	7238		7,588	7,837	7,352	8,221	7,109	7,191	8,194	7,667				
	Other referrals for First OP appointment	RO	RO	3522		3,499	3,878	3,566	3,906	3,788	3,670	3,725	3,379				
	First OP attendances following GP referral	RO	RO	6927		6,371	6,768	6,518	7,418	6,066	6,509	7,224	6,709				
	All First OP attendances	RO	RO	10475		10,039	10,535	10,386	11,557	9,751	10,359	11,233	10,372				
	All subsequent OP attendances	RO	RO	23048		25,375	24,588	23,843	26,321	23,007	24,336	25,757	24,911				
	Elective FFCes	RO	RO	799		730	772	846	787	760	790	822	867				
	RTT – admitted – 90% in 18 weeks	90%	85%	90%		84.62%	82.97%	76.78%	92.81%	92.43%	91.79%	91.41%	90.03%				
	RTT – non-admitted – 95% in 18 weeks	95%	90%	96%		96.57%	96.85%	96.60%	96.91%	96.79%	95.42%	95.77%	95.06%				
	RTT – incomplete 92% in 18 weeks	92%	87%	96%		94.81%	94.99%	95.50%	94.86%	94.24%	93.86%	92.42%	92.40%				
	RTT - Specialty Compliance	0	20	8		11	9	11	4	5	6	9	9				
	% Uncoded Spells	RO	RO	TBC		0.04%	0.04%	0.05%	0.04%	0.09%	0.02%	0.03%	0.06%				
WorkForce	7. Workforce																
	Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Permanent FTE	RO	RO	6,048		5,964	5,926	5,895	5,877	5,848	5,868	5,911	5,909				
	Bank FTE	RO	RO	341		397	338	272	334	337	293	378	319				
	Agency FTE	RO	RO	181		145	175	168	167	180	158	105	101				
	% Permanent FTE	RO	RO	92.05%		91.67%	91.10%	90.62%	90.34%	89.90%	90.20%	90.87%	90.83%				
	% Bank FTE	RO	RO	5.19%		6.10%	5.20%	4.17%	5.14%	5.19%	4.50%	5.82%	4.90%				
	% Agency FTE	RO	RO	2.76%		2.23%	2.69%	2.58%	2.56%	2.77%	2.43%	1.61%	1.55%				
	Monthly Sickness	3.30%	3.80%	4.52%		3.97%	3.64%	4.17%	4.26%	4.02%	4.19%	4.45%	4.69%				
	Annual Sickness	3.30%	3.80%	4.52%		4.51%	4.46%	4.48%	4.50%	4.49%	4.50%	4.49%	4.50%				
	Induction Uptake	90.00%	75.00%	90.31%		91.10%	94.60%	95.30%	95.09%	95.22%	95.08%	93.62%	94.06%				
	Fire Training Uptake	90.00%	75.00%	75.10%		74.27%	76.18%	77.57%	75.12%	77.85%	78.87%	79.49%	80.50%				
	Manual Handling uptake	90.00%	75.00%	70.40%		70.83%	71.89%	71.69%	72.32%	71.50%	73.70%	73.06%	72.90%				
	Infection Control Training Uptake	90.00%	75.00%	78.73%		78.43%	80.24%	80.33%	80.75%	79.74%	80.71%	81.19%	82.32%				
	Information Governance Training Uptake	90.00%	75.00%	81.53%		79.04%	76.83%	77.53%	76.91%	75.34%	76.56%	75.77%	74.43%				
	MCA Training Uptake	90.00%	75.00%	80.56%		84.67%	84.86%	84.53%	84.93%	85.60%	86.56%	86.69%	87.45%				
	Deprivation of Liberty Training Uptake	90.00%	75.00%	72.60%		75.71%	76.19%	76.46%	77.15%	76.12%	78.29%	78.22%	79.40%				
	Appraisal Compliance	90.00%	75.00%	64.75%		63.68%	62.36%	62.12%	62.58%	60.12%	58.60%	57.76%	59.15%				

FINANCE REPORT – December 2013

Vanessa Harris – January 2014

Financial Summary – December 2013

Key Issue	Summary	YTD
Key Performance Indicators	Measured against Monitor criteria the year to date position at the end of December remains a red rating of 1.	R
Financial Summary	The Trust performance for the year to date was a run rate deficit of £22.3m, an adverse variance against original plan of £7.2m. Income was £0.4m below original plan and total costs were £6.9m over original plan. Compared to the In-year Recovery Plan (IRP) profile of £1.0m deficit in the month the Trust has underachieved by £0.7m. Year to date (YTD) the Trust has underachieved by £1.7m compared to the IRP.	R
Activity & Income	Total income received during December was £1.3m above original planned levels which has reduced the YTD adverse variance to £0.4m. The in month variance is principally due to inpatient emergency activity performing above plan.	G
Expenditure	Pay costs YTD are above original plan by £6.9m, which includes £10.5m of costs in respect of agency staff, overtime and ad-hoc payments. However, total costs for December were £31.4m which is £0.9m below the average for the first eight months of the year. December pay expenditure is £0.8m below the average for the first eight months of the financial year. Non pay, including 3 rd party costs, is £0.1m above original plan.	R
CRES plans	CRES achievement YTD including turnaround CRES increased to £10.1m, 76% achievement, compared to the target of £13.3m, an underachievement of £3.2m.	R
Balance Sheet	The balance sheet is IFRS compliant and includes the value of properties transferred from the former PCTs.	G
Cash Flow	Creditor balances continue to increase and cash management remains a key area of focus. Temporary borrowing loans were drawn down in June and October to ease liquidity and a further draw down is expected in January. Further temporary borrowing will be required in the near future pending a longer term cash funding solution. The Trust has applied via the Trust Development Authority (TDA) for non-repayable Public Dividend Capital (PDC) to pay off current borrowing and reduce creditors to a manageable level.	R
Capital Programme	The demand for capital expenditure continues to place the capital programme under significant financial pressure. In order to mitigate this pressure the public dividend capital (PDC) application that has been made via the TDA includes £5m of additional capital cash funding. The decision on the application for additional funding is expected in January 2014.	G
Risk Summary	The overall Trust rating is a red rating of 1.	R

Income & Expenditure – December 2013

Headlines
<ul style="list-style-type: none"> • In the month of December the Trust made a deficit of £1.7m against the original £2.6m deficit plan submitted to the Trust Development Authority (TDA), a favourable variance of £0.9m. • Cumulatively, the deficit is £22.3m against the original plan of £15.2m, resulting in a shortfall to date against original plan of £7.2m. • Cost improvements of £10.1m have been achieved after nine months, £3.2m behind the year to date plan. • Total income in the month was £29.7m against the original plan of £28.4m, a £1.3m favourable variance. Cumulatively, income is now £0.4m behind plan. • Pay costs in the month, including ad hoc costs, were £0.3m in excess of plan. Cumulatively, pay is £6.9m ahead of plan with ad hoc costs of £1.9m and agency costs of £7.7m. • Non Pay costs, including 3rd party costs, are marginally below plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	25,527	26,778	1,251	241,818	242,214	396	321,943
Private Patient/ ICR	354	253	-101	3,037	2,007	-1,030	3,519
Trading Income	406	419	13	3,653	3,394	-259	5,201
Education	756	738	-18	6,524	6,361	-163	8,420
Other Non Clinical Income	1,385	1,493	108	12,946	13,587	641	17,739
Total Income	28,428	29,681	1,253	267,978	267,563	-415	356,822
Pay Costs	-20,246	-20,531	-285	-184,222	-189,642	-5,420	-244,546
Ad hoc Costs	-42	-32	10	-375	-1,879	-1,504	-500
Non Pay Costs	-9,158	-9,598	-440	-84,582	-85,377	-795	-112,530
3rd Party Costs	-125	-52	73	-1,127	-722	405	-1,500
Other	83	354	271	750	1,188	438	1,000
Total Direct Costs	-29,488	-29,859	-371	-269,556	-276,432	-6,876	-358,076
Surplus/- Deficit from Operations	-1,060	-178	882	-1,578	-8,869	-7,291	-1,254
P/L on Asset Disposal	0	0	0	0	0	0	0
Depreciation	-987	-1,009	-22	-8,884	-9,040	-156	-11,845
PDC Dividend	-485	-485	0	-4,367	-4,367	0	-5,823
Interest	-36	-82	-46	-329	-232	97	-439
Total Indirect Costs	-1,508	-1,576	-68	-13,580	-13,639	-59	-18,107
Total Costs	-30,996	-31,435	-439	-283,136	-290,071	-6,935	-376,183
Net Surplus/-Deficit	-2,568	-1,754	814	-15,158	-22,508	-7,350	-19,361
Donated Asset Adjustment	0	48	48	0	198	198	0
Adjusted Net Surplus/-Deficit	-2,568	-1,706	862	-15,158	-22,310	-7,152	-19,361
Surplus/- Deficit from Operations	-1,060	-178	882	-1,578	-8,869	-7,291	-1,254
Debtors	8	5,666	5,658	929	-13,806	-14,735	453
Creditors	-284	-3,958	-3,674	-2,234	9,760	11,994	-2,023
Other	-490	-160	330	-121	-945	-824	580
CF from Operations	-1,826	1,370	3,196	-3,004	-13,860	-10,856	-2,244
CAPEX	-2,540	-1,261	1,279	-16,395	-8,011	8,384	-22,041
Proceeds from Asset Sales	0	0	0	0	0	0	0
Interest Rec'd/Paid	2	2	0	-329	16	345	-539
PDC	0	0	0	0	24,000	24,000	0
Net movement in loans	10,000	0	-10,000	33,163	-837	-34,000	31,341
PDC	0	0	0	-2,912	-3,082	-170	-5,823
Other	4	0	-4	-445	781	1,226	-694
Net Cash Inflow/Outflow	5,640	111	-5,529	10,078	-993	-11,071	0

Balance Sheet & Cash Flow – December 2013

Headlines

- The Trust has a history of poor liquidity, high levels of creditors and a high level of debt over 30 days old.
- This position continues to result in poor 'Better Payment Practice Code' statistics and negatively impacts on supplier relations.
- In order to mitigate the impact of high creditor levels and the Trust's deficit position, a short term loan of £24m has been drawn down from the DH.
- A further £5m of temporary borrowing has been drawn down in January to meet short term cash pressures pending a longer term financing solution.
- The Trust has applied for non-repayable PDC to repay the temporary borrowing.
- Delivery of the IRP remains a critical element in achieving sustainable levels of liquidity.

Cash Flow Statement December 2013 - 12 Month Projection

£000s	Jan 2014	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
Receipts												
Block Contract	27,126	25,662	25,662	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000
Deanery	470	470	470	460	460	460	460	460	460	460	460	460
PDC	5,000	0	10,000	0	0	0	0	0	0	0	0	0
Sales ledger	2,540	2,200	2,309	2,675	2,500	2,500	2,800	2,300	3,100	3,100	3,100	3,500
Interest Receivable	2	2	2	1	2	2	2	2	2	2	2	2
Donated Assets	20	20	20	20	20	20	20	20	20	20	20	20
RTA/VAT/Sundry	198	248	248	250	250	250	250	250	250	250	250	250
Total Receipts	35,356	28,602	38,711	29,406	29,232	29,232	29,532	29,032	29,832	29,832	29,832	30,232
Payments												
Payroll costs	12,517	12,500	12,500	11,750	11,750	11,750	11,750	11,750	11,750	11,750	11,750	11,750
Tax/NV/Super	8,350	8,350	8,650	7,850	7,850	7,850	7,850	7,850	7,850	7,850	7,850	7,850
Non Pay expenditure	8,828	4,557	10,547	7,000	9,000	9,000	9,000	8,500	8,000	8,000	8,000	9,500
Capital programme	2,000	3,000	6,000	500	1,000	1,000	1,000	1,000	500	1,000	1,000	1,000
PDC dividend	0	0	2,741	0	0	0	0	0	2,741	0	0	0
Working Loan repayment	0	0	667	0	0	0	0	0	667	0	0	0
Capital Loan repayment	0	0	190	0	0	0	0	0	190	0	0	0
Loan interest	0	0	88	0	0	0	0	0	83	0	0	0
Total Payments	31,695	28,407	41,383	27,100	29,600	29,600	29,600	29,100	31,781	28,600	28,600	30,100
Net inflow/outflow	3,661	195	-2,672	2,306	-368	-368	-68	-68	-1,949	1,232	1,232	132
Opening balance	1,066	4,727	4,922	2,250	4,556	4,188	3,820	3,752	3,684	1,735	2,967	4,199
Closing balance	4,727	4,922	2,250	4,556	4,188	3,820	3,752	3,684	1,735	2,967	4,199	4,331

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2014	BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2014
Non Current Assets				Financed by			
Property plant and equipment	202,953	250,809	265,934	Public Dividend Capital (PDC)	111,969	136,722	150,969
Intangible Assets	285	545	1,615	Revaluation Reserve	82,175	96,494	116,980
Trade and other Receivables	898	647	1,200	Income & Expenditure Reserve	-11,029	2,797	-2,557
	204,136	252,001	268,749	Total Tax Payers Equity	183,115	236,013	265,392
Current Assets							
Inventories	6,869	6,791	6,289				
Trade and other receivables	14,051	28,108	20,061				
Other current assets	107	0	0				
Cash and cash equivalents	2,250	1,066	2,250				
	23,277	35,965	28,600				
Current Liabilities							
Trade and other payables	-33,044	-41,886	-22,797				
DoH Loan	-1,674	-1,674	-1,671				
Borrowings - Finance Leases	-308	-308	-320				
Provisions	-475	-419	-474				
	-35,501	-44,287	-25,262				
Non Current Liabilities							
DoH Loan	-5,209	-4,372	-3,538				
Borrowings - Finance Leases	-916	-687	-595				
Provisions	-2,672	-2,607	-2,562				
	-8,797	-7,666	-6,695				
Total Assets Employed	183,115	236,013	265,392				

Key Performance Indicators – December 2013

Headlines			
KPIs <ul style="list-style-type: none"> • The Trust has a planned annual deficit budget of £19.4m. • The EBITDA Margin for the year to date was negative 3.6% compared to the planned negative 0.9% resulting in a red risk rating of 1. • The EBITDA achieved as a percentage of plan is a risk rating of 1. • The I&E surplus margin is a red rating of 1. • The liquidity ratio, including the Working Capital Facility, now stands at 15 days, a risk rating of 3 following the draw down of working capital loans. It is the Trust's preferred option that these loans be converted into permanent Public Dividend Capital (PDC). • As a result of the year to date position the overall KPI rating remains a red rating of 1. 	KPIs	Last Month	YTD Actual
	EBITDA Margin (%)	-4.0	-3.6
	EBITDA Achieved (% of plan)	697.5	383.8
	Net Return After Financing (%)	-9.9	-10.7
	I&E surplus margin (%)	-8.7	-8.4
	Liquidity Ratio (days)	15	15
	Overall Monitor Risk Rating	1	1
	National & Local Measures	Last Month	YTD Actual
	Income v Plan (£m)	237.9	267.6
	Expenditure (before financing costs) v Plan (£m)	246.6	276.4
	CRES Plans (£m)	6.4	10.1
	BPPC – Trade invoices by value (%)	37.6	37.8
	BPPC – NHS Invoices by value (%)	65.8	64.8
	Monitor Ratings	YTD Risk Rating	
	EBITDA Margin	1	
	EBITDA % Achieved	1	
	Net Return After Financing	1	
	I&E Surplus Margin	1	
	Liquidity Ratio	3	
	Overall Risk Rating	1	

Activity & Contract Income – December 2013

Headlines

- Headline contract activity income is £2.2m adverse to plan year to date, excluding high cost drugs and device exclusions.
- High cost drugs and device exclusions income has a neutral impact on ESHT as they are offset by expenditure. After allowing for these areas, total contract income is £396k above planned levels.
- The major adverse activity variances relate to elective care, which is £1.1m under contract.
- The month 9 year to date position includes a provision of £6.6m for mandatory fines/penalties including re-admissions of £2.5m.
- The month 9 position assumes that CQUIN will achieve 95% overall.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,614	3,157	-457	32,361	31,992	-369
Elective Inpatients	849	709	-140	7,606	7,012	-594
Emergency Inpatients	3,327	4,588	1,260	29,522	32,803	3,281
Total Inpatients	7,791	8,454	663	69,488	71,807	2,319
Excess Bed Days	2,400	2,735	334	21,295	23,939	2,644
Total Excess Bed Days	2,400	2,735	334	21,295	23,939	2,644
Consultant First Attendances	8,089	7,016	-1,073	72,427	69,172	-3,255
Consultant Follow Ups	12,522	10,513	-2,009	112,115	110,244	-1,871
OP Procedures	4,034	4,267	233	36,123	41,088	4,965
Other Outpatients inc WA & Nurse Led	8,693	9,613	920	77,158	91,551	14,393
Community Specialist	244	358	114	2,188	2,145	-43
Total Outpatients	33,583	31,767	-1,816	300,011	314,200	14,189
Chemotherapy Unbundled HRGs	474	381	-93	4,247	4,462	215
Antenatal Pathw ays	334	214	-120	2,990	2,924	-66
Post-natal Pathw ays	334	171	-163	2,990	3,169	179
A&E Attendances (excluding type 2's)	8,354	8,266	-88	79,729	77,584	-2,145
ITU Bed Days	551	564	13	4,638	4,500	-138
SCBU Bed Days	309	297	-12	2,252	2,448	196
Cardiology - Direct Access	70	43	-27	623	666	43
Radiology - Direct Access	4,046	2,552	-1,494	36,229	41,425	5,196
Pathology - Direct Access	271,880	229,208	-42,672	2,434,345	2,487,654	53,309
Therapies - Direct Access	3,715	4,633	918	33,267	30,301	-2,966

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,774	4,182	-592	42,741	41,596	-1,145
Inpatients - Emergency	6,353	7,630	1,277	56,373	60,013	3,640
Excess Bed Days	558	636	78	4,945	5,546	601
Outpatients	3,891	3,688	-203	34,783	35,913	1,130
Other Acute based Activity	2,571	2,304	-267	22,814	22,435	-379
Direct Access	793	717	-76	7,100	7,006	-94
Block Contract	5,737	5,666	-71	51,609	51,624	15
Mandatory Fines & Penalties	-308	-761	-453	-2,777	-6,632	-3,855
Other	-1,233	70	1,303	2,757	960	-1,797
CQUIN	623	839	216	5,566	5,287	-279
Subtotal	23,759	24,971	1,212	225,911	223,748	-2,163
Exclusions	1,768	1,807	39	15,907	18,466	2,559
GRAND TOTAL	25,527	26,778	1,251	241,818	242,214	396

Divisional Performance (budgets) – December 2013

Headlines

Planned Care

The division over spent by £1378k in the month increasing the year to date (YTD) overspend to £9,817k. Income is currently £2,508k below plan. YTD pay is overspent by £4,627k due to agency, ad-hocs early in the year & unidentified CIP. Non-pay is overspent by £2,682k due to third party activity, theatres & undelivered CIP.

Urgent Care

An overspend of £7k in the month, has increased the year to date overspend to £3,800k. The YTD pay overspend of £3,776k relates to agency costs in the main. Non pay is cumulatively £1,825k overspent and income is cumulatively over-achieved by £1,801k.

Integrated Care

The division overspent by £765k in the month increasing the YTD overspend to £3,490k. Pay underspent in the month by £105k with a YTD overspend of £716k. Non pay overspent by £522k in the month and is overspent YTD by £2,579k. Income has under achieved YTD by £195k.

Commercial Directorate

The directorate underspent in December by £36k. This was due to pay under spending, mainly in Facilities Housekeeping & Estates. YTD the division overspending is £1,264k.

Corporate Services

The Directorate overspent in December. The YTD overspending is now at £731k.

Divisional Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Planned Care	4,079	2,701	-1,378	33,120	23,303	-9,817
Urgent Care	1,982	1,975	-7	16,715	12,915	-3,800
Integrated Care	-3,111	-3,876	-765	-30,843	-34,333	-3,490
Total Clinical Divisions	2,950	800	-2,150	18,992	1,885	-17,107
Commercial Directorate	-2,387	-2,351	36	-20,610	-21,874	-1,264
Corporate Services	-2,384	-2,440	-56	-20,904	-21,635	-731
Central Items	-2,419	-1,246	1,173	-22,150	-12,656	9,494
	-7,190	-6,037	1,153	-63,664	-56,165	7,499
Income	1,672	3,483	1,811	29,514	31,773	2,259
Donated Asset Adjustment	0	48	48	0	197	197
Total	-2,568	-1,706	862	-15,158	-22,310	-7,152

Workforce Plan FTE	Actual FTE	Divisions Pay Analysis	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
1,606	1,699	Planned Care	-5,913	-6,419	-506	-54,544	-59,171	-4,627
1,479	1,522	Urgent Care	-4,874	-5,045	-171	-44,089	-47,865	-3,776
1,658	1,547	Integrated Care	-5,649	-5,544	105	-50,914	-51,630	-716
4,743	4,768	Total Clinical Divisions	-16,436	-17,008	-572	-149,547	-158,666	-9,119
1,065	999	Commercial Directorate	-2,110	-1,963	147	-18,931	-18,287	644
520	500	Corporate Services	-1,704	-1,569	135	-14,920	-14,363	557
1,585	1,499	Total Non-Clinical Divisions	-3,814	-3,532	282	-33,851	-32,650	1,201
		Central Items	-38	-23	15	-1,199	-205	994
6,328	6,267	Total Pay Analysis	-20,288	-20,563	-275	-184,597	-191,521	-6,924

Divisional Performance (budgets) Planned Care Division – December 2013

Headlines

Pay

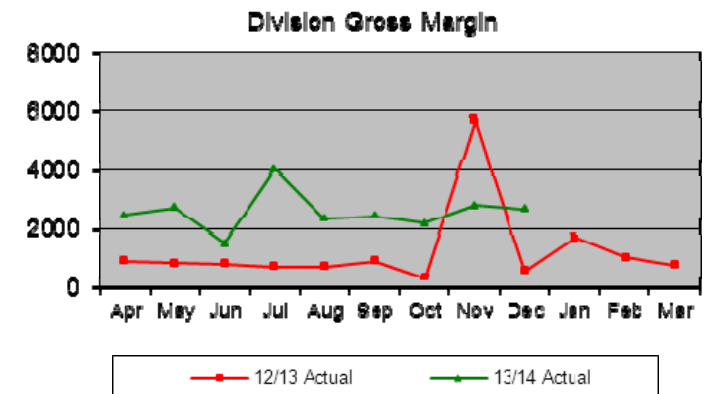
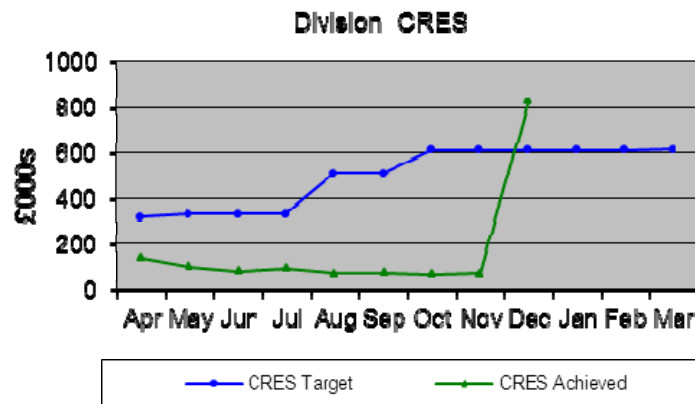
Pay overspent by £506k in the month, bringing the YTD pay overspending to £4,627k. This is due to ad hoc activity, agency, bureau & locum costs for acuity, maternity & sick leave which has been partly offset by vacancy savings. Month 9 agency spend was £325k which remains above the required level for the FRP but was lower than the level incurred in October and November.

Non Pay

Non-pay was overspent by £422k in the month, bringing the YTD overspend ing to £2,682k. The overspending in the month was due to undelivered CRES, high expenditure on prosthesis, orthopaedic consumables and general supplies.

Income

Contract income was £452k below plan in month and is now cumulatively £2,399k below plan.



Workforce		Planned Care	In mth Plan	In mth Actual	Var	YTD Plan	YTD Actual	Var
Plan FTE	Actual FTE		£000's	£000's	£000's	£000's	£000's	£000's
		Contract Income	11,175	10,723	-452	99,526	97,127	-2,399
		Other Income	242	244	2	2,176	2,067	-109
		Total Income	11,417	10,967	-450	101,702	99,194	-2,508
1,606	1,699	Pay	-5,913	-6,419	-506	-54,544	-59,171	-4,627
		Non pay	-1,425	-1,847	-422	-14,038	-16,720	-2,682
1,606	1,699	Total Expenditure	-7,338	-8,266	-928	-68,582	-75,891	-7,309
1,606	1,699	Gross Margin	4,079	2,701	-1,378	33,120	23,303	-9,817

Divisional Performance (budgets) Urgent Care Division – December 2013

Headlines

Pay

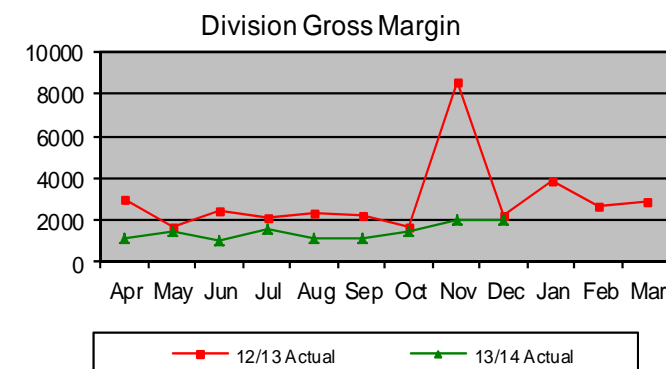
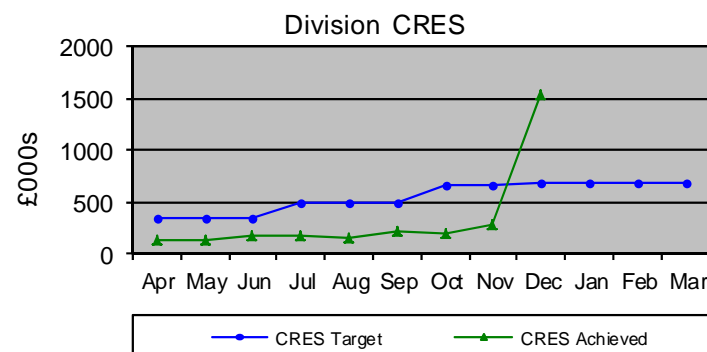
Pay overspent in the month by £171k due to underachieving CRES schemes. Agency costs have reduced to £166k in month compared to the previous monthly average of £391k. The main reduction being in respect of nursing agency. Medical agency pressures remain within A&E and Diabetes /Endocrinology.

Non Pay

Non pay over spent by £257k in month. This was due to underachieving CRES schemes (£150k) and Cardiology consumables expenditure. The YTD non pay is now £1,825k below plan.

Income

Income over achieved by £421k in the month. YTD income has over achieved by £1,801k.



Workforce		Urgent Care	In mth	In mth	Var	YTD	YTD	Var
Plan	Actual		Plan	Actual		Plan	Actual	
FTE	FTE		£000's	£000's	£000's	£000's	£000's	£000's
		Contract Income	7,658	8,077	419	68,868	70,570	1,702
		Other Income	28	30	2	259	358	99
		Total Income	7,686	8,107	421	69,127	70,928	1,801
1,479	1,522	Pay	-4,874	-5,045	-171	-44,089	-47,865	-3,776
		Non pay	-830	-1,087	-257	-8,323	-10,148	-1,825
1,479	1,522	Total Expenditure	-5,704	-6,132	-428	-52,412	-58,013	-5,601
1,479	1,522	Gross Margin	1,982	1,975	-7	16,715	12,915	-3,800

Divisional Performance (budgets) Integrated Care Division – December 2013

Headlines

Pay

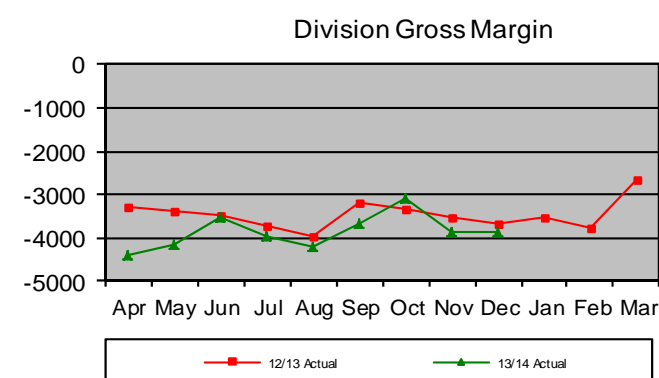
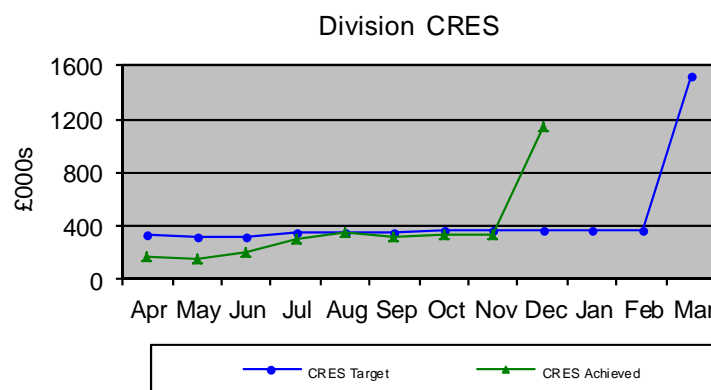
In Month 9, pay underspent by £105k which has reduced the YTD overspending to £716k. The in month under spend is a result of vacancies and tighter agency control. The YTD overspending is principally in respect of Children & Young persons medical paediatric cover supporting A&E.

Non Pay

In month the division reported a non pay overspending of £522k which has increased the YTD overspending to £2,579k. The adverse position is due to third party expenditure, mobile scanning & out of hours costs across radiology, together with activity driven clinical chemistry expenditure and slippage against the CRES target.

Income

Income under-achieved in the month by £348k (£195k YTD). YTD Contract income adverse variance of £481k, whilst non contract income is £286k above plan YTD.



Workforce		Integrated Care	In mth Plan	In mth Actual	Var	YTD Plan	YTD Actual	Var
Plan FTE	Actual FTE		£000's	£000's	£000's	£000's	£000's	£000's
		Contract Income	5,761	5,539	-222	51,248	50,767	-481
		Other Income	233	107	-126	2,094	2,380	286
		Total Income	5,994	5,646	-348	53,342	53,147	-195
1,658	1,547	Pay	-5,649	-5,544	105	-50,914	-51,630	-716
		Non pay	-3,456	-3,978	-522	-33,271	-35,850	-2,579
1,658	1,547	Total Expenditure	-9,105	-9,522	-417	-84,185	-87,480	-3,295
1,658	1,547	Gross Margin	-3,111	-3,876	-765	-30,843	-34,333	-3,490

Divisional Performance (budgets) Commercial Directorate – December 2013

Headlines

Pay

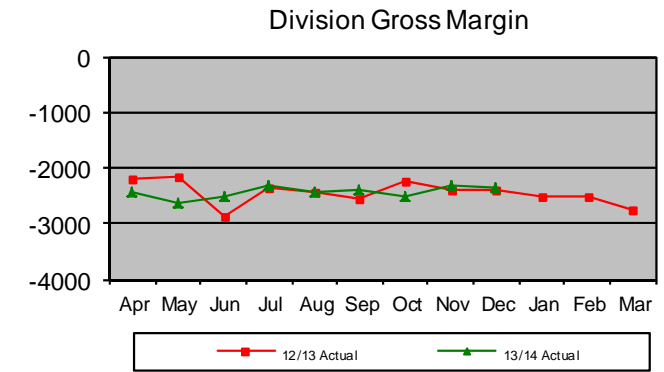
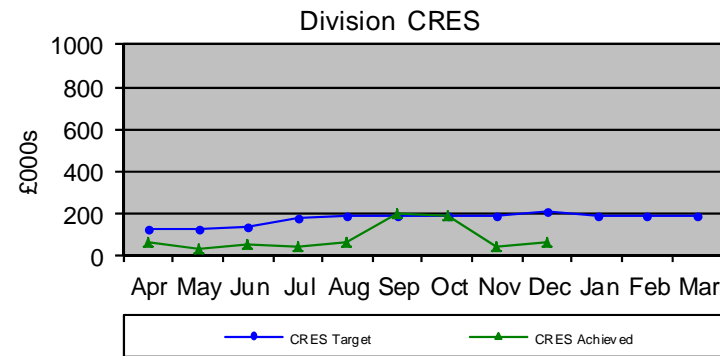
Pay underspent by £147k in December as a result of continued under spending within hotel services (mainly housekeeping), property services management & design team vacancies.

Non Pay

Non pay was £76k overspent in month. The main factor being slippage against CRES delivery

Income

Income underachieved in the month by £35k taking the YTD variance to £1,135k below plan. Underachievement was in respect of EHS external income, car parking, accommodation and restaurant income, partly offset by increased Michelham private patient income .



Workforce		Commercial Directorate		In mth	In mth		YTD	YTD	
Plan	Actual			Plan	Actual	Var	Plan	Actual	Var
FTE	FTE			£000's	£000's	£000's	£000's	£000's	£000's
		Other Income		1,177	1,142	-35	10,455	9,320	-1,135
		Total Income		1,177	1,142	-35	10,455	9,320	-1,135
1,065	999	Pay		-2,110	-1,963	147	-18,931	-18,287	644
		Non pay		-1,454	-1,530	-76	-12,134	-12,907	-773
1,065	999	Total Expenditure		-3,564	-3,493	71	-31,065	-31,194	-129
1,065	999	Gross Margin		-2,387	-2,351	36	-20,610	-21,874	-1,264

Divisional Performance (budgets) Corporate Services – December 2013

Headlines

Pay

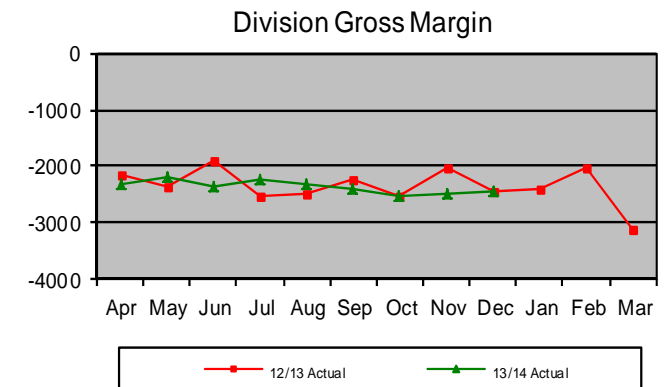
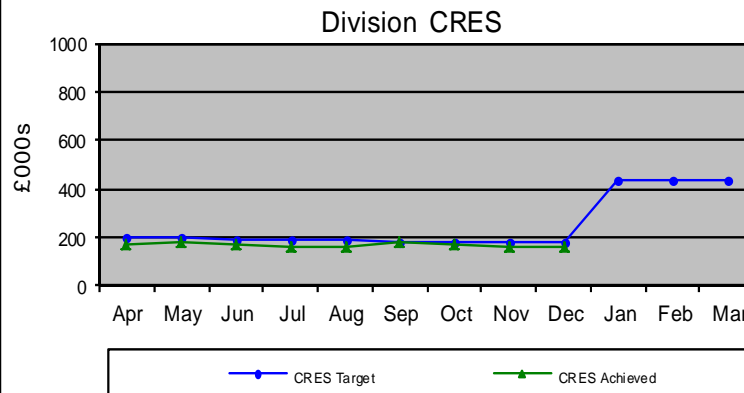
Corporate pay underspent in December by £135k increasing the cumulative under spending to £557k. The under-spending is principally due to vacancies within Finance, Strategic Development, Director of Nursing & Human Resources.

Non pay

Corporate non pay underspent by £45k in December which increased the YTD overspending to £652k. This overspending is due to Hosted Funds and consultancy fees

Income

Income underachieved by £146k in the month, increasing the YTD under achievement to £636k. This underachievement is in respect of child health, occupational health & University of Brighton Library/Education Centre income.



Workforce		Corporate Services	In mth	In mth	Var	YTD	YTD	Var
Plan	Actual		Plan	Actual		Plan	Actual	
FTE	FTE		£000's	£000's	£000's	£000's	£000's	£000's
		Other Income	483	337	-146	3,838	3,202	-636
		Total Income	483	337	-146	3,838	3,202	-636
520	500	Pay	-1,704	-1,569	135	-14,920	-14,363	557
		Non pay	-1,163	-1,208	-45	-9,822	-10,474	-652
520	500	Total Expenditure	-2,867	-2,777	90	-24,742	-24,837	-95
520	500	Gross Margin	-2,384	-2,440	-56	-20,904	-21,635	-731

CRES Plans – December 2013

Headlines

- The total initial Trust CRES target for 2013/14 was £20.0m. In addition, QIPP related savings total £0.95m. The initial divisional CRES targets of £22.0m included an over-planning margin of £2.0m.
- In month CRES achievement of £3.7m including turnaround CRES, was £1.7m above the initial plan CRES target. YTD total achievement of £10.1m was £3.2m below target.
- The profile of plans indicates the continued risk of a shortfall against the target for the full year. The Trust has developed a Financial Recovery Plan (FRP) to address this and other financial risks.

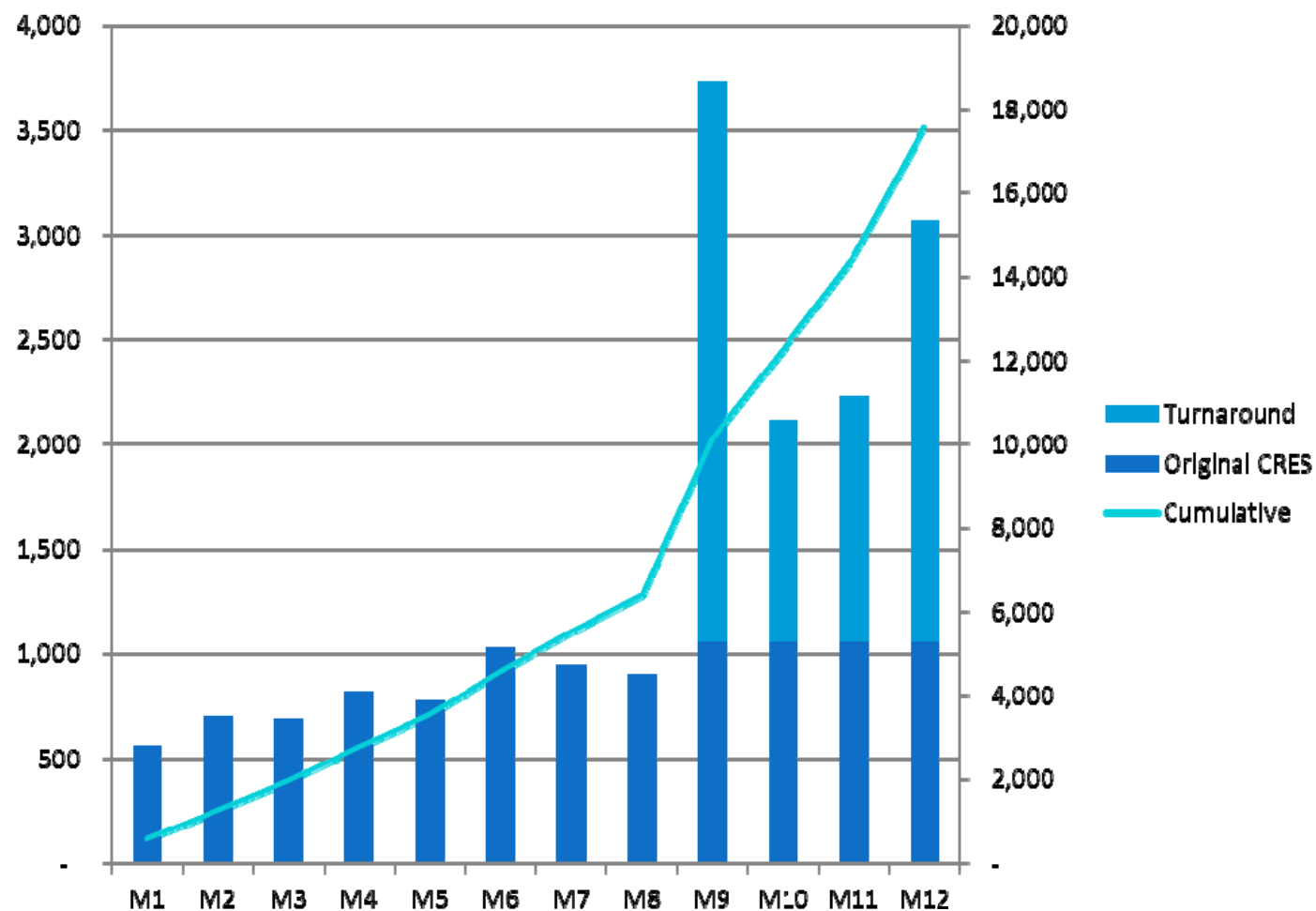
Division	2013/14 Target £000s	2013/14 In-year identified target £000s	2013/14 Target to forecast gap £000s	Red £000s	Amber £000s	Green £000s
Planned Care	6,010	6,010	0	3,508	1,479	1,023
Urgent Care	6,580	6,580	0	737	2,710	3,133
Integrated Care	5,300	6,295	995	0	2,743	3,552
Corporate Services	2,970	2,970	0	1,005	0	1,965
Commercial Directorate	2,090	2,090	0	1,158	0	932
Sub Total Divisions	22,950	23,945	995	6,408	6,932	10,605
QIPP Related Savings	-950	-950	0	-950		
Sub Total Divisions	22,000	22,995	995	5,458	6,932	10,605
Overplanning Margin	-1,963	-2,958	-995	-2,958	0	0
Total	20,037	20,037	0	2,500	6,932	10,605

Division	In-month CRES Target £000s	In-month CRES achieved £000s	In-month CRES variance £000s	YTD CRES Target £000s	YTD CRES achieved £000s	YTD CRES variance £000s
Planned Care	550	733	183	3,605	1,472	-2,133
Urgent Care	619	1,682	1,063	3,792	3,135	-657
Integrated Care	402	1,097	695	3,193	3,285	92
Corporate Services	204	156	-48	1,586	1,497	-89
Commercial Directorate	247	62	-185	1,126	746	-380
Sub Total Divisions	2,022	3,730	1,708	13,302	10,135	-3,167
Overplanning Margin			0			0
Total	2,022	3,730	1,708	13,302	10,135	-3,167

Cost Improvement Forecast

Headlines

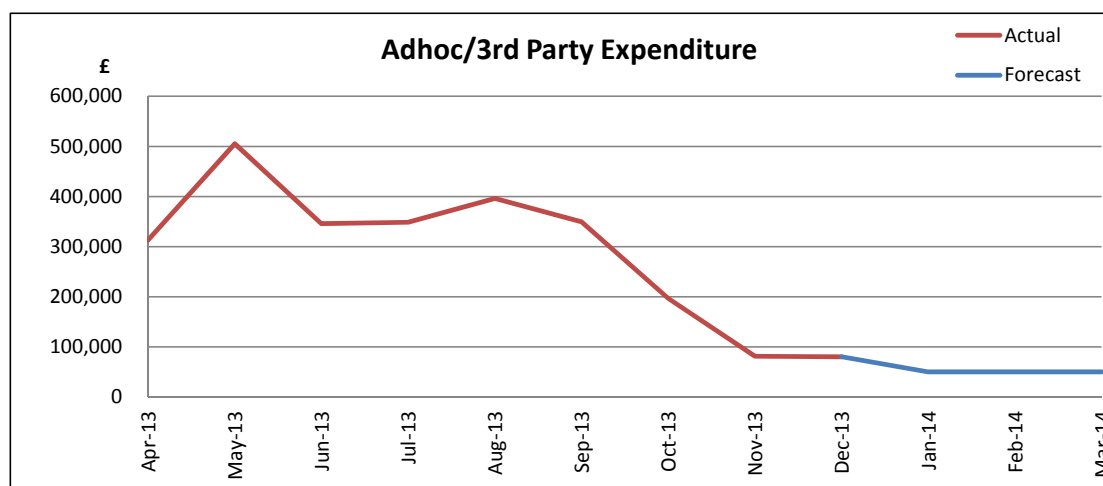
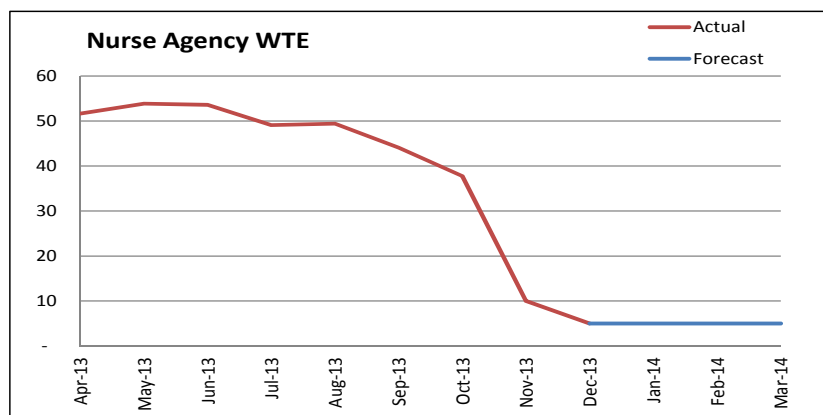
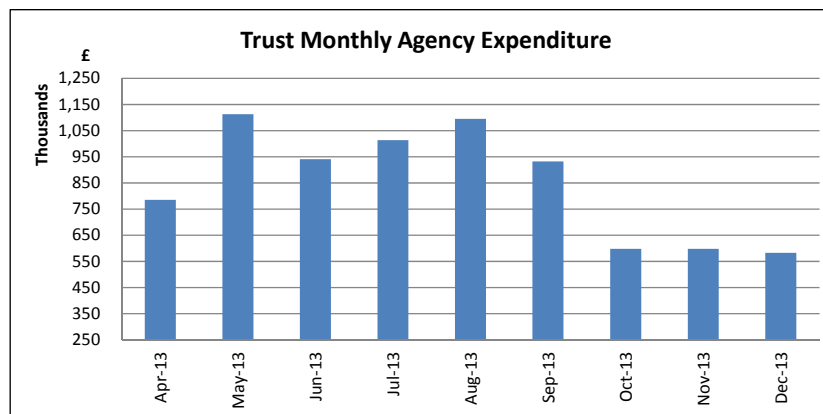
- The original plan is profiled to deliver £10.6m at year end.
- The Turnaround plan is included in this report for the first time; the actual delivery in M9 wraps up turnaround actions in M8-9.
- The Turnaround plan is forecast to deliver £6.9m additional cost improvements
- Year end delivery is forecast to be £17.5m, £2.5m short of the original plan.



Turnaround Update

Headlines

- Weekly Clinical Unit Reviews – started w/b 14/10. Led by Kingsgate, strong Finance support, alongside ops with CD, GM, Heads of Nursing (12 CU areas)
- Detailed re-forecast after M8
- Phase 1 focus upon:
 1. Agency
 2. Ad-hoc and outsourcing costs
- Trust Agency Spend reduction of 30%
- Nursing Agency WTE reduction of 90%
- Adhoc & Third Party Payments reduced by 79% .
- Closure of beds on/redesignation of Polegate Ward.
- Comprehensive planning round for 14/15 has commenced. Resource reviews, demand and capacity analysis and CIP modelling are all underway.



Year on Year Comparisons – December 2013

Headlines

- YTD total Inpatients were 0.5% higher than last year.
- YTD outpatients were 6.4% lower than last year.
- YTD A&E attendances were 0.3% lower than last year.

Activity	2013/14 YTD Actual	2012/13 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
Planned Same Day	31,992	32,322	-330	-1.0%
Elective Inpatients	7,012	7,577	-565	-7.5%
Emergency Inpatients	32,803	31,558	1,245	3.9%
Total Inpatients	71,807	71,457	350	0.5%
Elective Excess Bed Days	1,542	1,231	311	25.3%
Non elective Excess Bed Days	22,397	18,232	4,165	22.8%
Total Excess Bed Days	23,939	19,463	4,476	23.0%
Consultant First Attendances	69,172	75,534	-6,362	-8.4%
Consultant Follow Ups	110,244	120,423	-10,179	-8.5%
OP Procedures	41,088	33,791	7,297	21.6%
Other Outpatients (WA & Nurse Led)	91,551	103,897	-12,346	-11.9%
Community Specialist	2,145	2,194	-49	-2.2%
Total Outpatients	314,200	335,839	-21,639	-6.4%
A&E Attendances	77,584	77,798	-214	-0.3%
ITU Bed Days	4,500	4,918	-418	-8.5%
SCBU Bed Days	2,448	2,479	-31	-1.3%
Cardiology - Direct Access	666	612	54	8.8%
Radiology - Direct Access	41,425	40,022	1,403	3.5%
Pathology - Direct Access	2,487,654	2,322,422	165,232	7.1%
Therapies - Direct Access	30,301	24,396	5,905	24.2%

£000s	2013/14 YTD Actual	2012/13 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	242,214	260,787	-18,573	-7.1%
Private Patient/ RTA	2,007	2,564	-557	-21.7%
Trading Income	3,394	3,604	-210	-5.8%
Education	6,361	5,779	582	10.1%
Other Non Clinical Income	13,587	13,838	-251	-1.8%
Total Income	267,563	286,572	-19,009	-6.6%
Pay Costs	-191,521	-191,301	-220	0.1%
Non Pay Costs	-86,099	-87,115	1,016	-1.2%
Other	1,188	1,123	65	5.8%
Total Direct Costs	-276,432	-277,293	861	-0.3%
Surplus/-Deficit from Operations	-8,869	9,279	-18,148	-195.6%
Profit/Loss on Asset Disposal	0	15	-15	
Depreciation	-9,040	-7,547	-1,493	19.8%
PDC Dividend	-4,367	-4,702	335	-7.1%
Interest	-232	-281	49	-17.4%
Total Indirect Costs	-13,639	-12,515	-1,124	9.0%
Total Costs	-290,071	-289,808	-263	0.1%
Net Surplus/-Deficit	-22,508	-3,236	-19,272	595.6%
Donated Asset / Other Adjustment	198	140	58	41.4%
Normalised Net Surplus/-Deficit	-22,310	-3,096	-19,214	620.6%

Capital Programme – December 2013

Headlines

- The capital programme continues to be under severe pressure with demands for capital expenditure far outstripping available resources. As a result there will be significant risks arising from the deferral of capital schemes in order to bring the capital programme into balance.
- To try to address these risks and pressures in the current financial year, an application for an additional £5m of capital resource, with cash funding, has been submitted via the Trust Development Authority (TDA). A decision on this application is expected in mid January 2014.
- Following the approval of the clinical strategy full business case by the Trust Board at its meeting in December, it is now expected that the Trust Development Authority (TDA) will consider the business case, including the Trust's interest bearing capital loan application (IBL), in March 2014. As a result the 2013/14 IBL capital resource assumption has been revised down to zero on the basis that any funding approval will now not be approved, or received, until 2014/15.
- During December capital expenditure has increased by £1.3m to £7.1m year to date and the over commitment has increased to £0.8m which is 87% of the revised planned funding, excluding IBL, for this stage of the financial year.

	2013/14	
	Capital Programme	Expenditure to Month 9
Capital Investment Programme £000s		
Capital Resources		
Depreciation	10,602	
League of Friends Support	1,243	
Interest Bearing Capital Loan	0	
Cap Investmnt Loan Principal Repayment	-540	
Gross Capital Resource	11,305	
Less Donated Income	-1,243	
Capital Resource Limit (CRL)	10,062	-
Capital Investment		
Clinical Strategy - Capital Loan	252	252
Clinical Strategy - Trust Programme	594	411
Medical Equipment	1,558	1,190
Information Systems	677	135
Electronic Document Management	200	82
Child Health Information System	260	77
Endoscopy Development	1,360	1,367
Backlog Maintenance/Ward Deep Clean	1,601	543
Minor Capital Schemes	1,250	1,187
Maternity	497	488
Pathology CLD Estate costs	198	29
PACS.RIS	221	71
Other	814	366
Brought Forward Schemes	1,332	866
Sub Total	10,815	7,064
Donated Asset Purchases	1,243	764
Donated Asset Funding	-1,243	-764
Net Donated Assets	0	0
Sub Total Capital Schemes	10,815	7,064
Overplanning Margin (-) Underplanning (+)	-753	
Net Capital Charge against the CRL	10,062	7,064

Key Performance Indicators & Reserves – December 2013

Headlines	Underlying Performance				Liquidity			
		2012/13	2013/14	2013/14		2012/13	2013/14	
		Outturn	Plan	YTD	£000s	Outturn	YTD	
<ul style="list-style-type: none"> The EBITDA achieved was -£9.6m compared to the planned value of -£2.5m. This has resulted in a -10.7% Net Return after Financing. An application has been submitted via the Trust Development Authority for permanent PDC to replace the temporary loans which have been put in place to ease cash management in the short term. A decision on this application is expected in January 2014. The liquidity ratio, including the Working Capital Facility, stands at 15 days following the draw down of the temporary loans. 	Surplus/-Deficit from Operations	17,057	-1,578	-8,869	Opening Current Assets	23,294	35,965	
	Donated Asset Income Adjustment	-939	-932	-764	Opening Current Liabilities	-35,518	-44,287	
	EBITDA	16,118	-2,510	-9,633	Net Current Assets/Liabilities	-12,224	-8,322	
	Divided by:				Inventories	-6,869	-6,791	
	Total Income	387,400	267,978	267,563	Adj Net Current Assets/Liabilities	-19,093	-15,113	
	Donated Asset Income Adjustment	-939	-932	-764	In year working capital facility	30,439	30,294	
	EBITDA Margin	4.2%	-0.9%	-3.6%		11,346	15,181	
	EBITDA % Achieved				Divided by:			
	Actual EBITDA	16,118	-2,510	-9,633	Total costs in yr x-1	370,343	276,432	
	Divided by:							
	Budgeted EBITDA	18,880	-2,510	-2,510	Multiply by (days)	360	270	
	EBITDA % Achieved	85.4%	100.0%	383.8%	Liquidity Ratio	11	15	
	Financial Efficiency	2012/13	2013/14	2013/14	Reserves	Opening	Issued	Closing
	£000s	Outturn	YTD	YTD	£000s	Reserves		Reserves
	Actual	Actual	Plan	Actual				
Surplus / Deficit(-) from Operations	17,057	-1,578	-8,869		Wage Award	2,491	-2,409	82
Less:					CQUIN	2,162	-1,699	464
Donated Asset Income Adjustment	-939	-932	-764		High Cost Drugs	18,994	-14,245	4,749
Interest Expense	-368	-329	-232		Device Exclusions	2,216	-1,662	554
Depreciation & Amortisation	-10,040	-8,884	-9,040		Contingency	3,626	-2,732	895
PDC Dividend	-6,224	-4,367	-4,367			29,489	-22,746	6,743
Net Return	-514	-16,090	-23,272					
Total Debt	-6,883	-6,046	-6,046					
Finance Leases & Borrowings	-1,224	-995	-995					
Taxpayers Equity	-183,115	-236,013	-236,013					
Balance Sheet Financing	-191,222	-243,054	-243,054					
B/fwd Debt	-8,557	-6,883	-6,883					
Finance Leases & Borrowings	-1,514	-1,224	-1,224					
Taxpayers Equity	-186,312	-183,115	-183,115					
Balance Sheet Financing	-196,383	-191,222	-191,222					
Net Return after Financing Score %	-0.3%	-7.4%	-10.7%					
Net surplus/ deficit	472	-15,158	-22,310					
Less fixed asset impairments/disposals	-22	0	0					
	450	-15,158	-22,310					
Divided by:								
Total Income	387,400	267,046	266,799					
I&E surplus margin	0.1%	-5.7%	-8.4%					

Financial Risks & Mitigating Actions – December 2013

Summary	
RISKS:-	
As part of the ongoing review of the Trust's financial position the following risks have been identified to achieving the year end planned deficit.	
1) Activity and associated income not being delivered in line with plan, notably in Orthopaedics.	
2) Non NHS patient care income may not deliver at the budgeted level.	
3) Further unplanned contractual deductions, notably RTT, C Difficile and Stroke.	
4) Potential increase in the contract deduction in respect of marginal rate reimbursement for activity above the non-elective threshold.	
5) Increasing operational cost pressures including the continued use of medical agency.	
6) Pressure to incur premium costs in meeting the RTT.	
7) Continued adverse performance against cost improvement targets.	
8) Failure to deliver anticipated CQUIN income.	
MITIGATING ACTIONS:-	
An In-Year Financial Recovery Plan (IRP) has been developed to address all of the above risks and all Executive Directors are personally involved and responsible for its delivery. The IRP trajectory has been submitted to the Trust Development Authority (TDA). A Turnaround Director is in post and reports directly to the Chief Executive.	

East Sussex Healthcare NHS Trust

Date of Meeting:	29 th January 2014
Meeting:	Trust Board
Agenda item:	9
Subject:	Response to external review of Maternity and Paediatric services
Reporting Officer:	Dr Andy Slater, Medical Director - Strategy

Action: This paper is for (please tick)			
Assurance	<input checked="" type="checkbox"/>	Approval	<input checked="" type="checkbox"/>
Decision			
Purpose:			
The purpose of this paper is to provide the Trust Board with the assurance that recommendations from the external visits by the Royal College of Paediatricians and Child Health (RCPCH) and the joint visit by the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Paediatricians and Child Health are being actioned and addressed.			

Introduction:
At a risk summit that the Trust attended in February 2013 with NHS South of England; Trust Development Agency (TDA), NHS Commissioning Board, local Clinical Commissioning Groups (CCGs) and the Care Quality Commission (CQC); where the safety of maternity services was discussed, it was agreed that the Trust would commission a joint visit by the RCOG and RCPCH to review the Trust's arrangements for clinical governance and clinical risk management including the processes in place to review and act on serious incidents. The review took the form of interviews with staff, assessment of governance documentation and a random case note review and resulted in a number of recommendations.
Following the temporary re-configuration of maternity, paediatrics and emergency gynaecology onto one site in May 2013 the Trust invited the RCPCH to review the operational policy that had been developed to support the service change. The review took the form of a tour of the services provided on the Eastbourne site post re-configuration and interviews with internal staff and commissioners as well as a review of relevant documentation and resulted in a number of recommendations

Analysis of Key Issues and Discussion Points Raised by the Report:
The action plans related to both reviews are attached.
The joint RCOG/RCPCH review recommendations centre on improvements that can be made to the maternity risk strategy including ensuring the processes used to manage serious incidents and undertake Root Cause Analysis (RCAs) within the specialty are fully aligned to the whole Trust approach. It also identified the need to continue to audit practice and to ensure that staff have the appropriate skills and knowledge commensurate with their roles.

The RCPCH review centred on ensuring that the Trust has a robust operational policy to support safe service delivery. The value of benchmarking services and ensuring that there are staff with appropriate skills on duty in the Accident and Emergency Department to support sick children was also highlighted.

The two action plans will be regularly reviewed via clinical unit meetings in both specialities and the Associate Director and Assistant Director of Nursing will monitor that timescales are being adhered to and recommendations addressed and will report on progress by exception to the Clinical Management Executive

A meeting has been held with commissioners to review the Trust's action plans and the plans presented to the Board reflect the outcomes of this meeting. Future commissioner review of the implementation of the two action plans will take place through the regular Clinical Quality Review Group meetings held between the Trust and the CCGs.

Benefits:

A revised risk management strategy for maternity will be developed that reflects Trust wide improvements in the management of Serious Incident reviews and Root Cause Analysis.

A robust operational policy is finalised, ratified and adopted by all clinicians in support of the delivery of the current temporary configuration of paediatric services and that further service improvements are built in to the future service model to be delivered following once a commissioner decision is made on the long term future of the service.

Risks and Implications

Agreed timelines to address the recommendations are not met.

Assurance Provided:

This report provides the Board with assurance that appropriate actions have been identified to address the recommendations made as a result of the external reviews and that there are processes in place to monitor the implementation of the actions plans.

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

None

Proposals and/or Recommendations

The Board is informed of progress by exception through the Quality and Standards Committee.

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:

Paula Smith, Associate Director
Lindsey Stevens, Assistant Director of Nursing

Contact details:

(13) 3754



Royal College of
Obstetricians &
Gynaecologists

CONFIDENTIAL

Review of the Obstetric and Neonatal Services of East Sussex Healthcare NHS Trust at Conquest Hospital

Undertaken by:

Mr Paul L Wood MD FRCOG (Lead Assessor)

Mr Andrea Galimberti FRCOG (Co-Assessor)

Professor Stewart Forsyth OBE MD FRCPCH (Co-Assessor)

On 8 and 9 August 2013

On behalf of the
Royal College of Obstetricians and Gynaecologists
27 Sussex Place
Regent's Park
London NW1 4RG

Tel: +44 (0)20 7772 6200

Fax: +44 (0)20 7772 0575

Website: www.rcog.org.uk

Registered charity no. 213280

CONTENTS

INTRODUCTION	3
Terms of Reference.....	3
BACKGROUND	3
Care Quality Commission (CQC) Inspection Reports (Maternity & Paediatric), Conquest Hospital, Eastbourne District General Hospital – Inspections (24–25 June 2013).....	8
RCOG EXTERNAL CLINICAL ADVISORY TEAM REVIEW, 8–9 August 2013	10
Interviewees.....	10
Other Information received in advance of the visit	10
Information supplied during the visit.....	10
Site visit.....	11
Clinical risk and service delivery assessments	11
Service management and clinical decision making	13
RECOMMENDATIONS	14
Risk Management Strategy	14
Service management and clinical decision making	15
CONCLUSION.....	16

INTRODUCTION

This review visit took place at the same time as a separate review visit undertaken by the Royal College of Paediatrics and Child Health (RCPCH).

Terms of Reference

1. Using case note review, interviews with staff and review of policies and procedures, identify areas for development in respect of Clinical Decision Making, Clinical Risk Assessment and Clinical Risk Management.
2. To make recommendations as to how these areas for development should be addressed.
3. Review the serious incidents that have occurred in Maternity and Paediatrics over the last twelve months and assess the clinical decision making processes, the root cause analyses, the incident reporting timeliness, and in particular identify any:
 - Learning points following serious incidents.
 - Failures to make the correct diagnosis.
 - Failures to perform an appropriate examination.
 - Failures to offer or perform appropriate treatment.
 - Failures to arrange an appropriate review strategy in relation to the condition for which referred.
 - Failures to take appropriate action in a timely manner.
 - Failures to comply with relevant Trust Clinical Guidelines.
 - Failures to identify or report a serious incident in a timely manner.
 - Failures to take appropriate action within a reasonable time frame to minimise the risk of a similar incident occurring and/or to address the root causes identified.
4. To make recommendations for actions that will ensure that there are robust and clinically led systems and processes in place to enable clinicians to critically appraise incidents, to identify root causes and implement actions so that learning and appropriate changes in clinical practice can be delivered and evidenced.

BACKGROUND

East Sussex Healthcare NHS Trust held an Extraordinary Trust Board Meeting in public on Friday 8 March 2013. Included in the Board papers was a document entitled 'Ensuring Safety for Obstetrics and Gynaecology and Neonatal Services'. The report provided the Board with information required to make a decision on the preferred option for improving the safety of the maternity and neonatal services. The paper sets out the reasons behind the view that for some patients some of the time the maternity and neonatal services operated by the Trust did not deliver the safety and quality standards expected and required. The paper was based on the views of the Trust's senior clinicians

and also those of the National Clinical Advisory Team (NCAT). The current dependency on mitigating actions meant that the cumulative risk of service failure was at an unacceptable level, and that the delivery of a safe service could become rapidly unsustainable, leaving the Trust with little time to implement effective mitigating actions. The preferred option presented to the meeting on 8 March 2013 was the provision of a consultant-led obstetric service, neonatal service, inpatient paediatric service and an emergency gynaecology service at the Conquest Hospital. A stand-alone Midwifery-Led Unit (MLU) with enhanced ambulatory paediatric care was to be established at Eastbourne District General Hospital.

The main risk factors identified were:

- Increased numbers of high risk pregnancies.
- Lack of 24/7 availability of medical and midwifery staff with the required competences.
- An ongoing dependency on temporary staff.
- Potential failure of the risk mitigations at short notice.
- The lack of availability of clinical leadership in a service delivered on multiple sites.

The requirement to act had been triggered by an analysis of increasing numbers of serious incidents (SIs). The NCAT attended in January 2013 and a Risk Summit had taken place in February 2013. Both concluded that the Trust was operating with unsustainable levels of risk and urgent action was deemed necessary. Prior to 2013 approximately 2000 women were delivered in each of two separate sites at Conquest Hospital and at Eastbourne District General Hospital. The Trust's number of SIs per calendar year from 2007 are summarised as follows:

Year	Obstetrics	Paediatrics
2007	1	2
2008	6	2
2009	1	0
2010	10	2
2011	7	1
2012	8	3
2013 (to 8 March)	8	1

The processes in place in relation to serious incidents were as follows:

- Root Cause Analysis (RCA).
- Discussion at weekly conference calls with the Primary Care Trust (PCT)/ Strategic Health Authority (SHA).
- Action plans for RCA discussed at the bimonthly Divisional Patient Safety and Clinical Improvement Group and at core team meetings.
- Each serious incident was also discussed at the fortnightly Trust Wide Serious Incident Review Group.

The themes identified from recent serious incidents were:

- Senior opinion not being sought in a timely manner.
- Women not being reviewed in a timely way.
- Poor care resulting in harm to babies at birth.
- Poor communication in relation to planning and communicating care plans.
- Poor liaison with senior colleagues.
- Care given by agency staff causing harm.
- Junior staff not recognising the deteriorating condition of a patient and escalating appropriately.
- Inadequate supervision of junior staff.
- Maternal risk factors.

The report referred to the Dr Foster Patient Safety Indicator Data and explained how the Trust was a significant outlier in 2010–11 and 2011–12 for obstetric trauma at caesarean section and this continued to be the case. The Trust's observed rate for 2011 was 20 against an expected level of 3.1. In 2011–12 this was 15 against an expected rate of 3.1, meaning the risk of harm to a woman undergoing caesarean section at East Sussex Healthcare NHS Trust was five-fold more than anticipated. The majority of the caesarean sections resulting in obstetric trauma were identified as having been undertaken by locum/agency doctors or more junior registrars without the presence or supervision of a consultant. Analysis demonstrated that there was a greater risk of harm at the Eastbourne site.

The Maternity Dashboard had identified:

- A consistent need to divert women in labour from one site to another.
- The birth to midwife ratio was above that expected.
- High midwifery absence rates.
- Low normal delivery rates.
- Higher than expected numbers of term babies admitted to the Neonatal Unit.

Key factors that were adversely influencing the quality and safety of service provision included the inability to provide consultant labour ward presence at levels above 40 hours per week, lack of suitable applicants to fill established posts with accompanying requirements to take unplanned action to address shortfalls, staff not always being able to operate at the skill levels required and lack of availability of experienced staff 24/7.

NCAT had concluded the following:

- A decision on the location of inpatient maternity care and paediatrics was needed as a matter of urgency.
- The manner in which the maternity and paediatric services were operating was neither safe nor sustainable.

- The siting of inpatient maternity services was dependent on appropriate arrangements with other relevant services.
- The maternity services were the main driver but separate inpatient paediatric services were felt to be too small to be sustainable.
- In the presence of two separate emergency departments the provision of emergency gynaecology needed to be managed on the remaining site in the absence of resident gynaecology staff.

NCAT's recommendations included:

- Co-location of maternity and paediatric inpatients on one site as a matter of urgency.
- A Trust-wide strategy for maternity and paediatric services to be developed.
- Consideration to the establishment of alongside and stand-alone MLUs.
- Maternity, gynaecology and paediatrics should be on the same site.
- The Trust to reconsider the overall strategy for delivering services to acutely ill patients in order to improve service delivery and reduce clinical risk.
- Need to urgently address local leadership of the paediatric team and improve cohesion.
- A paediatric group to take forward standardisation of clinical guidelines and practice within an agreed time frame.

The paper considered a risk assessment of the various options and the advantages of the preferred option was adopted. This involved the provision of a consultant-led obstetric service, neonatal service, inpatient paediatric service, an emergency gynaecology service on the Conquest site and establishing a stand-alone MLU as well as enhanced ambulatory paediatric care at Eastbourne General Hospital.

The advantages included:

- Ability to provide a minimum of 60 hours consultant labour ward presence.
- Consolidation of activity providing a wider range of experience for trainees, improving recruitment and retention.
- Improved medical cover at night.
- Improvement in staffing, flexibility of midwifery resources, improved midwifery skill mix, and provision of dedicated consultant-led teams.

NCAT referred to an external review of four cases which had taken place without the benefit of the clinical records, clinical guidelines, knowledge of the working practice and knowledge of the staff involved. However the external review concluded:

1. The Trust acted responsibly in requesting external reviews. NCAT noted that overall the reviews were well contributed and written but there were significant omissions.
2. There were delays in escalating incidents for risk review and identifying them as serious incidents.
3. There were delays in completing planned actions and a lack of robust assessment that actions had been achieved.

4. There was a lack of escalation by midwifery, neonatal nursing or theatre staff directly to the consultant when there were concerns about a middle grade doctor's actions raising concerns regarding the profile of the Labour Ward Co-ordinator and Labour Ward Lead Clinician.
5. There appeared to be significant issues around obstetric staffing including decision-making relating to delivery at full dilatation and trials of instrumental vaginal deliveries.
6. The RCAs did not demonstrate sufficient evidence of support being offered to medical staff, especially locums and paediatricians after adverse outcomes and a failure to adhere to local clinical guidance was a common theme in the incidents reviewed.
7. Poor communication within and between teams was a common feature.

Concerns raised by NCAT included:

- Delays in escalation.
- Lack of supervision of locum and middle grade staff.
- Validity of the interpretation of Serious Incident Reports.
- A very worrying culture of complacency in relation to risk within maternity and paediatrics.
- Poor record keeping.
- Poor communication.
- Lack of plan of care.
- Lack of documentation.
- Lack of appropriate level for opinion/planning.
- Inappropriate grades/level of staff undertaking or providing care.
- Where a serious incident involved a poor outcome for the baby there appeared to be a minimal review of obstetric care prior to the birth.

NCAT felt that the RCA Enquiry Team did not appear to have asked the appropriate questions and therefore they felt the conclusions were likely to be incorrect. The NCAT refer to the Edgecumbe Report which was 'truly shocking in its account of failure of clinical leadership and of the dysfunction within the Paediatric Team'. NCAT concluded that neither the maternity nor the paediatric services were safe or sustainable in their current shape and that the paediatric department especially appeared to be dysfunctional with little insight. Urgent steps were needed to address these shortcomings. This report was dated 11 February 2013.

Care Quality Commission (CQC) Inspection Reports (Maternity & Paediatric), Conquest Hospital, Eastbourne District General Hospital – Inspections (24–25 June 2013)

The assessors were provided with favourable Care Quality Commission reports (in draft) for both hospitals following inspections in June 2013. These reports were later issued in their final form by the CQC following correction of some minor factual inaccuracies.

Points to note within the reports include:

- The temporary reconfiguration of maternity and paediatric services was completed on 7 May 2013.
- There had been prior concerns registered by a team of consultant paediatricians at Eastbourne District General Hospital.
- Care and welfare, safeguarding, requirements relating to workers, staffing and assessing and monitoring the quality of service provision had been inspected and assessed as meeting the standards.

The reports noted that:

- Systems were reviewed at both the Conquest Hospital and Eastbourne District General Hospital.
- There had been a marked increase in the reporting of incidents during the second half of the financial year ending March 2013.
- Conclusions reached were that the Trust is providing a safe, effective, responsive, caring and well led maternity and paediatric service.
- Staff felt that centralisation of obstetric intrapartum care was safer.
- Staffing was obtained by the use of 'familiar' bank and agency staff.
- Colleagues had been supportive following the relocation.
- Obstetricians were now 'present' on the labour ward rather than 'available'.
- The need for locum obstetric staff at night had been removed.
- There had been a reduction in clinical incidents since amalgamation.
- The Report referred to the computerised system for reporting incidents.
- Incident forms were reviewed daily with risk meetings Monday–Friday.
- Staff received feedback about incidents on a monthly basis.
- There had not been any clinical incidents regarding neonatal resuscitation since the reconfiguration.
- The Trust's maternity services had been assessed as Level 3 at the last Clinical Negligence Scheme for Trusts (CNST) visit. (N.B. This was an incorrect typographical error and should have read Level 2).
- In the context of the paediatric concerns, if reassessed by CNST the Trust would be assessed as higher risk, but this would not make it uninsurable.

- The CQC was satisfied that, within maternity and paediatrics, the Trust had taken appropriate steps to mitigate risk and ensure that care and treatment was planned and delivered in a way that ensured people's safety and welfare.
- Maternity staff confirmed they received safeguarding training annually.
- Staff interviewed had a clear understanding of mental capacity assessments.
- Temporary staff (locums) were subject to the same level of checks and similar selection criteria to staff in substantive posts.
- The risk of employing locums was on the Risk Register and specific controls had been put in place.
- The Trust compared its SIs with others and the national mean.
- The Trust may not be able to find evidence when consultants were on the ward on the basis of the attendance diary.
- All locums were directly supervised re decision-making and instrumental and operative deliveries.
- The Maternity Dashboard had been reviewed.
- Each clinical unit had a risk register and monthly risk meeting.
- The high-level risk register was reviewed.
- Minutes of the Serious Incident Review Group had been inspected for 29 May and 12 June. Contradictions in report were questioned by the Inspectors. The controls in place for locum staff were deemed to be 'adequate'
- Escalation was to the Divisional Risk Meeting, Health and Safety Group, Patient Safety Group, Clinical Management Executive, Quality & Standards Committee and Patient Safety and Clinical Improvement Group and finally the Trust Board.
- Six SI reports and their RCAs were examined in detail and, in general, the CQC found that the reports and reviews had been completed to a high standard.
- Some staff had been made personally accountable following RCA.
- Generally the action plans were relevant and had been completed, but not all.
- There has been a South Coast Audit that had only been able to provide limited reassurance that action plans were being completed. One recommendation was that actions were implements and monitored. Auditing of the quality of case notes had been incomplete.

RCOG EXTERNAL CLINICAL ADVISORY TEAM REVIEW, 8–9 August 2013

Interviewees

- Coordinator – Ms Paula Smith, Acting Associate Director, Women and Children – Integrated Care, East Sussex Healthcare NHS Trust, who facilitated the review
- Ms Amanda Harrison – Director of Strategic Development and Assurance
- Dr David Hughes – Medical Director (Governance)
- Mr Jamal Zaidi – Divisional Director – The Divisional Director has joint accountability for governance including risk, along with the Associate Director of Nursing
- Ms Marie Foreman – Matron Delivery Suite
- Dr Sebastien Adamson – ST4 Obstetrics and Gynaecology
- Mr Dexter Pascall – Clinical Unit Lead, Obstetrics. The Clinical Unit Lead has responsibility for the implementation of the Maternity Risk Management Strategy, this responsibility being shared with the Head of Women's Reproductive and Sexual Health Services
- Ms Anne Watt – Divisional Clinical Governance Manager
- Dr Noka Sadete – Middle Grade Trainee in Neonatology
- Dr Graham Whincup – Paediatrician
- Ms Lindsey Stevens – Head of Midwifery and Associate Nurse for the Division
- Ms Wendy Thompson – Neonatal Matron
- Ms Cathy O'Callaghan – Acting Clinical Services Manager

Other Information received in advance of the visit

- Maternity Risk Management Strategy
- Copy of notes and correspondence relating to serious incidents:
 - 2013/10044,
 - 2013/5108,
 - 2102/22311,
 - 2012/23709,
 - 2012/23168,
 - 2012/23709,
 - 2012/24174,
 - 2013/10830,
 - 2013/10040.

Information supplied during the visit

- Clinical records of 47 sets of notes relating to mothers and babies admitted to the Neonatal Unit by way of a random review of case notes.
- Maternity Dashboard April to July 2013.
- Risk Management Meeting Minutes dated 21 June 2013 and 26 July 2013.
- Adverse incidents by category and incident August 2012 to May 2013.
- Maternity Staffing Audit Report December 2012.

- Guidance for Maternity Unit Staffing Levels for all care settings relating to obstetrics and midwifery.
- Obstetrics and Gynaecology weekly rota.
- Daily reporting tools for Maternity Services, Gynaecology and Paediatrics.
- Complaint status as of 10 June 2013.

Site visit

The visit included a brief tour of the Neonatal and Obstetric Unit at the Conquest Hospital during which the labour ward staff were able to demonstrate familiarity with the Datix Incident Reporting System.

Clinical risk and service delivery assessments

Review of serious incidents

The documents relating to eight serious incidents during 2012–2013 were reviewed and a detailed analysis of these cases has been provided to the Trust.

The case reviews identified serious failures in clinical decision-making and service management including delays in escalation of level of care, excessive use of locum doctors, poor communication, inadequate supervision of middle grade doctors, inappropriate care, misinterpretation of CTGs, misleading documentation, and substandard clinical skills including neonatal resuscitation.

The review of the RCAs of each of the incidents revealed that they were invariably undated with no recognisable authorship. Review of the statements shows that these are not consistent in terms of their format or presentation.

These incidents predate the reconfiguration of services and it is vitally important that these serious risks to patient safety are rigorously audited in the new service configuration to ensure the quality of care provided within the new structure is at an acceptable level.

Review of case notes

Time constraints limited the number of case notes reviewed on a random basis but the Review revealed a good standard of neonatal note keeping and in particular the value of combined medical and nursing notes was observed.

Within the obstetric records the risk profiles were often not completed and the reviewers support the need for an ongoing random audit of case notes which has not been carried out within the Trust despite previous recommendations.

Staff were generally good at signing the booklets and the obstetric cases appear to have generally been well managed overall. Incomplete documentation relating to antenatal, labour and postnatal risk factors were evident despite provision of a well structured risk assessment form. Many important clinically relevant fields were not completed. It was gratifying to see that early warning scores had been acted upon appropriately. Not all medical entries were signed.

Maternity risk management strategy

The current version of the Maternity Risk Management Strategy (V1.0) was ratified in November 2012 and issued in January 2013. We were advised that this strategy was in place at the time of the SIs that have been reviewed. The previous strategy version V7 2011017 was dated January 2011.

The Strategy refers to cross-site Obstetric Risk Management and Labour Ward Leads. The document was apparently made available to all staff within the organisation, partner organisations and the public. Key objectives were to ensure that staff had an understanding of the risk management structure via mandatory training sessions and to encourage participation in the risk management process. Other objectives included undertaking audit of practice at three yearly intervals or six to nine months after a practice change, and regular review of the maternity service and labour ward dashboards.

There is no obvious convergence between the Trust's Risk Management Strategy and that for the maternity unit. Furthermore the existing Risk Management Strategy document (V1) is limited in what it provides with obvious gaps as listed below. As a document it is not user friendly and pre-dates obstetric working on a single site.

Root cause analyses

RCAs were generally of a satisfactory standard but hampered by the absence of forensic analysis typified by acceptance of statements without any interviews or meetings with the clinicians concerned where there were apparent conflicts between statements or when the clinical description of the sequence of events was not entirely credible. In addition there was a lack of clarity over outcomes following on from the conclusions reached as a result of the RCAs in relation to clinical governance. These outcomes should be clearly documented, monitored and developed, e.g. SUI 2013/10830. There was clear substandard care on behalf of the consultant and the registrar in this case but, in contrast to midwifery supervision, all that was noted was that the clinical director would have a conversation with the clinicians concerned. The outcome of this conversation or indeed whether this conversation ever took place has never been documented but should have been.

In addition there is a need to strengthen the responses to situations where good medical practice is potentially compromised, e.g. SUI 2012/20174 when the registrar's actions were entirely inappropriate as indeed were his subsequent comments. Under these circumstances there was no attempt to escalate concerns about this individual within the Trust itself and no mechanism to ensure that there was accountability for the responses to this inappropriate clinical behaviour.

Furthermore it became apparent to us that whereas a number of cases involved locum staff there appeared to be a tendency to apportion inappropriate blame on the locum/junior staff in comparison to situations where similar criticisms could be made of the more senior staff in substantive posts.

Daily Datix reporting meetings

The daily Datix reporting meetings appear to be extremely successful and reflect good practice. It would probably be helpful to attempt to involve the neonatal team in these daily meetings.

Service management and clinical decision making

The evidence from the clinical risk assessment highlights serious service delivery issues with significant risk to patient safety. It is acknowledged that these are the drivers for the change in service configuration within the service. However, a robust operational plan to address these issues within the new structure needs to be developed and implementation will require effective clinical and managerial leadership.

The operational plan should include a knowledge and skills review that ensures that at all locations within the maternity and neonatal services care is being provided by staff that are appropriately skilled to deliver safe and effective patient care.

It is clear that the Senior Management Team has trust in the obstetric team and the introduction of a management rota for the maternity unit has been a good move forward. There remain issues with paediatric clinical staff where two clinicians are currently restricted in their clinical work. It is noted that a review team from the RCPCH is providing advice on these issues.

There should be an identified Labour Ward Midwifery Manager Lead rather than a system of rotating the Band 7 coordinators. This will allow for accountability and continuity of responsibility in respect of clinical risk and day to day management of the unit.

Consultant presence on the labour ward involves a system of signing in and out, with which there is limited compliance. Trainees have reported that their supervision on the labour ward tends to amount to consolidation of skills rather than learning, raising the need for a greater degree of direct supervision by the labour ward consultant than is currently provided. There is a need to ensure progress is made in this respect to avoid the risk of poor practice.

Routine auditing of case notes has not been taking place on a regular basis and this should be reintroduced in order to maintain standards and reduce risk.

There would appear to be some additional work in terms of the understanding and implementation of existing guidelines.

RECOMMENDATIONS

Risk Management Strategy

The reviewers had sight of individual pages from a revised draft version of the strategy (V2) but before this is published we recommend the following:

- a) The Risk Management Strategy should be targeted beyond the Maternity Department itself.
- b) Titles are not necessarily appropriate and roles and responsibilities need to be clearly defined.
- c) There need to be references to guidelines, risk management coordination processes and responsibility for Root Cause Analyses.
- d) There should be separate sections on incident reporting, serious incidents and links to the Trust Risk Management Board.
- e) There should be references to the Maternity Dashboard, mechanisms for minimising risk and future risk management planning.
- f) There should be evidence of compliance monitoring and audit and hyperlinks to related documents.
- g) There are no references and there is a need to include links to external bodies.
- h) It seems unclear to us why there are separate lists relating to the type of incidents to be reported and we recommend that these are put together under one heading rather than for instance a separate supervisory list.
- i) The manner in which incidents are categorised should be reviewed with emphasis on breaking down incidents relating to antenatal, labour and postnatal care. This is especially important given the marked increase in incidents reported even prior to single site working. The increase in reporting has continued thereafter and the reasons for this should be explored and clarified.
- j) Root Cause Analyses should be more 'forensic' with detailed interviews with key members of staff corroborating the written information.
- k) Root Cause Analyses should have ownership and be dated appropriately with adequate evidence of closure of the process.

Service management and clinical decision making

- a) In keeping with previous recommendations, routine random audit of case notes should be regularly performed and viewed as an essential component of good practice.
- b) The merger provides the opportunity to ensure that the service provided at each of the locations is supported by staff with appropriate knowledge and skills. This will require a comprehensive review of staff numbers, knowledge and skills.
- c) Delivery of the recent service changes will require strong and effective clinical leadership and a review of service management structures should be considered.
- d) Continuing professional development of all clinical staff should focus on the deficiencies in service delivery highlighted in the reviews of the serious untoward incidents, for example, escalation of levels of care, interpretation of CTGs, record keeping, supervision of junior/locum clinical staff and neonatal resuscitation.
- e) There should be an identified Labour Ward Midwifery Manager Lead rather than a system of rotating the band 7 coordinators. This will allow for accountability and continuity of responsibility in respect of clinical risk and day to day management of the unit.
- f) The consultant presence and role within the labour ward requires consolidation. There is a need for clarity in respect of the role of the consultant, more robust monitoring of consultant presence and specific guidance as to when consultants should be supervising trainees directly.
- g) It is unusual for a hospital with over 3000 deliveries per annum to provide only Level 1 neonatal intensive care and the option of the neonatal unit operating as a Level 2 Unit should be achievable working in collaboration with a tertiary centre.

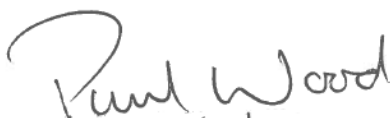
CONCLUSION

The interim arrangements for obstetric and neonatal services at the Conquest Hospital have had positive outcomes for clinical governance and these should be monitored and developed. The Trust appears to be generally risk averse and there is much to build on. Our recommendations will hopefully provide clear guidance on mechanisms to strengthen risk management and clinical governance. Working on one site since 7 May 2013 has resulted in increased opportunities for senior staff, improving the workforce, increasing the resilience of middle grade staff and increasing the workload and as a result staff appear to be happier, more confident and feel better supported. As a result the hospital is seen as a more attractive place to work and hopefully this will improve recruitment of both junior and senior staff. There is an incidental benefit of an enormous potential for reducing the numbers of staff in middle grade posts and potentially expanding consultant numbers to increase labour ward presence, supervision and training.

We note that the changes since the interim arrangements have been mainly operational and there is now an opportunity to consolidate governance arrangements.

Mr Paul L Wood

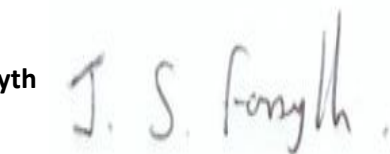
Date:


.....
16/9/13

Mr Andrea Galimberti


.....
Date: 10/9/2013

Professor Stewart Forsyth


.....
Date: 4 September 2013

RCPCH Invited Reviews Programme

Service Review

East Sussex Healthcare NHS Trust

November 2013

RCPCH

Royal College of
Paediatrics and Child Health

Leading the way in Children's Health

RCPCH Invited Reviews Programme
November 2013

© 2013 Royal College of Paediatrics and Child Health

Published by:
Royal College of Paediatrics and Child Health
5-11 Theobalds Road
London WC1X 8SH
Tel: 0207 092 6000
Fax: 0207 092 6001
Email: enquiries@rcpch.ac.uk
Web: www.rcpch.ac.uk

The Royal College of Paediatrics and Child Health (RCPCH)
is a registered charity in England and Wales(1057744) and in Scotland (SC038299)

Contents	Page
1 Introduction	3
2 Terms of Reference	3
3 Background Information	4
4 Context of the Review	5
5 Analysis of the Operational Policy	7
6 Summary and Recommendations	13
7 Conclusion	17

Appendix 1	Information sources and reference documents
Appendix 2	List of abbreviations

1 Introduction

1.1 The RCPCH was approached in June 2013 by Dr Andrew Slater, Joint Medical Director to conduct an invited review following reconfiguration of the paediatric service. This report provides an independent critique of the arrangements, and specifically the Operational Policy, against agreed terms of reference, based upon information provided to the reviewers and evidence gathered through a one-day site visit. .

1.2 The services are considered against published policy and standards documentation from the RCPCH and other professional bodies, where these are available, together with the objective workforce and service design experience of two senior reviewers representing the views of the College.

1.3 The report is the property of East Sussex Healthcare NHS Trust through the medical director. It remains confidential between the Trust and those appointed by the RCPCH to produce the report unless there are serious concerns that justify the RCPCH sharing it directly with regulatory authorities. This would in any case be discussed beforehand with the Trust.

1.4 The RCPCH encourages wider dissemination of this review report amongst those involved in the service but the RCPCH will not itself publish or comment on review reports without the permission and agreement of the review client.

2 Terms of reference

The RCPCH invited reviews team will conduct a review of the above service including studying advance materials, interviews with key individuals and a visit to the site(s) in question. This will follow the process set out in the “RCPCH Guide to Invited Reviews” dated April 2013 and include:

a) Consideration of safety concerns raised about the service following the recent reconfiguration with specific reference to emergency attendance and the ambulatory care model,

b) This will include

- Assessment of compliance with national guidance and standards for care and treatment of children and young people
- Referral pathways and links between paediatric services on the two acute sites (Eastbourne District General Hospital and the Conquest Hospital Hastings) and other acute services
- Information sharing and links with primary care and community services
- Staffing and workforce arrangements
- Child protection arrangements
- Involvement and patient feedback
- Clinical governance including accountabilities and quality improvement
- Benchmarking of services with equivalents elsewhere where possible and highlighting good practice

c) To make recommendations for the consideration of the Medical Director of the Trust as to: -

- Whether there is a basis for concern about the service in light of the findings of the review.
- Possible courses of action which may be taken to address any specific areas of concern which have been identified.
- Suggested indicators and approaches to inform and implement any changes to the short term transitional arrangements.

Note: This review will refer to and build on the Invited Review conducted by RCPCH across the Trust and published June 2012

3 Background Information

3.1 The acute paediatric service was until May 2013 configured across the two main hospital sites, namely Eastbourne DGH and the Conquest Hospital, Hastings which are 20.8 miles apart (40 minutes by car, 1hr 30mins by public transport)¹. Each site included a 15 bed paediatric inpatient ward, a 6-bed ambulatory care/ assessment unit and a Special Care neonatal unit. The service was funded for 5 consultant acute paediatricians supported by 8 Tier 2 paediatric posts at each site plus 7 Tier 1 doctors at Eastbourne and 8 at Hastings.

3.2 Further to the RCPCH report in 2012, there had continued to be difficulties with staffing of the middle grade posts – there are three vacancies and three doctors are not yet able to fulfil all the duties of the post and at times up to 50% of shifts are covered by locum doctors. Only two posts at Hastings are training grade, one being based in the community.

3.3 Since the merger of the two hospitals into one trust 10 years ago, the Trust has struggled to combine the paediatric teams as one service across the sites despite joint management and governance at senior level. The clinical lead is

¹ Source: Transport Direct - showing peak daytime journey

allocated 2PAs for the role; he is based in Hastings and works with the general manager to lead and support the medical staff across both sites.

3.4 The Trust is included within the pan-Sussex children and maternity commissioning review "Sussex Together" initiated by the Strategic Health Authority (SHA) in 2011. Clinical Commissioning Groups are developing their proposals for the future provision of Maternity and Paediatric services. This is likely to involve significant service change and therefore formal public consultation which is expected to take place in January 2014..

3.5 Neighbouring acute units include the Royal Alexandra Children's Hospital (part of Brighton Hospitals NHS Trust) which is 23 miles (36 minutes) to the west of Eastbourne DGH and provides specialist paediatric services including NICU and paediatric critical care. The new Pembury Hospital in Tunbridge Wells (part of Maidstone and Tunbridge Wells NHSFT) is 25 miles (38 minutes) from Hastings.

3.6 Activity and admissions were similar across both sites prior to the reconfiguration. Total admissions for all paediatric specialties including trauma and ENT averaged around 2,400 per year at Eastbourne and around 2,000 at Hastings, around 50% of these stay overnight and around 95% are non-elective or emergency. This equates to two 'Small' hospitals in the nomenclature adopted in the RCPCH document 'Facing the Future' published in 2011 and one medium size unit if combined. When the RCPCH reviewed the service in spring 2012 there were concerns that activity numbers and the level of demand appeared to be insufficient to support two inpatient and neonatal units and enable doctors to maintain their skills.

3.7 Eastbourne DGH has a small day surgery unit covering ENT and general surgery. There are no specialist paediatric anaesthetists although a small group of anaesthetists conduct most of the procedures on children. Outpatient surgical clinics are also hosted on the site for Brighton doctors.

3.8 The Friston ward on the first floor of the Eastbourne comprises a purpose built 16-bedded ward, plus four consulting rooms for Children's outpatients and community child health services within a bright and spacious environment. Safeguarding Non-accidental injury reviews can take place either on Friston or at the Scott Unit for community paediatrics on a floor below on the hospital site. CSA medicals can take place on Friston and the unit functions as a paediatric SARC. At the Conquest Hospital, Kipling ward provides a purpose built 21 bedded unit which is in the process of being expanded to 28 beds to meet the increased demand of the single sited service.

3.9 There is a consultant community paediatric team based at each of the two trust hospital sites, with onsite cover from 8-6 weekdays supported by the community paediatric nursing team. A community neonatal nurse practitioner who supports parents with babies discharged from Special Care is being considered as a service development. The team is developing an epilepsy service and has already established a diabetes service across the sites, benefitting from the Best Practice tariff. There is also one day per week CAMHS input.

4 Context of the review

4.1 Longstanding concerns about the safety and staffing of the maternity service across the two sites, together with a review in January 2013 by the National Clinical Advisory Team (NCAT) led to the Trust Board agreeing in March 2013 to consolidate obstetric and neonatal services onto the Hastings site, with a midwife-led unit remaining at Eastbourne. This was implemented in May as a temporary measure on safety grounds following a discussion with key stake holders including the Commissioners and HOSC but without formal consultation.

4.2 At the same time reconfiguration of the paediatric service was proposed to create a single inpatient ward and expanded special care neonatal service at Hastings and a 12-hour short-stay paediatric assessment unit (SSPAU) at Eastbourne. The plans included integration of the paediatric medical staffing, with cross-site working and specifically the on-call rota for the extended Hastings service including consultants from the Eastbourne team. There had been no specific safety-related incidents in paediatrics, but long standing difficulties in filling middle grade posts, increased neonatal activity at Hastings and compliance with the 'Facing the Future' standards were cited as the basis for including acute paediatrics alongside the changes to SCBU and maternity.

4.3 The reconfiguration of both services has been announced as a temporary solution with an expected duration of around 18 months, during which time analysis of the viability of the arrangements, exploration of alternative options and a public consultation on a permanent arrangement could be carried out. This requires the contracts and facilities to remain reversible until that is complete.

4.4 The move has largely been supported by the obstetric and midwifery teams, who were found by CQC to be much happier working in the new configuration, and the Paediatricians based at the Conquest site. However those paediatricians, based on the Eastbourne site have remained consistently unhappy with the arrangement. Concerns have been raised with the medical director who leads in this area and the Eastbourne consultant paediatricians presented management with a 10-point list of safety concerns about the new arrangements but these proved difficult to evidence and quantify in order to resolve them.

4.5 The Consultants have continued to raise concerns internally and externally, including to local politicians, regulators and the media, The Care Quality Commission discussed the issues with the doctors when it conducted an unannounced visit to the obstetric and paediatric services at both sites in June 2013 but did not uphold the concerns and the Medical Directors are confident the arrangement is fit for purpose pending a wider review and consultation towards permanency.

4.6 The RCPCH was invited to visit as an independent external source to examine the safety and viability of the model, benchmark the service against similar models and national standards and provide an opinion on the longer term arrangements.

4.7 In parallel with the RCPCH's involvement, all 3 local CCG's (Eastbourne, Hailsham and Seaford, Lewis Havens and High Wield, Hastings and Rother) have commenced the development of proposals for the future provision of maternity

and paediatric services, including 'the case for change' and a set of locally-defined standards, against which a self-assessment has been carried out by four units, including Brighton and the Princess Royal in Haywards Heath.

5 Analysis of the Current Service

5.1 Overview and compliance with national guidance and standards

5.1.1 Since 7th May 2013, the Friston inpatient ward at Eastbourne has changed to a 15-bed SSPAU, open from 9am to 9pm weekdays and 10-6pm at weekends and bank holidays. Consultant cover is available weekdays from 9-5pm with middle grade cover and consultant on-call availability to 9pm and at weekends and bank holidays. This does not meet the requirement² for consultant presence at times of peak activity which were stated to be 6pm to midnight. Nursing staff commence at 7am weekdays to welcome day case and surgery patients and there are at least two nurses available throughout the day to 9.30pm. Last weekday admission is 7pm (4pm weekends) During the SSPAU opening hours, agreed GP referrals may be brought by ambulance, and on rare occasions where a child deteriorates, emergency resuscitation and stabilisation may be carried out at Eastbourne. The review team were told that nurses on the ward are proactive and will seek out consultants if needed although several nurses are trained to carry out cannulation, immunisation and glucose monitoring.

5.1.2 The SSPAU at Eastbourne is currently located on the old children's ward and is not co-located with ED but the feasibility of co-location prior to the outcome of a public consultation on the future configuration of paediatric services is being considered.

5.1.3 The Eastbourne Emergency Department (ED) sees around 50,000 patients per year, with around 17% of them children. There is a small visually and audilogically separate waiting area, but this is cramped and in effect a corridor space. There is a dedicated cubicle in the minors area and separate paediatric and neonatal bays on the 6-bed resuscitation area. All children are seen by an Emergency Nurse Practitioner (ENP) and either referred to the Friston SSPAU when it is open or to the middle grade paediatrician if medical advice is required out of hours. Pain scores and pain management is audited regularly and usually benchmarks as good.

5.1.4 There are no paediatric-trained consultant emergency physicians and just two of the ED nursing staff are children-trained. Since the change to paediatric inpatient arrangements, senior medical cover is no longer available from the paediatric team after 9pm and paediatric emergencies are wherever possible diverted to neighbouring acute hospitals in Hastings, Pembury or Brighton. For those sick children brought in to ED out of hours, a middle grade short-term paediatric post had been established by the ED team. This role was designed as a six-month post to work alongside ED staff to manage paediatric demand out of hours as the new arrangements bedded in and also provide on-job training,

² Facing the Future standard 6

supervision and confidence building in children's emergency care to existing ED staff.

5.1.5 In practice a considerable amount of the out of hours activity by ED nurses and doctors is spent dealing with adults and members of the ED staff cannot always be present when the paediatrician is reviewing a child. This post is being filled by a series of locum doctors, and has not worked effectively as a source of training. The six months were complete in August but there is a commitment to continue this role for up to 18 months.

5.1.6 Since implementation of the new arrangements, activity has not notably reduced and in July there were 770 attendances by children and young people aged under 16. Of these 23 arrived by ambulance, 31 were admitted and 24 transferred to another hospital. The peak period for paediatric emergency and urgent attendance is between 6pm and midnight which does not align to the opening hours of the SSPAU, however paediatric expertise remains on site in the form of a paediatric middle grade doctor in ED out of hours with support from the on-call consultant. Despite publicity through schools and other public media there has been a small increase in parents bringing children in by car and some concerns were expressed that the GP Out of Hours service (IC24) was not fully fluent with the arrangements.

5.1.7 There have been no serious incidents since the reconfiguration. Paediatricians feel however that they do not 'own' the Operational Policy and raised concerns about high dependency transfer, cover for maternity, safeguarding / SUDI process and support for ED out of hours.

5.1.8 Amongst concerns raised by the Eastbourne paediatricians included the absence of resuscitation equipment except ambibags on the midwife led birthing unit. The lead midwife however confirmed that the unit operated as a stand alone MLU with operational policies that did not include an expectation for the paediatricians to attend in the event of an emergency even when the SSPAU open and they would themselves commence basic life-support and call for emergency support via a 999 call. Appendix 3 of the Standards for the Care of Critically Ill Children³ (Paediatric Intensive Care Society, 2004) lists the resuscitation equipment required in such facilities.

5.1.9 Throughout the review and report sections below reference has been made to relevant national and professional standards for the care of children and young people. The specific standards cited are detailed in Appendix 1

5.2 Referral pathways and links with the Hastings site and other acute services

5.2.1 Three of the Eastbourne paediatricians provide daytime Consultant of the Week cover at Hastings (two others are on restricted duties) and Hastings paediatricians also cover the Friston SSPAU on a rota basis with an aim of full joint working across the sites.

³ See http://www.ukpics.org.uk/documents/PICS_standards.pdf

5.2.2 The Review Team did not visit the Conquest hospital site in Hastings. Concerns were however raised about the ability of Eastbourne-based consultants to attend the Conquest at Hastings within 30 minutes when on call out of hours due to travelling distance. This particularly related to new-born care and the CNST minimum requirement for availability⁴ but there was no data or analysis available to the Review Team that indicated the intensity of the on-call duty. The Trust has made available hospital-based on-call rooms or hotel accommodation for consultants on call who have a greater travelling distance but this does not confer resident status to the shifts. Despite the reduction in on-call commitment due to more consultants on the single rota, more negotiation is required for the short term arrangement to be workable.

5.2.3 The focus of the Operational Policy and changes made were to transfer all out of hours or complex paediatric urgent and emergency attendances to Hastings but it is likely that a proportion attending Eastbourne would be more conveniently (for them) be redirected to Brighton Hospital subject to parental choice. It was not clear that this alternative which would benefit the patient experience had been considered.

5.3 Information sharing and links with primary care and community services

5.3.1 The community children's nursing team is based within the Trust but aligned with the community paediatric service. Increasingly in other organisations the role of community children's nursing (and in some areas GPs) is extended to minimise attendance at ED, particularly by those with long term conditions, and there is an opportunity within the current consultation to explore similar development of this service,

5.3.2 Some work has been proposed to upskill primary care to be able to improve initial assessment and refer appropriately, particular out of hours.

5.4 Staffing, training and workforce arrangements

5.4.1 There are only two children-trained nurses within the ED establishment at Eastbourne and only 4 at the Hastings site. The intercollegiate guidance requires at least one children trained nurse to be available at all times that children may attend, which would require at least six nurses at each site for one to be present on every shift. All ED staff are trained in Paediatric Immediate Life-Support (PILS) and around 50-60% are EPLS with all middle grades being APLS certified. Three nurses are undergoing Sick Child training in September and all ENPs have completed the paediatric module. A useful chart detailing the training required for ED and anaesthetic consultants can be found in Appendix 5 of the PICS standards.

⁴ Reference NHSLA CNST Maternity standards page 133 Standard 5 criterion 2

a. The maternity service has [approved documentation](#) for newborn life support, which as a minimum must include....c) deliveries to be attended by a clinician (doctors, advanced neonatal nurse practitioner, midwives) with [newborn life support skills](#)

5.4.2 The nursing team from Friston Ward have struggled to adapt to the changed arrangements of rotating across the two sites but although there was some difficulty integrating initially the teams are now starting to work well together with action learning sets for the matrons and improved communication.

Six Generic Skills

These skills can reasonably be expected of all personnel involved with the care of acutely or critically sick or injured ill children in the DGH

- To recognise the critically sick or injured child
- To initiate appropriate immediate treatment
- To work as part of a team
- To maintain and enhance skills
- To be aware of issues around safeguarding children and
- To communicate effectively with children and carers

Ref: The acutely or critically sick or injured child in the DGH – a team response

5.4.3 Nursing leadership is developing and staff feel listened to by the Chief Nurse, There is more to be done in terms of integration and team working, for example the matrons consider themselves to be responsible for a ward rather than being the lead or 'champion' for children across either of the sites. The clinical service manager is however encouraging wider thinking. The Trust clinical strategy aims among other plans to extend the community nursing team and employ more Advanced Nurse Practitioners (ANP) for ED and the SSPAU as well as nurse specialist's for the community, e.g. epilepsy nurse specialist. There is enthusiasm to develop extended role nurse-led clinics for review work and more follow-ups in patients' homes.

5.4.4 There are no ACNPs at present and no arrangements for SSPAU staff and ACNPs to rotate through the emergency service. In the short term a paediatric nurse rotation could be established between ED and the SSPAU in Eastbourne with, perhaps inclusion of the Kipling ward at Hastings. There are plans now to rotate SSPAU staff though the ED with ED staff also rotating to SSPAU.

5.4.5 Trainees are currently rostered across both sites to ensure benefit from all educational opportunities, and providing a single site for the IP service has enabled the middle grade rota to be fully and consistently staffed.

5.5 Child protection arrangements

5.5.1 There are three named nurses across the Trust – one each West and East for the community with a third covering the hospital sites. The named doctor only overs the Eastbourne site and there are concerns that the medical safeguarding roles are not working effectively together.

5.5.2 Staff are all trained to Level 2 or 3 depending on their role, and there is a liaison health visitor at each hospital site. Concerns were raised with the Review Team about the availability of medical staff to carry out statutory functions following child deaths, and the consequences of children and young

people from Eastbourne being diverted to Hastings which was 'out of area' in terms of liaison with social services.

5.6 Involvement and patient feedback

5.6.1 There is limited engagement with young people or families to seek feedback and involve them in designing improvements to the service although the Trust-wide Meridian service was reported to be in operation to gather views and feedback. The PREM tool developed by the RCPCH and partners was not in place and leaflets and posters were mainly aimed at young children and not attractive for adolescents. Adolescent care was however reported to be good at Hastings hospital although this location was not visited as part of the review.

5.6.2 Brighton has some examples of good patient leaflet and information (e.g. head Injury)

5.7 Clinical governance

Medical Management

5.7.1 The review team consider that the trust has serious problems with the management of its medical staff at Eastbourne and swift, visible action is required to restore the confidence and enthusiasm of other staff. There are some team and behaviour issues that have been internally and externally identified (including in a review by Edgecombe in January 2012) yet have not been effectively dealt with over several years. There is a risk of these issues provoking long term unhappiness and insecurity amongst the rest of the consultant body. This is also likely to affect all other staff groups.

5.7.2 The operating policy and changes to the service appear to have been imposed on the consultant body too swiftly with a failure to engage them fully in the rationale and consideration of the operational feasibility. There were reported difficulties with consultant attendance at the strategic meetings which were often convened at relatively short notice. It is acknowledged that SCBU had to move at the same time as maternity services and that the organisation made a decision to move inpatient paediatric services at the same time due to a lack of confidence in the sustainability of the middle grade workforce, the need to provide a consistent high quality service and the need for clear communication to the public. However in retrospect moving inpatient paediatrics could have been considered separately from obstetrics and SCBU and more time taken to iron out the issues with the acute paediatric personnel given the historical difficulties in managing change.

5.7.3 Although implementation of the agreed changes was managed through a programme approach this was run internally by the Trust's Programme Management Office. Given the long history of difficult relationships across and between the sites, it would have been prudent to have had an externally recruited project manager to oversee communications and full stakeholder engagement and ensure decision making and timescales are rational and adhered to. However it is acknowledged that the trust had to make decisions within a short timescale due to the pressing safety issues within the obstetric service.

5.7.4 Although the review team did find a number of areas where the Operating Policy needs strengthening these did not directly correlate to the concerns raised by the consultants at Eastbourne. The Review Team felt that some clinicians were expressing considerable discomfort about the changes to working practice and that this must be recognised in order to move forward; consultants need to be reassured and supported to move across to this new model but also recognise the expectations of the organisation and medical management in terms of their behaviours and activity.

The Operational Policy

5.7.5 The Operational Policy governs the procedures and arrangements for managing paediatric attendances, primarily at Eastbourne. It was developed using equivalents from neighbouring trusts such as Maidstone and Tunbridge Wells and Haywards Heath and although the ambulance service and other external stakeholders were involved, and the managers 'took time to ensure a safe solution' the review team heard that some paediatricians within the service did not feel engaged with the process or the need for such urgency in agreeing a way forward. Whilst there was general agreement about the benefit operationally of running paediatric inpatients from a single site, the doctors reported that whilst they had been invited to some of the meetings their clinical timetables and short notice made it impossible for many of them to attend and there appeared to be no other mechanisms or for a for discussion and understanding of the new policies.

5.7.7 The operational policy marked 'final 7th May' was reviewed by Dr Ryan Watkins (a Brighton neonatologist and clinical director for the Maternity, Newborn, Children and Young People Strategic Clinical Network, Kent/Surrey and Sussex) against the RCPCH Intercollegiate standards shortly after implementation and a number of recommendations were made which have not been formally implemented, apparently pending the RCPCH visit. These points address many of the concerns picked up by the RCPCH during the visit and feedback and indeed could be built on to fulfil guidance such as the Tanner report⁵.

5.7.8 The operational policy covers The Women and Children's Division, but due to the service delivery model it relies very heavily on the ED department in Eastbourne identifying and managing sick children when the assessment unit is closed. This should therefore also be covered in the strengthened operational policy to include issues over staff training, policies and procedures. The RCPCH identified issues at both sites with the level of staffing, particularly children's trained staff and the lack of additional training to try and counteract this.

5.7.9 There are differences in standards and procedures between the two acute sites, for example in staff training and competencies and the policy for medical assessment and treatment of babies under one year. Information management is poor at Eastbourne and the informatics system is inadequate. The trust is implementing SystmOne for the community but this will not be operational for at least a year.

⁵ The sick and injured child at the DGH – a team response DH 2009

5.7.5 The paediatricians at the Eastbourne site, together with some of the nursing and support staff, had proposed an alternative model of a 23hr 'rolling' SSPAU at the Eastbourne site to more fully support ED and address, in their opinion, the 'five key safety concerns' with the current model. The status of this proposal was unclear; the RCPCH would not usually support such a model but it is important that such proposals are properly considered by management as part of genuine engagement with the clinicians involved.

5.8 Benchmarking of services with equivalents elsewhere where possible and highlighting good practice

5.8.1 The Review Team did not see hard data such as clinical audit, critical incident, mortality information and were not offered examples of good practice other than a comment that there had been a Best Practice initiative that had secured additional funding for diabetes care in children

5.8.2 The arrangements that have been put in place are similar to reconfigurations that are being planned or implemented around the country. Each setting is different in its approach but most changes are triggered by difficulty in recruitment of middle grade doctors and compliance with the standards set out in 'Facing the Future'. Some equivalent models are further advanced than East Sussex, particularly the 'making it better' redesign project in Manchester where Salford operates with a single SSPAU supporting ED without inpatients.

6 Summary and Recommendations

6.1 The Review Team is aware that the current arrangement is temporary in terms of paediatric services, and, building on the June 2012 review, considers that restoration of an inpatient unit is not appropriate or sustainable.

6.2 The opportunity being taken by the CCG and 'Sussex Together' programme to design a networked model of service that would be best for children, unbounded by constraints of the Trust's own facilities is positive, but in the meantime the Trust must prioritise strengthening the Eastbourne ED's paediatric expertise in line with the Tanner report and other standards for urgent care and SSPAUs and agree shared policies and procedures within the Operating Policy.

6.3 It is important during the temporary phase that staff on both sites continue to develop their competencies in assessing and treating children and young people and that trainees are offered an appropriately rich experience. Current concerns about lack of training opportunities and the provision of cover on the Eastbourne site are counterbalanced with the higher quality of training experienced on a fuller inpatient ward at Hastings, and the potential to enhance the roles and experience of nursing staff should be recognised and exploited.

6.4 The unit at Eastbourne relies quite heavily upon senior paediatric trainees. In terms of "future proofing" the RCPCH has two concerns with this arrangement. The first is that trainee numbers will be reduced in the fairly near future leaving the model unsustainable in the longer term and the second that this activity is inappropriate for paediatric trainees if they are spending a considerable amount

of their time in working in a relatively quiet SSPAU; this may not be viewed as positive placement in terms of their training experience.

6.5 The Review Team believes that implementing the recommendations below will enable the provision of an appropriately safer service for infants, children and young people at the Trust's two sites. However this will not be safer unless there is engagement and buy-in from the consultant body. They must be led effectively and encouraged to contribute their professional judgement and expertise to developing policies and risk assessments on the basis of hard evidence and data about the service and activity levels.

6.6 The following recommendations reflect information detailed in the sections above together with conclusions and priorities identified in the CQC report and other correspondence available to the review team.

Recommendations

Short Term

- a) Establish a formal mechanism for review of the operational policy and address the areas identified below including the recommendations made by Dr Ryan Watkins by e-mail on 10th May 2013 and specific amendments communicated by the RCPCH shortly after the visit. It is important to fully involve the paediatricians as long as there is an agreement to cooperation at the outset and a very clear and tight deadline.
- b) Take positive steps to tackle the longstanding difficulties within the paediatric consultant team and the relationship with senior Trust management. It is suggested that professional, independent external advice is engaged swiftly to facilitate restoration of a positive working environment and tackle issues around behaviours and communication.
- c) Assess the current arrangements against the 'Tanner' report and the PICU standards relating to the model of 'some children's services but no onsite inpatient facility' to provide assurance that the service at Eastbourne is safe round the clock for children. For example for transfer of children from Eastbourne requiring inpatient care for whom there is a risk of requiring resuscitation including airway support. (PICS⁶ standards B1 and B2).
- d) Consider appointment of an 'independent' project manager to oversee the continued implementation and monitoring of the new operational arrangements.
- e) Recruit / commit to develop up to four further children-trained nurses to cover ED at Eastbourne (and consider requirements at Hastings to meet the standard for presence in ED), perhaps using existing nurses from SSPAU and/or Hastings inpatient wards on a rotation.
- f) Ensure there is at least one APLS-trained nurse or doctor on each shift in ED and that staff are familiar with spotting the sick child⁷. This is not happening as

⁶ Paediatric Intensive Care Society http://www.ukpics.org.uk/documents/PICS_standards.pdf

⁷ See Department of Health DVD *Spotting the Sick Child* available from <https://www.spottingthesickchild.com>

intended through the middle grade doctor so specific training should be arranged for ED staff, including anaesthetists⁸ until the team has gained paediatric skills and is confident that the locum is no longer needed. Regular team moulages led by the resuscitation team should be implemented to allow all professionals to practise their skills and working together.

f) Identify clinical champions for children throughout the Trust- these could be the ward managers/matrons. There should also be an identified executive lead for children and young people and a non-executive lead. Many hospitals have established a Children and Young People's board chaired by an executive which enables strategic and operational cross-trust issues around children's and young people's services to be discussed appropriately.

g) Review current communications and develop further clarification to ensure staff, parents, GPs and young people know what conditions the Eastbourne site does and does not assess and treat. .

h) Ensure policies and procedures are agreed and implemented on a Trust-wide basis – for example using NICE guidelines including patient leaflets and implementation tools, and the policy for treating Under 1 year olds in ED.

i) Continue to invest in community children's nursing to allow development of a comprehensive children's community nursing team that can be available for extended hours 7 days a week and deal both with specialist conditions and support acute care by supporting early discharge and admission

j) Agree an immediate course of action between the local unit and transport team to manage the occasional child who is unsafe to transfer but does not require intubation and ventilation. This may mean keeping the child in ED for observation until a safe plan can be made which may require a children's nurse to stay on site.

k) Agree arrangements for a consultant to attend a child death. The RCPCH notes that attempts were made to instigate 2 on-call rotas whilst issues were addressed but this did not prove viable as there are a number of consultants not participating in the on-call rota.

l) Increase evening consultant presence during the opening hours of the SSPAU and at least part of the day at weekends to help with decision making and ensure more patients are discharged and transfers are appropriate and safe.

m) Review urgently the availability of resident or on-call consultant paediatric expertise local to the Hastings site, including for new-borns to ensure compliance with National and RCPCH standards. This will have a short and long term solution as workforce is expanded or renewed and will depend on the final configuration of paediatric services as determined by the public consultation.

Longer term

n) Consider alternative models for the SSPAU with the consultants and commissioners as part of the work on the future of maternity and paediatric

⁸ See PICS standards appendix 5

services– the RCPCH have concerns that the activity may be insufficient for the proposed 23hour unit to be a feasible option but discussion about indicators and rationale for alternative should take place with those who will be operating them.

o) Consider moving the assessment and observation unit adjacent to ED to enable sharing of paediatric skills and staffing. This would be best practice to be considered for both sites.

p) Review medical and nursing workforce and consider the need for adjustments based on the future configuration of the service and published standards⁹ to enable consultant presence at both sites during peak periods of activity and development of extended roles of nursing staff to include children's advanced nurse practitioners and children's emergency nurse practitioners.

7 Conclusion

The review team would like to thank all staff for contributing helpfully and openly to the review, and it is encouraging that the Trust has openly requested the RCPCH to assist in resolving some of the differences of views between paediatricians and senior managers. We hope that this provides an opportunity to move forwards and ensure the continued safe care of children

The operational policy will only be fully effective if health professionals understand, support, and most importantly, comply with it. We do not underestimate the challenge of new ways of working but shared, open engagement in development and agreement of standards alongside adherence to contractual obligations is important for all involved to ensure that the team is providing the safest and most effective care in all situations.

This independent review and critique of the proposed model of paediatric services was commissioned by the Medical Director of East Sussex Hospitals NHS Trust. It was carried out by Dr Edward Wozniak FRCPH and Dr Melanie Clements FRCPH with additional Quality Assurance input and verification from Dr Stephanie Smith and Dr David Shortland, members of the RCPCH Invited Review panel.

It satisfies the terms of reference set out in section 2 above and we hope provides useful information and rationale for future decisions by the partners over the structure and design of paediatric services in East Sussex

⁹ See Facing the Future (RCPCH, 2011)

Appendix 1 Information sources and reference documents

A1.1 The following standards are referenced in the review

Intercollegiate Standards for care of CYP in emergency care settings (RCPCH 2012) covers staffing, training, facilities, communications and interfaces set out in a clear style and agreed by all professional colleges involved with urgent and emergency care.

Good medical Practice (GMC 2013) sets out the principles and values on which good practice is founded; which together describe medical professionalism in action.

The acutely or critically sick or injured child in the district general hospital – a team response (DH and intercollegiate 2006 – “Tanner report”) details issues around anaesthesia and other services available. It has 42 clear service and competence recommendations and provides a clear checklist when reviewing urgent care services.

Short Stay Paediatric Assessment Units advice for commissioners and providers (RCPCH 2009) sets out models for provision of observation and assessment facilities to complement emergency care and reduce pressure on inpatient services.

Guidance on the role of the consultant paediatrician in the acute general hospital (RCPCH May 2009) offers models of paediatric care including consultant of the week, resident on call and includes information on job planning, rotation and competencies for acute care

Standards for the Care of Critically Ill Children (Paediatric Intensive Care Society, 2010) sets out measurable standards for care from arrival at hospital ED through reception, assessment, inpatient, HDU/ITU and general care across services. Sections on anaesthesia, retrieval and transfer complete the pack

Appendix of guidance to the Standards for care for Critically Ill Children (Paediatric Intensive care Society, 2010) supports the standards with checklists and tools to enable clinicians and managers to establish effective arrangements are in place. These include details of knowledge and skills required, guidance on resuscitation training, referral information, and support for families.

Children and Young People Assessment Service Standards (EoESHA 2012) Developed locally by the SHA to support a peer review programme these achievable standards are based on operational practicality and set out with indicators and examples to demonstrate compliance.

Maternity Clinical Risk Management Standards 2011/2 (NHSLA/CNST 2011) define the thresholds for achievement of assessed levels of risk management and consequently reduced premiums payable to CNST. These standards are currently not being updated pending review of the NHSLA function and approach but provide a basis for assessment of safety and risk reduction.

A1.2 The following staff were interviewed as part of the review

Interviewee	Role & Responsibility
Dr Jamal Zaidi	Divisional Director – Integrated Care
Dr David Hughes	Joint Medical Director Clinical Governance
Richard Sunley	Chief Operating Officer
Paula Smith	Acting Associate Director Women’s & Children’s
Dr Maggi Wearmouth	Consultant Paediatrician
Dr Graham Whincup	Consultant Paediatrician
Dr Keith Brent	Consultant Paediatrician
Dr Tracy Ward	Consultant Paediatrician
Dr Geeta Gopalkrishnam	Consultant Paediatrician
Dr Imad Boles	Consultant Paediatrician
Dr Padmani De Silva	Consultant Paediatrician
Dr Nadia Muhi-Iddin	Consultant Paediatrician
Dr Sarah Hall	Emergency Medicine Consultant
Liz Vaughn	Ward Matron, Friston Ward EDGH
Lindsey Stevens	Consultant Midwife
Caroline Stephenson	Ward Matron, Kipling Ward CQ
Stephanie Kennett	Non-Executive Director
Amanda Philpott	Accountable Officer (Interim), Eastbourne, Hailsham and Seaford CCG/COO, Eastbourne, Hailsham and Seaford and Hastings & Rother CCGs
Martin Writer	Head of Quality, EHS & H & R CCGs
Jo Thomas	Chair, Eastbourne, Hailsham & Seaford CCG
Anne Singer	General Manager CYP Services – Integrated Care
Christine Craven	Deputy Director of Nursing
David Fox-Dossett	Senior Charge Nurse, ED

A1.3 Documents were provided by the Trust relating to the following areas:

Minutes of meetings including
Trust Board seminar 23rd February, Public meeting 8th March
Operational Policy
Activity records and reports
CQC visit reports

Appendix 2 – List of Abbreviations

ADHD – Attention Deficit Hyperactivity Disorder
ANP – Advanced Nurse Practitioner
ASD – Autistic Spectrum Disorder
CCG – Clinical Commissioning Group
CDOP – Child Death Overview Panel
CYP – Children and Young People
ED – Emergency Department
EDGH – Eastbourne District General Hospital
ENP – Emergency Nurse Practitioner
GP – General Practitioner
SHA – Strategic Health Authority

East Sussex Healthcare NHS Trust

THE Joint RCOG / RCPCH ESHT Service Review Recommendations Action Plans.
November 2013

RAG Rating:

All recommendations completed – no further action	
Some recommendations completed - further action required	
Few recommendations completed – action required	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Review of the Risk Management Strategy.	Risk management strategy in place; met with CNST approval at Level 2 assessment in 2013.	Roles and responsibilities need to be clearly defined. Needs to be referenced to guidelines; risk management co-ordination processes and responsibilities for Root Cause Analysis.	A Watt	L Stevens & P Smith	Re-drafted risk management strategy	End February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
		<p>Need to separate sections on incident reporting; serious incidents and links to the Trust Risk Management committee.</p> <p>Should be references to the maternity dashboard; mechanisms for minimizing risk and future risk management planning.</p> <p>Should be evidence of compliance monitoring and audit and hyperlinks related to documents.</p>					

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
		<p>References need to be included.</p> <p>Lists of incidents need to be put together under one heading rather than separate lists.</p> <p>Needs to be reviewed to ensure it is user friendly.</p> <p>Ensure maternity risk management strategy is linked to Trust's risk management strategy.</p>					
Review the incident categorisation within the maternity Risk Management	Risk management strategy in place; met with CNST approval at Level 2 assessment in 2013.	Break incidents into categories relating to antenatal; labour; and postnatal care.	A Watt	L Stevens & P Smith	Re-drafted risk management strategy	End February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Strategy		The reasons for increase in incidents should be explored and clarified.					
Root Cause Analysis needs to be more forensic.	RCAs carried out in line with Trust policy.	<p>There is currently a Trust wide review of how RCAs are undertaken to ensure consistent processes across all areas.</p> <p>To include introducing a process of undertaking interviews with key members of staff involved to corroborate their written statements.</p>	A Watt & Emily Keeble	L Stevens & P Smith & A Webster	Re-drafted risk management strategy	End February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
		Need to ensure robust processes to evidence closure after a Root Cause Analysis is completed.					
Case note audits to be carried out	Monthly audit of 40 (random) case notes undertaken	<p>Ensure random case note audit is undertaken and presented to the multi-professional team</p> <p>Introduction of an annual Supervisor of Midwives random audit of 100 sets of notes</p>	D Pascall	M Nair – Audit lead	<p>Presented at audit meetings to the multi professional team with documented learning points</p> <p>Presented to Supervisors of Midwives; senior midwives; at consultant meetings and audit</p>	<p>In progress by February 2014</p> <p>By April 2014</p>	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
					meeting		
To ensure staff have appropriate knowledge and skills.	<p>Staff undertake annual Trust mandatory training and annual mandatory obstetric related study days to include management of obstetric emergencies.</p> <p>Attendance is monitored by the practice development midwife and kept on an comprehensive Training Needs Analysis (TNA). Data also maintained within</p>	<p>Ensure a comprehensive review of staff numbers, knowledge and skills via the TNA to include medical staff.</p> <p>Ensure this references and reviews work being undertaken nationally regarding appropriate workforce numbers.</p>	D Pascall; L Stevens & G Clarke	P Smith	<p>Workforce numbers as agreed with HR</p> <p>Knowledge in accordance with grade – appraisal for consultants and specialty doctors/ e portfolio for trainees</p> <p>Knowledge for midwifery by ongoing assessment of clinical</p>	Baseline – April 2014/ then ongoing assessment	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	the Trust's Electronic Staff Records (ESR)				knowledge and skills using a clinical competency framework via supervision; line management and peer review Skills – Mandatory training		
Ensure appropriate service management.	Currently have a management structure for Women's health but this has not been reviewed since the temporary reconfiguration of	Undertake a review of service management structures to ensure strong and effective clinical leadership – the Trust will commence a programme of	Senior Trust managers	HR	Appropriate management structure in place	End April 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	services	organisational structure review in April 2014. Continue to support clinical leaders via the clinical leaders forum that commences in 2014.					
Continuing Professional Development (CPD) for all clinical staff should focus on deficiencies in service delivery.	Skills training in relation to interpretation of CTGs; record keeping; neonatal resuscitation is offered within the mandatory obstetric study days that staff are required to attend annually Learning through complaints; incidents and SIs	Wider learning is undertaken through feedback to staff by	D Pascall; L Stevens G Clarke & A Watt	P Smith	Mandatory training / Remedial training as necessary	Baseline by March 2014 then rolling	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	is taken forward on a one to one basis with individuals as appropriate.	the governance team on an add hoc basis this needs to be formalised with attendance at sessions mandatory					
Accountability and continuity of responsibility in respect of clinical risk and day-to-day management by a Band 7.	Every shift (day and night) is supported by a band 7	Advert out to appoint an identified labour band 7 lead rather than rely on a system of rotating the Band 7 co-coordinators.	C O'Callaghan	L Stevens	Appointment of band 7 matron as labour ward lead	End January 2014	
Consolidation of consultant presence on labour ward.	The role of the consultant on labour ward has been clearly clarified and consolidated since the temporary reconfiguration Consultants' are	Robust monitoring of consultant presence on labour ward needs to continue.	D Pascall	All consultants	Continued robust evidence of consultant availability by use of 'consultant daily sign in' on labour ward	Ongoing	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	required to sign in x3 times daily to monitor labour ward presence	Further audit of presence of consultant on labour ward through the maternity documentation audit – audit to ask the question ‘did consultant see the woman’ (applicable to high risk women only)	L Stevens & A Watt	Supervisors of midwives	Evidence in maternity records of consultant presence and involvement in care of the high risk women	Commence in the March Supervisor of midwife audit	
Supervision of trainees.	72 hour labour ward cover allows appropriate support and supervision of trainees. There needs to be specific guidance as to when consultants	Continued monitoring	D Pascall	All consultants	Completion of recommended assessments	In place	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	should be supervising trainees that is shared with the whole multi-disciplinary team.						
Review the level at which the SCBU is functioning at.	Currently level 1	<p>Work in collaboration with a tertiary centre to review if SCBU should be a Level 2.</p> <p>This will require discussions with commissioners and the network as to the service that they wish to commission and is required by the network locally.</p>	P Smith & F Edmunds	L Stevens	Report from tertiary centre	June 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Ensure staff are trained in statement writing	There is a Trust wide review of how statements are written to ensure consistent processes across all areas. This will include a robust process to ensure statements are consistent in terms of format and presentation.	Training to continue Monitor attendance at training	C Howath A Watt & E Keeble	P Smith & L Stevens & A Webster	Improved statement writing by all staff	By April 2014	
Neonatal presence at daily incident reviews.	Paediatricians and SCBU staff are invited to join the daily incident review meetings.	Monitor attendance to ensure there is always a paediatrician available for any incident that involves a poor outcome for a neonate	D Pascall	S Mansy	Attendance log	January 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
All staff to have a understanding of current guidelines.	A variety of systems in place to ensure that staff are aware of guidelines, that they understand these and can implement them	Monitor current process and ensure staff have a good working knowledge of guidelines	G Clarke & D Pascall as this requires Drs to be cognisant of these as well	L Stevens & J Crowe & C O'Callaghan	Evidence of understanding at appraisals; SOM reviews Improvement in management of care and decrease in datix/ changes in trends of incidents	ongoing	

East Sussex Healthcare NHS Trust

THE RCPCH ESHT Service Review Recommendations Action Plans

November 2013

RAG Rating:

All recommendations completed – no further action	
Some recommendations completed - further action required	
Few recommendations completed – action required	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Establish a formal mechanism for review of the operational policy.	<p>Policy is being revised to reflect the comments made.</p> <p>A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes</p>	<p>Address the areas identified in the report including the recommendation s made by Dr Ryan Watkins.</p> <p>Agree and ratify policy</p>	Anne Singer/ Andy Slater	Jane Sumner. Salah Mansy Fran Edmunds	Policy ratified	Jan 31 st 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Take positive steps to tackle the longstanding difficulties within the paediatric Consultant team and the relationship with senior Trust management.	<p>New Clinical Lead has been recruited who is not an integral member of the paediatric Clinical Unit. He has identified a Paediatric Consultant to act as operational lead for the day to day management of the service</p> <p>A monthly cross site face to face Consultant meeting has been set up</p> <p>There are three paediatric taskforce groups overseen by an external facilitator - Acute, Community and Long Term Conditions.</p>	Commitment by the Consultant body to engage in these actions; groups and meetings	Andy Slater/ Anne Singer	Salah Mansy	Regular attendance and contribution at the Consultant meetings where majority decisions are made and then adhered to by whole consultant body.	Ongoing	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Assess the current arrangements against the 'Tanner' report and the PICU standards	<p>Ensure all areas of non compliance are addressed</p> <p>Policy is being revised to reflect the comments made</p> <p>A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes.</p>	Agree and ratify policy	Anne Singer/ Andy Slater	Salah Mansy	Policy ratified	Jan 31 st 2014	
Consider appointment of an 'independent' project manager to oversee the continued implementation and monitoring of the new operational arrangements.	Since the new management structure was implemented this has facilitated majority decisions within the paediatric unit	No action required	N/A	N/A	N/A	N/A	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Recruit / commit to develop up to four further children-trained nurses to cover the Emergency Department at the non acute site	Nurses have always been seconded from the Emergency department to undertake their paediatric training This will be a rolling programme	There needs to be Internal rotation of nurses between the SSPAU and the ED	Sarah Wilmer/ Fran Edmunds	Jenny Darwood	Successful recruitment Sufficient paediatric trained nurses available in ED.	ongoing	
Ensure there is at least one APLS-trained nurse or doctor on each shift in the ED who are familiar with spotting the sick child.	It is mandatory for all nurses to undertake annual basic life support training	Specific training should be arranged for the ED staff, including anaesthetists until the team has gained paediatric skills and there is confidence that the locum is no longer needed.	Paul Cornelius/ Utham Shanker/ S Wilmer	Jenny Darwood	Successful training of staff in paediatric settings	ongoing	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	Nurses from the ED are routinely offered APLs training	There needs to be a rolling programme until all ED nurses have completed APLs			A rolling plan is in place to maintain training		
Identify clinical champions for children within the Trust There should also be an identified executive lead for children and young people	Within the Paediatric clinical unit the clinical services manager/ HoN is the link between paediatric and ED Services and there are ED/Paediatric meetings held regularly on both sites.	Clinical champions need to be identified at executive and non executive level Consider establishing a Children and Young People's board chaired by an executive	The Trust Board need to identify the leads	Andy Slater	Confirmation of Board leads	April 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
		lead to enable strategic and operational cross-trust issues.					
Review current communications and develop further clarification to ensure staff, parents, GPs and young people know what conditions the Eastbourne site does and does not assess and treat.	Policy is being revised to reflect the comments made. A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes	Once ratified the operational policy needs to be widely distributed across partner agencies to clarify the model for East Sussex	Andy Slater	Anne Singer, Fran Edmunds, Jane Sumner, Salah Mansy	Operational policy distributed and also available on the GP intranets	February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Ensure policies and procedures are agreed and implemented on a Trust-wide basis for treating Under 1 year olds in ED.	All policies currently in place have been distributed to their authors for review.	The operational lead will be responsible for ensuring that the policies have been updated and reviewed appropriately to meet Trust policy. CU considering a Policy review sub group	Salah Mansy	Andy Slater Fran Edmunds	All policies updated, reviewed and archived when appropriate	March 2014	
Continue to invest in community children's nursing to allow development of a comprehensive children's community nursing team that can be available	The current strategy developed by the CCGs in conjunction with representatives from Pan Sussex services features the development of community children's services	Work needs to continue across the clinical network to discuss the future model of children's acute and community service Pan Sussex.	Commissioners/ Fran Edmunds	Andy Slater/ Anne Singer/ Jane Sumner	Development of a 7 day community service	ongoing	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
for extended hours 7 days a week							
Agree an immediate course of action between the local unit and transport team to manage the occasional child who is unsafe to transfer but does not require intubation and ventilation.	<p>On occasions a child may need to be kept in ED for observation until a safe plan can be made which may require a children's nurse to stay on site</p> <p>Policy is being revised to reflect the comments made.</p> <p>A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes</p>	Agree and ratify policy	Anne Singer/ Andy Slater/ Paul Cornelius/ Utham Shanker/ SECAMB	Salah Mansy	Ratified policy	February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Agree arrangements for a consultant to attend a child death.	<p>Currently there is a middle grade paediatric doctor working in ED when the SSPAU is closed. Policy is being revised to reflect the comments made.</p> <p>A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes</p>	To consider developing a community on call rota	Andy Slater	Salah Mansy	Ratified policy and introduction of an on call rota	April 2014	
Increase evening consultant presence during the opening hours of the SSPAU and at least part of the day at weekends to help with	Currently there is an on-call Consultant for the SSPAU during opening hours	Need to assess requirements for consultant presence	Andy Slater	Anne Singer/	Children are assessed; discharged or transferred appropriately	April 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
decision making and ensure more patients are discharged and transfers are appropriate and safe.							
To urgently review the availability of on-call consultant paediatric expertise to the acute unit to ensure we are compliant with national standards that suggest 24-hour availability of a consultant paediatrician (or equivalent non-consultant career-grade doctor)	ESHT are compliant with this as they have resident trained middle grade doctors 24/7.	No further action required	N/A	N/A	N/s	N/A	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
trained and assessed as competent in advanced neonatal life support, who can attend within 30 minutes”.							
Consider alternative models for the SSPAU with the consultants and commissioners as part of the work on the future of maternity and paediatric services.	The CCGs have announced their proposals for the future model of acute paediatrics across Sussex which has gone out for public consultation in January 2014	No further action for the Trust	N/A	N/A	N/A	N/A	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Consider relocation of the SSPAU to be adjacent to the ED on the non acute site.	The CCGs have announced their proposals for the future model of acute paediatrics across Sussex which has gone out for public consultation in January 2014.	No further action for the Trust until outcome of consultation	N/A	N/A	N/A	N/A	

East Sussex Healthcare NHS Trust

Date of Meeting:	29 th January 2014
Meeting:	Trust Board
Agenda item:	10
Subject:	Planning Process 2014/15 to 2018/19
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 a two year and five year plan to cover the planning period 2014/15 to 2018/19 in line with the Trust Development Authority guidance <i>Securing Sustainability</i> .			

Introduction:
<p>The Trust Development Authority (TDA) issued planning guidance on 23 December 2013 to Trust Boards entitled <i>Securing Sustainability</i>. The document sets out the context for the TDA's 2014/15 to 2018/19 planning requirements which inform a number of expectations on Trusts in relation to the approach to be taken and the content of plans.</p> <p>In summary; the NHS is facing unprecedented financial challenges together with rising patient expectations and a renewed emphasis on quality in the light of the events at Mid Staffordshire NHS Foundation Trust and subsequent reports from Sir Bruce Keogh, Professor Don Berwick and others. Trust plans must address how these challenges will be addressed and sustainability will be secured.</p>

Analysis of Key Issues and Discussion Points Raised by the Report:
<p>There are three main parts to the planning process. The first part focuses on the completion and agreement of a two year plan which is clearly aligned to commissioning intentions; and in line with agreed contracts that is to be submitted to the TDA by the end of March 2014. The second part relates to the completion of a five year integrated business plan by 20 June 2014 in line with extant Monitor guidance. The final part is the agreement of a development support plan between the Trust and the TDA that will underpin the delivery of the above plans and the Trust's Organisational Development Plan.</p> <p>This paper sets out the planning process that will be undertaken within the Trust to develop and ratify the above plans. This process will build on that already undertaken in the development of the Trust's Clinical Strategy and previous Annual Business Plans.</p> <p>A risk based approach will be taken to ensure the risks to sustainability and improvement opportunities are identified and inform planning priorities. The process will include the following components:</p>

- Analysis of 2013/14 performance
- Identification of current and future safety risks based on an assessment of services against existing safety standards and informed assumptions about future safety standards. This will include building in requirements for safe staffing levels, the implications of seven day working and the need to maintain an appropriately skilled and capable workforce.
- Identification of current and future performance risks based on existing performance standards and informed assumptions about future performance requirements.
- Identification of current and future financial risks based on the common financial assumptions set out in Monitor guidance and taking into account the impact of commissioning intentions on forecast activity.
- Identification of current and future infrastructure risks based on the need to maintain and improve service quality and ensure that the Trust can meet future estates, Information Technology and Information Management requirements.

Benefits:

The following programme benefits have been identified and the steering group will ensure that these are delivered within the programme timetable:

- Integrated planning for sustainability which incorporates quality, finance, workforce and activity across the Trust
- Review and refresh of the Integrated Business Plan submitted in January 2013
- Longer term view for planning of transformational strategic redesign and reconfiguration
- Programme of engagement with key stakeholders including staff and patients

Risks and Implications

The following programme risks have already been identified. Programme risk management will be undertaken by the steering group which will develop and maintain a project risk register:

- There is insufficient clinical and operational engagement in the process
- CCG and Trust plans may not align because of differing assumptions e.g. about demand management
- There is insufficient engagement with public patients and other stakeholders e.g. local authority
- Cost improvement plans may affect quality of services
- Clinical business units may develop plans which require reconfiguration and will be subject to public consultation

Assurance Provided:

The programme set out in this paper provides the Board with assurance that the Trust will be able to develop and deliver the 2014/15 to 2018/19 plans with full clinical and Board involvement and that the plans will be developed in line with TDA requirements..

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

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

For further information or for any enquiries relating to this report please contact:	
Name: Amanda Harrison, Director of Strategic Development and Assurance	Contact details: Amanda.Harrison11@nhs.net

East Sussex Healthcare NHS Trust

Planning Process 2014/15 to 2018/19

1. Introduction

- 1.1 The Trust Development Authority (TDA) issued planning guidance on 23 December 2013 to Trust Boards entitled *Securing Sustainability*. The full version can be found on <http://www.ntda.nhs.uk/blog/2013/12/23/planning-guidance/>. The document sets out the context for the TDA's 2014/15 to 2018/19 planning requirements which informs a number of expectations on Trusts in relation to the approach to be taken and the content of plans.
- 1.2 In summary; the NHS is facing unprecedented financial challenges together with rising patient expectations and a renewed emphasis on quality in the light of the events at Mid Staffordshire NHS Foundation Trust and subsequent reports from Sir Bruce Keogh, Professor Don Berwick and others. Trust plans must address how these challenges will be addressed and sustainability will be secured.
- 1.3 There are three main parts to the planning process. The first part focuses on the completion and agreement of a two year plan which is clearly aligned to commissioning intentions; and in line with agreed contracts that is to be submitted to the TDA by the end of March 2014. The second part relates to the completion of a five year integrated business plan by 20 June 2014 in line with extant Monitor guidance. The final part is the agreement of a development support plan between the Trust and the TDA that will underpin the delivery of the above plans and the Trust's Organisational Development Plan.
- 1.4 This paper sets out the planning process that will be undertaken within the Trust to develop and ratify the above plans. This process will build on that already undertaken in the development of the Trust's Clinical Strategy and previous Annual Business Plans. It sets out the scope of the work, the governance framework and the timetable for the process that will ensure clinical engagement and Board oversight and agreement for each stage.

2. Background

- 2.1 The Trust is already three years into a five year improvement journey to improved clinical sustainability and financial viability. We have
 - Transformed clinical quality and safety
 - Made progress on building a culture that makes best use of resources
 - Improved operational performance
 - Developed our Clinical Strategy and implemented the first phase through the redesign of our emergency, acute medical and cardiology services, centralising acute and hyperacute stroke services at Eastbourne; and centralising emergency and high risk surgery at the Conquest Hospital. Planning continues on the centralisation of emergency and high risk orthopaedics at Conquest
 - Developed and approved a Full Business Case in support of the capital investment required to ensure the benefits of the above elements of the Clinical Strategy can be fully realised.

- Addressed safety risks in our maternity services by temporarily centralising consultant led maternity services and inpatient paediatric services at the Conquest Hospital together with inpatient paediatric services. The future configuration of these services is currently subject to full public consultation by the local clinical commissioning groups.
- Ensured we are well governed and further developed our Board

2.2 In 2014/15 we will carry on this journey by:

- Continuing to ensure that our clinical services are safe and of good quality
- Continuing to drive financial turnaround through efficiency and productivity
- Implementing the redesign and reconfiguration elements of phase 2 of our clinical strategy
- Ensuring plans for further service transformation are developed in line with our strategic intent.

2.3 Based on the Trust's Clinical Strategy the following broad clinical priorities have been identified for the next planning period:

- 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 sustainability criteria (operational, clinical and financial) to identify priorities for transformation and opportunities for differentiation followed by a review of the models of care and delivery options for the clinical services identified.

3. Process for developing the 2014/15 to 2018/19 plan

3.1 The process for developing the plan will build on that already undertaken to develop the clinical strategy and previous years' business, cost improvement and turnaround plans. A risk based approach will be taken to ensure the risks to sustainability and improvement opportunities are identified and inform planning priorities. The process will include the following components:

- Analysis of 2013/14 performance
- Identification of current and future safety risks based on an assessment of services against existing safety standards and informed assumptions about

future safety standards. This will include building in requirements for safe staffing levels, the implications of seven day working and the need to maintain an appropriately skilled and capable workforce.

- Identification of current and future performance risks based on existing performance standards and informed assumptions about future performance requirements.
- Identification of current and future financial risks based on the common financial assumptions set out in Monitor guidance and taking into account the impact of commissioning intentions on forecast activity.
- Identification of current and future infrastructure risks based on the need to maintain and improve service quality and ensure that the Trust can meet future estates, IT and IM requirements.

- 3.2 This process has already begun to build specific service plans at clinical unit level and secure clinical engagement in the planning process. Each clinical unit lead is identifying service risks and developing transformation plans that will be reviewed and refined through an executive led challenge process. This process is outlined in Appendix 1 and includes ensuring agreed demand and capacity plans, ward establishments, consultant job plans and cost improvement plans, support plan development and delivery.
- 3.3 The Director of Nursing, the Chief Operating Officer and the Medical Directors will ensure that a Quality Impact Assessment (QIA) is undertaken on all plans. All clinical unit plans for service transformation will be assessed using the Trust's current methodology for undertaking QIAs. The outcome of the QIA will inform the executive challenge process and will be considered through the governance process outlined below so that an assessment is made of cumulative impact at a Trust level and the impact of service plans on interdependent services is identified and assessed.
- 3.4 There will be ongoing engagement with local Clinical Commissioning Groups (CCGs) and East Sussex County Council (ESCC) throughout the plan development process to ensure that plans are aligned and the requirement and impact of transformation is fully understood.
- 3.5 The process for review and further development of underpinning plans including the Organisation Development Plan is underway and will be aligned to the planning programme identified within this document. This will ensure that the Trust will be able to submit and agree a development support plan in September 2014 as part of the implementation of the Trust's OD Plan.

4. Timetable for development of the 2014/15 to 2018/19 plan

- 4.1 The table below sets out the high level timetable for ensuring that we comply with our internal governance requirements and facilitate full Board engagement in developing our 2014/15 to 2018/19 business plan whilst meeting TDA deadlines. This is supported by the detailed plan development and executive challenge process. The exact requirements for each submission are in Appendix 2 and further information is also available in the technical guidance referenced above.

What	When	Notes	Lead Director	Lead Manager
High level 1 year plan to CME	13 January		AH	JR
High level 1 year plan to TDA	13 January	Inc workforce plan plus planning checklist and paper on Trust planning process	AH	JR
Planning Process and first cut plan to TB for information	15 January		AH	JR
Draft 2 year plan to TB	12 February		AH	JR
Draft 2 year plan to F and I Committee	26 February	F and I to approve and report to TB on 12 March	AH/VH	PA/JR
Contracts signed	28 February		VH	MI
2 year plan submitted to TDA	5 March		AH	JR
2 year plan submitted to TB	12 March	Selected CUs invited to present their plans for Board consideration – based on scale of impact and risk assessment	AH	JR
Final 2 year plan approved by TB	26 March		AH	JR
Final 2 year plan submission to TDA	4 April		AH	JR
Draft 5 year plan to Q and S	6 May		AW	CC
Draft 5 year plan to F and I	28 May		VH	PA
Draft 5 year plan to CME	9 June		AH	JR
Draft 5 year plan to TB	11 June		AH	JR
Draft 5 year plan to TDA	20 June			JR
Development plan agreed with TDA	30 September		AH	JR

Key:

TB	Trust Board	
F and I	Finance and Investment Committee	(Chaired by Non Executive Director)
Q and S	Quality and Standards Committee	(Chaired by Non Executive Director)
CME	Clinical Management Executive	(Chaired by Chief Executive)
TDA	Trust Development Authority	

5. Governance

5.1 The Corporate Leadership Team (CLT), which is chaired by the Chief Executive, will act as the steering group for the programme of work which will deliver all three parts of the planning process. Given the tight timescales, the 2014/15 Planning Process will be a weekly agenda item and this part of the meeting will be serviced by the Associate Director for Planning and Business Development. Terms of reference for the steering group are at Appendix 3. Key roles for the steering group will be to:

- Identify the programme of work required
- Clarify roles and responsibilities within workstreams
- Monitor the schedule of work and highlight issues on timing or resource
- Identify the critical milestones
- Identify and monitor risks and issues
- Obtain assurance on quality impact assessments
- Report on progress to the Trust's Clinical Management Executive and the Trust Board.

5.2 The following programme risks have already been identified and as outlined the ongoing programme risk management will be undertaken by the steering group:

- There is insufficient clinical and operational engagement in the process
- CCG and Trust plans may not align because of differing assumptions e.g. about demand management
- There is insufficient engagement with public patients and other stakeholders e.g. local authority
- Cost improvement plans may affect quality of services
- Clinical business units may develop plans which require reconfiguration and will be subject to public consultation

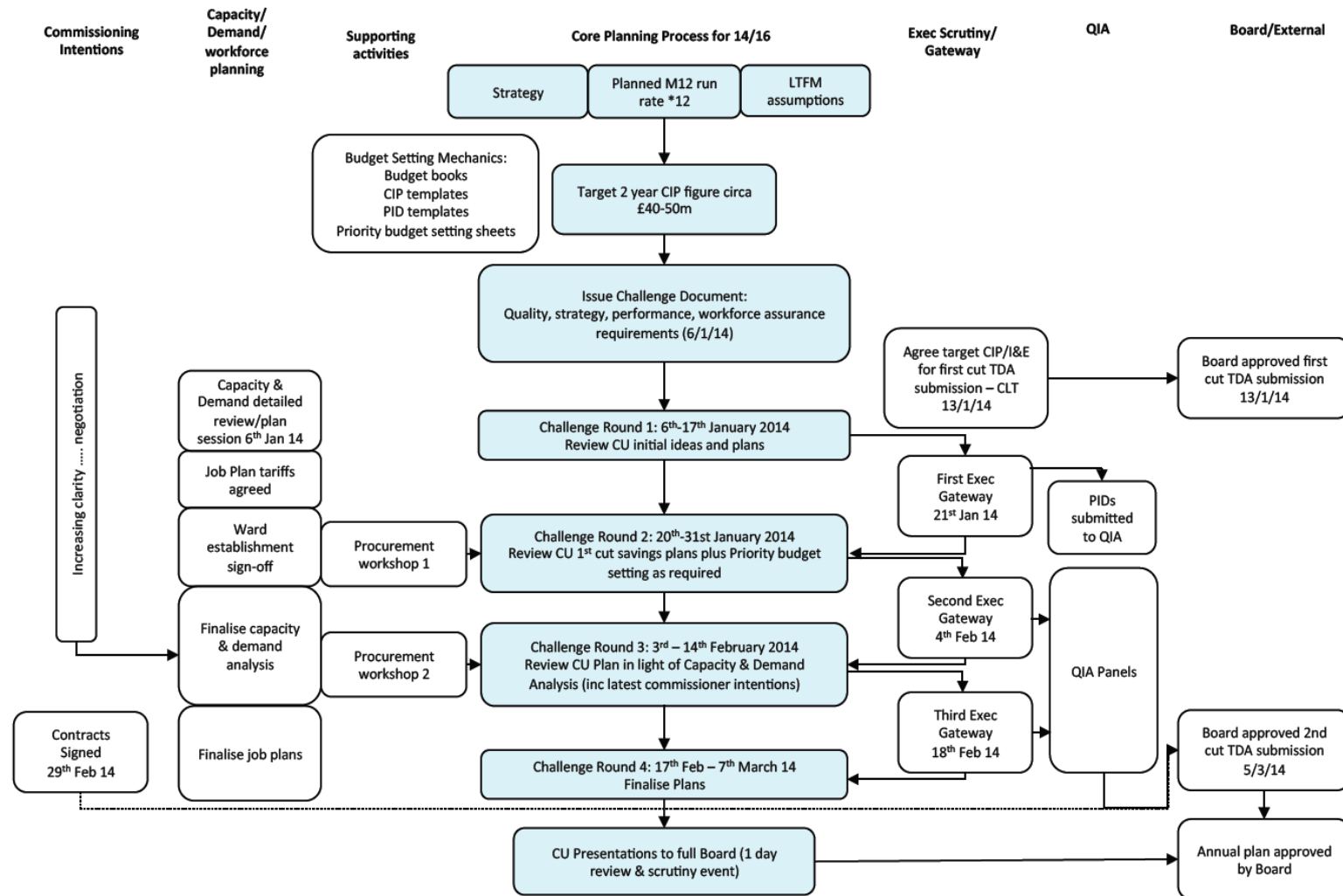
6. Conclusion

6.1 The above programme sets out how the Trust will deliver the 2014/15 to 2018/19 plans in line with TDA requirements. The following programme benefits have been identified and the steering group will ensure that these are delivered within the programme timetable:

- Integrated planning for sustainability which incorporates quality, finance, workforce and activity across the Trust
- Review and refresh of the Integrated Business Plan submitted in January 2013
- Longer term view for planning of transformational strategic redesign and reconfiguration
- Programme of engagement with key stakeholders including staff and patients

Annendix 1

Figure 1 – Overall process



Submission Requirements Appendix 2

Collection date	Plan collection	Finance submission		Activity submission		Quality and workforce submission		Other plan templates to be submitted	
		Detail	No. of years	Detail	No. of years	Detail	No. of years	Detail	No. of years
13 Jan 2014	Initial plan	High level revenue / capital and cash. Details of CIP programme, source and application of funds, exception reporting commentary	1 Year Revenue Plan - (2014/15) plus 2013/14 FOT) Capital 5 years Cash financing 5 years	Not required		Workforce plan	1 year plan 2014/15	Planning checklist	2 years 2014/15 and 2015/16
								Planning process	Five years, 2014/15 to 2018/19
5 March 2014	Full plan 1st draft post contract sign off date of 28/02	Detail revenue, capital and cash. Balance sheet and cash flow. Income by commissioner by point of delivery. Details of CIP programme, source and application of funds, exception reporting commentary	2 Year Plan - (2014/15 and 2015/16 plus 2013/14 FOT)	Activity plan and C Difficile Trajectory	2 Year plan (monthly profiles)	Workforce plan	2 years 2014/15 to 2015/16	Planning checklist	2 years 2014/15 and 2015/16
								Two year plan summary	2 years 2014/15 and 2015/16
4 April 2014	Final full plan post dispute resolution process with NHSE	Detail revenue, capital and cash. Balance sheet and cash flow. Income by commissioner by point of delivery. Details of CIP programme, source and application of funds, exception reporting commentary	2 Year Plan - (2014/15 and 2015/16 plus 2013/14 FOT)	Activity plan and C Difficile Trajectory	2 Year plan (monthly profiles)	Workforce plan	2 years 2014/15 to 2015/16	Planning checklist	2 years 2014/15 and 2015/16
								Two year plan summary	2 years 2014/15 and 2015/16
20 June 2014	5 Year Long Term Financial Model and Integrated Business Plan	Full 5 year integrated submission. Years 1 and 2 of the 5 year plan must be consistent with the Final Full Plan submitted on the 4th April 2014	5 Year LTFM and IBP	Activity plan	2014/15 to 2018/19	Workforce plan	Five years 2014/15 to 2018/19	Five year plan summary	Five years, 2014/15 to 2018/19
30 Sept 2014	Development support plan	Not required						Development support plan	As appropriate

Appendix 3

Business Planning Steering Group

Terms of Reference

1. Purpose

The Business Planning Steering Group is a task and finish group that exists to ensure that the following are delivered on time and in accordance with the requirements of the TDA and, where appropriate, Monitor:

- Trust two year plan for 2014/15 to 2015/16 by 4 April 2014
- Trust five year plan for 2014/15 to 2018/19 (IBP) by 20 June 2014
- Development support plan by 30 September 2014.

2. Duties

- Identify the programme of work required
- Clarify roles and responsibilities within workstreams
- Monitor the schedule of work and highlight issues on timing or resource
- Identify the critical milestones
- Monitor risks and issues
- Assurance on quality impact assessments
- Report progress to CME and the Trust Board

3 Membership

Membership of the Group will comprise:

- CEO
- Company Secretary
- Director of Finance
- Director of Strategic Development and Assurance
- Director of Operations
- Director of Human Resources
- Director of Nursing
- Medical Director Governance
- Medical Director Strategy
- Turnaround Director
- Associate Director of Planning and Business Development

Others may be invited by the Chair to attend all or any part of the meeting.

Members may not send deputies to this Group unless agreed by the Chair

4 Chair

All meetings of the Business Planning Steering Group will be chaired by the CEO or in his absence by the Director of Strategic Development and Assurance.

5 Secretary

The Director of Strategic Development and Assurance will nominate a Secretary to the Group meeting.

The Secretary is responsible for:

- Drafting and agreeing the agenda
- Receiving and finalising papers for distribution
- Preparing a note of actions arising from, and decisions taken at, each meeting
- Ensuring that appropriate items are referred to CME or the Trust Board

6 Quorum

The Group is not a democratic decision making body. However, meetings will not normally take place unless four members are present and meetings can only take place if they are chaired by the CEO or the Director of Strategic Development.

7 Frequency of meetings

Unless otherwise agreed the group shall meet weekly.

8 Notice of meetings

Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed and supporting papers, shall be forwarded to each member of the Group and any other person required to attend no later than two working days before the date of the meeting.

At the discretion of the Chair papers may be tabled at the meetings.

9 Conduct of meetings

Meetings of the Business Planning Steering Group shall be conducted in accordance with its Terms of Reference and the provisions of Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions approved by the Board of East Sussex Healthcare NHS Trust.

10 Notes of meetings

The Secretary shall take notes of all meetings of the Group, including recording the names of those present and in attendance. Notes of the meeting will record actions arising from the meeting.

11 Reporting

The Business Planning Steering Group is accountable to the Trust Board. Notes of the meetings will be made available to the Board.

12 Review of Terms of Reference

The terms of reference will be reviewed as required by the Business Planning Steering Group.

East Sussex Healthcare NHS Trust

Date of Meeting:	29 th January 2014
Meeting:	Trust Board
Agenda item:	11
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. <ul style="list-style-type: none"> • Audit Committee • Finance and Investment Committee • Quality and Standards Committee • Remuneration and Appointments Committee <p>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.</p>

Analysis of Key Issues and Discussion Points Raised by the Report:
The attached reports provide a summary of the key discussion points at each of the sub-committee meetings that have taken place since the Board last met.

Benefits:
This practice will increase Board awareness of key issues being considered by its sub-committees.

Risks and Implications
Failure to implement the arrangement effectively may result in Board members being unaware of key issues within the Trust.

Assurance Provided:
This report provides the Board with assurance that effective governance arrangements are in place.

Review by other Committees/Groups (please state name and date):
Not applicable.

Proposals and/or Recommendations
The Board is asked to review and note the documents.

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

For further information or for any enquiries relating to this report please contact:	
Name: Lynette Wells, Company Secretary	Contact details: (13) 4278

East Sussex Healthcare NHS Trust

AUDIT COMMITTEE

1. Introduction

- 1.1 Since the last Board meeting an Audit Committee meeting has been held on 8th January 2014 and a summary of the matters discussed at this meeting is provided below.
- 1.2 The minutes of the meeting held on 6th November 2013 are attached at Appendix 1.

2. Board Assurance Framework and High Level Risk Register

- 2.1 The Company Secretary presented the Board Assurance Framework (BAF) and the high level Risk Register and these documents were reviewed and discussed by the Committee.

3. Clinical Audit

- 3.1 The Associate Medical Director – Clinical Audit presented an update report and the Committee noted progress with the audits on the Clinical Audit Forward Plan for 2013/14.

4. Internal Audit

- 4.1 The Committee received an audit update report and noted the actions being taken in relation to the infection control audit which had received limited assurance.
- 4.2 The Committee was pleased to note the progress made on payroll authorisation as the internal audit opinion had provided significant assurance following its recent review. It was noted that there were some further recommendations in relation to locums and these were being addressed, following which they would be re-audited for further assurance.

5. Local Counter Fraud Service

- 5.1 The Committee received the progress report and noted the actions being taken in respect of on-going investigations.

6. External Audit

- 6.1 The Committee received the progress report and noted that the draft financial statements would need to be submitted to the Department of Health by 23rd April and the audited statements by noon on 9th June 2014.

7. Audit Fees for 2014/15

- 7.1 The Director of Finance provided an update report and noted that the fees for internal audit, external audit and the counter-fraud service would come to the next meeting for approval.

8. Internal Reports

8.1 The Committee received reports on the following areas:

- Tenders and Waivers
- Review of Aged Debts
- Review of Losses and Special Payments
- Update on Information Governance Toolkit submission

9. Payroll Authorisation Project

9.1 The Payroll Manager updated the Committee on the recent bi-annual exercise to verify that all staff were on the payroll and their correct hours noted and noted that compliance was at 88% at the date of the meeting. Non returns would be followed up to ensure 100% compliance achieved.

9.2 The Committee noted the update on the roll-out of the Healthroster project.

James O'Sullivan
Audit Committee Chairman

13th January 2014

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

**Minutes of the Audit Committee meeting held on
Wednesday 6th November 2013 at 9.30 am
in the Committee Room, Conquest Hospital**

Present: Mr James O'Sullivan, Non-Executive Director (Chairman)
Ms Stephanie Kennett, Non-Executive Director
Mr Barry Nealon, Non-Executive Director (items 1-6 inclusive)

In attendance Mrs Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development and Assurance
Mrs Lynette Wells, Company Secretary
Mr Steve Hoaen, Head of Financial Management
Mr Leigh Lloyd-Thomas, BDO (BDO)
Mr Michael Townsend, South Coast Audit (SCA)
Mr Mick Fyfe, SCA
Mr Alex Hughes, Deloitte
Ms Emily Keeble, Head of Assurance (for item 5)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

Action

1. Welcome and Apologies for Absence

The Chairman opened the meeting and noted that a quorum was present.

Apologies for absence had been received from Mrs Alice Webster, Director of Nursing, Dr David Hughes, Medical Director, Dr Janet McGowan, Deputy Medical Director and Darren Grayson, Chief Executive.

2. Minutes

i) The minutes of the meeting held on the 4th September 2013 were reviewed and agreed as a correct record.

ii) Matters Arising

All matters arising had been discharged or were covered in the business of the meeting.

3. Board Assurance Framework & High Level Risk Register

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

She advised that updates were provided and that some gaps in control had been removed as they were complete or not relevant to the BAF any more or the narrative changed.

Ms Kennett asked how the impact of the removal of the divisional structure would impact on risk reporting. Dr Harrison reported that for the short term divisional reporting would continue through the Assistant Directors of Nursing and Associate Directors but once the finalised structure was known the governance structure would be amended to reflect it.

Mrs Harris advised that reporting would continue at divisional level for accounting purposes for the remainder of the financial year.

The Committee noted the Board Assurance Framework and the High Level Risk Register.

4. Clinical Audit Forward Plan Update

Ms Keeble presented the Clinical Audit Forward Plan update and advised that there were still 3 audits open from 2011/12, 86 from 2012/13 and 200 open on the forward plan for 2013/14.

She reported that 27 audits had been completed and closed from the 2013/14 plan, there had also been 7 audit slippages on 13/14 and she anticipated that 3 audits would be closed by the end of 2013.

She explained that for the Clinical Audit Steering Group meeting on 7th October divisions had been requested to report by exception on any audits that they did not expect to be completed on time or on plan. The CASG requested at the meeting that the divisions provided a summary status of the 86 outstanding audits for 2012/13, which priority they were and action being taken.

Ms Keeble reported that of the 86 outstanding audits from 2012/13 27 were priority 1, 28 priority 2, 10 priority 3 and 21 at priority 4. Of the priority 1 audits 10 were awaiting national report, 9 awaiting local report, 4 still in progress, 2 no updated provided and 2 where the audit lead had left Trust. None of the outstanding priority 1 audits were national ones.

Mr O'Sullivan asked what were the consequences of not completing the priority 1 audit and Ms Keeble stated that it was reputational as there were no fines attached. She advised that the categories were set by the Trust itself and she would provide the definition for the next meeting.

EK

Ms Kennett commented that the Committee now had an understanding of what the issues were with clinical audit and the

next steps were to address these.

Discussion took place on how this was addressed in other Trusts and Mr Townsend commented that other audit committees did not review clinical audit so regularly and Mr Fyfe commented that other Trusts had the same issues around local clinical audits.

Mr Lloyd-Thomas commented that progress had been made in other Trusts by the Assistant Medical Director focusing on and driving compliance.

Ms Keeble reported that on the 2013/14 plan there were 200 audits still on-going for this year and the likelihood was that not all would be completed. The focus would be on priority 1 areas and divisions had been asked to provide an update at the next CASG on 12th December. Dr McGowan was also meeting with the clinical audit leads to understand their position as part of the issue was communication between the governance team and doctors.

Mr O'Sullivan asked if he could attend the CASG on 12th December and Ms Keeble agreed to send him an invitation with the details of the meeting.

EK

Ms Keeble reported that the Trust would be participating in the national audits, apart from the diabetes one as previously reported, and noted that the national thoracic audit components had been reduced and the Trust would be participating.

She highlighted that the reasons for the slippage on 7 audits on the 2013/14 plan were noted in her report and the actions being taken to address them. She believed that there was slippage on a number of other audits but information was still awaited on progress.

She updated the Committee on progress with the changes discussed at the last Audit Committee meeting.

Ms Kennett queried whether progress with audits were affected by turnaround efforts and Ms Keeble advised that they should not be and, whilst the November audit meetings had been cancelled, clinical audit was supported and it should not affect plans for the remainder of the year.

Mr Nealon requested that the list of closed audits also be provided with the next report in order to identify the good performers.

EK

The dates of the Audit Committee meetings for 2014 would be sent to Dr McGowan for her diary.

TR

Mr O'Sullivan commented that the Committee now had a clearer picture of the issues relating to clinical audit but further discussion was required on how these would be taken forward and addressed

and he would attend the next CASG as part of this discussion.

The Committee noted the update on the Clinical Audit Forward Plan.

5. Integrated Care Risk Register/Clinical Audit Review

As no representative attended from the division, it was agreed that this item would be taken forward to the next meeting.

TR

6. Corporate Risk Register

Mrs Wells reported that the register covered the risks in the corporate areas and were broken down by function and the link into the BAF could be made.

Ms Kennett queried the last time some of the risks had been reviewed and Dr Harrison advised that there should be a regular update on Datix to note that the risk had been reviewed even if there had been no change to the mitigations or rating.

Mrs Wells agreed that the risks should be reviewed monthly and advised that a number of risks related to the operations areas and the issue of governance support for the directorate had recently been resolved. A Clinical Governance Manager had now been appointed and a review of the risks would be one of her first priorities.

Mrs Harris confirmed that she reviewed the risks in her directorate on a monthly basis and provided an update on the three main financial risks around cash, achievement of plan and reduction in cost base. They were all currently rated at 16 as there were controls and action plans in place to address the risks. She advised that the cash position was temporarily eased as the Trust had received a further £9 million in October. The financial plan was off target but the Turnaround Director and financial recovery plan were in place and the organisation was totally focused on turnaround.

Discussion took place on the top five risks for the organisation and Dr Harrison explained that the risk registers were focused on risks identified within the organisation and the BAF looked at the materiality of those risks in relation to the corporate objectives of the organisation. Therefore the top five organisational risks should be drawn from the BAF rather than the Corporate Risk Register

The Committee noted the update on the Corporate Risk Register.

7. Internal Audit

a) Progress Report

Mr Fyfe reported that the following reports had been finalised since the last meeting:

Health and Safety (significant assurance)
Essential Mandatory Training Clinical (significant/limited assurance)
Activity Data Depository Controls Review (significant assurance)

Mr Fyfe explained that in relation to the mandatory training audit he had been able to give significant assurance over the operational processes but limited assurance over actual attendance. He noted that the management response advised that mandatory training provision was under constant review to streamline as far as possible including assessing staff as to their competency and mandatory training requirements. He noted that regular reports were sent to managers and they were required to complete recovery plans to achieve performance targets but these were not being provided.

Mr O'Sullivan commented that the Board was aware that this was an issue as the Board performance report detailed compliance levels and Mr Nealon agreed and queried whether the priorities were right.

Mrs Harris said that the organisation needed to be much clearer on the result of continual non-compliance as outlined in the management response and the executive team needed to take this forward and expect challenge at the Board.

Ms Kennett commented that she struggled with the logic of achieving significant assurance on process if it was not being delivered and was there an issue preventing delivery of the process. Mr Townsend explained that the significant assurance was that the process, ie building blocks, were in place, but limited assurance was on delivery as they were not being used.

Mr Fyfe reported that four audits were currently in progress:

- Business Continuity plan
- Infection Control
- Medical Staff Appraisal and Revalidation
- Safer Staffing

He advised that discussion notes had been issued on the infection control audit and provisionally a limited assurance opinion would be given. Ms Kennett requested that in view of the opinion and the fact that the Trust was already incurring fines, issuing of the final report be accelerated and Mr Fyfe agreed to share the final report with Mrs Harris for onward circulation to the Committee as soon as possible.

Mr Fyfe reported that the audit plan was on schedule for completion by 31st March 2014.

The Committee noted the report.

b) Audit Recommendations Tracker

Mrs Wells presented the report and noted that there were 11 recommendations rated red from this year's plans and the tracker clearly showed where progress had been made on the recommendations.

Mr Lloyd-Taylor recommended that the recommendation in relation to VTE assessment be closed as there was now a track record of VTE assessment.

LW

The Committee were assured of the progress made in recording and implementing audit actions.

8. Payroll Authorisation Project

Mrs Harris reported that the majority of the actions had been completed on the action plan. There were two areas which were still open – e-rostering and sign-off by budget manager of employees listed under them and their hours.

She reported that there was an increased focus on e-rostering with the project team being reinforced in terms of resource and the intention was to have all the wards using e-rostering properly and linked to ESR and payroll by the end of December, following which roll-out of the system to other areas would continue. She suggested that there should be a written report on progress with e-rostering to the next Committee meeting which was agreed.

**VH/
MG**

Mrs Harris reported that she had revitalised the bi-annual exercise of asking every single budget manager to sign-off that the employees listed in their area worked there and that their hours were correct. This exercise had been undertaken based on the September payroll and to date there had been a 40% sign-off rate with very few issues. She advised that in order to focus accountability the payroll function had moved from human resources to finance management from 1st November 2013 and she would provide a progress report at the next meeting.

VH

Mr Fyfe reported that South Coast Audit was now auditing the authorisation controls but it was too early to give a view on their findings. They would report back at the next meeting.

SCA

The Committee noted the update report.

9. Local Counter Fraud Service

a) Progress Report and Investigations Update

Mr Hughes presented his progress report and noted that 46 days of proactive work had been undertaken and 18 investigation days.

Mr Hughes advised that since the last meeting 2 new referrals had been received, proactive exercises had been continued, additional work had taken place on key risk areas and on payroll liaising with SCA.

He referred to the recommendations from the proactive and reactive work and management responses and asked for the Committee's view in relation to whether monitoring of compliance should be listed in the Company Representative Policy. The department believed that there was sufficient control but his advice was that it should be visible in the policy to provide a deterrence effect. The Committee agreed that a formal process should be included and the review date amended to every two years.

AHu

The Committee also agreed that a formal process for compliance should be included in the Disposal of Goods Policy and that the policy should be reviewed every two years.

AHu

Mr Hughes reported that he had carried out a review of some of the policies relating to tendering to consider whether additional work was required and he would discuss this with the Director of Finance.

AHu

Mrs Harris suggested that under the days set aside within the internal audit plan for capital, SCA should undertake a quick review of the capital programme and this was agreed by the Committee.

SCA

Mr Hughes reported that in terms of investigations there was 1 open case, 3 had been referred to Human Resources, 2 cases had been closed, 4 were under consideration and 9 had not been taken forward.

The total value of fraud year to date was £1,502 gross and an amount of £1,389 had been agreed for recovery.

In response to the request at the last Committee meeting for benchmarking information, Mr Hughes tabled a schedule which compared the Trust to a number of his clients and advised that the Trust was not a significant outlier compared to other NHS organisations.

b) Investigations Update

Mr Hughes presented an update on the referrals received and the progress being made with investigations.

10. External Audit

a) Progress Report

Mr Lloyd-Taylor reported that the detailed risk assessment was being undertaken, following which the detailed audit plan would be issued in January next year.

He advised that the audit would commence in March in readiness for sign off of the Annual Report and Annual Accounts in the first week of June and the Quality Report would be signed off at the end of June. He anticipated that there would be a qualified conclusion again on use of resources as the Trust would continue to be in historical breach of break even. The legal advice was that it was not necessary to issue another Section 19 letter to the Secretary of State.

b) The highlights briefing paper was noted.

The Committee noted the progress report and the briefing paper.

11. Tenders and Waivers Report

Mrs Wells presented the report and noted that it was not possible to link the three contracts awarded to the tender information provided and she would ask Mr Binks to clarify and circulate the information to the Committee.

LW

She reported that there had been 25 waivers recorded during August to October totalling just over £500k and the breakdown of reasons for waivers year to date was also shown.

LW

Mrs Wells advised that she would be exploring the reasons why Mr Binks believed that there was such a risk around the programme for procurement if not given sufficient time.

The Committee noted the report.

12. Information Governance Toolkit (IGT) Mid Year Submission Report

Mrs Wells reported that it was a requirement to report progress on the IGT to the Committee and as at the end of October 49% was uploaded to the website. She was confident that the year end target of 66% would be reached. As part of the requirements 15 standards needed to be audited and South Coast Audit would be starting their work on 18th November.

She advised that the only risk related to information governance training and the Information Governance Manager was reviewing how the training could be provided in different way.

The Committee noted progress with the IGT Submission and approved the Information Governance Management Framework attached at Appendix 1 of the report.

13. Annual Review of Corporate Governance Documents

Mrs Wells reported that the review this year principally covered amendments to terminology in the documents as a result of the restructuring within the NHS.

The Audit Committee endorsed the amendments to the Standing Orders, Standing Financial Instructions, Schedule of Matters Reserved to the Board and Scheme of Delegation recommended them to the Trust Board for approval.

14. Surrey and Sussex CRLN Quarter 1 Report

Mrs Wells explained that assurance around research governance was one of the Committee's Terms of Reference and presented the report from the Research Support Manager which was self-explanatory.

The Committee noted the report.

15. Consultation on Department of Health proposals for new constitutional requirements for the audit committees of NHS Trusts and Clinical Commissioning Groups

Mrs Wells advised that with the disbandment of the Audit Commission NHS Trusts and Clinical Commissioning Groups would be required to have an auditor panel from April 2017/18 to advise on the appointment of external auditors.

The view of the meeting was that for NHS Trusts this would not prove an issue as their Audit Committees were made up of non-executive directors but would prove more difficult for Clinical Commissioning Groups as the membership composition was different.

The Committee noted the report but agreed that it would not respond to the consultation.

16. Internal Audit and Local Counter Fraud Services Tender

Mrs Harris asked Mr Townsend to explain the future arrangements of South Coast Audit and Mr Townsend explained that SCA was a shared service/consortium with membership of 11 NHS Trusts/Foundation Trusts in the South of England. As the host

organisation for the consortium, Sussex Community Trust employed the SCA staff and had a Service Level Agreement with all the member Trusts. The consortium had moved host a few times since its inception and the current host had given notice that it wished to end the arrangement and no other Trust had come forward as an alternative host.

Mrs Harris asked for clarification around the liability issue that might arise from this change and Mr Townsend was unable to provide this and suggested she should seek clarification from Sussex Community Trust.

Mr Fyfe, Mr Townsend and Mr Hughes left the room.

a)

Internal Audit

Mrs Harris proposed that in view of the changes to the organisation form of SCA and that because of residual liability issues a change of internal auditor in this year would not be good value for money the Trust should re-engage SCA for internal audit services for a further year subject to written confirmation from Sussex Community Trust on the liability issue.

She advised that the procurement department had advised that provided the Audit Committee was content with the level of service being provided the Trust could continue with the same provider following completion of a waiver on the basis of best value for money.

The Committee approved the proposal to appoint South Coast Audit for a further year to provide internal audit services, subject to confirmation from Sussex Community Trust on the liability issue.

b)

Local Counter Fraud Service

Mr Hoaen reported that the proposal was to tender for local counter fraud services with the current contract ending on 31st March 2014. A review panel would be established in November to define the service specification for the tender and, once finalised, the service would be tendered in compliance with statutory requirements via the local NHS Procurement Hub framework.

SH

The Committee approved and took assurance from the proposed tender process.

17. Dates of meetings for 2014

The Committee noted the meeting dates for 2014.

18. Date of Next Meeting

Wednesday, 8th January 2014, at 9.30 in the Committee Room,
Conquest Hospital.

Signed:

Date:

East Sussex Healthcare NHS Trust

Finance and Investment Committee

1. Introduction

Since the Board last met there has been a Finance and Investment Committee held on 11 December 2013. A summary of the items discussed at the meeting is set out below.

2. Performance Report – Month 7

- 2.1 The Committee received the month 7 Performance Report which detailed the Trust's in month performance against the National Performance Framework metrics as described in the National Operating Plan for 2013/14.

3. Finance Update – Provisional Month 8 Flash Report

- 3.1 Mrs Harris provided the Committee with an update on the month 8 financial position.
- 3.2 There was an in month deficit of £1.2m. Compared to the original TDA plan the Trust was overspent by £8m ytd at month 8. The Trust had over achieved by £.9m compared to the in year FRP planned in month deficit of £2.1m.
- 3.3 M8 income was better than Plan but expenditure remained above Plan. However, it was noted that pay costs had reduced in month. Mr Astell shared a M8 income analysis with the Committee. There had been an improvement within the month as both income from non-elective and elective activity had increased. The Committee also reviewed the M8 expenditure in more detail and noted the comparison to the previous monthly average. High costs drugs had been removed from the comparison so as not to distort the key messages. Total pay expenditure had reduced by £464k from the previous average. There had been a significant reduction in nurse agency expenditure. Non pay costs had increased by £235k but this variance related to activity related costs. Overall there was an improving trend in the results. However, there was still much more to be done.

4. PDC (Public Dividend Capital) Application

- 4.1 Mrs Harris provided an update on the Trust's application for cash in the form of non-repayable Public Dividend Capital.
- 4.2 It was noted that the ITFF was meeting to consider the Trust's application in January.

5. Cash Update at Month 8

5.1 Mrs Harris updated the Committee on the cash position at the end of Month 8.

5.2 It was noted that the cash position had been very difficult throughout the financial year because of the planned deficit and historically high level of creditors. £24m of temporary borrowing has already been received in year. The current PDC application with the TDA includes £15m for creditor payments of which £5m had already been received as part of the £24m. Unless the position changes significantly in December, a further temporary loan would be needed in January.

6. EBITDA Quarterly Report – Q2

6.1 Mrs Brandt gave an update on the 2013/14 Quarter 2 EBITDA statement which had been reconciled to the Trust's finance report. The service lines that had a positive and negative EBITDA were highlighted to the Committee.

7. Reference Costs

7.1 Mrs Brandt updated the Committee on the published 2012-13 reference cost index (RCI). The Committee noted the 2012-13 reference cost index of 105 for the Trust.

8. Turnaround Update

8.1 Mr Murphy reported on Turnaround progress at M8. As a result of new substantive nursing appointments having been made and rigorous controls being put in place, nurse agency expenditure had reduced without compromising quality and safety. However, medical agency costs remained high and needed further review.

9. Policy & Procedure for the Submission, Evaluation and Approval of Business Cases

9.1 Mr Astell presented the Policy and Procedure for Submission, Evaluation and Approval of Business Cases.

9.2 The Policy explained the key principles involved in putting forward proposals requiring investment. Its purpose was to ensure that the Trust adopted a robust and consistent approach to the preparation and consideration of business cases.

9.3 The Finance & Investment Committee approved the Policy and Procedure for implementation throughout the Trust.

10. Business Case to replace the current PAS (Patient Administration System/Service) System

- 10.1 Mrs Walton presented the full business case on the PAS Managed Service.
- 10.2 The Trust was required, under Public Contracts Regulations 2006/2009, to re-tender the Contract. The tender process had concluded and the business case recommended Award of Contract to a contractor to provide a service from 1 April 2014 for a minimum period of 5 years up to a maximum of 10 years.
- 10.3 The successful bidder from the procurement project was Oasis Medical Solutions (OMS), the incumbent supplier.
- 10.4 It was recommended that the Committee accept the outcome of the procurement and proceed to recommend a Chairman's action in the absence of a Trust Board in December to ensure TDA approval as soon as possible to assure contract sign-off for Oasis PAS V16 with OMS.

11. Market Testing Update - Occupational Health Business Case & Pharmacy Manufacturing Unit (PMU)

- 11.1 Following Board approval of the market testing outline business case (OBC) in September 2013 and the project initiation document (PID) in October 2013, Mr Horne presented the Committee with an update on the first two services being taken through the programme.
- 11.2 A transformational plan on Occupational Health was presented which required a decision on whether to proceed to market testing an an update was provided on the PMU service.
- 11.3 The Committee agreed the following recommendations from the market testing steering group and the CME meeting of 9 December 2013:

Occupational Health:

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

Pharmacy Manufacturing Unit:

- To note the update given in the report
- To request the transformational plan at its next meeting

12. Community & Child Health Project Update

- 12.1 The Committee received an update on progress of the Community & Child Health System (SystmOne) project.
- 12.2 The report indicated that Phase one Child Health data migration activities had been completed and were due to be signed off on 18 December 2013. The second phase was due to begin soon after this date with a sign off due in March 2014 prior to final data production.

13. Capital Programme Quarterly Report

- 13.1 Mrs Harris presented the Committee with a review of the 2013/14 capital programme at 30 November 2014 together with a forward look over the next four years until 2017/18.
- 13.2 The report highlighted that the demand for capital expenditure continued to place the capital programme under significant financial pressure at a time when the overall capital resources available in 2014/15 remained uncertain.
- 13.3 The Committee noted:
 - the current performance of the capital programme
 - the significant risks arising from the deferral of capital schemes in order to bring the capital programme into balance
 - the further revision of the capital programme would be required by the Capital Approval Group (CAG) in order that the Trust does not breach its capital resource limit (CRL) at 31 March 2014
 - the 5 year capital programme which was the subject of ongoing development to meet the changing needs of the Trust.

14. Work Programme

- 14.1 The 2014 draft work programme was reviewed and updated.

15. Schneider Business Case

- 15.1 The Chairman asked what was happening with the Schneider Business Case. Mrs Harris explained that there was a new Estates & Facilities Advisor in place, Ian Humphries, who was reviewing some of the Estates & Facilities issues including the Schneider project. It was noted that there was further work which needed to be done on the Business Case for this project.

16. Conclusions

16.1 The Trust Board is asked to note:

- The Committee reviewed the Finance month 8 flash report and the Performance Report for month 7
- The Committee noted the latest position with regard to the PDC (Public Dividend Capital) Application and the associated risks
- The Cash update at the end of month 8 was noted
- The Committee noted the EBITDA statement position and agreed that it would continue to invite individual clinical specialities to attend the Committee to present the outcome of their deep dive reviews.
- The Reference Cost Index was noted
- Turnaround progress was noted
- The Committee approved the Policy and Procedure for the Submission, Evaluation and Approval of Business Cases for implementation throughout the Trust.
- The Committee accepted the outcome of the procurement for the Business Case to replace the current PAS system and recommended a Chairman's action in the absence of a Trust Board in December to ensure TDA approval as soon as possible.
- An update on Market Testing was received
- An update on the Community & Child Health System was made
- The Committee noted the update on the 5 year capital programme and the ongoing development to meet the changing needs of the Trust
- The Committee noted the 2014 work programme

Barry Nealon
Chair of Finance and Investment Committee

20 December 2013

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

**Minutes of the Finance & Investment Committee held on
Wednesday 23rd October 2013 at 2.30pm in St Mary's Board Room, EDGH**

Present

Mr Barry Nealon, Non Executive Director (chair)
Mr James O'Sullivan, Non Executive Director
Mr Darren Grayson, Chief Executive
Mrs Vanessa Harris, Director of Finance
Mr Philip Astell, Interim Deputy Director of Finance
Mr Andrew Murphy, Turnaround Director
Mr Andy Horne, Market Testing Programme Director
Dr David Hughes, Medical Director

In attendance

1.	Welcome and Apologies Mr Nealon welcomed members to the Finance & Investment Committee. Apologies were received from Stephanie Kennett and Richard Sunley.	Action
2.	Minutes of Meeting of 18 September 2013 The minutes of the meeting of 18 September 2013 were agreed as an accurate record	
3.	Matters Arising <u>(i) Finance Update - Month 5</u> Performance against trajectory was included in the Mid-Year Financial Performance Review Report <u>(ii) EBITDA</u> It was noted that progress against actions plans and the theatre utilisation review had been scheduled into the work programme. <u>(iii) Clinical Strategy Full Business Case</u> Members of the Committee had been asked to feed back any comments on the Clinical Strategy FBC to Mr Saunders <u>(iv) Work Programme</u>	

	It was noted that the Work Programme had been updated and EBITDA reviews included in the forward programme.	
4(i)	<p>Performance Report – Month 5</p> <p>The Committee received the month 5 Performance Report which detailed the Trust's in month performance against the National Performance Framework metrics as described in the National Operating Plan for 2013/14.</p> <p>It was noted that month 5 performance maintained a 'performing' status against core National Performance Framework metrics.</p> <p>Elective Referral to Treatment targets remained above target and only 5 specialities failed to achieve.</p> <p>Final month 5 Cancer performance shows the trust failing against both 2WW (Breast Symptoms) and 62 day urgent referral targets.</p> <p>There were four C-Difficile cases reported in month 5. Current outturn is 18 against a target outturn of 25. This remains a challenging target to meet.</p> <p>There were 44 breaches of mixed sex accommodation in month 5 causing the trust to fall below threshold this was a result of pressures in A&E. Measures have been taken to ensure this can be avoided in future.</p> <p>Action The Committee noted the Performance Report for month 5.</p>	
4(ii)	<p>Finance Update – Month 6</p> <p>Mrs Harris provided the Committee with an update on the month 6 financial position.</p> <p>Compared to the original TDA plan the Trust was overspent by £6.6m at month 6. Compared to the in year FRP planned in month deficit of £2.5m the Trust had underachieved by £0.5m; however this was £0.7m better than the worst case trajectory. Total costs reduced to £31.5m in September compared to £33m in August, income was adverse to plan and this was partly due to elective inpatient levels being below plan. Mr Nealon queried the favourable variance on central items. This is due to central uncommitted reserves being phased in over the course of the year</p> <p>Cash remains an issue but £9m of temporary loan had been received at the beginning of October. Capital expenditure remains under pressure; an application for an additional £4m of capital resource has been made via the TDA.</p>	

	<p>Action The Committee noted the month 6 position</p>	
5.	<p>Mid Year Financial Performance Review</p> <p>Mr Astell presented the Committee with a mid year update on the key financial issues that had arisen in the first six month and an assessment of prospects for the remainder of the financial year.</p> <p>It was noted that at the end of the period the Trust had incurred a deficit of £16.7m, which was £6.6m worse than the profiled plan at this stage. Income was adverse to plan by £1.7m and total costs exceed plan by £4.9m. Agency expenditure had been a significant contributor to the overspend, cumulative total agency spend was just under £5.9m. Cost improvements delivered to date of £4.6m achieved 57% of the year to date target and less than 23% of the full year requirement.</p> <p>The in- year recovery plan monthly trajectory was noted. It was agreed that this would need linking to the Turnaround Programme.</p> <p>The Trust had embarked on a rigorous in year financial recovery plan with a view to getting on track to deliver the planned deficit of £19.4m for the year. It was noted that there were significant risks to delivery of the plan but there were also numerous opportunities and progress was already being made.</p> <p>Action The Committee noted the key issues and risks identified and the action taken to address these through the in year recovery plan.</p>	VH/AM
6.	<p>Medium Term Financial Recovery Plan</p> <p>Mrs Harris updated the Committee on progress with developing the medium term financial recovery plan.</p> <p>At the September Finance & Investment Committee meeting, it was agreed that the Plan which had been developed over the summer should be forwarded to the TDA as part of the cash application due on 27 September, subject to Board discussion and agreement at a private meeting on 26 September 2013. The Plan was agreed by the Board at that meeting as part of the cash financing submission and had been submitted to the TDA on the due date. Subsequent to the initial application an additional request for £4m of capital resource has also been made via the TDA.</p> <p>It was noted that feedback on the financing submission which included the Medium Term Financial Plan made to the TDA was awaited.</p>	

	<p>A request had been received from the TDA today for some further information to support the application. This would need to be provided by the deadline of tomorrow.</p> <p>The Committee noted:</p> <ul style="list-style-type: none"> • The Trust continues to plan on a base case projection of breakeven run rate by 2016/17 and sustainable surplus thereafter. However there are numerous risks to delivering this position and the unmitigated downside that has been modelled would present significant challenge • The addition of balance sheet and cash flow statements has highlighted the ongoing liquidity risk and the affordability of loans • The Trust has produced an LTFM based on the FRP and this was used to support an application for PDC in the current year <p>Action The Committee noted the update on the medium term financial recovery plan</p>	VH
7.	<p>Turnaround Update</p> <p>Mr Murphy who had taken up an interim role as Turnaround Director on 1 October 2013 updated the Committee on the approach to Turnaround. The aim would be to reduce expenditure by £10m before year end. His focus was on run rate reduction and he was currently meeting with all the clinical units on a weekly basis to identify opportunities. Already productivity gains and length of stay reductions had been achieved on one site and as a result a ward had been closed with a saving of over £500k by year end. Over the next few weeks the main effort would be on reducing agency, ad hoc and third party expenditure.</p> <p>Dr Hughes explained that all Turnaround schemes were subject to a Quality Impact Assessment process which required sign off by himself and the Director of Nursing at weekly meetings which were also attended by the Chief Operating Officer and Turnaround Director.</p> <p>Action The Committee noted progress to date</p>	
8.	<p>Financial Planning Peer Review Summary Report</p> <p>Mrs Harris presented the peer report provided by another Trust on the Trust's in year position at month 4, both in terms of the original plan, delivery against it and in particular performance of the CIP</p>	

	<p>programme. There were no new issues identified and the conclusions reached were noted. The main recommendations had already been identified by the Board as part of the actions to be taken to escalate the Turnaround process. The actions were themed under 7 main areas and these had been set out in an Action Plan with progress made against them recorded.</p> <p>Action The Committee noted the peer review report and the related Action Plan</p>	
9.	<p>Market Testing Programme Initiation Document (PID)</p> <p>Following Board approval of the market testing OBC, Mr Horne presented the Committee with a Programme Initiation Document and terms of reference for approval to move forward to develop service specific transformation plans and a series of pre-procurement full business cases.</p> <p>It was noted that development work would start on some small niche services as a learning exercise. A transformation plan for these services would be presented to the Committee at its December meeting. It was recognised that over the next few weeks the Turnaround programme would need to take priority.</p> <p>A communication strategy would need to be put in place to keep staff briefed.</p> <p>Action The Committee noted the Market Testing update</p>	AH
10.	<p>Community & Child Health Project Update</p> <p>The Committee received an update on progress of the Community & Child Health System (SystemOne) project.</p> <p>It was noted that data migration activities had commenced for the Child Health data.</p> <p>A Business Case for the mobile working component will be presented to the November meeting of the Committee.</p> <p>Action The Committee noted the Community & Child Health System update.</p>	
11.	<p>Clinical Strategy Update</p> <p>The Board had reviewed aspects of the Full Business Case at its recent Seminar and a meeting held earlier today had been used to</p>	

	<p>review design plans and further detail around the capital expenditure. The finance team had also provided further information as requested.</p> <p>Action The Committee noted the update on the Clinical Strategy</p>	
12.	<p>Work Programme</p> <p>The revised work programme was presented for information and some further changes were agreed.</p> <p>Action The Committee noted the revised work programme</p>	
13.	<p>Date of Next Meeting</p> <p>It was noted that the next meeting will take place on Wednesday 20 November 2013 at 2pm – 4pm in St Mary's Board Room, Eastbourne DGH.</p>	
14.	<p>Dates of 2014 Meetings</p> <p>Dates of 2014 meetings were noted.</p>	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

**Minutes of the Finance & Investment Committee held on
Wednesday 20th November 2013 at 2.30 pm in the St Mary's Board Room,
Eastbourne DGH**

Present Mr Barry Nealon, Non Executive Director (chair)
Ms Stephanie Kennett, Non-Executive Director
Mr Darren Grayson, Chief Executive
Mr Andrew Murphy, Turnaround Director
Dr David Hughes, Medical Director – Clinical Governance
(for item 8 onwards)
Mr Philip Astell, Interim Deputy Director of Finance

In attendance: Warwick Davis, Clinical Service Manager – Pathology (for item 7)
Graham Rayner, General Manager – Clinical Support (for item 7)
Flowie Georgiou, Associate Director – Urgent Care (for item 8)
Mark Inman, Head of Contracting (for item 9)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

1. Welcome and Apologies Action

Mr Nealon welcomed members to the Finance & Investment Committee and reported that apologies had been received from Vanessa Harris, Richard Sunley and James O'Sullivan.

2A(i) Minutes of Meeting of 23 October 2013

The minutes of the meeting of 23 October 2013 were agreed as an accurate record

3. Matters Arising

a) In year Financial Recovery Plan

Mr Grayson confirmed that the in year financial recovery plan had been linked to the turnaround programme.

b) Market Testing

Mr Grayson reported that market testing was progressing in some areas but in line with the other turnaround activities taking place. Mr Horne was aware of the need to ensure that staff were fully informed of progress as appropriate.

Ms Kennett queried how the market testing programme linked to turnaround and Mr Murphy reported that he had met with Mr Horne to discuss the programme and there would be no clash with the

turnaround activities this year as market testing was for the medium and long term. Mr Astell confirmed that Mr Horne was meeting with the staff groups.

4(i) Performance Report – Month 6

Mr Grayson advised that the quality report was in a new format and would be grateful for any comments on whether this format was helpful or not.

He advised that the Trust was still in the green performing category for the National Performance Framework as it had been for virtually the whole of the year. The A&E target had only just been missed due to the Trust being on black for a few days in the month but the position had been recovered in October. The RTT position remained unchanged with the Trust being compliant overall but not delivering in 2/3 of the specialities.

He reported that the Trust had not achieved two of the key cancer metrics. For the 62 day screening service this related to a small number of patients coming late into the pathway. The 62 day urgent referral related to the urology cancer issue and one or two specialities. These were the two areas of greatest volatility and there were plans to address the issues but they would remain volatile for the foreseeable future.

Mr Grayson advised that in response to the recent cancer reporting issues in the media he had requested the Cancer Services Manager to provide an assessment of the robustness of reporting mechanisms. Her report had been reviewed by the Corporate Leadership Team and they remained assured that reporting was taking place appropriately.

He reported that the mixed sex breaches related in the main to a specific issue in the A&E department at Conquest and the solution required physical changes to the environment to be completed and the breaches would then reduce in the future.

Action

The Committee noted the Quality Report for month 6.

4(ii) Finance Update – Month 7 Flash Report

Mr Astell reported that there had been a £2.7 million deficit in the month which was £2.3 million adverse to plan and the deficit was now £19.4 million cumulatively. The organisation therefore had to effectively break even for the remainder of year to meet its original plan.

Mr Astell reported that there had been a £1.5 million adverse on income made up of fines and penalties (unbudgeted) and a shortfall on elective income. As October was the month with the highest

number of working days in the year, the plan had been for higher than average income but the reduction in elective income had contributed to a larger than usual shortfall.

He reported that expenditure was £32 million for the month which was slightly less than average due to improvements on agency but overall the Trust was still struggling to get costs down below that level.

Mr Nealon requested that the high cost drugs be removed from both income and expenditure and shown as a below line issue and Mr Astell agreed to action this.

PA

Mr Nealon queried whether the impact of turnaround measures on staffing was impacting on income and Mr Astell advised that there was more work to be undertaken on reducing costs before there would be an adverse impact.

Mr Murphy commented that he had only started work halfway through October and, whilst work had been started to reduce some ad hocs and agency, it had not been sufficient to impact on the October numbers.

Mr Grayson asked how much of the £8.9 million variance with the plan related to fines, penalties and the impact of the marginal rate. Mr Astell reported that the total for fines and penalties was £3.5 million and the marginal rate was £1.5 million and therefore the Trust would not receive £5 million income. The Trust had budgeted for readmissions of £1.9 million.

Mr Nealon requested that there be an update on the CRES position at the next meeting.

AM

Action:

The Committee noted the month 7 position

5. TDA Cash Application Update

Mr Astell reported that the Trust had previously put in an application for temporary working capital funding of £24 million for this year to date, based on £19.4 million deficit budget and a further £5 million to reduce creditors. This funding would need to be repaid and therefore an application had been put in for Public Dividend Capital funding. The Independent Trust Financing Facility (ITFF) had considered an outline application and had asked the Trust to submit a revised application to cover the £19.4 million deficit, as well as an amount to cover creditors, which would enable the Trust to achieve the BPPC limit and of which £5 million had already been received, the Trust's revised application in this respect is for £15m as well as £1 million for clinical strategy set up costs and £4 million for urgent capital above the Capital Resource Limit.

He advised that a revised application of £39 million in total would be submitted for consideration at the ITFF meeting in January.

Action

The Committee noted the current position.

6. Turnaround Update

Mr Murphy reported that the aim of the turnaround plan was to identify improvements to release £10 million of cash by the year end. The phase 1 focus was on improving the month 1-6 run rate and make changes quickly to release cash. Phase 2 covered comprehensive planning for next year and this phase was about to start with a planning session arranged for the following afternoon.

He reported that his team met with the clinical lead, head of nursing and general manager for each clinical unit (CU) and divisional representatives every two weeks and spending was reviewed on a line by line basis. All decisions arising from the CU meetings were reviewed by a quality impact panel consisting of the Director of Nursing, Medical Directors, the Chief Operating Officer and himself to assess the risks and mitigations. He noted that a number of plans had not been passed by the panel or had been sent back for further work before being approved.

He advised that the focus had been on the clinical areas in the first instance as these areas provided the most opportunities for reduction in spending, eg through tighter controls on discretionary expenditure.

Mr Grayson reported that compliance with decisions and policies was an important issue for the organisation and it was very important that individuals were held to account for any breaches of compliance.

Mr Nealon asked what progress was being made with recruitment to help impact on the agency costs and Mr Murphy reported that nurses were driving recruitment forward with 20 nurses recently recruited, ODPs were looking at internal recruitment and a urology consultant had been appointed.

Mr Murphy reported that some issues were emerging operationally in terms of waiting times and he was awaiting information on prospective outpatients and 18 weeks so that these could be tracked through.

He advised that the tracker would predominantly start in month 8 and based on the first two weeks actual for November he anticipated there would be a reduction of 15/16 WTE in nursing agency and, if this continued at the same rate, there would be no agency usage at all from the beginning of the new year. Mr Grayson noted that the level of nurse agency usage was low when benchmarked with other Trusts.

Mr Nealon asked if the Trust could be subject to criticism of undermanning the wards and Mr Grayson stated that this was not the case as agency was coming down due to vacancies being filled or bank staff filling them. The quality impact assessments provided this assurance. Mr Murphy advised that a daily check on staffing was carried out by a head of nursing working with the cross site management team who reviewed staffing gaps and decided whether staff could be moved, filled with bank or needed to go out to agency.

Mr Murphy highlighted a number of schemes that were taking place included reductions in adhoc, rationalisation in bed numbers, including the closure of Polegate ward, and rationalisation of surgical capacity. Focus was now starting on the corporate and commercial divisions, with a review of the non pay run rate and their structures.

Mr Murphy reported that the two big risks to the programme were managing the cost pressures over winter and 18 weeks.

Action

The Committee noted the update from the Turnaround Director.

Mr Murphy left the meeting.

7. Clinical Laboratory Diagnostic Managed Service Contract

Mr Davis presented an update on progress in procuring the managed service contract for clinical laboratory diagnostics.

He reported that the contract would provide a number of benefits that the Trust would not be able to provide including replacing old and failing pathology equipment; automation of a number of areas; reduction in staffing costs through skill mix review; the opportunity to reclaim VAT on consumables and maintenance; a reduction in overall service costs through service redesign and single siting of departments and the opportunity to retain CCG diagnostic activity. This would enable the Trust to make significant savings and transfer the risk to the contract provider. He outlined the key elements of the Invitation to Tender (ITT) documentation for the contract and the weighting of the criteria.

Mr Davis advised that five potential suppliers had been identified and following the PPQ had reduced to three.

Mr Davis confirmed that the timescale was ITT opening on 2nd December for 70 days, there would then be a 6 week evaluation and the business case would come to the Board for approval in June with final sign-off in August. The resources to support this work were noted.

Mr Nealon asked what the short term risks were and Mr Davis reported that these related to the breakdown of the old equipment but

these could be mitigated.

Mr Grayson requested that Mr Davis advise him if he was encountering any issues around engagement with corporate support as this project was as equally important as the turnaround activities.

Action

The Committee noted the progress report.

Dr Hughes joined the meeting.

8. Community Mobile Working Business Case

Mrs Georgiou presented the business case for a mobile working solution aligned with the new Community and Child Health information system information.

She advised that the preferred option was option 2 and the devices would be purchased over two years through capital - £225,000 in 2013/14 and £273,000 in 2014/15.

She reported that the costs included a mobile device management system which had GPS to locate equipment and, if they were lost or stolen, would locate and remotely wipe the devices of any information.

Mr Grayson queried the protocols for the equipment and Mrs Georgiou stated that they would be same as if they were carrying patient notes.

Ms Kennett reported that she attended the project board and the project had a good momentum behind it and the devices were key to its continuance.

Action

The Committee supported the business case option 2 and recommended it to the Clinical Management Executive for approval.

9. IM&T Update

Mr Astell presented the update from the Head of IM&T and advised that there were no issues to raise with the Committee.

Mr Grayson noted that one of the CQUIN targets was to provide 50% of clinical correspondence electronically to GPs by mid December and there was a risk to achievement of this target.

Action

The Committee noted the update.

10. 2014/15 National Tariff Payment System

Mr Inman presented the proposed 2014/15 National Tariff Payment System and noted that there was very little actual change but for the first time next year would be based on this year's tariff with a built in efficiency requirement of 4%. He noted that the details of the £3.8 billion Integration Transformation Funds were awaited.

He noted that there was more clarity on movement away from tariff and local variations/modifications and Monitor would be the final arbiter if local agreement could not be reached.

He outlined the proposed tariff deflator which would be confirmed in December and was 1.9% gross but 1.6% net after taking account of the CNST cost increase assumption that had been embedded in the tariff. Local price negotiations are to be based on 1.9% reduction. Any variations to the national tariff had to be reported to the centre.

He reported that more explicit guidance was being provided for situations where a Trust received less than 100% of tariff, the main areas for ESHT being 30 day readmissions and marginal elective activity. The guidance states that the provider and commissioner should jointly engage in reinvestment decisions with transparent reinvestment in appropriate demand management and improved discharge schemes.

Mr Inman reported that the 4% efficiency requirement was recognised by Monitor as stretching.

He advised that there may be some minor changes that could affect the Trust but further detail was awaited and these were:

- More granular HRGs for complex laparoscopic work
- Amended best practice tariff for paediatric
- New best practice tariff for hip and knee replacements linking to patient reported outcome measures.

He outlined the key risks including the income deflator, the normalisation of specialist prices, the 30% marginal rate and the movement towards payment by outcomes.

Mr Inman said that there would be road testing in December to assess the financial impact of the tariff for 2014/15.

Action:
The Committee noted the report.

11. Clinical Strategy Update

Mr Grayson reported that there would be a further discussion on the Full Business Case in the private part of the Board Meeting on 27th

November 2013 and then it would go for approval at an additional single item Board Meeting in December. The discussion on timescale was outstanding with the TDA but he anticipated that it would go to their Board in March for approval.

He noted that there had been a discussion on the general surgery move at the Board seminar the previous week and there were still a couple of matters requiring significant assurance.

Action

The Committee noted the update provided.

12. Work Programme

It was agreed that the SLR report on T&O would be deferred to January.

CKYP

Action

The Committee agreed the amendment to the work programme.

13. Date of Next Meeting

Wednesday, 11th December 2013, from 2.30 – 4.30 pm in the Sara Hampson Room, Post Grad, Eastbourne DGH.

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 7th January 2014. A summary of the issues discussed at the meeting is provided below.
- 1.2 The minutes of the meeting held on 12 November 2013 are attached at Appendix 1.

2. Issues discussed at 7th January 2014 Meeting

2.1 Shared Learning in Practice (SLiP)

A presentation was made regarding a serious incident that had occurred and been fully investigated. The Committee listened to the presentation of the case and the findings, along with the lessons learnt. Discussion also took place as to the 'journey' those involved had made and what changes to practice had occurred.

2.2 Assurance Framework and High level risk Register

The assurance framework was received and the detail noted. Discussion took place as to the scoring of risks and this was specific to one of the entries which had a particularity high rating. Further work was requested as to where controls were in place and reported as inadequate.

2.3 Audit from the learning of grade 2 serious incidents

Audit work was presented in relation to a review of Grade 2 serious incidents which showed that learning had taken place in the areas and was being transposed in other areas, however further evidence was sought to ensure that organisational learning was embedded.

2.4 Healthcare Associated Infections (HCAI)

A review of the requirements of the HCAI current issues was provided coupled with the need to ensure deliverability of the improvement issues. The group was assured that the Trust Infection and Control group had taken this matter forward and were overseeing the development and monitoring of the plans.

2.5 Gentomycin Audit Update

Pharmacy presented work on a specific audit that had been completed as a result of an incident reported. This was some considerable time ago and work has been ongoing to ensure that patient safety is maintained and progress made. Significant assurance was provided that the systems in place are robust, however the issues around prescribing remain an area that requires monitoring as staff move around and out of the organisation.

2.6 Quality of Services

This was tested out through a number of reports – safeguarding, Incidents, safety thermometer, morbidity and mortality. Those present noted the development and progress being made, however also noting that in some areas progress does need to be made more rapidly ie HCAI's. The committee will continue to monitor the indicators. Discussion was had over the future of reporting and how best this could be achieved into the coming months.

3 Conclusion

- 3.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meetings held on 7th January 2014 and the minutes of the meeting held on 12 November 2013.

Charles Ellis
Quality and Standards Committee Chairman

15th January 2014

East Sussex Healthcare NHS Trust (ESHT)

Quality and Standards Committee /Patient Safety and Clinical Improvement Group

**Minutes of the Combined
Quality and Standards Committee /Patient Safety and Clinical Improvement Group
Meeting (PSCIG)**

**Tuesday, 12 November 2013
St Mary's Room, Eastbourne District General Hospital**

Present: Mr Charles Ellis, Non-Executive Director, (Joint Chair)
Mrs Alice Webster, Director of Nursing, (Joint Chair)
Mr Darren Brand, Divisional Clinical Governance Manager, Planned Care
Mrs Linda Brown, Assistant Director of Nursing, Urgent Care
Mrs Angela Colosi, Nurse Consultant for Advanced Practice
Mrs Janet Colvert, Ex-Officio Committee Member
Mrs Edel Cousins, Assistant Director Human Resources
Mrs Nicky Creasey, Assurance Manager, Health and Safety
Ms Jenny Crowe, Clinical Services Manager
Mrs Margaret England, Assurance Manager – Patient Safety and Risk
Mrs Liz Fellows, Assistant Director of Nursing, Planned Care
Ms Emma Jones-Davies, Medicines Management and VTE Nurse
Dr Amanda Harrison, Director of Strategic Development and Assurance
Miss Emily Keeble, Head of Assurance
Ms Stephanie Kennett, Non-Executive Director
Ms Brenda Lynes O'Meara, Assistant Director of Nursing
Professional Practice and Standards
Ms Emma Tate, Clinical Outcome Improvement Manager
Miss Abi Turner, Allied Health Professional Lead
Mrs Lynette Wells, Company Secretary
Dr James Wilkinson, Associate Medical Director

In attendance: Mr Jonathan Palmer, Clinical Pharmacy Manager obo Mr Ian Bourns
Mrs Susan Cambell, PA to Director of Nursing (minutes)

1 Welcome and Apologies for Absence

Mr Ellis welcomed everyone to the combined Quality and Standards Committee /Patient Safety Improvement Group meeting and explained this would be piloted in this format until March 2014. It was noted that the Committee was quorate.

Mr Ellis noted that apologies for absence had been received from :

Mr Ian Bourns, Director of Pharmacy

Mr Kevin Burns, Data Quality Manager
Mrs Christine Craven, Deputy Director of Nursing
Dr Peter Greene, Ex-Officio Committee Member
Ms Katharine Horner, Deputy Clinical Governance Manager, Integrated Care
Mrs Paula Hunt, Senior Clinical Nurse, Occupational Health
Ms Tina Lloyd, Assistant Director of Infection Prevention and Control
Dr Janet McGowan, Trust Clinical Governance Lead
Ms Linda Piper, Divisional Clinical Governance Manager
Mrs Anita Smith, Patient Experience Manager
Mrs Moira Tenney, Deputy Director of HR
Ms Anne Watt, Clinical Governance Manager, Integrated Care
Dr Jamal Zaidi, Associate Medical Director

2 Shared Learning in Practice /Patient Story

Due to time constraints it was agreed that this item would be deferred until the next meeting.

3 Minutes of the Last Meetings

Minutes of the Quality and Standards Committee meeting held on 26 September 2013 were considered and agreed as an accurate record except that Ms Stephanie Kennett, Non-Executive Director was not chair of the meeting.

Minutes of the 30 September 2013 PSCIG meeting were considered and agreed as an accurate record except that it was noted that Mrs England did not attend the meeting, but had sent her apologies.

4 Matters Arising

Item 11, Mr Ellis noted that a robust PLACE report had not been received from the Facilities department and Mrs Webster agreed to follow this up.

AW

Item 9, Mr Ellis confirmed that a meeting to discuss Schwartz Centre Rounds® had been arranged for 6 December 2013 by the HR department.

The action log from the PSCIG meeting was updated and would be circulated with the minutes.

5 Interventional Radiology Care Pathway

This item was deferred until the 6 December 2013 combined PSCIG /Essential Compliance Group (ECG) meeting due to staff sickness.

6 Board Assurance Framework (BAF) /High Level Risk Register

Mrs Wells presented the latest version of the BAF, and explained the document outlined the risks against achieving organisational strategic objectives. Mrs Wells confirmed that the document had been presented to the Audit Committee and would be considered at the next Trust Board. Mrs Wells stated that concerns had been raised at the Audit Committee regarding review dates, on the high level register but it was felt this was a Datix administration issue rather than actions not being undertaken.

Mr Ellis highlighted Risk ID 1006, the deterioration of patients and inadequate numbers of medical staff on the hospital at night. Mrs Webster assured the group that this had been significantly debated at CME and that Dr Hughes and Dr Slater, joint Medical Directors, were reviewing and assessing the current situation. ESHT CME minutes, 11 November 2013 refers.

Mr Ellis emphasised the shortage of therapists which had been highlighted on the risk register and Mrs Wells explained that this was a national trend. Miss Turner confirmed that Allied Health Professional teams were flexing staff across all services and working towards recruiting more therapists to minimise clinical impact. This would be monitored to ensure that patient safety was maintained.

Mrs Webster and Mr Ellis agreed to reflect on ensuring that the same quality issues were not repeatedly discussed in different forums.

AW/CE

7 Quality and Exception Reports

7.1 Quality Walks and Assurance Visits

Mrs Wells explained that the report summarised Quality Walks between July and September 2013, and Assurance visits between July and October 2013 which had been undertaken across both Acute and Community sites. She stated that positive feedback had been received and there had been evidence of embedded learning from incidents. Dr Harrison commented that the information pre-dated changes to CQC standards which were now moving towards Keogh style reports.

Miss Keeble commented that issues around clinical supervision had been highlighted at all the Assurance visits. This was predominantly due to understanding of what constitutes clinical supervision.

Mrs Creasey confirmed that the low compliance with the Team Stress Risk assessment had been identified as a gap as part of the Health and Safety audit work and this had been fed back to teams as essential.

Mrs Webster questioned how best practice could be captured and shared across the Trust. Miss Keeble agreed to produce a Shared Learning in Practice (SLiP) and liaise with the Communications department regarding the introduction of a Wiki type web page on the intranet.

EK

7.2 CQC Compliance

Mrs Wells presented the report and commented that whilst the inspection regime had changed, the PCA remained a useful tool around good practice. She highlighted the eight issues of moderate concerns and one of major concern which were also reflected on the risk register. Mr Ellis sought assurance around the Pharmacy staffing capacity and Mr Palmer confirmed that the business case was due to be discussed in the near future. Mr Palmer went on to state that the Pharmacy national CQUIN, giving Pharmacy staff access to GP NHS Summary Care Record, would be helpful in the future.

Mrs Fellows highlighted the difficulties faced by clinicians when health records were frequently not available, particularly for outpatient appointments. Dr Wilkinson stated that clinical correspondence would be available on eSearcher from Quarter 1, 2014 and along with the JOE system mitigating the risk.

7.3 External Visit Report

Mrs Wells presented a detailed report showing that obligations had been fulfilled at Trust inspections. Mrs Webster sought assurance around processes for completion of outstanding actions and suggested that Attachment 2 of the report should be versioned for ease of monitoring actions. Mrs Wells agreed to feed this back.

LW

8 Safeguarding Report for Adults and Children

Ms Lynes O'Meara presented a suite of safeguarding reports that covered both adults and children. She clarified that the Trust were held accountable for child safeguarding via the biennial Section 11, Child Safeguarding Audit. The report assured the Committee that the Trust had seen improvement in four key areas. She commented that CQC and OFSTED were expected to audit the Trust within the next three to six months.

Ms Lynes O'Meara explained that the Trust had recently undergone a Level 4 safeguarding alert at the Conquest site. The alert outcome was found to be inconclusive, but highlighted areas for improvement around discharge and understanding the Deprivation of Liberties Safeguard (DoLS) processes. Ms Lynes O'Meara confirmed that 79% of staff had now undertaken DoLS training and a Discharge Policy Group had been established. Ms Lynes O'Meara confirmed that the Trust worked collaboratively with Adult Social

Care and Social Services. Mrs Webster sought assurance around Child Protection training levels and Ms Lynes O'Meara confirmed that 73% of staff had received level 3 training and that work with Learning and Development to improve this and Level 2 training was underway. Mrs Webster agreed to circulate the Annual Safeguarding Children's report from Local Safeguarding Children Board to the Committee. **AW**

9 **Serious Incidents**

9.1 Patient Safety Incident Report September 2013

Mrs England presented the report and stated that Staffing and Resources had appeared in the top five reported incidents for the first time in this fiscal year. All were negligible or none in terms of severity, 34 related to inadequate levels of care due to staffing and 37 related to a delay or no provision of care. Mrs England confirmed that 36 incidents had been reported by Dietetics. Mrs Webster sought clarity around this and Miss Turner explained that these were due to patients that had not been seen despite being referred, but often due to them being discharged. No patient safety incidents had taken place and a review of the reporting was being undertaken.

Mrs England confirmed that the two highest numbers of incidents related to falls and pressure ulcers and both groups met monthly to monitor these. She stated that she had liaised with Health Records, the third highest number and confirmed the incidents related to inappropriate tracking of notes and that further PAS training for staff had been initiated. Health Records had informed Mrs England that forty-four thousand records were due to be moved and space was an issue. Mrs Webster asked for assurance that this had been highlighted on the risk register.

Dr Harrison requested that future reports inform of specific trends and suggested the information should be translated into patients' bed days and mapped to activity. Mrs England agreed to liaise with Business Intelligence to facilitate this. **ME**

Dr Harrison sought assurance around feed back to staff when incidents did not meet the reporting criteria and Mrs England confirmed that this was discussed amongst the team and feedback was given to individual practitioners.

Dr Harrison raised concerns regarding the calling of a serious incident and that there should be a 'check and balance' around processes, thus ensuring that decision making did not rely on an individual's judgment, but was a considered, consistent and documented process. Dr Harrison also stated that where a known link to a patient death existed, legal team advice should be sought. Mrs England explained the current process and confirmed the audit trail for the decision making. Mrs Webster confirmed that any unclear

incidents were discussed with both herself and the Medical Directors and a meeting was held for Maternity incidents and re-iterated that the Trust only had 48 hours to report incidents. Mrs Creasey clarified the Health and Safety involvement.

Mrs Webster, Mrs England and Mrs Wells agreed to meet with Dr Hughes to consolidate a robust system.

**AW/ ME/
LW/ DH**

9.2 Serious Incidents Report October 2013

Miss Keeble presented a detailed Serious Incidents (SIs) monthly report and confirmed that this had also been presented to CME; she explained that this was a 'snapshot' in time, as information altered daily.

There had been significant progress on improving the quality and timeliness of RCAs. Miss Keeble highlighted the Trust compliance for reporting SIs within 48 hours in line with national guidance and this showed that improvement was required.

Miss Keeble highlighted the new, versus closed number of SIs and clarified that the low closure rate in October 2013 might have related to the move from the Commissioning Support Unit to Brighton and Hove CCG for review. She confirmed that the move would not affect the scrutiny process and the standard of information requested should be maintained.

Dr Harrison suggested that it would be helpful for Board members to see a brief summary of the Root Cause Analysis (RCA) referring to an SI, detailing key lessons learnt. Mrs Webster noted that the SI front sheets could contain this information along with identified key lines of enquiry for the RCA demonstrating that recommendations had been actioned and a robust process had been followed.

9.3 Quarter 2 Serious Incidents Report

Miss Keeble presented the updated Serious Incidents information from Quarter 1 and explained this would lead to a full annual report.

Dr Harrison again asked for the information to be reported by number of bed days to ensure themes and trends were captured.

EK

Miss Keeble explained the somewhat misleading term open, 'overdue' SIs, where these were sitting with the CCG for review. Mrs Webster confirmed she had requested further information from the CCG, but to date none had been received. Dr Harrison suggested that accurate information was collated and forwarded to the CCG, asking them to investigate the discrepancy in open and overdue SIs and Mrs Webster agreed to action this.

AW

Mr Ellis sought assurance regarding dissemination of lessons learnt. Miss

Keeble confirmed that this was feedback to the Prevention of Falls Steering Group as a monthly report, but agreed, as previously noted, a web page on the intranet would ensure wider dissemination.

10 Human Resources (HR) Incident Report

Mrs Cousins presented the HR incident report and confirmed that 85 formal incidents had been recorded in the first six months of this financial year and that it was possible that the previous year's total would be exceeded.

Mrs Cousins explained that the length of time taken to investigate incidents remained an issue and assured the Committee that an increased number of investigators within the Trust would help resolve this.

Mrs Webster updated the Committee regarding a recent tribunal where the type of mediation training undertaken by key witnesses had been crucial to the positive outcome. Mrs Webster reiterated that a consistent, quality approach was needed when using internal mediators. Mrs Cousins stated that external mediation remained the preferred choice to ensure objectivity was maintained.

11 Mandatory Training and Appraisal Compliance Report

Mrs Cousins presented the report and confirmed that compliance levels had improved although there had been a reduction in appraisal compliance with a 30-40% consistent gap noted, mainly across clinical units. Mrs Cousins confirmed that a new appraisal policy would be introduced with effect from April 2014 when automatic increment payments would cease and hard and soft targets would be implemented.

Mr Ellis stressed the importance of compliance with appraisals and how this impacted on the organisation. Mrs Colvert sought assurance around training for staff undertaking appraisals and Mrs Cousins confirmed that group sessions, along with 1:1 training was available for staff.

Mrs Webster raised concerns around mandatory training figures for the Commercial directorate and Mrs Cousins confirmed that various ways of training this large group of staff were being developed.

12 Heath Care Acquired Infection (HCAI) Report July and August 2013

Mrs Webster stated that there continued to be zero hospital attributable cases of MRSA bacteraemia reported. She confirmed that there had been 30 *Clostridium Difficile* infection (CDI) cases to date, against a trajectory of 25. Mrs Webster explained that the Trust Development Authority (TDA) had provided support in meeting the challenge to prevent and control CDI and

would revisit the Trust at the end of November 2013. An action plan had been approved at the Trust Infection Control Group (TICG) and this was also being monitored by CME.

Mr Ellis sought assurance that recommendations in the report had been completed and Dr Wilkinson confirmed that urgent and sustained action had made progress in this area.

Ms Kennett confirmed that the South Coast independent audit, undertaken in July 2013, had suggested limited assurance around measuring compliance with CDI policies and evidence of lessons learnt from outbreaks across the organisation. Ms Kennett stated that an accelerated report had been requested by the Audit Committee.

13 **NHS Safety Thermometer**

Mrs Colosi presented the NHS Safety Thermometer report and confirmed that this related to a spot audit, not total numbers. Mrs Colosi reported that the Trust were successful in receiving a first National CQUIN payment, however October's target had been breached. Mrs Colosi stated that 75% of the pressure ulcers had occurred in patients prior to being treated by the Trust, which had affected CQUIN results. Mrs Colosi confirmed that work around coding continued to ensure a robust process was in place. She stated that raising public awareness of pressure ulcers was a key issue and a Public Health initiative was required, although this was unlikely to occur in the near future. She confirmed that a Prevention of Pressure Ulcers leaflet would be attached to staff pay slips in December 2013 and Prevention of Pressure Ulcer Guidelines had been published via the intranet. Mrs Colosi highlighted the preventative pressure ulcer plan which brought together lessons learnt long with risk assessments in one booklet. Mrs Colosi assured the Committee that internal processes were in place with the CCGs and that grade three and four pressure ulcers no longer needed to be routinely reported to Adult Safeguarding as a safeguarding alert.

14 **Patient Experience Report – 4Cs**

Mrs Webster presented the report which highlighted compliance with the 4Cs. Mrs Webster was pleased to report that 100% compliance for acknowledging complaints within three days had been achieved. Mrs Webster confirmed that the Trust fell just below the national response rate of 18.8% for Friends and Family testing at 17.4 %.

Dr Harrison suggested it would be helpful if a denominator along with the crude numbers was included in the report and she stated some information was not easily readable.

AW

Mr Ellis highlighted the many reports awaiting a Government response including Ann Clwyd's recommendations around NHS complaints procedures.

Dr Harrison reminded the Committee that following new guidelines for the Quality walks, Board members were encouraged to follow through specific complaints if they wished to do so.

15 **Mortality Indicators Update Report**

Ms Tate presented the report that provided an update of both the current and previous financial year's position on Hospital Standard Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) and outlined what information would be printed in the Dr Foster Good Hospital Guide. Ms Tate explained that this year the guide would be site specific and the expected values for Eastbourne were 97.2 and Conquest 104.5 with SHIMI statistics for the same period published at 107.7, which were within the expected range. Ms Tate stated that the Trust would possibly show as an outlier for Death in Low Risk Diagnosis. Dr Harrison reported that the Health and Social Care Information Centre had acknowledged that problems existed and the Trust awaited a response from Dr Foster regarding this.

Ms Tate explained that CHKS was now being used in place of Dr Foster and the Risk Adjusted Mortality Indicator (RAMI) tool would enable a different approach to be used, allowing metrics and indicators to be embedded and measured at Clinical Unit level. Dr Wilkinson explained the advantages of the unrestricted license which allowed individual team consultants being able to interrogate data.

Ms Tate reported the change of focus for the Morbidity and Mortality monthly group meeting which in future would be chaired by the Medical Director. She stated that the group had piloted a mortality database which enabled the electronic capture and review of all deaths within the Trust allowing transparency and key themes highlighted. The in-house database would be fully implemented by February 2014.

Dr Harrison commented that mortality reviews had been well embedded within the Trust but sought assurance regarding the way forward for morbidity reviews. Ms Tate stated that an option was to introduce a global trigger tool where case notes were reviewed on a monthly basis giving a concise understanding of areas of concern within the organisation and allowing harm to be looked at in a systemic and tracked way. Ms Tate confirmed that this would be discussed further at the Morbidity and Mortality group meeting.

16 Improving Quality and Safety /Establishment and Skill Mix Review /Salford Initiative.

Mrs Webster explained that this report identified actions and progress following the recommendations of the recent reviews by Professor Sir Bruce Keogh and Professor Don Berwick and provided the Committee with assurance that nursing staff and establishment reviews were being undertaken in November 2013 using the Hurst model. Mrs Webster stated that as part of the review the Salford initiative would be examined and how the reporting of the number of staff on duty would be taken forward.

Mrs Webster reported that the National Quality Board would be producing their 'how to' guide in mid November but it would be unlikely that staffing levels would be stipulated.

17 CQC Intelligent Monitoring Report

Mrs Wells explained that this monthly report replaced the Quality Risk Profile report and risk rated the Trust against 168 key indicators. Mrs Wells highlighted the risks, and elevated risks which had led to the Trust being categorised as band 2, with band 1 representing the highest risk and band 6 the lowest.

Dr Harrison highlighted that the report compared the Trust to Acute Trusts and is inequitable for Integrated Trusts. She commented that this would be an example of where the separation of the number of bed days between acute and community would provide more meaningful data.

Mrs Wells confirmed that the Trust was not expected to be in the next wave of 19 Acute Trusts due to be inspected.

18 For Information

Quality and Standards and Committee and Patient Safety Clinical Improvement Group noted receipt of the following;

- (i) Minutes of the Consent and Clinical Ethics Committee
- (ii) Minutes of the East Sussex Pain Interest Group
- (iii) Data Quality Update

19 Any Other Business

None recorded.

20. **Date of the Next Meeting**

(i) Patient Safety and Clinical Improvement Group /Essential Compliance Group

Friday, 6 December 2013, 9.30am – 12.30pm, via video conference between Princess Alice Room Eastbourne District General Hospital and Committee Room, Conquest Hospital.

(ii) Quality and Standards Committee /Patient Safety and Clinical Improvement Group

Tuesday, 7 January 2014, 14.30 - 16.30hrs, St Mary's Board Room, Eastbourne District General Hospital

EAST SUSSEX HEALTHCARE NHS TRUST

**Notes of the Trust Board Seminar held on 13th November 2013
at 10.00 am in the Sara Hampson Room, Postgraduate Centre,
Eastbourne DGH**

- Present: Mr Stuart Welling, Chairman
Ms Stephanie Kennett, Non-Executive Director
Mr James O'Sullivan, Non-Executive Director
Mr Darren Grayson, Chief Executive
Ms Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development
& Assurance
Dr David Hughes, Medical Director (Governance)
Dr Andy Slater, Medical Director (Strategy)
Mr Richard Sunley, Deputy Chief Executive/Chief
Operating Officer
Mrs Alice Webster, Director of Nursing
Ms Lynette Wells, Company Secretary
- In Attendance: Mr Philip Astell, Deputy Director of Finance
Mrs Debbie McGreevy, Assistant Director Medical Revalidation
& Clinical Governance (for item 3)
Jane Darling, Deputy Chief Operating Officer (for item 3)
Dr Nick McNeillis, Associate Medical Director – Strategy
Implementation (for item 4)
Ms Sarah Goldsack, Associate Director – Business Intelligence
(for item 4)
Ms Liz Still, Research & Development Manager (for item 5)
Dr Sam Panthakalam, Clinical Lead – Research & Development
(for item 5)
Teresa Baumber – Research Governance Co-ordinator
(for item 5)
Dr Gita Gopal, Consultant Paediatrician (for item 5)
Liz Foster, Paediatrics Research Nurse (for item 5)
Emma Barbon, Stroke Research Nurse (for item 5)
Ms Imelda Donnellan, Clinical Unit Lead – Urology, General,
Vascular and Breast Surgery (item 6)
Ms Dee Daly, Cancer Services Manager (item 6)
Mrs Trish Richardson, Corporate Governance Manager (notes)

ACTION

**1. Apologies for Absence and Notes of the Seminar meeting held
on 9th October 2013**

a) Apologies for absence were received from:

Charles Ellis, Non-Executive Director
Barry Nealon, Non-Executive Director
Vanessa Harris, Director of Finance

Mr Welling welcomed Mr Astell to the meeting deputising for Mrs Harris.

- b) The notes of the seminar meeting held on 9th October 2013 were agreed as a correct record.

2. Update on Current Issues

- a) Strategic and Operational Planning

Mr Grayson updated the Board on discussions held with the TDA over planning for the medium/long term and how this would be carried forward.

He referred to the letter received from David Nicholson, Chief Executive of NHS England, which outlined the joint approach to be taken between commissioners and providers around planning.

- b) Urology Cancer Service

Dr Harrison reported that agreement had been reached between the providers on how the urology cancer service should be run and individual business cases would be written based on common data. Agreement from the commissioners was awaited on the proposed way forward but in the meantime the Trust had a derogation for its current service based on delivering a single site service in the next 12-18 months.

- c) Radiotherapy Service

Mr Sunley reported that the business case for the provision of the radiotherapy service required discussion with the Specialist Commissioning Unit in relation to the finances to support the service.

- d) Meeting with Eastbourne Borough Council

Mr Welling and Mr Grayson reported that they would be meeting with Eastbourne Borough Council that evening to discuss the future of healthcare in Sussex.

- e) Shaping our Future Full Business Case

Mr Sunley and Dr Slater reported that the revised version of the case would be available by the end of the week and it was agreed that it would be presented at the private part of the Board on 27th November.

f) MSK Tender

Dr Harrison updated the Board in discussions held in relation to the MSK Tender and noted that the best way forward for the Trust would be to enter into a sub-contracting contract with a prime provider and she would keep the Board updated with progress.

g) Month 7 Flash Report

Mr Astell reported that the Trust was reporting a £19.4 million deficit at month 7 and in the last five months of the year the organisation would have to break even to deliver the original plan. This was £2.3 million adverse to plan and £1.4 million adverse to the in year recovery plan trajectory. He reported that costs were around the same level as the first 6 months and income was down in the month.

Mr Grayson reported that he had discussed the figures with Mr Murphy and his view was that there would not be a substantial impact in month 1 but he remained confident that the £10 million savings could be achieved by the year end.

3. Medical Revalidation

Dr Hughes outlined the benefits of medical revalidation for patients, doctors and the Trust, and explained the governance process supporting medical revalidation.

He reported that there was 86% compliance with appraisal for consultants and Staff Grade and Associate Doctors were at 74% compliance. Discussion took place on the steps to be taken if doctors did not engage with the process which could result in doctors being referred to the GMC as non-engagers. Mrs McGreevy explained that the expectation going forward would be that all doctors would have their appraisals between April and December each year.

Dr Hughes outlined the challenges which included incomplete employment data, clinical governance information, part-time doctors and continuing professional development (CPD) and IT issues.

Mrs McGreevy reported that the computer system purchased for revalidation for one year was found not to be an intuitive system and an options appraisal was being conducted as to whether to continue with this system or go through a tendering process for another system.

Mrs Webster suggested consideration should be given to linking with nurse revalidation which would be starting in 2015.

Dr Hughes outlined the next steps which would focus on embedding culture around a more robust and improved alignment of job planning.

Mr Grayson congratulated the team on behalf of the Board in the good progress made.

4. Mortality Indicators and Metrics Report

Dr Hughes reported that the Dr Foster Good Hospital Guide was due to be published in late November and the guide would not only publish the overall Trust level HSMR but also the HSMR for each acute site. The overall Trust level would be 99.75 and 104.5 for Conquest and 97.2 for Eastbourne.

Dr McNeillis and Ms Goldsack explained that the Trust was just below average for HSMR and the difference between the two acute sites related to support around coding. The coders at Eastbourne were more experienced and reported on co-morbidities whereas at Conquest the historical practice had been not to list co-morbidities in the notes. A new experienced coding manager had been recruited who would be reviewing the skill mix across the two sites and the coding processes.

Ms Goldsack reported that there was a very good assurance process in relation to the monitoring of the indicators at speciality level. These were reviewed on a regular basis and any issues of concern were reviewed through a case note review conducted by Dr McNeillis and the reviews undertaken had not highlighted any cases of avoidable mortality.

Ms Goldsack advised that the Trust was in discussion with Dr Foster over the issue of SHMI and its impact on integrated sites as previously highlighted.

Dr Hughes commented that working with CHKS would enable the information to be provided more rapidly and on a contemporaneous basis to the clinical units and teams and the principle of the notes based case reviews would become part of the embedded day to day practice of the clinical units and teams.

Ms Goldsack reported that the development of the mortality database would enable the outcomes of M&M reviews to be analysed, identifying any themes, outcomes and share learning.

Dr Harrison acknowledged the huge amount of work undertaken by Dr McNeillis in conducting the detailed reviews and this had put the Trust into a position for these reviews to be undertaken at clinical unit level with the information being provided by CHKS.

She highlighted the proposal that any cardiac arrest should be investigated as a Serious Incident through a RCA and that there was also a LiA event on the deteriorating patient and the focus was moving to events that cause morbidity rather than mortality.

The Board took assurance from the information provided and noted that it was also being reviewed at Quality and Standards Committee.

5. Research and Development (R&D)

Mr Welling welcomed the R&D team to the meeting and Mrs Still outlined the drivers that had led the development of R&D in the NHS.

She noted that patients expected to take part in research and it was one of their rights under the NHS Constitution.

She advised that all research undertaken in the Trust (student to multinational studies) needed to receive approval from R&D following satisfactory governance checks. The governance structure was being revisited in light of the structural changes taking place in the organisation.

She explained that the Trust was funded from the Department of Health through the Comprehensive Local Research Network (CLRN) to local networks to undertake adopted portfolio studies and these were held on a national database. The Department of Health funding was static and all Trusts were being encouraged to increase their commercial work where costs were covered by an industry sponsor.

She outlined the current studies taking place in the Trust and explained that research studies were either observational or interventional and the Trust was keen to increase the number of observational studies it was participating in.

She showed how the Trust benchmarked with other Trusts in the region in terms of recruitment into studies and progress with the workstreams feeding into R&D.

Emma Barbon, Stroke Research Nurse, gave a presentation on current studies taking place in stroke and focused on one study – CLOTs – and demonstrated how the outcomes had changed practice.

Liz Foster, Paediatric Research Nurse, gave a presentation on the current studies taking place in paediatrics and noted that the single siting of the service had presented more research opportunities.

Mr Welling thanked the team for their presentations and noted that the main issue was how to create space, headroom and resources for the Trust to play a bigger role in research.

Mr Grayson acknowledged the good work currently going on and suggested that the team produce a R&D plan for the next 2, 3 and 5 years time for consideration by the Board at the end of the financial year.

SP/LS

6. General Surgery Move – Update and Assurance

Mr Sunley introduced the report which identified the work undertaken to be ready for a planned move date of 14th/15th December.

Miss Donnellan reported that the new Surgical Assessment Unit at the Conquest was on line and the new team was visiting the unit that day. She advised that there was still a shortfall in nursing staff for the SAU but recruitment was on-going, and there were mitigations in place not to open one bay should the unit not be fully staffed at the time of the move.

She advised that in relation to medical staffing on-going meetings with taking place with her consultant colleagues and the junior tiers of staff and arrangements would be finalised in the next few weeks.

Mr Grayson asked for clarification on the possible impact for Brighton and Sussex University Hospitals Trust and Mr Sunley reported that the issue related to how many additional patients would go to Brighton from the west side of the patch. A meeting had taken place with the commissioners the previous day to agree the numbers and they had been shared with Brighton and the ambulance service, although not accepted.

Ms Daly outlined the background to the difficulties in establishing a single site colo-rectal cancer multi-disciplinary team (MDT) meeting and the discussions held with the South East Coast Strategic Clinical Network and the Regional Peer Review Manager.

Miss Donnellan advised that the proposal would be to hold the single site meeting on a Friday afternoon, at which a Maidstone oncologist would be present but Brighton could not provide oncology support at the present time. Brighton had been given notice under the Service Level Agreement that the MDT meeting would be moving to a Friday afternoon and it was anticipated that they would be in a position to support this by April.

Ms Daly advised that the regional team's view was that whilst it was not ideal it was a pragmatic solution until the Trust became compliant in April. The review team would be due to visit the Trust in November of next year.

Mr Grayson asked how the potential risks for patients would be mitigated and Miss Donnellan stated that the interim arrangement for support of the MDT meetings had the support of the ESHT consultants and there would be support from the Maidstone oncology team to provide an opinion. The Brighton oncology team had proposed that there should be a mini-meeting on the following Monday to cross check any of their patients who had been discussed. Miss Donnellan stated that she was satisfied with the interim arrangements and both Dr Hughes and Dr Slater confirmed that they were assured by the arrangements.

Mr Welling asked about nursing and support staff and Miss Donnellan advised that the support therapies had all been spoken to about the workload and the extra dietician support required was already in the business case.

She advised that in terms of nursing staff recruitment was on-going and Mrs Webster stated that there would be a greater risk in terms of nursing staff if the current configuration remained as it would not be possible to cover rotas on both sides and throughput would be better on a single site.

Mr Grayson asked if the move would in any way increase the risk around delivery of safe services and meeting standards at the Conquest and Mr Sunley noted that there would be direct ambulance access to the SAU and this would help with the winter pressures. Both Mr Sunley and Dr Slater were confident that the move would provide a number of efficiency gains including taking the pressure of the front end of the hospital.

Miss Donnellan confirmed that both the main inpatients wards were fully staffed and work was still on-going in terms of theatre utilisation. Dr Slater confirmed that the clinical leads for theatres and ITU were of the view that there was sufficient capacity to cope with the additional emergency and elective work.

Discussion took place on the provision of elective vascular services and Miss Donnellan advised that the long term intention was for Brighton to provide elective vascular services, as it did for emergency vascular, but this had been delayed for a number of reasons. Brighton's view was that they would be planning to take these patients from April at the earliest. The proposal was therefore that the vascular work would be undertaken at EDGH by the vascular surgeons with the complex high risk work being undertaken at the Conquest by the vascular lead.

She was confident that there would be the appropriate level of expertise in theatres and ITU to provide the service at the Conquest. Rehabilitation beds would be provided at Rye and Meadow Lodge and it had always been the intention to provide these beds after the elective vascular service moved to Brighton.

Dr Harrison noted that there were significant risks with the delay in the transfer of the elective vascular service to Brighton but these were not significantly increased as a result of the general surgery move as described.

Mr Astell stated that the current year financial impact if the move took place in mid-December would be £236,000, with a full year effect of £600,000.

Mr Grayson stated that the main unresolved issue was the impact on Brighton issue and it was agreed that Mr Sunley and Dr Harrison would write to the commissioners and Brighton setting out the details on which the numbers were based.

RS/AHA

Mr Welling thanked Miss Donnellan for her hard work and support which was appreciated by the Board.

7. Agenda for Change

It was agreed that the presentation on Agenda for Charge would be circulated following the meeting and the item would be rescheduled for a Board seminar once the two new NEDs had been appointed and were attending meetings.

8. Quality Walks

Dr Harrison reminded members that it had been agreed at the last Board Meeting that they would feed back on their quality walks at the next meeting.

9. Date and Time of Next Meeting

Wednesday 11th December 2013, 10am to 2pm, St Mary's Board Room, EDGH

East Sussex Healthcare NHS Trust

Date of Meeting:	29 th January 2014
Meeting:	Trust Board
Agenda item:	13
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:	
The following meetings were attended in December and January:	
Sussex Chairs meeting	06.12.13
NHS Confederation regional meeting	10.12.13
HOSC Chair & CEO meeting	16.12.13
Sussex Chairs meeting	10.01.14
The following correspondence is attached to the report:	
<ul style="list-style-type: none">• Chairman’s brief• Letters to Stephen Lloyd, MP for Eastbourne	

Proposals and/or Recommendations
The Board is asked to note the activities undertaken by the Chairman since the last Board meeting.

For further information or for any enquiries relating to this report please contact:	
Name: Stuart Welling, Chairman	Contact details: s.welling@nhs.net



Chairman's **brief**

Update of key issues at the Trust

16th January 2014

Happy New Year – Another challenging year ahead

May I wish you all a happy New Year and thank you for your continuing support over the past year. Last year was a challenging one and this year is likely to be no different. However, our priority will continue to be to provide our patients with good quality and safe standards of care.

Overall our performance throughout the last year has been good however our financial performance is our most pressing challenge. You will be aware the Trust board agreed a deficit budget for 2013/14 of £19.4 million to ensure we maintained the quality of services we provide. Delivering this budget requires significant savings and doing this whilst maintaining quality of services, still requires significant savings to be achieved which is a major challenge for everyone in the Trust. We continue to work with the NHS Trust Development Authority and our clinical commissioners to find solutions that ensure we can continue to provide high quality, safe and financially sustainable services to patients in East Sussex.

In 2013 we started to implement our clinical strategy - Shaping our Future. Stroke services were centralised on the Eastbourne DGH site in July. We are now beginning to see the improvements in patient outcomes patient care that come from having one centralised specialist stroke unit. In mid December emergency and high risk surgery services moved to Conquest Hospital, Hastings. Ambulances are now able to take patients requiring emergency surgery directly to the Surgical Assessment Unit (SAU) at Conquest Hospital, bypassing the need to go through A&E. GPs are also able to refer patients directly to the unit. By having all emergency and high risk surgery based on one site, we have been able to ensure our surgeons, anaesthetists and nurses are available to carry out planned procedures and that there is always a dedicated on-call surgeon to assess and treat any patients needing emergency care.

As has been well documented in the local media the Board took the decision to centralise Obstetric care into one unit for safety reasons. It was not a decision taken lightly but our overriding priority has to be the safety of the service. We have seen a considerable improvement in the safety of the service since this change was made. When we made the change it was temporary pending the consideration of the long term options for the service by our commissioners. The local Clinical Commissioning Groups (CCGs) have now started a public consultation on the future provision of maternity and paediatric services in East Sussex later this month and this will determine how we provide these services in the future. There are three models for these services with six possible configurations for delivering them across Eastbourne, Hastings and Crowborough. All the options include one consultant led obstetric unit in East Sussex. Our senior clinicians and I agree with the conclusions reached by the CCGs that it is not possible to deliver safe services and maintain two consultant led obstetric units and that we must consult on options that are clinically safe.

To implement the first phase of the 'Shaping our Future' Clinical Strategy we recently agreed the full business case for a £30 million capital investment. This will see the redevelopment of the Trust's main acute hospitals and is the foundation stone to improving the quality of services in both hospitals. The implementation of our clinical strategy offers us an important opportunity to ensure that we are able to deliver sustainable health care 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. The business case has now been submitted to the Trust Development Authority for their approval. We anticipate a decision from them in the Spring.

Our challenge for this coming year is to continue to build on our successes and work hard to ensure our services are clinically and financially sustainable in the future. Everyone in this Trust is playing their part to deliver effective care that is safe and responds to patient need.

New Endoscopy Unit

The new endoscopy unit at Eastbourne DGH opened its doors to patients in early November. This impressive new extension to the hospital cost £5.7 million which includes a generous £260,000 donation from The Friends of the Eastbourne Hospitals for which we are very grateful. Our patients and the unit's staff have all been very positive about the new unit. It is hard to comprehend the massive difference between this new unit and the area where endoscopy has been operating out of for the past few years. Most importantly it will allow us to deliver a more enhanced patient centred service.

Care Quality Commission

The Care Quality Commission (CQC) recently published a report on Avenue House in Eastbourne. The Trust provides community services from this location and was found to be compliant with the five standards assessed:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Cooperating with other providers
- Safeguarding people who use services from abuse
- Assessing and monitoring the quality of service provision

The CQC also undertook a visit to the Conquest Hospital on 1st November to monitor the use of the Mental Health Act 1983. A report is pending and the Trust will work with the support of Sussex Partnership NHS Foundation Trust to make any improvements needed to ensure compliance with the Act and its Code of Practice. Mental Health Act visits are scheduled to take place every 12-18 months.

Performance

The organisation continues to make good progress on the majority of key performance indicators. Given the continuing challenges that the Trust faces I am proud of what we are achieving. There are some cancer targets where we are underperforming, the reasons for this are well understood and work is underway to improve performance in these areas although it is not all in our own hands. For example, in July the target for two week wait for potential breast cancer was amber due to 12 breaches, all of which were due to patients being on holiday at the time of their appointment. We are looking into which GPs were referring patients who were due to go on holiday and will raise this issue with the Clinical Commissioning Groups.

Successful Nurse Recruitment Campaign

Our 'calling all nurses' recruitment drive has proved a great success. Not only have we been able to boost our registered nurse numbers but we have also been able to increase our healthcare assistant numbers. The successful recruitment drive has seen over 40 new registered nurses appointed to nursing posts across the Trust bringing our nursing workforce to over 2,200. These new nurses will boost our staffing capacity and will help us to minimise the use of temporary staff by filling existing vacancies across all services.

Eastbourne Midwifery Unit

The 200th baby was born in the Eastbourne Midwifery Unit on 14th December. The unit is becoming increasingly popular as more women choose to give birth there. Women who have used our service tell us they have had very positive birthing experiences and this message is starting to spread locally.

New state-of-the-art Interventional Radiology suite

The new state-of-the-art Interventional Radiology suite at the Conquest Hospital is the most progressive in the south east. It cost £1.2million, including a £25,000 contribution from the Friends of Conquest Hospital, and contains the latest cutting edge technology, replacing equipment installed at the hospital 22 years ago.

Interventional Radiology (IR) allows procedures to be performed using imaging, avoiding the need for open surgery. Conditions that can be treated in this way include aortic aneurysms, poor blood supply to the legs, collapses of vertebrae and cancers blocking the liver and gut. As IR is minimally invasive, the majority of procedures are undertaken as day cases, with the patient able to return home within hours of receiving treatment.

The suite at Conquest complements facilities at Eastbourne DGH which opened four years ago and means that a greater range of procedures can now be undertaken using IR. We have six IR Consultants working across the Trust, and we're very proud and excited about the expanded service we can now provide. No other hospital in the south east offers the range of procedures that we now can and the Conquest is also the only hospital where an IR Consultant is available on-call 24 hours a day.

New Sleep Studies Unit

A new Sleep Studies Unit has been opened by representatives of the Friends of the Conquest Hospital following their generous donation of £39,000 for new equipment in the unit.

The Sleep Studies Unit has relocated within the hospital to Cookson Attenborough ward. The new purpose built sleep studies unit is fitted with the latest equipment thanks to the generosity of the Friends who funded the polysomnography equipment. This measures the brain activity during sleep and videos the sleeping patient to allow clinicians to assess the causes of sleeping problems. By providing these in-depth sleep studies locally we are now able to do will save local patients having to travel to London. I would like to thank the Friends for their generosity.

Non-Executive Directors

I am absolutely delighted to announce we have appointed Professor Jon Cohen as a Non-Executive Director and Susan Bernhauser OBE as a Designate Non-Executive Director. It is excellent that we have been able to appoint two such talented individuals with vast clinical experience in the NHS to join the Trust Board.

Many of you will know Professor Jon Cohen who is currently Dean and Professor of Infectious Diseases at Brighton & Sussex Medical School. He has worked in the NHS for over 30 years both as a clinician and latterly in more managerial roles, including being a Non-Executive Director of two very different NHS Trusts in Sussex. Susan Bernhauser OBE, lives in Bexhill, and has spent a large part of her professional career in clinical practice, in both Adult and Learning Disability Nursing and within Higher Education as a teacher and senior academic.

SW/ajp

6th December 2013

Stephen Lloyd MP
100 Seaside Road
Eastbourne
East Sussex

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 01323 417400
Website: www.esht.nhs.uk

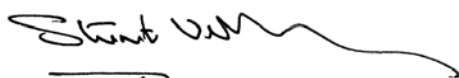
Dear Mr Lloyd

I am writing in response to a number of comments you made in an interview on the BBC Radio Sussex Breakfast Show on 3rd December 2013. Specifically you stated that you “did not know how to get through to senior managers” at the Trust to raise your concerns. I find this surprising as I have on a number of occasions offered you the opportunity to come and meet one to one with myself or with myself and the Chief Executive to discuss your concerns. In addition I have offered you the opportunity to meet with senior clinicians with or without management or Board presence. You have refused all such offers made since the beginning of this year.

A number of the statements you made on the 3rd December were factually inaccurate and you made no attempt to check their accuracy with the Trust in advance of the interview. I believe I have done all I can to provide you with opportunities to discuss the issues and to check with the Trust whether you are in possession of facts rather than opinion or assertion. It is therefore disappointing that you continue to make inaccurate and misleading public statements about the changes in clinical services that we are bringing about. As you are aware local commissioners and the Trust continue to make decisions about the future of services based on clinical safety and quality. We have taken trouble to ensure that these decisions are evidence based and that we put this evidence into the public domain.

Whilst we may disagree on the implications of the changes to services and how the Trust should develop its services so that it delivers safe, effective and sustainable services to the people of East Sussex I am sure you would agree that it is important that we ensure that information we provide to the public is factually accurate. I and the Trust Board are committed to making sure that we consider all the evidence and information available in making our decisions. Therefore if you truly wish to “get through to senior managers” I suggest that you take up my offer of a meeting at the earliest possible opportunity.

Yours sincerely



STUART WELLING
Chairman

SW/ajp

16th December 2013

Eastbourne District General Hospital

Kings Drive
Eastbourne
East Sussex
BN21 2UD

SENT BY EMAIL

Stephen Lloyd MP
100 Seaside Road
Eastbourne
East Sussex

Tel: 01323 417400
Website: www.esht.nhs.uk

Dear

I refer to our telephone conversation on Thursday evening regarding a totally without any basis rumour you had heard and on which you had contacted Dr Martin Writer Chair Eastbourne, Seaford and Hailsham CCG.

As I shared with you if there are any issues associated with the Trust that you would like information or clarification I would ask that you direct those to me or Darren.

I would also urge you again to agree to meet me to have a 1:1 discussion on matters relating to the Trust. Whilst I accept that we have differing views on how services should develop in East Sussex I do believe there is merit in us meeting and your continual refusal to enter into a conversation is counterproductive.

I look forward to hearing from you.

Yours sincerely

STUART WELLING
Chairman

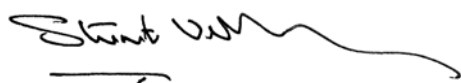
cc Dr Martin Writer, Chair Eastbourne, Hailsham and Seaford CCG
Darren Grayson, Chief Executive, ESHT

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PRIVATE

**A meeting of East Sussex Healthcare NHS Trust Board will be held in private on
Wednesday, 29th January 2014, following the public Trust Board meeting
In the St Mary's Board Room, Eastbourne DGH**

		Lead
1.	Apologies for Absence	Chair
2.	Declarations of Interest	Chair
3.	Minutes of the meeting held on 27 th November 2013 (attached)	Chair
4.	Financial Position 2013/14	DF
5.	Patient Administration System (PAS) Managed Service Business Case	DF
6.	Update on Current Issues	CEO



STUART WELLING
Chairman

23rd January 2014