EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 30th July 2014, commencing at 10.00 am in the Manor Barn, 4 De La Warr Road, Bexhill-on-Sea, TN40 2JA

AGENDA

			Lead:
1.	a) Chairman's opening remarks b) Apologies for absence c) Quality Walks		Chair
2.	Monthly award winner(s)		Chair
3.	Declarations of interests		Chair
4a.	Minutes of the meeting held on 3rd June 2014	Ai	Chair
4b.	Matters arising	Aii	Chair
5.	Chief Executive's report (verbal)		CEO
6.	Board Assurance Framework	B	CSec

QUALITY, SAFETY AND PERFORMANCE

7.	Quality Governance Strategy and Quality Improvement Plan	Approval	C	DN/ MDCG
8.	a) Performance report month 2 (May) and Finance report month 3 (June) b) Safe Nurse Staffing Levels report June 2014 c) Complaints Report Quarter 1 (April to June 2014) d) Friends and Family Test Quarter 1 (April to June 2014)	Assurance	D	ALL DN DN DN
9.	Medical Revalidation Annual Report 2013-14	Assurance	E	MDCG

STRATEGY

10.	Knowledge Management Strategy 2014-17 and Information Technology Strategy 2014-19	Approval	F	DSA/ DF
11.	Radiotherapy Treatment Centre Update	Assurance	G	COO

DELIVERY

12.	Annual Business Plan 2014-15 Quarterly Update	Assurance	H	DSA
13.	Operational Performance Management Framework	Assurance	I	COO

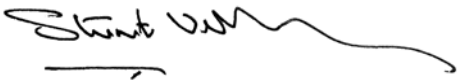
GOVERNANCE & ASSURANCE

14.	Annual Reports: a) Emergency Planning and Business Continuity 2013-14 b) Safeguarding Adults and Children 2013-14 c) Annual Equality Report 2013-14 d) Updated Fire Safety Annual Report January 2013-June 2014	 Assurance Assurance Assurance Assurance	J	 COO DN CoSec COO
15.	Ratification of Employer Based Clinical Excellence Awards for 2013 Round	Ratification	K	MDCG
16.	Board sub-committees: a) Audit Committee 09.07.14 b) Finance and Investment Committee 26.06.14 c) Quality and Standards Committee 07.07.14 d) Trust Board seminar notes 12.03.14, 16.04.14 and 14.05.14	Assurance	L	Comm Chairs
17.	Review of Board Governance and Leadership	Approval	M	Chair
18.	Themes for Quality Walks	Assurance		Chair

ITEMS FOR INFORMATION

19.	Chairman's Briefing	Assurance	N	Chair
20.	Questions from members of the public (15 minutes maximum)			Chair
21.	Date of Next Meeting: Wednesday, 24th September 2014 – Annual General Meeting at 10.00 am and public Trust Board meeting at 10.30 am, St Mary's Board Room, EDGH			Chair

22.	**To adopt the following motion:** *That representatives of the press and other members of the public will be excluded from Part 2 of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest* *(Section1(2) Public Bodies (Admission to Meetings) Act 1960)*		O	Chair



STUART WELLING
Chairman 23rd July 2014

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

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks May/June 2014
Reporting Officer:	Amanda Harrison, Director of Strategic Development and Assurance

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

Purpose:

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

Introduction:

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

Themes for the walks are decided by the Board and the focus during May and June was as follows:

- Health Visiting
- Maternity and Paediatric Services
- Trauma and Orthopaedics
- General Nurse Staffing Levels
- Impact of new Information Management and Technology

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

27 services/departments were visited as part of the Quality Walk programme during May and June as detailed in the attached. 25 of these were arranged by the Assurance Manager or the Chief Executive's office and the Ward or Unit Manager notified in advance to expect the visit. The remainder were carried out as ad hoc visits so staff may or may not have been notified to expect them. (NB other adhoc visits may have taken place, but reports have not yet been received).

Feedback forms have been received to date relating to 25 of the visits, a copy has been passed on to the relevant department/service managers for information.

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

<u>Health Visiting</u>

Excellent working with Health Visitors was described by the Child Protection Team, and regular joint meetings are held. Close working relationships were also reported with the Kipling Unit and the lead midwife for Child Protection.

<u>Maternity and Paediatric Services</u>

Staff reported that since the majority of maternity services have moved to the Conquest Hospital access to doctors has improved and fewer complaints have been noted. Staff also stated that there is now good team working in place within the department.

The Special Care Baby Unit felt that there had been a lack of investment to accompany the move from the DGH to the Conquest and that it is sometimes a challenge for mums living in Eastbourne to be able to breast feed effectively if they have other family to care for.

The Emergency department at EDGH had concerns about the lack of support and advice for Paediatric and Trauma and Orthopaedic patients, now that services are based at the Conquest.

Trauma and Orthopaedics
Therapy staff appear to have adapted to the change of location for the service very positively although it has required some staff relocate bases due to the increase in requirements of the service being on one site.

General Nurse Staffing Levels
No major issues were reported on the acute sites apart from one area noting a high turnover of newly qualified staff who move on to other areas as vacancies arise, and another stated that staff are often taken from their ward to cover other areas that may be short staffed.

District Nursing is finding that the demands on the service are increasing due to the acuity and complexity of their patients and that in some areas there is a high dependency on bank staff. One team also stated that 'they felt under pressure from GPs who believed that the Trust had reduced services'.

Impact of new IM&T
A positive response to the implementation of Vitalpac was noted and staff are welcoming the opportunity to move away from paper records, however a lack of hardware was reported relating to the implementation of SystmOne. One area stated that they have difficulties with e-rostering due to the time it takes to make staff changes.

Other key issues
Concern was raised about the Trust's financial position; District Nursing reported a lack of opportunity for staff development and a lack of administrative support. Low staff morale was reported in the Health Records Department due to staffing levels, they also reported feeling undervalued and felt that there was a lack of investment in the service. Staff working in Outpatients continue to report problems with the availability of health records for clinics.

Patient feedback
A number of patients were spoken to during the Quality Walks all of which gave positive feedback.

Benefits:

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

Risks and Implications

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

Assurance Provided:

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

Further visits are scheduled to take place in July and August as detailed on the attached.

It was agreed at the June Board meeting that the following themes will be the focus of those visits:

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

The feedback forms have been amended accordingly and are distributed with the briefing documents prior to each scheduled visit.

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

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

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

Quality Walks May - June 2014				
DATE	**TIME**	**SERVICE**	**SITE**	**Visit by**
May				
1.5.14	12pm	Baird Ward	Conquest	Vanessa Harris
7.5.14	3pm	Irvine Unit	Bexhill	Darren Grayson
12.5.14	5.45pm	Irvine Unit	Bexhill	Vanessa Harris
12.5.14	3pm	Dowling Unit	Bexhill	Amanda Harrison
12.5.14	11am	District Nursing Meadow Lodge	Lewes	Stuart Welling
15.5.14	2pm	DN's	Crowborough	Stuart Welling
23.5.14	2pm	SCBU	Conquest	Vanessa Harris
22.5.14	10pm	A&E	EDGH	Vanessa Harris
26.5.14	10am	Sovereign Ward	EDGH	Stephanie Kennett
28.5.14	3pm	Friston SSPAU	EDGH	Jon Cohen
29.5.14	10pm	Jevington	EDGH	Sue Bernhauser
30.05.14	11am	Electro Medical Engineering (EME)	CQ	Monica Green
June				
2.6.14	3pm	Jubilee Eye Suite	EDGH	Stuart Welling
2.6.14	11am	District Nurses	Hailsham	Stuart Welling
4.6.14	12.30pm	OPD	Conquest	Stuart Welling
5.6.14	3.30pm	Health Records	EDGH	Stuart Welling
6.6.14	9.30am	Sexual Health	Avenue House	Vanessa Harris
9.6.14	11am	Newington	Conquest	Monica Green
9.6.14	10.30am	East Dean & Sovereign	EDGH	Stuart Welling
9.6.14	12 noon	Radiology	EDGH	Stuart Welling
9.6.14	1.30 pm	Theatres	EDGH	Stuart Welling
9.6.14	3pm	Sexual Health	Station Plaza	Darren Grayson
9.6.14	3.30pm	District Nurses	Station Plaza	Darren Grayson
9.6.14	10.am	Cookson Devas	CQ	Darren Grayson
13.6.14	2pm	Child Protection Team	Conquest	Sue Bernhauser
16.6.14	2.30pm	Delivery Suite	Conquest	Vanessa Harris
18.6.14	9am	Occupational Therapy	EDGH	Monica Green
25.6.13	10am	Audiology	Eastbourne Park Primary Care Centre	Amanda Harrison
Quality Walks Scheduled July - August 2014				
July				
1.7.14	6am	Tressell	Conquest	Vanessa Harris
2.7.14	9am	Day Surgery Unit Retinal Screening	Bexhill	Alice Webster
7.7.14	12.30 pm	Community Paediatric Team	Bexhill	Amanda Harrison
7.7.14	9am	School Nurses	Old Ladies Court, Bexhill	Amanda Harrison
17.7.14	9am	District Nurses	Station Plaza	Stuart Welling
17.7.14	2pm	Health Records	Conquest	Stuart Welling
18.7.14	1pm 1.30pm	Health Visitors District Nurses	Heathfield Community Centre	Sue Bernhauser
21.7.14	10.30am	Audiology	EDGH	Monica Green
21.7.13	10am	Frank Shaw	CQ	Amanda Harrison
23.7.14	12-2pm	Endoscopy	EDGH	Jon Cohen
24.7.14	7.30pm	AAU	Conquest	Vanessa Harrison
25.7.14	4.30 pm	Endoscopy	Conquest	Monica Green
August				
1.8.14	9.30 am	Day Surgery Unit OPD	Uckfield	Monica Green
5.8.14	11.30 am	Health Records	Brampton Road	Stuart Welling
5.8.14	1pm	District Nurses	Eastbourne Park Primary Care Centre	Stuart Welling
6.8.14	1pm	District Nurses	Arthur Blackman Clinic	Monica Green
6.8.14	1pm	District Nurses	Eastbourne Park Primary Care Centre	Stephanie Kennett
11.8.13	2pm	Delivery Suite	EDGH	Amanda Harrison
14.8.14	9.30 am	Health Records	Apex Way Hailsham	Stuart Welling
14.8.14	12 noon	Outpatients	Eastbourne DGH	Stuart Welling
14.8.14	11.30am	Gardner	Conquest	Vanessa Harris

20.8.14	10am	Estates and Facilities	EDGH	Sue Bernhauser
20.8.14	2pm	Rye Hospital	Rye	Stuart Welling
22.8.14	10am	HV's School Nurses Fellowship of St Nicholas St Leonards	Hastings	Alice Webster
27.8.14	2.30pm	Ward OPD	Crowborough	Alice Webster
27.8.14	10.30-12	Meadow Lodge	Lewes	Alice Webster
27.8.13	2pm	Intermediate Care beds	Meadow Lodge	Amanda Harrison
29.8.14	12.30	District Nurses	Hailsham	Vanessa Harris

To be Rearranged/has been requeste

Date should have happened	Time	Ward / Service	Location	Director
	3pm	Podiatry	EDGH	Alice Webster
		Pain Clinic (Burton Unit)	CQ	Monica Green
3.2.14		Podiatry	LVH	
21.2.14	10.30am	TVN's	CQ	Monica Green
19.2.14	9am	Community Paediatric Team	EDGH	Monica Green
31.3.14	10.30am	Dental Services	Ian Gow Centre	James O'Sullivan
29.4.14	11am	Occupational Health	Conquest	James O'Sullivan
1.5.14	4.30pm	School Nurses	Bexhill Health Centre	Vanessa Harris
25.4.14	9.30am	Community Respiratory Nurse	CQ	Monica Green
10.6.14	8.30am	Folkington	EDGH	Monica Green
6.8.14	midday	Community Dietetics	Avenue House	Monica Green

ed

Contact			
Neil Simonite	07.1.14		17.1.14
Dr J Lethbridge/Bob Lott	6.1.14		14.1.14
Brenda Davey			
Deirdre Connors	6.2.14		14.2.14
Louise Pike	5.2.14	11.2.14	11.2.14
David Brabner/Lorraine Addems	04.3.14	04.3.14	04.3.14
Christian Lippiatt	15.4.14		22.4.14
Debbie Mentessi	24.3.14		17.4.14
Dierdre Connors	9.4.14		17.4.14
Lisa Flindall	20.5.14		3.6.14
Lesley Houston			

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Tuesday, 3rd June 2014 at 10.00 am in the Oak Room, Hastings Centre

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

In attendance: Mrs Sue Bernhauser, Non-Executive Director Designate
Ms Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development and Assurance
Mrs Lynette Wells, Company Secretary
Ms Jan Humber, Joint Staff Side Chairman
Ms Liz Still, Research and Development Manager (for item 045/2014)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

035/2014 **Welcome and Apologies for Absence** **Action**

a) Chairman's Opening Remarks

Mr Welling welcomed Sue Huggins, new full-time officer of the Joint Staff Committee, who was in the audience at the meeting.

b) Apologies for Absence

Mr Welling reported that no apologies for absence had been received.

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

c) Feedback from Quality Walks

Dr Harrison presented the report which provided information on the quality walks undertaken by Board members during April and May.

Mr Ellis reported on his visits to the Rye, Winchelsea and District Memorial Hospital and the discharge lounge at the Conquest Hospital.

Mr Ellis reported that at Rye the staff were very proud of their unit and he spoke to a number of patients who were very complimentary about the care they were receiving, in particular the friendliness and compassion of staff, and the food with the introduction of the new kitchen. He advised that staffing and teamwork seemed to be good and he had met one of the community artists who had been very enthusiastic about their work. The staff had raised a concern around patients being transferred to their hospital without discharge letters which caused issues for the GPs who looked after the patients at the hospital. In addition, the social workers based at the hospital were not able to access the internet but he understood that this was being addressed by the IT department.

He reported that he had visited the discharge lounge at the Conquest Hospital shortly after its opening and the staff had been enthusiastic and motivated with a number of ideas to make the discharge process run more smoothly whilst ensuring patients, relatives and carers received the best possible care. He reported that discharge letters also appeared to be an issue as well as drugs to accompany patients home and staff spent a lot of time chasing these up. He also highlighted that patients were waiting a long time for transport and staff had raised this as a concern. He advised that the patients had been complimentary about the care they had received, both whilst in the lounge and across all aspects of their stay.

Mr Grayson reported that he had also visited Rye recently and he endorsed everything Mr Ellis had highlighted. He advised that staff across all the hospitals had raised concerns about patient transport which was a service commissioned for patients by the Clinical Commissioning Groups and the contract was currently provided by South East Coast Ambulance Service. He advised that the contract period finished at the end of this financial year and this provided an opportunity for the Trust to discuss any concerns and issues with the Clinical Commissioning Groups so that they could specify a service which met patients and the Trust's requirements going forward. The Chief Executive of the ambulance service, Paul Sutton, would be attending the Sussex Acute Partnership Group to present his views on how he saw the service developing in the future.

Professor Cohen reported that he had undertaken an unannounced visit to the community diabetes nursing team in Eastbourne and had had a very interesting discussion with the senior nurse. He had been very impressed at how professional and committed the team were to providing a first class service. The only concern that had been raised was in relation to a regrading of staff at senior nurse level and Mrs Webster advised that she would investigate this with the staff concerned. **AW**

Professor Cohen reported that he had also visited the Short Stay Paediatric Unit at Eastbourne DGH and he was hugely impressed by the professionalism, compassion and skill the staff demonstrated.

He reported that they were absolutely committed to the provision of a first class paediatric service. He highlighted that it would not be sustainable in the long term to remain in such a large clinical area and the staff understood the issues and were keen for the unit to be moved to a more appropriate setting. Dr Slater reported that once the decisions were made following consultation plans could be made to relocate the unit next to the A&E department and this would be of benefit to both services.

The Board noted the reports on quality walks.

036/2014 **Monthly Award Winners**

Mr Welling reported that the winner for April was Susan Heywood, Senior Theatre Practitioner, who, while out on a day off, provided life saving care to a gentleman suffering a heart attack while retrieving his boat from a lake. Susan had given CPR for 14 minutes until an ambulance crew arrived. Susan had recently not been well and was still not 100% herself and ended up very wet, cold and exhausted. As a very modest person, Susan believed that anyone would have done the same.

He reported that the winners for May were Dr Suzanne Daniel, a Foundation Year 2 doctor, and Janki Patel, a Specialist Pharmacist, who had been nominated by Ian Bourns, Head of Pharmacy, and Jonathon Palmer, Clinical Pharmacy Manager. They had been nominated for their work on a leadership project for improving the prescriptions of controlled drugs for patients being discharged home for end-of-life care. During the project they identified that 89% of prescriptions for these discharge medicines had a problem which required amending. Their project created a standard dispensing chart which had reduced the error rate by 67% and improved the turnaround time of these prescriptions within pharmacy.

Their managers had nominated them as they deserved recognition within the Trust as this had been a voluntary project that Dr Daniel and Ms Patel were very passionate about. They had shown leadership to overcome the obstacles that they faced with when trying to make changes to practice. As a multi-professional collaboration their work had been presented to the Kings Fund and both were currently hoping to have it published within their respective professional journals.

Mr Welling reported that at the Staff Awards Ceremony held on 14th May the winner of the Chairman's Cup was not able to attend as she was on holiday. He advised that he had the privilege of selecting the winner of the Chairman's Cup, and he tried to choose someone who had really made a difference and in that respect this year's winner had been yards ahead.

Mr Welling announced that the winner was Chin Barton, ENT Matron, as she went way over and above the expectations of even the most caring nurse and never failed to uphold the dedication and professionalism that was expected.

He reported that she had been described by one of her patients as “an angel” and she provided support to many of her patients after they had left hospital, visiting them in her own time.

037/2014 **Declarations of Interest**

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

038/2014 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 26th March 2014 were considered and approved as an accurate record.

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

b) Matters Arising

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

039/2014 **Chief Executive’s Report**

Mr Grayson reported that 2013/14 had been a tough but rewarding year with significant successes and some disappointments. He noted that the Trust had continued its focus on patient safety and quality which had been borne out by the clean bill of health from the Care Quality Commission following the visits they had made during the year.

Mr Grayson referred to the action taken to improve the safety and quality of maternity services in particular and highlighted the outcomes and benefits now being received by mothers and babies across the county.

Mr Grayson noted that during the year the Trust had consistently continued to meet the A&E target in challenging circumstances and there had been a significant improvement in the Trust's performance against the stroke indicators following centralisation which was being sustained.

Mr Grayson reported that it had been a difficult year financially but the Trust had managed to produce savings equivalent to 5% of its turnover and finance had taken its rightful place alongside safety and quality.

He was pleased to report that the Trust had implemented many parts of its Shaping our Future clinical strategy not only through centralisation of stroke and emergency and high risk general surgery but also through increased efficiency and productivity and the benefits realisation for patients were starting to come through.

He advised that the consultation on the future long term provision of maternity and paediatric services had concluded and the Clinical Commissioning Groups decision making process was currently underway.

Mr Grayson reported that in looking forward to 2014/15 the NHS would be entering the fourth year of an age of austerity which was unprecedented since 1948 and the NHS in general and this organisation had been experiencing the very severe effects of this. The Trust continued to face up to the challenge focusing on the services it needed to provide and had been able to make some investments particularly in nurse staffing on the wards despite the difficult financial position,. The plan for the year was to reduce expenditure by a further £20 million (5% of turnover) as outlined in the Annual Business Plan.

He referred to the work on the challenged health economy and highlighted that the new Chief Executive of NHS England had talked about the challenges and how whole health economies had to find the solutions to address them. In East Sussex the work was being led by Clinical Commissioning Groups through their commissioning intentions for the next five years.

Mr Grayson reported that the Trust would receive a Chief Inspector of Hospitals inspection in the autumn and would be one of the first integrated acute and community organisations to be inspected. He advised that he was looking forward to the inspection as it would give the organisation a good sense of where it stood and where it needed to make progress.

The Board noted the report.

040/2014 **Board Assurance Framework**

Mrs Wells presented the May update of the Board Assurance Framework and noted that revisions and updates were provided in red text.

She reported that three gaps in control/assurance had been removed and three revised or replaced. In addition, increased assurance had been provided in two areas and therefore the risk had been reduced.

Mrs Wells advised that the first related to diabetic retinopathy as additional funding had been received enabling more staff to be recruited to the service and the Trust was working with commissioners to improve the integrated service. The second related to recruitment following the successful recruitment campaign for nursing staff.

Mrs Wells advised that the framework had not been reviewed by the Audit and Quality and Standards Committees due to the timing of the Board Meeting but had been reviewed at the Corporate Leadership Team meeting. Mr Welling advised that the Board needed to be clear about the assessment of the risks and be satisfied with the controls and actions put in place to address these.

Mrs Harris highlighted the risk around capital expenditure and the prioritisation for 2014/15. She advised that the Finance and Investment Committee would have a continual focus on how capital expenditure was being managed and the impact on medical equipment replacement, estates refurbishment and IT systems during the year.

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

041/2014 **Quality Account 2013-14**

Mrs Webster reported that the Quality Account was the annual report to the public from healthcare providers which was split into three domains. It confirmed the Trust's commitment to make quality and safety its priority.

She advised that the Account contained information on activities carried out in 2013/14 and the priorities for 2014/15 which focused on cross cutting themes for the organisation. She noted that since submitting this draft to the Board feedback had been received from the commissioners which would be included in the final version.

Mr Welling asked if there had been any significant comments from the commissioners and Mrs Webster advised that their main comment had been that the Account had an acute focus although the Trust had tried to include both acute and community services. Mr Grayson commented that this in part reflected the availability of reliable data for the community service but with the roll-out of SystmOne, the new community and child health system, data collection of community activity would improve in future years.

Professor Cohen asked how the priorities would be implemented and Dr Harrison advised that these were incorporated within the annual business plan.

Mrs Harris asked where there was a comparison with the previous year in relation to the positive experience of care and it was agreed that Mrs Webster would provide a response to be appended to the minutes as she did not have the information at the meeting. **AW**

Mrs Harris commented that it would be useful to have a comparison of the incidences of C Difficile for quarter 4 against the national data for quarter 4. Mrs Webster agreed to investigate to see if it was possible to provide this comparison. **AW**

Mr Ellis reported that a summary document of the Quality Account would be produced for this year.

The Board reviewed the Quality Account for 2013-14 and delegated approval for final sign-off by Chair's action.

042/2014 **Performance Reports**

Mr Grayson reported that the quality report would be moving to a new layout from July onwards to reflect the recently issued guidance from the Trust Development Authority (TDA) on domains and performance indicators. Detail on the parameters for each of these indicators was awaited from the TDA and these would be reflected in the next report.

a) Quality Report including Performance, Activity and Workforce – March 2014 (Month 12)

i) Quality

Mrs Webster reported that there had been 43 cases of C Difficile against the limit of 25 for the Trust during 2013/14 which was a 60% reduction on the 2012/13 figures. She said that of these 36 cases had been unavoidable and 7 avoidable. Dr Slater asked for an explanation of the definitions for avoidable and unavoidable and Mrs Webster explained that there was no standard definition but the seven avoidable cases related to patients who had been in the Trust's care and should not have acquired C Difficile - 6 cases related to cross infection and 1 to anti-biotics and each incident had undergone a root cause analysis to support learning. There had been one case of MRSA in the year.

She reported that there had been no mixed sex accommodation breaches in March.

She highlighted that there had been a slight decrease in reported patient safety incidents in March and there had been 6 severe harm incidents in the month.

She advised that the number of falls and MUST assessments had increased with the full implementation of an electronic recording mechanism on the wards. There had also been a reduction in the actual number of falls and the number of severe injuries occurring from falls.

Mrs Webster reported that the Trust was above target for the Friends and Family Test (FFT) and the information from the FFT was now being used to populate 'you said we did' boards' on the wards.

She highlighted that compliance with personal integrated care plans was at 97%.

She noted that a figure had not been entered for compliance with NICE guidance in March and reported that this was at 99% for the month and the Trust had been at 100% during the rest of the year.

Mrs Webster advised that there had been a reduction in the number of grade 3 and 4 pressure ulcers (PUs) across the Trust and in 2013/14 there had been a 38.54% reduction in PUs against an agreed reduction with the Clinical Commissioning Groups of 25%.

Mr Grayson asked for the baseline position for PUs and Mrs Webster reported that the baseline was zero. He asked Mrs Webster if she could assure the Board that the number of avoidable PUs was reducing against a reasonable benchmark and she confirmed that the number was reducing with all grade 3 and 4 PUs now reported as serious incidents and a root cause analysis undertaken. She added that a full report on PUs was provided to each meeting of the Patient Safety and Clinical Improvement Group and Quality and Standards Committee.

Mr Welling asked why complaint responses had slipped back in February and March following the improvement in January. Mrs Webster reported that there had been changes in the governance structure and she expected to see an improvement in the next report. Mr Ellis reported that this area had been discussed at Quality and Standards Committee and it had been assured that the Trust was moving in the right direction but there was still work to do and the Committee would keep a watching brief.

Mr Grayson referred to the report on stroke indicators and noted that there had been a slight slippage on direct admission to a stroke unit to 84%. Mr Sunley reported that there had been 44 stroke admissions during the period and 7 patients had breached the target, of these 3 patients had been seen and admitted to the Conquest Hospital as it had been judged clinically inappropriate to transfer them to the stroke unit at Eastbourne DGH. One of the patients had been admitted straight to the ITU at the Conquest Hositla and the other two patients had not been identified as stroke patients until their admission to the Conquest A&E. He advised that for April all stroke indicators had been achieved.

Dr Hughes reported that performance in relation to medical revalidation had been maintained and as at the meeting date only one doctor had not had an appraisal in 2013/14 and further action was being taken to ensure that the appraisal was conducted as soon as possible.

Dr Hughes advised that appraisal dates were in the process of being set for 2014/15 and the work of Ms McGreevy and the revalidation team had been utilised as an example of best practice by the South of England revalidation team.

Mr Ellis asked Dr Hughes to outline the benefits of revalidation and Dr Hughes advised that it prompted clinicians to reflect on their own performance including more engagement at Mortality and Morbidity meetings, how they worked within teams, their responses to incidents and complaints and how they ensured they were fit to practice. Dr Hughes advised that the aim for the coming year was to improve the quality of Personal Development Plans to reflect the data being collected.

Dr Hughes reported that the Trust was an outlier on the Summary Hospital-level Mortality Indicator (SHMI) which was due to a spike in mortality during the winter period of 2012/13. The Associate Medical Director had conducted an in-depth clinical review of the patient notes in the groups of patients concerned and no clinical concerns had been identified. Issues arising from the review highlighted further improvements were required in identifying patients who were nearing the end of life and the complexity of being a combined acute and community Trust. Dr Harrison reported that the CHKS system allowed individual clinicians to drill down and see their individual data for mortality.

ii) Performance

Mr Sunley reported that performance in March (Month 12) was similar to that throughout the final quarter of 2013/14, as the Trust managed the operational impact of reduced capacity and the challenges of activity and service changes although, as previously reported to the Board, delivery of the Accident and Emergency target for the year was secured at above 95%. It had also been delivered above 95% in April (month 1 of 2014/15).

He reported that cancer waiting targets had been delivered for all but the 2 week wait symptomatic breast for the final quarter but underperformed in month 12 in 2 week wait symptomatic breast, 62 day urgent GP referral and 62 day screening service.

He advised that the 2 week wait symptomatic breast fell into an amber rating with 15 breaches, all of which unfortunately related to patients unable to make time to attend their urgent two week appointment. The pathway for booking these patients had been reviewed to ensure timely contact from the Trust and discussion was taking place with the Clinical Commissioning Groups on making this target a joint Quality, Innovation, Productivity and Prevention (QIPP) project. In the interim the Trust had introduced a system to notify GPs when their patients failed to agree a timely appointment.

Mr Sunley advised that the 62 day GP urgent referral target was also on amber and there were issues across a number of tumour sites but primarily related to urology and colorectal services. He highlighted that issues in these specialities related to complexity and capacity.

He reported that the overall complexity of the pathway would be tackled through the reorganisation of the Patient Pathway Coordinators. In relation to capacity the Trust had employed an extra consultant in urology, who had started, and in colorectal services who was about to start and he anticipated that performance would start to improve.

He reported that in relation to the 62 day screening service small numbers had again affected the target with 1 colo-rectal breach out of 5.5 treatments

He reported that the Trust had failed on the referral to treatment (RTT) 18 weeks and diagnostic 6 weeks targets in March as it implemented the agreed efficiency and effectiveness improvements set out in the 2013/14 plan whilst continuing to address the waiting list backlog in some clinical areas, particularly orthopaedics.

He advised that in relation to diagnostics the key area was endoscopy where the balance of capacity and demand still left a substantial backlog. The Trust was attempting to clear the backlog through using locum endoscopists to cover leave and support a Saturday service, and to use third party providers and the aim was to be back on target by the end of May and then to sustain the target.

He reported that the revised trajectory for admitted and non admitted RTT currently placed delivery at an aggregate level in November 2014 but discussions were still ongoing to make this delivery earlier. He summarised the key actions that were being taken to improve performance and advised that the backlog for admitted patients had reduced from over 700 to over 300 whilst the Trust had maintained levels of clinically urgent work and treating those moving from the non-admitted list to the admitted list.

Mr Welling referred to the previous assurance given to the Board in relation to 18 weeks RTT that the Trust would be back on track in early 2014/15 but this had now slipped back to November. He asked what action could be taken to bring this forward apart from ad-hocs and Mr Sunley advised that the Trust was working with the Trust Development Authority and the Clinicial Commissioning Groups to identify opportunities to reduce waiting times and were also ensuring accuracy in validation of the data. He advised that two locum consultants in colo-rectal and urology had been recruited to ensure that internal capacity was used to maximum effect.

Mr Sunley also advised that a performance framework was being introduced to hold the general managers to account to ensure that available capacity was being maximised.

Mr Welling asked if Mr Sunley was confident that once the backlog had been cleared the position could be maintained and Mr Sunley advised that it relied on staff maintaining the level of activity but was also dependant on the amount of activity coming into the hospitals continuing as expected by commissioners.

Mr Welling reported that the Board should not overlook the progress made and sustained in other areas of performance.

Mr Grayson reported that some areas such as cancer would benefit from a quarterly perspective as the reporting covered small numbers of patients on complex pathways.

iii) Workforce

Ms Green presented the workforce report and advised that the figures for March in relation to the number of staff employed were skewed due to accruals at the year end. She reported that 57 staff had left the Trust at the end of March on a voluntary redundancy programme but advised that there had been a nurse recruitment campaign over the last six months – calling all nurses – and the Trust had taken on a significant number of qualified and unqualified nurses.

She reported that there had been a reduction in the monthly sickness rate for the third successive month and the annual sickness rate remained unchanged at 4.43%. She noted that the Trust was not an outlier when compared with similar Trusts, nor in comparison of staff groups. There had been progress in reducing the number of periods of short term sickness, especially during national holiday periods, with staff being asked to produce a sick certificate from their GP and this had resulted in a 33% reduction in sickness levels during these periods.

She reported that the training figures continued to be disappointing but this was being addressed in different ways, including the introduction of a Staff Passport with requirements for statutory and mandatory training agreed with Trusts across the South of England and providing training within the Trust in a number of different ways to allow staff to attend.

She advised that there had been a slight increase in appraisal for non medical staff and she anticipated that this increase would continue as from April incremental payments would only be awarded based on a review of performance at the annual appraisal.

Mr Nealon commented on the increase in bank and locum staff in March and Ms Green advised that this was due to accruals at the year end and she believed that the April figures would show a further decrease.

Mr Grayson advised that a formal improvement plan was required for mandatory training and he would work with Mr Sunley and Ms Green on producing this. **DG/RS/ MG**

The Board noted the quality report for March 2014.

b) Finance April 2014 (month 1)

Mrs Harris presented the report for April (month 1) and advised there had been a deficit of £2.65 million in month which was better than plan by £44,000 due to income and costs being slightly less than plan and cost improvement savings over delivering by £196,000.

She highlighted that the Better Payment Practice Code target was showing amber for April and 75% of non NHS creditors had been paid within the timeframe. Following the resolution of the Trust's cash flow issues in 2013/14, the payments process within the Trust needed to be speeded up to ensure the target was achieved.

Mr Welling queried the reasons for the Out of Hospital unit overspend of £56,000 and Mrs Harris agreed to investigate and provide the detail outside of the meeting. **VH**

Mr Welling asked if there was assurance that the plan for the delivery of the cost improvement programme plans would be achieved and Mr Sunley said that the plans were very challenging but the performance management framework for the clinical units and cross cutting issues would help in aiding delivery.

The Board noted the finance report for April 2014.

c) Serious Incident Annual Report 2013/14

Mrs Webster presented the report and advised that there had been no grade 2 serious incidents (SIs) or Never Events in 2013/14.

Mrs Webster advised that section 4 of the report provided a breakdown of incidents by division, percentage and category. She noted that falls and pressure ulcers (PUs) were the most reported incidents. She highlighted that there had been significant spike in incidents in the community in quarters 3 and 4 and the majority were related to PUs and the Trust had put in specific support to staff in this area.

She highlighted that there was a high return rate for root cause analysis (RCA) compliance and this was a significant improvement on previous years.

Mrs Webster reported that section 9 highlighted the specific actions being taken around falls and PUs and the learning would be shared across the organisation.

Mr Ellis queried whether the community SIs related solely to the community hospitals and Mrs Webster advised that community included the community hospitals and those patients being treated by community services in their own homes.

Professor Cohen commended Mrs Webster and her colleagues on the very robust process used which provided a good level of assurance.

The Board reviewed and noted the Serious Incident Annual Report for 2013/14.

043/2014 **Response to the external reviews of Maternity and Paediatric Services**

Dr Slater presented the update on the action plans in relation to:

- the joint review by the Royal College of Obstetrics and Gynaecology (RCOG) and the Royal College of Paediatrics and Child Health (RCPCH) of the adequacy of the clinical governance and risk management processes in the maternity service
- the review by the RCPCH of the operational policy developed for the paediatric service prior to single siting and whether it was safe and whether it could be further strengthened.

Dr Slater reported that the majority of the actions on the joint review action plan were now green and the remainder could not be further actioned until the outcome of the Better Beginnings consultation was known.

In relation to the RCPCH review, he reported that there were no actions rated at red and the amber actions related to the outcome of the Better Beginnings consultation and formal ratification of the operational policy.

He reported that the further development of the operational policy had been led and owned by the consultant paediatricians, as recommended by the RCPCH. This process had taken longer than he originally anticipated and the final draft was awaiting approval from the paediatricians, following which it would be sent to the Clinical Management Executive for final approval. Dr Slater commended how well the paediatricians had worked together in order to develop the improvements to the policy.

Dr Harrison emphasised that the current operational policy was fully functioning and addressed all the recommendations made and the draft awaiting approval was an improved version.

The Board noted the action plans and agreed that they would be monitored by exception through the Quality and Standards Committee.

044/2014 **Staff Survey 2013 Summary**

Ms Green presented the summary report on the results of the annual staff survey for 2013 and noted that 37% of staff had responded.

Ms Green advised that the results were disappointing but noted that the survey had been conducted at a time of great change with clinical services being moved between sites and management changes also taking place at the same time, all of which had impacted on staff.

She reported that the results were further complicated by the fact that the Trust was compared with acute Trusts rather than similar integrated organisations.

She reported that there were:

- 6 areas where performance worsened significantly
- 22 areas statistically no significant change in results
- 4 areas better than average

Ms Green explained that since the survey had been conducted a number of actions had been taken including further steps along the Listening into Action journey, leadership conversations, the introduction of clinical engagement forums, executive quality walks and a successful annual awards ceremony.

She highlighted that the staff Friends and Family Test (FFT) would commence in April which would ask two questions around recommending the Trust as a place for treatment and as a place to work and the results would be published as part of the performance report.

Mr Welling agreed that the results were disappointing and there were significant areas which required attention. He asked if the results could be broken down between sites and Ms Green advised that it was only broken down by the former divisional management structure.

Ms Humber highlighted that an additional external factor for staff related to pay and she agreed that the internal reconfigurations had caused uncertainty. She reported that there was a new executive team on the Joint Staff Committee and they were keen to work with management and she was hopeful that there would be an improvement in future.

Mrs Webster commented that it would be important to understand the views of the 63% of staff who had not responded and she was hopeful that the staff FFT would provide this information. She highlighted that in addition to the quality walks a programme to improve staff engagement was about to be launched to encourage staff to tell the story of the improvement in their services.

Mr Grayson reported that the issue of comparisons with similar organisations had been raised nationally. He commented that the apparent disconnect between the teams and the organisation had been recognised by the executive team and they would be focusing on this as part of the staff engagement work.

Mr Ellis commended the very professional staff the Trust had who carried out an excellent job looking after patients.

Mr Nealon expressed concerns at the results of KF 24 – staff recommendation of the Trust as a place to work – which needed to be addressed. Ms Green advised that this would be one of the questions in the staff FFT.

The Board noted the report and the Trust-wide approach being used to address the areas of concern and requested a report back on progress in due course.

045/2014 **Research and Development Report**

Dr Hughes introduced the report and advised that there was a committed management team for research and development and the appointment of the Associate Medical Director for Academic, Educational and Research Development had added impetus to their work.

Ms Still joined the meeting for this item and presented the report and highlighted that the Trust's internal auditors had reviewed the Trust's research governance processes and provided a significant assurance opinion.

She reported that the Department of Health funding for research came down via two new organisations, the National Institute for Clinical Research (NICR), and the Kent Surrey and Sussex Clinical Research Network (KSSCRN). Each Trust had a research target to achieve each year and the report highlighted the risks to utilising the funds effectively and achieving the target. She highlighted that actions being taken to address the risks included the development of a 5 year strategy which would come to the Board for approval, funding of research nurse time within a specialist nurse post, including research as part of the job descriptions for nurses, midwives and allied health professionals and including research as part of the care pathway.

Dr Hughes reported that Ms Still had built up energy and enthusiasm for research and development within the Trust and she was using the funding resource in co-ordinated way. He requested that the Board support the recommendations contained within the report in relation to SPA time and a footnote to all Trust correspondence.

Professor Cohen supported the addition of the footnote and suggested that in relation to SPA time this should be carefully supervised and be on a rolling one year basis. Dr Hughes stated that the attribution of SPA time would be linked to specific activity through job planning.

Mr Nealon commented that he was unsure whether the proposed footnote would achieve the intention of involving patients.

It was agreed that a hyperlink to the research page on the website should be included. **LS**

The Board approved the footnote to all Trust correspondence with the amendment referred to above and appropriate SPA time for research.

046/2014 **Response to the Better Beginnings Consultation**

Dr Harrison reported that the Board had had the opportunity to consider in detail the proposed response to the consultation at its Board seminar in April.

She advised that in making their decision the Clinical Commissioning Groups would take into account a number of pieces of evidence and information. These would include an analysis of the responses to the consultation produced by an independent body, the report produced by the Health Overview and Scrutiny Committee as a result of its evidence gathering process, national best practice and guidance documents, reports on reviews and inspections of the local services pre and post temporary reconfiguration produced by the Royal Colleges, the National Clinical Advisory Team and the CQC and data gathered pre and post temporary reconfiguration on the quality and safety of the local service.

The Board ratified the Trust's response to the Better Beginnings consultation.

047/2014 **Annual Business Plan 2014/15**

Dr Harrison presented the Annual Business Plan for the current financial year and noted that it was a fully integrated plan setting out priorities in terms of quality, operational and financial performance. She referred to appendix 2 which set out the key plans for delivery in year and said that these had been further developed into individual directorate plans and individual objectives.

She highlighted that the report also included the quality impact assessment process which was essential to ensuring the impact of plans on quality were fully considered. The report also included the renewed high level performance management framework and accountability framework and these would be further developed into an operational performance management framework for clinical units and into individuals' objectives.

Mr Sunley reported that the operational performance framework was starting to take shape around the maximisation of outpatients and theatres and weekly meetings were held with the general managers and then monthly accountability meetings with the clinical units. Mr Grayson requested that the operational performance management framework be presented at the next Board meeting. **RS**

The Board approved the Annual Business Plan for 2014/15.

048/2014 **Financial Planning and Budget for 2014/15**

Mrs Harris presented the financial plan for 2014/15 and advised that the plan was basically the same as the provisional plan presented at the March meeting.

She advised that the Board was being asked to approve a £18.5 million deficit budget for this financial year and £14 million for 2015/16 against the background of public sector austerity, the Trust being in turnaround and part of the challenged health economy. She reported that the Trust had ended 2013/14 with a deficit of £23.1 million.

She reported that the contract had been signed with the Clinical Commissioning Groups (CCGs) and noted that it assumed £1.5 million of winter funding available to the Trust. The specialist commissioning contract with NHS England had also been signed.

She highlighted that the savings plan totalled £20.4 million which was equivalent to 5.2% of expenditure and 5.7% of turnover and this was shown graphically in paragraph 5.6 and had been developed through a bottom up as well as top down approach.

She reported that the workforce plan aimed to reduce the overall number of whole time equivalents by the end of March 2015 through reducing bank and agency staff but there would be an increase in the substantive number of employees, particularly nursing staff.

Mrs Harris referred to the capital programme outlined in paragraph 7 which totalled £11 million to spend across medical equipment, IT systems and estates refurbishment. She noted that draw down of part of the funding for the Trust's clinical strategy £17.4m was also anticipated in the capital programme. She advised that the Finance and Investment Committee would be taking a strong interest in the capital plan throughout the year.

She reminded the Board that the Trust had receive Public Dividend Capital (PDC) funding towards the end of 2013/14 to clear historic creditors and the intention would be at some point in the year to apply to the Independent Trust Financing Facility via the Trust Development Authority (TDA) for further PDC funding of £18.5 million. A temporary mechanism had been agreed to draw down the cash at the end of every quarter.

Mrs Harris outlined the risks to the position of the Trust under section 9.

She reported that the Trust would be required to submit a 5 year plan to the TDA on 20th June 2014, of which 2014/15 and 2015/16 were the first two years. The Finance and Investment Committee had reviewed the assumptions on which the 5 year plan would be based.

Mrs Harris referred to the Going Concern section and advised that the Trust was a going concern as it had continuity of service provision in the future and access to sufficient cash. This rationale had been shared with the external auditors who were content with the position.

Mr Nealon reported that the highest priority was always given to the quality and safety of clinical performance and the Finance and Investment Committee would continue to ensure that the balance was upheld between quality, safety and financial control.

He highlighted that the Trust was required to make 4/5% savings in each year and the Committee had some doubts that this could continue to be achieved over a five year period. The Committee had been assured that the budget had been organised on a bottom up basis and been signed off by the clinical leads and he was taking growing comfort that the robustness of the plan was embedded within the Trust.

Mr Grayson agreed that the financial plan was stretching with £20 million being taken out during the year whilst maintaining safety and quality and he echoed Mr Nealon's comments regarding sustaining such savings over a 5 year period and this was why East Sussex was one of the challenged health economies. He highlighted that Appendix 1 which compared outturn with plan showed that the actual income to the Trust would reduce by a significant amount.

Professor Cohen asked Mr Grayson to explain why it had been decided to set an ambitious financial plan for the Trust and Mr Grayson agreed it was a demanding plan but the expectations placed on the Trust by commissioners and regulators had been taken into account and, following a meeting with the TDA, the plan was broadly in line with other organisations and, if achieved, the Trust would have delivered what was expected of the NHS. In the meeting with the TDA he and Mrs Harris had been able to clearly demonstrate that the plan was very robust and reasonable.

The Board noted the short to medium term financial context for the Trust and the assumptions used in developing its plans for 2014/15 and beyond and the indicative plan for 2015/16. It approved the revenue financial plan and budget for 2014/15 and the capital programme for 2014/15. It also noted the requirement to develop and submit a 5 year plan to the TDA by 20th June 2014.

049/2014 **Shaping our Future – Clinical Strategy Phase 1 – Move of Emergency and High Risk Trauma and Orthopaedic Services**

Mr Sunley reported that the move had taken place on 13th May 2014 and this report was to provide an update on the assurances around the risks which had been discussed fully at the Board seminar in April. He believed that this move had been the most difficult to achieve in terms of complexity but the result was that the Trust would be able to provide a much more high quality and efficient service in orthopaedics.

Mr Sunley praised Michele Elphick, the Head of Nursing, for her tireless work to ensure Egerton ward at the Conquest site was fully staffed and available for the moves to take place.

Mr Sunley also complimented the theatre staff, anaesthetists and surgeons who had all also worked hard to ensure the move was successful.

He reported that daily contact was taking place with Brighton and Sussex University Hospital Trust as, whilst the move was a relatively modest change in terms of patient flows across the patch, it was recognised that it had taken place during a particularly busy period in April and May and both organisations had worked co-operatively to ensure it worked.

Mr Welling on behalf of the Board thanked the surgeons and anaesthetists across the Trust and in particular at the Conquest Hospital who had gone over and above the call of duty, supported by their Eastbourne colleagues, to ensure that the move went well.

Mr Sunley reported that weekly data was being collected including the impact on the Conquest site and there would be a monthly review in the normal way and a quarterly appraisal of how the move had gone.

Dr Slater echoed the Chairman's comments and advised that he had been singularly impressed by the work of the theatre staff who had been integral in ensuring that the move took place.

The Board ratified the single siting of emergency and high risk Trauma and Orthopaedic services with effect from 13th May 2014 and noted that a robust monitoring mechanism was in place.

050/2014 **Fire Safety**

a) Annual Report

Mr Sunley presented the report which provided an overview of fire safety management within the Trust. He highlighted that the numbers undertaking training were continuing to improve and had reached 81% and the fire team continued to work closely with the Learning and Development to maintain the focus on fire safety.

He highlighted the fire risk assessments undertaken which identified area by area the issues, the risk rating, and the investment required to reduce the risks. He reported that the risk rating on the Conquest site had now reduced as the issues had been addressed and he anticipated that the risk rating on the Eastbourne DGH site would reduce as the issues were addressed as part of the capital programme for 2014/15. The fire team worked closely with the East Sussex Fire and Rescue Service to understand the risks involved.

Mrs Webster queried the issues around the emergency lighting at the Conquest and the potential for failure in these areas. Mr Sunley would investigate and the information would be appended to the minutes. **RS**

Ms Kennett queried the reference to risk assessments in relation to undocumented properties and Mr Sunley explained that undocumented properties referred to premises which were not owned by the Trust but its staff worked there. He stated that it was important that the Trust ensured that staff were not placed at risk in such premises.

The Board noted the annual report on fire safety.

b) Fire Safety Policy

Mr Sunley presented the fire safety policy for approval which was reviewed on an annual basis.

The Board approved the Fire Safety Policy.

051/2014 **Trust Development Authority Monthly Self Certification**

Mrs Wells reported that the Board was familiar with the two statements provided to the TDA each month which were signed off by the Chairman and Chief Executive. She highlighted the one area of risk on the board statement which referred to the Referral to Treatment target

The Board noted the Monthly Self Certification statements.

052/2014 **Board Sub-Committee reports and Trust Board Seminar Notes**

a) Finance and Investment Committee

Mr Nealon reported that the majority of issues had been covered during the meeting but highlighted the Committee's concern over capital funding and the Trust needed to find a way to improve its capital structure.

Mr Welling confirmed that this was an issue for the NHS as a whole. Mrs Harris reported that this issue was included in the Board Assurance Framework and in the financial plan and the Trust needed to identify its capital requirements for 2014/15 and devise other solutions to bridge the gap.

Mr Grayson reported that the Trust had received some additional capital funding at the end of 2013/14.

b) Quality and Standards Committee

Mr Ellis presented the report and referred to the Clywd-Hart review of the NHS complaints system,

Mr Ellis advised that the Committee had been assured by the progress the Trust had made in addressing the recommendations.

Mr Ellis commended the report to the Board as it embodied how organisations should be thinking (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf).

He reported that the review of the role and remit of the Quality and Standards Committee would take place in the coming month.

c) Trust Board Seminar Notes

The Board formally adopted the notes of the Trust Board Seminar held on 12th February 2014.

053/2014 **Delegation of Approval of the Annual Report and Accounts for 2013/14**

Mr Welling requested the approval of the Board to delegate approval of the Annual Report and Accounts for 2012/13 to the Audit Committee in order to meet the deadline for submission to the Department of Health. He advised that he would be in attendance at the Audit Committee.

Resolved:
The Board approved the delegation of approval of the Annual Report and Accounts for 2013/14 to the Audit Committee

054/2014 **Themes for Quality Walks**

The following themes were agreed for June and July:

Trauma and Orthopaedics
Community services and the impact of the implementation of SystmOne
Staff survey

Mr Welling would agree which previous themes would be carried forward with Dr Harrison outside of the meeting. **SW/AH**

It was agreed that Mrs Bernhauser and Ms Kennett would report back on their walks at the next meeting. **SB/SK**

055/2014 **Chairman's Briefing**

Mr Welling presented the briefing and thanked the Royal Voluntary Service for a cheque for £130,000 which he had received on behalf of the Trust to support the introduction of the new style of patient meal service introduced earlier this year. The money supported the building adaptations to ward kitchens, purchase of equipment and new patients' cutlery and crockery across the two main acute hospital sites.

Mr Welling also referred to a meeting that had been held with stakeholders regarding end of life care and a number of actions had been agreed to take forward delivery of care in this area.

056/2014 **Questions from members of the public**

a) Did Not Attend (DNA) for Appointment

Ms Walke asked how the Trust was addressing the number of DNAs and cited an example of how DNAs affected the podiatry service. Mr Sunley reported that the Trust operated an automated telephone and text reminder service for patients. In addition, the Trust was currently consulting with the booking staff to centralise the service in order to improve efficiency. He would welcome any specific suggestions that Ms Walke had to assist in reducing non-attendances.

b) Orthopaedic Service for Shoulders

Ms Walke asked if there was only one shoulder orthopaedic session being provided a month at Eastbourne DGH and Mr Sunley replied that this was not the case and he asked Ms Walke to provide him with the details outside of the meeting so that he could investigate and respond.

c) Board Papers

Ms Walke asked if she could receive a paper copy of the Board papers prior to the meeting and Mr Welling stated that he would review the current arrangements and advise her of his decision outside of the meeting. **SW**

057/2014 **Date of Next Meeting**

Wednesday, 30th July 2014, at 10.00 am in the Manor Barn, Bexhill.

058/2014 **Closed Session Resolution**

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

Signed …….

Position ……..

Date …….

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 03.06.14 Trust Board Meeting

Agenda Item	Action	Actioned By	When	Progress
035/2014 – Feedback from Quality Walks	Community diabetic team had raised a concern in relation to a regrading of staff at senior nurse level which the Director of Nursing agreed to investigate.	Director of Nursing		
041/2014 – Draft Quality Account 2013/14	Comparison with the previous year in relation to the positive experience of care to be provided which would be appended to the minutes.	Director of Nursing	04.07.14	
	Comparison of the incidences of C Difficile for quarter 4 against the national data for quarter 4 to be provided.	Director of Nursing		
042/2014 – Workforce Report	Formal improvement plan to be implemented for mandatory training	Chief Executive, Chief Operating Officer and Director of HR		
045/2014 – Research and Development Report	R&D footnote in all Trust correspondence to contain hyperlink to the research page on the website	Medical Director – Governance/ R&D Manager		

Agenda Item	Action	Actioned By	When	Progress
047/2014 – Annual Business Plan	Operational performance management framework to be presented at the next Board meeting.	Chief Operating Officer	30.07.14	
050/2014a) – Fire Safety Report	Explanation of the issues and the potential for failure of emergency lighting at the Conquest to be appended to the minutes.	Chief Operating Officer	30.07.14	
054/2014 – Themes for Quality Walks	Decision on previous themes to be carried forward to be taken outside of the meeting.	Chairman/Director of Strategic Development and Assurance		
	Mrs Bernhauser and Ms Kennett to report back on their walks at the next meeting.	Non-Executive Directors	30.07.14	On agenda.
056/2014 – Questions from members of the public	The Chairman to review the current arrangements in relation to paper copies of Board papers and advise Ms Walke of his decision outside of the meeting.	Chairman		

East Sussex Healthcare NHS Trust

Date of Meeting:	30 July 2014
Meeting:	Trust Board
Agenda item:	6
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

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

Introduction:

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

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

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

The Trust Board is asked to consider whether the main inherent/residual risks have been identified and that controls are appropriate to manage and mitigate the risks. Updates and revisions are shown on the document in red. Since the last review by the Audit Committee, gaps in control or assurance have been removed or revised as follows:

- Removed - inability to meet national screening standards for diabetic retinopathy due to increasing demand and limited capacity.
  Assurances in place that matter is being appropriately actioned.
  June 14 Additional £89k recurrent funding has enabled recruitment of 2 additional screeners, a failsafe officer and additional administrative support. New programme manager commenced in post June,. 2 screeners will be in situ by end July. Failsafe office commences Sep-14. Trust has approved case to introduce Scribetech mail management system to the programme which will enable the existing admin resource to provide clinical admin support. Working with programme commissioners to deliver improved screening interval of 12 months (a key KPI) by Apr-15 and to meet new common pathway in retinal screening, from Oct-14

Benefits:

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

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

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

Review by other Committees/Groups (please state name and date):
Quality and Standards Committee 7th July 2014 Audit Committee 9th July 2014

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

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

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

BOARD ASSURANCE FRAMEWORK

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

Key:

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

↔ Status of risk unchanged

↓ Risk reduced

↑ Risk increased

East Sussex Healthcare NHS Trust

Date of Meeting:	Wednesday 30th July 2014
Meeting:	Trust Board
Agenda item:	7
Subject:	Quality Governance Strategy and Quality Improvement Plan
Reporting Officer:	Alice Webster, Director of Nursing Dr David Hughes, Medical Director - Governance

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

Purpose:

To provide the Board with an updated version of the Quality Governance Strategy, and the first draft of the Quality Improvement Plan for comment and discussion.

Introduction

The Quality Governance Strategy is an overarching strategy that outlines the framework for the delivery of quality governance at East Sussex Healthcare NHS Trust (ESHT) and supports the provision of high quality services for patients.

The Quality Strategy will need to be owned by everyone in the Trust with a recognition that quality is at the heart of everything the organisation does. Real improvement and consistent quality will come from the efforts and actions of health professionals, both clinical and non-clinical. The Trust is committed to ensuring that we set out the ambitions in a way that provides the basis for an alignment of individual, team, system and organisational goals. This will be underpinned by clinical leadership and by a robust structure for the delivery of quality, clinical governance and risk management.

The Quality Improvement Plan is drawn from the Trust strategic aim to deliver a safe, effective, caring, responsive and well led service to the population of East Sussex. It encompasses the Trust priorities identified through Listening into Action (LiA), internal risk and incident analysis, national guidelines, the Commissioning for Quality and Innovation (CQUIN) framework and quality improvements the Trust has actively chosen to undertake.

Analysis of Key Issues and Discussion Points Raised by the Report

The Quality Governance Strategy incorporates parts of the quality system, committee structures and includes a quality governance reporting framework (appendix B).

The governance structure will be subject to continuous review so that structures can be adapted to be efficient and effective and meet the functional requirements of the organisation as well as national governance requirements.

The strategy will support the implementation of the Quality Improvement Plan (see section 7).

Under the headings of ‘Patient Safety’, ‘Patient Experience’ and ‘Clinical Effectiveness’ the Quality Improvement Plan draws together the various improvement projects being planned for delivery to address the improvement priorities identified (Appendix A includes a matrix of improvement projects).

Benefits
A robust quality governance system and Quality Improvement Plan will provide assurance to the Board, the local population, commissioners of services and external regulators that the organisation is committed to ensuring that quality is at the heart of everything the organisation does and takes action to improve outcomes for patients.

Risks and Implications
Without a robust quality governance system the organisation will not be able to comply with outcome 16 of the Care Quality Commission's essential standards of quality and safety. It also supports the Trust's annual governance statement.

Assurance Provided
This is a review of the Quality Governance Strategy written and ratified in 2012. Systems, processes and management groups are embedded within the Trust although have required review given the recent organisational changes.

Review by other Committees/Groups (please state name and date)
Quality and Standards Committee/Patient Safety and Clinical Improvement Group - 03.03.14 Staff Conversations – through LIA process - throughout March 2014

Proposals and/or Recommendations
The Board is asked to: • agree the revised Quality Governance Strategy • To consider the Quality Improvement Plan

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

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

East Sussex Healthcare NHS
NHS Trust

Quality Governance Strategy

Version:	2.1
Approved by:	Quality and Standards Committee 03.03.14
Ratified by:	Version 1.2 ratified by Trust Board
Date ratified:	28 March 2012
Name of author and title:	Emily Keeble, Head of Assurance
Date Written:	January 2012 March 2014
Name of responsible committee/individual:	Patient Safety and Clinical Improvement Group Quality and Standards Committee Trust Board
Date issued:	V1.2 2012104 – May 2012
Review date:	March 2015
Target audience:	All staff
Compliance with CQC outcome	Outcome 16

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

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.2 2012104	March 2012	Emily Keeble	New Document	First Version

Consultation Table

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

Name of Individual or group	Title	Date

Contents

1. Statement of Intent

East Sussex Healthcare NHS Trust is committed to continuously improving the outcomes for its patients and achieving excellence in patient care. It recognises that it has a statutory and regulatory duty to ensure that systems of control and governance are in place to monitor and improve the quality of care provided.

2. Introduction

The Quality Governance Strategy is an overarching strategy that outlines the framework for the delivery of safe, high quality, effective services within East Sussex Healthcare NHS Trust (ESHT). It describes the systems and processes that the Trust will use to gain assurance that the services it provides are meeting national and local quality, safety and regulatory standards. It sets out how these processes will provide assurance and enable the Trust to identify priorities for improvement. The Quality Governance systems in the Trust are an integral part of the way the Trust manages and improves quality and safety across all its services. It supports the Trust in ensuring the Performance Management Framework can be implemented and informs the Quality Improvement Programme by providing an assessment of the quality and safety of the Trusts services and identifying areas of risk in the delivery of care quality.

The Strategy will need to be owned by everyone in the Trust with a recognition that safety and quality are at the heart of everything the organisation does. Real improvement and consistent quality will come from the efforts and actions of health professionals, both clinical and non-clinical. The Trust is committed to ensuring that we set out the ambitions in a way that provides the basis for an alignment of individual, team, system and organisational goals. This will be underpinned by clinical leadership and by a robust structure for the delivery of quality, clinical governance and risk management that will ensure that:

- Quality standards are set and achieved.
- Quality and safety risks are identified and remedied.
- Good practice is encouraged, identified and shared.

ESHT will embed this Strategy by implementing:

- A quality governance reporting structure and framework
- A committee structure based on functional need
- A risk management system which is understood and used by all staff
- A quality improvement loop which allows for the systematic identification and treatment of issues and the measurement of improvement

By getting this right, ESHT will be able to provide continuous assurance from ward to board that demonstrates the delivery of sustained improvements in quality and also demonstrates compliance with standards and statutory obligations.

Key to the Trust's commitment to provide high quality, safe and effective services is the implementation of the Clinical Strategy: Shaping our Future which aims to ensure the Trust delivers high quality and sustainable services in the future and continues to provide excellent, safe healthcare for every patient, every day of the year. Quality services will be ensured through the delivery of a service model which is clinically effective and financially sustainable. The Clinical Strategy outlines the Trust's approach to improving quality and will enable the Trust to measure the quality benefits realised through its implementation

.

3. Strategic Objectives

Vision
To be the healthcare provider of first choice for the people of East Sussex.

Mission
Deliver better health outcomes and an excellent experience for everyone we provide with healthcare services.

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

Aims
In delivering its strategic objectives the Board has stated that its aim is that all services delivered by the Trust are:
- Safe
- Effective
- Caring
- Responsive and
- Well led.

Values
- Working together
- Improvement and continuous development
- Respect and compassion
- Engagement and involvement

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

Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority

Strategic Objective 2 – Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences.

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

4. Quality Governance Objectives

Monitoring standards and quality outcomes to ensure they are achieved

- To provide high quality data to monitor clinical care
- To monitor quality improvements through the use of agreed national and local metrics

Identifying and managing risks to quality of care

- To ensure that pro-active and reactive risk management processes are in place throughout the organisation to identify, control, monitor and reduce all risks to quality of care and patient safety. Specifically:
    - To ensure robust risk management and mitigation processes are in place to maintain and sustain quality
    - To ensure that risks to maintaining and sustaining quality performance are identified at an early stage and dealt with promptly
    - Risks to delivery of quality improvements are identified and managed
    - Risks to compliance with regulatory standards are identified and managed
- To identify and investigate quality and safety risks ensuring that any required performance improvements are recognised at an early stage and dealt with promptly
- To ensure that patient and staff feedback informs the assessment and measurement of quality and safety within the Trust

Promoting an open culture of reporting and learning

- To promote an open culture in which untoward incidents and near misses are freely reported and investigated, and lessons learnt and shared with no fear of unfair blame
- To ensure that learning from complaints, Patient Advice and Liaison Service (PALS), information, litigation and claims is systematically analysed and disseminated throughout the Trust

Ensuring robust governance systems are in place and are operating effectively

- To ensure that arrangements for clinical governance accountability and leadership are in place in order to promote a fair and open learning culture
- To ensure that the quality improvement processes in place result in measurable improvements in quality outcomes

Providing assurance and evidence of improvement

- To demonstrate that actions taken to improve quality result in measurable benefits for patients
- To provide assurance and evidence that quality standards are being met and quality outcomes delivered for communication with stakeholders and regulators.

5. Board and Committee Responsibilities and Accountabilities

5.1 Trust Board

The Trust Board is ultimately accountable for the delivery of high quality care through the implementation of the Clinical Strategy, the Quality Governance Strategy, the Performance Management Framework and the Quality Improvement Plan and has a statutory duty of quality. The Board receives an Integrated Performance Report at each of its formal meetings of which Quality is an element.

The Trust sets out its plans for quality improvement in its integrated Annual Business Plan and agrees high level quality improvement priorities that are published in the annual Quality Account and progress is reviewed and monitored throughout the year.

The Trust Board is committed to ensuring Board visibility within the organisation improving the Board's understanding of the organisation and the organisation's understanding of the

Board facilitated via Quality Walks where all Board members commit to regular visits to clinical and service areas. Visits are recorded and actions and learning shared across the organisation. Themes for the next round of Quality Walks are discussed and agreed at each meeting of the Trust Board and are informed by the risks set out in the Board Assurance Framework..

5.2 Audit Committee

The Audit Committee is a Board Committee that provides assurance to the Board on: the effectiveness of Trust governance, risk management and internal control systems; the integrity of the financial statements of the Trust, in particular the Trust's Annual Report; the work of internal and external audit and any actions arising from their work; compliance by the Trust with legal and regulatory requirements. The Audit Committee supports the Board by critically reviewing governance and assurance processes including those for Quality Governance on which the Board places reliance.

5.3 Quality and Standards Committee

The Quality and Standards Committee is a Board committee which ensures, on behalf of the Board, and taking account of best practice there are effective structures and systems in place that support the continuous improvement of quality services and safeguard high standards of patient care. The Committee also ensures that quality of decisions and effective decision making is based on information from robust systems and processes that are used effectively across the organisation in a culture that supports challenge, scrutiny and learning.

The Committee:

- Empowers proactive clinical leadership of the quality agenda.
- Seeks assurances that patients, staff and other key stakeholders are actively and effectively engage in quality and safety issues.
- Reviews and monitors the effectiveness of Trust processes in respect of compliance with standards, national best practice and guidance.
- Seeks assurance that action is being taken to ensure compliance with regulatory and statutory standards and requirements and that performance management arrangements are effective in this respect. Any identified gaps in control and assurance are reported to the Board.
- Reviews the risk registers and Board Assurance Framework to identify relevant quality and safety risks and seek assurance that appropriate management action has been taken to mitigate the risks thereby supporting the Trust Audit Committee which has responsibility for the oversight of the Trusts risk management system.
- Reviews themes and trends that occur in patient and staff feedback, findings from quality walks, patient safety and quality data, clinical audit, complaints, patient safety and serious incidents. Seek assurance that learning from incidents has been shared across the organisation and that actions required to deliver improvements are captured in the Quality Improvement plan and are delivered in a timely manner resulting in agreed and measurable improvements in quality and safety.
- Reviews the Trust's quality performance using agreed national and local performance metrics. Seek assurance that areas of underperformance are identified and that appropriate quality improvements actions are taken in a timely manner to deliver the measurable improvements required.

5.4 Clinical Management Executive

The Clinical Management Executive (CME) exists to ensure that the organisation is able to plan and undertake the actions required to effectively deliver its strategic objectives. Its prime responsibility is to ensure that all aspects of Quality Governance are bought together

to ensure that there is a clear perspective on the quality of services provided by the trust, that quality improvements are identified and that appropriate actions are taken to manage risk and improve quality with measurable results. It has a number of Quality Governance responsibilities for planning and delivery including

- Ensuring the organisation identifies and effectively manages risks to delivery and effectively operates a system of internal control
- Ensuring that the organisation is able to provide evidence that it is delivering safe and clinically effective care and is compliant with requirements in respect of service provision
- Holding clinical units and directorates to account for their performance and delivery
- Monitoring service delivery and performance and agreeing action to address risks and ensure performance and quality standards are met
- Ensuring that the organisations risk registers reflect current risks to delivery and ensuring that effective action is being taking to mitigate and manage the identified risks
- Assessing and monitoring Clinical Governance arrangements and activities ensuring that the Trust is able to provide evidence that the care provided is safe and clinically effective
- Ensuring that patient's experience is measured and monitored and information from this informs quality improvements and supports the identification of risks to quality
- Assessing and monitoring compliance with regulatory standards and ensuring that the trust is able to provide evidence of compliance
- Developing, agreeing and overseeing the implementation of such policies procedures and protocols that are necessary to ensure the effective and efficient operation of the Trust
- Commissioning, setting up and overseeing such sub-groups, task and finish groups or working groups as are required to undertake the business of the CME and ensure appropriate reporting from these groups to the CME

5.5 Patient Safety and Clinical Improvement Group

The Patient Safety and Clinical Improvement Group reports into the Quality and Standards Committee and Clinical Management Executive and is chaired by the Director of Nursing. Its purpose is to ensure that patient safety issues are discussed and appropriate actions are taken as a result and receives and reviews data from key safety indicators including Morbidity and Mortality, Serious Incidents, Patient Safety Incidents, the Safety Thermometer, Complaints and Claims. It identifies areas for quality improvement and ensures that these are reflected in the Quality Improvement Plan. It monitors progress with the implementation of the Quality Improvement Plan and with any action plans developed in response to quality and safety risks. The Clinical Units provide quality / governance reports to the group on a bi-monthly basis.

5.6 Mortality Overview Group

Chaired by the Medical Director – Governance, the Mortality Overview Group is responsible for monitoring and reviewing Trust mortality indicators and overseeing a programme of work aimed at supporting the reduction of avoidable mortality and improving the quality of services for patients. The Mortality Overview Group is supported by the Mortality Review Group which is responsible for analysing and monitoring a range of internal and external mortality data and indicators.

5.7 Patient Experience Steering Group

The purpose of the Patient Experience Steering Group is to focus on the strategic issues for patients, service users and carers in order to drive and support improvements to the patients' experience. The group will do this by considering the views and needs of all patient and carers, coordinate work being undertaken across the trust to improve patient experience, review and make / implement recommendations from patient surveys and

feedback, patient experience reports, trends from PALS, complaints and litigation and staff surveys, and support increased patient and public involvement and engagement in the business of the trust.

5.8 Essential Compliance Group

The purpose of the Essential Compliance Group is to oversee and provide assurance that compliance is being achieved across the organisation against National Institute of Clinical Excellence (NICE) guidance, National Confidential Enquiries into Patient Outcome and Death (NCEPOD), Care Quality Commission Essential standards of quality and safety, Information Governance Toolkit and any other relevant compliance measures that may be applicable. The group is chaired by the Director of Nursing.

5.9 Clinical Audit Steering Group

The Clinical Audit Steering Group meets quarterly and is responsible for monitoring progress with the implementation and completion of the annual Clinical Audit Forward Plan and receive reports on outcomes and lessons learnt from Clinical Audit ensuring that necessary changes are made to improve quality.

5.10 Clinical Unit Quality Governance

Each Clinical Unit is required to have a monthly Quality Governance Meeting to discuss and oversee governance issues within the Clinical Unit. They share a common core agenda including review of audit, complaints, incidents and near misses, clinical and non-clinical risks, health and safety, morbidity and mortality, safeguarding, infection control and compliance. A summary of issues discussed at these meetings is submitted to the Patient Safety and Clinical Improvement Group. See Figure 1.

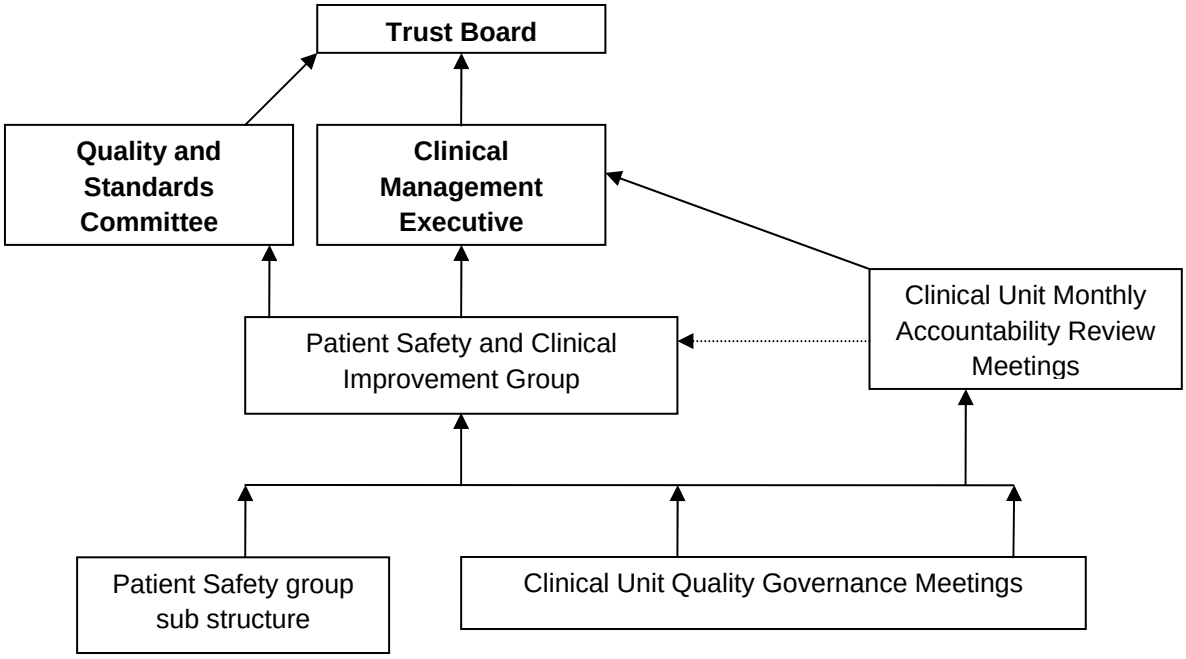
5.11 Other Groups, Working Groups and Task and Finish Groups

Beneath the level of Board committees and sub groups, other groups exist which play an important role in quality governance. A Trust-wide agreed template for Terms of Reference will be established to ensure that all groups which meet have their role clearly defined and include monitoring arrangements.

5.12 Quality Governance Reporting Structure

The high level Quality Governance reporting structure can be seen in figure 2 below. The governance structure will be subject to continuous review so that it can be adapted to be efficient and effective and meet the functional requirements of the organisation as well as national governance requirements.
The framework of interlinked responsibilities for aspects of the quality system is described through the responsibilities and accountabilities of key committees. This is summarised in Appendix II.

Figure 1 – ESHT Quality Governance Reporting Structure



6. Duties of Key Individuals

6.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that an effective Quality Governance system and a system of internal control is in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance. The Chief Executive has delegated responsibility for the strategic management of Quality Governance to the Director of Nursing and Medical Director (Governance).

6.2 Medical Director (Governance)/Director of Nursing

The Medical Director (Governance) and the Director of Nursing have delegated responsibility for ensuring and overseeing the implementation of the Quality Governance framework and supporting the development and implementation of the Quality Improvement Plan. They will provide the leadership to ensure the Trust undertakes this function in accordance with best practice, legal and statutory duties and will lead the Trust's approach on achieving compliance with standards relating to patient safety and compliance with CQC standards.

6.3 Director of Strategic Development and Assurance

The Director of Strategic Development and Assurance has delegated responsibility for leading the strategic direction for the organisation, which includes the development and maintenance of appropriate corporate governance systems that ensure effective delivery against Trust business plan targets, Care Quality Commission registration standards and requirements of other regulators and is the lead Director for Communications, Freedom of Information and legal issues.

6.4 Deputy Director of Nursing and Midwifery

The Deputy Director of Nursing and Midwifery is responsible for leading the governance agenda which encompasses patient safety, risk, health and safety, clinical effectiveness, patient experience and clinical improvement.

6.5 Assistant Medical Director – Quality and Innovation

The Assistant Medical Director – Quality and Innovation is responsible for supporting the development of governance, research, quality, CQUINS, NICE, HSMR/ SHMI mortality and morbidity data and Trust wide audit. They support and enable Clinical Units to identify areas of potential noncompliance with mandatory professional standards, including responding to incidents, complaints, inquests and claims and to identify and take remedial action and share learning.

6.6 Head of Clinical Improvement

The Head of Clinical Improvement is responsible for developing and managing the work programme (Quality Improvement Plan) for Quality Improvement, undertaking high level information analysis, providing timely and accurate reports on quality and performance and management of the Quality Impact Assessment process across the Trust. The Head of Clinical Improvement works closely with the Head of Governance and Patient Safety function of the central governance team. The Head of Clinical Improvement role includes responsibility for the management of specific improvement programmes within the Trust including those for CQUINS and mortality.

6.7 Head of Governance

The Head of Governance is the Trust lead for governance and is responsible for the central governance team which provides specialist support and advice including training on the implementation of Trust policies and procedures for incident reporting and investigation, risk management, clinical audit, national guidance implementation, complaints, equality and diversity and health and safety.

6.8 Clinical Unit Leads / Heads of Nursing and Governance

Clinical Unit leads and Heads of Nursing are responsible for the implementation, within their respective clinical areas, of the relevant strategies, policies and plans which support the Trust in delivering its Quality Governance framework and Quality Improvement Plan.

6.9 All staff

All staff are responsible for the day to day delivery of safe care and for taking action to ensure quality standards are met. The Trust will encourage staff to make changes that further enhance quality, using national, local and benchmark data to identify issues and drive improvements. This will include:

- Commitment to developing staff as clinical leaders
- Providing staff with data that shows how much patients value the care they provide, how safe their practice is and what their clinical outcomes are
- Development of patient experience metrics that will be triangulated with staff focus groups to improve services

7. Implementation of the Quality Governance Strategy

7.1 The Trust Quality System

The Trust is committed to developing an open learning culture that supports the identification of priorities for improvement and of successes in delivery, to facilitate the sharing of best practice. This should be seen as a key part of the operational systems within the Trust.

The quality system allows the accurate and evidence based assessment and monitoring of the quality of services delivered by ESHT. By setting and delivering clear outcomes, identifying and managing risks, and establishing effective controls and assurance mechanisms, the quality system supports ESHT to ensure that desired quality outcomes are identified, achieved and evidenced.

The quality system is delivered through a committee structure accountable to the Trust Board and includes the Audit Committee and Quality and Standards Committee, which have

interlinked responsibilities for the review and monitoring of aspects of the quality system. The Clinical Management Executive (CME) is responsible for the operational management and the delivery of quality services. (See section 5 – Board and Committee Responsibilities and Accountabilities).

7.2 Quality Improvement Plan

In order to ensure a systematic and programme management approach to quality improvement, the Trust will develop and implement a quality improvement plan which will draw together the various quality improvement action plans and priorities from:

- The Quality Account (see 7.5)
- Commissioning for Quality and Innovation (CQUIN) (see 7.6)
- Annual Business Plan
- National guidance / reports
- Identified quality risks (i.e. those identified through governance processes including Serious Incident and Incident analysis, patient feedback and audit)
- Listening into Action (see 7.7)

The Quality Improvement Plan will identify the Trust priorities for quality improvement, the desired outcome, the actions required in order to ensure delivery of the improvements required, the timeframe, how the outcomes will be measured to provide adequate assurance of improvement delivery as well as the leads responsible. The Quality Improvement Plan will be owned by the Director of Nursing and the Medical Director and will be reviewed annually to ensure that it continues to reflect the organisation's quality improvement needs and any new national guidance. The Trust's Annual Business Plan will include those actions which the Trust will take in year to deliver the Quality Improvement Plan. The Head of Quality Improvement will manage the quality improvement plan and will be responsible for providing assurance to the Board and its sub committees on its implementation and delivery.

7.3 Delivery

Clinical Units are accountable for delivering safe, quality care to patients through the implementation of internal performance management and processes that support continuous improvement, minimise risk and foster an environment of excellence in care.

Their remit encompasses ensuring that effective processes are in place for delivering clinical governance including risk management, clinical audit, health and safety and the monitoring and improvement of compliance with a wide range of standards. In addition they need to ensure quality improvement loops are in place so that they are able to learn from adverse incidents, complaints, compliments, audits, feedback, observations and claims and apply the learning to deliver measurable improvements. This includes having systems in place to ensure they are monitoring and responding to patient need and feedback from patients and or their carers.

The Clinical Units are responsible for collating, analysing, acting upon, learning lessons from and reporting data. They will be supported in this by the Trust's Knowledge Management function which will work with them to produce a quality dashboard that will enable them to monitor the quality of their provision and will ensure that risks and actions required are identified and reported into the Trust Patient Safety and Clinical Improvement Group. This will enable the Patient Safety and Clinical Improvement group to identify common themes and ensure consistency in approach when delivering quality improvement.

The outcomes of the Clinical Unit's work will provide sound evidence and data that supports the provision of quality assurance to the Board and external bodies.

7.4 Performance Management

The Clinical Units are accountable for their performance to the Board via the Chief Operating Officer, the Director of Finance and Performance, the Medical Director and the Director of Nursing as set out in the Trust's Performance Management Framework. Performance measurement includes reporting and management against defined quality outputs and outcomes and regulatory standards, the assessment and management of risk and the effectiveness of improvement actions to be measured against the agreed outcomes. Monthly Accountability Review meetings are held with the Clinical Units to monitor performance.

Effective quality performance management is based on an agreed set of quality indicators, allowing the effective analysis of the overall quality of the care provided. The Quality Dashboard and the Clinical Governance Performance Report will support effective performance management.

7.5 Quality Account

Each year the Trust produces a Quality Account, a public report about the quality of its services, which demonstrates the improvements the Trust has made to its services in the past year as well as where and how it will improve patient care in the year ahead through setting new Quality Improvement Priorities. The Quality Improvement Priorities are developed through engagement with stakeholders including service users and carers and are monitored throughout the year. The outcomes are reported at the end of the year in the next years' Quality Account.

7.6 Commissioning for Quality and Innovation (CQUINs)

A proportion of the Trust's income is conditional on achieving quality improvement and innovation goals agreed between East Sussex Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. This framework enables commissioners to reward excellence, by linking a proportion of income to the achievement of local quality improvement goals. Past CQUIN schemes have covered Venous Thromboembolism, Patient Experience, Dementia, Safety Thermometer, Enhancing Quality and Enhanced Recovery programmes, High Impact Innovations, and Reducing Unscheduled Care.

7.7 Listening into Action (LiA)

Listening into Action (LiA) is about achieving a fundamental shift in the way the Trust works and leads, putting staff at the centre of positive change for the benefit of patients, staff and the Trust as a whole.
Through service level workstreams projects are being taken forward to deliver improvements including in quality and safety of care and patient experience. Projects also support the development of individuals and teams and are part of the Trust's work to support an improvement culture across the organisation.

7.8 Assurance

The seeking and provision of assurance is an essential part of the Trust quality system. It allows the Board to assess the organisation's compliance with agreed standards by taking an integrated view of the achievement against related outcomes. Assurance will be based on

evidence produced by the Head of Quality Improvement through their programme management of the Quality Improvement Plan, the Clinical Units, other parts of the organisation, internal and external audit and external assessments including those undertaken by regulators. It will allow the Trust to bring together information about all aspects of the quality of care and consider whether this gives assurance that agreed aims and objectives are being delivered.

8. Communication

Following ratification this strategy will be placed on the Trust's Intranet and all staff notified by email. All directors, heads of clinical units and managers are responsible for ensuring that all staff are aware of the document for example by discussing it at local team meetings. New staff will be alerted to the strategy at induction training.
Consistent messages on quality will be communicated using formal and informal communication processes such as the weekly message from the Chief Executive. Quality indicators will be translated into individual objectives for members of staff**.**

9. Monitoring

Delivery of this strategy will be reviewed by the Trust Board Quality and Standards Committee through the review of quality outcome measures and receipt of the annual quality report. The Quality and Standards Committee will:

- Seek assurance that the Trust's Quality Improvement Plan addresses key areas of concern and risk and is being delivered in a timely way and that there is an evidence base for the effectiveness of the plan and the delivery of the required quality improvements
- Receive reports and assurances (including those from internal and external audit) that the Trust's Quality Governance strategy is being effectively operated and agree any amendments to the strategy prior to recommending these to the Board for approval

10. Conclusion

This Strategy outlines the Trust's commitment to place quality at the heart of everything it does. Implementation of this Strategy will support the Trust to deliver high quality, safe and compassionate care and demonstrate to our patients, staff and commissioners that we are the healthcare provider of first choice for the people of East Sussex.

11. Equality and Human Rights Statement

An equality impact assessment has been carried out in order to establish that this strategy does not discriminate or have a detrimental impact upon employees or service users on the grounds of disability, age, race, gender, sexual orientation, religion or belief.

12. Copy Available

An electronic copy of this document is available on the Trust Intranet page under 'document search'.
Stakeholders can access a copy through the Trust website.

13. Strategy Review Arrangements

This Strategy is ratified by the Trust Board and will be reviewed annually in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of the Trust.

14. Supporting and Related Documents

The Quality Governance Strategy should be read in conjunction with the:

Risk Management Strategy (updated 2014)
Patient Experience Strategy (2013)
Performance Management Framework
Quality Improvement Plan

Appendix A – Staff Feedback Form

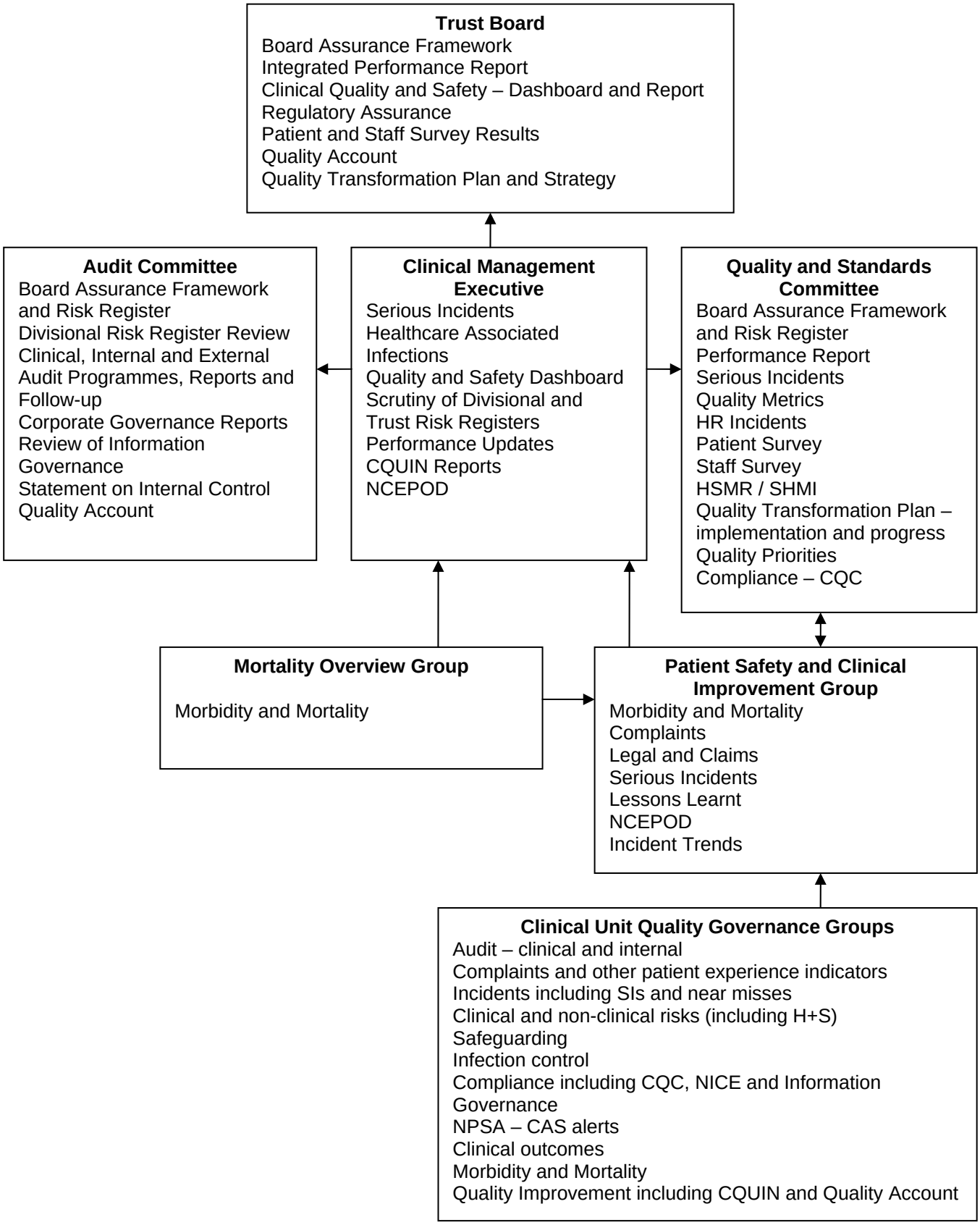
Please complete this form if you would like to make a comment on the procedural document you have just read. Your feedback will be held by the Assurance Manager and your views will be taken into account at the next review date of the document.

Title of the procedural document:	
Date of next review:	
Your name (optional):	
Date today:	
Your comments:	

Thank-you for your feedback

Please forward this form to: **Assurance Manager**

Appendix B - Quality Governance Reporting Framework



ESHT Quality Improvement Plan 2014/15

1. Introduction

East Sussex Healthcare NHS Trust is committed to continuously improving the outcomes for its patients and achieving excellence in patient care. It recognises that it has a statutory and regulatory duty to ensure that systems of control and governance are in place to monitor and improve the quality of care provided. In line with the Trust Quality Governance Strategy, East Sussex Healthcare NHS Trust has identified quality governance objectives to monitor standards and quality outcomes to ensure they are achieved, by:

- Providing high quality data to monitor clinical care
- Monitoring quality improvements through the use of agreed national and local metrics

Our goals are:

- To ensure that safety always comes first within our organisation
- To improve our communication with, and listen, act upon and be responsive to the feedback we receive from our patient and their carers
- To consistently provide high quality patient care in line with identified best practice

2. Quality Improvement Plan

In order to ensure a systematic and programme management approach to quality improvement, the Trust has developed and will implement a quality improvement plan. The quality improvement plan is drawn from the trust strategic aim to deliver a safe, effective, caring, responsive and well led service to the population of east Sussex. It encompasses the trust priorities identified through LIA, Internal risk and incident analysis, National guidelines, the Commissioning for Quality and Innovation (CQUIN) framework and quality improvements the trust has actively chosen to undertake:

- The Quality Account
- CQUIN
- Annual Business Plan
- National guidance / reports
- Identified quality risks (i.e. those identified through governance processes including Serious Incident and Incident analysis, patient feedback and audit)
- Listening into Action

The Quality Improvement Plan identifies the Trust priorities for quality improvement, the desired outcome, the actions required in order to ensure delivery of the improvements required, the timeframe, how the outcomes will be measured to provide adequate assurance of improvement delivery as well as the leads responsible.

The Quality Improvement Plan will be owned by the Director of Nursing and the Medical Director and will be reviewed annually to ensure that it continues to reflect the organisation's quality improvement needs and any new national guidance. The Trust's Annual Business

Plan will include those actions which the Trust will take in year to deliver the Quality Improvement Plan. The Head of Quality Improvement will manage the quality improvement plan and will be responsible for providing assurance to the Board and its sub committees on its implementation and delivery.

Continuous improvement, focused on the quality of services and the care we provide to our patients' is essential for the achievement of these aims and to reflect 'safe, caring, reliable' care. The improvement plan describes how we are going to meet those improvement aims for:

- Safer Patient Care
- Patient Centred Care
- Clinically Effective Care

The following programme of improvement work has been defined under these three priorities of, improving safety, clinical effectiveness and patient experience, however are all interlinked.

In addition to delivering this programme the Trust is committed to ensuring that it is open and transparent about the quality and safety of the services it provides. The Trust makes quality and safety information available through a variety of routes including through the publication of its Integrated Performance Report on a monthly basis and through the publication of the annual Quality Account. In line with national and local requirements and guidelines the Trust is also committed to making available information about clinical outcomes at consultant level and about ward staffing.

3. Quality Improvement Priorities

The Trust has a systematic approach to identifying its quality improvement priorities which is driven by the quality assessment framework including that overseen by the Trust Development Authority (TDA). As described below, the priorities are drawn from key documents and processes such as the Quality Account, CQUINs and the Annual Business Plan, as well as nationally published guidance and reports, and locally identified quality risks for example those identified through the analysis of incident data (see Appendix A). The Annual Business Plan will include those actions which the Trust will take in year to deliver the Quality Improvement Plan.

4. Quality Account

Each year the Trust produces a Quality Account, a public report about the quality of its services, which demonstrates the improvements the Trust has made to its services in the past year as well as where and how it will improve patient care in the year ahead through setting new Quality Improvement Priorities. The Quality Improvement Priorities are developed through engagement with stakeholders including service users and carers and are monitored throughout the year. The outcomes are reported at the end of the year in the next years' Quality Account.

The 2014/15 Quality Improvement Priorities are:

Patient Safety	Maximising our efforts to reduce healthcare associated infections

Patient Experience	Continuing to implement the Patient Experience Strategy Ensuring that we provide optimal care for patients in our care who have mental health disorders
Clinical Effectiveness	Early recognition and action to support the care of the deteriorating patient

5. Commissioning for Quality and Innovation (CQUIN)

A proportion of the Trust's income is conditional on achieving quality improvement and innovation goals agreed between East Sussex Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. This framework enables commissioners to reward excellence, by linking a proportion of income to the achievement of local quality improvement goals. Past CQUIN schemes have covered Venous Thromboembolism, Patient Experience, Dementia, Safety Thermometer, Enhancing Quality and Enhanced Recovery programmes, High Impact Innovations, and Improving End of Life Care.

In 2014/15 our agreed CQUIN goals are:

	CQUIN
National Scheme	Dementia (FAIR assessment)
	Friends and Family Test
	NHS Safety Thermometer
Local Scheme	Clinical correspondence – 7 schemes
	Mortality Review and Database implementation.
	Frailty – Patient Moves
	COPD Discharge Bundle
	Ambulatory Emergency Care pathway
	Reduction of avoidable pressure ulcers via an integrated approach with local health and social care providers.

6. Annual Business Plan

In line with TDA guidance, *Securing Sustainability,* the Trust has prepared a two year business plan which meets national and local requirements. The first year of this plan has been developed in detail and forms the Trust's Annual Business Plan (ABP) for 2014/15. The ABP is aligned to the Trust's strategic objectives and is fully integrated setting out the projects and programmes that will deliver improvements in quality and operational and

financial performance in 2014/15. It also includes the corporate workplan that will support the delivery of these improvements.

The Annual Business Plan Objectives include the following quality focused actions:

Undertaking Quality Impact Assessments for all programmes of service change
Instituting a process to allow staffing at ward level to be monitored in line with national requirements
Responding to national plans for the revalidation of nursing staff
Further strengthening Clinical Audit reporting to the Board and its Committees
Implementing the Quality Improvement Programme including QUIPP and CQUIN Plans
Implementation of Vitalpac

7. Patient Safety

In planning for improvement we will work to the following key principles:

- We will investigate and take action where performance improvement is required
- We will identify and manage risks to quality of care
- We will monitor standards and quality outcomes to ensure they are achieved
- We will plan and drive continuous improvement
- We will encourage the reporting of incidents and near misses, support investigations and ensure lessons identified are learnt and shared.

Our Patient Safety Priorities are to:

1. Reduce mortality indices
2. Reduce Healthcare Associated Infections
3. Reduce avoidable Pressure Ulcers
4. Reduce harm associated with falls
5. Reduce harm associated with medication errors

8. Patient Centred Care

In enhancing the patient experience we will work to the following key principle:

- We will ensure that learning from complaints, Patient Advice and Liaison Service (PALS), information, litigation and claims is systematically analysed, disseminated and learnt from throughout the Trust.

Our Patient Experience Priorities are to:

1. Ensure optimal care is provided for patients who have mental health disorders

2. Continue the implementation of the Friends and Family Test for Patients, relatives and staff.

3. Improve Patient Engagement in the design of services

4. Act on feedback received from patients, relatives, friends, carers and staff

9. Clinically Effective Care

In delivering effective care we will work to the following key principles:

- We will systematically and consistently identify, review, share and ensure delivery of best-practice, providing assurance and evidence of improvement.
- We will deliver an annual Clinical Audit programme disseminating the learning from completed audits across the organisation.

Our Clinical Effectiveness Priorities are to:

1. Improve the early recognition and action of acute illness

2. Improve VTE assessment, recognition and treatment.

3. Reduce non-clinical transfers of frail patients

4. Continue to improve care for patients with Dementia

5. Improving care for patients with COPD

10. Improvement Approaches

We intend to implement the proposed projects using appropriate quality improvement methods developed on a project by project basis using a programme management approach. Some projects will already have a proven change package and are intended to address system wide issues involving different stakeholders.

For smaller projects it may be appropriate to take a more localised view involving supporting teams leading and managing their improvement work by focusing on the needs of the patient, feeding into the Head of Clinical Improvement.

Individual teams are supported in identifying and addressing areas for improvement through a framework of data collection and tools and techniques, Plan Do Study Act (PDSA), case review for example.

The timescales for each of these projects will vary, depending on the availability and complexity of underlying re-design, resources and complexity of the change, data

requirements and service integration. All programmes will require a project initiation document and plan outlining the following minimum data:

- Outline plan
- Expected outcome
- Timeframe
- Measures of success
- Lead (accountable for delivery)

All programmes will be included in an overarching database to ensure we have oversight and knowledge of progress against all programmes. It is envisaged that each operational area will have their own quality programme board that will maintain and update progress against their own projects.

11. Listening into Action (LIA)

Listening into Action (LiA) is about achieving a fundamental shift in the way the Trust works and leads, putting staff at the centre of positive change for the benefit of patients, staff and the Trust as a whole.
Through service level workstreams projects are being taken forward to deliver improvements including in quality and safety of care and patient experience. Projects also support the development of individuals and teams and are part of the Trust's work to support an improvement culture across the organisation.

A number of key priority areas have already been identified for LIA projects during 2014/15 with improvement projects aligned to each area. These are:

Quality and Safety of Care	Care of the deteriorating patient
	Falls prevention across all wards
	Pressure ulcers prevention across all wards and community areas
	Infection control and prevention
	Stroke care pathway
	Improving the availability, accuracy and completeness of medical records
The Patient Experience	Patient nutrition plan on admission using MUST tool
	Reducing the length of stay for non-elective surgical patients
	Improved screening for dementia care patients
	Patient led improvements based on complaints, Serious Incidents, and the Friends and Family Test results

	Making things better in Maternity and Paediatrics for all our patients

12. Risks and Mitigation

All programmes will utilise the trust wide risk management approach, completing risk registers using the Datix system and managed as set out in the risk management strategy. Any identified risks against not delivering clinical improvement objectives and programmes and the potential impact to the organisation will be shared across and within the organisation.

13. Conclusion

The improvement programmes need to be flexible and responsive to change with the changing needs of the organisation and external demands whilst re-structuring of the NHS continues. At the core of this plan is improving patient care and bringing about a step change in ‘how we improve and manage the quality agenda’. The aim is to make quality everyone’s business to increase the profile of the work staff currently do in relation to this agenda, bring about a system of total quality management that creates a culture of team working, efficient working practices, based on the newest technology, systems based thinking, best evidence and a culture of continuous improvement.

Appendix A – Matrix of Improvement Projects

	Quality Account	CQUIN	ABP	LIA	National Guidance	Identified Risk	TDA
Patient Safety							
Reducing healthcare associated infections	✓			✓			✓
Active use of the Patient Safety Thermometer		✓					✓
Mortality Review and Database		✓					✓
Reduce mortality indices					✓	✓	✓
Reduction of avoidable pressure ulcers		✓		✓		✓	
Reduce harm associated with falls				✓		✓	
Reduce harm associated with medication errors							✓
Improving the availability, accuracy and completeness of medical records				✓		✓	
Undertaking Quality Impact Assessments			✓				✓
Monitoring staffing at ward level			✓				✓
Patient Experience							
Continuing the implement the Patient Experience Strategy	✓						
Ensuring that we provide optimal care for patients in our care who have mental health disorders	✓						
Continue the implementation of the Friends and Family Test		✓					
Clinical Correspondence		✓					
Reducing the length of stay for non-elective surgical patients				✓			
Making things better in Maternity and Paediatrics				✓			
Clinical Effectiveness							
Early recognition and action to support the care of the deteriorating patient (Vitalpac)	✓		✓	✓			✓
Continue to improve care for patients with dementia		✓		✓			
Frailty (reduction of non-clinical transfers for frail patients)		✓					
Improving care for patients with COPD		✓					
Stroke care pathway				✓			
Improve VTE assessment, recognition and treatment							
Ambulatory Emergency Care pathway		✓					
Revalidation of nursing staff			✓				
Strengthening Clinical Audit			✓				
Implementation of SystmOne						✓	
Improve patient nutrition planning				✓			

East Sussex Healthcare NHS Trust

Date of Meeting:	23rd July 2014
Meeting:	Trust Board
Agenda item:	8a
Subject:	Performance Report – May 2014 Finance Report – June 2014
Reporting Officer:	Alice Webster, Director of Nursing Dr David Hughes, Medical Director (Governance) Richard Sunley, Chief Operating Officer Monica Green, Director of Human Resources Vanessa Harris, Director of Finance

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

Purpose:

The attached documents provide information on the Trust's performance for the month of May 2014/15 against quality and workforce indicators and to the end of June 2014/15 for finance.

Introduction:

The monthly Quality report details ESHT's in month performance against key Trust metrics as well as activity and workforce indicators.

The NHS Trust Development Authority (NTDA) has reviewed its reporting requirements for 2014/15, publishing the new Accountability Framework.

The model describes how NHS Trusts can expect to be assessed by the NTDA, how they can expect to be held to account for what they have promised to deliver, and what indicators will be used to determine whether an organisation is delivering high quality care.

For 2014/15 it is recommended that the TDA reports Oversight and Escalation on two parts 'quality and delivery' and 'finance and sustainability'. 'Quality and delivery' is to be sub-divided into five sections, one for each of the Chief Inspectorate of Hospitals (CIH) domains (Caring, Effective, Responsive, Safe and Well Led).

Finance and Sustainability are not part of the CIH inspection or CQC Risk Rating but are still a very important part of Oversight and Escalation and therefore will be reported as the second section of the Oversight and Escalation Model.

The NTDA will adopt a similar scoring system of the CQC where 1 is high risk and 5 is lower risk, to reduce the potential of any confusion that might arise if the NTDA was to continue with 5 being the highest risk. The NTDA will continue to use the term 'escalation levels' as opposed to 'bands' to retain the distinction between its assessment of risk and that of the CQC. There is no intention that Oversight and Escalation will attempt to replicate or estimate future CQC risk ratings.

The scorecard to support Oversight and Escalation has been re-designed to move away from one for acute, community, mental health and ambulance services, to a single scorecard as the increasing multifaceted provision of services by Trusts mean these are increasingly artificial differentiations.

The indicators for 2014/15 have been reviewed and updated. These are shown in the attached report along with the full guidance.

It should be noted that the Trust is still awaiting guidance on the definition and calculations of some indicators and therefore the attached performance report is draft pending any further clarifications and may subsequently change.

Scoring Methodology

The approach to scoring the domains is described below. This general methodology is applied to all domains.

INDICATOR SCORE	Each indicator will receive the weighted score for that indicator if the standard **is not** achieved, or will receive 0 (zero) if the standard is achieved.
DOMAIN % PERFORMANCE	The sum of all indicator scores is calculated to give a total weighted score for the domain (a). The total achievable score for that Domain equals the sum of all indicator weightings (b). Trust percentage performance is calculated by dividing (a) by (b) and multiplying by 100. NOTE a good score is a low score. Poor performing indicators and domains will score higher.
DOMAIN SCORE	The Domain score is calculated from the % Performance figure as below: 0 - <= 20 would result in a Domain score of 5 GOOD >20 - <= 40 would result in a Domain score of 4 >40 - <= 60 would result in a Domain score of 3 >60 - <= 80 would result in a Domain score of 2 >80 would result in a Domain score of 1 (BAD)
OVERALL QUALITY SCORE	The Overall Quality Score is calculated from the SUM of all Domain scores as follows: 5 - < 10 would result in an OQS of 2 (BAD) >10 -<= 15 would result in an OQS of 3 >15 - <= 20 would result in an OQS of 4 >20 - <= 25 would result in an OQS of 5 (GOOD)
NOTE	IN THE ORIGINAL CALCULATION OF TOTAL POSSIBLE SCORE (WEIGHTING) AND DOMAIN %, LESSER SCORE = BETTER PERFORMANCE. IN THE SUBSEQUENT CALCULATIONS OF DOMAIN SCORE AND OVERALL QUALITY SCORE, LESSER SCORE = POORER PERFORMANCE
RAG RATINGS	SUGGEST THAT FOR DOMAIN SCORING; RED = 1 OR 2 , AMBER = 3 OR 4 AND GREEN = 5 SUGGEST THAT FOR OVERALL QUALITY SCORE; RED = 2 AMBER = 3 OR 4 AND GREEN = 5

The finance RAG rating is calculated separately and is shown in the Month 3 Finance Report. It should be noted that the overall score is the result of a moderation process bringing together the rules-based scores for quality and delivery and finance along with other intelligence held by the NTDA. The moderation process will include the application of override rules for Mortality, Finance and some key performance indicators.

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

Overall Performance Score: The Trust's overall Performance Score for May was 4 (maximum achievable 5). The accompanying document produced by the TDA details the scoring methodology. Each of the following domains are also scored out of 5.
(1=Poor performance, 5=Excellent)

Responsiveness Domain (Score: 2);
A reduced performance score on account of failures within Admitted and Non-Admitted Referral to Treatment (RTT), Cancer (2 Week Waits (2WW) and 62 Days) and Diagnostics. Standards relating to Incomplete RTT pathways, 31 Day Cancer and cancellations were achieved.

Effectiveness Domain (Score: 4);
Performance within certain Mortality Indicators below standard. *30 Day Emergency Re-Admission rate* remains below ceiling standard.

Safe Domain (Score: 5):
Only one indicator within this domain did not achieve the sufficient standard: *Patient Safety Incidents that were harmful*. All other indicators achieved the required standard.

Caring Domain (Score: 4);
Performance was below the required standard within A&E Friends and Family Test (FFT) scoring.

Well Led Domain (Score: 3);
Performance was below the required standard within A&E FFT response rates, Staff Turnover, Staff Sickness and Annual Appraisal Rate.

Finance Report
At the end of M3 financial performance was a year to date run rate deficit of £6,944,000, which was a favourable variance against plan of £226,000. Income and expenditure were both slightly under plan. The cost improvement achievement was £3,272,000 which was ahead of plan by £466,000.

Benefits:

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

The Board is aware of the Month 3 financial position.

Risks and Implications:

The Trust Score against the responsiveness domain reduced to 2 in the month. This domain contains a number of contractual targets, and thus the risk of financial penalties is raised.

At the end of Month 3 the financial risks remain unchanged from those associated with the plan for the year.

Assurance Provided:
This report includes all indicators contained within the NTDA's Accountability Framework for 2014/15. Information contained within this report has been extracted from the Trust Data Warehouse in line with guidance supplied by the NTDA. The financial performance at Month 3 is slightly better than plan.

Review by other Committees/Groups (please state name and date)**:**
This report will be reviewed by The Clinical Leadership Team during months that the Trust Board does not meet.

Proposals and/or Recommendations
The Trust Board are asked to review the report in full and note Trust Performance against each domain.

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

For further information or for any enquiries relating to this report please contact:	
Name: Andy Bailey, Head of Information Management	**Contact details:** andybailey@nhs.net

East Sussex Healthcare Trust
Quality and Performance Report

Detailing Performance against the Trust Development Authority's Accountability Framework 2014/15

Month 2
May 2014

EAST SUSSEX HEALTHCARE NHS TRUST KNOWLEDGE MANAGEMENT

1.0 Overall Performance Score

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

2.0 Responsiveness Domain

Responsiveness Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
			3	2										
Metric	**Standard**	**Weighting**												
Referral to Treatment Admitted	90.00%	10	82.68%	84.06%										
Referral to TreatmentNon Admitted	95.00%	5	94.08%	94.12%										
Referral to Treatment Incomplete	92.00%	5	92.37%	92.89%										
Referral to Treatment Incomplete 52+ Week Waiters	0	5	4	6										
Diagnostic waiting times	1.00%	5	7.32%	6.31%										
A&E All Types Monthly Performance	95.00%	10	95.20%	93.60%										
12 hour Trolley waits	0	10	0	0										
Two Week Wait Standard	93.00%	2	89.97%	89.07%										
Breast Symptom Two Week Wait Standard	93.00%	2	84.21%	92.06%										
31 Day Standard	96.00%	2	97.33%	96.71%										
31 Day Subsequent Surgery Standard	94.00%	2	100.00%	100.00%										
31 Day Subsequent Drug Standard	98.00%	2	100.00%	100.00%										
62 Day Standard	85.00%	5	86.01%	82.08%										
62 Day Screening Standard	90.00%	2	76.92%	80.00%										
Urgent Ops Cancelled for 2nd time (Number)	0	2	0	0										
Proportion of patients not treated within 28 days of last minute cancellation	0.00%	2	0.00%	0.00%										
Delayed Transfers of Care	3.50%	5	4.17%	6.22%										

2.1 RTT Performance

RTT Performance is working to a trajectory agreed with the TDA and Local Commissioners. The focus is to moving the trust to a sustainable position by reducing the waiting list. Work continues with the Intensive Support Team, with whom the trust holds weekly meetings to keep the action plan on track. It is anticipated that RTT Performance will be achieved across all 4 indicators by November 2014.

2.2 Diagnostics

Diagnostics performance improved slightly in May, but remains significantly above the ceiling target of 1%. This is due to a high number of patients currently waiting for Endoscopy. The Trust have developed an Endoscopy Recovery Plan to reduce the waiting list and bring the percentage waiting over 6 weeks below this threshold. The recovery plan focuses on service re-design, increasing utilisation of existing facilities, six

day working and limited use of a third party provider (Benenden). The Trust is confident that performance will be at target levels by the end of June.

2.3 A&E Performance
Having delivered 95.20% in April, A&E performance reduced to 93.60% in May on account of a significantly high number of breaches sustained over a two week period. Performance has subsequently recovered and there is high confidence that June will achieve the target. Performance across the quarter however, will fall below the 95% target.

2.4 Cancer Performance
The Trust did not meet the 2WW targets due to a combination of patients choosing to delay treatments and insufficient outpatient capacity. The Trust has put in place a process to feedback to individual General Practitioners those patients who are choosing to delay appointments. It is hoped that the GPs will be able to support the trust in reducing the risk of this happening in the future. Outpatient capacity has been increased to ensure that patients referred with a 2WW priority are able to access the relevant outpatient clinic.

2.5 Cancellations
There were no breaches of the 28 day cancellation rule in April. At the time of writing this report there have been no breaches in May, although there are a small number of cancellations that have not yet reached 28 days. These will be reported if necessary in the June Report.

2.6 Delayed Transfers of Care
The Trust has changed the way it calculates Delayed Transfers of Care. We have moved away from the previous SHA (Strategic Health Authority) methodology and taken on the TDA's methodology. The new methodology uses the Monthly Central DTC submission which has snapshot of the number of patients waiting on the last Thursday in the month together with the sum of all delayed beddays throughout that month. Performance is a measure of the average number of days delayed each day against the total number of Trust occupied beddays.

Performance for May is adversely higher than the ceiling standard.

For acute DTCs, 58% of delayed beddays (260) were due attributable to NHS (Social Care were responsible for 42% of delayed beddays). A significant Majority of these delays were due to either the requirement of further non acute NHS Care or Patient/Family Choice.

For Non-Acute DTCs, 93% of delayed beddays (937 in the month) were attributable to NHS, with the same reasons being cited as for acute DTCs (predominantly the requirement of further non-acute care or Patient/Family Choice).

3.0 Effectiveness Domain

Effectiveness Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Metric	Standard	Weighting	4	4										
Hospital Standardised Mortality Ratio (DFI)		5	99.7	99.7										
Deaths in Low Risk Conditions		5	1.4	1.4										
Hospital Standardised Mortality Ratio - Weekday		5	101.4	101.4										
Hospital Standardised Mortality Ratio - Weekend		5	100.6	100.6										
Summary Hospital Mortality Indicator (HSCIC)		5	107.7	107.7										
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	10%	5	7.15%	7.55%										

3.1 Mortality

The Mortality indicators within the TDA's accountability framework are source from Dr Foster Intelligence here http://myhospitalguide.drfosterintelligence.co.uk/#mortality

As yet the TDA have not set any standards against mortality rates but these are expected to be confirmed soon.

Dr Foster does provide an indication of whether the trust scores for these indicators are higher or lower than expected. This has been reflected in the above table, to highlight that both Deaths in low risk Conditions and SHMI are currently higher than expected.

Further detail is being sought from the TDA and DFI at present and will be presented in the month 3 report.

3.2 Emergency Re-Admissions

The rate of emergency Re-Admissions within 30 days of a previous discharge, has increased slightly but continues to meet the standard, and is significantly lower than 2013/14. Weekly notification and analysis of these re-admissions with the Service Managers now takes place and is helping to identify themes at ward and specialty level. This will help the trust to improve processes and reduce the risk of patients being re-admitted.

4.0 Safe Domain

Safe Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Metric	Standard	Weighting	4	5										
Clostridium Difficile - Variance from plan	4	10	5	3										
MRSA bactaraemias	0	10	0	0										
Never events	0	5	0	0										
Serious Incidents rate	TBC	5												
Patient safety incidents that are harmful	0	5	3	4										
Medication errors causing serious harm	0	5	0	0										
Overdue CAS alerts	0	2	0	0										
Maternal deaths	0	2	0	0										
VTE Risk Assessment	95.00%	2	99.00%	97.90%										
Percentage of Harm Free Care	92.00%	5	94.02%	93.08%										

4.1 Healthcare Acquired Infections

The Trust reported 3 C-Difficile cases in May, to stay within the ceiling target. Year to date out-turn is above plan however on account of 5 cases being reported in April.

4.2 Patient Safety

As yet the TDA has not set a standard against Serious Incidents or detailed the methodology required to re-produce a rate.

There were 4 harmful incidents in May, three of which were falls related and the remaining one related to C-Difficile. The Trust reviews all serious incidents and undertakes a Root Cause Analysis against each incident to ensure that lessons are learnt and processes can be redesigned where necessary to reduce or eliminate the risk of re-occurrence.

5.0 Caring Domain

Caring Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
			5	4										
Metric	Standard	Weighting												
Inpatient Scores from Friends and Family Test	60.00%	5	66.00%	64.00%										
A&E Scores from Friends and Family Test	46.00%	5	49.00%	44.00%										
Complaints	TBC	5												
Mixed Sex Accommodation Breaches	0	2	0	0										
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	7.8	2	7.9	7.9										

5.1 Friends and Family Test (Patient Experience)

Inpatient scores remained above target levels for the second consecutive month, however within Accident and Emergency departments scores did fall slightly below the required standard. A contributing factor is likely to be the unusually high number of 4 hour breaches in the last two weeks of May. This issue has now been resolved and so it is expected that performance will be back to standard next month.

5.2 Complaints

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

6.0 Well Led Domain

Well Led Domain			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
			3	3										
Metric	Standard	Weighting												
Inpatients response rate from Friends and Family Test	30.00%	2	46.43%	44.22%										
A&E response rate from Friends and Family Test	20.00%	2	13.59%	15.76%										
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	40.70%	2	41.00%	41.00%										
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	42.30%	2	51.00%	51.00%										
Data Quality of Returns to HSCIC	TBC	2												
Trust turnover rate	10.00%	3	12.45%	12.89%										
Trust level total sickness rate	3.30%	3	4.08%	3.87%										
Total Trust vacancy rate	10.00%	3	6.04%	6.40%										
Temporary costs and overtime as % of total paybill	10.00%	3	7.02%	7.29%										
Percentage of staff with annual appraisal	85.00%	3	63.37%	63.84%										

6.1 Friends and Family Test (Response Rate)

Inpatient response rates for the month remain above the required standard, however the A&E response rate remains below standard. The A&E environment remains a challenging place to gain feedback from patients and the Trust has put in place a

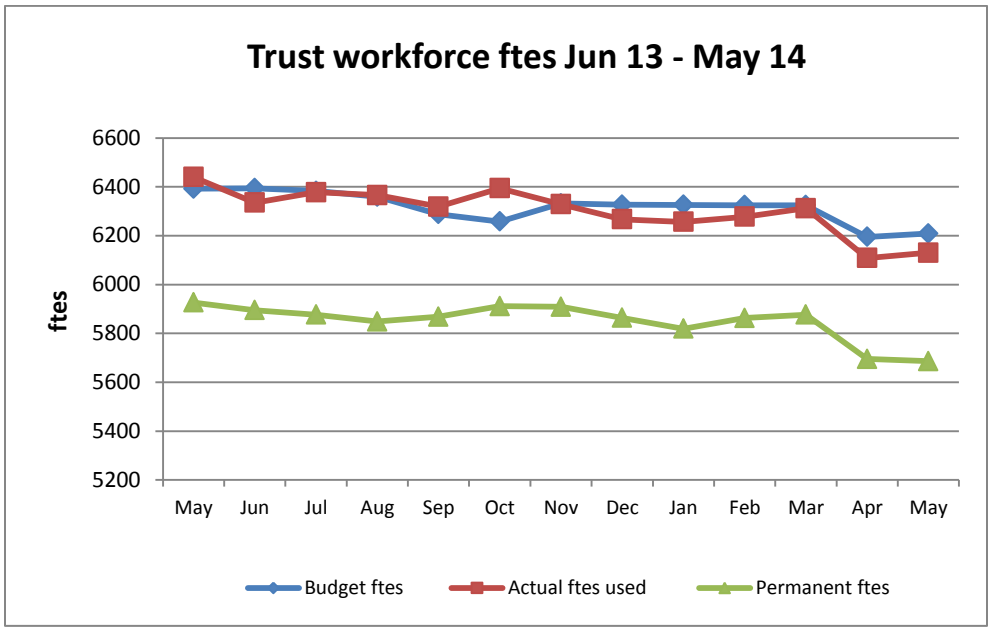
number of measures to maximise responses. The Trust also continues to review national best practice at other trusts and aims undertakes to implement any new ideas or processes that will improve performance against this standard.

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

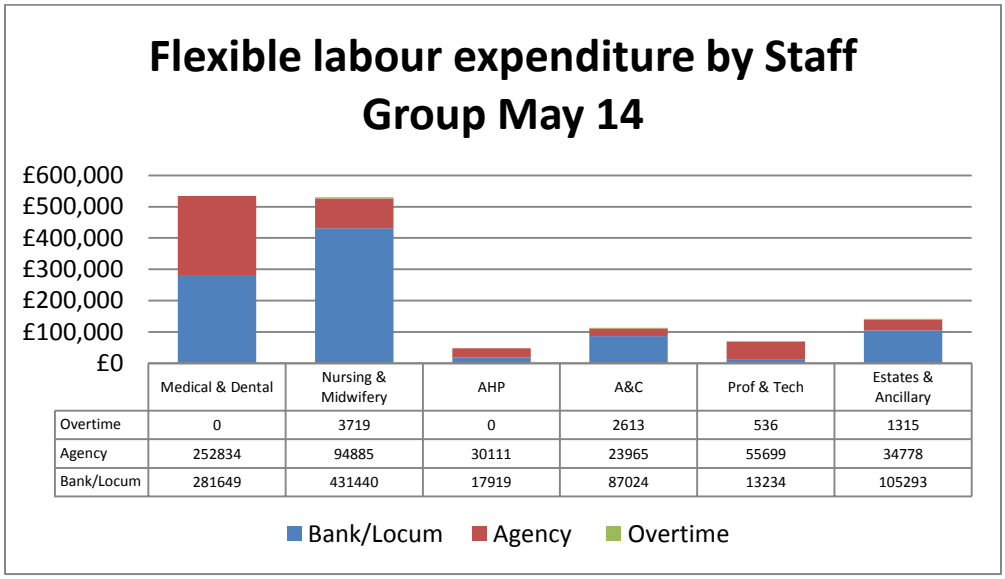
7.0 Workforce

Pay expenditure is £578K under budget at May. This is again partly due to unfilled vacancies in Clinical Units and, as a consequence, agency expenditure has increased this month by £90K and bank expenditure by £8K (overtime is down by £2K to just under £6K). Other factors impacting upon agency expenditure include additional medical agency cover in Surgery to meet 18 weeks targets and for night cover and delayed agency invoices in Housekeeping and Laundry.

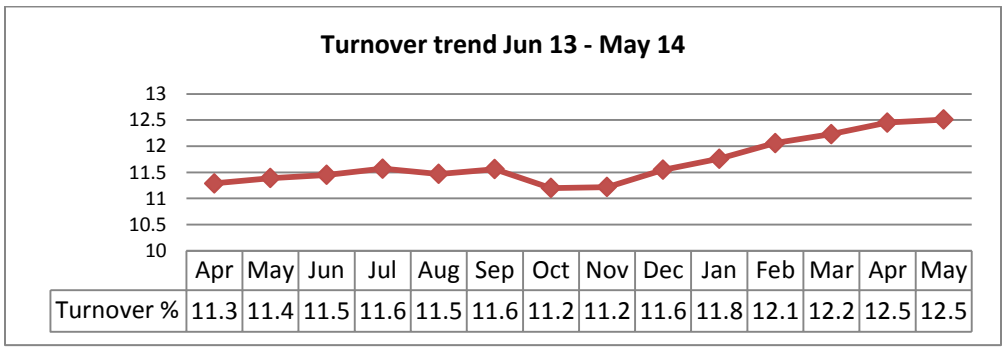
7.1 FTEs



	Year to Date	
	Target	Actual
WTE in post (actual worked)	6208.97	6129.8
Paybill (£m)	41.31	40.74
Staff turnover	10%	12.5%
% of Bank, agency and overtime spend		7.29%



	Medical & Dental	Nursing & Midwifery	AHP	A&C	Prof & Tech	Estates & Ancillary
Overtime	0	3719	0	2613	536	1315
Agency	252834	94885	30111	23965	55699	34778
Bank/Locum	281649	431440	17919	87024	13234	105293



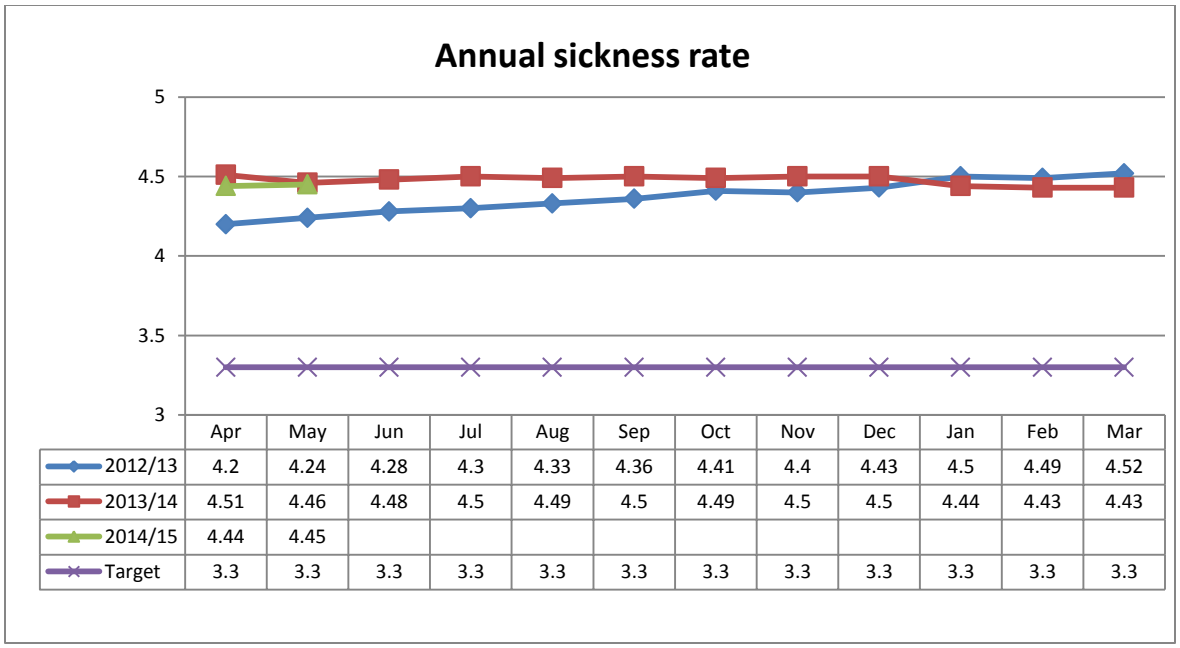
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Turnover %	11.3	11.4	11.5	11.6	11.5	11.6	11.2	11.2	11.6	11.8	12.1	12.2	12.5	12.5

7.2 Sickness

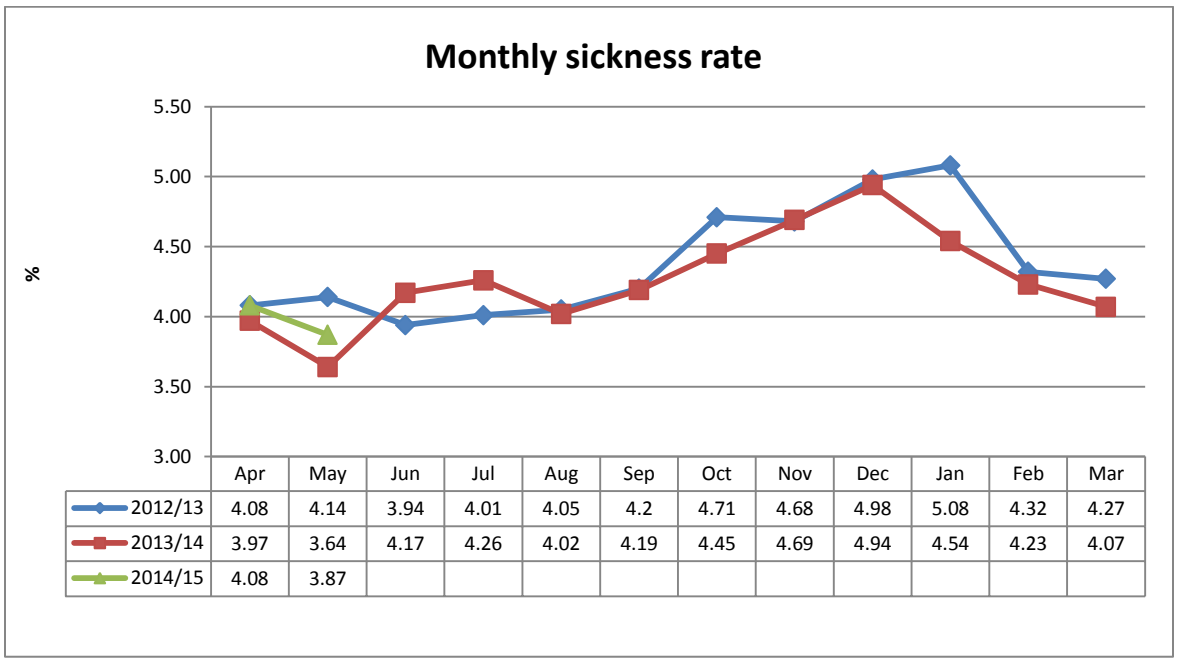
Monthly sickness in May is down by 0.21% at 3.87%. This rate is, however, higher than for May last year and, consequently, the annual rate has risen marginally to 4.45%.

The Clinical Units with the highest monthly sickness rates were Acute & Emergency Medicine at 5.57%, Out of Hospital Care at 5.05% and Theatres, Anaesthetics & Critical Care at 4.82%. Monthly sickness was lowest in Clinical Support at 2.27%, Musculoskeletal at 2.49% and Cardiovascular at 2.69%.

Latest figures published by the Health and Social Care Informatics Centre show that in January 2014 the national monthly sickness rate for NHS organisations was 4.44%. For Acutes it was 4.21% and for Community Providers it was 4.76%. For Kent, Surrey and Sussex as a whole it was 4.15%. In January, the Trust's monthly sickness rate was 4.54%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.2	4.24	4.28	4.3	4.33	4.36	4.41	4.4	4.43	4.5	4.49	4.52
2013/14	4.51	4.46	4.48	4.5	4.49	4.5	4.49	4.5	4.5	4.44	4.43	4.43
2014/15	4.44	4.45										
Target	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.08	4.14	3.94	4.01	4.05	4.2	4.71	4.68	4.98	5.08	4.32	4.27
2013/14	3.97	3.64	4.17	4.26	4.02	4.19	4.45	4.69	4.94	4.54	4.23	4.07
2014/15	4.08	3.87										

7.3 Clinical Unit Summary

Mandatory training compliance percentages are slightly down this month, with the exception of Trust Induction, Deprivation of Liberties and Health & Safety. In Manual Handling, the use of an external company to deliver training should start to make inroads into the training backlog following the departure of two of the training team. Across the courses there has been an increasing level of staff booked but then not attending.

Appraisal compliance has shown a marginal increase of 0.47%. We have been receiving some historic information from areas who have not previously reported appraisals undertaken, so this will, hopefully, continue to improve. Some Clinical Units, however, still have compliance rates below 60%.

Clinical Unit/Directorate	Annual sickness	Monthly sickness	Short term sickness <28 days	Long Term sickness >=28 days	Cumulative pay expenditure v budget (£000s)	Appraised /exempt in last yr	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training
Musculoskeletal	2.77%	2.49%	83.63%	16.37%	-£52	67.40%	67.96%	64.56%	100.00%	78.64%	61.65%	35.44%	90.34%	86.67%
Theatres, Anaes & Crit Care	4.86%	4.82%	56.03%	43.97%	-£49	74.44%	83.12%	68.97%	80.00%	82.21%	78.40%	22.87%	90.73%	88.17%
Cardiovascular Medicine	3.70%	2.69%	77.03%	22.97%	£1	69.45%	71.57%	65.44%	90.70%	77.21%	63.24%	22.55%	87.92%	84.40%
Acute & Emergency Medicine	5.21%	5.57%	60.75%	39.25%	-£27	47.09%	77.07%	65.72%	98.18%	75.18%	47.04%	43.50%	81.19%	80.29%
Specialist & Planned Medicine	4.68%	4.01%	71.52%	28.48%	-£32	70.56%	84.08%	74.26%	100.00%	85.57%	70.98%	32.89%	89.04%	80.12%
Out of Hospital Care	5.18%	5.05%	49.88%	50.12%	£126	52.51%	74.29%	66.10%	97.73%	66.29%	77.05%	39.05%	93.86%	90.21%
Surgery	3.70%	3.99%	64.56%	35.44%	-£70	80.08%	78.79%	72.19%	100.00%	82.89%	73.80%	42.42%	93.35%	91.08%
Clinical Support	3.19%	2.27%	65.17%	34.83%	-£35	58.22%	75.05%	78.02%	100.00%	82.57%	71.68%	43.96%	72.16%	50.59%
Womens & Childrens	5.18%	3.39%	65.34%	34.66%	-£75	62.19%	82.54%	72.62%	96.43%	75.79%	64.02%	44.58%	84.49%	71.46%
Commercial	5.22%	3.81%	23.84%	76.16%	£54	60.46%	70.47%	41.18%	91.67%	90.43%	72.66%	13.03%	75.00%	100.00%
Corporate	3.18%	2.90%	60.35%	39.65%	£19	70.60%	89.91%	82.24%	96.00%	88.60%	81.31%	49.53%	91.95%	89.55%
TRUST	**4.45%**	**3.87%**	**56.74%**	**43.26%**	**-£578**	**63.84%**	**78.02%**	**67.28%**	**96.01%**	**80.07%**	**70.81%**	**34.91%**	**88.69%**	**82.20%**

7.4 Medical Appraisals

Medical Appraisal Compliance Status May 2014

	Number of doctors	Compliant	Percentage Compliant	Total expected to be compliant by 31/03/14	Percentage expected to be compliant by 31/03/14
Consultants (including honorary contract holders)	216	216	**100%**	**216**	**100%**
Staff grade, associate specialist, speciality doctor (including hospital practitioners / clinical assistants who do not have a prescribed connection elsewhere)	98	97	**99%**	**98**	**100%**
Locum Appointed for Service doctors	17	17	**100%**	**17**	**100%**
Total	331	330	**100%**	331	**100%**

The total number of doctors in the Trust are those doctors with a prescribed connection to the Responsible Officer. Doctors who are compliant with medical appraisals are those who have either had an appraisal in the last 12 months and/or have been in the Trust for less than 12 months. Doctors who are expected to be compliant by 31/12/14 are doctors who have either had their appraisal since 1st April 2014 or have a planned medical appraisal date scheduled with a named medical appraiser. All appraisals should now take place between April and December each year.

East Sussex Healthcare NHS
NHS Trust

FINANCE REPORT – June 2014

Vanessa Harris – July 2014

Financial Summary – June 2014

Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) has revised and reissued its finance risk assessment criteria and these are shown in full on page 4. The Trust's overall RAG rating under the revised TDA criteria is Red.	R
Financial Summary	The Trust performance in month 3 was a year to date run rate deficit of £6,944k, with a favourable variance against plan of £226k. Income was £505k below plan and this shortfall was offset by an under spending on total costs and the donated asset adjustment.	R
Activity & Income	Total income received during June was £143k below planned levels increasing the year to date variance to £505k below plan.	G
Expenditure	Pay costs YTD are below plan by £630k. Non pay, including 3rd party costs is £162k above plan.	G
CIP plans	The CIP achievement YTD was £3,272k which was ahead of plan by £466k.	G
Balance Sheet	Improving the efficiency of debt collection is a key task for 2014/15, to help support the management of creditor balances and to retain liquidity.	G
Cash Flow	Cashflow forecasting and management will remain a key task for 2014/15, whilst the deficit position is covered by the agreed draw-down of PDC this will only be accessed on a quarterly in arrears basis, thus leading to challenges in timing of cashflows.	G
Capital Programme	The Capital Approval Group (CAG) will continue to review and monitor the capital programme on a monthly basis paying particular attention to the risks associated with limited capital funds.	G

Income & Expenditure – June 2014

Headlines

• Total costs in the month were £31.8m. This was £0.1m below plan and brings the YTD position to £474k below plan.

• The run rate deficit against plan YTD was a favourable variance of £226k.

• Cost improvements of £3.3m have been achieved YTD month 3 which is £0.5m ahead of the planned target.

• Total income in the month was £29.1m against a plan of £29.2m, an adverse variance of £143k. YTD income is now £505k below plan.

• Pay costs in the month, including ad hoc costs, were £52k below plan. YTD pay is now £630k below plan.

• Non Pay costs, including 3rd party costs, were £59k below plan in the month and are YTD £162k above plan.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	27,299	26,812	-487	80,299	80,326	27	323,730
Private Patient/ ICR	256	123	-133	817	585	-232	4,160
Trading Income	369	444	75	1,105	1,210	105	4,421
Other Non Clinical Income	1,324	1,726	402	6,438	6,033	-405	25,049
Total Income	**29,248**	**29,105**	**-143**	**88,659**	**88,154**	**-505**	**357,360**
Pay Costs	-20,566	-20,476	90	-61,879	-61,146	733	-241,875
Ad hoc Costs	0	-38	-38	0	-103	-103	0
Non Pay Costs	-9,707	-9,651	56	-29,188	-29,359	-171	-114,922
3rd Party Costs	-43	-40	3	-64	-55	9	-123
Other	183	183	0	550	550	0	2,200
Total Direct Costs	**-30,133**	**-30,022**	**111**	**-90,581**	**-90,113**	**468**	**-354,720**
Surplus/- Deficit from Operations	**-885**	**-917**	**-32**	**-1,922**	**-1,959**	**-37**	**2,640**
P/L on Asset Disposal	0	0	0	0	0	0	0
Depreciation	-1,049	-1,031	18	-3,146	-3,093	53	-12,585
Impairment	0	0	0	0	0	0	0
PDC Dividend	-676	-689	-13	-2,028	-2,067	-39	-8,272
Interest	-25	-29	-4	-74	-82	-8	-295
Total Indirect Costs	**-1,750**	**-1,749**	**1**	**-5,248**	**-5,242**	**6**	**-21,152**
Total Costs	**-31,883**	**-31,771**	**112**	**-95,829**	**-95,355**	**474**	**-375,872**
Net Surplus/-Deficit	**-2,635**	**-2,666**	**-31**	**-7,170**	**-7,201**	**-31**	**-18,512**
Donated Asset/Impairment Adjustment	0	104	104	0	257	257	0
Adjusted Net Surplus/-Deficit	**-2,635**	**-2,562**	**73**	**-7,170**	**-6,944**	**226**	**-18,512**

Cash Flow – June 2014

Headlines

- The cash flow statement has been revised this month to bring the layout into line with the external reporting format to the Trust Development Authority (TDA).
- The opening cash balance of £2.3m is currently planned to be reduced to £1.0m at year-end.
- Temporary revenue PDC is planned to be received quarterly in arrears to finance the annual deficit plan. Clinical strategy capital PDC of £17.4m is also planned to be received during the financial year.

Cash Flow Statement April 2014 to March 2015

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2015	Feb	Mar
Cash Flow from Operations												
Operating Surplus/(Deficit)	-1,719	-1,385	-1,948	304	-1,185	-1,583	576	181	-1,553	607	-1,432	-808
Depreciation and Amortisation	1,031	1,031	1,031	1,048	1,048	1,048	1,048	1,048	1,048	1,048	1,048	1,108
Interest Paid	-31	-31	-31	-10	-5	-5	-5	-5	-5	-5	-5	-9
Dividend (Paid)/Refunded						-4,137						-4,136
(Increase)/Decrease in Inventories	-279	34	255	-10								0
(Increase)/Decrease in Trade and Other Receivables	1,954	2,301	-4,770	92	91	921	91	91	92	91	92	880
Increase/(Decrease) in Trade and Other Payables	1,719	440	1,369	-1,333	2,777	-7,555	-5,950	3,226	-2,401	1,602	31	3,475
Provisions Utilised	125	14	16	-19	-19	-18	-19	-19	-19	-19	-19	-231
Net Cash Inflow/(Outflow) from Operating Activities	**2,799**	**2,403**	**-4,077**	**72**	**2,707**	**-11,329**	**-4,259**	**4,522**	**-2,838**	**3,324**	**-285**	**279**
Cash Flows from Investing Activities:												
Interest Received	6	3	2	2	2	2	2	1	1	1	1	1
(Payments) for Property, Plant and Equipment	-1,132	-1,060	-1,408	-4,191	-2,511	-946	-3,342	-4,413	-2,169	-1,474	-1,268	-4,125
(Payments) for Intangible Assets	-29	-42	-50	-40	-40	-40	-40	-40	-40	-40	-40	-40
Net Cash Inflow/(Outflow) from Investing Activities	**-1,156**	**-1,099**	**-1,456**	**-4,229**	**-2,549**	**-984**	**-3,380**	**-4,452**	**-2,208**	**-1,513**	**-1,307**	**-4,164**
Net Cash Inflow/(Outflow) before Financing	**1,644**	**1,304**	**-5,533**	**-4,157**	**158**	**-12,313**	**-7,639**	**70**	**-5,046**	**1,811**	**-1,592**	**-3,885**
New Temporary PDC	0	0	5,000	0	0	4,628	0	0	4,628	0	0	4,256
Repayment for Temporary PDC	0	0	0	0	0	0	0	0	0	0	0	-18,512
New Permanent PDC	0	0	0	0	0	17,400	0	0	0	0	0	18,512
Loans and Finance Lease repaid	-76	0	0	0	0	-945	0	0	0	0	0	-970
Net Cash Inflow/(Outflow) from Financing Activities	**-76**	**0**	**5,000**	**0**	**0**	**21,083**	**0**	**0**	**4,628**	**0**	**0**	**3,286**
Net Increase/(Decrease) in Cash	**1,568**	**1,304**	**-533**	**-4,157**	**158**	**8,770**	**-7,639**	**70**	**-418**	**1,811**	**-1,592**	**-599**
Opening balance	2,257	3,825	5,129	4,596	439	597	9,367	1,728	1,798	1,380	3,191	1,599
Closing balance	3,825	5,129	4,596	439	597	9,367	1,728	1,798	1,380	3,191	1,599	1,000

Balance Sheet – June 2014

Headlines

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

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Non Current Assets			
Property plant and equipment	257,258	255,698	279,286
Intangilble Assets	826	947	1,593
Trade and other Receivables	708	708	647
	258,792	**257,353**	**281,526**
Current Assets			
Inventories	6,238	6,229	6,511
Trade and other receivables	25,426	25,941	20,274
Other current assets	0	0	0
Cash and cash equivalents	2,257	4,596	1,000
	33,921	**36,766**	**27,785**
Current Liabilities			
Trade and other payables	-32,063	-35,590	-29,652
DoH Loan	-1,674	-1,674	-340
Borrow ings - Finance Leases	-320	-320	-320
Provisions	-462	-617	-483
	-34,519	**-38,201**	**-30,795**
Non Current Liabilities			
DoH Loan	-3,535	-3,535	-3,198
Borrow ings - Finance Leases	-598	-522	-282
Provisions	-2,632	-2,632	-2,435
	-6,765	**-6,689**	**-5,915**
Total Assets Employed	**251,429**	**249,229**	**272,601**

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Financed by			
Public Dividend Capital (PDC)	-153,130	-158,130	-189,042
Revaluation Reserve	-106,395	-106,396	-109,885
Income & Expenditure Reserve	8,096	15,297	26,326
Total Tax Payers Equity	**-251,429**	**-249,229**	**-272,601**

Key Performance Indicators – June 2014

TDA Finance Risk Assessment Criteria.

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

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

• 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 Continuity of Service Risk Rating.

• The Trust has a liquidity ratio rating of 2 and a capital servicing ratio of 1, resulting in an overall rating of 2. This overall rating is classified by Monitor as representing a material level of financial risk.

Better Payments Practice Code (BPPC)
•Systems and procedures are currently being strengthened to ensure better performance against the Better Payments Practice Code (BPPC).

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

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

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	85	95
BPPC – NHS Invoices by value (%)	54	95

Activity & Contract Income – June 2014

Headlines

- Contract activity income is £487k below plan in the month and this has reduced the YTD performance to £27k above plan.
- Tariff-excluded drugs and devices income has a neutral impact on ESHT as they are offset by expenditure. After allowing for these areas, total contract income is £516k below planned levels.
- Total Inpatient activity is £473k below plan in June. There are 6,186 un-coded spells for which the income has been estimated, and therefore these figures are subject to significant change. Elective Activity YTD is £126k below plan in month and £498k YTD, the main area being T&O, which is 148 spells below the same period last year and 227 spells below plan this year.
- Re-admissions fines have been accrued based on agreed planning assumptions.
- CQUIN performance is based on ESHT achieving 100%.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,379	3,311	-68	9,829	10,750	921
Elective Inpatients	816	789	-27	2,373	2,208	-165
Emergency Inpatients	3,495	3,439	-56	10,602	10,710	108
Total Inpatients	**7,690**	**7,539**	**-151**	**22,803**	**23,668**	**865**
Excess Bed Days	2,461	2,684	223	7,441	6,342	-1,099
Total Excess Bed Days	**2,461**	**2,684**	**223**	**7,441**	**6,342**	**-1,099**
Consultant First Attendances	6,173	7,828	1,655	17,978	22,513	4,535
Consultant Follow Ups	10,877	11,592	715	31,665	34,544	2,879
OP Procedures	4,884	4,670	-214	14,255	13,825	-430
Other Outpatients inc WA & Nurse Led	6,857	4,931	-1,926	34,726	29,470	-5,256
Community Specialist	259	215	-44	752	672	-80
Total Outpatients	**29,050**	**29,236**	**186**	**99,377**	**101,024**	**1,647**
Chemotherapy Unbundled HRGs	499	-6	-505	1,450	1,010	-440
Antenatal Pathways	362	327	-35	1,053	952	-101
Post-natal Pathways	322	228	-94	934	802	-132
A&E Attendances (excluding type 2's)	8,931	9,077	146	26,683	26,808	125
ITU Bed Days	613	587	-26	1,666	1,457	-209
SCBU Bed Days	238	-49	-287	713	638	-75
Cardiology - Direct Access	82	40	-42	237	181	-56
Radiology - Direct Access	4,948	5,074	126	14,371	14,603	232
Pathology - Direct Access	299,647	271,248	-28,399	870,404	798,070	-72,334
Therapies - Direct Access	3,623	3,230	-393	10,523	9,505	-1,018

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,603	4,477	-126	13,382	12,884	-498
Inpatients - Emergency	6,364	6,017	-347	18,703	18,873	170
Excess Bed Days	563	641	78	1,703	1,442	-261
Outpatients	3,786	3,925	139	11,021	11,558	537
Other Acute based Activity	2,659	2,324	-335	7,663	7,042	-621
Direct Access	824	789	-35	2,396	2,296	-100
Block Contract	5,409	6,473	1,064	16,794	18,066	1,272
Re-admissions	0	-217	-217	0	-550	-550
Other	415	-364	-779	592	127	-465
CQUIN	592	712	120	1,792	1,792	0
Subtotal	25,215	24,777	-438	74,046	73,530	-516
Exclusions	2,084	2,035	-49	6,253	6,796	543
GRAND TOTAL	**27,299**	**26,812**	**-487**	**80,299**	**80,326**	**27**

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

Headlines

Clinical Units (CUs)

The overall clinical unit performance was an over spending of £337k in the month which has resulted in a YTD over spending of £620k. The principal factors being an under spending on pay offset by non pay overspendings and adverse contract income performance.

Commercial Directorate

The Commercial Directorate is underspent by £37k year to date largely due to Facilities ancillary non pay budgets under spending.

Corporate Services

Corporate Services above plan year to date by £558k principally due to the timing of income.

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
Acute & Emergency Medicine	2,317	2,186	-131	6,943	5,805	-1,138
Specialist Medicine	255	250	-5	284	1,172	888
Cardiovascular	-106	-298	-192	-405	-381	24
Surgery	2,459	2,413	-46	7,056	7,359	303
Women & Children	2,048	1,892	-156	3,791	3,660	-131
Out of Hospital Care	462	410	-52	1,320	1,112	-208
Theatres	-2,588	-2,354	234	-8,040	-7,974	66
MSK	1,918	1,828	-90	5,546	5,105	-441
COO Operations	-2,007	-1,904	103	-6,223	-6,176	47
Clinical Support	-1,308	-1,310	-2	-2,603	-2,633	-30
Total Clinical Units	**3,450**	**3,113**	**-337**	**7,669**	**7,049**	**-620**
Commercial Directorate	-2,406	-2,431	-25	-7,089	-7,052	37
Corporate Services	-1,750	-2,200	-450	-5,063	-5,621	-558
Tariff-Excluded Drugs & Devices	-2,006	-1,954	52	-6,767	-6,715	52
Central Items	-1,526	-1,779	-253	-4,969	-5,138	-169
	-7,688	**-8,364**	**-676**	**-23,888**	**-24,526**	**-638**
Income	1,603	2,585	982	9,049	10,276	1,227
Donated Asset/Impairment Adjustment	0	104	104	0	257	257
Total	**-2,635**	**-2,562**	**73**	**-7,170**	**-6,944**	**226**

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
433	442	Acute & Emergency Medicin	-1,654	-1,680	-26	-5,042	-5,041	1
528	520	Specialist Medicine	-1,635	-1,646	-11	-5,359	-5,336	23
338	350	Cardiovascular	-1,226	-1,265	-39	-3,752	-3,791	-39
474	482	Surgery	-2,018	-2,068	-50	-6,150	-6,124	26
626	608	Women & Children	-2,312	-2,284	28	-7,108	-7,005	103
854	843	Out of Hospital Care	-2,426	-2,458	-32	-7,335	-7,493	-158
545	518	Theatres	-2,147	-2,131	16	-6,562	-6,495	67
210	197	MSK	-845	-799	46	-2,575	-2,477	98
481	444	COO Operations	-1,776	-1,715	61	-5,374	-5,277	97
396	409	Clinical Support	-1,259	-1,272	-13	-2,478	-2,507	-29
4,884	**4,813**	**Total Clinical Units**	**-17,298**	**-17,318**	**-20**	**-51,735**	**-51,546**	**189**
825	846	Commercial Directorate	-1,613	-1,672	-59	-4,873	-4,981	-108
507	480	Corporate Services	-1,550	-1,511	39	-4,498	-4,476	22
1,332	**1,326**	**Total Non-Clinical Divisions**	**-3,163**	**-3,183**	**-20**	**-9,371**	**-9,457**	**-86**
		Central Items	-105	-13	92	-773	-246	527
6,217	**6,139**	**Total Pay Analysis**	**-20,566**	**-20,514**	**52**	**-61,879**	**-61,249**	**630**

Clinical Unit Performance (budgets) Acute & Emergency Medicine – June 2014

Headlines

Pay

Overall pay for Acute & Emergency medicine overspent by £26k in the month due to Agency in A&E covering Medical and Nursing vacancies.

Non Pay

Non pay underspent in the month by £10k which has reduced the cumulatively overspending to £4k.

Divisional Income

Contract income was below plan by £114k in the month and is now £1.1m below plan YTD.

Workforce Plan FTE	Workforce Actual FTE	Acute & Emergency Medicine	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	4,059	3,945	-114	12,250	11,119	-1,131
		Other Income	3	2	-1	8	4	-4
		Total Income	**4,062**	**3,947**	**-115**	**12,258**	**11,123**	**-1,135**
433	442	Pay	-1,654	-1,680	-26	-5,042	-5,041	1
		Non pay	-91	-81	10	-273	-277	-4
433	**442**	**Total Expenditure**	**-1,745**	**-1,761**	**-16**	**-5,315**	**-5,318**	**-3**
433	**442**	**Gross Margin**	**2,317**	**2,186**	**-131**	**6,943**	**5,805**	**-1,138**

Clinical Unit Performance (budgets) Specialist Medicine – June 2014

Headlines

Pay

Pay overspent by £11k in the month principally due to agency expenditure. Cumulatively pay remains underspent by £23k YTD.

Non Pay

Non-Pay underspent by £7k in the month.

Income

Contract income was above plan by £8k in month and is now £881k above plan YTD. Activity is up 102 spells, and £280k on Q1 13/14.

Workforce Plan FTE	Workforce Actual FTE	Specialist Medicine	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	2,037	2,045	8	5,987	6,868	881
		Other Income	180	171	-9	541	524	-17
		Total Income	**2,217**	**2,216**	**-1**	**6,528**	**7,392**	**864**
528	520	Pay	-1,635	-1,646	-11	-5,359	-5,336	23
		Non pay	-327	-320	7	-885	-884	1
528	**520**	**Total Expenditure**	**-1,962**	**-1,966**	**-4**	**-6,244**	**-6,220**	**24**
528	**520**	**Gross Margin**	**255**	**250**	**-5**	**284**	**1,172**	**888**

Clinical Unit Performance (budgets) Cardiovascular – June 2014

Headlines

Pay

Pay overspent by £39k in the month due to medical agency cover.

Non Pay

Non pay budgets are underspent by £17k due to cardiology consumables and Michelham expenditure. Cumulatively the under spending has increased to £42k.

Income

Contract income has underachieved by £94k in month but remains above plan by £196k YTD.

Other income under achieved by £76k in the month. The Michelham unit had 65% under occupancy during June.

Workforce Plan FTE	Workforce Actual FTE	Cardiovascular	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	1,340	1,246	-94	3,959	4,155	196
		Other Income	203	127	-76	656	481	-175
		Total Income	**1,543**	**1,373**	**-170**	**4,615**	**4,636**	**21**
338	350	Pay	-1,226	-1,265	-39	-3,752	-3,791	-39
		Non pay	-423	-406	17	-1,268	-1,226	42
338	**350**	**Total Expenditure**	**-1,649**	**-1,671**	**-22**	**-5,020**	**-5,017**	**3**
338	**350**	**Gross Margin**	**-106**	**-298**	**-192**	**-405**	**-381**	**24**

Clinical Unit Performance (budgets) Surgery – June 2014

Headlines

Pay

Pay overspent by £50k in the month but remains underspent by £26k year to date. The Overspending in the month was in respect of medical agency cover.

Non Pay

Non pay underspent by £30k in the month due to low hearing aid expenditure.

Income

Contract income has underachieved by £32k in the month, but remains overachieved by £229k YTD.

Workforce Plan FTE	Workforce Actual FTE	Surgery	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	4,713	4,681	-32	13,893	14,122	229
		Other Income	45	51	6	133	139	6
		Total Income	**4,758**	**4,732**	**-26**	**14,026**	**14,261**	**235**
474	482	Pay	-2,018	-2,068	-50	-6,150	-6,124	26
		Non pay	-281	-251	30	-820	-778	42
474	**482**	**Total Expenditure**	**-2,299**	**-2,319**	**-20**	**-6,970**	**-6,902**	**68**
474	**482**	**Gross Margin**	**2,459**	**2,413**	**-46**	**7,056**	**7,359**	**303**

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

Headlines

Pay

Pay underspent in month by £28k predominantly due to midwifery & paediatric medical vacancies.

Non Pay

Surplus variance of £24k in June due to in month activity reduction in relation to Sexual Health drugs.

Income

Contract income underachieved by £220k in the month and is YTD £274 below plan.

Other income was above plan by £12k in the month.

Workforce Plan FTE	Workforce Actual FTE	Women & Children	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	4,676	4,456	-220	11,830	11,556	-274
		Other Income	36	48	12	109	135	26
		Total Income	**4,712**	**4,504**	**-208**	**11,939**	**11,691**	**-248**
626	608	Pay	-2,312	-2,284	28	-7,108	-7,005	103
		Non pay	-352	-328	24	-1,040	-1,026	14
626	**608**	**Total Expenditure**	**-2,664**	**-2,612**	**52**	**-8,148**	**-8,031**	**117**
626	**608**	**Gross Margin**	**2,048**	**1,892**	**-156**	**3,791**	**3,660**	**-131**

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

Headlines

Pay

Pay overspent by £32k in Month 3 largely due to the Enhanced and District Nursing Service being above planned establishment levels (£35k). Therapies underspend in month by £20k due to vacancies. Year to date position for the clinical unit is £158k above plan.

Non Pay

£6k underspent against the plan for June.

Income

Contract income is £11k underachieved in the month.

Workforce Plan FTE	Workforce Actual FTE	Out of Hospital Care	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	3,255	3,244	-11	9,757	9,729	-28
		Other Income	109	94	-15	327	297	-30
		Total Income	**3,364**	**3,338**	**-26**	**10,084**	**10,026**	**-58**
854	843	Pay	-2,426	-2,458	-32	-7,335	-7,493	-158
		Non pay	-476	-470	6	-1,429	-1,421	8
854	**843**	**Total Expenditure**	**-2,902**	**-2,928**	**-26**	**-8,764**	**-8,914**	**-150**
854	**843**	**Gross Margin**	**462**	**410**	**-52**	**1,320**	**1,112**	**-208**

Clinical Unit Performance (budgets) Theatres – June 2014

Headlines

Pay

Pay underspent by £16k in the month due to medical and ITU nursing under spending against establishment plan.

Non Pay

Non pay underspent by £155k in the month due to low expenditure on prosthesis, theatre supplies recharges and equipment.

Income

Contract income was above plan by £70k in the month, reducing YTD adverse variance to £252k.

Workforce Plan FTE	Workforce Actual FTE	Theatres	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Contract Income	813	883	70	2,211	1,959	-252
		Other Income	12	5	-7	36	13	-23
		Total Income	**825**	**888**	**63**	**2,247**	**1,972**	**-275**
545	518	Pay	-2,147	-2,131	16	-6,562	-6,495	67
		Non pay	-1,266	-1,111	155	-3,725	-3,451	274
545	**518**	**Total Expenditure**	**-3,413**	**-3,242**	**171**	**-10,287**	**-9,946**	**341**
545	**518**	**Gross Margin**	**-2,588**	**-2,354**	**234**	**-8,040**	**-7,974**	**66**

Clinical Unit Performance (budgets) MSK – June 2014

Headlines

Pay

Pay underspent by £46k in the month with under spending on Benson and Cookson Devas wards due to vacancies and low use of medical cover.

Non Pay

Non pay overspent by £4k in the month.

Income

Contract income has underachieved by £128k in the month, increasing YTD position to £536k below plan.

Workforce Plan FTE	Workforce Actual FTE	MSK	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	2,821	2,693	-128	8,297	7,761	-536
		Other Income	4	0	-4	14	9	-5
		Total Income	**2,825**	**2,693**	**-132**	**8,311**	**7,770**	**-541**
210	197	Pay	-845	-799	46	-2,575	-2,477	98
		Non pay	-62	-66	-4	-190	-188	2
210	**197**	**Total Expenditure**	**-907**	**-865**	**42**	**-2,765**	**-2,665**	**100**
210	**197**	**Gross Margin**	**1,918**	**1,828**	**-90**	**5,546**	**5,105**	**-441**

Clinical Unit Performance (budgets) Clinical Support – June 2014

Headlines

Pay

Pay underspend of £61k in June due to vacancies across the clinical unit.

Non Pay

Non-pay expenditure was £40k under plan in month. This was largely due to a reduction in drug expenditure and increased activity recharge within the Pharmacy manufacturing Unit (PMU).

Income

Contract income was below plan by £37k YTD.

Other income above plan by £39k mainly due to PMU activity increase.

Workforce Plan FTE	Workforce Actual FTE	Clinical Support	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	1,108	1,071	-37	3,223	3,069	-154
		Other Income	318	357	39	892	969	77
		Total Income	**1,426**	**1,428**	**2**	**4,115**	**4,038**	**-77**
481	444	Pay	-1,776	-1,715	61	-5,374	-5,277	97
		Non pay	-1,657	-1,617	40	-4,964	-4,937	27
481	**444**	**Total Expenditure**	**-3,433**	**-3,332**	**101**	**-10,338**	**-10,214**	**124**
481	**444**	**Gross Margin**	**-2,007**	**-1,904**	**103**	**-6,223**	**-6,176**	**47**

Clinical Unit Performance (budgets) COO Operations – June 2014

Headlines

Pay

The new Chief Operating Officer area was overspent by £13k in the month.

The pay pressures in the areas are Clinical Administration booking room. £7k and Temporary Workforce Services (TWS) bank support £4k.

Non Pay

Non pay was under by £4k.

Workforce Plan FTE	Workforce Actual FTE	COO Operations	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Contract Income	6	6	0	6	6	0
		Other Income	4	11	7	26	23	-3
		Total Income	**10**	**17**	**7**	**32**	**29**	**-3**
396	409	Pay	-1,259	-1,272	-13	-2,478	-2,507	-29
		Non pay	-59	-55	4	-157	-155	2
396	**409**	**Total Expenditure**	**-1,318**	**-1,327**	**-9**	**-2,635**	**-2,662**	**-27**
396	**409**	**Gross Margin**	**-1,308**	**-1,310**	**-2**	**-2,603**	**-2,633**	**-30**

Divisional Performance (budgets) Commercial Directorate – June 2014

Headlines

Pay

Pay in month was £59k overspent due to porters & housekeeping expenditure above plan. The year to date position is now £108k above plan.

Non Pay

In June the non pay was under spent by £44k. This was due to Estates Property & catering provisions in month, resulting in a YTD under spending of £162k.

Divisional Income

Commercial income has under achieved due to below plan accommodation and car parking income.

Workforce Plan FTE	Workforce Actual FTE	Commercial Directorate	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	686	674	-12	2,093	2,076	-17
		Total Income	**686**	**674**	**-12**	**2,093**	**2,076**	**-17**
825	846	Pay	-1,613	-1,672	-59	-4,873	-4,981	-108
		Non pay	-1,478	-1,434	44	-4,309	-4,147	162
825	**846**	**Total Expenditure**	**-3,091**	**-3,106**	**-15**	**-9,182**	**-9,128**	**54**
825	**846**	**Gross Margin**	**-2,405**	**-2,432**	**-27**	**-7,089**	**-7,052**	**37**

Divisional Performance (budgets) Corporate Services – June 2014

Headlines

Pay

Pay was underspent by £39k in the month, mainly in the Nurse Training & Finance. Taking the YTD position to £22k

Non Pay

Non pay was under spent by £19k in relation to Hosted funds budgets.

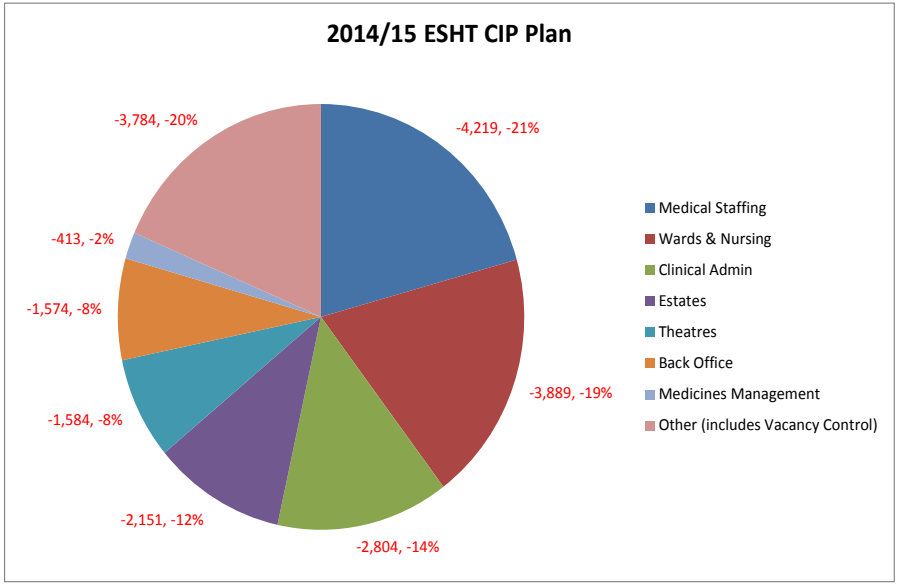
Income

YTD income is below plan by £503k.

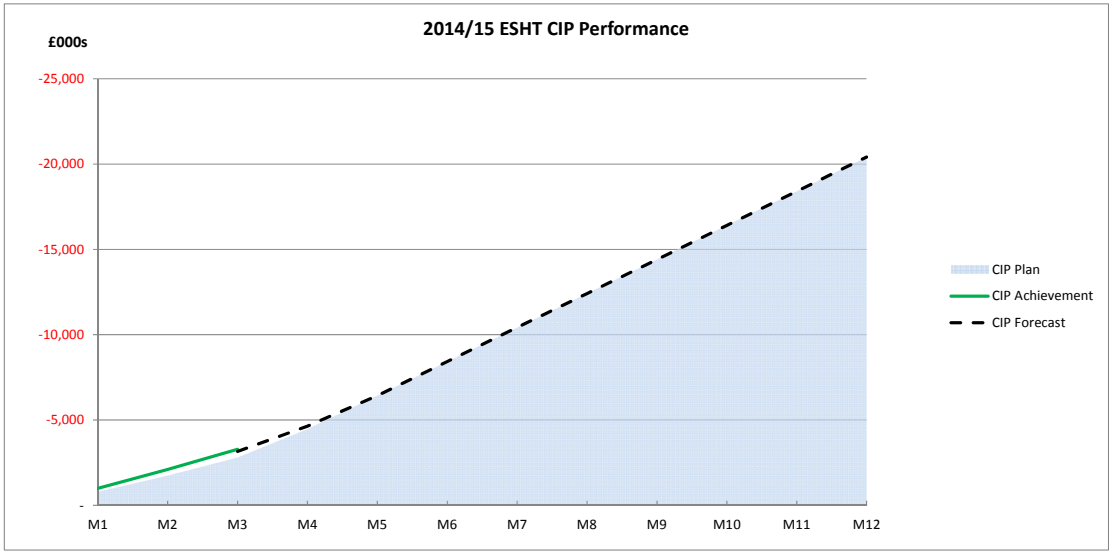
Workforce Plan FTE	Workforce Actual FTE	Corporate Services	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	1,216	710	-506	3,365	2,862	-503
		Total Income	**1,216**	**710**	**-506**	**3,365**	**2,862**	**-503**
507	480	Pay	-1,550	-1,511	39	-4,498	-4,476	22
		Non pay	-1,416	-1,399	17	-3,930	-4,007	-77
507	**480**	**Total Expenditure**	**-2,966**	**-2,910**	**56**	**-8,428**	**-8,483**	**-55**
507	**480**	**Gross Margin**	**-1,750**	**-2,200**	**-450**	**-5,063**	**-5,621**	**-558**

2014/15 ESHT CIP Plan

Themes	Full Year Plan	Key Dates	Status
Medical Staffing	-4,219	ongoing	
Wards & Nursing	-3,889	Jul-14	
Clinical Admin	-2,804	Jul-14	
Estates	-2,151	ongoing	
Theatres	-1,584	Jul-14	
Back Office	-1,574	Aug-14	
Medicines Management	-413	Jun-14	
Other (Includes Vacancy Control)	-3,784	ongoing	



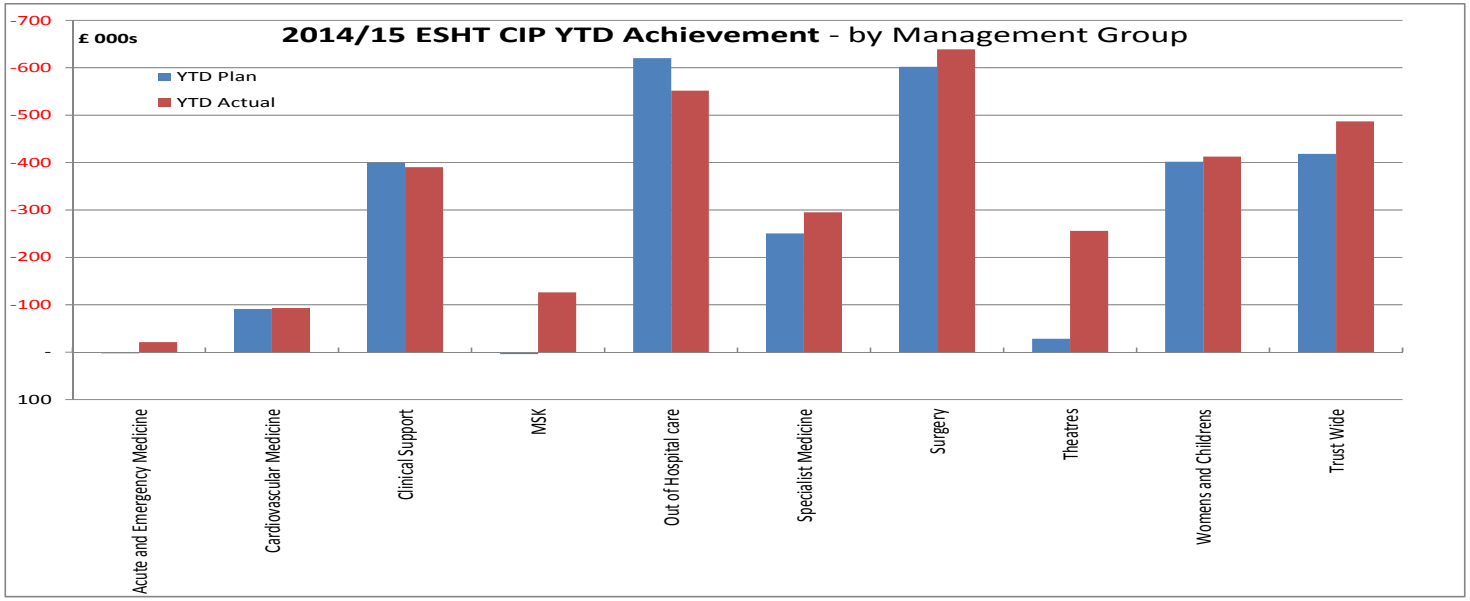
2014/15 ESHT CIP Performance to date – M3



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

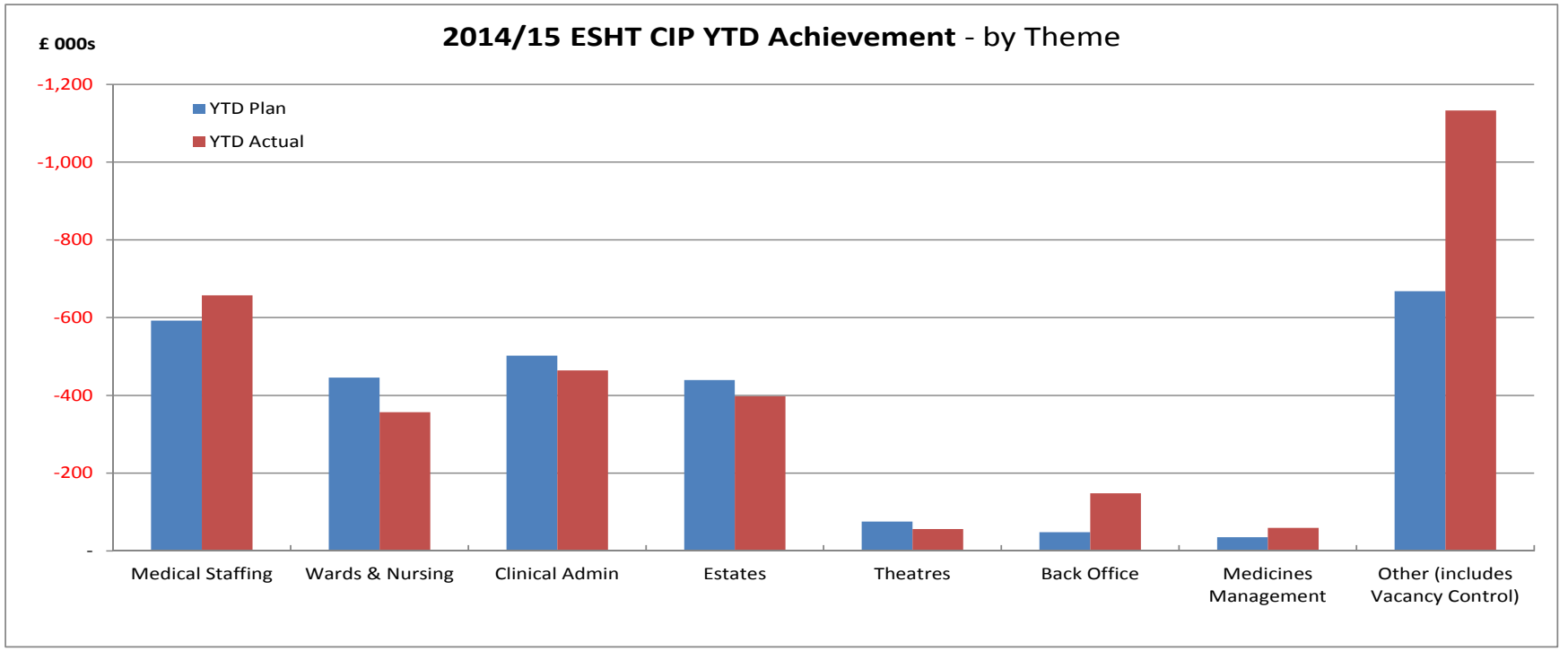
2014/15 ESHT CIP Performance by Management Group – M3

	In Month			Year to Date			Forecast		
Management Groups	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Full Year Plan	Full Year Forecast	Full Year Variance
Acute and Emergency Medicine	-4	4	-8	2	-21	23	-474	-474	-
Cardiovascular Medicine	-30	-30	-	-91	-93	2	-650	-650	-
Central	137	159	-22	494	445	49	1,442	1,442	-
Clinical Administration	-123	-123	-	-306	-313	7	-2,222	-2,222	-
Clinical Support	-165	-171	6	-400	-390	-10	-1,783	-1,783	-
Commercial Directorate	-157	-84	-73	-471	-398	-73	-2,276	-2,276	-
Corporate Services	-45	-102	57	-135	-221	85	-1,924	-1,924	-
MSK	3	-57	60	4	-126	130	-299	-299	-
Out of Hospital care	-212	-227	15	-620	-552	-68	-2,761	-2,761	-
Specialist Medicine	-84	-93	9	-251	-295	45	-3,181	-3,181	-
Surgery	-227	-193	-34	-602	-639	37	-3,038	-3,038	-
Theatres	-9	-104	95	-28	-256	227	-1,397	-1,397	-
Womens and Childrens	-147	-150	3	-402	-413	11	-1,853	-1,853	-
Total	-1,063	-1,169	106	-2,806	-3,272	466	-20,417	-20,417	-



2014/15 ESHT CIP Performance by Theme – M3

	In Month			Year to Date			Forecast		
TDA Theme	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Full Year Plan	Full Year Forecast	Full Year Variance
Back Office	-273	-347	74	-751	-808	57	-5,271	-5,271	-
Clinical Services Productivity	-269	-250	-18	-761	-842	81	-5,686	-5,686	-
Clinical Services VFM	-336	-358	22	-825	-1,009	185	-6,572	-6,572	-
Estates Non Pay Total	-80	22	-102	-239	-202	-37	-1,258	-1,258	-
Medicines Mgt Total	-42	-49	7	-35	-59	24	-413	-413	-
Procurement	-63	-186	123	-195	-351	156	-1,217	-1,217	-
Total	-1,063	-1,169	106	-2,806	-3,272	466	-20,417	-20,417	-



Year on Year Comparisons – June 2014

Headlines

- Total Inpatients activity was 1.4% higher than last year's activity level.
- Total outpatients were 9.2% lower than last year.
- YTD A&E attendances were 3.7% higher than last year.

Activity	2014/15 YTD Actual	2013/14 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Planned Same Day	10,750	10,684	66	0.6%
Elective Inpatients	2,208	2283	-75	-3.3%
Emergency Inpatients	10,710	10,383	327	3.1%
Total Inpatients	**23,668**	**23,350**	**318**	**1.4%**
Elective Excess Bed Days	483	650	-167	-25.7%
Non elective Excess Bed Days	5,859	8,139	-2,280	-28.0%
Total Excess Bed Days	**6,342**	**8,789**	**-2,447**	**-27.8%**
Consultant First Attendances	22,513	22,758	-245	-1.1%
Consultant Follow Ups	34,544	37,034	-2,490	-6.7%
OP Procedures	13,825	12,459	1,366	11.0%
Other Outpatients (WA & Nurse Led)	29,470	38,416	-8,946	-23.3%
Community Specialist	672	566	106	18.7%
Total Outpatients	**101,024**	**111,233**	**-10,209**	**-9.2%**
A&E Attendances	26,808	25,858	950	3.7%
ITU Bed Days	1,457	1,577	-120	-7.6%
SCBU Bed Days	638	780	-142	-18.2%
Cardiology - Direct Access	181	260	-79	-30.4%
Radiology - Direct Access	14,603	14,864	-261	-1.8%
Pathology - Direct Access	798,070	820,181	-22,111	-2.7%
Therapies - Direct Access	9,505	11,555	-2,050	-17.7%

£000s	2014/15 YTD Actual	2013/14 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	80,326	80,542	-216	-0.3%
Private Patient/ RTA	585	526	59	11.2%
Trading Income	1,210	1,133	77	6.8%
Other Non Clinical Income	6,033	6,441	-408	-6.3%
Total Income	**88,154**	**88,642**	**-488**	**-0.6%**
Pay Costs	-61,249	-64,826	3,577	-5.5%
Non Pay Costs	-29,414	-28,222	-1,192	4.2%
Other	550	250	300	120.0%
Total Direct Costs	-90,113	-92,798	2,685	-2.9%
Surplus/-Deficit from Operations	**-1,959**	**-4,156**	**2,197**	**-52.9%**
Profit/Loss on Asset Disposal	0	0	0	
Depreciation	-3,093	-2,996	-97	3.2%
Impairment	0		0	
PDC Dividend	-2,067	-1,456	-611	42.0%
Interest	-82	-56	-26	46.4%
Total Indirect Costs	-5,242	-4,508	-734	16.3%
Total Costs	**-95,355**	**-97,306**	**1,951**	**-2.0%**
Net Surplus/-Deficit	**-7,201**	**-8,664**	**1,463**	**-16.9%**
Donated Asset / Other Adjustment	257	23	234	1017.4%
Normalised Net Surplus/-Deficit	**-6,944**	**-8641**	**1,697**	**-19.6%**

Capital Programme – June 2014

Headlines

Year to Date performance:-
After three months of the financial year capital expenditure amounts to £1.6m.

Commitments entered into total £5.3m compared to the total capital resource of £28.3m. This planned total capital resource of £28.3m includes assumed clinical strategy additional exceptional public dividend capital (PDC) of £17.4m. However, the final decision on clinical strategy full business case, submitted to the Trust Development Authority (TDA) in 2013/14, is yet to be notified to the Trust. Essential planned clinical strategy enabling works are therefore currently being funded from the Trust's routine capital programme.

The current over planning margin of £0.8m is considered acceptable at this stage of the financial year but will require careful management during the year to ensure the Trust does not exceed its capital resource limit.

The Capital Approvals Group (CAG) will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital.

Capital Investment Programme £000s	2014/15 Capital Programme	Expenditure at Month 3
Capital Resources		
Depreciation	11,285	
Clinical Strategy exceptional additional PDC	17,400	
League of Friends Support	1,300	
Cap Investmnt Loan Principal Repayment	-340	
Gross Capital Resource	29,645	
Less Donated Income	-1,300	
Capital Resource Limit (CRL)	**28,345**	**-**
Capital Investment		
Clinical Strategy Reconfiguration	17,400	
Clinical Strategy Essential Enabling Works	250	78
Medical Equipment	2,599	119
Information Systems	895	256
Electronic Document Management	200	16
Child Health Information System	619	138
Backlog Maintenance	1,071	
Infrastructure Improvements - Infection Control	700	
Electrical Supply to DGH	600	
Minor Capital Schemes	2,200	550
Pevensey Ward	1,000	1
Other various	711	208
Brought Forward Schemes	811	220
Sub Total	**29,056**	**1,586**
Donated Asset Purchases	1,300	78
Donated Asset Funding	-1,300	-78
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**29,056**	**1,586**
Overplanning Margin (-) Underplanning (+)	-711	
Net Capital Charge against the CRL	**28,345**	**1,586**

Continuity of Service Risk Ratings – June 2014

Headlines

Continuity of Service Risk Ratings (COS):-

- Liquidity (days)
  - Days of operating costs held in cash or cash equivalent forms.

- Capital service capacity ratio (times)
  - The degree to which the organisation's generated income covers its financial obligations.

- Monitor assigns ratings between 1 and 4 to each component of the continuity of service risk ratings with 1 being the worst rating and 4 the best. The overall rating is the average of the two.

- The Trust has a liquidity ratio of -8 days, a rating of 2.

- The capital servicing ratio of -0.90 results in a rating of 1.

- As a result the overall Trust rating is 2. This rating is classified as representing a material level of financial risk.

Liquidity Ratio (days) £000s	2013/14 Outturn	2014/15 YTD
Opening Current Assets	33,908	62,726
Opening Current Liabilities	-34,506	-64,161
Net Current Assets/Liabilities	-598	-1,435
Inventories	-6,238	-6,229
Adj Net Current Assets/Liabilities	**-6,836**	**-7,664**
Divided by:		
Total costs in year	369,719	90,113
Multiply by (days)	360	90
Liquidity Ratio	**-7**	**-8**

Capital Servicing Capacity (times) £000s	2013/14 Outturn Actual	2014/15 YTD Plan	2014/15 YTD Actual
Net Surplus / Deficit (-) After Tax	-33,412	-7,170	-7,201
Less:			
Donated Asset Income Adjustment	-999	-325	-77
Interest Expense	305	80	93
Profit/Loss on Sale of Assets	-9	0	0
Depreciation & Amortisation	11,385	3,146	3,093
Impairments	10,018	0	0
PDC Dividend	6,251	2,028	2,067
Revenue Available for Debt Service	**-6,461**	**-2,241**	**-2,025**
Interest Expense	305	80	93
PDC Dividend	6,251	2,028	2,067
Temporary PDC repayment	29,000		
Working capital loan repayment	1,334		
Capital loan repayment	340		80
	37,230	2,108	2,240
Capital Serving Capacity	**-0.17**	**-1.06**	**-0.90**

Financial Risks & Mitigating Actions – June 2014

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

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	ESHT Board
Agenda item:	8b
Subject:	Safe Nurse Staffing levels
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

To update the Board on the progress made towards fulfilling the expectations of NHS England and the National Quality Board (NQB) with regard to safe nurse staffing levels on acute inpatient wards.

To provide information to support the consideration of the nursing, midwifery and care staff workforce capacity from ward to Board, alongside quality indicators.

Introduction:

Following the publication of the Francis Report (2013) and the Berwick Report (2013), there is a NHS England/NQB requirement for Trusts to 'optimise nursing, midwifery and care staff capacity and capability' as it is clearly evidenced that inadequate staffing levels are linked to safety and patient outcomes.

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

Good progress has been made against the key actions in relation to safe staffing levels.

All inpatient areas have a new 'Knowing How We are Doing' board that incorporates the requirement to display information on a shift by shift basis at ward level.

A process has been put in place to complete, as accurately as possible, the NHS England return on staffing levels, with sign off from the nominated Executive.

The escalation process has been agreed and the supporting policy will be finalised by the end of July 2014.

Any numerical data needs to be considered alongside professional judgement. On a daily basis nurse staffing levels are monitored across all sites by 2 nominated senior nurses who utilise professional judgement, alongside ward and department Matrons.

The development of staffing data alongside quality metrics is ongoing and will be supported by a more robust scoring system for wards and departments.

Benefits:

The Trust formally receives information regarding nurse staffing levels for all inpatient areas and is able to consider the impact of capacity.

Risks and Implications
• There is no national RAG rating for the NHS England report as yet • The data sets without narrative could be incorrectly analysed

Assurance Provided:
The Trust has responded to the expectations of the NQB and NHS England and can demonstrate that all inpatient areas are assessed as to their planned and actual staffing levels, within the parameters described above.

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

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

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Alice Webster, Director of Nursing	01424 755255 ext 6302
Liz Fellows, Assistant Director of Nursing	01323 417400 ext 4389

East Sussex Healthcare NHS Trust

SAFE NURSE STAFFING LEVELS

1. Introduction

1.1 Following the publication of the Francis Report (2013) and the Berwick Report (2013), there is a NHS England/NQB requirement for Trusts to 'optimise nursing, midwifery and care staff capacity and capability' as it is clearly evidenced that inadequate staffing levels are linked to safety and patient outcomes.

1.2 There are a number of expectations which are:

- Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.
- Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.
- Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability
- Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.
- A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.
- Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.
- Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.
- NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.
- Providers of NHS services take an active role in securing staff in line with their workforce requirements.
- Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.

1.3 This paper provides a progress report, following the paper received at the Trust Board on 26th March 2014, along with additional information that has since been requested by NHS England, with particular emphasis on the reporting requirements and progress with aspects of the above expectations.

2. Progress against expectations

2.1 Processes to enable staffing establishments to be met on a shift-to-shift basis

The Safe Nursing Staffing levels for Adult Inpatient Areas policy is in final draft stages, subject to approval at the next Trust Nursing, Midwifery and Allied Health Professionals Group. This clarifies responsibilities of individuals in meeting the above expectation along with the escalation process when there are concerns/unresolved issues.

2.2 **Boards receive monthly updates on workforce information, at ward level, on a shift by shift basis alongside quality and safety indicators.**

There are no standard templates to meet this requirement therefore an internal report is being developed to achieve this requirement. The report to analyse this meaningfully is currently in progress with ongoing support from the Knowledge Management team.

From July 2014 the quality performance review for wards and departments will be revised. Subject to evidence wards will be allocated a score based on their quality and safety metrics. It is anticipated that once this system is embedded it will provide an overview of quality to include in the above monthly rather than individual metrics.

2.3 **Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability and the Board will receive a full report on nurse capacity and capability at least every six months.**

A full establishment review was undertaken in March 2014 using the Hurst model, a nationally recognised tool. A further review was planned for September 2014 however additional, evidence based, guidance is being published by NICE with regard to safe staffing levels in the autumn. This guidance will specify a range of tools that can be used, therefore the second establishment review will take place after the guidance is published.

2.4 **NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift**

The Trust have introduced a new 'Knowing How We are Doing' board (Appendix 1) that has been developed in consultation with service users to ensure that the information provided is meaningful to them, whilst meeting mandatory requirements.

3. NHS England Report

3.1 In addition to the above expectations the Trust is required, via Unify, to publish monthly staffing data on the NHS Choices website. This report has been developed in hours rather than shifts as indicated by the NQB. The report is also linked to the Trust's website and can be accessed at http://www.esht.nhs.uk/nursing/staffing-levels/.

3.2 The data was extracted from the Trust's e-rostering system and incorporated temporary workforce and agency staff.

3.3 At present the data is based on the 2013/14 nursing establishments as recruitment to the 2014/15 establishments agreed in March 2014 is ongoing. It is anticipated that ESHT will move to reporting against the 2014/15 establishments in July 2014.

3.4 The data needs to be considered in the context of the following information:

- Whilst the funded establishment is agreed at a fixed level, the actual staffing will vary according to patient acuity, bed occupancy and professional judgement.
- There are operational practices that also influence variations in staffing, such as the delivery of percutaneous coronary intervention service, which alternates from one site to the other on a weekly basis.
- There are a higher number of positive variations due to progress with recruitment to additional post identified for 14/15
- The data has been further refined since last month to reflect changes in staffing establishments, usually at the weekend.

- There is not currently a method for incorporating 1:1 supervision of vulnerable patients into the planned hours which can result in a 'false' positive figure.
- The guidance from NHS England also advises that supervisory time is included, again this may contribute to an enhanced positive figure.
- The data retrieved from e roster cannot be 100% reliable until after the final payroll return. The dates for this do not correspond with the monthly submission dates for Unify therefore there is currently some risk regarding accuracy. Further work to move the Trust to 'real time' use of e roster is underway and will assist in mitigating this risk.
- At present the data cannot be supported with narrative to reflect the above information and professional judgement at the time.

It is not possible to undertake comparison with other organisations due to the lack of consistency in reporting, which is likely to develop further following the publication of the NICE guidance for safer staffing.

4. Conclusions

4.1 The Trust has responded to the expectations of the NQB and NHS England and can demonstrate that all inpatient areas are assessed as to their planned and actual staffing levels in hours, within the parameters described above.

4.2 Any numerical data needs to be considered alongside professional judgement. On a daily basis nurse staffing levels are monitored across all sites by 2 nominated senior nurses, at least 4 times a day, to support safe care and appropriate escalation of concerns.

4.3 Staffing levels, by shift, will be monitored alongside quality metrics and where necessary actions will be taken to address areas of concern and share good practice.

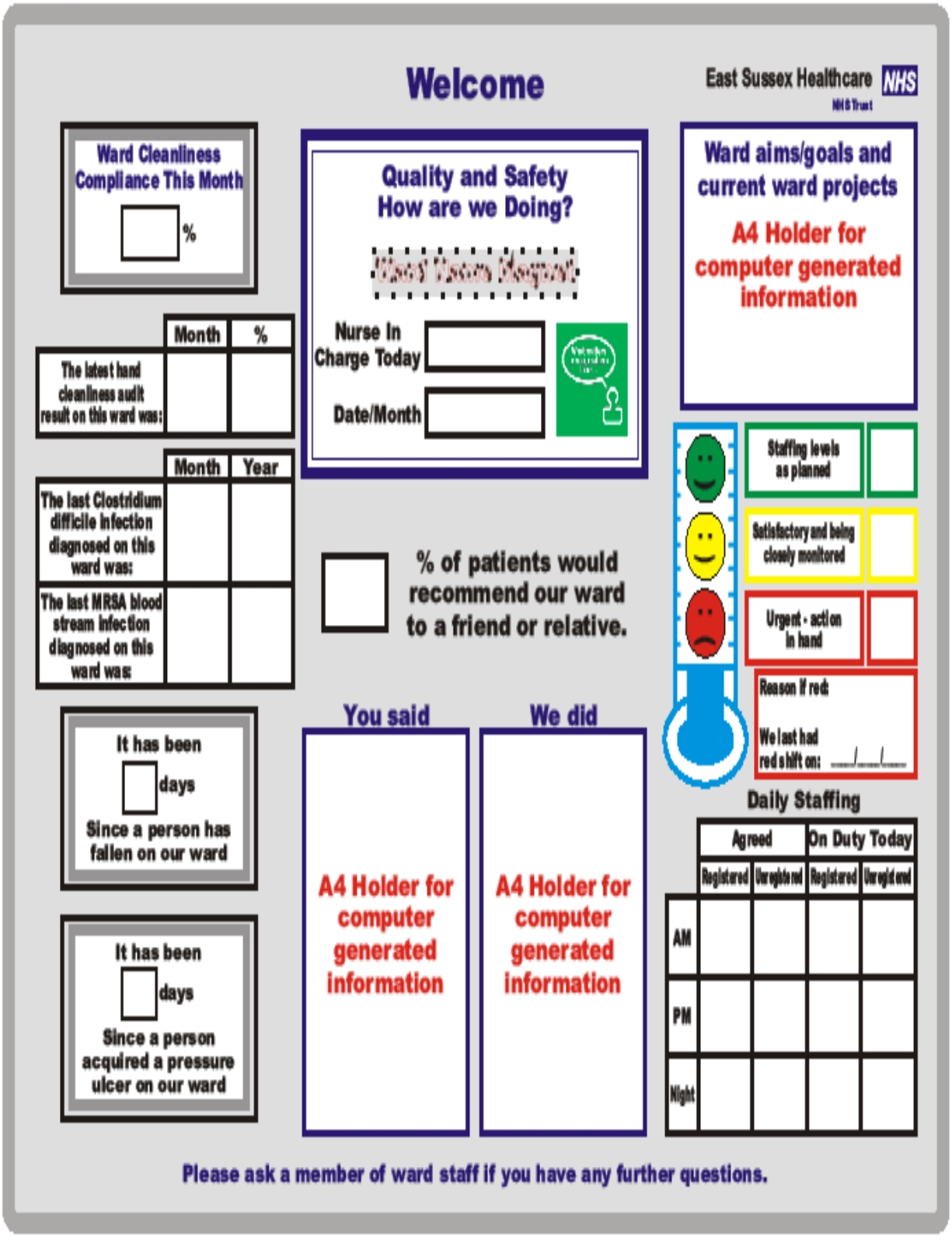
ALICE WEBSTER
Director of Nursing

LIZ FELLOWS
Assistant Director of Nursing

July 2014

Appendix 1

East Sussex - Quality & Safety Boards Size 1200mm x 900mm - Scale 1:5



East Sussex Healthcare NHS Trust

Date of Meeting:	30 July 2014
Meeting:	Trust Board
Agenda item:	8c
Subject:	Complaints Report – Quarter 1 April – June 2014
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

The purpose of this paper is to provide the Trust Board with information about the formal complaints received by the Trust in quarter 1 of 2014 (April – June). Formal complaints are usually written complaints although some verbal complaints that come through the PALS department may be taken as formal after discussion with the patient or relative who is raising a concern.

Introduction:

It is important to consider complaints in context. ESHT provides in-patient and day surgery services from 7 different sites. In the last financial year 2013/14 care was provided to over 98,000 people as in-patients (this includes both emergency and elective admissions); over 142,000 people attended the emergency departments and more than 390,000 came for outpatient appointments.

Set against these statistics, in the last financial year the Trust received 622 formal complaints. Although complaints can be viewed negatively by staff they can be a very powerful patient voice and should be seen constructively as a way to help us improve the services we offer.

Attached is the full quarter 1 data report for information.

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

Key points from quarter 1 (April – June 2014)

175 new formal complaints received – previous quarter 148
75% of complaints were responded to in time (time frames are agreed with the patient/relative at the time of receipt. Length of time may depend on the complexity of the complaint and if the concerns are cross clinical units)
104 formal complaints were 'open' at the end of June
98-100% of complaints were acknowledged within 3 working days
There were 17 overdue complaints at the end of June.

The top five concerns raised within the complaints received during this quarter were:

122 care
98 communication
60 attitude
57 pathway (ie problems with clinic appointments; lack of specialist equipment/staff)
33 discharge

Over this quarter it was noted, through the Chief Executive office's quality checks, that there was an increase in the number of draft responses that had to be returned to the CU for further work and/or corrections. This has been addressed through training with the complaints team.

The Trust is considering a proposal from SEAP, who are an independent advocacy services who can help people resolve issues or concerns they may have about health and social care services, on how they could further support the Trust with complaints management.

Benefits:

Examples of changes that have occurred in this quarter in response to formal complaints include:

- Following a complaint about lack of information for stroke patients and relatives a leaflet has been produced called "Welcome to the Stroke Unit"
- Complaint from a woman whose partner missed the birth of their baby – open visiting is now available for partners or significant others 24 hours a day on maternity

Risks and Implications

30% of complaints in this quarter were not responded to in time. The reasons for delays are many; in some cases the complaint is complex covering a number of disciplines and clinical units (CUs); in some statements cannot be obtained because staff have left or are on long term sick leave. However, many of these could have been answered within the time frame if staff had returned statements and/or managers had proof read the draft responses provided by the complaints team in an appropriately timely manner. Work needs to be done to increase the staff's awareness of the importance of patient complaints, of giving an honest and clear response within the time frame and where necessary taking on board constructive comments and changing practice/systems to improve the service.

Assurance Provided:

This report sets out to inform the Board of the number of complaints received; the nature of the complaints; that actions are taken following a complaint to improved services and patient care.and to demonstrate comparisons to previous quarter and year.

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

None

Proposals and/or Recommendations

The Trust Board is asked to note the Complaints Report for quarter 1 (April – June 2014)

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

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

Not applicable.

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

Name:	**Contact details: (13) 3754**
Lindsey Stevens, Head of Midwifery and Assistant Director of Nursing	lindseystevens@nhs.net

ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of new formal complaints received	48	64	63										175
Number of informal complaints	6	6	7										19
Number of informal complaints transferring to formal complaints	0	0	0										0
No of complaints acknowledged within 3 working days	47	61	63										171
% of new complaints acknowledged within 3 working days	98%	95%	100%										98%
Number of reopened complaints	2	10	5										17
Number of complaints responded to	54	53	53										160
Number of complaints upheld	44	44	46										134
% breakdown of complaints upheld	81%	83%	87%										84%
Number of new ombudsman complaints	0	1	1										2
Number of open complaints	71	84	103										258
Number of overdue complaints	23	17	17										57
Complaints responded to during month within timescale - number	45	35	37										117
Complaints responded to during month within timescale - %	83%	66%	70%										73%

Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of concerns	194	191	186										571
Number of PALS contacts	457	506	455										1418
Number of formal written compliments	1013	1085	1499										3597
Number of informal compliments	39	35	31										105
Number of requests for advice	224	280	238										742
% of PALS contacts responded to within 2 days	190	445	414										0
Friends and Family Test net promoter score	64	60	52										

Complaints KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	YTD	Variance Q1 2013/14	Variance Q2 2013/14	Variance Q3 2013/14	Variance Q4 2013/14	**Variance YTD**
Number of new formal complaints received	175				175		▲	148	143	155	176	500	27				27
% of new complaints acknowledged within 3 working days (average)	98%				98%	100%	▲	84%	99%	97%	97%	94%	14%				14%
Number of informal complaints	19				19		▼	21	33	14	28	96	-2				-2
Number of informal complaints transferring to formal complaints	0				0	0	▼	2	1	0	0	3	-2				-2
Number of reopened complaints	17				17		▼	19	21	20	27	87	-2				-2
Number of complaints responded to	160				160		▼	181	153	159	158	651	-21				-21
% breakdown of complaints upheld	84%				84%		▲	82%	86%	85%	79%		2%				2%
Number of new ombudsman complaints	2				2		▲	1	1	6	11	19	1				1
Number of open complaints in a month (average)	86				86		▲	64	55	63	77	65	22				22
Number of overdue complaints in a month (average)	19				19	0	▲	15	6	6	11	9	4				4
Complaints responded to during month within agreed timescale - nur	39				39		▼	42	44	47	44	44	-3				-3
Complaints responded to during month within agreed timescale - % (						100%	▼	70%	87%	88%	83%	87%					

Patient Experience KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**	**YTD**
Number of concerns	571				571		▼	468	511	550	521	2050
Number of PALS contacts	1418				1418		▼	1160	1246	1346	1398	5150

Number of formal written compliments	3597				3597			107	113	106	108	434
Number of informal compliments	105				105			1185	2337	1911	2587	8020
Number of requests for advice	742				742			558	620	690	768	2636
% of PALS contacts responded to within 2 days	74%				74%	100%		78%	90%	95%	78%	85%
Friends and Family Test score	59				15			67	61	53%	58%	60

Complaints Trends	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	21	20	19	**60**												
Communication	29	43	26	**98**												
Discharge	6	15	12	**33**												
Environment Total	3	4	0	**7**												
Equality Total	0	1	0	**1**												
Human Rights Total	0	0	0	**0**												
Infection Total	2	3	2	**7**												
Nutrition Total	2	6	1	**9**												
Property Total	0	0	3	**3**												
Pathway Total	13	16	28	**57**												
Services Total	5	6	20	**31**												
Tests Total	0	3	1	**4**												
Care Total	25	52	45	**122**												

PALS Concerns	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	15	12	7	**34**												
Communication	85	68	81	**234**												
Discharge	7	7	4	**18**												
Environment Total	0	0	2	**2**												
Equality Total	0	0	0	**0**												
Human Rights Total	0	0	0	**0**												
Infection Total	0	0	0	**0**												
Nutrition Total	0	0	0	**0**												
Property Total	1	4	0	**5**												
Pathway Total	36	35	48	**119**												
Services Total	12	26	21	**59**												
Tests Total	9	7	4	**20**												
Care Total	29	32	18	**79**												

Clinical Unit	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Acute Emercency Complaints	9	18	18									
Acute Emrgency Compliments (Sum)	527	52	654									
Cardiology Complaints	4	4	2									
Cardilogy Compliments (Sum)	25	78	113									
CSS Complaints	3	0	0									
CSS Compliments (Sum)	0	1	1									
CYPS Complaints	1	2	1									

CYPS Compliments (Sum)	17	9	7										
Head and Neck Complaints	5	4	4										
Head and Neck Compliments (Sum)	31	81	52										
Out of Hospital Complaints	3	4	6										
Out of Hospital Compliments (Sum)	15	44	56										
Planned Med & Adult OPD Complaints	3	8	6										
Planned Med & Adult OPD Compliments (Sum)	143	316	254										
Private Complaints	0	0	0										
Private (Sum)	0	0	0										
Specialist Medicine Complaints	3	4	5										
Specilaist Medicine Compliments (Sum)	21	52	61										
Surgery Complaints	5	9	9										
Surgery Compliments (Sum)	38	86	96										
Theaters Ana CC & Pain Complaints	1	1	2										
Theaters Ana CC & Pain Compliments (Sum)	44	136	39										
Trauma & Ortho Complaints	5	5	5										
Trauma & Ortho Compliments (Sum)	78	129	140										
Womans Health Complaints	6	5	5										
Womans Health Compliments (Sum)	113	137	59										

Summary	**Q1**	**Q2**	**Q3**	Q4
Acute Emercency Complaints	45			
Acute Emergency Compliments (Sum)	1233			
Cardiology Complaints	10			
Cardilogy Compliments (Sum)	216			
CSS Complaints	3			
CSS Compliments (Sum)	2			
CYPS Complaints	4			
CYPS Compliments (Sum)	33			
Head and Neck Complaints	13			
Head and Neck Compliments (Sum)	164			
Out of Hospital Complaints	13			
Out of Hospital Compliments (Sum)	115			
Planned Med & Adult OPD Complaints	17			
Planned Med & Adult OPD Compliments (Sum)	713			
Private Complaints	0			
Private (Sum)	0			
Specialist Medicine Complaints	12			
Specilaist Medicine Compliments (Sum)	134			
Surgery Complaints	23			
Surgery Compliments (Sum)	220			
Theaters Ana CC & Pain Complaints	4			
Theaters Ana CC & Pain Compliments (Sum)	219			
Trauma & Ortho Complaints	15			
Trauma & Ortho Compliments (Sum)	347			
Womans Health Complaints	16			
Womans Health Compliments (Sum)	309			

ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of new formal complaints received	48	64	63										175
Number of informal complaints	6	6	7										19
Number of informal complaints transferring to formal complaints	0	0	0										0
No of complaints acknowledged within 3 working days	47	61	63										171
% of new complaints acknowledged within 3 working days	98%	95%	100%										98%
Number of reopened complaints	2	10	5										17
Number of complaints responded to	54	53	53										160
Number of complaints upheld	44	44	46										134
% breakdown of complaints upheld	81%	83%	87%										84%
Number of new ombudsman complaints	0	1	1										2
Number of open complaints	71	84	103										258
Number of overdue complaints	23	17	17										57
Complaints responded to during month within timescale - number	45	35	37										117
Complaints responded to during month within timescale - %	83%	66%	70%										73%

Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of concerns	194	191	186										571
Number of PALS contacts	457	506	455										1418
Number of formal written compliments	1013	1085	1499										3597
Number of informal compliments	39	35	31										105
Number of requests for advice	224	280	238										742
% of PALS contacts responded to within 2 days	190	445	414										0
Friends and Family Test net promoter score	64	60	52										

Complaints KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	YTD	Variance Q1 2013/14	Variance Q2 2013/14	Variance Q3 2013/14	Variance Q4 2013/14	**Variance YTD**
Number of new formal complaints received	175				175		▲	148	143	155	176	500	27				27
% of new complaints acknowledged within 3 working days (average)	98%				98%	100%	▲	84%	99%	97%	97%	94%	14%				14%
Number of informal complaints	19				19		▼	21	33	14	28	96	-2				-2
Number of informal complaints transferring to formal complaints	0				0	0	▼	2	1	0	0	3	-2				-2
Number of reopened complaints	17				17		▼	19	21	20	27	87	-2				-2
Number of complaints responded to	160				160		▼	181	153	159	158	651	-21				-21
% breakdown of complaints upheld	84%				84%		▲	82%	86%	85%	79%		2%				2%
Number of new ombudsman complaints	2				2		▲	1	1	6	11	19	1				1
Number of open complaints in a month (average)	86				86		▲	64	55	63	77	65	22				22
Number of overdue complaints in a month (average)	19				19	0	▲	15	6	6	11	9	4				4
Complaints responded to during month within agreed timescale - nur	39				39		▼	42	44	47	44	44	-3				-3
Complaints responded to during month within agreed timescale - % (						100%	▼	70%	87%	88%	83%	87%					

Patient Experience KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**	**YTD**
Number of concerns	571				571		▼	468	511	550	521	2050
Number of PALS contacts	1418				1418		▼	1160	1246	1346	1398	5150

Number of formal written compliments	3597				3597			107	113	106	108	434
Number of informal compliments	105				105			1185	2337	1911	2587	8020
Number of requests for advice	742				742			558	620	690	768	2636
% of PALS contacts responded to within 2 days	74%				74%	100%		78%	90%	95%	78%	85%
Friends and Family Test score	59				15			67	61	53%	58%	60

Complaints Trends	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	21	20	19	**60**												
Communication	29	43	26	**98**												
Discharge	6	15	12	**33**												
Environment Total	3	4	0	**7**												
Equality Total	0	1	0	**1**												
Human Rights Total	0	0	0	**0**												
Infection Total	2	3	2	**7**												
Nutrition Total	2	6	1	**9**												
Property Total	0	0	3	**3**												
Pathway Total	13	16	28	**57**												
Services Total	5	6	20	**31**												
Tests Total	0	3	1	**4**												
Care Total	25	52	45	**122**												

PALS Concerns	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	15	12	7	**34**												
Communication	85	68	81	**234**												
Discharge	7	7	4	**18**												
Environment Total	0	0	2	**2**												
Equality Total	0	0	0	**0**												
Human Rights Total	0	0	0	**0**												
Infection Total	0	0	0	**0**												
Nutrition Total	0	0	0	**0**												
Property Total	1	4	0	**5**												
Pathway Total	36	35	48	**119**												
Services Total	12	26	21	**59**												
Tests Total	9	7	4	**20**												
Care Total	29	32	18	**79**												

Clinical Unit	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
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Cardiology Complaints	4	4	2									
Cardilogy Compliments (Sum)	25	78	113									
CSS Complaints	3	0	0									
CSS Compliments (Sum)	0	1	1									
CYPS Complaints	1	2	1									

CYPS Compliments (Sum)	17	9	7										
Head and Neck Complaints	5	4	4										
Head and Neck Compliments (Sum)	31	81	52										
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Planned Med & Adult OPD Complaints	3	8	6										
Planned Med & Adult OPD Compliments (Sum)	143	316	254										
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Private (Sum)	0	0	0										
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Womans Health Complaints	6	5	5										
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Summary	**Q1**	**Q2**	**Q3**	Q4
Acute Emercency Complaints	45			
Acute Emergency Compliments (Sum)	1233			
Cardiology Complaints	10			
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CSS Complaints	3			
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Head and Neck Complaints	13			
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Planned Med & Adult OPD Complaints	17			
Planned Med & Adult OPD Compliments (Sum)	713			
Private Complaints	0			
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Specialist Medicine Complaints	12			
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ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of new formal complaints received	48	64	63										175
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Number of open complaints	71	84	103										258
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Complaints responded to during month within timescale - number	45	35	37										117
Complaints responded to during month within timescale - %	83%	66%	70%										73%

Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of concerns	194	191	186										571
Number of PALS contacts	457	506	455										1418
Number of formal written compliments	1013	1085	1499										3597
Number of informal compliments	39	35	31										105
Number of requests for advice	224	280	238										742
% of PALS contacts responded to within 2 days	190	445	414										0
Friends and Family Test net promoter score	64	60	52										

Complaints KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	YTD	Variance Q1 2013/14	Variance Q2 2013/14	Variance Q3 2013/14	Variance Q4 2013/14	**Variance YTD**
Number of new formal complaints received	175				175		▲	148	143	155	176	500	27				27
% of new complaints acknowledged within 3 working days (average)	98%				98%	100%	▲	84%	99%	97%	97%	94%	14%				14%
Number of informal complaints	19				19		▼	21	33	14	28	96	-2				-2
Number of informal complaints transferring to formal complaints	0				0	0	▼	2	1	0	0	3	-2				-2
Number of reopened complaints	17				17		▼	19	21	20	27	87	-2				-2
Number of complaints responded to	160				160		▼	181	153	159	158	651	-21				-21
% breakdown of complaints upheld	84%				84%		▲	82%	86%	85%	79%		2%				2%
Number of new ombudsman complaints	2				2		▲	1	1	6	11	19	1				1
Number of open complaints in a month (average)	86				86		▲	64	55	63	77	65	22				22
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Complaints responded to during month within agreed timescale - % (						100%	▼	70%	87%	88%	83%	87%					

Patient Experience KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**	**YTD**
Number of concerns	571				571		▼	468	511	550	521	2050
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Complaints Trends	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
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PALS Concerns	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
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ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
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Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
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Complaints KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	YTD	Variance Q1 2013/14	Variance Q2 2013/14	Variance Q3 2013/14	Variance Q4 2013/14	**Variance YTD**
Number of new formal complaints received	175				175		▲	148	143	155	176	500	27				27
% of new complaints acknowledged within 3 working days (average)	98%				98%	100%	▲	84%	99%	97%	97%	94%	14%				14%
Number of informal complaints	19				19		▼	21	33	14	28	96	-2				-2
Number of informal complaints transferring to formal complaints	0				0	0	▼	2	1	0	0	3	-2				-2
Number of reopened complaints	17				17		▼	19	21	20	27	87	-2				-2
Number of complaints responded to	160				160		▼	181	153	159	158	651	-21				-21
% breakdown of complaints upheld	84%				84%		▲	82%	86%	85%	79%		2%				2%
Number of new ombudsman complaints	2				2		▲	1	1	6	11	19	1				1
Number of open complaints in a month (average)	86				86		▲	64	55	63	77	65	22				22
Number of overdue complaints in a month (average)	19				19	0	▲	15	6	6	11	9	4				4
Complaints responded to during month within agreed timescale - nur	39				39		▼	42	44	47	44	44	-3				-3
Complaints responded to during month within agreed timescale - % (						100%	▼	70%	87%	88%	83%	87%					

Patient Experience KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**	**YTD**
Number of concerns	571				571		▼	468	511	550	521	2050
Number of PALS contacts	1418				1418		▼	1160	1246	1346	1398	5150

Number of formal written compliments	3597				3597			107	113	106	108	434
Number of informal compliments	105				105			1185	2337	1911	2587	8020
Number of requests for advice	742				742			558	620	690	768	2636
% of PALS contacts responded to within 2 days	74%				74%	100%		78%	90%	95%	78%	85%
Friends and Family Test score	59				15			67	61	53%	58%	60

Complaints Trends	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	21	20	19	**60**												
Communication	29	43	26	**98**												
Discharge	6	15	12	**33**												
Environment Total	3	4	0	**7**												
Equality Total	0	1	0	**1**												
Human Rights Total	0	0	0	**0**												
Infection Total	2	3	2	**7**												
Nutrition Total	2	6	1	**9**												
Property Total	0	0	3	**3**												
Pathway Total	13	16	28	**57**												
Services Total	5	6	20	**31**												
Tests Total	0	3	1	**4**												
Care Total	25	52	45	**122**												

PALS Concerns	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	15	12	7	**34**												
Communication	85	68	81	**234**												
Discharge	7	7	4	**18**												
Environment Total	0	0	2	**2**												
Equality Total	0	0	0	**0**												
Human Rights Total	0	0	0	**0**												
Infection Total	0	0	0	**0**												
Nutrition Total	0	0	0	**0**												
Property Total	1	4	0	**5**												
Pathway Total	36	35	48	**119**												
Services Total	12	26	21	**59**												
Tests Total	9	7	4	**20**												
Care Total	29	32	18	**79**												

Clinical Unit	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Acute Emercency Complaints	9	18	18									
Acute Emrgency Compliments (Sum)	527	52	654									
Cardiology Complaints	4	4	2									
Cardilogy Compliments (Sum)	25	78	113									
CSS Complaints	3	0	0									
CSS Compliments (Sum)	0	1	1									
CYPS Complaints	1	2	1									

CYPS Compliments (Sum)	17	9	7										
Head and Neck Complaints	5	4	4										
Head and Neck Compliments (Sum)	31	81	52										
Out of Hospital Complaints	3	4	6										
Out of Hospital Compliments (Sum)	15	44	56										
Planned Med & Adult OPD Complaints	3	8	6										
Planned Med & Adult OPD Compliments (Sum)	143	316	254										
Private Complaints	0	0	0										
Private (Sum)	0	0	0										
Specialist Medicine Complaints	3	4	5										
Specilaist Medicine Compliments (Sum)	21	52	61										
Surgery Complaints	5	9	9										
Surgery Compliments (Sum)	38	86	96										
Theaters Ana CC & Pain Complaints	1	1	2										
Theaters Ana CC & Pain Compliments (Sum)	44	136	39										
Trauma & Ortho Complaints	5	5	5										
Trauma & Ortho Compliments (Sum)	78	129	140										
Womans Health Complaints	6	5	5										
Womans Health Compliments (Sum)	113	137	59										

Summary	**Q1**	**Q2**	**Q3**	Q4
Acute Emercency Complaints	45			
Acute Emergency Compliments (Sum)	1233			
Cardiology Complaints	10			
Cardilogy Compliments (Sum)	216			
CSS Complaints	3			
CSS Compliments (Sum)	2			
CYPS Complaints	4			
CYPS Compliments (Sum)	33			
Head and Neck Complaints	13			
Head and Neck Compliments (Sum)	164			
Out of Hospital Complaints	13			
Out of Hospital Compliments (Sum)	115			
Planned Med & Adult OPD Complaints	17			
Planned Med & Adult OPD Compliments (Sum)	713			
Private Complaints	0			
Private (Sum)	0			
Specialist Medicine Complaints	12			
Specilaist Medicine Compliments (Sum)	134			
Surgery Complaints	23			
Surgery Compliments (Sum)	220			
Theaters Ana CC & Pain Complaints	4			
Theaters Ana CC & Pain Compliments (Sum)	219			
Trauma & Ortho Complaints	15			
Trauma & Ortho Compliments (Sum)	347			
Womans Health Complaints	16			
Womans Health Compliments (Sum)	309			

ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of new formal complaints received	48	64	63										175
Number of informal complaints	6	6	7										19
Number of informal complaints transferring to formal complaints	0	0	0										0
No of complaints acknowledged within 3 working days	47	61	63										171
% of new complaints acknowledged within 3 working days	98%	95%	100%										98%
Number of reopened complaints	2	10	5										17
Number of complaints responded to	54	53	53										160
Number of complaints upheld	44	44	46										134
% breakdown of complaints upheld	81%	83%	87%										84%
Number of new ombudsman complaints	0	1	1										2
Number of open complaints	71	84	103										258
Number of overdue complaints	23	17	17										57
Complaints responded to during month within timescale - number	45	35	37										117
Complaints responded to during month within timescale - %	83%	66%	70%										73%

Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of concerns	194	191	186										571
Number of PALS contacts	457	506	455										1418
Number of formal written compliments	1013	1085	1499										3597
Number of informal compliments	39	35	31										105
Number of requests for advice	224	280	238										742
% of PALS contacts responded to within 2 days	190	445	414										0
Friends and Family Test net promoter score	64	60	52										

Complaints KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	YTD	Variance Q1 2013/14	Variance Q2 2013/14	Variance Q3 2013/14	Variance Q4 2013/14	**Variance YTD**
Number of new formal complaints received	175				175		▲	148	143	155	176	500	27				27
% of new complaints acknowledged within 3 working days (average)	98%				98%	100%	▲	84%	99%	97%	97%	94%	14%				14%
Number of informal complaints	19				19		▼	21	33	14	28	96	-2				-2
Number of informal complaints transferring to formal complaints	0				0	0	▼	2	1	0	0	3	-2				-2
Number of reopened complaints	17				17		▼	19	21	20	27	87	-2				-2
Number of complaints responded to	160				160		▼	181	153	159	158	651	-21				-21
% breakdown of complaints upheld	84%				84%		▲	82%	86%	85%	79%		2%				2%
Number of new ombudsman complaints	2				2		▲	1	1	6	11	19	1				1
Number of open complaints in a month (average)	86				86		▲	64	55	63	77	65	22				22
Number of overdue complaints in a month (average)	19				19	0	▲	15	6	6	11	9	4				4
Complaints responded to during month within agreed timescale - nur	39				39		▼	42	44	47	44	44	-3				-3
Complaints responded to during month within agreed timescale - % (						100%	▼	70%	87%	88%	83%	87%					

Patient Experience KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**	**YTD**
Number of concerns	571				571		▼	468	511	550	521	2050
Number of PALS contacts	1418				1418		▼	1160	1246	1346	1398	5150

Number of formal written compliments	3597				3597			107	113	106	108	434
Number of informal compliments	105				105			1185	2337	1911	2587	8020
Number of requests for advice	742				742			558	620	690	768	2636
% of PALS contacts responded to within 2 days	74%				74%	100%		78%	90%	95%	78%	85%
Friends and Family Test score	59				15			67	61	53%	58%	60

Complaints Trends	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	21	20	19	**60**												
Communication	29	43	26	**98**												
Discharge	6	15	12	**33**												
Environment Total	3	4	0	**7**												
Equality Total	0	1	0	**1**												
Human Rights Total	0	0	0	**0**												
Infection Total	2	3	2	**7**												
Nutrition Total	2	6	1	**9**												
Property Total	0	0	3	**3**												
Pathway Total	13	16	28	**57**												
Services Total	5	6	20	**31**												
Tests Total	0	3	1	**4**												
Care Total	25	52	45	**122**												

PALS Concerns	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	15	12	7	**34**												
Communication	85	68	81	**234**												
Discharge	7	7	4	**18**												
Environment Total	0	0	2	**2**												
Equality Total	0	0	0	**0**												
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Infection Total	0	0	0	**0**												
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Clinical Unit	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Acute Emercency Complaints	9	18	18									
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CSS Compliments (Sum)	0	1	1									
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Summary	**Q1**	**Q2**	**Q3**	Q4
Acute Emercency Complaints	45			
Acute Emergency Compliments (Sum)	1233			
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Planned Med & Adult OPD Compliments (Sum)	713			
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ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
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Complaints KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	YTD	Variance Q1 2013/14	Variance Q2 2013/14	Variance Q3 2013/14	Variance Q4 2013/14	**Variance YTD**
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ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
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% of new complaints acknowledged within 3 working days	98%	95%	100%										98%
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Number of complaints responded to	54	53	53										160
Number of complaints upheld	44	44	46										134
% breakdown of complaints upheld	81%	83%	87%										84%
Number of new ombudsman complaints	0	1	1										2
Number of open complaints	71	84	103										258
Number of overdue complaints	23	17	17										57
Complaints responded to during month within timescale - number	45	35	37										117
Complaints responded to during month within timescale - %	83%	66%	70%										73%

Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of concerns	194	191	186										571
Number of PALS contacts	457	506	455										1418
Number of formal written compliments	1013	1085	1499										3597
Number of informal compliments	39	35	31										105
Number of requests for advice	224	280	238										742
% of PALS contacts responded to within 2 days	190	445	414										0
Friends and Family Test net promoter score	64	60	52										

Complaints KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	YTD	Variance Q1 2013/14	Variance Q2 2013/14	Variance Q3 2013/14	Variance Q4 2013/14	**Variance YTD**
Number of new formal complaints received	175				175		▲	148	143	155	176	500	27				27
% of new complaints acknowledged within 3 working days (average)	98%				98%	100%	▲	84%	99%	97%	97%	94%	14%				14%
Number of informal complaints	19				19		▼	21	33	14	28	96	-2				-2
Number of informal complaints transferring to formal complaints	0				0	0	▼	2	1	0	0	3	-2				-2
Number of reopened complaints	17				17		▼	19	21	20	27	87	-2				-2
Number of complaints responded to	160				160		▼	181	153	159	158	651	-21				-21
% breakdown of complaints upheld	84%				84%		▲	82%	86%	85%	79%		2%				2%
Number of new ombudsman complaints	2				2		▲	1	1	6	11	19	1				1
Number of open complaints in a month (average)	86				86		▲	64	55	63	77	65	22				22
Number of overdue complaints in a month (average)	19				19	0	▲	15	6	6	11	9	4				4
Complaints responded to during month within agreed timescale - nur	39				39		▼	42	44	47	44	44	-3				-3
Complaints responded to during month within agreed timescale - % (						100%	▼	70%	87%	88%	83%	87%					

Patient Experience KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**	**YTD**
Number of concerns	571				571		▼	468	511	550	521	2050
Number of PALS contacts	1418				1418		▼	1160	1246	1346	1398	5150

Number of formal written compliments	3597				3597			107	113	106	108	434
Number of informal compliments	105				105			1185	2337	1911	2587	8020
Number of requests for advice	742				742			558	620	690	768	2636
% of PALS contacts responded to within 2 days	74%				74%	100%		78%	90%	95%	78%	85%
Friends and Family Test score	59				15			67	61	53%	58%	60

Complaints Trends	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	21	20	19	**60**												
Communication	29	43	26	**98**												
Discharge	6	15	12	**33**												
Environment Total	3	4	0	**7**												
Equality Total	0	1	0	**1**												
Human Rights Total	0	0	0	**0**												
Infection Total	2	3	2	**7**												
Nutrition Total	2	6	1	**9**												
Property Total	0	0	3	**3**												
Pathway Total	13	16	28	**57**												
Services Total	5	6	20	**31**												
Tests Total	0	3	1	**4**												
Care Total	25	52	45	**122**												

PALS Concerns	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	15	12	7	**34**												
Communication	85	68	81	**234**												
Discharge	7	7	4	**18**												
Environment Total	0	0	2	**2**												
Equality Total	0	0	0	**0**												
Human Rights Total	0	0	0	**0**												
Infection Total	0	0	0	**0**												
Nutrition Total	0	0	0	**0**												
Property Total	1	4	0	**5**												
Pathway Total	36	35	48	**119**												
Services Total	12	26	21	**59**												
Tests Total	9	7	4	**20**												
Care Total	29	32	18	**79**												

Clinical Unit	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Acute Emercency Complaints	9	18	18									
Acute Emrgency Compliments (Sum)	527	52	654									
Cardiology Complaints	4	4	2									
Cardilogy Compliments (Sum)	25	78	113									
CSS Complaints	3	0	0									
CSS Compliments (Sum)	0	1	1									
CYPS Complaints	1	2	1									

CYPS Compliments (Sum)	17	9	7										
Head and Neck Complaints	5	4	4										
Head and Neck Compliments (Sum)	31	81	52										
Out of Hospital Complaints	3	4	6										
Out of Hospital Compliments (Sum)	15	44	56										
Planned Med & Adult OPD Complaints	3	8	6										
Planned Med & Adult OPD Compliments (Sum)	143	316	254										
Private Complaints	0	0	0										
Private (Sum)	0	0	0										
Specialist Medicine Complaints	3	4	5										
Specilaist Medicine Compliments (Sum)	21	52	61										
Surgery Complaints	5	9	9										
Surgery Compliments (Sum)	38	86	96										
Theaters Ana CC & Pain Complaints	1	1	2										
Theaters Ana CC & Pain Compliments (Sum)	44	136	39										
Trauma & Ortho Complaints	5	5	5										
Trauma & Ortho Compliments (Sum)	78	129	140										
Womans Health Complaints	6	5	5										
Womans Health Compliments (Sum)	113	137	59										

Summary	**Q1**	**Q2**	**Q3**	Q4
Acute Emercency Complaints	45			
Acute Emergency Compliments (Sum)	1233			
Cardiology Complaints	10			
Cardilogy Compliments (Sum)	216			
CSS Complaints	3			
CSS Compliments (Sum)	2			
CYPS Complaints	4			
CYPS Compliments (Sum)	33			
Head and Neck Complaints	13			
Head and Neck Compliments (Sum)	164			
Out of Hospital Complaints	13			
Out of Hospital Compliments (Sum)	115			
Planned Med & Adult OPD Complaints	17			
Planned Med & Adult OPD Compliments (Sum)	713			
Private Complaints	0			
Private (Sum)	0			
Specialist Medicine Complaints	12			
Specilaist Medicine Compliments (Sum)	134			
Surgery Complaints	23			
Surgery Compliments (Sum)	220			
Theaters Ana CC & Pain Complaints	4			
Theaters Ana CC & Pain Compliments (Sum)	219			
Trauma & Ortho Complaints	15			
Trauma & Ortho Compliments (Sum)	347			
Womans Health Complaints	16			
Womans Health Compliments (Sum)	309			

ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of new formal complaints received	48	64	63										175
Number of informal complaints	6	6	7										19
Number of informal complaints transferring to formal complaints	0	0	0										0
No of complaints acknowledged within 3 working days	47	61	63										171
% of new complaints acknowledged within 3 working days	98%	95%	100%										98%
Number of reopened complaints	2	10	5										17
Number of complaints responded to	54	53	53										160
Number of complaints upheld	44	44	46										134
% breakdown of complaints upheld	81%	83%	87%										84%
Number of new ombudsman complaints	0	1	1										2
Number of open complaints	71	84	103										258
Number of overdue complaints	23	17	17										57
Complaints responded to during month within timescale - number	45	35	37										117
Complaints responded to during month within timescale - %	83%	66%	70%										73%

Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of concerns	194	191	186										571
Number of PALS contacts	457	506	455										1418
Number of formal written compliments	1013	1085	1499										3597
Number of informal compliments	39	35	31										105
Number of requests for advice	224	280	238										742
% of PALS contacts responded to within 2 days	190	445	414										0
Friends and Family Test net promoter score	64	60	52										

Complaints KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	YTD	Variance Q1 2013/14	Variance Q2 2013/14	Variance Q3 2013/14	Variance Q4 2013/14	**Variance YTD**
Number of new formal complaints received	175				175		▲	148	143	155	176	500	27				27
% of new complaints acknowledged within 3 working days (average)	98%				98%	100%	▲	84%	99%	97%	97%	94%	14%				14%
Number of informal complaints	19				19		▼	21	33	14	28	96	-2				-2
Number of informal complaints transferring to formal complaints	0				0	0	▼	2	1	0	0	3	-2				-2
Number of reopened complaints	17				17		▼	19	21	20	27	87	-2				-2
Number of complaints responded to	160				160		▼	181	153	159	158	651	-21				-21
% breakdown of complaints upheld	84%				84%		▲	82%	86%	85%	79%		2%				2%
Number of new ombudsman complaints	2				2		▲	1	1	6	11	19	1				1
Number of open complaints in a month (average)	86				86		▲	64	55	63	77	65	22				22
Number of overdue complaints in a month (average)	19				19	0	▲	15	6	6	11	9	4				4
Complaints responded to during month within agreed timescale - nur	39				39		▼	42	44	47	44	44	-3				-3
Complaints responded to during month within agreed timescale - % (						100%	▼	70%	87%	88%	83%	87%					

Patient Experience KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**	**YTD**
Number of concerns	571				571		▼	468	511	550	521	2050
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% of PALS contacts responded to within 2 days	74%				74%	100%		78%	90%	95%	78%	85%
Friends and Family Test score	59				15			67	61	53%	58%	60

Complaints Trends	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	21	20	19	**60**												
Communication	29	43	26	**98**												
Discharge	6	15	12	**33**												
Environment Total	3	4	0	**7**												
Equality Total	0	1	0	**1**												
Human Rights Total	0	0	0	**0**												
Infection Total	2	3	2	**7**												
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Property Total	0	0	3	**3**												
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PALS Concerns	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	15	12	7	**34**												
Communication	85	68	81	**234**												
Discharge	7	7	4	**18**												
Environment Total	0	0	2	**2**												
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Clinical Unit	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
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ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
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CYPS Compliments (Sum)	33			
Head and Neck Complaints	13			
Head and Neck Compliments (Sum)	164			
Out of Hospital Complaints	13			
Out of Hospital Compliments (Sum)	115			
Planned Med & Adult OPD Complaints	17			
Planned Med & Adult OPD Compliments (Sum)	713			
Private Complaints	0			
Private (Sum)	0			
Specialist Medicine Complaints	12			
Specilaist Medicine Compliments (Sum)	134			
Surgery Complaints	23			
Surgery Compliments (Sum)	220			
Theaters Ana CC & Pain Complaints	4			
Theaters Ana CC & Pain Compliments (Sum)	219			
Trauma & Ortho Complaints	15			
Trauma & Ortho Compliments (Sum)	347			
Womans Health Complaints	16			
Womans Health Compliments (Sum)	309			

ANALYSIS OF COMPLAINTS DATA - TRUSTWIDE

	Q1			Q2			Q3			Q4			
Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of new formal complaints received	48	64	63										175
Number of informal complaints	6	6	7										19
Number of informal complaints transferring to formal complaints	0	0	0										0
No of complaints acknowledged within 3 working days	47	61	63										171
% of new complaints acknowledged within 3 working days	98%	95%	100%										98%
Number of reopened complaints	2	10	5										17
Number of complaints responded to	54	53	53										160
Number of complaints upheld	44	44	46										134
% breakdown of complaints upheld	81%	83%	87%										84%
Number of new ombudsman complaints	0	1	1										2
Number of open complaints	71	84	103										258
Number of overdue complaints	23	17	17										57
Complaints responded to during month within timescale - number	45	35	37										117
Complaints responded to during month within timescale - %	83%	66%	70%										73%

Patient Experience KPIs	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**YTD**
Number of concerns	194	191	186										571
Number of PALS contacts	457	506	455										1418
Number of formal written compliments	1013	1085	1499										3597
Number of informal compliments	39	35	31										105
Number of requests for advice	224	280	238										742
% of PALS contacts responded to within 2 days	190	445	414										0
Friends and Family Test net promoter score	64	60	52										

Complaints KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	YTD	Variance Q1 2013/14	Variance Q2 2013/14	Variance Q3 2013/14	Variance Q4 2013/14	**Variance YTD**
Number of new formal complaints received	175				175		▲	148	143	155	176	500	27				27
% of new complaints acknowledged within 3 working days (average)	98%				98%	100%	▲	84%	99%	97%	97%	94%	14%				14%
Number of informal complaints	19				19		▼	21	33	14	28	96	-2				-2
Number of informal complaints transferring to formal complaints	0				0	0	▼	2	1	0	0	3	-2				-2
Number of reopened complaints	17				17		▼	19	21	20	27	87	-2				-2
Number of complaints responded to	160				160		▼	181	153	159	158	651	-21				-21
% breakdown of complaints upheld	84%				84%		▲	82%	86%	85%	79%		2%				2%
Number of new ombudsman complaints	2				2		▲	1	1	6	11	19	1				1
Number of open complaints in a month (average)	86				86		▲	64	55	63	77	65	22				22
Number of overdue complaints in a month (average)	19				19	0	▲	15	6	6	11	9	4				4
Complaints responded to during month within agreed timescale - nur	39				39		▼	42	44	47	44	44	-3				-3
Complaints responded to during month within agreed timescale - % (						100%	▼	70%	87%	88%	83%	87%					

Patient Experience KPIs	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**	**Trend**	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**	**YTD**
Number of concerns	571				571		▼	468	511	550	521	2050
Number of PALS contacts	1418				1418		▼	1160	1246	1346	1398	5150

Number of formal written compliments	3597				3597			107	113	106	108	434
Number of informal compliments	105				105			1185	2337	1911	2587	8020
Number of requests for advice	742				742			558	620	690	768	2636
% of PALS contacts responded to within 2 days	74%				74%	100%		78%	90%	95%	78%	85%
Friends and Family Test score	59				15			67	61	53%	58%	60

Complaints Trends	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	21	20	19	**60**												
Communication	29	43	26	**98**												
Discharge	6	15	12	**33**												
Environment Total	3	4	0	**7**												
Equality Total	0	1	0	**1**												
Human Rights Total	0	0	0	**0**												
Infection Total	2	3	2	**7**												
Nutrition Total	2	6	1	**9**												
Property Total	0	0	3	**3**												
Pathway Total	13	16	28	**57**												
Services Total	5	6	20	**31**												
Tests Total	0	3	1	**4**												
Care Total	25	52	45	**122**												

PALS Concerns	**Apr-14**	**May-14**	**Jun-14**	**Q1**	**Jul-14**	**Aug-14**	**Sep-14**	**Q2**	**Oct-14**	**Nov-14**	**Dec-14**	**Q3**	**Jan-15**	**Feb-15**	**Mar-15**	**Q4**
Attitude	15	12	7	**34**												
Communication	85	68	81	**234**												
Discharge	7	7	4	**18**												
Environment Total	0	0	2	**2**												
Equality Total	0	0	0	**0**												
Human Rights Total	0	0	0	**0**												
Infection Total	0	0	0	**0**												
Nutrition Total	0	0	0	**0**												
Property Total	1	4	0	**5**												
Pathway Total	36	35	48	**119**												
Services Total	12	26	21	**59**												
Tests Total	9	7	4	**20**												
Care Total	29	32	18	**79**												

Clinical Unit	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Acute Emercency Complaints	9	18	18									
Acute Emrgency Compliments (Sum)	527	52	654									
Cardiology Complaints	4	4	2									
Cardilogy Compliments (Sum)	25	78	113									
CSS Complaints	3	0	0									
CSS Compliments (Sum)	0	1	1									
CYPS Complaints	1	2	1									

CYPS Compliments (Sum)	17	9	7										
Head and Neck Complaints	5	4	4										
Head and Neck Compliments (Sum)	31	81	52										
Out of Hospital Complaints	3	4	6										
Out of Hospital Compliments (Sum)	15	44	56										
Planned Med & Adult OPD Complaints	3	8	6										
Planned Med & Adult OPD Compliments (Sum)	143	316	254										
Private Complaints	0	0	0										
Private (Sum)	0	0	0										
Specialist Medicine Complaints	3	4	5										
Specilaist Medicine Compliments (Sum)	21	52	61										
Surgery Complaints	5	9	9										
Surgery Compliments (Sum)	38	86	96										
Theaters Ana CC & Pain Complaints	1	1	2										
Theaters Ana CC & Pain Compliments (Sum)	44	136	39										
Trauma & Ortho Complaints	5	5	5										
Trauma & Ortho Compliments (Sum)	78	129	140										
Womans Health Complaints	6	5	5										
Womans Health Compliments (Sum)	113	137	59										

Summary	**Q1**	**Q2**	**Q3**	Q4
Acute Emercency Complaints	45			
Acute Emergency Compliments (Sum)	1233			
Cardiology Complaints	10			
Cardilogy Compliments (Sum)	216			
CSS Complaints	3			
CSS Compliments (Sum)	2			
CYPS Complaints	4			
CYPS Compliments (Sum)	33			
Head and Neck Complaints	13			
Head and Neck Compliments (Sum)	164			
Out of Hospital Complaints	13			
Out of Hospital Compliments (Sum)	115			
Planned Med & Adult OPD Complaints	17			
Planned Med & Adult OPD Compliments (Sum)	713			
Private Complaints	0			
Private (Sum)	0			
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East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	8d
Subject:	Friends and Family Test (FFT) Quarter 1 (April – June 2014)
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose
To update the Board on progress against the patient and staff FFT for Quarter 1.

Introduction
ESHT have continued to implement the patient and staff FFT in line with national guidance. All areas required have been achieved within the CQUIN target for the patient FFT with in-patient wards achieving 44.90%, with a target of 30%. A&E achieved a target of 44.90% with a CQUIN target of 30%. Full delivery of nationally set milestones achieved for maternity:

Analysis of Key Issues and Discussion Points Raised by the Report:
• Maternity FFT implemented in August 2013 • 100% of in-patient wards are actively obtaining FFT feedback on discharge in line with set criteria • A&E departments have implemented FFT as per National criteria • Implementation of out-patient and Day surgery FFT has commenced • Implementation of staff FFT for Q1

Benefits
ESHT note an increasing response rate throughout 13/14 of FFT responses, all data is analysed at minimum monthly and triangulated with other ward based data, with actions where required to improve patient experience put in place.
Risks and Implications
No risks noted.

Assurance Provided:
ESHT have achieved the Quarter 1 target for both the patient and staff FFT, data is triangulated from a number of sources obtained from service users in order to improve patient experience. The sources include for example other in-patient and out-patient surveys, NHS Choices data, complaints and safeguarding data.

Review by other Committees/Groups (please state name and date)**:**
Quality and Standards Committee 7th July 2014 Nursing Quality Review Meetings; Report data discussed at regular fortnightly meetings. Corporate Leadership Team 15th July 2014

Proposals and/or Recommendations
The Trust Board is to take assurance that Quarter 1 targets have been achieved for both the patient and staff FFT, with data being triangulated, and actions are being taken as appropriate to improve patient experience.

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 Brenda Lynes-O'Meara, Assistant Director of Nursing for Professional Practice and Standards	**Contact details:** b.lynes-omeara@nhs.net

East Sussex Healthcare NHS Trust

Friends and Family Test – Quarter 1 Report 2014/15

1. Introduction

East Sussex Healthcare Trust has continued to implement the patient Friends and Family Test (FFT) in line with national guidance, achieving the required FFT Commissioning for Quality and Innovation (CQUIN) targets for all areas:

- In-patient wards achieving 44.01% against the target set of 30%.
- Accident and Emergency Departments achieved 35.03% against the target of 30%.

Maternity implemented FFT in August 2013 as required ahead of the national milestone and achieved 100% of in-patients actively obtaining FFT feedback on discharge in line with set criteria.

The implementation of outpatient and day surgery FFT is evolving as is the implementation of staff FFT.

There has been a steady increasing response rate throughout 2013/14 for FFT responses received. All data is analysed monthly and triangulated with other ward based data and actions identified to improve patient experience. All actions are followed up through the Nursing and Midwifery Performance Quality Review Clinical Unit and Governance meetings.

The following sections demonstrate the work completed but also the continued work required in implementing the FFT and raising awareness from board to ward.

2. Quarter 1 FFT Targets

Month	Return	Hospital Site name	Total number of responses for each department	Total Number of people eligible to respond	CQUIN
April	A&E	CONQ	362	2642	13.70%
		EDGH	373	2767	13.48%
		ESHT	735	5409	13.59%
	Inpatient	CONQ	354	811	43.65%
		EDGH	413	841	49.11%
		ESHT	767	1652	46.43%
	Trust Total	ESHT	1502	7061	21.27

Month	Return	Hospital Site name	Total number of responses for each department	Total Number of people eligible to respond	CQUIN
May	A&E	CONQ	445	2911	15.29%
		EDGH	468	2883	16.23%
		ESHT	913	5794	15.76%
	Inpatient	CONQ	359	811	44.27%
		EDGH	368	833	44.18%
		ESHT	727	1644	44.22%
	Trust Total	ESHT	1640	7438	22.05%
June	A&E	CONQ	788	2888	27.29%
		EDGH	1186	2747	43.17%
		ESHT	1974	5635	35.03%
	Inpatient	CONQ	277	756	36.64%
		EDGH	414	814	50.86%
		ESHT	691	1570	44.01%
	Trust Total	ESHT	2665	7205	36.99%

During Quarter 1 of 2014/15, an improved system was introduced into both A&E areas for collection of FFT data. This has increased the response rates for these areas. Overall response rates for Quarter 1 were A&E 21.5%, against a target of 15%, and adult in-patients 44.01%, against a target of 25%.

FFT has now been fully implemented within Maternity services. NHS England are asking that within maternity services FFT questions are asked at 4 Touch points:

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

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

Response rates for maternity are improving slowly with some particularly hard work from the community midwives as the Touch Points 1 & 4 are more difficult to get users of the service to complete.

We are still working on the eligibility of Touch Point 1 and 4 but the schedule below demonstrates the % compliance for Touch Points 2 and 3 as we have computer data on a weekly basis of the births that have taken place and are therefore able to provide accurate eligibility data.

	April	May	June
Touch Point 1(36 weeks)	24	11	12
Touch Point 2&3 (labour and immediate postnatal period)	134 surveys completed 295 births (45.42%)	126 surveys completed 298 births (42.28%)	61 surveys completed 240 Births (25.41%)
Touch Point 4 (10 day D/C)	24 Surveys	26	30

The dial below shows the overall satisfaction score of all patients surveyed during Q1 2014/15. This demonstrates that 88.09% of all women who used our services were satisfied (468 responses). This has increased slightly from Q4 from 86%. Response rates do fluctuate according to the birth rate.

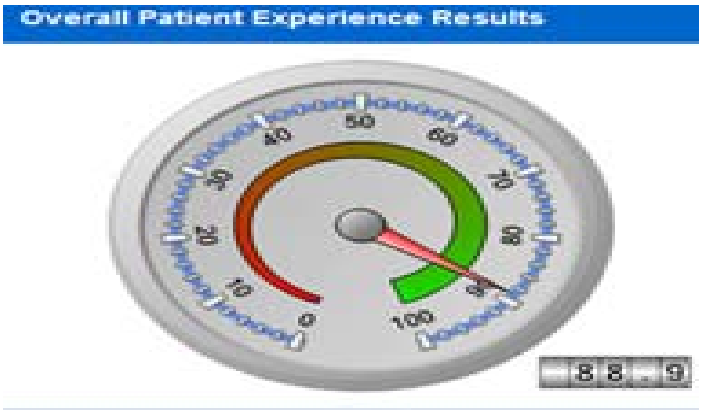
The following are examples from the 'you said' 'we did' comments from women using the service:

- Delay in going home – the Trust is training 8 midwives this year to be qualified in performing the Examination of the newborn which must take place within 72 hours of birth. Currently only the paediatricians and some GPs are qualified to perform the checks. The aim is to assit in supporting a smoother discharge for women and their families from the Conquest, Eastbourne and Crowborough units.
- Women wish their partners to stay - the Clinical Service Managers are working on this project currently and this will be offered soon once all the details are finalised.

Trending heat maps are often showing an increasing satisfaction with the food since the introduction of Steamplicity:

	April	May	June
20. How would you rate the hospital food?	68.19%	63.36%	72.21%

The dial below shows the overall satisfaction score of all patients surveyed during Q1 2014/15. This demonstrates that 88.9% of all patients who used our services were satisfied (11135 responses). This is in line with Q3, as are the number of responders.



3. Trust Improvement Indicators

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

Indicator	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
We will make sure you have the support and advice you need before being discharged from our care	89%	88%	88%									
We will give you clear high quality information about your condition, treatment and our services	91%	89%	90%									
We will treat you as an individual, listen to your views and respect your privacy and dignity	95%	94%	93%									
We will provide you with nutritious and appetising food, with as much support as you need, whilst in our care	78%	77%	79%									
Whilst you are an inpatient we will keep noise from staff at night to a minimum so that you can get the rest you need	82%	79%	79%									
Overall patient experience satisfaction	89%	88%	88%									
Total number of Responses	674	853	846									

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

3.2 The new meal service steamed meals have been rolled out across both acute areas in March 2014, ESHT have seen a rise in satisfaction since the implementation.

4. Quarter 1 Patient Feedback: FFT

4.1 This is a simple question “How likely are you to recommend us”. This provides a benchmark figure; the Net Promoter Score (NPS). The NPS is calculated between -100 and + 100. The NPS for ESHT Q4 was 64. The NPS for Quarter 1 is 58.

Q1	Total number of responses for each department	Total number of people eligible to respond	Response rate for each A&E department
CONQ A&E	1595	8441	18.89%
EDGH A&E	2027	8397	24.13%
ESHT	5807	21704	26.76%
ESHT Inpatient	2185	4866	44.90%

88.7% of inpatients were extremely likely to recommend us
(based on 2185 responses in Q1)

85% of patients who attended our emergency departments were extremely likely to recommend us
(based on 5807responses in Q1)

4.2 Appendix 1 provides a breakdown of the total responses between wards.

5. Ward level feedback examples

5.1 Ward level data from each individual area is reviewed monthly and analysed. On each patient facing clinical area, data is displayed on the 'How we are Doing' board in the format of "You said, We did" for all service users to view. Appendices 2 and 3 provide examples of actions from "You said, We did" and patient feedback.

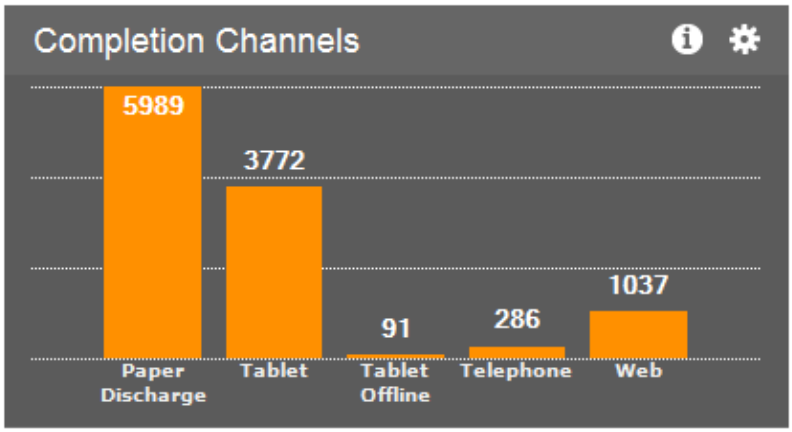
5.2 Additionally this data is triangulated with other quality information gathered by each clinical area, for example safety thermometer data, monthly quality review data, Serious Incident and Safeguarding data, in order to act on and improve service user experience.

6. Quarter 1 Staff FFT

The staff FFT response for 2014/15 was based on measuring one question asked in the annual staff questionnaire. Approximately 8000 questionnaires were distributed in June. ESHT Staff FFT score in 2013 was 3.28; the NPS score for 2014 is -18. Two listening into action sessions have been booked for July 2014, where the "You said We did" philosophy will be used to both provide feedback to staff of immediate and longer term actions based on the responses received and offer a further opportunity to gather staff views. Results and actions will be available to staff through communications.

7. Conclusion

7.1 The Trust has collected almost 11500 responses to the Friends and Family test within the last three months. Staff actively engage with patients and their families by offering a number of ways with which they can provide feedback as illustrated below:



7.2 The Trust believes that offering choice is an essential element of engaging with our patients and engages with patients by publicising the Friends and Family test throughout the Trust with posters explaining the process and encouraging patients to let us have their feedback. It also has an active Patient Experience (PE) Champion Programme in place. PE Champions are members of staff supporting and publicising the Patient Experience Strategy and the eight commitments staff have pledged to work by. Wards and departments are also encouraged to display their local "you said, we did" information to demonstrate to patients and their families that they are committed to making improvements based upon feedback. It is planned to extend this information to the Trust's website in the near future.

7.3 The Trust also works with its Service User Champions whom we have involved and will continue to involve in our further FFT roll out plans. We gain valuable feedback about whether methodologies will work and whether our publications are written in a way that people can understand.

7.4 The Trust is currently working on strengthening the triangulation of patient experience feedback. Patient experience data is essentially triangulated through two routes; one being quality reviews at a local team level, and the other being at Trust wide level through the Patient Experience Steering Group. Membership of this group includes representatives from each clinical unit, an Assistant Director (chair), a Non-executive Director and Patient Experience Lead. The group also invites patient and service user representatives and PE Champions. The steering group is currently being reviewed, new stakeholder groups run in conjunction with the LIA process will be held in September and October 2014.

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

7.6 The Patient Experience Steering Group is accountable for reviewing and triangulating data at a higher level across the Trust. The group reviews all feedback including feedback from National CQC surveys and discusses and determines action and monitors action plans with clinical units where appropriate. An example of change in this respect was the overall negative feedback the Trust had been receiving about food which led to the commissioning of a new meal service called 'Steamplicity' offering a wider choice of meals.

7.7 The next step for the Patient Experience Steering Group and locals teams will be review data in even greater detail to compare and identify where valid connections between the data may account for factors influencing the patient experience.

7.8 The Trust will continue to roll out of FFT and looks forward to ensuring patients/service users (through our Champion programme) are given an opportunity to be both involved in setting up the system and assisting us in ensuring feedback is provided in a way that is understood by all stakeholders.

8. Recommendation

8.1 The Trust Board is to take assurance that Quarter 1 targets have been achieved for both the patient and staff FFT, with data being triangulated, and actions are being taken as appropriate to improve patient experience.

BRENDA LYNES-O'MEARA
Assistant Director of Nursing for Professional Practice and Standards

July 2014

Appendix 1

Ward name	Total responses in each category for each ward						Total Number of people eligible to respond	Main 2 Specialties on each ward		Total responses for each ward	Response rate for each ward
	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know		S1	S2		
Benson Trauma	11	7	0	0	0	0	40	GERIATRIC MEDICINE	GENERAL MEDICINE	18	45.0%
Berwick	11	3	0	0	1	0	55	GENERAL MEDICINE	CARDIOLOGY	15	27.3%
Cookson Devas Elective	41	14	1	0	0	0	111	TRAUMA & ORTHOPAEDICS		56	50.5%
Cuckmere	15	4	0	1	0	0	24	GENERAL MEDICINE	GASTRO-ENTEROLOGY	20	83.3%
De Cham	6	3	0	0	0	0	59	GENERAL SURGERY		9	15.3%
EDGH CCU	42	6	0	0	0	0	66	CARDIOLOGY	GENERAL MEDICINE	48	72.7%
Folkington	7	3	0	0	0	0	34	GENERAL MEDICINE	ENDOCRINOLOGY	10	29.4%
Gardner	18	6	2	1	1	0	79	GENERAL SURGERY		28	35.4%
Glynde	1	0	0	0	0	0	31	ENT	ORAL & MAXILLO FACIAL SURGERY	1	3.2%

Hailsham 3	37	26	2	0	1	0	73	TRAUMA & ORTHOPAEDICS		66	90.4%
Hailsham 4	78	27	5	0	0	1	237	GENERAL SURGERY	GENERAL MEDICINE	111	46.8%
ITU / HDU (CONQ)	1	0	0	0	0	0	7	GENERAL MEDICINE	GENERAL SURGERY	1	14.3%
James/CCU	32	7	1	0	1	2	56	CARDIOLOGY	GENERAL MEDICINE	43	76.8%
Jevington	20	8	0	0	0	1	37	GENERAL MEDICINE	RESPIRATORY MEDICINE	29	78.4%
MacDonald Complex Elderly	8	5	1	0	0	3	33	GERIATRIC MEDICINE	GENERAL MEDICINE	17	51.5%
Mirrlees	45	8	0	1	0	0	57	GYNAECOLOGY		54	94.7%
Newington	12	14	1	2	0	4	43	GENERAL MEDICINE	GASTRO-ENTEROLOGY	33	76.7%
Pevensey Unit	29	6	1	0	0	0	36	HAEMATOLOGY	GENERAL MEDICINE	36	100.0%
RTU SAU	4	5	0	0	0	0	178	TRAUMA & ORTHOPAEDICS	GENERAL SURGERY	9	5.1%
Seaford 4 - Urology	29	5	2	1	0	0	137	UROLOGY		37	27.0%
Stroke Unit EDGH	38	3	2	0	1	0	81	GERIATRIC MEDICINE	GENERAL MEDICINE	44	54.3%
Tressell	3	1	1	0	0	0	57	RESPIRATORY MEDICINE	GENERAL MEDICINE	5	8.8%
Wellington	3	1	0	0	0	0	36	ENDOCRINOLOGY	GENERAL MEDICINE	4	11.1%

Chiddingly	0	0	0	0	0	0	0	GENERAL SURGERY		0	-
Hailsham 2	0	0	0	0	0	0	0	GYNAECOLOGY	GENERAL MEDICINE	0	-
ITU / HDU (EDGH)	0	0	0	0	0	0	3	GENERAL MEDICINE	GENERAL SURGERY	0	0.0%

Appendix 2 – "You Said, We Did"

Seaford 4 - Urology ward

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

Jubilee Suite

You said	We did
A warmer waiting area	We provide blankets, hot drinks and now have portable radiators when needed.

OPD – EDGH

You said	We did
Could we not go through old magazines and throw away old and tatty ones	We now regularly re-cycle old magazines as part of our housekeeping checks.

Benson ward - Conquest

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

General feedback – multiple wards

You said	We did
A number of you said our meal service needed improving.	The trust now serves an improved "steamplicity" meal service where patients have a wider choice of meals. We have now received lots of positive feedback. (May 2014).

Appendix 3 - Sample Patient Feedback from Family and Friends

Surprised by the level of support on offer post discharge

Being woken up unnecessarily at night on the first night of my stay. Long wait to be seen initially in assessment. I do realise that you were very busy and that there is a shortage of staff. I think they handled the situation very well

I would have liked to have spoken with the surgeon earlier than my release date but understand the constraints on the service I would have liked a copy of the X-ray to look at to understand what had happened

I couldn't of been treated any better to girls do a great job so keep it up cos u was all great

All staff compassionate and friendly and made me feel safe despite not having my friends or family here as far away from home.

Night time noise from other patients and staff was the only down side. All staff were helpful and friendly though

East Sussex Healthcare NHS Trust

Date of Meeting:	30 July 2014
Meeting:	Trust Board
Agenda item:	9
Subject:	Medical Revalidation & Medical Appraisals Annual Report 2013-2104
Reporting Officer:	Dr David Hughes, Medical Director (Governance) & Responsible Officer

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

Purpose:

The purpose of this paper is to provide assurances to the Trust Board, colleagues, patients and the public that the doctors in ESHT are compliant with the relevant legislation and GMC requirements for medical revalidation and medical appraisal.

The Chief Executive and/or the Chair of the Trust Board will be asked to sign a statement of compliance following presentation of this report that will be submitted to NHS England before 31st August 2014.

Introduction:

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

This paper highlights the achievements made by ESHT in relation to medical revalidation and appraisal in ESHT from 1st April 2013 to 31st March 2014.

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

The paper provides information about:

- The governance arrangements for medical revalidation and appraisals
- Medical appraisals in ESHT
- Medical Revalidation recommendations
- Quality assurance
- Challenges

Benefits:

The benefits of achieving medical revalidation and high medical appraisal rates for our trained medical staff are that they support our aim to make safe patient care our highest priority; it also assists in maintaining a skilled and motivated workforce. It additionally ensures that the Trust complies with current Responsible Officer Regulations and guidance issued by the General Medical Council (GMC) with regard to medical revalidation and medical appraisal.

Risks and Implications

The key risks associated with not implementing a medical revalidation system and processes are:

1. The RO (and therefore ESHT) will be in contravention of the Medical Professions (Responsible

Officers Regulations) 2010 and 2013;

2. The RO will be unable to make recommendations to the GMC about the fitness to practise of doctors employed in the Trust;
3. The doctors in the Trust are at risk of operating without a licence to practise;
4. The Trust would be unable to offer assurance to regulators, patients or public about the fitness to practise of the doctors employed in ESHT and there would be a loss of confidence in the Trust and damage to its reputation;
5. Doctors may not receive quality assured medical appraisals with all the benefits they confer for their personal development;
6. Timeliness of remediation would be affected with likely consequences for patient safety;
7. ESHT would be exposed to increased risk for clinical negligence claims, poor practice and reduced quality of patient care and patient safety;
8. ESHT may lose its CQC registration and NHSLA cover.

Assurance Provided:

Processes and systems are in place to support doctors to have their quality assured annual medical appraisal and for medical revalidation recommendations to be made to the GMC for all trained doctors in ESHT with a prescribed connection to the Responsible Officer. Where challenges have been identified there are actions planned to address them.

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

Clinical Management Executive – 23.06.14

Proposals and/or Recommendations

Members of the Trust Board are asked to approve this annual report and to support the medical revalidation and appraisal system in ESHT.

The Chief Executive and/or the Chair of the Board is/are asked to sign off the attached compliance statement so that it can be submitted to NHS England before the deadline of 31st August 2014.

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

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

Medical Revalidation and medical appraisals apply to all trained doctors with a prescribed connection to the Responsible Officer, therefore no risk to Equality & Human Rights has been identified.

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

Name:	**Contact details: EDGH**
Dr David Hughes, Medical Director (Governance) Dr Debbie McGreevy, Assistant Director – Medical Revalidation and Clinical Governance	Ext (13) 6253 or 6285

East Sussex Healthcare NHS
NHS Trust

MEDICAL REVALIDATION & MEDICAL APPRAISAL ANNUAL REPORT 2013 - 2014

1. INTRODUCTION

This annual report provides members of the Trust Board with information about the medical revalidation and appraisal system for all trained doctors in the financial year 2013 - 2014. The report is divided into the following sections:

- Governance arrangements
- Medical appraisals in ESHT
- Revalidation recommendations
- Challenges

2. BACKGROUND

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

2.1 Each provider organisation has a statutory duty to support their Responsible Officer (RO) in discharging their duties under the Medical Profession (Responsible Officer) Regulations 2010, as amended in 2013, and the General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012. The Responsible Officer role in ESHT is included within the Job Description of the Medical Director (Governance) and the RO was revalidated in early 2013. Arrangements have been agreed with NHS England for the provision of an alternative Responsible Officer in the infrequent occurrence of a conflict of interest or potential perception of bias.

It is expected that Trust Boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking that there are effective systems in place for monitoring the conduct and performance of their doctors;
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment checks (including pre-engagement for Locum Doctors) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 The key focus of the year 2013-2014 was the drive to ensure that all doctors will have their annual medical appraisal. The year 2014 – 2015 sees a shift towards appraisal becoming embedded as part of the culture with a targeted focus on the quality of the appraisals and the resultant drive in quality improvement for our patients within each individual doctor's practice.

3. GOVERNANCE ARRANGEMENTS

3.1 <u>Internal governance and assurance</u>

3.1.1 A performance report is submitted to the Trust Board each month, which provides details of the medical appraisal status of all doctors in the Trust who have a prescribed connection to the Responsible Officer.

ESHT also has a Service Level Agreement to provide Responsible Officer services to the doctors employed at St Wilfrid's Hospice and St Michael's Hospice. The appraisal status of these doctors is excluded from the overall Trust performance report but is monitored independently by the RO.

3.1.2 An annual report is provided to the Trust Board to provide assurances that the appropriate system and processes are in place, to provide information about the compliance status of doctors with regard to medical revalidation and medical appraisal and to bring to their attention any challenges or areas of concern. A Trust Board Seminar took place in November 2013 to familiarise members of the Trust Board with the systems and processes employed in ESHT for medical revalidation and medical appraisals.

3.1.3 As part of the 2-14/14 Annual Internal Audit Plan, it was agreed that TIAA, the Trust's internal auditor, would undertake a high priority review to provide assurance that appraisals are being effectively undertaken for doctors on a timely basis and in accordance with the GMC's medical revalidation requirements.

The audit assessed and evaluated the:

1. Appointment of the Responsible Officer and their training;
2. Support provided to doctors by ESHT;
3. Appraisal cycle and its link to the revalidation cycle;
4. Evidence and assurances that can be provided to show that all appraisals are being completed on a timely basis;
5. Quality and effectiveness of the appraisal process;
6. Reasons for missed and incomplete appraisals; and
7. Number of trained medical appraisers is sufficient to provide the number of appraisals needed each year

The final audit report, dated 3 February 2014, found that the system and process was well controlled overall, most of the expected key controls were in place and complied with, and there are no major weaknesses or unmanaged risks identified. The report provided an opinion of Significant Assurance to the Trust Board.

The audit report found the RO to be very effectively supported by the Medical Revalidation team. The report also highlighted the implementation of a Medical Revalidation Panel (MRP), which has been established to provide guidance and support to the RO in the decisions related to the recommendations made to the GMC for each doctor; this is regarded as good practice.

3.1.4 A medical appraiser tracker is maintained by the medical revalidation team which provides real time data regarding the medical appraisal and revalidation status of the trained medical workforce in ESHT. Until the end of March 2013, the tracker was supplemented by Revalidation Management System software supplied by Equiniti 360 Clinical. Following extensive consultation with the medical workforce and the medical appraisers, this software was replaced by using the Excel spreadsheet tracker and the GMC-prepared Medical Appraisal Guide Form (MAG).

3.1.5 All data is maintained according to Information Governance guidelines and policy and the tracker provides a thorough history of each doctor' appraisal progress, of lack thereof. If a doctor misses an appraisal, the reasons for this are noted and support offered to the doctor to have their missed appraisal at the earliest opportunity.

3.1.6 Each doctor is obliged to provide multi-source feedback (also known as '360 appraisal') supplied to them by patients and colleagues, within each five year medical revalidation cycle. Until 31st March 2013, this software was also supplied by Equiniti 360 Clinical.

Following a rigorous procurement process, the contract for this software has recently been awarded to Allocate for the coming three years, with an option to extend the contract by another two years, at the request of ESHT. This system is considerably less expensive than the previous system and appears to be more comprehensive and easier to navigate. Doctors are offered the opportunity of having a 360 appraisal at least twice per five year revalidation cycle and more frequently, if desired. Doctors are reminded to have their 360 appraisal report prepared for the medical appraisal immediately before medical revalidation.

3.1.7 The performance of doctors is monitored by the Clinical Unit Leads, who are professionally accountable to the Medical Director, and the Deputy Director of Human Resources who can also call upon the support of the GMC's Employer Liaison Adviser - South East & Channel Islands when appropriate.

Any concerns regarding a doctor's performance or conduct are raised at a bi-monthly meeting held between the Medical Director (Governance) and the Deputy Director of Human Resources. There is a 'Responding to Concerns' Policy, 'the Remediation Policy', in place in ESHT that specifies the process and support in place to address these concerns that is linked to the 'Maintaining High Professional Standards' document.

As an integral part of the appraisal process, each doctor is obliged to bring an Appraisal Governance Report to their annual medical appraisal for a reflective discussion with their medical appraiser. This report is developed by each Clinical Unit's clinical governance team and includes information on complaints, compliments and incidents.

3.2 <u>External governance and assurance</u>

3.2.1 Annual Organisational Audit

An Annual Organisational Audit was submitted by the RO to NHS England in June 2014 which provides end of year information and helps to:

1. provide an understanding to NHS England of the progress that organisations have made during 2013/14;
2. provide a tool that helps Responsible Officers to assure themselves and their Boards that the systems underpinning the recommendations they make to the GMC on doctor's fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place; and
3. provide a mechanism for assuring NHS England (as the senior Responsible Owner for medical revalidation in England, the England Revalidation Implementation Board and the GMC that systems for evaluating doctors' fitness to practise are in place, functioning, effective and consistent.

No concerns have been raised within this report.

3.2.2 Quarterly report to NHS England (South)

A quarterly report is submitted to NHS England that includes information regarding the running total of medical practitioners who have had their annual medical appraisal and/or have had a recommendation made about their revalidation during the current financial year.

3.2.3 Compliance with NHS England Core Standards

A comprehensive overview of the requirements of the Responsible Officer Regulations and associated mandatory guidance, alongside NHS England's suggestions of good practice, has recently been provided to all Designated Bodies in a single document.

In ESHT, the medical revalidation team has adapted this document to form a combined status report and development plan. The status report demonstrates that ESHT is already compliant with 93 of the 107 standards and has actions in place for those standards for which we declare as 'amber' or 'red'.

One of the core standards is that of public involvement in the medical revalidation process. A Non-Executive member of the Trust Board has been invited to take an interest in medical revalidation. The Non-Executive Director will have a responsibility for advising the Medical Director in his role as Responsible Officer and for providing further assurances to the Trust Board.

3.2.4 Trust Board Compliance Statement

Each year the Trust is expected to submit a statement of compliance with the quality assurance core standards to NHS England. This year the deadline for submission of the statement of compliance is 31 August 2014. This statement is submitted with commentary with this annual report for signature by the Chief Executive and/or the Chair of the Trust Board.

ESHT can be considered as compliant, or working towards full compliance, with all the following standards:

1. A licensed practitioner with appropriate training and suitable capacity has been nominated or appointed as a Responsible Officer
2. An accurate record of all licensed medical practitioners with a prescribed connection to the Designated Body is maintained
3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners
4. Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements
5. All licensed medical practitioners either have an annual appraisal in keeping with the GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken
6. There are effective systems in place for monitoring the conduct and performance of all licensed practitioners, which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal
7. There is a process established for responding to concerns about any licensed medical practitioners' fitness to practise
8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's Responsible Officer and other Responsible Officers in other places where licensed medical practitioners work
9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licensed medical practitioners have qualifications and experience appropriate to the work performed
10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations

4. MEDICAL APPRAISALS IN ESHT

4.1 On 31st March 2014 ESHT employed 192 Consultants, 70 Staff Grade and 55 Locum Doctors with a prescribed connection to the Responsible Officer in ESHT.

4.2 Of these 317 doctors, 313 had their annual medical appraisal within the 12 months as dictated by the ESHT Medical Revalidation & Medical Appraisal Policy. (All four remaining doctors have now had their annual medical appraisal). If doctors do not have their appraisal or fail to submit their documentation to the medical revalidation team within 28 days of their appraisal, there is a robust process for addressing what is perceived as 'non-engagement'. Non-engagement culminates, after the exhaustion of all exploring all avenues of support, in the reporting of the doctor to the GMC. This can lead to the loss of the doctor's licence to practise. The process for addressing non-engagement is explained in the recently revised ESHT Medical Revalidation & Medical Appraisal Policy (2014). No doctors in ESHT have yet been reported to the GMC for non-engagement.

4.3 There has been a significant increase in medical appraisal activity in 2014/14 compared to the years 2011/12 and 2012/13. Please see Fig.1 below.

Fig.1 Doctors' compliance with medical appraisals over the past three years

	total	***2011-2012 compliant***	***%***	***total***	***2012-2013 compliant***	***%***	***total***	***2013-2014 compliant***	***%***
Consultants	203	136	67	197	154	78	192	190	99
SAS	91	54	59	81	59	73	70	68	97
LAS/Locum	12	0	0	0	0	0	55	55	100
Total	306	190	**62**	278	213	**77**	317	**313**	**98.5**

4.4 The year 2013-2014 saw a focused effort by the Responsible Officer, assisted by the Medical Revalidation team and the Medical Revalidation Panel, to ensure that all trained doctors engaged with the medical appraisal process. This means that ESHT has achieved a compliance percentage of over 98% for medical appraisals, which is in excess of the 90 – 95% expected by NHS England for acute Trusts. Benchmarked data should be available from NHS England later this year for medical appraisals and medical revalidation in all acute Trusts.

4.5 For the appraisal year 2014 – 2015, doctors were offered an opportunity to choose their medical appraiser before the end of February 2013. Those who did not take up this opportunity were allocated an appraiser. There is new guidance included within the revised Medical Revalidation and Medical Appraisal Policy on the process for randomised allocation of medical appraisers and details of the appeal process if there is a conflict of interest or perception of bias.

4.6 Medical appraisals are conducted between April and December each year and Clinical Unit Leads are being advised that job plans should be completed before April each year so that there is an increased opportunity for alignment between personal, Clinical Unit and organisational objectives.

4.7 Quality assurance of medical appraisals

The quality and effectiveness of appraisals and the performance of medical appraisers is monitored by the Medical Revalidation Panel (MRP) using triangulated data from:

1. The number of appraisals undertaken between 1 April 2013 and 31 March 2014
2. The quality of the outputs of appraisals – Appraisal Summary (as audited by MRP)
3. The quality of the outputs of appraisals – Personal Development Plan (PDP) as audited by the MRP

4. The results of feedback from doctors who were appraised by the medical appraiser
5. Any relevant Continuing Professional Development that the medical appraiser has undertaken i.e. attendance at medical appraiser update sessions
6. Mandatory training compliance

7. Receipt by the medical revalidation team of the PDP that includes an objective that refers to updating and improving their skills as a medical appraiser
8. Reflection statement by appraiser

If there are any perceived training or developmental needs these are offered to the medical appraiser on an individual basis and/or as part of the ongoing training and support to medical appraisers.

4.8 There are currently 39 trained medical appraisers in the Trust, which exceeds the requirements of the core standards; however, it is beneficial to have sufficient numbers of medical appraisers to cope with the additional appraisal demands of locum doctors and those working on short term contracts. To address this, a recruitment drive for medical appraisers is being implemented. Medical appraisers are well supported with regular training and action learning sets to ensure that they are kept up to date with GMC, NHS England and Trust requirements. We have been fortunate in ESHT to have a committed core of medical appraisers; not taking into account those who have left the Trust, very few of the original medical appraisers have relinquished this role so far.

All new medical appraisers receive full training and support, supplied internally by the Assistant Director – Medical Revalidation & Clinical Governance who also acts as the Appraisal Lead for the Trust and liaises directly with NHS England as such. The first three appraisals undertaken by new medical appraisers are monitored and supported closely and new medical appraisers are also subject to a six month probation period.

5. MEDICAL REVALIDATION RECOMMENDATIONS 2013 – 2014

5.1 During 2013 – 2014, the first year of medical revalidation, the target in ESHT for revalidation recommendations to the GMC was a total of **56**; ESHT submitted **88** recommendations.

Fig 2. The following numbers of recommendations were made during 2013 - 2014:

2013 – 2014 medical revalidation recommendations	
Target for total recommendations	**56**
Positive recommendations made	**84**
Deferrals made*	4
Non-engagement	0

* includes one doctor who was deferred twice

5.2 The target for 2014 – 2015 is for 93 recommendations to be made to the GMC and ESHT is already making good progress towards reaching this target with 31 recommendations due to be made by mid July 2014.

5.3 Quality assurance of medical revalidation recommendations

During 2013, MRP members undertook a GMC-prescribed consistency check to assess whether recommendations made to the GMC would be consistent with those suggested by the GMC for differing scenarios. This check demonstrated a 100% pass rate for all panel members.

6. CHALLENGES

6.1 This year some of the key challenges faced by the medical revalidation team can be summarised as:

6.2 *The lack of engagement with doctors with the Equiniti Revalidation Management System (RMS)*

Despite offering extranet guidance, numerous training sessions for groups and individual doctors, specific guidance documents and direct support from Equiniti such as webinars and a helpline, the majority of doctors still preferred to use the GMC-prepared Medical Appraisal Guide (MAG) form. A consultation was held with the medical appraisers who voted to discontinue with the Equiniti RMS and to use the MAG only for appraisals. The MAG is free to use and is not web based but has many advantages to doctors who are less familiar with using software.

Actions being taken:

The contract with Equiniti was terminated on 31st March 2014 and doctors advised to use the MAG as the only method of medical appraisal from 1st April 2014.

The 360 appraisal, also known as Multi Source Feedback (MSF), software and service was also supplied by Equiniti until 31st March 2014 when the contract was terminated. A tender process was implemented and a contract has recently been awarded to Allocate Software who also provide the Trust's software for e-rostering.

6.3 *Workforce planning for medical appraisers*

It is essential that ESHT has sufficient medical appraisers to offer a full quality assured medical appraisal to all medical staff who have a prescribed connection to the Responsible Officer. It is also the case that medical staff join and leave ESHT every month so there are more doctors to appraise over the year than are necessarily reported on a 'snapshot' monthly basis.

Actions being taken:

A recruitment drive for more medical appraisers has been planned to take place over the summer. Doctors will need to undertake formal GMC-prescribed training; the Assistant Director – Medical Revalidation & Clinical Governance is fully trained and quality assured to provide this training at no cost to ESHT.

6.4 *Capacity for increased recommendations*

There is a need to support the RO in the increased external governance requirements and there is also an exponential increase in the numbers of doctors needing to be recommended for revalidation; there are numerous changes in monitoring requirements as medical revalidation matures as a process. The Medical Revalidation team now also monitor compliance with job planning and act as a repository for job plans.

Actions being taken:

The Medical Revalidation team have adopted methods of working that support the RO and doctors, whilst simultaneously limiting the time this support takes to provide by implementing a Trust extranet site and the frequent use of template emails and letters. The use of the revised Medical Revalidation and Medical Appraisal Policy provides structure for a consistent approach to be provided across the medical workforce. Nonetheless,

frequently there is no substitute for offering individual support, or for addressing fitness to practise concerns, and this inevitably will pull heavily on the team's resources.

6.5 *Quality of medical appraisal outputs*

The focus in the first year of medical revalidation was on the quantity of medical appraisals, which was very successful for the year 2013-14 and all doctors are now engaging with the process, albeit with varying degrees of enthusiasm.

The focus in year 2 builds upon that engagement and shifts its focus to the quality of the appraisal itself. The key messages from the GMC are that medical appraisals allow doctors to reflect upon their performance and their own development needs, whether to address personal aspirations or to comply with the requirements of their agreed job plan. There were training needs identified for many of the medical appraisers with developing effective Personal Development Plans and appraisal summaries in the medical appraisals they were providing.

Actions being taken:

The most recent medical appraiser action learning sets supported medical appraisers in developing effective Personal Development Plans and Appraisal Summaries. The quality of the medical appraisers has been described in section 4.7 of this document.

6.6 *Establishing the prescribed connection*

This situation is improving as doctors engage with the medical revalidation system but there is still a potential for new doctors to be unaware of how to establish a prescribed connection with the RO of the relevant Designated Body.

Actions being taken:

As new doctors join ESHT they are provided with a welcome pack regarding their medical appraisals and medical revalidation by the medical revalidation team. This has the effect of supporting the doctor at an early stage in their employment and provides data to the medical revalidation team regarding the prescribed connection status.

6.7 *Incomplete employment data*

As medical revalidation was a relatively new system last year it was soon identified that there was a need to communicate with the Responsible Officer, via the medical revalidation team, when employing new medical staff so that information could be passed on from their previous RO.

Actions being taken:

A process has been agreed with medical recruitment, but is not yet fully embedded, for the transfer of information for doctors joining ESHT. There is a plan in place to address this.

There is a transfer of information process in place for doctors who have a prescribed connection to ESHT but who also work elsewhere, the evidence of which is required at annual appraisal. NHS England has recently developed an electronic method of transferring information which is more effective and efficient.

6.8 *Responsible Officer training*

The RO has been unable to attend mandatory RO network meetings and training due to clashes with other work commitments.

Actions being taken:

An agreement has been reached between the CEO and the RO that the RO will protect the requisite time to attend these training and update sessions.

6.9 *Assessment of cost and impact of investigation and responding to concerns*

A method of providing this information to the relevant sub committee of the Trust Board is being developed by the Deputy Director of Human Resources.

7. CONCLUSION

The system for medical revalidation and medical appraisal processes has been further and successfully developed in ESHT over the last year. There remain some challenges as outlined in this annual report but these are being addressed in collaboration with colleagues in the Trust. The Trust continues to be regarded as an example of good practice in the NHS England South Region and can be proud of its achievements in implementing its medical revalidation system and processes to promote patient safety and the development of its medical staff.

Dr Debbie McGreevy
Assistant Director Medical Revalidation & Clinical Governance

30 July 2014

East Sussex Healthcare NHS
NHS Trust

1. Equality and Human Rights Analysis (EHRA)

Guidance is appended to this form or click the 'Help' links… Help

Title(s): Medical Revalidation and Medical Appraisal Annual Report
Aims: The Annual Report for Medical Revalidation & Medical Appraisal aims to provide a summary of: the governance arrangements relating to medical revalidation and medical appraisals; and data relating to medical revalidation and medical appraisals for the year 1.4.13 – 31.3.14 in order to provide assurances to the Trust Board

2. Evidence

Help

Please describe any relevant evidence about people's characteristics (e.g. health inequalities) and how people's views have been included ➲ E.g. admission / incident data; NICE / clinical guidance / research; surveys ➲ Mark with an '**X**' in the columns the relevant characteristics	Mark '**X**' relevant characteristics							
	Age	Disability and Carers	Gender Reassignment	Pregnancy or Maternity	Race	Religion or Belief	Sex	Sexual Orientation
Medical Revalidation is applicable to all trained doctors in the Trust								

+ Insert more rows if necessary

3. Equality Impacts

Help

Please evaluate how the work impacts people with protected characteristics differently to meet the three **aims (A-C)** of the Equality Duty below. If a particular aim is not relevant to the work please explain why.

Aim A. Eliminate discrimination – Please describe if the work might treat people negatively: ➲ Include who is impacted (e.g. carers with learning disabilities) ➲ Explain if it is lawful (e.g. exceptions, exclusions or statutory authority) ➲ Include the reasons if it can be objectively justified	Mark '**X**' relevant characteristics							
	Age	Disability and Carers	Gender Reassignment	Pregnancy or Maternity	Race	Religion or Belief	Sex	Sexual Orientation
Medical Revalidation is applicable to all trained doctors in the Trust								

+ Insert more rows if necessary

Aim B. Advance equality of opportunity – Please describe how the work: ➲ Minimises disadvantage linked to a characteristic (e.g. health outcomes) ➲ Meets different needs (e.g. within care or at work) ➲ Encourages participation when it is disproportionately low (e.g. therapies)	Mark '**X**' relevant characteristics							
	Age	Disability and Carers	Gender Reassignment	Pregnancy or Maternity	Race	Religion or Belief	Sex	Sexual Orientation
Medical Revalidation is applicable to all trained doctors in the Trust								

+ Insert more rows if necessary

Aim C. Foster good relations – Please describe how the work: ➲ Tackles prejudice (i.e. reduces negative bias by changing attitudes) ➲ Promotes understanding (e.g. staff guidance on diverse patients' needs)	Mark 'X' relevant characteristics							
	Age	Disability and Carers	Gender Reassignment	Pregnancy or Maternity	Race	Religion or Belief	Sex	Sexual Orientation
Medical Revalidation is applicable to all trained doctors in the Trust								

+ Insert more rows if necessary

4. Monitoring Arrangements

Help

Please describe how any equality impacts will be monitored: (e.g. annual policy / incident data review)
n/a

5. Human Rights Impacts

Help

Please describe how the work promotes or supresses fairness, respect, equality, dignity and autonomy:
Medical Revalidation is applicable to all trained doctors in the Trust

Mark **'X'** in the relevant column which rights are safeguarded or breached by the work	+	–
Article.2 Right to life (e.g. Pain relief, DNAR notices, staff competency, suicide prevention)		
Article.3 Prohibition of torture, inhuman or degrading treatment (e.g. Informed consent)		
Article.4 Prohibition of slavery and forced labour (e.g. Safeguarding trafficked people)		
Article.5 Right to liberty and security (e.g. Deprivation of liberty protocols, security policy)		
Articles.6-7 Rights to a fair trial; and no punishment without law (e.g. Legal services policy)		
Article.8 Right to respect for private and family life, home and correspondence (e.g. Confidentiality, records, patient letters, patient visitors or staff leave)		
Article.9 Freedom of thought, conscience and religion (e.g. Last offices, prescribing, uniform)		
Article.10 Freedom of expression (e.g. Patient information or whistle-blowing policies)		
Article.11 Freedom of assembly and association (e.g. Trade union recognition)		
Article.12 Right to marry and found a family (e.g. Fertility, maternity services)		
Article.14 Prohibition of discrimination in human rights (e.g. Literacy and the right to privacy)		
Protocol.1.A1 Protection of property (e.g. Patient property, last offices policies)		
Protocol.1.A2 Right to education (e.g. Student nurse agreement policies)		
Protocol.1.A3 Right to free elections (e.g. Foundation Trust elections)		

6. Outcome

Help

X	Mark 'X' against the final outcome(s) **a-d** of the analysis and note the reasons why in the space below:	
X	**(a)** Continue the work	Medical Revalidation is applicable to all trained doctors in the Trust
	(b) Change the work	
	(c) Justify and continue the work	
	(d) Stop the work	

If you selected outcome **(d)** please score any equality or human rights risks below:

Consequence score:		x	Likelihood score:		=	**Equality and Human Rights Risk Score:**	

Assurance Statement: I have reviewed the evidence with rigour and an open-mind and am satisfied there has been due regard to the need to eliminate discrimination; advance equality of opportunity and foster good relations, and there is compliance with Section 149 of the Equality Act 2010.	
Analysis Lead(s) Sign-off:	Date:
Quality Assessor (Office Use):	Date:

7. Equality Improvement Plan

Help

Actions (Reference the findings within previous sections to show cause and effect)	Target Date	Lead Person	What action plan will this be built into?
2) Actions to improve evidence or engagement:			
3a) Actions to eliminate discrimination, harassment, victimisation and any other prohibited conduct: • This **must** be completed prior to submitting your work for ratification or approval			
3b) Actions to advance equality of opportunity: • i.e. Overcome or minimise disadvantage; meet different people's needs and encourage participation			
3c) Actions to foster good relations, tackle prejudice and promote understanding:			
4) Actions to improve monitoring arrangements:			
5) Actions to promote and safeguard human rights:			

\+ Insert more rows if necessary

Append this form to the main paperwork and send it to equality@esht.nhs.uk for quality assurance before ratification or approval. After this the form will then be published on the Trust's website.

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Version 4, April 2014

DH Department of Health

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England INFORMATION READER BOX		

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	01142
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http:// www.england.nhs.net/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

Annex E – Statement of Compliance

Designated Body Statement of Compliance

The Trust Board of East Sussex Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   The Medical Director (Governance) has been formally appointed as the Responsible Officer and has received full training.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   A real time tracker is maintained by the medical revalidation team for all doctors with a prescribed connection to ESHT

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Over ten per cent of the trained medical workforce are fully trained and supported medical appraisers.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Medical appraisers receive regular updates, support and development activities that include peer review and calibration of professional judgements.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   All licensed medical practitioners in ESHT should have an annual medical appraisal. Those who are slow to engage are followed up and the reasons for a delayed appraisal are noted.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Comments: A more effective system is being developed for monitoring the conduct and performance of individual doctors and a system is in place for doctors to include relevant clinical governance data within their supporting information.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

There is a ratified Remediation Policy in place.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

A process has been agreed with medical recruitment, but is not yet fully embedded, for the transfer of information for doctors joining ESHT. There is a plan in place to address this. There is a transfer of information process in place for doctors who have a prescribed connection to ESHT but who also work elsewhere, the evidence of which is required at annual appraisal.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licensed medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Pre-employment checks are conducted on locum doctors; doctors recruited via an agency have their own Responsible Officer.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

A development plan is in place with medical recruitment for implementing the RO transfer of information for doctors joining ESHT.

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

[Chief Executive or Chair]

Date: _ _ _ _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	10
Subject:	Knowledge Management and Information Technology Strategies
Reporting Officer:	Dr Amanda Harrison, Director of Strategic Development and Assurance Vanessa Harris, Director of Finance

Action: This paper is for **(please tick)**					
Assurance	✓	**Approval**	✓	**Decision**	
Purpose:					
The attached documents detail the strategies for Knowledge Management (Information Management and Clinical Information Systems) and Information Technology					

Introduction:

The strategies have been developed following the review of the Business Intelligence (BI) function and the associated key areas such as coding, data quality and clinical information systems. Widespread interviews were held with a range of staff both corporately and across the divisions and staff were also invited to comment on the review through an on-line survey. This strategy has been based on the views of those involved and outlines the way in which Knowledge Management and Information Technology will operate and function in order to support the Trust in its Aims and Objectives.

The vision for the strategies are:

- Real time, accurate, transparent data and information supporting the trust operationally and strategically
- Information systems which support clinicians and staff to provide safe, efficient and effective patient care
- Access to clinical and corporate systems any time, any place and anywhere
- Provide a robust technology platform ensuring a reliable and consistent service to service users
- To digitise processes creating a fully electronic workspace to improve corporate and clinical processes

The Strategies outline how the departments will support the Trust in moving forward in the increasingly digital environment to support clinicians and patients in improving the efficiency and effectiveness of their care and to assist in the delivery of real time information that will improve decision making across the Trust and assist in improving outcomes for patients.

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

The Trust currently has a number of areas requiring development within these areas and the strategies aim to address these issues:

- Aging infrastructure
- Multiple in house developed and managed systems
- Fragmented warehouse
- Silo-ed systems unable to interact with other systems
- Aging servers
- Multiple log on's for medical staff access
- Paper based systems still in place in many areas
- Many systems reliant on the knowledge of one individual
- Limited disaster recovery
- Limited governance
- Poor flow of information
- Embedded legacy practices

Benefits:

Implementation of the strategies would enable:

- A robust infrastructure with technology that supports electronic paper free systems.
- Integrated systems which share information appropriately to support patient care and information flows
- The ability for staff to access appropriate information at any location, at any time.
- High quality information which allows appropriate decision making
- Assurance of sustainability and disaster recovery
- Supporting staff to work in a more efficient and modern way

Risks and Implications

Should the Trust adopt a do nothing approach it would be at risk of the following:

- Healthcare may be disjointed across the system as a result of poor information flows and outdated technology
- Operating costs may be increased due to the requirements of sustaining multiple aging systems, warehouses and servers
- Poor manual data capture may result in an inability to meet requirements of commissioners in terms of reporting and demonstrating performance
- There is a potential loss of future income as a result of not meeting tendering requirements through IT infrastructure and data flows and therefore the Trust may not be able to demonstrate competitive ability
- The insufficient and untimely flow of information may affect appropriate decision making for management and operations
- There is the potential of large scale outage due to system failures

Assurance Provided:

The strategies have been developed cohesively to work together and ensure they support the overall Trust Objectives. A process of external and internal review for both strategies has been undertaken.

Review by other Committees/Groups (please state name and date)**:**
Trust Board Seminar 16.07.14

Proposals and/or Recommendations
The Trust Board is asked to approve the Knowledge Management Strategy 2014-17 and IT Strategy 2014-19

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: (13) 3754**
Sarah Goldsack, Associate Director – Knowledge Management	sarah.goldsack@nhs.net
Tony Deal, Associate Director - IT	tony.deal@nhs.net

Knowledge Management Strategy
2014-2017

East Sussex Healthcare NHS
NHS Trust

Associate Director of Knowledge Management
June 2014

Knowledge Management Strategy
2014-2017

Contents Page

Knowledge Management Strategy
2014-2017

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1. Introduction

1.1 This strategy sets out the vision and principles with regards to Knowledge Management within East Sussex Healthcare NHS Trust (ESHT) over the next 3 years and outlines how we intend to deliver the objectives. The strategy is focussed on the Information Management and Clinical Information Systems. Clinical Coding and Data Quality have been developed and together these form the entirety of the Knowledge Management Strategy.

1.2 The strategy takes into account the national and local drivers within Information Management to ensure that ESHT is meeting and where possible exceeding the requirements with regards to data collection, provision, analysis and sharing.

1.3 The strategy has been developed following the review of the Business Intelligence (BI) function and the associated key areas such as coding, data quality and clinical information systems. Widespread interviews were held with a range of staff both corporately and across the divisions and staff were also invited to comment on the review through an on-line survey. This strategy has been based on the views of those involved and outlines the way in which Knowledge Management will operate and function in order to support the Trust in its Aims and Objectives.

2. Vision

2.1 The vision is for Knowledge Management to be the trusted hub of information management and knowledge for the Trust.

Mission

2.2 To provide an information and data based service for the Trust by developing a proactive knowledge culture based on real-time, accurate, assured data which is transparent, available at multi-levels and driven by fit for purpose clinical systems and coding processes.

Objectives

2.3 To ensure that our information systems support our clinicians and staff to provide safe, efficient and effective care for patients. We will plan to integrate and consolidate existing systems to reduce duplication of effort and aspire to procure / implement systems that are more user-friendly and use newer technologies.

2.4 To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust.

Aims

2.5 Solid BI systems will be in place to ensure accessible and useable data from multiple sources

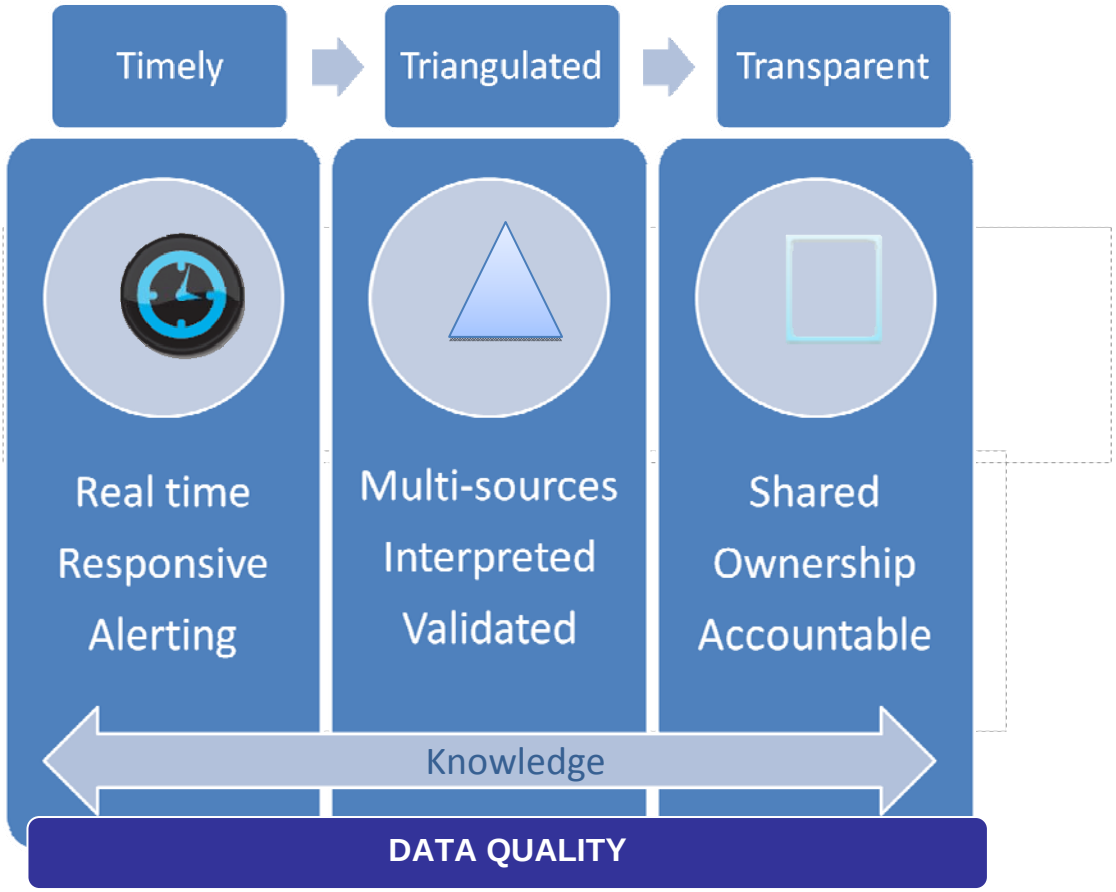
2.6 To build a central resource of system management experts across the full range of our patient systems to enable the trust to maximise use of this resource and ensure that each of the systems is supported internally. For some systems the system management resource will stay in the clinical unit but need to have strong accountability into a central team / person?

2.7 To provide a central “go to” portal area where information from systems will be made available using the most appropriate output mechanism for that information and the target audience.

2.8 Data from these systems will be stored in a central data repository (Data warehouse) which will better enable the organisation to validate and share where-ever possible and appropriate both internally and externally. We will move towards having more live data available from as many systems as possible to better enable use of the data by other clinical / administrative systems and potentially to help feed more live reporting where relevant.

2.9 To ensure that all systems have robust contract / support arrangements with their suppliers and that each system has a forward plan

2.10 The strategy therefore is based around the 3 T’s principle of Timely, Triangulated, and Transparent:



3. Business Context

3.1 East Sussex Healthcare NHS Trust is a large multi-site Integrated Trust providing acute and community services across East Sussex.

3.2 Each year the Trust treats:

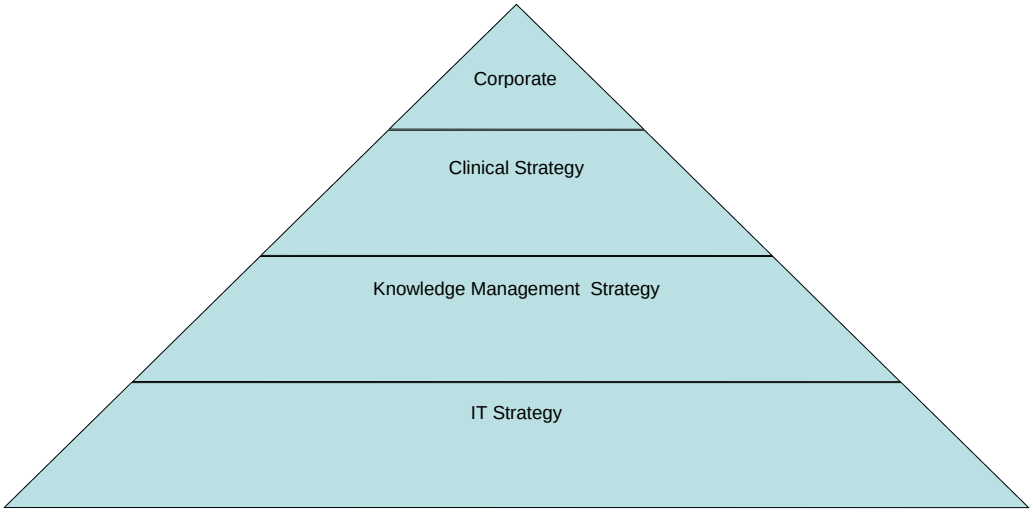
3.3 The Trust Mission, objectives and aims are:

Mission Statement:
Deliver better health outcomes and an excellent experience for everyone we provide with healthcare services.

Objectives:
- 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.

Aims:
- Communicate effectively with our patients, our staff, our community and our partners
- Deliver the right care in the right place at the right time by working in partnership and through clinical networks
- Drive productivity and efficiency and, where appropriate, maximise our market share
- Provide high quality, innovative and accessible care
- Maintain and develop a skilled and motivated workforce

3.4 The Knowledge Management strategy has been developed to support the aims and objectives of the corporate and clinical strategies and in turn will be supported by the IT strategy



4. National Context

4.1 The Power of Information

4.1.1 In May 2012 the Department of Health published its new information strategy – The Power of Information. This sets a ten year framework for transforming information for the NHS, public health and social care. The focus of the strategy is on improving access to information. Implicit in the strategy is a central theme of sharing information between health and social care providers.

4.1.2 The key ambitions of the national strategy are:

- **Information will be used to drive integrated care** across the entire health and social care sector
- **Information regarded as a health and care service in its own right for us all** –with appropriate support in using information available for those who need it, so that information benefits everyone and helps reduce inequalities
- **A change in culture and mindset**, in which our health and care professionals, organisations and systems recognise that information in our own care records is fundamentally about us – so that it becomes normal for us to access our own records easily
- **Information recorded once, at our first contact with professional staff**, and shared securely between those providing our care – supported by consistent use of information standards that enable data to flow between systems whilst keeping our confidential information safe and secure
- **Electronic care records become the source for core information** used to improve our care, improve services and to inform research, etc. – reducing bureaucratic data collections and enabling us to measure quality
- **A culture of transparency**, where access to high-quality, evidence-based information about services and the quality of care held by Government and health and care services is openly and easily available to us all
- **An information-led culture** where all health and care professionals take responsibility for recording, sharing and using information to improve care
- **The widespread use of modern technology** to make health and care services more convenient, accessible and efficient
- **An information system built on innovative and integrated solutions and local decision-making**, within a framework of national standards that ensure information can move freely, safely, and securely around the system

4.1.3 The national strategy includes a number of central and local level actions. All of these will require increased partnership working:

4.1.4 Centrally

- A **standards route map** will be developed
- A comprehensive **online portal** will bring together the best of the relevant information on health, public health, care and support
- All nationally held **clinical datasets will be published by 2014**, but not at a level which allows identification of patients
- Central bodies (the CQC, Monitor, the NHS CB) will consider how they can **incentivise the vision** in this strategy
- An **independent review of information governance** will be led by Dame Fiona Caldicott.

4.1.5 Locally

- Organisations will seek and respond to **patient and service user feedback**
- Procurement decisions will be made in line with the **information standards** roadmap
- **Support for interpreting information** will be provided to those who need it
- **Electronic transactions** will be made available to patients
- The **informatics profession** will be developed
- Online **professional access to records** will allow the sharing of records
- Patients will, in time, have **access to records beyond general practice.**

4.1.6 Every organisation is directed to nominate a board-level information lead, with the aim of improving accountability and strengthening governance around the quality of an organisation's data.

4.1.7 The document states that as part of this transformation, information must be regarded as a health and social care service in its own right. It says there is a need to catalyse a cultural shift in favour of information sharing and information enabled services.

4.2 The Francis Report

4.2.1 Following the public enquiry, on 6th February 2013 Robert Francis QC published his report into the failings of Mid-Staffordshire NHS Foundation Trust.

4.2.2 The report is clear about the positive role that information can play, encompassing the issues such as: highlighting inadequate performance; accountability; informing the public; and supporting patient choice. Francis advocates an integrated system with common information practices, while acknowledging that the Government's information strategy "appears to contain most if not all" of his suggested elements.

4.2.3 A number of recommendations relate to information management and are therefore applicable within the scope of Knowledge Management. The recommendations cover:

- A focus on transparency and sharing of information in a relevant, useable way
- The provision of accurate information regarding compliance with standards
- Outcomes and performance data to be shared with staff, patients and regulators
- Effective, real time information where possible
- Performance information at service and consultant level should be accurate and shared
- A board level responsible office for Information should be nominated

4.2.4 These recommendations have been incorporated into the Knowledge Management Strategy

4.3 The Keogh Report

4.3.1 The Keogh Report made a number of recommendations and comments regarding information management and quality reporting including:

- Information should be streamlined and easily accessible with a common data set for quality
- The NHS data sets are complex and present difficulties for professionals, patients and the public who wish to use them
- There is a shortage of key skills in data analysis and interpretation available to trust boards and management teams
- Quality metrics and information require more consistency
- All trusts need to review their quality performance reporting to ensure it is measuring the right things, triangulated effectively to identify risk areas and is tested through systematic assurance programmes.

4.4 The Care Quality Commission (CQC)

4.4.1 The CQC will be publishing their "Intelligent Monitoring" on a quarterly basis. This covers a range of indicators which are used to "grade" hospitals and highlight potential trusts for inspection.

4.5 The Trust Development Authority (TDA)

4.5.1 The TDA has its own set of indicators, methodology and thresholds it measures trusts against. This supersedes the previously used National Performance Framework.

4.6 National guidance and requirements will continue to be reviewed and will be reflected in further updates of the Knowledge Management Strategy

5. Local Context

5.1 Following research at different trusts around England it was agreed that by ESHT that the way in which functions associated with Knowledge Management are organised and managed at East Kent Hospitals University Foundation Trust (EKHUFT) represented a successful model and as such it was agreed that EKHUFT would provide an external review to ESHT in order to recommend changes which would improve performance.

5.2 As a result of the review a number of key themes emerged:

- Organisational structure
- Performance Management
- Ownership and control of data
- Raising the profile of data

5.3 These elements need to be tackled and improved to ensure data is used more effectively within the trust to improve quality, efficiency and clinical outcomes.

5.4 EKHFT proposed a new and separate department is created called Knowledge Management, encompassing Data Quality, Clinical Coding, Information Management and Clinical Information Systems.

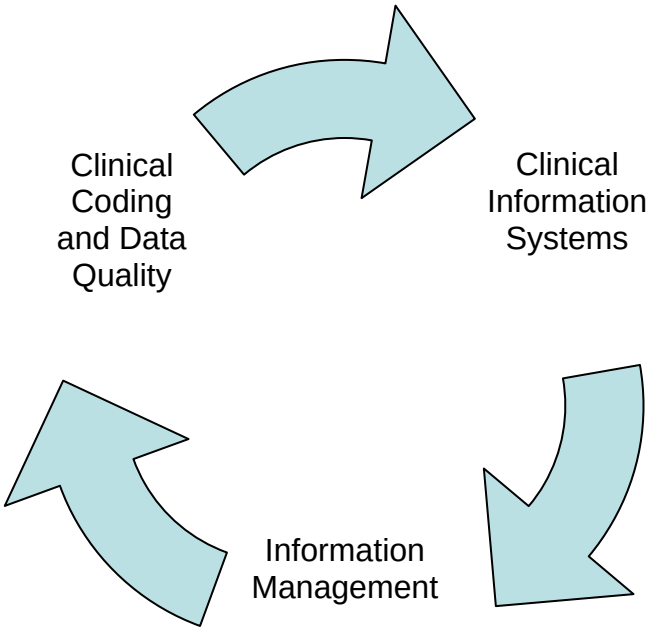
Medical Records was considered within this structure however it was agreed that this would be further reviewed at a later stage. This structure should help improve communication, remove some of the barriers to progress and provide clearer ownership and better control of data.

5.5 These recommendations have formed the basis for the implementation of an Information Management team and are incorporated into the Strategy.

5.6 In order to fulfil the vision for Knowledge Management outlined above ESHT needs to work towards the following objectives which will be achieved through the implementation of the Knowledge Management Strategy:

- Create a 'knowledge culture' including performance management
- Real-time information being used operationally
- Maintain flexibility and delivery
- Clear ownership of data quality
- Improved morale, skills and efficiency of staff
- Clinical Unit Business Partner mentality
- IT driven by IM strategy
- Increase income
- Transparent data – internally and externally

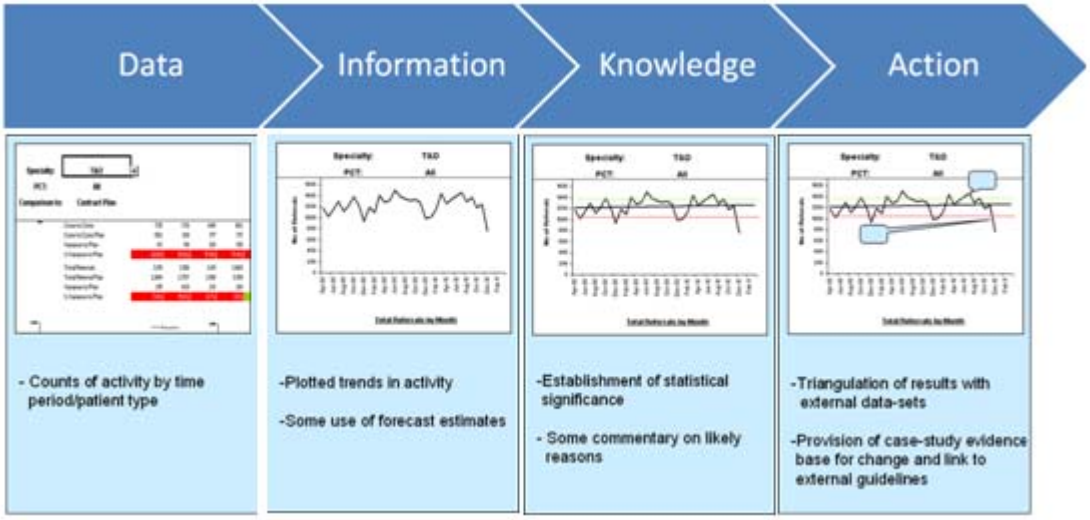
The composition of the wider Knowledge Management department will be as shown below:



5.7 The development of the department is embryonic and a substantial amount of work will need to be done in order to fulfil the visions and principles of the strategy.

6. Information Management

6.1 Data needs to be interpreted to provide information for action



6.2 Taking into account local and national requirements and the Advisory Board's Global E-Health Executive Council's Assessment of BI within ESHT (Appendix 1), Information Management will be developed on the following aims:

a) Share Learning and Research

We will work collaboratively with other trusts and information networks to build a knowledge management network, sharing learning and research, and developing with the top information teams in the country. We will improve our own performance with Knowledge Management to demonstrate our skills, competencies and capabilities. This will be done by driving up performance with key indicators and targets for achievement, including developing collaboration.

b) Creating a Knowledge Function

We will move from delivering data requests to reporting information which has been interpreted and understood with appropriate analysis to enable staff to act on the reports.

c) Build Trust and Confidence with our Stakeholders

We will work to improve the levels of confidence and trust in the integrity of our data through a principle of openness and sharing and by working together to improve issues.

d) Ownership of Data Accuracy

As the NHS moves to the increased publication of outcomes data at consultant level it is vital that all staff take ownership for the quality and accuracy of their data and understand the impact that it will have in the public domain.

e) Increasing Efficiency

We will look to reduce/automate business as usual reporting thereby increasing development and research time.

f) Use of Technology

We will increase the use of reporting tools such as Qlikview which will improve the presentation, useability and timeliness of reports to enable more responsive action to take place.

g) Publishing and Reporting Data

We will work towards a culture of transparency and openness sharing data at consultant, specialty and divisional levels wherever possible to demonstrate areas of good practice, drive performance and understand areas for improvement. We will ensure we meet the requirements of national data reporting for the NHS and system regulators.

6.3 We will achieve this by:

- Ensuring the team are trained appropriately including in SQL
- Deploying and utilising appropriate Business Intelligence Tools
- Ensuring that procured systems are able to integrate data appropriately into the data warehouse
- Implementing automated reporting where appropriate and possible
- Undertaking further Qlikview applications development

6.4 The development plan is attached as Appendix 2. This is reviewed and updated on a monthly basis.

7. Clinical Information Systems

7.1 Taking into account local and national requirements and the current assessment of Clinical Information Systems (appendix 3.), Clinical Information Systems will be developed on the following aims:

- Ensuring that all information systems deliver real, quality, safety and efficiency improvements for patients.
- Implementing systems that deliver essential requirements on a corporate basis.
- Allowing individual clinical services to deploy specialist departmental systems where appropriate and possible once they have gone through a robust review process (led by Clinical systems) to ensure there is no other solution.
- Ensuring all future systems share data appropriately, within and out with the Trust for clinical / administrative purposes primarily but also to support performance reporting via the Trust central data store
- Providing fit for purpose information technology infrastructure and support services.
- Improve technology to support reporting.

7.2 We will achieve this by:

- Reviewing and assessing existing systems and implementing standards for all new systems (Standards are shown in Appendix 4)
- Ensuring that robust business cases for systems incorporate the essential requirements for users and the trust and deliver the perceived benefits
- Work with clinical units to understand the needs and requirements for systems and support
- Ensure integration of systems in the data warehouse
- Work with IT to develop a single robust data warehouse to improve reporting and triangulation
- Develop reporting processes which support Information Management such as Qlikview.

8. The development plans are attached as Appendices. These are reviewed and updated on a monthly basis.

9. Monitoring and Evaluation

9.1 The strategy and implementation plan are reviewed and monitored through the Clinical Management Executive.

10. Key Risks

10.1 The key risks for implementation are:
10.1.1 Organisation change affecting capacity
10.1.2 Lack of funding to support training to develop staff capability
10.1.3 Lack of funding to support implementation of systems and appropriate tools
10.1.4 Lack of ownership of data and input throughout the Trust
10.1.5 Changing reporting requirements

11. Appendices

11.1 The appendices included in the document are shown below:

1. Advisory Board, Global E-Health Executive Council's Resource, "Bi Maturity Model" Business Intelligence assessment.

2. Information Management Development Plan

3. Current Systems Assessment

4. Standards

5. Clinical Information Systems Development Plan

APPENDIX 1 – :

Advisory Board, Global E-Health Executive Council's Resource, "Bi Maturity Model" Business Intelligence assessment.

The red circles show the current assessment of the ESHT BI model

Table 1: BI Maturity Model[1]

	Fragmented	Enterprise Perspective	Advanced Analytics	Big Data
BI architecture	None or several point solutions	Central infrastructure basics implemented	BI core and self-service infrastructure in place	Optimised infrastructure (e.g., data marts, ODS)
Data sources / data currency	Transaction application from one system or BI tool specific from limited number of internal source systems	ETL established for primary data sources	ETL established for secondary data sources	Web, patients, genomics, and other external sources
Types of analysis / use of analytics	Automated internal reporting	Enterprise KPIs and automated external reporting	Predictive and prescriptive analytics and evidence-based analytics	Analytics combining multiple and complex data sources
Data models	Departmental	Common vocabulary, star schema, dimensional	Multiple data models	No schema
Data governance	Independent and departmental	Common policies and standards, centrally-managed KPIs, and security management	Agreed-upon agenda and priorities, data normalisation, and initiate source system changes	Stewards of internal and external data, complex analysis review, and sophisticated delivery methods
Tools	Redundant toolsets	Consolidated data management tools	Extended analytic capabilities	Specialised, targetted capabilities
Skills	SQL, Excel, light data modeling, light visualisation	In-depth knowledge of physical and logical data modelling, and light statistics	In-depth knowledge of statistics and operations analysis, procedural programming	NLP, genomics, and rules engine programming
Culture / enterprise data literacy	Value of data under-appreciated and "gut feel" decisions	Champions emerging and growing emphasis on fact-based decisions	Training on data literacy, identifying BI opportunities, and making changes	Engrained understanding of BI capabilities and limitations

BI governance / org structure	Local control	Central agenda and central funding	Coordinated resources	Includes relevant, external resources

1) SQL = structured query language; ETL = extraction transformation loading; KPI = key performance indicator; ODS = operational data store; NLP = natural language processing.

APPENDIX 2 – Information Management Development Plan

Organisational / Departmental Objective	Departmental Objective	Goal number	Goal / Task	Date Due	Progress	RAG Status
Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	1.	Development and delivery of a Weekly Snapshot report (at Trust and Clinical Unit Level) to be used by CU GMs and back up with delivery of a "pro-active" intelligence report.	30/06/2014	Complete	G
	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	2.	Development and delivery of a combined Monthly Board and Commissioner Report that includes all relevant national and local indicators including those mandated by the Trust Development Authority, and followed by a Pro-Active intelligence report to be provided to clinical units.	30/06/2014	Completed as far as guidance currently permits	G
	To ensure that information will be provided in the most appropriate	3.	Ensure Team is fully trained in the use of CHKS and uses outputs to provide intelligence to Clinical Units.	31/05/2014	Initial training completed, analysts objectives for year include CHKS reporting	G
Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences.	To ensure that information will be provided in the most appropriate	4.	Agree SLA terms with Clinical Units and maintain standards.	30/09/2014	In progress	G

	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	5.	Provide Information for All Trust FOI within the national response time limits.	Ongoing	On going	G
	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	6.	Agreement and Delivery of 2014/15 commissioner reporting (including exception reports).	30/06/2014	Agreed with the exception of community KPIs	A
	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	7.	Support the integration of SystmOne reporting functionality into data flows.	Ongoing	Ongoing	G
	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust.	8.	Establish a relationship with Local Information peers to share best practice.	Ongoing	Ongoing - Links with EKHUFT	G

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.	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	9.	Embed New Clinical Unit Structure within all reports, data flows and remits.	30/07/2014	Clinical Units agreed and reporting structures being amended	G
	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	10.	Provide opportunity for SQL training and experience across the team and ensure that capability exists to build **all** new routine reports in SQL. This will be undertaken in line with Clinical Systems Team protocols and will enable more efficient delivery of automated reports.	31/07/2014	Training funding agreed and in the process of booking	G
	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	11.	Establish an annual work programme to "stock-take" existing routine reports and identify continued need or discontinue.	31/07/2014	Underway	G
	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	12.	Begin a work programme to convert all *relevant* existing routine outputs to SQL and Automate.	31/12/2014	Not yet started as dependent on training	G

	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	13.	Establish as part of normal practice regular "working" integration with clinical units (e.g. Senior Analyst works alongside CU colleague one day per week/fortnight. Details to be confirmed.	31/05/2014	Delayed pending restructuring	A
	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	14.	Begin a work programme to ensure that the team undertake an agreed amount of time at an agreed frequency shadowing a clinical colleague or team.	31/05/2014	Staff have shadowing in their objectives for 14/15 but dependent on capacity	A
	To ensure that information will be provided in the most appropriate, most timely and accurate manner and be useful and intelligent to allow decision making across the Trust	15.	Establish a Rotation pattern for the team to ensure that the responsibility for clinical units "rotates" at an agreed frequency and embed the standardization of reporting within.	31/03/2015	Not yet due	G

APPENDIX 3 – Current Systems Assessment

System Name (function)	Current position	Action
Joe* (EPR)	ESHT developed system. Not able to support in medium to long term	Joe functionality being incorporated into eSearcher
eSearcher* (portal)	Main Clinical portal	Review against EDM / Clinical Portal procurement
Oasis* (PAS; bed management etc)	Upgrade procured	Upgrade project underway for implementation during 2014
TPP Systm One (Community PAS)	Upgrade procured	Upgrade project underway for implementation during 2014
Sunquest Ice* (Order comms / discharge Summaries)	In process	Continue to develop order communications for multiple services
TomCat (Cardiology)	Two instances of image store	Integrate into one image store in clinical repository
Phillips PACS / RIS	New system implanted	Expand Vendor Neutral Archive to include other imaging services
ePrescribing*	No current system	Procure new ePrescribing system
Euroking (Maternity)	Upgrade procured	Upgrade project underway for implementation during 2014
Theatreman (theatres)	Recent upgrade	Ensure benefits realisation
Vital Pac	Implementation underway	Full implementation and benefits realisation
Electronic Medical records	Procurement underway	Implement Electronic document management system and scanning bureau
Apex – Pathology	System in place	To be reviewed
Endobase (endoscopy imaging / reporting)	System in place	To be reviewed
Medisoft – ophthalmology	System in place	Glaucoma management joint with CCG
Diabetic Retinopathy	Upgrade planned	Imaging / reporting an upgrade planned in the summer delayed from February
Auditbase - Audiology / hearing aid system	System in place	To be reviewed
Sexual Health system (Blythe)	System in place	To be reviewed

Soel (Dental System)	System in place	To be reviewed
Best (Wheelchairs)	System in place	To be reviewed
Ascribe (Pharamacy)	BI update planned to enable enhanced reporting	To be reviewed
Somerset (Cancer pathways)	System in place	To be reviewed
Chemocare (chemo drug regimes)	Recent upgrade to do national SACT submission.	Development work needed to fix some of the reporting
BlueTeq (high cost drug system)	CCG but being used by Esht and expanded use	Reporting element required to meet High Cost Drug Submissions. Ian Bourns scoping.
'*' denotes part of clinical 5		

APPENDIX 4 – Standards

Standards
The Trust will adopt the following principles and frameworks to measure progress.

- HSCIS Interopability Toolkit (ITK)
- Healthcare Information and management systems Society (HIMSS)

Clinical Systems standards
All clinical systems must conform to:

- Open database architectures
- HL7 integration
- Flexible reporting tools
- HTML5 compliant and device agnostic
- Cloud computing potential

APPENDIX 5 – Clinical Information Systems Development Plan

Organisational / Departmental Objective	Departmental Objective	Goal number	Goal / Task	Date Due	Progress	RAG Status
Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	16.	Euroking move to E3	30/09/2014	Procurement complete	G
	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	17.	Implement Maternity MDS	30/11/2014	Pending upgrade	G
	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	18.	Implement Oasis upgrade(s) (to be specified)	30/09/2014	Dependent on scoping of clinic manager and RTT	A
	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	19.	Support Vitalpac implementation	Ongoing	In progress	G

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.	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	20.	Create a "new system" process to ensure they meet a minimum criteria	30/09/2014	In progress. Standards pending agreement	G
	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	21.	Move to Automate more Theatre reporting	30/06/2014	Dependent on resource,	A
	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	22.	Automate Maternity reporting	Ongoing	Ongoing	G
	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	23.	Review of Clinical Systems within the Trust and full scoping of options moving forward	28/02/2015	Not yet started	A
	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	24.	Create a portal area for information to be disseminated	31/03/2015	Not yet started	G

	Information systems which support clinicians and staff to provide safe, efficient and effective patient care	25.	Review of current reporting arrangements and assessment of needs moving forwards	30/12/2015	In progress	G

East Sussex Healthcare NHS Trust

IT Strategy 2014 – 2019

Version 1.0

Associate Director of IT

February 2014

Contents

1 Introduction

This document outlines the Information Technology (IT) strategy at East Sussex Healthcare NHS Trust over a five year period 2014 – 2019. The Strategy aims to underpin the Information Management strategy, Clinical strategy and overall Trust objectives.

The purpose of Information Technology (IT) within the Trust is:

- To support the strategic clinical and corporate aims of the Trust and in terms of its future status as a Foundation Trust and service redesign through the Clinical strategy 'Shaping our Future'.
- To provide a reliable, effective infrastructure to support a diverse range of technologies which improve communications both within the Trust and across the health care system, and deliver step change efficiencies in the process and delivery of care;
- To ensure that information technology is used to support staff in giving patients the best possible care within the Trust, by ensuring the information they need is provided when and where they need it. To support information sharing in support of patient pathways and safe care with all health and social care partners

This paper defines the strategic direction for IT to support the Trust's core strategy and vision. It aims to support and improve the Trust's position as a service provider and as a business. The belief underpinning this is that many of the service improvements, new developments and efficiency gains proposed by the Trust clinical strategy rely on a modern and robust IT infrastructure supporting good quality and relevant information systems.

2 Vision

The Vision for the IT strategy is ***'to provide modern technologies that support the delivery of healthcare in East Sussex through robust, reliable and innovative systems'.***

We will do this through:

- **Access – *Any time, any place, anywhere*** by using technologies to improve staff mobility both within and without the Trust along with integration to GP partners and collaboration with other health providers.

- **Capability – *provide a robust technology platform ensuring a*** reliable and consistent service to our patients and staff.

- **Workflow – *Efficient, automated and flexible*** technologies that will digitise processes creating a fully electronic workspace to improve corporate and clinical processes.

3 Trust Objectives

3.1 Mission Statement:

Deliver better health outcomes and an excellent experience for everyone we provide with healthcare services.

3.2 Objectives:

- 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.

3.3 Aims:

- Communicate effectively with our patients, our staff, our community and our partners
- Deliver the right care in the right place at the right time by working in partnership and through clinical networks
- Drive productivity and efficiency and, where appropriate, maximise our market share
- Provide high quality, innovative and accessible care
- Maintain and develop a skilled and motivated workforce.

4 Business Context

East Sussex Healthcare NHS Trust (ESHT) is an integrated acute and community services provider. It covers 2 main hospital sites and 105 community locations employing over 7000 staff. In 2012/13 there were:

- 309,650 outpatient consultations and treatments;
- 141,520 attendances at the emergency departments;
- 42,762 admissions for emergency assessment or treatment;
- 43,143 admissions for treatment as day cases

- 52,914 admissions for planned inpatient treatment; and
- 4,091 babies delivered

5 National Context

5.1 The Power of Information

The Power of Information was published in May 2012 and sets a ten-year framework for transforming information for health and care by harnessing the value of information and new technologies to achieve higher quality care and improve outcomes for patients and service users.

There is a focus on information in its broadest sense, including providing the support people need to navigate and understand the information that is available and ensuring that information reduces, not increases, inequalities and benefits all. The main ambitions of the Power of Information are:

- Information used to drive integrated care across all settings
- Information regarded as a health service in its own right
- "Nothing about me without me"
- Information recorded once at first contact
- Electronic care records to become the source for core information
- A culture of transparency
- An information-led culture

5.2 NHS Belongs to the People – A call to Action

NHS Belongs to the people, published in 2013, comments that the NHS is '*a health service, not just an illness service*' and requires a new way of thinking about how to provide integrated services in the future in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale.

It goes on to say this can be achieved through harnessing transformational technologies such as offering patients online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves

5.3 Safer Hospitals Safer Wards

The *Safer Hospitals Safer Wards* report published in July 2013 comments that 'The creation and routine use of care records held in a safe, digital format enables timely, compre4hensive and accurate communication between health and care professionals, patients and their carers. It is a critical component of a dynamic and innovative health and care system, which strives to provide a safe, effective and positive patient experience. – High quality care is underpinned by access to high quality information.'

5.4 Local Context

For many years the local health economy has taken a collaborative approach to delivering IM&T services in line with the expectations of the National programme for IT. However this programme failed to deliver the expected IT systems in Sussex and as a result the Trust experienced a planning and investment blight. At a local level the trust continued to develop clinical and corporate systems to meet its tactical needs with no real strategic direction.

Following the demise of the national programme for IT the Sussex Health Informatics service tasked with delivering centralised IT services was disbanded in 2012 with IT teams returning to local Trust control.

East Sussex Hospitals merged with East Sussex Community services and became East Sussex Healthcare in 2011. This combined acute and community services provider has a clear strategic direction as laid out in *'Shaping Our Future'* clinical strategy.

With the ever increasing requirements to deliver cost efficiencies in the NHS it is imperative that ESHT looks to exploit technology to improve ways of working and reduce unnecessary cost. The Trust is looking to ensure that all systems are fully utilised to their full potential in order to realise all benefits available.

The Trust can use innovative technologies to allow for more flexible and novel ways of working, thereby allowing increased activity without having to increase human resources – and so deliver the NHS Quality, Innovation, Productivity and Prevention (QIPP) agenda.

6 Principles

6.1 **IT will become a key enabler** for the achievement of the Trust's strategic direction by adopting the following guiding principles to ensure that the Trusts strategic requirements are met:

- ***Align with the Trust*** *clinical and information management strategies and objectives*

- ***Deliver innovative, high quality*** information technology to promote new ways of delivering healthcare and develops a culture of innovation - *Objectives 1, 2 & 3*

- ***Consistent standards*** will ensure that all IT and information solutions fit within a strategic systems architecture and enable information to be shared and exchanged – *Objectives 2 & 3*

- ***A robust and safe infrastructure*** that provides flexibility to meet Trust requirements – *Objectives 1 & 3*

- ***Training and support*** will be provided for Trust staff in the utilisation of technology, to maintain effective use of systems – *Objective 3*

- ***A professionally managed IT service delivery*** function will be delivered, which is service based and customer focused, and balances flexibility and responsiveness with support for a robust, reliable, high availability systems infrastructure – *Objectives 2 & 3*

- ***Collaborative working*** with partner organisations will be actively promoted – *Objectives 2 & 3*

7 Plans

7.1 We will achieve the strategy by:

- **A robust and reliable server infrastructure**
  - Improved network and server infrastructure running clinical and corporate systems
  - Disaster recovery providing resilience in the event of a major failure
  - Improved communications for staff through use of online collaborative tools

- **Fast Network and wireless access**
  - providing clinicians fast and secure access to modern clinical systems where and when required
  - ability to treat patients seamlessly in multiple locations
  - providing staff with access to key information from both inside and externally to the trust
- **Sufficient and appropriate user devices**
  - Access to real-time patient information when and where required.
  - Upgrade PC's and business software
  - Use of tablet devices providing mobile and agile working across wards and in the community
- **Corporate systems providing efficient processes**
  - Email that can be accessed anywhere on any device
  - Electronic systems replacing paper intensive processes
  - Integrated HR systems improving management functions
- **Delivery of patient and corporate notes electronically**
  - Paper based documents scanned and provided electronically in any location
  - Centralisation of digital images providing faster access to key clinical information
  - Single portal providing single point of access to all clinical information
- **Extend use of telemedicine**
  - Exploring the role of telehealth in monitoring and preventative care of patients.
  - Exploring the potential for telehealth to support clinical decision making in both the emergency and the routine clinic environment.
  - Understanding the technology available and the practicalities of the monitoring of long term conditions in patients within their own home environment.

7.2 A work plan is provided in Appendix 1 & 2

8 Monitoring & Evaluation

The strategy and implementation plan are reviewed and monitored through the IM&T Steering Group which reports to the Clinical Management Executive.

9 Key Risks

Key Risks to delivering this strategy are:

- Financial – Insufficient funding available to deliver plan
- Acceptance – Lack of adoption of new technologies and willingness to change delays or inhibits new system Implementation
- Resources – Lack of staff resources or necessary skills available locally to deliver work plan

Appendix 1

Work plan to deliver the IT strategy

1 Shorter-term imperatives

In order to deliver the vision there are key projects that are currently underway or are in planning stage to be delivered in the next two years that will underpin both the IT and Knowledge Management strategies, these are:

a) Make case for and deliver Electronic Document Management and Clinical Portal as part of the Southern Acute collaborative procurement

b) Successful project implementation of the new Community and Child Health system

c) Successful implementation of the VitalPac bedside monitoring system

d) Implement the recently procured patient administration system (PAS) for the acute hospitals

e) Extend ward order communications to Radiology, Cardiology and other disciplines

f) Deploy Digital Information sharing technologies to support service redesign and collaborative working between primary, secondary and social care services.

g) Upgrade of desktop operating systems and office applications to Windows 7 and Office 2010

h) Implement a trust wide printing solution to improve efficiencies and reduce overall printing costs

These are an ambitious list of projects that will enable the Trust to move forward coherently in support of its overall objectives.

2 Actions to deliver the IT Vision

The IT Strategy will deliver the following project work streams:

2.1 Improving IT Infrastructure

ESHT IT services will develop a fast, resilient, standardised, and optimised integrated IT infrastructure that will allow data to be shared securely across the organisation and to external organisations. Investment will be made into wireless technologies to improve access to clinical systems at both acute and community sites and from mobile devices in the community. Server rooms will be refurbished and infrastructure upgraded to provide full disaster recovery services.

Where are we now?	What we will do, and when
Data services are provided from two data centres at Conquest and Eastbourne hospitals, both facilities require refurbishment. 80% of servers are virtualised on technical architecture that is six years old. There is no disaster recovery failover facility. Over 4000 PC's and laptops are deployed with 70% over 3 years old. Printing is delivered through networked laser printers with no centralised control. The IT service desk handles an average of 3200 calls per month. Services are provided by a mixture of in-house and out sourced providers.	• Refresh of core trust desktop, bedside and mobile devices – on-going • Implement 'bring your own device' option to trust employees by 2016 • Implement enterprise printing solution by 2015 • Centralise fax services by 2015 • Provide 95% on-site services from virtual servers by 2015 • Evaluate and make recommendation on data and infrastructure management options – 2014 • Enhance business continuity provision – on going • Review and re-structure IT services, service level agreements and service delivery options to meet service demands including extended hours support. • Implement wireless access at all community sites and upgrade wireless and local area network infrastructure. • Create and implement a 'clinical desktop' designed around operational requirements. • Implement 'single sign-on' technologies to enable fast access to clinical systems.

2.2 Integrated Telecommunications

Trusts telephony and Video conferencing services will be moved into the IT department to enable implementation of aligned collaborative technologies such as Voice over IP and Sussex wide video conferencing. This will become the backbone of all telehealth initiatives.

where are we now?	What we will do, and when
Telephony services are currently managed by the facilities department. There is a mixture of telephone systems across sites linked by separate connections. Capacity for phones is under pressure. Originally Video conferencing was installed to provide MDM facilities as part of the Sussex Cancer network. Additional facilities have purchased by individual departments. Video conferencing is not centralised. The original	• Review options to move telephony infrastructure and video conferencing management into IT department - 2014 • Evaluate and make recommendation to provide enterprise telephony services across the trust - 2014 • Use of Voice-over-IP (VoIP) technologies to integrate telephony with computing by 2016 • Evaluate and make recommendation to provide improved video conferencing facility capable of delivering high definition telehealth across the trust • Implement desk and mobile based video conferencing service by 2016

2.3 Expanding Digital Imaging

The Trust has procured a VNA solution from its Radiology and Picture Archiving and Communication System (PACS) supplier to create a totally integrated solution. In addition to storing radiological images, the VNA will store all Trust images e.g. Cardiology, Endoscopy, Ophthalmology, EEGs, Medical Photography, which will be made available in patient context via a clinical portal.

Where are we now?	What we will do, and when
Individual services have Images stored separately with no disaster recovery options. The trust has procured a Vendor neutral Archive (VNA) for storing PACS images that can store all types of images in one place allowing images to be	• Evaluate and recommend a migration plan to move images from Cardiology, endoscopy, Ophthalmology, EEG's medical photography etc to the VNA storage - 2015 • Develop integration plan to present all images to Integrated digital care record – 2016 • Further develop image sharing facilities between partner organisations by 2016

2.4 Digital Documents

By extending the use of the planned electronic document management (EDM) system we will digitise patient and staff records and corporate documents creating a single instance of any document and making them available wherever and whenever required

Where are we now?	What we will do, and when
The trust does not digitise medical records or staff files at present. Medical records libraries are full to capacity are stored across both acute hospitals and off-site storage facilities incurring additional costs. Tracking of notes is difficult resulting in availability issues and risk to patient care. Staff records are stored in individual departments with no tracking.	• The Trust is part of the Southern acute Procurement tendering for an EDM and clinical portal. Completion 2104. • Medical records and corporate documents will be scanned and presented electronically to users. • A scanning bureau will be implemented to provide scan-on-demand and back-scanning services.

2.5 Use of Telehealth to improve patient care

Telehealth services will continue to be explored to exploit opportunities to improve healthcare between the hospitals and community locations.

Where are we now?	What we will do, and when
There is limited telehealth services provided within the Trust with Stroke services being the only user at present. The infrastructure in place can be used to support more telemedicine services	• Instigate a full assessment of possible telehealth services that will: o Explore the role of telehealth in preventative care of patients, particularly in remote locations o Understand the technology available and the practicalities of the monitoring of long term conditions in patients within their own home environment o Explore the further potential for telehealth to support clinical decision making in both the emergency and routine clinic environment

2.6 Web services to improve the patient experience and staff experience

We will provide patients better access to their own records and use technology to help involve them in the planning and review of their care.

Where are we now?	What we will do, and when
Patients receive paper copies of key correspondence on their treatment. Other information is offered in either leaflet form or via signposting to electronic sources. Access to appointments via national systems such as Choose and Book is available but used little. Patients can request paper copies of their medical records.	• Implement a patient portal style web site for patients and carers to view their records, communicate with their healthcare team, access and book our services from 2016 • Implement an Extranet for staff to access their personnel information and tailor service information to meet individual requirements with integrated messaging and chat services from 2016

2.7 Ensuring the appropriate governance and clinical engagement

The scale of the IT agenda and the critical dependence of the Trust's strategy on delivery of Information and IT solutions require that the management and governance of IM&T must be robust and fit for purpose.

Where are we now?	What we will do, and when
Governance of IT is provided by the IM&T Steering group. The IT department has implemented best practice frameworks for IT service delivery. The IT programme management office has been established to deliver large scale IT projects. Information Security is managed by the IT department to meet information governance standards.	• The Trust will develop the role of Clinical Lead for IT - 2014 • The Clinical Advisory Group for IT will be promoted as a forum for IT and IM decision making - 2014 • Governance of IT will be provided by the Executive IM&T steering group with membership consisting of senior clinical and non-clinical staff and representation from key areas of the Trust. This group will report to the CME. - 2014 • The Information Technology Infrastructure Library (ITIL) best practice framework for IT service management and service delivery has been adopted to provide assurance to the Trust board – On-going • Information Governance and Information security policies and processes will be embedded in IT service delivery • All significant system implementations will be managed according to Prince 2 project management methodology –

	On-going

2.8 IT Change Management and Training

Successful use of clinical systems is imperative to realise maximum benefits. IT training will be developed to provide the correct level of support during large-scale system implementations.

Where are we now?	What we will do, and when
Limited IT training is available to support all system requirements. Training is provided for new clinical systems as required. There is no training provided for standardised applications such as Microsoft Office	• Review the IT training department and make recommendations to develop the service to meet future training requirements – 2014. • Develop use of eLearning services to provide core and mandatory IT and corporate training - 2015

2.9 Appendix 2- Implementation timetable

Work Programme Schedule																							
Programme Workstream		Work Programme Plan	2014/15				2015/16				2016/17				2017/18				2018/19			
		Proposed Action	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
IT Governance & Service Management		Implement ITIL Governance to all IT services																				
		IT Service Review and transformation																				
Infrastructure		Strategic technical architecture design																				
		OBC/implement data centre refurbishment																				
		OBC / Implement server infrastructure and DR																				
		Implement VDI Desktop and end user computing																				
		Review videoconferencing and telephony services																				
		OBC and implement Integrated Communications																				
		OBC and implement single sign-on																				
		Windows 7 and Office XP upgrade																				
		Replacement PC and tablet programme																				
		Enterprise printing FBC and implementation																				
Systems		Implement new PAS system																				
		Implement Community and Child Health System																				
		EDM / Clinical Portal Procurement / Rollout																				
		Electronic discharge summaries - Phase 2																				
		Ward order communications development																				
		Make case for corporate digital documents / EDM																				
		Make case for and implement ePrescribing																				
Telehealth		Review and make case for telehealth services																				
		Rollout of telehealth																				
Non Clinical Systems		Implement medical records Scanning Service																				
		Make case and tender for Web services																				
		Implement Web services																				

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	11
Subject:	Provision of a Radiotherapy Treatment Centre in East Sussex
Reporting Officer:	Richard Sunley, Chief Operating Officer

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

Purpose:

To inform the Board of progress with the proposal to provide a Radiotherapy Treatment Centre in East Sussex based on the Eastbourne DGH site.

Introduction:

The need for radiotherapy had been previously underestimated and that capacity in Cancer Networks needed to increase to ensure that all patients who required radiotherapy had appropriate access closer to home.

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

The Outline Business Case (OBC), produced by the Brighton & Sussex University Hospitals (BSUH) in conjunction with East Sussex Healthcare NHS Trust (ESHT), recognised the need for the development of a satellite radiotherapy treatment centre at Eastbourne DGH. Radiotherapy had been previously underestimated and capacity in Cancer Networks needed to increase to ensure all patients who required radiotherapy had appropriate access.

The development would enable BSUH to provide clinical and outpatient services to patients who use their services and live in the east of Sussex and currently have to travel considerable distances for treatment.

The OBC covered the construction and maintenance of a new Radiotherapy Unit with the provision of 2 linear accelerators, a CT scanner and all other appropriate equipment with maintenance, on going replacement and management services to the accommodation and equipment for a period of 25 years.

The Finance and Investment Committee reviewed the OBC, which is currently with the Trust Development Authority for initial comment, and approved the Heads of Terms for the proposed lease of land at Eastbourne DGH at its meeting on 30th April 2014.

Benefits:

The development will enable BSUH as the Radiotherapy Hub to provide clinical and outpatient services to patients who use their services and live in the east of Sussex and currently have to travel considerable (and unacceptable) distances for treatment, through a spoke facility situated at the EDGH.

Risks and Implications
The maximum machine capacity at Brighton is threatened by staff shortages and outdated and ageing equipment. In order to achieve future excellence in patient care, the centre needs this essential expansion: • To attract new and retain existing staff • To improve the quality of radiotherapy provision (equity of access for Sussex patients) • Recruit to future national clinical trials for radiotherapy (that require modern equipment)

Assurance Provided:
The Finance and Investment Committee reviewed the OBC and approved the Heads of Terms for the proposed Lease of land at Eastbourne District General Hospital for redevelopment as a new Radiotherapy Treatment Centre.

Review by other Committees/Groups (please state name and date)**:**
ESH Trust Finance & Investment Committee 30th April 2014 Sussex Radiotherapy Programme Board – monthly meetings (last meeting 06th June 14) Currently under review by the Trust Development Authority

Proposals and/or Recommendations
The Board is asked to note progress with the above project.

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: Les Saunders, Head of Strategy Implementation	**Contact details:** Ext 3850 - lessaunders@nhs.net

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	12
Subject:	Annual Business Plan 2014-15 Quarter 1 update
Reporting Officer:	Dr Amanda Harrison, Director of Strategic Development and Assurance

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

Purpose:

The attached high level report outlines progress against the objectives of the Annual Business Plan for 2014/15 which was approved by the Board at its meeting on 3 June 2014. Each Director has an underpinning plan which provides milestones for delivery to achieve the corporate objectives and demonstrates progress against these milestones.

Introduction:

The Annual Business Plan has been developed in collaboration with clinical units and corporate departments. It highlights the key objectives for the organisation and highlights the key risks to delivery. To facilitate and support the delivery of the ABP objectives, the following have been developed:

- Performance Management and Accountability Framework
- A process for monitoring the impact of service changes on quality
- Programme Management arrangements.

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

- Key deliverables will come to the Board for approval, eg the Knowledge Management and IT Strategies and the Operational Performance Management Framework are on the agenda this month
- Progress on plans addressing access targets will be reported regularly through the performance report (Month 2 is on the agenda)
- Some objectives, eg the Trust marketing and engagement strategy, are work in progress and will come to the Board later in the year.

Benefits:

There is clarity about the organisational priorities and targets for 2014/15 and the risks attached.

Risks and Implications

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

Assurance Provided:
The Annual Business Plan has been developed in collaboration with clinical units and corporate departments. It highlights the key objectives for the organisation and highlights the key risks to delivery.

Review by other Committees/Groups (please state name and date)**:**
Business Planning Steering Group 01.07.14, 15.07.14 and 22.07.14

Proposals and/or Recommendations
The Board is asked to note progress on the Annual Business Plan.

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

For further information or for any enquiries relating to this report please contact:	
Name: Jane Rennie, Associate Director – Planning and Business Development	**Contact details:** Janerennie1@nhs.net

East Sussex Healthcare NHS Trust

PROGRESS REPORT ON ANNUAL BUSINESS PLAN OBJECTIVES 2014/15 – QUARTER ONE

STRATEGIC OBJECTIVE	ANNUAL BUSINESS PLAN OBJECTIVE	KEY PLANS	LEAD(S)	RAG RATING
Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	Ensure the organisation is able to demonstrate the quality of its services and compliance with regulatory standards	Completion of the Quality Governance Assessment Framework	DIRECTOR OF STRATEGIC DEVELOPMENT	**A/R**
		Refresh of the Board Governance Assessment Framework	DIRECTOR OF STRATEGIC DEVELOPMENT	**G**
		Development and implementation of a Knowledge Management Strategy	DIRECTOR OF STRATEGIC DEVELOPMENT	**G**
		Publication of clinical quality measures and survival rates in line with national guidance	MEDICAL DIRECTOR GOVERNANCE	**R**
		Undertake Quality Impact Assessments for all programmes of service change	DIRECTOR OF NURSING MEDICAL DIRECTOR GOVERNANCE	**A**
		Institute a process to allow staffing at ward level to be monitored in line with national requirements	DIRECTOR OF NURSING	**A**
		Respond to national plans for the revalidation of nursing staff	DIRECTOR OF NURSING	**A**
		Further strengthen Clinical Audit reporting to the Board and its Committees	DIRECTOR OF NURSING MEDICAL DIRECTOR GOVERNANCE	**R**
	Ensure the organisation takes action to improve quality and outcomes for patients	Implementation of mortality screening tool and review of all deaths	MEDICAL DIRECTOR GOVERNANCE	**R**
		Implementation of the Quality Improvement Programme including QUIPP and CQUIN plans	DIRECTOR OF NURSING MEDICAL DIRECTOR GOVERNANCE DIRECTOR OF FINANCE CHIEF OPERATING OFFICER	**G**

STRATEGIC OBJECTIVE	ANNUAL BUSINESS PLAN OBJECTIVE	KEY PLANS	LEAD(S)	RAG RATING
		Review and redesign of key specialties and subspecialties	CHIEF OPERATING OFFICER DIRECTOR OF STRATEGIC DEVELOPMENT MEDICAL DIRECTOR - STRATEGY	**A/R**
		Monitor and review the outcomes of service reconfiguration	CHIEF OPERATING OFFICER MEDICAL DIRECTOR STRATEGY	**G**
		Implementation of Vitalpac	DIRECTOR OF NURSING MEDICAL DIRECTOR STRATEGY MEDICAL DIRECTOR GOVERNANCE	**G**
Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	Ensure opportunities and risks of the local health and social care market and of commissioning intentions are understood and responded to	Implementation of a tender review and response process	DIRECTOR OF STRATEGIC DEVELOPMENT	**G**
		Development and implementation of a marketing and engagement strategy	DIRECTOR OF STRATEGIC DEVELOPMENT	**A**
	Ensure active participation in joint programmes of work to improve clinical service design and delivery	Engage in the further development of the commissioner led Better Together programme	DIRECTOR OF STRATEGIC DEVELOPMENT	**A**
		Engage in the further development of the Trust Development Agency/NHS England led Challenged Health Economy programme	DIRECTOR OF STRATEGIC DEVELOPMENT	**A**
		Engage in the programme of work to support the re-design of community services	MEDICAL DIRECTOR STRATEGY CHIEF OPERATING OFFICER DIRECTOR OF STRATEGIC DEVELOPMENT	**G**

STRATEGIC OBJECTIVE	ANNUAL BUSINESS PLAN OBJECTIVE	KEY PLANS	LEAD(S)	RAG RATING
		Establish the Clinical Leadership Forum as a key vehicle for clinical engagement within the Trust and ensure its members are able to engage in external clinical fora as appropriate	MEDICAL DIRECTOR STRATEGY	**A**
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.	Ensure the Trust's business model and long term strategic plan deliver clinical, operational and financial sustainability	Development of an IBP and LTFM based on the outcome of the Better Together and Challenged Health Economy programmes	DIRECTOR OF FINANCE DIRECTOR OF STRATEGIC DEVELOPMENT	**R**
	Ensure efficiency and effectiveness are improved through the implementation of the Cost Improvement Programme	Act to reduce spend on medical agency	MEDICAL DIRECTOR GOVERNANCE	**R**
		Improve efficiencies in clinical administration	CHIEF OPERATING OFFICER	**G**
		Improve theatre utilisation and productivity	CHIEF OPERATING OFFICER	**G**
		Implementation of a revised Hospital at Night provision at EDGH	CHIEF OPERATING OFFICER	**R**
		Development and implementation of a revised medical model across the Trust	CHIEF OPERATING OFFICER MEDICAL DIRECTOR STRATEGY	**R**
		Delivery of the clinical correspondence programme	CHIEF OPERATING OFFICER	**G**
	Implement plans for the delivery of key operational requirements	RTT compliance plan	CHIEF OPERATING OFFICER	**G**
		Diagnostic waits compliance plan	CHIEF OPERATING OFFICER	**G**
		Ambulance handover improvement plan	CHIEF OPERATING OFFICER	**G**
		Cancelled operations improvement plan	CHIEF OPERATING OFFICER	**G**

STRATEGIC OBJECTIVE	ANNUAL BUSINESS PLAN OBJECTIVE	KEY PLANS	LEAD(S)	RAG RATING
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.	Develop and implement enabling strategies and programmes to ensure efficiency and effectiveness of the Trust	Development of an estates strategy that supports the Trust's agreed clinical services model	CHIEF OPERATING OFFICER	**G**
		Development of a Sustainability Management plan	CHIEF OPERATING OFFICER	**G**
		Development of an IT strategy and delivery plan	DIRECTOR OF FINANCE MEDICAL DIRECTOR STRATEGY	**R**
		Review and further development of the Major Incident and Business Continuity Plans	CHIEF OPERATING OFFICER	**G**
		Review and revision of the Workforce Plan and Trust wide workforce risk register	DIRECTOR OF HUMAN RESOURCES	**A**
		Conclude the implementation of the Health Rostering programme	DIRECTOR OF HUMAN RESOURCES	**A**
		Embed programme management processes in support of delivery of the ABP	DIRECTOR OF STRATEGIC DEVELOPMENT	**A**
		Embed the Performance Management Framework in the operational management of the Trust	CHIEF OPERATING OFFICER	**G**
		Develop and implement a Procurement Strategy	DIRECTOR OF FINANCE	**A**
		Implement key IM&T programmes including PAS upgrade, NHS mail, SystmOne	DIRECTOR OF FINANCE MEDICAL DIRECTOR STRATEGY	**A**
		Development and implementation of an Innovation Strategy	MEDICAL DIRECTOR GOVERNANCE	**R**

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	13
Subject:	Operational Performance Framework
Reporting Officer:	Richard Sunley, Chief Operating Officer

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

Purpose:

This report provides assurance to the Board that a robust operational performance framework is in place to ensure that the Trust meets its performance targets and goals..

Introduction:

The operational performance framework details how clinical units, supported by corporate directorates, will be held to account for their performance against the targets and goals.

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

The operational units, whilst delivering many of the primary goals of the organisation, rely on support from all corporate services, to varying degrees, and the structure and performance framework needs to reflect this.

In particular the framework will depend on the Knowledge Management department to work with operations to develop performance monitoring.

The operational performance structure is outlined in the framework and the links to corporate committees.

Benefits:

There is clarity about the organisational priorities and targets for 2014/15 and the risks attached.

Risks and Implications

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

Assurance Provided:

A robust framework has been developed to hold clinical units, supported by corporate directorates, to account for delivery of performance targets and goals.

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

Corporate Leadership Team 29/07/14

Proposals and/or Recommendations
The Board is asked to take assurance that there is a robust framework in place to ensure delivery of performance targets and goals.

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

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

East Sussex Healthcare NHS Trust

Operational Performance Framework

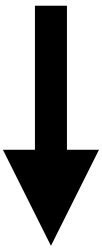
1. Purpose

The primary focus of the design of this performance framework is to achieve:

1.1 Corporate Goals

- Creating a structured approach to focusing on strategic and annual performance objectives
- Setting up mechanisms for accurately reporting organisational performance
- Ensuring that responsibility for performance improvement is clearly identified
- Ensuring accountability for results
- Addressing quality and safety issues as well as those of activity and cost

1.2 Connecting Corporate Goals with Performance



Corporate Goals

Corporate Objectives

Clinical Unit Objectives

Departmental Objectives

Individual Objectives

2. Key Relationships

The operational units, whilst delivering many of the primary goals of the organisation, rely on support from all corporate services, to varying degrees, and the structure and performance framework needs to reflect this.

In particular the framework will depend on the Knowledge Management department to work with operations to develop performance monitoring which will:

- Define performance targets and goals, across the key aspects of service delivery. Including management of resources (personnel, infrastructure), services and financial viability
- Provide a comprehensive picture of the organisation's progress towards achieving its performance targets and goals
- Provide an early indication of emerging issues and cost pressures that may require remedial action

3. Structure within Operations

The operational performance structure will have:

3.1 Clinical Unit Accountability Review Meetings

- Frequency – This group will meet monthly

- Focus – the focus will be on:
  i. Quality, Finance, Access
  ii. Clinical Unit Performance against objectives
  iii. Corporate support required

- Chair – Chief Operating Officer

- Attendees
  i. Clinical Unit Leads and team.
  ii. Finance
  iii. Governance

- Reports required and expressed at a Clinical Unit Level
  i. Clinical Unit Budget reports and Cost Improvement Programme performance
  ii. Trust performance Dashboard
  iii. Risk Register

3.2 Performance Exception Meeting

- Frequency – This group will meet weekly

- Focus – Individual Clinical Units by exception as highlighted by the *Clinical Unit Accountability Meeting*

- Chair – Chief Operating Officer

- Attendees – Specialty specific Clinical Unit Team and relevant corporate services

- Reports required – As relevant

- Report Produced by – Clinical Unit

3.3 Start the Week

- Frequency – This group will meet weekly on a Monday afternoon

- Focus - The focus will be on Operational day to day:
  i. identifying issues from the previous weeks performance that require action
  ii. share issues for the current week
  iii. monitor weekly performance against agreed objectives

- Chair – Deputy Chief Operating Officer or Head of Performance or Chief Operating Officer

- Attendees – Clinical Unit General Managers and Heads of Nursing

- Reports required – Start the week performance report

3.4 Theatre Maximisation

- Frequency – This group will meet weekly on a Monday

- Focus - The focus will be on Theatre utilisation:
  i. Maximising lists booked 6:4:2 weeks ahead
  ii. Utilising theatre capacity to deliver access targets
  iii. Monitoring theatre performance

- Chair – Associate Director - Delivery and Performance or Deputy Chief Operating Officer or Chief Operating Officer

- Attendees – Clinical Unit General Managers

3.5 **Outpatients Maximisation**

- Frequency – This group will meet weekly

- Focus - The focus will be on OPD utilisation:
  i. Maximising lists booked 6:4:2 weeks ahead
  ii. Utilising OPD capacity to deliver access targets
  iii. Monitoring OPD performance

- Chair – Assoc Director - Delivery and Performance or Deputy Chief Operating Officer or Chief Operating Officer

- Attendees – General Manager Specialist Medicine and Clinical Unit General Managers

3.6 **Referral To Treatment and Diagnostic Waits Patient Target List**

- Frequency – This group will meet weekly on a Friday morning

- Focus - The focus will be on:
  i. Specialty Specific and patient level review of admitted and non admitted pathway progress and incomplete pathways
  ii. Specialty and patient level review of diagnostic pathways
  iii. Ensure all patients are treated in accordance within agreed access times
  iv. Escalating to the Accountability Review Meeting or a Performance Exception Meeting, as appropriate, any patients who will not be treated within the required timeframe

- Chair – Head of Performance or Deputy Chief Operating Officer or Chief Operating Officer

- Attendees – General Managers, Knowledge management

3.7 **Cancer Patient Target List, Specialty specific review**

- Frequency – This group will meet weekly on a Monday afternoon

- Focus - The focus will be on:
  i. Specialty and patient level review of pathway progress
  ii. Ensure all patients are treated in accordance within agreed cancer access times
  iii. Escalate to Start the Week patients that will not be treated within required timeframe
  iv. Escalate to CCG, screening and tertiary providers patients referred late

- Chair – General Manager Specialist Medicine or Lead Cancer Manager or Lead Patient Pathway Coordinator, Deputy Chief Operating Officer or Head of Performance or Chief Operating Officer

- Attendees – Patient Pathway Coordinators and relevant General Managers
- Reports required – SOMERSET information
- Report Produced by the cancer tracking team

4. Links to Corporate Structures

Key links will be to the:

- Quality and Standards Committee
- Finance and Investment Committee
- Corporate Leadership Team
- Clinical Management Executive
- Audit Committee

The Chief Operating Officer will attend these meetings and or their Deputy and individuals or teams from the Clinical Units will be asked to attend by the relevant Chairs as required.

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	14a
Subject:	Emergency Preparedness Annual Report 2013-14
Reporting Officer:	Richard Sunley, Chief Operating Officer

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

Purpose:

To inform the Board of the work undertaken in the field of Emergency Preparedness and Business Continuity Management.

Introduction:

The Trust is a Category 1 Responder under the Civil Contingencies Act 2004 (CCA 2004) and as such has a number of statutory duties in relation to both Emergency Planning and Business Continuity Management. These duties are expanded upon in the NHS England Core Standards for Emergency Preparedness, Response and Recovery 2013.

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

The report raises several issues relating to:

- The importance of developing and delivering further training, at all staff levels, in both Emergency Response and Business Continuity Management
- The need for the Trust to ensure that in delivering organisational change it also ensures that Business Continuity Management is further imbedded within all Clinical Units and at all management levels.

These are both statutory duties under the CCA 2004

Benefits:

The Trust will further develop robust and effective Emergency Plans and Business Continuity Plans and have staff trained and exercised in delivering them. This will enhance the reputation of the Trust, and provide assurance, in the event of future incidents regardless of whether they are Major Emergencies or of Business Continuity in nature.

Risks and Implications

Failure to have effective response plans, and staff fully trained and practiced in their roles and responsibilities, puts the safety of staff and patients at risk.

Failure to develop Emergency Preparedness puts the Trust at risk of being in breach of it's statutory duties under the CCA 2004 and failing to meet the NHS England Core Standards for Emergency Preparedness, Response & Recovery (EPRR).

Assurance Provided:
The Trust has an active Emergency Planning Team and they are progressing work on Emergency Preparedness within the Trust but also in consultation with other category 1 responders and all Sussex Acute and Community Trusts, to ensure that their work embraces 'best practice'.

Review by other Committees/Groups (please state name and date)**:**
Clinical Management Executive 14th July 2014

Proposals and/or Recommendations
This report is accepted by the Board and a commitment is given to continue to support all aspects of Emergency Preparedness within the Trust, particularly in reference to the development of robust and effective Emergency Response Plans and Business Continuity Management.

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

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Ian Taylor. Head of Emergency Planning	(13) 3890 i.taylor1@nhs.net

East Sussex Healthcare NHS Trust

Emergency Preparedness Annual Report 2013-14

1. Introduction

1.1 This annual report is to give the Board assurance that required activities are taking place to support their delivery of our statutory duties as a Category 1 responder under the Civil Contingencies Act 2004. Since April 2013 there are also Core Standards laid down by NHS England and the Trust will be audited on achievement of those standards.

1.2 East Sussex Healthcare Trust is subject to the requirements of the Civil Contingencies Act 2004, and has statutory responsibilities as a Category 1 responder to Emergencies and Incidents. As a Cat 1 responder, we are required to have sufficient Emergency Preparedness processes, policies and plans in place, and are required to be able to show that these are updated regularly, and exercised appropriately. We also need to be able to prove that all staff are trained appropriately, according to the role and function they hold during major incidents or business continuity incidents. There are now National Occupational Standards (NOS) in place for Operational, Tactical and Strategic leaders. Training within the Trust must be developed, up to executive level, so that the Trust is resilient 24 hrs per day, 365 days per year.

2. Background

2.1 Emergency Planning within the Trust is a function which sits within the Chief Operating Officer Structures. The Chief Operating Officer / Deputy Chief Executive is the Accountable Officer to NHS England for Emergency Planning and Business Continuity.

2.2 Following the formation of the Healthcare Trust and the subsequent organisation changes, work has continued throughout this period to ensure that Emergency Preparedness develops across both Acute and Community sectors and that staff throughout the Trust have access to suitable training to enable them to respond effectively to a Major Incident, or to a community based incident where support is requested by a Local Authority.

2.3 With the reorganisation of the NHS during 2013, Emergency Planning and Business Continuity was re-titled, within the NHS, as Emergency Preparedness, Response and Resilience (EPRR) and there is now a new set of Core Standards for EPRR published by NHS England.

2.4 Whilst there has been some progress during the last year, more work still needs to take place to develop the Trust in the area of Business Continuity planning. This is of particular importance with the changes taking place to implement the Clinical Strategy and the risks associated with single sites for services.

2.5 The Trust has one part-time Head of Emergency Planning (Band 7) and a full time Deputy Emergency Planning Officer (Band 6)

3. Content

3.1 Emergency and Business Continuity Plans

3.1.1 The Trust Major Incident Plans have undergone a review during 2013 to ensure that they reflect the changes as the Clinical Strategy has been implemented and to ensure that they are fit for purpose. These reviews have considered the implications of any changes to the Sussex Community Risk Register. This review will be ongoing during 2014 as further areas of the Clinical Strategy are implemented and as any further reorganisation of Trust Management Structures are announced.

3.1.2 The Pandemic Influenza Plan has been reviewed and updated to include the revised National guidance that became available during the year and to organisational changes within ESHT. This remains a 'living document' and will require further work as we move into 2014 to reflect organisational change.

3.1.3 The Severe Weather Plan was reviewed and updated for this current winter and includes, amongst others, enhanced arrangements for dealing with the effects of heavy snow in terms of the operation of the Snow Desks, getting critical staff into Trust hospitals and the maintenance of community based services to clients in their own homes. Enhanced arrangements have been made with various 4x4 users, groups and organisations to support the Trust with transport during severe weather incidents. Training workshops have been offered to staff who may have to implement the plan.

3.1.5 As implementation of the Clinical Strategy continues, it will remain essential that Emergency Planning and Business Continuity are fully considered and continue to be an integral part of the process to ensure that during change we are able to offer a full and integrated response to any emergencies. With some services now centred on a single site it is increasingly important that the Trust develops suitable and sufficient contingency and Business Continuity Plans to ensure that 'single site' does not become 'single point of failure'. In relation to further Organisational Change, it is essential that there is consultation in relation to impacts on Emergency Preparedness and that the Emergency Planning Team are proactively engaged in discussions, rather than putting the Trust at risk of having to be reactive 'after the event', which can result in periods of time when the Trust may not be capable of responding due to changes that invalidate existing plans.

3.1.6 Business Continuity Planning (BC) is essential for compliance with the Civil Contingencies Act, DoH, NHS England and CQC requirements. The Deputy Emergency Planning Officer continues to support clinical teams and other departments in developing their BC strategies and therefore

their BC plans. Work has been slow and hampered by staff changes and organisational management changes, as well as changes on sites as a result of implementation of the Clinical Strategy. This work will be ongoing throughout 2014 /15 and will not be concluded until all changes are implemented and plans can be updated or produced to reflect those changes. Once the Plans have been reviewed or produced the Emergency Planning Team will produce and facilitate exercises to validate the various BC Plans. It is essential that the Trust continues to support this work and ensure that staff assigned the task of BC Planning, within Teams, are supported and given time to train and then undertake the important work of plan writing and testing.

3.1.7 There have been a number of serious Business Continuity Incidents within the Trust during 2013 and the Emergency Planning Team have offered support and advice both during the response and post incident.

3.1.8 BC Planning is a legal requirement under the Civil Contingencies Act and the current enhancement of that Act is widely expected to require more detailed audit of Category 1 Responders particularly in respect of BC Planning.

3.1.9 This Trust has continued to lead on developing a plan with East Sussex Fire & Rescue Service, Sussex Police and South East Coast Ambulance Service NHS Trust for support to our two Emergency Departments, and our Minor Injuries Units, in the event of self presenters following a Hazmat or CBRNe incident. This work will continue into 2014 as a new multi-agency concept of 'first response' to those potentially contaminated is introduced.

3.1.10 The Emergency Planning Team worked closely with, and advised, Estates and Facilities staff who developed new draft 'Lockdown Plans' for all the hospital sites in the Trust. These plans were exercised during 2013 and learning taken from that exercise is being used to further revise and improve the plans. The Emergency Planning Team will write, deliver and facilitate further exercises, as required, once the plans are finalised in 2014.

3.1.11 .The Emergency Planning Team have worked closely with the other Acute and Foundation Trusts in Sussex to develop plans that are consistent across the county using the same terminology and action cards. This will allow staff moving between Trusts to integrate into the Response Plans more easily. This work has included Lockdown Plans, Evacuation Plans and CBRN decontamination., and will be ongoing into 2014. Future projects include Command & Control Planning and Control Room Management.

3.1.12 The Improvised Explosive Device Plan was reviewed following changes to national guidance and an incident at Conquest where white powder was delivered by letter to a member of staff. The revised response plan has been renamed the Malicious Acts and Acts of Terrorism Response Plan. It has been circulated to Managers and Executives on call.

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3.2 Training

3.2.1 Major Incident and Emergency Planning training continues to be delivered to junior doctors joining the Trust by e-learning. The course was further updated during 2013. We now deliver training in Emergency Preparedness, by e-learning, to all staff on their Induction to the Trust. This training is a requirement of the statutory guidance which accompanies the Civil Contingencies Act 2004.

3.2.2 A one day Major Incident Training programme continues to be developed in line with the principles outlined in the nationally recognised Hospital Major Incident Medical Management and Support (HMIMMS) course and this has been delivered across both sites during the year with additional courses already planned and open to applicants throughout the year of 2014. This course targets specific staff groups e.g. consultants, senior clinicians, senior nurses, site management team and on-call managers in the first instance and then offers additional places to all staff groups. The course includes all the latest updates from the most recent revision of the Major Incident Plan and generic information regarding the response to community based incidents that do not require an acute hospital response. Community staff training is already in place for 2014.

3.2.3 The Major Incident Training is being reviewed and changed, this commenced in 2013 and will continue during 2014 to reflect the need for three different levels of training – Operational, Tactical and Strategic.

3.2.4 A role specific training session on Decision Making for those on the ‘Executive on Call’ rota and ‘Managers on Call’ rota was developed and delivered in 2013, this training will be ongoing.

3.2.5 An event specific training session on the new Malicious Acts & Acts of Terrorism Response Plan was developed and delivered in December 2013 this training will be ongoing.

3.2.6 To ensure compliance with both DoH Guidelines, and the statutory requirements of the Civil Contingencies Act, it is essential that training continues to be developed and delivered in all areas of Emergency Preparedness and Business Continuity Management across all Clinical Teams and other Departments, and at all staff levels, within the Trust.

3.2.7 Training logs are maintained and are now updated on the ESR.

3.3 Exercises

3.3.1 A programme of Communications exercises has continued in line with the NHS 2005 Guidelines and to test the cascade call-out systems across the Trust. These have been successfully carried out and will be on-going.

The aim of these exercises is to identify any gaps or omissions and allow them to be rectified before the cascade is required in response to a real incident.

3.3.2 The development of an Exercise Schedule was further suspended during 2013 as there were numerous local and regional exercises based on the changes to the NHS and the move from Strategic Health Authorities and Primary Care Trusts to NHS England and local Clinical Commissioning Groups as well as the devolvement of Public Health to Local Authorities. This Trust was represented at Emergency Planning practitioner and strategic management level at exercises both regionally and locally.

3.3.3 The work on an Exercise Schedule was recommenced late in 2013. This will include the full range of exercise options including Live Exercises, tabletop exercises, control post exercises and live drills to test individual components of more complex plans. It is anticipated that these exercise options will include both planned and 'no notice' events.

3.3.4 The Exercise Schedule will include all aspects of Trust response and will cover both responses to incidents resulting in casualties arriving at our hospitals, community based incidents and to business continuity issues; however it cannot be effectively delivered until staff training has been undertaken and this work, particularly in relation to business continuity planning, was commenced during the second half of 2013 and will continue into 2014 and beyond. The timescales will depend on how quickly Teams are able to develop their business continuity plans in light of changes resulting from the implementation of the Clinical Strategy and other organisational change.

3.3.5 The Trust is represented on the Exercise Planning Team for Exercise Citizen, a Sussex wide multi-agency exercise due to take place in 2014. The Trust will undertake live play in one scenario of this exercise.

3.4 Internal co-ordination (meetings)

3.4.1 The Trust Emergency Planning Group was not active in 2013. Changes within both the Trust and the wider NHS / health communities were a barrier to this group meeting effectively. It is anticipated that this group will be restructured once organisational change is complete.

3.4.2 Business Continuity Planning Workshops have continued in 2013.

3.4.3 The Trust Pandemic Group is convened as required according to guidance from the DoH on the likelihood of pandemic status escalation. The Trust group did not convene in 2013 as flu incidence has been low nationally, so the Pandemic group has not been required to meet. However, Pandemic Planning is currently under a further review as a result of implementation of the Clinical Strategy.

3.5 External co-ordination (groups and meetings)

3.5.1 We have been represented throughout the year at multi-agency meetings within the Sussex Resilience Forum and are sitting members of the groups looking at planning for Shelter & Evacuation, Local Authority Response, Community Resilience, Voluntary Sector Response, Mass Fatalities, Pandemic Influenza and other emerging diseases, Chemical, Biological, Radiological and Nuclear (CBRN) Incidents and the Sussex Health Responders Group. The role of the Emergency Planning Team has increased within the Sussex Resilience Forum (SRF) due to the disbandment of the PCT Emergency Planning Team. The provider trusts across Sussex have undertaken to ensure Health representation across all the SRF groups formerly undertaken by the PCT team. This supports our continued compliance with our role as a Category 1 Responder under the Civil Contingencies Act 2004.

3.5.2 The Acute Hospitals Emergency Planning Group, which allows emergency planning practitioners to meet and work together to ensure that areas of work that are common to all acute hospitals are not completed in isolation but that experience and lessons identified are shared across all Trusts, has met throughout the year. This is of particular importance now that the provider Trusts represent each other on various SRF groups.

3.5.3 Within the wider NHS Community we are represented on the CCG Pandemic Flu Group and the Local Health Resilience Partnership (LHRP).

3.5.4 During the lead up to, and during, the St Judes Day storm, the Emergency Planning Team were represented at all the multi-agency Tactical Advisory Group (TAG) teleconferences and meetings. The team was also present throughout the night as part of the multi-agency Tactical Coordination Centre that operated at Sussex Police Headquarters.

3.5.5 Later in December and through Christmas into the New Year, the team were also part of the TAG that was in place for the succession of storms and flooding events that occurred and impacted on Sussex. With certain areas of East Sussex being at a high risk of flooding, which would have required a response to support evacuated residents in Rest Centres, the team often represented all the provider Trusts in Sussex.

3.6 Horizon Scanning / Event Planning

3.6.1 Severe Weather has once again featured heavily during 2013, including in the run up to, and over, the Christmas period. The weather information that is considered and circulated relates to both severe weather incidents and also to changes to the general winter weather that may impact on our day to day services by increasing attendances at our Emergency Departments.

The risk of evacuation due to flooding also increases the likelihood that community staff may be required to support our clients at Local Authorities at Rest Centres.

3.6.2 Information relating to large Public Events or Mass Gatherings is passed to the Emergency Departments, and others, to ensure that it is considered in relation to staffing levels, access to the hospitals and other relevant factors. Lewes Bonfire was again supported by additional staff and extended hours at the Lewes Victoria Hospital MIU as well as both a Clinical Manager and Emergency Planning team member attending the health planning group for the event.

3.6.3 The Trust has actively participated in Event Safety Groups and Safety Advisory Groups for large public events to ensure that our planning can adequately respond to the challenges that Mass Gatherings can present. These groups were held in all the Districts and Boroughs in East Sussex with the exception of Wealden District Council.

4. Conclusion

4.1 The Trust is fulfilling its statutory obligations.

4.2 Much more work is needed to support the development of service level BC plans, and to ensure that all service areas completely understand the requirements related to BC and why it is so important in our healthcare delivery.

4.3 There have been significant improvements during 2013, particularly in the understanding of the differences between a Major Incident, a Business Continuity Incident and purely operational capacity issues but we have not yet succeeded fully in embedding the BC planning in day to day operational delivery, and this needs to change throughout this coming year and beyond, so that it is seen as an important part of delivery of our services to patients..

Ian Taylor
Head of Emergency Planning

July 2014

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	14b
Subject:	Safeguarding Annual Report for Safeguarding Adults and Children
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

This paper provides the board with a summary of the work over the past financial year 2013/14 for East Sussex Healthcare Trust.

Introduction:

Detail is presented to provide both context of safeguarding and a summary of the activity of the work accomplished through 2013/2014 and a resume of the planned activities for 2014/15.

Also presented in this report under appendix 1 is the annual Mental Health Act Activity 1st April 2013 to 31st March 2014

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

Review of 2013/14 key actions for Safeguarding adults and children Update of current National reports
Local plan for 2014/15

Benefits:

To advise the Board of the significant work in progress within the organisation regarding safeguarding Adults at Risk and Safeguarding Children.

Risks and Implications

Not meeting statutory requirements

Assurance Provided:

Assurance is contained within the report

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

Safeguarding Adults Board
Safeguarding Children's Board
Clinical Management Executive
Corporate Leadership Team
Safeguarding Adults and Children strategic group
Safeguarding Adults operational Group
Safeguarding Children's operational group

Proposals and/or Recommendations
The Board are asked to note the contents of this paper and to have assurance around processes in place to protect adults at risk and children at risk.

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: Brenda Lynes O'Meara, Assistant Director of Nursing for Professional Practice and Standards	**Contact details:** b.lynes-omeara@nhs.net

East Sussex Healthcare NHS Trust

ANNUAL SAFEGUARDING REPORT 2013-14

1. Introduction

1.1 This paper informs East Sussex Healthcare Trust (ESHT) Board of current high level key issues regarding safeguarding both adults and children within ESHT.

1.2 ESHT is committed to working in partnership with key stakeholders to ensure that the adults and children at risk in East Sussex are identified in a timely manner and protected from harm. The purpose of this report is to:

- Provide ESHT Trust Board with an overview of the safeguarding activity undertaken in 2013/14 and outline those areas requiring further development
- Outline the safeguarding priorities for the forthcoming year

1.3 This report deals collectively with adults and children's safeguarding

2. Summary of Key Documents / National Strategy and Guidance

2.1 Safeguarding Children

2.1.1 Working together to safeguard Children

The new Working together to safeguard children (2013) streamlines previous guidance documents to clarify the responsibilities of professionals towards safeguarding children and strengthen the focus away from processes and onto the needs of the child.

It replaces: Working together to safeguard children (2010). Framework for the assessment of children in need and their families (2000), and Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 (2007).

Most of the responsibilities and procedures in the new 2013 Working together remain the same as the 2010 guidance, but the guidance is presented in a much more succinct and less detailed way.

The guidance seeks to emphasise that effective safeguarding systems are those where:

The **child's needs are paramount**, and the needs and wishes of each child, should be put first, so that every child receives the support they need before a problem escalates;

All professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children;

All professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care;

High quality professionals are able to use their expert judgement to put the child's needs at the heart of the safeguarding system so that the right solution can be found for each individual child;

All professionals contribute to whatever actions are needed to safeguard and promote a child's welfare and **take part in regularly reviewing the outcomes** for the child against specific plans and outcomes;

Local areas innovate and changes are informed by evidence and examination of the data. Effective safeguarding arrangements in every local area should be underpinned by two key principles: Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

2.1.2 Children Act 1989 Children Act 2004 (Children's Services) Regulations 2005

The Children Act 1989 aimed to ensure that the welfare of the child was paramount, working in partnership with parents to protect the child from harm. The Act was intended to strengthen the child's legal position; to give him/her equal rights, feelings and wishes; and to ensure children were consulted and kept informed. The Children Act 2004 aims to further improve children's lives and gives the legal underpinning to 'Every Child Matters: Change for Children' (2004).

There have been a few structural changes in response to the Children Act 2004 which mean that, from April 2006, education and social care services for children have been brought together under a director of children's services in each local authority.

The Children and Young Person Act 2008 has also been introduced. Its main purpose is to effect the recommendations set out in the White Paper 'Care Matters: Transforming the Lives of Children and Young People in Care' and "forms part of the Government's programme to ensure children and young people receive high quality care and support."

The Act includes provisions in relation to the well-being of children and young people and private fostering. It has a particular focus on older young people in care and those making the transition from care.

Other Acts closely linked to the Children Act are:

a) Protection of Children Act 1999
b) Safeguarding Vulnerable Groups Act 2006
c) Childcare Act 2006

2.1.3 Savile Review

The Saville review in May 2013 has resulted in both Safeguarding Adults and Children's Boards producing an action plan to ensure policies and procedures are in place within local services, which provide assurance that vulnerable adults and Children are protected from the risk of exploitation. ESHT have reviewed all related policies within adult and children's services.

The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust was published in June 2014. ESHT have reviewed this report and which is attached at appendix 1.

2.2 Safeguarding Children

Section 11 of the Children Act 2004 (duty to safeguard and promote the welfare of children) sets out specific duties on agencies with regard to safeguarding.

This is a self assessment tool and ESHT identified itself as being compliant in all areas apart from the delivery of statutory child safeguarding supervision in the 2012/13 audit. The Child Safeguarding Supervision Policy has been re-written. The ESHT Safeguarding Children Nursing Team completed the NSPCC supervision training, in July 2013.

All areas are now receiving regulated Child safeguarding supervision in line with the section 11 recommendations and the ESHT Child Safeguarding Supervision Policy. It is to be noted that updated changes were required only within the acute areas of ESHT and within Sexual Health Community Teams. Community Health Visiting and School Nursing Services were fully compliant with child safeguarding supervision. There is further work underway to address the supervision of medical staff. The Community Safeguarding Children Team has undergone a re-structuring, with one full-time Named Nurse now overseeing the community and a Deputy Named Nurse in place to support this role. There is a full-time Named Nurse to oversee the acute services and Minor Injury Units.

ESHT has a Named Doctor based at EDGH who predominantly oversees safeguarding in the West of the Trust however there is limited capacity for the named doctor responsibilities on the East. ESHT are currently planning to increase the Named Doctor function in the East of the County, a member of staff has been identified to deliver this function.. The Designated Nurse and Doctor activity now sits within the CCG's.

3. Annual activity - Child Protection (CP) Statistics ESHT (source: priority database)

3.1.1 Children on a Child Protection Plan

	August 2009	Dec 2010	Feb 2012	May 2013	Jan 2014
Total	**480**	**637**	**726**	**598**	**534**

3.1.2 Child Protection Statistics (source: ESCC) January 2014:

Area reviewed	Number of cases
LAC	**534**
Lac & CP Plan	**42**
CP Plan	**547**
CIN	**2586**

4. Child Safeguarding Training

Overall Trust % Trained	Level 1 Safeguarding Children *All staff*	Level 2 Safeguarding Children *Clinical staff*	Level 3 Safeguarding Children *Staff working directly with children*
March 2014	**100%**	**56.41%**	**78.56%**
March 2013	**100%**	**39.04%**	**42.74%**
March 2012	**100%**	**65.0%** (Combined level 2 & 3)	**N/A**

- There has been a sustained improvement in compliance with Safeguarding Children Training within ESHT. Level 3 compliance is at 78.56%. Staff evaluation of the training has been positive.
- A focussed approach to ensure all areas of poor compliance for level 2 training are targeted with training by September 2014.

- Level 1 Child Safeguarding leaflets are distributed throughout ESHT to all staff twice a year to maintain a focus on Child Safeguarding.
- LSCB multiagency courses and THRIVE workforce training is available to relevant ESHT staff.

4.1 Domestic Abuse/ Training

- Mandatory domestic violence training for community and acute staff is ongoing.
- East Sussex Safer Communities Partnership Domestic Abuse Strategy,
  - 2014-2019 consultation has taken place.
- The Named Nurse Community sits on the newly formed MARAC Quality and Audit Group.
- MARAC cases are now reviewed fortnightly on both sides of the county.
- Claire's Law Domestic Violence Disclosure Scheme (DVDS) has been rolled out across Sussex. Staff have access to appropriate referral forms.

5. Serious Case Reviews SCRs/Multiagency Reviews, MARs.

2 LSCB serious case review reports were during 2013/14. Reports are publically available.

5.1 Progress of action plans relating to SCRs/MARs

- Outstanding actions from community – Audits of New ESHT Safeguarding Supervision Policy Due November, 2014 and Ante-Natal Audit of Primiparas due September, 2014.
- Audit of consultant paediatrician sign off of middle grade OPD clinic letters.

5.2 Early Help Intervention

There is a continued focus on Early Help intervention in line withThe Munro review of child protection: 2012. The Integrated Screening Hub (ISH) continues to strengthen the ethos of multi-agency working. ISH refers Universal Partnership Plus (UPP) cases directly to TAF (Team Around Family) meetings for early help intervention. Senior Practitioners in Early Help (ESCC) and Children's Centre Keyworkers (CCKW's) support this process.

5.3 Child Sexual Exploitation (CSE)

- The CSE group has now become a permanent sub-group of the LSCB and is developing a CSE strategy.
- CSE is covered within Level 2 and 3 ESHT CP training. Staff working intensively with children will be encouraged to attend the LSCB specialist CSE training.
- Named Nurses are the contact point for health services for all Child Safeguarding queries.
- Referral pathways for CSE are in place, Police are undertaking a data collection within East Sussex and specialist WISE workers are in place to support case management.

5.4 Record-Keeping

Systmone online recording system is currently in the implementation phase within ESHT community services. This will support improved Child Safeguarding information-sharing.

6. Improving Quality within Child Safeguarding

ESHT continue to improve quality of care within safeguarding, key areas of focus currently are:

- Communication and information sharing
- Partnership working
- Domestic abuse
- CSE
- Disability/SEN and transitional work
- Public health to include school nursing service

7. Safeguarding Adults

Safeguarding adults is about protecting those at risk of harm. It involves both identifying abuse and acting where harm is occurring and ensuring preventative measures are in place for future adults at risk. The UK Department of Health's 'No Secrets' guidance defines a vulnerable adult as a person aged 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themselves.

Identifying and reporting safeguarding events is the duty of all clinicians. Preventing abuse is a key component of any effective safeguarding system. Listening to concerns, promoting self determination, and offering choice supports people in protecting themselves. Working in partnership with other agencies and organisations is recognised as good practice and fundamental to ensuring that services provided are safe and of a high quality. Adults at risk may receive care from several different providers, and so a coordinated approach is most effective in safeguarding adults.

In the UK we know that more than 342,000 older people suffer some form of abuse every year. Abuse can be categorised into a number of types. In the UK we know that more than 342,000 older people suffer some form of abuse every year. Abuse can be categorised into a number of types:

- Discriminatory Abuse
- Physical abuse
- Sexual Abuse
- Emotional abuse
- Psychological Abuse
- Financial Abuse
- Neglect and acts of omission

7.1 NHS Guidance regarding Safeguarding Adults

This was published in March 2011 by the Department of Health following a review of "No Secrets 2000". It is statutory guidance that outlines the responsibilities for practitioners, managers, NHS Boards and Commissioners for safeguarding adults work. New safeguarding principles were published in May 2011 and are as follows:

- Empowerment
- Protection
- Prevention
- Proportionality
- Partnership
- Accountability

7.2 Law Commission Review of Adults Social Care Law Consultation

The Law Commission's recommendations (April 2011) include adults safeguarding boards to be placed on a statutory footing and multi-agency duties of co-operation for adults safeguarding work.

The Government's response to the Law Commission's recommendations broadly welcomed the recommendations and confirmed that Safeguarding Adults Boards are to be placed on a statutory footing. ESHT are represented on the Safeguarding Adults Board by the Director of Nursing

7.3 Government & Care Quality Commission (CQC) response to Winterbourne View

This was in response to a Panorama programme on the care people with learning disabilities received in a special hospital. Local Safeguarding Adults Boards were required to confirm the action they were taking to safeguard people with learning disabilities living in Hospital and some Care Home settings.

The CQC undertook unannounced emergency reviews of provider services where advised by a "whistle-blower" of concerns of suspected abuse.

7.4 Disclosure and Barring Service (DBS)

The Vetting and Barring Scheme and the role of the Independent Safeguarding Authority (ISA) were reviewed along with the Criminal Records Bureau in 2011. The Protection of Freedoms Act (2012) led to the creation of the Disclosure and Barring service which requires a reduced number of people working in specific regulated activity (including healthcare) to be registered. The impact on ESHT includes the need for job adverts to specify whether the job includes regulated activity. In addition, regulated activity providers (including healthcare) have a legal duty to refer to the DBS if a member of staff is permanently removed from regulated activity. Staff training in relation to DBS is underway.

7.5 Mid Staffordshire NHS Foundation Trust Public Enquiry

The Francis Report published on 6th February 2013, is the final report of the public inquiry set up to look into the failings at the Mid Staffordshire NHS Foundation Trust. The public inquiry, led by Robert Francis QC, has been looking at the role of commissioning, supervisory and regulatory bodies and why serious problems at the trust were not identified and acted on sooner.

The report makes recommendations on eight key themes:

- Emphasis on and commitment to common values throughout the system by all within it
- Readily accessible fundamental standards and means of compliance
- No tolerance of non compliance and the rigorous policing of fundamental standards
- Openness, transparency and candour in all the system's business
- Strong leadership in nursing and other professional values
- Strong support for leadership roles
- A level playing field for accountability
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation.

Its impact is far reaching, across health and social care, and from the highest levels of management to frontline service delivery. ESHT has produced an action plan outlining key themes and the current activity which reflects ongoing compliance against the eight key themes, to which actions have now been delivered.

7.6 The Care Act

The Care Bill (now the Care Act) was passed through Parliament to gain Royal ascent in May 2014. In relation to safeguarding, the Care Act will do the following:

- Make Safeguarding Adult Boards statutory
- Make safeguarding enquiries a corporate duty for local authorities
- Make Serious case reviews mandatory

- Place duties to cooperate over the supply of information
- Place a duty on local authorities to find advocacy for people who do not have anyone else to speak up for them
- Re-enact existing duties to protect peoples property when in residential care or hospital
- Place a duty of candour on providers about failings in hospital and care settings and create a new offence for providers of supplying false or misleading information

The Act will provide 20-30 sets of regulations and will require new statutory guidance and regulation, publication is expected in October 2014. The new legal framework comes into effect from April 2015.

7.7 Key NHS South of England Developments

Development of the Safeguarding Vulnerable Adults Dashboard

Data on safeguarding adults' cases for the dashboard continues to be submitted monthly.

Further dashboard refinements are underway. ESHT continue to submit monthly data to NHS England.

7.8 Trust Developments

The Safeguarding of Adults and Children is part of the portfolio for the Assistant Director of Nursing for Safeguarding. Safeguarding leads now sit corporately. The Director of Nursing is a member of the Safeguarding Adult and Children's Board.

8. Training

8.1 Mandatory Training (ESHT)

Safety days cover both Adult and Child mandatory training, these sessions are delivered on appointment and 3 yearly following appointment for all patient facing staff within ESHT. Feedback analysis demonstrates a clear learning and practical knowledge application following training sessions.

All mandatory training criteria relating to Mental Capacity Act/ Safeguarding and DoLS is available via learning and development.

Training figures show a steady increase over the past year in line with the three year training plan for safeguarding, although a slight dip is noted in February 2013 (see table). Online level two training was launched as planned in January 2013. Targeted work continues with Allied Health Professionals and Medical staff.

Overall Trust % Trained	**Level 2 Safeguarding Adults** ***All clinical staff***	**Mental Capacity Act**	**Deprivation of Liberty safeguards**
March 2014	**77.07%**	**84.86%**	**76.19%**
March 2013	**76.27%**	**80.56%**	**72.60%**
March 2012	**59.43%**	**69.78%**	**50.18%**

8.2 Overview of Substantiated alerts comparative data

Substantiated alerts against ESHT	**% 2012/13**	**%2013/14**		
All adult safeguarding alerts against the Trust	29%	26%		
All pressure ulcers raised as safeguarding	22%	18%		
Other alerts raised against the Trust	42%	29%		

Data evidences a reduction of overall substantiated adult safeguarding alerts, which is reflected in both alerts relating to pressure ulcers category 3 &4 and all other safeguarding alerts. Overall actions are captured within the table below.

Actions Identified for 2013/14:

Review of the process of ensuring all patients have cannula removed prior to leaving Hospital (specifically A&E)	HON for A&E has written to all relevant staff regarding continuing with standards implemented for this in Department	Ongoing activity continues
ESHT to continue focussed training in relation to Deprivation of Liberty Safeguards	Focused training sessions delivered by the Safeguarding Leads both at ward level when required and as standard L&D training sessions.	Ongoing mandatory training shows a steady increase over 13/14
Focus on zero tolerance for pressure ulcer prevention	ESHT have a Trust action plan based on findings from Serious Incidents and Safeguarding cases, this action plan is available for review. Not routinely alerting since 12/13 as figures show marked improvement.	Activity is ongoing: A prevention plan and patient leaflet released in July 2013 The TVN service has been re-launched, the policy re-written in June 2013. All actions complete within the action plan
Improve the discharge and Handover process within ESHT	A discharge operational group commenced in June 2013. New Policy for Admission, Transfer & discharge ratified.	Implemented Jan 2014.
Improve initial assesments of Falls and the re assessment following each fall.	New Policy ratified in May 2013.	Implemented in September 2013. Falls leaflets printed and distributed to staff. Falls audit commenced.
Delay in alerting Social Care Direct re SAARs Standard says within 24 hrs.	Individuals spoken to on a one to one. Pathway discussed as part of mandatory training	Ongoing activity continues

63% of all alerts against ESHT in 2013/14 were not taken into safeguarding as opposed to 50% of alerts raised in 2012/13 were not taken forward by Adult Social Care. These cases include both falls and Pressure ulcers. It has been identified that ESHT have improved their documentation which evidences the excellent care provided to patients.

8.3 Analysis of Safeguarding alerts

The drive to ensure accurate reporting of all Category 3 and 4 pressure Ulcers through both the Serious Incident and Safeguarding process in 2011 through to 2013, saw an increased reduction in referrals. Indications suggest that the pressure Ulcer prevention policy is embedded and that preventative action is prevalent in practice. Therefore, since December 2013, pressure ulcers are no longer routinely referred into safeguarding unless there are initial indications of neglect. Corporate action helped move to a zero tolerance for avoidable pressure ulcer damage within ESHT.

During 2012/13 22% of outcomes were substantiated for neglect for pressure Ulcer care (DH definition of Avoidable Pressure Ulcer) from ESHT compared to 20% during 2011/12. 2013/14 saw a reduction to18% of these referrals resulting in an outcome of substantiated. The Trust pressure ulcer prevention action plan is in place with actions have been completed.

Analysis of Data 2013/14
CQC/SEC visits
SEC – Last visit November 2012 – Compliant against audit with significant assurance
All CQC visits during 2013 found ESHT compliant for Adult Safeguarding
Ofsted visit May 2014 - Good

Response to actions for Safeguarding Adults and Children 2013/2014

Action Identified	ESHT action during 2013/14
Establish audit programme to benchmark and quality assure performance Measures	An audit programme for both adult and child safeguarding has been established. Available on the Trust audit database
Ensure that learning from case outcomes, audits, SCRs is captured and implementation of learning is embedded in to practice through relevant processes	A process has been established for the Safeguarding services to disseminate learning from SCR's – this includes a whole Trust Child safeguarding supervision process and regular training updates
Ensure policies and procedures are effectively safeguarding adults and children at risk who use Trust services and minimise the abuse and neglect of adults at risk who use Trust services	Child safeguarding supervision process provides a route for monitoring effectiveness Adult safeguarding includes a robust process for the monitoring of action plans relating to safeguarding alerts
Develop and maintain a network of stakeholders through the engagement of users of services, their carers, friends, families, and advocates	Patient experience conference held in March 2014 Further large stakeholder engagement forums booked for September and October 2014
Development of a staff supervision policy in relation to safeguarding children	Policy has been written and full implementation completed with active child safeguarding supervision in place across all relevant clinical areas
Implementation of a new flagging system for people with learning disabilities	Flagging system implemented , this will be further progressed with the implementation of electronic patient records system
Ongoing revision and delivery of level 1, 2 & 3 training	Training compliance as reported is improving annually – action to improve Child safeguarding level 2 training is currently in progress
To build on current multi agency working relations to assist in the implementation of Dementia Care work ensuring clear linkage to Safeguarding Adults at Risk.	This activity is in progress, however further work is required to ensure a robust system

8.4 Actions identified for 2014/15

- Audit the effectiveness of Child Safeguarding supervision process within the Trust
- To build on current multi agency working relations to assist in the implementation of Dementia Care work ensuring clear linkage to Safeguarding Adults at Risk.
- The Trust to ensure that action is taken in line with the Supreme Court ruling in relation to the Mental Capacity Act
- The Trust to implement all policy in line with the Care Act

8.5 Mental Capacity Act/ Deprivation of Liberty Safeguards

Following the cases P vs Cheshire County Council and M&M vs Surrey County Council, the Supreme Court Judges ruled In March 2014, that to be deprived of one's liberty,
The person must be under continuous supervision and control. All three elements must be present:

- is the person free to leave?
- i.e. how would staff react if the person did try to leave or if relatives/friends tried to remove them?

8.6 Mental Health Act

Sussex Partnership Foundation Trust oversees training and regulatory function in relation to the Mental Health Act for ESHT. A separate annual report is in appendix 1

8.7 Deprivation of Liberty Safeguards (DoLS)

The DoLS process is part of the Trust's safeguarding process, where a patient lacks capacity the Mental Capacity Act (MCA) care planning tools are used. DOLS training is available for relevant staff. Statutory notification of all DOLS applications and outcomes are reported quarterly to the CQC. At ward level specific care plans exist for patients who lack or have fluctuating capacity.

8.7 Activity and actions for 13/14

In 2011/12 there were concerns raised about the standard and consistency of activities relating to SAAR. In October 2012 Southeast Coast re-audited safeguarding process and noted they had gained significant assurance in relation to processes in place. In December 2013 an audit commissioned by the Safeguarding Adults Board (SAB) found ESHT to be fully compliant against SAB requirement.

9. Governance

The updated Pan Sussex Adult Safeguarding policy is available in a downloadable format at website: http://pansussexadultsafeguarding.proceduresonline.com/chapters/contents.html

The 2013 Multi-Agency audit is now complete, findings included;

- Improved strengths in practice compared to the 2012 audit
- Evidence of proportionality of response and application of procedures
- Positive partnership working
- Improvement in the involvement of families and 'persons alleged responsible'
- Improvement in the quality of Mental Capacity assessment
- Issues relating to the response time of Police involvement

There were no specific recommendations for ESHT

One case was reviewed as a Serious Case Review – a Multi-Agency panel progressed this work.

The main findings of this SCR were:

- The application of the mental capacity act must be decision specific. This action forms part of mandatory training for ESHT staff
- SAB to review improved methods of sharing of information between agencies.

The Domestic Homicide action plan is currently being delivered within ESHT

East Sussex County Council ran a highly successful Safeguarding Conference in June 2013 – ESHT Safeguarding Team supported this conference – 15 members of staff attended from ESHT.

Clinical Commissioning Group Update:
The Designated Nurse for Adult Safeguarding post was appointed to in June 2013
Deprivation of Liberty Safeguards (DoLS) applications moved to Adult Social Care on 01/4/2013

ESHT currently has one level 4 safeguarding investigation in progress.

The Director of Nursing is a member of the Safeguarding Adults and Children's Board.

In 2011/12 there were concerns raised about the standard and consistency of activities relating to Safeguarding Adults at Risk (SAAR). In October 2012 South Coast Audit (SCA) re-audited the safeguarding process and noted they had gained significant assurance in relation to processes in place. The CQC has since found the Trust to be compliant against outcome 7.

10. Reporting arrangements

The more detailed arrangements for Adult safeguarding is a monthly operational meeting which oversees all alerts, from the point of receiving the alert to the implementation of actions where required. This is a multidisciplinary meeting with Health and Adult Social Care which allows for regular update and senior management support for safeguarding processes within the Trust. There are 3 multi-agency operational sub-groups which meet quarterly: Operational, training and audit, ESHT have representation on all sub-groups to audit and improve the safeguarding process and practice.

The Trust monthly operational meetings review trends and monitors actions that are in place as a result of substantiated safeguarding alerts.

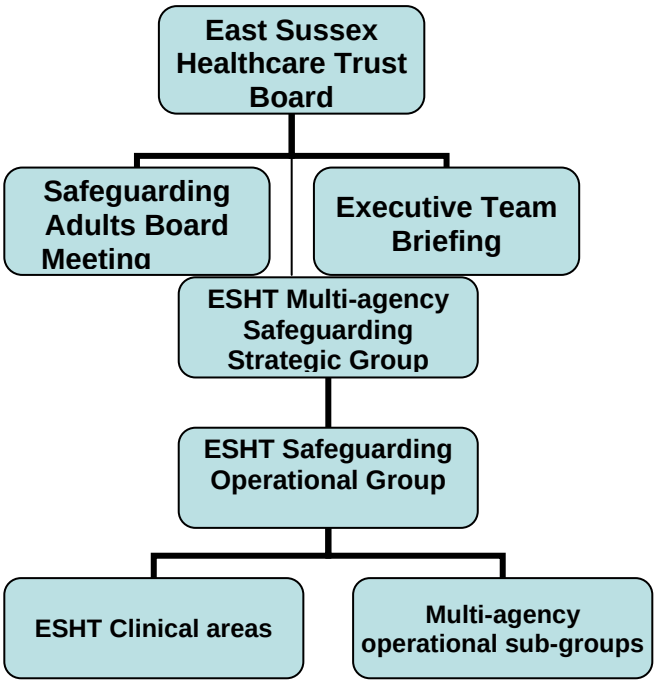
The DoLS process is part of ESHT's safeguarding process, where a patient lacks capacity the use of the Mental Capacity Act (MCA) care planning tools are used. DOLS training is available for relevant staff. Statutory notification of all DOLS applications and outcomes are reported quarterly to the CQC.

At ward level personalised care plans exist for patients who lack or have fluctuating capacity.

ESHT has a clear reporting structure for Safeguarding Adults. The flowchart below outlines the key elements of the structure, outlining that there are 4 steps between Safeguarding vulnerable adult activity and the Board of Directors.

Safeguarding information is provided on a fortnightly basis the Clinical Leadership Team (CLT). Quarterly reports outlining ongoing activity are provided to: Clinical Management Executive, Clinical Quality Review Group, Trust Nursing, Midwifery and Allied Health Professional Groups. These reports outline ongoing activity and relevant actions taken to mitigate risk within ESHT.

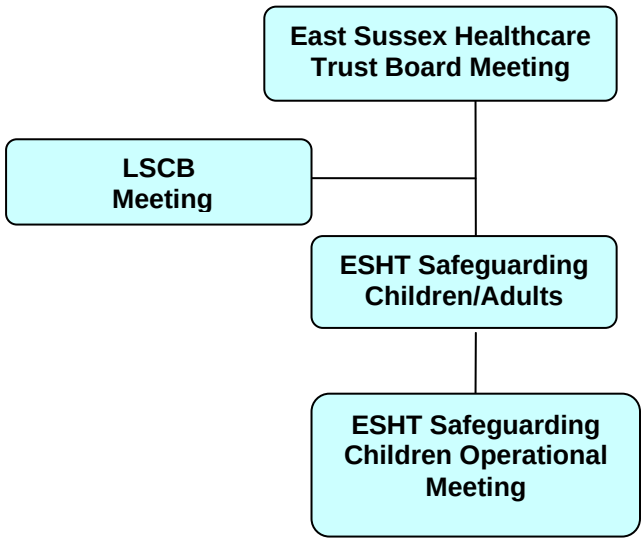
11. Safeguarding Adults Meeting structure:



11.1 Safeguarding Children

Safeguarding Children Strategic Group Meetings are now combined with the Safeguarding Adults Strategic Group Meetings. They are held quarterly and chaired by the Director of Nursing. Safeguarding Children Operational Group Meetings are held monthly.

11.2 ESHT safeguarding Meeting structure:



12. Conclusion

ESHT continues to maintain a high profile both locally and nationally with regard to both Adult and Child Safeguarding.

The absence of consistent national processes for adult safeguarding prevents the availability of national benchmarking data.

ESHT remains fully compliant with CQC Outcome 7.

Brenda Lynes-O'Meara
Assistant Director of Nursing for Professional Practice and Standards

July 2014

Appendix 1

East Sussex Healthcare NHS Trust

Sussex Partnership NHS Foundation Trust

East Sussex Healthcare Trust

Mental Health Act Activity
1st April 2013 to 31st March 2014

Use of section 5 – short term holding powers
Section 5(2) was used on 14 occasions during the reporting period, compared with ten the previous year. Eleven patients had their detentions under section 5(2) discharged, two were 'regraded' to section 2 and one to section 3.

The section 5(2) detentions were split equally between the Conquest Hospital and Eastbourne District General Hospital. The wards on which detentions under section 5(2) were applied are as follows:

The Conquest Hospital		Eastbourne DGH	
AAU	1	Cuckmere Ward	2
Baird Ward	2	Folkington Ward	1
Gardener Ward	1	Herstmonceux Ward	1
ITU	1	Medical Assessment Unit	1
Kipling Ward	1	Seaford 1	2
Wellington Ward	1		

Section 2
There were 18 detentions under section 2 in 2013, which is in line with 2012's total of 14. Of these, four section 2 detentions were of patients already admitted informally on wards at East Sussex Hospitals Trust, one patient was already detained under a section 5(2) holding power and the remaining patients were admitted to hospital whilst detained under section 2.

One patient was detained under section 2 on two separate occasions on admission to the Intensive Treatment Unit at Eastbourne DGH.

Of these patients, ten were transferred to more specialist care at Sussex Partnership, seven had their section 2 discharged and remained in acute hospital informally and one patient's section was permitted to lapsed whilst they were in hospital.

Those detained patients who transferred from BSUHT to Sussex Partnership moved within the following timescales:

Same day	3
1 to 3 days	1
4 to 7 days	4
8 to 14 days	1
More than 14 days	1

Eight detentions under section 2 were applied at the Conquest Hospital and ten at Eastbourne DGH. The wards on which the patients were detained were as follows:

The Conquest Hospital	AAU	1
	Baird Ward	1
	High Dependency Unit	1
	Kipling Ward	1
	Tressell Ward	1
	Wellington Ward	3
Eastbourne DGH	Cuckmere Ward	1
	ITU	2
	Jevington Ward	2
	MAU	4
	Seaford 2	1

Section 3
There were just three detentions under section 3, compared with five in 2012-13. One patient was detained on admission to hospital, one was detained under section 3 whilst already in hospital as an informal patient and the third had his 5(2) detention 'regraded' to a section 3.

Of these three patients, one was transferred to Oak Ward in our Secure and Forensics service three days following detention. The remaining two patients had their detentions discharged and remained informally on acute hospital wards.

Wards to which patients were detained or transferred are:

The Conquest Hospital	AAU	1
	Tressell Ward	1
Eastbourne DGH	Herstmonceux Ward	1

Equality Data
Age

	Section 5(2)	Section 2	Section 3
Under 20	1	1	-
21-30	5	2	-
31-40	1	1	-
41-50	4	3	1
51-60	-	1	-
61-70	-	3	-
71+	3	7	2

Gender

	Section 5(2)	Section 2	Section 3
Male	7	6	2
Female	7	12	1

Ethnicity

	Section 5(2)	Section 2	Section 3
White British	14	15	3
White Irish	-	-	-
Any other White	-	-	-
Gypsy / Traveller	-	-	-
White/Black Caribbean	-	-	-

White / Black African	-	-	-
White / Asian	-	-	-
Any other Mixed Background	-	-	-
Indian	-	-	-
Pakistani	-	-	-
Bangladeshi	-	-	-
Chinese	-	-	-
Any other Asian	-	-	-
Black Caribbean	-	-	-
Black African	-	1	-
Any other Black Background	-	-	-
Arab	-	-	-
Any other Ethnic group	-	-	-
Not stated/known/undefined	-	2	-

Religion and Belief

	Section 5(2)	Section 2	Section 3
Agnostic	1	-	-
Atheist	1	-	-
Baha'i	-	-	-
Buddhist	-	-	-
Christian	5	9	3
Hindu	-	-	-
Humanist	-	-	-
Jewish	-	-	-
Muslim	-	-	-
Pagan	-	-	-
Rastafarian	-	-	-
Any other	1	1	-
Not disclosed	6	8	-

Relationship Status

	Section 5(2)	Section 2	Section 3
Married / Civil Partnership	2	2	-
Co-habiting	-	-	-
Single	10	10	1
Separated	-	-	-
Divorced/Dissolved Civil Partnership	1	2	-
Widowed/Surviving Civil Partner	-	2	2
Not disclosed	1	2	-

Sexual Orientation

	Section 5(2)	Section 2	Section 3
Heterosexual	-	1	-
Lesbian/gay	-	-	-
Prefer not to say	-	3	-
Undefined/not disclosed	14	14	3

Disability

	Section 5(2)	Section 2	Section 3
None/not disclosed	14	18	3

Appendix 2

East Sussex Healthcare NHS
NHS Trust

ESHT response to:
The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust

Leeds General Infirmary is part of the Leeds Teaching Hospitals NHS Trust. James Wilson Savile was born in Leeds in 1926. He died in Leeds aged 84 in 2011. During his lifetime he was a radio disc jockey, television presenter, media personality and charity fundraiser. For over 50 years he had a close association with the Infirmary and its associated Hospitals. Over the years, the nature of this association evolved through his roles as a volunteer, celebrity advisor to the hospital radio service, volunteer porter and fundraiser.

Initially highlighted in an ITV *Exposure* documentary first shown in October 2012, and then through subsequent investigations including Operation Yewtree led by the Metropolitan Police, it is now known that Savile was also a prolific sexual predator, paedophile and rapist. He operated across the country through his work at the BBC, and in a number of NHS hospitals, including the Infirmary at Leeds.

In December 2012, the Board of Leeds Teaching Hospitals NHS Trust commissioned an external team to investigate matters relating to Jimmy Savile and the Trust (and its predecessor bodies). Led by Dr Susan Proctor, the investigation team started its work in January 2013 and has continued over the last 18 months to fulfill the terms of reference of the investigation.

The terms of reference for the investigation are as follows:

1 Thoroughly examine and account for Jimmy Savile's association with Leeds Teaching Hospitals NHS Trust (LTHT) and its predecessor bodies, including approval for any roles and the decision-making process relating to these.
2 Identify a chronology of his involvement with LTHT and its predecessor bodies.
3 Consider whether Jimmy Savile was at any time accorded special access or other privileges, and/or was not subject to usual or appropriate supervision and oversight.
4 Consider the extent to which any such special access and/or privileges and/or lack of supervision and oversight resulted from Jimmy Savile's celebrity or fundraising role within the organisation.
5 Review relevant policies, procedures and practices throughout the time of Jimmy Savile's association with LTHT and its predecessor bodies and compliance with these.
6 Review past and current complaints and incidents concerning Jimmy Savile's behaviour at any of the hospitals owned or managed by LTHT and its predecessor bodies, including:
- where the incident(s) occurred;
- who was involved;
- what occurred; and
- Whether these incidents were reported at the time and whether they were investigated and appropriate action taken.

The investigation does not have the power to impose disciplinary sanctions or make findings as to criminal or civil liability. Where evidence is obtained of conduct that indicates the potential commission of criminal offences, the police will be informed. Where such evidence indicates the potential commission of disciplinary offences, the relevant employers will be informed.

This report highlighted 31 recommendations for the Trust Board, which are grouped into six themes:

- Leadership, organisational values and executive accountability
- Patient centred drivers and safeguarding
- Board and ward coherence
- Security and controls on the physical access to hospital premises
- Policy development and implementation; and
- Fundraising

Part of the investigation included reviewing numerous reports of inquiries and studies considering failings in healthcare services, the safeguarding of children and young people, and the safeguarding of adult patients (Francis, 2013; Keogh, 2013; Erooga et al, 2012; Laming, 2003; Laming, 2009). The report noted a resonance in mutual findings on the factors associated with organisational weaknesses and safeguarding standards. It was noted that the following characteristics are invariably associated with healthcare organisations striving to be safer:

- strong, visible, credible and accessible Board leadership;
- clearly defined and commonly agreed organisational values and behaviours;
- executive accountability for the safeguarding of children, young people and adults;
- leadership that fosters a culture of curiosity, scrutiny and constructive challenge, with processes to underpin these behaviours;
- clearly defined, patient-centered drivers for all internal policies and practices;
- a commitment to lead and safeguard patients on a 24 hours, seven days a week basis;
- coherence and connection between the Board and wards/departments;
- a secure environment with regulated access to care settings;
- effective and well-understood policies for staff and patients to raise concerns;
- robust systems of employment checks for staff, volunteers and contractors;
- effective processes of induction, training, review and management of performance; and
- zero tolerance of the abuse, harassment or victimisation of staff or patients.

It was recognised that in recent years there has been considerable improvement in many of the corporate systems and processes, but there is still much to do. There were specific recommendations on the Trust's fundraising governance processes and its relationship with the Charitable Trustees, and some specific points about corporate policies.

Recommendations are presented in a way that links them to the characteristics of a safer organisation set out above.

ESHT have used the recommendations posed to Leeds Royal Infirmary to monitor our own organisation and provide assurance against each relevant recommendation.

The full report can be obtained from the Director of Nursing.

	Recommendation outline	Action area	Date to be addressed by	Assurance provided for ESHT	Action required Date and by Who
1	Leadership, organisational values and executive accountability	The organisational development programme should incorporate the following: • The safety of patients, staff, volunteers and visitors as • The promotion of enquiring leadership at all levels in the organisation. It should value a culture of curiosity and questioning, and behaviours that enable all staff and volunteers to have the courage to challenge any inappropriate behaviour witnessed in the Trust (source: chapters 4, 6, 7, 8 & 9)); • A review of existing policies, knowledge and understanding about how staff and volunteers can effectively raise concerns, and a new approach that empowers them to speak out (source: chapters 7, 8 & 9); and • A review of the effectiveness of current approaches to the management of, and responses to, complaints from patients and visitors (source: chapters 6, 7 & 8).	September 2014	ESHT provide supervision/training and opportunity for staff and volunteers to raise concerns Related policies: Whistleblowing Voluntary services Safeguarding Adults Child Safeguarding Complaints policy Supporting staff with Incidents, Complaints or Claims Management and Prevention of aggression and violence Patient Privacy and Dignity policy	All policies to be reviewed by September 2014. Action: policy authors
2	Patient centred drivers and safeguarding	The Executive Director with responsibility for safeguarding patients, and the Executive Director with responsibility for facilities and estates, should jointly assure the Board on how support services (including porters, security and mortuary services) contribute to safeguarding patients, particularly in the following areas: • That the Trust's safeguarding policies extend explicitly to the care and transportation of deceased patients (source: chapters 6 & 9);	September 2014	All staff receive Adult and Child Safeguarding training at the appropriate level. Training data reviewed monthly – ongoing Related policies: Adult Safeguarding Child Safeguarding Chaperone guidelines	Action: B. Lynes-O'Meara

		• That there are policies and controls in place covering security at the mortuary, and that these are regularly audited (source: chapters 6 & 9); • On the quality of the Trust's safeguarding compliance in respect of adult and child patients, and its duty to protect staff. Working with the Safeguarding Boards for Children and Adults, an audit programme should include a review of the safeguarding of adults and children in in-patient areas; staff training; and employment checks (source: chapters 4, 6, 7, 8 & 9); • That current Disclosure and Barring Service (DBS) checks are in place for all relevant employees, volunteers and, where appropriate, contractors as a matter of urgency, and that this position is reviewed to inform each Board meeting (source: chapters 8 & 9); • on the quality of the complaints system; the Board should monitor full adherence to the recommendations of the 2013 Clwyd/Hart Review (source: chapters 6, 7, 8 and 9); and • On the robustness of the Trust's processes for staff and others to raise concerns, and on how such matters are responded to and addressed. Particular attention should be given to allegations of sexual impropriety (source: chapters 6, 7 & 8). **13** There should be a Trust-wide campaign to raise awareness of the safeguarding duty to patients across all patient contact staff and volunteer groups (source: chapters 6, 7 and 8). **14** All safeguarding promotional material, educational material or information used in the Trust should be explicit in the inclusion of all patient contact and support services (source: chapters 6 & 8). **15** The quality of work carried out by porters should include reference to patient experience and safeguarding, in addition to the measurement of time to complete tasks (source: chapter 6). **16** Porters should receive training and support about the transportation and handling of deceased patients. De-briefing and counselling should be available for porters who are adversely affected by carrying out this duty (source: chapters 6 & 9).		Emergency 'Out of Hours' viewing in the mortuary Guidelines for women and their partners to have access to their babies from the mortuary DBS data is available through HR Adult and Child Safeguarding audit timetable and completed audits available through the audit system Ongoing awareness raising through 3 yearly training Available to service users through the updated patient information booklet	All policies to be reviewed by September 2014 Proposal to introduce a monthly light bites for Adult and Child safeguarding electronic update bulletin, Sept 2014 Action: Safeguarding Leads Currently available online – printed version to be available from September 2014 – action L. Stevens

		18 Guidance and active support on interacting with VIP patients should be developed and issued to consultants and senior clinicians, and its use monitored through the appraisal process (source: chapters 4, 5 & 6). More broadly, the following recommendations look to the role of the Board in corporate and system-wide assurance regarding the safety of patients. **19** sanctioned visitor policy should be established and implemented across all sites of the Trust with some urgency. It should set clear boundaries regarding the role of celebrities, VIPs and media contractors in the Trust, including their access to hospital premises. This policy should include robust processes for Board assurance and information about the rules of engagement with media, celebrity visitors and other VIP or non-essential visitors to the hospital (source: chapters 4, 6, 7, 8 7 9). **20** The Trust should conduct a review to ensure that the support, advice and care it provides to victims of sexual assault and statutory rape are consistent with current best practice (source: chapters 6 & 7). **21** The Trust should conduct an audit of placements of children and young people on adult in-patient areas to ensure that this no longer happens (source: chapters six, seven and eight).		This process is included in porters induction process Guidelines available on Trust website Policy for the management of External Agency visits, Inspections, Accreditations and Investigations An external visitors assurance process is currently in place ESHT do not place children or young people under 16 in adult in-patient areas	
3	Board and ward coherence	**24** Development of strategies and actions should continue to improve the visibility of executive and non-executive directors across the organisation (source: chapters 4, 6, 8 & 9). **25** As part of their Board responsibility, directors should foster a culture of curiosity, internal scrutiny and constructive challenge, particularly on matters that have a major impact on public confidence in Trust services (source: chapters 8 & 9)	October 2014	ESHT provide Trust wide visits by Exec and Non-Exec Directors – ongoing Safeguarding issues are scrutinised at Board level. This may be weekly where required through Serious Incident and Safeguarding process	

		26 The Board should develop an understanding of how it feels to be a patient in the Trust and identify methods of communication to share good practice and celebrate success, in addition to ensuring that concerns are addressed promptly (source: chapters 6, 7 & 8).		The Board is presented with a patient story quarterly, weekly visits to ward areas support this process	
4	Security and controls on the physical access to hospital premises	**27** The Trust should review security across all sites, including on-call residences and decommissioned areas in its estate, to develop a comprehensive strategic security plan. The Board should seek regular assurance that all restricted areas are secure, including high-risk areas (source: chapters 6 & 8)	October 2014	Security plan currently in place for ESHT	
5	Policy development and implementation	**28** A unified HR system should be established across the Trust that fulfils the recruitment and employment requirements for all employees, volunteers and contractors in a consistent manner (source: chapters 8, 9 & 10). **29** The Trust should review its policy on gifts and hospitality and seek assurance that all staff (including volunteers and non-executive directors) are aware of their responsibilities and comply with the policy. Compliance should be reviewed at least annually by Internal Audit (source: chapters 5 & 10) **11** Trust should develop with some urgency a volunteer policy. This should cover volunteers' employment checks, induction, training, access to the Trust and clarity about the boundaries of their roles (source: chapters 4, 6, 8 & 9). **31** The Trust should develop a major strategic plan for the management of potentially catastrophic issues where public confidence in the organisation may be at stake in the light of unprecedented events. This will enable greater clarity and consistency in matters of communication, accountability and action (source: chapters 8 & 9). **33** The Trust Dignity at Work policy has been in place since 2011, but does not explicitly mention sexual harassment in its definition of what constitutes harassment or unwanted behaviour. This should be reviewed and sexual harassment clearly defined, with examples given. Following review, this policy should be audited: in particular, to gain assurance that staff who have line management responsibility for others are fully conversant with the required actions to take	December 2014	HR system in place tbc Volunteer policy covering all relevant safeguards in place for ESHT Serious Incident process and related policies in place for ESHT The ESHT Dignity at Work policy covers all areas identified within this recommendation. Management training includes guidance as identified within this	

		when faced with allegations of sexual harassment or unwanted behaviour (source: chapters 6, 7, 8, 9 & 10). **34** All policies should be reviewed to ensure that they comply with statutory obligations about the retention of records (source: chapters 9 & 10). **35** All Trust policies should extend in their scope to the broader community, including volunteers, non-executive directors and, where appropriate, contractors; and, in time, to governors (source: chapters 8, 9 & 10). **36** The Trust should review how it seeks the views of a wider range of stakeholders in developing policies, and should ensure that all policies are patient centered. In doing so, it should draw best practice from other organisations within and outside the NHS (source: chapter 10). **37** All policies should be succinct, clearly set out in plain language, and identify the points that people need to know in order to implement them safely (source: chapter 10). **38** There should be mandatory compliance with policies designed to protect patients and staff. The role of the Trust's Internal Audit should be reviewed as part of this (source: chapters 9 & 10)		recommendation ESHT policies are regularly reviewed – action above to review selected policies ESHT currently provide separate policies and guidance for external contractors and volunteers ESHT to review how wider key stakeholders views are gained, ensuring policies are patient centred All policies are reviewed by the policy group which monitors for recommendations identified Compliance to policies is included within the ESHT annual audit process e.g. Child Safeguarding	Service User forum to commence in September 2014 Action J. Dewing
6	Fundraising	A baseline review of the range of projects supported by the Leeds Teaching Hospitals Charitable Trust should be undertaken to assess consistency with the current priorities of the Trust (source: chapter 5).	December 2014	To work with all leagues Friends (LoF) to establish a way forward. Each LoF has a named Director associated with them.	

East Sussex Healthcare NHS Trust

Date of Meeting:	30 July 2014
Meeting:	Trust Board
Agenda item:	14c
Subject:	Annual Equality Report 2013-14
Reporting Officer:	Lynette Wells, Company Secretary Dr Amanda Harrison, Director of Strategic Development and Assurance

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

Purpose:

This paper introduces the Annual Equality Report 2013-14 and provides assurance of the performance of care and workplace equity in 2013-14. The paper requests approval of the provisional national Equality Delivery System (EDS2) grades for the Trust to go out for public consultation and recommends a structured approach to improvement planning with clinical and business units to address the findings and approve renewed governance arrangements.

Introduction:

The Trust's mission is to deliver better health outcomes and an excellent experience for *everyone* we provide with healthcare services. The Annual Equality Report provides an opportunity for the Trust to check that we are delivering what we said we would do.

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

The report highlights achievements in 2013-14 to promote care and workforce equality as well as areas for further development.

Benefits:

The report sets out how equitable the Trust performs in certain key performance measures, derived largely from the NHS Outcomes Framework and the Trust Development Authority assurance framework. The report highlights areas of good practice and also potential barriers to receiving high quality care for certain communities and inequalities within employment.

Risks and Implications

The Trust must take proportion actions to eliminate relevant discrimination and disadvantage. Failure to do so may result in the Trust not meeting national standards and the Equality Act 2010 which may give rise to a complaint and a range of enforcement actions (e.g. investigations and improvement notices) taken against the Trust by the Equality and Human Rights Commission.

Assurance Provided:

Throughout 2013/14 the Trust has continued to progress against the outcomes of the Equality Delivery System. Focus will be given to implementing and monitoring the E&D programme of work throughout the year to support achievement of our goals.

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

Clinical Management Executive – July 2014

Proposals and/or Recommendations
The Committee is asked to note the report and agree the recommendations and agree provisional EDS grades (Appendix 1 to the main report) The annual equality report and the full technical data will be published online for consultation at www.esht.nhs.uk/equality and distributed for public comment

Outcome of the Equality & Human Rights Analysis (EHRA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
See 'Risks and Implications' above.

For further information or for any enquiries relating to this report please contact:	
Name: Jourdan Durairaj, Equality and Human Rights Manager	**Contact details:** 13 (3085) jourdan.durairaj@nhs.net

Annual Equality Report
2013 – 2014

This document is available in alternative community languages and formats upon request, such as large print and electronic. Please contact the Equality and Human Rights Manager: esh-tr.equality@nhs.net or telephone 01323 417400 ext. 3085

Contents

Executive Summary

1. **Introduction**

1.1 Many patients, service-users, carers, workers and communities face marginalisation and inequities linked to healthcare and wider social factors (The King's Fund, 2010). 20.4% of the East Sussex population have a long-term health problem or disability, higher than the South East (15.7%) and for England (17.9%) (ESCC, 2013).This document outlines our organisation's progress to deliver care and workplace equality in 2013-14. Page references are given in the summary below to corresponding sections in the main report). Quarterly progress reports from the equality steering group should be noted via CME

2. **Service delivery equality**

2.1 The Trust has improved knowledge systems to measure disparities and equity in clinical outcomes, such as improved performance in 2013-14 for female stroke patients under the 'Helping people to recover from episodes of ill health' national outcomes domain (pg. 9)

- It is recommended that knowledge management continue to develop the systems and standards to measure care equity

2.2 There were 349 admissions for patients recorded as 'White Other' with Ambulatory Care Sensitive (ACS) conditions that should normally be managed outside of hospital, a higher rate of 2,245 against their proportion in the underlying population (per 100,000) than for patients recorded as 'White British' with a rate of 654.9 (pg. 10)

- It is recommended that there is further validation of the data to determine whether certain minority ethnic patients are being admitted with conditions that should normally be managed outside of hospital

2.3 The 85 years and older age group experienced the greatest increase in waiting times longer than the 18-week target from the previous year (an increase of 8.7% compared to an increase of 4.9% for patients overall; pg. 11) with 1,675 out of 1,939 (86%) admitted completing within 18 weeks, compared to 2,284 out of 2,401 (95%) in 2012-13

- It is recommended the Trust engages with the older people's forums in East Sussex to understand patient experiences of the disproportionate increase in waiting time lengths

2.4 Physical barriers to accessibility remain an aspect of disabled people's experience measured by the PLACE assessments and a risk for the Trust without more funding for estates and facilities improvements

- Members are requested to consider the feasibility of commissioning an estates audit to support the development of an online guide for disabled people which can be viewed prior to visiting the Trust and will support them in planning and accessing our sites. This type of facility is used by many NHS organisations (including BSUH and SPFT) on their corporate websites

3. **Workplace equality**

3.1 Equal pay audits using the national toolkit were not undertaken and it is recommended HR establish a project group to deliver these in 2014-15.

3.2 The Trust performed worse than average against a number of Staff Survey 2013 equality indicators (pg. 15-16). For example, 40% of the 115 respondents in Acute Medicine reported harassment, bullying or abuse from other staff; higher than the Trust average (26%) or the national average (24%).

- It is recommended that targeted anti-discrimination initiatives be added to the Listening into Action (LIA) programme.

3.3 Because of these two areas the Trust is graded as 'undeveloped' against the national Equality Delivery System (EDS2) equal pay and staff experience outcomes. It is graded as developing or achieving against all other outcomes, subject to consultation.

- It is recommended that members endorse the provisional grades to go out for community consultation (app 1 of the main report, pg. 57).

4. **Representative leadership**

4.1 None of the Board identifies as black and minority ethnic (BME); all identified as White British, the same as in the previous two years. All 13 appointees to senior management (agenda for change) posts recruited in 2013-14 were White British. There were 789 individuals (11.4%) in the workforce overall who identified as BME in 2013-14. The underlying White British population in East Sussex is 91.7% (ONS, 2011). Members are requested to:

- Endorse and personally participate in *reverse* mentorship with staff from under-represented groups looking to develop their career in the Trust
- Ensure the Trust's workforce development strategy includes a requirement to increase representative leadership
- Endorse recommendations that senior managers evidence inclusive leadership in their appraisals and interviews.

5. **Governance**

5.1 There needs to be an improvement in quoracy and attendance from the Trust's equality objective leads on the equality steering group in 2014-15 to demonstrate 'due regard' to the equality duty. With the authority of the Clinical Leadership Team in December 2013 the Equality and Human Right Manager reviewed the governance and presented an options paper in early 2014.

- It is recommended that following the restructure of the Trust's senior leadership that this paper is updated and a steering group reconvened.

5.2 Board members are advised that: *'the [equality] duty must be exercised in substance, with rigour and with an open mind'* as laid out in the judgement of Brown[1]. Eight of the 16 items that went to Board in 2013-14 for approval or decision had an up-to-date equality analysis, which includes a simple screening for whether the decision is relevant to the equality duty. Please note that items tabled for assurance are not required to be analysed. Four of the remaining eight items relied upon previous analyses from earlier phases of development where assurance for the performance of the duty in later phases is not present.

- Members are requested to require reporting officers to update analyses for items returning to the agenda (such as business cases) by supporting the refresh of existing governance controls. If an analysis is not completed by a reporting officer then it is recommended to Board that the rationale for this is recorded in the minutes.

6. Conclusion

6.1 Throughout 2013/14 the Trust has continued to progress against the outcomes of the Equality Delivery System; there are still some areas that are underdeveloped and focus needs to be given to implementing and monitoring the E&D programme of work throughout the year to support achievement of our goals.

6.2 The findings of this report will be taken forward through clinical and business unit management teams. The purpose of this will be to engage clinicians and operational staff to identify and prioritise their service and workplace equality improvement initiatives. This will support the delivery of the Trust's equality objective and will be monitored through the Equality and Diversity Steering Group

[1] R.(Brown) v. Secretary of State for Work and Pensions (2008) *EWHC 3158*, Admin.

Introduction

The Trust's mission is to deliver better health outcomes and an excellent experience for everyone we provide with healthcare services. The annual equality report provides an opportunity for the Trust to check that we are delivering what we said we would do. It paints broad portraits of the people in our care and those providing care within the past year. The report outlines some of the activities we have undertaken, achievements we have made and areas we still wish to develop.

An electronic version of this report and more can be found online: www.esht.nhs.uk/equality.

Equality for patients and service-users

People are individuals with a wide range of health needs who we support to make choices about their lives and their care. From prevention through to admission, assessment, treatment and aftercare, we promote health, wellbeing and dignity for everyone who we care for.

Our care is accessed and provided by a large diverse population. We listen to our communities and workers to plan our services around their priorities. Where there is evidence of unfair barriers or unlawful discrimination we improve our services to ensure they are removed.

East Sussex Healthcare NHS Trust provides NHS hospital and community services throughout East Sussex. We provide our services at two district general hospitals, Conquest Hospital in Hastings and Eastbourne District General Hospital; community hospitals in Bexhill, Crowborough, Lewes, Rye and Uckfield and a number of clinics and health centres, GP surgeries, schools and in people's homes. For more information about us please visit www.esht.nhs.uk/about-us.

Equality for workers

Our 6,942 workers in 2013-14 were our greatest resource. We actively promoted a culture that encouraged their richly diverse talents to lead services that deliver inclusive care, tackle prejudice and promote understanding.

About the report

The report summarises key findings and then presents information about advancement of equality structured under seven overall goals that represent national NHS priorities:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm
6. Workforce
7. Leadership

The information includes 'indicators' (measurements) of equality or progress updates from teams. Throughout the report you will also see links to the public sector equality duty and the goals and outcomes of the national Equality Delivery System.

The data for each of these indicators is published at www.esht.nhs.uk/equality

Public Sector Equality Duty

The annual equality report is an integral part of monitoring the quality of our services through the delivery of the Trust's equality objectives to meet the three aims of the public sector equality duty (known as the 'general duty'):

a. Eliminate discrimination, harassment and prohibited conduct
b. Advance equality of opportunity between different people
c. Foster good relations between different people.

NHS Equality Delivery System

The progress of the Trust against the second version of the NHS Equality Delivery System (EDS) is contained within this report. The four aims of the EDS are:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

Grouped under these aims are eighteen outcomes which are graded throughout the report against four levels: Excelling, Achieving, Developing and Undeveloped.

Key findings 2013-14

Below are the key findings and achievements from the main annual equality report 2013-14.

Leadership

Board and senior leaders

Older people involvement

Vanessa Harris, Director of Finance, chaired the Age and Healthcare Steering Group in 2013-14. Membership comprised representatives from seniors' groups across East Sussex. The group reflected on national and local issues from an older people's point of view and tried to ensure that local services delivered by the Trust reflected the needs and preferences of the older population.

During the year the group completed its age equality action plan, including addressing issues such as: nutrition and dietetics, ambulance handovers, privacy and dignity, "This is me" dementia care document, the Friends and Family Test (FFT) and feedback, human rights in healthcare, the Berwick report into patient safety in England, waiting times and discharge, and transport between the Conquest Hospital and Eastbourne District General Hospital sites.

Maternity and paediatric reconfiguration equality

Amanda Harrison, Director of Strategy and Assurance, ensured that the Board's decision to temporarily reconfigure Maternity and Paediatric services on safety grounds was informed by an equality impact assessment.

She ensured all engagement in respect of this proposed service change had been inclusive and focused on women of child bearing age and seldom heard groups. In particular engagement took place with those who have protected characteristics including minority ethnic communities, lesbian, gay, bisexual and trans (LGBT) groups, parents and carers of disabled children and young people.

Disability Positive

Monica Green, Director of Human Resources, ensured that the Trust retained the 'Two ticks' symbol as part of the 'Disability Positive' employment programme. Being able to display the symbol shows that as an employer the Trust is serious about employment opportunities for disabled people; we acknowledge and value the contribution disabled people can make to the Trust and we welcome potential disabled job applicants on the basis of their abilities.

Project Search

Project Search is a new employment initiative currently being scoped by Human Resources for young people with learning disabilities. It is a joint project between East Sussex County Council, Sussex Downs College and East Sussex Healthcare NHS Trust as the host employer. The first cohort will commence in September 2014. The primary objective is to give students the skills and confidence to secure paid employment in the future.

Clinical services leadership

Cardiovascular services

During 2013-14 there has been close working with the 'Health in Mind' mental health service to support the emotional needs of people within the Cardiac Rehabilitation service helping to deliver parity of esteem.

There were a range of measures to promote sex equality for patients such as single sex accommodation, chaperones provided for patient assessments and single sex lists for catheter lab sessions.

Women's Health

Tailored support was provided for women with complex mobility issues to ensure a comprehensive care plan was in place from booking to birth during the past year.

Maternity services have ensured that women with Female Genital Mutilation (FGM) are identified and reported centrally by embedding within assessments and updating information systems.

Children and Young People Services

Children's services introduced a feedback chart with smiley faces for children to be able to express how they felt their visit had gone. The services also worked alongside the learning disability liaison nurse to support transition of young people to adult services.

Following an observation made during the year by same sex parents the documentation used on paediatrics wards is to shortly be updated to allow two males to be identified as a child's parents.

Surgical services

The bays and toilets on the surgical wards and Surgical Assessment Unit (SAU) have been colour-coded specifically to help patients with dementia, the risk factors for which increase in older people.

Refurbishment of the bathrooms on the general surgical wards included conversion to wet-rooms for step free access to improve accessibility for disabled people with reduced mobility.

The Head of Nursing and Urology Matron specifically included the views of men and their family members who were represented on the local Prostate Cancer Support Group and helped develop the quiet area on the Urology Ward.

Head and Neck

Specially trained staff known as 'Dementia Champions' undertook enhanced training to meet patients' needs and promote understanding and sensitive practice amongst their colleagues. Memory boxes were used to help patients with dementia recollect and share information about their lives.

Out of Hospital Care

Patients' religious and philosophical needs were promoted through ensuring that a new clinical information system rolled out during the past year included recording of patients' needs.

Specialist Medicine

One of the service's specialist respiratory nurses was supported to attend her duties as Chair of the Trust's BME Staff network, with other staff also released to attend conferences and meetings to promote leadership.

Acute and Emergency Medicine

Interpreters and signers were provided for patients with little or no English or who had reduced communication to promote care equity during 2013-14.

Musculoskeletal (MSK)

The newly located Trauma wards at Conquest Hospital, following the recent reconfiguration of services, now all have level access with accessible parking nearby.

Select clinic appointments are provided outside of normal working hours to reduce distress for patients with learning disabilities and x-rays arranged at community hospitals.

Equality and Human Rights Corporate Work Programme

Culturally inclusive care

Patient documentation across a range of care pathways was updated to include patient diversity monitoring. This should lead to both more culturally appropriate care and also better data being available in the future to support decision-makers evaluate service performance.

Translation and interpreting

The Trust's new Language and Communication policy was ratified, including extensive engagement with community members. A programme of staff development and awareness-raising is being rolled out. Improvements in individual practice and negative patient experiences have been dealt with via contract management of the service providers and management coaching.

LGB friendly healthcare

The Trust successfully applied for and gained Stonewall 'Health Champions' status to work with the UK's leading lesbian, gay and bisexual charity to promote LGB-friendly healthcare. Consultancy support worth up to £6,500 and access to NHS specific training on sexual orientation equality is part of the programme with support entering the Stonewall Healthcare Equality Index to benchmark progress against other organisations year on year.

Trans inclusive healthcare

Following a number of reports of poor experiences from Trans patients, members of the Hastings and Rother Rainbow Alliance (HRRA) Trans Group were engaged with. A series of evening workshops and online engagement has increased understanding of community members' concerns. These included: privacy, health records, single-

sex accommodation and cultural competency of staff. Solutions to improve Trans patient experiences, such as staff training and new procedures to change patient gender on health records have been identified for co-production and further engagement with community members. Members are also helping construct Trans care experience measures for inclusion in a regular follow-up survey to allow the Trust to continually review and learn from their experiences proactively.

Mandatory training

During 2013-14 face-to-face equality and diversity training was rolled out to the majority of nursing, administrative and support staff following staff feedback about barriers to the e-learning module. Staff feedback has been very positive.

Equality and Human Rights Analyses (EHRA)

The Trust uses an Equality and Human Rights Analysis (EHRA) toolkit to assist with meeting the equality duty within policy-making. Sixteen reports went to Board in 2013-14 for approval or decision of which eight reports are noted to have undergone an up-to-date analysis. Four reports were not analysed and a further four reports relied upon potentially outdated analyses.

Recommendations

- Trust Board are requested to consider that all sponsors / authors presenting an item for decision or approval have analysed evidence of the impact upon equality of opportunity for patients, service-users, carers and workers in advance, and completed an Equality and Human Rights Analysis (EHRA) form

- Trust Board are requested to consider that when developments in a policy area come back on future agendas that the sponsor / author is required to update the equality analysis before approval.

Cultural competency

63 people (16%) of the 393 disabled respondents to the Staff Survey 2013 question reported discrimination at work in the previous 12 months, compared to 11% of non-disabled respondents.

63 people (28%) of the 225 BME respondents to the Staff Survey 2013 question reported discrimination at work in the previous 12 months, compared to 10% of white respondents.

Recommendations

- Add Equality and Diversity mandatory training to the mandatory training performance dashboard for Trust board

- Prioritise anti-discrimination as a staff experience improvement initiative and run Listening into Action workshops to collect staff stories and suggestions from the urgent care unit, the cardiovascular unit and partner with the BME Staff Network

- Human Resources (HR) requested to improve measurement of discrimination, harassment and prohibited conduct by mandating the monitoring of incidents that were resolved informally

- All clinical and business units to respond to the recommendations within this summary and the Trust's progress (Appendix 2: Equality objectives progress) with implementation plans and locally agreed governance arrangements

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

Management of acute stroke

The focus this year for recovery equality was upon stroke. Timeliness and specialist care are critical factors in the management of acute stroke to improve outcomes. In July 2013 we centralised hyper acute and acute stroke services at Eastbourne DGH and increased stroke rehabilitation beds at Bexhill Irvine Unit from 12 to 18. The changes were focussed on improving the quality of the service, making it safer with better outcomes for patients who suffer a stroke. This is demonstrated by the significant increase in the number of patients who are admitted directly to a Stroke Unit and in some of the data below.

Two national quality indicators were measured in 2013-14, firstly the percentage of patients who spent at least 90% of their time on a stroke unit, and secondly the proportion of stroke patients scanned within one hour of hospital arrival.

There were 594 patients with stroke out of 694 (85.6%) who spent at least 90% of their time on a stroke unit in 2013-14. Breaking this down by gender there were 304 out of 353 (86%) females and 290 out of 341 (85%) males. This observed parity is a 13% point increase for females on the 2012-13 results where there were only 224 female stroke patients out of 307 (73%) spending 90% of their time on a stroke unit compared to 215 out of 249 (86.3%) males. The previously observed gender inequity in access to specialist stroke care has disappeared from last year.

Additionally, there was an 11.8% increase in time on a stroke unit in 2013-14 for stroke patients aged 85 years and more. There were no relevant inequities observed within the proportion of stroke patients scanned within one hour of hospital arrival.

There were only six black and minority ethnic patients recorded with a primary diagnosis of stroke (excluding those whose first admission was CCU or who died on same day as arrival / onset of symptoms) out of 694 patients in 2013-14. Within that total there was a further 139 patients whose ethnicity was unknown, up considerably from 26 unknown out of 556 patients in 2012-13.

Recommendation

- Cardiovascular unit to review and update patient documentation and staff training to ensure that ethnicity is being recorded for all patients.

Preventing people from dying prematurely

Mortality

Evidence of health outcomes being improved for all groups is limited. The crude mortality and the Risk Adjusted Mortality Index (RAMI) rates are available by age-band and sex. Further clinical analysis is required to understand outliers.

Recommendation

- The Mortality Group are requested to analyse Risk Adjusted Mortality Index (RAMI) outliers by age-band for inequalities and explore further the relevance and feasibility of reporting Summary Hospital Mortality Indicator (SHMI) data by age-band and sex in future years.

Cardiac rehabilitation completion

Equality of cardiac rehabilitation is one of the Trust's equality objectives. It was proposed that cardiac rehabilitation completion be measured as per the Clinical Commissioning Group (CCG) Outcomes Indicator Set 2014-15 (NHS England, 2014) which is the same as the Chronic Heart Failure Quality Standard, QS9 (NICE, 2011). Technical difficulties processing the data mean that it cannot be reported in 2013-14.

Recommendation

- The Knowledge Management team put in place a strategy to report equality of cardiac completion in time for 2014-15 annual reporting.

Enhancing quality of life for people with long term conditions

Data indicated patients from particular ethnic groups are admitted disproportionately for certain chronic conditions that should usually be managed outside acute hospitals. There could be many causes for this that will require further analysis.

Unplanned inpatient admissions for adults with chronic Ambulatory Care Sensitive (ACS) conditions

This indicator measures effective management and reduced deterioration in people with Ambulatory Care Sensitive (ACS) conditions. Active management of ACS conditions such as COPD (Chronic Obstructive Pulmonary Disease), diabetes, congestive heart failure and hypertension can prevent acute problems and reduce the need for emergency hospital admission.

There were 349 admissions for patients recorded as 'White Other', a higher rate of 2,245 against their proportion in the underlying population (per 100,000) than for patients recorded as 'White British' with a rate of 654.9.

Recommendations

- Produce information about accessing primary care in Russian, Albanian, Czech, Portuguese and Polish and supply to relevant patients with unplanned admissions

- Urgent Care unit to review and update patient documentation and staff training to ensure that ethnicity is being recorded for patients with unplanned hospitalisations.

Unplanned time in hospital for people under 19 years with asthma, diabetes and epilepsy per resident population

The rate of emergency admissions involving children and young people with asthma, diabetes or epilepsy recorded as black and minority ethnic is considerably higher than for white children and young people, compared to underlying populations, although the numbers were small. There were only 28 black and minority ethnic (BME) children and

young people emergency admissions in 2013-14, so the data was analysed for the past three years and showed that the trend persisted.

Recommendations

- Children's and Young Peoples Services conduct a case note review to ascertain if there are any common social factors affecting access to community care for BME children and young people

- Children's and Young Peoples services review patient documentation and update staff training to identify and assess patients' religious needs.

Patient experience (including access)

There is mixed evidence about the Trust's equity in improving the experience of care, including access for patients. Waiting time data still requires improvements for ethnicity and BME people report worse experiences in A&E than white people. The younger a person over 16 years, the more likely they are to not recommend A&E.

Waiting times

The target is for 95% of patients to complete referral to treatment waiting times in 18-weeks. There were 18,020 out of 21,406 white patients who completed referral to treatment in 18 weeks (84.2%) in 2013-14, down by 5.1% from 89.3% in 2012-13.

There were 407 out of 512 BME admitted patients who completed referral to treatment in 18-weeks (79.5%) in 2013-14, down by 7.2% from the 345 out of 398 (86.7%) in 2012-13.

The 85 years and more age group experienced a greater increase in waiting times (8.7%) not completing within target from 2012-13 data compared to any other age group. In 2013-14 1,675 out of 1,939 admitted patients aged 85+ years completed referral to treatment in 18 weeks (86.4%) compared to 2,284 out of 2,401 (95.1%) in 2012-13.

Recommendations

- Patient documentation for all 18-week pathways should be updated to include the Census 2011 ethnicity categories, religion and belief, sexual orientation and disability and relevant staff members should receive training on asking patient demographic questions

- The Trust's operations function engage with BME community groups and older people's forums about experiences of waiting times and suggestions to improve performance.

Four hours in A&E from arrival to transfer, admission or discharge

There were 29,274 attendances in A&E by people where their ethnicity was unknown and 39,986 where the religion or belief was unknown out of 73,621 attendances in total, which compromises the reliability of any analysis.

Where the ethnicity was known patient ethnic groups who experienced longer times in A&E than those recorded as 'White British' (68.6%) were: 'Black Caribbean'

(47 out of 76 people or 61.8%), 'Any other Black background' (48 out of 78 people or 61.5%) and 'White Irish' (128 out of 213 people or 60.1%).

The reasons are unknown why the older a patient is the more likely they will spend longer than four hours in A&E. There is an inverse correlation between the age of people attending A&E and the percentage of people in that age-band who spend less than four hours from arrival to transfer, admission or discharge.

Recommendations

- The Urgent Care unit management team should evaluate A&E diversion schemes with members of BME community groups to include information and signposting, for example directions to the local walk-in centres

- Patient documentation for all urgent care pathways should be updated to include religion or belief and the Census 2011 ethnicity categories (including Irish Traveller), sexual orientation and disability and that relevant staff in A&E and MIU receive training on asking patient demographic questions.

Friends and Family Test (FFT)

The 259 patients in A&E who described themselves as BME and filled in the friends and family patient survey had an average FFT score of 39. This is lower than for the 7,037 patients who described themselves as white and had an average FFT score of 51, and for all 7,918 respondents overall where the FFT score was 49, although it is the same as the 611 patients for whom no ethnicity was disclosed where the FFT score was 39.

Recommendations

- Urgent Care unit use 'key-word' algorithms to analyse the free-text responses for both BME patients and also 17-29 year old patients who were unlikely to recommend A&E to friends and family to identify any trends and produce an improvement plan

- Patient experience team review the current implementation of ethnic monitoring to reduce the number of broad ethnic group values reported so that more reliable specific ethnicity codes are collected from survey respondents

- Report key patient experience indicators from the patient surveys and complainant data for protected groups in the annual equality report 2014-15.

Languages

Interpreter and communication support activity increased by 17% from 863 sessions in 2012-13 to 1,009 sessions meeting patients, service-users and carers needs in 2013-14. Correspondingly over the same period there was a 9.7% decrease in average verbal interpreter invoice costs from £101.16 in 2012-13 to £91.32 in 2013-14.

58% of the Trust spend on interpreter and communication support came from the 'Women and Children' unit for which the Trust received various significantly enhanced tariffs to support women with little or no English. Early findings from as yet unpublished research commissioned by Healthwatch East Sussex indicates that Trust usage and spend may be comparatively low.

There were 92 sessions of hearing support (British Sign Language and lip-speaking) provided in 2013-14 up by 35% on the 68 sessions in 2012-13. There was nothing spent on visual support (braille, audio recordings and large) in 2013-14.

Recommendations

- The interpreting and language budgets for units are top-sliced in 2015-16 on the basis of 2013-14 usage and a centralised budget established, with operational managers retaining authorisation.
- Women and Children unit audit records of BME women on maternity pathways to establish if language needs are being correctly coded so that enhanced payments are received.
- Patient information explaining rights to communication support should be made available in a variety of languages and formats to raise awareness.

Patient safety

The Trust has an open culture of reporting harm. All incidents are reviewed and investigated. This supports the organisation in developing good practice and learning.

Patient safety incidents

Nearly two thirds (5,822 out of 9,509) of reported patient safety incidents affected disabled people (61.2%) in 2013-14. There were 393 reported incidents that involved people with learning disabilities (4.1%). There were 490 incidents where the person was recorded with behaviour or emotion related disability (5.2%). The biggest was mobility disability at 16.6% (1,574) of recorded incidents.

20.4% of the East Sussex population have a long-term health problem or disability, higher than the South East (15.7%) and for England & Wales (17.9%). At 23.5%, Rother has the highest percentage of the population with limiting long-term health problems in the county (ESIF, 2013).

There were 3,483 patient safety incidents (36.6%) that did not record the ethnicity of the person concerned out of 9,509 in total.

Incidents involving severe harm or death

There were 43 incidents involving severe harm or death in 2013-14 of which 14 occurred to disabled people (34%); 65% of the incidents involving disabled people were falls resulting in harm such as a fracture. The incidents have been reviewed and there does not appear to be a link between the disability and the incident. This will continue to be reviewed to monitor incidents to identify and evaluate any trends in respect of disability.

There were also 40 incidents (82%) involving severe harm or death where the religion or belief of the person concerned was not recorded which highlights potential issues for some people who may benefit from chaplaincy support and religious observance. Two of the incidents (4%) occurred for patients whose religion or belief was defined as ‘Other’ whereas no patient safety incidents were recorded for any of the major world

faiths apart from Christianity. There were seven incidents (14.3%) where the ethnicity was unrecorded, which compromises analysis for ethnicity factors.

Patients between 85-94 years old (13 people or 26.5%) were four times as likely to be involved in a patient safety incident involving severe harm or death than those between 65-74 years (three people or 6.1%).

Recommendations

- Patient safety to review the top types of patient safety incident for each type of disability and devise an improvement plan if required
- Patient safety to review the root cause analyses of the two people involved in incidents of severe harm or death whose religion or belief was defined as 'Other' in 2013-14 so that the Trust is assured that these were recorded correctly and any improvements recommended
- Patient safety incidents involving severe harm or death should record ethnicity and religion as a mandatory requirement

Care discrimination

There were four incidents of perceived discrimination to patients and service-users by Trust employees reported in 2013-14. Three of those were disability discrimination with the fourth incident being sex discrimination or harassment. In addition there was one disability related hate incident and one sexual assault recorded.

A number of issues reported by staff throughout 2013-14 were resolved with the support of the Equality and Human Manager without escalating to incidents.

Recommendation

- Patient experience team engage with community groups about experiences and suggestions to increase reporting of discrimination and harassment.

Workforce

There is a lack of diverse representation for many groups at executive and Board level. Detailed analysis is included under the sub-headings below.

NHS boards are under intense national scrutiny at the moment through the 'Snowy White Peaks' report (Kline, 2014) that revealed BME leadership representation in the NHS has regressed over the past few years. The response to the report by the national Equality and Diversity Council (EDC) although not yet finalised is likely to mandate certain equality performance measures upon NHS organisations.

There is evidence that a diverse workforce in which all staff contributions are valued is linked to good patient care (West 2012, Dawson 2009). In light of this and because the Trust was scored lower (84%) than the national average (88%) for equality of career progression in the Staff Survey 2013, the Trust graded itself as 'undeveloped' in this area on the corresponding Equality Delivery System (EDS2) outcome.

26% of staff reported harassment, bullying or abuse from other staff in the Staff Survey 2013, which was higher than the national average (24%). This rose to a high of 40% of the 115 respondents in Acute Medicine. There is a clear link between discrimination, aggression against staff, and patient satisfaction (West, 2012).

Racial equality

There were 789 individuals (11.4%) who identified as black and minority ethnic (BME) in the 2013-14 workforce overall.

This includes 253 BME staff (16.9%) in agenda for change (AfC) band 5 and 76 BME people (7.4%) at AfC band 6. The degree to which BME nursing career progression is self-limited or limited by institutional barriers is unknown.

None of the Board identified as BME. The Chief Executive, all eight of the Trust Executives, the Chair and all six of the NEDS were White British, the same as in the previous two years. The underlying 'White British' population in East Sussex is 91.7% from the Census 2011.

There were 40 BME senior management applicants (34.5%) for agenda for change (AfC) roles in 2013-14 of which only one person (16.7%) was shortlisted. Although ethnicity information is not part of the shortlisting process it might be possible to guess national origins based on an applicant's prior experiences and education.

No appointees were BME; all 13 AfC appointees (100%) were White British. This is down from the two BME people (15.4%) appointed in 2011-12 and the one BME person (6.3%) appointed in 2012-13.

There were 20 BME people promoted across all AfC pay bands (7.2%) lower than the representation of BME people in AfC posts overall (8.9%) and within typical nursing bands AfC 5-7 (11.5%).

There were 240 White people promoted across all AfC pay bands (87%) higher than the representation of white people in AfC posts overall (82.3%) and within AfC 5.7 (81.4%).

Across the medical workforce there was a drop off of 15.3% for BME doctors between shortlisting to appointment. This is worse than 2012-13 where the drop off was 12%

169 (77%) of the 225 BME respondents to the Staff Survey 2013 felt the Trust provides equal opportunities of career progression, compared to 1,779 (85%) of 2,093 White respondents.

63 people (28%) of the 225 BME respondents to the Staff Survey 2013 reported harassment, bullying or abuse by staff, compared to 26% of White respondents.

Religion and belief data is largely incomplete.

Sexual equality

57.1% of executives (4 people) and 28.6% of non-executives (2 people) were female compared to 78.6% (5,256 people) of the workforce.

There were 486 people (27%) of the 1,799 female respondents to the Staff Survey 2013 who reported harassment, bullying or abuse by staff, compared to 101 (22%) male respondents.

Equal pay

Equal pay audits using the national NHS Employers toolkit have not been completed so the Trust has been graded 'undeveloped' against the corresponding national Equality Delivery System (EDS2) outcome.

Disability equality

3.3% of the workforce is recorded as being disabled (227 people). Only 229 (76%) of the 393 disabled respondents to the Staff Survey 2013 felt the Trust provides equal opportunities of career progression, compared to 1,625 (86%) of 1,890 non-disabled respondents.

138 (35%) of the 393 disabled respondents to the Staff Survey 2013 reported harassment, bullying or abuse by staff, compared to 454 (24%) of non-disabled respondents

Sexual orientation equality

No executives, non-executives or very senior members of staff who have locally negotiated pay are recorded as lesbian, gay or bisexual (LGB). 0.8% of the workforce overall is recorded as LGB (59 people).

Data was largely unavailable to analyse workforce sexual orientation and no data was available in respect of gender reassignment.

Recommendations

- Request representatives of the Board participate in a reverse mentoring or coaching arrangement with BME members of staff
- Request senior medical leaders participate in a reverse mentoring or coaching arrangement with a female doctor
- Request senior managers (bands 8a-d) and consultants participate in a reverse mentoring or coaching arrangement with an LGBT junior member of staff or LGBT non-consultant career grade or junior doctors
- Update recruitment guidance to mandate that applicants to posts at AfC band 7 and above demonstrate at interview their team or organisation's profile and what they will do to promote inclusion and address any under-representation
- Update performance development review (PDR) guidance so that managers on AfC band 7 and above, and doctors with management responsibilities, demonstrate actions taken to promote inclusion and address any under-representation in their team or the wider organisation
- Implement the NHS Employers equal pay audit toolkit to assure there is equal pay for equal work and reconvene the workforce equality meetings
- Implement equality monitoring of participants within the learning evaluation feedback form and report for 2014-15

- Prioritise anti-bullying and harassment as a staff experience improvement initiative and run Listening into Action workshops to collect staff stories and suggestions from the urgent care clinical unit, the BME Staff Network and the disabled workforce

- Prioritise equality of career progression as a staff experience improvement initiative and run Listening into Action workshops to collect disabled and BME staff stories and suggestions.

Clinical effectiveness equality analysis

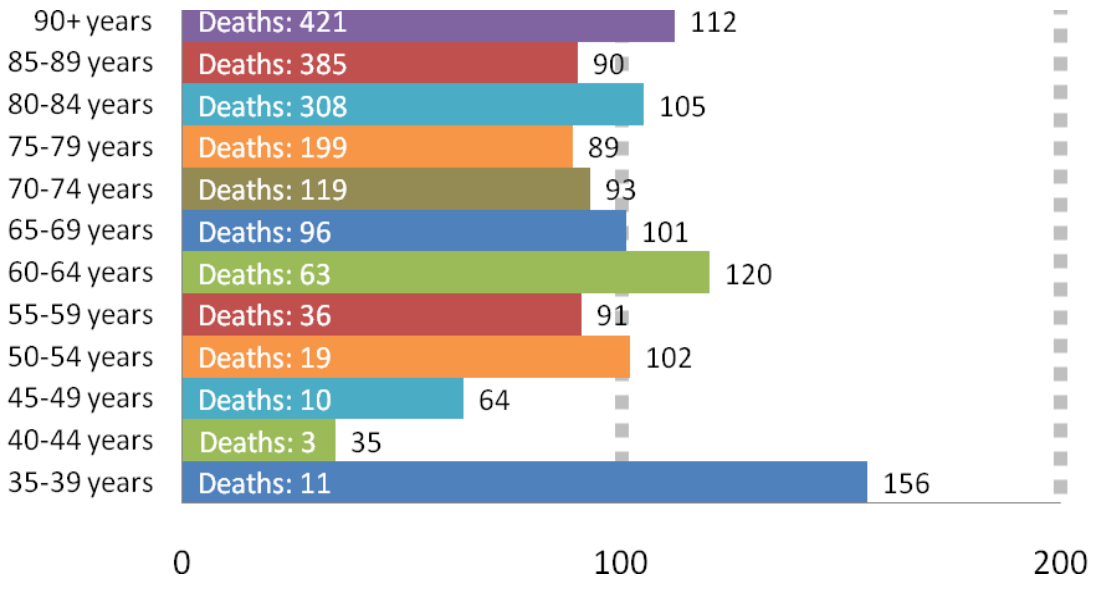
Equality Delivery System Goal 1: Better health outcomes

1. Preventing people from dying prematurely

The equality indicators presented in this section capture how successfully the Trust is meeting its objective to prevent people from dying prematurely where it can make a difference.

The Risk Adjusted Mortality Index (RAMI) takes the crude mortality rate, i.e. the number of deaths in the acute hospitals, and adjusts it for a wide variety of factors – population size, age, poverty, treatments and operations, palliative care and so on. Delving beneath headline mortality rates allows for a deeper understanding of outcomes for people in different age-bands.

Figure 1 Risk Adjusted Mortality Index (RAMI) in the over 35 years (100 is normal ratio)



Evidence of health outcomes being improved for all groups is limited. The crude mortality and the Risk Adjusted Mortality Index (RAMI) rates are available by age-band and sex. Further clinical analysis is required to understand outliers.

- Being over 100 is not a problem in itself. Values that are outside of statistical confidence limits should be investigated further with examination of other relevant safety and quality indicators to see if there is a consistent problem.
- Summary Hospital Mortality Indicator (SHMI) data was the main mortality ratio not available by age-band or sex.

Recommendation

The Mortality Group are requested to analyse Risk Adjusted Mortality Index (RAMI) outliers by age-band for inequalities and explore further the relevance and feasibility of reporting Summary Hospital Mortality Indicator (SHMI) data by age-band and sex in future years.

Cardiac rehabilitation completion

Cardiac rehabilitation completion measures the number of patients with coronary heart disease (CHD) who complete cardiac rehabilitation. Completion indicates the end of the cardiac rehabilitation delivery phase and second assessment.

Cardiac rehabilitation enables people with CHD to have the best possible help (physical, psychological and social) so that they may, by their own efforts preserve or resume when lost, as normal a place as possible in the community.

The equality impact assessment for Adult Cardiology (ESHT, 2012) revealed national differences in both the prevalence of the risk factors and incidence of CHD between genders and ethnic groups and consequences for cardiac rehabilitation services.

Equality of cardiac rehabilitation is one of the Trust's equality objectives. It was proposed that cardiac rehabilitation completion be measured as per the Clinical Commissioning Group (CCG) Outcomes Indicator Set 2014-15 (NHS England, 2014) and the Chronic Heart Failure Quality Standard, QS9 (NICE, 2011). Problems processing the data mean that it cannot be reported in 2013-14.

Recommendation

The Knowledge Management team put in place a strategy to report equality of cardiac completion in time for 2014-15 annual reporting.

Progress	Equality Delivery System
Developing	Outcome 1.1: Services are commissioned, procured, designed and delivered to meet the health needs of local communities
People from only some protected groups fare as well as people overall	

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

The equality indicators reported in this section provide a picture of the Trust's contribution to improving the quality of life for those affected by long-term conditions.

The two following indicators measure the equality of how well care has been integrated between community and acute care. This is relevant for patients with chronic conditions who should usually be managed in primary or community care to avoid acute hospitals.

Figure 2 Unplanned inpatient admissions for adults with chronic Ambulatory Care Sensitive (ACS) conditions by very broad ethnic group

This indicator measures effective management and reduced deterioration in people with Ambulatory Care Sensitive (ACS) conditions. Active management of ACS conditions such as COPD, diabetes, congestive heart failure and hypertension can prevent acute problems and reduce the need for emergency hospital admission.

There were 2,944 unplanned adult inpatient admissions for patients where the ethnicity was unknown who had chronic Ambulatory Care Sensitive (ACS) conditions in 2013-14. Only 34 black and minority ethnic (BME) inpatient admissions were recorded. In addition there were 482 involving patients whose ethnicity was unknown.

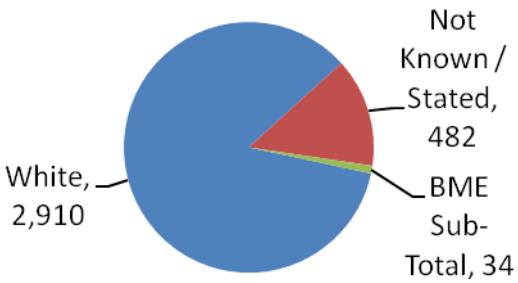
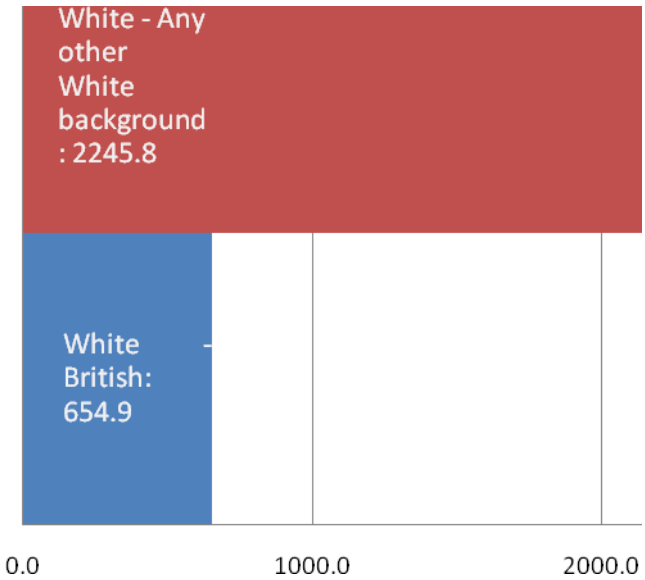


Figure 3 Proportion of unplanned hospitalisations for white adults to underlying population sizes (per 100,000)



The proportion of admissions to underlying populations (per 100,000) is much higher for patient admissions where 'White Other' was recorded. There were 349 admissions (a rate of 2,245) and 2,545 admissions for 'White British' (a rate of 654.9).

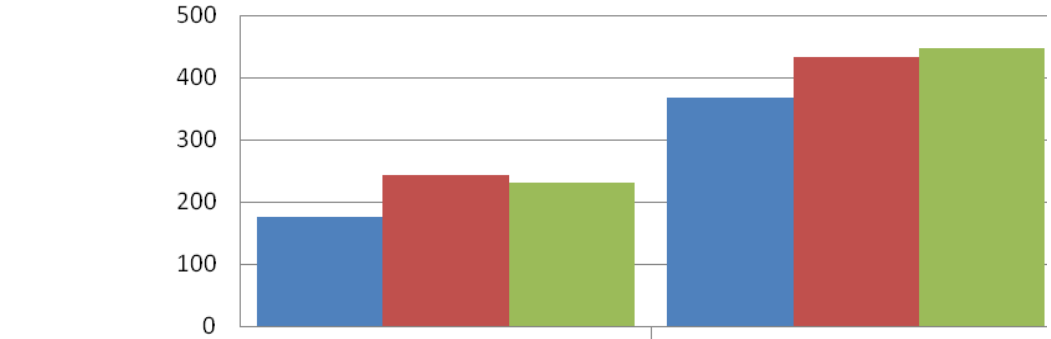
'White Irish' figures were excluded because there were only 16 inpatient admissions. In addition overall males were more likely to require an unplanned inpatient admission with chronic ACS than females.

Recommendations

Produce information about accessing primary care in Russian, Albanian, Czech, Portuguese and Polish and supply to relevant patients with unplanned admissions

Urgent Care unit to review and update patient documentation and staff training to ensure that ethnicity is being recorded for patients with unplanned hospitalisations.

Figure 4 Unplanned time in hospital for people under 19 years by broad ethnic group with asthma, diabetes and epilepsy per resident population (format = 100,000)



	WHITE	BME Sub-Total
Rate 2013-2014	175.7	368.0
Rate 2012-2013	242.8	433.7
Rate 2011-12	231.8	446.8
Emergency admissions 2013-14	191	28

The rate of emergency admissions involving BME children and young people (C&YP) is considerably higher than for white C&YP compared to underlying populations. Because there were only 28 BME C&YP emergency admissions in 2013-14, previous years' rates are included to demonstrate that the trend is persistent.

The reasons for the greater need for certain services to support BME children and young people are unknown and it is recommended that Children's and Young Peoples Services perform a case note review to ascertain if there are any common social factors affecting access.

Boys were more likely to be admitted in an emergency because of asthma, diabetes and epilepsy than girls, but this difference is less pronounced than in previous years.

There were 180 admissions involving children and young people who did not have their religion or belief recorded. It is recommended that Children's and Young Peoples Services review patient documentation and staff training to assess religious needs.

Recommendations

Children's and Young Peoples Services conduct a case note review to ascertain if there are any common social factors affecting access to community care for BME C&YP.

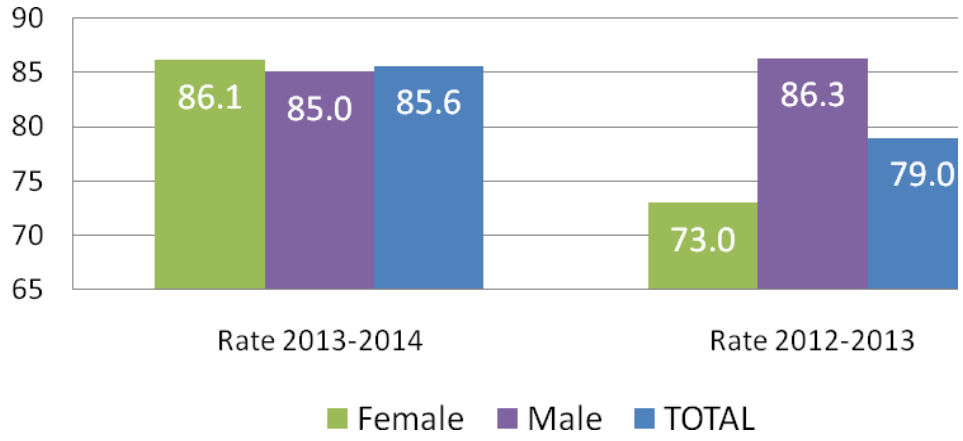
Children's and Young Peoples services review patient documentation and update staff training to identify and assess patients' religious needs.

Progress	Equality Delivery System
Developing	Outcome 1.3: Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
People from only some protected groups fare as well as people overall	

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

The equality indicators presented in this section cover the effectiveness of care to improve health following ill-health, specifically stroke. Stroke was chosen because it is one of the Trust's equality objectives. Indicators that measure adverse outcomes for patients (such as emergency readmissions) more generally will be evaluated for inclusion in next year's report.

Figure 5 Female and male patients admitted to hospital following a stroke who spend at least 90% of their time on a stroke unit



National audits of stroke found that with increasing numbers of patients treated in stroke units over the past ten years, there was a corresponding reduction in deaths and hospital length of stay (DH, 2014). The equality impact assessment for Stroke Services also found nationally higher death rates from strokes among women at older ages (ESHT, 2012).

In response the Trust measured the equality of patients who spend at least 90% of their time on a stroke unit. This quality marker highlights the importance of time and specialist care as the critical factors in the management of acute stroke. The target is based on the Cardiovascular Disease Outcomes Strategy (DH, 2014)

The data for 2012-13 found that only 224 out of 307 (73%) females with stroke spent 90% of their time on a stroke unit compared to 215 out of 249 (86.3%) males. There was a 13.3 percentage point gender difference indicating potential unmet needs for female patients with stroke.

This quality indicator was measured again for 2013-14. The data for 2013-14 found that 304 out of 353 (86%) of females with stroke spent 90% of their time on a stroke unit and 290 out of 341 (85%) males. The previously observed inequity had disappeared.

Additionally, in 2012-13 only 152 out of 204 (74.5%) people aged 85 years and more with a stroke spent 90% of their time on a stroke unit, whereas in 2013-14 performance against the 90% target improved to 201 out of 233 (86.3%).

During 2013-14 stroke services were reconfigured and from July 2013 acute and hyper acute stroke services were provided on the Eastbourne DGH site only. The improvement in access to timely specialist stroke care appears to have benefited all patients with stroke, particularly females and those aged 85 years and more.

There were only six black and minority ethnic patients recorded with a primary diagnosis of stroke (excluding those whose first admission was CCU or who died on same day as arrival / onset of symptoms) out of 694 patients in 2013-14. Within that total there was a further 139 patients whose ethnicity was unknown, up considerably from 26 unknown out of 556 patients in 2012-13.

Recommendation

Cardiovascular unit to review and update patient documentation and staff training to ensure that ethnicity is being recorded for stroke patients.

Progress	Equality Delivery System
Achieving	Outcome 1.2: Individual people's health needs are assessed and met in appropriate and effective ways
People from most protected groups fare as well as people overall	

Patient experience equality analysis

Equality Delivery System Goal 2: Improved patient access and experience

4. Ensuring that people have a positive experience of care

The equality indicators in this section provide a picture of the Trust's contribution to improving the experience of care, including access to care.

Waiting times

Patients have the legal right to start NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically necessary. In the NHS this is called 'Referral to Treatment' (RTT) and we aim to make sure that patients do not wait longer than necessary. Consultant-led treatment is when a consultant has overall responsibility for patients' treatment, whether in hospitals or in clinics based in the community.

Patients with urgent conditions such as cancer and heart disease have further rights to be seen quicker. For example, when a patient has suspected cancer they have the right to be seen by a specialist within a maximum of two weeks with an urgent referral from a GP.

Admitted patients with referral to treatment waiting times in 18 weeks

Admitted patients are those who are admitted to hospital (either inpatient or day case) for treatment. There has been a 4.6% increase on the known ethnicity for admitted patients on the 18-week pathways between this year and the previous year. This represents an improvement in the quality of data; only 8.8% of 18-week patients had an unknown ethnicity in 2013-14.

The target is for 95% of patients to complete referral to treatment waiting times in 18 weeks. The actual rate for white patients was 84.2%, down by 5.1% from 89.3% in 2012-13.

There were 407 out of 512 BME admitted patients who completed referral to treatment in 18 weeks (79.5%) in 2013-14, down from the 345 out of 398 (86.7%) in 2012-13.

There is considerable variation in RTT waiting time performance within and between ethnic groups however the overall numbers are small. The ethnic group that fared worst was 'Black or Black British' where 65 out of 98 admitted patients completed referral to treatment in 18 weeks (66.3%) in 2013-14, down by 20.3% from the 71 out of 82 (86.6%) in 2012-13.

The 85 years age group experienced the worst increase in waiting times (8.7%) against the target from last year compared to any other age group. In 2013-14 1,675 out of 1,939 admitted patients completed referral to treatment in 18 weeks (86.4%) compared to 2,284 out of 2,401 (95.1%) in 2012-13.

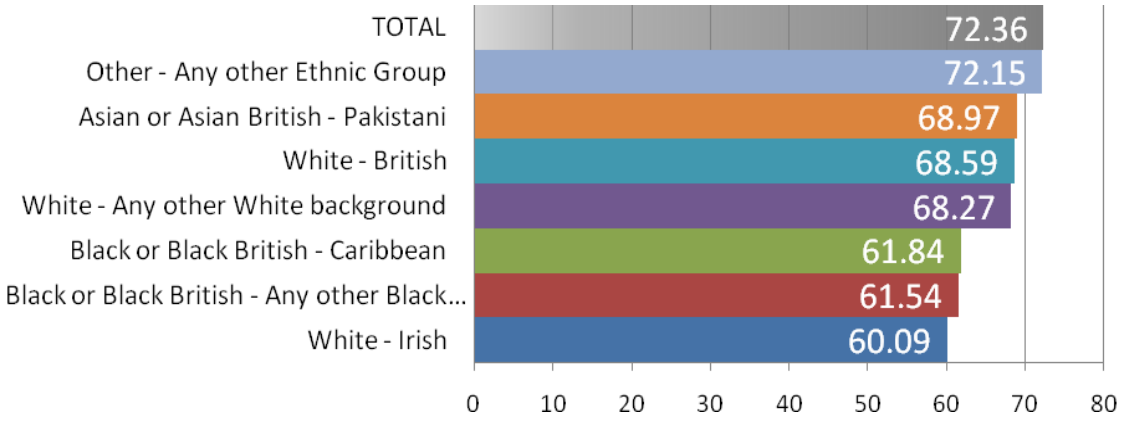
These patterns of inequality were not seen in non-admitted patients waiting times where the target of 95% was met for all protected groups except for 'Black or Black British' non-admitted patients where only 61 out of 68 people (89.7%) waited within target.

Recommendations:

Patient documentation for all 18-week pathways should be updated to include the Census 2011 ethnicity categories, religion and belief, sexual orientation and disability and relevant staff members should receive training on asking patient demographic questions.

The patient experience team engage with BME community groups and older people's forums about experiences of waiting times and suggestions to improve performance.

Figure 6 The percentage of patients from different ethnicities who spend four hours or less from arrival in A&E to transfer, admission or discharge



The graph above shows the seven ethnicities of people who attended A&E and waited less than four hours as a proportion of the known attendances. Only ethnicities with figures less than the Trust total overall are included.

There were only 128 'White Irish' people out of 213, or 60.09%, who were recorded as attending A&E and waited less than four hours. By comparison the White British figures were 42,954 out of 62,687, or 68.59%.

There were 815 East Sussex residents who declared their ethnicity as 'Gypsy or Irish Traveller' according to the 2011 Census. This represents 0.2% of the county's population, a slightly higher proportion than in England and Wales (0.1%) (ESIF, 2014). The systems and documentation in A&E have not been updated to record the Census 2011 categories

The Gypsy or Irish Traveller group is the smallest within the county's white ethnic groups, with 'Irish' and 'Other White' representing 0.8% and 3.4% of the population respectively (ibid).

However there were 29,274 attendances in A&E by people where their ethnicity was unknown out of 73,621 in total, which comprises the reliability of any analysis. There were only 1,393 A&E attendances recorded by staff of BME people.

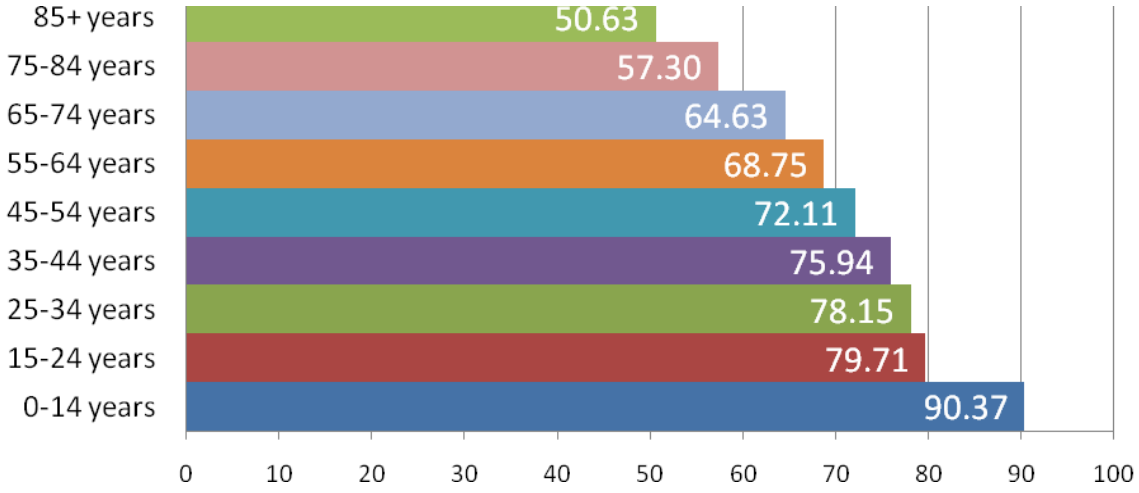
There were 39,986 attendances from people who did not have their religion or belief recorded and curiously 14,435 who had their religion recorded as 'Other'.

Recommendations

Patient documentation for all urgent care pathways should be updated to include religion or belief and the Census 2011 ethnicity categories (including Irish Traveller), sexual orientation and disability and that relevant staff in A&E and MIU receive training on asking patient demographic questions.

The Urgent Care unit management team should evaluate A&E diversion schemes with members of BME community groups to include information and signposting, for example directions to the local walk-in centres.

Figure 7 The percentage of patients from different age-bands who spend four hours or less from arrival to transfer, admission or discharge



The older you are the more likely you will spend more than four hours in A&E. There is an inverse correlation between the age of people attending A&E and the percentage of people in that age-band who spend less than four hours from arrival to transfer, admission or discharge. Women also did slightly worse (70.88%) overall than men (73.90%).

Progress	Equality Delivery System
Developing	Outcome 2.1: People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
People from only some protected groups fare as well as people overall	

Friends and Family Test

The Friends and Family Test (FFT) is a simple, comparable test that provides a way to identify both good and bad performance and encourage staff to make improvements where care does not live up to expectations.

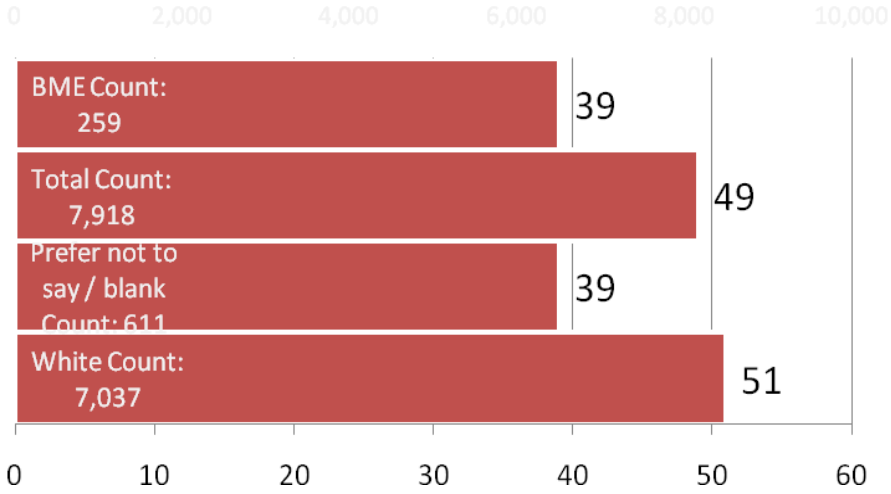
The test asks patients the following question: “How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?”

Patients answer the questions with the following six responses: “Extremely likely”, “Likely”, “Neither likely nor unlikely”, “Unlikely”, “Extremely unlikely” and “Don’t know”.

FFT Score

The FFT score is worked out as the proportion of respondents who would be extremely likely to recommend minus the proportion of respondents who would not recommend.

Figure 8 A&E Friends and Family Test score by broad ethnic group



The graph above shows that the FFT score of 39, for patients who disclosed they were BME when surveyed in A&E, is considerably lower than for patients who disclosed they were white, although the same as patients for whom no ethnicity was disclosed.

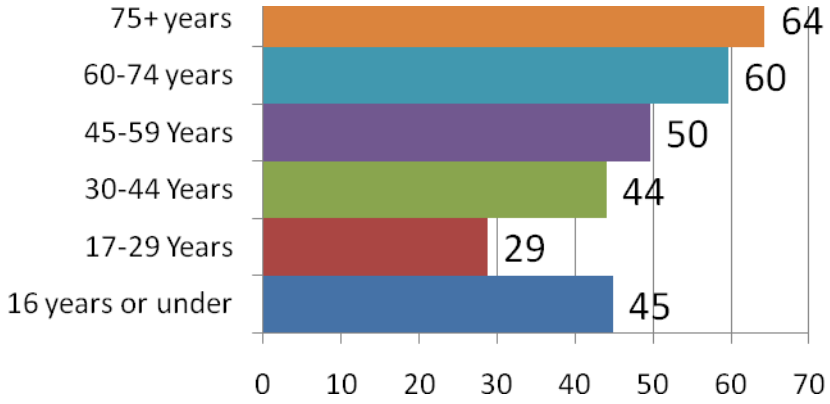
Recommendations

Urgent Care unit use ‘key-word’ algorithms to analyse the free-text responses of all the BME disclosing patients who were unlikely to recommend A&E to friends and family to identify any trends and produce an improvement plan

The data for ethnicity from FFT was non-standard and it is recommended that the patient experience team review the current implementation of ethnic monitoring to reduce the number of broad ethnic group values reported so that more reliable specific ethnicity codes are collected

Report key patient experience indicators from the patient surveys and complainant data for protected groups in the annual equality report 2014-15.

Figure 9 A&E Friends and Family Test score by age band



The younger the patient in A&E filling in the FFT survey the less likely they would be to recommend the service to their friends and family, with the exception of children and young people under 16 years. This could be for a variety of different reasons: expectations, perceptions, clinical factors, survey response behaviours etc., so it is hard to draw any conclusions from this.

Recommendation

It is recommended that Urgent Care review the free-text responses of all the 17-29 year old patients who were unlikely to recommend A&E to friends and family to identify any trends and produce an improvement plan.

Language and communication

Good communication between health care professionals and patients is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Patients should have access to an interpreter or advocate if needed. (NICE, 2012, Quality Standard (QS15) Patient Experience in Adult NHS Service)

Figure 10 Top six languages requested in Eastbourne, Hailsham and Seaford

Language	Count
Portuguese	131
Polish	71
Mandarin	29
Spanish	19
Bulgarian	15
Cantonese	13
Russian	13

Figure 11 Top six languages requested in Hastings and Rother

Language	Count
Mandarin	129
Czech	84
Sorani	30
Bengali	28
Russian	28
Albanian	24

Interpreter and communication support sessional activity increased by 17% to 1,009 sessions in 2013-14 from 863 sessions in 2012-13 supporting patients, service-users and carers needs. Over that same period total spend increased by only 9.1%, with the average sessional cost decreased by 9.7% from £101.16 in 2012-13 to £91.32 in 2013-14 for verbal communication support. It is likely the move to a new contractual arrangement has achieved better value for money to meet the increasing patient needs.

Nothing was spent on visual support such as audio recording, braille and large print in 2013-14 although usage may increase with the already planned introduction of staff training.

There were 92 sessions of hearing communication support (British Sign Language and lip-speaking) provided in 2013-14 up by 35% on the 68 sessions in 2012-13.

Table 1 Expenditure on communication support

Clinical / business unit	Count	Cost (before tax)	Average invoice cost
Acute & Emergency Medicine	3	664.80	221.60
Cardiovascular	14	990.00	70.71
Clinical support	66	5,546.40	84.04
Commercial Division	24	1,431.60	59.65
MSK	44	4,491.60	102.08
Out of Hospital Care	73	5,770.80	79.05
Specialist Medicine	80	9,667.20	120.84
Surgery	104	12,438.00	119.60
Theatres	13	1,980.00	152.31
Women & Children	588	59,209.20	100.70

58% of the Trust spend on interpreter and communication support came from the 'Women and Children' unit for which the Trust received various significantly enhanced tariffs to support women with little or no English. For example within the antenatal pathway alone the Trust receives an additional £677 per woman with little or no English to support interpreters at her antenatal sessions.

Recommendation

The interpreting and language budgets for units are top-sliced in 2015-16 on the basis of 2013-14 usage and a centralised budget established, with operational managers retaining authorisation.

Women and Children unit audit records of BME women on maternity pathways to establish if language needs are being correctly coded so that enhanced payments are received.

Patient information explaining rights to communication support should be made available in a variety of languages and formats to raise awareness.

Progress	Equality Delivery System
Developing	Outcome 2.3: People report positive experiences of the NHS
People from only some protected groups fare as well as people overall	

Patient safety equality analysis

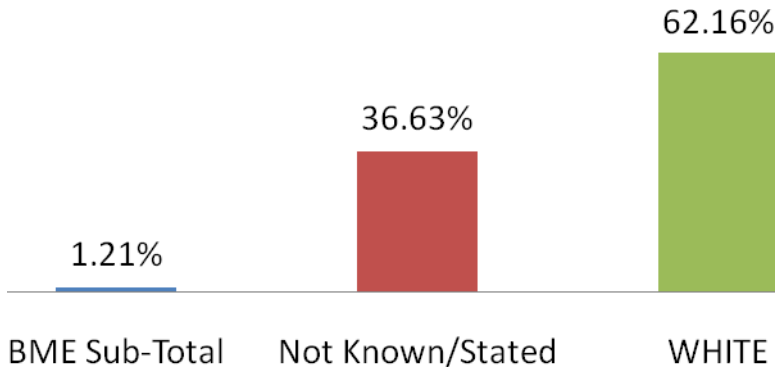
Equality Delivery System Goal 1: Better health outcomes

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

The equality indicators in this section measure the culture of reporting harm and learning from it.

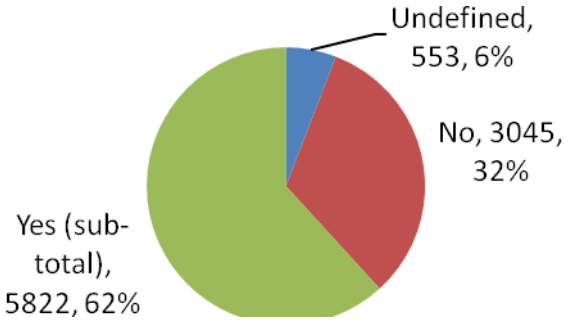
Patient safety incidents reported, describes the readiness of the Trust to report harm. A patient safety incident describes 'any unintended or unexpected incident(s) that could have, or did, lead to harm for one or more person(s) receiving NHS funded healthcare'. The Trust has an open and positive culture for reporting patient safety incidents. All incidents are reviewed and investigated with an in-depth root cause analysis for those incidents that require it. This supports the organisation in developing good practice and learning.

Figure 12 Patient safety incidents by very broad ethnic group



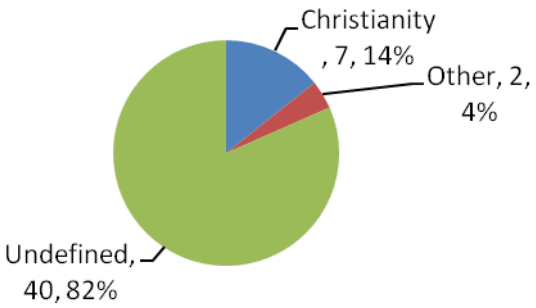
There were 9,509 patient safety incidents, of which 115 involved a BME person and 3,483 involved people for whom their ethnicity had not been recorded.

Figure 13 Patient safety incidents by disability status



Two thirds of reported patient safety incidents happened to disabled people (61.2% or 5,822 incidents). 4.1% (393) of reported incidents involved people with learning disabilities. 5.2% (490) to people recorded with behaviour or emotion related disability. The biggest was mobility disability at 16.6% (1,574) of recorded incidents.

Figure 14 Patient safety incidents involving severe harm or death by religion and belief



Safety incidents involving severe harm or death indicate how the Trust is reducing the severity of harm arising from safety problems. There were 43 incidents overall of which 14 occurred to disabled people and one occurred to a BME person. 65% of the incidents involving disabled people were falls resulting in harm such as a fracture. The incidents have been reviewed and there does not appear to be a link between the disability and the incident. This will continue to be reviewed to monitor incidents to identify and evaluate any trends in respect of disability.

82% (40) incidents occurred to people who did not have their religion defined. The implications of this are for the observance in practice of death rites and rituals or chaplaincy support for severe harm. Two of the incidents (4%) occurred for patients whose religion or belief was defined as 'Other' whereas no incidents were recorded for any of the major world faiths apart from Christianity (see chart above). In the resident population in East Sussex from the Census 2011 less than 1% defined as 'Other'.

Recommendations

Patient safety to review the top types of patient safety incident for each type of disability and devise an improvement plan

Patient safety to review the root cause analysis of the two people involved in incidents of severe harm or death whose religion or belief was defined as 'Other' so that the Trust is assured that these were recorded correctly and any improvements recommended.

Discrimination, harassment, hate incidents and sexual assaults in healthcare

There were four incidents of perceived discrimination of patients and service-users by Trust employees reported in 2013-14. Three of those were disability with the fourth incident being sex discrimination or harassment. In addition there was one disability related hate incident and one sexual assault recorded.

A number of care equality issues for patients occurred through 2013-14 that local teams with the support of the Equality and Human Manager resolved without escalating to an incident.

Recommendation: The patient experience team engage with community groups about experiences and suggestions to increase reporting of discrimination and harassment.

Progress	Equality Delivery System
Developing	Outcome 1.4: When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
People from only some protected groups fare as well as people overall	

Workforce equality analysis

Equality Delivery System Goal 3: A representative and supported workforce

6. Workforce

The workforce analysis below considers representation overall as well as recruitment, promotions and leavers. Agenda for Change (AfC) are the national pay scales used for most members of staff who are not doctors or very senior members of staff who have negotiated pay locally.

Where the term ‘senior management’ is used below it refers to people with jobs on AfC bands 8a, 8b, 8c and 8d, which spans staff with basic salaries in 2013/14 ranging from £39k through to £98.5k. Senior management includes modern matrons and senior nurses.

Qualified nurses typically start at AfC band 5, with nurse team leaders typically at AfC band 6 and advanced nurse practitioners at AfC band 7 (NHS Careers, 2014).

Ethnicity

- There were 789 individuals (11.4%) who identified as black and minority ethnic (BME) in the 2013-14 workforce overall
- This includes 253 BME staff (16.9%) in agenda for change (AfC) band 5 and 76 BME people (7.4%) at AfC band 6. The degree to which BME nursing career progression is self-limited or limited by institutional barriers is unknown
- None of the Board was BME. The Chief Executive, all eight of the Trust Executives, the Chair and all six of the NEDS were White British, the same as in the previous two years. The underlying 'White British' population in East Sussex is 91.7% from the Census 2011
- There were 40 BME senior management applicants (34.5%) for agenda for change (AfC) roles in 2013-14 of which only one person (16.7%) was shortlisted. Although ethnicity information is not part of the shortlisting process it might be possible to guess national origins based on an applicants prior experiences and education
- No appointees were BME; all 13 AfC appointees (100%) were White British. This is down from the two BME people (15.4%) appointed in 2011-12 and the one BME person (6.3%) appointed in 2012-13
- There were 20 BME people promoted across all AfC pay bands (7.2%) lower than the representation of BME people in AfC posts overall (8.9%) and within typical nursing bands AfC 5-7 (11.5%).
- There were 240 White people promoted across all AfC pay bands (87%) higher than the representation of white people in AfC posts overall (82.3%) and within AfC 5.7 (81.4%)

- Across the medical workforce there was a drop off of 15.3% for BME doctors between shortlisting to appointment. This is worse than 2012-13 where the drop off was 12%

- 169 (77%) of the 225 BME respondents to the Staff Survey 2013 felt the Trust provides equal opportunities of career progression, compared to 1,779 (85%) of 2,093 White respondents

- 63 people (28%) of the 225 BME respondents to the Staff Survey 2013 reported harassment, bullying or abuse by staff, compared to 26% of White respondents
- 175 leavers (16.7%) were BME, higher than the representation within the workforce overall (11.4%). Only 58 people gave reasons for leaving with the main reason being voluntary resignation (25 people)
- The workforce in 2013-14 was 6,942, down from 7,155 in the previous year.

Sex

- 57.1% of executives (4 people) and 28.6% of non-executives (2 people) are female compared to 78.6% (5,256 people) of the workforce.
- 23% of consultants (51 people) and 53.2% of junior doctors (126 people) are female.
- There was a drop off of -7.7% between shortlisting to appointment for males

Disability

3.3% of the workforce is recorded as being disabled (227 people). Reported rates between broad contract types are lowest within doctors (0% in junior doctors). Census statistics indicate disability in the 16-64 years old East Sussex population at 8.3% (ONS, 2012).

Sexual Orientation

No executives, non-executives or very senior members of staff who have locally negotiated pay are recorded as lesbian, gay or bisexual (LGB). 0.8% of the workforce overall is recorded as LGB (59 people) with 1.1% of leavers (12 people) LGB. 5-7% of the underlying population in East Sussex is estimated to be LGB (ESIF, 2013)

464 applicants (2.4%) were LGB in 2013-14. 29 were shortlisted (1.9%) and 14 were appointed (1.6%). Conversely people who do not disclose had a 1.6% advantage between shortlisting (99 people or 6.3%) to appointment (70 people or 7.9%).

Religion or Belief

35% of the workforce identified as Christian (2,429 people). 50.1% actively chose not to disclose their religion or belief or it was not recorded within their staff record. 10.4% of appointees in 2013-14 did not disclose their religion or belief at recruitment.

In 2013-14 there was a drop off of -4.5% between shortlisting (98 shortlisted) to appointment (16 appointees) for Muslims. Conversely Christians have a 4.9% increase between shortlisting (854 shortlisted) to appointment (526 appointees).

Recommendations:

Request representatives from the Board participate in a reverse mentoring or coaching arrangement with a BME member of staff

Request senior medical leaders participate in a reverse mentoring or coaching arrangement with a female doctor

Request senior managers (bands 8a-d) and consultants participate in a reverse mentoring or coaching arrangement with an LGBT junior member of staff or LGBT non-consultant career grade or junior doctors

Update recruitment guidance to mandate that applicants to posts at AfC band 7 and above demonstrate at interview their team or organisation's profile and what they will do to promote inclusion and address any under-representation

Update performance development review (PDR) guidance so that managers on AfC band 7 and above, and doctors with management responsibilities, demonstrate actions taken to promote inclusion and address any under-representation in their team or the wider organisation.

Progress	Equality Delivery System
Developing	Outcome 3.1: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
Staff members from only some protected groups fare well compared with their numbers in the local population and/or the overall workforce	

Remuneration and equal pay

82.6% of people at the top of their pay bands are female (2,830 people) but females only make up 78.6% of the Agenda for Change (AfC) workforce. This suggests possible limits to career progression for females at all levels except bands 1 and 7. The reasons for this are unknown. Detailed pay audits using the national toolkit have not been completed.

Recommendation: Implement the NHS Employers equal pay audit toolkit to assure there is equal pay for equal work and reconvene the workforce equality meetings

Progress	Equality Delivery System
Developing	Outcome 3.2: The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
Equal pay audits are not carried out	

Learning and Development

Overall completion of mandatory training and non-essential training was broadly the same between groups. Where there was under-representation the amounts were too small to draw any conclusions. The EDS rating (see table below) is only graded as

'developing' because data on evaluations by staff of training and development opportunities is not available

Recommendations:

Implement equality monitoring of participants within the learning evaluation feedback form and report for 2014-15.

Progress	Equality Delivery System
Developing	Outcome 3.3: Training and development opportunities are taken up and positively evaluated by all staff
Staff members from some protected groups fare as well as the overall workforce	

Human Resources – Operational

Harassment and bullying

There were 21 cases of bullying reported in 2013-14 with only one of those being harassment, specifically disability harassment

This low reporting using the Trust's 'Dignity at Work' policy is contrary to the results of the Staff Survey 2013, in which 26% of all respondents reported harassment, bullying or abuse, rising to a high of 40% in the Acute Medicine unit

27% of the 1,799 female respondents (486 females) reported harassment, bullying or abuse, compared to 22% of male respondents

35% of the 393 disabled respondents (138 people) reported harassment, bullying or abuse, compared to 24% of non-disabled respondents

28% of the 225 BME respondents (63 people) reported harassment, bullying or abuse, compared to 26% of White respondents

26% staff reported harassment, bullying or abuse from other staff was higher than the national average in the staff survey 2013 (24%). This rose to 40% of the 115 respondents in Acute Medicine largely with equity across the protected groups reported.

Recommendation:

Prioritise anti-bullying and harassment as a staff experience improvement initiative and run Listening into Action workshops to collect staff stories and suggestions from the urgent care clinical unit, the BME Staff Network and the disabled workforce.

Progress	Equality Delivery System
Developing	Outcome 3.4: When at work, staff are free from abuse, harassment, bullying and violence from any source
Staff members from only some protected groups fare as well as the overall workforce	

Flexible working

Maternity, carers and special leave

Females accounted for all maternity and adoption leave taken in 2013/14, also taking 91.9% of carers leave and 86.5% of special leave. Overall females comprised 78.6% of the workforce, showing that flexible working opportunities are being taken up disproportionately. This sex difference continues the pattern in 2012-13.

It is unknown whether any interventions by the Trust to improve uptake of flexible working by men would have any effect given the personal choices involved. With the statutory changes in flexible parental leave due to come into effect in 2015 it is recommended that uptake of flexible working is monitored through this report.

The percentage of staff reporting working extra hours (68%) was lower than the national average in the staff survey 2013 (70%) largely with equity across the protected groups reported.

Progress	Equality Delivery System
Achieving	Outcome 3.5: Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
Staff members from most protected groups fare as well as the overall workforce	

Staff experience

Only 76% of the 393 disabled respondents felt the Trust provides equal opportunities of career progression, compared to 86% of 1,890 non-disabled respondents

Only 77% of the 225 BME respondents felt the Trust provides equal opportunities of career progression, compared to 85% of 2,093 White respondents

Data regarding sex did not reveal any difference (12% for both sexes) and there was none available for sexual orientation or religion and belief

Only 75% of the 172 respondents from maintenance / ancillary occupations, and 67%of the 51 respondents in EHS (Eastbourne Healthcare Services), reported they believed the Trust provides equal opportunities of career progression compared to 84% of the workforce overall.

Recommendations:

Prioritise equality of career progression as a staff experience improvement initiative and run Listening into Action workshops to collect disabled and BME staff stories and suggestions.

Progress	Equality Delivery System
Undeveloped	Outcome 3.6: Staff report positive experiences of their membership of the workforce
Staff members from all protected groups fare poorly compared with the overall workforce OR evidence is not available	

Leadership

Equality Delivery System Goal 4: Inclusive leadership

Board and senior leaders commitment to promoting equality

Directors share their contributions to promoting equality in 2013-14 below:

Vanessa Harris, Director of Finance

I chaired the Age and Healthcare Steering Group throughout 2013-14. Membership comprised representatives from seniors' groups across East Sussex, ESCC Adult Social Care as well as the Trust's Equality & Human Rights Manager and clinicians from within the Trust.

The group reflected on national and local issues from an older people's point of view and tried to ensure that local services delivered by the Trust reflected the needs and preferences of the local older population.

The older people's representatives contributed information and suggestions for improvements from their groups into our discussions and fed back outcomes from the meetings to their membership.

During the year the group completed its Age Equality Action Plan that it had been using to inform its work and discussed such issues as:

- Nutrition and dietetics
- Ambulance Handovers
- Privacy and dignity
- "This is me" dementia care document
- The Friends and Family test and feedback received
- Human rights
- The Berwick Report
- Waiting times
- Discharges
- Transport between the Conquest Hospital and Eastbourne DGH sites

At our meetings the Trust listened carefully to the views and improvement ideas of the representatives and tried to ensure that concerns and recommendations were addressed in the meeting or referred to the appropriate person within the Trust to take forward.

One example of this is nutrition in respect of older and frail patients and the improvements the Trust made to dedicated mealtime arrangements at the start of the year. Older people's representatives asked for information about our dentures policy that we were able to provide as well as details of the new mealtime arrangements so

that they could assure themselves that they were appropriate. They were pleased with the new arrangements and the Assistant Director of Nursing, Professional Practice & Standards, Brenda Lynes-O'Meara was able to explain the MUST (Malnutrition Universal Screening Tool) that we use as well as offer to arrange ward visits for members wishing to see the new arrangements for mealtimes working in practice.

> *"Members asked that it was noted that they had received feedback from their members that services had improved significantly at the Trust over the last year or so"*

I was pleased with the progress we have made in the year to involve older people in our Trust and at the end of the January 2014 meeting the seniors representatives asked that the statement above be recorded in the minutes.

Amanda Harrison, Director of Strategy and Assurance

I ensured that the Board's decision to temporarily reconfigure Maternity and Paediatric services on safety grounds was informed by an equality impact assessment

I have actively participated in the pre-consultation engagement and consultation on the future of Maternity, Paediatric and Gynaecology services in East Sussex. Working alongside Clinical Commission Group (CCG) colleagues as part of the programme Board we have ensured all engagement in respect of this proposed service change has been inclusive and has focused on women of child bearing age and seldom heard groups.

In particular engagement has taken place with those who have protected characteristics including minority ethnic communities, lesbian, gay, bisexual and trans (LGBT) groups, parents and carers of disabled children and young people. Views and concerns arising from these groups have been considered and addressed during the consultation and will inform the decision making process. I have personally attended consultation events and discussed the proposals and any issues arising with members of the public.

I have participated in a number of staff engagement events and regularly undertake visits to clinical areas where I represent the Board and am able to provide a way of staff promoting their work and raising concerns directly with a Board member.

Monica Green, Director of HR Personal Statement

Disability Positive

Jobcentre Plus reviews the Trust annually for compliance with the 'Two ticks' symbol as part of the 'Disability Positive' employment programme. They look for evidence to demonstrate that as an employer we continue to embrace the ethos of the programme and to meet the criteria of the five commitments. Being able to display the symbol shows that as an employer, we are serious about employment

opportunities for disabled people; we acknowledge and value the contribution disabled people can make to the Trust and that we welcome potential disabled job applicants on the basis of their abilities.

The Trust was first awarded the symbol in 2001 and following annual reviews, has been allowed to use it continuously since then. We received our award for 2013-14 in March 2014.

We are scrutinised on such areas as recruitment and our redeployment process, although the independent assessors look at all our policies and processes to ensure that equality is embedded.

The five commitments of the disability positive programme are:

- To interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities
- To ensure that there is a mechanism in place to discuss, at any time, but at least once a year, with disabled employees what can be done to make sure they can develop and use their abilities
- To make every effort when employees become disabled to make sure they stay in employment
- To take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work
- Each year to review the five commitments and what has been achieved, to plan ways to improve on them and let employees and Jobcentre Plus know about progress and future plans

Project Search

Project Search is a new employment initiative currently being scoped for young people with learning disabilities, run as a joint project between the local authority, Sussex Downs College and East Sussex Healthcare NHS Trust as the host employer. The first cohort will commence in September 2014.

Project Search offers supported work placements to enable these young people to have a one-year internship in the last year of their education. The students have a dedicated workplace co-ordinator for the duration of the programme and these coordinators are also available to support managers and teams to support the interns.

The primary objective is to give students the skills and confidence to secure paid employment in the future.

Employer Based Clinical Excellence Awards for Consultants

The Trust has recently concluded a round of employer-based Clinical Excellence Awards for 2013 (CEAs).

Clinical Excellence Awards are given to consultants to recognise excellence and reward contributions to the NHS that are *'over and above'* that normally expected. Their effect is to ensure recognition of exceptional personal contribution by consultants who show a commitment to achieving the delivery of high quality care to patients and to the continuous improvement of the NHS.

The awards are determined by a Local Awarding Committee (LAC), whose function is to take the annual decision as to which consultants will be recommended to the Remuneration Committee of the Trust Board to receive local CEAs. The LAC bases their decisions on the criteria laid down by the Advisory Committee on Clinical Excellence Awards (ACCEA).

The composition of the LAC takes into consideration the ACCEA recommended guidance and includes appropriate representation from consultants in a range of specialties, and is representative in terms of gender, ethnicity and site.

Appropriate guidance and training regarding both the process and equal opportunities is given to LAC members. This includes all LAC members having undertaken equality training.

Progress	Equality Delivery System
Developing	Outcome 4.1: Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
Only some of the examples show a strong and sustained commitment	

In their own words the leaders of different clinical services describe how they have made progress in 2013-14 in advancing equality.

Cardiovascular

Cardiovascular services include cardiology, stroke, diabetes and endocrinology. The service also manages the Private Patient Unit.

A wet room is available for stroke patients to allow for easier access. A new recovery trolley also offers better accessibility. In addition home visits for patients who cannot access hospital services enhance access for disabled people to getting appropriate care.

There is a close working with the 'Health in Mind' mental health service to support the emotional needs of people within the Cardiac Rehabilitation service. There are also low impact exercise classes that run which benefit disabled people.

The service was involved with a Stroke Patient event to support understanding about Heart Failure. Also the service is working on a stroke experience pathway with local patient groups and the stroke association.

A selection of cardiac literature produced by the British Heart Foundation is available in different languages for patients with little or no English. Telephone and face-to-face interpreters are brought in whenever a patient requires one.

Religious needs are met for our patients by ensuring that they are established during pre-assessment and that there is a close working relationship with the Chaplaincy service with quiet rooms provided.

Equality is promoted for the sexes by having a range of measures designed to ensure patients' dignity is respected, including: single sex accommodation, chaperones for patient assessment and single sex lists for catheter lab sessions.

Women and Children

Women

Women's services include maternity, reproductive medicine and sexual health.

Tailored support is provided for women with complex mobility issues with multi-professional input to ensure a comprehensive care plan is in place from booking to birth.

A wide range of maternity services are offered. This includes access to community antenatal and postnatal clinics across the community within children's centres and GP surgeries as well as from birth centres and the acute hospital sites. Home visits by midwives are provided for those women who have particular individual problems with access to services. A choice of place of birth is offered to women including home, birth centre and acute hospital.

The service has been quick to ensure that the requirements to identify women with Female Genital Mutilation (FGM) within maternity and to report data about this

centrally have been embedded. This includes updating assessment tools and making changes to information systems.

Children and Young People

Children and Young People's (C&YP) services include Paediatrics, the Special Care Baby Unit (SCBU), as well as Health Visiting and School Nursing.

Nurses from the Paediatric wards attended the Trust's Patient Experience group and have implemented a feedback chart with smiley faces for children to be able to express how they felt their visit had gone.

The service works alongside the learning disability liaison nurse to support transition of young people to adult services. This work will be developed further in 2014-15 as part of a transition working group.

The service is working towards becoming a UNICEF baby friendly service. It is a three-year programme that will better meet the needs of new mothers and their babies.

Staff members within the service ensure that clients with little or no English have access to an interpreter to ensure that they are supported to be informed and can participate within decision-making.

There is a new Homeless team now working in the West of the county ensuring their health needs are being assessed and care given. This team is also assisting with housing issues and acting as an advocate for this client group. They are aligned with other practitioners to limit social exclusion and its effects on families.

The team will be working strategically within the community in partnership with other agencies and the particular focus is on the prevention of health and social inequalities.

The Special Care Baby Unit (SCBU) has reinstated dedicated quiet times for families and their infant, which allows any religious observances to be made with dignity.

A male nurse has successfully completed the Health Visitor (HV) training and a further two are in training and due to complete later this year. Male health visitors can encourage fathers' engagement with the HV service and further promote inclusion for families and children.

As a result of an observation made by same sex parents' the documentation used on paediatrics wards is to be reviewed to allow two males to be identified within the section about parents.

Surgery

The surgery clinical unit includes various surgical services and also services for Head and Neck.

Surgical services

Services include breast, vascular, urology and general surgery.

The bays and toilets on the surgical wards and Surgical Assessment Unit (SAU) have been colour-coded specifically to help patients with dementia, the risk factors for which increase in older people.

The newly located SAU and general surgical wards at Conquest Hospital, following the recent reconfiguration of services, now all have level access with accessible parking nearby. Refurbishment of the SAU included removing barriers and implementing recommendations from the access audit for that area. Refurbishment of the ward bathrooms on the general surgical wards included conversion to wet-rooms for step free access to improve accessibility for disabled people with reduced mobility.

The main patient documentation used by many services has been updated to include gender history.

Interpreters and signers are provided for patients with little or no English or who have reduced communication.

A quiet room is available on Seaford 4 Ward (Urology) to supports any patients or carers requiring a private area for reflection or grieving and as a place to break bad news.

The Head of Nursing and Urology Matron specifically included the views of men and their family members who were represented on the local Prostate Cancer Support Group and helped develop the quiet area on the Urology Ward.

Head and Neck

Head and neck services include ENT (Ear, Nose and Throat), maxillofacial, ophthalmology, audiology, acute and community dentistry and sleep studies.

Staff within all departments of the service known as ‘Dementia Champions’ have enhanced training to meet patients’ needs and promote understanding and sensitive practice amongst their colleagues. Memory boxes are used within departments to help patients with dementia recollect and share information about their lives.

The relocation of the Acute Macular Degeneration (AMD) service to Bexhill was assessed for care equality impacts on patients and carers, through the completion of an Equality and Human Rights Analysis (EHRA).

All departments have a designated ‘Learning Disability Champion’ with strong working links to the Trust’s Learning Disability Liaison Nurse. ‘Care Passports’ are special records to empower some disabled patients and their carers to make their

needs and preferences more readily known to health care professionals within the unit.

Patients' rights are advocated by staff undertaking mental capacity and deprivation of liberty training to ensure they have up-to-date skills, including identifying and arranging for Independent Mental Capacity Advocates to support patients where appropriate.

Care planning always includes the identification and provision of reasonable adjustments to support disabled patients. Additionally the refurbishment of a ward within the unit has improved accessible facilities for disabled people.

The service engaged with wide ranging patient groups which encouraged participation of disabled people, including: Glaucoma support groups, Laryngectomy Support Group, the local Blind Society and the Macular Society.

During the past year a patient was supported to ensure that the information within their health records reflected their gender. This safeguarded their dignity and promoted their identity within their care.

For patients an admission of a breast-feeding mother within the past year included facilities being made available to support her and her family. For staff, family friendly working and flexible hours are implemented.

For patients the implementation of new food menus has enhanced equality to meet diverse cultural dietary requirements. Within the workforce a BME nurse was supported to undertake an anaesthetic practitioner course. Subsequently that nurse has gained an internal promotion.

Both patients and staff are supported to have time for prayer to meet their religious needs. Staff members also have close working links to support patients with the Chaplaincy service, including within the past year supporting a patient at the end of their life to organise a wedding. Other patients at the end of their lives have their privacy and family lives enhanced with overnight accommodation provided for their relatives.

There are 'End of Life Champions' on wards with strong links to the pain team. Their role is to safeguard patient's right to life and support patients at the end of their life to have their needs met and be able to have as good a death as possible.

The newly refurbished ward brings single-sex bathrooms and accommodation to enhance patient dignity for women and men. In addition the Ophthalmology Day Unit at Eastbourne District General Hospital has a designated side room for patients undergoing procedures under a general anaesthetic.

Out of Hospital Care

Out of hospital services include community hospitals, dementia, therapies, district nursing, specialist nursing and the integrated care assessment service (ICAP).

Health care professionals within the service have supported people with learning disabilities by providing appropriate advice and support on continence.

Measures identified by undertaking risk assessments to promote health and safety has supported pregnant women in the workplace.

Within the past year service developments have been assessed to ensure that racial equality is advanced, with adherence to workplace policies for staff.

Patients' religious and philosophical needs were met through ensuring that a new clinical information system included documentation of those needs.

Specialist Medicine

Specialist medicine services include respiratory, oncology, haematology, planned medicine, endoscopy, gastroenterology, dermatology, neurology, outpatients, cancer services, palliative care and rheumatology.

Wards have specially training 'Dementia Champions' and an activity box has been put together to support patients with dementia, reducing anxiety and encouraging communication.

Each ward within the service has a learning disability link nurse to support patients. There is multi-disciplinary working to ensure that disabled patients have their needs met, with actively encouraged participation from patients' carers and relatives as well as liaison with care homes.

The service's health care professionals make use of the 'This is me' document and patient's 'Care Passport' to ensure that needs have been identified and sensitive care delivered. This has been backed up by the introduction and implementation of a special observation policy.

Staff members within the respiratory service have encouraged participation of disabled people and promoted independence by attending and supporting the 'Breathe Easy' support group.

Workers have also been supported to remain in employment through the provision or reasonable adjustments within the workplace, including by providing a specialist chair and the offer of adjustment to rotas.

The service has a number of very diverse ward teams and we support one of the service's specialist respiratory nurses to attend her duties as Chair of the Trust's BME Staff network, with other staff also released to attend conferences and meetings to promote racial equality.

Patients' religious needs are supported by close working with the Chaplaincy service. On one occasion a patient's priest was brought in at their request to support them receive medical infusion.

We promote patient dignity and privacy by having single sex bays and washing facilities available as well as single rooms for patients where appropriate.

Acute and Emergency Medicine

Services include Accident and Emergency departments, the Medical Assessment Unit (MAU) and the Minor Injuries Units (MIU)

Health care professionals within the service have supported people with learning disabilities by providing appropriate advice and support.

Measures identified by undertaking risk assessments to promote health and safety has supported pregnant women in the workplace.

Interpreters and signers were provided for patients with little or no English or who have reduced communication.

Patients' religious and philosophical needs were met through ensuring that any identified support from the multi-faith team was provided.

Patient dignity and privacy were promoted by having cubicles within the Emergency Department and also single sex bays and washing facilities, as well as single rooms for patients within the Medical Assessment Unit.

Musculoskeletal (MSK)

Services include Trauma and Orthopaedics, MSK and Pain management.

The bays and toilets on the Trauma wards have been colour-coded specifically to help patients with dementia, the risk factors for which increase in older people.

The newly located Trauma wards at Conquest Hospital, following the recent reconfiguration of services, now all have level access with accessible parking nearby. All toilets and shower rooms were designed to promote accessibility.

Select clinic appointments are provided outside of normal working hours to reduce distress for patients with learning disabilities and x-rays arranged at community hospitals. The Trust's specialist nurse is involved with patients' treatment plans.

A quiet room is provided in outpatient and fracture clinic areas for mothers wishing to breast-feed and duties were adjusted for pregnant members of staff.

Interpreters and signers were provided for both in-patients and outpatients with little or no English or who had reduced communication. Pain assessment documentation was also made available in several languages for patients use.

There is a room available on Egerton (Trauma ward at Conquest) to support any patients or carers requiring a private area for reflection or grieving and as a place to break bad news.

We promote patient dignity and privacy by having single sex bays and washing facilities available as well as single rooms for patients where appropriate

Theatres

Services include theatres, anaesthetics, Intensive Therapy Unit (ITU), admission lounge, pre assessment, day surgery and resuscitation. Theatres will be requested to provide an update for the 2014-15 report.

Clinical Support Services

Services include radiology, pathology, pharmacy and the Pharmaceutical Manufacturing Unit (PMU). Clinical support services will be requested to provide an update for the 2014-15 report.

Equality and Human Rights Manager

The Equality and Human Rights Manager trains, coaches and advises staff, managers and staff networks about healthcare and employment equality and engages and improves the experience of services for patients, carers, service-users and community members. The manager also ensures the Trust has equality objectives to improve services and performance measurement and reporting through effective governance arrangements. Highlights of the 2013-14 work programme are summarised below:

Aim: Advance equality of opportunity, minimise disadvantage, meet different needs and encourage participation

- Patient documentation across a range of care pathways has been updated to include patient diversity monitoring. This programme is on-going and will need further targeted improvements in the forthcoming year. This should lead to both more culturally appropriate care and also better data being available in the future to support decision-makers
- The Trust's new Language and Communication policy has been written and ratified, including extensive engagement with community members. A programme of staff development and awareness-raising is currently being developed. Improvements in individual practice and negative patient experiences have been dealt with via contract management of service providers and management coaching
- HIV Awareness training was organised working in partnership with Terrence Higgins Trust (THT) a local third sector provider. The training has been well attended by clinicians
- The Trust partnered with MindOut, a local LGB&T mental health charity, to provide facilities at no cost to deliver self-esteem training from Eastbourne Park Practice
- Advice and guidance was offered to managers refurbishing wards and units as part of the Clinical Strategy implementation to improve disability accessibility
- The Joint Community Rehabilitation (JCR) service was reviewed in conjunction with Adult Social Care and the clinical lead to improve data about client diversity for future reporting of therapeutic equality
- The Trust successfully applied for and gained Stonewall 'Health Champions' status to work with the UK's leading lesbian, gay and bisexual charity to promote LGB-friendly healthcare. The Trust is also now a member of the East Sussex LGB&T Health and Social Care Forum in partnership with community members and Adult Social Care
- Following a number of reports of poor experiences the Trust engaged with the Hastings and Rother Rainbow Alliance Trans Group and is mid-way through a piece of work to respond to their feedback and make improvements
- The Equality and Human Rights Manager supported input into multiple Equality and Human Rights Analyses (EHRA) and business cases. Significant work including market testing business cases for Pharmaceutical Manufacturing Unit, Child Care Services (including Staff Crèche) and Occupational Health. A list of EHRA's is published in the next section

- Compliance reports were returned at the commissioners' request and for the Trust Development Authority (TDA). Assessments of compliance with essential standards of care (CQC) and endoscopy quality standards accreditation were also supported.

Aim: Eliminate discrimination, harassment, victimisation and other prohibited conduct

- A number of ad-hoc queries were responded to across 2013-14 by the Equality and Human Rights Manager including 42 major queries (including FOI requests, patient and staff queries, incidents and complaints).

Aim: Foster good relations tackle prejudice and promote understanding

- Face-to-face equality and diversity training was rolled out to the majority of nursing, administrative and support staff following staff feedback about barriers to the e-learning module. Additionally the Training Needs Analysis for staff and the corporate equality induction module were reviewed and updated
- The LGB&T staff network has not physically met since the Chair left his substantive post at the Trust half-way through the year. Members continue to contribute to the Stonewall 'Health Champions' work and the Trans patient participation work
- The BME Staff Network has supported members attend national conferences and organised staff development sessions, including a presentation about the experiences of nurses recruited from abroad
- The first issue of the 'Equality News' staff newsletter was published to support leadership of the equality agenda across the Trust's different functions
- The Equality and Human Rights Manager set-up and led the Kent, Surrey and Sussex Equality and Health Inequalities network to promote shared learning and best practice amongst NHS and public health commissioners and providers across the region.

Health inequalities

Equality indicators for screening, vaccination and other health promotion services have not been presented in this report; however a rating against the equivalent Equality Delivery System outcome has been included below.

The rationale for scoring the outcome as 'developing' is because health promotion training for clinical staff in the areas of mental health and HIV awareness were delivered as part of the corporate equality and human rights work programme.

Progress	Equality Delivery System
Developing	Outcome 1.5: Screening, vaccination and other health promotion services reach and benefit all local communities
People from only some protected groups fare as well as people overall	

Equality and Human Rights Analysis (EHRA)

The Trust uses an Equality and Human Rights Analysis (EHRA) toolkit to assist with meeting the equality duty within policy-making. All policy making and functions of the NHS are relevant to the equality duty because patients are at the heart of decision-making. All policy authors and business case writers are required to submit their analyses for scrutiny by the approving and ratifying committees. The Equality and Human Rights Manager provides staff training on request.

Trust Board

Sixteen reports went to Board in 2013/14 for approval or decision. Of those there were eight reports noted to have undergone an up-to-date Equality & Human Rights Analysis (EHRA). Four were not analysed and of those, four reports had previously been assessed under earlier phases of work.

Recommendations

Trust Board are requested to consider that all sponsors / authors presenting an item for decision or approval have analysed evidence of the impact upon equality of opportunity for patients, service-users, carers and workers in advance, and completed an Equality and Human Rights Analysis (EHRA) form

Trust Board are requested to consider that when developments in a policy area come back on future agendas that the sponsor / author is required to update the equality analysis before approval.

Table 2 Trust Board reports 2013/14 equality compliance

Item	Data	EHRA?
Patient Experience Strategy	27.03.13	Yes
Maternity & Paediatric Services	05.06.13	No (but assessment conducted as part of Clinical Strategy Full Business Case)
Medical Revalidation Annual Report	05.06.13	No
Quality Account	05.06.13	Yes
Shaping our future Phase 2 - Programme Brief	05.06.13	No (but assessment conducted as part of Clinical Strategy Full Business Case)
Safeguarding Annual Report	24.07.13	Yes
Shaping our future: Clinical Strategy Phase 1 - Stroke Services	24.07.13	No (but assessment conducted as part of Clinical Strategy Full Business Case)
Annual Equality Report	25.09.13	Yes
Application to the Trust Development Authority (TDA) for a cash financing solution for 2013/14	25.09.13	No

Item	Data	EHRA?
Financial Planning Update	05.06.13	No
Market testing strategy and strategic outline business case	25.09.13	Yes
Shaping our future Phase 1 - General Surgery	27.11.13	Yes
Shaping our future Phase 1 - Implementation Full business case	11.12.13	Yes
Patient Administration System Managed Service Full Business Case	29.01.14	No
Quality Improvement Priorities	26.03.14	No (each priority will be subject to its own EHRA as part of implementation)
Risk Management Strategy	26.03.14	Yes

Progress	Equality Delivery System
Developing	Outcome 4.2: Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
Only some of the papers took account of equality-related risks and their management	

Cultural competency

Grievance and discrimination

There were 11 grievances raised in 2013-14, one of which was in relation to discrimination. This contrasts with four respondents reporting racial discrimination from their manager, team leader or other colleagues in the 2013 staff survey. Additionally there were two reports of gender discrimination, one of disability discrimination and three of age discrimination.

This low reporting using the Trust's grievance procedures is contrary to the results of the Staff Survey 2013, in which 13% (220 people) of full-time respondents reported discrimination, rising to a high of 18% (12 people) of respondents from the Cardiovascular unit.

16% of the 393 disabled respondents (63 people) reported discrimination at work in the previous 12 months, compared to 11% of non-disabled respondents.

28% of the 225 BME respondents (63 people) reported discrimination at work in the previous 12 months, compared to 10% of White respondents.

Disciplinary and Performance Management

Two BME members of staff out of 11 in total (18%) were dismissed following disciplinaries in 2013-14, compared to 11.4% BME representation in the workforce overall. Three other BME members of staff out of 22 in total (14%) were dismissed for 'other' reasons.

Currently only reports involving formal action are monitored which may explain the much poorer results reported in the staff survey. It is recommended that this situation is improved.

Equality training

The percentage of staff reporting completion of equality and diversity training in the past 12 months is 53%, up from 51% in the year previous and lower than the national average of 60%. The two lowest reports of completion were: 25% of the 67 respondents (17 people) from Eastbourne Hospital Services (EHS); and 39% of the 203 respondents (71 people) from Facilities.

Recommendations:

Add Equality and Diversity mandatory training to the mandatory training performance dashboard for Trust board.

Prioritise anti-discrimination as a staff experience improvement initiative and run Listening into Action workshops to collect staff stories and suggestions from the urgent care clinical unit, the cardiovascular clinical unit and partner with the BME Staff Network.

Improve measurement of discrimination, harassment and prohibited conduct by mandating the monitoring of incidents that were resolved informally by HR.

Progress	Equality Delivery System
Developing	Outcome 4.3: Middle managers and other line managers support their staff to work in culturally competent ways within a work environment
Staff members from some protected groups fare as well as the overall workforce	

Next steps

The findings and recommendations within this paper will be reported to the Clinical Management Executive (CME) and the Trust Board with the following next steps to be taken:

1. Agreement of the provisional EDS grades so that they may go out for community consultation. Feedback will then be responded to with final grades coming back to a future meeting for assurance
2. The findings from this report will be tabled as part of a series of service reviews with clinical and business unit management teams. These will be facilitated by the senior leads for the Trust's equality objectives (see appendix 2), and supported by the new equality officer post, to engage clinicians and operational staff to identify and prioritise their service and workplace improvement initiatives
3. The findings from these reviews will be used to update and refocus the Trust's equality objectives. These will be monitored through the new steering group and reported against a dashboard of equality performance indicators

On the back of the decisions from the Clinical Management Executive the draft annual equality report and the technical data will be published online at www.esht.nhs.uk/equality and distributed for public comment

Appendix 1: Equality Delivery System (EDS) grades

The Trust's EDS outcome grades are summarised below using four levels:

- ▲ Excelling – **Purple**
- ▲ Achieving – **Green**
- ▲ Developing – **Amber**
- ▲ Undeveloped – **Red**

1.	**Better health outcomes for all**	
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Achieving
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Developing
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Developing
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	Developing
2.	**Improved patient access and experience**	
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Developing
2.3	People report positive experiences of the NHS	Developing
2.4	People's complaints about services are handled respectfully and efficiently	Developing
3.	**A representative and supported workforce**	
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**Undeveloped**
3.3	Training and development opportunities are taken up and positively evaluated by all staff	Developing
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Achieving
3.6	Staff report positive experiences of their membership of the workforce	**Undeveloped**

4. Inclusive leadership

4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Developing
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing

Appendix 2: Equality objectives progress

Equality Objective	Status	Progress Update
1. Review age linked mortality inequalities and establish monitoring of deteriorating patients from certain protected groups	**A**	The annual reporting of mortality data was improved in 2013-14 however there was no clinical analysis of the differences between age-bands and the sexes • The recommendation for the mortality group to review the findings (page 10 of the annual equality report) should be implemented and then a decision taken as to whether this objective should be retained **Proposed Lead: Clinical leadership**
2. Improve inclusive end of life care approach for patients with an expected death from protected groups and the experiences of their bereaved	**A**	The Trans community were approached with an offer to engage around end of life care (EoLC) as part of the work to improve Trans care • It is recommended that the end of life care team engage with patients and carers about their experiences of EoLC **Proposed Lead: Nursing and governance**
3. Improve reporting about equality of emergency presentation by cancer patients from protected groups	**A**	Cancer presentation equality was not reported in the annual equality report 2013-14. • It is recommended that the timescales are updated for inclusion in the 2014-15 work programme **Proposed Lead: Specialist Medicine**
4. Improve understanding of cardiac rehabilitation equality	**A**	The metric for cardiac rehabilitation equality was agreed and the reporting template designed but for technical reasons there is a delay in reporting the data for 2013-14 • It is recommended that the Knowledge Management team put in place a strategy to report equality of cardiac completion in time for 2014-15 annual reporting (pg. 10 of the annual equality report) • It is recommended that the cardiovascular unit review and update patient documentation and staff training to ensure that ethnicity is being recorded for all patients

Equality Objective	Status	Progress Update
		(pg. 9 of the annual equality report). **Proposed Lead: Cardiovascular unit**
5. Reduce unplanned time spent in hospital for BME children and young people under 19 with asthma, diabetes and epilepsy as the primary diagnosis	**A**	Further analysis of unplanned time spent in hospital for BME children and young people with asthma, diabetes and epilepsy over the past 3 years was reported in the annual equality report 2013-14. • The timescales should be updated and the equality action plan revised on the basis of the findings on page 11 of the annual equality report **Proposed Lead: Women's and Children**
6. Increase female patients admitted to hospital following a stroke spending at least ninety percent of their time on a stroke unit	**G**	There were 594 patients with stroke out of 694 (85.6%) who spent at least 90% of their time on a stroke unit in 2013-14. Breaking this down by gender there were 304 out of 353 (86%) females and 290 out of 341 (85%) males. This parity is a 13% point increase for females on 2012-13. • It is recommended that this objective is now removed.
7. Increase the percentage of Asian or Asian British admitted patients completing referral to treatment waiting times in 18 weeks	**A**	There were 407 out of 512 BME admitted patients who completed referral to treatment in 18 weeks (79.5%) in 2013-14, down from the 345 out of 398 (86.7%) in 2012-13. The rate for white patients was 84.2%, down by 5.1% from 89.3% in 2012-13 • The waiting time recommendations on page 11 of the annual equality report should be incorporated within an update to the Trust's equality action plan **Proposed Lead: Operations**
8. Increase reporting of serious incidents and discrimination affecting patients from protected groups	**A**	Improvements to the reporting and monitoring of patient safety have included the mandating of ethnicity monitoring. Communications work to increase staff awareness about reporting discrimination is delayed and timescales need to be updated within the annual equality plan.

Equality Objective	Status	Progress Update
		The patient safety findings and recommendations on page 14 of the annual equality report should be used to update the Trust's equality action plan. **Proposed Lead: Nursing and governance**
9. Improve understanding of times from arrival in A&E until admission, transfer or discharge for patients from protected groups	**G**	The 2013-14 data was reported and a series of recommendations included within page 12 of the annual equality report • It is recommended that the A&E wait recommendations on page 12 of the annual equality report are used to update the Trust's equality action plan **Proposed Lead: Urgent care**
10. Improve understanding of pregnant women from protected groups booking for pregnancy care before 12 completed weeks	**A**	This data set was not reported in the annual equality report 2013-14 data; although the racial equity of incidents in maternity was examined separately by the Assistant Director of Nursing for Professional Practice and Standards. It is recommended that the timescales are updated for inclusion in the 2014-15 work programme **Proposed Lead: Women's and Children**
11. Identify, attract and aspire to recruit the best talent, from a diverse range of backgrounds to achieve improved workforce representation for BME, disabled and LGBT leaders and female non-executives	**A**	An increase in diversity at Board level was not achieved in 2013-14. The Trust's 'disability positive' ('two-ticks') accreditation was retained. • It is recommended that HR reconvene their equality meetings to improve assurance of performance. • The recommendations within this report (pg. 5 and 16-17) should be used to update the plan and promote diverse representation and inclusive leadership within the Trust's workforce strategy, senior manager's appraisals and recruitment. Also the establishment of reverse-mentoring between senior leaders and employees from under-represented groups • It is further recommended that this objective is reworded to reflect the EDS2 update: *A more representative workforce at all levels*

Equality Objective	Status	Progress Update
		Proposed Lead: Workforce and organisational development
12. Develop the capability and capacity of the clinical and non-clinical workforce, including at Board level, to promote equality of opportunity	**A**	• It is recommended that the actions under this objective that were not achieved in 2013/14 are rolled into objective 11 (above). Replacement actions should be added to this objective as per the recommendations in the annual equality report 2013-14: *Add Equality and Diversity mandatory training to the mandatory training dashboard for Trust board (page 8)* *Implement equality monitoring of participants within the learning evaluation feedback form and report for 2014-15 (page 17)* • It is further recommended that this objective is reworded to reflect the EDS2 update: *Training and development opportunities are taken up and positively evaluated by all staff* **Proposed Lead: Workforce and organisational development**
13. Increase staff reporting of bullying, harassment and discrimination grievances	**G**	Improvements to monitoring staff bullying, harassment and grievances were included within the annual equality report with resulting recommendations for improvement • Given the increased levels reported in the Staff Survey 2013 it is recommended that the Listening into Action improvement programme includes anti-discrimination / harassment initiatives as per the recommendations on pages 8 and 17 of the annual equality report 2013-14 and the Trust's equality action plan updated. **Proposed Lead: Workforce and organisational development**
14. Engage with staff to promote workplace	**A**	Disabled staff engagement occurs through Occupational Health's (OH) work to ensure

Equality Objective	Status	Progress Update
adjustments and flexible working		accreditation to quality standards for OH providers. • A procedure to support disabled staff requiring reasonable adjustments has not been agreed and it is recommended that this is trickled over into the new year **Proposed Lead: Workforce and organisational development**
15. Conduct equal pay audits annually to monitor whether the Trust is providing equal pay and rewarding employees fairly	**R**	The Trust agreed in November 2013 with the introduction of the Equality Delivery System 2 to implement equal pay auditing as per national guidance. The timescales for this require agreement from HR • HR should establish equal pay auditing using the national toolkit, as per the recommendation on page 17 of the annual equality report 2013-14 and the Trust's equality action plan updated. **Proposed Lead: Workforce and organisational development**
16. Increase listening to and learning from patients, their families and carers and representatives	**G**	A range of new patient experience measures were included in the annual equality report 2013-14 with a set of recommendations to improve experiences for patients from diverse backgrounds • It is recommended that minority patient experience is prioritised within a new work patient experience work programme, including disability accessibility • It is recommended that the recommendations on pages 11-13 of the annual equality report 2013-14 are used to update the Trust's equality action plan **Proposed Lead: Nursing and governance**
17. Review, upgrade and report from patient systems that support the advancement of equality	**A**	The Trust is still using Census 2001 categories in a number of IT systems. A programme to review systems was cancelled by the Information Management and Technology department. • It is recommended that the IM&T required

Equality Objective	Status	Progress Update
		upgrades are reinitiated and the timescales revised **Proposed Lead: Finance**
18. Support the equality strategy and maintain good governance arrangements	**A**	A number of the Equality and Human Rights Steering Group (EHRSG) meetings were cancelled in 2013-14 which affected governance of the equality objectives to improve care and employment. Face-to-face equality training was rolled out for staff on agenda for change bands 1-7. • It is recommended that the deferred decision on the November 2013 review of governance by the Equality and Human Rights Manager is revisited once the staff restructure has concluded. • It is recommended that the recommendations on page 8 of the annual equality report 2013-14 are used to update the Trust's equality action plan **Proposed Lead: Nursing and governance**

Appendix 3: Technical data

There is a technical data appendix available to view online at
www.esht.nhs.uk/equality

Data Reporting Principles

Measuring how well we perform for everyone

This is the report for how well the Trust promoted equality in 2013-14. The full data is published in a technical appendix available online at www.esht.nhs.uk/equality

Information is presented where available by: ethnicity, age, sex, disability status, sexual orientation, and religion or belief. No data is present about gender reassignment because either reporting systems are not yet compatible or recorded numbers are zero.

The term 'BME' (Black and Minority Ethnic) is used variously within the report to refer to a broad grouping of people whose ethnicity is coded using Census 2001 categories D-S. These codes are explained within the report itself. The term 'LGB' is used to refer to a broad grouping of people who have disclosed that they identify as lesbian, gay or bisexual.

Health outcomes

Health data is ultimately drawn from the patient administration system 'Oasis PAS'. Health indicators are chosen for relevance to equality from performance indicators already used within the Trust.

Incident data is presented drawn off the Datix incident reporting system about people concerned within recorded incidents.

Empowered, engaged and well supported staff

Employee information has been obtained from the following systems: Electronic Staff Records (ESR) and the Employee Relations Database held by the Human Resources (HR) directorate. Workforce figures include permanent and fixed term employees. They exclude apprentices or contract workers. Nil-hours employee figures (for example internal staff bank) are presented separately where applicable, but do not include locum doctors.

Employee information was largely absent for: disability, sexual orientation and religion or belief, which affects overall reliability.

Numbers measured within certain employment policies are very low, so are not statistically significant but may still be relevant to the performance of the equality duty. Workforce totals of less than five people are excluded when presenting data to ensure anonymity.

Band 1 through to Band 8d is used within data tables and refers to staff on Agenda for Change contracts (the majority of contracts within the workforce, e.g. nurses, allied-health professionals, administrators).

Medical contract figures are generally presented as: Consultants, NCCG (Non-Consultant Career Grades) and Junior Doctors.

The following terms are used throughout the report and are explained in more detail here:

NCCG includes the following contracts: Speciality Doctors; Associate Specialists [Associate Speciality (pre-2008 Contracts); Associate Speciality (2008 Basic Contract)]; Staff Grades [Staff Grade (1997) and, Staff Grade (pre-1997)]; Hospital Practitioner; Clinical Assistant; and Other Medical Staff

Junior Doctors (Jr Dr) include: Registrar Group [Speciality Registrar (full); Speciality Registrar (fixed term) Specialist Registrar (old)]; Foundation House Officer Year 1 (FHO1) and Foundation House Officer Year 2 (FHO2)

Other includes pay scales for very senior managers.

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	14d
Subject:	Fire Safety Annual Report Updated July 2014 V 5
Reporting Officer:	Richard Sunley, Chief Operating Officer

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

Purpose:

To provide the Board with an update regarding Fire Safety Management arrangements following:-

- The allocation of initial Capital Funding Resources for 2014/15 in June 2014
- Discussions and prioritisation clarification meetings with East Sussex Fire and Rescue Service on 13th and 24th June 2014
- A subsequent Estates Management reappraisal of risk assessments in respect of key fire safety matters.

Updates to the report are in red.

Introduction:

Effective Fire Safety Management is a legal required under Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum (HTM) 05-01 Second Edition 2013.

The main focus of the report is to highlight three major capital work programmes which require support over the next 2-4 years.

The Capital works identified in the report are required to avoid the Trust breaching various articles within the of the Regulatory Reform (Fire Safety) Order 2005.

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

Fire Training
Now at 81% of Staff trained with 100% Staff places provided during 2013

Fire Risk Assessments
100% of the departments / services at the 2 Acute Hospital sites have had risk assessments completed during the past 12 months.
100% of the Community sites transferred to ESHT from the PCTs have had risk assessments completed during the past 12 months.

Main Risks and Mitigation Plans involving Capital Investments
See detail within body of report

Benefits:

Preservation of life and business continuity by restricting the spread of fire, heat and smoke.
Maintaining illuminated means of escape routes in an emergency.

Compliance with the Regulatory Reform (Fire Safety) Order 2005. Compliance with CQC Outcome 10 – 'Safety and Suitability of Premises'

Risks and Implications
Fire Compartmentation EDGH: Current Risk Rating 15 Requires funding for the next 4 years at 250K per year- £250K agreed for 2014/15. Emergency Lighting Conquest :Current Risk Rating 15 Requires funding for the following 3 years. Total 750K. Fire Compartmentation Conquest: Risk Rating 9 Requires funding for the following 2 years. Total 200K.

Assurance Provided:
Suitable and Sufficient Fire Risk Assessment Programme. High percentage of Staff trained in Fire Safety. Compliance with CQC Outcome 10 – 'Safety and Suitability of Premises' On completion of Capital schemes compliance with the Regulatory Reform (Fire Safety) Order 2005.

Review by other Committees/Groups (please state name and date)**:**
Estates and Facilities Senior Management Group- 16.07.14

Proposals and/or Recommendations
The Board is asked to review and note the updated report and in particular the requirements for capital funding to comply with the Regulatory Reform (Fire Safety) Order 2005.

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 undertaken.

For further information or for any enquiries relating to this report please contact:	
Name: Jan Ingram, Senior Fire Advisor	**Contact details:** Norman.ingram@esht.nhs.uk

East Sussex Healthcare NHS
NHS Trust

Fire Safety Report

UPDATE
January 2013- June2014

V5.0 July 2014

In accordance with HTM 05-01 2013 “Managing Health Care Fire Safety”, the role of Fire Safety Manager is undertaken by Richard Sunley, Deputy Chief Executive & Chief Operating Officer.

Compiled and completed by

Norman (Jan) Ingram
Senior Fire Advisor
Property Management

July 2014

East Sussex Healthcare NHS
NHS Trust

Fire Safety Report

January 2013 – June 2014

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Fire Safety Report

January 2013 – June 2014

1.0 PURPOSE

To provide the Board with a further update of the Fire Safety Management arrangements following:-

1) The allocation of initial Capital Funding Resources for 2014/15 in June 2014.
2) Discussions and prioritisation clarification meetings with East Sussex Fire and Rescue Service (ESFRS) on the 13th and 24th of June 2014.
3) A subsequent Estates Management reappraisal of risk assessments in respect of key fire safety matters.

1.1 Context

The NHS workplace and working environment changes significantly from year to year. The delivery of safe and effective health services has become more important as public attitudes to risk, redress, blame and compensation have escalated.

The key challenge for the Trust is to ensure a dynamic healthcare environment compliant with all relevant fire safety legislation.

Effective Management of Fire Safety is an essential to preserve life, lower the impact of any fire and to ensure business continuity and care.

Effective Fire Safety Management is also a legal requirement under the auspices of the Regulatory Reform (Fire Safety) Order 2005 and recommendations found within the Health Technical Memorandum (HTM) 05-01 managing healthcare fire safety second edition April 2013.

To ensure the continuing identification and appreciation of Fire Safety risks, monthly fire reports are forwarded to the Fire Safety Manager and quarterly fire reports forwarded into the Health and Safety Steering Group (HSSG).

1.2 Legal background

The Regulatory Reform (Fire Safety Order) 2005 came into effect on 1 October 2006 and applies to England and Wales. The Fire Safety Order replaces previous fire safety legislation applying to this Organisation.

2.0 FIRE SAFETY POLICY

The 2013 Fire Policy produced to reflect new national guidelines included in Hospital Technical Memorandum (HTM) 05-01 2013 second edition has now been ratified.

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2.1 Fire Safety Protocols

As identified in the new Fire Safety Policy, new Fire Safety Protocols will be developed for all aspects of Fire Safety identified in HTM 05-01 and the suite of documents completed by October 2014.

3.0 RISK ASSESSMENTS

3.1 The Regulatory Reform (Fire Safety) Order 2005 focuses on the requirement for all premises to have a suitable and sufficient Fire Safety Risk Assessment. The suitability being assessed against a series of guidance notes specific to the accommodation type. PAS 79 2012 and the LACORS document are both considered to provide the information required to carry out fire risk assessments in Trust premises or premises where Trust Staff are employed.

ESFRS consider the current format and content of fire risk assessments to be "suitable and sufficient".

3.2 100% of the 164 Acute Hospital areas have been subject to risk assessments in the past 12 months.

100% of the Community sites transferred to ESHT from the PCTs have been subject to risk assessments in the past 12 months.

48% of the "undocumented" properties occupied by ESHT in the community have been assessed and a strategy has been devised to ensure full completion by April 2015.

100% of all properties owned by NHS Property Company Ltd in East Sussex, covered by the current service level agreement, have been subject to risk assessments in the past 12 months.

3.3 The current documentation has been reviewed during 2013 to reflect the principles of PAS79 2012 and current HTMs.

3.4 A Fire Emergency Plan has been issued to 100% of workplaces. Individual Personal Emergency Evacuation Plans (PEEPs) and Group Emergency Evacuation Plans (GEEPs) will be completed for each site/Ward by the Responsible Person on ratification of the draft PEEP Policy. This Policy will be ready for scrutiny by the 1st of October 2014.

4.0 CAPITAL WORKS

A comprehensive list of remedial works has been identified and forms the basis of the Trust's investment in fire safety remedial measures over the coming financial years.

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The schedule includes work needed to meet Firecodes standards and items which are not mandatory but are considered to be best practice. Therse are works that become as legislation evolves and new systems and procedures are introduced.

The changing nature of legislation regarding the Trusts estate, the take over of new buildings and the continual change of use of rooms will attract additional risk assessments and therefore additional remedial work year on year.

4.1 CAPITAL PROJECTS – Current ongoing Risks & Mitigation measures

Continued investment in fire safety standards will demonstrate that the Trust has a responsible and proactive approach to dealing with fire safety issues, risks and compliance requirements. The risks set out in the following sections comprise an assessment of "Life and Business Continuity" aspects plus risks associated with the possible issue of enforcement or improvement notices by the Fire Authority and the subsequent "Reputational Risks" which would ensue.

4.1.1 Fire alarm system Conquest Hospital – Current Risk Rating 2

The installation of the new fire alarm system is practically completed; however the programming of the alarm sounders and the interface with the building ventilation systems is still to be completed.
Target date October 2014.

The Risk Rating as at July 1st 2014 for Life and Business Continuity is 2 and the Reputational Risk exposure is also 2.

The Risk exposure ratings prior to installing the new system were 12 and 15 respectively.

For the Risk Rating calculation method see Appendix 1.

4.1.2 Fire Compartmentation EDGH – Current Risk Rating 15

Parts of the EDGH were built with "crown immunity" and not covered by the Building and Firecode regulations of the time. Sixty minute fire compartments were not properly established and alterations to the building have since occurred causing breaches in any established fire compartments.

East Sussex Fire and Rescue visited in 2010 and 2012 regarding this issue. Their instruction dated 10/2/2012 on the "Record of Inspection SF21" was a requirement to plan, identify and upgrade all identified 60 minute fire compartments.

A comprehensive compartmentation report was commissioned on the 3rd of July 2013 and the report received from the Fire Protection Association on the 1st November

2013. Subsequently a full intrusive survey of the EDGH has been carried out and a programme of remedial works identified.

East Sussex Fire and Rescue Service are satisfied with the Estates Management proposal as set out in June 2014 to undertake the following.

Year 1 (2014/2015)
Upgrade the towers, stairwells and means of escape to the stairwells on all floors to provide 60 minute fire resistance. Estimated cost £250K. Funding is now allocated to progress these works.

Year 2 (2015/2016)
Upgrade higher dependency inpatient areas and inpatient areas identified by risk assessment to provide 60 minute fire resistance.
Estimated cost £250K.

Year 3 (2016/2017)
Upgrade lower dependency inpatient areas and all other inpatient areas identified by risk assessment to provide 60 minute fire resistance.
Estimated cost £250K.

Year 4 (2017/2018)
Upgrade outpatient areas, non patient facing areas and educational areas to provide 60 minute fire resistance.
Estimated cost £250K.

The Risk Rating as at the 1st June 2014 for Life and Business Continuity is 12 and the Reputational Risk exposure is 15.

The Risk Rating which will be achieved by 2017/18 provided the investments set out above are made will be 3 for Life and Business Continuity and 3 for Reputational Risk exposure.

4.1.3 Fire Compartmentation at the Conquest - Current Risk Rating 9

When the Conquest Hospital was built Building and Firecode regulations applied to Hospital premises however uncoordinated alterations to the building have occurred causing breaches in 60 minute fire boundaries. Therefore the breaches are not as extensive or as high a risk as EDGH.

East Sussex Fire and Rescue Service visited in 2012 regarding this issue. Their instruction dated 27/2/2012 on the “Record of Inspection SF21” was a requirement to plan, identify and upgrade all breaches identified in 60 minute fire boundaries.

A comprehensive compartmentation report was commissioned, for the Fire Protection Association to identify existing boundaries requirements prior to work commencing.

East Sussex Fire and Rescue Service are satisfied with the Estates Management proposal as set out in June 2014 to undertake the following.

Year 1 (2014/2015)
Identify and list the works required to achieve the required fire resistance in the existing compartments. Estimated cost £25K. Funding is now allocated to progress this work.

Year 2 (2015/2016)
Carry out works to upgrade breaches in the existing fire compartmentation between April 2015 and April 2016. Estimated cost £175K.

The Risk Rating as at the 1st June 2014 for Life and Business continuity is 6 and the Reputational Risk exposure is 9.

The Risk Rating which will be achieved by 2015/16 provided the investments set out above are made will be 3 for Life and Business Continuity and 3 for Reputational Risk exposure.

For the Risk Rating calculation method see Appendix 1.

4.1.4 Emergency Lighting Conquest - Current Risk Rating 15 – *To be finalised *

On failure of the buildings electrical supply, emergency lighting illuminates escape routes for a period of 3 hours in Hospital premises. British Standard 5266 deals with emergency lighting provision.

The Conquest does do not comply with the current British Standard as Maternity Delivery, SCBU, Maternity Theatre and Frank Shaw ward do not have “suitable and sufficient” emergency lighting provision. These areas were omitted during the 2003 installation.

The current Conquest building emergency lighting system consists of five separate central systems linked together by a central controller to approximately 950 luminaries.

The system is a complex one with components compatible only with other parts of the same system. Due to the software design of the system, the controller, the central monitoring equipment and system luminaries cannot be added to or replaced by any replacement part either new or second hand.

The system manufacturer is no longer trading. No other support is available. There is a current risk of a whole or part failure of the system at any time.

East Sussex Fire and Rescue Service visited in 2014 regarding this issue. Their instruction to ESHT dated 25/4/2014 was a requirement to have a suitable replacement plan in place by the end of 2014/2015.

East Sussex Fire and Rescue Service are satisfied with the Estates Management proposal to.

Year 1 (2014/2015)
Commission the design of a replacement emergency lighting system, identifying and listing the works required to achieve compliance with BS5266 Part1 at the Conquest site. Estimated cost £25K.

Year 2 (2015/2016)
Replace three of the five system loops, batteries and controllers. The upgrade will include all areas that have no current emergency lighting provision.
Estimated cost £450K.

Year 3 (2016/2017)
Replace the remaining two system loops, batteries and controllers.
Estimated cost £275K.

The Risk Rating as at the 1st June 2014 for Life and Business continuity is 9 and the Reputational Risk exposure is 15.

The Risk Rating which will be achieved by 2015/16 provided the investments set out above are made will be 3 for Life and Business Continuity and 3 for Reputational Risk exposure.

For the Risk Rating calculation method see Appendix 1.

5.0 FIRE TRAINING

The current level of mandatory Fire Training is at 81%, which has increased from 62% (February 2012).

The training has either not been supported sufficiently by Managers or the Trust cannot physically release the numbers required to achieve 100%.

The training figures for the past three years are shown below for comparison.

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Year	2011	2012	2013/14
Number of ESHT Staff	6917	6808	**6727**
Number of ESHT Staff in date	4515	5116	**5415**
Percentage	65.27%	75.15%	**80.50%**
Non ESHT Staff trained Volunteers, Sussex University and Doctors Surgery Staff)	No records	No Records	564

5.1 **Fire Warden Training and Fire Team Training- Internal**
Has taken place and included practical extinguisher use. The courses received excellent feedback from Staff.

5.2 **Practical evacuation exercises.**
Ward based training has been well received and practical evacuation exercises have taken place including Theatre areas. Practical evacuation exercises have been identified as an area for improvement during 2014.

5.3 **Fire Drills:**
Organised and carried out by Fire Advisors and the Fire Trainer at the Acute sites and Community Hospitals.
Organised and carried out by Premises Managers at the Community sites.

6.0 **INCIDENT REPORTS**

6.1 **False Alarm Activations**

The installation of the new Conquest Fire Alarm and the installation of the new fire alarm at the Irvine Unit have increased the number of alarm activations (faults and accidental) and will continue to do so until October 2014 when the Conquest Fire Alarm project is concluded.

6.2 **Fires**
There were four fires during 2013 with no injuries reported.
Department of Psychiatry (Sussex Partnership) Notice Board -Arson
ESHT Crèche –Tumble Dryer fault.
EDGH Switchboard- Light Fitting overheated.
EDGH Residency – Cooking –Accidental.

There was one malicious fire call made during 2013 from the Intensive Care Unit on 1st April 2013. Caller not identified despite an investigation.

A table and analysis of Fire Calls is attached at Appendix 2.

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7.0 AUDIT AND REVIEW

An audit of Trust Fire Safety Management systems will be undertaken by a Chartered Health and Safety Practitioner in September 2014.

8.0 LEGISLATION UPDATES SINCE THE PREVIOUS REPORT

8.1 The HTM Managing Healthcare Fire Safety Second Edition April 2013 giving new or amended guidance for all aspects of fire safety management has been scrutinised by the fire safety group. All new guidance and amendments from the previous HTM 05-01 have been considered and where necessary amended.
Fire Training content and frequencies now reflect the new HTM Guidance.
Fire Safety Protocols will be amended or re written by 1st October 2014.

9.0 INSPECTIONS BY THE ENFORCING AUTHORITY.

Action Plans containing details of any outstanding issues and recommendations from audits by ESFRS have been forwarded to the Eastbourne Borough Fire Safety Manager.

EDGH Visits:
26th of February2014
13th of June
24th of June 2014

Conquest Visits:
25th of April 2014

10.0 RECOMMENDATIONS

There has been considerable investment agreed by the board to enable the Conquest fire alarm project to be practically completed.

There are three major capital work requirements still to be addressed:.

10.1 EDGH Compartmentation

Comprehensive compartmentation upgrading is required under legislation enforced by East Sussex Fire and Rescue Service £250K funding has now been allocated to commence these works in 2014/15.It is recommended that the project continues to be supported for the next three years to the same value each year.

10.2 Conquest Emergency Lighting

Current supplier status and various other installation measures have led to the buildings emergency lighting system void of coverage in some areas, with an unsupported system in other areas. It is recommended that the project is supported for the next three years to ensure compliance with the current British Standard for Emergency Lighting required under legislation enforced by East Sussex Fire and Rescue Service. Total cost £750K.

10.3 Conquest Compartmentation

Upgrading of targeted areas of compartmentation is required under legislation enforced by East Sussex Fire and Rescue £25K funding has now been allocated to complete the initial stages of these works in 2014/15.It is recommended that the project continues to be supported during 2015/16 to the value of 175K.

N Ingram
Senior Fire Safety Advisor
15th July 2014

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Appendix 1

In order for the Risks to be transferred to the Trusts Risk Register, the non-compliance issues raised during the assessment must be "translated" in to a Risk Rating using the following scoring method.

Likelihood score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Table 3 Risk scoring = consequence x likelihood (C x L)

			Likelihood		
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

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For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 to determine the consequence score(s) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the _organization's risk management system. Include the risk in the organisation risk register at the appropriate level.

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Appendix 2

Hospital sites and residencies are shown separately

Summary of Fire Calls		**Hospital Residences**			**Conquest ,EDGH, Bexhill, Irvine Unit***		
		2011	2012	**2013**	2011	2012	**2013**
Fire calls made	Accidental		2				
	Arson				2	0	1^
	Fires						4(1^)
	Smoking					1	
	Automatic calls via dialler system						20
Unwanted activations	Accidental Damage		2		4	5	7
	Alarm activated by patient or public				4	6	9
	Environmental – cooking	54	57	50	11	17	16(3^)
	Environmental – insects						
	Environmental – other(steam deodorants)	4	2		18	15	31
	Environmental – smoking				1	2	8^
	Good Intent				1	1	4
	Malicious						1*
	System fault/design	9	18	28	8	9	41
	System procedures not complied with	1					
	Unknown	6	9		2	7	3
	Other						
	Management procedures not complied with.		5		4	11	0
Total number of alarm activations		74	95	78	55	74	145

***Intensive Care Unit on 1st April 2013**
^ Sussex Partnership (Woodlands/DOP)

Fires = DoP-Notice Board
Crèche –Tumble Dryer
Switchboard-Light Fitting
Residency – Cooking

***The Lewes and Crowborough sites have not submitted any records of fire calls/alarm activations.**

East Sussex Healthcare NHS Trust

Date of Meeting:	30 July 2014
Meeting:	Trust Board
Agenda item:	15
Subject:	Consultants' Clinical Excellence Awards – 2013 Round
Reporting Officer:	Monica Green, Director of Human Resources

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

Purpose:

The attached report provides background to the Consultants' Clinical Excellence Award Scheme and the Awarding Panel's Recommendation for employer based awards for the 2013 round. The Trust Board is asked to note the recommendations made by the Awarding Panel, which were ratified by the Trust's Remuneration Committee on 3 June 2014, on behalf of the Trust Board.

Introduction:

The Consultants' Clinical Excellence Awards scheme is a national scheme to recognise the contributions of consultant staff over and above what is expected as part of their everyday jobs. The Trust runs this process on an annual basis in accordance with national guidance and this year the Local Awarding Committee recognised the practice of thirty two consultants in this way.

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

This is a national scheme which dictates both a minimum number of awards to be made and the minimum expenditure. A representative Panel scrutinise applications from consultants and determine the allocation of awards.

Benefits:

This is a national scheme to encourage and reward outstanding contribution.

Risks and Implications:

There are risks to both the financial position of the Trust and to morale and engagement if the awards process is not undertaken.

Assurance Provided:

The Panel, which also included lay and external representation, discussed at length the criteria and method of allocating the awards and followed national guidance.

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

The awards were reviewed and ratified by the Trust's Remuneration Committee on 3 June 2014.

Proposals and/or Recommendations

The Panel recommended that 33 awards were made. Two awards were made to the highest scorer, and one award each to the next thirty one highest scorers.

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

For further information or for any enquiries relating to this report please contact:	
Name: Monica Green, Director of Human Resources	**Contact details:** monicagreen@nhs.net, (13) 3879

East Sussex Healthcare NHS Trust

EMPLOYER BASED CLINICAL EXCELLENCE AWARDS 2013 FOR CONSULTANT MEDICAL STAFF

1. Purpose of the paper

This paper details the recommendations made by the Clinical Excellence Local Awarding Panel which met on 2 June 2014. The awards were ratified by the Trust's Remuneration Committee on behalf of the Trust Board on 3 June 2014. The Trust Board is asked to note these recommendations.

2. Background

2.1 The Clinical Excellence Awards (CEAs) scheme is a mechanism to recognise excellent performance for consultant medical staff over and above contractual requirements. It provides for 12 levels of award, of which the first 8 are employer-based with level 9 awards being awarded either nationally or locally, dependent upon the type of achievement being recognised, and levels 10-12 being awarded nationally. Awards are cumulative and, for awards lower than level 9, there is no current mechanism for re-evaluation of past awards which are then paid year on year.

2.2 CEAs are part of the national contract for consultants based on a process determined by the Advisory Committee on Clinical Excellence Awards (ACCEA). The calculation of the number of awards available is based on 0.20 per eligible consultant. The Trust has developed a local policy in accordance with the national guidelines and has consulted on this with the Local Negotiating Committee (LNC).

2.3 The local Employer Based Awarding Panel is responsible for making recommendations for award of the local levels, and the panel is constituted in accordance with national guidance, ensuring that there is consultant representation to reflect the range of specialties within the Trust and also to represent the gender, ethnic and site split of consultants. The committee is predominantly made up of consultants and has 9 consultant representatives plus the Chairman, the Chief Executive, the Medical Director and the Director of Human Resources. The panel is chaired by a Non-Executive Director. In accordance with the ACCEA recommendations, there is one further lay panel member. An observer from the LNC also attends.

2.4 In allocating awards the panel follow both the locally agreed policy document and the national guidance. All panel members are required to undertake diversity training and, in an attempt to ensure consistency of scoring, training for scorers was held prior to the applications being sent to the panel. Support and training sessions were also offered to consultants applying for awards.

2.5 In agreeing the determination of awards, and in accordance with the guidance, the following factors are taken into account:

- Delivering a high quality service
- Developing a high quality service
- Managing a high quality service
- Research and innovation
- Teaching and training.

All panel members' score all applications following the nationally specified system of scoring, taking into account the above criteria. Only information recorded on the application form is taken into account when scoring, and applicants can only include work undertaken since their last award.

2.6 The normal timescale for the award of local applications is for the invitation to apply to be issued during the autumn with the local awarding panel convening in February. For the 2013 round however, this process was delayed whilst national negotiations were on-going and awards are now being made to recognise performance up to 31 December 2012 and will be paid backdated to 1 April 2013.

3. AWARDS AVAILABLE FOR DISTRIBUTION

Using the ratio of 0.20 per eligible consultant, the minimum number of awards available for 2013 is 33. The minimum value of the awards must meet the minimum number of awards multiplied by the unit value of a local award (£2,957) which equates to £97,581 for the 2013 round.

4. ALLOCATION OF AWARDS

The process is not formally linked to appraisal, however to be eligible for points all applicants must have actively participated in the job planning process, have met contractual obligations and undertaken an appraisal in the twelve months prior to submitting their application. Applicants must have also completed Fire, Infection Control, Basic Life Support, Mental Capacity Act (MCA) and Deprivation of Liberties Safeguarding (DOLS) mandatory training within the same timeframe. Clinical Unit Leads were asked to sign off applications and confirm compliance with the above requirements. In addition, applicants were asked to verify whether they gave permission to make their applications available for others to see.

5. RECOMMENDATIONS FOR AWARDS

5.1 In determining the award of the 33 available awards, the panel considered the ranking table of the panel's scores, taking into account the difference between the total scores for applicants' applications and the number of maximum scores awarded.

5.2 The panel awarded two awards to the highest scoring candidate in recognition of their achievements and because their scoring was significantly higher than that of other applicants. Single awards were then awarded to the next thirty one highest scoring applicants, again in recognition of their contributions to the Trust.

5.3 The recommended awards have an initial value of £114,582, however, when employers' costs (superannuation, national insurance) are added to this, and the figure is adjusted for those consultants working either over or under 10 PAs, the total cost to the Trust will be £161,191. This amount exceeds the minimum stipulated cost to be allocated as many of those to whom points are to be awarded are now on a higher level of award, the cost per award being greater the higher up the scale.

6. FEEDBACK TO UNSUCCESSFUL CANDIDATES

6.1 The applications from the unsuccessful candidates were discussed in detail with feedback being identified and noted. It was agreed that the Medical Director and Director of Human Resources would offer to meet with all unsuccessful applicants to provide feedback and it was noted that any notice of appeal would not be accepted until such feedback had been sought.

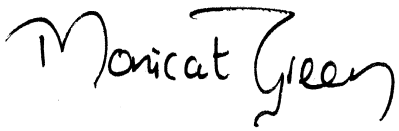
6.2 The appeals process is clearly set out in the Trust's local procedure which states that appeals can only be made about the process followed.

7. LESSONS LEARNED FOR NEXT YEAR

The Medical Director and the Director of Human Resources are currently working with the newly appointed NED Chair of the Local Awarding Committee to make recommendations for slight changes to the local process based on lessons learned from this round of local awards. These will be discussed with the Chairman of the Local Negotiating Committee (LNC).

8. RECOMMENDATION

The Trust Board are requested to note the recommendations made by the Local Awarding Committee that have been ratified by the Remuneration Committee, and to endorse the process followed.



Dr David Hughes
Medical Director - Governance

Monica Green
Director of Human Resources

July 2014

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	16
Subject:	Board Sub-committee Reports and Trust Board Seminar Notes
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

The attached report provides a summary of the meetings of the Board sub-committees and the notes of Trust Board seminars held since the last meeting.

Introduction:

The following committees have been established as formal sub-committees of the Board.

- Audit Committee
- Finance and Investment Committee
- Quality and Standards Committee
- Remuneration and Appointments Committee

It is best practice for each Committee to summarise key points from their meetings and share these with the Board along with formal minutes of the meeting. The Board has also agreed that notes of the Trust Board Seminars will be circulated with the Trust Board agenda papers.

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

The attached reports provide a summary of the key discussion points at each of the sub-committee meetings that have taken place since the Board last met.

Benefits:

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

Risks and Implications

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

Assurance Provided:

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

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

Not applicable.

Proposals and/or Recommendations

The Board is asked to review and note the documents.

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

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

East Sussex Healthcare NHS Trust

AUDIT COMMITTEE

1. Introduction

1.1 Since the last Board meeting Audit Committee meetings have been held on 4th June 2014 9th July 2014 and a summary of the matters discussed at 9th July meeting is provided below.

1.2 The minutes of the meeting held on 5th March and 4th June 2014 are attached at Appendix 1 and 2 respectively.

2. Commercial Risk Register

2.1 The Facilities and Security Manager presented the risk register and noted that it had been recently reviewed and the majority of the risks had had their ratings reduced and only three risks were now rated as extreme on the register and actions were in place to mitigate the risks.

2.2 He advised the Committee that the risks relating to fire safety had been suspended from the register as discussions had taken place with the East Sussex Fire and Rescue Service on the risks and a four year plan had been agreed to address them.

2.3 The Committee noted the report and the actions being taken to manage the risks.

3. Annual Security Report 2013/14 and Workplan for 2014/15

3.1 The Facilities and Security Manager advised that the Trust was required to produce an annual report on security for submission to NHS Protect.

3.2 He took the Committee through the statistical analysis of incidents during the year 2013/14 and noted that clinical assaults, which were minor assaults by a patient due to their capacity, medication or condition, had increased from 33 to 68 but physical assaults by patients had reduced to 49 from 66 and had not required any staff to be treated for harm. He highlighted that verbal abuse had increased from 86 to 123 incidents but thefts had remained the same as the previous year. He anticipated that there would be a reduction in the coming year in thefts and lost property incidents with the implementation of the new patient property policy.

3.3 The Committee noted the Annual Security Report for 2013/14 and supported the Workplan for 2014/15.

4. Board Assurance Framework and High Level Risk Register

4.1 The Company Secretary presented the Board Assurance Framework (BAF) and it was reviewed and discussed by the Committee.

4.2 She advised that the High Level Risk Register was currently being reviewed by the Head of Assurance as she was attending clinical unit accountability meetings in order to ensure that their risk registers were up to date.

4.3 The Committee had discussed the results of the Staff Survey and the actions being taken through engagement with staff, focused conversations, continuation of leadership conversations and staff Friends and Family Test.

5. Clinical Audit

5.1 The Assurance Manager – Clinical Effectiveness presented the annual report for 2013/14 and noted that the Trust had participated in 32 of the 34 nationally mandated audits in the year. It had not participated in the National Adult Diabetes Audit as it did not have the required specialist software and there had been no cases for the Paediatric Bronchiectasis Audit.

5.2 She reported that attendance at the Clinical Audit Steering Group had been poor throughout the year and the Group was now moving to a more outcome focused agenda and, together with the development of relationships with the new clinical unit, she anticipated that there would be better attendance in 2014/15.

5.3 The Committee noted the current status of the Clinical Audit Forward Plan for 2014/15.

5.4 The Committee discussed the difficulties the clinical lead was experiencing in uploading data for the National Audit for Rheumatoid and Early Inflammatory Arthritis and the Committee requested that the Assurance Manager and the clinical lead explore the possibility of providing additional administrative support to the audit.

5.5 The Committee also discussed the difficulties being experienced in providing data for the National Vascular Registry Audit and the Committee asked the Assurance Manager to review the audit requirements to see if it could be progressed with additional administrative support.

6. Internal Audit

6.1 The Committee received the progress report and noted that three audits had been completed since the last meeting and reviewed their conclusions.

6.2 The Committee reviewed the audit recommendations tracker and noted the good progress being made in completing audit recommendations.

7. Local Counter Fraud Service

7.1 The Committee received the progress report and noted the actions being taken in respect of on-going investigations. It approved the workplan for 2014/15 which included aspects coming out of the Local Counterfraud Survey conducted in 2013/14 and any recommendations coming out of the Focused Fraud Assessment undertaken by NHS Protect in June.

8. External Audit

8.1 The external auditor presented the annual audit letter for 2013/14 which would become a public document. The Committee approved the letter subject to an amendment to the wording proposed by the Director of Finance.

9. Information Governance

9.1 The Company Secretary presented the Annual Report for 2013/14, the Workplan for 2014/15 and an update on the Information Governance Toolkit guidance for 2014/15 which were noted by the Committee.

10. Tenders and Waivers

10.1 The Committee noted the Tenders and Waivers report.

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

11.1 The Committee noted the Department of Health consultation response.

Charles Ellis
Acting Audit Committee Chairman

22nd July 2014

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 5th March 2014 at 9.30 am in the St Mary's Board Room, Eastbourne DGH

Present: Mr James O'Sullivan, Non-Executive Director (Chairman)
Mrs Sue Bernhauser, Non-Executive Director
Mr Barry Nealon, Non-Executive Director

In attendance Mrs Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr David Hughes, Medical Director – Clinical Governance
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary
Mr Leigh Lloyd-Thomas, BDO
Mr Jody Etherington, BDO
Mr Mick Fyfe, Account Manager, TiAA
Mr Simon Muir, Director, TiAA
Mr Steffen Wilkinson, CounterFraud Manager, TiAA
Ms Emily Keeble, Head of Assurance (for item 4)
Mrs Emma Moore, Assurance Manager – Clinical Effectiveness (item 4)
Ms Anne Watt, Clinical Governance Manager (item 5)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

Action

1. Welcome and Apologies for Absence

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

Apologies for absence had been received from:

Charles Ellis, Non-Executive Director
Dr Janet McGowan, Associate Medical Director – Clinical Audit
Alex Hughes, CounterFraud Specialist, Mazars
Mike Townsend, Tiaa

2. Minutes

i) The minutes of the meeting held on 8th January 2014 were reviewed and agreed as a correct record.

ii) Matters Arising

Board Assurance Framework and High Level Risk Register

Mrs Wells reported that a review was being undertaken of the risk registers to ensure there was consistency around scoring and controls.

Review of Aged Debts

Mrs Harris reported that the public sector sundries comprised of three elements:

- East Susssex Healthcare Services – laundry
- Non-contracted activity – out of area contracted activity
- SLA income from NHS customers, eg payroll work for other NHS organisations

3. Board Assurance Framework

Mrs Wells presented the Board Assurance Framework and noted that she had received updates on the majority of actions. She had also reviewed the controls and assurances and removed the assurances received from NHSLA as the system had now changed and the NHSLA no longer carried out inspections.

She highlighted that some of the risks had reduced and noted that the risk relating to cash on page 18 had reduced to green as the Trust's application for Public Dividend Capital had been approved.

She noted that there was only one risk rated as red which related to the inability to recruit to some specialities.

Mr O'Sullivan queried progress in relation to the risk around diabetic retinopathy and Mrs Wells reported that this was a national issue which was monitored through a regional network and the Trust had escalated the issues to the commissioners as it could not meet the capacity.

Mrs Harris queried whether the control should move from red to amber in relation to recruitment as the Trust had recruited a significant number of nurses and had appointed all the newly qualified student nurses to post. Mrs Webster also noted that progress had been made in therapies recruitment where the vacancy rate had moved from 30% to 13%. She noted that there were still difficulties in the recruitment of theatre staff and A&E medical staff. Mrs Wells agreed to review how the gap was written to ensure that it reflected the current position. **LW**

The Committee noted the Board Assurance Framework.

4. Clinical Audit Forward Plan Update

Ms Keeble reported that 2 audits remained open from 2011/12 which was a reduction of 1 since the last meeting and 47 audits remained open from the 2012/13 plan as at the meeting date.

She advised that there were currently 253 audits open on the 2013/14 plan and Mrs Moore was meeting with the clinical units to review the plan and check on the progress of their audits. She noted that in relation to Integrated Care the CNST audits had been completed and an overall report was awaited. Mrs Watt confirmed that this was in progress.

Ms Keeble reported that the forward plan for 2014/15 was being developed through the usual top down and bottom up approach and advised that there were still the same number of national audits as in the previous year. The plan would be submitted to the Clinical Audit Steering Group, the Clinical Management Executive and then to Audit Committee for approval.

Mr O'Sullivan noted the good progress being made with clinical audit and asked how the process was working and in particular the Clinical Audit Steering Group. Ms Keeble was of the opinion that the process was much tighter and believed that there was better understanding of the audits and changing the format of the Steering Group had concentrated focus on the lessons learnt and sharing this information among the clinical units.

Mr Fyfe reported that the recent internal audit of the clinical audit process supported this and he had been able to provide a significant assurance opinion.

Dr Harrison agreed that significant progress had been made and advised that the next step was to inform the committee of the assurances provided by those audits, the risks identified and how they were being addressed. Ms Keeble advised that the exception reports requested from the clinical units for the Steering Group should be able to provide such information.

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

5. Integrated Care Risk Register and Clinical Audit Forward Plan

a) <u>Clinical Audit Forward Plan</u>

Mrs Watt reported the following progress:

Radiology – 6 audits had been completed and 6 were in progress.

Mrs Watt reported that the unit had requested to defer their presentation to the Clinical Audit Steering Group until the new financial year which had been agreed.

Pathology – 4 audits completed and 7 were in progress.

Pharmacy – they had rolling audits, regular meetings were held and the audits were up to date. Pharmacy students were involved in the audits as part of their training.

Paediatrics – 14 audits were registered and 16 audits had been presented.

Women's – 15 audits had been completed and 6 were on-going. Audit meetings were scheduled for March and June.

Risk Register

Discussion took place on a number of the risks rated as extreme:

Discussion took place on the following risks:

- Pharmacy resourcing – Mrs Harris noted that this issue had been discussed at the Board seminar in February and advised that as part of the 2014/15 plans there would be an investment in pharmacy resource. Dr Hughes stated that improvements in pharmacy efficiency would release patient facing pharmacists onto the wards. The Committee took assurance that action was being taken to address the risk.

- Lack of consultant presence in Conquest SCBU – Mrs Watt advised that this risk related to the daily consultant ward round. Due to the increased number of patients on Kipling ward the consultant was not able to carry out the ward round on SCBU as early as he/she would want in order to prevent delays in discharge of SCBU patients. The consultants had discussed this risk and were investigating other ways of working to ensure Kipling and SCBU patients were reviewed in a timely manner for discharge. Mrs Watt assured the Committee that it did not prevent a SCBU patient receiving urgent review or treatment if required.

- Midwifery staffing levels – Mrs Webster requested that the unit describe the frequency when community midwives were non-European Working Time Directive compliant in order to understand the actual risk.

- Unsafe storage of children's records – Mrs Watt advised that this risk related to the accessibility of notes stored off site and ensuring their retrieval in a timely manner.

Mrs Webster expressed concern that the wording of the risks did not reflect the actual risk and therefore consequent grading.

Mrs Bernhauser noted that patient records seemed to be a recurring issue across the organisation.

Mr O'Sullivan thanked Mrs Watt for her attendance.

The Committee noted the report from Integrated Care on its Clinical Audits and its Risk Register.

6. Local Counter Fraud Service

Mrs Harris presented the report from Mazars and noted that there had been 12 new referrals since the last meeting and the Committee noted the details in the confidential appendix.

She advised that the Crown Prosecution Service had confirmed that charges were to be made in respect of the ongoing prosecution case as outlined in the confidential appendix.

She noted that pro-active counter fraud work had continued through refreshing publicity and two pro-active exercises were being undertaken on accounts payable and payroll controls. In addition, the counter fraud survey had continued to be publicised via the communications team.

Mrs Harris reported that with effect from 1st April 2014 Tiaa would be taking over the LCFS contract for the Trust and welcomed Mr Wilkinson, the Tiaa LFCS manager, to the meeting.

Mr Wilkinson circulated a briefing note explaining how the contract would be taken forward and noted that it had been agreed that Mazars would continue to take forward the Crown Court case and would also support the NHS Protect follow up review on 8th May as it related to work in 2012/13 but Tiaa would pick up any outcomes from the review.

The Committee noted the Local Counter Fraud Service report and the handover arrangements being put in place between Mazars and Tiaa.

7. Local Counter Fraud Service Tender

Mrs Harris reported on the procurement process undertaken for the Local Counter Fraud Service which had resulted in the appointment of Tiaa as the new service providers from 1st April 2014.

The Committee noted the appointment of Tiaa as the providers of the Local Counter Fraud Service to the Trust with effect from 1st April 2014.

8. Internal Audit

a) Progress Report

Mr Fyfe reported that the four final reports had been issued since the last meeting:

Critical Financial Assurance Pay – Part 1 – Limited Assurance

Mr Fyfe advised that this audit would form part of the Head of Internal Audit opinion and related to the period April to September 2014. The key issues highlighted referred to locum payment authorisation and incorrect authorisation on timesheets. He was aware that improvements had been put in place from 13th January including a new process and time sheet and Part 2 of the review would confirm whether these new controls were operating satisfactorily.

Medical Staffing Revalidation – Significant Assurance

Mr Fyfe reported that the Trust could be held up as an example of good practice with the revalidation team providing excellent support to consultants. He noted that the team had a target of 57 consultants to achieve revalidation in the current year and 53 had been achieved by the end of December with an anticipated further 19 to be achieved by the end of March. The challenges going forward would be maintaining the number of appraisers and the lack of a single robust national electronic and web-based medical revalidation management system to effectively facilitate the management of appraisals and medical revalidation.

Safer Staffing – Significant Assurance (Qualified)

Mr Fyfe reported that the audit had been carried out in November and December and a significant assurance opinion could be provided that there was a process in place for maintaining safe nursing staffing levels on a daily basis and ensuring that clinical staff were deployed in an effective way. However, the opinion was qualified as at the time of the audit the number of vacancies, maternity leave, long term absences and slowness of the recruitment process left ward matrons struggling and under pressure to fill the shifts, a fact born out in the high use of temporary staffing.

It was recognised however that since the audit the recruitment and bank processes had been improved and more nurses had been recruited.

Discussion took place on nurse staffing levels and Mrs Webster reported that the staffing levels had been reviewed and were in the process of being signed off organisationally and would be coming to the Trust Board for approval on 27th March.

Information Governance Toolkit – Limited Assurance

The audit was undertaken in December and at the time it was not possible to provide assurance that 8 out of the 15 standards would achieve Level 2.

Mr Fyfe reported that the majority of the field work would be completed by the end of March for the remaining audits in the current year.

The Committee noted the Internal Audit progress report.

b) Draft Internal Audit Plan for 2014/15

Mr Fyfe advised that this was the first draft of the plan for 2014/15 and note that it included the core areas required to inform the Head of Internal Audit Opinion at the year end and areas identified either from the Risk Register, Board Assurance Framework, or experience at other Trusts.

Mrs Harris reported that the draft plan had been reviewed by CLT and agreed that it covered the risks being carried in the organisation.

It was agreed that Mrs Harris, Dr Harrison and Mrs Wells would meeting with Tiaa to finalise the plan in readiness for it to be approved at the next meeting. **VH/AH/ LW/MF**

c) Audit Recommendations Tracker

Mrs Wells presented the tracker and noted that there had been an in-depth review of the tracker led by the Corporate Governance Manager and out of the 48 Tiaa recommendations still open only 5 actions were now rated red with a good rationale as to why. In relation to BDO audits 8 recommendations were still active but none were rated red.

Mr Nealon understood that there was a significant maintenance backlog and he was concerned that the Trust had an ageing infrastructure. Mrs Harris noted that this had previously been reviewed by the Finance and Investment Committee and suggested that estates be requested to provide an update on the backlog maintenance position to that Committee. **VH**

The Committee noted the progress made in implementing audit actions.

9. External Audit

a) External Audit Plan 2013/14

Mr Lloyd-Taylor presented the external audit plan and noted that he had summarised his view of the significant risks on pages 5 and 6.

He detailed these as management override, revenue recognition, revenue and going concern in terms of setting a deficit budget. He anticipated that there would be a qualified opinion on use of resources as had been the case for the last 3-4 years but he would not be issuing a Section 19 statement as this had been undertaken last year.

Mrs Harris advised that the Trust was forecasting a year end deficit of £23.1m for 2013/14 and noted the issues raised by Mr Lloyd-Taylor.

The Committee noted the external audit plan for 2013/14.

b) Progress report

Mr Etherington reported that the internal controls work would commence the following week and he would be working with Tiaa in relation to their audits in relation to Critical Financial Assurance. He had flagged this area as amber due to prior years' concerns around payroll.

He advised that the team would arrive in the Trust from mid-April to work on the financial statements, consolidation schedules and annual report. The review of the Quality Account data would commence at the same time and he would discuss with Mrs Wells the areas to be reviewed but this would include the FFT scores. **JE/LW**

The Committee noted the progress report.

c) Planning Letter 2014/15

Mr Lloyd-Taylor advised that the proposed fee would be as set by the Audit Commission and would be the same as for 2013/14.

He noted that BDO's appointment had been extended to cover 2014/15 and he anticipated that there would be a decision in two to three months' time on what would happen in 2015/16.

The Committee noted the Planning Letter for 2014/15.

10. Payroll Authorisation Project – Payroll Review

Mrs Harris reported 100% compliance had been achieved with sign-off of substantive staff against budget by the end of February and the payroll team was currently working on a more streamlined approach for sign-off going forward.

She advised that LCFS would be undertaking testing of the departments that had provided late confirmation and a random sample of other departments. Results of that work would be reported through the regular LCFS report.

She reported that the project had now completed with the recommendations addressed and Tiaa would be testing the payroll controls for the last six months of the year to see whether any weaknesses still existed.

11. Draft Annual Governance Statement

Mrs Wells presented the first draft of the Annual Governance Statement and advised that some of the data could not be provided until after the year end.

The Committee agreed the first draft of the Annual Governance Statement.

12. Changes in Accounting Policies

Mrs Harris reported that there were a number of accounting changes in 2013/14, some of which would require additional analysis before the impact of the changes could be confirmed.

She advised that it was not the intention to consolidate the charitable funds due to their immaterial value and this was based on the annual accounts guidance and the external auditor's advice.

She reported that the transfer of legacy balances from the PCTs would have an impact on 2013/14 finances and these could result from under or over accrual, provisioning, debtors transferred and impairment or revaluation of long term asset.

She advised that an additional disclosure would required in the accounts in relation to the impairment of assets which had arisen as a result of a valuation by the District Valuer with effect from 1 April 2013. This had resulted in a charge to the income and expenditure account of £10 million, of which just over two-thirds related to the community assets transferred from the former PCTs with effect from 1 April 2013. The £10 million did not affect financial performance

She noted that further disclosures were required around the green agenda both in the financial statements and in the annual report.

The Committee noted the changes in Accounting Policies.

13. Tenders and Waivers Report

Mrs Wells presented the report and noted that it contained the waiver relating to the extension of the internal audit contract.

The Committee noted the report.

14. Review of declarations of interests, gifts, hospitality, sponsorship and ex gratia payments

Mrs Wells presented the report and noted that some pro-active work was being undertaken in relation to compliance with declarations of interest and ex gratia payments.

The Committee noted the report.

15. Information Governance Toolkit (IGT) Year End Submission 2013/14

Mrs Wells reported that the IGT submission had been reviewed by the Information Governance Steering Group which supported the submission at 69% with four requirements at level 3.

She noted that the internal audit report had been disappointing, due primarily a timing issue, as the Trust's Information Governance Manager was exceptionally diligent and had developed the process for compiling information for the IGT Toolkit with supporting governance processes and Mrs Wells was confident in the data being submitted.

The Committee approved the IGT Year End Submission for 2013/14 at 69%.

16. Date of Next Meeting

Wednesday, 4th June 2014, at **10.00 am, Room 6, Education Centre, Conquest Hospital** (please note change of time and room venue) – **single item meeting** to agree the Annual Report, Financial Accounts and Quality Account for 2013/14.

The Non-Executive Directors will meet privately with the Auditors at the end of the meeting.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 4th June 2014 at 10.00am In Room 6, Education Centre, Conquest Hospital

Present: Mr Charles Ellis, Non-Executive Director (Chair)
Mrs Sue Bernhauser, Non-Executive Director
Mr Stuart Welling, Trust Chairman (in his capacity as a qualified accountant)

In attendance Mr Richard Sunley, Chief Operating Officer
Mrs Margaret Musenja, (Interim) Assistant Financial Controller
Mrs Vanessa Harris, Director of Finance
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary
Mr Leigh Lloyd-Thomas, BDO
Mr Mick Fyfe, Account Manager, TiAA
Mr Steffan Wilkinson, Counter Fraud Manager, TiAA
Mr Stephen Hoaen, Head of Financial Management Finance
Gary Bryant, Deputy Director of Finance
Mike Townsend, TiAA
Mrs Christina Morphew, Business Administrator (minutes)

Action

1. Welcome and Apologies for Absence

Mr Ellis opened the meeting and noted that a quorum was present.

Apologies for absence had been received from:

Darren Grayson, CEO
Mr Barry Nealon, Non-Executive Director
Dr Amanda Harrison, Director of Strategic Development & Assurance
Dr David Hughes, Medical Director – Clinical Governance
Dr Janet McGowan, Associate Medical Director – Clinical Audit

2. Minutes

i) The minutes of the meeting held on 5th March 2014 were reviewed and agreed as a correct record.

ii) Matters Arising

3 -*Board Assurance Framework*
Mrs Wells reported that the gap in control on recruitment had been rated amber following Audit Committee review.

8b – Draft Internal Audit Plan for 2014/15
Mrs Wells reported that a meeting with TiAA had taken place to finalise the plan. For discussion and approval - Item 7.

8c – Audit Recommendations Tracker
Mrs Harris reported that an update had been provided by estates on the backlog maintenance at Finance & Investment Committee 28.05.2014.

9b- External Audit Progress Report
A meeting has taken place with the Company Secretary to discuss and review the Quality Account data.

3. Quality Account 2013/14

Mrs Wells presented a paper on the Quality Account to the Committee, stating that the Trust had complied with mandatory guidance. This document was due to be submitted to the Secretary of State by 30 June. Mr Lloyd-Thomas advised that BDO were satisfied that the document met statutory requirements and was not materially inconsistent with their knowledge of the Trust. Two indicators VTE and CDiff had been subject to spot check audit and this was just being finalised. .

It was noted that the national indicator for C-Diff cases per 1000 bed days would not be published until July. The Trust had a methodology for calculating the required data and Mr Lloyd-Thomas confirmed the auditors were satisfied that this was robust and tracked the national data.

The Committee noted that the Quality Account was compliant with statutory requirements and would be submitted by the 30 June deadline.

4. Annual Accounts & Report 2013/14

a) ISA260 BDO Annual Governance Report on the Annual Accounts 2013/14

Mr Lloyd-Thomas presented the report and noted that in respect of the financial statements no material misstatements had been identified.

He advised the Committee of six unadjusted audit differences, of which two related to errors identified in previous years. Subject to satisfactory completion of outstanding work, he anticipated issuing an unqualified true and fair opinion on the financial statements for the year end 31 March 2014.

He highlighted the following areas:

Control areas
Adequate controls are noted and progress, specifically around payroll control improvement has been made. No significant deficiencies in internal controls were identified but a number of improvement areas had been discussed with management. It was noted that work is ongoing in respect of the authorised signatory lists.

Use of resources
The Trust's deficit position for 2013/14 and future budgeted deficit position and requirement for PDC was noted. The audit report would therefore be qualified in respect vfm because of the Trust's ability to put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Going Concern **LL-T/SW**
Mr Lloyd-Thomas confirmed that auditors were satisfied that appropriate disclosure had been included in the financial statements to support the basis of preparation as a going concern.

The wording of the disclosure in respect of vfm was discussed and it was agreed that Mr Welling and Mr Lloyd-Thomas would agree appropriate wording.

Mrs Harris clarified that the deficit amount referred to on page 1 included the adjustment for impairment. The deficit for the year excluding the impairment adjustment was £23.1m.

Land & Buildings Fair Values
It was noted that a full revaluation of all land and building was carried out at 1 April 2013 by the District Valuer and valuation movements had been correctly accounted for in line with the requirement of the NHS Manual for Accounts.

Classification of property, plant and equipment
Capital expenditure of £1.757 million for the Endoscopy Unit was incorrectly recorded under buildings rather than assets under construction.

A discussion took place around the classification of Duncan House, currently used as office accommodation.

The Auditors reported that this had been misclassified as a dwelling and should be office accommodation. Mr Welling thought it appropriate to be classified as a dwelling, as any sale would be in this category.

Capitalisation of CT Scanner Rental Costs
The new CT scanner, was originally rented but then purchased by the Trust. Rental costs of £226,000 were capitalised and auditors have included this as an unadjusted error. Mrs Harris acknowledged the Auditors opinion, however the Trust considered the accounting treatment appropriate.

Remuneration Report Disclosures
The report reflected compliance with MfA requirements. Mrs Harris advised that further changes would be made to clarify the calculations and to provide a brief statement to clarify Directors pay, specifically taking into account pension benefits which are now added within the total amount disclosed.

Cut Off & Year End Close Procedures
Mrs Harris confirmed that in future there would be a de minimis limit of £1,000 for accruals.

Directors Disclosures
Mrs Harris confirmed that each director had confirmed they had taken action in order to make themselves aware of any relevant audit information and that they had disclosed information to auditors as appropriate.

The Audit Committee noted the external auditor's Annual Governance Report for 2013/14, the unqualified opinion on the financial accounts and the qualified conclusion on the use of resources.

b) Annual Report including Annual Governance Statement for 2013/14;

Mrs Wells confirmed that the document followed national guidance and revisions had been made in line with auditors' recommendations. It was noted that Mrs Harris would be reviewing and revising the Remuneration Report (as noted above).

Mr Lloyd-Thomas advised that following final sign off, adjustments to the Annual Report were not permitted, apart from layout changes and this was noted.

The Significant Issues section of the Annual Governance Statement was discussed. Mr Welling suggested and it was agreed, to move the obstetric and paediatric update to another section of the report as the Trust had managed this appropriately and it was not a significant issue as per the guidance. **LW**

The Audit Committee approved the Annual Report and Annual Governance Statement for 2013/14 subject to the amendments to be carried out by the Company Secretary.

c) *Annual Account & Associated Certificates & Summary Financial Statements 2013/14*

Mr Hoaen gave a detailed breakdown on the Trust accounts.

It was agreed an addition would be made to the Chief Executive's Statement of Responsibility in respect of the variance to the planned deficit. Mr Welling and Mrs Harris would address outside of the Committee, **SW/VH**

The MARS figures would be checked as a variance had been noted by Committee members. These were subsequently confirmed as correct. Mr Welling queried whether the MARS packages had been approved by the TDA and Mrs Harris provided assurance that the Trust had followed due process.

Mrs Berhauser queried whether the figures around revenue from patient care were correct, as an increase had been perceived around overseas patient care. Mr Hoaen responded that historically this had been a weakness, but relevant systems and processes were now in place to recover income. Mr Hoaen also stated that a chip and pin initiative was currently being looked into which would simplify recovery of funds.

Mrs Harris reported that the accounts had been prepared on the going concern basis as discussed at the Board Meeting the previous day. The signed contract with the commissioners provided the continuity of service provision into the future and a cash application would be made to the Trust Development Authority for PDC. In the meantime temporary cash would be drawn down as per the 2014/15 Plan.

Mr Ellis thanked Mrs Harris and her team for their work in preparing the accounts.

Resolved:
The Audit Committee approved the Annual Accounts and associated certificates for 2013/14 and noted that they would be signed by Mr Sunley on behalf of the Chief Executive.

d) Internal Audit Annual Report & Head of Internal Audit Opinion for 2013/14

Mr Townsend reported that he had provided a significant assurance opinion for the Trust in respect of the internal controls that had been reviewed during the year.

He noted that the report provided a summary of the audits undertaken during the year and the assurance opinions provided. Individual reports were considered in detail at each Audit Committee.

Mrs Webster queried the Infection Control audit as the wording implied non-compliance, but the data was perceived as robust. An action plan had been put in place and should be reflected in the documents and there had been a reduction in CDiff. Mr Townsend responded that compliance with Trust policies had proved an issue and Mr Townsend and Mrs Webster would discuss outside of the Committee. **AW/MT**

The Committee noted the Internal Audit Annual Report and the Head of Internal Audit's Opinion of Significant Assurance for 2013/14

5. **LCFS Annual Report 2013/14**

It was noted that the LCFS Report had been prepared by Mazars so the document was presented by Mrs Harris. The report summarised the counter fraud activity of the Trust during the 2013/14 financial year, together with any key findings and/or the contribution made to countering fraud within the Trust.

Mr Wilkinson was at the meeting, representing the new counter fraud provider TiAA.

The Committee noted the LCFS Annual Report 2013/14.

6. Audit Committee Annual Report 2013/14

Mrs Wells presented the Audit Committee Annual Report on behalf of Mr O'Sullivan, former Audit Committee chair.

The Committee approved the Audit Committee Annual Report 2013/14 for submission to the Trust Board.

7. Internal Audit Plan 2014/15

Mr Townsend presented the Internal Audit Plan for 2014/15.

The Committee approved the Internal Audit Plan for 2014/15.

Date of Next Meeting

Wednesday, 9th July 2014, at 9.30am in the Committee Room, Conquest Hospital

Signed: ……..

Date: ……

East Sussex Healthcare NHS Trust

Finance and Investment Committee

1. Introduction

Since the Board last met a Finance and Investment Committee has been held on 25 June 2014. A summary of the items discussed at the meeting is set out below.

2. Performance Report – Month 1

The Committee received the month 1 Performance Report which detailed the Trust's performance for the month of April 2014 against quality and workforce indicators and highlighted the key issues.

It was noted that Admitted and Non-Admitted Elective Referral To Treatment (RTT) targets did not achieve target and this included 16 specialties. Final month 1 Cancer performance showed the Trust failing against 2 week wait and 2 week wait - Breast Symptoms. Diagnostic waiters remained above the 1% ceiling for the third consecutive month.

There were 5 C-Difficile cases reported in month 1.

Mr Sunley gave an update on the recovery plans that were put in place around diagnostics, A&E performance and Referral to Treatment and explained the difficulties with pressures within the system.

The Committee sought assurance that each area of underperformance had a specific timeline and process for recovery.

3. Finance Update – Month 2

Mr Astell presented the Finance Report for Month 2 and highlighted the key issues. It was noted that financial performance year to date was a run rate deficit of £4.382 million which was £153,000 favourable to plan. Income and expenditure were both slightly under plan. The cost improvement programme had achieved £2.102 million of savings to date, which was ahead of plan by £359,000.

Total income received during May was £111,000 below planned levels increasing the year to date variance to £326,000 below plan.

4. Long Term Financial Model/Integrated Business Plan Refresh

Mr Astell reported that the Trust had submitted a 5-year Long Term Financial Model (LTFM) together with the Trust's Integrated Business Plan (IBP) to the TDA on 20 June 2014.

At its last meeting on 28 May the Finance & Investment Committee had reviewed the assumptions and modelling that supported the 5-year financial plan for the Trust. The Committee had asked that in making a submission to the TDA it should be made clear that there were significant risks to achieving the outlined position, in particular delivery of the level of planed savings.

Also, that making planned predictions over a 5 year period could not be done with any accuracy bearing in mind the range of reviews being undertaken to bring about an agreed strategy for the overall Health Economy.

The risks had been highlighted in the IBP and at the routine Integrated Delivery Meeting with the TDA on 29 May. The Portfolio Director had confirmed that the 20 June 2014 submission was understood to be an 'as is' position which would, in due course, be overtaken by a Plan informed by the outcome of the Challenged Health Economy work.

5. Turnaround Update

Mr Murphy provided an update on the Turnaround Programme, noting the successful delivery of plans in the first two months. He indicated that he expected month 3 also to be in line with plan but cautioned that there were more significant risks to delivery in the second quarter. That would be the point at which an increased level of savings was planned from bed number reductions, theatre efficiencies and the rationalisation of clinical administration. He expected there to be some slippage on the bed reductions and theatre plans. He stated that some beds would need to be kept open to meet the RTT pressures mentioned earlier. However, this could potentially be offset by the national funding being made available to help meet this target. He concluded by expressing confidence that the Trust would deliver its CIP targets across the year.

6. EBITDA Quarterly Report – Q4

Mrs Brandt presented the 2013/2014 Qtr 4 EBITDA statement and the 2013-2014 quarterly EBITDA comparison statement.

The Committee noted the 2013/14 Q4 EBITDA deficit position for the clinical units and the number of service lines that had a negative EBITDA.

7. Capital Programme Quarterly Report

Mr Wells gave an update on the performance of the capital programme as at the end of May and provided detail on the risks arising from the need to reduce capital expenditure due to limited capital resources.

It was noted that at the end of May the year to date capital expenditure amounted to £0.8 million and the capital programme had an over planning margin of £0.7 million.

As a result of the need to reduce capital expenditure due to limited capital resources the Capital Approvals Group (CAG) carried out a review of the capital expenditure considered high priority for 2014/15. The review looked at the key areas of high priority medical equipment, radiology equipment, IT, estates backlog maintenance and infection control (details of which were set out in the report). Following discussion with the leads for each of the key areas, who are members of the CAG, the highest priority expenditure was agreed and included in the 2014/15 Capital Programme. The leads, who are members of the CAG, will keep all areas under review and, if necessary, reprioritise and reallocate resources to meet need.

8. Challenged Health Economy Update

Mr Grayson provided a progress report on the work being undertaken with PWC to develop a fully aligned five-year plan. He stated that the final meeting of the Programme Board, chaired by the NHS England/Trust Development Authority, was due to take place the next day and that he would report to the next Committee meeting on progress

9. Specialist Contract Update

Mr Inman gave a presentation on the risks arising from the Trust's contract with NHS England (NHSE).

As a result of the funding constraints NHSE has contracted for a lower level of activity/high cost exclusions than is likely to arise based on past experience. As a consequence, it is likely that the contract will over perform in activity/exclusions (primarily drugs) terms and NHSE have advised that they will use all available contract levers to manage the overall contract value. The planned value of CQUIN and DQUIP funding under this contract is also at risk. Mr Inman described the mitigations the Trust can used to manage the risk.

10. Market Testing Update

Following discussion at the Finance & Investment Committee and the Corporate Leadership Team (CLT), it was agreed that there would be clarification regarding the pace of the services to be considered for market testing.

Mr Horne presented an update paper which had identified recommendations for the Committee to consider, and gave a further update on progress.

Mr Horne asked the Committee for a decision on the following three issues:

- That the market testing of hard FM services is delayed until 2015/16.
- That Corporate Directors should be given time to deliver current turnaround plans and further develop their 2015/16 proposals, which will need to incorporate efficiency savings of 10%, prior to market testing.
- That priority is given to the development of service specifications leading to the development of a transformation plan for soft FM services, where a decision can be made on market testing.

11. Windows 7 Upgrade compatibility – Progress Report

The Committee received a progress update on the proposed migration of Trust PCs and laptops from Windows XP/Office 2003 to Windows 7/Office 2010 and the associate software application compatibility testing. The Committee noted the risks and benefits of the proposed migration.

12. Community & Child Health System - Project Update

The Committee received an update on progress of the Community & Child Health System (SystmOne) project.

Mr Deal explained that some of the 'go live' dates had been re-scheduled, however the project was still on target for completion in January 2015.

13. Clinical Laboratory Diagnostics Managed Service Contract

Mr Bourns and Ms Costigan presented an update on progress in procuring the Clinical Laboratory Diagnostic Managed Service Contract. The Committee were assured that due process had been undertaken during the evaluation of the bidder submissions and the development of the associated Draft Full Business Case (FBC) in preparation for the submission of the Contract Award and final FBC to the Finance & Investment Committee and Trust Board in July 2014.

The Committee was asked to approve the governance process, including the submission of final documentation to the Trust Development Authority post approval by the Trust Board.

14. Making Better Use of Government Resource Services Procurement & Service Delivery Platforms

Mr Astell presented a letter from Richard Douglas at the Department of Health (DH) inviting the Trust to take part in a review process.

It was noted that the DH, led by its Commercial Division, was examining the scope for increased use by Trusts of the DH's and Cabinet Office's central support platforms that have been put in place for NHS bodies to conduct their commercial business more efficiently and more cost effectively.

The first step to launching the review was for the Trust to create a time limited Task and Finish Group. This is being led by the Finance Director.

15. Work Programme

The revised 2014 work programme was reviewed.

15. Conclusions

The Trust Board to note:

- The Committee reviewed the Performance Report for month 1 and the recovery plans that had been put in place.
- The Committee noted the month 2 financial position
- The Committee noted that the Trust had submitted a 5-year Long Term Financial Model (LTFM) together with the Trust's Integrated Business Plan (IBP), to the TDA on 20 June 2014.
- The Committee noted the Turnaround progress
- The Committee noted the EBITDA Q4 position
- The Committee noted the current performance of the capital programme and the risks arising from the deferral of capital schemes in order to bring the capital programme into balance. The Committee noted that the Capital Approvals Group will carry out a monthly review to monitor any emerging issues that might result in patient or other risk and if necessary reprioritise and reallocate resources to meet need.
- The Committee noted the Challenged Health Economy update
- The Committee noted the Specialist Contract update
- The Committee discussed the market testing update and agreed to the recommendations
- The Committee noted the progress made on the proposed migration from Windows XP/Office 2003 to Windows 7/Office 2010 and noted the risks and benefits of the proposed migration.
- The Committee noted the progress made on the Community & Child Health System (SystmOne) project.
- The Committee reviewed the draft FBC documentation, noted and prepared for the submission of the contract award report and FBC to its meeting in July
- The Committee noted the Department of Health request to participate in a review process to make better use of Government Resource Services Procurement & Service Delivery Platforms

Barry Nealon

Chair of Finance and Investment Committee

8 July 2014

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 28 May 2014 at 9.30am in the Committee Room, Conquest

Present
Mr Barry Nealon, Chair
Professor Jon Cohen, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mrs Vanessa Harris, Director of Finance
Mr Richard Sunley, Deputy Chief Executive/COO

In attendance
Mr Andrew Murphy, Turnaround Director (for item 5)
Mr Dave Wells, Head of Financial Planning (for item 7)
Mr Ian Humphries, Interim Estates & Facilities Advisor (for item 10)
Miss Chris Kyprianou, PA to Finance Director (minutes)

1.	**Welcome and Apologies** Apologies were received from Stuart Welling, Darren Grayson, David Hughes and Philip Astell.	**Action**
2.	**Minutes of Meeting of 30 April 2014** The minutes of 30 April were agreed as an accurate record subject to the following amendments: Mrs Stephanie Kennett to be changed to Ms Stephanie Kennett Page 4 item 6 – Para 5 – should say Professor Cohen Page 6 item 8 – Para 6 – should say ....the Audit Chair who confirmed.....	
3.	**Matters Arising** <u>(i) Representation from Operations</u> Mrs Harris confirmed that Mr Grayson had taken up the issue raised at the last meeting regarding operations being represented at these meetings. <u>(ii) 2013-14 Reference Costs Submission</u> Mrs Harris confirmed that reference costs covered all trusts including Mental Health, Ambulance, etc.	

	(iii) Community Rebasing Project Update Mrs Harris reported that the matrix was not currently available as it was still being revised; however it would be available for the next quarterly update. (iv) Market Testing Update A paper was due to be presented to CLT in due course. (v) Radiotherapy Treatment Centre Outline Business Case It was noted that the issue regarding additional car parking and the potential cost to the Trust was still under discussion. Mrs Harris reported that there was a new Project Advisor from BSUH in place who was due to meet with Mr Saunders and herself the following week.	**PA**
4(i)	**Performance Report – Month 12** The Committee received the month 12 Performance Report which detailed the Trust's performance against the National Performance Framework metrics, as described in the National Operating Plan for 2013/14, and performance against other key trust metrics as well as activity and workforce indicators. It was noted that as the trust move into reporting for 2014/15, it will be reporting in line with the new TDA Accountability Framework rather than the National Performance Framework. This reporting structure also takes account of the Board Level reporting discussions which were undertaken earlier this year. The detailed reporting structures, data definitions and weighting of the metrics were currently being finalised by the TDA and were expected to be agreed on 15th May. Once these are received the internal report will be developed and shared for future reporting. It was noted that Month 12 performance fell below the required standard and the Trust remained in "Under-Performing" Status. Admitted and Non-Admitted Elective Referral To Treatment targets did not achieve target and 19 specialties failed to achieve. Final month 11 Cancer performance shows the trust failing against 2WW and 2WW- Breast Symptoms. Diagnostic waiters remained above the 1% ceiling for the third consecutive month. There were 4 C-Difficile cases reported in month 12. Final outturn for	

	2013/14 was 43 against a target outturn limit of 25. The Committee discussed the disappointing operational performance over the last few months of the year. The 18 week backlog is being cleared but this will take several months to fully achieve. It was noted that the increase in breast related referrals was driving a higher demand for services. Performance against the diagnostic target should be recovered by the end of May. The Committee sought assurance that the rigour of financial control was not prejudicing the delivery of the Trusts operational performance. The issue of balancing quality/safety/finance was discussed and is under constant review. The matter will also be raised at the Board for discussion. The Committee asked that an operational recovery plan be brought back to the next meeting which should set out the improvements already made and a timetable for achievements of compliance with operational targets. The Committee also asked that, if timescales permitted, the Board cover sheet for the June meeting be amended to reflect more fully the performance issues. **Action** **The Committee noted the Performance Report for month 12.**	**BN** **RS** **RS**
4(ii)	**Finance Update – Month 1** Mrs Harris presented the Finance Report for M1. Compared to the Trust Board provisional budget the Trust performance in month 1 was a run rate deficit of £2,365k, with a small favourable variance compared to plan of £44k. Income was £252k below plan and this shortfall was offset by an under spending on costs of £208k. The Committee received a commentary on the financial position which highlighted the key issues and risks that may impact on the delivery of the Trust's financial plan. Cost improvements of £1.0m were achieved in month 1, a favourable variance against plan of £0.2m. The cash balance at the end of April was £3.8m (4 days' operating costs). The Committee reviewed the reasons for the small pay overspend in the commercial and corporate areas and were assured that this could be recovered. It was noted that, in spite of beds being available, income from the private patients unit was less than plan and this underutilisation of resource would be kept under review. **Action** **The Committee noted the Month 1 financial position.**	

5.	**Turnaround Update** Mr Murphy presented a M1 report on Turnaround delivery. Performance in April against the CIP target was £196k better than planned. It was noted that a step up in CIP savings was expected from M4 onwards. This was dependent on a reduction in bed numbers as well as a reduction in theatre sessions as a result of productivity and rescheduling changes. These schemes were still subject to discussion and Quality Impact Assessments and the risks around the delivery of the schemes were discussed. **Action** **The Committee noted the Turnaround update**	
6.	**Financial Plan and Annual Budget 2014/15** Mrs Harris presented the annual budget paper that had been prepared for the Board to consider at its meeting on 3 June 2014. The Finance and Investment Committee were asked to review and discuss and recommend the annual 2014/15 budget to the Board. The paper was intended: - To advise the Board on the short to medium term financial context and the assumptions used in developing its plans for 2014/15 and beyond; - To seek Board approval for the revenue and capital plans for 2014/15; and - To highlight the requirement to produce and submit a 5-year plan. The Trust set a planned deficit for 2013/14 of £19.4m. This deficit was based on delivery of a cost improvement programme of £20m. Slippage on the savings programme of £2.5m and cost pressures of £1.2m meant that the outturn for that year was a deficit of £23.1m. The Trust needs to return to 'run rate' surplus as swiftly as possible to demonstrate that it can continue to provide high quality services in a financially sustainable way and achieve independent Foundation Trust status in the foreseeable future. The plan for 2014/15 was a deficit of £18.5m after application of the internal cost improvement programme of £20.4m and after providing for known cost pressures and inflationary increases. The Trust had reached a contract agreement with its CCG commissioners for 2014/15 which recognised the heavy burden of risk on both provider and commissioner within this challenged health economy and the need for a collaborative approach to managing that	

	risk. It was noted that there were significant risks to the delivery of the plan arising from the pressures and uncertainties faced by NHS providers in general and those within the local 'Challenged Health Economy' in particular. The structure of contractual arrangements agreed with local commissioners will help to reduce the income risk relative to 2013/14. The Capital Programme for 2014/15 has had to be scaled back by the Capital Approvals Group to match the funding available. This had meant limiting spend on replacement medical equipment, backlog maintenance and IT. The Committee asked that details of items that had been requested, but excluded from the 2014/15 Programme because of lack of available capital funding, be reported to its next meeting. The Committee noted and agreed the going concern statement. **Action** **The Committee recommended that the Board is asked to** • **Note the short term medium term financial context for the Trust and the assumptions used in developing its plans for 2014/15 and beyond;** • **Note the indicative plan for 2015/16;** • **Approve the revenue financial plan and budget for 2014/15; and** • **Approve the capital programme for 2014/15** • **Note the requirement to develop and submit a five-year plan to the TDA by 20 June 2014**	**VH**
7.	**5 Year Financial Plan Update** Mr Wells updated the committee on the proposed 5-year Long Term Financial Model (LTFM) which is required by the Trust Development Authority (TDA), together with the Trust's Integrated Business Plan (IBP), by the 20th June 2014. It has been agreed with the TDA that the LTFM should be prepared on the basis of the "as is" business model of the Trust pending conclusion of the Challenged Health Economy work. Once that work has concluded there will be a requirement to submit a LTFM that reflects agreed outcomes. This plan was intended to show how the Trust can move out of recurrent financial deficit into a sustainable surplus. The Plan was largely very similar to the LTFM which was agreed and submitted to the TDA in January 2014. The main change being the consequential effect of the 2013/14 deficit being larger than originally planned. The proposed 5 year financial plan (LTFM) had been modelled at a high level on a view of the expected or most likely range of	

	assumptions. It also needed to demonstrate that the Trust has a credible plan to achieve financial sustainability and to support any further requests for transitional cash financing. The TDA do not require the submission of a downside scenario in this planning round. The assumptions outlined in the report start with the income and expenditure projections contained in the 2 year plan submitted to the TDA on 4th April 2014. The base year is the provisional 2014/15 budget approved by the Trust Board in March 2014. Future year projections are based on the planning assumptions set out in the report and on the supporting assumptions schedule. The cost improvement target is £20.4m in 2014/15 and £20m in each of the next three years, reducing to £16m in in the final year of the planning period. This represents between 5.2% and 5.4% of baseline expenditure over the first four years reducing to around 4.4% in the final year. The projections indicate that the Trust could, based on the assumptions made, achieve a breakeven run rate by 2017/18. However, there are numerous risks to delivering this position and what has been modelled does present a significant challenge. Pending the outcome of the Challenged Health Economy work the Committee agreed that the submission based on the "as is " model should be made on 20 June but asked that it was made clear that there were significant risks to achieving the outlined position in particular delivery of the level of planned savings. To achieve levels of savings of 5%+ year after year would need system change. The Committee emphasised that making planning predictions over a 5 year period could not be done with any accuracy bearing in mind the range of reviews being undertaken to bring about an agreed strategy for the overall Health Economy. **Action** **The Committee noted:** - **The projections indicate that the Trust could, based on the assumptions made, achieve a breakeven run rate by 2017/18. However, there are numerous risks to delivering this position and what has been modelled does present a significant challenge.**	**VH**
8.	**Challenged Health Economy (CHE) Update** Mrs Harris presented an update paper provided by Amanda Harrison on the Challenged Health Economy (CHE) work. The CHE work had been commissioned nationally by NHS England, the Trust Development Authority (TDA) and Monitor and was focussed on eleven economies in England that had long standing financial problems.	

	The following progress so far was noted: • Size of the commissioning and provider gap has been identified • Commissioning intentions have been developed at a high level - including indicative levels of future activity at specialty level based on 'best in class' models of primary and community care. These intentions demonstrate that the commissioning gap can be closed. It was noted that plans for the delivery of these primary and community care models and the required activity reductions now needed to be designed through clinically led care design groups and tested for their ability to deliver the activity changes identified. The work would also need to describe the configuration of primary and community services based on population groupings. The Committee noted that the impact on the sustainability of acute provision and providers of the planned changes in activity was currently being modelled. Mrs Harris reported that she and other Senior Trust Executives had attended a recent CCG/Provider/PWC meeting in Lewes to discuss models for going forward. It was noted that PWC were due to submit a further interim report to the TDA/ NHS England/Monitor on 27 May. **Action** **The Finance and Investment Committee noted the update.**	
9.	**Community Rebasing Project Briefing – Quarterly Update** The Committee received a progress update on the status of the Community Rebasing Project. It was noted that the cost matrix for community services needed to be refreshed to reflect outturn for 2013/14 and a more robust basis for attribution of overheads. While work on updating costs and improving data quality was continuing in the background, the emphasis of this project was now shifting towards the rewriting of service specifications based on output measures and the development of 'unit of service' currencies to support service line reporting and, potentially, cost per case reimbursement. The report indicated that discussions were to be held at the Corporate	

	Leadership Team with a view to formalising the project management and strengthening the resourcing of this important project. **Action** **The Finance and Investment Committee noted the further progress on this project and the associated opportunities, risks and challenges involved.**	
10.	**Estates Matters** Mr Humphries was welcomed to the Finance & Investment Committee to provide an update on key estates matters that he was involved in. Mr Humphries reported that Balfour Beatty had been commissioned to produce an Estates Strategy before he came to the Trust and their draft proposals had only been received by the Trust that morning. It was noted that these would be reviewed and assessed later that day. Mr Humphries gave the Committee some background to his experience with Estates Strategies. He reported that he had been heavily involved with reviewing the Trust Backlog Investment requirement and the risk register which accompanies this. Mr Humphries reported that, in his view, a business critical condition survey was required in parallel with an investment plan to deliver what was needed to maintain the critical business. The Chair asked if the business criticality issues had been identified for the current year. Mr Humphries reported that a capital bid requirement had been produced which focuses on a few key areas such as power, minimisation of infection risks and statutory compliance issues, as outlined in the 2014/15 capital programme (agenda item 6 above) being presented to the Trust Board at its meeting on 3 June. Mr Humphries said he had been focusing on some business cases and, in particular, an energy savings scheme with Schneider. Mr Humphries reported that the Trust had worked with Schneider and a revised proposal had been received, further revenue clarification was being sought. Mr Humphries reported that he had been reviewing some of the areas where Commercial Services had been operating external supply contracts. He has produced a report which will shortly be presented to the Corporate Leadership Team. Mr Humphries said he had also been involved in the market testing work and would be contributing towards the discussions around the timing and alignment of the proposals around hard FM.	

	Action **The Committee noted the update on Estates Matters.**	
11.	**IT Projects Update** The Committee received a progress report on the proposed implementation of the key IM&T projects due to be implemented in 2014/15. The report provided a summary status position of the following projects: • Community and Child Health system • NHS Mail Migration • Southern Acute Programme - Electronic Document Management and Clinical Portal • Electronic clinical correspondence • Acute PAS upgrade • VitalPac patient bedside monitoring • Psuedonymisation • Windows 7 / Office 2010 migration All core projects were being facilitated by the IT Project Office which was tasked with implementing these projects on behalf of the Trust. Each Project Board is chaired and led by a senior officer within the Trust. All projects are on track to deliver within the project timescales despite a number of risks to delivery mainly driven by third party risks. Projects are being delayed due to recruitment requirements and finding the relevant skills availability to match projects. **Action** **The Committee noted the progress made on the key IM&T projects due to be implemented in 2014/15.**	
14.	**Work Programme** The Committee reviewed the 2014 work programme. It was noted that a Specialist Contract Update would be provided at the June Meeting. **Action** **The Committee noted the revised work programme**	
15.	**Date of Next Meeting** The next meeting will take place on Wednesday 25 June 2014 at 9.30am – 11.30 am in the Princess Alice Room, Eastbourne DGH.	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 30 April 2014 at 9.30am in St Mary's Board Room, Eastbourne DGH

Present
Mr Barry Nealon, Chair
Professor Jon Cohen, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mrs Vanessa Harris, Director of Finance
Mr Darren Grayson, Chief Executive
Mr Philip Astell, Interim Deputy Director of Finance
Dr David Hughes, Medical Director

In attendance
Mr Andrew Murphy, Turnaround Director (for item 5)
Mr Andy Horne, Market Testing Programme Director (for item 10)
Mr Les Saunders, Head of Strategy Implementation (for Item 13)
Miss Chris Kyprianou, PA to Finance Director (minutes)

1.	**Welcome and Apologies** Apologies were received from Stuart Welling and Richard Sunley. The Chair reported that he had raised the importance of having representation from Operations at these meetings with Mr Welling. Mr Grayson agreed that this was important and undertook to follow this up.	**Action** **DG**
2.	**Minutes of Meeting of 19 March 2014** The minutes of 19 March 2014 were agreed as an accurate record.	
3.	**Matters Arising** (i) Finance Update – Month 11 Following a query at the last meeting, Mr Astell confirmed that there was no inconsistency as agency costs had increased in month 10 as well as agency usage; therefore both statements were correct. Mr Astell confirmed that he had provided Mrs Harris with a BPPC update prior to the March Board meeting.	

	(ii) 2 year – 2014/16 Financial Planning Update Mr Astell confirmed that the information requested on the risk measurement was included within item 7 on the agenda. It was confirmed that some of issues raised in delivering the 2014/15 CIP were discussed in Part 2 of the Board Meeting on 26 March 2014. A table showing the breakdown, by initiative, of the £20.4m savings was included in the Board Report for the meeting on 26 March 2014, together with a high level summary income and expenditure statement for 2014/15 with comparison to 2013/14. (iii) Community Rebasing Project Update Mr Astell reported that there was no easily available benchmarking information on available community overheads. Discussions were taking place with other trusts and the work was still ongoing. (iv) Capital Programme Review The capital expenditure for Pevensey ward was reviewed at the Capital Approvals Group at its meeting on 23 April 2014.	
4(i)	**Performance Report – Month 11** The Committee received the month 11 Performance Report which detailed the Trust's performance against the National Performance Framework metrics, as described in the National Operating Plan for 2013/14, and performance against other key trust metrics as well as activity and workforce indicators. It was noted that Month 11 performance, key messages from which had been previously shared at the April Board seminar, fell below the required standard and the Trust remained in "Under-Performing" Status. Admitted and Non-Admitted Elective Referral To Treatment targets did not achieve target and 16 specialties failed to achieve. Final month 10 Cancer performance shows the trust failing against 2WW and 2WW- Breast Symptoms. There were 3 C-Difficile cases reported in month 11. Current outturn to month 11 is 39 against a target outturn limit of 25.	

	The Trust achieved all Accelerating Stroke Improvement Metrics for the third consecutive month. **Action** **The Committee noted the Performance Report for month 11.**	
4(ii)	**Finance Update – Year Ended 31 March 2014** Mrs Harris presented the Finance Report for M12 which set out the unaudited financial position for 2013/14. It was noted that the unaudited year end deficit was £23.1m (as previously forecast) against an original plan of £19.4m deficit. The adverse variance of £3.7m comprises non-delivery of CIPs £2.5m and £1.2m being cost of the MARs scheme and a late adjustment to annual cost of capital Mr Astell gave some key messages from the review of the year. Income had been £10m higher in the second half of the financial year compared to the first six months. Pay costs had been £3.5m lower in the second half of the year; a large part of this was due to reduced agency costs. Non pay costs were higher in the second half of the year, some of this was due to cost of MARS, change in calculation of PDC and stock adjustments. In addition the second half is affected by winter pressures and other year-end adjustments. Compared to 2012/13 there had been a reduction in costs but there had also been a much larger reduction in income principally due to non-availability of transitional support from Commissioners, this had been received in previous years. **Action** **The Committee noted the unaudited year end financial position.**	
5.	**Turnaround Update** Mr Murphy reminded the Committee of the financial challenges faced by the Trust over the next few months. It would be important to maintain financial and operational grip. There would need to be a focus on reducing medical agency and locum expenditure and a number of initiatives had been put in place to achieve this. No ad hoc clinics were planned in 2014/15. Good progress had been made in reducing nurse agency although this had recently increased but was now being managed downwards again as winter escalation beds were closed. By 1 July 2014 a reduction bed numbers was expected as well as a reduction in theatre sessions. The Executive Team would receive a detailed plan in this respect.	

	Other work was ongoing to streamline clinical administration and corporate functions. **The Committee noted the Turnaround update**	
6.	**EBITDA Quarterly Report** Mrs Harris presented the 2013-2014 Qtr 3 EBITDA statement. The Committee noted the number of service lines that had negative EBITDAs. It was noted that this report was helpful in identifying the main problem areas and that there was a rotating programme in place whereby the clinical unit from those areas was invited to the Finance & Investment Committee to discuss any initiatives they were taking. The Chair asked if there were any particular areas that should be added to the work programme. It was noted that the Committee were reviewing Geriatric Medicine in June and Breast in July. It was agreed to review this again at the end of Q4 and select some of the specialities that they felt required a deep dive. Professor Cohen asked if there was a trend. Mrs Harris reported that she had asked Mrs Brandt, Head of SLR to set this out when producing the EBITDA for Q4. Professor Cohen asked what could be done in each area to improve the position. Mrs Harris confirmed that Clinical Units were being invited to attend to present a deep dive, and comparison work was being carried out. Professor Cohen questioned whether this had been effective and if a positive effect on the outcome could be demonstrated. It was agreed that specialities would be invited back to report on progress. **Action** **The Committee noted the EBITDA statement position. The Committee would 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.	**5 Year Financial Plan** At its last meeting the Committee agreed that a provisional budget for a £18.5m deficit be set to enable budget holders to proceed with the operational management of the Trust pending agreement of the final 2014/15 plan. This provisional recommendation was subsequently approved by the Board at its meeting on 26 March 2014.	

	Following agreement at the end of the March with the 2 main commissioners East Sussex CCGs (for majority of acute and community activity) and NHSE (for specialist commissioning, Heads of Agreement not yet signed which means there could be a risk to the income assumed) the 2014/15 Plan was submitted to the TDA on 4 April 2014 for a deficit budget of £18.5m this amount is unchanged from the previous submission. Feedback on the Plan from the TDA is awaited. The financial plan for 2015/16 is for a deficit of £14.0m, this amount is unchanged from the previous submission to the TDA. Approval was being sought from the Committee for a recommendation to the Board to set a final budget for 2014/15 based on a £18.5m deficit (as per previous recommendation on 19 March 2014 for a provisional budget of the same amount). The Committee was reminded of the presentation that was given at the Board seminar on 16 April 2014 which sets out the details of the contract arrangements for both main commissioners; highlighted the main assumptions underpinning the latest TDA submission for a £18.5m deficit in 2014/15 and demonstrated the unmitigated downside risk position and the mitigating actions that will need to be in place to address those risks. A separate paper updating the Committee on financial planning for the final 3 years of the 5 year planning period was noted. Mr Grayson updated the Committee on the Challenged Economy work being undertaken by PWC. An initial set of data had now been produced based on Commissioning intentions to 2018/19. The Trust was now working with PWC to identify any key issues with the assumptions. Progress would be reported at the next Committee meeting. **Action** **The Committee agreed the recommendation in the paper that: A final budget for a £18.5m deficit be issued for approval at the next Finance and Investment Committee on 28 May 2014 and the Board on 3 June 2014.**	
8.	**2013-14 Reference Costs Submission** Mr Astell presented an update on the arrangements for the 2013-14 Reference Cost collection. As was the case last financial year the Board of each NHS trust and NHS foundation trust, or its Audit Committee or other appropriate sub-committee, is required to confirm in advance of the reference costs submission that it is satisfied with the trust's costing processes and	

	systems, and that the trust will submit its reference cost return in accordance with guidance. The Finance and Investment Committee, reporting directly to the Board was considered the most appropriate Committee to carry out this review. Specifically, Boards or their appropriate sub-committees are required to confirm that: (a) costs will be prepared with due regard to the principles and standards set out in Monitor's *Approved Costing Guidance* (b) appropriate costing and information capture systems are in operation (c) costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance (d) procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs return. The Committee agreed that as the same process and resource is still in place for the submission, it could place continuing reliance on the work carried out last year by the then Audit Chair who confirmed he was satisfied with those processes and systems. Paragraph 1.4 of the report presented to the Committee reports that a score of 110 suggests that costs are 10% below the average. It was noted that this should say 'above' the average. Mr Grayson asked if the reference cost index had been impacted with the integration of community services. Mr Astell confirmed it had increased which might be as a result of the integration with Community Services. Mr Grayson asked if the score of 100 was across other acute trusts. Mrs Harris said she thought this was across all trusts (including mental health, ambulance etc) but this would be checked and reported back to the next meeting. Mr Grayson said it would be helpful, when looking at the results of this, to see a comparison with other integrated Trusts. **Action** **The Finance and Investment Committee confirmed that it was satisfied that the costing process, supported the 2013-14 reference costs submission and that the trust will submit its reference cost return in accordance with guidance.** **Minutes of this meeting will be taken to the Board and this will provide documentary evidence should the Trust be subject to**	**PA**

	external review.	
9.	**Community Rebasing Project Briefing – Quarterly Update** Mr Astell gave a progress update on the status of the Community Rebasing Project. It was noted that the cost matrix for community services needed to be refreshed to reflect outturn for 2013/14 and a more robust basis for attribution of overheads. No changes had been proposed to community funding for 2014/15. Commissioners had indicated that an element of these services would be retendered and this was likely to affect contractual arrangements for 2015/16. The community rebasing work was critical in supporting the Trust's response to any invitations to tender and the emphasis of the next phase of work will be on strengthening service specifications and data quality. The project team had been strengthened with additional community services managerial input. The Trust continued to make good progress on this initiative, with strong commitment from all those involved. Mr Murphy asked when the Committee would see the refreshed matrix. Mr Astell reported that the figures were currently available, however there were areas where these needed to be strengthened, over time. It was agreed that the figures would be reviewed at the next meeting. **Action** **The Finance and Investment Committee noted the further progress on this project and the associated opportunities, risks and challenges involved.**	**PA**
10.	**Market Testing Update** Following Board approval of the first three services through the market testing process (Occupational health, Pharmacy Manufacturing Unit and Crèche) Mr Horne provided an update on progress within these services and also updated the Committee on the progress and challenges with Commercial and Corporate services. It was noted that an 'exemplar' Standard Service Level Agreement Specification would be produced with the Interim Commercial Director and rolled out to all other commercial services departments. With regard to the Crèche, Mr Horne reported that there was some	

	market interest. With regard to Occupational Health, Mr Horne reported that another Trust has asked to work with the Trust in market testing both Occupational Health Services. Progress had been made with the 'niche' services but the largest efficiency was likely to be generated from commercial services. It was noted that the Turnaround Director expects significant savings to be made this year but this still allows the opportunity to test the costs against the market. The Interim Commercial Director expects there to be some extra costs associated with delivering the required, compliant standards. It was noted that there needed to be clarify about what was and was not being market tested together with a clear timetable. It was agreed that Mr Horne would put a proposal to the Corporate Leadership Team (CLT). **Action** **The Committee noted the Market Testing update.**	**AH**
11.	**Consultant and SAS doctor Job Planning Review** Dr Hughes gave an update on the progress relating to the review of the Trust's job planning processes, and outlined the anticipated benefits. It was noted that the Trust's job planning process has been re-launched with an emphasis on gaining greater alignment between consultant and other medical staff's time and what the activity and service provision that the Trust required. It is anticipated that all consultants will have new job plans by end May 2014. Key principles underpinning the process included a reinforcement of clinical leadership, transparency and consistency, greater scrutiny and robustness. It was noted that good progress had been made with the majority of job plans coming in by the end of May and the expected outcomes were noted **Action** **The Committee supported the proposed changes to job planning and the approach the Trust was taking.**	
12.	**Community & Child Health Project Update** Mrs Harris gave an update on progress of the Community & Child	

	Health System (SystmOne) project. It was noted that Phase one: Child Health successfully went live on 8 April 2014, with very few issues. Mrs Harris reported that the next go live was phase 1 of District Nursing on 13 May 2014. Preparations for this are going well and support is being received from Accenture. **Action** **The Committee noted the Community & Child Health System Project update**	
13.	**Radiotherapy Treatment Centre Outline Business Case** Mr Saunders presented the Radiotherapy Treatment Centre Outline Business Case produced by the Brighton & Sussex University Hospitals (BSUH) in conjunction with East Sussex Healthcare NHS Trust (ESHT). This recognised the need for the development of a satellite radiotherapy treatment centre at Eastbourne DGH. Radiotherapy had been previously underestimated and capacity in Cancer Networks needed to increase to ensure all patients who require Radiotherapy have appropriate access. It was noted that development would enable BSUH to provide clinical and outpatient services to patients who use their services and live in the east of Sussex and currently have to travel considerable distances for treatment. It was noted that the paper was currently with the TDA for initial comment and the Committee were asked to approve the Heads of Terms for the proposed lease of land at Eastbourne DGH for development as a new Radiotherapy Treatment Centre. Professor Cohen raised an issue over additional car parking and the potential cost to East Sussex Healthcare Trust of providing this. It was agreed that Mr Saunders would raise this issue prior to the approval of the Heads of Terms. After further discussion it was agreed that the Committee would approve the Heads of Terms subject to reference being made within the Heads of Terms relating to the parking arrangements. **Action** **The Committee noted the Radiotherapy Centre OBC and approved the BSUH/EDGH Heads of Terms subject to a reference within the Heads of Terms regarding the parking arrangements.**	**LS**

14.	**Work Programme** The revised 2014 work programme was reviewed. It was agreed to add a separate item for May on: Challenged Health Economy update. Reference costs 2013-14 will be added once it is known that they have been published, this is likely to be late Autumn. **Action** **The Committee noted the revised work programme**	
15.	**Date of Next Meeting** The next meeting will take place on Wednesday 28 May 2014 at 9.30am – 11.30 am in the Committee Room, Conquest.	

East Sussex Healthcare NHS Trust

QUALITY AND STANDARDS COMMITTEE

1. Introduction

1.1 Since the last Board meeting a combined Quality and Standards Committee /Patient Safety Clinical Improvement Group meeting has been held on 7 July 2014. A summary of the issues discussed at the meeting is provided below.

1.2 The minutes of the meeting held on 6 May 2014 are attached at Appendix 1.

2.0 Issues discussed at 7 July Meeting included detailed discussion on the following:-

2.1 Staffing NHS Choices which will be presented to the board. There is further analysis of the data being undertaken however as there is only a single return at the time of writing the report it is difficult to identify any trends or issues.

2.2 Morbidity and Mortality was presented and a full detailed presentation was provided by James Wilkinson.

2.3 A review of the Patient Safety Incidents and Serious Incidents reports took place and identified the need for further analysis of specifics in relation to falls. It was noted that the NRTLS data is not current.

2.4 A TIAA report on the findings from provider survey of Francis Implementation was also considered.

3 Conclusion

3.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meetings held on 7 July 2014 and the minutes of the meeting held on 6 May 2014.

Charles Ellis
Quality and Standards Committee Chairman

9 July 2014

East Sussex Healthcare NHS Trust (ESHT)

Minutes of the Combined Quality and Standards Committee / Patient Safety and Clinical Improvement Group (PSCIG)

Tuesday 6th May 2014
St Mary's Board Room, Eastbourne District General Hospital

Present:
Mr Charles Ellis, Non Executive Director (Chair)
Ms Stephanie Kennett, Non Executive Director
Mrs Alice Webster, Director of Nursing
Mrs Chris Craven, Deputy Director of Nursing
Mrs Lynette Wells, Company Secretary
Mrs Janet Colvert, Ex-officio Committee Member
Mrs Margaret England, Assurance Manager Patient Safety
Mrs Moira Tenney, Deputy Director of HR
Ms Emily Keeble, Head of Assurance
Ms Tina Lloyd, Deputy Director of Infection Prevention & Control
Mrs Nicky Creasey, Assurance Manager Health & Safety
Mrs Liz Fellows, Assistant Director of Nursing
Mr Ian Bourns, Director of Medicines Management & Pharmacy
Mrs Anne Watt, Clinical Governance Manager
Ms Katharine Horner, Deputy Clinical Governance Manager
Ms Emma Jones-Davies, Medicines Management & VTE Nurse

In attendance:
Ms Charlotte Marchant, student nurse (observing)
Mrs Fiona Saville, PA to Deputy Director of Nursing (observing)
Mrs Alison Prout, EA to Chief Executive and Chairman (minutes)

1. Welcome and Apologies for Absence

Mr Ellis welcomed participants to the Combined Quality and Standards Committee / Patient Safety Improvement Group meeting and confirmed that the meeting was quorate.

Apologies for absence were received from:

Professor Jon Cohen, Non Executive Director
Mrs Angela Colosi, Assistant Director of Nursing
Dr Amanda Harrison, Director of Strategic Development & Assurance
Dr David Hughes, Medical Director Governance

Paula Hunt, Clinical Nurse Specialist
Dr Janet McGowan, Trust Clinical Governance Lead
Ms Eanna McKnight, Head of Legal Services
Mrs Lindsey Stevens, Assistant Director of Nursing
Dr James Wilkinson, Associate Medical Director
Mr Jamal Zaidi, Associate Medical Director
Mr Kevin Burns, Data Quality Manager

2. **Minutes of the previous meeting**

The minutes of the combined Quality and Standards Committee / Patient Safety Improvement Group held on 3rd March 2014 were considered and agreed as an accurate record.

3. **Matters Arising**

The updated action log would be circulated with the minutes.

4. **Patient Story**

Mrs Webster welcomed a relative to the meeting to present the patient story about her late husband's care at Eastbourne District General Hospital. Mrs Webster advised she had first met the lady through Healthwatch. Since then, she had attended the dignity day and worked with Jan Dewing to pull together her husband's story.

The relative said that working with the patient experience champions meant she was able to contribute towards making improvements in the care patients and their families received. She stated that she had received excellent care and treatment from the hospital during her recent admission. The patient story focussed on the care that her husband had received, and the way in which the family were treated by the staff caring for her late husband.

Mrs Craven asked if a communication sheet would have helped to communicate the problems she had encountered. The relative said she didn't feel she would have utilised this as these may be used in anger rather than provide constructive criticism. Ms Lloyd said the main theme was about changing the culture of visitors being able to talk to members of staff without the challenge as they feel uncomfortable in a hospital environment.

Mr Ellis thanked the relative for attending, and he hoped that her story would have a profound effect on making changes to the organisation. Mrs Webster said this was essential care that everyone was entitled to and the compassion we have to show our patients and each other.

5. **Morbidity and Mortality report**

Mr Ellis advised that the morbidity and mortality report would be presented to the Clinical Management Executive (CME) on the 12th May. In the absence of Dr Wilkinson, comments and questions were invited.

Mrs Wells asked those present to note that the publication of the next SHMI data would rate the Trust as an outlier and that would have significant implications for the Trust. Mr Ellis said this was due in part to East Sussex Healthcare NHS Trust (ESHT) being an integrated Trust but the committee needed to be assured that it was satisfied with that as a justification. Mr Bourns asked if it was possible to split the data and look at only the acute data of the Trust. Mrs Wells responded that a lot of the admissions were readmissions that did not relate to the Trust, and this could be picked up with Sarah Goldsack. Mr Ellis asked Mrs Webster to take that forward.

Mr Ellis noted that the other point was the vulnerability of community hospitals and no real notion whether or not they were outliers. Mr Bourns said if the Trust was benchmarked against other community trusts then perhaps it would be the norm. Mrs Webster stated that if the higher acuity could not be taken out, then the Trust should be benchmarked against other integrated trusts.

Mrs Colvert asked for some feedback in relation to deaths in community hospitals. Mrs Webster agreed to raise this at the next meeting of CQRG on the 7th May.

Ms Kennett said she would be interested in hearing a clinical reaction to the report. Mrs Webster reiterated that the report would be discussed at CME, and she suggested that this was raised with Dr Wilkinson at the next meeting of the Quality and Standards Committee. Mrs Wells noted that mortality performance was presented to the Trust Board as part of the quality improvement report and there would be an opportunity to raise it there. Mr Ellis asked that this was added to the agenda for Trust Board seminar on the 14th May.

There were no further questions raised and the Committee noted receipt of the report.

6. **Integrated Quality report update**

Ms Keeble provided the committee with a verbal update as the data was not available. She advised that she continued to have concerns about developing another dashboard, and she had recently attended a meeting with Sarah Goldsack and Emma Tate when a number of dashboards were discussed. Ms Keeble advised there would be a further meeting to go through the dashboards in existence. This

information would be presented to the Quality and Standards Committee at a later date.

Mrs Fellows noted there was a requirement through NHSE and national quality board to provide a quality dashboard of nursing staff levels and it was important that this was linked to the work that Ms Keeble was undertaking.

The Committee noted the update.

7. **Healthcare Associated Infections (HCAI) – Trust self assessment of compliance against Outcome 8 Reg. 12 "Cleanliness and Infection Control"**

Ms Lloyd presented the report which provided the committee with evidence of compliance against Outcome 8. She noted that the assessment had been approved by the Trust Infection Control Group (TICG) and following a review of the terms of reference for TICG these were attached for the Committee's information. Ms Lloyd advised that since integration, each of the clinical units had been self assessing against their compliance with Outcome 8, and the TICG had not been assured by the local assessments. The report identified that the overall compliance by the Trust was in excess of 82% and Ms Lloyd said she expected to see significant improvement against quarter 1.

Ms Kennet asked what the overall compliance was benchmarked against. Ms Lloyd advised that the tool was for guidance purposes only and this was done differently across the network. She advised compliance rate was what Ms Lloyd expected to see.

Ms Kennett said she found it difficult to understand why criterion 2 was difficult to achieve. Ms Lloyd said this related to the investment required in the estate to get it into the position it should be. She noted there was a report going to the Trust Board regarding the investment required in the hospitals to bring it up to standard. Ms Lloyd added that the TICG would monitor progress and review compliance quarter and report to the Quality and Standards Committee. This would enable the committee to be assured that actions were in place to address non compliance or to raise it further with Trust Board if improvements were not forthcoming.

Mrs Webster said there has been a lot of work undertaken to get the tool to this point, and she thanked Ms Lloyd. Mr Ellis echoed the thanks of the Committee.

The Committee noted that the Terms of Reference for the Infection Control Group had been ratified by CMT. The report was noted and received.

8. **CQC Intelligent Monitoring Report**

The report summarised the findings of the Intelligent Monitoring report which had been published by the CQC. The CQC categorises Trust into bands, with 1 being the worst and 6 being the best. Mrs Wells advised that the Trust was rated as band 3. She noted the staff survey was now done annually, and unless the CQC changed the methodology of reporting, the risks would remain.

Mrs Wells advised that the Trust had undertaken a case note review for the in hospital mortality risks, and although the Trust was an outlier this was in relation to coding rather than issues of care. The Trust's financial position would always put us at risk with the TDA escalation score, and the issues with 18 weeks could move the Trust to a lower category.

Mrs Fellows asked about publication of the report. Mrs Wells advised it was published quarterly. Mrs Fellows asked if the metrics were adjusted following receipt of the Trust's response. Mrs Wells responded that whilst the Trust was shown as an outlier on Dr Foster, these were the sort of issues that the CQC would seek assurance on.

Mrs Tenney agreed to discuss the staff survey with Edel Cousins as there may be an opportunity to include the question about recommending the Trust as a place to work.

The report was noted and received.

9. **HR Incident Report**

Mrs Tenney presented the report. During the period in question 62 formal incidents had been addressed which was comparable against the previous year. She said it was important to recognise during this period the Trust was facing significant change. Whilst there had been some improvement in the time taken to investigate incidents, further work was required to reduce the time taken to complete investigation and reduce the length of time that each case is open. Mrs Tenney advised that a trial to complete investigation interviews by telephone was being considered, and noted that the NMC had introduced this. She noted that employment tribunals were frequently found in the Trust's favour which showed that policies and processes were followed.

Mr Bourns said the biggest delays with investigation had been access to union support and that was outwith the remit of the Trust. Mrs Tenney said a number of the RCN investigations were supported externally, but the majority were supported internally. She stated the Trust did not have any less support from the BMA or RCN than other Trusts, but perhaps could do more to support the

union representatives being released from their day to day jobs.

Mrs Horner asked if the Trust recorded the reasons for leaving as part of the exit interview process. Mrs Tenney responded that in terms of formal reporting, if there was an issue with a line manager that would be taken up with the relevant manager. Mrs Fellows said if this data was collected it would highlight whether there were consistent themes for staff leaving. Mrs Webster suggested that an element of the FFT should include the staff experience, the number of leavers and the top 5 reasons for leaving. Mrs Tenney said the turnover of staff was not looked at in depth and perhaps the data collection needed to be revamped.

The report was noted.

10. **Compliance**

10.1 **External Visits report**

Mrs Wells presented the report which provided the committee with a summary of the external visits that had taken place. She drew the committee's attention to the outstanding actions related to previous visits.

Mr Bourns provided a brief update on the visit to the Pharmacy Manufacturing Unit (PMU). He confirmed that work was underway to address the issues raised but noted that to resolve all the issues, there would need to be some capital investment which may prove difficult in the current climate.

In relation to the CQC visit to the District Nursing Service, Mrs Webster confirmed IPD4 has been printed and that Systm 1 was going live.

Ms Lloyd provided an update on the HCAI visit by the TDA. She confirmed that a number of processes had been changes so the whole system was more robust and any significant issues were fed back at the time of the audit. The audit team had been retrained and had moved from facilities to infection control.

The Committee were assured that actions were in place to address the concerns raised.

10.2 **CQC Action Plans report**

The report provided the Committee with the latest version of the CQC action plans and confirmed the position regarding due and overdue actions. Mrs Wells advised that the red actions related to Integrated Patient Documentation (IPD) and Systm 1. She advised that the final report for the recent District Nursing Service visit had

been received the Trust was compliant, with a minor concern about record keeping but the feedback about the service was very good about the changes that had taken place since the last visit.

The Committee noted the report.

11. Assurance

11.1 Quality Walks report

Mrs Wells presented the report which highlighted the quality walks undertaken in January and February. She confirmed that the actions raised were fed back to the wards.

The Committee noted the report

11.2 Assurance Visits

Ms Keeble advised that the assurance team had undertaken 13 visits all of which were announced to ensure that the Matron or Ward Manager was available to answer the questions. The general recommendations and findings were attached to the report, and the main area of concern was around VTE. It was interesting that people knew there was a policy but were not sure what was required. Ms Keeble assured the Committee that all the feedback from the visits is shared with the ward. Ms Jones-Davie said one of the main problems was that the Trust did not offer VTE training to existing staff. She advised she had had discussions with learning and development but there were no resources available to progress this. VTE awareness was raised through ad hoc events and updates in the medicines management bulletin but this was not enough, and the Trust needed a more proactive approach.

Mr Ellis asked Mrs Webster how best this could be taken forward. Mrs Webster said she would raise the Committee's concerns with the matrons. Ms Jones-David noted that at present there was no VTE lead consultant, and Mrs Webster suggested picking this up with either Dr Walmsley or Dr Wilkinson. Ms Lloyd questioned whether the policy needed to be rewritten. Mr Bourns advised that the policy was written in line with NICE guidance but training was on an ad hoc basis. Ms Jones-David confirmed that most trusts have taken a more formal approach to address this issue.

The Committee asked Mrs Webster to raise their concerns in respect of VTE with the ward matrons.

12. Quality Account Progress Review

Mrs Wells advised that this document have been circulated previously for comment. She was pleased to report that the

statutory requirement in terms of sending the document to stakeholders for comment had been met. This would be presented to the Trust Board for final sign off.

The Committee noted the update.

13. **Patient Safety Incidents Report**

Mrs England presented the report which provided a summary of the incidents that had been reported across the Trust during February and March. There were a total of 696 patient safety incidents reported in February, and 692 in March. She confirmed that the top 5 incident categories would be reviewed in greater detail. She was pleased to advise that the Trust had made an application to the Patient Safety and Care awards regarding the insertable heart monitor, but had not yet heard whether the application had been shortlisted.

Mrs England advised that the committee would see a reduction in the number of pressure ulcers being reported as serious incidents (SIs). The Trust previously had to report all unstageable ulcers, but with effect from April 1st only category 3 or 4 were reported. She noted that community pressure ulcers in end of life patients, remained high and a lot of work had been done by the district and community nurses to educate patients and carers. She advised there had been a slight increase in health records incidents where patients had appointments at different sites and often their records were not available. To address this, Mrs England confirmed she would be meeting with the Health Records Manager to agree a way forward.

The Committee noted receipt of the report.

14. **Serious Incident Quarter 4 / Annual Report 2013-14**

Ms Keeble presented the report which provided information about the serious incidents (SIs) that had occurred during the year. The report contained detailed analysis of the data, by area, theme and the processes and action in place. She advised that the Trust had reports 166 SIs which was a slight decrease on the previous year. The Committee were asked to note that pressure ulcers and falls remained the two most frequently reported SIs, and she confirmed there were action plans in place to ensure recommendations were implemented and learning was shared across the organisation. Comments and questions were invited.

Ms Kennet asked if there was a consequence for the Trust being above the national mean. Ms Keeble said the CCG were aware of this data and she was not aware of any consequence, particularly as the data has been available for sometime. Mr Ellis enquired about

the community SIs and whether these had taken place within the community hospitals, or the patient's own home. Ms Keeble confirmed this would include all community settings where the community nursing teams were involved.

Ms Keeble concluded by assuring the Committee that the Trust had submitted all RCAs on time but there was a backlog awaiting closure from the CCG. Mr Ellis thanked Ms Keeble and this was a really useful report.

Ms Horner queried the rate of serious harm patient safety incidents per 100 admissions graph. Mrs Webster agreed to look into this. Mr Ellis asked for a definition of serious harm.

There were no further comments or questions, and the report was noted by the Committee.

15. **Serious Incidents Monthly reports**

Ms Keeble presented the SI reports for February, March and April. Mr Ellis asked the Committee to note receipt of the February and March report, and asked Ms Keeble to highlight any areas of concerns from the April report.

Ms Keeble advised that of the 9 new SIs 8 were pressure ulcers. She confirmed that the Trust was 100% compliant in reporting SIs within the required 48 hours, and noted that only 3 SIs were closed. The Trust continued to submit the RCAs ahead or on time and had achieved 100% against a target of 90% for the month.

The Committee noted receipt of the report.

16. **Review of the NHS Complaints system: Putting Patients back in the picture**

Mrs Webster presented the report which provided the Committee with an update in respect of the Trust's response to the Clywd-Hart review which was published in 2013. The first draft of the response was appended to the report and a significant amount of work was required about the communications and customer service. Mrs Webster noted this was partially covered in the induction course but this was everybody's business. She was pleased to report that the lanyards had been a huge success with patients and staff alike. There was more work to be done and the Trust needed to learn from complaints as well as compliments. Mrs Webster noted that PALs contacts had increased significantly. As patients felt their concerns were being responded to in a timely manner, this has avoided formal complaints.

Mr Ellis said that the quote from Dame Judy Mellor was profound

given the patient story. Mrs Webster agreed and said there would always be things that were not done right, and the Trust needed to enable staff to read the signs earlier and to ask for help and feel empowered.

The Committee received and noted the report.

17. **Any Other Business**

There were no other items of business raised.

18. **Items for Information**

The following items were noted by the Committee:

18.1 Draft minutes from the Trust Health and Safety Steering Group meeting held on 7th April 2014

18.2 Minutes from the Health Records Steering Group meeting held on 26th March 2014

Mrs Wells noted that within the minutes, a small project team would be established to look at missing and duplicate health records. Mrs Wells asked for the outcome of that group to be presented to the Quality and Standards Committee.

18.3 Minutes from the Consent and Clinical Ethics Committee meeting held on 25th March 2014

The meeting closed at 4.45pm.

19. **Date of next meeting**

<u>PSCIG / Essential Compliance Group</u>
Monday 9th June 2014 at 10.30 – 12.30 in the Committee Room, Conquest Hospital

<u>Quality and Standards Committee</u>
Monday 7th July 2014 at 2.30 – 4.20 in the Committee Room, Conquest Hospital

EAST SUSSEX HEALTHCARE NHS TRUST

Notes of the Trust Board Seminar held on 12th March 2014 at 10.00 am in the Lecture Theatre, Conquest Hospital

Present: Mr Stuart Welling, Chairman
Mrs Sue Bernhauser, Non-Executive Director Designate
Professor Jon Cohen, Non-Executive Director
Mr Darren Grayson, Chief Executive
Ms Monica Green, Director of Human Resources
Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Medical Director (Governance) (for items 1-3)
Dr Andy Slater, Medical Director (Strategy)
Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Mrs Alice Webster, Director of Nursing
Ms Lynette Wells, Company Secretary

In Attendance: Clinical Unit Management Teams
Mrs Trish Richardson, Corporate Governance Manager (notes)

ACTION

1. Welcome and Apologies for Absence

a) Apologies for absence were received from:

Mr Charles Ellis, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mr Barry Nealon
Mr James O'Sullivan, Non-Executive Director
Dr Amanda Harrison

b) Update on current issues

Mr Grayson reported that he had circulated some documentation in relation to the challenged health economy and the contract for the work was being with the expectation that the work would start in detail from the 1st week of April.

He advised that the Clinical Commissioning Groups had commissioned their own piece of work on commissioning plans and the report would be available from mid-April.

2. Clinical Unit Presentations

Mr Welling advised that the intention of seminar was to enable the Board to assure itself on the process gone through by the Clinical Units in order for them to make their presentations today, the deliverability and ownership of their plans and understanding the risks around them.

The following units gave presentations:

- Trauma and Orthopaedics – Oliver Keast-Butler, Jan Brewer, Katey Edmundson

  Issues requiring further work:
  - Theatre capacity
  - Trauma move

- Ophthalmology – Mike Wearne, Matt Hardwick, Sue Allen

- ENT – Paul Kirkland, Matt Hardwick, Sue Allen

  Issues requiring further work:
  - Out of hours discussions with MTW and BSUH – executive lead
  - Paediatric and adult A&E on both sites

- Maxillo-Facial – Andrew Moody, Matt Hardwick, Sue Allen

  Issues requiring further work:
  - Move of community dental services
  - IMOS contract

- Therapies – Abigail Turner, Lloyd Barker

  Issues requiring further work:
  - Estates to support therapies move, eg centralising booking
  - Alignment of therapy and diagnostic services

- Cardiovascular – Nik Patel, Sandra Field, Lucy Scragg

  Issues requiring further work:
  - Cardiac rehab move to Bexhill
  - Recruitment to vacant stroke consultant posts

- General Surgery – Imelda Donnellan, Jayne Cannon

  Issues requiring further work:
  - Elective vascular service
  - Theatre staffing – patient movement

- Urology – Steve Garnett, Jayne Cannon

  Issues requiring further work:
  - Theatre staffing

- Anaesthetics and Theatres – Tim Arnold, Pauline Simes

  Issues requiring further work:
  - Staffing Conquest including transport for staff
  - Hospital at night EDGH
  - Achievement of savings plans

- Specialist Medicine – Deidre Connors

  Issues requiring further work:
  - Closure of two medical wards

- Complex, Intermediate & Community Care – Hugh McIntyre, Nicky Walker, Mia Cruttenden

  Issues requiring further work:
  - District nursing

- Women's Health – Dexter Pascall, Paula Smith, Lindsey Stevens

  Issues requiring further work:
  - Sexual health tender

- Paediatric Services – Andy Slater, Annie Singer, Fran Edmunds

  Issues requiring further work:
  - Opening hours of SSPAU
  - School nursing tender

- Emergency Medicine – Andrew Leonard, Jenny Darwood, Sarah Wilmer

  Issues requiring further work:
  - Medical staffing recruitment
  - Implementation of new medical model
  - MIUs

- Medical Model – Hugh McIntyre

  Issues requiring further work:
  - Implementation of new model on both sites

- Radiology – Neil Barlow, Christian Kasmerides

  Issues requiring further work:
  - Backlog of imaging reports

- Pathology – Warwick Davis, Graham Rayner

  Issues requiring further work:
  - Pathology managed service contract

- Pharmacy – Ian Bourns, Graham Rayner

- Clinical Admin Services – Paula Smithj

- Planned and Specialist Medicine – Johann Rademaker, Debbie Cooke

  Issues requiring further work:
  - Capacity versus demand
  - JAG accreditation

- Ward Nursing – Alice Webster

  Issues requiring further work:
  - Paper to come to Board for approval

3. Conclusion

Mr Welling recognised that the day had been a high level review of the CIPs for each unit but believed that the Board could take assurance that the clinical units had fully engaged with their staff on drawing up the plans and he was impressed with the degree of understanding of the issues by the teams.

Mr Cohen agreed that it had been an excellent process and he appreciated the work of the clinical unit teams and how well they had presented. He agreed that the day had provided a degree of reassurance and had highlighted those plans which were more robust and those which were rather more aspirational.

5. Date and Time of Next Meeting

Wednesday, 16th April 2014, 9.30 am to 3.00 pm, in the Committee Room, Conquest Hospital.

EAST SUSSEX HEALTHCARE NHS TRUST

Notes of the Trust Board Seminar held on 16th April 2014 at 9.30 am in the Committee Room, Conquest Hospital

Present: Stuart Welling, Chairman
Sue Bernhauser, Non-Executive Director Designate
Professor Jon Cohen, Non-Executive Director
Charles Ellis, Non-Executive Director
Barry Nealon, Non-Executive Director
James O'Sullivan, Non-Executive Director
Darren Grayson, Chief Executive
Monica Green, Director of Human Resources
Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development & Assurance
Dr David Hughes, Medical Director (Governance)
Dr Andy Slater, Medical Director (Strategy)
Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Alice Webster, Director of Nursing

In Attendance: Mr Dexter Pascall, Clinical Unit Lead – Women's Health (item 2)
Lindsey Stevens, Head of Midwifery (item 2)
Trish Richardson, Corporate Governance Manager (notes)

ACTION

1. Welcome and Apologies for Absence

a) Apologies for absence were received from:

Ms Stephanie Kennett, Non-Executive Director
Mrs Lynette Wells, Company Secretary

Mr Welling noted that this was Mr O'Sullivan's last meeting and thanked him for his work and wished him well in the future.

b) **Notes of the Seminar meetings held on 12th February and 12th March 2014**

The notes of the seminar meeting held on 12th February 2014 were agreed as a correct record. It was agreed that the notes of the seminar held on 12th March 2014 needed to be revised to provide more information on the business planning review held. **TR**

Matters Arising

It was agreed that the outstanding issues from 12th March 2014 would be reviewed in Finance and Investment Committee and reported through to the Trust Board.

c) Update on Current Issues

i) Month 11 Performance

Mr Sunley reported that although performance in February (month 11) had been similar to Month 10 progress had improved on cancer times and had been consolidated on Referral to Treatment targets whilst delivery of the Accident and Emergency target for the year had been secured.

He was pleased to report delivery of the 2 week waits targets for both "symptomatic breast" and all cancers which had underperformed in month 10. This was a result of the work that Dee Daly was undertaking on improving cancer performance as outlined at the Board meeting in March. The performance for the 30 day target fell into amber with small numbers again affecting the target – one colo-rectal patient breached. The Trust was continuing to engage with the screening services to resolve this issue.

He noted that the 62 days to treatment target was also amber and the issues were primarily in relation to urology and colorectal services. He advised that the overall complexity of the pathway would be tackled by the re-organisation of the pathway co-ordinators and specifically the employment of an extra consultant post in urology. The benefits of the general surgery re-organisation had been expected to be seen as well but senior and junior medical staffing continued to be a problem.

Mr Sunley reported that the February figure for A&E waits was 95% and, having now completed the year, quarter 4 had also been delivered which was a tremendous achievement by all the staff involved. He highlighted that the March figure would fall marginally short of 95%, primarily due to Norovirus in the hospitals which had affected bed capacity and throughput, particularly on the Conquest site.

In relation to RTT and diagnostic waits, Mr Sunley reported that both the planned targets had failed in Month 11 and were expected to fail again in March as the focus had been to treat the backlog of patients that had built up as a result of the cessation of ad-hoc and private capacity work, particularly in orthopaedics. He noted that key improvements had been seen in engagement with the clinical units at the weekly performance meeting and the new operational 'start the week' meetings which had refocused and re-energised attention in this area. In addition, a consultancy had been brought in to lead surgery and theatre planning from the beginning of the month and support continued from the TDA and the CCGs as well as the Intensive Support Team who were on site and working with the organisation on its recovery plans.

Mr Sunley advised that the aim was to deliver RTT targets at an aggregate level by month 1 and at a specialty level for the first time ever by month 7 with orthopaedics being the last to deliver.

He reported that in relation to diagnostic waits with the cessation of ad-hoc sessions in November it had been a struggle to achieve the required capacity to be undertaken in planned sessions. The expectation was that the Trust would recover to performing in April following early success in efficiency which had seen capacity increase from an average of 350 cases a week up to 424 through pooling of lists, changes to training sessions and improved focus on efficiency. The diagnostic recovery plan showed the service reaching a sustainable capacity level by September through the training of nurse endoscopists.

He reported that the stroke service had continued its tremendous performance since the reorganisation and centralisation in Eastbourne and for the third month running the direct access to a stroke unit indicator had been achieved with a delivery of 96% against a target of 90%.

Mr Sunley was confident that in the new financial year with a more robust turnaround and business planning focus the Trust would not only deliver on the operational agenda but also on the quality and financial agendas.

Mr Grayson noted that in March there had been 90 beds out of action due to Norovirus on the Conquest site but the March A&E performance was 94.76%, just missing the 95% level.

ii) <u>Finance Month 12 Flash Report</u>

Mrs Harris reported that the Trust had met its revised forecast at the year end of £23.1 million which was £3.7 million beyond the original deficit target. She noted that at the end of September the Trust had a deficit of £16.6m and through the turnaround process the downward decline in financial performance had been addressed. The plan for 2014/15 plan was for a £18.5 million deficit at the year end.

She reported that the Trust would enter 2014/15 in a strong cash position but there would be a need for further Public Dividend Capital during the year. She would provide a full report to the Finance and Investment Committee at the end of April.

She advised that the Better Payment Practice Code would be 94.8% in March 2014.

Mr Welling commented that there were a number of lessons to be learnt as to why the position had drifted out from £19.4 million and this could not be allowed to happen in 2014/15.

iii) Challenged Health Economy

Dr Harrison reported that Price Waterhouse Cooper (PWC) had been engaged to carry out the work and they had also been commissioned by the CCGs and the Local Authority to undertake a separate piece of work on commissioning which would inform the CCGs' future commissioning intentions in May.

Mr Welling asked how the Board would be able to input to the process as there was no direct engagement of the full Board. Dr Harrison reported that the timescales were only just emerging and there would be at least one event planned to review scenarios but as yet the date had not been confirmed.

Mr Welling stressed the importance of the Board being involved in the development of the Trust's plans and Mr Grayson advised that there would be a discussion the following week with the TDA about what should go into 5 year plan as it was acknowledged by TDA that the output from the PWC work would only be the baseline LTFM.

iv) High Weald Lewes and Havens CCG Community Services Tender

Mr Grayson reported that the High Weald Lewes and Havens CCG were intending to give notice on the aspects of the community services supplied by the Trust as they had expressed a level of dissatisfaction with some aspects of the provision.

He advised that further details were being sought from the CCG on how the process for recommissioning the services would work and to agree a joint communications plan for the staff within these services.

Mr Welling reported that he and Mr Grayson had requested a meeting on 23rd April with the Chair and the acting Accountable Officer of the CCG to seek more clarity about their intentions.

Dr Harrison also informed the Board that the Local Authority was intending to tender for services that they now commissioned including school nursing and sexual health services.

2. Better Beginnings Consultation – Trust response

Dr Harrison reported that the Board needed to confirm the Trust's response to the Better Beginnings consultation. Following receipt of all responses the CCGs would be sending them to an independent organisation for analysis which would be presented to the CCGs as part of their decision-making process and also presented to HOSC.

She noted that the response from the Trust was attached at appendix 4 of her report.

Dr Pascall and Ms Stevens were welcomed to the meeting and they provided an overview of the maternity service since the single siting of consultant led maternity and paediatric services on to the Conquest site in May 2013 for safety reasons.

Dr Slater provided an overview of the paediatric services and how the recommendations of the Royal College of Paediatricians and Child Health report had been addressed.

The Board agreed the response to the Better Beginnings consultation as set out in the report from Dr Harrision.

3. High Risk and Emergency T&O Reconfiguration Assurance

Mr Sunley reported that following the CLT meeting of 25th February 2014 it was agreed that the reconfiguration of emergency and high risk Trauma and Orthopaedics (T&O) should be implemented on 3rd May 2014. He advised that subsequently the implementation date had been extended by the T&O Implementation Group to 13th May to allow some contingency for the estates work to be completed on Egerton ward.

He advised that the service reconfiguration planned was that Seaford 3 ward (29 beds) would be transferred to Egerton ward (28 beds) at Conquest and 17 elective beds would remain on Hailsham 3 at EDGH.

The number/length of trauma lists at the Conquest would be extended both during the week and at the weekend.

He outlined the benefits to be gained by the move:

- improvement in quality of care with improved consultant presence, therapies and social services presence 7 days a week
- dedicated radiology sessions
- ring fenced orthopaedic capacity on EDGH site

- improvement in efficiency – trauma length of stay forecast to move over the year to top decile performance
- medical staffing savings
- theatre rationalisation

In addition to the assurances provided in his report, Mr Sunley highlighted the following areas:

Internal

- medical staffing – rotas were in place and were EWTD compliant.

- theatre staffing – agency use would need to increase by 4.0 WTE in the short term until permanent staff were in post.

- Wards – with the anticipated staffing at 13th May it would be possible to open 16 beds on Egerton and, once the full complement of staff was recruited to, 28 beds would be opened.

- bed management & A&E – there were a number of initiatives underway to improve the utilisation of existing beds and support the move and he was confident that they would be able to cope.

Discussion took place on theatre staffing in terms of skill mix and numbers as there was concern at the high level of vacancies. Mr Grayson reported that he had discussed these issues with the theatre manager and, whilst they did have a high level of vacancies, she was confident that they would be covered with agency staff although it would not be easy.

Mrs Webster advised that the recruitment of Operating Department Practitioners (ODPs) was a national issue as it was a UK only qualification and discussions had taken place with the Local Education Training Boards re this issue.

Mr O'Sullivan queried why staff were leaving and Mr Sunley advised that it was the degree of uncertainty caused as services were being moved and the same situation had been experienced in both stroke and general surgery prior to their moves.

It was agreed that Mr Sunley and Dr Slater would provide further assurance to the Corporate Leadership Team (CLT) on the rotas and how they would be covered.

In relation to ward staffing, Mrs Webster advised that if the current configuration remained Seaford would become unsustainable to staff and the safer option in terms of patient safety was to make the move. It was agreed that Mr Sunley would provide further assurance to CLT on the implications for ward staffing.

Mrs Harris commented that the move would make the Conquest site busier through A&E and Mr Sunley advised that plans were to improve throughput in that area including providing more Clinical Decision Unit space and more trolley space in A&E.

It was agreed that the Board supported the move in terms of internal capacity and capability provided that CLT received further assurance from Mr Sunley on theatre and ward staff and the tipping points.

External

- Brighton and Sussex University Hospitals NHS Trust – discussions were continuing with BSUH on how patients in the Seaford area would be managed – it was estimated by ESHT that there could be an extra 2.5 patients a week being taken to BSUH by the ambulance service as the move only affected patients on a 999 pathway.

- Ambulance service – no additional activity but patients needed to be re-routed to Conquest and discussions continued with SECamb and the commissioners over this.

Mr Grayson reported that he had received confirmation from the Chief Executive of BSUH that he could not support an increased number of trauma patients from the periphery of East Sussex until the autumn when it was BSUH's intention to move hip fracture patients to the Princess Royal Hospital in Haywards Heath in September/October.

He commented that both organisations needed to understand the numbers and how they were calculated and he would then write formally to Mr Kershaw and then escalate to the TDA. In addition, Mr Sunley and clinical colleagues would continue discussions with colleagues at BSUH to see if an agreement could be brokered.

Mr Sunley reported that discussions were also continuing with SECamb and the commissioners around transferring these patients to the Conquest, rather than BSUH, and his view was that the commissioners were supportive of the Trust.

Dr Harrison commented that it would be useful to review the analysis of where patients would go from the peripheral areas of East Sussex in light of the Brighton proposal to move fractured neck of femur patients to Haywards Heath.

The Board agreed that further assurances were required around internal capability and capacity to implement change from 13th May which would be provided to CLT but the final decision on the date would be dependent on discussions with BSUH, SECamb and the commissioners.

4. NHS Terms and Conditions of Service (Agenda for Change)

Ms Green outlined the background to terms and conditions of service prior to the introduction of Agenda for Change (AfC) in March 2006. She noted that Agenda for Change did not apply to medical staff or executive directors.

She reported that there were 9 paybands under AfC and each band was made up of a number of increments. Historically each member of staff moved up an increment every year on the date of their appointment and in addition all staff had an annual pay award.

She provided a breakdown of staff across the bands and the position was not dissimilar to other Trusts, apart from bands 2 and 3 where the Trust had more staff as it provided estates and facilities services in-house. She noted that there were no band 9s in this Trust.

She highlighted that most staff were on the top of their bands as staff turnover was fairly and historically a lot of staff had been in post for a long time on old contracts. This had caused an issue in relation to moving services between sites as the old contracts gave a base where someone was working and the Trust has had to negotiate on an individual basis for moving base and pay travel expenses for four years. The only way to address this would be to individually re-negotiate contracts. In addition, the Trust's paybill was higher than other Trusts where turnover was higher.

She reported that from this April incremental progression would no longer be automatic and progression would now be dependent on performance. As a result, the appraisal process was being re-negotiated with staff side and staff would be expected to achieve a number of performance criteria which would be a combination of hard/soft measures.

She noted that the system would be dependent on managers carrying out robust appraisals and training was being provided.

Ms Green reported that for this year staff on AfC would receive either an increment or, if not eligible, a 1% non-consolidated and non-pensionable increase and the government's intention was that this would also apply in 2015/16.

She advised that AfC staff working between 7 am and 7 pm received unsocial hours payments/enhancements and this would impact on 7 day working. The level of enhancement depended on the pay bands and those staff working nights and Saturdays received an extra 30-50% of pay, and those working Sundays and public holidays an extra 60-100% of pay. Mrs Bernhauser noted that two Foundation Trusts had removed unsocial hours and given a cash payment to staff instead.

Ms Green reported that on call payments had been made subject to local agreement from 2011 and a simplified system had been put in place with staff on call receiving £1.34 per hour and, if required to come in, they would receive time and a half.

In relation to the Recruitment and Retention Premia she advised that the only group paid nationally were maintenance and craft staff. There was the ability to pay local premia but it would involve a lengthy process with the TDA if the Trust wanted to introduce it for other groups of staff and at moment only cardiac technicians received a local premia. .

She highlighted that annual leave and sick pay were set nationally and holiday entitlement was accrued during maternity or sick leave.

Ms Green noted that it was a complex process to evaluate where posts were placed on a band with 16 weighted factors including knowledge, skills, management responsibilities and effort.

She outlined the benefits of AfC as follows:

- Harmonised terms and conditions
- Single and transparent system for employing staff
- Reduces risk of equal pay claims
- Makes budget management easier
- Simplifies administration of pay
- Job evaluation scheme devised specifically for NHS jobs and facilitates new ways of working

She outlined the hard to recruit to posts under AfC:

- Clinical physiologists
- Experienced theatre nurses
- Operating department practitioners
- Health visitors
- Therapists – speech and language, senior podiatrists

and the hard to recruit to medical posts:

- Stroke physician
- A&E/MAU consultant
- Community paediatrician
- Deanery appointments – middle grades

Mr Grayson commented that a group of Foundation Trusts in the South West were looking to move away from AfC and Ms Green reported that they had been asked to stop local negotiations, so as not to impact on the national pay discussions. She was aware that one Foundation Trust in Southend had moved away from AfC in and offered more generous pay and conditions.

Mrs Harris advised that there was also the complication of those staff that came in at different times in the preceding organsiations were paid different rates for travel and consideration needed to be given to how this was managed going forward.

Professor Cohen asked if the expectation was that all staff would achieve the performance levels required to receive their increment and Ms Green advised that the new process had only just been agreed and the expectation had not yet been set on how many staff would achieve the required level.

Mr Welling thanked Ms Green for her useful presentation.

5. Financial Planning Update

Dr Harrison reported that the final submissions of the 2 year plan had been sent to the TDA within the required timescale.

She advised that the Board would receive at its meeting on 3rd June the full annual business plan, the process for performance management of the delivery and the description of the revised structures and programme management.

She added that the business plan would pick up all the issues the Trust was asked to respond to in terms of Annexe E and incorporate the CIP programmes.

Mrs Harris reported that in relation to financial planning the contract with the Clinical Commissioning Groups (CCGs) and Specialist Commissioning had been agreed. The contract with the CCGs was Payment by Results (PbR) with a risk management arrangement. This type of contract had been agreed in the light of being a challenged health economy and being able to manage the totality of risk to each organisation and in a collaborative approach.

She reported that it had been assumed £1.5 million of winter pressures money would be received and it had been agreed that the first tranche would come to the Trust and the Trust had allowed for additional costs.

She noted that fines and penalties would apply and it was set out in the Heads of Agreement how these would be managed but they would be able to be reinvested against plans.

She highlighted that on 18 weeks the Trust would be measured against an agreed trajectory with the CCGs and the TDA and the agreement was that if the Trust went off trajectory it would have six weeks to come back on track or the CCGs would require the Trust to outsource the work.

She advised that there were no significant changes to the nature of community services delivery.

She stressed the importance of ensuring that both the Trust and the CCGs were on top of the activity management and a joint group was being set up to monitor this which would replace the single performance conversation meetings.

Mr Welling asked the process for agreeing how the Better Care Fund would be allocated and Mr Grayson reported that the CCGs and Local Authority would be coming up with plans and Mrs Harris advised that there would be no negative impact in 2014/15.

Mrs Harris reported that the proposed specialist commissioning contract was a block contract for activity with high cost drugs and devices excluded and they would be paid on a cost per case basis. Contracts with the Local Authority had been rolled over and not changed.

She advised that the financial submission to the TDA on 4th April had provided a planned deficit of £18.5 million and outlined the key assumptions.

She outlined the downside case for 2014/15 (before mitigation) which resulted in a downside deficit risk of £24 million and outlined the potential mitigations to offset this.

Dr Hughes queried the size of demand managerment and Mrs Harris advised that the QIP assumption was £4 million.

Mrs Harris outlined the requirements of the five year plan submission which would be made to the TDA on 20th June.

Mr Welling thanked Mrs Harris for her explanation of the detail and nature of the contract the Trust had signed up to.

6. Date and Time of Next Meeting

Wednesday, 14th May 2014 at 10.00 am in the Committee Room, Conquest Hospital.

EAST SUSSEX HEALTHCARE NHS TRUST

Notes of the Trust Board Seminar held on 14th May 2014 at 10.00 am in the Committee Room, Conquest Hospital

Present: Stuart Welling, Chairman
Sue Bernhauser, Non-Executive Director Designate
Charles Ellis, Non-Executive Director
Stephanie Kennett, Non-Executive Director
Barry Nealon, Non-Executive Director
Monica Green, Director of Human Resources
Dr David Hughes, Medical Director (Governance)
Alice Webster, Director of Nursing
Lynette Wells, Company Secretary

In Attendance: Lesley McIlrath, Associate Director – Planning and Performance (item 2)
Dr James Wilkinson, Associate Medical Director – Improving Outcomes (item 4)
Trish Richardson, Corporate Governance Manager (notes)

ACTION

1. Welcome and Apologies for Absence

a) Apologies for absence were received from:

Professor Jon Cohen, Non-Executive Director
Darren Grayson, Chief Executive
Vanessa Harris, Director of Finance
Amanda Harrison, Director of Strategic Development and Assurance
Dr Andy Slater, Medical Director (Strategy)
Richard Sunley, Deputy Chief Executive/Chief Operating Officer

b) **Notes of the Seminar meetings held on 12th March 2014 and 16th April 2014**

The notes of the seminars held on 12th March and 16th April 2014 were agreed as a correct record.

c) Update on Current Issues

i) Financial Update

Mr Welling reported that the month 1 finances were on plan and the Trust was predicting an £18.5 million deficit for the year 2014/15.

ii) 18 weeks

Mr Welling presented the report from Mr Sunley on 18 weeks and noted that in reviewing the backlog a problem had been identified with the mechanism for counting and recording patients. Further investigations were taking place to identify the number of patients involved. He advised that the TDA had been informed of the situation and had requested a revised plan by the end of the week.

Mrs Webster reported that the mechanism had now been changed to ensure that this situation did not recur.

Chief Inspector of Hospitals Visit

Mr Welling reported that the Trust would receive a Chief Inspector of Hospitals visit from the 9th September and it was expected that it would cover both the acute and community services. However clarification was being sought on the approach that would be taken in respect of community services.

Preparation was already under way for the visit including learning experiences from other Trusts who had or were about to have visits.

Emergency and High risk Trauma and Orthopaedics (T&O)

Mr Welling reported that the move of emergency and high risk T&O had taken place the previous day.

He advised that there had not been any significant problems with the move and, whilst Brighton was not happy at the timing, they understood why the move had to be made and discussions were continuing with them to reduce the impact as far as possible.

Special Care Dental Service

Mr Welling noted that Dr Harrison had circulated with the agenda a briefing paper on the relocation of the special care dental service from Peacehaven Healthcare Centre to Seaford Health Centre which was being provided to the Health Overview and Scrutiny Committee. Mrs Webster said that the move would ensure that the service was delivered in facilities that were fit for purpose and therefore safer for patients.

Non-Executive Director Replacement

Mr Welling reported that the interviews for a replacement for Mr O'Sullivan would take place on Monday, 19th May.

2. Review of Breast Services

Mrs McIlrath reported that the driver for the review of breast services concerned the potential lack of capacity to provide an elective breast surgical service on the Conquest site following the move of emergency and high risk general surgery and trauma and orthopaedics to the Conquest site and a working group consisting of the three breast surgeons, cancer lead and other colleagues had been set up to look at options available for the service.

She advised that a patient survey would take place in June to understand patients' requirements from the service and the working group was also looking at best practice models of care and visiting other service providers. Six possible options for the provision of the service had so far been identified but these were not exclusive. An options appraisal exercise would be undertaken to review all the options and the criteria for this exercise were currently being established.

Mrs McIlrath asked whether the Board wished to take into account the outcome of the challenged health economy work and it was agreed that the review should continue but be cognisant of anything arising from that work.

She agreed to aim to provide a report to the Trust Board at its meeting on 30th July 2014. **LMCI**

3. Update on Challenged Health Economy

Mr Welling provided an update on the work being undertaken with the Clinical Commissioning Groups and Price Waterhouse Cooper (PWC) in relation to the challenged health economy.

He advised that there would be further discussion on this work at the Board awayday in June.

4. Mortality and Morbidity Report

Mr Welling welcomed Dr Wilkinson to the meeting and explained that his report had been reviewed by the Quality and Standards Committee at its meeting the previous week but neither Dr Wilkinson nor Dr Hughes had been in attendance for the discussion. It had therefore been agreed that because of the importance of this issue it should come to the seminar today for discussion rather than wait for the next meeting of the Quality and Standards Committee. It was noted that the Board required adequate assurance and evidence that there was a programme of work in place to support a reduction in avoidable mortality and improve the quality of services for patients.

Dr Wilkinson reported that there were three main indices used to measure mortality rates and they all looked at the rates in a slightly different way. This had been reviewed at previous Board seminars and a Board refresh was provided:

- Hospital Standardised Mortality Ratio (HSMR) – produced nationally by Dr Foster and widely publicised
- Risk Adjusted Mortality Indicator – used by CHKS and based on Dr Foster published methodology to produce own version of HSMR – provided basically the same information as the HSMR

Both of the above indices covered mortality for a subset of diagnoses and took into account the age and co-morbidities of patients.

- Summary Hospital Level Mortality Indicator – used by the Department of Health and included all causes of mortality, other than maternal, and included deaths within 30 days of leaving hospital and did not take account of people with palliative care codes.

Dr Wilkinson advised that this indicator disadvantaged integrated Trusts who had patients moving from an acute hospital into a community hospital within the 30 day period, whereas other Trusts moved patients into intermediate care. This disadvantage had been raised by this Trust and other similar organisations with the Health and Social Care Information Centre and the methodology was being reviewed but no date had been given for the outcome of the review.

Mr Welling asked if it was possible to quantify this impact and Dr Willkinson advised that this data was not available but he would ask CHKS if they would be able to extract it. He was aware however that 75% of the deaths in community hospitals were for patients who had been admitted for end of life care or were towards the end of life. This had highlighted an issue with coding as the documentation received if the patients were GP admissions did not provide details of the patient history and co-morbidities, it only recorded the immediate palliative care treatment required.

Dr Wilkinson emphasised that the indices were designed to point to areas where further investigation was required as a higher than expected rate of death was shown.

He advised that all indices were relatively high in the first quarter of 2013/14 for all Trusts and then reduced down but ESHT had had a significantly greater increase in its mortality rate from November/December 2012 through the winter and spring until April/May 2013.

He believed that this was a combination of a severe winter followed by many cases of respiratory illness in the spring.

Dr Wilkinson reported that this sustained increase had rendered the Trust as an outlier on the indicators for that period. There had been a clinical review of patient notes in those particular specialities where it had been flagged up as having statistically significant mortality rates in that particular period – Acute Myocardial Infarctions and Chronic Obstructive Pulmonary Disease and Bronchiectatsis - and he was able to assure the Board that the review of notes had identified no major failings in care. There were always lessons to be learned from undertaking a review and this had highlighted that documentation in the records was not always of a good standard and that doctors were not recognising when patients were at the end of life and should be moving to palliative care.

Dr Wilkinson noted that following the recent mild winter the indices had not risen and were in line with the Trust's peer group.

He highlighted a number of actions that were being taken to improve processes within the Trust including:

- Clinical review of all deaths in community hospitals during 2013
- Clinical review of other conditions flagged by the CQC which had now been completed and no cases of avoidable mortality had been identified
- Patients dying in community hospitals, having stepped down from the acute hospital, should be included in the Mortality and Morbidity (M&M) review by the speciality team responsible for them in the acute service
- Recruitment of a new head of coding who had reviewed the Trust's processes and implemented changes
- Review by an external company of the coding process used for the 5 month period discussed and report awaited
- Continuing education of doctors to improve standard of documentation and recognition of end of life

Dr Wilkinson also reported that a robust mortality review process had been instituted as under the CHKS system it was possible to roll out data to units/speciality/individuals. Every clinical unit was now expected to review all of its deaths within three months of the date of death which would result in every single death in the Trust being review over the course of this year. These were reported at the clinical unit M&M meetings and the review, minutes of meetings, conclusions and action plan were input on to a centralised database.

Dr Wilkinson advised that clinical units also had to provide a scorecard of their performance on a monthly basis for the Mortality Overview Group (MOG) chaired by Dr Hughes and clinical units would be invited to attend the MOG to present on the data. The MOG reported into the Clinical Management Executive and also to the external Clinical Quality Review Group.

Mrs Webster reported that following discussion at the CME on 12th May it had been agreed that the MOG should also report to the Quality and Standards Committee.

Dr Wilkinson was of the view that this improved robust and transparent system was designed to identify warning signs and provide assurance that action had been taken to investigate and address issues where required, both internally and externally.

Mr Nealon requested that for further assurance he would wish to see the results of the in-depth case note review carried out and Dr Wilkinson agreed to send the details of the review to Mrs Richardson for circulation to the Board. **JW/TR**

Dr Hughes stated that the Board needed to be assured that there were no clinical failings and that the processes were in place to review deaths and complications in hospital, recognise those areas where further improvements were required and share the learning across the organisation.

Mr Welling asked if there were any issues that required support from the Board and Dr Wilkinson advised that the clerical support for the mortality database was only on a temporary basis and a permanent Band 4 post was required for the long term. Mr Welling asked Dr Hughes and Mrs Webster to raise this at the Corporate Leadership Team meeting as this was a critical area that needed to be resourced. **DH/AW**

Dr Wilkinson also raised concern that the Trust was sometimes on the “backfoot” with outlier alerts generated from Dr Foster as it utilised a different system, CHKS. Discussions were taking place with CHKS to ascertain if the alerts could be mirrored to allow the Trust to review all alerts in a timely manner. If this was not feasible it would be useful for the Trust to have access to the Dr Foster system.

Dr Hughes reported that he and Dr Wilkinson were taking advice from one of the national TDA experts on the issue of community mortality indices and how these should be approached and Mrs Webster was also making contact with other Trusts to see how they had approached the issue.

Mr Welling thanked Dr Wilkinson for his very helpful report and requested that he and representatives from the Knowledge Management team attend a board seminar before September in order that the Board could have a deep dive into the issues. Dr Wilkinson agreed and invited directors to attend the MOG for further assurance.

5. National Nurses Day – 12th May 2014

Mrs Webster reported that patients had been asked to complete postcards to nurses and so far 150 had been sent back and the majority had been very positive. In addition, to celebrate the day poems from the dignity conference had been broadcast on the hospital radios.

6. Date and Time of Next Meeting

Wednesday, 11th June 2014, from 9.00 am to 6.00 pm, followed by supper, at the East Sussex National Golf Course

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	17
Subject:	Review of Board Governance and Leadership
Reporting Officer:	Stuart Welling, Chairman

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

Purpose:

The Board must review its arrangements for governance and leadership to ensure they are robust and fit for purpose. This is an ongoing process undertaken on an annual cycle in line with recognised good practice..

Introduction:

As part of the organisations process of ongoing review of the effectiveness and efficiency of its governance and leadership arrangements the Board reviewed its performance and governance arrangements at the July seminar, this encompassed

1. Review of the Board Assurance Framework
2. Review against the nationally developed Board Governance Assurance Framework
3. Review of the Board Committee structure

Information about the Well Led framework recently published by Monitor which supersedes the Quality Governance Assurance Framework was also circulated and will be considered in detail at the August Board seminar.

This process supports the Board to identify and address any risks to the achievement of its strategic objectives, strengthen its governance mechanisms, assess its current performance and identify and assess the robustness of the evidence that should be used to support self assessment.

Analysis of key issues and actions to be taken

1. Review of the Board Assurance Framework (BAF)
   The Board reviewed the risks contained in the BAF and it considered that these, subject to minor revisions, represented the totality of the risks the organisation faces in achieving its strategic objectives. It was agreed to revise the wording of risk 3.1 and to add a new risk that encapsulates the capital constraints. It was considered that the BAF reflects existing controls and assurance and identifies where there are gaps in controls or assurance. The BAF will be refreshed and an updated version will be presented at the September public Board meeting

2. Review of Board Governance Assurance Framework (BGAf)
   The Board should undertake at least an annual review of the effectiveness of its leadership. It should consider the strength of the evidence that supports its assessment and identify development needs aligned to the outcomes of the assessment. The Board reviewed each indicator of the BGAF and agreed RAG ratings, evidence and further actions. The document will be updated by the Company Secretary and circulated to members for consideration.

3. Review of the Board Committee Structure
   All Board committees should undertake a review of their effectiveness on an annual basis. To date this has been completed by the Audit Committee, Remuneration Committee and Quality and Standards Committee. An annual review of the Finance and Investment Committee is in hand. As a result of its annual review the Quality and Standards Committee proposed a revision of its terms of reference to ensure it is able to fulfil its functions effectively. The Board considered the proposed changes at the July seminar and revised terms of reference are attached for the Board to ratify. It was agreed that the Committee will review how it will deliver against the terms of reference and revise its work plan accordingly.

4. Well Led Framework
   Monitor issued guidance for NHS Foundation Trusts in May 2014 setting out an assessment framework for governance reviews. In addition, Monitor, the Trust Development Authority and the Care Quality Commission have published a document setting out how they will work together to assess how well led organisations are. Together these documents provide guidance on the way in which the Board should assess its effectiveness and leadership. The Monitor guidance describes four domains:

   - Strategy and planning
   - Capability and culture
   - Process and structures
   - Measurement

   Under each domain there are a series of questions that further develop the governance review and provide examples of good practice. An initial assessment has been undertaken against this framework and the Board will review its performance in all four domains over the next few months in order to identify areas for development so that these can inform Board and Organisational Development Plans.

Benefits:
Undertaking regular reviews of all governance processes and Board effectiveness enables the organisation to take steps to continuously improve its leadership.

Risks and Implications
In assessing the effectiveness of its governance and leadership the Board may identify risks that cannot easily or effectively be addressed through further refinements of governance processes or through Board and organisational development.

Assurance Provided:
By undertaking the reviews described above the Board is ensuring that it is able to make progress in developing an appropriately governed and led organisation

Proposals and/or Recommendations
The Board is asked to ratify the revised Quality and Standards Committee terms of reference and note that the Committee will review its work plan to support it in delivering its responsibilities.

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Lynette Wells, Company Secretary Dr Amanda Harrison, Director of Strategic Development and Assurance	Lynette.wells2@nhs.net Amanda.harrison1@nhs.net

Quality and Standards Committee
Terms of Reference

1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Quality and Standards Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. These terms of reference shall apply for as long as the Trust is an NHS Trust and can only be amended by the Trust Board

2. Purpose

The main duties of the Committee are to ensure, on behalf of the Board, that taking account of best practice

- there are effective structures and systems in place that support the continuous improvement of quality services and safeguard high standards of patient care

- that quality of decisions and effective decision making is based on information from robust systems and processes that are used effectively across the organisation in a culture that supports challenge, scrutiny and learning.

- that where risks and issues in respect of quality are identified these are being managed in a controlled and timely way.

- that staff are supported to speak up and be innovative and ideas focused to achieve excellent outcomes

3. Responsibilities

Seek assurance that patients, staff and other key stakeholders are actively and effectively engaged in quality and safety issues and that the mechanisms for seeking and responding to feedback from staff and patients are robust and effective

Review and monitor the effectiveness of Trust processes in respect of compliance with standards, national best practice and guidance. This will include scrutinising any concerns or adverse findings and monitoring actions taken by management to address these, for example mortality outlier alerts.

Seek assurance that effective management processes are in place that ensure the Trust has taken appropriate action and shared learning in response to relevant national and local reports, guidance and reviews to improve the safety and quality of care

Review the risk register and BAF to identify relevant quality and safety risks and seek assurance that appropriate management action has been taken to manage and mitigate these risks. Reporting any gaps in control or assurance to the Board

Approve the quality improvement components of the Annual Business Plan prior to its approval by the Board seeking assurance that these are fully aligned to organisational priorities and the QIP and that appropriate and achievable timescales

for delivery have been identified. Agree the measures that will be used to evidence delivery

Seek assurance that the Trust's Quality Improvement Plan addresses key areas of concern and risk and is being delivered in a timely way and that there is an evidence base for the effectiveness of the plan and the delivery of the required quality improvements

Periodically review governance arrangements in the Trust, both clinical and non-clinical, to ensure that they remain effective and compliant with best practice

Seek assurance that action is being taken to ensure compliance with regulatory and statutory standards and requirements and that performance management arrangements are effective in this respect. Identify gaps in control and assurance and report these to the Board.

Review themes and trends that occur in patient and staff feedback, findings from quality walks, patient safety and quality data. clinical audit, complaints, patient safety and serious incidents. Seek assurance that learning from incidents has been shared across the organisation and that actions required to deliver improvements are captured in the Quality Improvement plan and are delivered in a timely manner resulting in agreed and measurable improvements in quality and safety.

To support the work of the trust's audit committee, which has responsibility for the oversight of the trust's risk management system. The chairman of the committee will liaise with audit committee chairman in order to ensure a unified approach to matters of common interest.

Monitor the Trust's Quality Accounts and ensure effective consultation with stakeholders takes place and to monitor the delivery of the quality targets.

Review the Trust's quality performance using agreed national and local performance metrics. Seek assurance that areas of underperformance are identified and that appropriate quality improvements actions are taken in a timely manner to deliver the measurable improvements required

To monitor and review the systems and processes in place in the Trust in relation to Infection Control and to review progress against identified risks to reducing hospital acquired infections.

Review feedback and associated action plans from Quality Walks and Assurance visits.

Receive reports and assurances (including those from internal and external audit) that the Trust's Quality Governance strategy is being effectively operated and agree any amendments to the strategy prior to recommending these to the Board for approval

4. Membership and attendance

The Committee and the Committee Chair will be appointed by the Chairman of the Trust Board. Members of the Committee shall be:

- Three Non-Executive Directors one of whom will be the Committee Chair
- Chief Operating Officer
- Medical Director
- Director of Nursing
- Company Secretary
- Head of Governance
- HR Representation
- Clinical Improvement Manager
- Two associate medical directors
- Associate Director Knowledge Management
- Ex-Officio Members, numbers to be determined by the Committee.

  Note: Ex-officio members of the Committee will have the same rights and privileges as do all other members, although this excludes the right to vote

Membership may be extended to support the Committee in the discharge of its duties this may include for example inviting Clinical Unit representatives or Associate Directors of Nursing to attend relevant meetings.

Members of the Trust Board not specified as members of the Committee shall have the right of attendance. The Secretary to the Committee shall circulate minutes of the meetings of the Committee to all members of the Trust Board.

5. Quorum

Quorum of the Committee shall be four members at least one of which must be a non-executive director. Fully briefed deputies should be sent in the absence of a core member and will count towards the quorum.

6. Frequency

Meetings shall be held not less than four times a year and at such other times as the Chairman of the Committee shall require.

7. Authority

The Committee is authorised by the Trust Board to review any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employers are directed to cooperate with any requests made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee may establish sub-committees or working groups if this would support it in achieving its objectives.

8. Reporting arrangements

Minutes of the Committee meetings shall be formally recorded by the Secretary to the Committee and submitted to the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

The Committee will report to the Board annually on its work in support of the statement on internal control and by exception as and when necessary.

The Committee shall undertake a self-assessment of its effectiveness annually. The Company Secretary will support the Committee to develop and implement an annual work programme

These Terms of Reference shall be reviewed by the Committee and proposed revisions considered by the Trust Board on at least an annual basis.

East Sussex Healthcare NHS Trust Annual Board Planner

Each Meeting

- Quality walks feedback
- Monthly staff award
- CEO report
- Board Assurance Framework
- CQC visits
- Performance reports
- Business cases over £500k as recommended by Finance and Investment Committee/Contracts awarded in excess of £1m
- Sub-committee reports & minutes and Board Seminar notes
- Themes for Quality Walks
- Chairman's correspondence

January

- Complaints and FFT quarterly report
- Annual Business Plan quarterly report
- Quality improvement plan

March

- Quality Improvement Priorities 14/15
- Annual business plan and budget
- Capital programme
- Risk Management Strategy
- Delivering same sex accommodation annual declaration of compliance

June

- Quality Account
- Staff Survey
- Complaints and FFT year end report
- Annual Business Plan year end report
- R&D annual report
- Fire annual report
- Single equality scheme annual report
- Review of committee structure/work programme
- Delegation of approval of Annual Report and Accounts 2013/14

July

- Complaints and FFT quarterly report
- Annual Business Plan quarterly report
- Medical revalidation annual report
- Emergency planning and business continuity annual report
- Health and Safety annual report
- Safeguarding annual report (adults and paediatrics)

September

AGM

- To receive 2013/14 Annual Report and Accounts and Quality Account 2013/14

BOARD

- Capital programme – mid year review
- Winter preparedness
- Meeting dates for next year

November

- Review of Quality Account indicators
- Complaints and FFT quarterly report
- Annual Business Plan quarterly report
- Review of standing orders, financial instructions, and declaration of interests

Board seminars

Each month standing items –
Finance flash report, update on performance & current issues

- January – business planning
- February – business planning
- March – business/financial planning
- April – review of BAF
- May – review of committee structure/work programme

Board seminars

- June
- July
- August
- September – winter preparedness
- October
- November
- December

East Sussex Healthcare NHS Trust

Date of Meeting:	30th July 2014
Meeting:	Trust Board
Agenda item:	19
Subject:	Chairman's Briefing
Reporting Officer:	Stuart Welling, Chairman

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

Purpose:

To keep the Board informed of the activities undertaken by the Chairman since the last Board meeting.

Introduction:

The purpose of this paper is to provide an overview of activities undertaken and relevant correspondence received or sent by the Chairman since the last Board meeting.

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

Meetings attended in July included:

- FTN Annual Governance Conference – 1st July
- HealthWatch – 2nd July
- Greg Barker MP – 4th July
- Crowborough League of Friends AGM - 15th July
- NHS Trust Development Authority – 23rd July
- Sussex Provider and Clinical Commissioning Group Chairs – 24th July
- Health Overview and Scrutiny Committee – 28th July
- Various Quality Walks

The following correspondence is attached to the report:

- NHS Confederation letter to The Guardian – 2nd June
- Letter to Stephen Lloyd – 12th June
- Letter to Stephen Lloyd – 18th July
-

Use of Trust Seal

The following document has been sealed since the last meeting:

Deed of Surrender of the Lease Agreement between the Trust and the University of Brighton

Proposals and/or Recommendations

The Board is asked to note the activities undertaken by the Chairman since the last Board meeting.

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

Name:	**Contact details:**
Stuart Welling, Chairman	s.welling@nhs.net

the voice of NHS leadership

NHS CONFEDERATION

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To The Editor
The Guardian
Kings Place
90 York Way
London
N1 9GU

2 June 2014

FOR PUBLICATION

Sir,

We, as leaders of NHS organisations and organisations providing NHS care across England, believe that the NHS is at the most challenged time of its existence. Rising demands mean that the cost of providing health service rises every year by about 4 per cent above inflation. At the same time, the services we commission and run are not designed to cope with the care needs of the 21st Century - especially the large numbers of people with multiple long-term conditions and an increasingly elderly population.

As local organisations, we are urgently planning the transformation of how we care for people to ensure we continue to deliver a service that meets people's needs and improves the public's health. Our plans start to address the challenges that are well set out in the 2015 Challenge Declaration, published by the NHS Confederation on 6 May, in association with medical royal colleges, local government and patient organisations. But more will need to be done if we are to be successful.

With a year to go to the general election it is vital that the political parties recognise the scale of the challenge we are addressing - and that their manifestos must address. At the 2010 General Election not one of the political parties mentioned the financial challenge facing the NHS in its manifesto. In 2015, the parties must address the full range of challenges

facing the NHS or take responsibility for it becoming unsustainable in the form people want it.

We call on each of the party leaders to publicly recognise the challenges facing health as spelt out in the NHS Confederation's 2015 Challenge Declaration - and to ensure that their manifestos are written to support how we will address them.

Yours faithfully,

Rob Webster, chief executive, NHS Confederation
Sir Ron Kerr, chief executive, Guy's and St Thomas' NHSFT
Peter Homa, chief executive, Nottingham University Hospitals NHS Trust
Professor Tricia Hart, chief executive, South Tees Hospitals NHSFT
Dr Matthew Patrick, chief executive, South London and Maudsley NHSFT
Prem Singh, chair, Derbyshire Community Health Services Trust
Sir Jonathan Michael FRCP, chief executive, Oxford Univ. Hospitals NHS Trust
Ken Jarrold CBE, chair, North Staffordshire Combined Healthcare NHS Trust
Robert Dolan, chief executive, East London NHS Foundation Trust
John Wilderspin, managing director, Central Southern CSU
Sir Andrew Cash, chief executive, Sheffield Teaching Hospitals NHSFT

and 60 others (full list attached)

cc. Denis Campbell, health correspondent

Rob Webster	Chief Executive	NHS Confederation
Sir Ron Kerr	Chief Executive	Guy's and St Thomas' NHS Foundation Trust
Peter Homa	Chief Executive	Nottingham University Hospitals NHS Trust
Professor Tricia Hart	Chief Executive	South Tees Hospitals NHS Foundation Trust
Dr Matthew Patrick	Chief Executive	South London and Maudsley NHS Foundation Trust
Stuart Bain	Chief Executive	East Kent Hospitals University NHS Foundation Trust
Sir Jonathan Michael FRCP	Chief Executive	Oxford University Hospitals NHS Trust
Tim Goodson	Chief Officer	Dorset Clinical Commissioning Group
Christopher Baker	Chair	Aintree University Hospital NHS Foundation Trust
Marie Gabriel	Chairperson	East London NHS Foundation Trust
Dr Avi Bhatia	CCG Clinical Chair	NHS Erewash CCG
Stephen Swords	Chairman	Hounslow & Richmond Community Healthcare NHS Trust
David Edwards OBE	Chairman	Cambridgeshire and Peterborough FT
Michael Luger	Chair	Airedale Hospitals NHS Foundation Trust
Dr Nick Marsden	Chair	Salisbury NHS Foundation Trust
Prem Singh	Chairman	Derbyshire Community Health Services Trust
David Griffiths	Chairman	Kent Community Health NHS Trust
Ken Jarrold CBE	Chair	North Staffordshire Combined Healthcare NHS Trust
Stuart Welling	Chairman	East Sussex Healthcare NHS Trust
Stephen Wragg	Chairman	Barnsley NHS Foundation Trust
Chris Wood	Chair	Burton Hospitals NHS Foundation Trust
Gary Page	Chair	Norfolk and Suffolk NHS Foundation Trust
Robert Dolan	Chief Executive	East London NHS FT
David Wright	Chairman	James Paget University Hospital FT
David Jenkins	Chair	Aneurin Bevan University Health Board
Ruth FitzJohn	Chair	²gether NHS Foundation Trust
Stephen Ladyman	Chairman	Somerset Partnership NHS Foundation Trust
Harry Turner	Chairman	Worcestershire Acute NNS Trust
Jane Fenwick	Chairman	Humber NHS FT
Hugh Morgan Williams OBE	Chairman	NTW NHS health trust
Jo Manley	Director of Operations	Hounslow Richmond Community NHS Trust
Dr Christina Walters	Programme Director	Community Indicators Programme
David Law	Chief Executive	Hertfordshire Community NHS Trust
Julia Clarke	Chief Executive	Bristol Community Health CIC
Matthew Winn	Chief Executive	Cambridgeshire Community Services NHS Trust
Simon Perks	Accountable Office	NHS Ashford CCG & Canterbury and Coastal CCG
Stephen Conroy	CEO	Bedford Hospital

Stephen Firn OBE	Chief Executive	Oxleas NHS Foundation Trust
Katrina Percy	Chief Executive Officer	Southern Health NHS Foundation Truts
Mark Hindle	Chief Executive	Calderstones Partnership NHS Foundation Trust
Christine Briggs	Director of Operations	NHS South Tyneside CCG
John Wilderspin	Managing Director	Central Southern CSU
Alison Lee	Chief Executive Officer	NHS West Cheshire Clinical Commissioning Group
Andrew Cash	Chief executive	Sheffield Teaching Hospitals NHS Foundation Trust
Christine Bain	Chief Executive	Rotherham Doncaster & South Humber NHS FT
Sarah-Jane Marsh	Chief Executive Officer	Birmingham Children's Hospital
Tracy Allen	Chief Executive	Derbyshire Community Health Services NHS Trust
Chris Dowse	Chief Officer	NHS North Kirklees CCG
Stuart Poynor	CEO	SSOTP
Dominic Wright	Chief Officer	Guildford & Waverley CCG
Steven Michael	Chief Executive	South West Yorkshire Partnership NHS Foundation Trust
Dr Mark Newbold	Chief Executive	Heart of England NHS Foundation Trust
Andrew Donald	Chief Officer	Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups
John Matthews	Clinical Chair	NHS North Tyneside CCG
Lisa Rodrigues	Chief Executive	Sussex Partnership NHSFT
Jonathon Fagge	Chief Executive Officer	NHS Norwich CCG
Steve Trenchard	CEO	Derbyshire Healthcare Foundation NHS Trust
Louise Patten	Accountable Officer	Aylesbury Vale CCG
Jane Tomkinson	CEO	Liverpool Heart and Chest Hospital FT
Allan Kitt	Chief Officer	South West Lincolnshire Clinical Commissioning Group
Darren Grayson	Chief Executive	East Sussex Healthcare NHS Trust
Katherine Sheerin	Chief Officer	NHS Liverpool CCG
Edward Colgan	Chief Executive	Somerset Partnership NHS Foundation Trust
David Stout	Managing Director	NHS Central Eastern Commissioning Support Unit
Andrew Bennett	Chief Officer	Lancashire North CCG
John Brewin	Interim Chief Executive	Lincolnshire Partnership Foundation Trust
Andrew Foster	Chief Executive	Wrightington, Wigan & Leigh NHS Foundation Trust
Richard Paterson	Associate Chief Executive	
Glen Burley	Chief Executive	South Warwickshire NHS FT
Joe Sheehan	Managing Director	Medical Services Ltd
Robert Flack	Chief Executive	Locala
Martin Flaherty OBE	Managing director	Association of Ambulance Chief Executives

Your ref: DGH/0501614/JW
Our ref: SW/ajp/4595

East Sussex Healthcare NHS
NHS Trust

12th June 2014

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 01323 417400
Website: www.esht.nhs.uk

Stephen Lloyd MP
House of Commons
London
SW1A OAA

Dear Stephen

I am responding to your letter of 6th June regarding bed reductions at Eastbourne District General Hospital. It is important not to confuse changes in the number of beds with changes in the service provided. In common with hospitals everywhere we constantly adjust the number of beds we have to ensure we are able to meet the needs of patients. For example it is usual for our bed numbers to go up in the winter months. We keep our bed numbers under constant review and opening and closing wards/beds is one of the many steps we take to ensure we are making best use of our resources.

We need to plan ahead to ensure we are able to deliver our services safely. Our plans for 2014/15 include using our beds more efficiently by reducing length of stay for patients so that they are able to return to their home quicker, implementing new and better ways of working and using the creativity of our staff, new treatments and advances in technology to help us transform the way we deliver services.

We constantly aim to drive up our effectiveness and efficiency and raise the quality of the services. Along with our commissioners our focus is on making sure that patient care is being delivered in the right place which is not always within an acute hospital environment. We take steps to discuss any planned changes with staff both collectively and on an individual basis. We provide staff with the opportunity to raise concerns in a number of ways and have previously provided you with information about these routes. We continue to hope that you will encourage staff to raise concerns with the Trust so that they can be dealt with directly.

Yours sincerely

Stuart Welling
Chairman

THE RT HON GREGORY BARKER MP
(BEXHILL & BATTLE)

4666.

HOUSE OF COMMONS
LONDON SW1A 0AA

21 JUL 2014

Mr Stuart Welling
East Sussex Healthcare NHS Trust
Conquest Hospital
The Ridge
St Leonards-on-Sea
East Sussex
TN37 7RD

Our Ref: GB/FM/10039

15 July 2014

Dear Stuart,

Thank you and Darren for meeting me on 4 July for a general update on the East Sussex Healthcare NHS Trust. I was pleased to hear that the outcomes for maternity services have improved since the service was transferred to the Conquest hospital and I should be grateful for sight of any data which supports this.

I was concerned to hear that local women were not taking up their appointments to see specialists within the two week timescales following their referrals from GPs for breast cancer. If there is anything I can do to support a campaign to encourage local women to keep these important appointments then please do let me know.

I was encouraged to hear that 95% of A&E patients at the DGH and Conquest are seen within the national target of 4 hours. I appreciate that there are still a high number of local people who arrive at A&E with conditions which should be dealt with in primary care. I recognise that this is also a national problem which must be tackled if our A&E Units are to provide the quality emergency care we expect. I have discussed the issue of better GP access with the local CCGs with a view to actively supporting any moves to increase local access to GPs, smaller injury units and better health education.

I should be grateful if you would keep me updated with any data to support the centralisation of other services including stroke and general surgery as this becomes available and of any subsequent improvements in recruitment and retention.

Kind regards,

Yours sincerely,

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www.gregorybarker.com

SW/ajp

East Sussex Healthcare NHS
NHS Trust

18th July 2014

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 01323 417400
Website: www.esht.nhs.uk

Stephen Lloyd MP
100 Seaside Road
Eastbourne
East Sussex

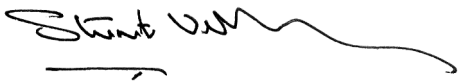
Dear Stephen

I recognise that you have supported the provision of consultant led maternity and in patient paediatric services at Eastbourne District General Hospital (EDGH) with passion and sincerity. I also recognise that we share a common objective of ensuring that your constituents are able to access safe and effective care. With this in mind we would like to share with you the extensive evidence that we have that the CCGs proposal to locate consultant led obstetric services and in patient paediatric services at the Conquest Hospital will achieve this shared objective.

Now that Parliament is in recess and you have more time in Eastbourne I would like to offer you the opportunity to come to EDGH and meet with the midwives and doctors providing these services. They are eager to meet tell you directly why they believe the service has improved and talk through the evidence and their day to day experiences as front line clinicians.

I hope that you will take up this offer and the opportunity to understand how over the last year our clinicians have developed and enhanced local maternity and paediatric provision to the benefit of local people.

Yours sincerely



Stuart Welling
Chairman

cc Cllr Ensor, HOSC

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PRIVATE

A meeting of East Sussex Healthcare NHS Trust Board will be held in private on Wednesday, 30th July 2014, following the public Trust Board meeting In the Manor Barn, Bexhill-on-Sea

		Lead
1.	Apologies for Absence	Chair
2.	Declarations of Interest	Chair
3.	Minutes of the meeting held on 3rd June 2014 (attached)	Chair
4.	Update on Current Issues	CEO
5.	Review of public board meeting	Chair

STUART WELLING
Chairman

24th July 2014