EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 2nd December 2015, commencing at 10.00 am in the St Mary's Board Room, EDGH

	AGENDA		**Lead:**	**Time:**
1.	a) Chairman's opening remarks b) Apologies for absence c) Project Search Update d) Quality Walks - Sue/Charles		Chair	1000 – 1050
2.	Monthly award winner(s)		Chair	
3.	Declarations of interests		Chair	
4a.	Minutes of the Trust Board Meeting in public held on 30th September 2015	A i	Chair	
4b.	Matters arising	A iii	Chair	
5.	Chief Executive's report (verbal)		CEO	
6.	Board Assurance Framework	B	CSec	

QUALITY, SAFETY AND PERFORMANCE

					Time:
7.	Quality Improvement Plan	Assurance	C	CEO/DN	1050 – 1200
8.	Quality Improvement Director's Report (verbal)	Assurance		QID	
	Questions from members of the public relating to the Quality Improvement Plan above (10 minutes maximum)				
9.	a) Performance report month 7 (October) and Finance report month 7 (October) b) Current Quality Improvement Priorities	Assurance	D	ALL DN	
10.	Safe Nurse Staffing Levels report	Assurance	E	DN	
11.	Patient Experience Report Quarter 2 (July-September 2015)	Assurance	F	DN	
12.	Mortality Report	Assurance		MDG	

13.	End of Life Care (verbal)	Assurance		MDG	
14.	Research and Development report	Assurance	G	MDG	

STRATEGY

					Time:
15.	Annual Business Planning Framework for 2015-16	Approval	H	DSA	1200 - 1220
16.	Health Records Update	Approval	I	Liz Fellows	
17.	Strategic Objectives	Approval	J	CEO	

GOVERNANCE AND ASSURANCE

					Time:
18.	Annual Review of Corporate Documents	Approval	K	CoSec	1220 – 1235
19.	Board sub-committees: a) Finance and Investment Committee b) Quality and Standards Committee	Assurance	L	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
20.	Use of Trust Seal	M	Chair	1235 - 1300
21.	Meeting Dates for 2016	N	Chair	
22.	Questions from members of the public (15 minutes maximum)		Chair	
23.	Date of Next Meeting: Wednesday, 10th February 2015 at 10.00 am in the Cooden Beach Hotel, Cooden Beach		Chair	
24.	**To adopt the following motion:** *That representatives of the press and other members of the public will be excluded from Part 2 of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest* *(Section1(2) Public Bodies (Admission to Meetings) Act 1960)*		Chair	

Sue Bernhauser
Acting Chair

2nd November 2015

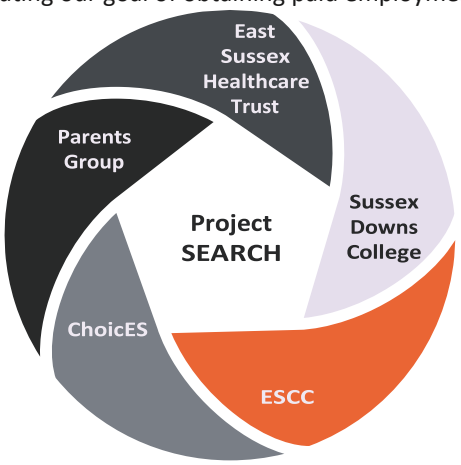
Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
CSec	Company Secretary
DF	Director of Finance
DN	Director of Nursing
DSA	Director of Strategic Development and Assurance
HRD	Director of Human Resources
MDCG	Medical Director (Clinical Governance)
MDS	Medical Director (Strategy)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

What is Project SEARCH?

Project SEARCH is a supported employment initiative for young people with learning difficulties and disabilities. It started in the USA in 1996 and is now being taken forward in Europe and the UK.

Within the UK, Project SEARCH is essentially a joint project between a local authority, a local college or school and a host employer. One of Project SEARCH's most unique attributes is its emphasis on collaboration.

Project SEARCH is driven by partnerships and a network of tutors, job coaches and job developers and business leaders that play an integral role in executing our goal of obtaining paid employment for individuals with disabilities.



What's involved in the programme?

All interns are unpaid members of staff in the host business and so the first part of the programme is spent fully inducting the interns and completing orientation activities.

After induction, the programme runs Monday to Friday, with breaks during academic holidays.

A Typical Day:

10:45 - 12:45 Work
Interns begin initially with 1-2-1 coaching before the Job Coach progresses to observation and skills development support. Utilisation of 'natural supports' from host business staff provides developmental opportunities. Skills are developed over each rotation to reach competitive paid employment working standards and quality benchmarks.

1:30 - 3:30 Work
These hours increase over the year. For the 3rd rotation interns are expected to work the same hours as their colleagues in preparation for full time employment.

After Work
Our interns like to organise social activities after work too!

9:30 - 10:30 Training session
The curriculum is bespoke and aims to support the acquisition of skills and preparation for getting and keeping a job. Interns will gain a Supported Employment qualification.

12:45 - 1:30 Lunch
Either at the project base room, the employer's canteen or integrated within the department routine.

3:45 - 4:30 Back to base room
'Book-ended' support ensures interns can share their individual experiences through peer support sessions, reflect on and evaluate their experiences, work on an individual career plan and apply for work with our Job Developer from ChoicES.

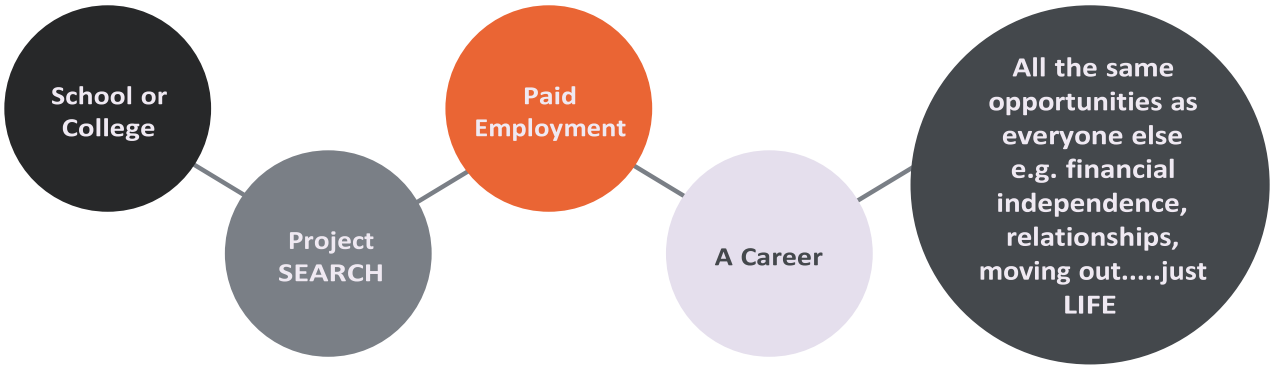
Key info:

- Project SEARCH seeks to work in a collaborative way and immerses the intern within a host employer to enable them to acquire employability and marketable work skills.
- Interns participate in three 10 week rotations to explore a variety of job and career paths.
- The progression goal is into competitive paid employment.
- There is no obligation on the host employer to provide permanent employment.
- Interns can continue to claim DLA/ESA whilst on the programme.

Eligibility Criteria

- Age 18-24
- An Education Healthcare Plan
- Be willing to travel independently

The Project SEARCH Journey



Benefits of Project SEARCH

Benefits to the intern:

- Participate in a variety of internships to explore employment aspirations and interests
- Acquire competitive, transferable and marketable job skills
- Gain increased independence, confidence, and self esteem
- Obtain work based individualised instruction, coaching, support and feedback from job coaches and host business managers and buddy/supervisors
- Develop links to adult support agencies and community networks

Benefits to the host business and potential employers:

- Increased work capacity by carefully selected candidates who are ready for work, who match labour needs and improve performance and retention in some high-turnover or hard-to-fill posts
- Departmental opportunities for staff as mentors/buddies to interns
- On site trained and experienced disability employment specialists who can provide disability awareness training, advice on the Disability Discrimination Act and reasonable adjustments
- Help to develop accessible recruitment practices
- Enhanced business profile through increased local, regional, and national recognition

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The PS Express

October 2015

"Project SEARCH offers young people with a Learning Difficulty or Disability a chance to get paid work" Sam Roberts, 18.

Project SEARCH has a clear goal to give young people the skills to gain competitive paid employment rather than the typical volunteering roles often associated with adults with learning difficulties or disabilities. Last year 11 interns graduated from Project SEARCH in East Sussex with 8 graduates having found sustainable employment to date. This equates to just over 72%, which is in huge contrast the employment rate nationwide of people with a Learning Difficulty or Disability, which stands at just 7%.

Interns talk about their placements so far….

Louis Reynolds

I'm Louis and I'm working in Equipment Library. On a day to day basis I clean lots of different medical machinery. I test if it is working ok and I help my team to fix the equipment. If we can't fix it we take it to EME. I help the team pick up equipment from the wards and deliver it back to the ward once it has been checked and cleaned. I'm getting to know different pieces of equipment all the time, it's hard work but I do enjoy it.

Luke Dowling

I'm Luke and I'm working in the dispatch area of Decontamination. So far I have learnt how to batch sterile items using a dynamo gun, put them into bags and store them in the correct place. I have improved my counting skills and have enjoyed cleaning the store room. I have delivered medical items to theatre with a member of my team. I like working with my team and I'm really enjoying working there.

October 2015, Employment Update . . .

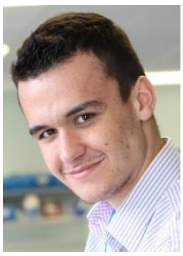
Alex is available for Administrative Bank Work here at the EDGH particularly in HR & Occupational Therapy. She continues to look for full time work.

Roshanne is available for Housekeeping Bank Work here at the EDGH. She also continues to look for full time work within this area.

Gemma is currently looking for employment and is eager to start a new role.

Adam is currently looking for part-time paid work in the retail or warehouse industry. In the meantime he is volunteering for Age UK.

Dan has been offered the full time role of Clinical Orderly here at the EDGH. He is very keen to get started.



Oscar is available for Administrative Bank Work here at the EDGH. He enjoyed his experience in Health Records Library. He continues to look for a full time position.

Toby has been in paid employment here at the hospital since June 2015. He is currently Bank staff as a Post Porter.

Macaulay has been in his full-time position as a HSDU Flowline Technician since June. He is really enjoying working.

Liam is currently seeking full time work in the retail and administration sector. He is however also available for Administrative Bank work particularly in locating and tracking patient records here at the EDGH.

Joe is currently looking for full-time employment. Although to continue to gain & develop skills he is volunteering in the warehouse of St Wilfrids Hospice.

Last but not least …

Andrew Walker had a successful interview for McDonalds where he was offered a 4 week paid trial. Andrew really impressed and has now successfully completed his paid work trial at McDonalds in Uckfield.

Andrew is now working full time and really enjoying it. Andrew has met lots of new people and is enjoying working as part of a team. The experience he gained through Project SEARCH has enabled him to be a valuable, hard-working employee.

We are sure that Andrew will carry on his hard work at McDonalds.

Let's Celebrate Our Success!

KSS Leadership Nomination

Over the past year, Project SEARCH has been a joint partnership between Sussex Downs College, the host employer East Sussex Healthcare NHS Trust, East Sussex County Council and supported employment service ChoicES. This collaboration has seen the project shortlisted for the KSS Leadership Recognition Award for Outstanding Collaborative Leadership, the winner of which will be announced at a ceremony on the 12th of November. Penny, Stacey & intern Macaulay will be attending the event at Sandown Park.

Celebration Event

At the celebration event held at the hospital on the 12th of October, Richard Sunley Acting Chief Executive said: "I am very proud that we are a host employer for this project. I know from our experiences last year that it will help to change the way people think, as it will challenge ideas about what people with a learning disability can do. It will help to raise expectations of employability and the general public will see people with a learning disability hard at work as part of everyday life. I hope the project is as successful here as it is in the States with 80% of the interns achieving full time paid employment."

Adding to Richard Sunley's speech, the new Principal of Sussex Downs College, Mike Hopkins said: "I am very passionate about inclusion and meeting the needs of our local community. Project SEARCH builds on both of these elements by promoting the importance of work and providing a sense of belonging for each young person on the programme. These young people now have the chance to gain confidence, respect and develop their skills whilst working towards gaining more independence, stability and security. All of the interns, both past and present, have clearly made a valuable contribution to each department that they have worked in, many of whom have now gone on to working within the hospital . I'd like to thank everyone for the invaluable commitment which all Project SEARCH partners have made to the programme, particularly during a period of austerity and challenging times."

Penny Morgan, Programme Co-ordinator said: "The aim is for the interns to gain the skills and confidence to progress into employment. Many of our students have the skills an employer is looking for and will prove to be very hard working, punctual, good employees. They just need the opportunity and support to find employers who'll give them the chance to prove they can make a valuable contribution in the work place. We are hoping to find local employers who are recruiting and who would consider following the lead of the Trust. We are immensely proud of our interns, both past and present, and are looking forward to seeing them develop their careers."

Special Features

Caroline Ansell Visit,

Caroline Ansell joined us for our reflection session on Friday 23rd. It was a chance for Caroline to find out more about the Project and meet the interns. Each intern explained what their current placement was and what the job entails. The interns then had a chance to ask Caroline some questions. It was an absolute pleasure to have Caroline here and we hope that she will join us again.

Bang & the bugs are gone..... Intern Andy has designed the latest Infection Control Poster, here's a sneak preview …

Interns at their Halloween themed lunch . . .

We hope that you enjoyed your Halloween as much as we did!

Meet Penny the Programme Co-ordinator. Penny joined the team in September and has a multitude of experience in managing various employability projects. Her role at Project SEARCH includes managing all things operational. Penny also delivers the employability qualification that we offer to all interns. She leads sessions in the morning to develop the interns employability skills, so far the interns have explored their needs and aspirations and workplace behaviour to name a few. Every afternoon Penny leads a reflection session where each intern gets to talk about their day, it is a chance for them to voice any worries or concerns. This also prepares the interns for interviews as they recall what experience they are gaining.

Meet Stacey and Hannah the Project SEARCH Job Coaches. Their role begins with securing placements within the hospital, they will liaise with department managers and staff and complete a job analysis. A job analysis informs them of all the skills and qualities the young person needs to work in that department. They will help departments to identify appropriate tasks and any reasonable adjustments to suit the prospective intern. Stacey and Hannah support the interns in the workplace and help to build those natural supports for interns from their colleagues. Their goal is for the intern to develop core skills that are transferable to any workplace.

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EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday, 30th September 2015 at 10:45 am in the Oak Room, Hastings Centre, Hastings

Present: Mrs Sue Bernhauser, Acting Chair
Mr Mike Stevens, Non-Executive Director
Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Joint Medical Director - Clinical Governance
Ms Maggie Oldham, Improvement Director
Mr Richard Sunley, Acting Chief Executive
Mrs Alice Webster, Director of Nursing

In attendance:

Mrs Pauline Butterworth, Deputy Chief Operating Officer
Ms Monica Green, Director of Human Resources
Ms Jan Humber, Joint Staff Side Chairman
Mrs Lynette Wells, Company Secretary
Ms Tina Lloyd, Assistant Director of Infection Prevention and Control (for item 14a only)
Ms Kim Novis, Equality & Human Rights Lead (for item 14b only)
Mr Peter Palmer, Assistant Company Secretary (minutes)

079/2015 **Welcome and Apologies for Absence**

a) Chair's Opening Remarks

Ms Bernhauser welcomed everyone to the meeting of the Trust Board held in public. She advised that Mr Welling had stepped down as Chairman and formally thanked him for his valued contributed to the Trust.

It was noted that the Trust had received final reports from the Care Quality Commission (CQC) following their March 2015 inspection, and that as a result of these reports the Trust had been placed into special measures. She explained that the Board and the Trust accepted the findings contained within the reports and formally apologised to patients, staff and stakeholders for the Trust's failure to meet the standards expected of them.

b) Apologies for Absence

Mrs Bernhauser reported that apologies for absence had been received from:

Prof. Jon Cohen, Non-Executive Director
Charles Ellis, Non-Executive Director
Barry Nealon, Non-Executive Director
Andy Slater, Joint Medical Director – Strategy
Dr. Amanda Harrison, Director of Strategic Development and Assurance

c) Feedback from Quality Walks

Mrs Webster reported that she had recently undertaken a quality walk around Theatres at the Conquest. She explained that a number of issues had been highlighted to her during her visit, including availability of theatres scrubs and issues around privacy and dignity in recovery. Mrs Webster reported that new theatre scrubs had since been introduced into theatres, with different colours for permanent and temporary staff. She explained that this enabled permanent staff to quickly identify staff who may be new to the department and therefore need help or advice.

She said that during her visit she had joined in with an exercise class in the recovery department. She explained that historically some recovery staff had suffered from injuries whilst stretching to move patients, and that morning exercises had been introduced in order to warm staff up prior to patients arriving in their area. She noted that this had reduced the number of injuries suffered by staff, and had also enhanced team morale.

Mrs Webster reported that a review had been undertaken of patient journeys through the theatre complex, and that as a result new signs had been introduced in order to reduce non-clinical traffic in the department. She said that “clinical fairies” had been nominated amongst staff, who were responsible for ensuring that equipment was well looked after and cleaned.

Mrs Webster explained that there was a specialist child friendly area in recovery, which ensured that children were as comfortable as possible following their operations. She noted that a specific area for recovering patients with dementia was now being planned.

She reported that, despite the huge amount of activity that passed through theatres every day, staff were all extremely positive, welcoming and dedicated to their jobs. She reported that the issues that had been raised about the department within the CQC’s reports had been addressed, and said that the department was a credit to both the excellent staff and management.

The Board noted the report on quality walks.

080/2015 **Monthly Award Winners**

Mrs Bernhauser reported that the Monthly Award Winners for August were the Diabetic Eye Screening Programme (DESP) Team. She explained that they had greatly improved their service over the last 12 months, to the point were other regional and national programmes were approaching the team for advice and support on how to run their services. She said that turning the service around in this fashion was a wonderful achievement by the entire DESP team.

081/2015 **Declarations of Interest**

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

082/2015 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 5th August 2015 were considered and agreed as an accurate account of the discussions held.

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

b) Matters Arising

067/2015 a) ii) – Performance Report - Effectiveness

Dr Hughes reported that work to provide details about the mortality rate for patients admitted at weekends against patient deaths at weekends was on-going. He said that he would report back to the Board when the work was completed.

072/2015 a) – Health & Safety Annual Report 2014/15

Mrs Webster reported that plans to reduce incidences of violence and aggression towards Trust staff had been completed and were being reviewed by the Health and Safety team.

083/2015 **Acting Chief Executive's Report (verbal)**

Mr Sunley explained that he had nothing further to add following his report to the Annual General Meeting.

084/2015 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework (BAF) had been updated with revisions shown in red. She explained that the areas that had been rated red within the BAF were health records, the configuration of the A&E departments on both sites and mandatory training and appraisals. She noted that two new areas had been added to the BAF, concerning young people admitted with mental health requirements, and A&E staffing. She explained that many areas of concern raised by the CQC were already included within the BAF, but this would be reviewed to ensure issues were appropriately captured.

Mr Sunley acknowledged that the administrative review and changes made within the Trust had not been as effective as had been expected and that a further review would be undertaken, in conjunction with staff. He explained that the Trust had recently introduced the iFIT Health records tracking system, which tracked notes electronically and had enabled a move away from the old system of numbering health records. He noted that over 50,000 health records from across the Trust had already been tracked and moved to off-site locations.

Mr Sunley reported that work was being undertaken to improve the quality of existing notes and that the iFIT system would work alongside the upcoming upgrade of the Trust's Patient Administrative System in order to ensure that health records were traceable.

He explained that administrative processes within the Trust were being amended in order to achieve a balance between the centralisation of administrative systems and complying with Standard Operating Procedures. He reported that a contract had been signed for the introduction of a core management booking system for the Trust, which would be introduced before the end of 2015. He explained that this system would help to identify any problems that existed within the Trust's booking procedures, and that he would welcome conversations with staff, members of the public and the Health Oversight Committee about ways in which processes could be further improved.

Mr Sunley reported that plans to improve services within the A&E departments on both sites were on-going, and that he anticipated that these would be brought before the Board for approval before the end of 2015. He noted that any changes would require the Trust to receive additional funding from the TDA.

Mr Stevens asked whether staff training was a mandatory requirement, and Ms Green confirmed that this was the case. She explained that the Trust had provided additional training sessions within departments for staff who may have found it difficult to attend regular training sessions.

Mrs Webster reported that the company who had been working with the Trust to arrange international recruitment of nurses had cancelled

events planned for August and September due to a national problem with issuing visas to overseas nurses. She explained that conversations were taking place with the government in order to try to resolve the problem.

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

QUALITY, SAFETY AND PERFORMANCE

085/2015 **Information Governance (IG) Breach (Data Stick) Recommendations and Actions**

Mr Sunley noted that a number of members of public were attending the meeting in order to discuss the IG breach and that questions would be taken following discussion of the item.

He explained that an unencrypted data stick had been lost by a clinician and recovered by a member of the public on 15th June 2015 and that it contained person identifiable information. He explained that following the incident, the Trust had taken the following actions:

- a comprehensive review of information governance policies
- a reminder was circulated to all staff about their responsibilities
- a review was undertaken of mandatory information governance training
- a review was undertaken of technology safe guards in the Trust
- a disciplinary process for the member of staff responsible for the data breach has commenced.

Mr Sunley unreservedly apologised to anyone who had been affected by the breach, and expressed the hope that the actions taken by the Trust would eliminate the possibility of a recurrence of such a breach in the future.

<u>Questions from members of the public:</u>
Mr Campbell asked if the Trust planned to prevent all downloads of data from their computers in the future, and Mr Sunley confirmed that any downloads could now only occur on to Trust approved, encrypted data sticks. He explained that the original data was downloaded in relation to an clinical audit being undertaken by the clinician and that this was the first time such a breach had occurred within the Trust.

Maria Caulfield, MP for Lewes, said that she did not get any sense of urgency from the Trust about how the issue of downloading data from Trust equipment was being addressed. Mrs Harris apologised if this was the impression given and advised that that it was now not possible

for data to be downloaded to unencrypted memory sticks, but that there had been a slight delay in enforcing this change of policy as there was a need to ensure that essential medical equipment would not be affected by the change.

Ms Walke asked why the data that had been lost had been unencrypted whilst on Trust computers. Mrs Harris replied that downloading patient data from Trust computers was a breach of Trust policy, and that all staff had been, and would continue to be, reminded of their responsibilities in ensuring that patient data remained secure.

Ms Caulfield asked about the percentage of staff who had undertaken mandatory information governance training, and Dr Hughes replied that about 80% of staff had undergone this training.

The Board noted the Action Plan and recommendations following the IG Breach, and agreed to receive an update in February 2016.

086/2015 **Quality Improvement Plan**

Mrs Bernhauser noted that questions would be taken from the public about the Trust's CQC reports and QIP following discussion of this item and the Quality Improvement Director's verbal report.

Mrs Webster explained that the data produced within the Quality Improvement Plan (QIP) being presented to the Board had been collected prior to the Quality Summit with the CQC and subsequent publication of their reports, and had been updated since that time. She noted that a fully updated action plan was available on the Trust's website.

Mrs Webster reported that clinical units were monitoring the action points for their areas and that the entire plan had been widely circulated throughout the Trust. She noted that project management support was being put in place and that a review programme was being developed in order to ensure that improvement was a continuous process.

Mrs Webster explained that the Trust had just held interviews in order to appoint a Speak Up Guardian, who would be dedicated to the concerns of staff and who would act as an independent first point of contact for any staff who wished to raise concerns. She noted that Speak Up Champions, who would enable staff to access a support network if they needed to, had also been identified throughout the Trust.

She highlighted on-going work in other areas which included a review of maternity staffing, a review of health records storage and a review of the privacy and dignity of patients in A&E. She advised that any actions raised within the CQC reports would be included within the QIP and that the Trust was working with CCGs, the TDA and NHS England to monitor

their progress. She explained that the Trust would be happy to work with any other stakeholders who could help in meeting Quality Improvement targets.

Mr Stevens noted that the TDA had provided the Trust with investment in order to resolve the issues that were faced with medical records, and asked if further funding would be made available to help resolve the structural issues found in both A&E departments. Mr Sunley explained that Chris Hodgson, Associate Director of Estates and Facilities, was producing detailed reports on the changes that would need to be made in the A&E departments, and that conversations would take place with the TDA once these reports were completed.

Mrs Harris noted that as the Trust was in special measures, it would receive additional support from the TDA. She explained that the TDA had asked the Trust to provide details of any capital requirements it had identified.

087/2015 **Quality Improvement Director's Report (verbal)**

Ms Oldham thanked the executive colleagues and Trust staff who had made her feel very welcome since shejoined.. She explained that during conversations with staff she had found them to take great pride in their services, and that they had shown real enthusiasm in helping to improve the Trust.

She explained that she had been appointed to the Trust by the TDA and that she would report to them about the Trust's progress. She noted that her reports to the TDA had been very positive so far and that she had been impressed by the Trust's on-going improvement work. She reported that it was clear that the Trust knew where improvements needed to be made, but that they would need some help and guidance in ensuring that this information was effectively communicated to staff, patients and other stakeholders.

Ms Oldham explained that improving the Trust would not be a quick process. She said that the process would give the Trust the opportunity to reflect on how to implement sustainable improvements, whilst engaging with staff and patients and measuring what success would look like. Ms Oldham said that she had been appointed to the Trust in order to provide help and support, and not to dictate how changes should be made.

Questions from members of the public:

Ms Walke asked how long the TDA had been overseeing ESHT for, and whether having a Quality Improvement Director in place would change the Trust's plans for improvement. Ms Oldham noted that the TDA had been responsible for the Trust for some time. She explained that the TDA had offered a greater level of support to the Trust once it had been

placed into special measures and that she was in post to ensure that the TDA would receive swift and accurate feedback from the Trust. She explained that patient and staff satisfaction surveys would be used to measure the Trust's success in making improvements.

Mrs Bernhauser commented that the Board were aware that the biggest challenge that they faced was in engaging with and supporting the Trust's staff. She noted that the CQC's reports had provided renewed impetus to make improvements within the Trust, and that the TDA was supporting the Trust in achieving these improvements.

Ms Walke asked how the Trust planned to address the challenge posed by staff who were unhappy with having moved following the reconfiguration of services. Mrs Bernhauser explained that HR and managers were working with staff to try to minimise the impact that reconfiguration had on them. She noted that the reconfiguration took place in order to develop specialised services and to improve patient safety, and that evidence now available showed that the Trust was delivering improved outcomes in these reconfigured services.

Mr Campbell asked if the Trust had an 'Issues List' which could be used to run on-going staff and patient surveys, rather than having to wait for yearly national survey results to be published. Ms Oldham replied that she thought that this was a good idea, and that work was being undertaken locally. She explained that staff needed to be presented with an overall plan for change rather than being given many small changes to undertake at the same time. She noted that changes within the Trust would need to be undertaken in a controlled and timely fashion.

The Board noted the Quality Improvement Director's verbal report.

088/2015 **Performance Reports**

a) Performance Report – July 2015 (Month 4)

i) Responsiveness

Mrs Butterworth reported that the Trust's score for the responsiveness domain for Month 4 was 3. She advised that the Trust had met its Referral To Treatment (RTT) targets for admitted patients for July, with no patients having waited more than 52 weeks for treatment. She reported that A&E waiting targets had been met in July.

The Board noted that cancer targets for 31 day waiting had been met in July, but that targets for two week waiting and 62 day waiting had been missed. Mrs Butterworth explained that due to a local cancer campaign, referrals to the Trust's services had increased demand for two week waits by 9.5%, and that a new cancer tracking system was being introduced in order to help alleviate the issues being faced.

Mrs Bernhauser asked if the Trust had been successful in raising awareness amongst patients of the need to attend their first appointment following a diagnosis of cancer within two weeks. Mrs Butterworth explained that GPs had been distributing leaflets to patients in order to raise their awareness, but that most two week breaches were still due to patient choice. She said that the Trust needed to improve the initial choices it gave to patients for attending an appointment within two weeks in order to better meet the two week targets.

ii) Effectiveness

Dr Hughes reported that mortality figures within the Trust were now being reported in real time, and that feedback received from the TDA about this change in procedure had been positive.

iii) Safer Caring

Mrs Webster updated that the figure for mixed sex breaches reported to the Board for June 2015 had been incorrect, and that it should have been zero. She explained that the Friends and Family response rate had dropped below the 30% standard due to a change in the way in which information was collected.

iv) Workforce (August 2015)

Ms Green reported that the Trust had seen an increase in workforce expenditure during August due to an increase in the use of temporary staff. She explained that the Trust had increased the hourly rates of pay for bank staff in an effort to reduce the Trust's usage of agency staff.

Ms Green noted that there had been an increase in the recruitment of both nursing and medical staff during July, and that the Trust had enjoyed great success in recruiting HCAs during the month. She reported that the Trust's monthly sickness rate had been below the national position.

The Board noted the Performance Report for July 2015 and the Workforce report for August 2015 and actions in place to support delivery of objectives.

b) Finance Report – August 2015 (Month 5)

Mrs Harris reported that the key features contained within the Finance Report were:

- The in-month position was £500k worse than planned, and the Trust was now £1.8million behind its planned financial position for the year.
- Some of the Trust's escalation beds, which had remained open

throughout the year, had been closed during September. She noted that closing the beds should bring about a reduction in associated staffing costs for the month.
- A high vacancy rate within the Trust had led to increased spend on agency staff.
- The Trust has cash reserves in place to support the expected yearly deficit, which was forecast to be £35.2 million.
- A stretch target for 2015/16 had been filed with the TDA.

Mr Sunley reported that the performance report was currently being reviewed and that when it had been updated it would provide the Board with greater narrative.

The Board noted the Finance Report for August 2015.

c) Safe Nurse & Midwifery Staffing Levels

Mrs Webster reported that there were no areas of concern within the report.

The Board noted the Safe Nurse & Midwifery Staffing Levels report.

STRATEGY

089/2015 **Operational Resilience and Capacity Plan 2015/16**

Mrs Butterworth explained that the Operational Resilience and Capacity Plan reflected the work undertaken by the Systems Resilience Group to manage seamless care and quality during periods of increased pressure that may occur within the Trust. She advised that the report outlined four levels of escalation that the Trust would use depending on the level of operational pressure being experienced.

Ms Oldham asked what the biggest risks were in not being able to deliver the proposed plans. Mrs Butterworth replied that there was a risk that the proposed actions would not have the impact that was expected. She reported that there was a shortage of patient capacity across East Sussex which could lead to an inability to move patients out of the Trust and into the community. She explained that community services and GPs were undertaking projects to try to alleviate these issues. Mrs Butterworth reported that a Quality Impact Assessment had been undertaken on the plan by the Systems Resilience Group, and Mrs Wells noted that this had been considered at the Board Seminar in September 2015.

The Board noted the Operational Resilience and Capacity Plan 2015/16.

090/2015 **Revision to the NHS Constitution**

Mrs Wells explained that the NHS Constitution had recently been updated to reflect fundamental standards of care within the NHS, and a new duty of candour and this was shared with the Board for information

The Board noted the Revision to the NHS Constitution.

091/2015 **Capital Programme Mid-Year Review**

Mrs Harris reported that the Trust's Capital Programme was on target and that a very small over planning margin was built into the Programme. She noted that there was competing priorities within the Trust for Capital Expenditure, making it likely that the Capital Programme would have to be re-prioritised during the course of the year.

The Board noted the Capital Programme Mid-Year Review.

GOVERNANCE AND ASSURANCE

092/2015 **Annual Reports**

a) Infection Control Annual Report 2014/15

Mrs Lloyd noted that the Annual Report included activities undertaken by the Infection Control service and reviewed the service's performance across the entire Trust. She reported that in comparison to the previous year, MRSA infections had increased from 1 to 2, and Clostridium Difficile infections (CDI) had increased from 41 to 49. She explained that during 2014/15, the Department of Health had recognised that not all CDIs that were reported were avoidable.

Mrs Lloyd explained that the Trust had a robust process of investigation in place for any infections that were reported. She noted that of the 49 CDIs reported in 2014/15, 22 were considered as lapses in care that were unlikely to have contributed to the patient developing CDI, whilst 3 were considered as lapses in care that may have contributed to the patient developing CDI. Mrs Lloyd reported that the Trust was working with the head of infection control at the TDA to reduce the number of infections during 2015/16.

Mrs Webster noted that the Trust had carried out a significant amount of work to prepare for potential ebola patients during 2014/15 and that she wanted to thank the infection control team and Dr Barry Phillips for all their hard work. She also noted that Dr Phillips was standing down from his position as Infection Control Lead for the Trust and thanked him for all his hard work and support during his time as lead for the service.

Ms Oldham asked how many cases of MRSA had been reported so far in 2015/16, and Mrs Lloyd replied that 4 cases had been reported and were all subject to full root cause analysis.

The Board approved the Infection Control Annual Report 2014/15.

b) Equality Delivery System Annual Report 2014/15

Mrs Wells reported that the Trust used the 18 Equality Delivery System 2 standards in order to monitor practice in eliminating discrimination and reducing inequalities in care. She noted that there was an error on page 4, item 2.2 of the report which should read 'Developing' and not 'Achieving'. She explained that the Trust did extremely well in meeting some of the standards, but that it needed to improve in other areas.

Mrs Webster enquired about the Trust's ranking in the Stonewall Health Equality Index 2015, and Ms Novis informed her that the Trust was ranked 17th out of 39 healthcare providers. Mrs Webster thanked Ms Novis for her hard work, tenacity and energy in raising the Equality agenda profile across the Trust.

The Board noted the Equality Delivery System Annual Report 2014/15

c) Safeguarding Annual Report for Safeguarding Adults and Children 2014/15

Mrs Webster explained that the Trust was committed to reviewing safeguarding issues on a daily basis to ensure that patients remained safe, and that significant progress had been made during the previous year.

She reported that the Trust was fully compliant with the safeguarding recommendations made following the Savile Enquiry, and that the Trust was a member of both the local children's and adult's safeguarding boards. She noted that the Trust was working to ensure that all staff undertook appropriate safeguarding training.

Mrs Bernhauser said that it was vital that progress continued to be made in training staff, and Mrs Webster reported that Clinical Units had renewed their focus on improving the number of staff undergoing training. She explained that it was important for staff to undergo face-to-face training which would enable best practices, learning and experiences to be shared with colleagues.

The Board noted the Safeguarding Annual Report for Safeguarding Adults and Children 2014/15

d) Fire Safety Annual Report 2014/15

Mr Sunley explained that the Annual Report highlighted the Trust's continued improvement in providing fire safety training to its staff. He reported that the capital investment needed to reduce these risks had been put in place and work was being carried out in conjunction with the Fire and Rescue Service.

The Board noted the Fire Safety Annual Report 2014/15

093/2015 **Board Sub-Committee Reports**

a) Audit Committee Summary 3rd August 2015 and Annual Report 2014/15

Mr Stevens presented the annual report for 2014/15 and commented that he felt that 2015/16 would provide an opportunity for the Trust to improve the processes that were in place around clinical audit. .

The Board noted the minutes and annual report 2014/15.

b) Finance and Investment Committee Minutes 24th June 2015, 29th July 2015, Annual Review of Effectiveness 2014/15 and Updated Terms of Reference

Mrs Harris reported that an Annual Review of Effectiveness of the Finance and Investment Committee had been undertaken which was included within the Board papers. She noted that updated Terms of Reference for the Committee were also included

The Board noted the minutes and the Annual Review of Effectiveness 2014/15. The updated Terms of Reference for the Finance and Investment Committee were formally adopted.

c) Quality and Standards Committee Report

The Board noted the report.

ITEMS FOR INFORMATION

094/2015 **Chairman's Briefing**

The Board noted the Chairman's Briefing.

095/2015 **Questions from Members of the Public**

Quality Improvement Plan

Mr Campbell asked if it was possible to include the names of individuals responsible for each item within the QIP. Mrs Webster replied that these were intentionally omitted from the version circulated to the public, but were included within the internal version of the QIP.

Mr Campbell asked whether it might be possible to hold a meeting in public prior to the next Board meeting to present and discuss QIP progress. Ms Oldham explained that she felt that this was a good idea, but that it would require further consideration. She explained that the Trust wanted to ensure that it was open with staff and the public during its recovery plans.

Liverpool Care Pathway

Mr Campbell noted that the Trust's progress on meeting targets for the Liverpool Care Pathway were not included within the annual reporting, and asked why this was. Dr Hughes replied that the Trust, in line with national guidance, no longer used the Liverpool Care Pathway for End of Life Care. He reported that the Trust was in the process of undertaking a review of End of Life Care in order to provide a better experience for patients.

Speaking Up Guardian

Mr Campbell asked whether by appointing a Speaking Up Guardian, the Trust felt that managers should no longer listen to concerns that were raised by their staff. Ms Green replied that this was absolutely not the case, and managers were still wholly responsible for their staff. She said that the Speaking Up Guardian would provide an additional level of support for staff.

Agenda Timings

Ms Walke asked whether item timings could be put on to the Board agenda. Mrs Bernhauser said that the Board would consider adding timings to the Trust Board agenda.

Ms Walke then asked whether the Speak Up Guardian would be the same as a National Guardian. Ms Green replied that the two types of Guardian were different, and that the Trust would publish details of who the Speak Up Guardian was once they were in post.

Chair

Mr Campbell thanked Mrs Bernhauser for taking the chair for the Board meeting, given the short notice and difficult circumstances.

Mrs Bernhauser thanked Mrs Harris, Dr Harrison, Mr Welling and Prof. Cohen for their commitment to ESHT's Board and for all of their hard work during their time at the Trust.

096/2015 **Date of Next Meeting**

Wednesday 2nd December 2015 at 1000, in the St Mary's Board Room, EDGH.

097/2015 **Closed Session Resolution**

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

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 30.09.15 Trust Board Meeting

- There are no matters arising from the agenda of the Trust Board Meeting on 30th September 2015

East Sussex Healthcare NHS Trust

Date of Meeting:	2 December 2015
Meeting:	Trust Board
Agenda item:	6 Bi
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

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

Introduction:

The Assurance Framework has been reviewed and updated since the last meeting of the Board. The BAF clearly demonstrates whether the gap in control or assurance remains unchanged, has increased or decreased since the last iteration. There are clear actions against identified gaps in control and assurance and these are individually RAG rated. Updates are clearly shown in red text.

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.

Two gaps in control have been removed following agreement at the Trust Board:

- Number of out of date polices as an effective monitoring process is in place. The Audit Committee have requested assurance on this.

- 1.2.3 in respect of incomplete referral to treatment pathways, due to national change to the metric.

There are two areas rated red 1.1.3 (page 1) relating to health records and 1.2.2 (page 5) regarding reconfiguration of the emergency departments. The Quality and Standards reviewed health records at the 2nd November meeting.

Assurance has increased in the following areas:

- 1.2.5 (page 6) clinical laboratory diagnostics analytical equipment as TDA approval has been given to the full business case.
- 1.3.1 (page 9) mandatory training and appraisal
- 3.3.1 (page 17) workforce strategy and planning
- 3.3.2 (page 18) nursing skill mix and establishment review.
- 3.3.2 (page 20) embedding values based recruitment

Benefits:
Identifying the principle strategic risks to the organisation provides assurance that 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.

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

Consideration by other Committees
Quality and Standards 2nd November Audit Committee 4th Novmeber

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

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

Assurance Framework - Key

RAG RATING:

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

Status:

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

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

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

C indicated Gap in control
A indicates Gap in assurance

Board Assurance Framework - October 2015

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.2	A	CQC inspection reports identified a number of quality improvements that are required across the Organisation.	Project Group in place, action plan developed and delivery of actions being monitored. Monthly report to CME on progress. Monitored at Q&S. Oct-15 Mar-15 reports published, trust in special measures. Quality Improvement plan reviewed and revised and submitted to CQC and TDA. Improvement Director working with the Trust. Internal quality summits in progress.	end Mar-16	◄►	DN	Q&S CME

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							
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.3	C	There is a requirement to improve controls in Health Records service; to encompass systems and processes, storage capacity and quality of case note folders.	Implementation of business case commencing to include storage and tracking of health records. Continued issues with record availability being monitored and actions developed. Staff Forums/meetings taking place to manage staff communication and concerns. EDM contract signed and iFIT being introduced to track and monitor records. Oct-15 iFIT starting to embed with some good results but is a rolling improvement programme. Mitigating actions continue and are being extended to provide daily information re availability of notes. New escalation procedure for missing notes. Project to centralise Health Records is underway. Health records management structure under review to enhance supervision.	end Dec-15	◄►	COO	Q&S CME

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

Board Assurance Framework - October 2015

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.2.1	C	Gap in control in delivery of cancer metrics and ability to respond to demand and patient choice.	New monitoring tool developed by information department available to operations team. Trajectories for delivery identified and part of Trust Board performance report. IST review in July to supplement work with KSS Cancer network on pathway management. Aug-15 Monitoring tool trialled but data discrepancies remain; being reviewed with resolution target end of Aug. Poor performance results in June not meeting trajectory revised to 2WW and 31 days by end Sept, 61 days by end Mar. IST working with the Cancer Services team on a 'Scope of Works.' Oct-15 – Continued poor performance of targets in Aug and Sept. Cancer Recovery has now been merged with Trusts 8 high impact cancer priority plan. Focused piece of work taking pace to initially cover the 2ww performance position.	end Mar-16	◄►	COO	CME

Board Assurance Framework - October 2015

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.2.2	C	Further controls required in emergency services as demand is impacting patient assessment-treatment time and subsequent discharge to other specialist/bed areas. CQC report identified privacy and dignity issues.	Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place Capital bid with TDA to support expansion; outcome awaited, planning permission being sought in advance. Aug-15 Capital bid still with TDA	end Jun-15	◄►	COO	CME
1.2.4	A	Assurance is required that there are systems in place to develop and evidence shared learning from infection control incidents	Root Cause Analysis undertaken for all outbreaks and SIs and shared learning through governance structure. Cleaning controls in place and hand hygiene audited. Pevensey Ward separation of Day Unit from inpatients as interim measure until purpose built unit in place. Jun-15 Audit cleaning team strengthened. Infection control team being restructured, to increase management of audit / assurance process. Weekly walks round both sites with facilities and IC to review areas highlighted by the auditors as 'areas of risk'. Further assurance requested by Quality & Standards Committee. Aug-15 NSC Audit Group meeting and reviewing reporting of metrics. NSC audits scrutinised at Accountability Reviews. Oct 15 Reporting to Q&S Nov. Increased numbers of auditors recruited Meeting / Governance structure to be reviewed Nov-15	end Mar-16	◄►	DN	Q&S

Strategic Objective 1: Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority							
Risk 1.2 Continued - We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.							
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.2.5	A	There is insufficient assurance that clinical laboratory diagnostics analytical equipment will be replaced in a timely way following internal approval of the managed service contract.	Agreed to replace via managed services contract. Full Business case agreed by Board but with TDA for approval. Aug-15 Additional information provided to TDA anticipate approval by end Sept-15 Oct-15 TDA approved FBC on the 30th Sept 15, will sign contract with Roach within the next 4 weeks. Estates going out to tender.	end Dec-15	▲	COO	F&I CME
1.2.6	C	Additional controls are needed to reduce the backlog of plain film reporting and delay in reporting non urgent radiological investigations.	Process in place to reduce plain film backlog to Sept 2010; no new patients added to backlog since April 2014. IST supporting the Trust with risk stratification relation to backlog pre 2010 and spot check audit. Oct-15 Plain film continues to be reported, no further adverse outcomes from backlog	end Dec 15	◄►	COO/ MD(G)	CME

Board Assurance Framework - October 2015

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.2.7	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 Action plan in place to reduce waiting list; working in partnership with commissioner to develop service specification and care pathways Apr-15 Recruitment of two additional locum consultants. Jun-15 Waiting list required reduction delivered in May 2015 Aug-15 Backlog confirmed with CCG as now cleared. Now building a PTL for this service so that future activity can be monitored. Oct 15 – First draft of new PTL in place but being sense checked. Plan to have a follow up PTL in place for early Nov. Service spec and business case to be presented at Nov Contract Performance meeting with CCG.	end Nov 15	◄►	COO	CME Q&S
1.2.8	C	Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards with mental health and deliberate self harm diagnoses are assessed and treated appropriately.	Aug-15 Training requested from mental health team at CAMSH for ward nurses to ensure a competent and confident workforce. Mental health nurse requested via TWS to special the young people Reviewing options for cohorting mental health young people. Liaising with SPT and commissioners re purchasing adequate tier 4 beds. Oct-15 Creating amenity beds and liaising with SPT on a case by case basis for CAMHS patients	end Dec-15	◄►	COO	CME Q&S

Risk 1.3 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.	
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of CME involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings Succession Planning
Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. Outcome of monitoring of safety and performance of reconfigured services to identify unintended consequences Personal Development Plans in place

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.3.1	A	Assurance is required that the controls in place in relation to mandatory training and appraisals are effective and evidenced by improved compliance in these two areas.	Mandatory training passport and e-assessments rolled out to support competency based local training. Additional mandatory sessions and bespoke training on request, temporary resource to help develop competency assessments. Training and support for line managers provided. Reduction in compliance flagged early to Clinical Units through performance meetings. Oct 15 – Compliance for mandatory training and appraisal is improving month on month and is a continuing upward trend. Specific actions to be taken over the next few months to support areas include: Tailoring mandatory courses to meet the needs of clinical units/departments. Continued review of mandatory training and appraisal compliance at Clinical Unit Accountability meetings. Facilitated e-learning drop in library sessions, also team sessions and 1:1's. Once revised appraisal paperwork formally approved, will begin a process of awareness raising from Jan-Mar. Also providing additional appraisal training to coincide with the launch of nurse revalidation in April -16.	end Mar-16	▲	HRD	Q&S CME

Strategic Objective 2: Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences							
Risk 2.1 We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.							
Key controls		Develop effective relationships with CCGs and the TDA Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners and stakeholders					
Positive assurances		Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Monthly performance and senior management meetings with CCG and TDA. Working with clinical commissioning exec via Better Together and Challenged Health Economy to identify priorities/strategic aims. Board to Board meetings with stakeholders. Membership of local Health Economy Boards and working groups Participant in clinical senates					
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls and engagement are required to ensure the Trust can model and respond to the potential loss of any services and reconfiguration following tender exercises.	Process in place for operational and financial management of transition to new community provider in HWLH CCG area. Aug-15 Programme management in place and progress monitored through business planning. Oct-15 Continued working with new provider and commissioners to facilitate Nov transfer.	end Oct 15	◄►	COO/DF	F&I CME
			Working with prime provider to facilitate implementation of MSK model of care. Impact on current service configuration being determined. June 15 - Contract with MSK signed, long stop items to be agreed by end Sep 15. Oct-15 Long stop items agreed, ongoing work on developing and improving the model of care.	end Mar-16	◄►	COO	CME

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.2.1	A	There is insufficient assurance that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work on-going. Trust submitted 15/16 plans in line with TDA requirements. Next stage Clinical Strategy development work commences in May 2015 and is expected to conclude by November 2015	end Mar 16	◄►	MD(S)	F&I CME

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.3.1	A	Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience.	Incidents logged, issues escalated to SECAMB /CCG. Service spec reviewed by commissioner; Trust engaging with process. Apr-15 Inpatients - Trust has access to additional vehicles via Elite. Issue remains with outpatients. . Oct-15 Tender for service to be awarded end Oct with April implementaton date. Will work with CCG and new provider to support improvement.	end Apr-16	◄►	COO	CME

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.3.3	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Further controls are required to support delivery of an efficient service and good patient experience.	Review instigated to support implementation of focussed actions. Feb-15 Central team in place and systems being monitored. Considering developing specialist teams to support areas with complex processes. Apr-15 Close liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard. Aug-15 Weekly Dashboard now in place monitored by senior management team. Accountability Reviews for Clinical Admin service being set up. Oct-15 Reviewing processes to minimise short notice clinic cancellation and ensure appropriate clinical assessment of affected patients. New call management system ordered to address technical and resource issues in the appointments centre/provide enhanced service Review of 700+ letter templates underway to improve patient communication. SOPs and specialty booking rules agreed and implemented. Following review of call reminder system significant improvement in DNA rates, more scope within the programme	end Dec-15	◄►	COO	CME Q&S

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, resulting in our services becoming unsustainable.

Key controls	Clinical strategy development informed by commissioning intentions, with involvement of CCGs and stakeholders QIPP delivery managed through Trust governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work Modelling of impact of service changes and consequences Monthly monitoring of income and expenditure Accountability reviews in place
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Written reports to CME on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored. Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.1.1	C	Require evidence to ensure achievement of the 2015/16 Financial Plan and prevent crystallisation of risks as follows: activity levels exceed baseline amount and are not paid for or paid for by CCGs/NHSE at marginal rate only; stranded costs arise from the transfer of the HWLH community contract; contractual fines and penalties are levied; activity, capacity and unplanned cost pressures arise; the CIP plan of £11.4m is not delivered; revenue costs of re-financing.	Contract arrangements incentivise both parties to reduce activity. Activity and delivery of CIPs regularly managed and monitored. Monthly accountability reviews in place and remedial action undertaken where necessary. Timely reporting of finance/activity/workforce performance in place. Regular reviews by BPSG, CLT, CME, Finance & Investment Committee and Board. Aug15- End of Q1 run rate deficit was £0.7m adverse to Plan. There is now a TDA requirement to improve the year end deficit position by £1.8m. Oct 15 – End of Q2 run rate deficit £3.6m adverse to plan. Key drivers behind this deterioration of performance are increased spending on agency costs and CIP slippage. Recovery plan being developed to improve position.	Commenced and on-going review and monitoring to end Mar-16	◄►	DF	F&I

Risk 3.2 In running a significant deficit budget we are unable to invest in delivering and improving quality of care and patient outcomes. This could compromise our ability to invest in our ability to make investment in infrastructure and service improvement.	
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Monitoring by F&I Committee
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.	Essential work prioritised within Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. The Board approved a capital programme at its meeting on 2 June 2015. Delivery of this capital plan will be reported regularly to the Finance & Investment Committee and Board. Oct 15 – At the end of Q2 capital expenditure was £5.5m (marginally behind plan). The planning margin was being maintained, however as the programme is over committed, any new capital schemes will mean a re-prioritisation of the existing projects.	On-going review and monitoring to end Mar-16	◄►	DF	F&I

Strategic Objective 3: Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	
Risk 3.3 We are unable to effectively recruit our workforce and to positively engage with staff at all levels.	
Key controls	Workforce strategy approved Jun-15 - aligns workforce plans with strategic direction and other delivery plans; - ensures a link between workforce planning and quality measures Recruitment and Retention Strategy approved Jun-15 with planned ongoing monitoring Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data (plans to include vacancies) Rolling recruitment programme Monthly vacancy report and weekly recruitment report to CLT Nursing establishment and skill mix review undertaken and monitored by Board TRAC recruitment tool in place
Positive assurances	Training and resources for staff development Workforce planning aligned to strategic development and support Workforce assurance quarterly meetings with CCGs Implementing Values Based Recruitment and supported training programme Success with some 'hard to recruit to' posts Well functioning Temporary Workforce Service. Full participation in HEKSS Education commissioning process.

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.1	C	There is a gap in control because the final workforce strategy has been delayed as a result of market testing and service reconfigurations that have arisen or may arise from tenders. Workforce plan to be aligned with business planning.	Workforce plans submitted to TDA and HEKSS Workforce strategy and appendices approved by Board Jun-15. Feedback requires specific measures of effectiveness (being developed Aug 15 – HEKSS Workforce Summit to review Provider Workforce Plans Sept. Undertaken project to review turnover and retention issues. Oct 15 – Workforce Strategy end of year update will be provided in Dec/Jan. Trust fully engaged with HEKSS workforce planning and input to regional summits and workshops in relation to current staffing pressures, eg shortage areas, new roles etc. Workforce Planning will be discussed with CUs and Departments as part of the 16/17 Business Planning commencing Oct - 15.	end Dec-15	▲	HRD	CME

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.2	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	Nursing Skill mix review now being widened to include original out of scope areas, to be completed by end June 2015. Aug-15 Nurse staffing levels review conducted Apr 2015 finalised and reported to Aug Board. Increased commissions in Foundation Degrees and Advanced Nurse Practitioners to support skill mix and development of new roles. Oct 15 – Nursing establishment half-year review undertaken Oct 15 to go to Board in Jan	end Jan-15	▲	HRD	CME
			International Recruitment Programme for nurses to start Jan-15. European recruitment campaign started Feb-15 4 new recruits to start. Apr 15 – Recruitment agencies appointed to supply 80 Phillipino nurses and international recruitment initiated for middle grade A&E Doctors from India. Oct 15 – Philippines recruitment delayed until Nov due to visa restrictions; candidates not likely to commence in the Trust until Apr-16. European nurse recruitment commenced. Five doctors offered in Sept but only one accepted position; recruitment commenced again in India for middle grades A&E and other specialties. Meetings arranged with CU teams to agree recruitment priorities in the next 6 months. Strategic Workforce Planning to be incorporated into Business Planning process to include the exploration of new roles and skill mix to address shortage in specific staff groups	Apr-16	◄►	HRD	CME

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
			HCA local recruitment initiative commenced Jan with aim to achieve full establishment by June-15. Feb 15 - 23 new staff recruited. Apr-15 – Undertaken 3 generic recruitment events, planning HCA recruitment open day in May, objective to appoint 50 new starters. Jun 15 - 11 x bank HCAs recruited, 17 x substantive HCAs recruited and started, and 53 x substantive HCAs - recruitment process in progress. Further open days planned. Aug 15 HCA vacancies reduced from 76 in March 15 to 57 in June15 . Two further cohorts of HCA have been recruited to substantive and bank posts starting Jul and Sept. Oct 15 – HCA vacancies reduced to 40 at the end of September with 52 appointees in the pipeline. Generic recruitment at CU Level will continue to ensure the vacancy level continues to decrease	end Oct-15	◄►	HRD	CME

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.2	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	TRAC recruitment tool implemented in March 2015. Will be rolled out to recruitment managers as required. Positive feedback received to date. Jun 15 – Management reporting tool now being developed to provide information on recruitment metrics. Oct 15 – TRAC tool fully implemented and management reporting capability developed and now exploring the management and use of this information within the organisation.	complete will be removed	◄►	HRD	CME
			Value based recruitment to be incorporated into the recruitment process for all posts. Feb 15 - Implemented for newly qualified nurses. Apr 15 – Implemented for HCA's and plan being developed to extend to all staff groups as part of the R&R Strategy. Oct-15 Continuing implementation and embedding	end Jan-16	▲	HRD	CME
3.3.3	C	Assurance is required that the Trust has effective controls in place to maintain sufficient staffing levels in A&E; recruitment difficulties in consultant, middle grade and nursing. Deanery short falls in fill rate for junior positions.	Aug-15 Business continuity plans in place to cover short term difficulties. Overseas recruitment taking place. Longer term review of staff model planned.	end Mar-16	◄►	COO	CME

Strategic Objective 3: Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	
Risk 3.4 If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.	
Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and being embedded Staff Engagement Plan developed OD Strategy and Workstreams in place
Positive assurances	Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Embedding organisation values across the organisation - Values & Behaviours Implementation Plan Staff Engagement Action Plan Leadership Conversations National Leadership programmes Surveys conducted - Staff Survey/Staff FFT/GMC Survey Staff events and forums - "Unsung Heroes"

Board Assurance Framework - October 2015

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.4.1	A	The CQC staff survey 2013 provided insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	Involved in national OD cultural change work. Meetings with CU teams to review staff survey. OD Strategy and workstreams approved, workstreams led by Exec and NED, staff invited to participate. Aug-15 Rollout of staff resilience training. Piloting use of 'electronic' staff forum graffiti boards in two areas. In response to Listening Conversations re Bullying and Harassment launching awareness campaign for staff in Sept which will be followed up with training and support for managers and staff. Oct-15. Unsung Hero week took place – very positive feedback. Campaign to encourage as many staff as possible to complete staff survey. Launched “what have you done to make a difference“ postcard for staff to complete during Oct/Nov 2015 as part of ensuring that all staff know that ‘Every Roles Counts.’ Listening conversations continue to take place seeking a bottom up approach Bid for Human Factors funding to help develop safety culture by providing training and on-going support for Speak Out champions and to develop and implement a robust feedback mechanism when staff raise concerns.	end Mar-16	◄►	HRD	Q&S CME

3.4.2	C	Transition in executive team and inability to successfully recruit to Chief Executive and Chairman posts could impact on Board effectiveness.	Aug-15 Chief Executive left July, Director of Strategy and Director of Finance leave the Trust at the end of September. Interim CEO and Director of Finance in place. Portfolio of Director of Strategy being redistributed. Oct-15 Recruitment processed commenced for CEO, Chairman and Chief Executive positions. Portfolios of existing directors and objectives being reviewed.	end Mar-16	◄►	CEO/ Chair	Rem Comm/ Board

Strategic Objective 3: Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.

Risk 3.5: We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.

Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital Approvals Group and Finance and Investment Committee
Positive assurances	Essential work prioritised with Estates, IT and medical equipment plans Capital approvals group meet monthly to review capital requirements and allocate resource accordingly Monitoring by Finance and Investment Committee

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.5.1	C	There is a gap in control as a result of the Trust not having an aligned estates strategy in place.	Estates Strategy being developed. Progress updated presented to Board seminar in April. Substantive Head of Estates in post Aug-15 Presentation on progress to date at Board seminar in Jul-15 on track for submission to December Board.	end Dec-15	◄►	COO	F&I CME
	A	Also refer to 3.2.1					

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.6.1	A	Lack of assurance in respect of capacity and capability to effectively respond to tenders. Specialist skills are required to support Any Qualified Provider and tendering exercises by commissioners.	Business planning team in place and supported by PMO. Ongoing review of processes and evaluation of outcomes to identify learning. Tendering support in place with coaching for those involved in the process. Evaluation and lessons learnt assessment to take place to conclude by end August 2015 Oct-15 Portfolio moved to DF and being reviewed.	end Dec-15	◀▶	DF	CME

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	7C
Subject:	Quality Improvement Plan
Reporting Officer:	Alice Webster Director of Nursing

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

Purpose:

To provide a highlight report of the Quality Improvement Plan developed from the recommendations made by the CQC in their reports published in March and September 2015 following the Chief Inspector of Hospitals visits in September 2014 and March 2015

Introduction:

The Trust was inspected in September 2014 by the Care Quality Commission (CQC) under the new Chief Inspector of Hospitals (CIH) regime. This was part of the planned programme of inspections that the CIH is undertaking to ensure all acute trusts are inspected before the end of March 2016. The Trust was inspected as a whole and therefore included both the acute and community services provided by the Trust in a number of locations.
Further follow up inspections of the Conquest Hospital and Eastbourne District General Hospital also took place in March 2015.

The aim of the inspections was for the CQC to establish if our services were: safe; effective; caring; responsive; and well-led.

An overarching Quality Improvement Plan has been developed which details those recommendations that the CQC identified in their reports as 'Must do's, for the organisation. Other recommendations identified as 'Should do's' are in local action plans relevant to the areas in which the issues were identified.

The latest Quality Improvement Plan and full CQC reports are available at:
http://www.esht.nhs.uk/about-us/cqc-report/

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

See attached highlight report

Benefits:

The report notes that there is progress being made against the actions and by addressing the recommendations services and patient care will be improved.

Risks and Implications
Non-compliance with the action plan may mean the Trust is not providing high quality care and good experience for our patients. If the recommendations are not acted upon the Trust is also at risk of not meeting the Regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and may receive sanctions. Warning notices are in place for failure to fully comply with Regulations 10, 12, 15, 16, 17 and 18. The current pressures on the hospital are having an impact on the management of this large programme of work.

Assurance Provided:
Specific meetings take place weekly chaired by the Director of Nursing and attended by the Executive leads and representation from the Clinical Units to update and monitor the action plan.

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

Review by other Committees/Groups (please state name and date)**:**
Quality and Standards Committee 2.11.15 Clinical Quality Review Group 4.11.15

Proposals and/or Recommendations
The Trust Board are asked to note the report The Trust Board are also asked to review the attached appendix one for comment.

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

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

Quality Improvement Plan
Highlight report

Author: Hilary White Date: 20th November 2015

Project Summary
The purpose of this report is to update on progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visits in September 2014 and March 2015.

The aim of the programme is to ensure the Trust is able to respond to the recommendations made in the reports published in March 2015 and September 2015 and make any improvements required in order to ensure compliance is met with the Regulations (2014) of the Health and Social Care Act 2008.

Project Budget
An amount of £1.5m has been set aside in the 2015/16 Plan to invest in the programme. The Director of Finance is a member of the Project Improvement Working Group and is aware of potential changes/additional costs as they are identified.

Project milestone update
The Quality Improvement Plan has been finalised in agreement with the Trust Development Authority working within the themes identified in the CQC's overarching Trust reports to ensure that all the 'Must do' recommendations are being addressed. The current document is available at http://www.esht.nhs.uk/about-us/cqc-report/ along with copies of the reports.

The clinical units manage other issues that were identified within their core services and included in the CQC reports as 'Should do's'. The clinical units also ensure that they are proactively monitoring progress against achieving full compliance with Regulations 10, 12, 15, 16, 17 and 18.and that all the fundamental standards of care are being fully met.

Progress and planned
Following the publication of the latest report in September the action plan has been refreshed and any further actions identified in the report have been added.
Specific meetings are taking place weekly chaired by the Director of Nursing and attended by the Executive leads and representation from the Clinical Units to update and monitor the action plan.

Current Status
Following a thorough review of the Quality Improvement Plan at 20th November 2015 there were a total of 122 actions identified. Progress against these is broken down as follows:-

Red	Amber	Green	Blue
2(2%)	33 (27%)	4 (3%)	83 (68 %)

Red = Not on track to deliver and action is at risk with no resolution likely, or is overdue (no tolerance applies)
Amber = Actions in place but insufficient evidence to support full assurance of delivery by due date
Green = On track to deliver by due date
Blue = Action is complete and evidence available

Progress last month

- Weekly meetings have commenced to review and update progress against the actions identified in the latest report published in September.
- Executives have continued to visit staff groups to give feedback and have held staff forums where staff can ask questions of the Executive Directors.
- A log of evidence to support the completed actions has been populated.
- Pilot of mock CQC style visits commenced to assess compliance against the CQC Regulations and give assurance of compliance.

Planned next month

- Planned delivery of those actions with a deadline for November and December.
- Continue to oversee work where possible on those actions classed as 'red'.
- Continue to review the evidence available for those items completed to ensure that it is robust and easily accessible.
- Monitor and test the evidence to support compliance against the Warning Notices.
- Executives to continue with staff forums.

Significant risks and issues

Those items that are overdue relate to:

- Completing a review of the organisational culture in relation to perceived bullying allegations.
  A number of actions have been already implemented such as holding listening conversations with staff to gain their ideas and input; trialling a cultural diagnostics barometer in one area; introducing a medical engagement scale for medical staff; implementing a Medical Leaders Development Programme which will commence in December 2015; providing 'Speak Up' supporters to support staff that have identified bullying and harassment as an issue.
- Mandatory training and appraisal rates remain below the Trust target of 90% compliance, (currently in the region of 78%).
  Actions already implemented are as follows: flexible delivery of mandatory training has been put in place including E-assessments being offered to areas where appropriate, facilitated e-learning sessions in the libraries as drop in sessions, also team sessions and 1:1's and this continues to be developed; the appraisal paperwork and process is being reviewed to include revalidation requirements; mandatory courses are being tailored where possible to meet the needs of clinical units/departments and a continued review of mandatory training and appraisal compliance is undertaken at Clinical Unit Accountability meetings.

Failing to fully implement all the actions may result in a breach of the CQC Regulations resulting in imposed sanctions on the Trust.

Planned changes to the board reporting

As discussed previously there are plans to change the reporting templates within the Trust. An example of this is attached in appendix 1. It is anticipated that this will be developed in the coming month however forms part of a highlight report - supporting the full quality improvement plan, which is accessible to all of our staff and the public. The details as described in appendix one are not the totality of actions but are the key highlights in each area.

Recommendations
The Trust Board are asked to note the report.

The Trust Board are also asked to review and comment upon appendix one as a new style of template in development for future.

Appendix One

Regulations: Warning Notices

Regulation 10 – Dignity and Respect

- Single Sex Breaches Reporting template produced and now reviewed daily. Discussed at bed meetings. (WN1)

Regulation 12 – Safe Care and Treatment

- Theatre staff now 'buddied up' when working on ward areas. (WN4)
- VTE Guidance being followed, allow accurate reporting remains a challenge. (WN5)
- Daily review of controlled drugs being undertaken and safety checks in place. (WN6)
- Safe equipment storage and use now part of nurses' daily checks. (WN9 & 10)
- Oxygen cylinder holders now being fitted; to be completed by the end of November 2015. (WN11)
- Additional training and awareness in place for hand hygiene. Trust policy under review. (WN12)
- Daily escalation process in place to minimize unsocial hours bed moves. Template produced. (WN13)
- New patient discharge process in place; monitoring number of patient complaints to track effectiveness. (WN14)

Regulation 16 – Receiving and Acting on Complaints

- New patient complaints handling process in place. Complaint handling team being expanded. (WN16)
- Working with HealthWatch to ensure complaints are handled at local rather than PHSO level. (WN17)

WHAT MATTERS TO YOU MATTERS TO US ALL

Regulations: Warning Notices

Regulation 17 – Good Governance

- A&E Consultant cover remains a challenge. (WN18)
- Incident reporting processes have been reinforced and levels of incident reporting has increased. (WN19)
- Weekly Safety Summits are being held to share learning from incidents. (WN20)
- Monitoring ongoing to ensure no woman suffering pregnancy loss are contacted by midwives and health visitors to make visits. (WN21)

Regulation 18 - Staffing

- Preceptors now allocated to newly qualified staff to ensure adequate levels of support. (WN22)
- Recent international recruitment trips completed. (WN23)
- Two additional Histopathologists recruited. (WN24)

WHAT MATTERS TO YOU MATTERS TO US ALL

Well Led

Key achievements:

- Speak up Guardian starting in December
- 22 speak up supporters appointed
- Medical leadership course starts December
- Engaged in NHS Leadership courses
- Ongoing resilience training for all staff
- Midwives leadership development programme
- Unsung – Bands 1-4 which was well received
- Nurses revalidation programme in place
- Medical revalidation process in place and compliant
- Statutory & Mandatory training has made some improvements
- Internal Quality Summit has been held with planning for next steps
- Weekly staff forums in place led by CEO or one of the Executive Team
- Successful international recruitment – 40 recruited

Key challenges:

- Translation of the Trust values down and across the organisation
- Culture – staff don't feel valued
- Communications:
  - Needs to be two way
  - Use of social media
  - Requires more support
- Development of a more meaningful staff survey e.g. use of an app
- Capacity and speed
- Statutory and mandatory training particularly the correlation between actual training and what is recorded
- Use of agency staff

WHAT MATTERS TO YOU MATTERS TO US ALL

Effective

Key achievements:

- Number of standard operating procedures in place in outpatients
- Monitoring process for KPIs – clinical admin
- Reduced short notice clinic cancellations

Key challenges:

- Outpatients versus clinic versus records
- VTE process is challenging due to electronic recording

Caring

Key achievements:

- Redesigned a labour room

Key challenges:

- Privacy and dignity

WHAT MATTERS TO YOU MATTERS TO US ALL

Responsive

Key achievements:

- Strengthened complaints process
- Evidence of Ombudsman complaints has dropped
- Developed external relationships with:
  - HOSC
  - HealthWatch
  - CCGs
  - MPs
- Public engagement meetings set up for December and January
- Board session on external relationships

Key challenges:

- Health records
- Speed at which the Trust can communicate

Safe

Key achievements:

- Weekly patient safety summit with senior clinicians and nurses
- Increased reporting of incidents
- Review of pharmacist allocation to clinical areas

Key challenges:

- Oxygen cylinders due to be completed end of November due to supplier delay

Reviewing programme management for Improvement Plan

- Prederi have now been appointed and are working alongside the Executive Team and other internal staff
- With use of available Trust PMO staff, they are:
  - Streamlining co-ordination and reporting of individual action plans
  - Identifying any additional resources that may be required to speed up the implementation of the action plan
  - Ensuring there are robust issue & risk management processes in place
- Together we are identifying ways to improve communication about the improvement plan and progress updates for multiple audiences:
  - TDA
  - Trust Board
  - External Stakeholders e.g. HOSC
  - Staff
  - Patients and public
- Together we are ensuring sufficient level of scrutiny and challenge to actions, reporting and evidence

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	9a
Subject:	Integrated Performance Report – October 2015
Reporting Officers:	Finance Director

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

Purpose:

The attached document(s) provide information on the Trust's performance for the month of October 2015.

Introduction:

The purpose of this paper is to inform the Finance & Investment Committee of organisational compliance against national and local key performance metrics.

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

This is the first report in the revised format. The dashboard accompanying the report gives a greater level of detail than previous reports. Improvements in the data production has meant this is now a more timely reflection of the performance within the Trust.

- RTT incompletes continue to meet the target of 92%
- A&E performance remains challenged and under the target.
- Cancer targets remain challenged
- CDiff rate for October has improved compared to September and August
- The percentage of harm free care has increased on the previous 4 months.

Financial performance in month 7 was a run rate deficit of £5.6m which was £1.4m adverse to plan. This has increased the year to date deficit to £25.8m, which is £5m greater than plan. The impact on the forecast outturn of this deterioration in performance is currently being assessed, alongside any potential mitigation in actions that will recover the position. Any mitigation would ensure that patient safety and quality are not compromised through a Quality Impact Assessment review.

This report will develop over the coming months with more detailed commentary and monitoring of performance in areas such as CQUINs and Clinical Administration.

Benefits:

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

Risks and Implications

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

Assurance Provided:
This report includes all indicators contained within the Trust Development Authority's Accountability Framework for 2015/16 along with additional key, quality and performance information. The information contained within this report has been extracted from the Trust Data Warehouse in line with guidance supplied by the TDA.

Review by other Committees/Groups (please state name and date)**:**
CLT 24th November 2015 Finance and Investment 25th November 2015 Trust Board 2nd December 2015

Proposals and/or Recommendations
To review the report in full and note Trust Performance.

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

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Sarah Goldsack - Associate Director of Knowledge Management	sarah.goldsack@nhs.net
Garry East - Assistant Direct of Delivery & Performance	garryeast@nhs.net

Integrated Performance Report

M07 – October 2015

Presented by:

East Sussex Healthcare NHS
NHS Trust

Performance – October 2015

Key Issues

- Cancer performance
- Diagnostic Performance
- Mixed Sex Accommodation Breaches
- Infection Control
- Mandatory Training

Key Risks

- Failure to deliver national and local targets and trajectories for improvement
- Stranded costs post HWLH transfer
- Financial position

* Please refer to the Trust Integrated Performance Dashboard (IPD) to view the full set of monitoring indicators.

Action: The board is asked to note and accept this report.

Patient safety: Legal actions from unintentional harm to patients would normally be covered by negligence, an area of English tort (civil) law, providing the remedy of compensation. Case law is extensive. Criminal action could be pursued if investigation judged intentional harm and remedies will vary according to severity.

Staff safety: The Health and Safety at Work Act etc 1974 may apply in respect of employee health and safety or non-clinical risk to patients (usually reported under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995).

The Care Quality Commission (CQC) regulates patient safety and quality of care and the CQC register and therefore license care services under the Health and Social Care Act 2009 and associated regulations. The health and safety executive regulates compliance with health and safety law. A raft of other regulators deals with safety of medicines, medical devices and other aspects.

Patient Safety – October 2015

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Never events - incidence rate	0	0	0	0	0	0	0	0	0	NA	0	0	NA	
Serious Incidents rate (per 1000 beddays)	TBC	2.70	3.07	3.18	3.25	3.31	3.32	2.72	2.29	18.8%	3.07	1.59	93.1%	
Medication errors causing serious harm - incidence rate	0	0	0	0	0	0	0	0	0	NA	1	0	NA	
% of Patient safety incidents that are harmful	TBC	0.80%	0.34%	0.44%	0.11%	0.52%	0.11%	0.42%	0.14%	195.3%	0.39%	0.29%	33.0%	
Clostridium Difficile - Variance from plan	3.7	2	3	5	2	7	6	3	7	-4	28	29	-1	
MRSA bactaraemias rate	0	1	1	0	0	2	0	0	0	NA	4	0	NA	
VTE Risk Assessment	95%	96.6%	95.8%	96.9%	97.4%	96.4%	96.0%	96.0%	98.7%	-2.7%	96.5%	98.3%	-1.9%	
Number of Grade 3 or 4 Pressure Ulcers	TBC	1	5	1	2	2	1	2	3	-33.3%	14	20	-30.0%	
Percentage of Harm Free Care	92%	93.7%	94.6%	93.3%	93.3%	93.0%	93.3%	94.0%	95.0%	-1.0%	93.6%	94.7%	-1.2%	
Falls per Thousand bed days (All categories)	TBC	7.99	6.88	6.57	6.37	6.05	6.34	6.94	7.13	-2.7%	6.75	7.61	-11.4%	
Crude Mortality Rate (non-elective ordinary discharges)		150	146	131	134	133	120	133	136	-2.7%	7	8	-11.4%	

Patient Safety

- The percentage of safety incidents that are harmful has increased. These are being reviewed for accuracy, investigation and learning.
- CDIFF has reduced against the previous two months
- VTE is maintaining the standard, audits into the compliance process have been scheduled.
- Falls (as shown on the accompanying dashboard) have marginally increased although the number with" major or catastrophic consequences" has remained at zero.

Clinical Effectiveness – October 2015

Indicator Description	Target	Previous Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Summary Hospital Mortality Indicator (HSCIC)	TBC													
HSMR (CHKS)	108	112	104	135					97					
SHMI (CHKS)	TBC	119	99						107					
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	TBC	7.75%	7.28%	7.51%	7.68%	7.09%	6.93%	3.86%	#N/A	NA			NA	
% Spending 90% time on Stroke Ward	90.00%	97.7%	94.8%	90.9%	91.3%	86.0%	84.4%	83.3%	87.5%	-4.8%	91.2%	91.8%	-0.7%	
Stroke:% to Stroke Unit <4hrs	99.00%	83.3%	85.7%	81.1%	68.9%	88.1%	83.3%	66.7%	67.3%	-1.0%	81.4%	76.7%	6.1%	
Stroke: % scanned <1hr of arrival	90.00%	72.1%	72.4%	76.4%	78.3%	88.4%	78.1%	66.7%	69.6%	-4.3%	77.0%	74.1%	3.9%	
Stroke: % scanned <12hr of arrival	95.00%	100.0%	96.6%	94.5%	97.8%	100.0%	100.0%	100.0%	94.6%	5.7%	97.9%	97.9%	0.0%	

- HSMR and SHMI figures remain higher than the benchmark figures.
- Stoke data is not fully validated until the end of each quarter. An up to date SNAPP report is available on the Trust website.

Access and Responsiveness – October 2015

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
A&E Monthly Performance (4Hr Wait) - All Types (Reported)	95%	88.9%	92.4%	97.2%	95.6%	92.1%	93.3%	91.2%	93.4%	-2.3%	93.0%	94.87%	-2.0%	
A&E Monthly Performance (4Hr Wait)-Type 1 Only	95%	85.3%	89.9%	96.3%	94.1%	89.7%	91.4%	88.6%	91.4%	-2.9%	90.8%	93.10%	-2.5%	
Emergency A&E >12hr to Admission	0	1	0	0	0	0	0	0	0	0	1	1	0	

- The Trust has failed to meet the 4 hour standard over the last three months. The key contributing factors to this are:
  - 80% Middle Grade vacancy rate across the sites resulting in temporary workforce useage, with mixed ability to maintain the standard
  - Reduced flow into wards
  - Out of Hours GP coverage is variable with particular issues at the Eastbourne site.

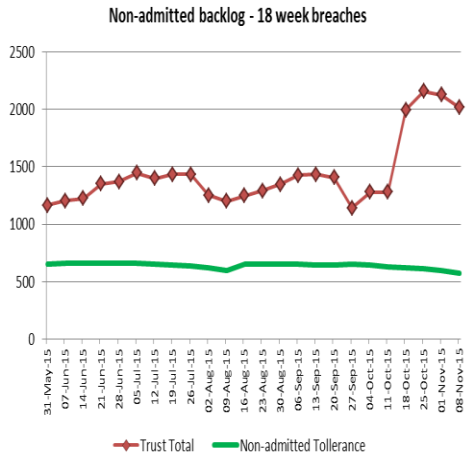
- Actions being taken to improve the position are:
  - During periods of low levels of discharges throughout the hospitals, 2 hourly consultant leadership board rounds take place along with challenge ward rounds in order to create flow.
  - Working with the CCGs and Local Authority to implement a “discharge to assess” model using 30 nursing home beds which are additional to previous resources.
  - Working to secure long term locums for both A&E sites.
  - Recruiting Pathway Facilitators (2 per site) in order to assist flow out of the department.
  - Working with the System Resilience Group to improve out of hours primary care.

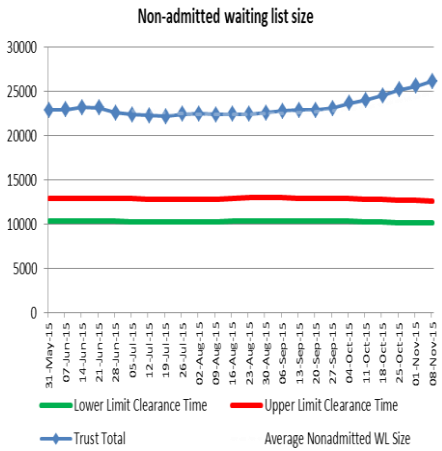
- A&E performance graphs can be found on page 13 of this report.

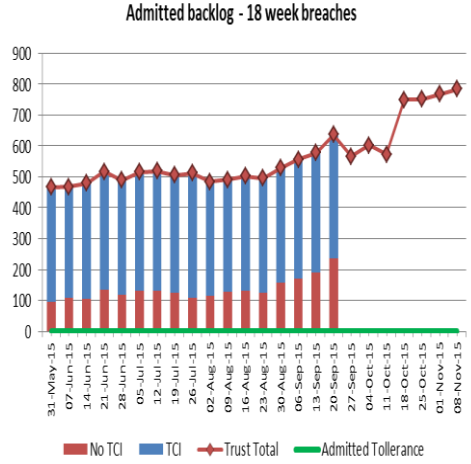
Access and Responsiveness – October 2015

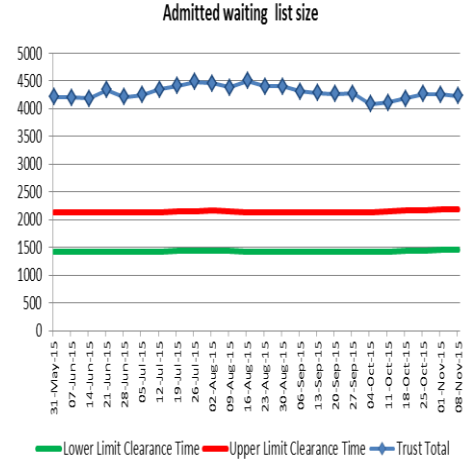
Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Referral to Treatment Incomplete	92%	94.3%	94.8%	93.81%	94.05%	93.53%	93.4%	92.7%	92.98%	-0.3%	93.8%	92.72%	1.2%	
Backlog (18+)	1200	1488	1371	1600	1571	1611	1719	2009	1734	15.9%	2009	1516	32.5%	
Referral to Treatment Incomplete 52+ Week Waiters	0	0	0	0	0	0	0	0	2	NA	3	23	-87.0%	

- Incomplete position for October 92.7% against a target of 92%.
- August 2015 shows a drop in performance which was the result of the separation of the MSK partnership activity (and was expected).
- Octobers drop in performance to below 93% is predominantly due to two key areas:
  - The PAS upgrade in October resulted in a large number of pathways requiring closing as a result of staff requiring additional training in new processes. The trust is now working through a validation exercise to bring this back in line.
  - A large number of TCIs were cancelled over previous weeks, this has impacted on the waiting list and backlog size.









Access and Responsiveness – October 2015

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Two Week Wait Standard	93.0%	90.6%	93.6%	93.1%	91.8%	85.9%	87.6%	91.3%	92.45%	-1.2%	90.4%	90.71%	-0.3%	
Breast Symptom Two Week Wait Standard	93.00%	94.9%	96.1%	91.2%	84.1%	75.8%	81.3%	89.1%	91.18%	-2.0%	87.8%	87.47%	0.3%	
31 Day Standard	96.0%	97.8%	98.2%	95.1%	95.0%	96.9%	98.9%	100.0%	90.42%	9.6%	96.9%	97.09%	-0.2%	
62 Day Standard	85.0%	82.0%	69.3%	70.5%	75.3%	73.9%	74.5%	75.4%	78.17%	-2.8%	74.5%	79.35%	-6.2%	
62 Day Screening Standard	90.0%	86.7%	87.5%	81.8%	84.6%	87.5%	80.0%	77.8%	87.50%	-9.7%	84.3%	81.71%	3.2%	
104 Day Waits	0	8.5	7.5	11.5	16.0	9.0	7.5							

- The position remains challenged for 2WW and 62 day pathways.
- The trust has developed an electronic Cancer PTL which is in the final stages of review and validation.
- The Cancer recovery plan has been developed to include the Cancer 8 high impact priorities plan. This is reviewed on a monthly basis with key stakeholders within the Trust and the CCG.
- All services are currently reviewing their 2WW capacity, reviewing slot allocation to provide patients with greater choice in the 14 day period.
- A revised implementation process has been implemented to ensure that no patient can be booked as a breach without the escalation to the Assistant Director for Delivery & Performance.
- Working closely with IMAS to implement best practice including a series of internal Cancer summits.

Access and Responsiveness – October 2015

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Diagnostic waiting times	1.0%	1.9%	2.4%	2.6%	0.9%	0.9%	2.2%	1.9%	0.28%	1.7%	1.8%	27.98%	-93.5%	
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	0	0	0	0	0	NA	0	0	NA	
Proportion of patients not treated within 28 days of last	0	4.35%	6.67%	0.00%	8.33%	2.94%	0.00%							
Delayed Transfers of Care	3.50%	5.50%	7.60%	7.38%	6.67%	7.37%	5.35%	7.76%	4.63%		6.80%	4.81%		

- The trust failed to meet the Diagnostic standard in October.
- Radiology equipment failures during October resulted in cancellations which were unable to be rebooked within the timeframe.
- The Trust continues to work closely with the Intensive Support Team in developing an action plan, assess processes and building a Capacity & Demand model.
- Booking processes and validation in Radiology have been improved and, despite Endoscopy challenges, we would expect to achieve the standard in November.

Patient Experience – October 2015

Indicator Description	Target	Pevious Months						Current Month			YTD				Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Mth	Var	
Written Complaints - Rate	TBC	2.46	1.99	1.85	2.79	3.39	3.11	2.80	NA	NA					
Number of compliments received	TBC														
Number of formal complaints raised	TBC	60.0	48.0	43.0	68.0	79.0	71.0	69.0		NA					
Number of new complaints responded to (within mandatory or agreed timescales)	TBC	59.0	50.0	43.0	62.0	75.0	64.0	57.0		NA					
Percentage of new complaints respond to (within mandatory or agreed timescales)	TBC	98.00%	89.00%	98.00%	91.00%	95.00%	94.00%	84.00%		NA					

- Complaints have dropped marginally in October although the pressure from previous months has seen a dip in performance against target for the response rate indicators
- Additional staff are being recruited to the team with the aim of improving liaison and coordination with the Clinical Units, improving investigations and reducing the number of overdue complaints
- A quality assurance process for complaints has been introduced to improve responses

Patient Experience – October 2015

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Staff Friends and Family Test % recommended care	TBC			64.5%			66.3%			NA	65.4%	65.7%	-0.6%	
Inpatient Scores from Friends and Family Test % positive	96.00%	96.6%	98.1%	97.5%	97.3%	97.8%	97.5%	97.4%	95.3%	2.2%	97.5%	95.9%	1.7%	
A&E Scores from Friends and Family Test % positive	88.00%	88.1%	87.8%	91.9%	88.2%	90.8%	92.6%	89.3%	89.3%	0.0%	89.8%	88.6%	1.3%	
Maternity Scores from Friends and Family Test % positive	96.00%	94.8%	93.5%	93.7%	95.7%	96.0%	93.3%	95.1%	94.4%	0.7%	94.6%	93.3%	1.4%	
Inpatients response rate from Friends and Family Test	45.00%	45.5%	47.2%	50.0%	9.7%	15.4%	15.3%	15.5%	47.9%	-67.7%	18.5%	47.1%	-60.6%	
A&E response rate from Friends and Family Test	25.00%	15.0%	15.0%	16.9%	9.3%	7.1%	8.9%	7.9%	25.1%	-68.5%	10.9%	27.7%	-60.6%	
Mixed Sex Accommodation Breaches	0	0	18	0	0	0	14	23	4	475.0%	82	31	164.5%	

- Inpatient and A&E scores for the Friends and Family Test remain above the target although there has been some variation over the last few months.
- Maternity is marginally under the target
- The inpatient response rate has dropped following the inclusion of day cases and paediatrics data into the calculations.
- A&E FFT response rate remains low – consideration should be given to reviewing the current process.
- Mixed Sex Accommodation breaches increased further in October. The trust experienced high levels of activity and as a result escalation areas were open to assist with bed pressures. One ward was closed for refurbishment during this period.

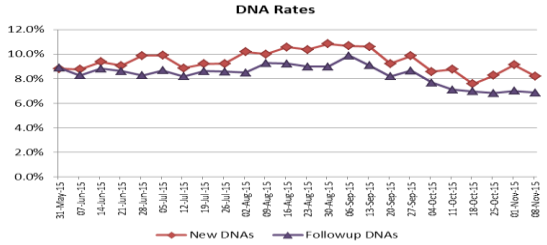
Workforce – October 2015

Indicator Description	Target	Pevious Months						Current Month			YTD				Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Mth	Var	
Trust turnover rate	10%	13.0%	12.9%	12.1%	12.3%	12.2%	11.8%	12.2%	13.3%	-1.1%	12.4%	13.1%	-8.1%	-0.7%	
Trust level total sickness rate	3%	4.7%	4.3%	4.3%	4.2%	4.3%	4.4%	4.5%	5.5%	-1.0%	4.4%	4.6%	-17.9%	-0.2%	
Total Trust vacancy rate	10%	8.8%	8.8%	8.6%	9.2%	7.8%	8.9%		5.7%	#N/A	8.7%	3.7%	NA	5.0%	
Temporary costs and overtime as % of total paybill	10%	13.4%	25.5%	13.5%	14.8%	16.1%	15.7%	16.1%	9.7%	6.4%	16.4%	9.3%	65.5%	7.1%	
Percentage of staff with annual appraisal	85%	75.2%	74.9%	74.5%	75.0%	73.6%	77.6%	77.9%	68.3%	9.6%	75.5%	65.5%	14.0%	10.1%	

- Actual workforce usage of staff in August was 6281.08 full time equivalents (ftes), 40.64 above budget.
- Temporary staff expenditure was £3,476K in October (16.10% of total pay expenditure). This comprises £1,183 bank expenditure, £2,246 agency expenditure and £47K overtime
- There were 514.02 fte vacancies (a vacancy factor of 8.45%)
- Monthly sickness was 4.51%, an increase of 0.15% from September. Annual sickness was 4.77%, a reduction of 0.09%
- Annual turnover was 12.24% which represents 641.96 fte leavers in the last year
- Mandatory training rates have are slightly down this month, with the exception of Information Governance, Health & Safety and Safeguarding Vulnerable Adults
- Appraisal compliance increased by 0.33% to 77.93%

Activity/Effectiveness – October 2015

Indicator Description	Target	Pevious Months						Current Month			YTD				Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Mth	Var	
Primary Referrals	TBC (LYr)	8,769	8,442	9,471	9,715	8,020	8,868	9,111	9,956	-8.5%	62,396	62,334	-8.5%	0.1%	
Cons to Cons Referrals	TBC (LYr)	1,661	1,442	1,600	1,760	1,396	1,420	1,525	1,712	-10.9%	10,804	10,918	-10.9%	-1.0%	
First OP Activity	TBC (LYr)	9,840	9,348	11,469	11,252	9,581	10,500	9,972	10,520	-5.2%	71,962	71,233	-5.2%	1.0%	
Subsequent OP Activity	TBC (LYr)	22,765	20,611	24,611	24,066	21,710	23,809	23,724	24,171	-1.8%	161,296	158,714	-1.8%	1.6%	
New:FU Ratio	TBC (LYr)	2.31	2.20	2.15	2.14	2.27	2.27	2.38	2.30	3.5%	2.24	2.23	3.5%	0.6%	
Elective IP Activity	TBC (LYr)	591	677	799	773	710	711	701	874	-19.8%	4,962	5,548	-19.8%	-10.6%	
Elective DC Activity	TBC (LYr)	3,667	3,567	4,024	4,118	3,684	3,754	3,710	3,721	-0.3%	26,524	25,356	-0.3%	4.6%	
Non-Elective Activity	TBC (LYr)	4,012	3,972	4,068	4,260	3,738	3,834	3,861	4,166	-7.3%	27,745	28,251	-7.3%	-1.8%	
A&E Attendances	TBC (LYr)	8,709	9,048	8,890	9,659	9,251	8,685	8,846	8,638	2.4%	63,088	62,185	2.4%	1.5%	
Average LOS Elective	TBC (LYr)	3.1	3.0	2.9	2.8	3.0	3.1	3.1	2.6	17.8%	3.0	2.8	17.8%	5.7%	
Average LOS Non-Elective	TBC (LYr)	5.7	5.4	5.1	5.5	5.1	5.7	5.5	5.3	4.9%	5.5	5.2	4.9%	5.1%	



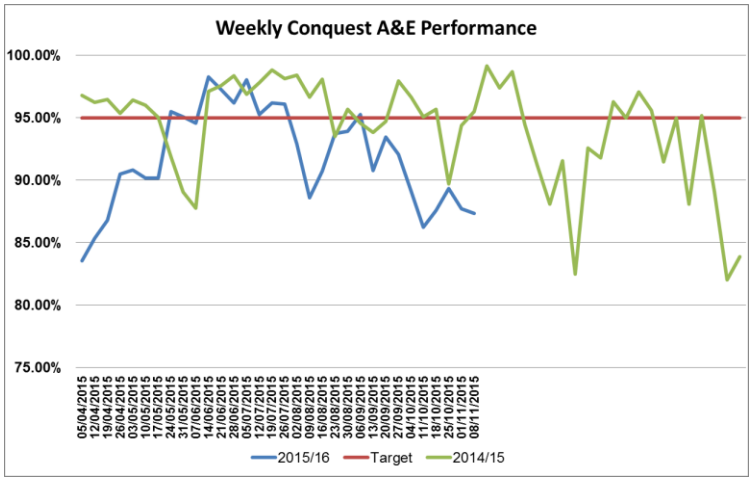
- As of 1st October the Clinical Admin service introduced an upgraded call reminder system (MainTel) which has shown instant improvements to the Trusts DNA rates.
- As part of our new Information Suite we have been able to develop clinic utilisation tools. This allows both clinicians and bookers with a live summary of available slots and clinic utilisation percentages. A similar tool has been developed for Theatre utilisation.
- Weekly monitoring of clinics cancellations <6 weeks is also part of this monitoring system.
- New PTL tool also monitors bookings against future capacity, week by week.

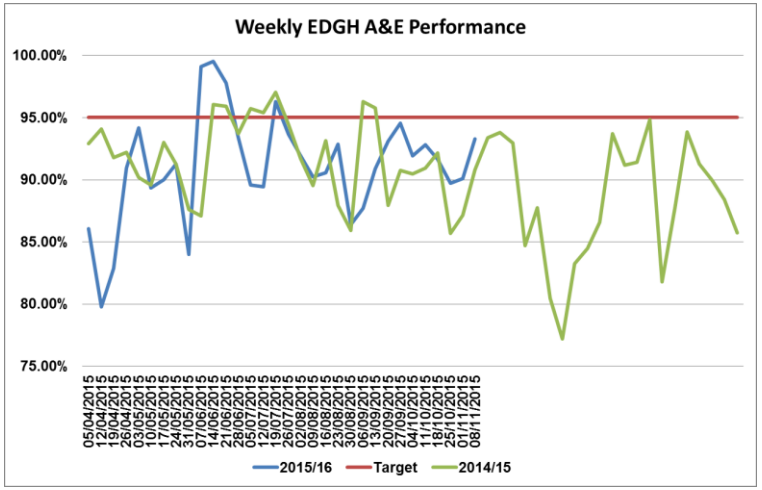
Community – October 2015

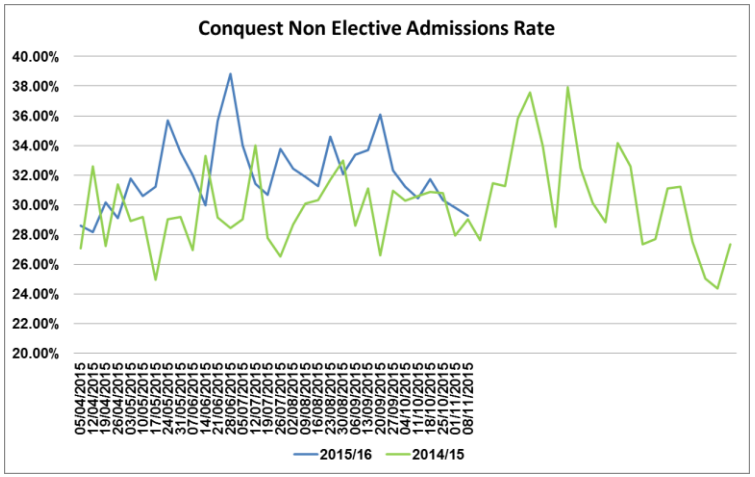
Indicator Description	Target	Pevious Months						Current Month			YTD				Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Mth	Var	
Community Nursing Referrals	85.00%	2,219	2,246	2,667	2,951	2,980	3,484	3,382	1,906	77.4%	19,929	10,397	77.4%	91.7%	
Community Nursing Total Contacts	TBC (LYr)	34,115	32,847	34,182	37,064	34,452	33,902	33,474	30,706	9.0%	240,036	117,167	9.0%	104.9%	
Community Nursing Face to Face Contacts	TBC (LYr)	20,157	19,536	20,093	21,660	19,739	18,925	18,822	20,864	-9.8%	138,932	73,314	-9.8%	89.5%	
% Patient Facing Time	TBC (LYr)	59.09%	59.5%	58.8%	58.4%	57.3%	55.8%	56.2%	67.95%	-17.2%	57.9%	62.57%	-17.2%	-7.5%	
Community Nursing ALOS	TBC (LYr)	61.72	42.6	35.3	44.1	52.9	38.3	44.7	48.52	-7.9%	44.7	33.99	-7.9%	31.4%	

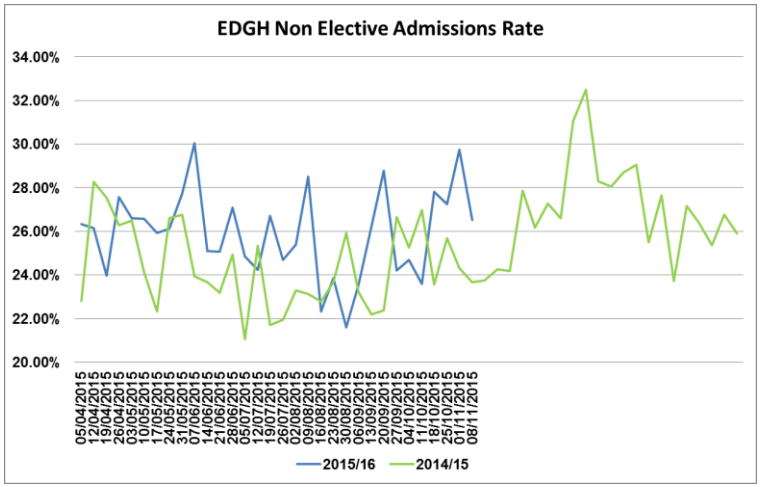
- Referrals into Community Nursing increasing exponentially since the beginning of the year. Whilst the service is responding to all rapid response referrals within 2 hours, the increased demand on the service is beginning to impact on the ability to meet routine referral targets.
- Total Community Nursing contacts are down for the second consecutive month. The YTD variance is showing a falsely high figure. Due to the introduction of SystemOne part way through 2014/15, activity data is only included from 1st August 2014.
- Patient facing time appears to have reduced over the previous two months. This is being investigated as it is thought the patient facing proportion shown is falsely low. This may be due to a change in process within certain teams. Findings will be reported next month.
- Community Inpatient length of stay (LOS) is reducing over the previous 12 months but has increased since month 6. Community LOS can be particularly erratic. This is caused by the frequent discharge of a small number of patients who have high LOS outside the normal range.

Appendix 1: A&E Performance Graphics

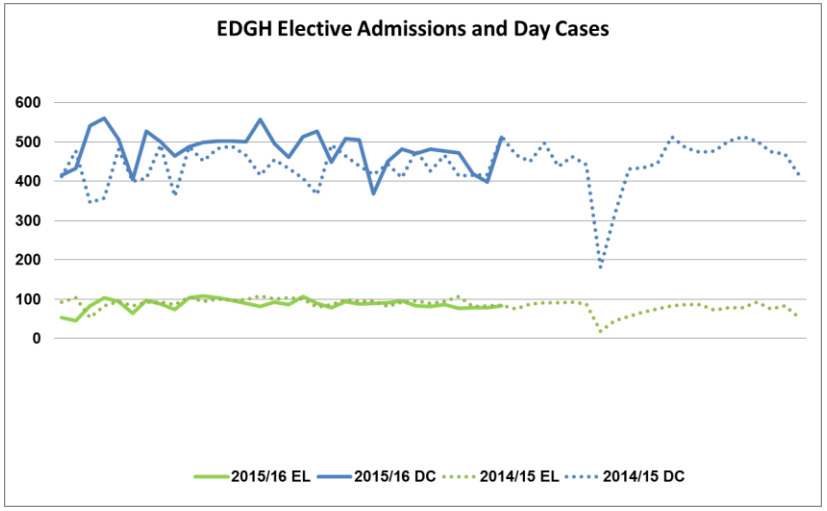


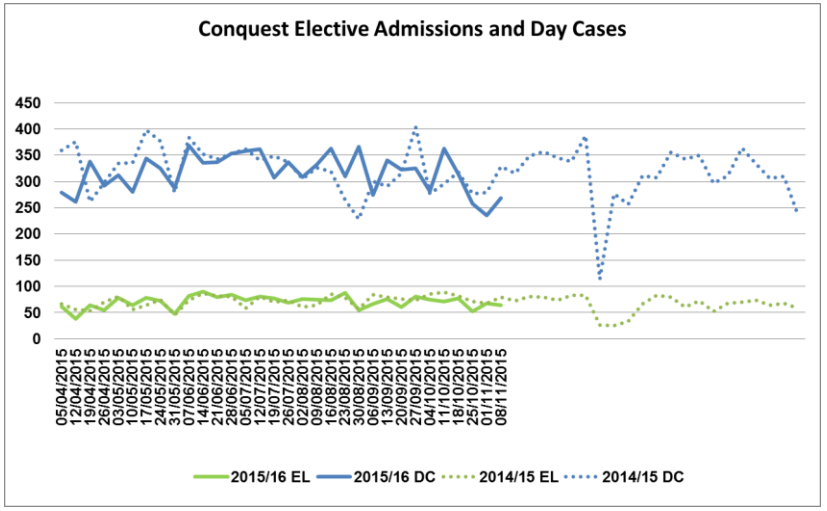


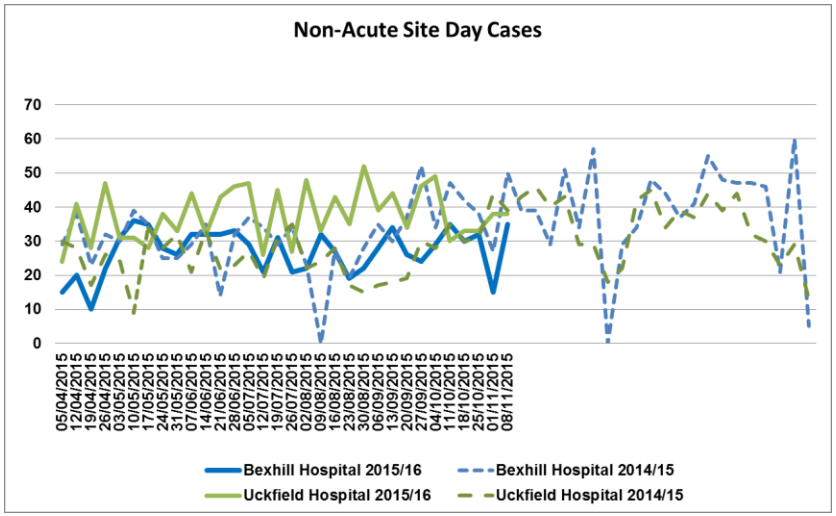


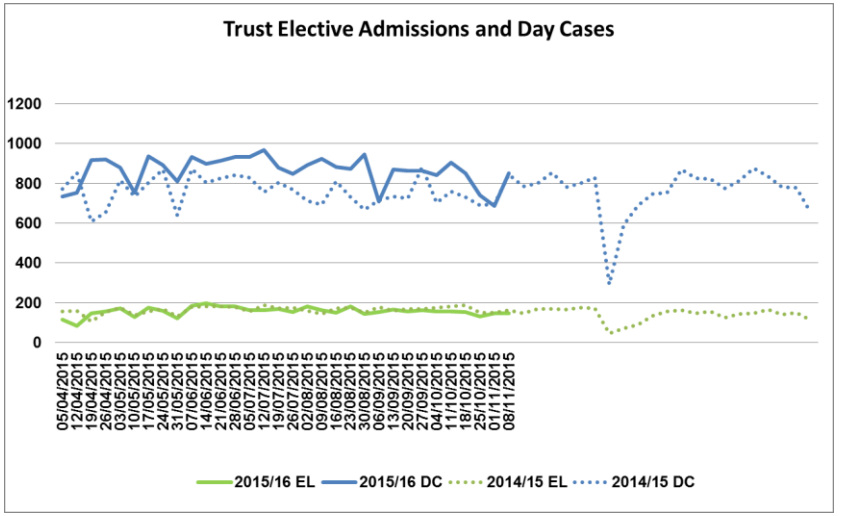


Appendix 2: Inpatient Performance Graphics









Finance – October 2015

Financial Summary – October 2015

Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) finance risk assessment criteria are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria is red in month 7.	R
Financial Sustainability Risk Ratings	The Continuity of Services Risk Rating has been enhanced and is now referred to as the Financial Sustainability Risk Rating (FSRR). The FSRR builds on the previous ratings by retaining the Liquidity Ratio and Capital Servicing Capacity, but with additional risk ratings for I&E Margin and I&E Margin Variance from Plan (see page 13). The current rating for the Trust is red.	R
Financial Summary	The Trust performance in month 7 was a run rate deficit of £5.6m with an adverse variance against plan of £1.4m. Year to date the deficit stands at £25.8m which is £5.0m worse than plan.	R
Activity & Income	Total income received during October was £0.4m above planned levels reducing the year to date variance to £0.5m below plan. Tariff-Excluded Drugs and Devices (TEDDs) income over-performed by £0.3m in month, underperformance now stands at £1.2m YTD. There is however, a corresponding underspend of £1.2m on TEDDs expenditure so therefore, this has a zero effect on the bottom line.	A
Expenditure	Operating Pay costs are above plan by £1.1m in month and are cumulatively £5.3m above plan. This is mainly due to high agency spend covering escalation beds and clinical vacancies. Operating Non Pay costs are £0.6m above plan in month and are cumulatively £0.7m below plan. This is mainly due to the underspend on TEDDs (as detailed above). Total costs are now £4.9m overspent year to date	R
CIP plans	The CIP achievement year to date was £4.8m which was below the plan of £5.8m.	R
Forecast Outturn	The forecast outturn is projected to be as per the revised plan at £35.2m deficit.	G
Balance Sheet	DH loans have increased by a further £2.0m to £21.4m as a result of the draw down of the revolving working capital facility (RWCF). The Trust Development Authority (TDA) have notified the Trust of an increase in the full year RWCF to £35.2m.	G
Cash Flow	An interim revolving working capital support facility agreement is currently in place and an application for re-financing is planned later in the financial year, which, if approved, will allow the repayment of the revolving working capital support and further cash to support the planned deficit. At the end of month 7 the Trust has drawn down £21.4m of the interim £35.2m revolving working capital facility.	G
Capital Programme	After 7 months capital expenditure has increased to £6.2m. The overall capital programme resource assumption has been revised to reflect the assumption that the interest bearing capital loan to support the clinical strategy is now unlikely to be approved in the current financial year. In its place a £7m CQC quality improvement plan bid has been assumed.	G

Income & Expenditure – October 2015

Headlines

• Total income in the month was £28.7m against a plan of £28.3m, a favourable variance of £0.4m and brings the YTD position to £0.5m below plan.

• Total costs in the month were £34.2m, this was £1.8m above plan. The YTD position is now £4.9m above plan.

• The year to date deficit against plan was an adverse variance of £5.0m.

• Cost improvement Plans of £11.4m have been developed for 2015/16 with a year to date achievement of £4.8m against a plan of £5.8m.

• Operating Pay costs in the month, including Ad hoc costs, were £1.1m above plan and are now £5.3m above plan YTD.

• Operating Non Pay costs, including 3rd party costs, were £0.6m above plan in the month and are £0.7m below plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	22,507	22,812	305	168,067	169,938	1,871	287,872
Tariff-Excluded Drugs & Devices	2,704	3,019	315	18,926	17,694	-1,232	31,453
Private Patient/ ICR	324	243	-81	2,266	1,686	-580	4,284
Trading Income	441	391	-50	2,183	3,308	1,125	5,220
Other Non Clinical Income	2,293	2,191	-102	16,947	15,302	-1,645	27,180
Total Income	**28,269**	**28,656**	**387**	**208,389**	**207,928**	**-461**	**356,009**
Pay Costs	-20,455	-21,549	-1,094	-144,202	-149,220	-5,018	-245,992
Ad hoc Costs	0	-40	-40	0	-277	-277	0
Non Pay Costs	-7,599	-7,954	-355	-54,056	-54,431	-375	-93,424
Tariff-Excluded Drugs & Devices	-2,704	-3,019	-315	-18,926	-17,693	1,233	-31,453
3rd Party Costs	-3	-116	-113	-146	-531	-385	-42
Other	125	325	200	875	1,075	200	1,500
Total Operating Costs	**-30,636**	**-32,353**	**-1,717**	**-216,455**	**-221,077**	**-4,622**	**-369,411**
Surplus/- Deficit from Operations	**-2,367**	**-3,697**	**-1,330**	**-8,066**	**-13,149**	**-5,083**	**-13,402**
P/L on Asset Disposal	0	0	0	0	14	14	0
Depreciation	-1,090	-1,093	-3	-7,627	-7,702	-75	-13,075
Impairment	0	0	0	0	0	0	0
PDC Dividend	-647	-679	-32	-4,528	-4,755	-227	-7,763
Interest	-82	-111	-29	-570	-552	18	-978
Total Non Operating Costs	**-1,819**	**-1,883**	**-64**	**-12,725**	**-12,995**	**-270**	**-21,816**
Total Costs	**-32,455**	**-34,236**	**-1,781**	**-229,180**	**-234,072**	**-4,892**	**-391,227**
Net Surplus/-Deficit	**-4,186**	**-5,580**	**-1,394**	**-20,791**	**-26,144**	**-5,353**	**-35,218**
Donated Asset/Impairment Adjustment	0	30	30	0	347	347	0
Adjusted Net Surplus/-Deficit	**-4,186**	**-5,550**	**-1,364**	**-20,791**	**-25,797**	**-5,006**	**-35,218**

Cash Flow – October 2015

Headlines

- The cash balance at the end of the last financial year was £1.0m and the Trust is planning for a £2.1m cash balance at year-end as required by the Department of Health.
- The interim revolving working capital support facility (RWCF) agreed with the Department of Health has been increased to £35.2m. The draw-down of this support is currently being accessed on a monthly basis and at 31st October £21.4m of the RWCF has been drawn down. An application for re-financing is planned for later in the financial year, which, if approved, will allow the repayment of the revolving working capital support to be replaced by permanent PDC
- The Trust will be submitting a request for an additional £7m of capital funding in respect of the CQC Quality Improvement Plan requirements.

Cash Flow Statement April 2015 to March 2016

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2016	Feb	Mar
Cash Flow from Operations												
Operating Surplus/(Deficit)	-2,181	-2,346	-3,580	-1,092	-3,148	-3,715	-4,789	-974	-148	-552	-2,512	-1,035
Depreciation and Amortisation	1,095	1,095	1,108	1,108	1,109	1,093	1,093	1,028	1,028	1,028	1,028	1,262
Impairments												
Interest Paid	-81	-81	-81	-31	-89	-92	-113	-84	-83	-84	-83	-100
Dividend (Paid)/Refunded	0					-4,247						-4,151
(Increase)/Decrease in Inventories	136	168	-68	103	90	-89	-28					-312
(Increase)/Decrease in Trade and Other Receivables	-637	-371	-6	-1,836	-2,340	1,254	1,531	0	402	0	0	553
Increase/(Decrease) in Trade and Other Payables	2,859	1,725	434	-53	3,628	652	6,848	-8,638	-2,421	-1,828	-140	-2,446
Provisions Utilised	-59	-10	0	33	10	-138	-98	-121	0	-111	0	12
Net Cash Inflow/(Outflow) from Operating Activities	**1,132**	**180**	**-2,193**	**-1,768**	**-740**	**-5,282**	**4,444**	**-8,789**	**-1,222**	**-1,547**	**-1,707**	**-6,217**
Cash Flows from Investing Activities:												
Interest Received	3	3	2	2	3	2	2	2	2	2	2	1
(Payments) for Property, Plant and Equipment	-1,817	-2,232	-1,567	-1,453	-1,365	-1,250	-1,441	-168	-471	-747	-986	-3,262
(Payments) for Intangible Assets	-42	-32	-40	-17	-28	-30	-29	-29	-29	-29	-29	-29
Net Cash Inflow/(Outflow) from Investing Activities	**-1,856**	**-2,261**	**-1,605**	**-1,468**	**-1,390**	**-1,278**	**-1,468**	**-195**	**-498**	**-774**	**-1,013**	**-3,290**
Net Cash Inflow/(Outflow) before Financing	**-724**	**-2,081**	**-3,798**	**-3,236**	**-2,130**	**-6,560**	**2,976**	**-8,984**	**-1,720**	**-2,321**	**-2,720**	**-9,507**
New Temporary PDC	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Revenue Support Loan	0	0	0	0	0	0	0	0	0	0	0	-35,218
Revenue Support Loans	7,440	936	4,039	3,000	2,000	2,000	2,000	6,000	2,000	2,000	2,000	1,803
New Permanent PDC	0	0	0	0	0	0	0	0	0	0	0	35,218
New Capital Loan	0	0	441	0	0	0	0	0	0	0	0	7,000
Loans and Finance Lease repaid	-40	-16	-28	-28	-28	-241	-28	-13	-13	-13	-13	-301
Net Cash Inflow/(Outflow) from Financing Activities	**7,400**	**920**	**4,452**	**2,972**	**1,972**	**1,759**	**1,972**	**5,987**	**1,987**	**1,987**	**1,987**	**8,502**
Net Increase/(Decrease) in Cash	**6,676**	**-1,161**	**654**	**-264**	**-158**	**-4,801**	**4,948**	**-2,997**	**267**	**-334**	**-733**	**-1,005**
Opening balance	1,008	7,684	6,523	7,177	6,913	6,755	1,954	6,902	3,905	4,172	3,838	3,105
Closing balance	7,684	6,523	7,177	6,913	6,755	1,954	6,902	3,905	4,172	3,838	3,105	2,100

Balance Sheet – October 2015

Headlines

- The overall value of property, plant & equipment is forecast to reduce by £29m due to the transfer of the High Weald, Lewes & Havens (HWLH) properties to NHS Property Services on 1st November. This will be partially offset by the indexation of assets and a planned £7m capital CQC quality improvement plan bid to the TDA. As the clinical strategy business case submission is yet to be approved by the Trust Development Authority (TDA) it has now been assumed that this funding will not be received in the current financial year.

- The year to date increase in non current borrowings is in respect of the planned interim revolving working capital support facility which has been increased to £35.2m by the TDA. This is being accessed from the DoH on a monthly basis.

- The planned application for re-financing is reflected in the total tax payers equity.

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast March 2016
Non Current Assets			
Property plant and equipment	271,373	270,058	258,437
Intangilble Assets	1,293	1,505	1,647
Trade and other Receivables	1,184	1,219	680
	273,850	**272,782**	**260,764**
Current Assets			
Inventories	6,599	6,286	6,511
Trade receivables	12,637	14,664	6,293
Other receivables	6,800	5,851	14,513
Other current assets	0	0	0
Cash and cash equivalents	1,008	6,902	2,100
	27,044	**33,703**	**29,417**
Current Liabilities			
Trade payables	-6,972	-17,807	-9,274
Other payables	-20,535	-20,251	-21,620
DH Capital Investment Loan	-383	-427	-1,297
Other Financial Liabilities	-335	-335	-263
Provisions	-591	-300	-773
	-28,816	**-39,120**	**-33,227**
Non Current Liabilities			
DH Capital Investment Loan	-3,583	-3,767	-9,683
Borrow ings - Revenue Support Facility	0	-21,415	0
Other Financial Liabilities	-263	-67	0
Provisions	-2,588	-2,615	-2,345
	-6,434	**-27,864**	**-12,028**
Total Assets Employed	**265,644**	**239,501**	**244,926**
Financed by:			
Public Dividend Capital (PDC)	-153,530	-153,530	-188,748
Revaluation Reserve	-119,711	-119,711	-117,674
Retained Earnings Reserve	7,597	33,740	61,496
Total Tax Payers Equity	**-265,644**	**-239,501**	**-244,926**

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

Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target achievement of BPPC is 95%.
- By value, year to date 90% of trade invoices has been achieved and 91% of NHS invoices.
- The Aged Debt (over 90 days) KPI is measured as a percentage of the total level of debt. The target is for this to be no more than 5%.
- The Aged Debt KPI has reduced from 37% at 30th June to 8% at 31st October.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	1,151	1,113	11,651	2,716
31 - 60 Days	517	421	1,113	1,672
61 -90 Days	183	225	701	307
91 - 120 Days	138	131	188	912
> 120 Days	796	845	1,011	1,061
Total	2,785	2,735	14,664	6,668

Trade Payables Aged Analysis - Purchase Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	5,559	5,290	6,831	6,277
31 - 60 Days	8,216	3,387	9,298	3,873
61 -90 Days	529	633	746	840
91 - 120 Days	362	263	303	323
> 120 Days	606	507	629	481
Total	15,272	10,080	17,807	11,794

Better Payments Practice Code	Month Number of Invoices	Month By Value	YTD Number of Invoices	YTD By Value
Trade invoices paid within contract or 30 days of receipt	58.67%	58.79%	94.69%	90.45%
NHS invoices paid within contract or 30 days of receipt	48.17%	90.76%	86.99%	91.15%

Key Performance Indicators – October 2015

TDA Finance Risk Assessment Criteria

• The TDA has set out its reporting requirements in the latest accountability framework.

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

• Although the majority of risk criteria are green the 1a) Bottom-line rating I&E position is the overriding rating which governs the overall Trust rating. As the Trust has set a deficit plan this rating is red and therefore, under the revised TDA criteria, the overall Trust rating is red.

Monitor Financial Sustainability Risk Ratings

• The Trust has a liquidity ratio rating of 2, a capital servicing ratio of 1, an I&E margin of 1 and a variance in I&E margin of 1. This results in an overall rating of 1.

Better Payments Practice Code (BPPC)

• Year to date performance is below the BPPC target for both Trade invoices and NHS invoices paid by value due to the difficult cash position which is being managed by the Trust.

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

Monitor Financial Sustainability Risk Ratings	YTD Actual	YTD Plan
Liquidity Ratio Rating	2	2
Capital Servicing Capacity Rating	1	1
I&E margin rating	1	1
Variance in I&E margin rating	1	4
Overall Monitor Risk Rating	1	2

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	90	95
BPPC – NHS Invoices by value (%)	91	95

Activity & Contract Income – October 2015

Headlines

- Re-admission fines have been accrued based on planning assumptions.
- CQUIN performance is based on ESHT achieving 100% of agreed targets.
- Activity plans are subject to finalisation with commissioners.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,434	3,530	96	24,035	26,238	2,203
Elective Inpatients	834	681	-153	5,842	4,845	-997
Emergency Inpatients	3,689	3,199	-490	25,465	24,950	-515
Total Inpatients	**7,957**	**7,410**	**-547**	**55,342**	**56,033**	**691**
Excess Bed Days	2,213	1,195	-1,018	15,276	13,508	-1,768
Total Excess Bed Days	**2,213**	**1,195**	**-1,018**	**15,276**	**13,508**	**-1,768**
Consultant First Attendances	8,230	7,705	-525	54,431	55,217	786
Consultant Follow Ups	12,821	13,916	1,095	82,595	86,358	3,763
OP Procedures	4,963	3,387	-1,576	31,043	31,621	578
Other Outpatients inc WA & Nurse Led	13,507	11,376	-2,131	87,778	86,115	-1,663
Community Specialist	264	184	-80	1,463	1,150	-313
Total Outpatients	**39,785**	**36,568**	**-3,217**	**257,310**	**260,461**	**3,151**
Chemotherapy Unbundled HRGs	544	463	-81	4,033	4,102	69
Antenatal Pathways	355	363	8	2,237	2,171	-66
Post-natal Pathways	345	238	-107	2,068	2,058	-10
A&E Attendances (excluding type 2's)	0	8,984	8,984	53,951	63,650	9,699
ITU Bed Days	418	362	-56	3,196	3,276	80
SCBU Bed Days	236	182	-54	1,865	2,149	284
Cardiology - Direct Access	67	80	13	371	474	103
Radiology - Direct Access	4,422	5,163	741	32,659	35,333	2,674
Pathology - Direct Access	320,058	283,416	-36,642	1,932,575	1,914,981	-17,594
Therapies - Direct Access	1,544	5,651	4,107	11,869	19,789	7,920
Audiology	720	1,306	586	5,689	7,018	1,329
Midwifery	8	6	-2	82	89	7

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,167	4,332	165	32,486	28,654	-3,832
Inpatients - Emergency	6,316	5,401	-915	43,603	41,372	-2,231
Excess Bed Days	485	265	-220	3,343	2,963	-380
Outpatients	4,154	4,024	-130	26,987	27,717	730
Other Acute based Activity	1,034	2,333	1,299	16,823	18,045	1,222
Direct Access	777	843	66	5,012	5,316	304
Block Contract / Other	4,470	5,185	715	35,913	42,577	6,664
Re-admissions	0	-97	-97	0	-606	-606
CQUIN	526	526	0	3,900	3,900	0
Subtotal	21,929	22,812	883	168,067	169,938	1,871
Exclusions	3,282	3,019	-263	18,926	17,694	-1,232
GRAND TOTAL	**25,211**	**25,831**	**620**	**186,993**	**187,632**	**639**

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

Headlines

Trust wide

Total Pay reported £1.1m overspend against the TDA plan in the month. £13.5m has been spent on agency in the first seven months of the year compared to £5.7m for the same period last year. Cumulatively pay was £4.2m overspent.

Clinical Units (CUs)

The overall clinical unit performance was £1.6m overspend in October against plan and £9.8m cumulatively (excluding TEDDs).
This was mainly due to continued agency usage covering medical and nursing vacancies, and escalation beds (£0.3m per month). Slippage on CIP savings also caused an adverse variance. The contingency is being phased in evenly (see central items) and this partly offsets the operational cost pressures.

Tariff-excluded drugs and devices reported £0.3m overspend in the month against plan, which was offset by Contract Income so overall has a neutral impact.

Estates and Facilities Directorate

October reported an overspend in month due to slippage on CIP and continued agency usage in portering, housekeeping and laundry.

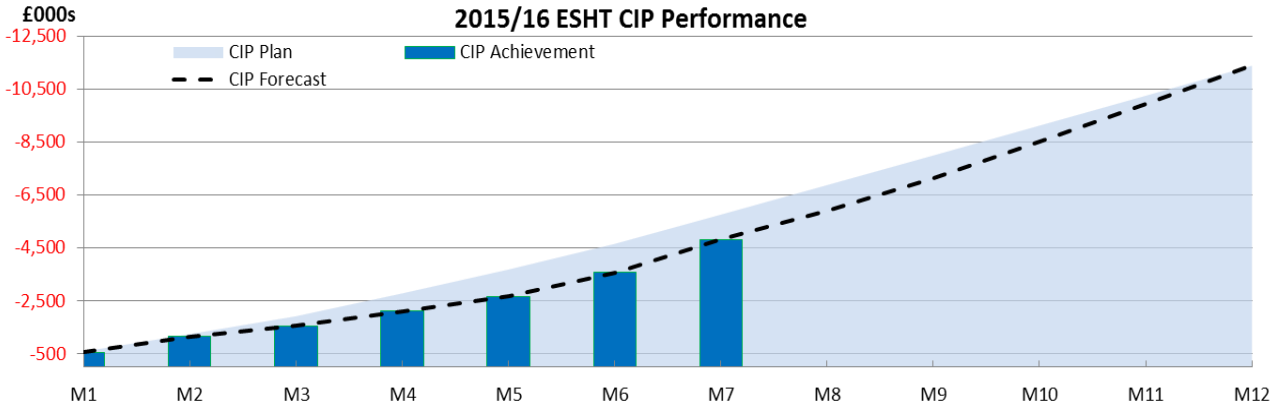
Corporate Services

Corporate Services was £0.1m off plan in month 7 due to clinical coding agency.

Income & Expenditure Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Urgent Care	-2,159	-2,582	-423	-14,410	-16,395	-1,985
Specialist Medicine	-1,732	-1,820	-88	-11,638	-12,346	-708
Cardiovascular	-1,103	-1,248	-145	-7,651	-9,312	-1,661
Surgery	-3,329	-3,575	-246	-23,257	-24,458	-1,201
Women & Children	-2,454	-2,398	56	-17,111	-17,444	-333
Out of Hospital Care	-2,760	-2,843	-83	-19,740	-20,289	-549
Clinical Support	-6,224	-6,702	-478	-44,204	-46,985	-2,781
Tariff-Excluded Drugs & Devices	-2,704	-3,019	-315	-18,926	-17,692	1,234
COO Operations	-966	-1,106	-140	-6,705	-7,245	-540
Total Clinical Units	**-23,431**	**-25,293**	**-1,862**	**-163,642**	**-172,166**	**-8,524**
Estates & Facilities	-2,172	-2,264	-92	-15,470	-15,551	-81
Corporate Services	-2,121	-2,255	-134	-15,333	-15,676	-343
Central Items	-2,021	-1,766	255	-15,768	-11,480	4,288
Total Central Areas	**-6,314**	**-6,285**	**29**	**-46,571**	**-42,707**	**3,864**
Contract Income	25,211	25,831	620	186,993	187,632	639
Income	348	167	-181	2,429	1,097	-1,332
Donated Asset/Impairment Adjustment	0	30	30	0	347	347
Adjusted Net Surplus/- Deficit	**-4,186**	**-5,550**	**-1,364**	**-20,791**	**-25,797**	**-5,006**

Workforce Plan FTE	Workforce Actual FTE	Pay Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
554	639	Urgent Care	-2,051	-2,436	-385	-13,704	-15,570	-1,866
435	417	Specialist Medicine	-1,616	-1,571	45	-10,800	-11,143	-343
267	321	Cardiovascular	-1,050	-1,239	-189	-7,176	-8,486	-1,310
728	760	Surgery	-2,905	-3,124	-219	-20,383	-21,610	-1,227
588	589	Women & Children	-2,274	-2,283	-9	-15,906	-16,369	-463
927	851	Out of Hospital Care	-2,497	-2,500	-3	-17,565	-17,862	-297
1,093	1,068	Clinical Support	-4,028	-4,274	-246	-28,828	-29,899	-1,071
374	405	COO Operations	-906	-970	-64	-6,287	-6,573	-286
4,965	**5,050**	**Total Clinical Units**	**-17,327**	**-18,397**	**-1,070**	**-120,649**	**-127,512**	**-6,863**
710	708	Estates & Facilities	-1,414	-1,409	5	-10,095	-10,275	-180
566	523	Corporate Services	-1,623	-1,670	-47	-11,455	-11,666	-211
1,275	**1,231**	**Total Non-Clinical Divisions**	**-3,037**	**-3,079**	**-42**	**-21,550**	**-21,941**	**-391**
0	**0**	Central Items	-91	-113	-22	-2,003	-44	1,959
6,240	**6,281**	**Total Pay Analysis**	**-20,455**	**-21,589**	**-1,134**	**-144,202**	**-149,497**	**-5,295**

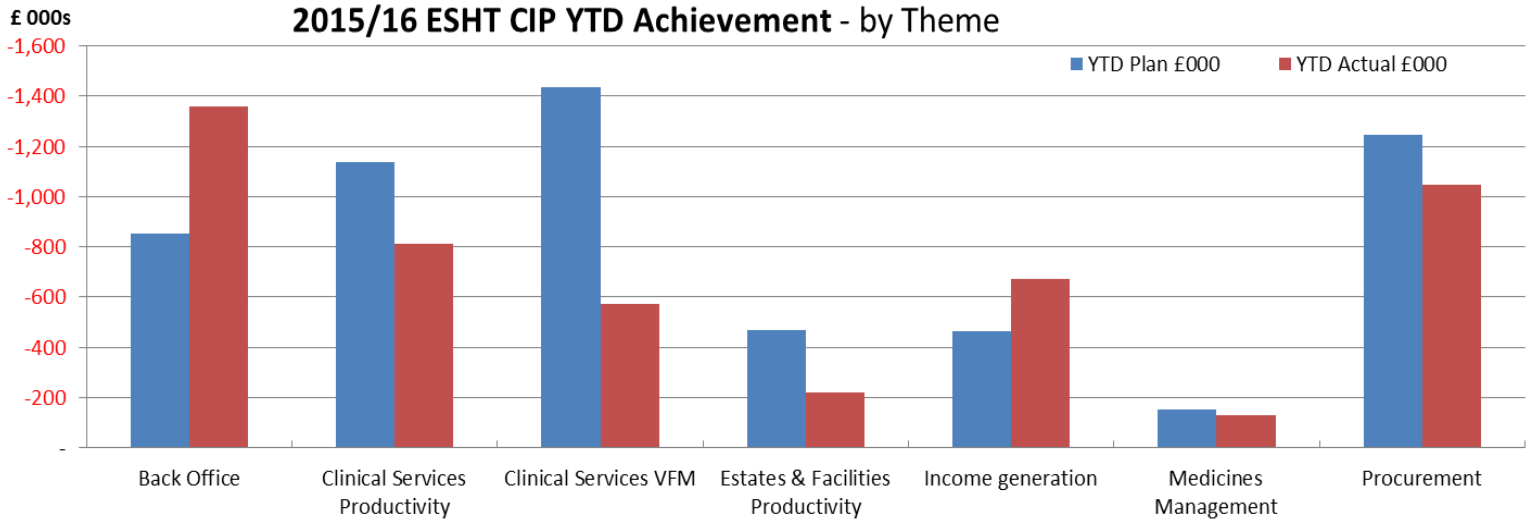
2015/16 ESHT CIP Performance to date – Month 7



Clinical Unit	In Month			Year to Date			Forecast		
	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast £000	Variance FOT £000
Cardiovascular Medicine	-83	-214	131	-446	-443	-3	-859	-616	-243
Estates and Facilities	-172	-57	-115	-727	-410	-316	-1,585	-728	-857
Corporate	-210	-229	19	-1,229	-1,308	79	-2,281	-2,440	160
Specialist Medicine	-35	-59	24	-229	-217	-11	-403	-279	-125
Surgery	-140	-99	-42	-802	-430	-372	-1,504	-734	-770
Trustwide	10	-	10	210	-	210	161	-2,783	2,944
Urgent Care	-35	-24	-11	-146	-110	-35	-320	-144	-176
Womens Health & Childrens Services	-62	-47	-14	-352	-386	34	-660	-703	43
Contract Income	-42	-42	-	-292	-292	-	-500	-500	-
Out of Hospital Care	-53	-21	-32	-369	-92	-278	-633	-167	-467
Clinical Support	-282	-438	156	-1,377	-1,125	-252	-2,790	-2,281	-509
Total	**-1,103**	**-1,230**	**127**	**-5,758**	**-4,813**	**-945**	**-11,375**	**-11,375**	**-0**

2015/16 ESHT CIP Performance by Theme – Month 7

TDA Theme	In Month			Year to Date			Forecast		
	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast £000	Variance FOT £000
Back Office	-139	-240	101	-852	-1,359	507	-1,547	-2,536	989
Clinical Services Productivity	-235	-327	92	-1,138	-811	-327	-2,319	-2,495	176
Clinical Services VFM	-274	-51	-223	-1,435	-575	-860	-2,805	-1,664	-1,141
Estates & Facilities Productivity	-125	-37	-88	-468	-219	-249	-1,105	-390	-715
Income generation	-67	-83	16	-465	-671	206	-800	-1,333	533
Medicines Management	-27	-78	51	-154	-130	-24	-293	-268	-26
Procurement	-236	-416	180	-1,246	-1,048	-198	-2,506	-2,690	184
Total	**-1,103**	**-1,230**	**127**	**-5,758**	**-4,813**	**-945**	**-11,375**	**-11,375**	**-0**



Year on Year Comparisons – October 2015

Headlines

- Total Inpatient activity to date is 0.7% higher than last year's level.
- Total outpatients are 0.9% higher than last year.
- Total A&E attendances are 1.6% higher than last year.

Activity	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	26,238	24,836	1,402	5.6%
Elective Inpatients	4,845	5480	-635	-11.6%
Emergency Inpatients	24,950	25,333	-383	-1.5%
Total Inpatients	**56,033**	**55,649**	**384**	**0.7%**
Elective Excess Bed Days	1,020	1,135	-115	-10.1%
Non elective Excess Bed Days	12,488	13,405	-917	-6.8%
Total Excess Bed Days	**13,508**	**14,540**	**-1,032**	**-7.1%**
Consultant First Attendances	55,217	54,577	640	1.2%
Consultant Follow Ups	86,358	83,968	2,390	2.8%
OP Procedures	31,621	31,938	-317	-1.0%
Other Outpatients (WA & Nurse Led)	86,115	86,320	-205	-0.2%
Community Specialist	1,150	1,403	-253	-18.0%
Total Outpatients	**260,461**	**258,206**	**2,255**	**0.9%**
Chemotherapy Unbundled HRGs	4,102	4,120	-18	-0.4%
Antenatal Pathways	2,171	2,214	-43	-1.9%
Post-natal Pathways	2,058	2,016	42	2.1%
A&E Attendances (excluding type 2's)	63,650	62,670	980	1.6%
ITU Bed Days	3,276	3,325	-49	-1.5%
SCBU Bed Days	2,149	1,913	236	12.3%
Cardiology - Direct Access	474	421	53	12.6%
Radiology - Direct Access	35,333	33,429	1,904	5.7%
Pathology - Direct Access	1,914,981	1,907,124	7,857	0.4%
Therapies - Direct Access	19,789	23,294	-3,505	-15.0%
Audiology	7,018	11,099	-4,081	-36.8%
Midwifery	89	84	5	6.0%

£000s	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	187,632	203,192	-15,560	-7.7%
Private Patient/ RTA	1,686	1,892	-206	-10.9%
Trading Income	3,308	2,970	338	11.4%
Other Non Clinical Income	15,302	15,804	-502	-3.2%
Total Income	**207,928**	**223,858**	**-15,930**	**-7.1%**
Pay Costs	-149,497	-143,029	-6,468	-4.5%
Non Pay Costs	-72,655	-71,725	-930	-1.3%
Other	1,075	1,283	-208	16.2%
Total Direct Costs	-221,077	-213,471	-7,606	-3.6%
Surplus/-Deficit from Operations	**-13,149**	**10,387**	**-23,536**	**226.6%**
Profit/Loss on Asset Disposal	14	22	-8	
Depreciation	-7,702	-7,220	-482	-6.7%
Impairment	0	0	0	
PDC Dividend	-4,755	-4,636	-119	-2.6%
Interest	-552	-195	-357	-183.1%
Total Indirect Costs	-12,995	-12,029	-966	-8.0%
Total Costs	**-234,072**	**-225,500**	**-8,572**	**-3.8%**
Net Surplus/-Deficit	**-26,144**	**-1,642**	**-24,502**	**-1492.2%**
Donated Asset / Other Adjustment	347	441	-94	21.3%
Normalised Net Surplus/-Deficit	**-25,797**	**-1,201**	**-24,596**	**-2048.0%**

Capital Programme – October 2015

Headlines

Year to Date Performance:-
The overall capital programme resource assumption has been revised to reflect the assumption that the interest bearing capital loan to support the clinical strategy is now unlikely to be approved in the current financial year. In its place a £7m CQC quality improvement plan bid has been assumed. Following discussions with the Trust Development Authority (TDA) this bid will be submitted to the TDA in November.

After seven months of the financial year, capital expenditure has increased to £6.2m. A significant element of the year to date expenditure is in respect of the Pevensey Ward redevelopment which had its official opening in early November.

Commitments entered into now amount to £8.0m compared to the total capital resource of £11.8m, excluding the £7m CQC quality improvement bid. The current over planning margin has increased to £891k and is considered manageable particularly in light of the current level of commitments and potential slippage anticipated within the capital programme.

The Capital Approvals Group (CAG) continues to monitor the capital programme, paying particular attention to the risks associated with limited capital resource.

Capital Investment Programme £000s	2015/16 Capital Programme	Expenditure at Month 7
Capital Resources		
Depreciation	11,820	
CQC Exceptional Additional Bid	7,000	
Additional Capital Loan - Health Records Storage	441	
League of Friends Support	1,121	
Cap Investment Loan Principal Repayment	-427	
Gross Capital Resource	19,955	
Less Donated Income	-1,121	
Capital Resource Limit (CRL)	**18,834**	**-**
Capital Investment		
CQC Quality Improvement Plan	7,000	0
Medical Equipment	1,788	1,143
IT Systems	1,028	493
Electronic Document Management	835	223
Child Health Information System	673	173
PAS Upgrade	523	88
Backlog Maintenance	1,303	110
Infrastructure Improvements - Modernisation of Inpatient Environment and Facilities	700	147
Pevensey Ward	2,055	1,801
Minor Capital Schemes	1,500	1,075
Health Records	721	441
Other various	1,599	548
Sub Total	**19,725**	**6,242**
Donated Asset Purchases	1,121	368
Donated Asset Funding	-1,121	-368
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**19,725**	**6,242**
Overplanning Margin (-) Underplanning (+)	-891	0
Net Capital Charge against the CRL	**18,834**	**6,242**

Financial Sustainability Risk Ratings – October 2015

Headlines

Financial Sustainability Risk Ratings (FSRR):-

- Liquidity Ratio (days)
  - Days of operating costs held in cash or cash equivalent forms.
- Capital Service Capacity Ratio (times)
  - The degree to which the organisation's generated income covers its financial obligations.
- Income and expenditure (I&E) Margin
  - The degree to which the organisation is operating at a surplus/deficit.
- Variance in I&E Margin
  - The variance between an organisation's planned I&E margin and its actual I&E margin within the year.

- Monitor assigns ratings between 1 and 4 to each component of the FSRR with 1 being the worst rating and 4 the best. The overall rating is the average of the four.
- The Trust has a liquidity ratio of -11 days, a rating of 2.
- The capital servicing ratio of -2.36 results in a rating of 1.
- The I&E margin of -12.6% results in a rating of 1.
- The variance in I&E margin is -2.6%, a rating of 1.
- As a result the overall Trust rating is 1.

Liquidity Ratio (days) £000s	2014/15 Outturn	2015/16 YTD
Opening Current Assets	27,044	33,703
Opening Current Liabilities	-28,815	-39,120
Net Current Assets/Liabilities	-1,771	-5,417
Inventories	-6,599	-6,286
Adj Net Current Assets/Liabilities	**-8,370**	**-11,703**
Divided by:		
Total costs in year	364,471	221,077
Multiply by (days)	360	210
Liquidity Ratio	**-8**	**-11**

Capital Servicing Capacity (times) £000s	2014/15 Outturn Actual	2015/16 YTD Plan	2015/16 YTD Actual
Net Surplus / Deficit (-) After Tax	473	-20,791	-26,144
Less:			
Donated Asset Income Adjustment	-1,107	-732	-368
Interest Expense	235	585	568
Profit/Loss on Sale of Assets	-29	0	-14
Depreciation & Amortisation	12,265	7,627	7,702
Impairments	-629	0	0
PDC Dividend	8,073	4,528	4,755
Revenue Available for Debt Service	**19,281**	**-8,783**	**-13,501**
Interest Expense	235	585	568
PDC Dividend	8,073	4,528	4,755
Temporary PDC repayment			
Working capital loan repayment	18,171	213	213
Capital loan repayment	320	254	196
	26,799	5,580	5,732
Capital Serving Capacity	**0.72**	**-1.57**	**-2.36**

Financial Efficiency £000s	2014/15 Outurn Actual	2015/16 YTD Plan	2015/16 YTD Actual	2015/16 YTD Variance
Normalised Net surplus/ deficit	88	-20,791	-26,144	
Less fixed asset impairments/disposals	-29	0	-14	
	59	-20,791	-26,158	
Divided by:				
Total Income (excl donated assets)	383,768	-207,657	-207,560	
I&E Margin	**0.0%**	**-10.0%**	**-12.6%**	**-2.6%**

Financial Risks & Mitigating Actions – October 2015

Summary	
RISKS:-	
The following areas of risk have been identified in achieving the projected year end £35.2m deficit.	
1) Application of fines and penalties above planned levels.	
2) Shortfall of activity and income on the MSK contract.	
3) The value of activity falls below the risk share threshold in the main contract and is paid at the marginal rate.	
4) Stranded costs arising from the outcome of competitive tendering, notably HWLH community services.	
5) Continuation of activity and capacity cost pressures, e.g. Escalation Wards, Radiology capacity	
6) Unplanned operational cost pressures, e.g. continued high use of agency staff.	
7) Non delivery of CIPs.	
8) Revenue cost implications of re-financing.	
9) Non delivery of the additional in-year saving.	
MITIGATING ACTIONS:-	
Potential mitigating actions include joint management of demand and continued improvement in productivity.	

East Sussex Healthcare NHS
NHS Trust

WORKFORCE REPORT

OCTOBER 2015

WHAT MATTERS TO YOU MATTERS TO US ALL

East Sussex Healthcare NHS
NHS Trust

HEADLINES

WORKFORCE EXECUTIVE SUMMARY – KEY POINTS

- Actual workforce usage of staff in August was 6281.08 full time equivalents (ftes), 40.64 above budget.
- Temporary staff expenditure was £3,476K in October (16.10% of total pay expenditure). This comprises £1,183 bank expenditure, £2,246 agency expenditure and £47K overtime
- There were 514.02 fte vacancies (a vacancy factor of 8.45%)
- Monthly sickness was 4.51%, an increase of 0.15% from September. Annual sickness was 4.77%, a reduction of 0.09%
- Annual turnover was 12.24% which represents 641.96 fte leavers in the last year
- Mandatory training rates have are slightly down this month, with the exception of Information Governance, Health & Safety and Safeguarding Vulnerable Adults
- Appraisal compliance increased by 0.33% to 77.93%

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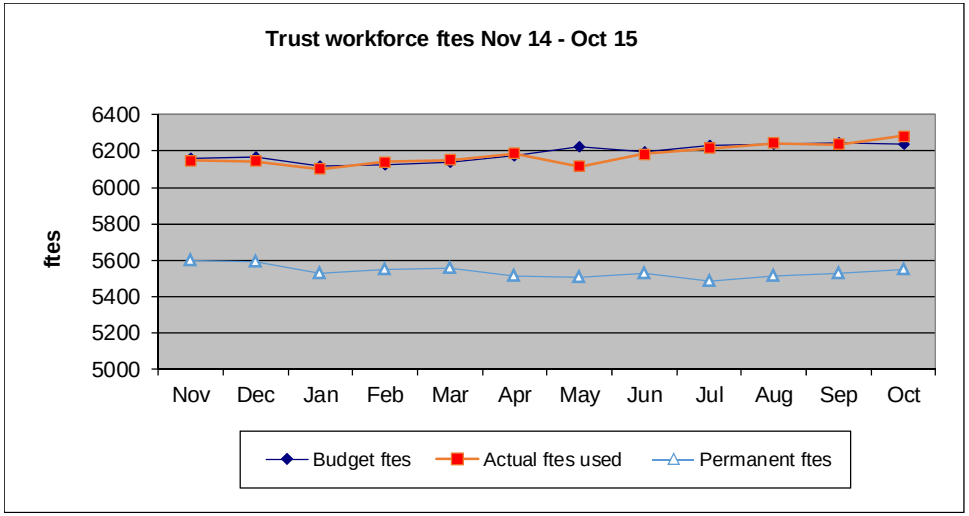
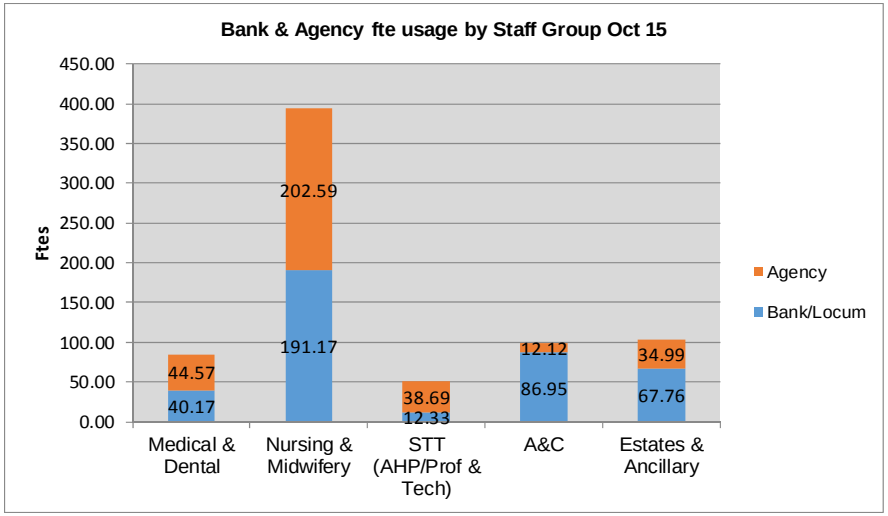
TRUST OVERVIEW

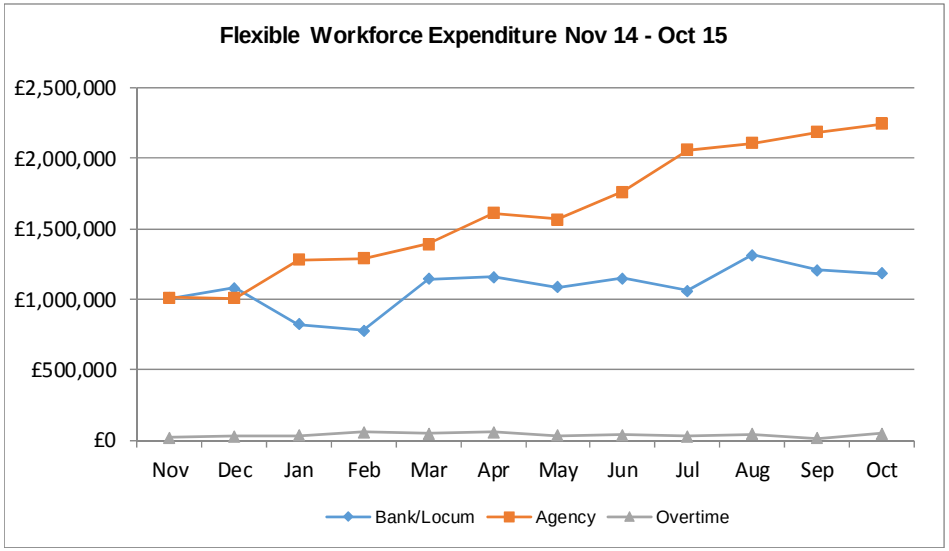
Oct-15	Budg estab fte	Actual worked fte	Vacancies fte	Vacancy trend since last month	Fill rate %	Monthly sickness %	Annual sickness %	Turnover	Temp staff expenditure	Appraised/exempt in last yr	Appraisal trend since last month
Theatres & Clinical Support	1,092.86	1,068.10	92.03	↓	91.42%	4.74%	4.76%	10.90%	£668,903	71.14%	↑
Cardiovascular Medicine	266.70	321.14	-0.62	↓	100.23%	3.09%	3.93%	10.47%	£283,881	89.59%	↑
Urgent Care	553.92	638.51	56.94	↓	89.72%	5.41%	5.07%	12.06%	£833,550	73.22%	↓
Specialist Medicine	434.65	417.00	45.44	↑	89.55%	3.38%	4.50%	10.59%	£238,449	89.13%	↑
Out of Hospital Care	927.27	850.91	119.85	↓	87.07%	5.24%	5.48%	19.98%	£253,375	67.85%	↓
Surgery	727.73	760.41	55.27	↓	92.41%	4.27%	3.89%	11.30%	£511,985	91.99%	↑
Womens & Childrens	588.48	588.94	15.55	↓	97.36%	4.54%	4.95%	10.81%	£156,155	82.09%	↑
COO Operations	373.60	404.98	15.58	↑	95.83%	3.95%	4.99%	9.70%	£88,765	80.78%	↑
Estates & Facilities	709.52	707.63	57.36	↑	91.33%	4.92%	5.77%	8.29%	£217,008	69.15%	↓
Corporate	479.74	435.11	56.62	↑	88.07%	4.05%	4.32%	12.21%	£223,921	84.68%	↑
TRUST	6240.44	6281.08	514.02	↓	91.55%	4.51%	4.77%	12.24%	£3,475,992	77.93%	↑

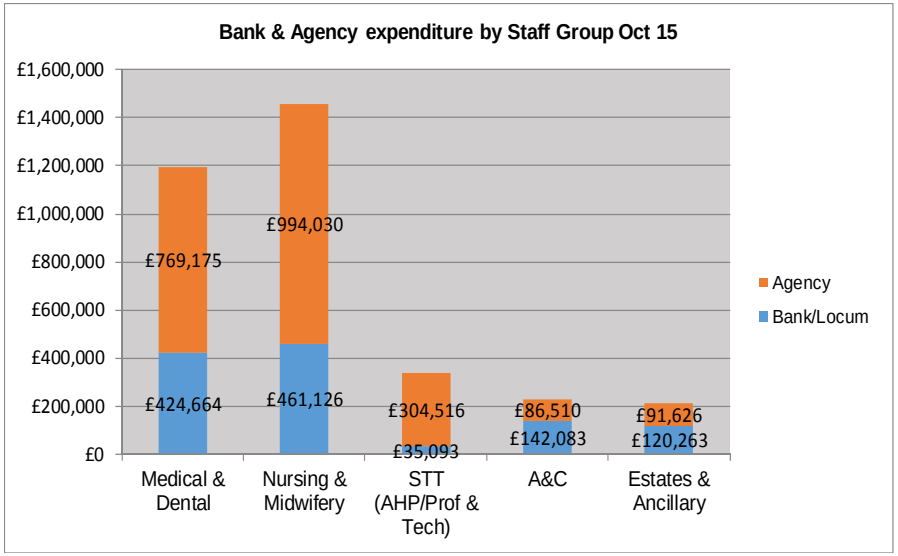
WHAT MATTERS TO YOU MATTERS TO US ALL

WORKFORCE USAGE









WHAT MATTERS TO YOU
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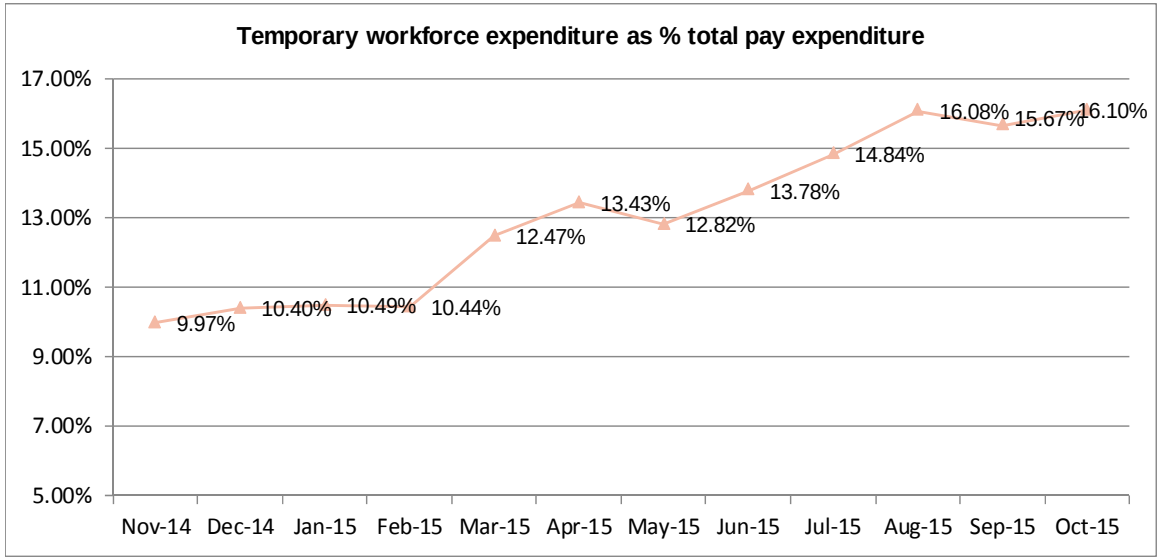
WORKFORCE USAGE



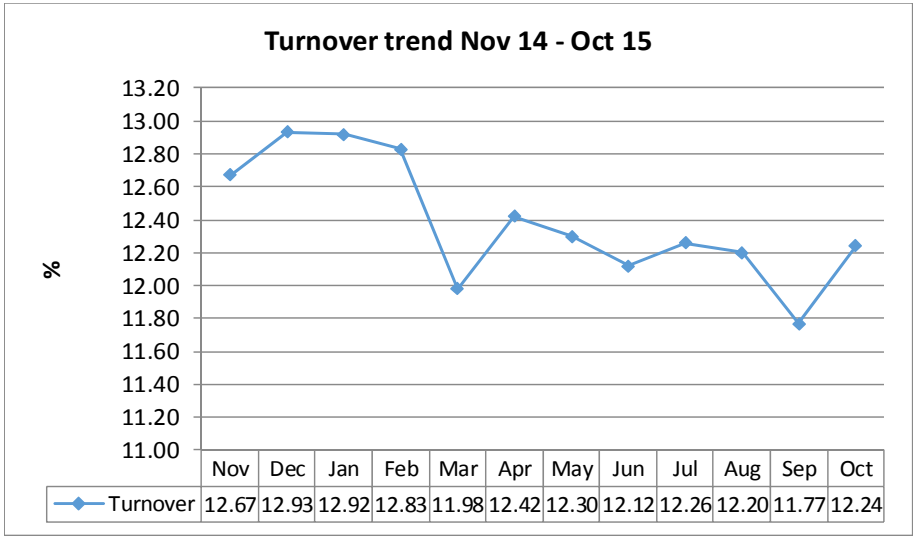
Workforce expenditure in month was £1,134K above budget at £21,589K. Temporary staff expenditure was £3476K comprising £1183K bank expenditure, £2,246K agency expenditure and £47K overtime.

Bank expenditure reduced by £26K compared to September but agency expenditure increased by £60K and overtime by £33K. The agency expenditure increase included an additional £160K spent on nursing agency. Reasons for this increase include staffing of the Escalation wards and the Clinical Decisions Unit, cover for extra beds on Hailsham 4, pending the ward move, and specialling on Hailsham 3, Hailsham 4 and Benson wards, as well as cover for continuing vacancies. Additional medical agency was used in the Emergency departments due to continuing recruitment difficulties though, overall, medical agency expenditure was down by £78K compared to September.

In Theatres, overtime has been used, in preference to agency, to cover vacant shifts and sickness, whilst Conquest porters worked additional overtime hours to enable a shift to a new 12 hour rota.

TURNOVER & VACAANCIES

STAFF GROUPS	Substantive budget ftes	Substantive actual ftes	Difference	Maternity ftes	Net vacancies	Vacancy trend since last month	Fill rate %
Medical & Dental	567.18	499.18	68.00	12.70	55.30	↓	90.25%
Registered Nursing & Midwifery	1,972.75	1,755.77	216.98	39.51	177.47	↓	91.00%
Unqualified Nurses	783.34	710.46	72.88	18.31	54.57	↑	93.03%
Sc. Therap & Techs (inc AHPs, Prof & Tech & Healthcare Scs.)	970.05	844.07	125.98	17.13	108.85	↓	88.78%
Administrative & Clerical	1160.64	1056.66	103.98	10.84	93.14	↑	91.98%
Estates & Ancillary	626.32	597.1	29.22	3.53	25.69	↓	95.90%
TRUST	6,080.28	5,463.24	617.04	103.02	514.02	↓	91.55%



STAFF GROUPS	FTE leavers in year	Annual Turnover %	Turnover trend since last month
MEDICAL & DENTAL	47.80	16.50%	↑
NURSING & MIDWIFERY REGISTERED	191.71	11.29%	↑
ALLIED HEALTH PROFESSIONALS	63.41	18.28%	↓
HEALTHCARE SCIENTISTS	17.00	13.53%	↓
PROF SCIENTIFIC & TECHNICAL	19.81	12.93%	↑
ADDITIONAL CLINICAL SERVICES	124.52	13.58%	↑
ADMINISTRATIVE & CLERICAL	118.66	11.12%	↑
ESTATES & ANCILLARY	45.05	7.56%	↓
STUDENTS	14.00	26.90%	↓
TRUST	**641.96**	**12.24%**	↑

(n.b. turnover now excludes employee transfer of services)

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TURNOVER & VACANCIES

Trust vacancies reduced by 28.12 ftes in October, with the overall vacancy rate down from 8.91% in September to 8.45% in October.

This improvement was largely due to the intake of newly qualified nurses in October. Overall qualified nursing vacancies were down by 33.02 ftes, whilst medical and dental vacancies reduced by 5.31 ftes. Unqualified nursing vacancies increased by 13.98 ftes although this is partly due to adjustments in respect of the newly qualified nurses (as they join the Trust in unqualified posts before their registration is confirmed). The vacancy rate for medical and dental staff is 9.75%, for qualified nurses it is 9.00% and for unqualified nurses it is 6.97%.

5 Consultants in Microbiology, Rheumatology, Gastroenterology, Anaesthetics and Obstetrics & Gynaecology have been recruited and have agreed start dates. There are also 10 non Consultant grades with agreed start dates in Obstetrics & Gynaecology, Gastroenterology, Radiology, Paediatrics, Cardiology and Trauma & Orthopaedics. There are a further 6 Consultant posts and 3 non Consultant posts at interview stage.

The Trust is pursuing overseas medical recruitment in India, via a recruitment agency, using Skype interviews. Histopathology, Cardiology, Anaesthetics and A&E Consultant & middle grades remain areas of recruitment difficulty.

The Trust had a successful nursing recruitment visit to the Philippines on 9 November and made job offers to 40 qualified nurses, though they would not be expected to be in post until around April 2016. A recruitment trip is also planned to Spain in December with a potential for up to 60 interviews. There are also plans for recruitment in Croatia. In addition, there 56 qualified nurses with job offers and awaiting start dates.

The Trust is continuing with generic recruitment of unqualified nurses. There are 40 with job offers and waiting start dates. Induction sessions have been scheduled in November and December and, due to demand, an additional session has now been set up for January.

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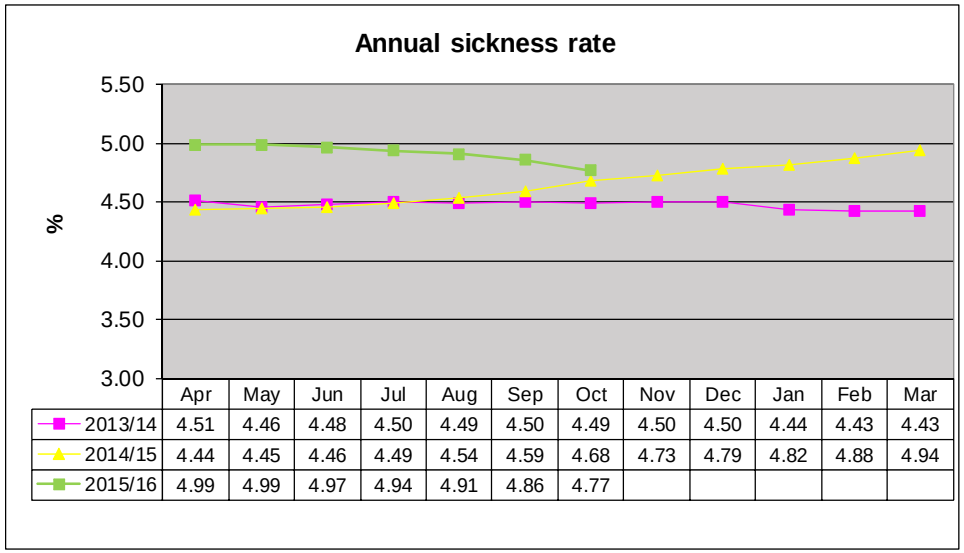
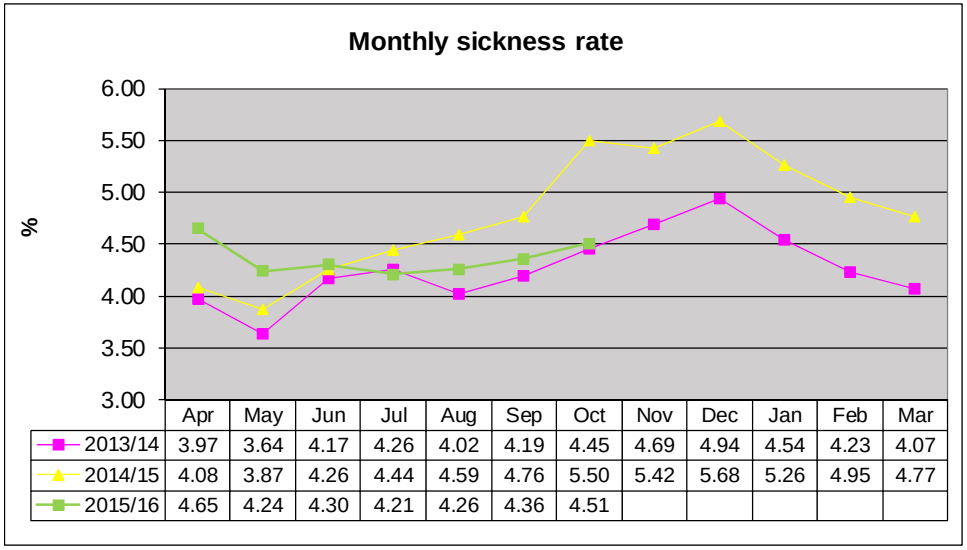
SICKNESS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14	4.51	4.46	4.48	4.50	4.49	4.50	4.49	4.50	4.50	4.44	4.43	4.43
2014/15	4.44	4.45	4.46	4.49	4.54	4.59	4.68	4.73	4.79	4.82	4.88	4.94
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77					



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14	3.97	3.64	4.17	4.26	4.02	4.19	4.45	4.69	4.94	4.54	4.23	4.07
2014/15	4.08	3.87	4.26	4.44	4.59	4.76	5.50	5.42	5.68	5.26	4.95	4.77
2015/16	4.65	4.24	4.30	4.21	4.26	4.36	4.51					

Monthly sickness has increased by 0.15% this month. Again, this reflects the usual seasonal increase at this time of year but the rate is 0.99% below that for October last year and thus the annual sickness rate has reduced by 0.09%. 7934 fte days were lost to sickness in October 2015.

In September the Support for you (S4U) absence management project was launched. HR team members visit departments, on a fortnightly basis, and discuss sickness absence management with the line manager. They focus on:-

- Ensuring managers have up to date knowledge of the Trust procedures and the support tool HR Liveflow.
- Checking local records and maintaining accuracy when using ESR and Health Roster
- Checking that local actions and Occupational Health referrals are relevant, effective, prompt and accurately recorded and tracked
- Return to work (RTW) interviews and absence management procedures are used effectively with the employee

As at the end of October, the HR teams have met with 49 Managers and considered and/or discussed 469 sickness absence cases since 1st July. 218 cases have now been closed and recorded cases of long term sickness have been reduced from 150 to 88.

Managers have responded positively to the HR Liveflow on line tool and HR teams have ensured that the sickness triggers introduced in April 2015 are being applied and Trust procedures followed. An update briefing was sent to managers in the week commencing 9th November to share progress so far and advise on good practice.

WHAT MATTERS TO YOU
MATTERS TO US ALL

TRAINING & APPRAISALS

Mandatory Training – Six Month Trend

Mandatory training course	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	6 month trend
Induction %	93.32	93.64	94.62	90.95	92.53	91.89	
Fire %	82.47	82.82	83.78	83.03	82.90	82.77	
Manual Handling %	82.97	84.59	85.44	84.21	85.24	85.02	
Infection Control %	86.27	84.85	85.78	84.58	85.82	85.81	
Info Gov %	77.26	81.89	82.57	82.38	82.25	83.41	
Health & Safety %	71.18	73.36	74.80	75.47	78.16	80.03	
Mental Capacity Act %	92.48	92.63	93.02	92.80	93.18	92.84	
Depriv of Liberties %	89.64	90.11	90.88	90.82	91.44	91.31	
Safeguard Vuln Adults	73.24	74.38	75.08	74.62	76.05	76.05	
Safeguard Child Level 2	79.61	79.87	80.13	79.19	80.59	80.40	

Clinical Unit Mandatory Training & Appraisals

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Appraisal compliance
Theatres & Clinical Support	84.04%	88.26%	93.90%	86.57%	86.67%	82.16%	93.00%	91.03%	76.34%	80.96%	71.14%
Cardiovascular Medicine	80.07%	81.85%	84.62%	79.00%	82.21%	64.06%	88.21%	86.60%	55.69%	53.25%	89.59%
Urgent Care	77.97%	79.69%	95.24%	78.74%	74.14%	66.67%	84.24%	84.66%	69.81%	71.07%	73.22%
Specialist Medicine	82.68%	84.76%	95.00%	80.14%	82.91%	79.45%	94.62%	88.46%	80.11%	80.59%	89.13%
Out of Hospital Care	84.05%	84.05%	93.68%	88.60%	81.52%	80.15%	96.22%	97.33%	79.82%	82.80%	67.85%
Surgery	84.20%	84.34%	91.40%	84.34%	95.05%	88.62%	94.82%	91.55%	82.62%	80.64%	91.99%
Womens & Childrens	87.04%	88.81%	94.12%	88.81%	81.59%	78.65%	93.00%	90.17%	73.40%	93.38%	82.09%
COO Operations	72.55%	83.75%	80.00%	78.71%	64.43%	58.54%	n/a	n/a	n/a	n/a	80.78%
Estates & Facilities	79.49%	77.51%	79.31%	88.97%	84.16%	89.39%	57.14%	100.00%	42.86%	66.67%	69.15%
Corporate	88.06%	94.72%	91.49%	93.54%	88.26%	89.63%	97.59%	97.14%	81.93%	87.37%	84.68%
TRUST	**82.77%**	**85.02%**	**91.89%**	**85.81%**	**83.41%**	**80.03%**	**92.84%**	**91.31%**	**76.05%**	**80.40%**	**77.93%**

(Green =85%+, Amber = 75-85% Red = <75%).

The mandatory training compliance figures are disappointingly static with just minor fluctuations. The Learning & Development Team, together with the specialist mandatory trainers, have responded to the Clinical Leadership Team request for individual, short courses in the main mandatory topics for September – December. These sessions equate to over 5500 training places across the various subjects. Attendance at these sessions has, however, been low to date. Learning & Development will continue to advertise and will resend details to Clinical Unit Leads to cascade to their teams. Workbooks for Information Governance, Safeguarding Adults & Children Level 2 have also been circulated

The appraisal rate has increased by a further 0.33% this month to 77.93% which is the highest rate yet recorded for the Trust.

WHAT MATTERS TO YOU MATTERS TO US ALL

Integrated Performance Dashboard

Patient Safety

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Never events - incidence rate	0	0	0	0	0	0	0	0	0	NA	0	0	NA	
Serious Incidents rate (per 1000 beddays)	TBC	2.70	3.07	3.18	3.25	3.31	3.32	2.72	2.29	18.8%	3.07	1.59	93.1%	
Medication errors causing serious harm - incidence rate	0	0	0	0	0	0	0	0	0	NA	1	0	NA	
% of Patient safety incidents that are harmful	TBC	0.80%	0.34%	0.44%	0.11%	0.52%	0.11%	0.42%	0.14%	195.3%	0.39%	0.29%	33.0%	
Potential under-reporting of Patient safety incidents - rate	TBC (Lyr)	880	886	901	910	767	872	959	708	35.5%	6,175	4,106	50.4%	
Potential under-reporting of Patient safety incidents resulting in death or severe harm- rate	TBC (LYr)	7	3	4	1	4	1	4	1	300.0%	24	12	100.0%	
CAS alerts outstanding	0	0	0	0	0	0	0	0	0	NA	0	0	NA	
Clostridium Difficile - Variance from plan	3.7	2	3	5	2	7	6	3	7	-4	28	29	-1	
MRSA bactaraemias rate	0	1	1	0	0	2	0	0	0	NA	4	0	NA	
VTE Risk Assessment	95%	96.6%	95.8%	96.9%	97.4%	96.4%	96.0%	96.0%	98.7%	-2.7%	96.5%	98.3%	-1.9%	
Number of Grade 3 or 4 Pressure Ulcers	TBC	1	5	1	2	2	1	2	3	-33.3%	14	20	-30.0%	
Percentage of Harm Free Care	92%	93.7%	94.6%	93.3%	93.3%	93.0%	93.3%	94.0%	95.0%	-1.0%	93.6%	94.7%	-1.2%	
Percentage of New Harms	TBC													
Falls per Thousand bed days (All categories)	TBC	7.99	6.88	6.57	6.37	6.05	6.34	6.94	7.13	-2.7%	6.75	7.61	-11.4%	
Number of Falls: no harm/near miss	TBC	110	97	101	96	103	108	109	106	2.8%	724	791	-8.5%	
Number of Falls: Minor/Moderate	TBC	84	68	50	59	37	37	62	55	12.7%	397	399	-0.5%	
Number of Falls: Major/Catastrophic	0	1	1	2	0	1	0	0	1	-100.0%	5	10	-50.0%	
Emergency c-section rate	TBC													
Crude Mortality Rate (non-elective ordinary discharges)		150.0	146.0	131.0	134.0	133.0	120.0	133.0	136					

Clinical Effectiveness

Indicator Description	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	Trend
Summary Hospital Mortality Indicator (HSCIC)	TBC													
HSMR (CHKS)	108	112	104	135					97					
SHMI (CHKS)	TBC	119	99						107					
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	TBC	7.75%	7.28%	7.51%	7.68%	7.09%	6.93%	3.86%	#N/A	NA			NA	
% Spending 90% time on Stroke Ward	90.00%	97.7%	94.8%	90.9%	91.3%	86.0%	84.4%	83.3%	87.5%	-4.8%	91.2%	91.8%	-0.7%	
Stroke:% to Stroke Unit <4hrs	99.00%	83.3%	85.7%	81.1%	68.9%	88.1%	83.3%	66.7%	67.3%	-1.0%	81.4%	76.7%	6.1%	
Stroke: % scanned <1hr of arrival	90.00%	72.1%	72.4%	76.4%	78.3%	88.4%	78.1%	66.7%	69.6%	-4.3%	77.0%	74.1%	3.9%	
Stroke: % scanned <12hr of arrival	95.00%	100.0%	96.6%	94.5%	97.8%	100.0%	100.0%	100.0%	94.6%	5.7%	97.9%	97.9%	0.0%	

Patient Experience

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Staff Friends and Family Test % recommended care	TBC			64.5%			66.3%			NA	65.4%	65.7%	-0.6%	
Inpatient Scores from Friends and Family Test % positive	96.00%	96.6%	98.1%	97.5%	97.3%	97.8%	97.5%	97.4%	95.3%	2.2%	97.5%	95.9%	1.7%	
A&E Scores from Friends and Family Test % positive	88.00%	88.1%	87.8%	91.9%	88.2%	90.8%	92.6%	89.3%	89.3%	0.0%	89.8%	88.6%	1.3%	
Maternity Scores from Friends and Family Test % positive	96.00%	94.8%	93.5%	93.7%	95.7%	96.0%	93.3%	95.1%	94.4%	0.7%	94.6%	93.3%	1.4%	
Inpatients response rate from Friends and Family Test	45.00%	45.5%	47.2%	50.0%	9.7%	15.4%	15.3%	15.5%	47.9%	-67.7%	18.5%	47.1%	-60.6%	
A&E response rate from Friends and Family Test	25.00%	15.0%	15.0%	16.9%	9.3%	7.1%	8.9%	7.9%	25.1%	-68.5%	10.9%	27.7%	-60.6%	
Written Complaints - Rate	TBC	2.46	1.99	1.85	2.79	3.39	3.11	2.80	#N/A	NA				
Number of compliments received	TBC													
Number of formal complaints raised	TBC	60.0	48.0	43.0	68.0	79.0	71.0	69.0	#N/A	NA				
Number of new complaints responded to (within mandatory or agreed timescales)	TBC	59.0	50.0	43.0	62.0	75.0	64.0	57.0	#N/A	NA				
Percentage of new complaints respond to (within mandatory or agreed timescales)	TBC	98.00%	89.00%	98.00%	91.00%	95.00%	94.00%	84.00%	#N/A	NA				
Mixed Sex Accommodation Breaches	0	0	18	0	0	0	14	23	0	NA	55	20	175.0%	

Access and Responsiveness

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
A&E Monthly Performance (4Hr Wait) - All Types (Reported)	95%	88.9%	92.4%	97.2%	95.6%	92.1%	93.3%	91.2%	93.4%	-2.3%	93.0%	94.87%	-2.0%	
A&E Monthly Performance (4Hr Wait)-Type 1 Only	95%	85.3%	89.9%	96.3%	94.1%	89.7%	91.4%	88.6%	91.4%	-2.9%	90.8%	93.10%	-2.5%	
Emergency A&E >12hr to Admission	0	1	0	0	0	0	0	0	0	0	1	1	0	
Ambulance Handover Delays >60mins	TBC													
Referral to Treatment Admitted	90%	85.0%	83.9%	78.76%	78.51%	81.53%	73.8%	71.9%	85.67%	-13.8%	79.3%	82.65%	-4.1%	
Referral to Treatment Non Admitted	95%	93.6%	93.3%	92.54%	89.87%	89.52%	87.6%	86.2%	91.42%	-5.2%	90.6%	92.06%	-1.6%	
Referral to Treatment Incomplete	92%	94.3%	94.8%	93.81%	94.05%	93.53%	93.4%	92.7%	92.98%	-0.3%	93.8%	92.72%	1.2%	
Backlog (18+)	1200	1488	1371	1600	1571	1611	1719	2009	1734	15.9%	2009	1516	32.5%	
Referral to Treatment Incomplete 52+ Week Waiters	0	0	0	0	0	0	0	0	2	NA	3	23	-87.0%	
Referral to Treatment Incomplete 35+ Week Waiters	0	37	23	18	22	9	22	14	161	-91.3%	14	65	-78.5%	
Diagnostic waiting times	1.0%	1.9%	2.4%	2.6%	0.9%	0.9%	2.2%	1.9%	0.28%	1.7%	1.8%		NA	
Two Week Wait Standard	93.0%	90.6%	93.6%	93.1%	91.8%	85.9%	87.6%	91.3%	92.45%	-1.2%	90.4%	90.71%	-0.3%	
Breast Symptom Two Week Wait Standard	93.00%	94.9%	96.1%	91.2%	84.1%	75.8%	81.3%	89.1%	91.18%	-2.0%	87.8%	87.47%	0.3%	
31 Day Standard	96.0%	97.8%	98.2%	95.1%	95.0%	96.9%	98.9%	100.0%	90.42%	9.6%	96.9%	97.09%	-0.2%	
31 Day Subsequent Drug Standard	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%	100.0%	100.00%	0.0%	
31 Day Subsequent Surgery Standard	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%	100.0%	98.57%	1.4%	
62 Day Standard	85.0%	82.0%	69.3%	70.5%	75.3%	73.9%	74.5%	75.4%	78.17%	-2.8%	74.5%	79.35%	-6.2%	
62 Day Screening Standard	90.0%	86.7%	87.5%	81.8%	84.6%	87.5%	80.0%	77.8%	87.50%	-9.7%	84.3%	81.71%	3.2%	
104 Day Waits	0	8.5	7.5	11.5	16.0	9.0	7.5							
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	0	0	0	0	0	NA	0	0	NA	
Proportion of patients not treated within 28 days of last minute cancellation	0	4.35%	6.67%	0.00%	8.33%	2.94%	0.00%							
Delayed Transfers of Care	3.50%	5.50%	7.60%	7.38%	6.67%	7.37%	5.35%	7.76%	4.63%		6.80%	4.81%		

Workforce

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Trust turnover rate	10%	13.0%	12.9%	12.1%	12.3%	12.2%	11.8%	12.2%	13.3%	-1.1%	12.4%	13.1%	-0.7%	
Trust level total sickness rate	3%	4.7%	4.3%	4.3%	4.2%	4.3%	4.4%	4.5%	5.5%	-1.0%	4.4%	4.6%	-0.2%	
Total Trust vacancy rate	10%	8.8%	8.8%	8.6%	9.2%	7.8%	8.9%		5.7%	#N/A	8.7%	3.7%	5.0%	
Temporary costs and overtime as % of total paybill	10%	13.4%	25.5%	13.5%	14.8%	16.1%	15.7%	16.1%	9.7%	6.4%	16.4%	9.3%	7.1%	
Percentage of staff with annual appraisal	85%	75.2%	74.9%	74.5%	75.0%	73.6%	77.6%	77.9%	68.3%	9.6%	75.5%	65.5%	10.1%	
Overall safe staffing fill rate	TBC													

Activity/Effectiveness

Indicator Description	Target	Pevious Months						Current Month			YTD			Trend
		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Oct-14	Var	Curr Yr	Last Yr	Var	
Primary Referrals	TBC (LYr)	8,769	8,442	9,471	9,715	8,020	8,868	9,111	9,956	-8.5%	62,396	62,334	0.1%	
Cons to Cons Referrals	TBC (LYr)	1,661	1,442	1,600	1,760	1,396	1,420	1,525	1,712	-10.9%	10,804	10,918	-1.0%	
First OP Activity	TBC (LYr)	9,840	9,348	11,469	11,252	9,581	10,500	9,972	10,520	-5.2%	71,962	71,233	1.0%	
Subsequent OP Activity	TBC (LYr)	22,765	20,611	24,611	24,066	21,710	23,809	23,724	24,171	-1.8%	161,296	158,714	1.6%	
New:FU Ratio	TBC (LYr)	2.31	2.20	2.15	2.14	2.27	2.27	2.38	2.30	3.5%	2.24	2.23	0.6%	
Elective IP Activity	TBC (LYr)	591	677	799	773	710	711	701	874	-19.8%	4,962	5,548	-10.6%	
Elective DC Activity	TBC (LYr)	3,667	3,567	4,024	4,118	3,684	3,754	3,710	3,721	-0.3%	26,524	25,356	4.6%	
Non-Elective Activity	TBC (LYr)	4,012	3,972	4,068	4,260	3,738	3,834	3,861	4,166	-7.3%	27,745	28,251	-1.8%	
A&E Attendances	TBC (LYr)	8,709	9,048	8,890	9,659	9,251	8,685	8,846	8,638	2.4%	63,088	62,185	1.5%	
Average LOS Elective	TBC (LYr)	3.1	3.0	2.9	2.8	3.0	3.1	3.1	2.6	17.8%	3.0	2.8	5.7%	
Average LOS Non-Elective	TBC (LYr)	5.7	5.4	5.1	5.5	5.1	5.7	5.5	5.3	4.9%	5.5	5.2	5.1%	
IP Occupancy Rate	85.00%													

Community

Indicator Description	Target	Pevious Months	Current Month	YTD

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	9b
Subject:	Quality Improvement Priorities Progress Report
Reporting Officer:	Alice Webster , Director of Nursing

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

Purpose:

The purpose of this paper is to update the Trust Board on the progress of the Quality Improvement Priorities (QIPs) identified within the Quality Account 2014/15.

Introduction:

The Quality Account 2014/15 identified five initiatives for improvement which align to the strategic aims of the Trust and the overarching objectives of improving Patient Experience, Patient Safety and Clinical Effectiveness. The five priorities are

1. Patient Experience - Improve the experience of our patients through improving face to face communication and the written information we provide.
2. Patient Experience - Improving compassion in care
3. Patient Safety - Reduce the number of fall's which cause significant harm.
4. Patient Safety - Deliver safe staffing by ensuring the right people with the right skills are in the right place at the right time.
5. Clinical Effectiveness - Improve the care of patients with dementia

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

The attached report provides an update on progress of the five quality improvement priorities. There is considerable progress for four of the QIPs and some work underway for the compassion QIP

The improvement programmes need to be flexible and responsive to change with the ability to adapt to the requirements of the organisation and external demands and a key challenge is to make quality everyone's business.

Benefits:
Specific benefits have been identified for each of the improvement areas which will be monitored throughout the duration of the projects by the aligned steering groups and through Q&S reporting.

Risks and Implications
If not progressed or delivered there is a risk to making improvements in quality and safety of patient care and trust reputation.

Assurance Provided:
The paper provides assurance that there is good progress with all the Quality Improvement Priorities and that there is effective monitoring and measurement to ensure projects are on track for delivery to realise the patient and staff benefits.

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

Proposals and/or Recommendations
The trust board is asked to note the contents of the report.

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

For further information or for any enquiries relating to this report please contact:	
Name: Emma Tate, Head of Clinical Improvement	**Contact details:** 01323 417400 ext 4498

Quality Improvement Priorities (QIP) for the Annual Quality Account Progress Report

1. **Purpose** The purpose of this paper is to update the board on the progress of the 5 Quality Improvement Priorities (QIPs) identified within the Quality Account 14/15.

2. QIP Progress Summary

Priority	Lead / Executive	Key Actions	Progress to date	Rag Rating
1 Improve the experience of our patients through improving face to face communication and the written information we provide.	Amy Reilly Alice Webster	Review Trust leaflets by speciality and produce a plan for the year. Ensure the 'Hello my name is ..' campaign is disseminated across the organisation. Test whether the campaign has had an impact by adding an additional question to the FFT. Raise awareness and importance of good communication with new Doctors at induction	Identified Clinical Units /speciality reviews for all patient leaflets and information across the year are ENT, Stroke Radiology, Orthopaedics, Urology, Cardiology, Diabetes Radiology has completed their review and are awaiting upload onto the extranet/website. Urology and Orthopaedics are progressing. ENT activity planned for Q3 Cardiovascular will be in Q4. 'Hello my Name is' campaign launched by the Director of Nursing in March 2015 and reinforced to nursing staff through Director of Nursing weekly newsletter in Q2 Work to include an additional question within the FFT to test whether patients feel that staff are introducing themselves by name is underway. Number of complaints in respect of communication is monitored at the Patient Experience Steering Group	Green

Priority	Lead / Executive	Key Actions	Progress to date	Rag Rating
2 - Improving Compassion in Care	Sara Songhurst Deputy Director of Nursing Alice Webster, Director of Nursing	Engage with our patients and Service users to understand what they see as compassionate care Review Trust performance against the 'Compassion in Practice – Our vision and strategy' and make recommendations for changes in practice Introduce Schwartz rounds Implement the 'Culture to care barometer 'at a pilot site	The introduction of Schwartz Rounds for staff commenced in May 15. The Rounds are open to all staff to attend, not just clinical or patient facing staff. Some non-clinical participants commented on how listening to others experiences provided them with a better understanding of the affect upon those colleagues and how they may be able to better support them. Further rounds have taken place in September and October with planned events on-going. The title 'When I made a difference' is the next Schwartz Round to be held in December. Culture survey being developed for Q4	Green
3 - Reduce the number of fall's which cause significant harm	Lucy Scragg, Associate Director of Nursing Alice Webster, Director of Nursing	Training and education of staff Develop a falls training workbook Falls prevention newsletter Quarterly falls awareness events Raise awareness and encourage staff to undertake falls training. Risk assessment and improving clinical care Ensure every patient in our acute sites is risk assessed using the falls risk assessment tool. Ensure that at risk patients have a further multifactorial risk assessment. Develop and implement an after falls	The trajectory to improve moderate harm fall rates is on track with a significant reduction in moderate harm in Q1and Q2 achieved. The falls to harm rate has increased but is being scrutinised and monitored In addition the trajectory to reduce total falls per 1000 bed days to be below 7/1000 is on track. Graph below for detail of charts A falls workbook has been piloted in 3 areas with positive feedback from staff. The workbook will be rolled out across the trust with the aim of completing by Q4 Falls workshops are running regularly Monthly snapshot audit of compliance for risk assessment through the ward based quality reviews identifies improvement in all three	Amber

Priority	Lead / Executive	Key Actions	Progress to date	Rag Rating
		care bundle to ensure we are maintaining best practice. Accessibility to equipment Ensure we have 24/7 accessibility to falls prevention equipment within our hospitals Audit data and reporting Regularly audit compliance with risk assessment Regularly audit compliance with falls care bundle.	Indicators An audit of the Safe Care bundle was also undertaken in August 2015, the results of which are currently being analysed with recommendations and actions to be made based on the findings. Initial analysis mirrors some of the SI themes about competed risk assessments and lying and standing BP's A lying and standing BP audit has now been added to the monthly meridian audit on fall's risk assessment. The first audit will take place in the third week of November.	
4 - Deliver safe staffing by ensuring the right people with the right skills are in the right place at the right time.	Moira Tenney, Deputy Director HR Lucy Scragg, Associate Director of Nursing	Develop a recruitment and retention strategy Undertake a twice yearly review of nursing establishment, present to board, seek approval of revised establishment and if required funding to support outcomes Regular campaigns to recruit to healthcare assistant posts In areas of high staff turnover ensure that full establishment is maintained by authorising recruitment to 110% of establishment to account for lead times in the recruitment Overseas recruitment campaigns to recruit registered nurses including	The Recruitment and Retention Strategy has been developed and was ratified in June 15. A recruitment and retention action plan has been developed and is being implemented. Actions include the embedding of the new TRAC recruitment system, Overseas and European recruitment to address shortage areas, new publicity materials, enhanced nursing bank rates of pay and a revised exit interview process rolled out in November. The TRAC continues to be rolled out to recruiting managers. The average time taken to recruit has reduced from an average 60 working days from receipt of authorisation to recruit to 37 working days. Nurse staffing levels were reviewed in April 2015. Clinical units have looked at their establishment and some agreements on changes in the interim have been made.	Green

Priority	Lead / Executive	Key Actions	Progress to date	Rag Rating
		theatre nurses and develop appropriate orientation plan. Introduce values based recruitment Develop career pathway for registered nurses	Data collection has commenced for the October establishment reviews. The report with recommendations scheduled to be with the DoN for Board in Jan 2016. There is on-going generic recruitment of HCAs - vacancies have now significantly reduced and generic recruitment of HCA's by Clinical Unit continues Principle of recruiting to 110% agreed. The trip to the Philippines took place w/c 9th November. 40 offers were made with an expected start date of Mar-16. European recruitment has also commenced planned for Dec to Spain Value based recruitment has been introduced with newly qualified nurses and is being rolled out to other areas. Some new roles have been developed, e.g. Ward Orderly. Further work to be taken forward via the newly established Workforce Planning Group with the first meeting held in October. Areas of initial focus will include skill mix and new roles	
5 - Improve the Care of Patients with Dementia	Elaine Lindfield, Lead Dementia Nurse & Dr Aktham Nahhas Dr Andy Slater	Expand our dementia care nursing team so that we are able to provide specialist knowledge, advice and support to our clinical teams, patients, relatives and carers across our community and acute hospitals. Further develop our educational	An education and training plan has been developed for the year. Specific focus for junior doctors is delivered through the induction handbook and sessions, on-going lunchtime educational sessions and grand round presentations. Joint working with Sussex partnership to deliver multidisciplinary training underway as open events for ESHT staff. The Butterfly Scheme has been launched and education delivered at	Amber

Priority	Lead / Executive	Key Actions	Progress to date	Rag Rating
	Medical Director Strategy	programme with focus on developing junior doctors awareness and understanding of effective care in dementia. Work collaboratively with our commissioners and Sussex Partnership Trust to develop a shared care ward on both acute hospital sites Undertake patient/carer and staff experience surveys and act upon the results. All environmental changes and improvements will be dementia friendly through a rolling programme for improvement.	EDGH and Conquest. Feedback evaluations are positive Patient/Carer surveys are underway and have been revised in conjunction with the Head of Quality for the CCGs with the aim of 10 per month received Agreement from the Estates department that changes to ward environments are dementia friendly with quarterly updates to the Dementia steering group in place. Compliance with CQUIN to find assess, investigate, refer and inform (FAIRI) shows a small improvement.	

3 Conclusion

The improvement programmes need to be flexible and responsive to change with the changing needs of the organisation and external demands however central to this plan is improving patient care and bringing about a step change in 'how we improve and manage the quality agenda', and make quality everyone's business.

It should be acknowledged that whilst there is progress in key areas there is further improvement work due to be completed in Quarter 3 and Quarter 4 in a number of areas. These areas will be closely monitored on their improvement and implementation of any necessary actions taken to ensure there is a postive change to the quality of care delivered.

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	10E
Subject:	Safe Nurse & Midwifery Staffing Levels – Quarter 2, 2015
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

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

Introduction:

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

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

- Appropriate Nurse staffing levels are critical to patient safety
- The Trust has systems in place to address and manage variations with support from senior nursing staff
- The variations that have occurred are managed appropriately
- Quality metrics and contributory factors are fully explored within the N&M Quality Review Group

Benefits:

- Maintaining adequate nurse/midwife staffing levels and skill mix is a key factor in reducing harm and poorer outcomes.

Risks and Implications

- It is acknowledged that these figures are an average across the month but the breakdown of this information is available at http://www.esht.nhs.uk/nursing/staffing-levels/
- This report does not negate the challenges of recruiting and maintaining a workforce that is robust and sustainable, without resorting to agency support.

Assurance Provided:

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

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

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

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

East Sussex Healthcare NHS Trust

SAFE NURSE & MIDWIFERY STAFFING LEVELS

1. Introduction

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

The current mandated reporting requirements also include the following inpatient areas: Paediatrics, Midwifery and Community Hospitals. It does not include escalation areas that are required during periods of high activity i.e. winter pressures.

2. Background

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

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

2.3 NICE also provides evidence that there is increased harm when there is less than 75% of the agreed Registered Nurse (RN) requirement on a shift.

3. Quarter 2 Report

3.1 The dashboards in Appendix 1, 2 & 3 have been prepared to reflect the above requirements for July, August & September 2015.

3.2 Throughout this period all areas maintained 75% or more of the required RN levels based on their planned establishment and professional judgment on the day.

3.3 Where the figure displayed is greater than 100% this is due to additional needs within the area, such as 1:1 supervision of vulnerable patients or to backfill lower ratio of Registered Nurse or Health Care Assistant workforce.

3.4 In August 2015 the Healthcare Assistant cover in the Crowborough Birthing Unit was low however this was assessed at the time and deemed acceptable.

3.5 All these quality indicators are closely monitored within patient safety and quality forums.

Conclusion/Recommendation

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

Whilst the information in this paper demonstrates that average staffing levels have been maintained over the period of each month it does not fully incorporate or reflect differing daily demand. Nor does it consider other key workforce factors such as maternity leave, absence rates and the impact of escalation areas.

This overview provides assurance that the systems and processes in place allow the Trust to monitor the provision of safe care in our inpatient wards, responding to changes in activity and demand. It does not however negate the challenges of recruiting and maintaining a workforce that is robust and sustainable.

Alice Webster
Director of Nursing

Elizabeth Fellows
Assistant Director of Operations

Appendix 1

Jul-15	CCU	Average fill day rate - registered nurses/midwives (%	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	82.40%	112.40%	87.10%	107.30%	3	10	3
CCU EDGH	Cardiovascular Clinical Unit	85.20%	100.00%	82.80%	100.00%	1	1	
James CCU	Cardiovascular Clinical Unit	97.80%	93.70%	96.40%	115.00%		4	
Michelham	Cardiovascular Clinical Unit	109.40%	88.70%	98.40%	101.60%	2	2	1
Stroke Unit EDGH	Cardiovascular Clinical Unit	90.50%	110.60%	99.50%	104.80%			
	Cardiovascular Clinical Unit Total					6	17	4
Crowborough Intermediate Beds	Out of Hospital	102.20%	107.70%	98.50%	84.10%		2	1
Uckfield Intermediate Care Beds	Out of Hospital	98.10%	99.00%	96.70%	109.70%	1	6	
Irvine Unit	Out of Hospital	90.80%	104.80%	102.30%	104.80%	1	2	5
Lewes Intermediate care	Out of Hospital	106.80%	89.60%	101.60%	100.50%		8	5
Rye Intermediate Care Beds	Out of Hospital	105.60%	93.00%	102.50%	100.00%		3	1
	Out of Hospital Total					2	21	12
Cuckmere	Specialist Medicine	91.80%	114.30%	96.80%	89.50%	2	5	
Jevington	Specialist Medicine	107.90%	103.90%	106.50%	102.10%	2		
Pevensey	Specialist Medicine	99.00%	103.30%	100.00%	93.50%	1	2	1
Wellington	Specialist Medicine	103.80%	92.80%	90.30%	94.20%		5	4
	Specialist Medicine Total					5	12	5
Benson Trauma	Surgery	91.50%	92.10%	100.00%	107.50%	2	3	2
Cookson Devas Elective	Surgery	88.70%	83.80%	87.10%	108.60%			
De Cham	Surgery	91.60%	103.90%	109.80%	93.60%	1	1	3
Egerton Trauma	Surgery	92.40%	89.90%	85.50%	104.50%	1	1	1
Gardner	Surgery	87.60%	127.70%	104.90%	109.00%	1	1	2
Hailsham 3 (Orthopaedic Elective)	Surgery	89.90%	102.80%	98.40%	101.10%	1		
Hailsham 4	Surgery	99.80%	99.20%	99.00%	92.70%	1		2
RT SAU	Surgery	84.20%	137.90%	93.40%	118.00%	1	1	1
Seaford 4 Urology	Surgery	88.10%	103.70%	100.00%	91.10%			
	Surgery Total					8	7	11
Cookson Attenborough - Surgical short Stay	Theatres and Clinical Support	109.50%	104.00%	105.60%	94.40%			
ITU/HDU Conquest	Theatres and Clinical Support	100.30%	87.20%	92.20%	100.00%	1		
ITU/HDU EDGH	Theatres and Clinical Support	99.50%	100.00%	82.00%	-	3		
	Theatres and Clinical Support Total					4	0	0
AAU Conquest	Urgent Care	84.20%	92.50%	95.70%	104.30%			
Baird MAU	Urgent Care	93.90%	100.60%	106.00%	102.90%		10	2
MacDonald	Urgent Care	89.90%	109.90%	104.80%	97.50%		5	
Newington	Urgent Care	86.90%	99.70%	105.70%	97.10%		10	
Seaford 1	Urgent Care	93.30%	104.90%	90.90%	105.40%			
Seaford 2/MSSU	Urgent Care							
	Urgent Care Total					0	25	2
Crowborough Birthing Unit	Women and Children	98.80%	90.50%	98.00%	106.70%			
EMU	Women and Children	97.90%	95.20%	99.80%	96.80%			
Frank Shaw	Women and Children	92.30%	98.10%	91.80%	88.20%	1		
Kipling	Women and Children	97.40%	92.90%	89.10%	108.80%			1
Mirrlees	Women and Children	106.20%	99.90%	101.10%	100.60%			
SCBU	Women and Children	102.60%	80.60%	89.50%	83.90%			
	Women and Children Total					1	0	1
	Grand Total					26	82	35

Appendix 2

Aug-15	CCU	Average fill day rate - registered nurses/midwives (%	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	87.10%	112.20%	91.50%	117.20%	1	1	
CCU EDGH	Cardiovascular Clinical Unit	82.30%	-	81.70%	100.00%			2
James CCU	Cardiovascular Clinical Unit	89.20%	99.20%	87.90%	100.00%		2	
Michelham	Cardiovascular Clinical Unit	81.60%	93.80%	88.70%	98.90%	1	1	1
Stroke Unit EDGH	Cardiovascular Clinical Unit	89.20%	116.10%	99.50%	99.60%	1	5	3
	Cardiovascular Clinical Unit Total					3	9	6
Crowborough Intermediate Beds	Out of Hospital	95.70%	105.00%	95.50%	100.30%	1	4	8
Uckfield Intermediate Care Beds	Out of Hospital	97.70%	98.40%	97.60%	101.50%		3	
Irvine Unit	Out of Hospital	92.10%	104.60%	94.20%	97.50%	5	2	1
Lewes Intermediate care	Out of Hospital	89.30%	100.20%	106.70%	89.40%		6	1
Rye Intermediate Care Beds	Out of Hospital	99.70%	98.60%	100.00%	96.80%		8	
	Out of Hospital Total					6	23	10
Cuckmere	Specialist Medicine	90.20%	102.20%	101.90%	97.10%		5	1
Jevington	Specialist Medicine	98.90%	101.40%	92.50%	96.20%		3	1
Pevensey	Specialist Medicine	96.90%	100.00%	100.00%	83.90%		1	
Wellington	Specialist Medicine	107.60%	94.20%	104.30%	81.40%	1	3	2
	Specialist Medicine Total					1	12	4
Benson Trauma	Surgery	86.90%	100.60%	95.20%	96.00%	2	5	
Cookson Devas Elective	Surgery	89.80%	104.80%	100.00%	100.00%		1	
De Cham	Surgery	93.70%	100.10%	88.00%	102.20%	1	4	3
Egerton Trauma	Surgery	92.40%	96.40%	90.30%	94.40%	4	4	4
Gardner	Surgery	80.00%	99.10%	97.00%	111.70%		2	4
Hailsham 3 (Orthopaedic Elective)	Surgery	83.00%	98.30%	84.30%	100.00%		2	4
Hailsham 4	Surgery	106.50%	98.80%	92.80%	101.40%	1	3	1
RT SAU	Surgery	93.60%	107.50%	81.40%	135.50%		2	1
Seaford 4 Urology	Surgery	93.20%	100.20%	96.50%	97.60%		1	
	Surgery Total					8	24	17
Cookson Attenborough - Surgical short Stay	Theatres and Clinical Support	100.00%	100.00%	100.00%	100.00%			
ITU/HDU Conquest	Theatres and Clinical Support	89.90%	80.60%	82.10%	100.00%			1
ITU/HDU EDGH	Theatres and Clinical Support	86.90%	100.00%	100.00%	-			2
	Theatres and Clinical Support Total					0	0	3
AAU Conquest	Urgent Care	89.50%	92.00%	92.50%	96.00%		2	
Baird MAU	Urgent Care	80.40%	106.20%	91.40%	115.10%	2	9	
MacDonald	Urgent Care	92.80%	102.80%	98.40%	84.50%		3	
Newington	Urgent Care	99.00%	110.20%	84.90%	89.40%	1	8	3
Seaford 1	Urgent Care	92.20%	110.80%	88.40%	112.60%			
Seaford 2/MSSU	Urgent Care							
	Urgent Care Total					3	22	3
Crowborough Birthing Unit	Women and Children	100.40%	53.20%	101.50%	87.70%			
EMU	Women and Children	90.40%	100.00%	83.10%	93.50%			
Frank Shaw	Women and Children	94.20%	104.90%	96.20%	96.80%			
Kipling	Women and Children	109.80%	95.60%	86.30%	80.90%			
Mirrlees	Women and Children	91.70%	97.00%	100.80%	100.00%			
SCBU	Women and Children	105.50%	100.00%	104.30%	80.60%			
	Women and Children Total					0	0	0
	Grand Total					21	90	43

Appendix 3

Sep-15	CCU	Average fill day rate - registered nurses/midwives (%)	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	
[redacted]	[redacted]	[redacted]	-	[redacted]	-		[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
	Cardiovascular Clinical Unit Total					0	17	4
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	
	Out of Hospital Total					4	19	1
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
	Specialist Medicine Total					4	8	4
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
	Surgery Total					13	23	10
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	-			[redacted]
	Theatres and Clinical Support					1	0	4
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	
	Urgent Care Total					5	15	2
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	Women and Children Total					0	1	5
	Grand Total					27	83	30

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	11 Fi
Subject:	Patient Experience Q2 2015/16
Reporting Officer:	Alice Webster

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

Purpose:

To inform the Trust board about Q2 feedback from patient's about their experience when using services provided by the organisation.

Introduction:

Patient Experience provides feedback from patients and the public on their experience of the Trust. The information in this report outlines the Trusts position in Quarter 2 in the following areas:

- Complaints including Parliamentary and Health Service Ombudsman (PHSO)
- Patient Advice and Liaison (PALs)
- Friends and Family Test (FFT)
- NHS Choices

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

Complaints Summary

In Q2 the Trust received 224 complaints compared to 172 in Q1; this is an increase of 23%.The Trust received 30 formal complaints relating to the Information Governance breach which accounts for the 23%.

179 complaints were closed during Q2, the percentage of complaints closed within timescales were 27.1% in July, 34.3% in August and 39.2% in September.

Top 5 themes of the complaints received in Q2 remain unchanged on the previous quarter; patient pathway, provision of service, communication, standard of care and attitude

During Q2 a total of 2 PHSO enquiries were received, three PHSO cases were closed (two cases partially upheld and one case not upheld).

Patient Advice and Liaison Service (PALS)

The total number of PALs contacts for Q2 was 2265 this is an increase compared to Q1 which was 1956. PALs experience two key spikes in activity; the first being related to the Information Governance breach and the second relate to the appointments line issue.

The majority of contacts were to raise and concern and the top theme was regarding appointment/ admission queries.

Friends and Family Test (FFT) Patient feedback

Inpatient areas achieved an overall satisfaction rating of 89.78%.
The Emergency departments achieved an overall satisfaction rating of 85.71%.
The Labour and Birth departments achieved an overall satisfaction rating of 85.47%.
The overall satisfaction score of all patients surveyed during Q2 was 90.2%.

NHS Choices
Of the 55 narratives posted 46 comments gave three stars or above with positive comments and 9 comments gave three stars or below with negative comments.

Benefits:

Triangulation at department, service and ward level with regular review of their patient feedback data arising from FFT, complaints, NHS choices, PALS and compliments is used to help improve services; patient pathways and front line care.

Regular meetings have been held between the Patient Experience Lead, Complaints and PALs Manager and the Patient Experience Manager to triangulate further this information and create work plans which can be fed back to the Clinical Units or identify where further analysis is required.

Risks and Implications

Responding to patients complaints within timescales, the number of out of time complaints continues to be an issue for the Trust. Implications could be the reputation of the Trust in handling complaints.

Assurance Provided:

Additional Complaint Officer posts (3 wte) have been funded to increase the establishment of the complaints team- currently out to advert.

Quarterly meetings with Clinical Units now take place to review closed complaints and actions/ learning set from these complaints.

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

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

Quality and Standards Committee (?date)

Proposals and/or Recommendations

Recruit to the additional Complaint Officer posts.

Implement a post complaint survey which will be sent to all complainants to identify areas of improvement in the handling of complaints.

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

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

For further information or for any enquiries relating to this report please contact:	
Name: Amy Reilly	**Contact details:** 07813369481

East Sussex Healthcare NHS Trust

Patient Experience Report Quarter 2 2015/16

1.0 Introduction

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

The information in this report outlines the Trusts position in Quarter 2 (Q2) in the following areas:

- Complaints including Parliamentary and Health Service Ombudsman (PHSO)
- Patient Advice and Liaison Service (PALs)
- Friends and Family Test (FFT)
- NHS Choices

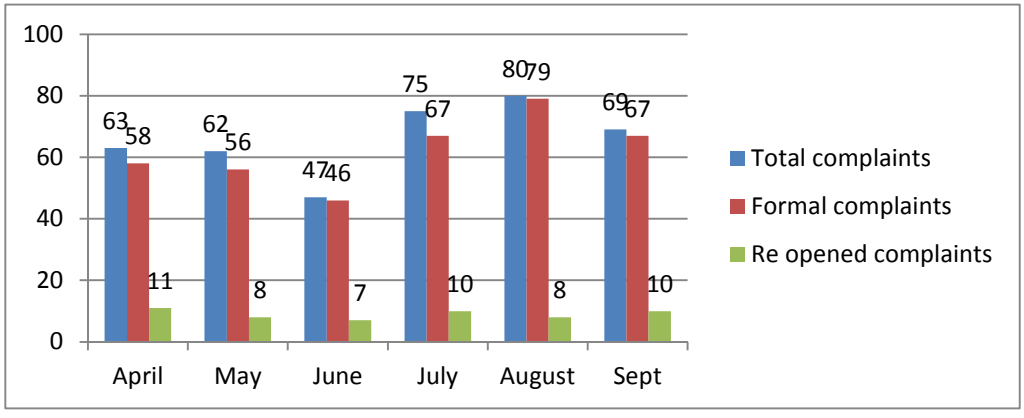
2.0 Complaints Summary (including Parliamentary and Health Service Ombudsman)

2.1 The complaints team experienced unexpected challenges this quarter due to the Information Governance breach (memory stick). The complaints team supported the PALs team which resulted in time being lost handling complaints, this impacted on our number of complaints responded to within timescale. As a result of this an additional complaints officer post (0.9wte) was created for three months and a bank administrator (band 2 1.0wte) was recruited for the same period.

2.2 In Q2 the Trust received 224 complaints compared to 172 in Q2 2015/16; this is an increase of 23%. The Trust received 30 formal complaints relating to the IG breach which accounts for 57% of the increase in complaints this quarter.

The following chart shows the total number of complaints, formal complaints and reopened received per month:

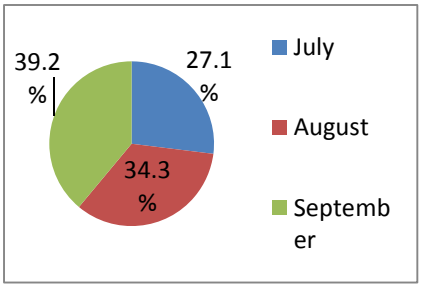
New Complaints received in Q1 and Q2



2.3 93.3% of complaints were acknowledged within three working days. Those complaints which were not acknowledged within the regulated time scale were complex in nature. It is recognise these should be acknowledged and action is being taken to rectify this.

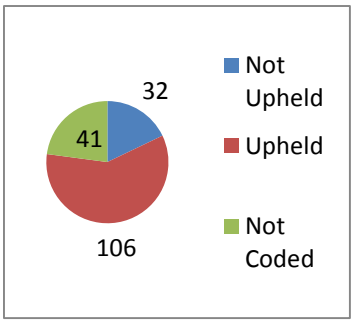
2.4 The number of complaints closed during Q2 was 179, this is an increase compared to 172 in Q2 2015/16. The chart below shows the percentage of complaints closed in time during Q2.

Complaints closed in time



2.5 The chart below shows the number of closed complaints recorded as “upheld”, “not upheld” or “not coded” as recorded on Datix.

Closed complaints status



The Complaints and PALs Manager has established a process whereby when a complaint is going through the quality assurance process the status is recorded, this is to ensure all complaints are clearly identified as upheld or not upheld.

Where a complaint is not upheld, there is still the opportunity to learn why the complainant has complained and the need to understand the motives and feelings of the complainant. This is something we plan of seeking through the use of our post complaint survey; our long term plan is to establish a user group to identify how we can handle complaints in a more effective way from the views of the complainant.

Examples of actions from closed complaints:

- The nurse did not introduce himself therefore the nurse in question has been asked to do this on all interactions with patients.
- Increase the number of Urology outpatient appointments available.
- Service Manager will ensure that the community midwife contacts the woman she is responsible for the day after discharge to find out if the woman wants a visit and to plan her care following the loss of her baby. Normal practice should be

that a discharge form is completed and given to the community midwife who should telephone the woman the following day to discuss when she would like to be visited. Service Manager will e-mail staff and reiterate to them at mandatory training the correct process for when a woman is discharged home following the loss of her baby.

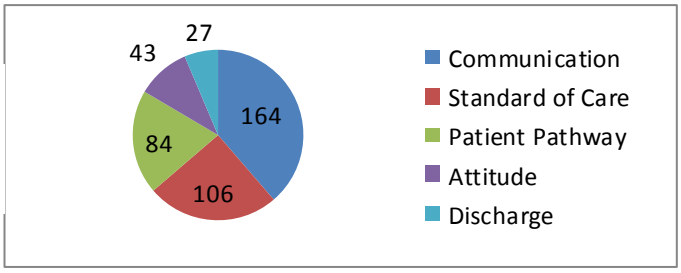
2.6 Our position at the end of Q2 regarding overdue complaints was a total of 74 overdue cases, this is an increase compared to Q1 which was 51cases.

As noted in 2.1 the department supported PALs during the initial IG breach from patients which impacted on time spent handling complaints.

The Complaints Department continues to experience difficulties with the Clinical Units in relation of timely and comprehensive statements, draft complaint responses, responses to queries or questions. These issues significantly contribute to the delays in providing complainants with a response in the timescales set out by the Trust and as a result, the Complaints Department are experiencing a higher number of chaser contacts from complainants who, understandably, are unhappy with the delays they are experiencing.

2.7 The chart below shows the top 5 themes of the complaints received in Q2 as recorded on Datix.

Top 5 Complaint Themes in Q1



The Patient Experience Lead has the lead role on delivering the “Communication” commitment set within the Quality Improvement Plan. Progress towards this includes:

- Medical Education adding a ‘Communications’ element to the Junior Drs teaching programme, as a large number of the complaints you have received have been around communication between our Junior Drs and patients.

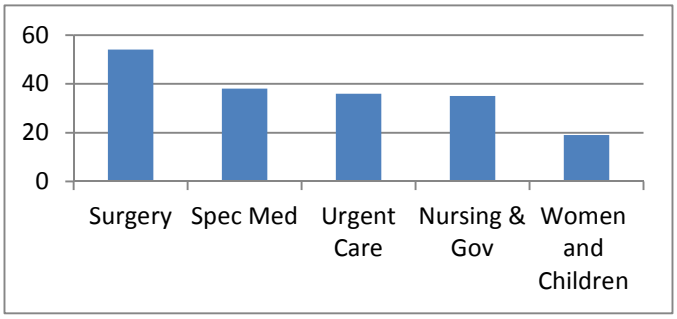
- “Hello my name is..” is due to be re launched and monitored through the Friends and Family Test. An initial reminder of the importance of introducing ourselves has been distributed to Nursing staff through the Director of Nursing weekly newsletter. Further work is to be carried out in Q3 around reinforcing the importance of this.

- The Patient Experience Manager is working with Clinical Units to ensure two specialities per quarter have reviewed their patient information.

- The Dignity Day 2016 is in the planning stages and this will include communication

2.8 The chart below shows the top 5 Clinical Units in receipt of complaints as recorded on Datix.

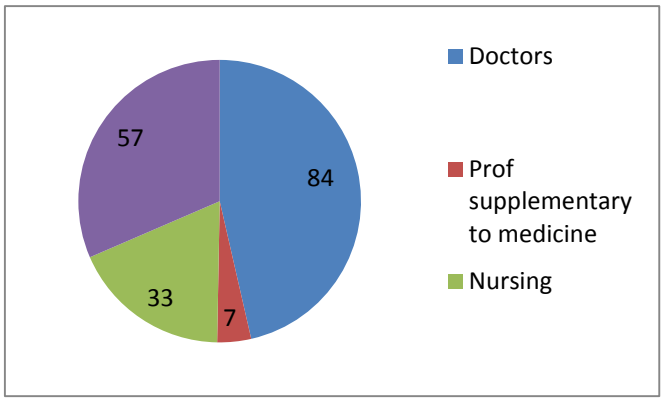
Top 5 Clinical Units



Surgery is noted to have the highest number of complaints in Q2, the top themes (as recorded on Datix) are communication, standard of care, patient pathway, attitude and discharge. This has been feedback to the General Manager and Head of Nursing.

2.9 The chart below shows the professions where a complaint has been raised against them (please note: "other" includes administrators) during Q2.

Complaints against professions in Q2



The chart above replicates the proportions of complaints against profession during Q1.

2.10 As noted in Q1 report the quality assurance check process has identified that there has been a failure to identify the questions raised by the complainant at the start of the process, this is improving as the team are clearly recording these for the Clinical Units to answer.

2.11 During Q2, the Patient Experience Lead and Complaints and PALs Manager met with all Clinical Units to gain assurance that lessons/ actions from complaints have been learnt and actions implemented. This identified that some managers require training to complete the WRAPP form in an efficient way which meets the needs of improving and developing the care we provide.

2.12 Parliamentary and Health Service Ombudsman Enquiries (PHSO)

During Q2 a total of two PHSO enquiries were received (outcome unknown at the time of writing this report).

During Q2, three PHSO cases were closed; (two cases partially upheld and one case not upheld).

Actions:

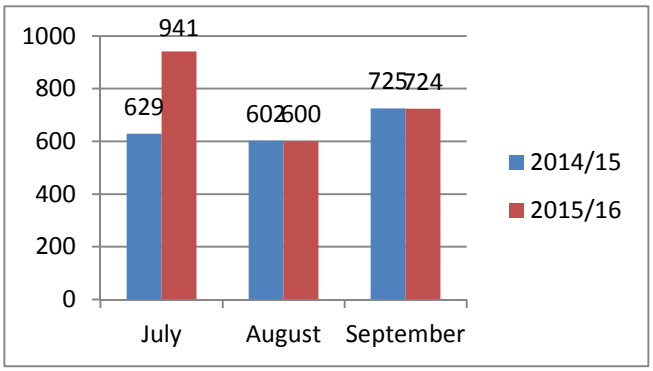
- An apology to be sent to the complainant.
- An apology and an action plan to negate further recurrence of the complaint happening (copy to be sent to complainant.

3.0 Patient Advice and Liaison Service (PALS)

3.1 During Q2, the PALs offices have experienced two key spikes in activity; the first related to the Information Governance breach, whereby the Trust directed all enquiries from the public to PALs. The second spike in activity relates to the appointments line issue, patients experiencing difficulty making contact with the appointments team. This was reported to the Assistant Director of Operations and as a result this matter has now been placed on the Trust Risk Register.

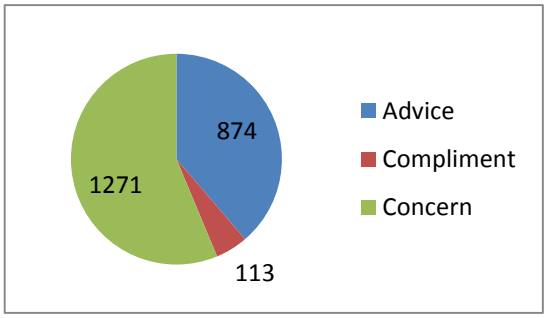
3.2 The graph below shows the number of PALs contacts by month for Q2 2014/15 and Q2 2015/16. The total number of PALs contacts for Q2 2015/16 was 2265 this is an increase compared to Q1 2015/16 which was 1956. This increase in contacts is a direct result of the IG breach.

PALs contacts in Q1 2015/16 compared to 2014/15



3.3 The chart below shows the type of contacts which PALs received in Q2 as recorded on Datix.

Types of PALs contacts received in Q2

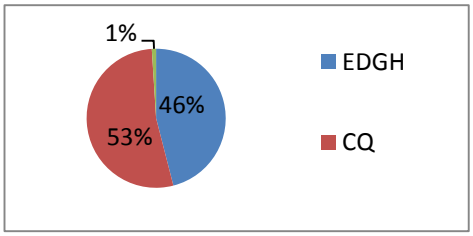


In Q2 1271 of PALs contacts were concerns (56%), this is a 8% increase from Q1 which can be identified as the IG breach contacts made.

3.4 PALS are continuing to provide a rapid access point of contact for patient's and the public with 91% of concerns being responded to within 2 working days. The response rate has increased by 1% from Q1.

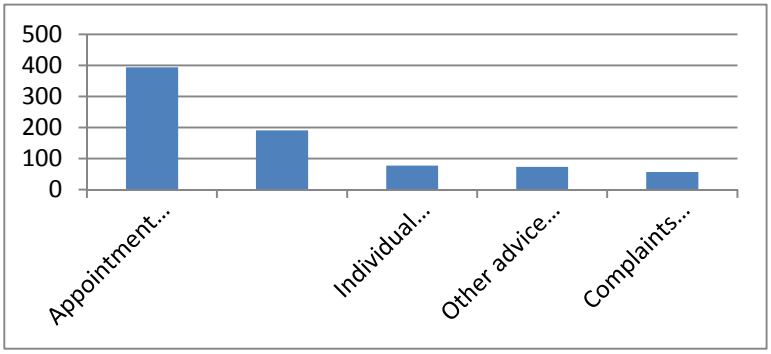
3.5 The table below shows the site in which the PALs contacts relate to:

Percentage of PALs contacts



3.6 The graph below shows the breakdown of PALS concerns by category as recorded on Datix.

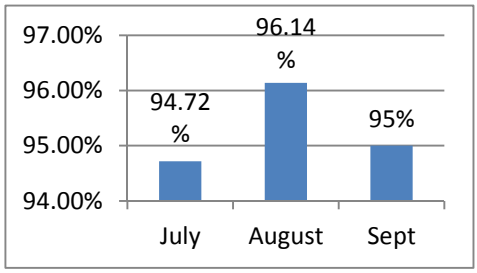
Top 5 PALs Themes in Q2



4.0 Friends and Family Test (FFT) Patient feedback

4.1 The chart below shows the Friends and Family Test Trust wide results.

FFT Trust wide results (% recommended)



4.2 The overall satisfaction score of combined results from all patients surveyed during Q2 was, **90.2%** of all patients who used the Trusts services were satisfied. This overall satisfaction score has remained the same from Q1 (which had an overall satisfaction score of 89.85%).

4.3 Inpatient areas achieved an overall satisfaction rating of **96.86%**compared to **89.78 %** in Q1. The overall satisfaction has increased by 7%.

4.4 The Emergency departments achieved an overall satisfaction rating of **87.56%** compared to **85.71%** in Q1. The overall satisfaction has increased by 1.85%.

4.5 The Labour and Birth departments achieved an overall satisfaction rating of **87.55%** compared to **85.47%** in Q1. The overall satisfaction has increased **2.08%**.

4.6 The collection of FFT data is soon to be refined as the Trust has committed to upgrade to the Meridian system. Optimum the company will provide better support to enable improved data analysis and training to staff so that they can access this data themselves. Currently the Business Intelligence team are working with Optimum on ensuring the structures are correct to reflect the Trust activity.

4.7 Sample Patient Feedback from Family and Friends Free Text

Arrived at 8.30 a.m., been called to go to the room to see doctor at 9.45. Kept there until 11.00 am, did not see doctor. I went home without any help. Really bad. (A&E Patient)

Spoke clearly and friendly. Did not speak down to me (I am disabled and Mums carer).

Things were explained well and pain treatment and was kept on top of, treated like an individual. The staff were friendly. (inpatient)

Organisation of booking in. It is quite ludicrous and a major waste of every ones time. Some of us are arthritic and have back ache so standing with no support is painful, and not conducive to a comfortable consultation. (Outpatient patient)

4.8 Ward feedback

As part of the FFT programme, the Trust has developed 'You said; We did' Boards. Ward Matrons can access the free text feedback from the Meridian system to populate these Boards. It has been identified that these boards are sometimes out of date, a bi weekly review of the boards will take place with the support of Patient Experience Volunteers (under the guidance of the Patient Experience Manager) to ensure that these are updated appropriately and regularly. The following tables provide some extracts of these Boards taken from Q2:

Tressell - You said	**We did**
1. We have great patience and compassion 2. You have made me feel safe and comfortable	Everything to make this the best patient experience

Seaford 4 - You said	**We Did**
You said that visiting times were not adhered to and felt you weren't able to rest properly. You said that you had to wait a long time for pain relief and that a few times you were completely forgotten.	We have put up extra signs at the entrance of each bay asking visitors to please respect our visiting times to allow our patients to rest and to give us the time to care for them properly. In exceptional circumstances can a special request be made to visit outside these hours to the ward matron. We are carrying out regular checks to ensure you are comfortable. At times there may be delays due to staffing shortages or increasing workload. We aim to review pain medication regularly to ensure adequate cover and have reminded staff to do this every morning. Pain relief can only be administered by a registered professional (e.g. staff nurse in blue uniform). Care assistants (green

	uniform) are not trained to give medication but will let your staff nurse know that you are in pain.

Frank Shaw & Murray - You said Patients have requested improvements in showering facilities of the ward	**We did** An application has been made to improve current bathroom and provide an additional shower room

5.0 NHS Choices

5.1 NHS choices is a website where service users can post comments about their experiences of using NHS services. The Patient Experience Manager acknowledges thanks and responds to these comments and signposts to other services as appropriate. All comments are shared with the relevant manager/ department and disseminated to all Patient Experience Champions for distribution amongst their teams.

There is also a facility for service users to rate the service using a star rating from 1 to 5 stars with 1 being a poor rating to 5 being excellent.

5.2 A total of 55 narratives were posted on NHS choices during Quarter 2, this is a increase of 36% in posts compared to 35 in Q1.

Of the 55 narratives posted 46 gave three stars or above with positive comments and 9 gave two stars or below with negative comments.

5.3 The following table shows the themes from the 55 narratives received in Q2.

For excellent ratings:	**For low ratings**
Staff kindness, efficiency and caring attitude. **Good communication.** **Many staff praised for their standards of care.**	***Accident and Emergency** **Staff attitude.** **Communication.** **Staffing levels (nursing and medical)**

5.4 Some examples of the comments received and the feedback provided are shown below.

Examples of comments received and responses provided

Comments received	**Our replies**
I had an angiogram in the Cardiac Care Unit at the hospital on 21st September. I was very nervous about the procedure, which involves the heart, but the staff who looked after me were the best. All staff were kind, caring, helpful, friendly and professional. I felt completely safe with them and had absolute	Thank you so much for your detailed account outlining your personal experience of undergoing an angiogram in CCU at Eastbourne DGH. The CCU staff will be very pleased to hear

confidence in their ability to carry out my procedure. From arrival to discharge, every member of staff that i encountered was helpful. Apart from the consultant, all gave their first names, and the communication was excellent. I saw a doctor before my procedure who explained everything, and the senior doctor came round afterwards to discuss the results. During my day stay I was in a small ward with 3 others who were undergoing the same procedure; three of us were women, plus one man. I personally didn't find this a problem. The cubicles were curtained, we were all mobile and able to leave the ward to use the toilets, and the staff were careful to protect our privacy. I have to return to the hospital for a second heart procedure, and obviously I'm not looking forward to that, but my experience on 21st September means that I can be more relaxed about it. Thanks to all the staff who looked after me.	that you found them all to be kind, caring and helpful as well as friendly and professional. Comments such as these truly reflect their commitment to high quality care and having confidence in the staff treating you is hugely important. It's kind of you to provide feedback. Please be assured that your posting will be shared with staff. We send you our kindest regards.

My husband who is due for a minor op ,day surgery case probably .stff were friendly. The question I have is he was told that they don't give pain relief he needs to bring his own, that not a problem, I find it odd that hospital doesn't give pain relief after any surgery minor or major. Does this mean if you don't bring pain relief with you, you have to suffer till you get home?	Thank you for your question about your husband's pending stay for day surgery at Eastbourne DGH, and the general arrangements for pain relief. The nurse in charge has advised that all patients are asked to bring in all their medications, this helps to improve the service and avoid unnecessary delays, should a patient require medication that is not stocked on the ward. May we re-assure you that all pain management needs are assessed after surgery and acted upon accordingly. Thank you for taking the time to post a question. Please do not hesitate to contact our Patient Advice & Liaison Service should you have any further queries. They can be contacted on 01323 435886 or by email at: esh-tr.PALSE@nhs.net.

6.0 Analysis and conclusion

6.1 Top five categories continue to remain the same for both PALS and Complaints, further analysis is to be undertaken and actions to be set and reviewed. This will be achieved through the use of a specific survey to establish better understanding of the issues raised and where improvements can be made.

6.2 Again communication issues remain within the top five themes, as noted in point 2.7 the Patient Experience Lead has the lead role for "Communication" set within the Quality Improvement Plan.

6.3 It has been identified that some information has not been entered correctly missing from Datix. The Complaints and PALs Manager is looking at reviewing some of the mandatory fields but also training to improve data entry.

6.4 Triangulation at a team level consists of each department, service and ward regularly reviewing their patient feedback data arising from FFT, complaints, NHS choices, PALS and compliments. Now the Complaints and PALs Manager is in post regular meetings will be held between the Patient Experience Lead, Complaints and PALs Manager and the Patient Experience Manager to triangulate this information and create work plans.

6.5 Patient Experience work plan has been devised for 2015/2016 and is shared and monitored at the Patient Experience Steering Group. Clinical Units are required to have a representative at each meeting who is responsible for taking back the lessons learnt. All Information is triangulated and reviewed at quality review meetings chaired by the Director (and Assistant Directors) of Nursing. This meeting still requires attendance from a "Medical" representative.

6.6 NHS Choices continues to provide us with rich patient feedback; we will respond to and share accordingly. Healthwatch have also established a feedback centre, we work closely with Healthwatch to ensure we capture the data they collate. Alongside this we also receive patient and GP feedback via "one click" some thought needs to take place as to how we report on this as sometimes it is not given to us in a timely manner or missing vital information in order for us to categories.

7.0 Recommendations and Actions from the Report

Activity	Action	Timescale
Responding to patient complaints.	Significantly improve on the number of out of time complaints.	**Ongoing-** The quality assurance process has impacted on the time delay to complainants.
Implement post complaint survey	Survey to be sent to complainants	**September 2015-** this has been delayed, due to start December 2015.
Meet with Clinical Units to review process for completing actions arising from complaints.	Meet Quarterly with Clinical Units to review the progress towards completing the actions.	**Completed**
Consider specific patient survey relating to patient pathway, to identify areas of improvement.	Compile a survey; include patient's participation in the set up to ensure we are covering areas of concerns.	**August 2015-** this has been delayed due to operational issues which clinical managers have faced.
Seek to find a greater understanding of the communication issues raised.	Further analysis into the data recorded on Datix by commissioning the delivery of a health check of our systems by Datix followed by training to the complaints and PALs teams.	Datix have put forward their recommendations and the Complaints and PALs Manager is reviewing these with the Team.
Patient Experience Manager	Patient Experience Manager to	**Ongoing**

to work with clinical areas to improve the number of responses received FFT	work with Matrons to increase the response rate of FFT	
Recruit to the vacant PALs Officer (0.6wte) and Complaints Officer (1.0wte) posts.	Currently out to advert, interviews due to be held on the 19th and 20th October.	**Candidates to be in post by December 2015.**

Patient Experience Lead
October 2015

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	12
Subject:	Mortality Report
Reporting Officer:	Dr James Wilkinson, Assistant Medical Director, Quality

Action: This paper is for

Assurance	√	Approval		Decision	

Purpose:

The purpose of this report is to:

- Provide a summary of trends in the main mortality indicators.
- Outline ESHT mortality monitoring and assurance mechanisms and progress in monitoring.
- Update the Clinical Quality Review Group on the Trust's current position with respect to the main indices, and the most recent alerts from CQC.
- Update on recent CQC CUSUM alerts or enquiries from other external bodies

Introduction:

Trust mortality monitoring and assurance mechanisms are explained in Section 2.

The current position with respect to mortality indicators, alerts and areas of concern is highlighted in sections 3 and 4.

The various mortality indices, and the main differences between them, are described in Appendix 1 Members may already be familiar with these.

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

- There was an increase in all mortality indices covering clinical activity in the months November 2014 to January 2015, since when indices have improved substantially.
- Summary Hospital-Level Mortality Indicator (SHMI) having fallen from a peak of 114 in 2012 to 108 in May, but has subsequently risen to 111 (July) and, in the most recent release (October) to 114, again lying outside the normal range (90-110). This has been investigated with CHKS.
- HSMR rolling 12 month average index for the full year 2014-15 rose to 120 (March 2015) from 105 in March 2014 and 116 in March 2013. Latest HSMR (July) is 100, and the rolling 12 month average to July is 110.
- Death in low risk groups currently lies at 0.09%. This is close to the median value for the national peer group of acute Trusts.
- The Trust has received no Cumulative Sum (CUSUM) alerts from CQC since March 2014. The most recent alert (therapeutic endoscopic biliary tract procedures) was closed by the CQC in August2014.
- Use of the electronic mortality database for recording mortality reviews is now fully established, thought there remains some variation between consultants. The 2014-15 Q4 CQUIN requirement of 75% reviewed within 3 months of death was achieved. Current status is 82% of 2015-16 Q1 deaths reviewed within 3 months.
- The Mortality Review Group (MRG) and Mortality Overview Group (MOG) continue to monitor mortality indices monthly.
- Monthly mortality scorecards are now completed for all CUs and are reviewed at MRG.

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

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

Assurance Provided
This paper aims to provide assurance both on the robustness of the Trust's mortality review systems.

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

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

Proposals and/or Recommendations
The Board is asked to: • take assurance on the increasing robustness of the Trust's mortality review systems • note the need to remap on PAS of clinical specialties and consultants to the relevant CUs • note the variation in both nationally published and internally monitored mortality metrics • consider the potential underlying factors driving the adverse increase in mortality indices in the period December 2014 to March 2015

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

For further information or for any enquiries relating to this report please contact:	
Name: Dr James Wilkinson, Assistant Medical Director – Quality	**Contact details:** 01323 417400 ext 3718

Report for Quality and Standards Committee

Mortality Indicators

1. Introduction

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

Trust mortality monitoring and assurance mechanisms are explained in section 2.

The current position with respect to mortality indicators, alerts and areas of concern is highlighted in sections 3-4.

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

2. Monitoring and review of mortality indicators and metrics

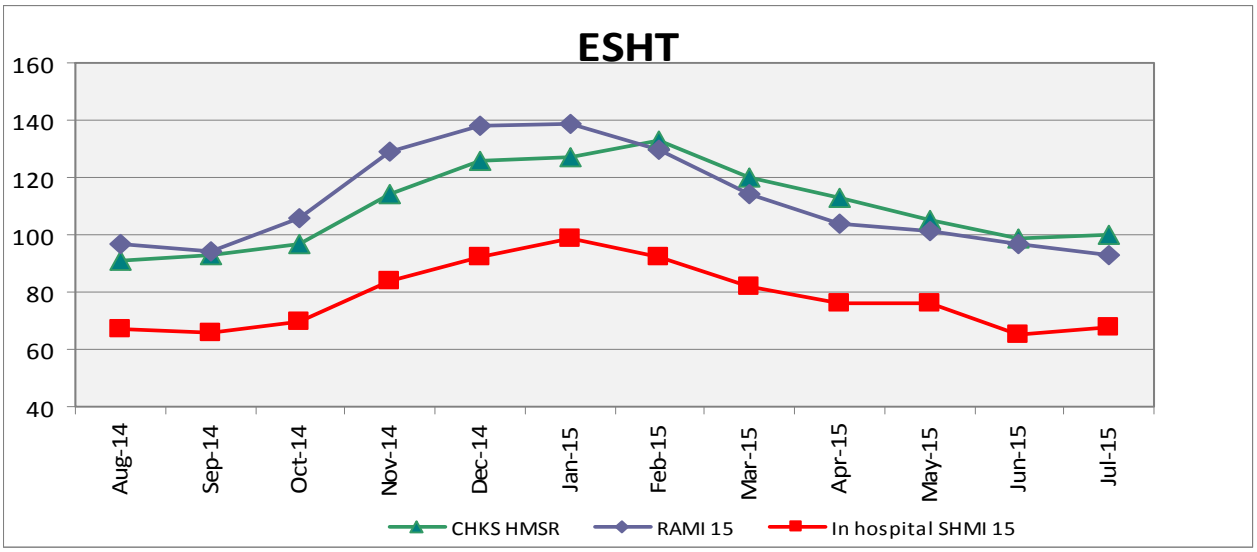
The Trust has developed a framework to review the three main SMR indicators (RAMI, HSMR and SHMI), crude mortality and a number of associated metrics on a monthly basis using the CHKS "Insight for Acute Healthcare" tools. These now also provides high level HSMR and SHMI by Diagnosis groups, with CUSUM alerting capacity, via the Mortality Profiler tool.

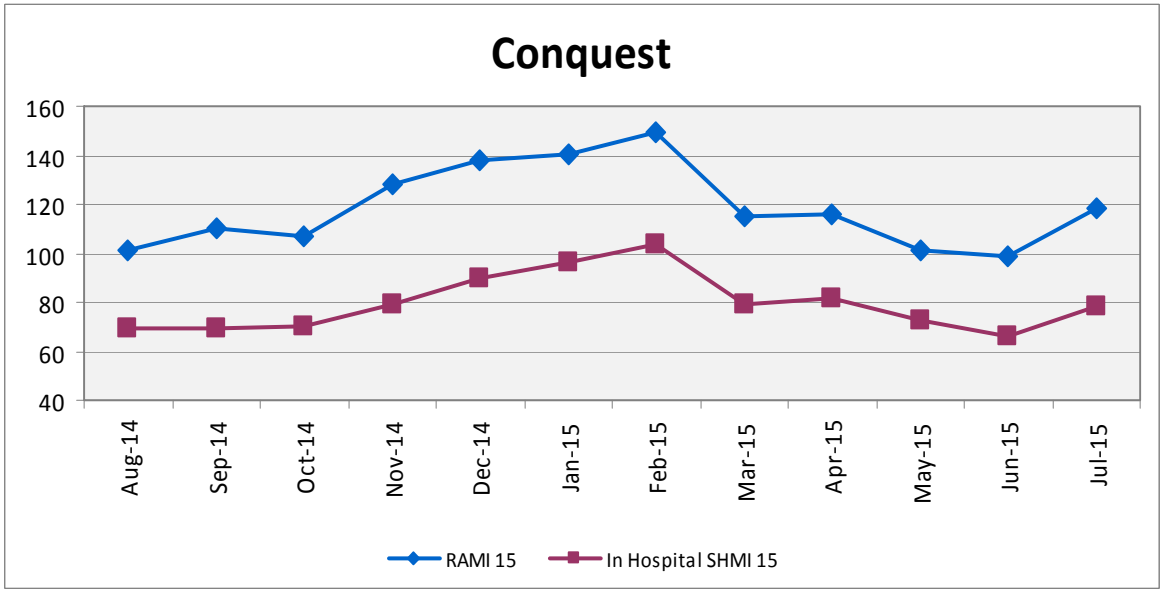
All CUs, and individual consultants, can utilize CHKS to access and assess their own data very quickly, drill down to find out where problems may exist. Although the CHKS tool uses a different methodology to that of Dr Foster (and consequently Imperial and CQC CUSUM alerts), it does appear to offer a similar degree of early warning of areas of increasing mortality. Generally, but not always, highlighting the same diagnostic groups that are picked up by Dr Foster.

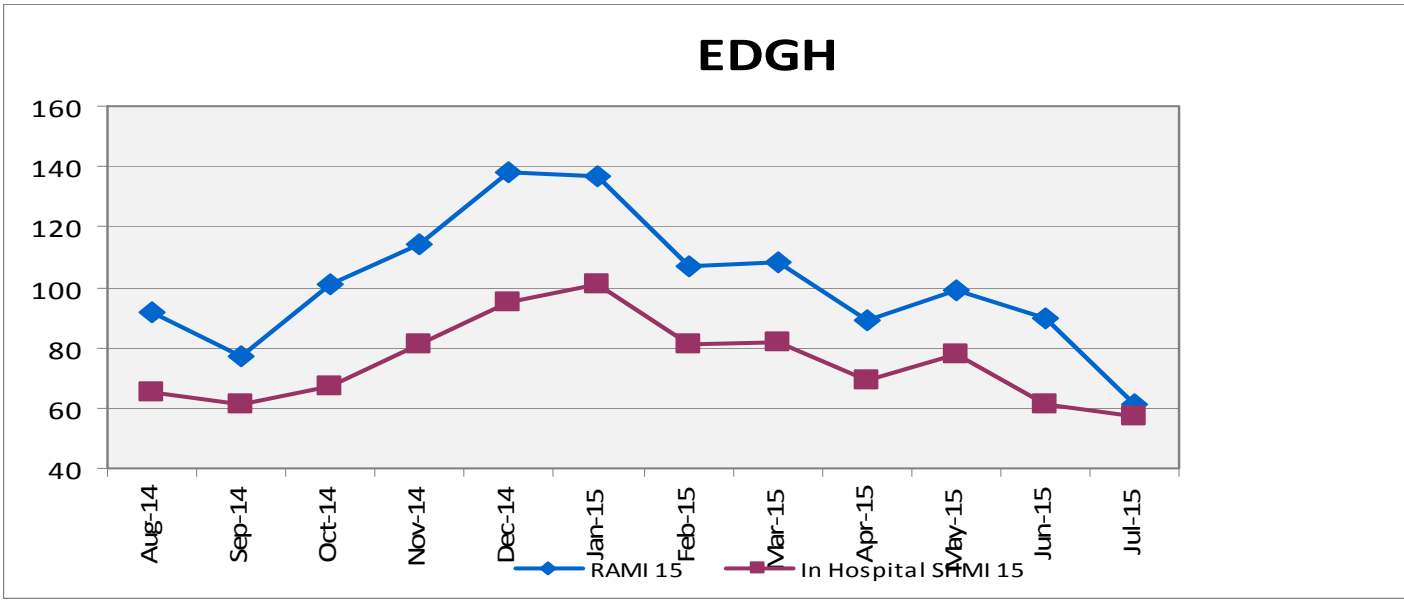
This difference has become a slight issue this year as the CCGs have acquired use of Dr Foster. This has generated requests for more information, which have proved challenging to investigate; the difference between the two systems. And the lack of patient information available to the CCGs make it difficult to drill down to the precice areas that has caught their intererest.

Comparison of RAMI, HSMR and in Hospital SHMI

Though the measures differ in their specifics, variations in each are, in general, similar. The tables below outline these metrics for the Trust, and for the acute sites; Conquest and Eastbourne DGH


ESHT
160
140
120
100
80
60
40
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
CHKS HMSR
RAMI 15
In hospital SHMI 15


Conquest
160
140
120
100
80
60
40
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
RAMI 15
In Hospital SHMI 15


EDGH
160
140
120
100
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Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
RAMI 15
In Hospital SHMI 15

Mortality Review Group (MRG)

The monthly multi-disciplinary Mortality Review Group (MRG) focuses on the review of CHKS mortality data, triangulating a variety of information from other quality indicators and supported by the production of a high level Trust Mortality scorecard. The work plan for the MRG is attached (Appendix 3), incorporating review of CQC Intelligent Monitoring reports from HSCIC. The recent provision of Band 5 level clerical support, commenced in July, has enhanced considerably the functionality of this group.

Revised and updated Terms of Reference were agreed at the August meeting. These will be reviewed in 1 year.

With considerable changes in, and turnover of the senior nursing and governance staff over the last few months, the meetings have not all been quorate.

CU monthly reporting of Mortality and patient indicators has been in place since July 2014. These form a part of the monthly quality scorecard and are currently completed by staff from Knowledge management, with CUs asked to add commentary.

The input to these scorecards from individual CUs has varied considerably between Units over the last year, but has generally been poor. The Band 5 Admin post has enabled us to collect, collate and track the monthly scorecards much more effectively.

Investigations undertaken in 2014-15

- Community hospitals
- Dermatological conditions
- Abdominal hernias
- Endoscopic procedures of biliary tract
- Low risk groups
- Lung cancer
- MI

Investigations completed in 2015-16

- Biliary tract mortality - presented to MOG in September
- Quality review of Electronic Mortality Database records.

Ongoing investigations

- General rise in RAMI in November and December, supported by CHKS.
- Organic mental disorders (Dr Nahhas)
- Devices and Implants (Dr Wilkinson)
- Biliary Mortality (Miss Morris)
- Urinary Tract Infections (Dr Wilkinson)

Mortality Overview Group (MOG)

From Q2 this year, a regular programme of CU attendance has been arranged, replacing the previous arrangement, in which CUs were called to attend at varying intervals, depending on whether issues were apparent from the MRG monitoring process. The regular schedule provides each CU with sufficient notice to ensure that the most appropriate representatives attend, appropriately briefed. Each CU attends 3 times a year. The detailed schedule is attached as Appendix 2.

The Terms of reference of the MOG have been reviewed and the updated ToRs agreed at the August meeting.

Morbidity and Mortality (M&M) Trust Policy

The Trust M&M Policy outlines the standards/expectations for all deaths to be reviewed using a standardised template, the classification of all death to identify if there were possible avoidable factors and that each review is now captured electronically on the trust developed mortality database. The policy was updated in 2014. The next review is due in 2016

Trust Electronic Mortality Database

The Trust electronic mortality database records details of deaths in Bexhill, Conquest and Eastbourne DGH, in which hospitals patients are under the direct care of ESHT consultants and their teams. This process is managed by the Trust bereavement offices. More than 99% of all deaths at the hospital sites are recorded on this database.

Since April 2014, the database has provided a transparent record of the details of review of deaths within the acute hospitals and now incorporates those deaths within 30 days of discharge from the acute sites.

Progress in implementing the database and recording of mortality reviews

The Trust achieved the 2014-15 CQUIN target of 75% of mortality reviews recorded on the database within 3 months of death, and the proportion has increased further since then. However there remains variation between CUs and between individual consultant teams.

Work has started on refining the database, making it more user friendly, and increasing the number of reports available, based on feedback from the CUs and individual users. However, the accuracy of the database reports has so far been limited by difficulty in mapping individual consultants to specialties and specialties to CUs. This is now being addressed with Knowledge Management. It is part of a larger issue involving the correct mapping of specialties to CUs on PAS, which also limits the accuracy and applicability of reports on the CHKS Live system CU level, though it does not affect Trust level data.

3. Current ESHT mortality indicator position

SHMI - Summary Hospital - level Mortality Indicator

SHMI is published, at intervals of 3 months, as a 1 year rolling average, published 6 months after the collection period. Hence a change in monthly SHMI will have an effect on the published SHMI data from HSCIC for another 4 quarters after the event.

Following a sustained increase in SHMI over the winter of 2012-13, peaking at 113.6 for the period October 2012 to September 2013 and making the trust a statistical outlier for this indicator, we experienced a steady reduction, to a value of 108 for the period January-December 2014, published in April.

The most recent data, published in October, has shown a substantial rise, to 114.0. This again takes the Trust outside the “expected” range for SHMI (90-110). Though the monthly SHMI has improved from January, the winter increase will continue to have an adverse affect on our published SHMI until, at the earliest, that published in April 2016.

	Apr 2012 to	Jul 2012 to	Oct 2012 to	Jan 2013 to	Apr 2013 to	Jul 2013 to	Oct 2013 To	Jan 2014 to	Apr 2014 to

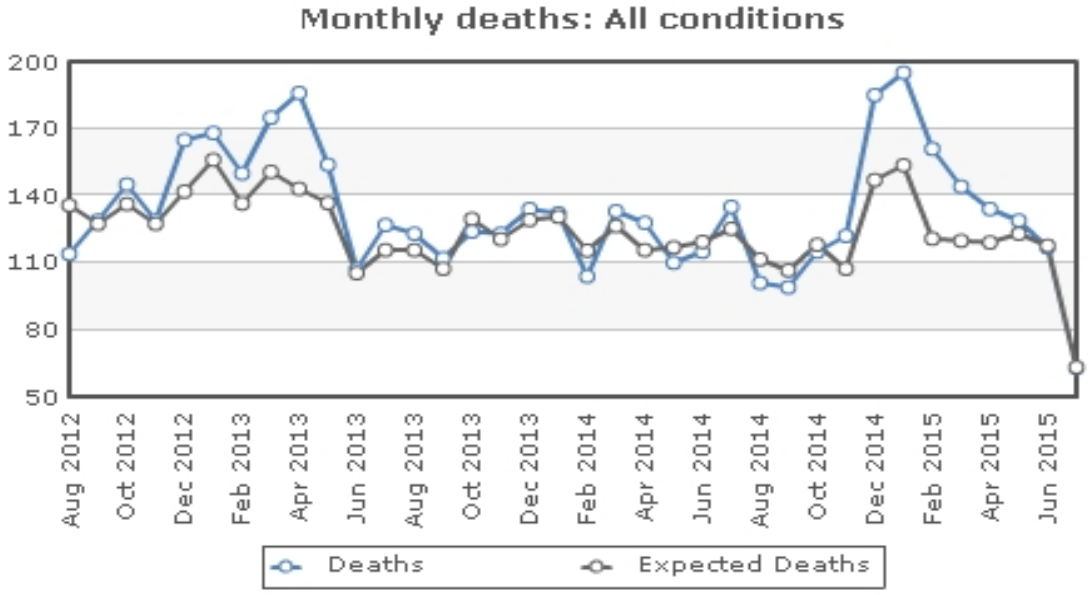
	Mar 2013	Jun 2013	Sept 2013	Dec 2013	Mar 2014	Jun 2014	Sept 2014	Dec 2014	Mar 2015
SHMI (12 month rolling average)	109.7	113.6	112.7	110.0	109.0	109.0	108.0	111.0	114.0

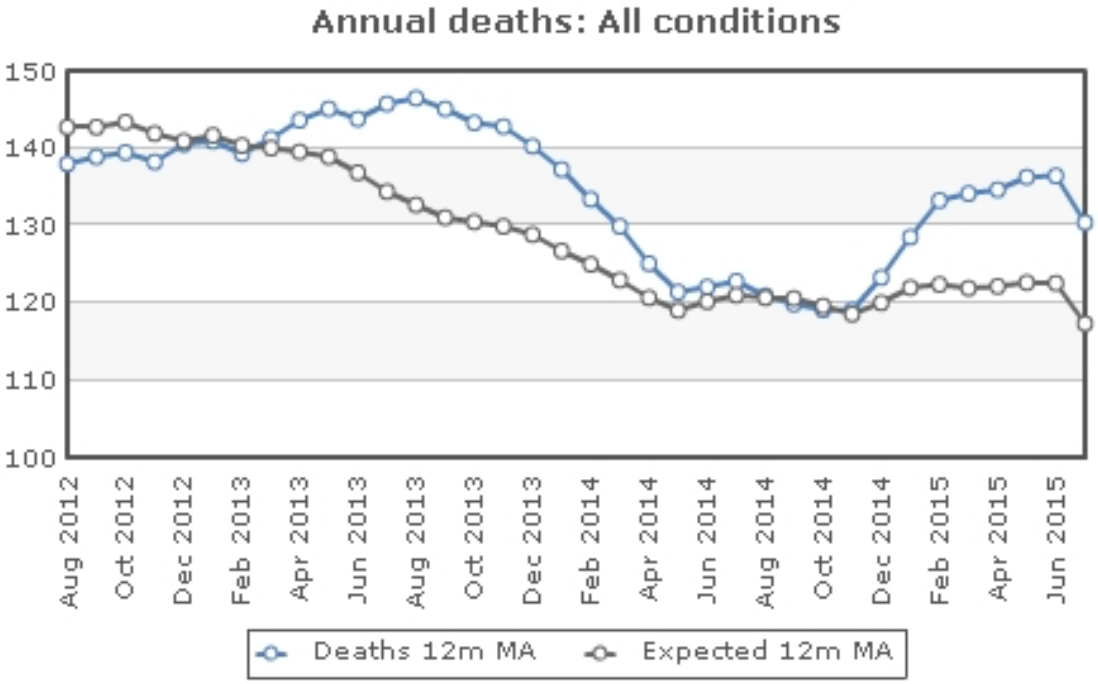
Though SHMI trending is not possible with the CHKS tool, we are able to trend our in-hospital SHMI. The variation in this corresponds with the nationally published SHMI.

Following the 2012/13 winter bulge, monthly SHMI has approximated to the national average SHMI. A further increase occurred, in line with increases in RAMI and HSMR, over the months November 2014 to January 2015. The situation improved in February and by March had again returned to similar values to the national average.

HSMR - Hospital Standard Mortality Ratio

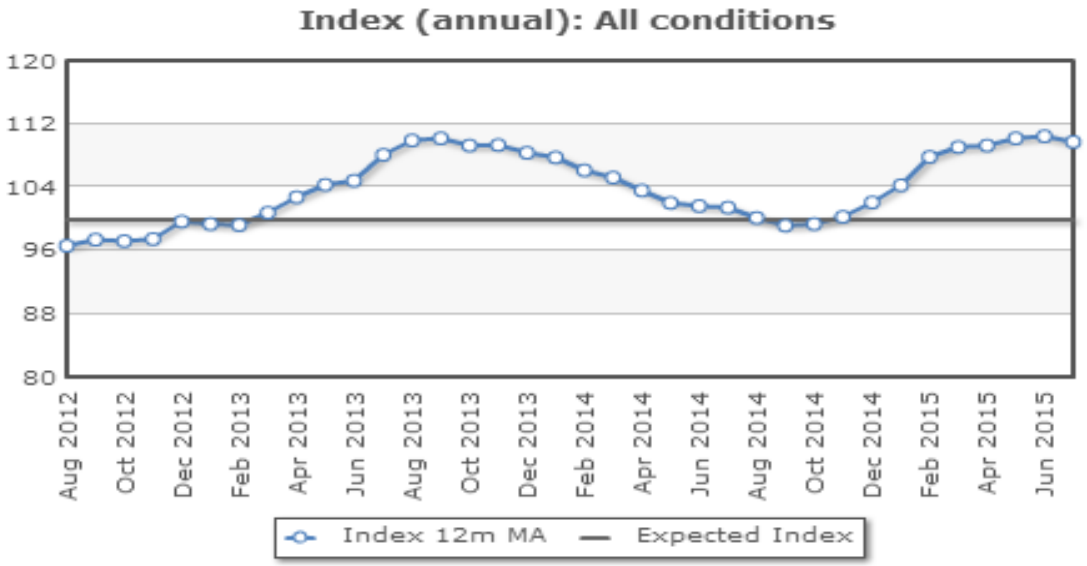
Monthly **HSMR** calculated by CHKS is displayed below. The value for July 2015 (latest data) is 100. The upper panel is monthly deaths, the middle panel the rolling 12 month average and the lower panel the annual mortality index. There was a substantial increase in November, December and January but HSMR subsequently improved steadily since the winter. The rolling 12 month average index to July was 110

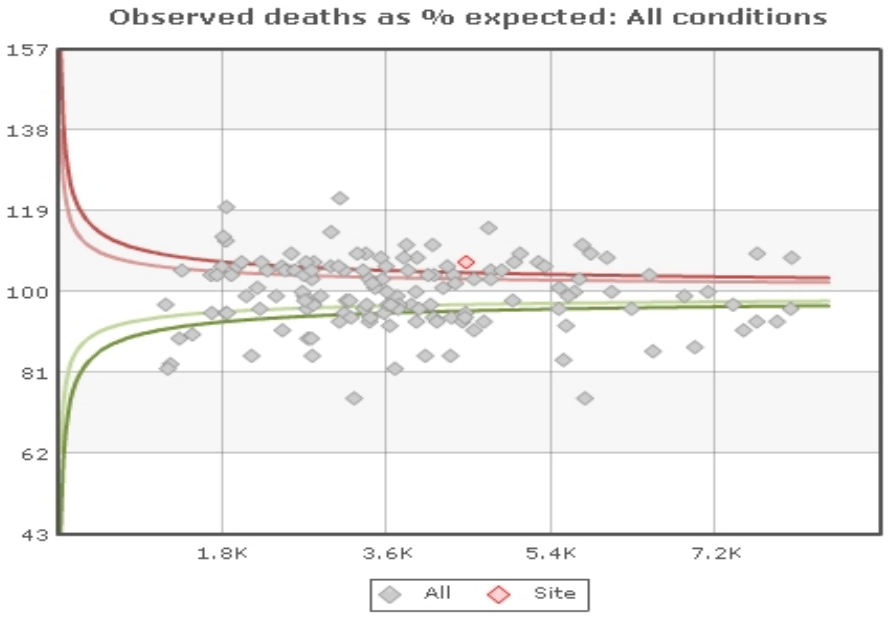




HSMR- National Context

Despite the winter bulge, for the full year HSMR for 2014-15, whilst the Trust lay in the highest quartile, it remained within the expected range.




Observed deaths as % expected: All conditions
157
138
119
100
81
62
43
1.8K
3.6K
5.4K
7.2K
All
Site

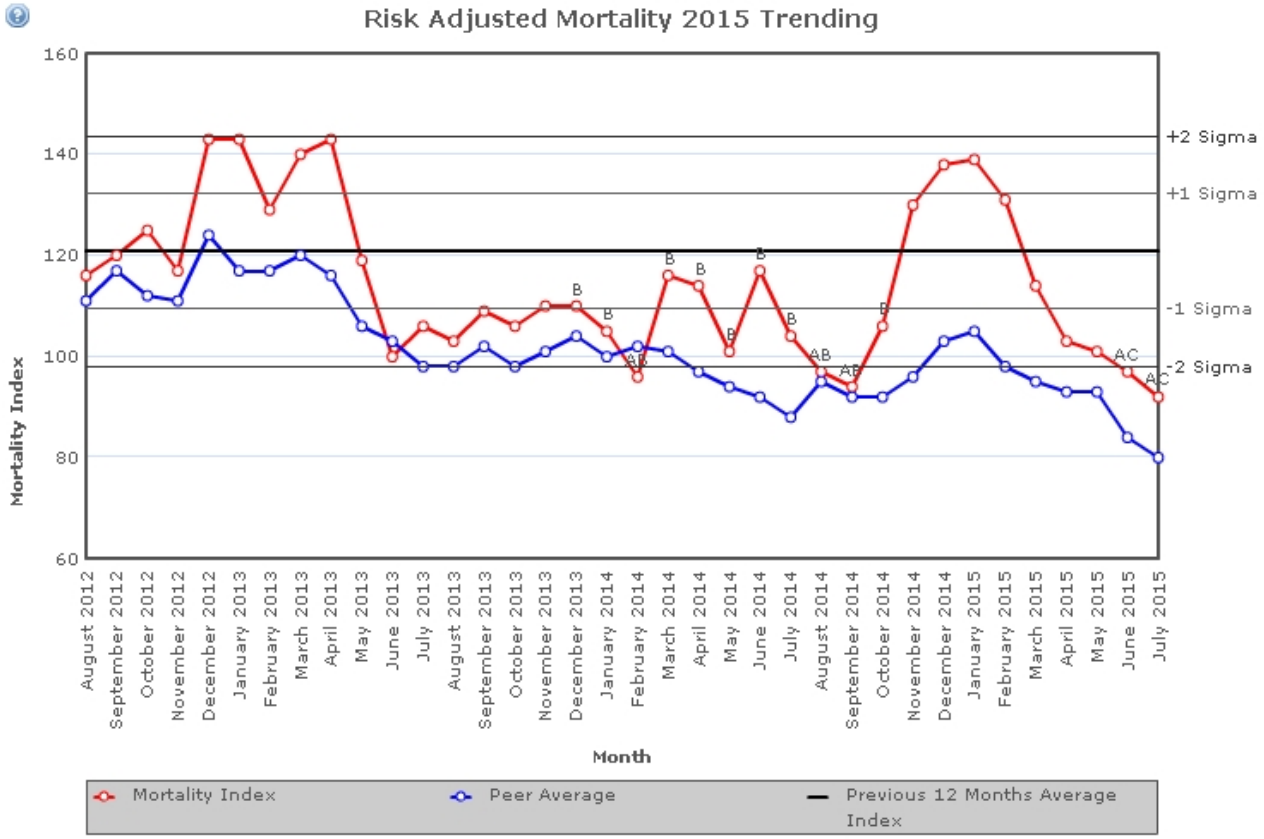

Observed deaths as % expected: All conditions
130
116
102
88
74
60
100

RAMI - Risk Adjusted Mortality Indicator

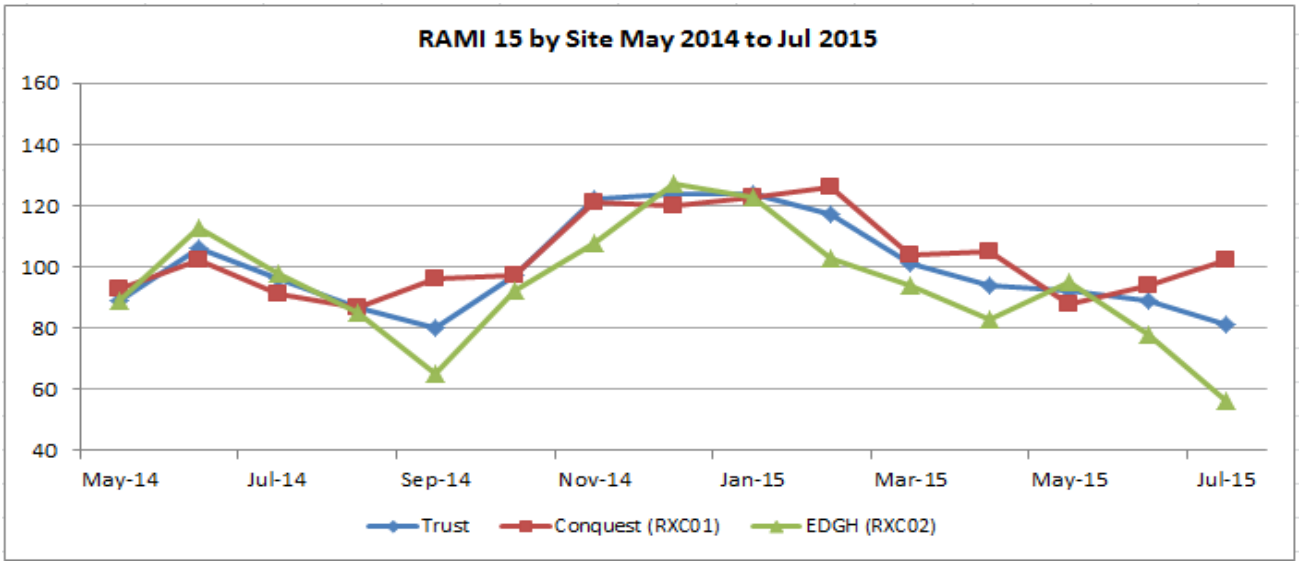
As with other indices, RAMI increased over the winter months, though th increase is not as sustained as the previous increase in 2012-13.

The full year RAMI for 2014-15 was 117. The 12 month rolling average to July 2015 was 115. and the Average 2014-15 YTD (first 4 months) was 113.

The monthly value for July (latest data) is 93.



Though RAMI appears slightly higher, and the increase more sustained, at Conquest, there do not appear to be major differences between the two acute sites.



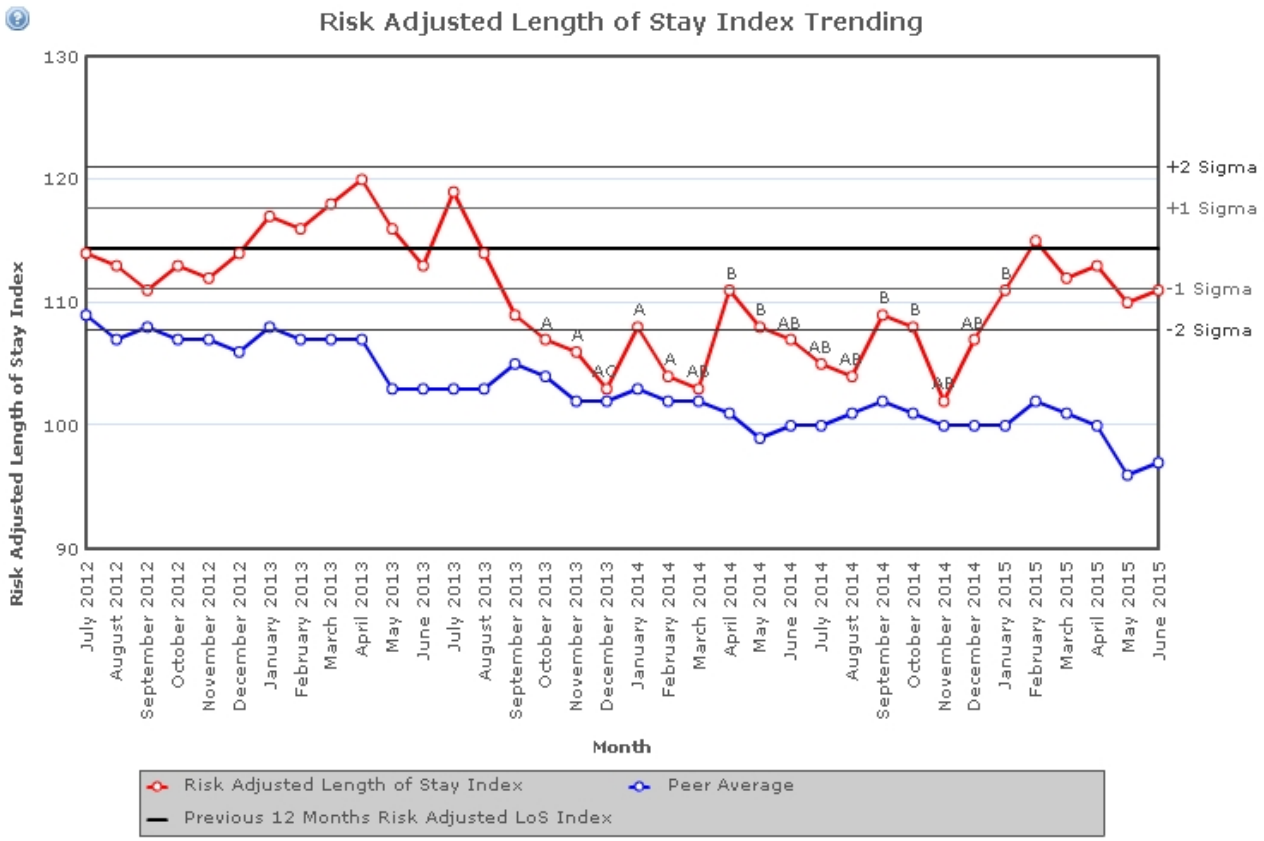
4. Increase in Adjusted Mortality over 2015-15 Winter

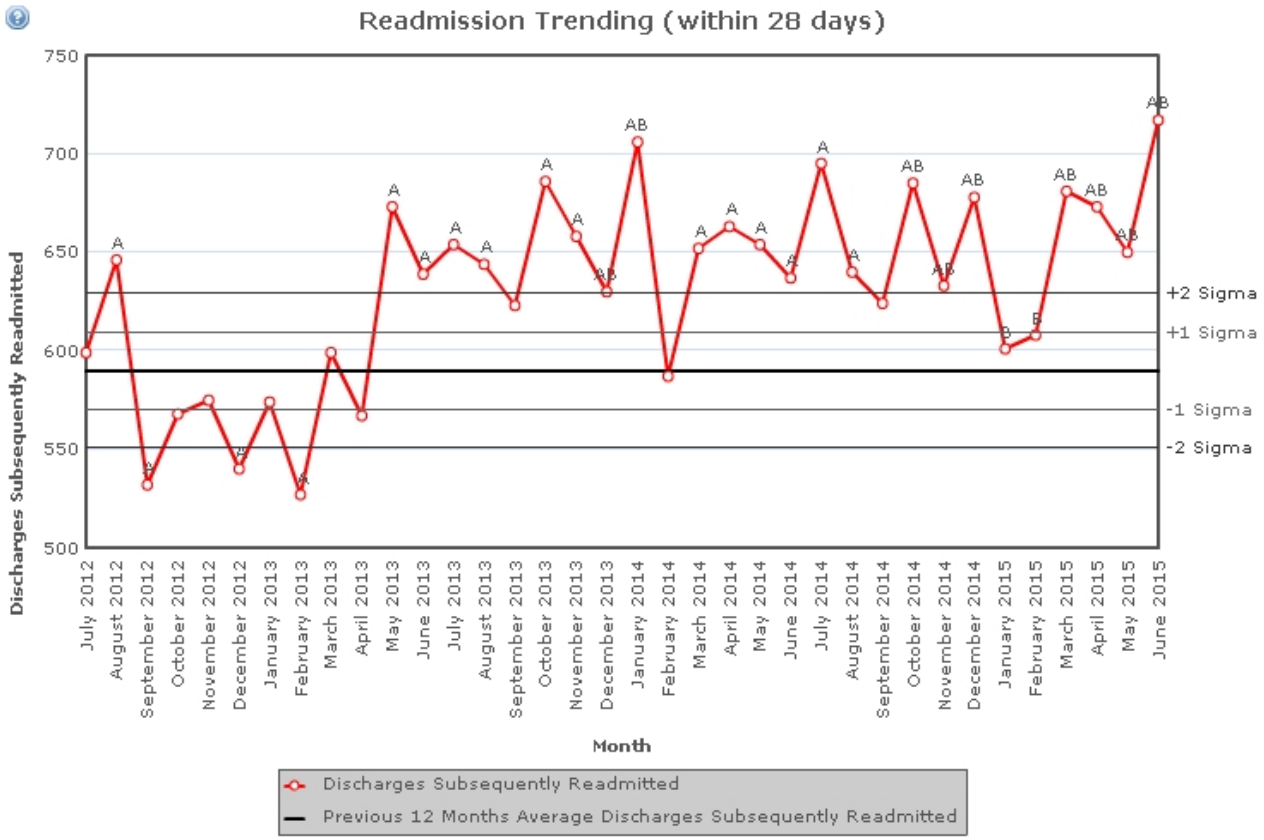
Amongst the CUs, the greatest increase in RAMI resides in Urgent Care, though it affects all acute specialties; predominantly those incorporating a component of acute medical care. The table below uses the 2014 version of RAMI.

Clinical Unit	Full Year RAMI 2014-15	National Average RAMI 2014-15	RAMI Nov - Jan	National Average RAMI Nov - Jan
Urgent Care	111	88	131	93
Specialist Medicine	104	93	118	98
Cardivascular	69	71	101	76
Surgery	88	81	99	87
Clinical Support	0	123	0	0
Women & Children	25	63	-	62
TRUSTWIDE	105	87	124	92

Within Urgent Care, the majority of the increase lies within ”General Medicne” (ie AAU and MAU), the other specialties of A&E and Frailty (geriatrics) remaining reasonably stable.

Length of stay increased over the winter period more than the national average, though readmission rates, whilst greater than average for the last 2 years,remained stable.





Further detailed analysis has been undertaken by CHKS. The preliminary report was discussed at the August MOG meeting. Further work has subsequently been done on depth of coding and number of spells per acute admission. The findings do not lead to a completely clear picture but the main findings are summarised below:

- The number of admissions was lower than in 2013-14, despite the latter being a milder winter.

- The emergency admissions formed a higher percentage of the total admissions than at any time since 2010-11 winter, at 44%.

- The acuity of these admissions, as assessed by the Charlson Index, was significantly greater over last winter than in the corresponding months in 2013-14.

- The main conditions driving the adverse indices were:
  Acute Bronchitis
  Biliary Tract Disease (currently under investigation by Surgery)
  COPD (discussions on this have already started with Respiratory Medicine)
  Chronic Renal Failure
  Senility (currently under investigation buy Dr Nahhas)
  Urinary Tract Infections (currently under investigation by Dr Wilkinson)

- The number of episodes of care within each spell (which translates into the number of changes of consultant or location) was higher (1.84 in October to 1.97 in November , dropping to 1.56 in March) over the winter, but the peak occurred in October and November, with fewer episodes in December (the month of highest mortality).

- Depth of clinical coding, as judged by the number of diagnoses per spell, had been higher than the national average until December 2013 but subsequently decreased,

reaching its lowest level in October and November 2014. Since January there has been an improvement, but still the number of diagnoses per spell remains substantially lower thant the national average. In contrast, the number of diagnoses per spell nationally has steadily risen since 2012. This strongly suggests that we have been unable to capture all the pathology in our acute admissions, as we would expect a higher number of diagnoses per admission, given outr population demographic.

- The proportion of "symptoms and signs" (rather than definitive disease) diagnoses, thought to be a marker of data quality, has been close to the national average over the last two years.

The report raises the possibility that, whilst some of the increase may relate to inadequate capture of clinical diagnoses, some may relate to clinical issues or patient flows.

5. CUSUM Alerts and CQC Intelligent Monitoring

The most recent alert, concerning therapeutic endoscopic procedures on biliary tract, raised in April 2014, was closed by the CQC in August 2014.

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

6. Other enquiries

An enquiry from the CCG concerning deaths associated with abdominal hernias was investigated by Surgery. The results were reported at the MOG meeting in June. Of the 8 deaths:

- 7 were emergencies, one elective.
- 2 patients did not have any mention of hernia in the index admission
- 3 patients had hernias which were completely incidental to the reason for admission, were not operated on, and did not contribute to the death in any way. These were patients who happened to have hernias, dying of other causes.
- 2 patients were emergencies, with emergency operations but very high risk of death or morbidity on preoperative POSSUM scoring (Case 1: mortality predicted at 21%, morbidity 88%. Case 2: mortality predicted at 40%, morbidity 90%).
- One patient was elective; a high risk patient for re-siting of an ileostomy. The patient died unexpectedly 3 days post-operatively and is currently with the Coroner.

No significant deficiencies in clinical care were apparent from the casenotes review.

It was apparent that the patients had significant co-morbidities which may not have been captured in the coding. The reasons for this are unclear and further discussions are being held between the CU and the senior coders to see how this may be addressed.

7. Conclusions

The system for mortality and morbidity review continues to increase in robustness. The Clinical Units are increasingly engaged in the processes and are making greater use of the CHKS Live software to probe their own mortality and other quality markers, and are receiving further training in this.

The winter mortality increase appears multifactorial, with components relating to capture of clinical diagnoses and comorbidities, and components possibly relating to care pathways and patient flows.

The following recommendations were discussed at the October meeting of the CME:

- Urgent remapping on PAS of consultants and specialties to conform with the current CU structures. Discussions on this are in hand.

- CUs were asked to ensure that comments are returned promptly, in the form of exception reporting, on their monthly scorecards.

- Specialist Medicine, in particular Respiratory Medicine, in liaison with Urgent Care, to consider and recommend interventions to improve in hospital mortality related to COPD that may be instituted in time to impact on this winter.

- Further education and advice to both senior and junior medical staff on simple steps leading to more accurate coding.

- Increased communication between clinical coders and consultant teams, including the possibility of clinical coders attending some ward rounds. As a result, pilot schemes, embedding clinical coders in MAU/AAU and the Respiratory Units, are being planned.

The Board is asked to note the current mortality trends, the activity of the MRG and MOG in investigating the winter increase in mortality indices, and to support their continuing efforts to improve our understanding and learning from mortality data.

Dr James Wilkinson
Assistant Medical Director – Quality 24th November 2015

Appendix 1 **Mortality Review Group Work Plan 2015/16**

Area or Item for review	Action	Source	Jul 15	Aug	Sep	Oct	Nov	Dec	Jan 16	Feb	Mar	Apr	May	Jun
MRG Action Log	Review and Update	JK	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trust Mortality Scorecard	Review and record actions	CHKS - LH	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CU Quality Scorecards	Review	JK sends to CUs - JK collates returns	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Death In Low risk Groups	Review	Mortality Database - JK	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trust SI themes	Review	Datix - ME/HW			✓			✓			✓			✓
Complaint themes	Review	Datix HK (JK)			✓			✓			✓			
SHMI	Review following publication	HSCIC - ET/JK		✓			✓			✓			✓	
Post 30 days deaths	Review	ET/JK		✓			✓			✓			✓	
Weekend Mortality	Review	ET/LH			✓			✓			✓			✓
CQC Intelligent Monitoring	Review following publication	CQC - ET		✓			✓			✓			✓	
Dr Foster Good Hospital Guide	Review following publication	Dr Foster - JK					✓							
Quality Review of M&M database entries	Group review	Mortality Database			✓			✓			✓			
TARN		JK				✓			✓			✓		
ICNARC		Christa Wood/JK												
M&M Action Log & Lessons Learnt		Database - JK			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MRG Terms of Reference	Review and Revise	ET		✓										

Appendix 2

Mortality Overview Group

Schedule for attendance by Clinical Units

2015/16 and 2016/17

Month	First CU	Second CU
2015		
July	Surgery	Cardiovascular
August	Urgent Care	Theatres & Clinical Support
September	Specialist Medicine	Women & Children
October	Out of Hospital Care	
November	Cardiovascular	Surgery
December	Theatres & Clinical Support	Urgent Care
2016		
January	Women & Children	Specialist Medicine
February	Out of Hospital Care	
March	Surgery	Cardiovascular
April	Urgent Care	Theatres & Clinical Support
May	Specialist Medicine	Women & Children
June	Out of Hospital Care	
July	Cardiovascular	Surgery
August	Theatres & Clinical Support	Urgent Care
September	Women & Children	Specialist Medicine
October	Out of Hospital Care	
November	Surgery	Cardiovascular
December	Urgent Care	Theatres & Clinical Support
2017		
January	Specialist Medicine	Women & Children
February	Out of Hospital Care	
March	Cardiovascular	Surgery

Appendix 3

1. Mortality Indicators

There are two main ways to measure mortality rates:

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

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

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

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

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

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

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

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

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

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

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

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

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

1. External monitoring of SMR Indicators

Imperial College and CQC CUSUM Alerts

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

CQC Intelligent Monitoring

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

Trust Development Authority (TDA)

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

Dr Foster Hospital Guide

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

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

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

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

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	14 G
Subject:	Research and Development Report
Reporting Officer:	Liz Still / David Hughes

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

Purpose:

This report is intended to update Trust Board on the research activity undertaken within ESHT, including Q2 2015

Introduction:

This paper is intended to update the Trust Board on developments intended during 15/16

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

Clinical Research Network Kent, Surrey & Sussex (CRN KSS) –15/16
Target = 836 participants

Inclusion of information on Trust research activity in footer of all Trust letters to increase patient expectation of being offered opportunities to take part in research study.

Benefits:

- Enable patients to access high quality research.
- Develop a commitment to the promotion and conduct of research as core business
- Demonstrate performance against key objectives
- Secure NIHR funding based on recruitment.

Risks and Implications

- Unable to meet agreed recruitment target
- Reduced NIHR funding as a result – threats to current workforce.
- Fewer patients have opportunity to access high quality research relevant to their care or condition

Risks that insufficient allocated research time for Chief Investigators/ Principal Investigators (CI / PI) to undertake activity will impact on KSS CRN designated patient recruitment target for ESHT remains a challenge.

Assurance Provided:

Research governance processes are assured.

To Note – Health Research Authority is rolling out single approval process. This will fundamentally change research governance and NHS approval processes. This roll

out is to be completed by April 2016.
This will entirely change the research permissions and management process. Research Governance Framework (2015) which supports as a local processes will no longer exist.
.
R&D are committed to recruiting staff to budget to enable support for CI / PI activity and increase recruitment of patients to research studies.

Review by other Committees/Groups (please state name and date)**:**
Associate Medical Director has reviewed. .

Proposals and/or Recommendations
• Monthly performance management of studies that are failing to recruit to agreed target. • Ensure future study targets are realistic and feasible. • Scan for observational studies that enable higher recruitment to ensure a balanced portfolio with the interventional studies (which tend to have lower recruitment targets) • Scan for opportunities for R&D to support research into new specialities in ESHT. • Adapt and develop new ways of working in line with HRA single approvals process. • Develop policy and guidelines to support new ways of working.

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

East Sussex Healthcare NHS Trust

Research and Development Report

1. Introduction

1.1 The intention of this report is to inform Trust Board of developments and challenges within R&D in 15/16.

2. Background

2.1 R&D Department is located in Polegate Ward, and research nurses are located variously across the Trust including : Cardiology OPD CQ, Sussex Cancer research Building CQ, diabetes and endocrinology, Cardiology EDGH, Friston Ward. This is working positively to encourage flexible working within clinical research to enable nurse support across specialities.

2.2 The R&D staffing was reconfigured to enable flexibility and sustainability of the current workforce and future developments to support research into novel specialities new to research activity. This has been achieved.

2.3 R&D Strategic Plan 2014 – 2018 was approved by Trust Board. This is a positive plan to underpin recognition of the importance of research activity

3. Main content of the report

3.1 CRN KSS funding has been granted to ESHT with a 5% reduction in standard funding in relation to previous year. The recruitment target for 15/16 is increased by 15% (Table 1). Activity to date is included and demonstrates an increase from this time last year. .

3.2 Funding is allocated year on year.

3.3 Bids for contingency funding amounted to 77K in 14/15. Bids for contingency have ended. This poses a risk to staffing.

3.4

Table 1

	13/14	14/15	**15/16**
Recruitment Target	613	727	**836**
Recruitment -Actual	335	481	**359 to Q1 & Q2**
Funding	535K	515K (plus 77K contingency)	**515K (Plus 2.3K)**
NIHR Total Staffing	12.09 wte	14.66 wte	**15.18 wte**
Commercially funded staffing		1.87	**4.86**

3.5 There are a total of 10.28 wte research nurses (17 individuals) funded by NIHR KSS CRN and commercial studies. There are currently 81 research studies open to recruitment with approximately 23 in follow up.

3.6 There are around 25 active CI / PI's involved in research within ESHT.

3.7 From April 2014 all KSS CRN funded posts are line managed within R&D. Consultant research SPA's requires continued Trust support and allocation.to enable Chief Investigator / Principle Investigator (CI /PI) activity

3.8 Associate Medical Director for Academic, Educational & Research Development, retired and AMD Dr James Wilkinson holds R&D within remit since June 2015

3.9 NIHR funding via R&D is intended to support UK Clinical Research Network (UKCRN) Portfolio studies.

3.10 Commercial portfolio studies meet the costs of delivering the research within the NHS, and R&D seeks a balanced portfolio of studies – both commercial and non-commercial.

3.11 NIHR recommend that Trusts Insert a standing research reference in all Trust patient letters to inform patients that the Trust is research active. This is still not achieved despite 3 years of negotiations. This is now part of the project looking at OP communication

3.12 R&D Steering Group meets quarterly and R&D Operational Working Group meets monthly.

4. Conclusion/Recommendation

4.1 Appropriate and managed SPA for research is supported by Trust Board
4.2 Acknowledgement of risks to staff associated with less contingency funding allocation from CRN KSS.

Name of Author; Liz Still
Title of Author; Research and Development Manager

Date; 20th November 2015

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	15
Subject:	Annual Business Planning Framework for 2016-17
Reporting Officer:	David Meikle, Director of Finance

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

Assurance	✓	Approval		Decision	

Purpose:

This paper provides an outline of the process the Trust has in place to develop its business plan for 2016-17

Introduction:

The attached paper details the process and assumptions for the business planning process for 2016-17. A timetable for delivery is included within the paper.

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

The Trust will be required to submit a final two year plan submission which is clearly aligned to commissioning intentions; and in line with TDA guidelines to the to the TDA by the 11th of April 2016.

This paper sets out the planning process that will be undertaken within the Trust to develop and ratify the above plan.

Benefits:

- Integrated planning for sustainability which incorporates quality, finance, workforce and activity across the Trust
- Programme of engagement with key stakeholders

Risks and Implications

- Areas of the draft plan that are not yet confirmed or values may change
- Decisions affecting major areas of service which have not yet been formalised and therefore not yet adjusted for

Assurance Provided:

- External and internal drivers will be played into the planning process
- Clinical units and corporate departments will be fully engaged in the process
- Executive and Board reviews have been factored into the timetable

Board Assurance Framework:

Review by other Committees/Groups (please state name and date):
Business Development Group 25/11/2015

Proposals and/or Recommendations
The Board are asked to note the process and the dates that have been earmarked for updates and decisions.

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

For further information or for any enquiries relating to this report please contact:	
Name: David Meikle	**Contact details:** david.meikle1@nhs.net

East Sussex Healthcare NHS Trust

Annual Business Planning Process for 2016/17

1. Introduction

In May 2015 the Trust prepared a one year business plan in line with guidance from the NHS Trust Development Authority (TDA). We will now need to refresh and build on this plan for 2016/17 and this paper sets out the framework for developing the plan with the accompanying timetable.

2. Key Planning Assumptions

Guidance from the TDA or NHS England (NHSE) normally comes out in late December of each year but it is unlikely to be materially different from last year with a continuing drive for financial and clinical sustainability.

The three East Sussex Clinical Commissioning Groups (CCGs) have issued their commissioning intentions for 2016-17 which can be accessed as follows:

- http://www.eastbournehailshamandseafordccg.nhs.uk/about-us/our-governing-body/meetings-in-public/?assetdet8984661=423657&categoryesctl10119667=17717&p=1
- http://www.hastingsandrotherccg.nhs.uk/about-us/our-governing-body/meetings-in-public/?assetdet8984067=423628&categoryesctl10103867=17724
- http://www.highwealdleweshavensccg.nhs.uk/about-us/our-governing-body/meetings-in-public/?assetdet8984882=423741&categoryesctl10089952=18154

LTFM Assumptions - Income

- Activity growth c1% per annum based on demographic change statistics
- No change in coding/case mix
- Tariff is deflated at 1.6% per annum but not for CCG risk share
- 'Cap and Collar' risk share with CCGs continues into all future years at current tariff-based activity/income levels
- Future activity/income growth for local CCGs is negated by 'East Sussex Better Together' initiatives
- Readmission penalty £2m but no other penalties for 'locals'
- CQUIN received in full
- No further loss of or reduction in services

LTFM Assumptions - Expenditure

- Pay awards will be at 1% and incremental drift will add another 0.5%
- Agency contained within prescribed limits
- Non pay costs (including CNST) will increase at an overall rate of 5% except for pass-through drugs
- High Weald stranded costs will have a full year effect of £3m from 2016/17 onwards
- Cost improvements of 3.5% per annum will be delivered from 2016/17

We will also need to build in any emerging NHSE plans for specialist and primary care commissioning.

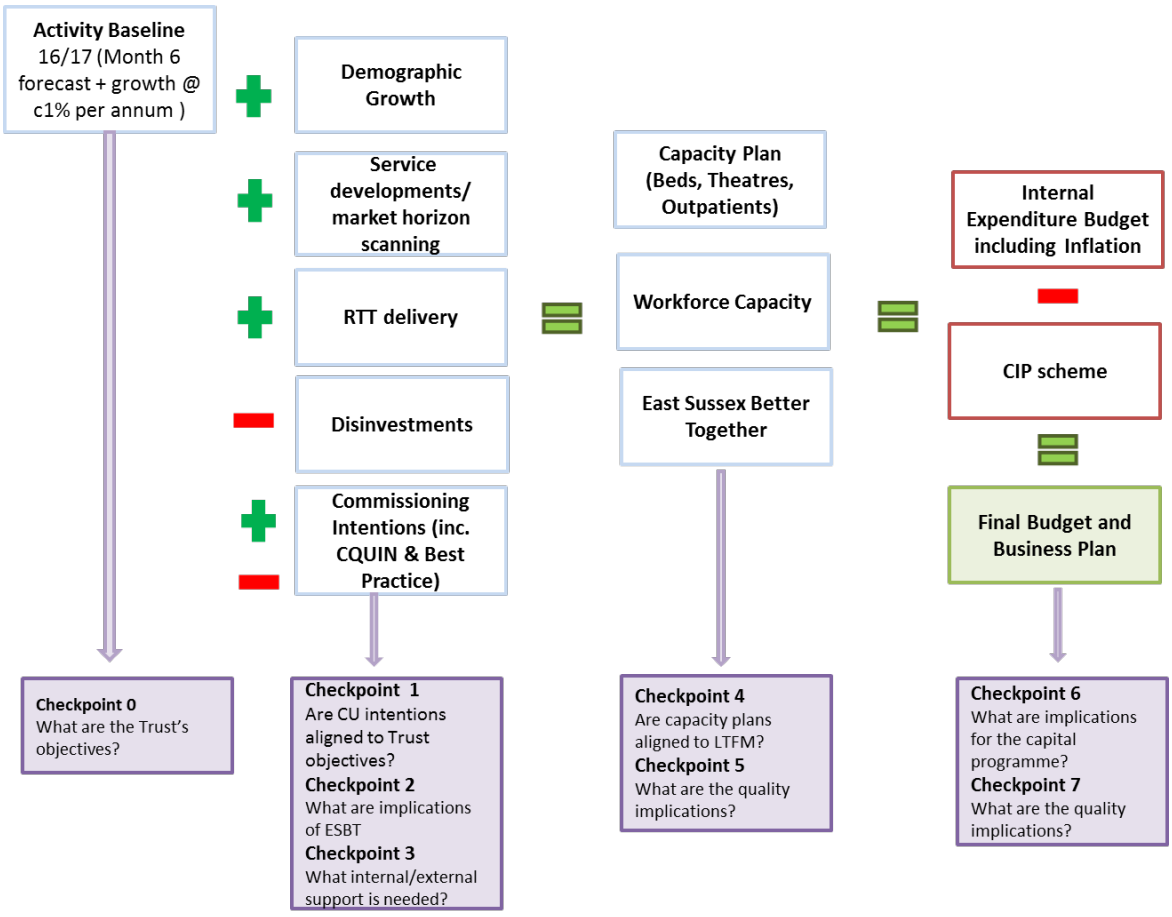
3. Other Known Service Changes following Procurement exercises

The following changes will need to be modelled into our plans for 2016/17:

- Continued impact of the MSK service in Eastbourne, Hailsham and Seaford being managed by Sussex MSK Partnership
- Managing down stranded costs from the decommissioning of HWLH community services
- Managing the outcome of the integrated sexual health & HIV service and BSUH and HWLH community diabetes service tenders
- Review of the Crowborough Birthing Centre

The financial risks are being calculated on all of the above.

4. Process



There are some key activities which need to be undertaken as part of the business planning process:

4.1 Establish the baseline/outturn position for all clinical units and corporate departments

4.2 Agree planning assumptions which are consistent across all workstreams

4.3 Complete templates and collate information at clinical unit and corporate level to cover:

a) Improvements arising from the Quality Improvement Plan
b) External drivers, e.g. Junior Doctor contracts, Consultant contracts, Agency cap, recruitment issues and 7/7 working
c) Contracting and commissioning plans e.g. Provider intentions, CCG intentions, ESBT
d) Activity and quality targets
e) Finance and Cost Improvement Programme
f) Workforce projections
g) Estates and Capital

4.4 Forecast baseline position to create draft plan for 2016/17, including demand and capacity plans

4.5 Review and test for consistency and moderate

4.6 Impact assess the quality of the plan

4.7 Identify risks/mitigations.

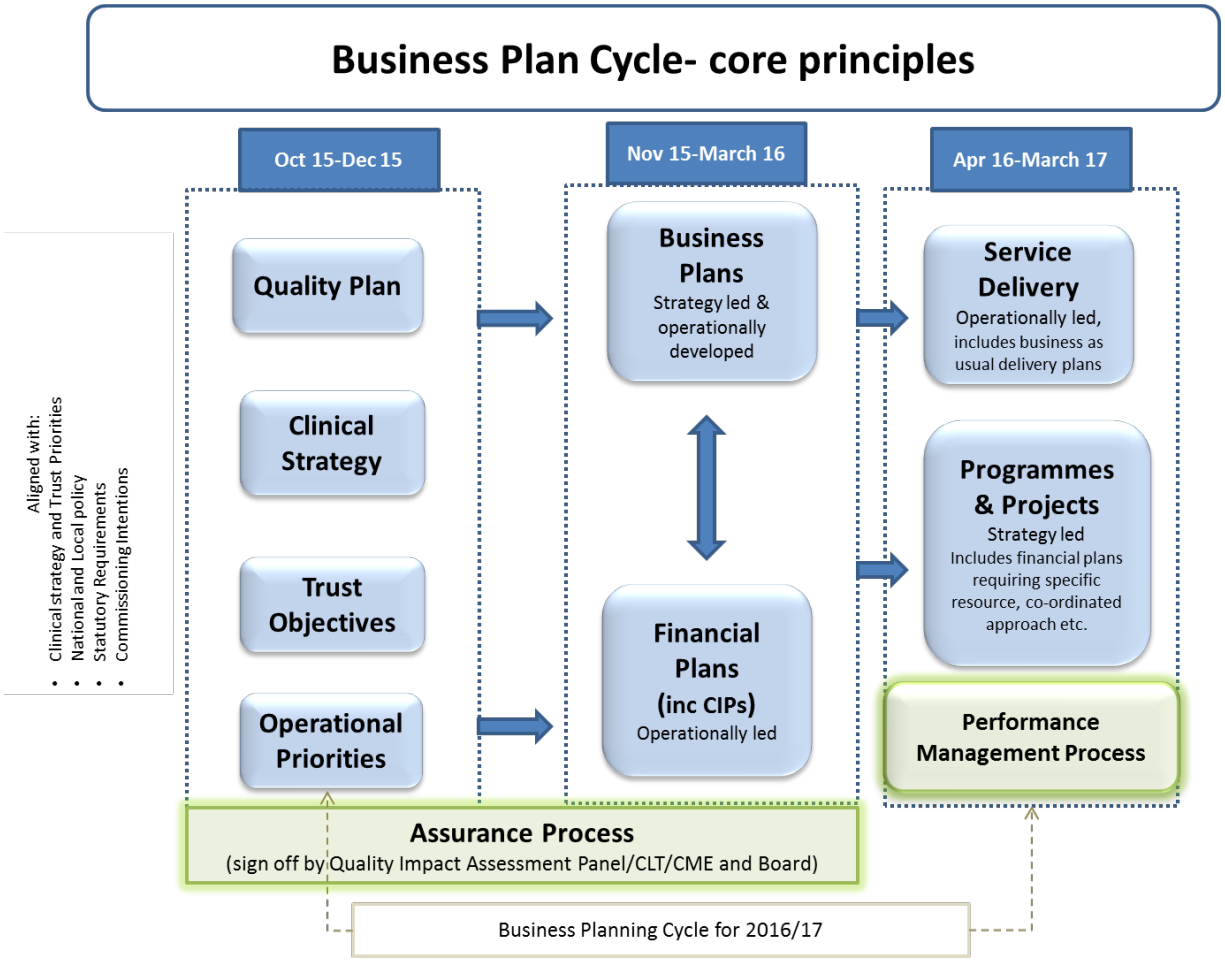
5. External and Internal Engagement

There is a programme of organisational engagement in place with a number of away days planned and representatives from the TDA and the Clinical Commissioning Groups will be invited to attend the December event to share their expectations of the coming year.

This is an iterative process and initial plans will be refined as more information becomes available.

Clinical Units are expected to engage their staff on development of their plans and a communications plan will ensure that all staff are updated throughout the process.

6. Timetable


Business Plan Cycle- core principles
Oct 15-Dec 15
Nov 15-March 16
Apr 16-March 17
Aligned with:
Clinical strategy and Trust Priorities
National and Local policy
Statutory Requirements
Commissioning Intentions
Quality Plan
Clinical Strategy
Trust Objectives
Operational Priorities
Business Plans
Strategy led & operationally developed
Financial Plans (inc CIPs)
Operationally led
Service Delivery
Operationally led, includes business as usual delivery plans
Programmes & Projects
Strategy led
Includes financial plans requiring specific resource, co-ordinated approach etc.
Performance Management Process
Assurance Process
(sign off by Quality Impact Assessment Panel/CLT/CME and Board)
Business Planning Cycle for 2016/17

Subject to confirmation from the TDA on their timetables this is the provisional schedule of dates:

What	When	Notes on process and deliverables
CCG Commissioning Intentions published	September 15	To be taken into account in planning assumptions
ESHT Provider Intentions published	September 15	To be taken into account in planning assumptions
LTFM modelling	October 15 – 23 November 15	Submission of LTFM & ITFF to TDA by 23 November 15
Planning/Activity and Income Assumptions determined	23 November 15	Requirement for LTFM submission
Finance and Investment Committee	25 November 15	Sign off LTFM & ITFF submission
2016/17 Business Planning Away day	1 December 15	Corporate services to present planning assumptions for 2016/17 as basis for CUs to start developing plans for 2016/17
TDA Planning Guidance published	14 December 15	To be taken into account in planning process
Notification of CCG allocations	21 December 15	
QIA Panel	January – April 16	Sign off CU and corporate plans for 2016/17
Corporate Leadership Team	6 January 16	Sign off key risks and issues and first cut of business plan for 2016/17
Board seminar	13 January 16	Presentation on financial planning update including key risks and issues, and first cut of business plan for 2016/17
Tariff consultation starts	15 January 16	
Business Planning Away day	26 January 16	CUs and Corporate to present top 3 worked up plans for 2016/17
Finance and Investment Committee	27 January 16	Financial planning update including key risks and issues, and first cut of business plan for 2016/17
TDA	8 February 16	Submission of first cut of business plan for 2016/17
Tariff agreed	15 February 16	
Corporate Leadership Team	23 February 16	Sign off of second of 2016/17 business and financial plans
Finance and Investment Committee	24 February 16	Sign-off of second cut of 2016/17 business and financial plans
Contracts signed	Last week February 16	Activity, finance, etc. finalised
Clinical units	Accountability review meetings March 16	Individual CUs sign off their plans for 2016/17
Corporate Leadership Team	3 March 16	Executive challenge and sign off CU plans for 2016/17
Clinical Management Executive	9 March 16	Sign off CU plans and final draft of business plan
TDA	15 March 16	Submission of second cut 2016/17 business, finance, activity and workforce plans, updated Annexe E
Board seminar	30 March 16	CUs and corporate directorates to present summary of their plans for Board review to include analysis of key risks and quality impact of plans
Finance and Investment Committee	30 March 16	Review plan
TDA	11 April 16	Submission of final 2016/17 business, finance, activity and workforce plans, updated Annexe E
Board Meeting	13 April 16	Approval of 2016/17 business plan and budget

7. Governance

The governance of the business planning process will be as follows:

8. Risks

- Areas of the draft plan that are not yet confirmed or values may change.
- Decisions affecting major areas of service which have not yet been formalised and therefore not yet adjusted for.

8. Recommendation

The Board is asked to note the process and the dates that have been designated for updates and decisions.

David Meikle
Finance Director

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	16
Subject:	Health Records
Reporting Officer:	Elizabeth Fellows, Assistant Director of Operational Planning

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

Purpose:

To provide assurance to the Board that the proposed reconfiguration of the Health Records service has been given sufficient consideration and is in line with the Trust strategy, objectives and priorities.

Introduction:

This paper details the difficulties and rationale for both the past and current situation regarding Health Records, along with details of the proposal for an 'off site' Health Records service with satellite units at each acute site.

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

There are a number of historical and on-going factors that contribute to the current performance of the Health Records service and the concerns that have and continue to be raised, particularly in relation to clinical care.

There are a number of mitigating actions that have been implemented over the last 2-3 years however the service is not sustainable in its current operational format and significant investment is underway to address this.

To support the key priorities within the Trust and to secure a sustainable service it is necessary to co-locate the existing Health Records facilities in one off site facility, with satellite services on both acute sites. This plan has been extensively considered and agreed as the most suitable option to address a situation that cannot continue.

It should also be noted that a further, existing off site unit will also be retained for a period of time, whilst further work is undertaken regarding the use of external contractors to provide long term storage of records.

There has been staff engagement through a number of methods, including Listening into Action forums, team meetings and on-going Clinical Administration staff forums.

Benefits:

The projects, in particular the relocation of the main Health Records library are essential if the Trust is to provide an effective and sustainable service.

Staff will have the opportunity to contribute to the modelling of the service within the parameters required by the organisation to provide safe and effective care.

Improved working environment that address the majority of issues that are currently impacting on the service and well-being of staff.

Risks and Implications
There are a number of risks highlighted within the project, which will be closely monitored. The primary risk, at this stage, is the staff directly affected by the planned are concerned regarding the proposed change and its impact on their roles. This may result in destabilisation of the service prior to and after the move due to demotivation and potential loss of experienced and skilled staff. The plan has already resulted in adverse publicity for the organisation at a time when extensive efforts are being made to improve staff and public confidence in the organisation.

Assurance Provided:
The planned move is part of a wider plan to address the working environment and provision of a Health Records service. It is acknowledged that the Health Records staff are concerned and every effort is and will be made to both engage and support them during this period of transition.

Review by other Committees/Groups (please state name and date)**:**
Capital Allocation Group, Corporate Leadership Team

Proposals and/or Recommendations
The current facilities for the Health Records service are not fit for purpose and are a major factor in the provision of records at the point of care. The Trust has explored different methodologies across other Trusts in the South to help inform the development of this model. The project team recommend that the next stage of the project continues, in order to develop and shape a robust 'off site' service that will provide sustainability as the electronic document management system is rolled out.

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

For further information or for any enquiries relating to this report please contact:	
Name Elizabeth Fellows	**Contact details:** 01323 417400 Ext 4389

East Sussex Healthcare NHS Trust - Health Records

1. Introduction

Through internal risk management and health and safety procedures a number of concerns have been identified regarding the Health Records within the Trust, some originating back to 2005. Whilst a number of mitigating actions have been taken the situation has deteriorated and these concerns were upheld in the CQC inspection in September 2014 and again in March 2015. It was recognised, in the quality summit, that the Trust had developed and started to implement plans to address these problems.

The key areas of concerns relate to the quality of health records and their availability for clinical care. There are a numerous contributory factors including:

- 4 separate numbering systems across the 3 main Trust sites (from previous organisational mergers), resulting in misfiling
- The number of duplicates in circulation
- Inability to 'volumise' the notes (due to lack of bar coding) leading to concerns regarding staff health and safety due to the size of records being carried/transported
- Poor environment of basement libraries again affecting staff health and well-being and service delivery.
- The volume of health records increasing every month at a greater rate than destruction, resulting in inadequate capacity. This in turn impacts on the quality as files are easily damaged
- Changes in clinical service resulting in greater patient movement between sites for clinical care
- Poor compliance with the Health records policy by users that limits the ability to track and monitor the whereabouts of records
- Storage of notes in multiple different sites and locations that reduces efficiency

2. Current situation

A wide range of mitigating actions have been taken and are on-going in order to support the provision of health records in an effective manner, see Appendix 1.

These actions are not sufficient to address all the concerns and provide an effective and sustainable service. There are 3 major initiatives that have been agreed to achieve this:

a. Implementation of iFIT Health Records tracking system. This system was implemented in August 2015 and is currently being rolled out across the Trust. The technology supports more effective tracking, storage and monitoring/audit of practice.
b. Review of existing storage capacity and the single siting of Health Records with satellite services at both acute sites to support the key priorities for the Trust which are incorporated within the Estates Strategy and Quality Improvement Plan.
c. Electronic Document Management (EDM) and scanning. The planning for EDM is underway but is not likely to have any direct impact before Summer/Autumn 2016. The expected outcome of the project is that the Trust will implement a 'paper light' system and over a period of time, as records are required for clinical care they will be scanned and available electronically. This will eventually negate the need for the high volume of paper records that are currently being used and stored although

there will always been some paper records that need to be retained in accordance with legislative requirements.

3. Single Siting of Health Records

The concept and potential of an 'off site' Health Records service has been developed over the last two to three years, with input from a number of services including senior Health Records staff, managers and Estates, taking into consideration the factors described above.

At different times various options have been considered and other Trusts have been visited to explore how the service is provided elsewhere. The general consensus, based on the capital available and the urgency to address the issues within Health Records was to use an industrial unit based in Hailsham, known as Apex Way. This unit is already used by the Trust to provide a proportion of the service, to all sites and has sufficient space for extension.

Funding for the project was not secured until 2015/16 and in August 2015 the project was formally launched. The above proposal was reconsidered in light of a number of factors that were put forward including:

- concerns re the lease of the building
- the impact on staff, the majority of whom are in lower pay bands
- the requirements regarding planning permission
- other essential plans including the proposed Estates strategy

It was agreed that no further action or planning would be taken until a risk and benefits analysis had been completed. The risk and benefits analysis was undertaken by the project team and is attached in Appendix 2. It demonstrates that the proposed option of Apex Way is the only viable option in terms of both finance and the wider Estates Strategy. This plan would be supported with satellite units on both acute sites and one further existing off site unit. The off-site unit is being retained as a 'safety valve' and whilst the current long term storage arrangements are reviewed. This is currently provided by an external contractor.

The Trust recognises that the location is not ideal however the Estates team undertook a review of other potential premises across East Sussex that have been excluded either due to inadequate capacity or cost.

4. Staff Engagement

Following a restructure in 2013 Health Records moved into the Operations Directorate. It was recognised at the time that there were significant health and safety issues and a staff injuries as a result of this. As described above a number of mitigating actions were put in place whilst attention was given to potential longer term solutions.

As part of this process Listening into Action forums took place in the summer of 2014 and it is recorded that staff put forward a number of solutions including the consideration of single siting the service (Appendix 3). This information was used to support planning and secure funding to future proof the service.

The Health Records service was involved in a further restructure in 2014, although it remained in the Operations Directorate. There was a handover of the intended plans that were further developed as described above. A project team was established, with

representation from trade union/staff side representatives. It was at the first meeting of this project team that concerns of the impact on staff and the long term lease arrangements at Apex Way resulted in a 'pause' to complete the benefits/risk analysis.

The leadership team have facilitated on-going staff forums and team meetings where staff have routinely raised concern regarding the speculation and rumours regarding the service moving. In order to address this they asked that they were communicated with as soon as the Trust had made a decision.

This was facilitated through a cross site meeting on 14th October where staff were advised of this outline proposal at an early stage. They were advised that the project team were keen to engage staff in the workstreams that were being set up, as the next stage of the project, to define the service model, prior to any formal consultation. These workstreams are now underway and will run concurrently with the planning and building works to shape the future provision of the service.

5. Conclusion

The project team has explored the options for providing an effective and sustainable Health Records service. Given all the available information, Apex Way is the best option available. There is however a need to define thaw service model in more detail, taking into consideration the needs of the organisation and wherever possible the staff affected by the proposed changes.

Appendix 1

Mitigating Actions

1. Provision of lifting equipment to minimise manual handling.
2. Merger of clinic preparation and Health Records teams to align performance and support clinical services more robustly.
3. Increase in courier services between main sites from three to four times a day to support cross sites working.
4. Hire of larger vehicles to support transfer of health records.
5. Identification of records by using colour coded bags to prioritise access when moved from one site to another.
6. Dedicated team reviewing duplicate records. Over the last year this has reduced from circa 64,000 to 10,000 duplicate records and it is anticipated these will continue to reduce at 1,000 per month.
8. Archiving/culling of 2,000 sets of records from 'out of area' and alternative storage for a further 22,000 records from the Conquest hospital.
9. Controlled access and regular liaison with Health & Safety Advisors to minimise risks of lone working and use of old filing systems.
10. Purchase of new trollies and PCs to support working environment.
11. Conversion of a storage area at the Conquest Hospital to provide work space for 13 staff, which is due for completion in February 2015.
12. Dedicated Health Records Courier
13. Additional staff both temporary and substantive to support the service

Appendix 2

Risk and Benefit Analysis Health Recor

Appendix 3

Copy of ESHT MSK Internal Working Grou

Health Records Service Improvement (PMO_00034)

Risk and Benefits Analysis

1. Project Summary

To fulfil the requirement for quality standards, patient records within Health Records need to be stored in a safe and secure environment. The present facilities are insufficient and unable to provide a high quality service to our patients and clinical services. There are also significant compliance and health and safety issues which have been recognised internally and by the CQC.

A brief was issued to produce a feasibility report with regard to increased patient note racking at the storage facility located at Unit 5 & 6 Apex Way, Hailsham. This was to include the capacity for the patient notes held at the storage facility located at Brampton Road Eastbourne, EDGH Library, Conquest Library and the capacity for future proofing the service prior to digitisation. This would then support the centralisation of Health Records, with satellite services at both acute sites, to address the issues above.

2. Comparison Analysis

	Apex Way Without CCG Contribution	Apex Way With CCG Contribution	Another Site Bexhill or Eastbourne Harbour 25000 sq/M
Total Cost over 5 years	**£2,566,375**	**£1,618,730**	**£3,781,260**
On-going yearly cost includes lease, IT, movement of notes, and staff travel	Year 1 £1,399,309.20 Year 2 £585,816 Year 3 £193,816 Year 4 £193,816 Year 5 £193,816	Year 1 £1,226,730 Year 2 £392,000 Year 3 £0 Year 4 £0 Year 5 £0	Year 1 £1,879,260 Year 2 £912,000 Year 3 £520,000 Year 4 £320,000 – estimated lease cost Year 5 £150,000 - estimated lease cost
Square Meters Required is 16,000 Square Meters	9,139 Unit 6 4064 Brampton 1628 Satellite sites 14,831 Total 1169 Deficit (EDM could potentially mitigate this within 4 months of scanning go live) 14000 records will also be created in the next 12 months increasing the deficit	9,139 Unit 6 4064 Brampton 1628 Satellite sites 14,831 Total 1169 Deficit (EDM could potentially mitigate this within 4 months of scanning go live) 14000 records will also be created in the next 12 months increasing the deficit	25,000 25,000 Total
Benefits	• The move is already Planned and contractor is ready to start • It would create longer opening hours and standardise processes across the sites • Staff would have a better working environment	• The Trust will not incur any extra Leasing Costs • The move is already Planned and contractor is ready to start • It would create longer opening hours and standardise processes across the sites	• Site will have space for all staff and notes mitigating the need to have additional sites • Minimal Building work

Risks	• With the new build of mezzanine the meter linierage is already 1169 short of what is needed to store just the acute Records and without future proofing for new records created • Additional Leasing and Utilities cost • Additional sites would need to be kept on for space for additional 3 years • Not enough office space for all staff • Contractor is an unknown as to their delivery of building work but have been used by the trust previously for Health Records moves, culling and supplying containers and racking	• With the new build of mezzanine the meter linierage is already 1169 short of what is needed to store just the acute Records and without future proofing for new records created • Additional sites would need to kept on for space issues • Not enough office space for all staff • Contractor is an unknown as to their delivery of building work but have been used by the trust previously for Health Records moves, culling and supplying containers and racking	• Additional costs to trust for Lease • Until a site is found the Health Records Staff remain in an inappropriate environment
Impact On staff	• Daily Commute could potentially increase considerably for staff • Better working environment • Defined processes to standardise work practise	• Daily Commute could potentially increase considerably for staff • Better working environment • Defined processes to standardise work practise	• Daily Commute could potentially increase considerably for staff • Better working environment • Defined processes to standardise work practise

Appendices

1.1

Cost	Apex Without CCG Contribution	Apex With CCG contribution	Another site
Litigation	£8,350.00	£8,350.00	Nil
Lease	£81,153.00	Nil	£450,000
Utilities	£62,663.00	Nil	£70,000
Move records	£245,000	£245,000	£245,000
Move staff	£392,000	£392,000	£392,000
Brampton Road	£70,000	£70,000	Nil
IT and infrastructure Costs	£82,000	£82,000	£159,050
Total	£941,166.00	£797,350.00	£1,316,050.00
Building Work	£224,925.00	£224,925.00	£250,000.00
Grand Total	£1,166,091.00	£1,022,275.00	£1,566,050.00
Plus VAT 20%	**£1,399,309.20**	**£1,226,730.00**	**£1,879,260.00**

1.2

% of Staff based on 100	Extra miles per week	Cost for 1 year	Cost for 2 years	Cost for 3 years
5%	20	£14,000	£28,000	£42,000
5%	80	£56,000	£112,000	168,000
5%	120	£84,000	£168,000	£252,000
10%	20	£28,000	£56,000	£82,000
10%	80	£112,000	£224,000	336,000
10%	120	£168,000	£336,000	£504,000
20%	20	£56,000	£112,000	168,000
20%	80	£224,000	£448,000	£672,000
20%	120	£336,000	£672,000	£1,008,000

1.3

	Another Site	Apex
Coin	£40,000	
Cabinet	£1,000	£1,000
Data Points	£15,000	£15,000
Power	£15,000	
Switch x3	£3,000	
Wireless	£30,000	£15,000
Switched for UPS cabinet	£55,000	
Dismantle and reinstall Racking	£50.00	£50,000

Total	£159,050	£81,000

1.4

Actual cost to deliver project

Cost	Apex Without CCG Contribution
Litigation	£8,350
Building work	£224,925
Move records	£245,000
Additional Staffing to Barcode records into Apex Way	£11,000
Additional Barcodes	£6,000
Furniture Removals	£4,000
redesign office space	£11,000
IT and infrastructure Costs	£82,000
Total	£592,275.00

Plus VAT (20%)	**£710,730.00**

Additional \Cost with no CCG contribution	
Lease	£81,153.00
Utilties	£62,663.00
	£143,816.00

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	17
Subject:	Strategic Objectives
Reporting Officer:	Richard Sunley, Acting Chief Executive

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

Purpose:

To consider and approve the revised strategic objectives for the Trust.

Introduction:

At the Executive Director Quality Improvement Planning Day on 14th October the executive directors reviewed the three strategic objectives for the organisation to consider whether they were still fit for purpose.

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

It was proposed that the second objective should be amended to reflect that the Trust worked with local partnerships, rather than playing a leading role, and a fourth objective should be included in relation to workforce engagement.

Monica Green, Director of Human Resources, discussed and agreed with Staff Side the appropriate wording for workforce engagement objective and at the same she also sought their views on the other objectives.

Staff Side were pleased that their views had been sought and agreed the wording for the fourth objective. They also suggested that each objective should start with a positive 'we will' affirmation as they saw this as having much more impact and meaning and this was supported by the Executive Directors.

Current objective	Revised objective
Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	We will ensure safe patient care is our highest priority by delivering high quality services and clinical outcomes
Play a leading role in local partnerships to meet the needs of our local population and enhance patients' experiences	We will enhance patient's experiences by working with local partnerships to meet the needs of our local population
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	We will 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.

	We will show that we value our staff by developing them and engaging with them to ensure they have the right skills and knowledge to deliver effective patient care and are involved in decision making

Once approved, the executive directors' objectives will be aligned to the revised Strategic Objectives.

Benefits:
• The strategic objectives will support our mission to deliver better health outcomes and an excellent experience for everyone we provide with healthcare services and meet the objectives of the Quality Improvement Plan. • Executive Director objectives will be aligned to the strategic objectives to support their delivery

Risks and Implications
• Failure to have robust and fit for purpose strategic objectives could hinder the Trust's ability to deliver the Quality Improvement Plan

Assurance Provided:
• The objectives have been reviewed and agreed by the executive directors and Joint Staff Committee

Review by other Committees/Groups (please state name and date):
Executive Directors Quality Improvement Planning Day 14.10.15 Trust Board Seminar 11.11.15

Proposals and/or Recommendations
The Board are asked to approve the revised strategic objectives.

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

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Richard Sunley,Acting Chief Executive	r.sunley@nhs.net

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	18
Subject:	Annual Review of Corporate Documents
Reporting Officer:	Lynette Wells, Company Secretary David Meikle, Director of Finance

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

Purpose:

The Trust Board is asked to review and ratify the proposed revisions to the Standing Orders, Standing Financial Instructions, Schedule of Matters Reserved to the Board and Scheme of Delegation and recommend their approval to the Trust Board.

Introduction:

The Trust Board is required to review its Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation on an annual basis. The revisions have been reviewed by the Audit Committee on 4th November and recommend approval.

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

- Standing Orders cover all aspects of the conduct of the Trust, including governance, committees and their duties and responsibilities.
- The Scheme of Delegation lays down in detail the specifics of committee responsibilities and duties together with that of the executive and the officers to which delegated authority has been designated.
- The Standing Financial Instructions detail the financial conduct and governance of the Trust and requirements therein.

Proposed revisions to these three documents are outlined in the attached appendix.

Benefits:

Annual review supports the strengthening of internal controls, recognise changes in the health care environment and ensure compliance with legislation.

Risks and Implications

None identified.

Assurance Provided:

The annual review provides assurance that the Trust's key corporate governance documents remain fit for purpose.

Review by other Committees

Audit Committee 2 December 2015

Proposals and/or Recommendations

The Trust Board is asked to ratify the Audit Committee's recommendation to approve the proposed changes to the Standing Orders, Standing Financial Instructions and Schedule of Matters Reserved to the Board and Scheme of Delegation.

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

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

Appendix A

Annual Review of Corporate Documents

Standing Financial Instructions		
Page No	**Section**	**Revision**
23, 30 and 60	7.5.3 7.7.1	Throughout document in respect of requirement to tenders for amounts exceeding **£35,000** Addition of *excluding VAT.*

Schedule of Matters Reserved to the Board and Scheme of Delegation		
Page No	**Section**	**Revision**
8	**18**	Chief Executive, supported by Director of Finance, Medical Director, Director of Nursing to ensure appropriate advice is given to the Board and Executive Committee on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness. Addition of *and Company Secretary*
25	**16.3**	Freedom of Information publication scheme. Amend lead from Director of Strategy to Company Secretary.
28	**4 b) c)**	Throughout document in respect of requirement to tenders for amounts exceeding £35,000 Addition of *excluding VAT.*
32	**Vi**	Medical staff leave of absence. Replace Divisional Director with Clinical Unit Lead
38	**g**	Ex gratia payments Revise limits from £200 to £500
39	**22 b**	Charitable funds authority over £5,000 revise to Trustee to authorise.
39	**26**	Retention of Records Amend lead from Director of Strategy to Company Secretary
40	**33c**	Complaints litigation Amend Director of Strategy to Company Secretary
40	**34a**	Press Amend Director of Strategy to Company Secretary
41	**37**	Fire Amend Commercial Director to Associate Director of Estates and Facilities

Standing Orders – reviewed, no revisions proposed.

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 26th August 2015 at 9.30am – 11.30am, St Mary's Board Room, Eastbourne DGH

Present

Mr Barry Nealon, Non-Executive Director/Chair
Professor Jon Cohen, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mr Stuart Welling, Chairman
Mrs Vanessa Harris, Director of Finance
Mr Richard Sunley, Acting Chief Executive
Dr David Hughes, Medical Director

In attendance

Ms Michele Small, General Manager, Out of Hospital and Therapies Clinical Unit (for item 7)
Miss Abi Turner, Interim General Manager, Out of Hospital (for item 8)
Mr Ajay Channana, Head of Procurement (for item 10)
Mrs Lesley Walton, PMO Programme Manager (for item 11)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee meeting. Apologies were received from Mr Philip Astell.	**Action**
2.	**Minutes of Meeting of 29 July 2015** The minutes of the meeting held on 29 July 2015 were agreed as an accurate record.	
3.	**Matters Arising** (i) Performance Report – Month 2 Mr Sunley gave an update on specific diagnostic issues under agenda item 4 below. (ii) Finance Update – Month 3 Mrs Harris provided further information and analysis of cost pressures under item 4 below.	

	(iii) Work Programme An update on East Sussex Better together was discussed under agenda item 8.	
4(i)	**Performance Report – Month 3** Mr Sunley presented the month 3 Performance Report which detailed the Trust's in month performance against key trust metrics as well as activity and workforce indicators. The report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15. Overall Performance Score: 4 (from a possible 5) Responsiveness Domain: 3 Due to the Trusts improving A&E Performance, this domain has remained at a score of 3. 9 out of the 17 indicators for this domain were achieved this month. The Trust remains below the higher scores predominately as a result of not achieving the RTT admitted standard of 90%. This indicator has a high weighting within the domain. The other indicators which were not achieved this month were: • RTT Admitted & Non Admitted • Diagnostic waiting times • Cancer 62 Day Standard • Cancer 62 Day Standard for Screening • Cancer Breast 2 Week Wait Standard • Cancer 31 Day Standard • Delayed Transfers of Care Effectiveness Domain: 5 The domain remained at a 5, achieving in all indicators. Safe Domain: 4 There were a total of 5 cases of C-Difficile in June; 2 of which were considered lapses in care. Due to there being no reported case of MRSA (high weighting within the domain) the Safe domain has remained at a 4. Caring Domain: 5 The Caring domain achieved a score of 5 due to A&E Friends and Family scores meeting the required standard. There was 1 Mixed Sex Accommodation breach reported in June. Well Led Domain: 3 The score for the Well Led domain remains at a 3 with achievement of 4 of the 9 indicators. A&E response rates, turnover, sickness,	

	temporary costs and appraisal rates remain below the required standard, keeping the domain score to 3. As requested at the last meeting Mr Sunley provided a more detailed update on diagnostics for July which showed that the Trust had achieved the target one month ahead of the recovery plan trajectory to meet the standard from August. The Committee asked that robust oversight be given by management to the A&E departments to ensure quality and safety is maintained pending the arrival of additional staffing. The Committee discussed the non-achievement of some of the cancer standards which is a longstanding issue. Mr Sunley confirmed that the cancer recovery plan is designed to ensure the Trust achieve compliance sustainably. **Action** **The Committee noted the Performance Report for month 3 and noted the Trust Performance against each domain and the Workforce update.**	
4(ii)	**Finance Update – Month 4** Mrs Harris gave an update on the Month 4 financial position. The Trust performance in month 4 was a run rate deficit of £1.8m with an adverse variance against plan of £0.5m. Year to date the run rate deficit stands at £11.9m which is £1.2m worse than plan. Mrs Harris summarised the downside case at M4. The Committee discussed the letter received from the TDA with regard to 2015/16 Finance Improvement and the Trust response. The Committee asked for clarity on how the cash position would be managed towards year end given the assumption that permanent PDC would replace the interim working capital support amount but this had not yet been confirmed. It was agreed that Mrs Harris would follow this up with the TDA. **Action** **The Committee noted the financial position as at Month 4.**	**VH**
5.	**Community Rebasing Project** It was noted that this work was ongoing. **Action** **The Committee noted that this work was ongoing.**	

6.	**Business Planning Framework** Mrs Harris presented the Business Planning Framework which provides clarity to the business planning process and development of the Annual Business Plan (ABP). It also supports other business cases outside the ABP process. The framework had recently been reviewed and updated and was presented the Committee for assurance purposes. The Business Planning Steering Group was responsible for the framework and had recently approved this final version which was presented to the Committee. All business cases are required to be registered on a central system administered by the finance department and are allocated a unique number, which assists in the tracking progress and helps to assure compliance with process. Benefits of the Business Planning Framework include: • A clear process set out enabling monitoring and identification of process failures in order to improve and develop the Trust's business planning ability and enhance its efficient use of resource. • Provide greater confidence and understanding of the process promoting forward thinking and planning to enhance patient services equitably whilst allowing for creativity within current financial constraints. • Develop leadership opportunities by enabling staff at all levels, the opportunity to understand and contribute to the planning process through ensuring that processes are transparent and equitable. • Promotion of the concept of patient engagement in service development • Enhance the benefits realisation process to ensure that cases realise their projected benefits and where not, lessons are learned. Mr Welling asked if there could be a simpler process for items below £25k. Mrs Harris said she would raise this at the Capital Approvals Group. **Action:** **The Committee noted that an updated and appropriate business planning framework was in place.**	**VH**
7(i)	**Tender & Service Development Schedule** The Committee received a schedule which provided an update on current tenders and service developments as at 18 August 2015. The Committee noted the position of the following PQQ/tenders in	

	the pipeline which had been considered by the Business Planning Steering Group (BPSG): • Community Diabetes Service for Brighton & Hove and High Weald Lewes & Havens CCGs • Integrated Sexual Health and HIV Service It was noted that following BPSG approval, support would be provided in writing the tender bid for the Integrated Sexual Health and HIV Service. The Committee also noted the service developments that had been considered by the BPSG. **Action** **The Committee noted the update on tenders and service developments.**	
7(ii)a	**HWLH Community Transition: Update** Ms Small gave an update on the High Weald, Lewes and Havens' Community Services transfer to the new provider, Sussex Community Health NHS Trust, with effect from 1 November 2015. It was noted that a comprehensive project plan had been developed incorporating risk and issues, which was updated on a regular basis and reported to the ESHT Project team which meets fortnightly. Ms Small presented a highlight report which provided some of the key issues and described the transition process in more detail and included: • Lessons learnt • Staffing • Communication • Freehold properties transfer • Review of existing services • Governance structure • General enquiries and issues It was noted that with regard to the Soft FM (facilities staff) NHS Property Services had stated that there was unlikely to be a transfer prior to 1 April 2016. **Action** **The Committee noted the governance process for the transfer of HWLH community services to the new provider, and the issues and risks associated with this transition.**	

7(ii)b	**HWLH Community Tender: Lessons Learned** Ms Small presented a report following a review of the tendering process in relation to the loss of the High Weald, Lewes and Havens' Community Services to the new provider, Sussex Community NHS Trust (SCT). It was noted that during the development of the Project Plan it became evident from a number of both corporate and operational staff that the Trust should review the tendering process, particularly in relation to the HWLH tender, to ensure that any lessons learned were taken account of when tendering for future bids. The views outlined within the paper were obtained from key staff involved with the tendering process. Ms Small gave an overview of the following key headlines provided in the report: • Strategic Direction • Alliance/Collaboration/Partnership • Planning and Preparation • Project Management • Project Implementation • Competitive Recommendations were highlighted for future tender submissions. **Action** **The Committee was made aware of the lessons learned paper and of the issues raised to date and how the recommendations can be implemented to support future decision making in relation to tender submission.**	
8.	**East Sussex Better Together** Miss Turner gave an update on progress with the East Sussex Better Together (ESBT) Programme. Miss Turner explained that the ESBT programme was a joint commissioning programme developed by the three clinical commissioning groups in East Sussex and East Sussex County Council in order to achieve a sustainable health and social care economy over the next five years. The planned impact of the programme centres on a 150 week plan of commissioning activity to deliver a fully integrated health and social care economy where people receive proactive, joint up care supporting them to live as independently as possible. The 150 week plan describes 3 key work streams that will help deliver this new approach; Streamlined Point of Access, Integrated Locality Teams and Urgent care redesign. It was reported that the Community First transformation programme	

	had been developed in response to the ESBT programme to align the transformation of our Out of Hospital Clinical Unit provision with the 150 week plan. This was to ensure that any service developments not only reflect the commissioning agenda but to also ensure that the risks and impact of service transformation were fully understood, assessed and mitigated through the appropriate Trust clinical/executive sponsorship and governance structures. The programme plan has two phases which include collating and analysing baseline data on Out of Hospital services and then facilitating service reviews, where the Trust, alongside commissioners and other stakeholders, can look at how new models of care can be developed to deliver strategic objectives and commissioning intentions in the most efficient and effective way. The Committee received an update on the following ESBT commissioning plans: • Proactive care • Frailty pathway • Crisis response • Integrated locality teams • Health and Social Care Connect It was noted that the Community First programme would continue to facilitate and support the alignment of Out of Hospital services with the commissioning intentions of the ESBT, ensuring that the Trusts strategic objectives are met and that there is agreement on system wide outcomes. **Action** **The Committee noted the progress with the East Sussex Better Together Programme.**	
9.	**Making Better Use of Government Resource Services & Service Delivery Platforms and the Lord Carter Review – Update on Initial findings from Lord Carter Review** The Committee received an update report on progress with the Department of Health invitation to take part in two projects. Project 1) a review of Government support services and delivery platforms and project 2) the Lord Carter review of efficiency and productivity metrics. It was noted that there was no further update on project 1 since the last Committee meeting. The Committee noted the update on the work to date on project 2, the Lord Carter programme, which described the Trust's engagement in the project and the steps being taken to ensure that the Trust validates and exploits the true potential efficiency improvements that	

	are identified. **Action** **The Committee noted the progress on project 2 to date.**	
10.	**Procurement update** Mr Channana presented an update on progress within the procurement function since 1 April 2015. This included details on: • The savings progress against the CIP target of £2 million • Contracts awarded and associated savings • Procurement Pipeline – Strategic Procurement and Materials Management It was reported that total contracts awarded and associated savings amounted to £332k. There were 14 new procurement projects in the pipeline, the Strategic procurement and estimated spend (4 years contracts) was £19m. Mr Channana reported the Procurement was now part of the Capital Approvals Group which allows them to look at new areas of spend which has not previously been looked at. Mr Channana gave an update on the 5 key projects for Materials Management – the annual spend was £378k. The projects in the pipeline would not only improve the Trust compliance levels but were also likely to deliver additional cash savings during the current and next financial year. **Action** **The Committee noted the Procurement update and the progress made against the target and key metrics.**	
11.	**PMO Update** Mrs Walton presented an report updating the Committee on the following core system developments and projects for 2015/16 and summarised the key issues: 1. Acute Oasis PAS Software upgrade 2. MSK ESHT 3. Community and Child Health system 4. Pathology Managed Equipment and Rationalisation 5. Clinical correspondence 6. Digital Medical Record Tracking (iFIT) 7. Health Records Service Improvement	

	8. JAG Accreditation 9. Windows 7 / Office 2010 migration 10. Pathology Managed Equipment and Rationalisation 11. Electronic Document Management and Clinical Portal 12. VitalPac patient bedside monitoring 13. Enterprise printing 14. Oasis PAS Hardware Upgrade 15. PACS Remediation Project 16. GS1 Programme Concerns were expressed by the Committee over two of the projects, VitalPac patient bedside monitoring and the Endoscopy Joint Advisory Group (JAG) Accreditation Plan. For Vitalpac, it was noted that stage 2 of the project had been delayed. The project was back in use but without the upgrade. It was agreed that an update would be provided at the next Committee meeting on the financial position with regard to the upgrade. With regard to the Endoscopy JAG Accreditation Plan, the intention was to apply as one unit based on two sites and be compliant on all standards by October 2015. However there were a number of issues impacting on this. Mr Welling said the Committee needed to understand the position regarding JAG accreditation. It was agreed that this would be referred to the Clinical Unit by the PMO office and a report would be requested for the Quality and Standards Committee. It was also agreed that Mr Sunley would provide a verbal update on the position at the September Finance & Investment Committee meeting. It was agreed that discussion should take place with the Improvement Director around the level of resource in the PMO office in view of some of the changes around CQC actions. **Action** **The Committee noted the PMO Project update and asked for an update on the financial position on the Vitalpac upgrade and a report to Quality & Standards on JAG accreditation, and a verbal update at the next Finance & Investment Committee Meetings.**	**LW** **LW/RS** **VH** **RS**
12.	**Annual Review of Committee Effectiveness** The Committee received a report on the Annual Review of the effectiveness of the Finance and Investment Committee. The report set out the outcome of the review which was conducted via a questionnaire to all Committee members in July 2015. Members agreed that the number of Committee meetings held had been sufficient and agendas appropriately structured to support the effective discharge of responsibilities.	

	Matters considered and decisions made by the Committee were taken on an informed basis and members agreed these decisions were understood, owned and properly recorded and would bear scrutiny; subsequent implementation of decisions and progress had been reported back to the Committee as required. Overall the Committee was considered to be well organised, well chaired and effective. Some minor changes to current Terms of Reference were agreed, some of these were to ensure alignment with the revised Business Planning Framework. These would need to go to the Board for approval. **Action** **The Committee noted the report and agreed to the minor changes to the Terms of Reference**	**BN**
13.	**Business Case** There were no business cases for review. **Action** **The Committee noted that there were no business cases for review.**	
14.	**2015 Work Programme** The updated work programme was noted. **Action** **The Committee noted the revised work programme.**	
15.	**Provisional dates for 2016 Meetings** The Committee received provisional dates for 2016 meetings for information.	
16.	**Date of Next Meeting** The next meeting will take place on Wednesday 23 September 2015 at 9.30am – 11.30am in the Committee Room, Conquest.	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 23rd September 2015 at 9.30am – 11.30am, in the Committee Room, Conquest

Present
Mr Stuart Welling, Chairman (for Barry Nealon)
Professor Jon Cohen, Non-Executive Director
Mrs Vanessa Harris, Director of Finance
Mr Philip Astell, Deputy Director of Finance
Dr David Hughes, Medical Director
Mrs Pauline Butterworth, Deputy Chief Operating Officer

In attendance
Mr David Meikle, Interim Director of Finance (from 1 October 2015)
Mr Garry East, Assistant Director of Delivery & Performance (for item 4)
Mrs Jo Brandt, Head of Planning & Performance (for item 6 & 7)
Mr Matt Hardwick, General Manager, Surgery Clinical Unit (for item 7)
Mr Chris Hodgson, Associate Director of Estates & Facilities (for item 11)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Welling welcomed members to the Finance & Investment Committee meeting and, in particular, Mr Meikle, to his first meeting. Mrs Harris was thanked for her support over the last three years. Apologies were received from Mr Sunley, Mr Nealon and Mr Stevens.	**Action**
2.	**Minutes of Meeting of 26 August 2015** The minutes of the meeting held on 26 August 2015 were agreed as an accurate record.	
3.	**Matters Arising** (i) Finance Update – Month 4	

	Mrs Harris confirmed that discussions were in hand with the TDA with regard to the cash position and it was noted that the Trust would be applying for permanent PDC from the ITFF at a date to be confirmed. (ii) Business Planning Framework Mrs Harris confirmed that the process for purchasing items below £25k had been discussed at the recent Capital Approvals Group meeting. (iii) PMO Update ***Vitalpac update*** - It was noted that this item would be deferred to the next meeting. ***JAG Accreditation*** – Mrs Butterworth provided an update on the JAG accreditation. The Committee noted that, in order to achieve full JAG accreditation, units will have to achieve level A for timeliness and level B for all other standards under clinical quality, patient experience, workforce and training. Both sites were currently struggling with time limits around this. However it was noted that the Eastbourne DGH site had a higher likelihood of achieving JAG accreditation as the Conquest site requires the refurbishment of the unit to be completed and improvement in timeliness to be within JAG accreditation requirements. Mrs Harris explained what the financial implications were of the trust not being JAG accredited. ***Level of resource in the PMO office*** – it was noted that discussions were ongoing with the Acting Chief Executive and the Improvement Director around the level of resource in the PMO office. (iv) Annual Review of Committee Effectiveness It was noted the revised Finance &Investment Committee Terms of reference were being presented to the September Board Meeting.	**RS** **RS** **VH**
4(i)	**Performance Report – Month 4** Mr East presented the month 4 Performance Report which detailed the Trust's in month performance against key trust metrics as well as activity and workforce indicators. The report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15. It was noted that the layout of the Performance report was being reviewed and it would be provide more up to date information. Overall Performance Score: 4 (from a possible 5)	

	Responsiveness Domain: 3 Due to the Trusts A&E Performance achieving the 95% target for a second month in a row, this domain has remained at a score of 3. 9 out of the 17 indicators for this domain were achieved this month. The Trust recovered the Diagnostic standard July but unfortunately the Trust did not achieve the Two Week Wait Cancer standard. The other indicators which were not achieved this month were: • RTT Admitted & Non Admitted • Cancer 62 Day Standard • Cancer 62 Day Standard for Screening • Cancer Breast 2 Week Wait Standard • Cancer 31 Day Standard • Delayed Transfers of Care Effectiveness Domain: 5 The domain remained at a 5, achieving in all indicators. Safe Domain: 5 There were a total of 2 cases of C-Difficile in July. There were no reported case of MRSA in July. Caring Domain: 4 Inpatient scores remain above the expected standard whilst the A&E scores dropped below the required standard. As such the Caring domain score has reduced to 4. There were no Mixed Sex Accommodation breaches reported in July. The June report incorrectly stated that there was a breach in June. This has now been corrected. Well Led Domain: 2 Friends and Family response has dropped to below the 30% standard because it is now a requirement that all day case and all children are included in the return (previously these had been excluded). This has increased the denominator but not the numerator and thus dropped the percentage. The Committee requested renewed effort be made to improve cancer performance. Mr East outlined initiatives that were being undertaken to offer patients appointments at an earlier point in the 2 week pathway. The staff vacancy factor (9.16%) was noted which was resulting a high rate of agency usage and additional cost for the Trust. Compliance with mandatory training was still below target and was being followed up with clinical units as appropriate. **Action** **The Committee noted the Performance Report for month 4 and**	

	noted the Trust Performance against each domain and the Workforce update.	
4(ii)	**Finance Update – Month 5** Mrs Harris gave an update on the Month 5 financial position. It was noted that the Trust performance was a run rate deficit of £3.8m with an adverse variance against plan of £0.5m. Year to date the run rate deficit stands at £15.8m which is £1.8m worse than plan. The Committee received a financial summary on the key issues at month 5. Mrs Harris summarised the downside case at M5. Mr Welling asked for a financial recovery plan to be developed. Progress against it will be monitored by the Finance and Investment Committee. It was agreed that this would be produced following finalisation of the M6 position. **Action** **The Committee noted the financial position as at Month 5.**	**DM**
4(iii)	**2015/16 Plan Resubmission** The Committee noted that ESHT had submitted a revised stretch plan of £35.2m deficit for 2015/16 as requested by the TDA. It was noted that the achievement of the Plan is high risk and assurance that it would be delivered could not be provided. The resubmission was made on 11 September 2015. The improved position of £1.8m had been achieved through reducing agency expenditure. It was noted that this had been applied across the main nursing, medical and non-clinical agency staff groups. The submission aligns with a further TDA request to submit an improved nursing agency expenditure trajectory for the last 6 months of 205/16 which was discussed under agenda item 5 (below). **Action** **The Committee noted that a plan resubmission had been made.**	
5.	**Nurse Agency Spending** Mrs Harris updated the Committee on the recent nurse agency spending requirements issued by the TDA. On 1 September 2015 the Trust received a letter from Monitor/TDA launching a set of rules for nursing agency spending. This letter set out the spending ceilings for ESHT which takes effect from 1 October.	

	The new rules, set out in the *Nursing Agency Rules* document, are: - an annual ceiling for total nursing agency spending for each trust - mandatory use of approved frameworks for procuring agency staff - there is an intention to implement price caps later in the year and further details from the TDA will follow The Trust had been given a ceiling of 3% for nursing agency costs from Q3 of 2015/16 onwards. It was noted that the Trust was a relatively low user of nursing agency in 2014/15. However in 2015/16 the proportion had grown to a current usage level of 10%. To make an immediate reduction to 3% will not be possible for ESHT so it has made an application for an adjustment to the ceiling trajectory citing exceptional circumstances. **Action** **The Committee noted the Trust's response to the requirements issued by the TDA.**	
6.	**EBITDA Quarterly Report (Q1)** Mrs Brandt presented the Committee with the 2015-2016 Q1 EBITDA statement, the 2015-2016 quarterly EBITDA comparison statement and the Patient Cost Benchmarking opportunity cost statement. It was noted that Fines and Penalties were not included in the EBITDA report. The Committee noted: - the 2015-2016 Q1 EBITDA deficit position for the clinical units - the number of service lines that had negative EBITDAs - the 2015-2016 quarterly EBITDA variances - the effect on the 2015-16 EBITDA using Patient Cost Benchmarking average unit costs when applied to ESHT inpatient activity for top 5 specialities only. **Action:** **The Committee noted the EBITDA statement position and recommended that the Committee continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews, and to return at a subsequent meeting to update on their progress.**	

7.	**Breast Surgery – Progress against action plan** Mrs Brandt presented the committee with an update on the subsequent actions following the presentation of the Breast Surgery Service Review to the June 2015 Finance & Investment Committee meeting. Breast Surgery had been chosen for a service review because it had an adverse Q4 2014-2015 EBITDA variance and a deficit position. Recommendations were made following this review and Breast Surgery had been asked to present an update on the progress made to date. It was noted that the Breast Surgery EBITDA position had deteriorated between Q4 2014-2015 to Q1 2015-16. This deterioration was cost related as opposed to activity/income and was caused by the increased CNST premium and senior medical pay locum costs. A progress update was given by Breast Surgery on: • Theatre utilisation and potential theatre list changes • Ward analysis, in particular nurse agency usage, vacancy and sickness levels • Bed occupancy levels by site • Re-admission and complication rates • Change of benchmark peer to Maidstone & Tunbridge NHS Trust • Conquest Pathway Nurse business case • Coding review and engagement Mrs Brandt and Mr Hardwick gave a brief summary of the next steps that were underway following the Breast Surgery Service review. It was noted that Mrs Brandt and Mr Hardwick were attending a PCB (Benchmarking) User Group on 7 October 2015 to present the Breast Surgery Deep Dive, for the purpose of sharing best practice and increase network coverage. **Action:** **The Committee noted the actions that Breast Surgery had put into place to improve its EBITDA statement position, at the same time improving quality. That Breast Surgery continues to work on the next steps highlighted in the Breast Surgery Service Review paper.** **The Committee would continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews.**	

8(i)	**Tender & Service Development Schedule** The Committee received a schedule which provided an update on current tenders and service developments as at 16 September 2015. The Committee noted the position of the following PQQ/tenders in the pipeline which had been considered by the Business Planning Steering Group: • Community Diabetes Service for Brighton & Hove and High Weald Lewes & Havens CCGs • Integrated Sexual Health and HIV Service Mrs Harris reported that the Trust had submitted the tender for the Integrated Sexual Health and HIV Service and would await the outcome of that. **Action** **The Committee noted the update on tenders and service developments.**	
8(ii)	**HWLH Community Transition: Update** The Committee received an update on the High Weald, Lewes and Havens' Community Services transfer to the new provider, Sussex Community Health NHS Trust, with effect from 1 November 2015. A comprehensive project plan had been developed incorporating risk and issues, which was updated on a regular basis and reported to the ESHT Project team which meets fortnightly. The Committee received a highlight report which provided a summary of the key issues and described the transition process in more detail including: • The tender process • Consultation process and staffing • Financial impact • Freehold properties transfer • Information Governance & Technology • Review of Existing services • General enquiries and issues It was noted that the Trust was meeting the deadlines that it needs to achieve. **Action** **The Committee noted the governance process for the transfer of HWLH community services to the new provider, and the issues and risks associated with this transition.**	

9.	**Making Better Use of Government Resource Services & Service Delivery Platforms and the Lord Carter Review** There was no update to report. **Action** **There was no update.**	
10.	**Job Planning update** Dr Hughes provided an update on consultant job planning. It was reported that every specialty in the Trust had participated in a job planning review. The CU and specialty leads were continuing to meet with their teams to discuss job plans in detail and were supported by the revalidation and job planning team to provide job plans in the new format. This ensures that they are all implementing the Trust new policy. Consistent use of the formal job plan template permits the interrogation of job plans to facilitate business planning of operational and clinical activity in the most cost effective manner. Monthly scrutiny meetings are undertaken with each CU from August 2014 through to March 2015. Regular contact with them continues by the Assistant Medical Director – Workforce and the revalidation and job planning team to ensure that progress continues to be made and that the job plans reflect the workload and activity the Trust needs to undertake. It is recommended that this work continues. Dr Hughes drew to the attention of the Committee a table summarising the job planning compliance and their trajectories for each clinical unit. **Action** **The Committee noted the Job Planning update and recommended that this work continues.**	
11.	**Energy Performance Contract** Committee discussions on this matter are considered to be commercially confidential and have therefore been removed from the publicly available minutes.	
12.	**Capital Approvals Group – Terms of Reference** Mrs Harris presented the Committee with the terms of reference of the Capital Approvals Group (CAG). It was noted that the CAG is responsible for the management and	

	monitoring of the Capital programme through the Finance and Investment Committee on behalf of the Trust Board. The Committee received assurance that under delegated authority from the Trust Board the CAG had a robust terms of reference enabling it to oversee the management of the Capital Programme. **Action** **The Committee noted and approved the terms of reference.**	
13.	**Banking Arrangements** Mrs Harris updated the committee on the implications of the award of the Government Banking service to RBS. The Committee noted that the national award for the provision of the Government Banking Service had been won by RBS, resulting in changes to the Trust's banking arrangements from 1 October 2015. It was noted that currently all payments made to the Trust go to the CITI bank account with payments made by the Trust going from the RBS account. Following this change the CITI account will close and all banking activity will be through the RBS account. **Action** **The Committee noted that the transition to the new arrangements was in hand.**	
14.	**2015 Work Programme** The updated work programme was noted. **Action** **The Committee noted the revised work programme.**	
15.	**Dates of 2016 Meetings** The Committee noted the dates of 2016 meetings.	
16.	**Date of Next Meeting** The next meeting will take place on Wednesday 21 October 2015 at 9.30am – 11.30am in the Committee Room, Conquest.	

East Sussex Healthcare NHS Trust

QUALITY AND STANDARDS COMMITTEE

1. Introduction

1.1 Since the last Board meeting a Quality and Standards Committee meeting has been held on 2 November 2015. A summary of the issues discussed at the meeting is provided below.

1.2 The minutes of the meeting held on 1 September 2015 are included at Appendix 1.

2. Issues discussed at 2 November 2015 meeting

2.1 Shared Learning in Practice

A shared learning in practice discussion was led by the Head of Nursing for Theatres and Clinical Support. This issue was pertinent to theatres and surgery and it was noted that the learning had been shared with theatre staff and the surgical clinical unit.

2.2 Mandatory Training and Appraisal Compliance

The Committee noted that mandatory training compliance percentages, although small, had increased month on month and the upward trend continued. The Assistant Director of Workforce stated that during 15/16 sufficient training places had been planned to meet training needs, which included drop-in sessions for suitable topics. Where there were specific issues, for example the backlog of appraisals, action continued to be taken to address this.

2.3 HR Incidents

The Committee was provided with information on the number of formal staff complaints and conduct issues which had been raised between 1 April to 30 September 2015. The Deputy Director of HR provided assurance that incidents /complaints had been managed, investigated and acted upon in accordance with Trust policies, within appropriate timescales and that any learning had been shared and policies amended where required.

2.4 HCAI (Healthcare Associated Infections) Report Quarter 2, 2015-16

The Director of Nursing presented the report on behalf of the Assistant Director of Infection Prevention and Control. The report informed the Committee of the current Trust performance against HCAI reduction objectives and incidents related to infection control. It was noted that a review of the work priorities of the Infection Prevention and Control (IP&C) team for 2015/16 had been undertaken with the Head of the IP&C from the Trust Development Agency (South) during October 2015.

2.5 **Clinical Unit Presentations**

The Committee welcomed the Heads of Nursing from the Surgery, Theatres and Clinical Support clinical units who informed the Committee around areas of concerns and the actions that had been taken to address them. The busy clinical units would continue to work with other units in order to achieve the best standards possible for patients.

2.6 **Quality Improvement Plan**

The Director of Nursing updated the Committee on the progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visit in September 2014. The report explained that the organisation worked within the themes identified in the CQC's overarching Trust report and an action plan ensured that all the 'must do' recommendations were being addressed.

2.7 **Weekly Patient Safety Summit**

The Director of Nursing described a new initiative to provide the Committee with assurance on the Trust's approach to reviewing incidents on a weekly basis, ensuring that the Trust promoted a culture of learning through review and reflection of incidents and near misses. The Weekly Patient Safety Summit group would also ensure that the Trust was compliant with its statutory duty of candour requirements.

2.7 **Deep Dive – Health Records**

The Committee welcomed the Head of Clinical Administration who provided them with assurance and an update on the Trust's plans to address identified areas for improvement within the Health Records Department. She provided a progress report on the improvements within Health Records and remaining issues, along with mitigating actions. She confirmed that the overall aim of the improvement programme was to provide a safe and effective service that would be sustainable for the next 5-10 years.

Following discussion assurance was provided to that Committee that whilst there were still concerns regarding the impact of health records and other administrative services every effort was being made to respond to these.

3 Conclusion

3.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meeting held on 2 November 2015 and the minutes of the meeting held on 1 September 2015.

Charles Ellis
Quality and Standards Committee
3 November 2015

Appendix 1

East Sussex Healthcare NHS Trust (ESHT)

Quality and Standards Committee

Minutes of the Quality and Standards Committee Meeting

Tuesday, 1 September 2015
St Mary's Room, Eastbourne District General Hospital

Present:
Mrs Sue Bernhauser, Non-Executive Director
Mrs Janet Colvert, Ex-Officio Committee Member
Mr Charles Ellis, Non-Executive Director (Chair)
Dr David Hughes, Medical Director
Ms Tina Lloyd, Assistant Director of Nursing Infection Prevention and Control
Mr Richard Sunley, Interim Chief Executive /Chief Operating Officer
Ms Emma Tate, Head of Clinical Improvement
Mrs Hilary White, Interim Head of Governance
Dr James Wilkinson, Assistant Medical Director, Quality

In attendance:
Mrs Edel Cousins, Assistant Director of HR (Workforce Development) obo Mrs Tenney
Ms Sandra Field, General Manger, Specialist and Planned Medicine for item 4.2 only
Mrs Maggie Oldham, Improvement Director

Mrs Susan Cambell, PA to Director of Nursing (minutes)

1.0 Welcome and Apologies for Absence

Mr Ellis welcomed participants to the Quality and Standards Committee meeting and confirmed that the Committee was quorate.

Mr Ellis noted apologies for absence had been received from;

Professor Jon Cohen, Non-Executive Director
Ms Elizabeth Mackie, Volunteer & Community Liaison Manager, Healthwatch
Miss Lindsey Morgan, Deputy Director of Nursing
Mrs Moira Tenney, Deputy Director of Human Resources
Mrs Alice Webster, Director of Nursing
Mr Stuart Welling, Chairman
Mrs Lynette Wells, Company Secretary
Dr Jamal Zaidi, Assistant Medical Director, Workforce

2.0 Patient Story

Mr Sunley confirmed that the filming of patient stories had commenced and would be shared with staff at induction and general staff development sessions. It was noted that the Committee valued listening to service users' experiences and welcomed their continued attendance at meetings.

3.0 Minutes and Matters Arising

3.1 Minutes of the Previous Meeting

Minutes of the Quality and Standards Committee meeting held on 6 July 2015 were considered and agreed.

3.2 Matters Arising

The action log was reviewed and updated.

4.1 Mandatory Training and Appraisal Compliance

Mrs Cousins was welcomed to the meeting and she updated the Committee on the Trust compliance rates for mandatory training and appraisals as at 31 July 2015. Mrs Cousins described the changes made to the compliance report, as requested by the Committee, which included the removal of the amber rating and to show green at 90% and above only. Mrs Cousins confirmed that clinical unit trends analysis would be presented at future Quality and Standards meetings.

Mrs Cousins explained that she awaited further updates from the Trust Health and Safety lead regarding the health and safety three year training cycle. Mrs Berhauser sought clarity around estates and facilities low compliance with health and safety training and Mr Sunley confirmed that this had now increased to 95% in July 2015.

Mrs Cousins highlighted the Surgical clinical unit as an area where some audit days had been given over to mandatory training which had resulted in the participation of large numbers staff, and this was commended by the Committee. Mr Sunley confirmed that this was being considered by other clinical units and resources would be targeted at this.

Mrs Cousins confirmed there had been a10% increase in appraisals compliance based on 2014 figures. Mrs Cousins described the current review of the appraisal process, required as part of nurse revalidation and scheduled to commence in January 2016. Mrs Cousins confirmed the review included a quality check to ensure consistent application of processes and she agreed that outcomes from the review would be shared with the Committee.

Mrs Oldham queried where poor appraisal and mandatory training compliance was recorded. In addition to being presented to the Committee, Mrs Cousins confirmed that it was noted on the Trust risk register and at accountability reviews.

4.2 Cardiovascular Clinical Unit Deep Dive on Staff Appraisal and Mandatory Training Compliance.

Ms Field was welcomed to the meeting. She explained that the Specialist Medicine Management team had been responsible for supporting the

Cardiovascular Clinical Unit since mid-July 2015. Ms Field described the benefits of the merged teams with a dedicated Manager to support and lead the challenges faced by each of the specialties in the unit. Ms Field stated that staff had supported the change and were proactive in achieving compliance but acknowledged it was essential staff had the tools and time to undertake training. It was noted that, to date, the unit had been unable to fulfill their vacancy factors for both interim and substantive staff. Ms Field detailed plans for meeting compliance by mid to end of September 2015. Ms Field described the ward based mandatory training sessions that would be delivered both in and out of hours and stated this would also benefit team building. Mrs Cousins reported that this blended approach to training would involve an assessment with a practical element.

4.3 **Board Assurance Framework and High Level Risk Register**

The updated organisational Board Assurance Framework (BAF) and High Level Risk Register were presented by Mrs White. The Committee was sighted on three areas of concern which were discussed and noted; health records, the configuration of emergency departments and mandatory training and appraisals compliance. The committee asked that it be kept regularly updated about progress in these three areas with specific focus on health records. It was agreed a deep dive into health records would take place at the next Committee meeting. **RS**

4.4 **Quarter 1 Update on Compliance against Regulation 12 'Cleanliness and Infection Control' Quarter 1, 2015- 16**

Ms Lloyd presented a report which detailed exceptions to criterion 2, 5, 6 and 7. These had been judged to be below 84.49% compliant by the Trust Infection Control Group (TICG). Discussion took place around recruitment to the National Specification of Cleanliness (NSC) audit team which would support full compliance with the NSC schedule and the implementation of the new electronic audit tool. Ms Lloyd suggested it could take up to three months to recruit five whole time equivalent staff members for this specialist role. Ms Lloyd confirmed that she was working with Linda Dempster, Head of Infection Prevention and Control, Trust Development Agency (TDA) and had spoken with other Trusts across the South East to find out how they met the level of auditing required by the schedule.
Mr Ellis sought clarity around the reduced compliance in ward areas reported by nursing staff at the Conquest site due to lack of regular housekeeping substantive staff and the use of 'runners'. Ms Lloyd explained that 'runners', time was split between wards to cover housekeeping tasks and there was a perception that they lacked consistency and thoroughness. Ms Lloyd confirmed that a newly appointed site manager had investigated this and interim adjustments to shifts had been made. In the long term, a large-scale, full service review of the housekeeping modernisation plan would have a significant impact.

Ms Lloyd described the ward orderly role to support nursing staff in the cleanliness of patient equipment and environment. This initiative had been piloted on four wards and following a positive response, 15 posts had been

advertised. Ms Lloyd reiterated this was not a replacement for housekeeping.

Mr Ellis queried if the lack of compliance correlated to staff shortages and it was noted that both high vacancy rates and lack of investment in estates, were major challenges which attributed to non-compliance. Mr Sunley confirmed that the focus of capital investment this year had been Pevensey ward with £750K set aside to cover the back log of maintenance requests. Mr Sunley stated that operationally gaining access to the wards had proved a challenge, particularly on the Conquest site. Ms Lloyd highlighted Egerton ward that had been identified as an area of risk but with the continued engagement and focus from staff was now an example of best practice for other areas.

Ms Lloyd confirmed that the provision or securing of adequate isolation facilities would be improved by the re-opening of Pevensey ward.

4.4 **Annual Report for Infection Prevention and Control 2014-15 and key priorities for Programme of Work 2015-16**

Ms Lloyd presented a report which had been developed with stakeholders and set out the key activities, incidents and achievements of the Trust related to infection prevention and control during 2014-15, and the key priorities for the programme of work for 2015-16.

Ms Lloyd stated that although the total number of cases of Clostridium difficile infections (CDI) reported had increased, the number of cases related to transmission had reduced from six the previous year to one in 2014/15. Ms Lloyd stated that CDI rate showed us as a high outlier which may have been due to the inclusion of the community bed rate activity. Ms Lloyd stated that the Trust had sought support from the TDA in addressing key priorities for 2015-16.

Ms Lloyd acknowledged the significant operational challenges and bed capacity which restricted planned programmes of refurbishment and delivery of a structured decant deep clean programme.

Mrs Oldham sought assurance around effective systems and plans to rapidly identify and manage outbreaks of infection given the housekeeping, training and infection control issues that had been described. Ms Lloyd confirmed that when there was a critical need, the Trust's response to outbreaks was excellent but ongoing planning and preventative work remained a challenge.

4.5 **Annual Report for Safeguarding Adults and Children 2014/15**

This item was deferred to the next meeting due to the non-availability of the presenter.

4.5 **Quality Improvement Plan (CQC Recommendations)**

Mrs White provided the Committee with a highlight report of the quality improvement plan which included actions from the September 2014 Care

Quality Commission (CQC) inspection.

The report explained that the organisation worked within the themes identified in the CQC's overarching Trust report. An action plan ensured that all the 'must do' recommendations were addressed with 'should do's' developed in local action plans relevant to the areas in which the issues had been identified. It was noted that updates were now reported weekly at extended Clinical Leadership Team (CLT) meetings and this included clinical unit representation. Mrs Bernhauser queried clinical unit attendance and Mr Sunley confirmed this was a new initiative with full attendance the first week, but there had been no representation from the Women and Children specialty in the second week. Mrs Bernhauser commented that staff engagement with the plan was key. Mrs Bernhauser was concerned that the implementation of a feedback process to ensure staff felt supported and able to say why they felt they were bullied or harassed had slipped. Mr Sunley confirmed that staff engagement would be a discussion topic at the forthcoming Quality Summits, both externally and internally and weekly, cross site staff focus groups had been planned. Mrs Cousins stated that there was a huge amount of work going on around staff engagement and highlighted the Speak Up, Speak Out campaign and recruitment of the guardian role. Dr Wilkinson stated that saying thank you for a job well done paid huge dividends in staff engagement.

5.1 **Quality Improvement Priorities 2015/16**

Ms Tate presented the Quality Improvement Priorities (QIP) plan 2015/16 progress to the Committee and confirmed the priorities had been identified in the Quality Account 2014/15. Ms Tate reported that each QIP had an identified lead with the exception of Improving Compassion in Care, which had multiple workstreams. She explained that limited progress had been made regarding this QIP except for the introduction of monthly Schwartz Centre Rounds, but confirmed that agreement for overall leadership of this QIP had been discussed with Mrs Webster and Miss Morgan.

Ms Tate described the challenge around achieving a 20% reduction in the number of patient falls that resulted in serious harm. Mrs White confirmed that to help identify areas of learning, a post falls audit, using guidance issued by NICE had been undertaken during August in five of the high risk areas. Mr Ellis requested the Committee looked in-depth at falls at the next Committee meeting. It was acknowledged that there had been an overall reduction in the total falls per 1000 bed days. **AW**

Ms Tate reported that short term measures had been implemented to improve the non-compliance of the Dementia Commissioning for Quality and Innovation (CQUIN), with a business case being developed for an expanded team in the long term.

Discussion took place around the communication of the Trust's priorities. Mrs Oldham explained that following a clear understanding of the regulators' requirements, guidance should be given to staff around how the Board approved recovery plan would be delivered. Mrs Oldham re-iterated that it was important the Board to provided strong leadership during every visit

undertaken with a focus on corporate objectives.

5.2 **Integrated Quality Report – Quarter 1, April – June 2015**

Mrs White provided the Committee with detailed information on patient experience, patient safety and clinical effectiveness activity within the Trust between April and June 2015. Dr Hughes noted that Trust wide NICE compliance had improved considerably and he thanked the team for their hard work. Mrs White agreed to liaise with the Patient Experience lead around improved services users' understanding of patient pathways and increased focus on patient engagement. **HW**

5.3 **NHS Constitution Update**

Mrs White provided information around the revised NHS Constitution and Handbook to the NHS Constitution which had been updated to reflect current policy and legislation. Mrs White confirmed that the Fundamental Standards of Care had been uploaded to the staff extranet and would be made available at induction programmes.

6.0 **Sub Committee Minutes**

The following items were noted by the Committee;

6.1 Minutes from the Trust Health and Safety Steering Group meeting held on 17 July 2015.

6.2 Minutes from the Patient Safety and Clinical Improvement /Essential Compliance Group meeting held on 29 June 2015.

7.0 **Any Other Business**

7.1 None noted.

8.0 **For Information**

8.1 None noted.

9.0 **Date of the Next Meeting**

Monday, 2 November 2015
2.30pm – 4.30pm
Committee Room, Conquest Hospital

East Sussex Healthcare NHS Trust

Date of Meeting:	2nd December 2015
Meeting:	Trust Board
Agenda item:	20
Subject:	Use of Trust Seal
Reporting Officer:	Sue Bernhauser, Chair

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

Purpose:

To keep the Board informed of the use of the Trust Seal since the last Board meeting.

Introduction:

The purpose of this paper is to provide an overview of the use of the Trust Seal since the last Board meeting.

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

Use of Trust Seal

13th October 2015 – Transfer of documents for Crowborough, Lewes and Uckfield Hospitals to NHS Property Services (due to HWLH Community Service Transfer, effective 1st November 2015).

Proposals and/or Recommendations

The Board is asked to note the use of the Trust Seal since the last Board meeting.

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

Name:	**Contact details:**
Sue Bernhauser, Chair	susan.bernhauser@nhs.net

East Sussex Healthcare NHS Trust

TRUST BOARD MEETING DATES 2016

10th February	10.00 am – 14.30 pm	Cooden Beach Hotel, Bexhill
13th April	10.00 am – 14.30 pm	Lecture Theatre, Education Centre, Conquest
8th June	10.00 am – 14.30 pm	St Mary's Board Room, EDGH
3rd August	10.00 am – 14.30 pm	Uckfield Civic Centre
12th October	10.00 am – 14.30 pm	Lecture Theatre, Education Centre, Conquest
14th December	10.00 am – 14.30 pm	St Mary's Board Room, EDGH