EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 30th September 2015, commencing at 10.45 am in the Oak Room, Hastings Centre, The Ridge, Hastings TN34 2SA

AGENDA

			Lead:
1.	a) Chairman's opening remarks (including CQC reports) b) Apologies for absence c) Quality Walks	A	Chair
2.	Monthly award winner(s)		Chair
3.	Declarations of interests		Chair
4a.	Minutes of the meeting held on 5th August 2015	Bi	Chair
4b.	Matters arising	Bii	Chair
5.	Acting Chief Executive's report (verbal)		CEO
6.	Board Assurance Framework	C	CSec

QUALITY, SAFETY AND PERFORMANCE

7.	IG Breach (Data Stick) Recommendations & Actions	Assurance	D	DN
	Questions from members of the public relating to the IG Breach item above (10 minutes maximum)			
8.	Quality Improvement Plan	Assurance	E	CEO / DN
9.	Quality Improvement Director's Report (verbal)	Assurance		QID
	Questions from members of the public relating to the CQC reports and Quality Improvement Plan above (10 minutes maximum)			
10.	a) Performance report month 4 (July), Finance report month 5 (August) and Workforce Report month 5 (August) b) Safe Nurse Staffing	Assurance	F	ALL

STRATEGY

11.	Operational Resilience and Capacity Plan 2015/16	Approval	G	COO
12.	Revision to NHS Constitution	Information	H	CSec

13.	Capital Programme Mid-Year Review	Approval	I	DF

GOVERNANCE & ASSURANCE

14.	Annual Reports: a) Infection Control b) Annual Equality Report c) Safeguarding Annual Report d) Fire Safety Annual Report	Assurance	J	DN CSec DN COO
15.	Board sub-committees: a) Audit Committee Summary 03.08.15 and Annual Report b) Finance and Investment Committee Minutes 24.06.15, 29.07.15, Annual Review of Effectiveness and Terms of Reference c) Quality and Standards Committee Report	Assurance	K	Comm Chairs

ITEMS FOR INFORMATION

16.	Chairman's Briefing	Assurance	L	Chair
17.	Questions from members of the public (15 minutes maximum)			Chair
18.	Date of Next Meeting: Wednesday, 2nd December 2015 – Public Trust Board meeting at 10.00 am, St Mary's Board Room, EDGH			Chair

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

STUART WELLING
Chairman

16th September 2015

Key:

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

Care Quality Inspection March 2015

The Care Quality Commission inspected the Trust in September 2014, when both Conquest Hospital and Eastbourne District General Hospital were both rated Inadequate and Community Services were rated as needing improvement. A team of CQC inspectors followed this up with a further unannounced inspection in March 2015 to review progress in addressing the main areas of concern, focussing on maternity services, outpatient and diagnostic imaging services, surgery and accident and emergency care.

The report was published on 22nd September 2015 and the Trust has again been rated as Inadequate overall. We are sorry if we have let down the people who use our services, our staff, and colleagues and acknowledge we have not delivered as we should have done to meet the standards people in East Sussex rightly expect from us. We have been through a difficult and challenging time and we know we need to deliver improvements urgently

The overarching, organisational report is attached and full reports for each hospital can be found on the CQC website: http://www.cqc.org.uk/provider/RXC and details of the individual ratings are attached as an appendix.

We are committed to working with our staff and our partners to prepare and deliver the improvements required for our patients. Areas of concern included aspects of surgery, maternity and outpatient services and as will be outlined in our Board meeting, actions have already taken place to make improvements in these areas with further action planned.

The CQC convened a Quality Summit on 18 September where the findings were shared with many of our stakeholders, and where we held meaningful conversations to find solutions to some of our challenges.

We fully acknowledge and value the dedication of our staff. It is a credit to them that the CQC recognised we are a caring organisation by rating caring as ‘good’ across our services and that the September inspections rated medical care at Conquest as ‘good’ and critical care ‘good’ at both sites.

On the recommendation of Professor Sir Mike Richards, the Chief Inspector of Hospitals for the CQC, the NHS Trust Development Authority (NTDA) has placed the Trust in special measures. The special measures regime is designed to support required improvement at pace by providing help and support where it is most needed. We welcome this support and are pleased to have a new Improvement Director in our organisation.

The CQC will return in approximately 12 months to do another inspection to see how we are making progress in the areas they have highlighted in these reports. We are committed to be in a position to demonstrate that we are delivering excellent healthcare for the people of East Sussex and that we are a great place to work.

Appendix

CQC Domain Ratings – East Sussex Healthcare NHS Trust

Domain	Rating
Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well led	Inadequate
Overall ESHT rating	Inadequate

East Sussex Healthcare NHS Trust

Quality Report

King's Drive, Eastbourne,
East Sussex BN21 2UD
Tel: 01323 417400
Website: http://www.esht.nhs.uk/

Date of inspection visit: 24, 25, 26 March and 10 April 2015
Date of publication: 22/09/2015

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Inadequate
Are services at this trust safe?	**Inadequate**
Are services at this trust effective?	**Requires improvement**
Are services at this trust caring?	**Good**
Are services at this trust responsive?	**Requires improvement**
Are services at this trust well-led?	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

East Sussex Healthcare NHS Trust (ESHT) provides acute hospital and community health services for people living in East Sussex and the surrounding areas. The trust serves a population of 525,000 people and is one of the largest organisations in the county. Acute hospital services are provided from Conquest Hospital in Hastings and Eastbourne District General Hospital, both of which have Emergency Departments. Acute children's services and maternity services are provided at the Conquest Hospital and a midwifery-led birthing service and short-stay children's assessment units are also provided at Eastbourne District General Hospital.

The trust also provides a minor injury unit service from Crowborough War Memorial Hospital, Lewes Victoria Hospital and Uckfield Community Hospital. A midwifery-led birthing service along with outpatient, rehabilitation and intermediate care services are provided at Crowborough War Memorial Hospital. At both Bexhill Hospital and Uckfield Community Hospital the trust provides outpatients, day surgery, rehabilitation and intermediate care services. Outpatient services and inpatient intermediate care services are provided at Lewes Victoria Hospital and Rye, Winchelsea and District Memorial Hospital. At Firwood House the trust jointly provides, with adult social care, inpatient intermediate care services.

Trust community staff also provide care in patients' own homes and from a number of clinics and health centres, GP surgeries and schools.

The trust employs almost 7,000 staff and has 706 inpatient beds across its acute and community sites. The trust serves the population of East Sussex which numbers 525,000.

We carried out this unannounced focussed inspection in March 2015. We analysed data we already held about the trust to inform our inspection planning. Teams, which included CQC inspectors and clinical experts, visited the two acute hospitals along with the Crowborough Birthing Centre and reviewed four of the eight core services that we usually inspect as part of our comprehensive inspection methodology. Services reviewed were maternity services, outpatient services, surgery and accident and emergency care; we reviewed these particular core services as in our comprehensive inspection in September 2014, we had identified serious concerns about the care and treatment provided. We spoke with staff of all grades, individually and in groups, who worked in these services. Staff from across the trust attended our drop in sessions on both sites.

In September 2014 we identified concerns about the provision of pharmacy services. We looked at this in our unannounced visits by a CQC pharmacist. A large number of people from the local community and staff had contacted CQC after the previous inspection report was published to tell us it was an accurate reflection of the way the trust provided services.

It is important to note that in the past two years the trust had been through a period of significant change with reconfiguration of some key services across both acute sites. The trust had followed guidance on both consultation and reconfiguration set out by the Secretary of State for Health. The consultation process was led by the local Clinical Commission Groups and has been assessed by an audit of its corporate governance. The assessment of this process by an internal audit company provided assurance to the board and stakeholders that "Corporate governance, in relation to the maternity project specifically, considered to be executed to a high standard and in compliance with the selection of Good Governance Institute outcomes examined". It also set out that "Structures and decision-making processes clearly set out and followed". We were aware that the reconfiguration was not universally accepted as a positive change by some members of the public and some staff. Despite the process, many people we spoke to said that they felt their concerns had not been listed to, and they had not been well engaged.

We met with the trust and Trust Development Authority (TDA) representatives on 23 March 2015 to hear about the action they had taken since the comprehensive inspection in September 2014. Details of the action plan were shared with us, with a copy of the draft plan being provided to us on 26 March 2015. Since then the trust has amended and finalised the action plan, making it more robust and focussed.

Summary of findings

During this unannounced follow up inspection and in the preceding comprehensive inspection we reviewed clinical services as they are currently configured. Our remit does not include commenting on local decisions about the configuration of services. We have, where pertinent, considered the safety and effectiveness of the services post reconfiguration and whether the trust is responsive to individual and local needs.

Our key findings from the unannounced follow up inspection were as follows:

- The trust board continues to state they recognise that staff engagement is an area of concern but the evidence we found suggests there is a void between the Board perception and the reality of working at the trust. At senior management and executive level the trust managers spoke entirely positively and said the majority of staff were 'on board', blaming just a few dissenters for the negative comments that we received.
- We found the widespread disconnect between the trust board and its staff persisted. This is reflected in the national NHS Staff survey.
- The most recent NHS staff survey showed the trust performing badly in most areas. It was below average for 23 of the 29 measures, and in the bottom 20% (worst) for 18 measures.
- Overall the trust was amongst the bottom 20% of all trusts in England for staff engagement. Only 18% of staff reported good communications between managers and staff against a national average of 30%.
- The trust was also in the bottom quintile for staff reporting that they had the ability to contribute towards improvement at work.
- The trust told us they were disappointed by the results; but we saw no direct programme to address this or to change the position.There remained a poor relationship between the board and some key community stakeholders. We found the board lacked a credible strategy for effective engagement to improve relationships.
- We saw a culture where staff remained afraid to speak out or to share their concerns openly. We heard from several sources about detriment staff had suffered when they raised concerns about patient safety.
- Staff remained concerned when they contacted us of the risk of doing so.
- We saw that there remained little public engagement in the wider benefits of the reconfiguration. The trust had followed its original strategy. We saw this had failed to engage significant elements of the community. We saw no new plan to address this issue.
- We saw that local managers had taken some steps that had resulted in an improved patient experience in the outpatient areas but there remained long delays in the referral to treatment time. The trust had taken steps towards improvement but these were yet to demonstrate a sustainable improvement.
- Patients were not being seen for follow-up appointments within the timescale requested by their clinician.
- The call centre for outpatient appointments was not effective. Patients were often unable to make contact with the staff.
- Clinics were sometimes cancelled, and patients had not been informed, or informed at very short notice. There was a lack of appropriate staff to ring patients; who arrived for their appointment and found the clinic was not being held.
- Within the trust, we did not see a cycle of improvement and learning based on the outcome of either risk or incidents.
- Staff remained unconvinced of the benefit of incident reporting, and were therefore not reporting incidents or near misses to the trust. the trust was not able to benefit from any learning from these. this position had not improved.
- The risk register was not capturing risks in a robust way.
- We saw a redesign of the governance structure, but were unable to yet see any significant benefits or improvements from this.

Summary of findings

- We saw low staffing levels that impacted on the trusts ability to deliver efficient and effective care.
- In maternity we saw some small improvements had been made to the governance systems but the major improvements needed to bring about sustainable improvements, such as staffing as yet remained unchanged.
- We saw that surgical services and outpatients' services did not report incidents in a way that would lead to the trust improving services from that learning. We saw that in maternity and surgery there had been improvements in incident reporting but learning was still limited and lessons learned were not embedded.
- We had concerns about the accuracy and robustness of data provided to external stakeholders and the board.
- Training for safeguarding for medical and nursing staff fell well below acceptable levels.
- In a number of areas we remained concerned about medicines management and pharmacy services.
- Checks on controlled drugs were inconsistent in ED, and remained sporadic in surgery, despite a drug register in one area noting an incidence of drugs missing.
- The trust was breaching the provision of single sex accommodation requirements frequently and regularly but not identifying or reporting these. Women and men were both accommodated overnight in the clinical decisions unit and had to walk past people of the opposite sex to use the lavatories and washing facilities.
- There was little consideration for affording privacy to people attending the OPD and radiology where patients changing and waiting facilities were unsuitable and where weighing and other procedures were carried out in corridors.
- The trust healthcare records and records tracking systems remained inadequate.
- The trust was failing to meet the requirements of the National Schedule for Cleanliness in the NHS. Scores from cleanliness audits provided by the trust did not match the aggregated scored from the cleanliness audits we were provided with.
- Staff we spoke with were unaware of their responsibilities regarding the Duty of Candour. Staff we spoke to had not received training on the statutory Duty of Candour (a legal duty to be open and honest with patients or their families when things go wrong that can cause harm) and were therefore unable to describe the processes the trust had in place.
- The trust does receive a higher than average number of complaints for its size although numbers of complaints have fallen over the last two years. We found a complaints system that gave both poor support for people who wished to raise a concern, and concerns on how the trust handled complaints.

We identified some good practice including

- The telephone triage system provided a high standard of information, guidance and support to women, without them necessarily needing to come into hospital.

There were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Give full consideration to whether there have been any breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5 (3)(d) Fit and proper persons: directors
- The board needs to give serious consideration to how it is going to rebuild effective relationships with its staff, the public and other key stakeholders. This was a requirement following our inspection in September 2014 but we are not yet assured from the action plan and speaking with the lead executive officer that this had begun to be addressed.
- The board needs to create an organisational culture which is grounded in openness, where people feel able to speak out without fear of reprisal. This was a requirement following our inspection in September 2014 but we are not yet assured that this work was underway.

Summary of findings

- Undertake a root and branch review across the organisation to address the perceptions of a bullying culture, as required in our previous inspection report.
- Review and improve the trust's pharmacy service and management of medicines.
- Review the reconfiguration of outpatients' services to ensure that it meets the needs of those patients using the service.
- Review the waiting time for outpatients' appointments such that they meet the governments RTT waiting times, and that this is sustainable.
- Ensure that health records are available and that patient data is confidentially managed.
- Review staff deployment in maternity services to ensure that they are sufficient for service provision such that the organisation meets the recommendations made by the Royal Colleges. This was a requirement following our inspection on September 2014 but we are not yet assured from the action plan and data provided by the trust that this has been fully addressed.
- Reduce the proportion of OPD clinics that are cancelled at short notice and develop systems to ensure that where this is unavoidable, that patients are informed in a timely manner.
- Develop achievable succession planning to minimise the impact of staff movements.
- Improve the governance of incident reporting systems to ensure that the number of incidents reported via the electronic system reflects all the incidents that happen.
- Ensure sustained compliance with the National Schedule for Cleanliness.

Additionally the trust should

- Ensure that fridges used for the storage of medicines are kept locked and are not accessible to people and that medicines are secured in lockable units.
- Develop sustainable systems to ensure equipment checks are carried out as required by trust policy and national guidance.
- Develop sustainable systems to ensure that VTE assessments and management are conducted in accordance with the guidance from the Royal Colleges.

Subsequent to this inspection visit a warning notice served under Section 29a of the Health and Social Care Act 2008. This warning notice informed the trust that the Care Quality Commission had formed the view that the quality of health care provided by East Sussex Healthcare NHS Trust requires significant improvement:

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to East Sussex Healthcare NHS Trust

The health of people in East Sussex is generally better than the England average. Deprivation is lower than average, about 18.1% (16,000) children live in poverty. Life expectancy for both men and women is higher than the England average. Life expectancy is 8.2 years lower for men and 5.4 years lower for women in the most deprived areas of East Sussex than in the least deprived areas.

In 2012, 22% of adults in East Sussex were classified as obese. The rate of alcohol related harm hospital stays was 543*, better than the average for England. This represents 3,007 stays per year. The rate of self-harm hospital stays was 145.2*, better than the average for England. This represents 719 stays per year. The rate of smoking related deaths was 263*, better than the average for England. This represents 1,037 deaths per year. Estimated levels of adult physical activity are better than the England average. The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average. The rate of new cases of malignant melanoma is worse than average. Rates of statutory homelessness, violent crime, long term unemployment, drug misuse and early deaths from cardiovascular diseases are better than average.

Priorities in East Sussex include circulatory diseases, cancers and respiratory diseases to address the life expectancy gap between the most and least deprived areas.

The trust has revenue of £364 million with current costs set at £387 million giving an annual deficit budget of £23 million. A turnaround team had been appointed to address this on-going deficit.

The trust serves a population of 525,000 people across East Sussex. It provides a total of 706 beds with 661 beds provided in general and acute services at the two district general hospital and community hospitals. In addition there are 49 Maternity beds at Conquest Hospital, and the two midwifery led units and 19 critical care beds (11 at Conquest Hospital, 8 at Eastbourne District General Hospital).

At the time of the inspection there was a stable trust board which included a chairman, five non-executive directors, chief executive and executive directors. The chair was appointed in July 2011 for a period of four years. The chief executive officer joined the trust in April 2010 and his appointment was made substantive in July 2010.

* rate per 100,000 population

Our inspection team

Our inspection team was led by:

Head of Hospital Inspection: Tim Cooper, Care Quality Commission.

The team of 29 people that visited across the two hospitals and the birthing unit on 24, 25 and 26 March 2015 included senior CQC managers, inspectors, senior registered general nurses, two consultant midwives and an obstetrician, a theatre specialist, consultants in surgery and emergency medicine, a pharmacist and experts by experience, data analysts and inspection planners.

How we carried out this inspection

To get to the heart of patients experiences of care, we always ask the following five questions of every service provider

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of findings

The inspection teams inspected the following acute hospital four core services across East Sussex Healthcare NHS Trust –

- Accident and emergency services
- Surgery
- Maternity services
- Outpatient services

We made an unannounced inspection of the trust services on 24, 25, 26 March 2015 and our pharmacist visited on 10 April 2015. We interviewed clinical and non-clinical staff of all grades, talked with patients and staff across all areas of the hospitals that we reviewed. We observed staff interactions with each other and with patients and visitors. We reviewed records including staffing records and records of individual patient's care and treatment. We observed how care was being delivered. We held drop in sessions on both sites to listen to staff from different areas of the trust. All staff were invited.

The Head of Hospital Inspection telephoned the most senior executive officer available at 3.00pm on Tuesday 24 March 2015 to inform them that we would be making an inspection visit that afternoon. Our inspection team then commenced their visits to the hospitals.

What people who use the trust's services say

The most recent published Friends and Families Test (FFT) overall score for inpatient services in April 2015 was published at the time of our inspection. Across the trust the FFT showed 95% of people using inpatient services would recommend the service. There was little variance between the two acute sites. These scores include those for community services which may make this difficult to compare with other trusts.

The national Cancer Patient Experiences Survey 2014 showed that the trust was in the middle 60% of trusts for 23 of the 34 key performance indicators. It was in the top 20% of trusts for a further 10 key performance indicators of this survey. In general, scores had risen for each question from the previous year. There was only one 'red rated' area from this survey where the Trust was in the bottom 20% of trusts which related to whether people were given enough privacy when discussing confidential issues.

The Patient Led Assessments of the Care Environments (PLACE) published in August 2014 showed the trust was just below the national average scores for cleanliness (96% against 97%), facilities (90% against 92%) and below the national average for privacy and dignity (84% against 88%).

The number of complaints has decreased since 2011/12 by around 10%, following a nearly 20% increase in complaints between 2010/11 and 2011/12. The number of complaints remains higher than would be expected for a trust of this size and a higher than expected number of complaints are accepted by the Parliamentary and Health Services Ombudsman for investigation.

The NHS Choices website rates trusts with a star rating based on feedback and reviews by people using the service. Both acute hospitals had an overall score of 3.5 stars based on patient reviews. This rating has remained unchanged since September 2014.

We continued to receive higher than expected levels of feedback from people using services and their relatives. Whilst a small number of contacts made positive comments, the overwhelming majority expressed concern and dissatisfaction with the service. The themes we identified included poor patient experiences, staffing concerns, poor communication and staff attitude, an unsatisfactory complaints process, poorly planned discharges, inadequate assessment and management of pain, delays in outpatient treatment and the treatment of people with mental health difficulties in the accident and emergency departments. All the trends identified were related mainly to maternity, surgery, accident & emergency and outpatient services.

The last published CQC Inpatient Survey 2014 showed that the trust was performing, 'about the same' as other trusts for nine of the 11 key performance indicators.

Summary of findings

The trust performed worse for two indicators relating 'hospital and ward' (which is driven by single sex accommodation which we have highlighted in our ED section) and 'operations' (relating to explanations of the risks and benefits of surgery).

Facts and data about this trust

Context

- Approximately 706 beds plus community services
- Serves a population 525,000
- Employs around 6,942 whole time equivalent members of staff

Activity

- 741,706 outpatient attendances in 2013/2014
- 41,846 inpatient admissions across trust hospitals in 2013/2014
- 101,744 accident and emergency department attendances in 2013/2014 (excluding Minor Injuries Unit figures).
- 3,329 births across trust sites, including homebirths, in 2013/2014

Intelligent monitoring

Data from our March 2015 Intelligent Monitoring showed the trust as being recently inspected (relating to the September 2014 visit) but the proportional risk score increased to 6.8%, which is equivalent to band two risk (where band one is the highest risk and band six is the lowest risk). This position had become worse over the past 12 months with three elevated risks related to the staff survey and two other risks identified. The situation is seen to have deteriorate further with the latest intelligence monitoring reports published with the trust showing an increase to four elevated risks and 7 risks.

Key Intelligence Indicators

The trust remains highlighted as an outlier for times for Referral to Treatment (RTT) which measure the waiting time for outpatient and inpatient treatments.

The 2014 NHS Staff Survey showed minimal change since 2013. For 23 out ot 29 areas the trust was rated worse than the national average for acute trusts. The trust was in the bottom 20% (worst) in the country for 18 of these.

The trust was in the bottom 20% overall for staff engagement. Only 18% of staff reported good communications between senior managers and staff which was worse than the national average of 30% for all acute trusts. We recognise that East Sussex Healthcare NHS Trust is a combined trust providing both acute and community services so therefore the results may be indicative rather than directly comparable.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We saw a number of issues that led to a rating for safety at the trust of inadequate. We noted some limited progress in some areas since our last inspection in September 2014. We saw low staffing levels in ED, Surgery, Maternity and Pharmacy. In some areas, incident reporting, the feedback from incidents and the learning by both the organisation and individual staff was not as good as it should have been. Learning from incidents was not well demonstrated, even when incidents were reported. We did see some improvements but staff still told us that time constraints caused by low staffing levels meant they, "did not have time to report everything". In surgery we found the threshold (tolerance) for staff reporting an incident via the electronic system was high and this had led to a potential under reporting. In the OPD we found that reception staff had been told not to report incidents through the proper channels. Instead of reporting incidents of missing notes, staff were keeping a local record of this. This meant that the outcomes were not being reported through the trusts governance process. Patients' records were not securely stored in outpatients. Medical records were often unavailable and when they were present, they were in poor state of repair. Clinicians had difficulty locating information upon which to base a decision. There was also an issue with the physical quality of records in surgery. There were times when records could not be found and this resulted in temporary files being created. The trust had a new records management system planned but this was not yet implemented. We observed staff, in the main, followed good hygiene and hand washing practices. However we saw some areas where we were concerned by lack of compliance with good hand hygiene and trust policy, as well as staff who appeared to lack basic understanding of the policy. We noted that Radiology services were demonstrating good practice in this area.	**Inadequate** 

Summary of findings

Duty of Candour

- The trust described the process they would use to inform patients of instances where harm or near miss had occurred. We did not see this in use during our inspection, but we reviewed two incidents in maternity that showed the trust followed its duty in this area.
- We noted that the PALS team had introduced duty of candour training across the trust.
- Staff we spoke to had not received training on the statutory duty of candour (a legal duty to be open and honest with patients or their families when things go wrong that can cause harm).
- Some staff we spoke with across the trust were aware of the duty of candour and understood their responsibilities. Some staff also told us they would feel happy raising concerns with their immediate line manager on issues relating to patient harm and safety.
- Others (a much larger proportion) were unaware of their responsibilities regarding the duty of candour. They also felt the organisation was not receptive to concerns being raised and felt they would suffer if they spoke out about risk or poor practice. Many were anxious for it not to be known that they had spoken with us.

Incidents

- National Reporting and Learning Service (NRLS) data suggested that the trust was a good reporter of safety incidents.
- The governance department were in the process of developing benchmarking across different clinical units within the trust to ensure that reporting was consistent across the organisation. However, the NRLS data provided was at some variance with the findings from our inspection visit.
- On the surgical wards we found staff had a high tolerance and threshold for reporting incidents on Datix and were under reporting.
- Incident reporting, the feedback from incidents and the learning by both the organisation and individual staff was not as good as it should have been. We did not see evidence of learning; nor did we see a systematic approach to sharing information or a culture to support this.
- We were not able to review all the root cause analysis (RCA) reports as, while we asked to seem those since our last inspection, the trust did not provide all of them. The trust told

us that they were not able to provide all of the RCAs as investigations were either on-going or reports were in early draft and had not been through the trust's internal review process.

- The trust was losing valuable opportunities to learn from these incidents and improve patient care. There were systems in place to ensure action following serious incidents had taken place but no evidence that there were objective measures identified and monitored to ensure that the actions had resulted in sustainable improvements.
- In maternity services there was also evidence that lessons learned were not embedded. For example, prior to the inspection of maternity services in September 2014 a number of incidents in maternity relating to poor interpretation and a lack of action when pathological cardiotocography recordings (CTGs) were seen. We saw an incident investigation report that demonstrated that this continued to be a problem subsequent to the inspection visit.
- Reception staff in OPD had been told not to report incidents relating to hospital notes through the proper channels. Instead of reporting incidents of missing notes, staff were keeping a local record of this. This meant that the outcomes were not being reported through the trusts governance process.

Safety Thermometer

- We saw poor use of the safety thermometer, and in some areas (e.g. surgical wards) data were left blank or remained out of date.

Cleanliness, infection control and hygiene.

- There was a variable response to infection prevention and control. It was clear that the trust did not have a strong oversight of this important issue.
- In ED and Maternity we saw staff complying with the trust hygiene policy while in Outpatients we saw some staff not compliant.
- Outpatients and Surgery did not meet the requirements of the national cleaning schedule.
- Maternity were unable to evidence compliance of cleaning through audits.

Safeguarding

- Mandatory safeguarding training was not always completed. In maternity services we saw, from the training matrix provided by the trust, that 78% of all staff had completed safeguarding adults training.

Summary of findings

- The adult safeguarding training uptake for medical staff was lower, with a 75% completion rate.
- .In ED 24 nurses had completed level 3 safeguarding for children. This was not all the nursing staff who should have done so in line with the intercollegiate recommendations.
- Of the senior medical staff in ED only 45.5% had completed level 3 safeguarding training for children. This is a requirement for all medical staff in ED.
- In maternity, the training for children's safeguarding was better, with 85% of staff receiving this training.

Environment and Equipment

- The waiting room in ED on the Eastbourne site was not designed to allow the staff to have clear sight of patients waiting to be seen, which is important should a patients condition deteriorate while waiting to be seen or treated.
- We saw that since our last visit, some areas of the trust had improved their checking of emergency equipment (e.g. theatres), while in other areas (e.g. surgical wards) the same progress was not evident.
- Testing of equipment was variable. In one area (OPD) we found only one out of five pieces of equipment within their test date.
- We did see adequate equipment available within services.
- Radiology had undertaken all necessary checks on their X-ray equipment.

Medicines

- We saw trust wide issues relating to the management of medicines.
- We saw improvements overall in the management of medicines in maternity.
- We saw gaps in the checking of controlled drugs. We had noted these in our last inspection and we continued to have the same level of concern.
- Checks on controlled drugs were inconsistent in ED, and remained sporadic in surgery, despite the register noting an incidence of drugs missing.
- We noted a lack of pharmacy audit in all areas.
- Fridge temperature checks were not consistently recorded which meant there was a risk of medicines being stored at temperatures which could render them ineffective.
- We saw not all Consultants followed the trust prescribing guidelines for medication. Syntocinon (in Maternity) was being used by some consultants outside of trust guidelines. this led to confusion for junior medical staff and lack of consistency.

Summary of findings

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

- We saw that staff followed the principles of the mental capacity act in dealing with patients. We did however still continue to see problems in the recording of this in patients records.
- The trust had made appropriate Deprivation of Liberty Safeguards (DoLS) applications and notified CQC as required under the current legislation. However, comparing the number of notifications regarding DoLS applications from East Sussex Healthcare NHS Trust the levels are comparatively low suggesting that either not all staff are aware when an application is necessary or that the correct process is not being followed whenever it is necessary to place restrictions on a patient's freedom to make choices.

Staffing

- Surgical services had insufficient nurse staffing for the duties required.
- There was a high reliance on agency staffing in surgical services. There was no documentary evidence to show temporary staff had received induction or were made familiar with the area. Theatres and recovery had a better oversight of the issues than surgical wards.
- In some areas, e.g. ED, data on staffing was poor and the trust was unable to provide information on the use of staff resources (for example on the use of locums to cover shifts).
- Staffing in ED relied heavily on locum doctors. Medical staffing in ED did not meet the College of Emergency Medicine guidance. Nurse staffing had high sickness levels and often reported running short staffed.
- The staffing arrangements on the obstetric led maternity unit at the Conquest hospital still failed to provide for one to one care in labour and a supernumerary labour ward co-ordinator as recommended in 'Safer Childbirth - Minimum Standards for the Organisation and Delivery of Care in Labour' (2007). There had been no significant improvement in this since our inspection in September 2014. The midwifery led birthing centres did provide one to one care for women who gave birth there.
- We saw evidence that staffing levels across the trust continued to impact on patient care. We had two recent examples one from the intensive care area where in February 2015 an elderly patient suffered a severe hypoglycaemic attack which led to anomalies in their ECG tracing. The Root Cause Analysis (RCA) report identified that the staffing fell short of the Core Standards for Intensive Care (2013). On the night the incident occurred the unit staffing did not meet the planned

Summary of findings

establishment. Neither was there a supernumerary clinical co-ordinator or additional supernumerary nurse as recommended in the core standards. Another example came from maternity services where a first time mother with established and efficient contractions was sent home in a distressed state and unable to have the requested opiate analgesia from the Crowborough Birthing Centre in April 2015 because of staffing shortages at the Conquest hospital.

Pharmacy Services

- Following the report from our last inspection in September 2014 the pharmacy department had considered all the shortfalls we identified and devised an action plan. Much of this was, "in discussion". We note the work on progress in this area.
- There were on-going concerns that the aseptic unit was not meeting the required standard and posed a significant risk.

Are services at this trust effective?

Requires improvement

We found that the effectiveness of services at the trust required improvement.

Some policies were out of date and compliance with them was poorly monitored. There were clear examples of where the trust staff were not following best practice guidance and the trust policies. The trust has subsequently told us that they have made significant improvements and now have 118 policies requiring review and that of these, only 26 of these relate to clinical areas.

Surgical teams did not undertake morbidity and mortality reviews regularly and consistently, although we saw a minor improvement since our September 2014 inspection.

Systems to ensure availability of hospital notes were being put into place; but much of this was not yet implemented and the problems remained. We remained concerned over the physical condition of some health records.

Evidence Based Care and Treatment

- We found the mortality overview group were aware of the variable submissions of morbidity and mortality reports from different clinical units, yet no firm action had been taken to address this. The risk adjusted mortality rate for the trust had, however, fallen during both 2013 and 2014.
- The Mortality and Patient Safety Dashboard for Surgery for the period January 2014 to December 2014 showed that the trust

surgical services performed less well than the peer trust group in 12 out of 20 key performance measures. In five of these East Sussex Healthcare NHS Trust was rated red, at the bottom end of the scale for patient safety outcome measures.

- We did see an improvement in the use of morbidity and mortality meetings since our last inspection.
- The trust was following NICE guidance where appropriate but was not meeting the recommendations of national professional bodies (such as the Royal College of Midwives/Royal College of Gynaecologists and Obstetricians and the Intensive Care Society) in relation to the quality of care provided.
- In August 2014, as part of an on-going review and monitoring process, 239 hospital policies were recorded as being out of date. This demonstrated that the trust policies were not always being monitored or reviewed regularly. We were unable to ascertain how many policies had been reviewed and updated prior to the inspection.
- We asked how the trust could be certain clinical areas were following the correct policies. We were told that one way of measuring this was through senior managers carrying out quality walks.
- We saw examples such as the management of venous thromboembolism (VTE) where trust staff did not always act in accordance with the guidance issued by NICE.
- We saw evidence that the trust staff did not always follow guidance published by the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Nursing when determining pre-operative fasting times. This resulted in some people being without food or drink for excessive periods.

Access to Information.

- Outpatients had begun to address the issue of access to notes raised from our 2014 visit. The previous problem of brining in notes from off-site was now largely resolved.
- We recognise the trust has a plan to address electronic tracking of notes and records. This is expected to be in place during 2015.
- We remain concerned about the physical condition of some of the health records.

Patient Outcomes

- The pain team configuration was inadequate to provide a service across both sites with the resources provided.
- We noted that data supporting outcomes show a variable picture.
- The trust participated in a number of clinical audits.

Summary of findings

Are services at this trust caring?

Good

We found that services across the trust were caring and have rated this as good.

We received many positive comments from patients and their carers but were also contacted by a number of people who talked less favourably about the way trust staff had treated them.

Operational staff spoken to were all clear that they saw patient care as their main driver for performing well. Some said this was difficult within the current culture and resourcing but that being able to make a difference to patients was why they continued to turn up to work even when things were difficult.

Compassionate Care

- We saw kind care provided across the trust.
- Most patients that we spoke with commented positively on their individual care and on the staff providing it. We do continue to hear stories from individuals who felt their care was not compassionate or kindly delivered.
- Staff we spoke to saw patient care as their main driver for performing well. Some said this was difficult within the current culture.

Understanding and involvement of patients and those close to them.

- Patients reported being involved in their care. Services were able to describe the processes they used to involve patients.
- Patients in ED (through the A&E Survey) reported being involved in their care.
- During the inspection people told us that their care and treatment options were explained to them.

Emotional Support

- Emotional support for patients was good. We observed staff giving support to patients and their relatives. We saw this being given in sympathetic surroundings.
- Patients gave very positive feedback about the one to one support from staff at the trust.
- The trusts chaplaincy service was widely available to patients.
- The support for staff was less readily available. The occupational health service was not able to meet the demands of the many staff who needed their services.

Summary of findings

Are services at this trust responsive?

Requires improvement 

The responsiveness of the trust's services requires improvement. The trust had consistently not met the operating standard for NHS consultant-led referral to treatment times (RTT) over the past year (the national standard is 18 weeks for patients who do not have a suspected cancer diagnosis).

Some specialties had longer waiting times than others. For example, rheumatology, where patients were left waiting 48 to 49 weeks for an appointment and then struggled to get follow up treatment. We were told by a senior member of staff that consultants in this speciality refused to see patients for follow up who had their initial consultation with a locum consultant; this was clearly detrimental to patient care. We met with a member of the executive team who shared the trust plans for addressing the backlog but these were yet to provide an effective solution to the delays experienced by patients. We were unable to see that these were sustainable, as they relied on additional capacity (through locums) to reduce the backlog that would not be available at a later date.

The redesign issues had begun to be addressed in outpatients. Progress was being made, but was far from complete.

Recruitment remained a challenge for the organisation; yet we saw lack of succession planning for senior individuals key to delivering clinical pathways.

The trust failed to meet single sex accommodation in the CDU on a regular basis.

The number of complaints received by the trust is higher than comparable organisations. We note from patient feedback that the quality of response remains a concern.

Service planning and delivery to meet the needs of local people

- The redesign of outpatients' services had previously been poorly implemented. Essential tasks had been missed in the service redesign. The trust had taken steps to address this since our last inspection. We noted that while this had begun, there was still much to do in this area. In radiology we found that the service began working before the reception desk opened, leaving patients unable to book in or register their arrival.
- The call centre for outpatient appointments was not effective. Patients were often unable to make contact with the staff.
- Clinics were sometimes cancelled, and patients had not been informed, or informed at very short notice. There was a lack of appropriate staff to ring patients; who arrived for their appointment and found the clinic was not being held.

Summary of findings

- In maternity, there was a continued failure of the trust to respond effectively to the fears and anxieties of the people it served. Ineffective communication meant that many of the public did not understand the advantages of midwifery-led care to pregnant and postnatal women and their babies. For others, the threat of closure of the midwifery led units made them reluctant to book to a service that they might not be able to access when necessary. Women who used the midwifery led units were very positive about the experience.
- The lack of replacement for consultants that had left the trust had caused significant difficulties and increased waiting times for patients.
- A backlog of referrals was delaying patients accessing timely care.

Meeting Individual Needs

- In one speciality, permanent consultants refused to provide follow up care to patients who were initially seen by locum consultants.
- The Patient Led Assessments of the Care Environments (PLACE) showed the trust was rated below the national averages for all four key areas of cleanliness; food; facilities and privacy, dignity & wellbeing. Although subsequent to our inspection visit the data for the PLACE has shown and improvement by the trust.
- The trust was breaching the provision of single sex accommodation requirements frequently and regularly but not identifying or reporting these.
- We saw that the trust had dementia champions and link nurses to support people living with dementia.
- We saw the trust had facilities for relatives of patients who were seriously ill. In ED there was an area where relatives could make a drink.
- In OPD we saw patients with learning difficulties, dementia and mental health needs were prioritised in clinic.
- There were no appropriate areas in ED for people with mental health needs.
- Information was available in different languages if required.
- In maternity, the trust did not have midwives with role specific responsibilities. For example there was not a midwife leading on teenage pregnancy or bereavement.

Access and Flow

- Patients were not being seen for follow-up appointments within the timescale requested by their clinician. There were no alerting systems in place to warn staff that patients had not been seen for follow-up appointments in a timely manner.

Summary of findings

- The new service redesign in outpatients had been previously poorly implemented. As a result, patients were waiting in long queues, being sent to the wrong areas, and being lost in the hospital and missing their appointments, due to computer systems that were not fit for purpose. The trust had put systems into place to address this issue since our last inspection. We noted that while these issues were not fully resolved, they had improved.
- Local changes in the patient pathway and system organisation for people attending outpatients had resulted in some improvements but these were insufficient to overcome the systemic issues.
- When we asked for a report giving the number of out of hours discharges for all locations including Crowborough, since October 2014, the trust advised us that they are unable to provide this information due to technical problems with their electronic system. We asked because we had been made aware of one woman being sent home at 1.00am to accommodate staff moves.
- In outpatients, the trust was not meeting its referral to treatment (RTT) times. In February 2015, the overall number of patients on the waiting list was 20,530. this had increased from the previous month. We saw work underway to reduce this; but we were not clear this was sustainable.
- In ED, whilst the trust failed to meet the national standard for the A&E 4 hour target; the trust performed better than the England average in this area.

Learning from Complaints and Concerns

- The trust does receive a higher than average number of complaints for its size although numbers of complaints have fallen over the last two years.
- The majority of the information we reviewed highlighted a deficient complaints system covering both poor support for people who wished to raise a concern, and how the trust handled complaints.
- The most recent (May 2015) CQC Intelligent Monitoring publication corroborates this. The trust had two risks relating to complaints, those referred to the PHSO and those received by CQC
- NHS choices website is also used to gather feedback about the service provided at the trust. We noted that when people complained on the website they were responded to and urged to contact the PALS department to discuss their concerns further.

Summary of findings

- A large number of people contacted the CQC during and after the inspection to tell us their experience, mainly to raise concerns about the trust.
- We have reviewed a sample of written responses from the trust which did not assure us that the trust had adequately addressed their individual concerns.
- The Listening Into Action (LiA) group had been set up to aid learning from incidents and patients feedback. This group encourages people who have raised a complaint to come and talk to health care professionals to give a first-hand account of their experiences. CQC was contacted by members of the public who contributed to this group who expressed their satisfaction with the learning that had occurred from their complaints

Are services at this trust well-led?

Inadequate

The trust had just undertaken a major and contentious reconfiguration of some of its clinical services, which was made permanent in July 2014; this continued to dominate the trust board and executive officers responses to failings. We did not see a clear vision for the trust going forward from this.

We note an internal audit report on the reconfiguration recognising the trust followed its processes, but we saw the engagement of local people had largely failed.

The trust executive were very defensive of challenge from a number of areas.

Culture in the trust remained one of fear and concern from staff about speaking out. We have been contacted by staff before, during and since this inspection to share their concerns regarding the trusts culture.

Low substantive staffing levels and sickness levels remain a challenge for the trust.

The trust scored below average for 23 of the 29 questions in the NHS staff survey; and scored in the bottom (worst) 20% for 18 of these questions.

There remains a clear disconnect between the views of the staff and those of the executive leadership. We saw examples where the staff view was a clear contradiction (more negative) from this in senior leaderships position. We remain convinced that the executive leadership is not acknowledging this as a significant challenge for the future of the trust.

Summary of findings

Vision and Strategy

- The chief executive's presentation prior to CQC inspection in September 2014 made it clear that the trust were aware of many of the issues that we found on our inspection. These issues had not been adequately addressed despite the trust seemingly already aware of them and having persisted for some time.
- The trust had completed a major and contentious reconfiguration of clinical services during the previous two year period. It is acknowledged that this reconfiguration had brought many challenges and strong criticism from community groups and some staff. However, the trust executive was unable to articulate a clear strategy for re-engaging the local community following these changes. It appeared that the trust continued to believe that it was a small but powerful cohort of local people who opposed these changes and were the cause of the trust problems. An executive told us that they were not prepared to consider alternative strategies saying, "We won't change it, we work around it".
- The senior executive officers remained convinced that the root cause of the trust problems was malicious objection to the reconfiguration, rather than any failings by the trust board and executive team. This was not what staff and local people told us during and subsequent to the inspection.
- We noted the trust still did not have a clear forward 5 year strategy, although there was a business plan in place which was being monitored and discussed at board meetings.
- Major service changes had been implemented and whilst the trust demonstrated its efforts to engage staff, the majority of staff we talked with continued to feel it was insufficient and ineffective.
- We were unable to identify a clear strategy that sought to address the breakdown in communications between some staff groups, members of the public and community groups and one local MP. When we spoke with senior staff about the communication strategy post reconfiguration they acknowledged that it wasn't working but said they were going to continue with it regardless of the lack of effectiveness.

Governance, risk management and quality measurement

- We did not see within the trust a culture of reporting, managing or improving based on risk and incidents. We were not able to evidence a cycle of improvement.
- Staff we spoke with were still unable to identify the governance structure or provide us with any feedback on its function, successes or any learning that had led to changes in practice.

Summary of findings

- Some staff remained unconvinced of the benefit of reporting incidents, some staff had been told by managers to record incidents in a different way to the trust policy. The trusts governance system cannot be effective if it is unable to consider all areas of risk.
- We found little evidence that the large amount of data collated through governance and incident reporting systems was used to drive quality improvement or to demonstrate that improvements had been sustained. For example, one of the medical directors when asked how they knew the service had improved since our previous inspection visit said, “It feels better”. We requested data based evidence to support this assertion but it was not supplied.
- The trust wide audit plan titled, ‘2014-15 On-going Audits @26.03.15’ showed that there was limited participation in the National Clinical Audit and Patient Outcomes Programme. Some audits, such as the audit against the NICE Quality Standard 33 for the management of Rheumatoid Arthritis were started but clinicians had refused to participate in data collection due to a lack of resources. Others such as the trust priority audit in consent were simply poorly managed and failed to deliver against the planned audit programme.
- A recent review of the trust governance structure had been completed. It had resulted in clearer lines of accountability which should enable the organisation to effectively manage the quality and safety of the services it provides. It was too early to judge if this would be effective.
- The trusts Quality and Governance Strategy set out quality and governance meetings that fed into the patient safety and clinical improvement group.
- We saw that the trust had a risk register. We saw that this was not robust. For example the staffing issues in maternity were added only after our draft report from our last inspection was sent to the trust. Additionally, nurse staffing risks were removed from the surgical risk register before the plan was complete (i.e. before the risk was removed)
- Staff remained unclear about their lines of accountability and some told us, “We never know who our manager is from one week to the next. They do a 'knee jerk reaction' and then everyone gets moved around again”.
- We saw specific examples of trust level issues, including regular short notice cancellation of outpatient appointments, lack of robust data in ward level dashboards and failure to meet RTT waiting times targets.

Summary of findings

- Following our last inspection, the trust CEO told us that the inspection 'told us very little we didn't already know'. The trust told us they were well sighted on many of the issues we raised.
- We saw that the trust had governance groups and structures. We recognised in our previous inspection that the governance structure didn't flow well. Given that many of these issues still existed even though the trust was aware of them; we have concluded that the governance structures were not effective in dealing with significant issues for the organisation.
- We were also made aware that the occupational health department still struggled to ensure the trust delivered its duty of care to staff. We received a letter with a very powerful and sad story of the impact of this lack of support to one particular member of staff who despite requests was not provided with the occupational health support that they need.
- Low staffing levels were compounded by high and increasing sickness levels. The papers presented to the Board dated 25 March 2015 showed a trend of increased sickness from August 2014 to January 2015. The annual sickness rate in January 2015 was 4.8% against a target of 3.3%.
- Concerns were also raised about the quality of support received from the HR department. CQC received comments from several staff who felt that they were not supported by the HR team. We were told of instances where staff had received inappropriate support and given misleading information.
- We found a lack of succession planning for posts where it was known that the post holder would be leaving or retiring. No forward measures had been taken to address the impact of this. This had occurred in spinal surgery, rheumatology and gastroenterology where there were long gaps where the consultant capacity was significantly reduced and left the team unable to respond to local needs.
- We saw an action plan prepared by the trust in response to our last inspection (report published March 2015). This set out the trusts response to many of the issues we identified.

Leadership of the Trust

- Staff across a number of areas told us of their experiences about their perceived failure of managers to act on their reported concerns. They also gave us specific examples of where managers had behaved very poorly when concerns were raised with them.
- We asked staff how involved they felt members of the board were in what happened in their clinical areas. One staff member

told us, “There is a chasm between frontline staff and the managers and that hasn’t changed”. Other staff told us they felt the disconnect had deepened and that relationships between management and staff had never been worse.

- During a drop-in sessions a number of frontline staff did raise concerns with us about the culture and leadership of the organisation. This was despite a disproportionate number of managers, including associate directors, being present.
- Following our inspection, we received a number of emails from managers and senior managers describing how they felt the leadership and culture in the trust was good. We also received a larger number of emails from staff telling us of their concerns. We saw that the senior management of the trust saw a different view of the challenges than the non-management staff.
- The most recent NHS staff survey showed the trust performing badly in most areas. It was below average for 23 of the 29 measures, and in the bottom 20% (worst) for 18 measures. Overall the trust was amongst the bottom 20% of all trusts in England for staff engagement. Only 18% of staff reported good communications between managers and staff against a national average of 30%.
- The trust was also in the bottom quintile for staff reporting that they had the ability to contribute towards improvement at work.
- The trust told us they were disappointed by the results; but we saw no direct programme to address this or to change the position.
- Staff told us that they could always email the Chief Executive’s Office with any concerns. They told us that although emails were always acknowledged, they did not always receive a response. We were shown emails that confirmed the CEO and head of HR were made aware of both the patient safety concerns and the problems raising these had caused for the member of staff. The issues of one member of staff being very poorly treated by their line manager were dismissed as a breakdown of relationship and mediation was suggested as the way to resolve 'the situation'. At no point was the manager held to account for their behaviour.
- As a consequence of the broken relationships, we received a significant amount of concerns from patients and the public, raising concerns about care. We had been overwhelmed by the number of people contacting us prior to the previous inspection in September 2014; high levels of contact from staff during and following this inspection demonstrated that the situation remained unchanged.

- The themes identified related to the quality of staff engagement, low morale, and a bullying and harassment culture from senior management.
- The Staff Survey 2014 showed that the trust score for the percentage of staff agreeing they would feel secure raising concerns about unsafe clinical practice was 58% against a national average for acute trusts of 67%.
- On 19 November 2013, the Secretary of State for Health issued his response to the Francis report, in which the Government undertook to fully implement 204 of the 290 recommendations. There was an expectation that trusts would not wait for the final recommendations before taking action to address the recommendations made in the Francis report published on 6 February 2013.
- The Staff Survey 2014 Results Report presented to Board on 25 March 2015 by the Head of Human resources said that the trust would, "Implement the findings from the Francis Report on raising concerns once the final recommendations were published".
- We saw documentary evidence that the HR department had failed to protect several whistle-blowers and that as a consequence, they suffered on-going detriment.
- Issues such as the travel time and distance between the two hospitals were taking centre-stage in the discussion and eclipsing the issues about managing a complex acute hospital service on two sites.

Culture within the Trust

- A large number of people contacted the CQC before, during and after the inspection to tell us their experience and some to raise concern about the trust. When asked whether there had been any improvements in the culture since the previous inspection, one member of staff said, "The climate of stress and fear is still just as potent."
- We had a larger than expected number of staff contact us during and subsequent to this inspection visit who were not prepared to reveal their identity until we could assure their confidentiality but who shared detailed information about the way they had been treated as a result of raising concerns. We found a real culture of blame and holding people to account for things they had very little control over. This remained unchanged since the previous inspection.
- There was an on-going disconnect between the trust board and the staff on many things. This was exemplified by attendance at a drop-in session offered to all staff where six senior managers, told us about trust achievements and the positive culture. The

only other staff were a small group of administrative staff who said, “What you are all describing is not the hospital we recognise”. This disconnect was supported through other conversations with staff.

- We saw a culture of concern and sometimes fear from staff in the trust about raising their concerns. We have been provided with evidence from the two years preceding our visit up to the present time where a number of staff have suffered detriment because they raised concerns about patient safety issues. They had tried to raise concerns at all levels, including with the executive officers and felt that speaking to CQC was the only way to make their concerns heard.
- We saw the papers for the Board Meeting in Public dated 25 March 2015. The Director of Human Resources explained that although significant progress had been made in meeting mandatory training targets the 85% target was still not being met. They advised that they had spoken to managers who had told them that clinical pressures were impacting on their ability to undertake appraisals. The chairman said that he had particular concerns around appraisals and that he didn’t feel that good progress was being made around achieving appraisal targets. The finance director said that she didn’t feel that it was good enough to set targets and then to miss them. She felt that sanctions should be made to those that didn’t meet the expected levels of appraisal. This demonstrated a board level attitude that mirrored what staff had told us.
- We experienced a challenging relationship with some senior staff within the trust. We felt that the style of communication employed was inappropriate in a professional arena. There were instances where senior staff chose to misrepresent conversations and interactions with the inspection team.
- In one instance, we found that the trust had directed staff to move evidence relating to patient records which the staff themselves construed as a deliberate attempt to mislead the inspection team.
- We heard about several other example which pointed towards potential misrepresentation of data.
- Some members of the public contacted us to tell us about their positive experiences at East Sussex Healthcare NHS Trust. However, the majority of contact with CQC was to raise concerns about the standard of care and the welfare of the staff. The level of contact was higher than is usually received about a trust around the time of an inspection visit and indicated some very strong feelings about the quality of care being provided.
- During our last inspection of the trust in September 2014, there was a strong feeling amongst staff and by some members of the

Summary of findings

public that they were not listened to, or engaged with by the senior leadership. This feeling persisted and many staff remained unhappy and felt unable to speak out for fear of retribution.

- The trust had a staff awards incentive in operation which was publicised through the staff newsletter. This recognised staff who were 'going the extra mile'.
- We noted that the trust had tried to provide reassurance to patients following the publication of our March 2015 report. An open letter was available on the trusts website and within the hospital referring to the trusts action plan.

Overview of ratings

Our ratings for Conquest Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Maternity and gynaecology	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Our ratings for Eastbourne District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Our ratings for East Sussex Healthcare NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Overview of ratings

Notes

These ratings form part of the core services of the East Sussex Healthcare NHS Trust. In this responsive inspection we have only inspected four core services.

Outstanding practice and areas for improvement

Outstanding practice

We identified some good practice including

- The telephone triage system provided a high standard of information, guidance and support to women, without them necessarily needing to come into hospital.

Areas for improvement

Action the trust MUST take to improve

Importantly, the trust must:

- The board needs to give serious consideration to how it is going to rebuild effective relationships with its staff, the public and other key stakeholders. This was a requirement following our inspection on September 2014 but we are not yet assured from the action plan and speaking with the lead executive officer that this had begun to be addressed.
- The board needs to create an organisational culture which is grounded in openness, where people feeling able to speak out without fear of reprisal. This was a requirement following our inspection in September 2014 but we are not yet assured that staff feel able to speak out without suffering detriment.
- Undertake a root and branch review across the organisation to address the perceptions of a bullying culture, as required in our previous inspection report.
- Review and improve the trust's pharmacy service and management of medicines.
- Review the reconfiguration of outpatients' services to ensure that it meets the needs of those patients using the service.
- Review the length of waiting time for outpatients' appointments such that they meet the governments RTT waiting times, and that this is sustainable.
- Ensure that health records are available and that patient data is confidentially managed.
- Review staff deployment in maternity services to ensure that they are sufficient for service provision such that the organisation meets the recommendations made by the Royal Colleges. This was a requirement following our inspection on September 2014 but we are not yet assured from the action plan and data provided by the trust that this has been fully addressed.
- Reduce the proportion of OPD clinics that are cancelled at short notice and develop systems to ensure that where this is unavoidable, that patients are informed in a timely manner.
- Develop achievable succession planning to minimise the impact of staff movements.
- Improve the governance of incident reporting systems to ensure that the number of incidents reported via the electronic system reflects all the incidents that happen.
- Ensure sustained compliance with the National Schedule for Cleanliness.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that they provide care and treatment in a safe way for service users. They must do this by (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; (g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; (i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider must ensure that all premises and equipment used by the service provider is secure.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider must respond appropriately (with a comprehensive response shared with the complainant and within the timescales set by the trust) to complaints and must ensure that (1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.(2)The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.(a) complaints made under such complaints system, (b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, (3) The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of (a) complaints made under such complaints system,

This section is primarily information for the provider

Enforcement actions

(b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and

(c) any other relevant information in relation to such complaints as the Commission may request.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Family planning services

Management of supply of blood and blood derived products

Maternity and midwifery services

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must ensure that there are comprehensive and effective monitoring and governance systems in place.

(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements of this regulation.

The provider must

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

(including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at

risk which arise from the carrying on of the regulated activity;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d) maintain securely such other records as are necessary to

be kept in relation to —

This section is primarily information for the provider

Enforcement actions

(i) persons employed in the carrying on of the regulated activity, and

(ii) the management of the regulated

activity;

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub paragraphs (a) to (e).

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks July/August 2015
Reporting Officer:	Alice Webster

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

Purpose:

This paper provides a summary of Quality Walks that have taken place during July and August 2015 and proposes changes to the current process in order to improve engagement with staff at ward and department level and measure the quality of services.

Introduction:

Quality Walks are currently 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 July and August were:

- How communication and engagement can be strengthened
- Reporting, action and learning from incidents and risks
- Fundamental safety issues – cleanliness, drug security, records management
- Other issues

The Quality Walk programme was implemented to give Board members an opportunity to observe and review care being delivered and to listen to feedback from patient's visitors and staff. One aim of the programme was to ensure Board visibility within the organisation. The process was last reviewed in 2013 and in order to continually improve the way the Board communicates with individual wards and departments and how quality is measured proposals for change are included in this report.

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

20 services/departments were visited as part of the Quality Walk programme during July and August as detailed below

Date	Time	Service	Site	Visit by
6.7.15	9.30am	Acute Admissions Unit (AAU)	Conquest	Stuart Welling
6.7.15	11am	Special Care Baby Unit	Conquest	Stuart Welling
6.7.15	1pm	Newington Ward	Conquest	Stuart Welling
9.7.15	8.30am 9am	District Nursing Team Health Visitors	Heathfield Community Centre	Vanessa Harris
13.7.15	1pm	Decham Ward	Conquest	Darren Grayson

16.7.15	10am	Sleep Disorders Unit	Conquest	Stuart Welling
17.7.15	9.30am 10am	Community Dietetics Sexual Health Services	Avenue House Eastbourne	Sue Bernhauser
23.7.15	10am	Outpatients	EDGH	Vanessa Harris
24.7.15	11am	Centralised Booking Team	EDGH	Sue Bernhauser
27.7.15	9am	Physiotherapy	EDGH	Monica Green
27.7.15	2pm	Medical Admissions Unit (MAU)	EDGH	Stuart Welling
28.7.14	2pm	In-Patients	Rye Hospital	Stuart Welling
5.8.15	2pm	Rainbow Nursery	EDGH	Monica Green
7.8.15	1pm	District Nursing Team	Eastbourne Park Primary Care Centre	Sue Bernhauser
28.8.15	9am	Health Visiting Team Hastings Children's Centre	Waterworks Road Hastings	Monica Green
28.8.15	12pm	Centralised Booking Team	Conquest	Vanessa Harris
28.8.15	11am	First Steps Nursery	Conquest	Monica Green

17 of these visits were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit. The remainder were carried out as ad hoc visits so staff may or may not have been notified to expect them. (NB other adhoc visits may have taken place, but reports have not yet been received).

At the time of writing the report feedback forms had been received relating to 19 of the visits to individual services or departments, copies of which have been passed on to the relevant managers for information.

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

<u>How communication and engagement can be strengthened</u>
Both the staff childcare facilities visited reported good communications within their teams and staff were very pleased that the decision not to outsource the service has been made. They felt a part of the Trust and their engagement was positive.

A dietetics team visited reported challenges with a lack of administrative support, which meant that some of the work was being done by clinicians.

There was good communication noted in a District Nursing Team who had regular team meetings. They stated that they appreciated the newsletters from CEO and Director of Nursing and that they felt integrated within the Trust, and reported the 'Listening into Action' (LIA) as a positive initiative.

<u>Reporting, action and learning from incidents and risks</u>
The staff childcare facilities reported that all incidents and risks were recorded on the risk register. The risks on the Conquest site were mainly all related to the fabric of the premises.
Dietetics reported that their caseloads were kept under constant review and adapted as needed in relation to staffing levels.

Within District Nursing outcomes from incidents were discussed at team meetings and lessons learned were discussed. Staff reported that they felt confident in reporting incidents.

Outpatients reported some problems with patient records not always being available for clinics but stated that this was improving.

<u>Fundamental safety issues – cleanliness, drug security, records management</u>
It was observed that the Conquest nursery building needed updating. Staff had tried to raise funds but more investment were needed in the short term and in the longer term a new building was required**.**

The Health Visitors felt their working environment was well resourced and practical but as a great percentage of their role was conducted within clients' own homes there were issues relating to lone working and using their own cars.

Other issues
Health visiting has been an area there had previously been difficulties with recruitment, but this had improved and the teams are able to support students. They reported welcoming the forthcoming integration with social services, but were concerned about losing the "health" professional and supervision aspects.

In the Central Booking Team, the main issues faced by the department were reported as the clinic cancellation process not working effectively. Recent analysis had shown that one of the main reasons for the cancellation process not working as well as it should was having to work around clinicians' annual leave. A new phone system was needed to manage incoming calls in a more efficient manner and this was being investigated. Rates of patients not attending for appointments was high, and automated calls could cause anxiety to some patients who didn't understand what response, if any, was required.

Recruitment to the District Nursing remained an issue but was a national problem. The transition of some of the teams to Sussex Community Trust was of some concern to the staff.

Moving Forward

Current Process

At present Trust Board members provide their availability to carry out Quality Walks and are matched with wards or departments accordingly. The ward or department is notified in advance and they are asked to complete a briefing paper outlining the function of their area and highlighting any issues or concerns they wish to discuss with the Board member in order to provide some insight prior to the visit. This process is generally adhered to but the quality of the briefing papers is variable.

A similar process is also carried out by the CEO office to manage the visits for the Chief Executive and the Chairman. A rolling programme of locations is used to try to ensure parity across the organisation. Due to diary changes and other commitments the programmes can be changed at short notice resulting in some areas receiving more or less visits than others and there are anecdotal reports from staff that they either have numerous visits (often in the same week) or none at all. Board members also carry out adhoc visits either as a follow up from a previous visit, or to investigate any issues they may have been made aware of.

Some Directors have been able to carry out early morning and late evening visits and the Director of Nursing often visits at night. There is a risk that staff working unsocial hours may have little contact with staff outside of those they directly work with.

Proposed Changes

Following each Board meeting all members will carry out formal visits to different agreed areas, either individually or in pairs, where they can observe practice and discuss any issues that may have been raised at the Board meeting with staff. All wards and departments will be notified that they may receive a visit following each Board meeting.

Every alternate Thursday there will be visits led by the Director of Nursing and a Medical Director; the panel will include a clinician, a patient representative, a Board member, a member of the governance team, and will include specialist involvement if necessary. The visits may be known as Trust Value visits and will focus on observing Patient Safety, Patient Experience, and Clinical

Effectiveness, and will be programmed to ensure that each Clinical Unit receives at least one visit every six months. The visits will always take place from 1-3pm, (but will be unannounced) with a debriefing from 3-4.30 to identify the findings and write a report. The Clinical unit will receive their feedback by the following week with any recommendations noted. If there are any significant concerns the unit will receive a further visit the following week.

This process could be further developed to eventually become a possible internal ward accreditation framework in the future.

Action Required

The Board are asked to consider the proposals and agree one of the following:

- Proposal 1 - Continue with the existing Quality Walk Programme
- Proposal 2 – Carry out visits following Board meetings only
- Proposal 3 – Carry out visits following each Board meeting and implement the Trust Value visits with a Board member on each panel

Benefits:

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

Risks and Implications

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

Assurance Provided:

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

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

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

None

Proposals and/or Recommendations

The Board are asked to note the report and make a decision about any proposed changes.

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

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

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday, 5th August 2015 at 10:00 am in the Ashdown Room, Uckfield Civic Centre, Uckfield

Present: Mr Stuart Welling, Chairman
Mrs Sue Bernhauser, Non-Executive Director
Prof. Jon Cohen, Non-Executive Director
Mr Charles Ellis, Non-Executive Director
Mr Barry Nealon, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Joint Medical Director - Clinical Governance
Dr Andy Slater, Joint Medical Director – Strategy
Mrs Alice Webster, Director of Nursing

In attendance:

Mrs Pauline Butterworth, Deputy Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mr Garry East, Assistant Director for Delivery & Performance (for item 068/2015)
Dr Amanda Harrison, Director of Strategic Development and Assurance
Ms Jan Humber, Joint Staff Side Chairman
Mrs Lynette Wells, Company Secretary
Mr Peter Palmer, Assistant Company Secretary (minutes)

062/2015 **Welcome and Apologies for Absence**

a) Chairman's Opening Remarks

Mr Welling reported that Darren Grayson had recently stepped down as Chief Executive of the Trust, and that Dr Harrison would be leaving the Trust at the end of September 2015. He explained that he was very appreciative of all of the hard work they had undertaken over the previous five years that had brought about increased standards and safety throughout the Trust.

Mr Welling explained that the CQC currently expected to publish their reports from their March inspection in the middle of September, following a Quality Summit between the CQC and the Trust. He noted that the Trust had not yet seen final versions of the CQC's reports.

Mr Welling reported that a considerable amount of time had been spent at the Trust Board Seminar on 15th July reviewing the Trust's Quality

Improvement Programme. He noted that the document was published on the Trust's website, and that because it was a live document it would be continually updated as progress was made towards achieving the Trust's objectives.

b) Apologies for Absence

Mr Welling reported that apologies for absence had been received from:

Mr Richard Sunley, Acting Chief Executive/Chief Operating Officer

c) Feedback from Quality Walks

Ms Green reported that she had undertaken quality walks in a number of administrative areas within the Trust, including visiting medical secretaries and the Health Records Department at the Conquest. She said that work was being undertaken in order to improve all of these areas and that of particular note were the solutions for increasing storage space within the Health Records Department and for tracking notes throughout the Trust. She explained that she planned to meet with these staff again as their input in helping to improve the Trust was vital, and commented that the manager of the Health Records Department at the Conquest Hospital was doing a particularly good job.

Ms Green reported that she had also visited the Physiotherapy and Occupational Therapy (OT) departments and was encouraged to see how the areas had changed and been improved under their new manager. She explained that there were difficulties in recruiting staff to the OT department, but that the Trust had managed to fill all 17 vacancies within the Physiotherapy department. Ms Green said that a 'one bleep' system had been introduced in order to make it easier for wards to access Physiotherapy and OT services.

Mr Stevens reported that he had been impressed by the staff that had shown him around the departments he had recently visited.

Dr Harrison noted that the themes for Quality Walks had been updated and that these would be included within the report to be presented at September's Trust Board meeting. Mrs Webster noted that some walks that had been undertaken had not been included in the report presented to the Board.

The Board noted the report on quality walks.

063/2015 **Monthly Award Winners**

Mr Welling reported that the Monthly Award Winners for June were Outpatient Departments throughout the Trust. They had been nominated for their work in continuing to demonstrate the Trust's core values, working together and improving patient care, while maintaining

the same high standards throughout the Trust's different sites. He explained that the teams showed great empathy and compassion for the wellbeing of their patients and continued to show the value of working together as a team.

He reported that July's Monthly Award Winner was the Special Care Baby Unit (SCBU) at the Conquest Hospital who had worked tirelessly over the last few months to safely manage during an extremely busy period for the unit.

064/2015 **Declarations of Interest**

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

065/2015 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 2nd June 2015 were considered. Three minor revisions were requested and the minutes were otherwise approved as an accurate record.

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

b) Matters Arising

It was noted that all matters arising had been discharged or would be considered during the business of the meeting.

066/2015 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework (BAF) had been updated with revisions shown in red. It was noted that the document had been reviewed at the Trust Board Seminar on 15th July 2015 and the risks updated. She explained that further narrative was due to be added to the BAF around leadership and succession planning and also about staffing within the A&E departments. Mrs Wells noted that two areas within the BAF were rated as red, and that the gap in control concerning the N3 Internet Gateway had been removed as the issue had been resolved nationally.

Mrs Butterworth explained that the first red rated area related to Health Records and that the Trust was introducing the iFIT Health Records tracking system in order to remediate the issues. Mrs Harris reported that the Trust had signed off a contract for Electronic Document

Management the previous day, and that the improvements brought about by iFIT would be even more pronounced once the two systems were working in tandem.

Ms Green explained that the second red rated area concerned appraisals and mandatory training. She reported that there had been an increase in the number of staff undergoing a Trust induction, but that the number of appraisals undertaken was not increasing. She noted that the surgical clinical unit had made great improvements in their appraisal rates and that their learning was being shared with other clinical units. Mrs Butterworth said that accountability reviews were to be held with clinical administration managers in order to improve rates of appraisal in that area.

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.

QUALITY, SAFETY AND PERFORMANCE

067/2015 **Performance Reports**

a) Performance Report – May 2015 (Month 2)

i) Responsiveness

Mr East explained that May's report had been circulated to the Trust Board, and that while June's figures had not been available early enough to write a formal report, he would include them during his verbal presentation. He advised that the performance reports were currently always slightly delayed due to national reporting standards, but that he was looking at changing working practices to ensure that more up to date information would be available for Trust Board meetings in the future.

Mr East reported that the Trust's scores in the responsiveness domain had improved, while those in the caring domain had dropped during May. He updated that there had been changes to the way in which Referral To Treatment (RTT) figures were reported nationally, and that the Trust had met its targets for admitted patients for both May and June.

Mr East explained that the Trust had missed its targets for diagnostic waiting times in May and June, but that a recovery plan was in place and that these targets should be met by September 2015. A&E waiting targets had been met in June and were continuing to be met in July.

The Board noted that cancer targets for two week waiting and 31 day waiting had been met in May, but had been missed in June due to issues with capacity and patient availability. Mr East explained that

work was on-going in order to resolve these issues.

Mr Welling asked whether improvements made in diagnostic performance would be sustainable and Mr East replied that in the endoscopy department a lot of work had been undertaken with an intensive support team who had been very helpful. He said that the TDA had recognised that a lot of Trusts were struggling to meet their targets and that he was hopeful that additional support and further capacity would be made available to the Trust as a result. Mr East explained that a business case was being prepared in order to address the increased demand placed upon diagnostic services in the long term.

Mrs Butterworth noted that diagnostic services were provided by several different clinical units. She said that regular meetings were taking place between the clinical units to ensure that interdependencies were properly understood and communicated between the teams. Mrs Butterworth said that it was not a simple task to ensure that improvements made were sustainable, but that a lot of work was being undertaken to ensure that this was the case.

Mr East reported that the backlog of community paediatric referrals had been reduced from 200 to 17 patients by the end of May. He noted that the CCG were happy with the Trust's progress and would no longer be reporting on the issue.

Mr East explained that work was being undertaken alongside the TDA and IMASS to produce live cancer patient tracking data in order to more effectively manage cancer waiting lists.

Mr Nealon asked for more information about the issues surrounding delayed transfer of patients out of the hospitals and Mrs Butterworth replied that on average 80 patients a day suffered from a delay in their transfer of care. She explained that delays in transfers caused issues throughout the Trust with patients not always being in the appropriate places for their needs, but that the problem was not caused by a lack of funding, but by a lack of capacity. Mrs Butterworth reported that the Trust felt that they had done all they could to resolve the problems internally and were now in discussions with the CCG in order to try to resolve the issues within social care and the community around delayed discharge that were outside of the Trust's control.

ii) <u>Effectiveness</u>

Dr Hughes explained that the Summary Hospital Level Mortality Indicator (SHMI) for May 2015 was within confidence limits despite being highlighted in red within the performance report. He explained that he expected the SHMI to rise in September due to the recognised increase in patient deaths during the winter months, and the nine month delay in SHMI reporting. Work was being undertaken to ensure that no issues around clinical care were related to this expected rise.

Dr Slater noted that the Hospital Standardised Mortality Rate (HSMR) was lower at weekends than it was on weekdays, and asked whether any data was available for the mortality rate for patients admitted during weekends rather than deaths at weekends. Dr Hughes said that he would find out this information. **DH**

Mr Nealon asked how the Trust managed to improve on its performance in meeting 30 day re-admission targets, and noted that the recent improvement was significant and was to be commended. Dr Hughes replied that the Trust maintained a rigorous focus on driving improvement in this area, and Mrs Butterworth explained that the Trust employed experienced nursing staff who did an excellent job of supporting complex discharges throughout the Trust.

iii) Safer Caring

Mrs Webster reported that there had been three incidents of clostridium difficile infection reported in May 2015, and five in June 2015. Directors of Nursing from across the South East were due to meet in order to discuss standardising the method of reporting on infections, in order to ensure that comparable data was being produced.

Mrs Webster reported that work had been undertaken to ensure that no adverse outcomes had occurred due to the backlog of community paediatric referrals, and that no adverse outcomes had been identified after completion of this work.

Mrs Webster reported that the token system for registering patient's feedback had been withdrawn from A&E's nationally, and that there were concerns about how feedback would now be collected. She advised that the Trust would not necessarily have chosen to remove the system if they had been given a choice.

Mrs Webster reported that no mixed sex breaches had occurred during April and May 2015.

iv) Workforce

The Board noted that an additional paper had been circulated containing June's workforce data. Mrs Green explained that usage of temporary workforce had increased during June due to vacancies, increased activity and the need for extra staff to achieve safer staffing levels. Ms Green said that there was a national problem with recruitment, and that the Trust was undertaking a campaign to recruit staff from overseas in order to mitigate the number of nursing and medical vacancies.

Ms Green reported that significant improvements had been made in mandatory training figures during the last quarter, but that further work still needed to be undertaken. Mr Welling noted that the figures for

mandatory training in infection control had dropped and Ms Green replied that training sessions were taking place within Clinical Units in order to resolve this.

Mr Nealon asked why workforce expenditure had increased markedly since the start of the year. Ms Green explained that vacancies had increased within the Trust whilst nursing establishment had risen, and Mrs Webster noted that patient dependence had increased and extra beds had been opened. Mr Welling explained that the Trust had not been able to recruit as many nursing staff as it had wanted to, so the workforce expenditure could have been even higher. Mrs Butterworth reported that an Agency Reduction Group had been set up in order to review spending on agency staff, and they were expected to help reduce the spending in this area.

Mr Welling asked if the Trust was acting flexibly in terms of offering existing staff the opportunity to work on the Bank, or to undertake overtime, as the costs of these options were substantially less than the cost of employing agency staff. Ms Green explained that a report was due to be presented to the Clinical Leadership Team the following week, which proposed a revision in existing arrangements in order to try to lessen the Trust's dependency on agency staff.

Ms Green reported that the introduction of Schwartz Rounds within the Trust had been very successful, and had been well attended by staff. Mr Ellis commented that there was a lot of evidence to show that they had successfully improved staff engagement across other organisations and hoped for a similar position at ESHT.

The Board noted the Performance Report for May 2015 and actions in place to support delivery of objectives.

b) <u>Finance Report – June 2015 (month 3)</u>

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

- The Trust's Year to Date deficit stood at £10.2 million, which was £700k worse than planned.
- Expenditure in May and June was higher than planned to the high use of temporary staff.
- The Trust's Cost Improvement Plans had under-delivered by £369k due to the continued usage of agency staff.

The Board noted the Finance Report for June 2015.

c) Safe Nurse & Midwifery Staffing Levels

Mrs Webster presented the report to the Board and it was noted that figures for fill rates above 100% within the report were related to high activity. She explained that the numbers of falls and pressure ulcers occurring had fallen.

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

d) Staffing Establishment Review

Mrs Webster explained that following the Francis enquiry, the Berwick review and the NICE review of safe staffing levels, the Trust had undertaken a review of its staffing establishments using the safer nursing tool and other methods. She reported that reviews had been undertaken in March 2015 in all inpatient areas with input from Ward Matrons and Heads of Nursing. Mrs Webster noted that the data collection was undertaken when the Trust was in Black Status, and a further review would be undertaken during a quieter period to ensure data accuracy.

Prof. Cohen noted that there had been an increase in the use of special nursing care within the Trust and asked what the reasons for this were. Mrs Webster explained that a recent change to the law required patients with safeguarding or deprivation of liberty requirements to undergo one to one nursing. She noted that some patients who were awaiting discharge also required special nursing and explained that special nursing care did not always have to be undertaken by a registered nurse, and could be done by a support worker. Mrs Webster reported that the Trust was increasing the number of support workers it employed in order to help mitigate this issue.

Mr Welling asked what evidence there was that the review of staffing establishment had taken place during a particularly busy period. Mrs Webster replied that Matrons and Senior Nursing staff did not feel that one week's evidence was sufficient to ensure that data was accurate, and it was planned that regular six monthly checks would take place to ensure a continually accurate picture of staffing levels. She reported that the next review would be undertaken in October, and that the results would be presented to the Board in November.

The Board noted the Staffing Establishment Review.

068/2015 **Patient Experience Report Quarter 1**

Mrs Webster reported that the key features contained within the Patient Experience Report were:

- A lot of work was being undertaken to maintain the level of

Friends and Family Test responses.

- Any concerns raised via NHS choices were responded to on that website.

- The increased number of contacts with the PALS service was being continually monitored.

- The number of referrals made to the complaints department was reducing and the number of complaints made had reduced from 190 during the last quarter to 172 this quarter.

- A review of the complaints service has been undertaken, the service had a new manager and quality of responses was improving.

Mr Welling noted that progress in reducing the number of complaints made to the Trust was of critical importance and there needed to be a sustained reduction in complaints and continued improvement in quality of responses.

The Board noted the Patient Experience Report Quarter 1 report.

069/2015 **Nursing Revalidation**

Mrs Webster reported that Nursing and Midwifery revalidation had recently been introduced for all registered nurses, and that they would need to undergo this process every three years, and continue to register every year. She explained that the process would be monitored by the same team who oversaw medical revalidation and that a rolling programme had been introduced in order to support the 2,200 nurses in the Trust who would have to undergo this process.

Mr Welling commented that nursing revalidation was a welcome process, and asked how the workload pressures of undergoing revalidation would be managed. Mrs Webster replied that the onus on completing the revalidation was placed on the nurses, but that it was essentially another form of appraisal and therefore should not involve much more work than the current appraisal process. She explained that the NMC had always had an expectation that nurses would undertake the work needed for the new revalidation process, but until now it had not been mandatory.

Mrs Webster said that the revalidation process had already been trialled in a number of large Trusts, and a lot of positive feedback had been received. She noted that two new members of administrative staff were to be appointed to ensure that the collection of revalidation data was accurate, and that she did not anticipate the need for any further support for the process.

The Board noted the Nursing Revalidation report and actions in place to achieve compliance with the requirements.

070/2015 **Medical Revalidation Annual Report 2014-2015**

Dr Hughes explained that the report outlined how appraisal and revalidation for doctors was one of the drivers of the quality improvement process for the Trust. He noted that there were 107 core standards, and that the Trust was compliant with the vast majority of these, and actively working towards becoming compliant in the others. Dr Hughes reported that NHS England had described the Trust's activities in relation to medical revalidation as being 'excellent', and that the Trust had achieved a rate of 98.7% by the end of 2014/15, with the remaining 1.3% having now undergone revalidation.

Dr Hughes advised that appraisers underwent a thorough process to ensure that they were fully trained, updated and competent, and that they received feedback from each appraisal they undertook. He noted that there were difficulties in ensuring that doctors on short term and honorary contracts underwent revalidation and work was being undertaken in order to resolve these issues.

Mr Welling said that the process that had been instigated for medical revalidation was clearly an effective one, and he thanked Dr Hughes and the revalidation team for all their hard work in driving this process.

Mr Ellis asked about the benefits patients could expect to see now that the challenges of medical revalidation had been met so successfully. Dr Hughes replied that the process enabled clinicians to have the chance to reflect on their practices, and on what they could improve, outside of their pressured clinical environment. He explained that the process ensured that the working practices of every clinician were inspected and reviewed on a regular basis.

The Board approved the report on Medical revalidation 2014-2015 and confirmed their support for the medical revalidation and appraisal system in ESHT. Mr Welling signed off the Trust's medical revalidation compliance statement for NHS England.

STRATEGY

071/2015 **Annual Business Plan 2015-16 Quarter 1**

Dr Harrison reported that an updated annual business plan had been submitted to the TDA for approval. She noted that the majority of objectives contained within the plan were rated as amber, showing that they were progressing.

Mr Welling asked for an update on 7 day working, which had been rated

as red on the report. Dr Slater reported that a self-assessment had been completed about the feasibility of 7 day working within the Trust, and that a formal gap analysis needed to be completed in order to calculate what additional resources would be needed in order to meet the standards for 7 day working.

Dr Slater advised that from a medical perspective the Trust was already close to meeting the standards for 7 day working. He explained that the in terms of support staff, such as radiographers and sonographers, the Trust was furthest away from meeting the criteria.

The Board noted the report on the Annual Business Plan 2015-16 Quarter 1.

GOVERNANCE AND ASSURANCE

072/2015 **Annual Reports**

a) Health and Safety Annual Report 2014/15

Mrs Webster presented the report and highlighted that the number of reported incidents within the Trust had increased which was a very positive sign. She said that it was important that any incident was reported so that it could be thoroughly investigated and that work was being undertaken to understand the variances in levels of reporting across different sites.

Mrs Webster noted that the way in which moving and handling training was delivered had been changed and that this had led to a reduction in moving and handling incidents.

Mr Welling said that he was concerned that the amount of risks being entered onto the Trust's reporting system, DATIX, was not matched by the feedback that staff received about the incidents. He asked what plans were in place to change this and ensure that staff received appropriate feedback. Mrs Webster reported that DATIX now contained a mandated filed which required assurance that feedback had been given to staff in an effort to ensure that this took place, and investigating staff were being given support and training to ensure that this occurred.

Mr Welling asked whether the Trust was doing enough to prevent violence and aggression against staff, and requested information about what was being done to reduce incidences within the Trust. Mrs Webster said that she would go back to her team to find out this information, and would report back to the Board. **AW**

The Board approved the Health and Safety Annual Report 2014/15.

b) Annual Complaints Report 2014/15

Mrs Webster reported that the number of formal complaints made to the Trust had increased during 2014/15, while the number of informal complaints had reduced. She explained that an interim complaints manager had undertaken a review of the quality of responses to complaints and as a result of this the length of time taken to respond to complaints had increased. Concomitantly, the number of complaints that were being reopened had been reduced. Mrs Webster explained that due to the need to employ duty of candour at all times, training for staff was on-going.

As the Non-Executive lead for complaints, Mrs Bernhauser added that she felt that some of the responses to complaints that she had reviewed had lacked warmth, and said that a lot of work was being done to make improvements in this area. She said that she felt that taking the time to say sorry, when appropriate, was important and she felt that the Trust could do this more than it currently did.

Prof. Cohen said that it was not acceptable that the number of overdue complaints continued to increase, and asked when this situation would be resolved. Mrs Webster replied that the complaints department were targeting a large reduction in overdue complaints by the end of August 2015.

The Board noted the Annual Complaints Report 2014/15

073/2015 **Workforce Race Equality Standard**

Mrs Wells explained that the paper outlined the requirements and key metrics of the Workforce Race Equality Standard (WRES) which had come into effect at the start of August 2015. The WRES aimed to identify inequalities within the Trust by comparing the Trust's data with that of other Trusts, and the data needed was currently being collected.

Ms Green noted that the next stage of the process would be to analyse the collected data, and then to produce an appropriate action plan. Mr Welling said that the work on WRES was very important as it harmonised with the work being done on the Staff Survey.

The Board noted that Workforce Race Equality Standard.

074/2015 **Board Sub-Committee Reports**

a) Audit Committee Minutes
3rd June 2015
Mr Stevens presented the minutes and it was noted there were no significant issues to highlight to the Board.

The Board noted the minutes.

b) Finance and Investment Committee
29th April 2015 and 20th May 2015

Mr Nealon reported that the Finance and Investment Committee had carried out deep dives into Clinical Units when there was a substantial variance in their tariff rate. He noted that the deep dive into Cardiology had been a very positive and useful exercise. He explained that the Trust's Capital Budget was still under pressure with spending needed on equipment and infrastructure outstripping available capital, and that the Finance and Investment Committee was addressing this issue

The Board noted the minutes.

c) Quality and Standards Committee Report

Mr Ellis reported that the Quality and Standards Committee had taken a close look at the Health Records and were satisfied that progress was being made in resolving the issues within the department. He noted that all the proposed changes needed to take place in order for the Committee to receive full assurance and that they would continue to monitor this area.

Mr Ellis explained that each Quality and Standards Committee meeting started with a Patient Story, which highlighted what patients felt had gone well, and what had not gone well during their treatment. He thanked the patients and relatives who had spoken before the Committee, and noted that it was a very brave thing to do, and a very useful exercise for the Trust. Mr Ellis explained that the Committee were going to ensure that any lessons learned from these stories were cascaded and embedded throughout the Trust, and that it was important for patients to know that the Trust would effect changes based on what they had said.

The Board noted the report.

ITEMS FOR INFORMATION

075/2015 **Chairman's Briefing**

Mr Welling presented the briefing which was self-explanatory.

Mr Nealon said that he was very pleased that Mr Welling had decided to remain as Chairman of the Trust for a further year, and thanked him for doing so. He said that the continuity provided by Mr Welling staying, as well as the gravitas he brought to the role, were very important to the organisation.

076/2015 **Questions from Members of the Public**

Saying Sorry

Mrs Walke said that she had been pleased to hear Mrs Bernhauser say that she felt the Trust should say sorry more often, and asked if the Board would apologise for the inadequate rating given by the CQC to the Trust. Mrs Bernhauser noted that she had been talking about apologising as individuals, not as an organisation.

Mr Welling said that the Trust regretted any deficiencies that had been found and work was in progress throughout the Trust to improve the quality of services.

Agency Staff

Mr Campbell asked if an approval process was in place for each member of agency staff employed by the Trust, and Mrs Harris replied that this was the case.

Service Level Agreements

Mr Campbell asked whether Service Level Agreements (SLAs) were applicable within CCG contracts and, if so, asked where he could find these SLAs and performance metrics. Mrs Harris replied that there was a national contract between commissioners and acute Trusts with mandated targets. She explained that the Trust was measured against these targets.

Kingsgate

Mr Campbell asked whether the final report from Kingsgate had been made public, and felt that if it had not then it should be published, given how much Kingsgate had been paid by the Trust. Mr Welling replied that the report had not been made public, and it was unlikely that it could be.

CQC Report

Mr Hardwick highlighted comments on page 62 of the CQC's report on surgery at EDGH where 'staff felt supported by team leaders and well supported by the Director of Nursing' and that 'staff felt their hands were tied'. He explained that he felt that this highlighted a disconnection between the perceptions of staff and management and asked how

feedback from surgery compared to feedback received from Schwartz Rounds.

Mrs Webster replied that she didn't feel that saying that the hands of staff were tied was an accurate description. She explained that Schwartz Rounds were open to staff across the Trust, and provided staff with a safe place to reflect on their work, to talk, and to discuss issues with one another. Mrs Webster explained that she did not feel that Schwartz Rounds and the CQC's reports were comparable.

Volunteers

Mrs Walke explained that patients had got in touch with her in order to highlight their concerns about visiting the Conquest Hospital and asked if it might be possible for volunteers to visit them prior to their visits in order to address any concerns they may have. Mrs Webster replied that this was already under consideration and would be taken forward by the new Voluntary Services Manager.

077/2015 **Date of Next Meeting**

Wednesday 30th September 2015, in the Oak Room, Hastings Centre, Hastings.

Trust AGM to start at 1000.
Followed by the Trust Board Meeting.

078/2015 **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.

Signed …….

Position ……..

Date …….

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 05.08.15 Trust Board Meeting

Agenda Item	Action	Actioned By	When	Progress
067/2015 a) ii) Performance Report - Effectiveness	Greater detail to be provided about mortality rate for patients admitted at weekends vs. patient deaths at weekends	Medical Director (Clinical Governance)	30.09.15	Medical Director (Clinical Governance) to provide greater detail to Public Trust Board
072/2015 a) Health & Safety Annual Report 2014/15	Greater detail about plans to reduce incidences of violence and aggression against Trust staff	Director of Nursing	30.09.15	Complete – Health and Safety team will review this in next iteration of the report.

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
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 Board Assurance Framework (BAF) which brings together the strategic priorities and objectives of the organisation, with an assessment of their risks, the controls in place and details of the internal and external assurance along with associated actions.

Introduction:

The Assurance Framework has been reviewed and updated since the last meeting of the Trust. 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.

There are three areas rated red: Health Records, configuration of emergency departments and mandatory training and appraisals. New gaps have been added in respect of young people being admitted with mental health needs and staffing levels in the A&E departments

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

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

Benefits:

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

Risks and Implications

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

Assurance Provided:

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

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

our patients and their care to ensure our services are clinically, operationally and financially sustainable.	

Review by other Committees/Groups (please state name and date):
Quality and Standards Committee 1st September 2015

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

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

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

Assurance Framework - Key

RAG RATING:

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

Status:

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

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

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

C indicated Gap in control
A indicates Gap in assurance

Board Assurance Framework - August 2015

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

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.1.1	C	There is a gap in control due to the number of policies that require review and updating. Gap to be remove on next iteration.	Policy schedule produced and circulated. Process in place for reviewing and updating policies to achieve compliance. Aug-15 number of out of date policies significantly reduced, 32 policies to be updated, progress tracked and leads identified.	end Aug 15	▲	DN/COO	CME
1.1.2	A	CQC inspection reports identified a number of quality improvements that are required across the Organisation.	Project Group in place, action plan developed and delivery of actions being monitored. Monthly report to CME on progress. Monitored at Q&S. Aug-15 Inspection report for Mar-15 to be published Sept 15. Improvement Director working with the Trust.	end Mar-16	◄►	DN	Q&S CME

Strategic Objective 1: Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority							
Risk 1.1 We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies							
1.1.3	C	There is a requirement to improve controls in Health Records service; to encompass systems and processes, storage capacity and quality of case note folders.	Implementation of business case commencing to include storage and tracking of health records. Continued issues with record availability being monitored and actions developed. SOPs and training developed and delivered with use of external resources. Staff sessions taking place to manage staff concerns Aug-15 EDM contract signed. IFIT being introduced to track and monitor records.	end Sep-15	◄►	COO	Q&S CME
Risk 1.2 We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.							
Key controls		Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with clinical units Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Monthly audit of national cleaning standards					
Positive assurances		Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG compliance.					

Board Assurance Framework - August 2015

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.2.1	C	Gap in control in delivery of cancer metrics and ability to respond to demand and patient choice.	New monitoring tool developed by information department available to operations team. Trajectories for delivery identified and part of Trust Board performance report. IST review in July to supplement work with KSS Cancer network on pathway management. Aug-15 Monitoring tool trialled but data discrepancies remain; being reviewed between the Cancer Services team and the BI team with resolution target end of Aug. Poor performance results in June not meeting trajectory revised to 2WW and 31 days by end Sept, 61 days by end Mar. IST working with the Cancer Services team on a 'Scope of Works.' Proposal to merge Cancer Recovery plan (currently on v26) with Trusts 8 high impact cancer priority plan which is part of national planning.	end Mar-16	◄►	COO	CME
1.2.2	C	Further controls required in emergency services as demand is impacting patient assessment-treatment time and subsequent discharge to other specialist/bed areas. CQC report identified privacy and dignity issues.	Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place Capital bid with TDA to support expansion; outcome awaited, planning permission being sought in advance. Aug-15 Capital bid still with TDA	end Jun-15	▼	COO	CME

1.2.3	C	Effective controls are required to ensure achievement of referral to treatment timescales for incomplete pathways. To be removed on next iteration	Aug-15 Admitted and Non-Admitted RTT targets abolished; Trusts will now only be held accountable for meeting the 92% 'incomplete' RTT target. Requires that a minimum of 92% of patients on an incomplete pathway (waiting list) should be waiting less than 18 weeks from receipt of referral. Standard includes all patients yet to receive their first definitive treatment or discharge and also all patients who are still waiting for an outpatient appointment, diagnostic test or elective admission. The Trust has only failed to meet this target once in the previous 14 months. Although pressures continue in order to meet the on-going challenges, the Trust has implemented regular PTL meetings where waiting list size, incomplete pathways and service capacity is reviewed	end Jun-15 Compliant with ongoing monitoring	▲	COO	CME
1.2.4	A	Assurance is required that there are systems in place to develop and evidence shared learning from infection control incidents	Root Cause Analysis undertaken for all outbreaks and SIs and shared learning through governance structure, CU and nurse meetings. Cleaning controls in place and hand hygiene audited. Feb-15 Pevensey Ward separation of Day Unit from inpatients as interim measure until purpose built unit in place. Jun-15 Audit cleaning team has been strengthened. The infection control team is being restructured, to include increased management of the audit / assurance process. Weekly walks round both sites with facilities and IC to review areas highlighted by the auditors as 'areas of risk'. Further assurance requested by the Quality and standards committee in July. Aug-15 NSC Audit Group meeting and reviewing reporting of metrics. NSC audits scrutinised at Accountability Reviews.	end Mar-16	◄►	DN	Q&S

Strategic Objective 1: Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority							
Risk 1.2 Continued - We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.							
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.2.5	A	There is insufficient assurance that clinical laboratory diagnostics analytical equipment will be replaced in a timely way following internal approval of the managed service contract.	Agreed to replace via managed services contract. Full Business case agreed by Board but with TDA for approval. Aug-15 Additional information provided to TDA anticipate approval by end Sept-15	end Sep-15	◄►	COO	F&I CME
1.2.6	C	Additional controls are needed to reduce the backlog of plain film reporting and delay in reporting non urgent radiological investigations.	Process in place to reduce plain film backlog to September 2010 and no new patients added to backlog since April 2014. IST supporting the Trust with risk stratification relation to backlog pre 2010 and spot check audit.	end Aug 15	◄►	COO/ MD(G)	CME
1.2.7	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 Action plan in place to reduce waiting list and working in partnership with commissioner to develop service specification and care pathways Apr-15 Recruitment of two additional locum consultants. Waiting lists being appropriately managed but increased number of referrals impacting progress. Jun-15 Waiting list required reduction delivered in May 2015 Aug-15 Backlog confirmed with CCG as now cleared. Now building a PTL for this service so that future activity can be monitored.	end Sept 15	◄►	COO	CME Q&S

1.2.8	C	Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards with mental health and deliberate self harm diagnoses are assessed and treated appropriately.	Aug-15 Training requested from mental health team at CAMSH for ward nurses to ensure a competent and confident workforce. Mental health nurse requested via TWS to special the young people Create an adolescent bay on the ward to cohort mental health young people. Liaising with SPT and commissioners re purchasing adequate tier 4 beds	end Dec-15	NEW	COO	CME Q&S

Risk 1.3 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.

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

Board Assurance Framework - August 2015

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.3.1	A	Assurance is required that the controls in place in relation to mandatory training and appraisals are effective and evidenced by improved compliance in these two areas.	Mandatory training passport and eassessments rolled out to support competency based local training. Additional mandatory sessions, temporary resource to help develop competency assessments. Apr 15 – Compliance figures improving. CEO/HRD discussions with lowest compliance CUs. Competencies by role being developed to clarify mandatory requirements. June 15 – Appraisals: Focus on Clinical Admin staff where compliance levels are low. Additional training and support for line managers provided. Mandatory Training – Continuing to send out matrix about compliance levels to advise Clinical Units who is out of date. Sufficient mandatory sessions for 15/16 planned and to cover all staff. WFD supporting use of traffic light system to plan and monitor training. Reduction in compliance will be flagged early to Clinical Units through performance meetings. Aug 15 – Bespoke training being delivered to CUs on request – eg. Surgery, this has improved compliance levels.Planning a full review of appraisal process and quality in Autumn 2015. Clinical admin staff fully trained and actively undertaking appraisals.	end Mar-16	◄►	HRD	Q&S CME

Board Assurance Framework - August 2015

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

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

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

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.3.1	A	Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience.	Incidents logged, issues escalated to SECAMB /CCG. Service spec reviewed by commissioner; Trust engaging with process. Apr-15 Inpatients - Trust has access to additional vehicles via Elite. Issue remains with outpatients. CCG reviewing. Service currently being tendered.	end Aug 15	◄►	COO	CME

2.3.3	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Further controls are required to support delivery of an efficient service and good patient experience.	Review instigated to support implementation of focussed actions. Feb-15 Central team in place and systems being monitored. Considering developing specialist teams to support areas with complex processes. Apr-15 Close liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard. Aug-15 Weekly Dashboard now in place monitored by senior management team. Accountability Reviews set up from August onwards for the Clinical Admin service.	end Dec-15	◄►	COO	CME Q&S

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

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

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.	Essential work prioritised within Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. The Board approved a capital programme at its meeting on 2 June 2015. Delivery of this capital plan will be reported regularly to the Finance & Investment Committee and Board. Aug-15- At the end of Q1 capital expenditure was £3.6m (marginally ahead of Plan). The capital programme had an over planning margin of £81k which is considered acceptable at this stage of the financial year.	On-going review and monitoring to end Mar-16	◄►	DF	F&I

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.3.1	C	There is a gap in control because the final workforce strategy has been delayed as a result of market testing and service reconfigurations that have arisen or may arise from tenders. Workforce plan to be aligned with business planning.	Workforce plans submitted to TDA and HEKSS to support development of specific plans. 14/15 Plan submitted in June 2014 and first high level iteration of 15/16 plan to TDA on 13th January 2015.Workforce strategy is being developed to incorporate: 15/16 Business Plans, Learning Plan 15/16, Recruitment Strategy and Staff Engagement Action Plan Jun 15 – Workforce strategy and appendices approved by Board. Feedback requires specific measures of effectiveness (being developed) and twice yearly update report – due Dec 15. Aug 15 – HEKSS Workforce Summit to review Provider Workforce Plans takes place Sept. Project to review turnover and retention issues being undertaken.	end Dec-15	◄►	HRD	CME

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.2	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	Nursing establishment and skill mix review being undertaken again in Dec-14. To be signed off at Board in Jan-15 Apr 15 – Skill mix review now being widened to include original out of scope areas, to be completed by end June 2015. Aug-15 Nurse staffing levels review conducted Apr 2015 finalised and reported to August Board. Increased commissions in Foundation Degrees and Advanced Nurse Practitioners to support skill mix and development of new roles.	end Jun 15	◄►	HRD	CME
			International Recruitment Programme for nurses to start Jan-15. European recruitment campaign started Feb-15 4 new recruits to start. Apr 15 – Recruitment agencies appointed to supply 80 Phillipino nurses however recruitment cannot commence until Aug-15. Two cohorts expected to commence Dec-15 & Mar-16. International recruitment initiated for middle grade A&E Doctors from India. Aug 15 Oversees nurse recruitment visit arranged end of Aug; concerns regarding the approval of visa's for nurse - Participating in the call for evidence to include nurses in the shortage category list , submissions to be received by 25th September. 5 middle grade Drs offered posts, undertaking pre-employment process which will be approx. 3-4 months.	Mar-16	▼	HRD	CME

					HCA local recruitment initiative commenced Jan with aim to achieve full establishment by June-15. Feb 15 - 23 new staff recruited. Apr-15 – Undertaken 3 generic recruitment events, planning HCA recruitment open day in May, objective to appoint 50 new starters. Jun 15 - 11 x bank HCAs recruited, 17 x substantive HCAs recruited and started, and 53 x substantive HCAs - recruitment process in progress. Further open days planned. Aug 15 HCA vacancies reduced from 76 in March 15 to 57 in June15 . Two further cohorts of HCA have been recruited to substantive and bank posts starting Jul and Sept.	end Oct-15	◄►	HRD	CME

3.3.2	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	TRAC recruitment tool implemented in March 2015. Will be rolled out to recruitment managers as required. Positive feedback received to date. Jun 15 – Management reporting tool now being developed to provide information on recruitment metrics.	end Sept-15	◄►	HRD	CME
			Value based recruitment to be incorporated into the recruitment process for all posts. Feb 15 - Implemented for newly qualified nurses. Apr 15 – Implemented for HCA's and plan being developed to extend to all staff groups as part of the R&R Strategy.	end Jan-16	◄►	HRD	CME
3.3.3	C	Assurance is required that the Trust has effective controls in place to maintain sufficient staffing levels in A&E; recruitment difficulties in consultant, middle grade and nursing. Deanery short falls in fill rate for junior positions.	01/08/2015 Business continuity plans in place to cover short term difficulties. Overseas recruitment taking place. Longer term review of staff model planned.	end Mar-16	New	COO	CME

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

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.4.1	A	The CQC staff survey 2013 provided insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	Listening into Action programme mainstreamed into wider engagement work. Values launched and being embedded. Staff Engagement Ops and Exec Groups established. Involved in national OD cultural change work - linked with Portsmouth for learning. Health & Wellbeing initiatives being developed. Leadership conversations programme. Jun 15 – Continuing to embed values and behaviours. Staff Engagement Plan developed based on Staff Survey, Staff FFT and CQC feedback. Meetings with CU management teams to discuss staff survey results and agree actions. OD Strategy and workstreams approved, workstreams led by Exec and NED, staff invited to participate. Aug-15 • Rollout of resilience training for staff • Piloting use of the graffiti boards in two areas- this is an electronic staff forum • Producing a video “every role counts” to be launched during Unsung Hero week in October • In response to Listening Conversations re Bullying and Harassment launching awareness campaign for staff in Sept which will be followed up with training and support for managers and staff. • Currently recruiting “Speaking out Champion” • Reviewing comms around staff engagement and really trying to bottom out how we share everything we are doing /What does staff engagement mean to staff. • Continuing to embed values	end Dec 15	◄►	HRD	Q&S CME

3.4.2	C	Transition in executive team could impact on Board effectiveness.	Aug-15 Chief Executive left July, Director of Strategy and Director of Finance leave the Trust at the end of September. Interim CEO and Director of Finance in place. Portfolio of Director of Strategy being redistributed.	end Mar-16	◄►	CEO/ Chair	Rem Comm/ Board
Strategic Objective 3: Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.							
Risk 3.5: We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.							
Key controls		Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital Approvals Group and Finance and Investment Committee					
Positive assurances		Essential work prioritised with Estates, IT and medical equipment plans Capital approvals group meet monthly to review capital requirements and allocate resource accordingly Monitoring by Finance and Investment Committee					
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.5.1	C	There is a gap in control as a result of the Trust not having an aligned estates strategy in place.	Estates Strategy being developed. Progress updated presented to Board seminar in April. Substantive Head of Estates in post Aug-15 Presentation on progress to date at Board seminar in Jul-15 on track for submission to December Board.	end Dec-15	▲	COO	F&I CME
	A	Also refer to 3.2.1					

Board Assurance Framework - August 2015

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

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

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	7
Subject:	Quality Improvement Plan
Reporting Officer:	Alice Webster Director of Nursing

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

Purpose:

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

Introduction:

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

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

They focussed on eight core services in the acute hospitals: ▪ Accident and Emergency; ▪ Intensive/Critical care; ▪ Surgery; ▪ Maternity and family planning; ▪ Children's care; ▪ Medical care (including older peoples care); ▪ Outpatients; ▪ End of life care,

In the community services they focussed on: ▪ Community health services for adults; ▪ Community health services for children;▪ Community health in patient services; ▪ End of life care

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

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

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

See attached highlight report

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

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

Assurance Provided:
Between March and August there was an identified Project Improvement Working Group to oversee progress on the delivery of the action plan, meeting every 2 weeks chaired by the Director of Nursing and was attended by identified executive leads for the relevant work streams. From August this work has been overseen by the Clinical Leadership Team. The actions/dates and leads have all been identified by the individuals concerned.

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	✓
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
Strategic Objective 3 - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	
Review by other Committees/Groups (please state name and date)**:**	
Quality and Standards Committee 1.9.15)	

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

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

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

Quality Improvement Plan
Highlight report

Author: Hilary White Date: 11th September 2015

Project Summary

The purpose of this report is to update on progress made in achieving the recommendations made by the CQC following their visit in September 2014.
The aim of the programme is to ensure the Trust is able to respond to the recommendations made in the reports published in March 2015 and make any improvements required in order to ensure compliance is met with the Regulations (2014) of the Health and Social Care Act 2008

Project Budget

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

Project milestone update

The Quality Improvement Plan has been finalised in agreement with the Trust Development Authority working within the themes identified in the CQC's overarching Trust report to ensure that all the 'Must do' recommendations are being addressed.
Version 11.9 is the current document.

The clinical units manage other issues that were identified within their core services and included in the CQC reports as 'Should do's'. The clinical units also ensure that they are proactively monitoring the indicators in the intelligent monitoring report and that the fundamental standards of care are being met.

Progress and planned

From March until August there was a Project Improvement Working Group in place to oversee progress on the delivery of the action plan meeting every 2 weeks chaired by the Director of Nursing and attended by identified executive leads for the relevant work streams. From August the monitoring process has been overseen by the Clinical Leadership Team. The actions/dates and leads have all been identified by the individuals concerned.

Current Status
At 11th September 2015 there were 118 actions. These are broken down as follows:-

Red - overdue	Amber – on track	Green - completed
7 (6%)	34 (29%)	77 (65%)

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

Progress last month

- The action plan has been reviewed regularly.
- Progress on the service/clinical unit action plans continues.
- A Key Actions paper to summarise what issues have been addressed so far has been written and may be used to help inform staff of progress to date.
- Executives have commenced visiting staff groups to give feedback and holding staff forums where staff can ask questions of the Executive Directors
- A log of evidence to support the completed actions is being populated and plans made to audit the evidence during September.

Planned next month

- Planned delivery of those Amber actions with a deadline for September (28% of the ambers), and October (42% of the ambers)
- Continue to oversee work on those actions that are overdue.
- Review the evidence available for those items completed to ensure that it is robust and easily accessible.
- Monitor the Clinical Unit's action plans.
- Executives to continue give feedback sessions to staff at acute and community hospitals.
- Progress to be monitored by the Clinical Leadership Team.

Significant risks and issues
Those items that are overdue relate to:

- Staff feeling able to 'Speak Up' and raise concerns about bullying without any fear of recrimination, much progress has been made in relation to this issue but 'speak up speak out' champions have not yet been recruited.
- The maternity staffing review is not yet fully completed and the staffing model will be revised as a result of the review. Improving the labour ward environment for low risk women is also still being considered.
- Resolving Issues with the storage and accessibility of patient health records is still on going, significant progress is being made, but there is still more to do
- Fully maintaining privacy and dignity in the Emergency Departments is still a challenge and requires capital investment .

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

East Sussex Healthcare NHS Trust

Date of Meeting:	23 September 2015
Meeting:	Trust Board
Agenda item:	9 a
Subject:	Integrated Performance Report – July 2015
Reporting Officers:	Director of Strategic Development & Assurance

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

Purpose:

The attached document(s) provide information on the Trust's performance for the month of July 2015/16 against quality and workforce indicators and August 2015/16 in respect of finance.

Introduction:

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

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

Overall Performance Score: 4 (from a possible 5)

Responsiveness Domain: 3
Due to the Trusts A&E Performance achieving the 95% target for a second month in a row, this domain has remained at a score of 3.

9 out of the 17 indicators for this domain were achieved this month. The Trust recovered the Diagnostic standard July but unfortunately the Trust did not achieve the Two Week Wait Cancer standard.
The other indicators which were not achieved this month were:

- RTT Admitted & Non Admitted
- Cancer 62 Day Standard
- Cancer 62 Day Standard for Screening
- Cancer Breast 2 Week Wait Standard
- Cancer 31 Day Standard
- Delayed Transfers of Care

Effectiveness Domain: 5
The domain remained at a 5, achieving in all indicators.

Safe Domain: 5
There were a total of 2 cases of C-Difficile in July. Due to there being no reported case of MRSA in July.

Caring Domain: 4

Inpatient scores remain above the expected standard whilst the A&E scores dropped below the required standard. As such the Caring domain score has reduced to 4.
There were no Mixed Sex Accommodation breaches reported in July. The June report incorrectly stated that there was a breach in June. This has now been corrected.

Well Led Domain: 2
Friends and Family response has dropped to below the 30% standard because we now have to include all day case and all children in the return (previously these had been excluded). This has increased the denominator but not the numerator and thus dropped the percentage.

Finance Report
The Trust performance in month 5 was a run rate deficit of £3.8m with an adverse variance against plan of £0.5m. Year to date the run rate deficit stands at £15.8m which is £1.8m worse than plan.

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 M5 financial position.

Risks and Implications

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

The financial risks are set out on page 14 of the report.

Assurance Provided:

This report includes all indicators contained within the Trust Development Authority'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 TDA.

2015/16 TDA Framework Indicators had not been released at the time of writing this report, but will be form the basis of subsequent reports.

The forecast outturn now reflects the resubmitted stretch target plan. However, there is significant risk of non-delivery of this revised plan.

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

Proposals and/or Recommendations

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?

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

East Sussex Healthcare Trust
Integrated Performance Report

Month 4
July 2015

EAST SUSSEX HEALTHCARE NHS TRUST KNOWLEDGE MANAGEMENT

East Sussex Healthcare Trust; Summary Performance against TDA Accountability Framework (2014/15 indicators)												
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
	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 (Out of 5: 1- Poor to 5-Good)	4	4	4	4								
Responsiveness Domain Score	2	2	3	3								
Effectiveness Domain Score	5	5	5	5								
Safe Domain Score	4	4	4	5								
Caring Domain Score	4	4	5	4								
Well Led Domain Score	3	3	3	2								

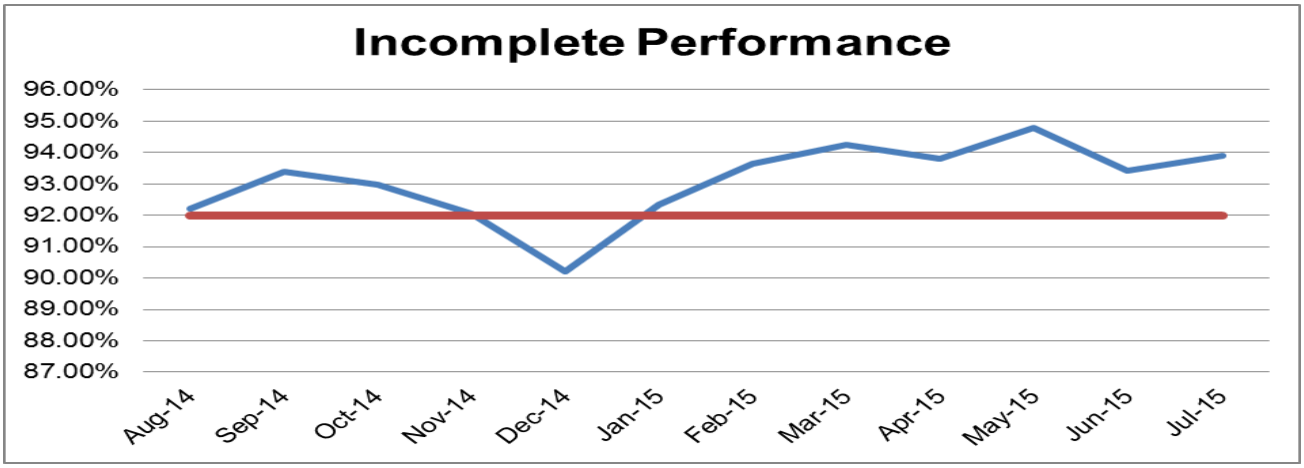
2.0 Responsiveness Domain: Score of 3

Responsiveness Domain		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
		DOMAIN SCORE											
Indicator	Standard	2	3	2	3	3	2	3	2	2	2	3	3
Referral to Treatment Incomplete	92.00%	92.22%	93.39%	92.97%	92.04%	90.20%	92.35%	93.64%	94.24%	93.80%	94.79%	93.41%	93.88%
Referral to Treatment Incomplete 52+ Week Waiters	0	1	3	2	4	2	0	0	0	0	0	0	0
Diagnostic waiting times	1.00%	0.97%	0.18%	0.28%	1.29%	1.29%	1.79%	0.66%	1.13%	1.90%	2.44%	2.59%	0.86%
A&E All Types Monthly Performance	95.00%	94.07%	95.00%	93.44%	95.63%	89.00%	91.82%	92.86%	91.48%	88.88%	92.41%	97.22%	95.55%
12 hour Trolley waits	0	0	0	0	0	0	0	0	0	0	0	0	0
Two Week Wait Standard	93.00%	90.16%	93.41%	92.80%	92.22%	91.98%	90.20%	93.94%	92.47%	90.60%	93.63%	93.08%	91.76%
Breast Symptom Two Week Wait Standard	93.00%	93.58%	80.65%	95.89%	93.75%	92.73%	93.48%	91.15%	91.03%	94.85%	96.08%	91.16%	84.11%
31 Day Standard	96.00%	95.57%	94.87%	86.14%	90.74%	96.43%	90.20%	94.81%	96.20%	97.77%	98.10%	95.45%	94.92%
31 Day Subsequent Surgery Standard	94.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
31 Day Subsequent Drug Standard	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
62 Day Standard	85.00%	80.00%	79.15%	76.87%	75.00%	83.11%	83.68%	78.06%	74.60%	82.03%	72.22%	71.49%	76.56%
62 Day Screening Standard	90.00%	83.33%	68.75%	83.33%	83.33%	100.00%	76.47%	88.89%	75.00%	86.67%	87.50%	81.82%	84.62%
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	0	0	0	0	0	0	0	0	0
Proportion of patients not treated within 28 days of	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Delayed Transfers of Care	3.50%	3.95%	5.43%	4.63%	7.81%	12.15%	11.84%	11.25%	6.57%	5.48%	7.60%	9.36%	9.16%
Referral to Treatment Admitted	90.00%	75.60%	82.74%	85.67%	78.26%	91.18%	74.76%	81.00%	84.75%	78.76%	83.93%	78.90%	77.59%
Referral to TreatmentNon Admitted	95.00%	91.16%	89.56%	91.42%	91.49%	90.55%	87.64%	89.74%	92.69%	92.54%	93.22%	92.20%	89.60%

Due to the Trusts improving A&E Performance, this domain has remained at a score of 3.

2.1 RTT Performance

Referral to Treatment (RTT/18 Weeks)



The Trust continues to achieve the 'Incomplete' standard of 92% with a July position of 93.88%.

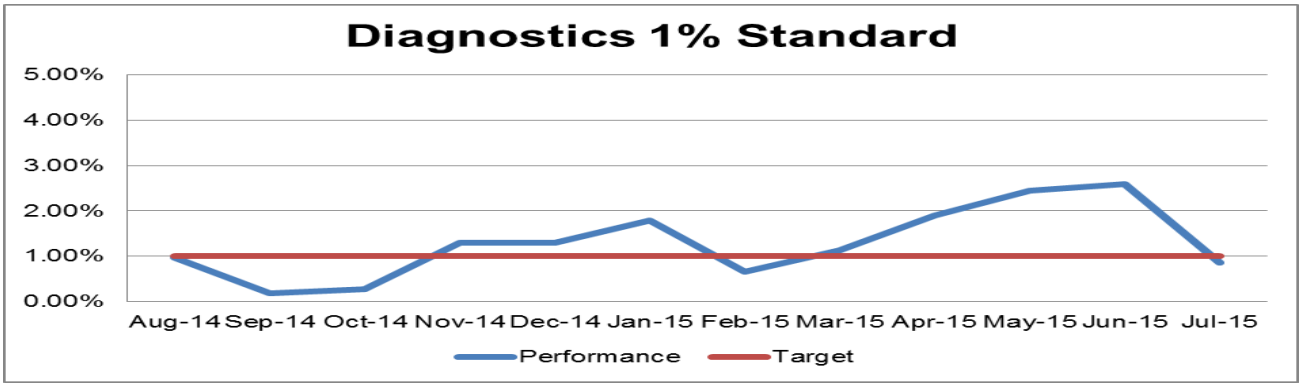
As of June 2015, the Admitted and Non-Admitted RTT targets were abolished and Trusts will now only be held accountable for meeting the 92% 'incomplete' RTT target.

This indicator requires that a minimum of 92% of patients on an incomplete pathway (waiting list) should be waiting less than 18 weeks from receipt of referral. This standard includes all patients who are yet to receive their first definitive treatment or discharge and also includes all patients who are still waiting for an outpatient appointment, diagnostic test or elective admission.

The Trusts Admitted position for July was 77.59% against a target of 90%. The Non-Admitted position was 89.60% against a target of 95%.

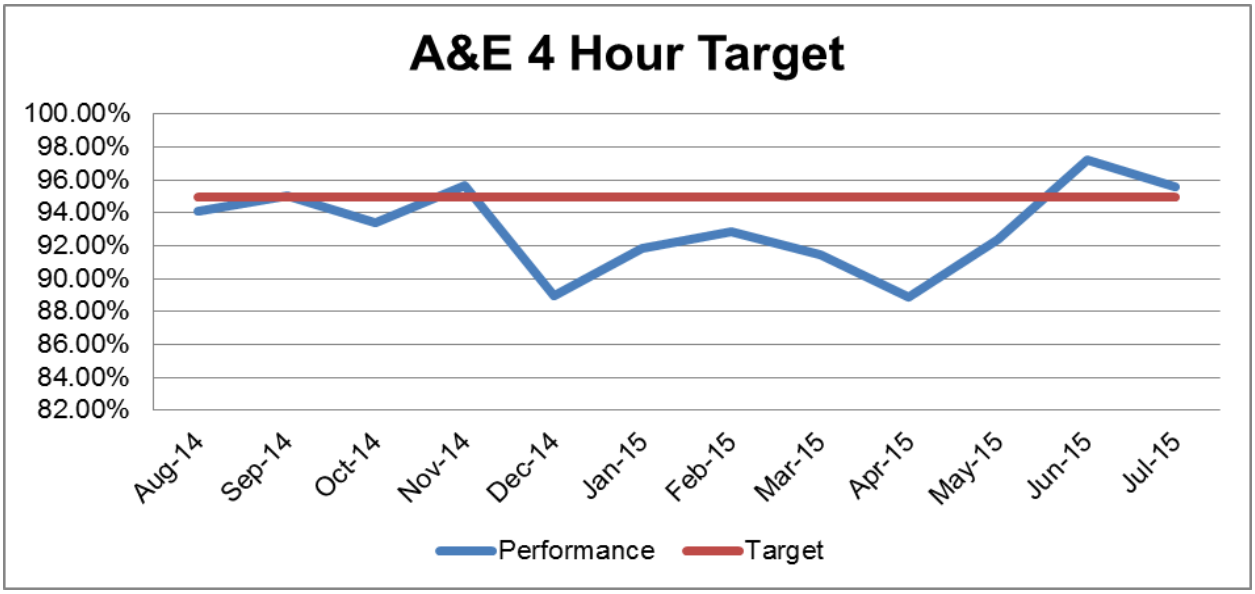
Both pathways continue to be particularly challenging and this is being monitored via the Trusts weekly PTL meetings.

2.2 Diagnostics



Diagnostic Waiting Times – With a final figure for July of 0.86%, the Trust achieved the 6 week diagnostic waiting time standard a month earlier than originally planned.

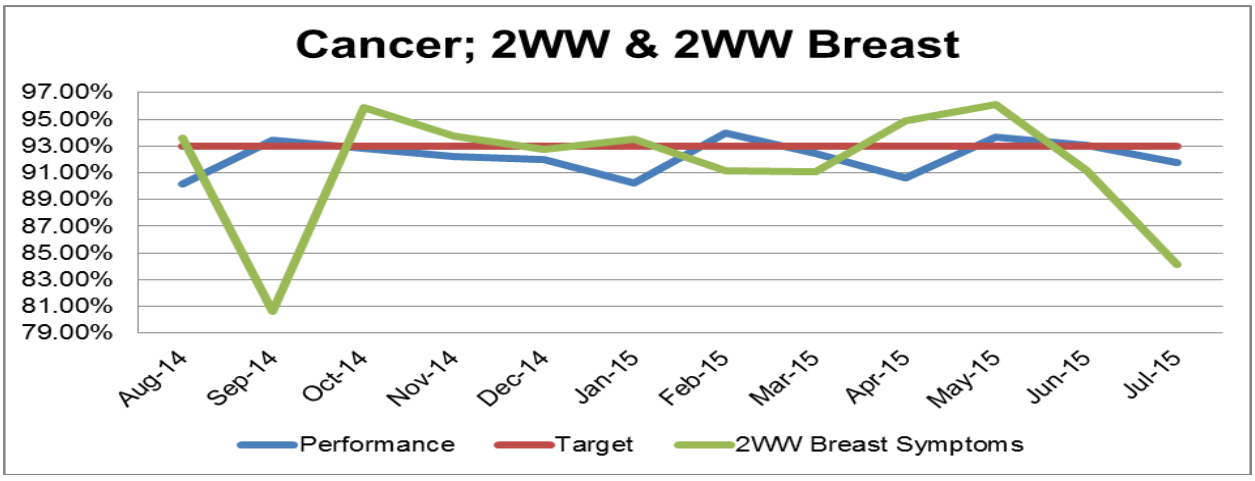
Demands on the Endoscopy service continue to be challenging and so it is expected that outsourced capacity will continue to be required during August and September. The IMAS Intensive Support team continue to work with the service on its Demand and Capacity planning and service improvements.

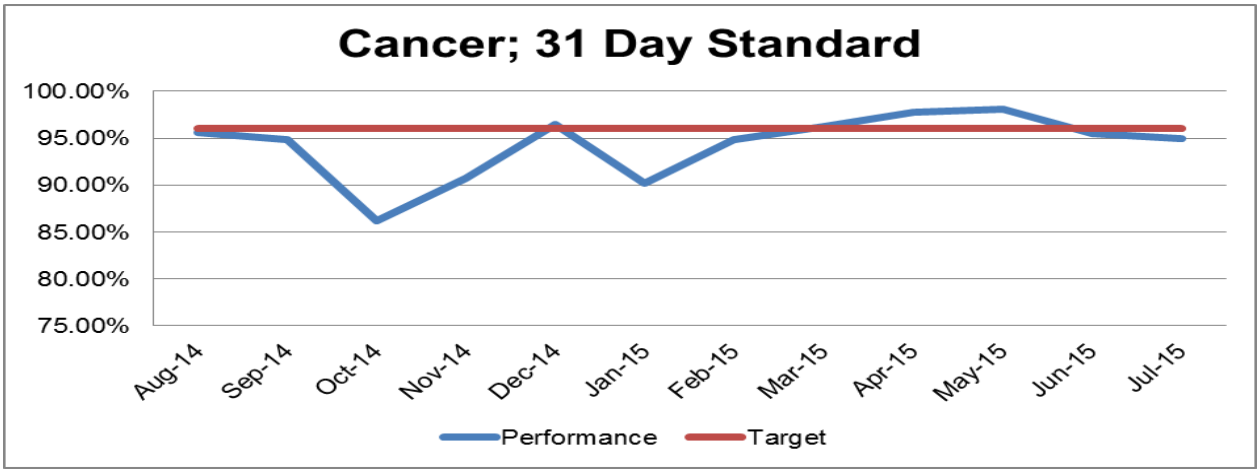


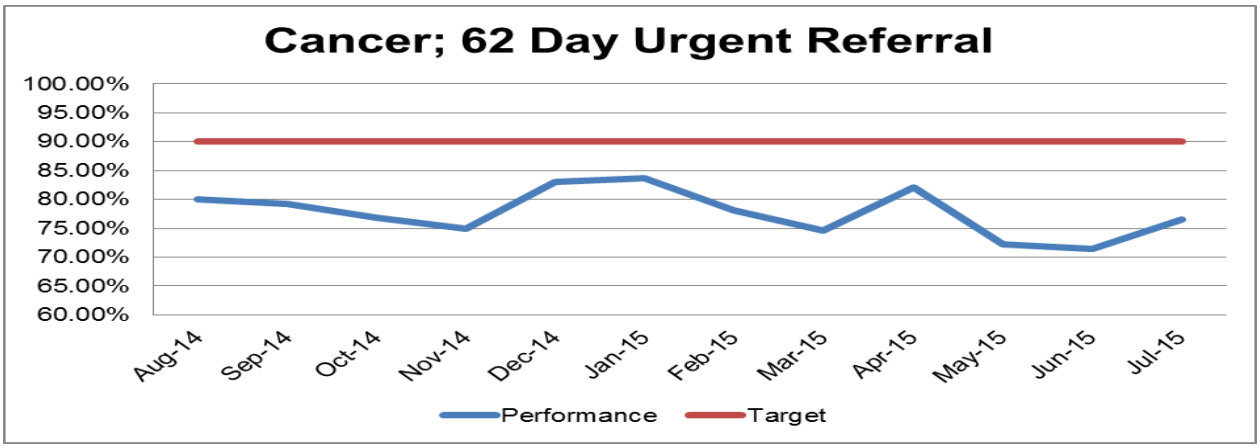
A&E compliance –July's position showed that 95.55% of patients waited less than 4 hours from arrival at A&E to admissions, transfer, or discharge, against a national standard of 95%. This is the second month in a row that the Trust has achieved the A&E 4 hour's target.

The view for August is suggesting a more challenging month with an increase in delays for beds, continued high level of patients MFFD remaining over 100 across the Trust and a significant reduction in discharges against predicted levels on both sites.

2.4 Cancer Performance







Cancer - July has been a particularly disappointing month in relation for achieving the Cancer standards.

Indicator	Standard	Jul-15
Two Week Wait Standard	93.00%	91.8%
Breast Symptom Two Week Wait Standard	93.00%	84.1%
31 Day Standard	96.00%	95.0%
31 Day Subsequent Surgery Standard	94.00%	100%
31 Day Subsequent Drug Standard	98.00%	100%
62 Day Standard	85.00%	75.3%
62 Day Screening Standard	90.00%	84.6%

Review of breaches continues to suggest that patient's availability and capacity to be the contributing factors.

Cancer standards are expected to be extremely challenging during the coming summer months with regards to patient availability, increased referrals rates and Trust capacity. Referral data suggests that Two Week Wait referrals have increased by 9.5% on the same period last year.

The Trust has now developed a 'Cancer Waiting Times & Improvement' plan as part of the focus on recovering the performance position.

2.5 Delayed Transfers of Care

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

Delayed Transfer of Care Breakdown	Target	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Delayed Transfers of Care (Combined)	3.50%	6.67%	4.92%	7.81%	12.15%	11.84%	11.25%	6.51%	5.48%	7.60%	9.36%	9.16%
Delayed Transfers of Care (Acute Only)	3.50%	5.11%	3.96%	5.61%	10.73%	11.27%	11.39%	4.80%	4.67%	6.14%	8.34%	6.80%
Delayed Transfers of Care (Non-Acute Only)	7.50%	13.56%	8.98%	18.91%	18.28%	12.99%	8.77%	13.79%	9.50%	16.17%	17.77%	25.73%

The whole systems work with Adult Social Care and the CCGs is on-going and being reported into the System Resilience Group for East Sussex. A concentrated piece of work is now in place with the community sites to ensure the DTC data is being recorded accurately in accordance with the guidance. This possible over reporting is thought to be contributing to the sharp rise since May from 9.5% to around 16%, however July has seen a sharp increase of nearly 8%. The shortage of nursing home and residential placements continues to delay discharges from both acute and community sites.

3 Effectiveness Domain: Score of 5

Effectiveness Domain		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
		DOMAIN SCORE											
Indicator	Standard	5	5	5	5	5	5	5	5	5	5	5	5
Hospital Standardised Mortality Ratio (DFI)	103.32	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08
Deaths in Low Risk Conditions	1.06	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75
Hospital Standardised Mortality Ratio - Weekday	110.03	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49
Hospital Standardised Mortality Ratio - Weekend	117.35	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6
Summary Hospital Mortality Indicator (HSCIC)	1.066	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	10%	7.64%	7.79%	7.94%	7.81%	7.81%	7.89%	7.14%	5.98%	6.26%	7.71%	8.52%	4.42%

3.1Mortality

TDA guidance for mortality, requests that Trusts use the Dr Foster web portal to view and report their mortality performance. This portal is only updated annually and so the numbers can appear static for long periods.

The latest SHMI figures were released in January to show a time period up to July 2014. The Trust figure was 1.077 which is within the confidence limits (upper limit 1.114). This has therefore been adjusted on the table above.

3.2 Emergency Re-Admissions

The rate of emergency re-admissions within 30 days of a previous discharge continues to meet the standard and has achieved the lowest level for over a year. This improvement is as a result of the regular analysis of emergency re-admissions, involving the key clinicians within clinical units.

4.0 Safe Domain: Score of 5

Safe Domain		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
		DOMAIN SCORE											
Indicator	Standard	3	5	4	3	4	5	5	5	4	4	4	5
Clostridium Difficile - Variance from plan	4	6	2	7	6	6	3	2	3	1	3	5	2
MRSA bactaraemias	0	1	0	0	1	0	0	0	0	1	1	0	0
Never events	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient safety incidents that are harmful	0	1	0	1	3	0	1	5	4	7	3	2	1
Medication errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Overdue CAS alerts	0	0	0	12	6	17	7	0	10	6	4	4	0
Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0
VTE Risk Assessment	95.00%	98.10%	97.98%	98.67%	98.21%	96.04%	96.51%	97.03%	96.39%	95.33%	95.73%	95.66%	95.79%
Percentage of Harm Free Care	92.00%	97.53%	94.60%	94.97%	97.67%	97.83%	93.66%	93.45%	94.68%	93.67%	94.64%	93.31%	93.32%

4.1Healthcare Acquired Infections

There were a total of 2 cases of C-Difficile in July.

The Head of IP&C TDA South has recommended that only cases where a lapse in care may have resulted in patients developing CDI (i.e. inappropriate antibiotics or cross infection) should count against our trajectory. For cases where there was a lapse in care yet was unlikely to have contributed to the patient developing CDI (low environmental scores for example) should NOT count against trajectory but we must work with our CCGs to show improvement.

There were no reported cases of MRSA in July.

4.2 Patient Safety

For the month of July there was 1 harmful reported incident. Incidents recorded onto the system with a severity level of 4 or above, are included within this indicator but will be routinely reviewed to ensure that the severity has been appropriately assigned. In some cases this may reduce the severity of the incident and thus remove it from this line. As such, subsequent reports may show a different number.

5.0 Caring Domain: Score of 4

Caring Domain		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Indicator	Standard	5	5	4	4	4	4	4	4	4	4	5	4
Inpatient Scores from Friends and Family Test	60	65	70	64	68	68	64	70	71	75	77	75	75
A&E Scores from Friends and Family Test	46	54	48	45	38	38	42	45	39	39	40	48	39
Mixed Sex Accommodation Breaches	0	0	20	0	31	26	15	1	6	0	0	0	0
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9

5.1 Friends and Family Test (Patient Experience)

Inpatient scores remain above the expected standard whilst the A&E scores dropped below the required standard. As such the Caring domain score has reduced to 4.

5.2 Mixed Sex Accommodation

There were no reported mixed sex accommodation breaches in July. The breach that was reported in June was an error and has since been corrected.

6.0 Well Led Domain: Score of 2

Well Led Domain		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
		DOMAIN SCORE											
Indicator	Standard	4	4	4	4	3	3	3	3	3	3	3	2
Inpatients response rate from Friends and Family Test	30.00%	39.40%	46.21%	47.94%	48.62%	46.48%	38.55%	42.18%	41.52%	52.17%	47.22%	50.03%	9.68%
A&E response rate from Friends and Family Test	20.00%	28.75%	30.40%	25.10%	20.87%	16.66%	17.55%	21.99%	19.38%	14.99%	15.04%	16.92%	10.02%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	40.70%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	42.30%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%
Trust turnover rate	10.00%	13.19%	13.41%	13.32%	13.60%	14.09%	14.03%	13.95%	12.64%	13.03%	12.91%	12.12%	12.26%
Trust level total sickness rate	3.30%	4.59%	4.76%	5.50%	5.46%	5.74%	5.33%	5.02%	4.81%	4.67%	4.27%	4.34%	4.21%
Total Trust vacancy rate	10.00%	4.72%	5.47%	5.74%	7.60%	5.58%	6.66%	6.19%	6.24%	8.75%	8.85%	8.57%	9.16%
Temporary costs and overtime as % of total pay	10.00%	9.58%	9.48%	9.73%	9.97%	10.16%	11.14%	12.41%	12.56%	13.44%	25.54%	4.65%	14.84%
Percentage of staff with annual appraisal	85.00%	67.02%	67.54%	68.34%	70.01%	68.28%	70.64%	71.71%	74.60%	75.17%	74.88%	74.54%	75.03%

6.1 Friends and Family Test (Response Rate)

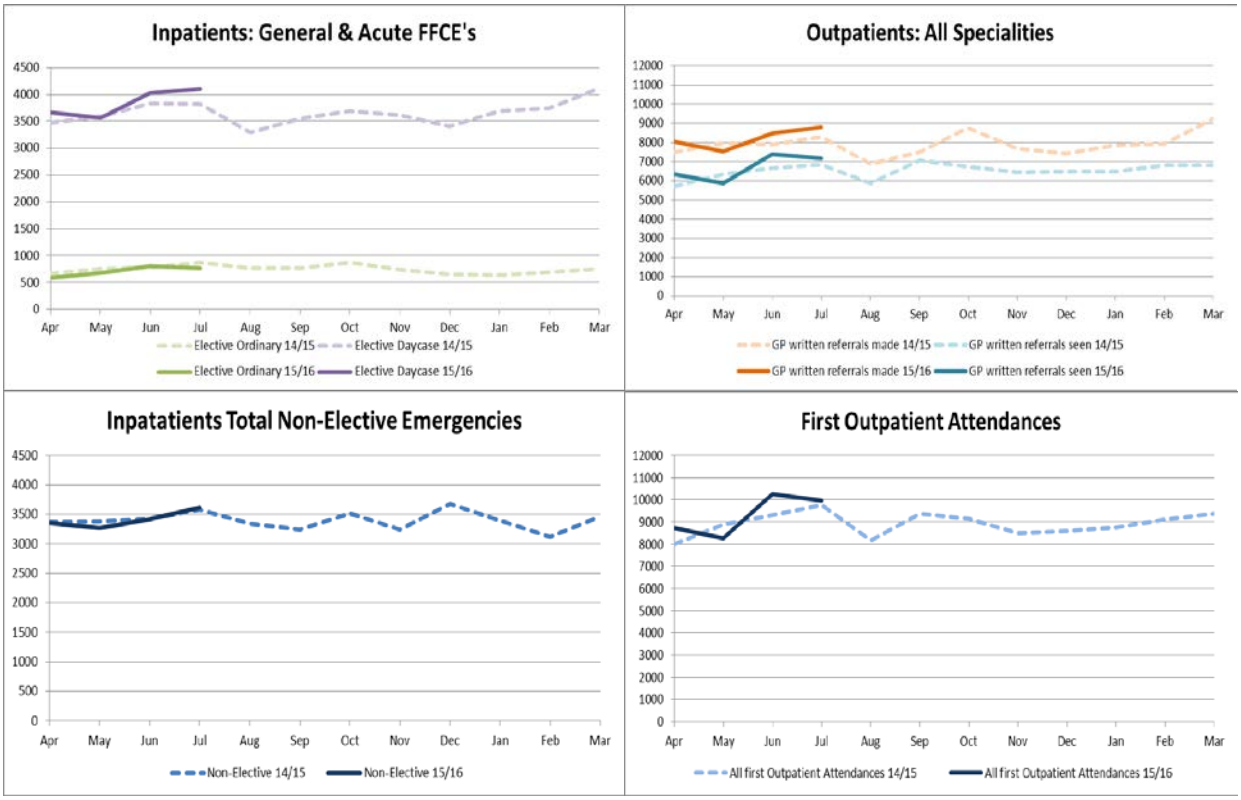
Friends and Family response has dropped to below the 30% standard because we now have to include all day case and all children in the return (previously these had been excluded). This has increased the denominator but not the numerator and thus dropped the percentage.

6.2 Workforce

Sickness rates have shown a slight decrease on the June position. Appraisal rates remain below the target figure of 85%. Further detail is given in section 8.

7.0 Activity

The graphics below illustrate current activity levels against the key activity metrics submitted to the department of health monthly; First Finished Consultant Episodes (Elective), GP Referrals, Non-Elective Spells and First Outpatient Attendances.



Year 14/15			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Inpatients	General and Acute FFCE's	Elective Ordinary 14/15	666	751	784	876	769	773	867	741	656	641	686	758
		Elective Daycase 14/15	3469	3589	3837	3824	3294	3551	3687	3615	3403	3687	3746	4110
		Non-Elective 14/15	3372	3377	3432	3581	3340	3244	3513	3243	3682	3389	3125	3472
		Total Inpatients	7507	7717	8053	8281	7403	7568	8067	7599	7741	7717	7557	8340
Outpatients	All Specialities	GP written referrals made 14/15	7494	7978	7886	8284	6880	7516	8785	7671	7438	7864	7930	9227
		GP written referrals seen 14/15	5743	6346	6665	6844	5885	7054	6751	6442	6486	6503	6803	6816
	All first Outpatient Attendances 14/15		8009	8893	9325	9759	8156	9375	9161	8514	8585	8746	9120	9390

Year 15/16			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Inpatients	General and Acute FFCE's	Elective Ordinary 15/16	588	675	804	770								
		Elective Daycase 15/16	3663	3560	4023	4102								
		Non-Elective 15/16	3359	3269	3417	3615								
		Total Inpatients	7610	7504	8244	8487								
Outpatients	All Specialities	GP written referrals made 15/16	8034	7553	8492	8789								
		GP written referrals seen 15/16	6347	5889	7401	7182								
	All first Outpatient Attendances 15/16		8730	8266	10260	9956								

8.0 Community Services

8.1 Intermediate Care Beds

The tables below detail the Occupancy, Average Length of Stay and Admission rates at the Trust's 6 community sites.

Intermediate Care Beds		31	31	30	31	30	31	31	28	31	30	31	30	31
Occupancy Level	**Target**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Irvine Unit	85.00%	91.53%	90.86%	99.26%	96.24%	99.58%	96.53%	96.99%	96.57%	83.06%	91.03%	83.31%	89.08%	92.64%
Crowborough Hospital	85.00%	90.09%	87.79%	88.33%	92.63%	94.67%	94.80%	95.34%	96.43%	93.87%	89.33%	93.87%	94.00%	90.17%
Firwood House	85.00%	77.27%	77.27%	87.14%	87.71%	85.87%	88.94%	86.79%	71.09%	88.06%	74.83%	95.16%	88.83%	98.83%
Lewes Intermediate Care Unit	85.00%	88.59%	92.93%	89.23%	85.36%	89.62%	89.33%	92.31%	93.41%	87.67%	91.15%	85.86%	94.10%	97.28%
Uckfield Hospital	85.00%	90.78%	94.01%	86.90%	93.55%	87.86%	90.09%	95.39%	90.31%	84.79%	84.29%	94.70%	89.52%	91.43%
Rye Memorial Care Centre	85.00%	93.55%	90.55%	70.71%	93.78%	86.90%	81.11%	89.63%	84.18%	73.98%	84.67%	80.43%	79.11%	82.22%
Total Occupancy	**85.00%**	**87.47%**	**85.40%**	**83.28%**	**89.71%**	**91.69%**	**91.99%**	**93.85%**	**90.46%**	**86.49%**	**86.64%**	**88.40%**	**89.73%**	**92.85%**

Total in Month Length of Stay (Days)	**Target**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Irvine Unit	25.00	20.74	15.38	19.85	16.38	16.52	21.72	16.61	26.90	23.81	18.36	16.20	20.88	26.48
Crowborough Hospital	25.00	21.31	23.74	14.67	28.23	23.85	18.52	26.00	16.79	21.42	19.73	20.25	36.37	34.47
Firwood House	25.00	24.04	24.94	26.04	27.09	20.00	23.92	23.17	24.68	20.72	26.00	22.88	25.43	23.63
Lewes Intermediate Care Unit	25.00	20.09	32.79	36.80	30.52	27.75	24.67	29.94	29.54	30.46	26.21	20.78	21.14	36.06
Uckfield Hospital	25.00	23.00	20.46	22.65	25.77	22.40	14.05	27.00	23.59	15.87	11.19	24.09	15.91	28.73
Rye Memorial Care Centre	25.00	23.79	22.24	25.50	24.39	20.33	22.50	16.89	21.75	20.53	23.74	20.06	21.48	15.89
Total YTD ALOS	**25.00**	**22.00**	**21.92**	**23.59**	**22.73**	**21.89**	**22.18**	**23.02**	**26.01**	**23.16**	**20.74**	**22.36**	**24.15**	**28.24**

Total in Month Length of Stay (Days) STEP UP	**Target**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Irvine Unit	10.00	1.00	9.33	#N/A	#N/A	28.00	14.00	3.00	13.00	16.00	#N/A	0.00	29.00	3.00
Crowborough Hospital	10.00	18.00	9.88	7.25	16.88	30.25	18.57	21.67	11.27	17.25	16.86	8.67	44.33	39.89
Firwood House	10.00	16.00	#N/A	26.50	19.00	20.00	#N/A	#N/A	36.00	#N/A	21.00	16.00	10.00	28.00
Lewes Intermediate Care Unit	10.00	9.38	48.33	39.67	17.25	57.00	19.67	2.00	20.00	19.40	28.50	17.43	12.67	18.67
Uckfield Hospital	10.00	19.85	20.59	15.50	22.43	18.58	14.92	27.56	19.88	10.67	10.00	18.00	9.64	8.08
Rye Memorial Care Centre	10.00	14.60	11.00	30.00	15.60	13.00	20.50	17.33	21.00	13.50	40.80	13.00	21.33	9.86
Total YTD ALOS	**10.00**	**14.94**	**18.91**	**18.44**	**18.17**	**24.62**	**16.85**	**21.73**	**18.11**	**13.56**	**19.45**	**15.15**	**20.52**	**18.56**

Total in Month Length of Stay (Days) STEP DOWN	**Target**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Irvine Unit	21.00	21.71	15.91	19.85	16.38	16.13	21.97	16.95	27.26	24.12	18.36	16.62	20.64	27.22
Crowborough Hospital	21.00	22.08	33.82	23.14	34.71	21.00	18.50	29.06	21.46	23.28	21.07	24.11	32.69	28.38
Firwood House	21.00	24.41	24.94	25.95	27.48	20.00	23.92	23.17	23.35	20.72	26.29	23.17	26.14	23.43
Lewes Intermediate Care Unit	21.00	25.80	29.88	36.29	35.13	25.09	25.22	31.59	30.78	32.87	25.84	21.72	22.47	39.53
Uckfield Hospital	21.00	33.25	20.14	56.00	29.67	28.13	12.78	25.33	36.20	26.80	12.78	34.75	22.18	53.50
Rye Memorial Care Centre	21.00	28.89	23.73	24.46	27.77	21.80	22.75	16.81	21.88	23.09	17.64	20.50	21.50	19.73
Total YTD ALOS	**21.00**	**23.81**	**22.72**	**25.00**	**23.56**	**21.23**	**23.17**	**23.25**	**28.31**	**26.15**	**21.01**	**23.46**	**24.85**	**31.27**

Admissions/Spells	**Target**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Irvine Unit	N/A	34	28	36	41	24	28	32	27	24	47	40	34	33
Crowborough Hospital	N/A	17	14	20	21	17	23	28	22	26	22	12	19	17
Firwood House	N/A	15	25	23	24	20	21	25	15	20	18	25	23	24
Lewes Intermediate Care Unit	N/A	26	15	20	30	25	30	21	25	26	29	32	22	18
Uckfield Hospital	N/A	19	24	18	11	18	25	11	22	28	21	11	22	22
Rye Memorial Care Centre	N/A	16	14	19	18	11	21	17	16	17	19	17	21	18
Total Admissions/Spells	**N/A**	**136**	**134**	**133**	**162**	**122**	**149**	**148**	**151**	**152**	**158**	**137**	**141**	**133**

Step Up Admissions/Spells	**Target**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Irvine Unit	N/A	2	3	0	0	1	1	1	1	1	0	1	1	1
Crowborough Hospital	N/A	3	8	8	8	4	7	12	11	8	7	3	6	9
Firwood House	N/A	1	0	4	1	4	0	0	2	0	1	1	1	1
Lewes Intermediate Care Unit	N/A	8	3	3	8	2	3	1	3	5	4	7	3	3
Uckfield Hospital	N/A	13	17	14	7	12	13	9	17	21	12	7	11	12
Rye Memorial Care Centre	N/A	5	2	3	5	2	2	3	3	4	5	1	3	7
Total Step Up Admissions/Spells	**N/A**	**32**	**33**	**32**	**29**	**26**	**26**	**26**	**37**	**39**	**31**	**20**	**25**	**34**

Step Down Admissions/Spells	**Target**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Irvine Unit	N/A	41	34	40	56	30	31	40	39	26	47	39	33	32
Crowborough Hospital	N/A	13	11	7	14	9	16	17	13	18	15	9	13	8
Firwood House	N/A	22	18	21	21	17	24	29	17	25	17	24	22	23
Lewes Intermediate Care Unit	N/A	15	16	17	23	22	27	17	23	23	25	25	19	15
Uckfield Hospital	N/A	4	7	3	6	8	9	3	5	10	9	4	11	10
Rye Memorial Care Centre	N/A	9	15	13	13	10	16	16	17	11	14	16	18	11
Total Step Down Admissions/Spells	**N/A**	**104**	**101**	**101**	**133**	**96**	**123**	**122**	**114**	**113**	**127**	**117**	**116**	**99**

Available beddays	**Target**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Irvine Unit	TBC	744	744	810	744	744	806	930	700	775	870	899	870	870
Crowborough Hospital	TBC	434	434	420	434	450	558	558	504	620	600	620	600	600
Firwood House	TBC	651	651	630	651	630	651	651	588	620	600	620	600	600
Lewes Intermediate Care Unit	TBC	806	806	780	806	780	26	806	728	868	780	806	780	810
Uckfield Hospital	TBC	434	434	420	434	420	420	434	392	434	420	434	420	420
Rye Memorial Care Centre	TBC	434	434	420	434	420	420	434	392	465	450	465	450	450
Total Available Beddays	**TBC**	**3503**	**3503**	**3480**	**3503**	**3444**	**2881**	**3813**	**3304**	**3782**	**3720**	**3844**	**3720**	**3750**
Total Occupied Beddays	**TBC**	**3552**	**3468**	**3348**	**3643**	**3631**	**3907**	**4102**	**3470**	**3834**	**3695**	**3929**	**3849**	**4030**

Total Available Beddays	**TBC**	**3503**	**3503**	**3480**	**3503**	**3420**	**3689**	**3813**	**3304**	**3875**	**3720**	**3844**	**3720**	**3750**
Total Occupied Beddays	**TBC**	**3089**	**3110**	**3082**	**3190**	**3117**	**3349**	**3546**	**2944**		**3223**	**3688**	**3209**	**2730**

Irvine Stroke Unit	**Target**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Occupancy Level	85.00%	91.53%	90.88%	99.26%	96.24%	99.58%	96.53%	96.99%	96.57%	91.76%	87.41%	95.16%	91.58%	98.21%
Total In Month LOS (Days)	25.00	22.95	20.87	20.06	16.12	26.00	31.35	28.27	45.85	35.58	21.82	45.86	35.92	40.45
Total in Month Length of Stay (Days) STEP UP	10.00	#N/A	#N/A	#N/A	#N/A	48.00	#N/A	#N/A	#N/A	#N/A	13.00	#N/A	#N/A	19.00
Total in Month Length of Stay (Days) STEP DOWN	21.00	22.95	20.87	20.06	16.12	24.00	31.35	28.27	45.85	35.58	22.70	45.86	35.92	42.60
Admissions		21	23	16	26	12	17	22	13	12	22	14	13	11
Step Up Admissions	N/A	0	0	0	0	1	0	0	0	0	2	0	0	1
Step Down Admissions	N/A	21	23	16	26	11	17	22	13	12	20	14	13	10
Available beddays	TBC	558	558	540	558	540	558	558	532	558	540	558	540	558

8.2 Community Nursing

Reporting extracts have been available to the Information Management team for several months.

In that time, an extensive validation exercise has been undertaken with a view to ensuring data quality and building the necessary data warehouse architecture.

The Trust now has a staff level data quality interface which provides service managers with detail on the completeness of activity input against all teams and staff.

In addition to this, the data warehouse architecture is now sufficient for reports to be produced in line with the agreed community nursing service specification. These reports are being presented to commissioners via monthly Community Technical meetings.

Going forward the Trust aims to build on the above by providing community nursing teams with a detailed activity interface to ensure the effective operational management of all services provided.

9.0 Community Therapy Referrals and Waiting List Trends

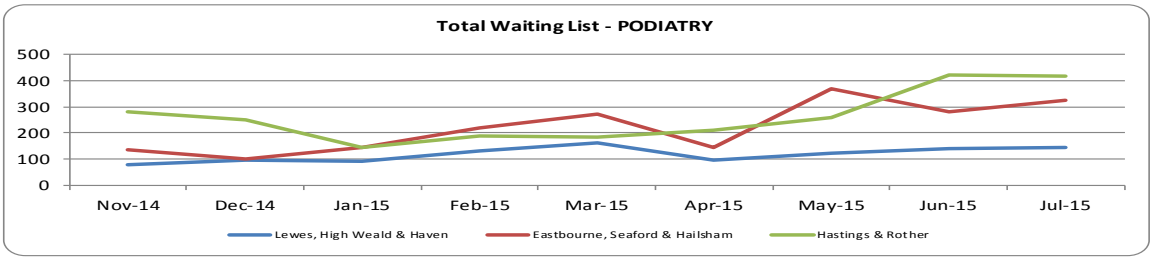
9.1 Referrals

Number of Referrals Received									
Service	CCG	Jan	Feb	Mar	Apr	May	Jun	Jul	Trend
Podiatry	Lewes, High Weald & Haven	51	59	91	46	66	61	91	
Podiatry	Eastbourne/Seaford/Hailsham	131	336	303	239	252	265	282	
Podiatry	Hastings & Rother	159	176	211	209	180	175	189	
TOTAL		**341**	**571**	**605**	**494**	**498**	**501**	**562**	
SaLT	Lewes, High Weald & Haven	23	22	35	38	34	34	32	
SaLT	Eastbourne/Seaford/Hailsham	46	30	58	64	40	48	44	
SaLT	Hastings and Rother	32	46	49	34	39	46	52	
TOTAL		**101**	**98**	**142**	**136**	**113**	**128**	**128**	
Community Dietetics	Lewes, High Weald & Haven	163	104	112	91	87	93	89	
Community Dietetics	Eastbourne/Seaford/Hailsham	157	161	181	152	164	201	208	
Community Dietetics	Hastings & Rother	144	162	167	145	121	137	154	
TOTAL		**464**	**427**	**460**	**388**	**372**	**431**	**451**	
MSK	Hastings & Rother	231	275	329	320	242	361	228	
TOTAL		**231**	**275**	**329**	**320**	**242**	**361**	**0**	
MSK-Neuro Outpatients	Lewes, High Weald & Haven	2	2	5	2	2	4	7	
MSK-Neuro Outpatients	Eastbourne/Seaford/Hailsham	40	18	29	24	19	29	29	
MSK-Neuro Outpatients	Hastings & Rother	16	26	55	33	31	35	34	
TOTAL		**58**	**46**	**89**	**59**	**52**	**68**	**70**	
MSK- Women's Health	Lewes, High Weald & Haven	14	17	20	28	10	8	33	
MSK- Women's Health	Eastbourne/Seaford/Hailsham	52	70	39	70	56	62	68	
MSK- Women's Health	Hastings & Rother	46	61	54	48	44	70	47	
TOTAL		**112**	**148**	**113**	**146**	**110**	**140**	**148**	

9.2 Total Waiting List by Discipline

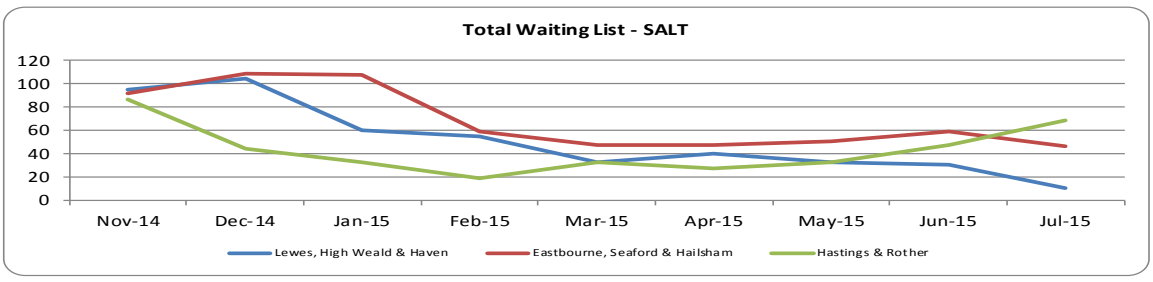
Service: PODIATRY

Podiatry	Number of Patients Waiting								
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Lewes, High Weald & Haven	79	97	89	133	163	95	123	138	144
Eastbourne, Seaford & Hailsham	136	101	144	220	273	145	368	282	327
Hastings & Rother	281	250	142	189	184	211	258	421	416
Total	**496**	**448**	**375**	**542**	**620**	**451**	**749**	**841**	**887**



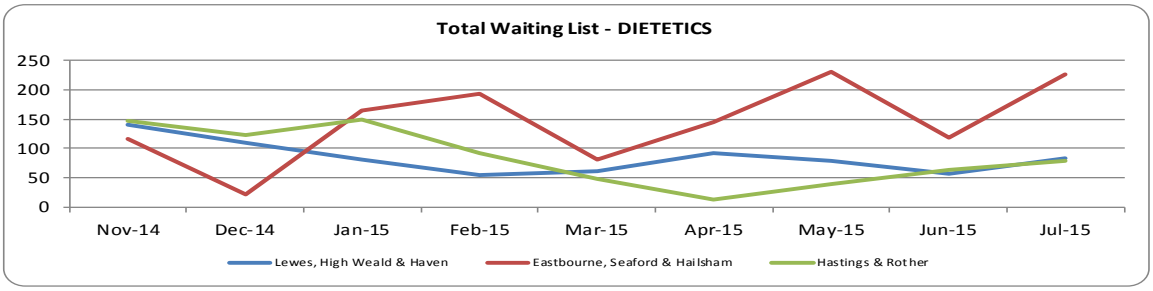
Service: SALT

SALT	Number of Patients Waiting								
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Lewes, High Weald & Haven	95	105	60	55	32	40	33	30	10
Eastbourne, Seaford & Hailsham	92	109	108	59	47	47	51	59	46
Hastings & Rother	86	44	32	19	33	27	33	47	69
Total	**273**	**258**	**200**	**133**	**112**	**114**	**117**	**136**	**125**



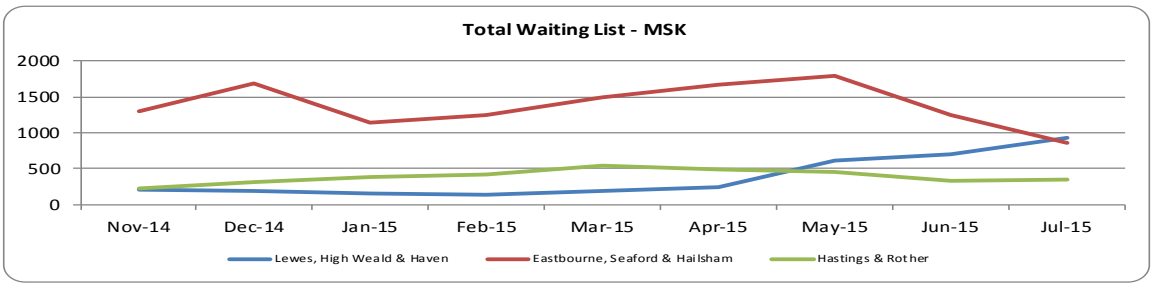
Service: DIETETICS

DIETETICS	Number of Patients Waiting								
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Lewes, High Weald & Haven	140	109	80	55	60	91	79	57	83
Eastbourne, Seaford & Hailsham	117	22	164	193	80	145	232	119	227
Hastings & Rother	148	123	149	91	47	13	38	63	78
Total	**405**	**254**	**393**	**339**	**187**	**249**	**349**	**239**	**388**



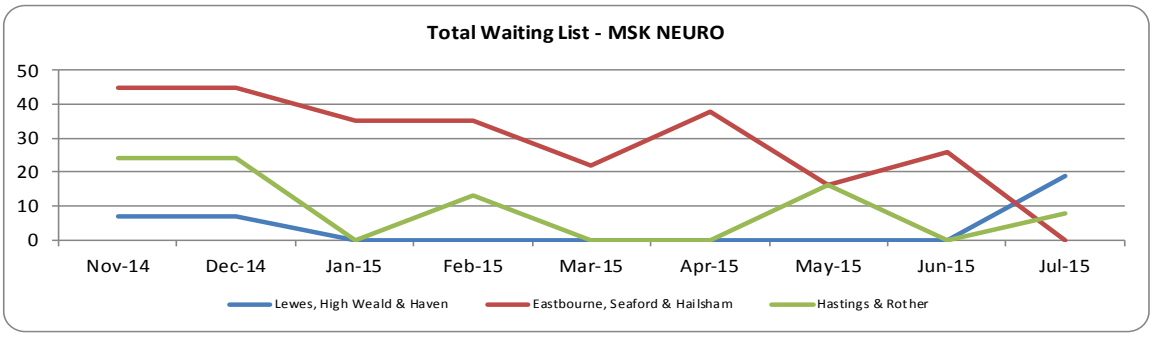
Service: MSK

MSK	Number of Patients Waiting								
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Lewes, High Weald & Haven	205	188	146	133	183	241	614	694	922
Eastbourne, Seaford & Hailsham	1299	1695	1133	1248	1494	1669	1798	1244	867
Hastings & Rother	223	317	387	425	542	497	454	326	343
Total	**1727**	**2200**	**1666**	**1806**	**2219**	**2407**	**2866**	**2264**	**2132**



Service: MSK NEURO

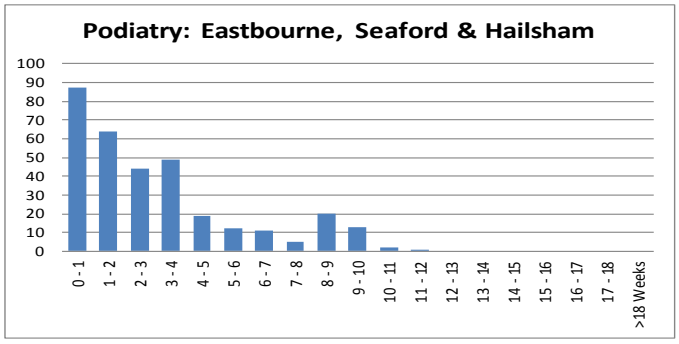
MSK Neuro	Number of Patients Waiting								
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Lewes, High Weald & Haven	7	7	0	0	0	0	0	0	19
Eastbourne, Seaford & Hailsham	45	45	35	35	22	38	16	26	0
Hastings & Rother	24	24	0	13	0	0	16	0	8
Total	**76**	**76**	**35**	**48**	**22**	**38**	**32**	**26**	**27**



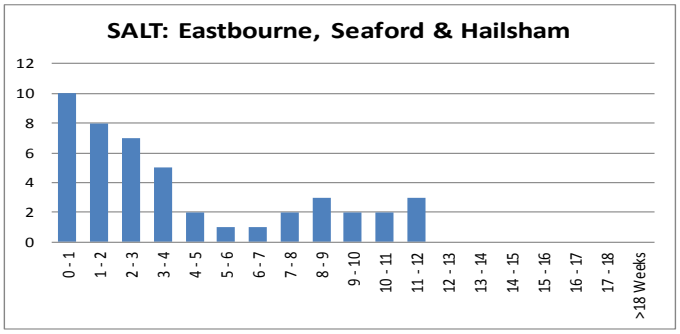
9.3 Community Therapy Waiting List Profiles

The below charts detail the waiting list profile and performance for each therapy discipline. The data includes patients waiting on 31st July 2015.

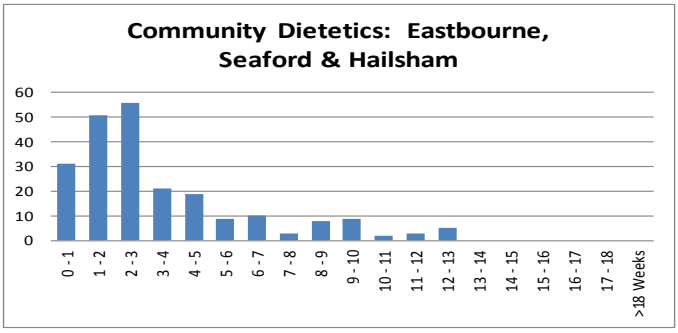
Eastbourne, Seaford and Hailsham; Therapy waiting list profiles



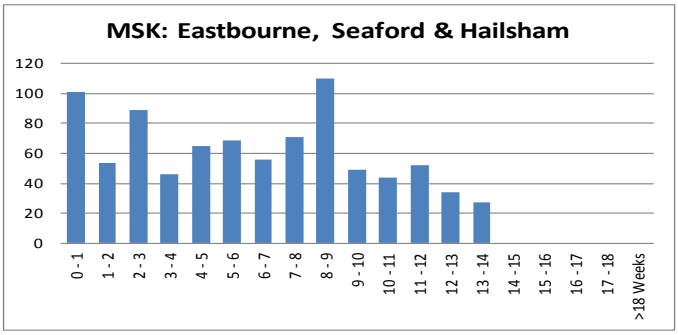
	July	June
Total Waiting List	327	282
% <13 Weeks	100%	100%



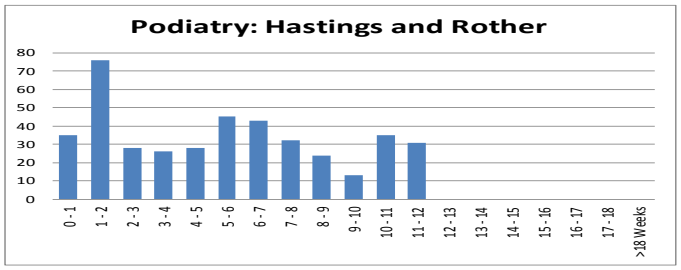
	July	June
Total Waiting List	46	59
% <13 Weeks	100%	100%



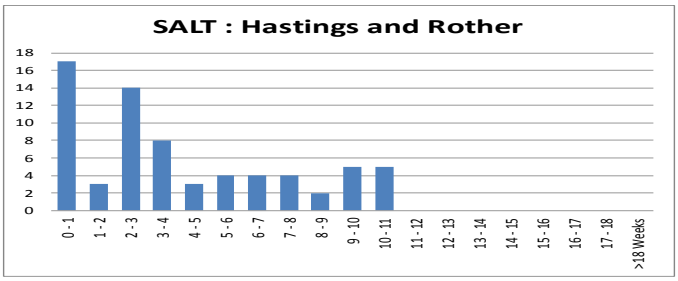
	July	June
Total Waiting List	227	119
% <13 Weeks	100%	100%



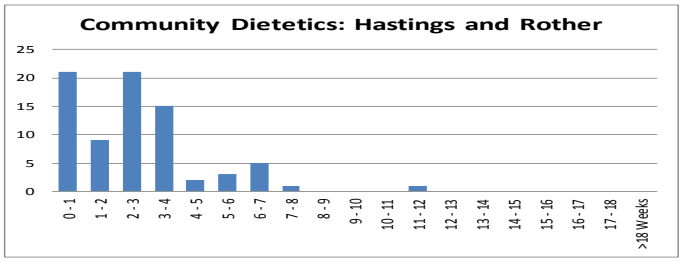
	July	June
Total Waiting List	867	1244
% <13 Weeks	97%	89%



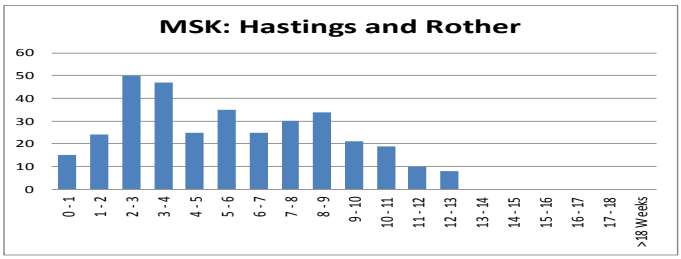
	July	June
Total Waiting List	416	421
% <13 Weeks	100%	100%



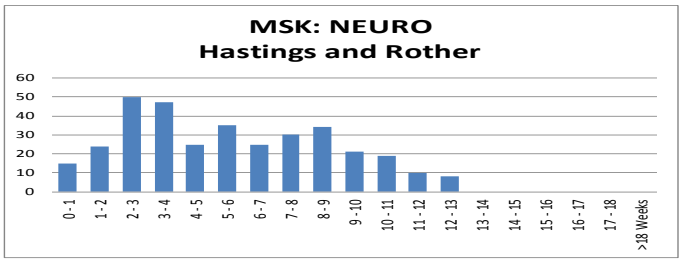
	July	June
Total Waiting List	69	47
% <13 Weeks	100%	100%



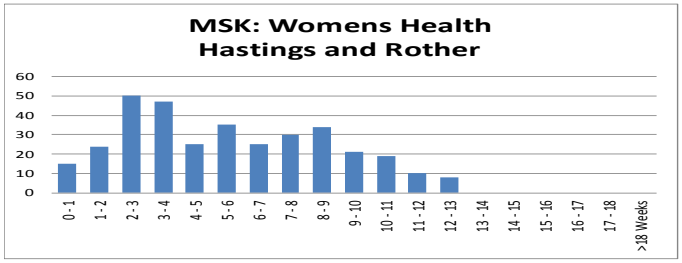
	July	June
Total Waiting List	78	63
% <13 Weeks	100%	100%



	July	June
Total Waiting List	343	326
% <13 Weeks	100%	88%

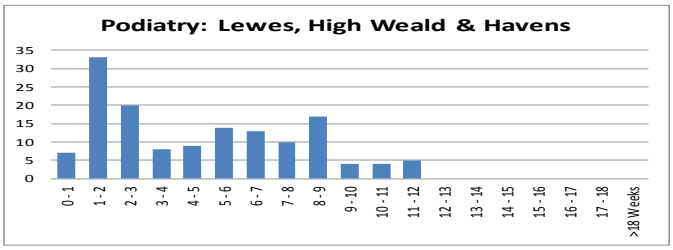


	July	June
Total Waiting List	8	0
% <13 Weeks	100%	0%

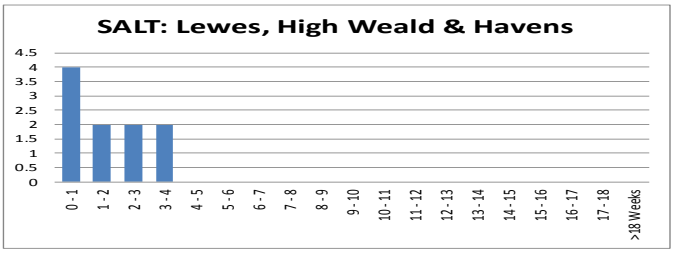


	July	June
Total Waiting List	28	0
% <13 Weeks	100%	0%

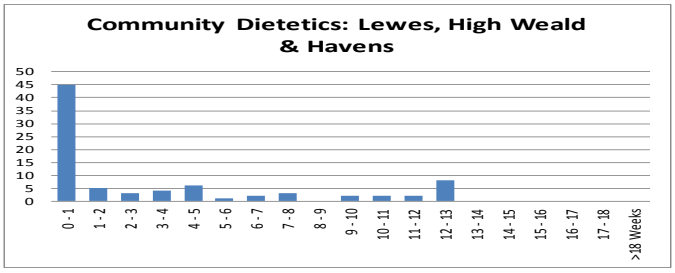
Lewes, High Weald and Havens; Therapy waiting list profiles



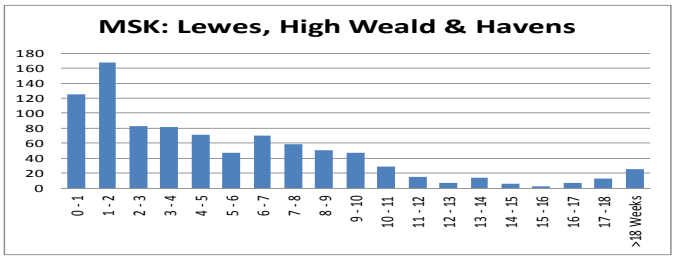
	July	June
Total Waiting List	144	138
% <13 Weeks	100%	100%



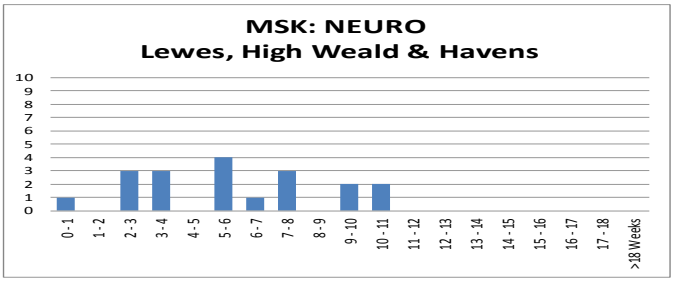
	July	June
Total Waiting List	10	30
% <13 Weeks	100%	100%



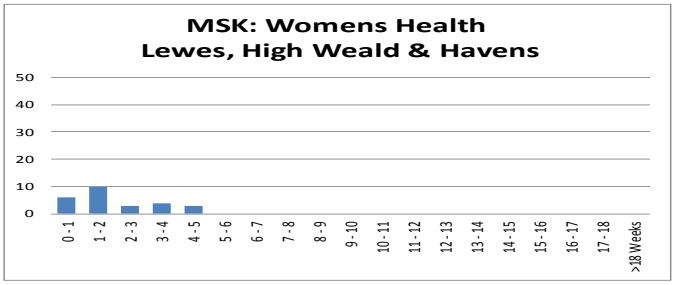
	July	June
Total Waiting List	83	57
% <13 Weeks	100%	100%



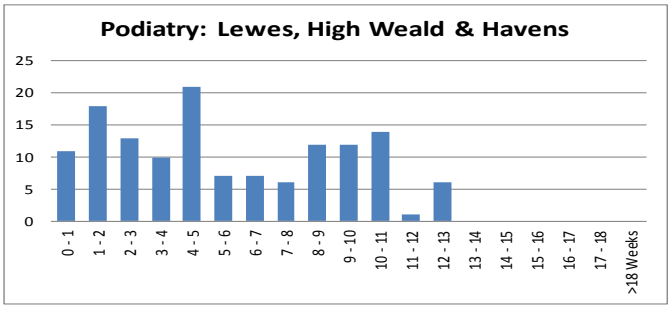
	July	June
Total Waiting List	922	719
% <13 Weeks	93%	89%



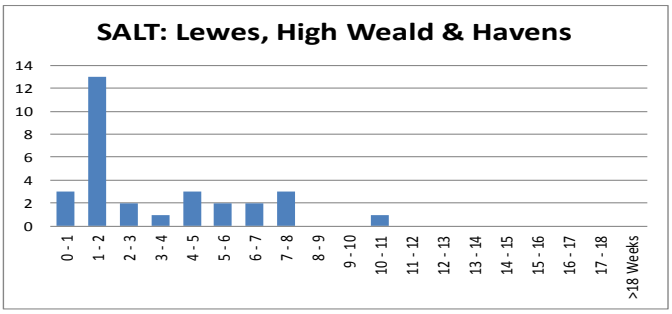
	July	June
Total Waiting List	19	0
% <13 Weeks	100%	0%



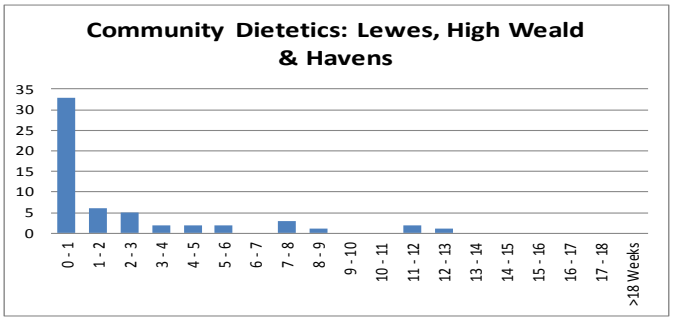
	July	June
Total Waiting List	26	0
% <13 Weeks	100%	0%



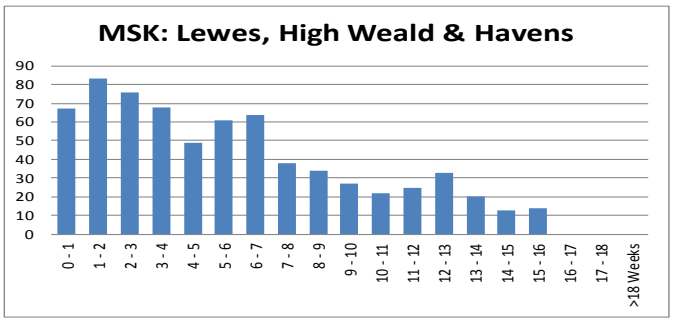
	June	May
Total Waiting List	138	123
% <13 Weeks	100%	100%



	June	May
Total Waiting List	30	33
% <13 Weeks	100%	100%



	June	May
Total Waiting List	57	79
% <13 Weeks	100%	100%



	June	May
Total Waiting List	694	614
% <13 Weeks	93%	96%

HEADLINES

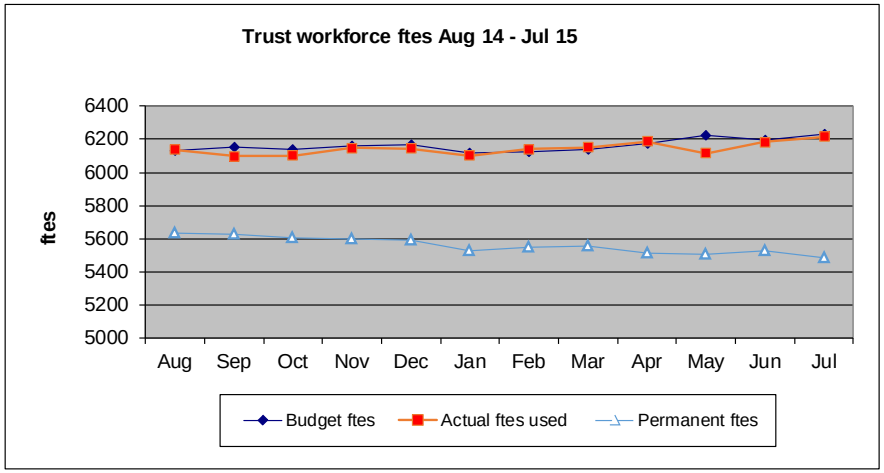
WORKFORCE EXECUTIVE SUMMARY – KEY POINTS

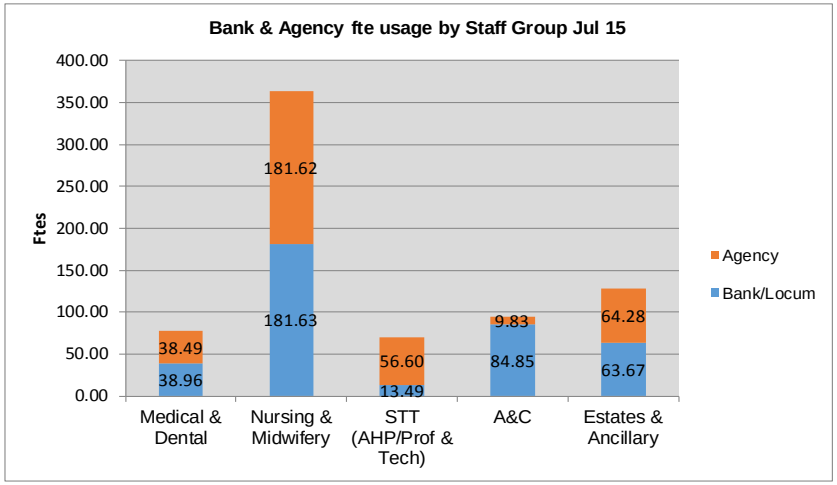
- Actual workforce usage of staff in July was 6216.76 full time equivalents (ftes), 16.80 below budget.
- Temporary staff expenditure was £3,144K in July (14.84% of total pay expenditure). This comprises £1,060 bank expenditure, £2,058 agency expenditure and £26K overtime
- There were 556.18 fte vacancies (a vacancy factor of 9.16%)
- Monthly sickness was 4.21%, an decrease of 0.09% from June. Annual sickness was 4.94%, a reduction of 0.03%
- Annual turnover was 12.26% which represents 665.06 fte leavers in the last year
- Mandatory training rates have all improved this month
- Appraisal compliance increased by 0.49% to 75.03%

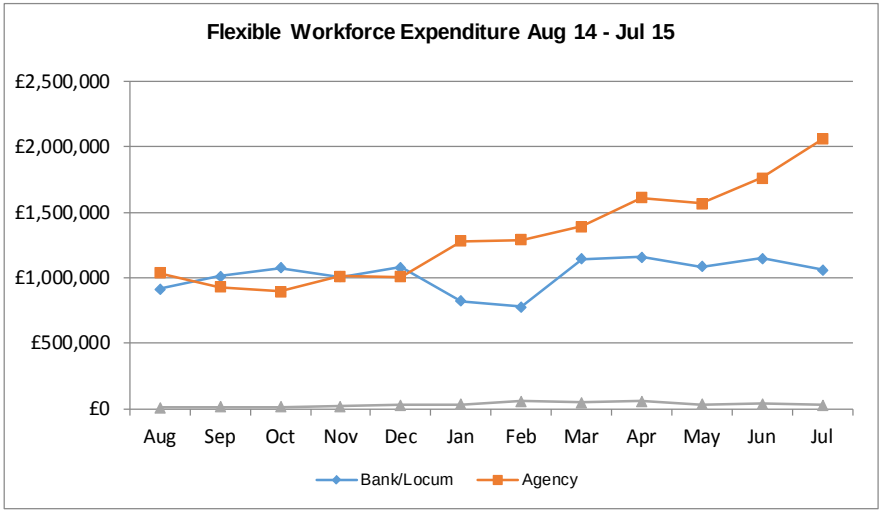
TRUST OVERVIEW

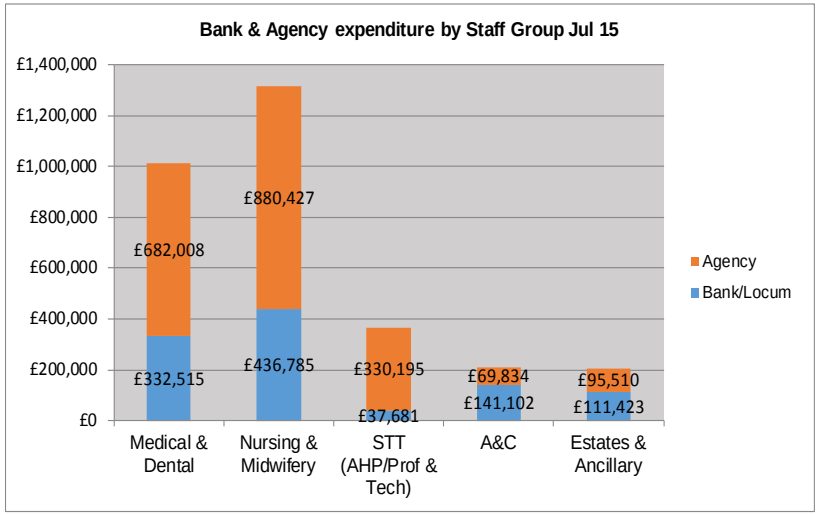
Jul-15	Budg estab fte	Actual worked fte	Vacancies fte	Vacancy trend since last month	Fill rate %	Monthly sickness %	Annual sickness %	Turnover	Temp staff expenditure	Appraised/ exempt in last yr	Appraisal trend since last month
Theatres & Clinical Support	1,085.89	1,044.51	99.48	↑	90.66%	4.28%	5.02%	11.25%	£644,998	69.67%	↓
Cardiovascular Medicine	268.33	313.05	11.43	↑	95.74%	2.69%	4.24%	9.31%	£291,222	62.01%	↓
Urgent Care	541.81	587.22	74.89	↓	86.17%	4.77%	4.93%	13.16%	£592,599	76.36%	↑
Specialist Medicine	433.45	420.13	38.61	↑	91.09%	4.46%	5.03%	9.57%	£220,283	79.66%	↑
Out of Hospital Care	926.51	863.76	112.44	↑	87.86%	4.91%	5.74%	16.14%	£248,689	68.97%	↓
Surgery	735.96	746.48	65.42	↑	91.11%	2.87%	3.95%	12.06%	£427,051	93.66%	↑
Womens & Childrens	590.46	583.97	29.07	↑	95.07%	5.26%	4.92%	11.75%	£220,276	82.98%	↑
COO Operations	381.44	406.15	17.91	↑	95.30%	4.22%	5.02%	8.21%	£84,006	57.68%	↑
Estates & Facilities	714.78	731.66	58.25	↑	91.27%	5.80%	6.27%	11.19%	£203,302	74.90%	↑
Corporate	469.53	434.08	48.68	↓	89.51%	2.17%	3.84%	11.55%	£302,178	78.52%	↓
TRUST	6233.56	6216.76	556.18	↑	90.84%	4.21%	4.94%	12.26%	£3,234,604	75.03%	↑

WORKFORCE USAGE

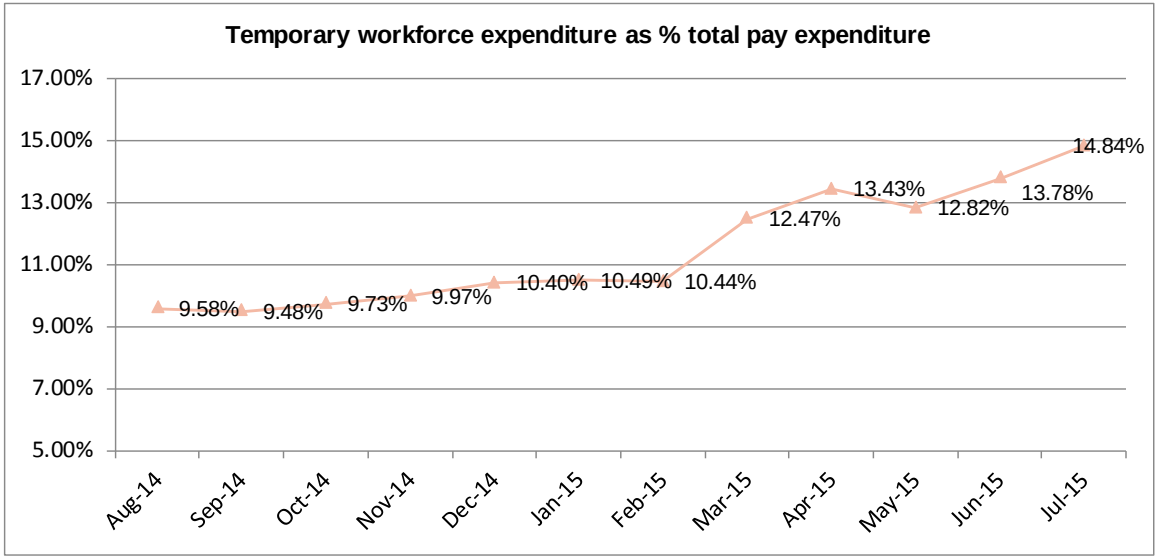








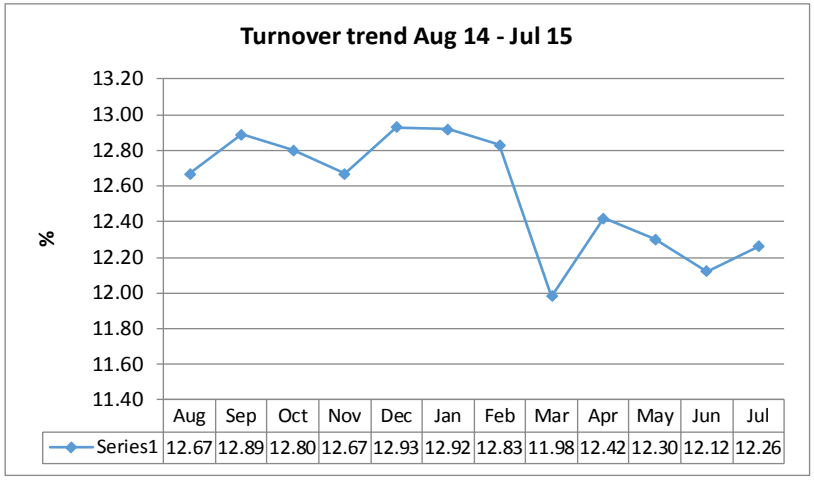
WORKFORCE USAGE



Workforce usage has increased this month,although substantive staff numbers fell by 38 full time equivalents (ftes), but bank usage increased by 6 ftes and agency usage by 71 ftes.
Temporary staff expenditure was £3,144K in July, comprising £1,060K bank expenditure, a decrease of £90K on last month, £2,058K agency expenditure, an increase of £295K, and £26K overtime, a decrease of £11K.
Agency usage has increased in Urgent Care on Conquest A&E, AAU, SSU and on MAU on both sites, due to vacancies, high acuity and sickness as well as specialling of Falls and Deprivation of Liberties patients on McDonald and Newington requiring agency backfill. In Specialist Medicine, agency usage increased on Wellington, Cuckmere and Jevington wards due to acuity and specialling (and vacancies on Jevington). In Clinical Support, two additional agency Radiologists were employed to help with a backlog of reporting on CT and plain film and to cover for long term sickness whilst agency was used to cover vacancies in Pharmacy and Pathology. In Out of Hospital Care, extra agency was used to cover waiting lists in Physiotherapy Outpatients and vacancies in Rotational Physiotherapy. In Estates & Facilities, there was agency cover for long term sickness and annual leave in Laundry and Transport.

TURNOVER & VACAANCIES

STAFF GROUPS	Substantive budget ftes	Substantive actual ftes	Difference	Maternity ftes	Net vacancies	Vacancy trend since last month	Fill rate %
Medical & Dental	570.72	496.81	73.91	9.60	64.31	↑	88.73%
Registered Nursing & Midwifery	1,963.32	1,727.94	235.38	46.42	188.96	↑	90.38%
Unqualified Nurses	790.72	709.16	81.56	21.61	59.95	↑	92.42%
Sc. Therap & Techs (inc AHPs, Prof & Tech & Healthcare Scs.)	967.80	839.83	127.97	15.72	112.25	↑	88.40%
Administrative & Clerical	1137.48	1033.69	103.79	10.32	93.47	↑	91.78%
Estates & Ancillary	634.33	593.04	41.29	4.09	37.20	↑	94.14%
TRUST	6,072.55	5,408.62	663.93	107.75	556.18	↑	90.84%



STAFF GROUPS	FTE leavers in year	Annual Turnover %	Turnover trend since last month
MEDICAL & DENTAL	52.97	18.05%	↑
NURSING & MIDWIFERY REGISTERED	198.98	11.10%	↑
ALLIED HEALTH PROFESSIONALS	64.48	17.75%	↑
HEALTHCARE SCIENTISTS	17.40	14.01%	↑
PROF SCIENTIFIC & TECHNICAL	24.13	15.62%	↓
ADDITIONAL CLINICAL SERVICES	115.03	11.96%	↑
ADMINISTRATIVE & CLERICAL	111.29	10.41%	↓
ESTATES & ANCILLARY	66.29	10.83%	↑
STUDENTS	14.50	27.11%	↑
TRUST	**665.06**	**12.26%**	↑

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

TURNOVER & VACANCIES

There has been an overall net increase of 35.57 fte vacancies in July, including increases of 4.71 Medical & Dental vacancies, 8.64 qualified nursing & midwifery vacancies and 2.75 unqualified nurse vacancies.

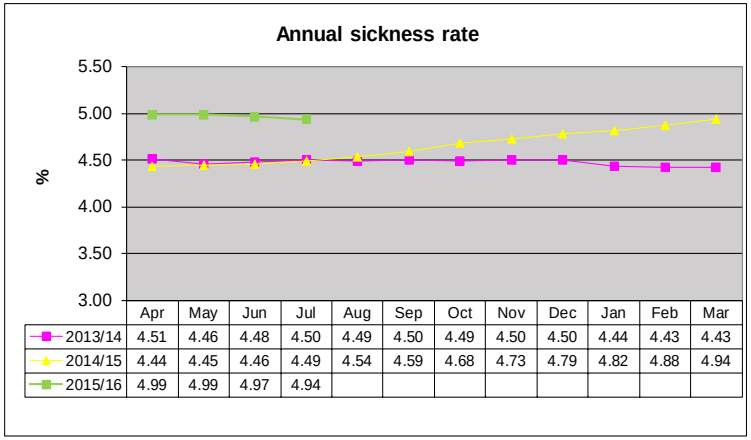
71 fte qualified nurses have been offered posts or are going through pre-employment checks, with a further 12 ftes awaiting start dates. These include 24 newly qualified nurses due to start in September and some vacancies have been held open for them to ensure we recruit our sponsored students. 38 fte unqualified nurses will undertake induction at the beginning of September with a further 19 having been offered posts or going through pre-employment checks.

Overseas nurse recruitment from the Philippines is taking place on 26 August. There is a national issue regarding the acquisition of sufficient visa allowances, with pressure on the Restricted Certificate of Sponsorship allowance. No visas were granted to the NHS in May, June or July as nurses did not meet the qualifying requirement. There is a call for evidence by the Migratory Advisory Committee to consider whether nurses should fall into a shortage occupational category. The Trust is responding to this and the deadline is 25 October. Due to this, we are continuing to explore the engagement of nurses from within the European Community as these individuals will not require a work visa and do not have the issues with gaining NMC registration that the overseas nurses do.

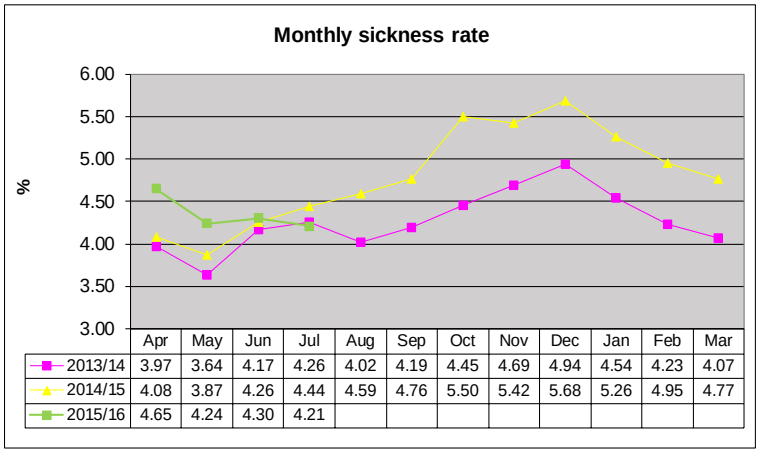
We have undertaken recruitment for medical staff from India and have offered five posts to A&E middle grade doctors and we anticipate these will be in post within the next three months. We are continuing to work with the recruitment agency on the recruitment of doctors for other specialities.

We are continuing a rolling programme of HCA recruitment open days. We anticipate start dates in August and September for those currently going through the recruitment process.

SICKNESS



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



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

Monthly sickness has decreased by 0.09% this month and, at 4.21%, represents the lowest July rate in the last three years. The annual rate has also fallen by 0.03% to 4.94%. Monthly sickness rates were highest amongst Estates and Ancillary staff at 5.78% and Additional Clinical Services (i.e. mostly unqualified nurses and therapy helpers) at 5.26%. Nursing & Midwifery staff sickness was 5.00%

7352 fte days were lost to sickness in July 2015. The top reasons for sickness remain musculoskeletal (other than back injury) at 1402 fte days lost and anxiety/stress/depression at 1262 fte days lost.

In July the HR liveflow on-line management advice tool was launched, which will provide on-line 24/7 guidance for managers and will support consistent application of the Absence Management policy.

A review is being undertaken to identify further sickness absence management initiatives and to develop an options paper to consider third party management

Mandatory Training – Six Month Trend

Mandatory training course	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	6 month trend
Induction %	94.91	94.47	95.16	93.32	93.64	94.62	
Fire %	83.64	83.22	81.52	82.47	82.82	83.78	
Manual Handling %	80.80	81.08	79.84	82.97	84.59	85.44	
Infection Control %	86.94	86.41	86.32	86.27	84.85	85.78	
Info Gov %	78.82	77.06	75.99	77.26	81.89	82.57	
Health & Safety %	65.06	67.04	68.79	71.18	73.36	74.80	
Mental Capacity Act %	91.76	92.36	92.31	92.48	92.63	93.02	
Depriv of Liberties %	88.17	89.09	89.03	89.64	90.11	90.88	
Safeguard Vuln Adults	84.65	85.98	72.98	73.24	74.38	75.08	
Safeguard Child Level 2	76.21	78.12	77.90	79.61	79.87	80.13	

Clinical Unit Mandatory Training & Appraisals

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Appraisal compliance
Theatres & Clinical Support	89.16%	91.25%	96.67%	88.97%	86.22%	74.81%	92.98%	89.72%	74.93%	80.15%	69.67%
Cardiovascular Medicine	82.73%	83.33%	90.63%	83.03%	73.33%	57.58%	91.49%	89.19%	63.83%	59.22%	62.01%
Urgent Care	80.79%	81.42%	98.44%	79.33%	70.77%	61.80%	85.46%	84.31%	70.25%	73.15%	76.36%
Specialist Medicine	86.04%	89.93%	97.73%	85.58%	78.95%	76.20%	94.96%	90.26%	82.76%	83.51%	79.66%
Out of Hospital Care	84.87%	87.15%	98.53%	86.32%	82.49%	76.06%	96.95%	97.97%	80.20%	82.81%	68.97%
Surgery	85.87%	85.73%	92.44%	85.60%	97.09%	79.92%	94.07%	92.28%	80.97%	76.13%	93.66%
Womens & Childrens	87.08%	87.96%	93.55%	81.35%	82.53%	72.98%	91.28%	87.41%	66.17%	94.10%	82.98%
COO Operations	67.95%	80.55%	100.00%	79.73%	62.74%	54.52%	n/a	n/a	n/a	n/a	57.68%
Estates & Facilities	75.80%	70.91%	100.00%	89.51%	85.73%	87.55%	62.50%	100.00%	37.50%	50.00%	74.90%
Corporate	87.30%	91.60%	77.78%	91.41%	84.57%	86.33%	95.24%	94.20%	73.81%	74.49%	78.52%
TRUST	**83.78%**	**85.44%**	**94.62%**	**85.78%**	**82.57%**	**74.80%**	**93.02%**	**90.88%**	**75.08%**	**80.13%**	**75.03%**

(Green =90%+, Red = <90%. Except for H&S Green = 67%+,Red = <67%)

Mandatory training compliance percentages have all improved this month.
The specialist trainers continue to target areas of low compliance focussing on particular Clinical Units or Staff Groups. Moving & Handling delivered an additional 14 training sessions in the first quarter of 2014/15.

Alternative methods of training are also being employed. Moving & Handling trialled “skills stations” at the Conquest on 7 August. The Safeguarding team have developed workbooks to allow staff to complete their training at a time suitable to them.

DNAs (did not attend) continue to be a problem. Learning & Development are conducting an audit to identify reasons for this which will be complete by the end of August.

Appraisal compliance has increased by 0.49% this month. There are 400 appraisals due to expire in August.

East Sussex Healthcare NHS
NHS Trust

FINANCE REPORT – August 2015

Vanessa Harris – September 2015

East Sussex Healthcare NHS
NHS Trust

Financial Summary – August 2015

Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) finance risk assessment criteria are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria is red in month 5.	R
Continuity of Service Risk Ratings	Current rating of 2.	A
Financial Summary	The Trust performance in month 5 was a run rate deficit of £3.8m with an adverse variance against plan of £0.5m. Year to date the deficit stands at £15.8m which is £1.8m worse than plan.	R
Activity & Income	Total income received during August was £0.2m above planned levels reducing the year to date variance to £0.3m below plan. Tariff-Excluded Drugs and Devices (TEDDs) income continues to underperform, £1.9m YTD. There is however, a corresponding underspend of £1.9m on TEDDs expenditure so therefore, this has a zero effect on the bottom line.	A
Expenditure	Operating Pay costs are above plan by £1.1m in month and are cumulatively £3.0m above plan. This is mainly due to high agency spend covering escalation beds and clinical vacancies. Operating Non Pay costs are £0.4m below plan in month and are cumulatively £1.3m below plan. This is mainly due to the underspend on TEDDs (as detailed above). Total costs are now £1.7m overspent year to date	A
CIP plans	The CIP achievement year to date was £2.7m which was below the plan of £3.7m.	R
Forecast Outturn	The forecast outturn is projected to be as per the revised plan at £35.2m deficit.	G
Balance Sheet	DH loans have increased by a further £2.0m as a result of the draw down of the revolving working capital facility.	G
Cash Flow	The cash balance marginally reduced in the month to £6.8m. An interim revolving working capital support facility agreement is currently in place and an application for re-financing is planned later in the financial year, which, if approved, will allow the repayment of the revolving working capital support and further cash to support the planned deficit.	G
Capital Programme	Capital expenditure after 5 months has increased to £5.0m which is marginally behind plan.	G

East Sussex Healthcare NHS
NHS Trust

Income & Expenditure – August 2015

Headlines

• Total income in the month was £29.4m against a plan of £29.2m, a favourable variance of £0.2m and brings the YTD position to £0.3m below plan.

• Total costs in the month were £33.3m, this was £0.7m above plan. The YTD position is now £1.7m above plan.

• The year to date deficit against plan was an adverse variance of £1.8m.

• Cost improvement Plans of £11.4m have been developed for 2015/16 with a year to date achievement of £2.7m against a plan of £3.7m.

• Operating Pay costs in the month, including Ad hoc costs, were £1.1m above plan and are now £3.0m above plan YTD.

• Operating Non Pay costs, including 3rd party costs, were £0.4m below plan in the month and are £1.3m below plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	26,187	26,538	351	134,838	135,367	529	319,325
Private Patient/ ICR	324	199	-125	1,618	1,225	-393	4,284
Trading Income	463	452	-11	2,202	2,390	188	5,220
Other Non Clinical Income	2,271	2,207	-64	11,459	10,853	-606	27,180
Total Income	**29,245**	**29,396**	**151**	**150,117**	**149,835**	**-282**	**356,009**
Pay Costs	-20,473	-21,510	-1,037	-103,193	-105,960	-2,767	-247,766
Ad hoc Costs	0	-35	-35	0	-195	-195	0
Non Pay Costs	-10,357	-9,920	437	-52,332	-50,766	1,566	-124,877
3rd Party Costs	-45	-95	-50	-140	-369	-229	-42
Other	125	125	0	625	625	0	1,500
Total Operating Costs	**-30,750**	**-31,435**	**-685**	**-155,040**	**-156,665**	**-1,625**	**-371,185**
Surplus/- Deficit from Operations	**-1,505**	**-2,039**	**-534**	**-4,923**	**-6,830**	**-1,907**	**-15,176**
P/L on Asset Disposal	0	0	0	0	6	6	0
Depreciation	-1,090	-1,109	-19	-5,448	-5,516	-68	-13,075
Impairment	0	0	0	0	0	0	0
PDC Dividend	-647	-668	-21	-3,235	-3,338	-103	-7,763
Interest	-82	-86	-4	-408	-351	57	-978
Total Non-operating Costs	**-1,819**	**-1,863**	**-44**	**-9,091**	**-9,199**	**-108**	**-21,816**
Total Costs	**-32,569**	**-33,298**	**-729**	**-164,131**	**-165,864**	**-1,733**	**-393,001**
Net Surplus/-Deficit	**-3,324**	**-3,902**	**-578**	**-14,014**	**-16,029**	**-2,015**	**-36,992**
Donated Asset/Impairment Adjustment	0	56	56	0	240	240	0
Adjusted Net Surplus/-Deficit	**-3,324**	**-3,846**	**-522**	**-14,014**	**-15,789**	**-1,775**	**-36,992**

East Sussex Healthcare NHS
NHS Trust

Cash Flow – August 2015

Headlines

- The cash balance at the end of the last financial year was £1.0m and the Trust is planning for a £2.1m cash balance at year-end as required by the Department of Health.
- An interim revolving working capital support facility has been agreed with the Department of Health and the draw-down of this support is currently being accessed on a monthly basis. At 31st August £17.4m has been drawn down. An application for re-financing is planned for later in the financial year, which, if approved, will allow the repayment of the revolving working capital support to be replaced by permanent PDC
- An interest bearing capital loan of £0.4m was drawn down in June in respect of the health records storage scheme. In addition, a £17.4m interest bearing capital loan in respect of the clinical strategy is planned to be received during the financial year but remains subject to TDA approval.

Cash Flow Statement April 2015 to March 2016

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2016	Feb	Mar
Cash Flow from Operations												
Operating Surplus/(Deficit)	-2,181	-2,346	-3,580	-1,092	-3,148	-771	-866	-2,874	-3,048	-1,452	-3,412	-1,088
Depreciation and Amortisation	1,095	1,095	1,108	1,108	1,109	1,090	1,090	1,090	1,090	1,090	1,090	1,020
Impairments												
Interest Paid	-81	-81	-81	-31	-89	-84	-83	-84	-83	-84	-83	-138
Dividend (Paid)/Refunded	0					-4,247						-4,151
(Increase)/Decrease in Inventories	136	168	-68	103	90							-429
(Increase)/Decrease in Trade and Other Receivables	-637	-371	-6	-1,836	-2,340	402	500	0	402	0	0	-80
Increase/(Decrease) in Trade and Other Payables	2,859	1,725	434	-53	3,628	-2,815	-995	164	-83	-1,790	198	3,568
Provisions Utilised	-59	-10	0	33	10	-121	0	-121	0	-111	0	-104
Net Cash Inflow/(Outflow) from Operating Activities	**1,132**	**180**	**-2,193**	**-1,768**	**-740**	**-6,546**	**-354**	**-1,825**	**-1,722**	**-2,347**	**-2,207**	**-1,402**
Cash Flows from Investing Activities:												
Interest Received	3	3	2	2	3	2	2	2	2	2	2	1
(Payments) for Property, Plant and Equipment	-1,817	-2,232	-1,567	-1,453	-1,365	-1,357	-997	-1,697	-1,700	-2,976	-4,015	-6,185
(Payments) for Intangible Assets	-42	-32	-40	-17	-28							
Net Cash Inflow/(Outflow) from Investing Activities	**-1,856**	**-2,261**	**-1,605**	**-1,468**	**-1,390**	**-1,355**	**-995**	**-1,695**	**-1,698**	**-2,974**	**-4,013**	**-6,184**
Net Cash Inflow/(Outflow) before Financing	**-724**	**-2,081**	**-3,798**	**-3,236**	**-2,130**	**-7,901**	**-1,349**	**-3,520**	**-3,420**	**-5,321**	**-6,220**	**-7,586**
New Temporary PDC	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Revenue Support Loan	0	0	0	0	0	0	0	0	0	0	0	-31,300
Revenue Support Loans	7,440	936	4,039	3,000	2,000	3,000	2,000	2,000	2,000	2,000	2,000	885
New Permanent PDC	0	0	0	0	0	0	0	0	0	0	0	31,300
New Capital Loan	0	0	441	0	0	500	1,100	1,600	1,700	3,000	3,500	6,000
Loans and Finance Lease repaid	-40	-16	-28	-28	-28	-253	-14	-13	-13	-13	-13	-304
Net Cash Inflow/(Outflow) from Financing Activities	**7,400**	**920**	**4,452**	**2,972**	**1,972**	**3,247**	**3,086**	**3,587**	**3,687**	**4,987**	**5,487**	**6,581**
Net Increase/(Decrease) in Cash	**6,676**	**-1,161**	**654**	**-264**	**-158**	**-4,654**	**1,737**	**67**	**267**	**-334**	**-733**	**-1,005**
Opening balance	1,008	7,684	6,523	7,177	6,913	6,755	2,101	3,838	3,905	4,172	3,838	3,105
Closing balance	7,684	6,523	7,177	6,913	6,755	2,101	3,838	3,905	4,172	3,838	3,105	2,100

Balance Sheet – August 2015

Headlines

• The overall value of property, plant & equipment is forecast to reduce by £29m due to the transfer of the High Weald, Lewes & Havens (HWLH) properties to NHS Property Services on 1st November . This will be partially offset by the indexation of assets and the planned clinical strategy investment. The clinical strategy full business case is yet to be approved by the Trust Development Authority (TDA).

• The year to date increase in non current borrowings is in respect of the planned interim revolving working capital support facility of £31.3m which is being accessed from the DoH on a monthly basis.

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

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast March 2016
Non Current Assets			
Property plant and equipment	271,373	270,958	268,837
Intangilble Assets	1,293	1,452	1,647
Trade and other Receivables	1,184	1,184	680
	273,850	**273,594**	**271,164**
Current Assets			
Inventories	6,599	6,170	6,511
Trade receivables	12,637	10,873	13,527
Other receivables	6,800	12,079	7,279
Other current assets	0	0	0
Cash and cash equivalents	1,008	6,755	2,100
	27,044	**35,877**	**29,417**
Current Liabilities			
Trade payables	-6,972	-8,622	-9,274
Other payables	-20,535	-26,420	-21,620
DH Capital Investment Loan	-383	-427	-1,297
Other Financial Liabilities	-335	-335	-263
Provisions	-591	-528	-773
	-28,816	**-36,332**	**-33,227**
Non Current Liabilities			
DH Capital Investment Loan	-3,583	-3,980	-20,083
Borrowings - Revenue Support Facility	0	-17,415	0
Other Financial Liabilities	-263	-123	0
Provisions	-2,588	-2,624	-2,345
	-6,434	**-24,142**	**-22,428**
Total Assets Employed	**265,644**	**248,997**	**244,926**
Financed by:			
Public Dividend Capital (PDC)	-153,530	-153,530	-188,748
Revaluation Reserve	-119,711	-119,711	-117,674
Retained Earnings Reserve	7,597	24,244	61,496
Total Tax Payers Equity	**-265,644**	**-248,997**	**-244,926**

East Sussex Healthcare NHS
NHS Trust

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

Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target achievement of BPPC is 95%.
- By value, year to date 94% of trade invoices has been achieved and 92% of NHS invoices.
- The Aged Debt (over 90 days) KPI is measured as a percentage of the total level of debt. The target is for this to be no more than 5%.
- As at month 5, the Aged Debt KPI stood at 20%, a significant reduction from the level seen earlier in the financial year.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	1,264	1,000	6,513	3,179
31 - 60 Days	441	451	1,502	1,163
61 -90 Days	178	167	413	475
91 - 120 Days	110	187	370	442
> 120 Days	936	902	2,075	2,336
Total	2,929	2,707	10,873	7,595

Trade Payables Aged Analysis - Purchase Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	4,998	5,805	5,525	6,112
31 - 60 Days	1,587	1,061	1,874	2,028
61 -90 Days	301	493	587	598
91 - 120 Days	120	184	207	358
> 120 Days	562	488	429	244
Total	7,568	8,031	8,622	9,340

Better Payments Practice Code	Month Number of Invoices	Month By Value	YTD Number of Invoices	YTD By Value
Trade invoices paid within contract or 30 days of receipt	94.89%	94.70%	94.54%	93.88%
NHS invoices paid within contract or 30 days of receipt	92.45%	92.11%	92.65%	91.58%

East Sussex Healthcare NHS
NHS Trust

Key Performance Indicators – August 2015

TDA Finance Risk Assessment Criteria

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

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

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

Monitor Continuity of Service Risk Rating

• The Trust has a liquidity ratio rating of 3 and a capital servicing ratio of 1, resulting in an overall rating of 2.

Better Payments Practice Code (BPPC)

• Year to date performance is marginally below the BPPC target for both Trade invoices and NHS invoices paid by value.

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	3	3
Capital Servicing Capacity Rating	1	1
Overall Monitor Risk Rating	2	2

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	94	95
BPPC – NHS Invoices by value (%)	92	95

Activity & Contract Income – August 2015

Headlines

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

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,278	3,582	304	17,168	18,988	1,820
Elective Inpatients	797	725	-72	4,173	3,461	-712
Emergency Inpatients	3,688	3,535	-153	18,206	18,498	292
Total Inpatients	**7,763**	**7,842**	**79**	**39,547**	**40,947**	**1,400**
Excess Bed Days	2,214	2,290	76	10,922	10,479	-443
Total Excess Bed Days	**2,214**	**2,290**	**76**	**10,922**	**10,479**	**-443**
Consultant First Attendances	7,143	8,266	1,123	38,010	39,717	1,707
Consultant Follow Ups	10,696	11,915	1,219	57,141	61,282	4,141
OP Procedures	3,568	5,125	1,557	21,746	21,979	233
Other Outpatients inc WA & Nurse Led	11,527	13,413	1,886	61,956	62,690	734
Community Specialist	139	128	-11	947	834	-113
Total Outpatients	**33,073**	**38,847**	**5,774**	**179,800**	**186,502**	**6,702**
Chemotherapy Unbundled HRGs	608	910	302	2,860	3,115	255
Antenatal Pathways	286	288	2	1,570	1,490	-80
Post-natal Pathways	297	258	-39	1,411	1,499	88
A&E Attendances (excluding type 2's)	8,969	9,181	212	45,397	45,740	343
ITU Bed Days	443	336	-107	2,328	2,300	-28
SCBU Bed Days	266	256	-10	1,309	1,703	394
Cardiology - Direct Access	61	77	16	247	356	109
Radiology - Direct Access	4,291	4,523	232	23,534	25,268	1,734
Pathology - Direct Access	242,112	249,317	7,205	1,329,576	1,354,756	25,180
Therapies - Direct Access	1,545	3,185	1,640	8,477	14,338	5,861
Audiology	564	675	111	4,325	4,915	590
Midwifery	10	10	0	63	65	2

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,463	3,990	-473	23,574	20,097	-3,477
Inpatients - Emergency	6,316	5,054	-1,262	31,174	30,598	-576
Excess Bed Days	484	498	14	2,390	2,288	-102
Outpatients	3,470	4,174	704	18,906	19,659	753
Other Acute based Activity	2,532	2,412	-120	13,128	13,013	-115
Direct Access	651	720	69	3,505	3,790	285
Block Contract / Other	4,507	6,715	2,208	25,647	31,543	5,896
Re-admissions	0	-93	-93	0	-283	-283
CQUIN	546	546	0	2,812	2,812	0
Subtotal	22,969	24,016	1,047	121,136	123,517	2,381
Exclusions	3,218	2,522	-696	13,702	11,850	-1,852
GRAND TOTAL	**26,187**	**26,538**	**351**	**134,838**	**135,367**	**529**

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

Headlines

Trust wide

Total Pay reported £1.1m overspend against the TDA plan in the month. £9.1m has been spent on agency in the first five months of the year compared to £3.9m for the same period last year. Cumulatively pay was £3.0m overspent.

Clinical Units (CUs)

The overall clinical unit performance was £1.2m overspend in August against plan and £4.6m cumulatively. This was mainly due to continued agency usage covering medical and nursing vacancies, and escalation beds. Slippage on CIP savings also caused an adverse variance.
The contingency is being phased in evenly and this partly offsets the operational cost pressures.

Tariff-excluded drugs and devices reported £0.7m underspend in the month against plan, which was offset by under achievement on Contract Income so overall has a neutral impact.

Estates and Facilities Directorate

August reported an overspend in month due to increased agency usage in housekeeping and laundry together with a one-off rates adjustment.

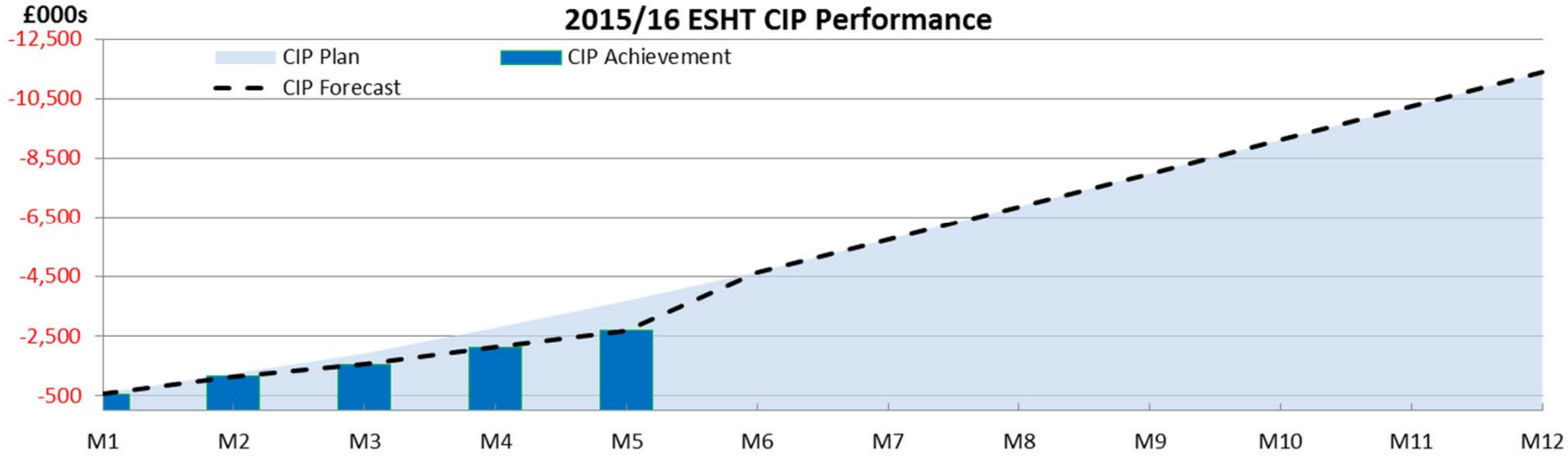
Corporate Services

Corporate Services was on plan in month 5.

Income & Expenditure Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Urgent Care	-2,040	-2,539	-499	-10,188	-11,333	-1,145
Specialist Medicine	-1,696	-1,753	-57	-8,296	-8,684	-388
Cardiovascular	-1,161	-1,405	-244	-5,474	-6,579	-1,105
Surgery	-3,262	-3,542	-280	-16,667	-17,381	-714
Women & Children	-1,948	-2,031	-83	-12,237	-12,529	-292
Out of Hospital Care	-2,755	-2,872	-117	-14,195	-14,545	-350
Clinical Support	-6,314	-6,878	-564	-31,599	-33,783	-2,184
Tariff-Excluded Drugs & Devices	-3,218	-2,482	736	-13,702	-11,850	1,852
COO Operations	-947	-1,051	-104	-4,826	-5,131	-305
Total Clinical Units	**-23,341**	**-24,553**	**-1,212**	**-117,184**	**-121,815**	**-4,631**
Estates & Facilities	-2,219	-2,305	-86	-11,087	-11,286	-199
Corporate Services	-2,184	-2,184	0	-11,054	-11,143	-89
Central Items	-2,075	-1,515	560	-11,253	-7,928	3,325
Total Central Areas	**-6,478**	**-6,004**	**474**	**-33,394**	**-30,357**	**3,037**
Contract Income	26,187	26,538	351	134,838	135,367	529
Income	308	117	-191	1,726	776	-950
Donated Asset/Impairment Adjustment	0	56	56	0	240	240
Adjusted Net Surplus/- Deficit	**-3,324**	**-3,846**	**-522**	**-14,014**	**-15,789**	**-1,775**

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
551	613	Urgent Care	-1,939	-2,432	-493	-9,687	-10,761	-1,074
434	425	Specialist Medicine	-1,555	-1,596	-41	-7,661	-7,914	-253
273	318	Cardiovascular	-1,099	-1,203	-104	-5,105	-5,990	-885
727	749	Surgery	-2,870	-3,167	-297	-14,608	-15,412	-804
590	576	Women & Children	-2,259	-2,381	-122	-11,377	-11,729	-352
927	857	Out of Hospital Care	-2,497	-2,528	-31	-12,571	-12,796	-225
1,088	1,042	Clinical Support	-4,144	-4,258	-114	-20,638	-21,307	-669
375	408	COO Operations	-888	-947	-59	-4,528	-4,683	-155
4,966	**4,987**	**Total Clinical Units**	**-17,251**	**-18,512**	**-1,261**	**-86,175**	**-90,592**	**-4,417**
715	739	Estates & Facilities	-1,449	-1,485	-36	-7,242	-7,343	-101
559	517	Corporate Services	-1,637	-1,646	-9	-8,196	-8,301	-105
1,274	**1,256**	**Total Non-Clinical Divisions**	**-3,086**	**-3,131**	**-45**	**-15,438**	**-15,644**	**-206**
0	**0**	Central Items	-136	98	234	-1,580	81	1,661
6,240	**6,243**	**Total Pay Analysis**	**-20,473**	**-21,545**	**-1,072**	**-103,193**	**-106,155**	**-2,962**

2015/16 ESHT CIP Performance to date – Month 5



	In Month			Year to Date			Forecast		
Clinical Unit	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast £000	Variance FOT £000
Cardiovascular Medicine	-78	40	117	-269	-199	70	-859	-859	-
Estates and Facilities	-93	-46	47	-463	-281	181	-1,585	-1,585	-
Corporate	-185	-218	-33	-808	-858	-50	-2,281	-2,281	-
Specialist Medicine	-35	-22	13	-159	-134	25	-403	-403	-
Surgery	-125	-86	39	-537	-344	193	-1,504	-1,504	-
Trustwide	35	30	-5	193	-	-193	161	161	-
Urgent Care	-35	-11	24	-76	-63	12	-320	-320	-
Womens Health & Childrens Services	-62	-60	2	-228	-299	-71	-660	-660	-
Contract Income	-42	-	42	-208	-	208	-500	-500	-
Out of Hospital Care	-53	-12	41	-264	-59	205	-633	-633	-
Clinical Support	-227	-174	53	-868	-462	407	-2,790	-2,790	-
Total	**-898**	**-558**	**340**	**-3,687**	**-2,699**	**988**	**-11,375**	**-11,375**	**0**

East Sussex Healthcare NHS
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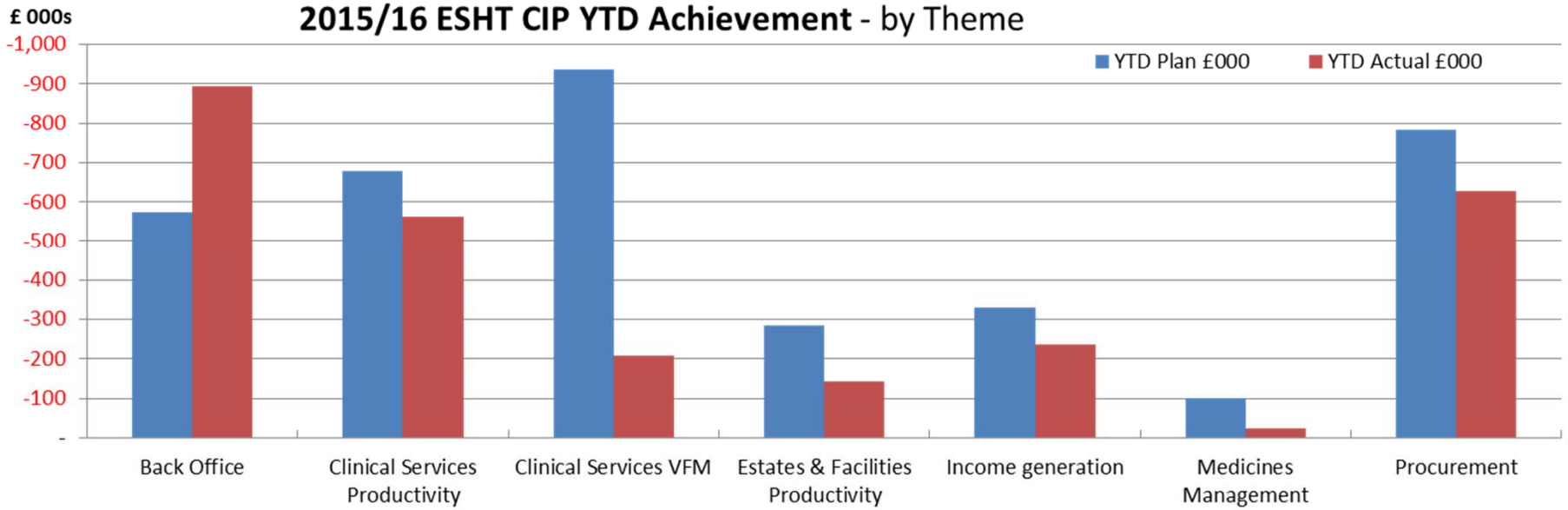
2015/16 ESHT CIP Performance by Theme – Month 5

TDA Theme	In Month			Year to Date			Forecast		
	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast £000	Variance FOT £000
Back Office	-139	-213	-74	-574	-894	-320	-1,547	-1,547	-
Clinical Services Productivity	-210	-99	111	-677	-564	113	-2,319	-2,319	-
Clinical Services VFM	-221	-43	178	-937	-209	728	-2,805	-2,805	-
Estates & Facilities Productivity	-57	-9	48	-285	-143	142	-1,105	-1,105	-
Income generation	-67	-130	-63	-331	-237	94	-800	-800	-
Medicines Management	-27	-25	2	-100	-25	75	-293	-293	-
Procurement	-177	-39	138	-783	-628	155	-2,506	-2,506	-
Total	**-898**	**-558**	**340**	**-3,687**	**-2,699**	**988**	**-11,375**	**-11,375**	**0**



East Sussex Healthcare NHS
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Year on Year Comparisons – August 2015

Headlines

- Total Inpatient activity to date is 2.6% higher than last year's level.
- Total outpatients are 2.4% higher than last year.
- Total A&E attendances are 0.7% higher than last year.

Activity	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	18,988	17,896	1,092	6.1%
Elective Inpatients	3,461	3835	-374	-9.8%
Emergency Inpatients	18,498	18,167	331	1.8%
Total Inpatients	**40,947**	**39,898**	**1,049**	**2.6%**
Elective Excess Bed Days	985	866	119	13.7%
Non elective Excess Bed Days	9,494	9,229	265	2.9%
Total Excess Bed Days	**10,479**	**10,095**	**384**	**3.8%**
Consultant First Attendances	39,717	38,489	1,228	3.2%
Consultant Follow Ups	61,282	58,640	2,642	4.5%
OP Procedures	21,979	22,689	-710	-3.1%
Other Outpatients (WA & Nurse Led)	62,690	61,306	1,384	2.3%
Community Specialist	834	1,070	-236	-22.1%
Total Outpatients	**186,502**	**182,194**	**4,308**	**2.4%**
Chemotherapy Unbundled HRGs	3,115	3,044	71	2.3%
Antenatal Pathways	1,490	1,552	-62	-4.0%
Post-natal Pathways	1,499	1,390	109	7.8%
A&E Attendances (excluding type 2's)	45,740	45,402	338	0.7%
ITU Bed Days	2,300	2,477	-177	-7.1%
SCBU Bed Days	1,703	1,110	593	53.4%
Cardiology - Direct Access	356	290	66	22.8%
Radiology - Direct Access	25,268	23,625	1,643	7.0%
Pathology - Direct Access	1,354,756	1,312,249	42,507	3.2%
Therapies - Direct Access	14,338	16,674	-2,336	-14.0%
Audiology	4,915	8,702	-3,787	-43.5%
Midwifery	65	66	-1	-1.5%

£000s	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	135,367	136,331	-964	-0.7%
Private Patient/ RTA	1,225	1,210	15	1.2%
Trading Income	2,390	2,060	330	16.0%
Other Non Clinical Income	10,853	11,196	-343	-3.1%
Total Income	**149,835**	**150,797**	**-962**	**-0.6%**
Pay Costs	-106,155	-101,990	-4,165	-4.1%
Non Pay Costs	-51,135	-50,746	-389	-0.8%
Other	625	917	-292	31.8%
Total Direct Costs	-156,665	-151,819	-4,846	-3.2%
Surplus/-Deficit from Operations	**-6,830**	**-1,022**	**-5,808**	**-568.3%**
Profit/Loss on Asset Disposal	6	9	-3	
Depreciation	-5,516	-5,161	-355	-6.9%
Impairment	0	0	0	
PDC Dividend	-3,338	-3,311	-27	-0.8%
Interest	-351	-137	-214	-156.2%
Total Indirect Costs	-9,199	-8,600	-599	-7.0%
Total Costs	**-165,864**	**-160,419**	**-5,445**	**-3.4%**
Net Surplus/-Deficit	**-16,029**	**-9,622**	**-6,407**	**-66.6%**
Donated Asset / Other Adjustment	240	389	-149	38.3%
Normalised Net Surplus/-Deficit	**-15,789**	**-9,233**	**-6,556**	**-71.0%**

Capital Programme – August 2015

Headlines

Year to Date Performance:-
The overall capital programme of £29.2m continues to assume an interest bearing capital loan of £17.4m to support the clinical strategy. However, the full business case for this scheme has yet to be approved by the Trust Development Authority (TDA).

After five months of the financial year, capital expenditure has increased to £5.0m, marginally behind the planned expenditure of £5.1m. A significant element of this expenditure is in respect of the Pevensey Ward redevelopment which has a planned handover date in mid September with an opening date in mid October.

Commitments entered into amount to £7.2m compared to the total capital resource of £11.8m, excluding the clinical strategy funding.

The current over planning margin has increased slightly to £224k and is considered manageable particularly in light of the current level of commitments.

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

Capital Investment Programme £000s	2015/16 Capital Programme	Expenditure at Month 5
Capital Resources		
Depreciation	11,820	
Clinical Strategy exceptional additional PDC	17,400	
Additional Capital Loan - Health Records Storage	441	
League of Friends Support	1,255	
Cap Investment Loan Principal Repayment	-427	
Gross Capital Resource	30,489	
Less Donated Income	-1,255	
Capital Resource Limit (CRL)	**29,234**	**-**
Capital Investment		
Clinical Strategy Reconfiguration	17,400	0
Medical Equipment	1,405	913
IT Systems	1,028	403
Electronic Document Management	835	205
Child Health Information System	673	127
PAS Upgrade	523	68
Backlog Maintenance	1,241	100
Infrastructure Improvements - Modernisation of Inpatient Environment and Facilities	700	19
Pevensey Ward	2,055	1,603
Minor Capital Schemes	1,500	625
Health Records	441	441
Other various	1,657	502
Sub Total	**29,458**	**5,006**
Donated Asset Purchases	1,255	272
Donated Asset Funding	-1,255	-272
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**29,458**	**5,006**
Overplanning Margin (-) Underplanning (+)	-224	0
Net Capital Charge against the CRL	**29,234**	**5,006**

Continuity of Service Risk Ratings – August 2015

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 -6 days, a rating of 3.
- The capital servicing ratio of -1.85 results in a rating of 1.
- As a result the overall Trust rating is 2.

Liquidity Ratio (days) £000s	2014/15 Outturn	2015/16 YTD
Opening Current Assets	27,044	35,877
Opening Current Liabilities	-28,815	-36,332
Net Current Assets/Liabilities	-1,771	-455
Inventories	-6,599	-6,170
Adj Net Current Assets/Liabilities	**-8,370**	**-6,625**
Divided by:		
Total costs in year	364,471	156,665
Multiply by (days)	360	150
Liquidity Ratio	**-8**	**-6**

Capital Servicing Capacity (times) £000s	2014/15 Outturn Actual	2015/16 YTD Plan	2015/16 YTD Actual
Net Surplus / Deficit (-) After Tax	473	-14,014	-16,029
Less:			
Donated Asset Income Adjustment	-1,107	-523	-272
Interest Expense	235	418	363
Profit/Loss on Sale of Assets	-29	0	-6
Depreciation & Amortisation	12,265	5,448	5,516
Impairments	-629	0	0
PDC Dividend	8,073	3,235	3,338
Revenue Available for Debt Service	**19,281**	**-5,436**	**-7,090**
Interest Expense	235	418	363
PDC Dividend	8,073	3,235	3,338
Temporary PDC repayment			
Working capital loan repayment	18,171		
Capital loan repayment	320	201	140
	26,799	3,854	3,841
Capital Serving Capacity	**0.72**	**-1.41**	**-1.85**

Financial Risks & Mitigating Actions – August 2015

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

East Sussex Healthcare NHS
NHS Trust

WORKFORCE REPORT

AUGUST 2015

WHAT MATTERS TO YOU MATTERS TO US ALL

East Sussex Healthcare NHS
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HEADLINES

WORKFORCE EXECUTIVE SUMMARY – KEY POINTS

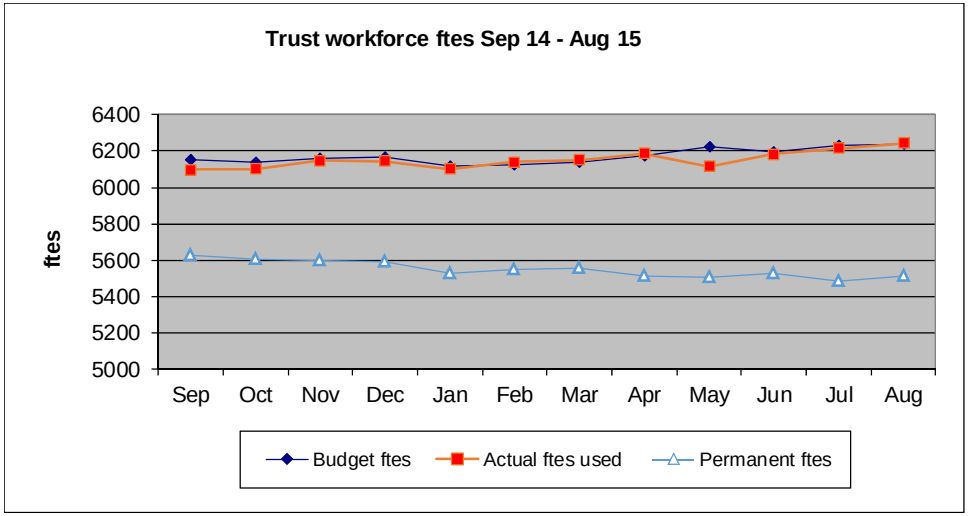
- Actual workforce usage of staff in August was 6243.02 full time equivalents (ftes), 3.12 above budget.
- Temporary staff expenditure was £3,465K in July (16.08% of total pay expenditure). This comprises £1,316 bank expenditure, £2,108 agency expenditure and £42K overtime
- There were 542.99 fte vacancies (a vacancy factor of 8.93%)
- Monthly sickness was 4.26%, an increase of 0.05% from July. Annual sickness was 4.91%, a reduction of 0.03%
- Annual turnover was 12.20% which represents 660.17 fte leavers in the last year
- Mandatory training rates have all decreased this month, with the exception of Health & Safety
- Appraisal compliance decreased by 1.34% to 73.69%

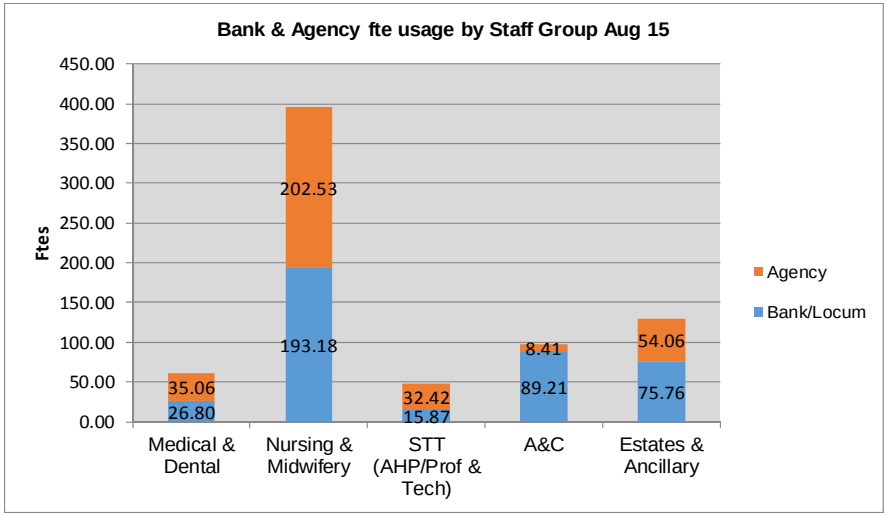
WHAT MATTERS TO YOU MATTERS TO US ALL

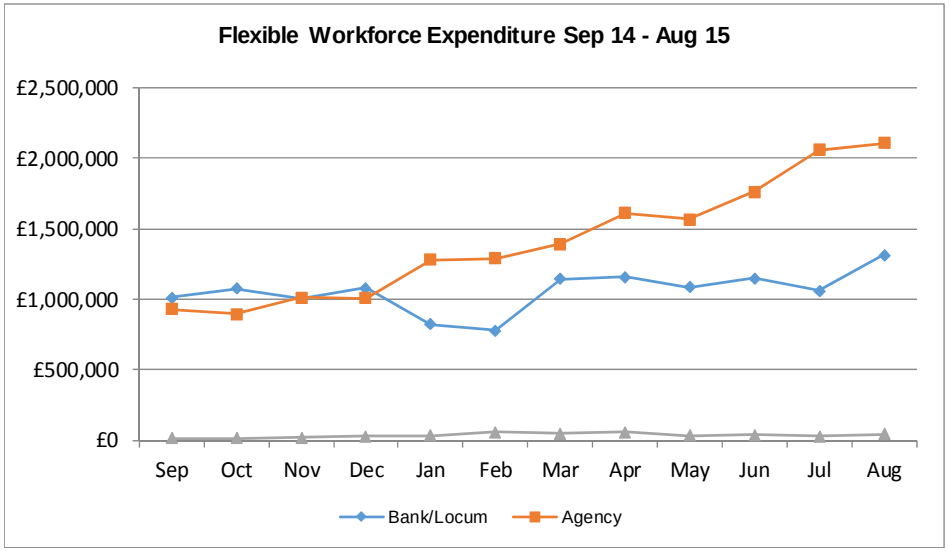
TRUST OVERVIEW

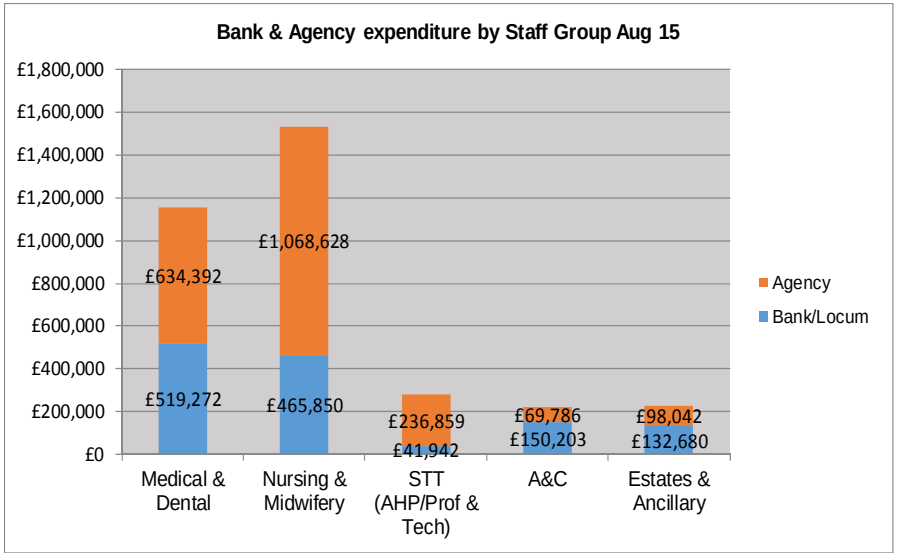
Jul-15	Budg estab fte	Actual worked fte	Vacancies fte	Vacancy trend since last month	Fill rate %	Monthly sickness %	Annual sickness %	Turnover	Temp staff expenditure	Appraised /exempt in last yr	Appraisal trend since last month
Theatres & Clinical Support	1,088.26	1,041.73	94.08	↓	91.19%	4.32%	4.92%	10.69%	£710,719	62.06%	↓
Cardiovascular Medicine	273.09	317.83	13.92	↑	94.90%	2.32%	4.20%	11.06%	£256,279	74.81%	↑
Urgent Care	550.83	612.94	69.91	↓	87.30%	5.19%	5.09%	12.65%	£869,720	71.18%	↓
Specialist Medicine	434.46	424.59	37.56	↓	91.35%	4.57%	4.95%	11.02%	£226,562	83.01%	↑
Out of Hospital Care	927.45	857.32	122.77	↑	86.76%	4.51%	5.66%	16.72%	£267,135	65.45%	↓
Surgery	727.05	749.27	54.61	↓	92.49%	3.50%	3.88%	11.38%	£538,006	91.00%	↓
Womens & Childrens	590.46	576.02	31.67	↑	94.63%	4.22%	5.00%	11.42%	£290,404	82.15%	↓
COO Operations	374.62	407.63	11.19	↓	97.01%	4.42%	5.10%	8.88%	£78,943	61.43%	↑
Estates & Facilities	714.78	739.01	56.35	↓	91.55%	5.94%	6.21%	10.40%	£231,462	76.64%	↑
Corporate	473.50	436.31	50.93	↑	89.14%	3.22%	3.88%	11.50%	-£3,894	77.23%	↓
TRUST	6239.90	6243.02	542.99	↓	91.07%	4.26%	4.91%	12.20%	£3,465,336	73.69%	↓

WORKFORCE USAGE









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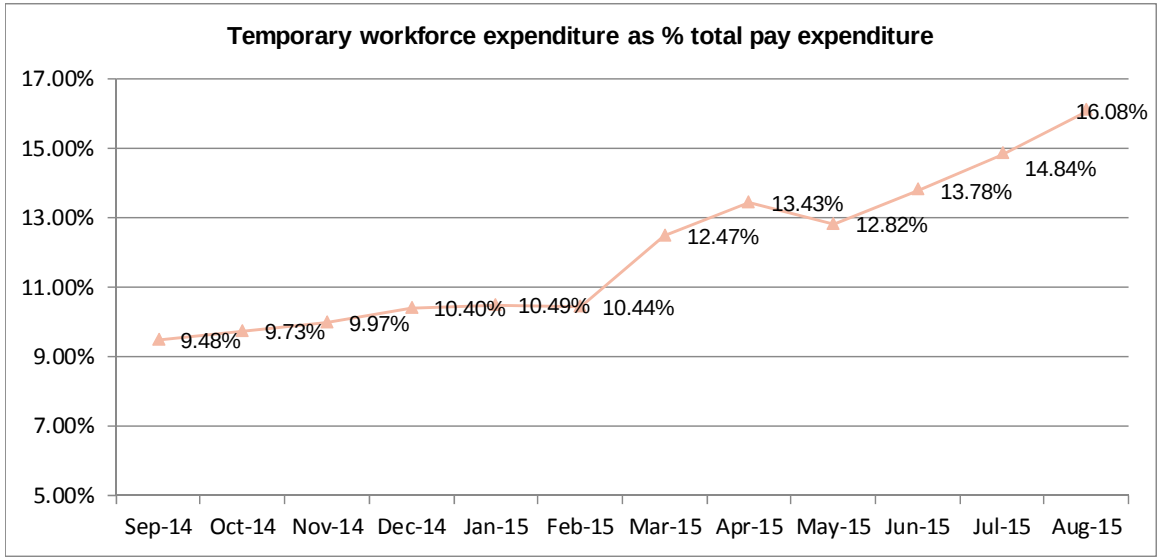
WORKFORCE USAGE



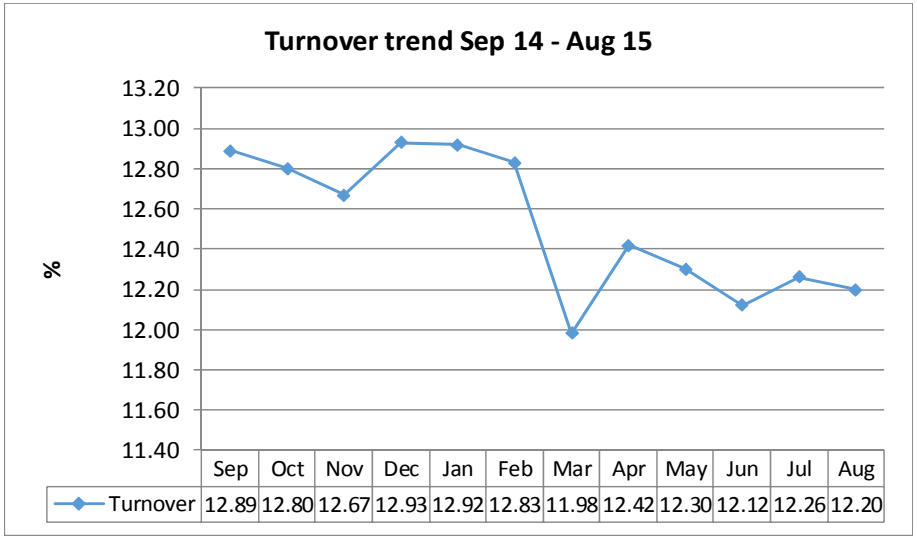
Workforce expenditure increased by £361K this month, mostly attributable to increasing expenditure on temporary workforce which accounted for 16.08% of workforce expenditure.

Agency expenditure was again over £2 million in month, including £634K spent on Medical Agency and £1069K on Nursing & Midwifery agency. This high level of usage reflects the continuing high level of vacancies as well as pressures on service delivery due to increased demand, the acuity of patients and an increase in the number of patients who are medically fit for discharge. This has resulted in the need to retain additional bed capacity which is usually only required in the winter months. As a result the use of temporary staff has remained high.

The Trust Development Authority and Monitor are implementing an annual ceiling for registered nursing & midwifery agency spending in all Trusts from 1 October. This is based on a percentage limit compared to total expenditure for this staff group. Given our current high levels of agency usage, which stand at 9.7% in Quarter 2 of 2015/16, the Trust has applied for approval for a sliding trajectory of 7% in Quarter 3 and 5% in Quarter 4, dropping to the recommended level of 3% in Quarter 1 of 2016/17. To help meet these targets the rates for bank staff have been reviewed to bring them more into line with neighbouring Trusts. This should further incentivise staff to provide shift cover on the bank and avoid agency usage.

TURNOVER & VACAANCIES

STAFF GROUPS	Substantive budget ftes	Substantive actual ftes	Difference	Maternity ftes	Net vacancies	Vacancy trend since last month	Fill rate %
Medical & Dental	568.22	502.14	66.08	9.60	56.48	↓	90.06%
Registered Nursing & Midwifery	1,971.42	1,721.98	249.44	45.33	204.11	↑	89.65%
Unqualified Nurses	784.98	712.31	72.67	22.52	50.15	↓	93.61%
Sc. Therap & Techs (inc AHPs, Prof & Tech & Healthcare Scs.)	971.00	844.79	126.21	14.59	111.62	↓	88.50%
Administrative & Clerical	1141.89	1042.13	99.76	10.32	89.44	↓	92.17%
Estates & Ancillary	634.33	599.24	35.09	3.93	31.16	↓	95.09%
TRUST	6,080.02	5,430.74	649.28	106.29	542.99	↓	91.07%



STAFF GROUPS	FTE leavers in year	Annual Turnover %
MEDICAL & DENTAL	46.73	16.05%
NURSING & MIDWIFERY REGISTERED	196.05	11.05%
ALLIED HEALTH PROFESSIONALS	68.31	18.67%
HEALTHCARE SCIENTISTS	19.40	15.70%
PROF SCIENTIFIC & TECHNICAL	21.35	13.72%
ADDITIONAL CLINICAL SERVICES	121.53	12.67%
ADMINISTRATIVE & CLERICAL	113.71	10.53%
ESTATES & ANCILLARY	59.10	9.72%
STUDENTS	14.00	26.42%
TRUST	**660.18**	**12.20%**

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

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TURNOVER & VACANCIES

There has been a net decrease of 13.19 Trust fte vacancies in August. Medical & Dental vacancies have reduced by 7.83 ftes and unqualified nurse vacancies by 9.80 ftes but qualified nursing & midwifery vacancies have increased by 15.15 ftes.

Nursing recruitment has been hampered due to the Home Office not granting Certificates of Sponsorship (CoS), formerly known as Work Permits, for registered nurses. There is currently a nation-wide review of the CoS system, led by the Migratory Advisory Committee, to review how this is implemented, as nearly every Trust is looking at recruiting from outside the UK/Europe to fill their nurse vacancies. The Trust has had 2 planned recruitment trips to the Philippines cancelled. The trips have been delayed by the Philippine Overseas Employment Agency (POEA) who denied us permission to interview because of the CoS situation.

The Trust is, additionally, engaging an agency to support us to recruit from Europe as well. This is a more difficult market and is unlikely to lead to the recruitment of large cohorts of nurses but the response to this recruitment will be monitored to discern how realistic this will be as a viable recruitment route.

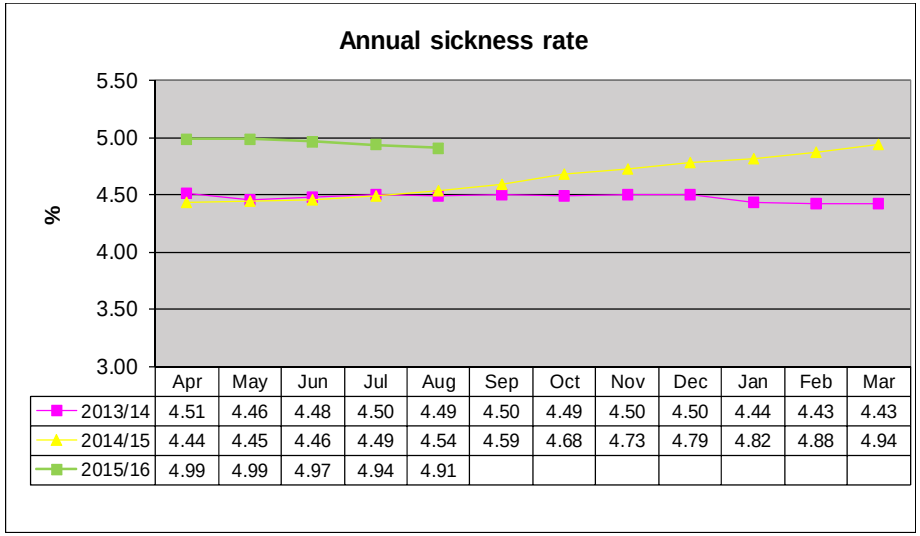
The Trust continues to advertise and recruit to vacancies through the normal routes; Return to Practice training is supported and there is a special recruitment programme for newly qualified nurses. The Trust has interviewed and offered posts to the cohort who qualify in early October and if all pass their courses and accept the posts then this will be an additional 28 nurses into the workforce.

We have appointed 5 Consultants in Anaesthetics(2), Gastroenterology, Ophthalmology and Radiology who will be starting between September – November.

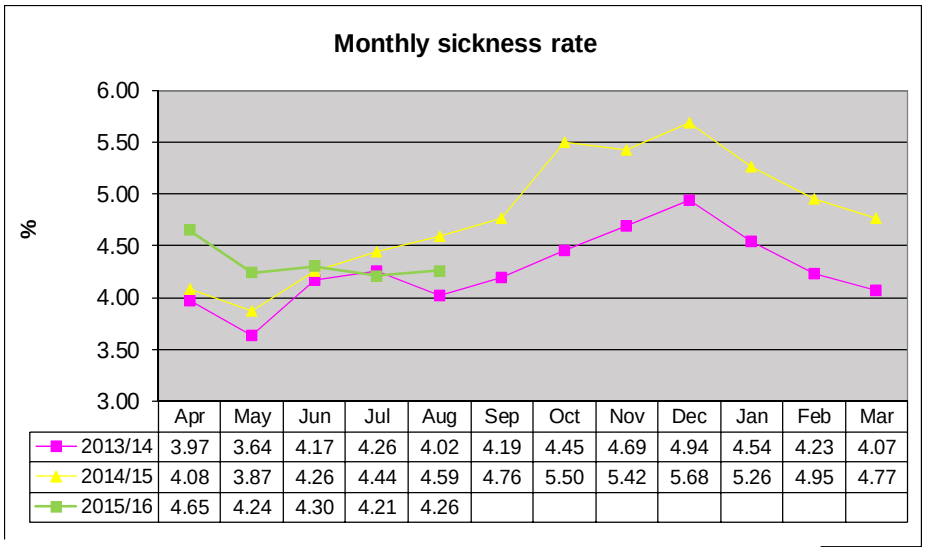
The Junior Doctor August intake commenced without problems and we are preparing for the October intake. In total, there will be 235 doctors in post. There are 14 vacancies not filled by the Deanery. This gives a fill rate of 94.5% overall, which is an improvement on last year by 5%.

In July and September 2 large cohorts of Healthcare Assistants were recruited, both substantive and bank, and active recruitment continues. This is reflected in the reduction in unqualified nursing vacancies. There are a further 39 HCAs starting in post in September, of these 20 are substantive and 19 will be on the bank.

SICKNESS



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



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

Mandatory Training – Six Month Trend

Monthly sickness has increased by 0.05% this month but is below the rate for August last year with the result that the annual rate of sickness has fallen again by 0.03% to 4.91%. Monthly sickness rates were highest again amongst Estates and Ancillary staff at 5.76% and Additional Clinical Services (i.e. mostly unqualified nurses and therapy helpers) at 5.44%. Nursing & Midwifery staff sickness was 4.65%, 0.35% lower than in July.

Monthly sickness was highest in Estates & Facilities at 5.94% and Urgent Care at 5.19%.

7446 fte days were lost to sickness in August 2015. 3542 of those fte days were due to long term sickness (i.e. sickness episodes of over 28 days duration) which is equivalent to 47.57% of monthly sickness.

The Human Resources department launched the “Support 4 You” programme in mid-September to support managers with return to work interviews and managing long term sickness.

East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISALS

Mandatory training course	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	6 month trend
Induction %	94.47	95.16	93.32	93.64	94.62	90.95	
Fire %	83.22	81.52	82.47	82.82	83.78	83.03	
Manual Handling %	81.08	79.84	82.97	84.59	85.44	84.21	
Infection Control %	86.41	86.32	86.27	84.85	85.78	84.58	
Info Gov %	77.06	75.99	77.26	81.89	82.57	82.38	
Health & Safety %	67.04	68.79	71.18	73.36	74.80	75.47	
Mental Capacity Act %	92.36	92.31	92.48	92.63	93.02	92.80	
Depriv of Liberties %	89.09	89.03	89.64	90.11	90.88	90.82	
Safeguard Vuln Adults	85.98	72.98	73.24	74.38	75.08	74.62	
Safeguard Child Level 2	78.12	77.90	79.61	79.87	80.13	79.19	

Clinical Unit Mandatory Training & Appraisals

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Appraisal compliance
Theatres & Clinical Support	87.36%	88.41%	91.14%	86.97%	87.16%	75.57%	92.41%	89.54%	73.48%	77.88%	62.06%
Cardiovascular Medicine	81.07%	84.29%	92.86%	82.50%	74.29%	51.07%	90.20%	87.76%	60.82%	55.92%	74.81%
Urgent Care	75.16%	76.92%	94.12%	74.51%	71.21%	59.12%	83.77%	80.67%	67.78%	70.17%	71.18%
Specialist Medicine	83.06%	85.88%	95.00%	81.88%	77.41%	75.53%	94.23%	88.81%	80.77%	81.32%	83.01%
Out of Hospital Care	83.14%	82.72%	94.81%	83.87%	81.99%	77.80%	96.79%	97.94%	79.70%	82.34%	65.45%
Surgery	86.07%	84.96%	91.67%	86.35%	95.68%	81.89%	95.06%	91.83%	81.98%	77.35%	91.00%
Womens & Childrens	87.82%	87.52%	89.09%	82.17%	79.20%	75.04%	91.56%	89.02%	67.74%	93.17%	82.15%
COO Operations	66.76%	81.59%	88.89%	79.12%	60.99%	55.77%	n/a	n/a	n/a	n/a	61.43%
Estates & Facilities	80.17%	75.39%	92.31%	89.31%	87.34%	87.48%	62.50%	100.00%	37.50%	37.50%	76.64%
Corporate	87.06%	92.16%	77.78%	91.37%	85.69%	87.65%	95.12%	94.03%	75.61%	78.57%	77.23%
TRUST	**83.03%**	**84.21%**	**90.95%**	**84.58%**	**82.38%**	**75.47%**	**92.80%**	**90.82%**	**74.62%**	**79.19%**	**73.69%**

(Green =90%+ Red = <90%).

Mandatory training percentages have dropped slightly, with the exception of Health & Safety. Seasonal fluctuations do occur with training compliance, particularly over August when a reduced amount of training is delivered due to staff and trainers annual leave, but overall the figures are an improvement on this time last year. From September onwards it will be the anniversary of last year's "push" for compliance and Learning & Development have met with mandatory trainers to assess initiatives to maintain compliance. These include team training, additional Clinical Updates and promotion/support for e-learning. The Moving & Handling trainers are also delivering some training on Saturdays and evenings and this is something which they hope to extend in the coming months. DNAs have continued to be a problem throughout the year and there needs to be continued emphasis on the need to release staff for training to improve compliance rates.

The appraisal rate has dropped by 1.34% as renewals have not kept pace with those expiring. Monitoring forms are still often received over a month after appraisals have taken place and appraisers need to be reminded to submit these promptly.

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East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	9b
Subject:	Safe Nurse & Midwifery Staffing Levels
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

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

Introduction:

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

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

- Appropriate Nurse staffing levels are critical to patient safety and throughout the period Apr-Jul all areas maintained appropriate RN staffing levels based on planned establishment and professional judgment on the day.
- The Trust has systems in place to address and manage variations with support from senior nursing staff
- The variations that have occurred are managed appropriately
- Where there is concern regarding quality metrics that full investigation is undertaken to understand contributory factors

Benefits:

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

Risks and Implications

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

Assurance Provided:

The Trust has responded to the expectations of the NQB and NHS England and can demonstrate

that all inpatient areas are assessed and monitored with regard to nurse staffing levels and related quality indicators.

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

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment? None identified. The Trust is committed to giving due regard to the protected characteristics and has a range of policies and procedures in place to support this including dignity at work, flexible working and recruitment and selection.

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

East Sussex Healthcare NHS Trust

SAFE NURSE & MIDWIFERY STAFFING LEVELS

1. Introduction

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

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

2. Background

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

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

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

3. April - July 2015

3.1 The dashboards in Appendix 1 have been prepared to reflect the above requirements, on a monthly basis, for April to July 2015.

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

3.3 The initial data submitted to Unify for April contained an error with regard the Registered Nurse staffing levels at night on Egerton ward, which has been corrected.

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

3.4 The quality indicators do not suggest that staffing levels had an adverse effect on the number of pressure ulcers, falls or medication errors reported during this period. It should be noted that the number of medication errors in May is not available due to a technical difficulty.

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

Conclusion/Recommendation

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

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

This overview provides assurance that the systems and processes in place allow the Trust to monitor the provision of safe care in our inpatient wards, responding to changes in activity and demand. It does not however negate the challenges of recruiting and maintaining a workforce that is robust and sustainable, without resorting to agency support.

Alice Webster
Director of Nursing

Elizabeth Fellows
Assistant Director of Operations

Appendix 1

Apr-15	CCU	Average fill day rate - registered nurses/midwives (%	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	93.75%	109.27%	94.44%	108.89%		12	1
CCU EDGH	Cardiovascular Clinical Unit	84.33%	100.00%	86.67%	100.00%			2
James CCU	Cardiovascular Clinical Unit	98.80%	89.44%	85.00%	106.67%		6	
Michelham	Cardiovascular Clinical Unit	102.93%	93.99%	95.00%	95.00%	1	2	1
Stroke Unit EDGH	Cardiovascular Clinical Unit	89.71%	114.53%	97.51%	111.67%			
Wellington	Specialist Medicine	111.81%	87.92%	108.41%	86.67%		4	2
	Cardiovascular Clinical Unit Total					1	24	6
Crowborough Intermediate Beds	Out of Hospital	93.14%	104.39%	98.91%	102.90%		12	
Harlands Medical	Out of Hospital	99.06%	115.38%	100.22%	100.14%			
Irvine Unit	Out of Hospital	85.41%	103.85%	90.72%	104.67%			
Lewes Intermediate care	Out of Hospital	93.09%	92.67%	100.00%	102.22%		1	
Rye Intermediate Care Beds	Out of Hospital	110.58%	100.47%	100.00%	100.58%		3	1
	Out of Hospital Total					0	16	1
Cuckmere	Specialist Medicine	86.01%	98.76%	82.67%	97.68%		1	
Jevington	Specialist Medicine	99.89%	106.09%	88.89%	106.13%	2	4	
Newington	Urgent Care	86.56%	96.78%	92.00%	95.56%	1	7	2
Pevensey	Specialist Medicine	107.19%	100.00%	100.00%	96.67%			1
	Specialist Medicine Total					3	12	3
Benson Trauma	Surgery	81.67%	107.01%	96.67%	98.74%	2	3	4
Cookson Attenborough - Surgical short Stay	Surgery	81.88%	111.12%	94.37%	112.67%		1	1
Cookson Devas Elective	Surgery	92.52%	92.92%	83.33%	100.00%		2	1
De Cham	Surgery	89.23%	98.39%	100.00%	117.49%		4	1
Egerton Trauma	Surgery	92.42%	82.50%	100.00%	103.83%	6	10	3
Gardner	Surgery	86.38%	115.77%	86.11%	108.00%		4	3
Hailsham 3 (Orthopaedic Elective)	Surgery	101.43%	96.18%	94.96%	89.02%	3	2	3
Hailsham 4	Surgery	94.66%	103.15%	86.50%	102.80%		3	2
MacDonald	Urgent Care	85.20%	112.48%	103.33%	97.78%	1	5	1
RT SAU	Surgery	83.90%	143.55%	83.04%	108.37%	1	5	3
Seaford 4 Urology	Surgery	97.90%	110.27%	94.44%	126.67%		1	2
	Surgery Total					13	40	24
ITU/HDU Conquest	Theatres and Clinical Support	114.83%	91.45%	103.67%	93.33%	2		1
ITU/HDU EDGH	Theatres and Clinical Support	118.36%	82.39%	95.96%	-			1
	Theatres and Clinical Support Total					2	0	2
AAU Conquest	Urgent Care	80.42%	93.17%	96.67%	94.44%		10	2
Baird MAU	Urgent Care	86.25%	92.92%	90.00%	88.89%	3	7	1
Seaford 1	Urgent Care	94.84%	96.83%	90.30%	105.56%			
Seaford 3	Surgery					1	5	
	Urgent Care Total					4	22	3
Crowborough Birthing Unit	Women and Children	97.86%	100.00%	101.74%	93.48%			
EMU	Women and Children	100.08%	100.00%	100.00%	100.00%			
Frank Shaw	Women and Children	94.74%	113.65%	95.81%	98.45%			
Kipling	Women and Children	101.10%	86.88%	90.95%	110.00%			1
Mirrlees	Women and Children	114.82%	97.25%	97.25%	96.67%			
SCBU	Women and Children	103.65%	100.00%	101.01%	96.67%			
	Women and Children Total					0	0	1
	Grand Total					23	114	40

May-15	CCU	Average fill day rate - registered nurses/midwives (%	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	88.40%	114.20%	90.40%	96.10%	1	6	
CCU EDGH	Cardiovascular Clinical Unit	83.55%	100.00%	88.17%	100.00%		1	
James CCU	Cardiovascular Clinical Unit	94.55%	87.38%	85.45%	100.00%		3	
Michelham	Cardiovascular Clinical Unit	88.70%	101.40%	98.40%	103.90%		3	
Stroke Unit EDGH	Cardiovascular Clinical Unit	80.80%	123.10%	98.10%	98.40%			
Wellington	Specialist Medicine	91.40%	91.10%	110.20%	88.60%		2	
	Cardiovascular Clinical Unit Total					1	15	0
Crowborough Intermediate Beds	Out of Hospital	109.20%	102.98%	97.34%	93.64%		5	
Harlands Medical	Out of Hospital	104.81%	98.39%	98.39%	102.38%			
Irvine Unit	Out of Hospital	87.50%	96.10%	87.00%	97.80%		8	
Lewes Intermediate care	Out of Hospital	90.60%	91.94%	83.98%	103.60%		3	
Rye Intermediate Care Beds	Out of Hospital	98.00%	105.70%	100.00%	98.50%		9	
	Out of Hospital Total					0	25	0
Cuckmere	Specialist Medicine	81.70%	83.60%	98.40%	122.70%	2	7	
Jevington	Specialist Medicine	106.20%	86.20%	96.80%	100.90%	1	3	
Newington	Urgent Care	82.70%	93.80%	83.90%	101.00%	2	4	
Pevensey	Specialist Medicine	96.40%	100.00%	100.00%	100.00%	1	1	
	Specialist Medicine Total					6	15	0
Benson Trauma	Surgery	80.60%	109.60%	101.60%	95.70%	3	8	
Cookson Attenborough - Surgical short Stay	Surgery	105.96%	100.89%	103.38%	97.22%			
Cookson Devas Elective	Surgery	100.30%	92.00%	83.90%	112.90%			
De Cham	Surgery	85.70%	104.90%	96.90%	94.90%	1	3	
Egerton Trauma	Surgery	84.50%	84.90%	82.80%	104.40%	3	5	
Gardner	Surgery	80.90%	125.90%	88.30%	137.10%		4	
Hailsham 3 (Orthopaedic Elective)	Surgery	97.63%	101.00%	104.84%	96.71%	2	3	
Hailsham 4	Surgery	97.60%	97.00%	100.10%	101.20%		4	
MacDonald	Urgent Care	92.12%	97.64%	100.00%	104.26%	1	5	
RT SAU	Surgery	83.78%	131.84%	84.01%	105.96%	1	1	
Seaford 4 Urology	Surgery	104.48%	104.66%	96.82%	88.17%	1		
	Surgery Total					12	33	0
ITU/HDU Conquest	Theatres and Clinical Support	111.00%	90.32%	99.39%	90.32%			
ITU/HDU EDGH	Theatres and Clinical Support	111.61%	100.00%	97.92%	100.00%		1	
	Theatres and Clinical Support Total					0	1	0
AAU Conquest	Urgent Care	93.15%	89.38%	96.77%	93.55%		2	
Baird MAU	Urgent Care	87.00%	94.50%	80.80%	96.80%	2	5	
Seaford 1	Urgent Care	90.17%	105.08%	88.51%	111.39%			
Seaford 2/MSSU	Urgent Care	85.89%	88.33%	100.00%	127.16%			
	Urgent Care Total					2	7	0
Crowborough Birthing Unit	Women and Children	95.80%	100.00%	94.00%	106.50%			
EMU	Women and Children	100.00%	100.00%	100.00%	90.30%			
Frank Shaw	Women and Children	100.10%	115.00%	96.80%	97.30%			
Kipling	Women and Children	94.50%	84.10%	86.60%	109.70%		1	
Mirrlees	Women and Children	109.50%	91.40%	104.30%	97.30%	1		
SCBU	Women and Children	102.70%	80.60%	84.50%	80.60%			
	Women and Children Total					1	1	0
	Grand Total					22	97	0

NB. Please note data re Medication Errors is not available due to technical issues

Jun-15	CCU	Average fill day rate - registered nurses/midwives (%	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick	Cardiovascular Clinical Unit	92.80%	125.80%	98.90%	122.50%	1	5	3
CCU EDGH	Cardiovascular Clinical Unit	82.90%	100.00%	85.60%	100.20%			
James CCU	Cardiovascular Clinical Unit	101.70%	88.00%	87.50%	134.30%	1	1	
Michelham	Cardiovascular Clinical Unit	83.10%	92.20%	100.10%	87.00%	1	1	
Stroke Unit EDGH	Cardiovascular Clinical Unit	89.50%	119.70%	98.00%	101.60%			
	Cardiovascular Clinical Unit Total					4	16	3
Crowborough Intermediate Beds	Out of Hospital	100.10%	100.00%	98.60%	94.50%		3	7
Uckfield Intermediate Care Beds	Out of Hospital	99.40%	99.30%	93.40%	105.50%	1	6	1
Irvine Unit	Out of Hospital	80.90%	119.00%	90.70%	95.60%	1	11	
Lewes Intermediate care	Out of Hospital	104.60%	88.10%	115.50%	107.80%		8	4
Rye Intermediate Care Beds	Out of Hospital	99.00%	103.90%	100.00%	100.00%			1
	Out of Hospital Total					2	28	13
Cuckmere	Specialist Medicine	82.80%	90.10%	99.10%	105.90%		5	
Jevington	Specialist Medicine	108.90%	119.00%	101.10%	103.30%		3	1
Pevensey	Specialist Medicine	93.20%	100.00%	100.00%	100.00%			
Wellington	Specialist Medicine	105.60%	91.60%	95.90%	87.60%	1	9	
	Specialist Medicine Total					1	17	1
Benson Trauma	Surgery	92.20%	95.70%	100.60%	98.10%	1	5	
Cookson Devas Elective	Surgery	92.40%	89.60%	90.00%	103.30%		1	
De Cham	Surgery	93.30%	113.80%	96.70%	135.60%	1	5	1
Egerton Trauma	Surgery	90.60%	86.70%	96.70%	128.50%	1	5	3
Gardner	Surgery	88.00%	97.50%	82.20%	88.90%		4	
Hailsham 3 (Orthopaedic Elective)	Surgery	97.60%	101.00%	103.00%	84.50%		4	
Hailsham 4	Surgery	103.60%	116.20%	84.80%	120.00%		6	5
RT SAU	Surgery	84.70%	146.30%	81.20%	128.00%		2	1
Seaford 4 Urology	Surgery	97.30%	106.50%	99.10%	123.30%		3	1
	Surgery Total					3	35	11
Cookson Attenborough - Surgical short Stay	Theatres and Clinical Support	103.00%	87.30%	100.00%	100.00%		1	
ITU/HDU Conquest	Theatres and Clinical Support	109.30%	90.30%	97.90%	90.00%	1		1
ITU/HDU EDGH	Theatres and Clinical Support	107.30%	100.00%	91.50%	-			2
	Theatres and Clinical Support Total					1	1	3
AAU Conquest	Urgent Care	90.50%	94.00%	93.30%	100.00%		2	1
Baird MAU	Urgent Care	86.00%	97.00%	101.00%	106.70%	2		1
MacDonald	Urgent Care	85.00%	109.10%	101.70%	91.90%	5	2	
Newington	Urgent Care	82.50%	103.50%	88.90%	115.60%		6	2
Seaford 1	Urgent Care	84.70%	103.50%	92.60%	107.40%			
Seaford 2/MSSU	Urgent Care							
	Urgent Care Total					7	10	4
Crowborough Birthing Unit	Women and Children	80.00%	85.70%	97.40%	100.00%			
EMU	Women and Children	100.10%	96.70%	100.10%	100.00%			
Frank Shaw	Women and Children	95.40%	114.80%	95.70%	94.80%			
Kipling	Women and Children	97.90%	84.80%	90.40%	100.00%	1		1
Mirrlees	Women and Children	100.00%	95.20%	107.70%	93.30%			
SCBU	Women and Children	98.00%	80.00%	98.90%	101.70%			
	Women and Children Total					1	0	1
	Grand Total					18	94	38

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

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	10
Subject:	Serious Incident Loss of Unencrypted Data Stick
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

To update the Board on the recent Information Governance (IG) Breach (loss of unencrypted data stick); the investigation that took place following this and the actions that have been put into place since.

Introduction:

On 16th June 2015 a member of the public informed the Patient Advice and Liaison Service (PALS) Department at the Conquest Hospital Hastings that on the 15th June 2015 she found a data stick containing patient identifiable information near The Oaks and Little Ridge Avenue in St Leonards-on-Sea; adjacent to the Trust's doctors' residency.

The memory stick was retrieved by the Head of Governance and further investigation revealed that the stick was the property of one of the Trust consultants and contained information of 3634 patients. Some of this pertained to patients from other Trusts and private patients.

This was reported as a serious incident; a root cause analysis was undertaken alongside an internal investigation under the Trust's Disciplinary Policy.

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

Having undertaken the above investigations it was found that the stick belonged to one of the Trust consultants. This was not a 'safe stick'; it had not been supplied by the Trust and was not encrypted. The information about patients had been kept for audit and appraisal/revalidation purposes and also contained responses to patient complaints. There was no password protection on the majority of this information. This Person Identifiable Information (PII) totalled 3634 individuals; some of this was demographic detail and some included diagnosis and treatments. Some of the information related to patients of other Trusts and private patients.

Benefits:

As a result of the investigation the following was out into place;

Reporting of the incident

The incident was immediately reported onto the Trust's incident reporting system, raised as a serious incident and senior personnel within the Trust were informed. This included the Chief Executive Officer (CEO); the Director of Strategic Development and Assurance (who is also the Senior Information Risk Owner or SIRO); the Medical Director (who is also the Caldicott Guardian for the Trust); the Director of Human Resources; the Trust Company Secretary; the Information Governance Manager; the Trust Patient Safety Lead and the Communications Department. Externally the following were informed and advice sought;

- Information Commissioner's Office
- Trust Development Authority (TDA)
- Care Quality Commission
- Quality leads for the local Clinical Commissioning Groups
- Local Healthwatch
- The Health Overview Scrutiny Committee
- General Medical Council (GMC)

Management of PII Data
Immediately on return of the data stick it was kept in a secure place and only identified and authorised staff were able to have access to the data. A mapping exercise was undertaken of all data on the stick to identify all files that contained PII.

As soon as this had been completed the data stick was safely destroyed. The data extracted from the memory stick is now password protected and stored on the Trust system.

An initial meeting was convened with the DDoN and the Associate Director of Knowledge Management with the consultant on 19th June 2015. At this meeting the consultant was able to confirm that none of the PII on the data stick had been downloaded or stored in any other format or in any unsecure area. The consultant also confirmed that they did not have any other PII held inappropriately or on any device outside of secure NHS IT systems. The consultant was informed that a date would be convened for a formal interview as part of the HR disciplinary investigation.

Patient notification
Once all information had been extracted from the stick work was undertaken to 'cleanse' the data. This included producing a list of all patients and removing duplication of names. Those patients who had since died were identified and patient addresses were checked and updated as necessary.

A letter of apology was drafted to be sent to all patients who had PII on the data stick. This letter also contained information on the investigation process and about arrangements in place for them to have sight of the data on the stick pertaining to them.

To date 23 patients have logged a formal complaint and 8 have taken legal advice and action.

Media Handling and information to staff
A media statement was prepared by the Trust Communication Team and agreed with the TDA. This was a 'reactive statement' in anticipation of any enquiry received from the media.
The on-call directors/managers were informed of the incident in case of media enquiries out of hours.

The Trust Communication Team circulated via global e-mail information about the incident informing staff of the possible media interest and more importantly reinforcing key policies around data protection and the use of encryption sticks.

HR disciplinary investigation
A meeting was arranged with the consultant, their BMA representative, the DDoN (investigating officer) and an HR representative under the Trust's disciplinary procedure to further explore the issues related to the data stick loss. Through this investigation it was concluded that there had clearly been a breach of policy and procedure in respect of Information Governance Strategy and Policy (including Data Protection and Confidentiality; Caldicott Guardian Function); the Trust's Mobile Technology Policy and The Trust Disciplinary policy. As such a disciplinary hearing will take place.

Risks and Implications
Reputational cost to the organisation.

Financial cost likely to incur fines and probable cost of litigation claims from patients.

Significant impact on Trust time and resources dealing with investigations, managing patient complaints and dealing with litigation claims.

Assurance Provided:
A robust action plan has been put together to prevent any future IG breaches of this nature. Copy attached.

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	x
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
Strategic Objective 3 - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	
Review by other Committees/Groups (please state name and date)**:**	
Serious incident reporting group 4th September 2015 Patient Safety and Clinical Improvement Group 28th September 2015	

Proposals and/or Recommendations

- Embed learning with staff to ensure they know that PII should never be stored in any format other than on a secure Trust computer or drive.
- Ensure the Trust Mobile Technology Policy is enforced to ensure that unencrypted data sticks cannot be used on any Trust computer.
- Review the Trust policy 'Information Governance Strategy and Policy (including Data Protection and Confidentiality; Caldicott Guardian Function)' and the Trust's 'Mobile Technology Policy' to ensure that this is up to date and relevant; incorporating any recent national changes.
- Review of Information Governance (IG) mandatory training to incorporate the downloading and storage of PII ensuring that staff know how to keep this data appropriately and safely.
- Review Trust guidelines for the process and procedure for Trust managers to follow in the event of any future IG breach; this should include the use of digital forensics
- Ensure that all staff are in date with mandatory IG training/updating
- Review the information on who has Trust safe/encrypted memory sticks
- Implement appropriate technology safeguards; for example a process whereby only encrypted data sticks can be used to download and store any information that is kept on Trust computers
- Review of the processes within the laboratories when providing information about patient investigations and tests
- Complete the HR disciplinary process.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
Actions are in place to ensure that the trust protects privacy of patient information.

For further information or for any enquiries relating to this report please contact:	
Name: Lindsey Morgan Deputy Director of Nursing	**Contact details:** lindsey.morgan2@nhs.net

SI ref: 2015/20954

Action Plan

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures:	Evidence of Progress and Completion:
1	Trust policy 'Information Governance Strategy and Policy (including Data Protection and Confidentiality; Caldicott Guardian Function)' and the Trust's 'Mobile Technology Policy' must be up to date and relevant; incorporating any recent national changes.	Policy to be reviewed to ensure that all national recommendations are within the document and that all safeguards to ensure PII security are noted within the document. This must also detail the necessary requirement for IT to ensure adequate PII protection	DDoN	30 September 2015	Policy will be updated and reflect all national guidance and appropriate safeguards in place in respect of the protection of PII	

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures:	Evidence of Progress and Completion:
2	Trust managers need to be made aware of the IT department digital forensic readiness and that there is the capability to investigate data sticks and how they had been used; i.e., if they were they just 'a backup' and also on which computers within the Trust data sticks have been used on. Port control monitoring mode is in place and it is possible to report on any data stick that is used.	IT department to highlight to Trust managers the capabilities within IT for support when investigating any IG breach Review Trust guidelines for the process and procedure for Trust managers to follow in the event of any future IG breach; this should include the use of digital forensics.	Head of IT/ IG Manager	30 September 2015	Trust managers aware of support and capabilities when investigation any IG breach	
3	IG mandatory training must incorporate the downloading and storage of PII ensuring that staff know how to	Update IG training to include latest national recommendations and information about	Head of Learning and Development	30 September 2015	90% of all staff will be up to date with IG mandatory training	

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures:	Evidence of Progress and Completion:
	keep this data appropriately and safely.	safe storage of PII. Ensure that training includes information about safe storage of PII and the use of data sticks.				
4	All staff must be in date with training/updating	Ensure that 90% of staff are in date with IG mandatory training	Head of Learning and Development	30 September 2015	90% of all staff will be up to date with IG mandatory training	
5	Information on who has Trust safe/encrypted memory sticks must be up to date	Keep a log of all staff who have an encrypted data stick	Head of IT	31 October 2015	All staff who need to save PII or any Trust identifiable information to data stick use a safe encrypted stick	A record of Safe sticks has been maintained for the last 2 years. Since the incident a significant number of Trust staff have requested encrypted USB sticks A copy has been provided to

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures:	Evidence of Progress and Completion:
						internal audit. In addition anyone using a secure stick will have an entry recorded in the port control logs
6	All appropriate technology safeguards are in place to protect PII when using data sticks	Improve the IT systems for example put into place a process whereby only encrypted data sticks can be used to download and store any information that is kept on Trust computers	Head of IT	31 October 2015	No information from Trust secure computers downloaded to an inappropriate source	Technical Controls were successfully implemented on Wednesday 26th August 2015. There are four categories of device configured within policies which are applied to Trust equipment. The four categories configured are: Floppy Drive (Read Only Access) Optical Drive (Full Access) Removable Storage (Read Only –

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures:	Evidence of Progress and Completion:
						Exemptions are only made for a whitelist of critical clinical equipment) Secure Removable Storage (Full Access) IT are reviewing the use of optical drives (e.g. Writable CD media) with a view to restricting their use within the next month. IT is also reviewing the equipment to not have optical drives fitted to new equipment by default. The significant risk of staff using unencrypted USB storage has been reduced and controlled.

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures:	Evidence of Progress and Completion:
7	All appropriate technology safeguards are in place to protect PII when sending email to destinations outside of the Trust	Improve the IT systems by putting into place a process whereby information can only be sent to a non-secure email address by an email denoted 'secure' and opened with a password	Head of IT	31 October 2015	No information from Trust secure computers downloaded to an inappropriate source	Policy in place regarding secure email and users advised of [SECURE} facility on 'NHS' mail system.
8	All appropriate technology safeguards are in place to prevent PII being uploaded to internet based services that are not approved for use by the Trust	Improve the IT systems by putting into place a process whereby Trust information can only be uploaded onto an approved internet service	Head of IT	31 October 2015	No information from Trust secure computers downloaded to an inappropriate source	There is currently no software in place to reduce the risk of data leak to on-line or cloud services not approved by the Trust. There are mitigations in place which are enforced by web filtering software. IT will be taking an action to review the filters to ensure protection remains current.

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures:	Evidence of Progress and Completion:
9	All appropriate safeguards are in place to prevent unauthorised access to Trust information and data stores i.e., individuals external to the Trust using Trust data points to attempt access to Trust systems	Improve the IT systems by putting into place a process that will prevent non Trust staff accessing Trust systems by using Trust data points	Head of IT	31 October 2015	No information from Trust secure computers downloaded to an inappropriate source	A formal request was made to the CSU in December 2015 to implement NAC as a pilot at the St. Anne's site, prior to rollout across the Trust. (CSU Service desk call number 2432788). The pilot has now been progressed and will be enabled in the next two weeks IT will continue the rollout of NAC across the trust over the next four months.
10	All end of life magnetic media i.e., computer discs, backup tapes are securely and safely disposed of	Improve the IT systems by putting into place a process to ensure that all magnetic media is appropriately disposed of when at end of life	Head of IT	31 October 2015	No information from Trust secure computers downloaded to an inappropriate source	Disposed of via contractor. Disks are removed from redundant equipment and catalogued. Disks are taken by the IT team to the supplier's place of business and shredding of the disk is supervised.

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures:	Evidence of Progress and Completion:
11	Review of the processes within the laboratories when giving information about patient investigation and tests	Ensure that all laboratory staff are aware of the correct procedure for the passing of patient identifiable information and work within the current IG policy	Pathology Manager	30 August 2015	All pathology staff are aware of the current policy for safe storage and transfer of PII	
12	Complete the HR disciplinary process	Hold a disciplinary hearing to consider allegations against consultant and disciplinary sanction if necessary	Head of Strategy Development	30 September 2015	Conclusion of process	

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	11
Subject:	Operational Resilience and Capacity Plan 2015/16
Reporting Officer:	Richard Sunley, Chief Operating Officer

Action: This paper is for **(please tick)**					
Assurance	√	**Approval**		**Decision**	
Purpose:					
This paper is to provide assurance to the board regarding the Trust's preparedness for winter.					

Introduction:

The Operational Resilience and Capacity Plan reflects the work undertaken by the System Resilience Group and is part of a whole systems approach to managing periods of increased pressure and establishing sustainability for both urgent care and elective activity throughout the year.

Analysis of Key Issues and Discussion Points:

The aim of the Operational Resilience and Capacity Plan (ORCP) is to ensure:

- Seamless, safe & timely care is provided despite variations in demand.
- Delivery of its contracts, national and local operational quality and operational standards and targets.
- Best use of available resources internally and in the local health economy.
- Robust escalation arrangements and processes are in place and understood and embedded as part of the whole systems response to significant operational pressures.

Benefits:

Provides solutions to enable the delivery of safe capacity management and maintain organisational performance.

Risks and Implications

Failure to maintain key services and patient safety if the escalation and control processes are not followed.

Assurance Provided:

Operational Resilience and Capacity Plan 2015/16

Review by other Committees/Groups

Corporate Leadership Team to be agreed 21/9/2015, Trust Board Seminar 16.09.15

Proposals and/or Recommendations

The Board is asked to note the Trust's preparedness for winter as outlined in the Operational Resilience and Capacity Plan for 2015/16

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

For further information or for any enquiries relating to this report please contact:	
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East Sussex Healthcare NHS
NHS Trust

OPERATIONAL RESILIENCE AND CAPACITY PLAN 2015/16

Produced By :	Title/Directorate	Date:
Pauline Butterworth	Deputy Chief Operating Officer	September 2015

Person Responsible for Monitoring Compliance& Review	Richard Sunley, Chief Executive
Signature& Date	TBC next CLT

Multi-disciplinary Evaluation/Approval

Name	Title/Specialty	Date:
Corporate Leadership Team		22/9/2015

Ratification Committee

Issue Number (Administrative use only)	Date of Issue& Version	Next Review Date	Date Ratified	Name of Committee/Board/Group
		October 2015		Trust Board

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East Sussex Healthcare NHS Trust

OPERATIONAL RESILIENCE AND CAPACITY PLAN

2015/16

1. Introduction

1.1 The ESHT plan reflects the work undertaken by the System Resilience Group and is part of a whole systems approach to managing periods of increased pressure and establishing sustainability for both urgent care and elective activity throughout the year.

This plan sets out the Trusts response to managing variations in non-elective demand whilst ensuring capacity to maintain the delivery of planned care standards.

It is accepted that these pressures may occur at any time throughout the year and this plan will be activated by the Executive Team when it is considered appropriate to the operational circumstances.

1.2 The aim of the Operational Resilience and Capacity Plan (ORCP) is to ensure:

- Seamless, safe & timely care is provided despite variations in demand.
- Delivery of its contracts, national and local operational quality and operational standards and targets.
- Best use of available resources internally and in the local health economy.
- Robust escalation arrangements and processes are in place and understood and embedded as part of the whole systems response to significant operational pressures.

2. The Plan

The operational model is a key component of the overall plan. Decisions must be made in a structured way and communication must be consistent, both internally and external to the Trust.

Capacity and escalation planning is key to understanding the steps needed to manage variations in demand and service implications. Clear guidance of the actions to be taken are laid out in both the Trust's Escalation Plan (see Appendix 1) and the Trust and Business Continuity Plans (BCPs) which can be accessed via the Trust Intranet.

A defined forward planning and decision making framework is highlighted in the plan to ensure coordination and an effective response.

The plan is aligned to the East Sussex Whole System Surge Plan which is being led by the Hastings and Rother CCG management lead.

3. Operational Readiness

3.1 Executive and Operational Lead

The Chief Operating Officer (COO) is the lead for developing the Trust's Operational Resilience and Capacity Plan. It is developed with engagement from all clinical and support areas within the Trust and sensitive to discussions with the wider health and social care community.

Engagement with staff in respect of ward moves, service redesigns and patient pathway changes that support operational resilience are subject to a communication plan developed by the Communication Team.

The COO or Deputy COO is responsible for leading any business continuity incident that arises from operational resilience, including infection outbreaks and inclement weather.

3.2 Managing Capacity

Trust forward planning and monitoring will be developed and managed through a senior operational group chaired by the COO.

The whole systems operational group meet via conference call weekly to discuss delayed transfers of care (DTCs) and plans to reduce these as well as whole system demand and capacity issues. There continues to be a drive to reduce the number of DTCs within both hospital sites and reflects the commitment from all organisations involved to work together in new and different ways to ensure that the number of patients delayed is minimised and that any associated risk is shared across all organizations.

The Whole Systems Task Group (WSTG) will be convened if deemed necessary by the COO or his/her nominated deputy (Executive Director out of hours) as per the Whole Systems Escalation process (WSEP).

The decision to open or close identified escalation beds will be agreed by the COO or nominated deputy (or Executive Director out of hours) but only after the following action has been taken:-

- Discussion between Clinical Units at General Manager/ Head of Nursing level to ensure communication about opening additional capacity is agreed with assurances around supporting staffing plans.
- A plan for de-escalation is agreed.
- Clear review and governance arrangements throughout escalation and de-escalation are agreed and signed off by the Clinical Director/ Head of Nursing/GM.

The bed utilisation plan for next day elective admissions will be formulated in the previous day Site Meetings.

The Trust and Clinical Unit/Department BCPs will be used when adverse events occur. This is a separate process from major incident planning.

Management of infection control issues will be carried out at the bed conference calls. Representatives from the Infection Control Team will attend and work with the Site Team to place patients appropriately and give advice. In the event of an infection outbreak being declared BCPs will be applied. Clinical leadership will be provided by the Director of Infection Prevention & Control (DIPC), and operational leadership led by the COO.

The Clinical Unit for Surgery will maintain elective activity within planned care bed base (taking account of their own efficiency plans and increased use of Day Surgery resources) in order to achieve and maintain delivery of 18 week and Cancer access targets. It will also ensure it is able to manage any variation in non-elective demand, particularly trauma activity, within its own bed base.

The Clinical Unit for Medicine will manage any variation in non-elective activity by maintaining good patient flow and appropriate and timely discharge. However, it is recognised that even with very active discharge management, demand can be such that additional capacity may be required. The senior operational group will manage the opening of any additional capacity in-line with the Trust Escalations/Business Continuity Plans. This must take into account the likely need for flexing bed capacity, including the community and social care setting and managing capacity appropriately for infection outbreaks.

Additional capacity will be available in the following areas:-

CONQUEST

28 beds on Tressell Ward: to be managed by Urgent Care Clinical Unit.

EDGH

28 beds on Folkington Ward: to be managed by Urgent Care Clinical Unit

Bexhill Irvine Unit

12 beds

The Theatres and Clinical Support Clinical Unit will manage any variation in demand on their services. They will ensure capacity is put in place to maintain good patient flow and appropriate and timely discharge and the delivery of all Trust access targets. The Clinical Unit will also support the opening of additional capacity and special measures to maintain services during periods of Infection outbreaks.

3.3 Site Management

The Site Manager at Conquest Hospital and Eastbourne DGH will coordinate elective and emergency patient flow. There will be regular meetings on each day at which senior representatives from all clinical and support services will attend. In addition, they will deal with site issues.

Staffing issues are the responsibility of the Heads of Nursing and Ward Managers within the Clinical Units during the hours of 8.00 am – 4.00 pm, and will be overseen and appropriate actions taken by the Site Team outside of these hours.

In escalation (amber onwards) there are four across site bed conference calls held at 09.30,12.00, 15.00 &17.30 hours .Operational staff use a task list (contained within the Escalation Plan which gives guidance on internal triggers & actions required at times of escalation.

The Whole System Operational Resilience Plan has been developed by the CCG which will support the Trust in its management of capacity pressures. The policy includes triggers for escalation and incorporates interventions required to support ESHT by all local partners. This will be reinforced through the System Resilience

In addition, to ensure a timely and consistent whole system response when levels of DTCs at the Trust reach 24 and above, the escalation to the WSTG is authorised by the COO or deputy. Senior managers will report into the COO or Deputy COO on outcomes and seek support for further escalation as required. In the Out of Ours (OoHs) scenario this will be the responsibility of Executive Directors.

The COO or deputy will require updates from a nominated General Manager of the Day relating to escalation issues, with assurance that the Escalation Plan has been followed. The COO or deputy will provide support/ advice/ intervention as required. In the Out of Ours (OoHs) scenario this will be the responsibility of Executive Directors.

General communications of actions taken at the conference calls will be part of the bed report (sent out via email). The Clinical Unit representative of the Day will attend site meetings and the On Call Manager (OCM) for the day will take handover no later than 4pm. If the Trust operational status is amber or red the Executive on Call will be informed.

Actions in the bed report will be linked to the indicators and triggers in the Escalation Plan. The Site Team must communicate to all relevant staff and agencies the actions identified at the 9.30am bed conference call. This needs to take place by 10am.

General Managers and Heads of Nursing will support the Site Team by for example contacting Consultant staff, liaising with Adult Social Care and other actions as appropriate. The actions will be clear with expected outcomes and timescales for

reporting back to the Site Team.

Each morning, the Site Team will produce a list of outliers (medical and surgical specialties) for distribution to the Clinical Teams. (This will ensure that the patient's location is known). The Medical Teams and Multi-Disciplinary Teams (MDTs) will manage the outliers proactively with the aim of repatriating to appropriate specialty ward as soon as possible or ensuring appropriate and timely discharge, 7 days per week.

Actions will include:

- Stroke & trauma patients are to have direct access to specialty beds (Network and SOE assurance to be included).
- Site Team to manage all admissions irrespective of 'decision to admit' point.
- Admissions areas will not be used as in-patient areas.

A daily winter situation report (SITREP) is agreed by a designated Executive Director and reported to the TDA.

3.4 Patient Flow - Additional Support

- Named Adult Social Care (ASC) workers are allocated to all Medical Wards and meet twice weekly to do Board Rounds. This will include the Lead Nurse, Discharge Nurse(s) and the named ASC worker(s). In addition, MDTs are now attended by the ASC and Discharge Nurse. This is essential to ensuring ward staff have accurate and timely information relating to discharge planning.
- Additional medical support is in place over the weekend and Bank Holidays to review in-patients and ensure appropriate and timely discharge.
- Hospital Intervention Team (HIT) will continue to cover weekends for Accident & Emergency (A&E), Medical Assessment Unit (MAU) and Medical Short Stay Unit (MSSU) on both sites.
- Extended bed conference on Friday 9.30 am will discuss plans for Weekend and Bank Holidays, including identified patients for discharge in order to maintain patient flow. (This will require support from Primary Care and ASC).
- Additional Patient Transport Service (PTS) arrangements for known periods of high demand, for example the Christmas and New Year period, will be the subject of discussion with Commissioners. This will be led by the Whole Systems Patient Flow Manager or their nominated deputy.
- As from 1st December six day therapies will be in place for the Medical wards.

- Weekly whole systems operational meetings will be held to focus on appropriate placement of patients in the community and DTC's.

- Health and Social Care Connect (HSCC) to circulate daily information of bed availability and demand, including number of patients that have been referred and those accepted. In return, providers to ensure HSCC have provider status available by 10am each morning. This will ensure patient placements can be prioritised appropriately.

3.5 Cancellation of Surgery

In the event of significant pressure on bed and theatre capacity there may be a need to cancel planned surgery. The following process will be adhered to.

Designation of beds for the next day elective activity will be considered as part of the daily Site Team meeting with the relevant General Managers present. All Clinical Units must be represented in this planning process to ensure all patients are prioritised according to clinical need and patient safety.

Decision

- The decision to cancel a scheduled operation lies with the COO or nominated deputy. The decision will be made in conjunction with the Clinical Unit Manager, the admitting Consultant and the Site Team and after the Protocol for Cancellation of Operations has been followed.

Reporting

- The cancellation(s) will be reported as per the Referral Management Administrative Guidance.

Follow up Action

- Following cancellation of any elective operation the Clinical Unit for Surgery is responsible for ensuring that the patient is given a date either on day of cancellation or within the next two working days.

- It is the responsibility of the Admissions staff to ensure that the PAS record includes details of cancellations. This information will be taken into account should further cancellations be required.

3.6 Mortuary Services

3.6.1 The Trust currently has storage capacity as follows:

Mortuary	Permanent Body Fridge Storage	Permanent Body Freezer Storage	Additional Cold Storage Capacity	Total Potential Storage Capacity
Conquest	79	4	12	95
Bexhill Hospital	8			
EDGH	85	4	12	101
Total	164	8	24	196

There are 12 additional cold stores for supply to either site.

The Trust has good working relationships with the local funeral directors who have previously responded to requests for support in times of increased demand, including weekends and Bank Holidays. It is anticipated that this level of service will continue. December 27th – 31st will be deemed to be routine working days. Monitoring of the body stores will be undertaken on a daily basis and decisions to utilise the Eastbourne body store to support the Conquest site may be taken at times of peak demand.

3.7 Christmas & New Year Plans

The Trust will produce a document, by December 1st 2014, detailing service arrangements to enable smooth consistent service delivery during the Christmas and New Year holiday period.

3.8 Flu Pandemic Implementation Strategy

The Trust has previously provided details of its contingency plans and expert groups to facilitate integrated planning and delivery of a pandemic response with partner agencies throughout the health economy (including the CCGs, Public Health, NHS Sussex, SECAMB and local authorities).

If a pandemic occurs, as per national guidance, the Hospital Coordination Group will meet on a daily basis and business continuity will be in place. This will be led by the Emergency Planning Lead, the DIPC and Assistant Director of Infection Control.

3.9 Major Incident Escalation

The Trust has a Major Incident Plan, with contribution in the health economy Emergency Planning Groups.

4. NHS/Social Care Joint Arrangements

The development of community based services is essential to reduce dependence on the acute setting and to provide an alternative to hospital admission.

All referrals for Intermediate Care Assessment (ICA) are dealt with by a single point of access telephone number (HSCC). The referral is considered by a clinician and appropriate action taken to ensure patients are assessed for suitability to intermediate care and for a transfer to be expedited by the team as required.

A single telephone access number system (PSL) operates which takes all calls for GP emergencies and is responded to by a clinician.

The WSEP has been developed which will support the Trust in its management of bed pressures. The policy includes triggers for escalation and incorporates interventions required to support ESHT by all local partners.

The health economy is optimising arrangements for discharge into community/social care by providing 7 day a week out of hour's access to community and social care teams.

Actions are being taken to minimise inappropriate attendances through alternative routes. CCG led communications across the county are in place.

5. Critical Care Services

ESHT has the funded capacity for 11 Level 3 Critical Care beds (Conquest 6, EDGH 5) and 8 Level 2 Critical Care beds (Conquest 5: EDGH 3). This capability can be flexed to meet demand. Flexibility to manage demand peaks is available through overnight post-operative recovery services at Eastbourne DGH.

This service provides overnight Level 2 care in the Post Anaesthetic Care Unit within the Operating Department and enables complex elective surgery to go ahead irrespective of the bed state in ICU/HDU.

The Critical Care Outreach Team has been particularly successful since it was introduced in November 2004. The aim of this team is to provide support, both clinically and educationally, to the ward staff and junior doctors in order that patients may be prevented from requiring Level 2 or Level 3 support in the intensive care units. This level of support has prevented a number of admissions to the units and will continue throughout the year. It also has a crucial role in following up patients discharged from critical care and helping to avert re-admissions.

The Critical Care Delivery Group will continue to meet to steer the direction of critical care services for the Trust.

The Sussex Critical Care Network is well established. The Critical Care Units

commence further bed exploration outside the transfer network for Critical Care beds once all potential 'in network placements' have been exhausted.

Critical Care Reporting Arrangements

The impact of pressures on the critical care bed state is reported in the following ways:

- Cancelled operations due to lack of an ITU bed are reported through the Theatre Information System.

- Use of extra non funded beds or any change in category (from Level 2 to Level 3) are reported through the Ward Watcher System and reported by the Critical Care Audit Nurse to the Critical Care Delivery Group.

- Transfers of patients to other Critical Care Units are recorded on the Critical Care Transfer Form. The clinical matron/general manager for critical care will be informed and will in turn inform the Chief Executive via the Chief Operating Officer.

  Out of hours site managers are informed who will escalate information to the executive team via the On Call Manager.

- Critical care level 2&3 beds are declared through Unify to SHA on a daily basis.

All transfers out of our Network will be reported to the relevant Chief Executive and Regional Director.

Escalation of Critical Care Services

In the event that there is insufficient funded capacity to meet the demand for critical care services, the following actions will be taken:

- Unfunded bed(s) will be utilized in the first instance. A clinical decision will be required as to whether the existing patients or the patients requiring admission would be more appropriately managed in another critical care facility.

- Patients can be cared for and ventilated in the theatre recovery area for a limited period of time, whilst arrangements are made to either transfer a patient from critical care to a general ward, or arrange to transfer a patient to another critical care unit within ESHT.
- In the event that there are no beds within ESHT; other critical care units within the local transfer Network will be approached for a bed. If necessary, the patient will remain in theatre recovery until a bed is located.

- In the event that it is considered necessary to undertake a transfer; arrangements are in place via the Policy for the Management of

Critical Care Beds and Sussex Critical Care Network Inter-hospital Transfer Protocol. This will be a Consultant-to-Consultant referral. The Chief Executive will be informed of this decision.

- It is possible to ventilate a patient in the Accident and Emergency Department (in life threatening circumstances only); until either theatre recovery or the critical care unit is able to take the patient.

- Discussions will be held between the critical care consultants and the clinical matron or unit managers to assess whether it is possible to mobilize nursing staff from one unit to another if the risk in moving patients is too great.

6. Preventative measures

The Trust is participating in the NHS Flu Immunization strategy for seasonal flu, including the strategic purchasing of the recommended flu vaccine.

The staff vaccination programme will run with a series of clinics arranged across all Trust sites.
Occupational Health will prioritize over subsequent forth coming months. A variety of internal communications will be used to advertise and promote clinics.

The Trust's Communication Department co-operates with communication leads from the local CCGs and Social Services to ensure that the media relation plans for winter are agreed and in place, including the campaigns, 'The Earlier the Better'.

7. Communications

The Head of Communications will ensure that all external communications are directed at the right areas and that local communities are aware of how they can help their local NHS.

The Trust co-operates with communication leads from the local CCGs, ASC & SECAMB to ensure that the media relations plans for winter are agreed and in place. This ensures a Whole Health economy approach and a consistent message throughout East Sussex.

There are established procedures for handling reactive media relations and adhoc adverse incidents/crisis for some time. Robust out-of-hours on-call arrangements are in place for Directors and Senior Managers.

The Trust provides proactive information to the TDA, CCGs and LHRP via a daily SITREP and capacity management tool. The Trust will use appropriate spokespersons including the Chief Executive, COO, Director of Nursing, Medical Director and Clinical Directors.

The Director of Strategic Development and Assurance, together with the Head of Communications, takes the lead in the event of adverse publicity about services, supported, if necessary, by the Chief Executive, COO, Chairman, the Executive Team and Board Directors.

A communications infrastructure is in place for supporting all Trust work. It includes team briefing, core brief, e-mail, Extranet and Internet facilities to help the timely cascading of information.

Front line staff must report operational problems or issues to their line managers. Any media contacts are reported to the Head of Communications.

Staff will be kept informed about preparations for winter through the existing communications infrastructure. This guidance will be made widely available on the Trust's intranet for all staff to access, or for internal service cascade. CCG, ASC and SECAMB information re support available from other departments and agencies are circulated when available.

East Sussex Healthcare NHS
NHS Trust

ADMINISTRATIVE GUIDANCE NOTES

Escalation Plan

Written/Produced By:	Title/Directorate	Date:
Pauline Butterworth	Deputy Chief Operating Officer	August 2014

Person Responsible for Monitoring Compliance &Review	Chief Operating Officer
Signature & Date	

Multi-Disciplinary Evaluation / Approval

Name	Title/Specialty	Date:

Ratification Committee

Issue Number (Administrative use only)	Date of Issue& Version	Next Review Date	Date Ratified	Name of Committee/Board/Group
	August 2014 V7			**CLT**

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Escalation Plan

1. Background

The NHS Commissioning Board (NHS England) Emergency Preparedness Framework 2013 states “NHS funded organisations must: set out how surges in demand will be managed.” The trust has developed an Operational Resilience and Capacity Plan which triggers specific measures when the Trust is operating beyond normal capacity.

2. Purpose of Guidance:

The purpose of the plan is to ensure that the Trust maintains patient safety and service delivery, when experiencing surges in demand. This is vital in maintaining public confidence and the reputation of the Trust. It is to ensure that all disciplines are clear on the actions required at various degrees of pressure and that processes are in place to enable an efficient response.

3. Process to Follow:

Cross site operational conference calls are held three times a day (9.30, 12.00, 15.00 and 17.30 hours). A bed report and action plan is provided immediately after each operational conference call detailing the current and predicted situation within the organisation, taking into consideration other ‘whole system’ issues.

A decision is made about the operational status, based on internal KPIs and judgment about expected pressures on the day. Intelligence from other providers may require us to move our services to escalation if the whole system is under significant pressure.
The operational status of the organization is based on 4 levels:

- Escalation Level 1 (Normal service - Green)
- Escalation Level 2 (Mitigation of Escalation– Amber)
- Escalation Level 3 (Whole System Compromised – Red)
- Escalation Level 4 (Severe Pressures and failure of actions- BLACK)

The plan is in operation at all times and should generally operate at level 1, when the Trust is in a steady state. The decision as to the current level is based on the factors/ triggers detailed below.

Changes to the response level will be communicated via the ‘bed report and action plan’ (please refer to Appendix 1) sent via email following each conference call. Additional communications will be discussed at the conference calls as required as per plan (Appendix 1), according to level of escalation.

The four levels of response are designed to increase operational resources in line with demand, to cope with periods of high activity and maintain the service provision.

4. Escalation Levels

Escalation Level 1- Normal - Green

The Trust is operating normally. Demand is at expected levels and being managed effectively. Resourcing is satisfactory and therefore workload is considered acceptable. There are no excessive demands on the Trust due to weather, significant events, NHS capacity or technology issues. **The Trust is meeting its key performance targets.**

Escalation Level 2 – Mitigation of Escalation – Amber

Five or more of the following factors/triggers need to be met before declaring this level:

- Over 10 **confirmed** A&E Breaches across site in previous 12 hours
- Less than 10 beds closed per site
- <6 beds available on MAU or <2 beds on SAU, per site before 10.00am hrs
- Medical outliers >15 but <30 per site
- <10 additional beds open per site
- DTC's across site between <24 but <30
- Difficulty admitting TCI's but no cancellations on day
- Nursing Staffing issues - <10 staff per shift, per site
- Medical staffing issues affecting front end or service delivery e.g. assessment times in A&E >4hrs<6hrs
- Up to 5 Ambulances unable to off load within 30 minutes within a defined 8 hour period (0.00hrs_08.00hrs, 08.00hrs_16.00hrs. 16.00hrs-00.00hrs)
- Less than 10 additional beds open across site
- Less than 1, level 3 critical care beds per site
- Less than 20 discharges identified per site (potential & confirmed)

Actions required to be taken at this level are in appendix 1

Escalation Level 3 – Whole System Compromised – Red

Six or more of the following factors/triggers need to be met before declaring this level:

- A&E flow KPIs are not being achieved
- Over 20 **confirmed** A&E breaches across site in the previous 6 hours
- No beds available in MAU/SAU
- More than 10 beds closed per site
- More than 20 additional beds open per site
- DTC's across site above 30
- Medical outliers >30
- Electivecancellations24hrspreviously
- TCI's cancelled on the day
- Nurse Staffing issues - >10 nursing staff per shift, per site
- Medical staffing issues affecting front end or service delivery, e.g. assessment times in A&E >6 hours
- More than 6 ambulances unable to offload within 30 minutes within a defined 8 hour period (0.00hrs -08.00hrs, 08.00hrs -16.00hrs, 16.00hrs-00.00hrs)
- No level 3 critical care beds per site

- Less than 5 discharges identified per site
- No beds available on MAU or SAU across site

Actions required to be taken at the level are in appendix 1.

Escalation Level 4–Severe Pressures and failure of

actions- BLACK Factors/Triggers at level 4 are:

- When RED triggers have continued for over 72 hours and not expected to resolve within the next 24 hours, the Chief Operating officer/Deputy must be informed, so that they can take a decision about whether to liaise with the Whole Systems Group *for consideration of escalation* to BLACK status. (Director on call out of hours). Black status may trigger a decision by the Chief Operating Officer or nominated deputy to declare the Trust to be in Business Continuity, and implement the BC plans. (See Trust policy). However, the Chief Operating Officer or their nominated deputy may decide that on the balance of all information available, red status can continue for a defined period of time, but with agreed short review times.

- If the Trust is unable to maintain normal services (normal can include operating at red status) due to adverse incidents, (e.g. severe weather conditions, infection outbreak, extraordinary depletion of resources, loss of priority fuel supplies) Business Continuity will likely be called if there is no obvious resolution within 4hours. In these cases, business continuity plans will be activated (see Trust and Divisional business continuity plans). Business Continuity meetings must have a note taker (loggist) assigned and a full pack of notes and information relating to the management of the incident must be maintained and kept for evaluation once BC has been stood down.

- Inform Chief Executive

5. Co-ordination & Assessment of information

- The General Manager for Urgent Care or nominated deputy will chair the daily bed conference calls where the assessment of triggers will be carried out and the current operational level agreed. The Chief Operating Officer/Deputy/Exec on call will be advised when escalation to red occurs. In hours, escalation will be to the Deputy COO if the COO is not available. This is to ensure senior overview of operational pressures is maintained at all times.

- Current and any change in operational status be disseminated via the 'Bed report and action plan' by email, following every conference call. In times of extreme pressure, additional information will be circulated via communications team.

- The daily bed conference calls will be the focal point for discussions and actions relating to escalation. If business continuity is implemented, the clinical site management offices will be the central hub for communication and meetings.

- The Chief Operating Officer/Deputy will consider additional meetings and frequency as required.

- The escalation process and bed reports are widely published. Every member of staff has a responsibility to know the current level of status and what action is required of them.

ERP LEVEL1- NORMAL SERVICE				
	ACTION	**RESPONSIBLE**	**IMPACT**	**REVIEW**
ERP LEVEL 1 - NORMALSERVICE	**Staffing**		**PREVENTATIVE ACTIONS REQUIRED TO SUSTAIN PERFORMANCE AND PATIENT CARE**	**REPORT BACK TO THREE TIMES DAILY CROSS SITE CONFERENCE CALLS**
	Highlight daily staffing shortages to CM's to report back within an agreed time frame	CSM's/CM's		
	Weekend staffing cover required for forward planning, report back within an agreed timeframe	CM's/CSM's		
	Staffing cover for bank holiday period required for forward planning, report back within an agreed time frame	CM's/CSM's		
	Patient Flow, Ward Rounds, Discharges			
	Limited discharges-escalate to GM's/HONs	CSM's/CM's/GM's		
	Identify early discharges, expedite confirmed discharges using the Discharge Lounge	CSM's		
	Potential discharges- clarify plan, and action as necessary	CSM's/ Ward Teams		
	Ensure all ward rounds have commenced by 9.30am,escalate to GM's if not achieved	CSM's/GM's		
	Deliver Discharge pro forma & reinforce need for info to be available by 12pm	CSM's		
	Reinforce discharge benchmark for each ward	CSM's/ HON		
	Patient Flow-A&E			
	Monitor Pt flow at front end, liaise with A&E leads for hourly SitRep	CSM's both sites		
	Highlight all potential breaches at 2.45 hours that do not have a plan	A&E Leads/CSM's both Sites		
	Highlight all potential breaches at 3.15hours that do not have a plan	CSM's Both sites to CM		
	A&E Lead to advise CSM's if Ambulances cannot be offloaded>15 mins	A&E Leads/CSM's both Sites		
	Escalate all ambulance queuing issues to HoN/GM Urgent care, if wait times likely to exceed 30mins	CSM's Both sites/HON		
	Report >3 ambulances waiting to off load at any given time to GM	CSM's Both sites/ HON		
	Escalate all unresolved site issues to GM	CSM's Both sites/ HON		
	Critical Care Beds			
	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSM's both sites /ITU Consultants		
	Infection Control			
	ICN review of side room provision (Monday & Wednesday)	ICN both sites/CSM's		
	ICN review of specific infection control issues	ICN both sites/CSM's		
	Whole Systems			
	Weekly Operational Conference Call	GM Out of hospital DN/CM,CSD		
	Board Rounds- Mon AM/Wed PM	SM Urgent		

ERP Level1 – Normal Service - Green - Notes
1. The Trust is operating normally
2. Demand is at expected levels and being managed effectively
3. Resourcing is satisfactory therefore work is considered and acceptable
4. There are no excessive demands on the Trust due to weather, significant events NHS Capacity or technology issues
5. The Trust is meeting its key performance targets

ERP Level 2 five triggers need to be met for declaring this level:					
	TRIGGERS	**ACTIONS**	**RESPONSIBLE**	**IMPACT**	**REVIEW**
ERP LEVEL 2 - CONCERN	**Staffing**	**Staffing**		**PREVENTATIVE ACTION REQUIRED TO SUSTAIN PERFORMANCEAND PATEINT CARE**	**REPORT BACK TO THREE TIMES DAILY CROSS SITE CONFERENCE CALL**
	Staffing issues-<10 nursing staff per shift, per Site	Highlight daily staffing shortages to HON's to report back within an agreed time frame	CSM's/HON		
		Weekend staffing cover required for forward planning, report back within an agreed timeframe	HON/CSM's both sites		
		Staffing cover for bank holiday period required for forward planning ,report back within an agreed timeframe	HON/CSM's both sites		
	Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E>4hoursbut<6hours	Review Medical Staffing Cover for key areas	GM'S/ADs		
	Patient Flow, Ward Rounds, Discharges	**Patient Flow, Ward Rounds, Discharges**			
	<6bedsavailableonMAUor<2beds available on SAU across the Site	Early discharges, utilize discharge lounge in order to create capacity in gateway areas	CSM's/MAU/SAU Teams		
	<20discharges(potential and confirmed) Identified per Site	Limited discharges- escalate to all GMs and HoNs.	CSM's/HON/GM's		
		Identify yearly discharges, expedite confirmed discharges using the Discharge lounge	CSM's both Sites		
		Potential discharges-clarify plan, expedite as able	CSM's/ Ward Teams		
		Ensure that all ward round shave commenced by 9.30am,escalatetoGM'sif not achieved	CSM's both sites/ GM's		
		Deliver Discharge proforma to all wards and reinforce need for info to be available by12pm	CSM's both sites		
		Reinforce discharge benchmark for each ward	CSM's both sites/ GM's		
	Medical outliers>15but<30perSite	Identify medical outliers, ensure robust management plan in place	Medical Teams		
	<10bedsclosedperSite	Review rationale for closed beds and report at cross site conference call	CSM's both Sites		
	<20additionalbedsopenperSite	Review rationale for additional open beds and report at cross site conference call	CSM's both Sites		
		Review cancellation of urgent/ cancer stream TCI's	CSM's/GM's		

ERP LEVEL 3 - CONCERN	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
	Patient Flow- A&E	**Patient Flow-A&E**		PREVENTATIVE ACTION REQUIRED TO SUSTAIN PERFORMANCE AND PATEINT CARE	REPORT BACK TO THREE TIMES DAILY CROSS SITE CONFERENCE CALL
	Over 10 confirmed A&E breaches across the site in the previous 12 hours	Monitor Pt flow at front end, liaise with A&E leads for hourly Sit Rep	CSM's both sites		
		Contact PSL/CCG(GP's),IC24: Current operational status	CSM's both Sites		
		Highlight all potential breaches at 2.45 hours that do not have a plan	A&E Leads/CSM's both Sites		
		Highlight all potential breaches at 3.00 hours that do not have a plan	CSM's Both sites		
	Up to 5 Ambulances unable to offload within 30 minutes within a defined 8 hour period(0.00Hrs- 08.00Hrs,08.00Hrs-16.00Hrs,16.00Hrs-00.00Hrs)	A&E Lead to advise CSM's if Ambulances cannot be off loaded within 15mins	A&E Leads/CSM's both Sites		
		Escalate all ambulance queuing issues to HON Urgent Care if wait times likely to exceed 30mins	CSM's Both sites to HON		
		Report>3ambulances waiting to offload at any given time to HON Urgent Care.	CSM's Both sites to CM,CSD		
		Liaise with SECamb regarding current operational status	CSM/HoN		
		Escalate all unresolved site issues to CM	CSM's Both sites to CM		
	Critical Care Beds	**Critical Care Beds**			
	<1 Level 3 critical care bed per Site	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSM's both sites liaise with ITU Consultants		
	Infection Control	**Infection Control**			
	Infection Control Issues impacting on bed capacity	ICN review of side room provision(Monday& Wednesday)	ICN both sites to CSM's		
		ICN review of specific infection control issues	ICN both sites to CSM's		
	Whole Systems	**Whole Systems**			
	DTC's across Site> 24but<30	Weekly Operational Conference Call	GM Out of Hospital		
		Board Rounds-Mon AM/ Wed PM	SMs Urgent care		

ERP Level 2 – Concern - Notes
1. Additional Attendees at cross site conference call–Assistant Director of Nursing, GM'S
2. Out of Hours-GM to chair the cross site conference calls and attend either hospital site as required. GM to remain on site till 7pm at least.

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ERP Level 3 - Six or more of the following triggers need to be met before declaring this level:					
ERP LEVEL 3 – SEVERE PRESSURE	**TRIGGERS**	**ACTIONS**	**RESPONSIBLE**	**REVIEW**	**IMPACT**
	Staffing	**Staffing**		PREVENTATIVE ACTION REQUIRED TO SUSTAIN PERFORMANCE AND PATEINT CARE	REPORT BACK TO THREE TIMES DAILY CROSS SITE CONFERENCE CALL
	Staffing issues- >10 nursing staff per shift, per Site	Highlight daily nursing shortages to HONs to report back within an agreed time frame, review use of specialist nurses & review use of alternative staffing groups	CSM's/ HONs		
		No short notice leave to be granted<48hours/review non essential training, consider re-scheduling	Deputy COO, ADs, and ADNs		
		Weekend staffing cover required for forward planning, report back within an agreed timeframe	HON to CSM's both sites		
		Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe	HON to CSM's both sites		
	Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E>6 hours	Re-deploy medical staff to the front end	Deputy COO/ADNs/GMs		
		Medical study leave/ training sessions to be reviewed & stopped as necessary	Deputy COO/ADNs/GMs		
		Audit half days to be cancelled	Clinical Leads/GMs		
		Consider use of locums	Deputy COO/ADNs/GMs		
	Patient Flow, Discharges	**Patient Flow, Ward Rounds, Discharges**			
	No beds available on MAU Or SAU across the Site	Early discharges, utilize discharge lounge in order to create capacity in acute access points	CSM's/ Ward Teams		
	Lessthan5discharges identified per Site	Limited discharges- escalate to all GMs/HONs/ADNs	CSM's/ADNs/HONs//GM's		
		Identify early discharges, expedite confirmed discharges using the Discharge lounge	SM's both Sites		
		Potential discharges- clarify plan, and action as necessary	SM's/Ward Teams		
		Continue Grand Rounds	Clinical leads		
		Deliver Discharge preform a & reinforce benchmark, info to be available by12pm	SM's both sites		
		Reinforce discharge benchmark for each ward	SM's both sites HONs		

	TRIGGERS	ACTIONS	RESPONSIBLE	REVIEW	IMPACT
ERP LEVEL 3 – SEVERE PRESSURE	**Patient Flow**	**Patient Flow-Bed Capacity**		PREVENTATIVE ACTION REQUIRED TO SUSTAIN PERFORMANCE AND PATEINT CARE	REPORT BACK TO THREE TIMES DAILY CROSS SITE CONFERENCE CALL
	More than10 beds closed per Site	Review rationale for closed beds and report at crosssite conference call	CSM's both Sites		
	More than 20 additional beds open per the Site	Review rationale for additional open beds and report at cross site conference call	CSM's both Sites		
	TCI's cancelled on the day	Review plan going forward for TCI's except urgent and cancer stream. No cancellations without agreement of COO/Deputy COO	CSM's both Sites		
	Elective cancellations 24 hours previously				
	Patient Flow- A&E	**Patient Flow-A&E**			
	A&E flow KPIs not being met	Monitor Pt flow at front end, liaise with A&E leads for hourly Sit Rep	CSM's both sites		
	Over 20 confirmed A&E Breaches across the Site in the previous 6 hours	Contact HERMES/PCT(GP's),South East Health recurrent operational status, request alternatives pathways/admission avoidance	CSM's both Sites		
		Highlightallpotentialbreachesat2.45hoursthatdo not have a plan	A&E Leads to CSM's both Sites		
		Highlightallpotentialbreachesat3.15hoursthatdonothavea plan	CSM's Both sites/HON		
		Open additional bed capacity including day surgery & other clinical areas	CSM's both sites		
	More than 6 Ambulances unable to off load within 30 minutes within a defined 8 hour period(0.00Hrs-08.00Hrs,08.00Hrs-16.00Hrs,16.00Hrs-00.00Hrs)	A&E Lead to advise CSM's if Ambulances cannot be offloaded> 1hour,implementcohorting	A&E Leads to CSM's both Sites		
		Escalate all ambulance queuing issues to GM/HON Urgent care if wait times exceed 30mins	CSM's Both sites/HON		
		Report >3 ambulances waiting to off load at any given time to CM	CSM's Both sites/HON		
		Liaise with SECamb regarding operational status, consider Divert	COO/Deputy COO/ AD UCD		
		Escalate all unresolved site issues to GMs/HONs/Deputy COO	CSM's Both sites/ HON		

ERP LEVEL 3- SEVERE PRESSURE	TRIGGERS	ACTIONS	RESPONSIBLE	REVIEW	IMPACT
	Critical Care Beds	**Critical Care Beds**		ACTION REQUIRED TO SUSTAIN PREVENTATIVE PERFORMANCE AND PATEINT CARE	REPORT BACK TO THREE TIMES DAILY CROSSSITE CONFERENCE CALL
	No Level 3 critical care beds per site	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSM's both sites liaise with ITU Consultants		
	Infection Control	**Infection Control**			
	Infection Control Issues impacting on bed capacity	ICN review of side room provision (Monday & Wednesday)	ICN both sites to CSM's		
		ICN review of specific infection control issues	ICN both sites to CSM's		
	Whole Systems	**Whole Systems**			
	DTC's across Site>30	Increase Operational Conference Calls to daily	GM Out of Hospital with Whole System		
		Board Rounds – Mon AM/Wed PM	CM's		
		Chief Operating Officer/Deputy to inform whole systems task group	COO/Deputy COO		

Notes:
1. Additional attendees at Bed Meetings-, COO &/ or Deputy COO, ADNs Senior Facilities representation 2. Representation from A&E Leads
3. ASC & CCG Provider to be present at 9.30 hours and12.00hrs bed meetings
4. Out of Hours- GM to attend bed meeting and either Hospital Site as required. Must remain on site until 10pm at least.
5. Out of Hours-Exec on Call to chair bed meetings and attend either Hospital Site as required

ERPLevel 4 -Triggers:

1. **When the RED Triggers continue for over 72hours and are not expected to resolve within the next 24hours**.COO or deputy to Liaise with Whole Systems Task Group for consideration to elevate to Black Status:
2. Implement Business Continuity Plans due to inability of the Trust to maintain normal service delivery due to adverse events e.g severe weather conditions, infection outbreak, extraordinary depletion of resources, loss of priority fuel supplies-in these cases business continuity plans will be activated

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERP LEVEL 4 – POTENTIAL SERVICE FAILURE	**Staffing**	**Staffing**		POTENTIAL SERVICE FAILURE WHICH WILL AFFECT PERFORMANCE AND PATIENT CARE	REPORT BACK TO CROSS SITE CONFERENCE CALL
	Staffing issues- >10 nursing staff per shift, per Site	Highlight daily nursing shortages to HONs to report back within an agreed timeframe, review use of specialist nurses & review use of alternative staffing groups	CSM's/ HONs		
		No short notice leave to be granted<48hours/ review non essential training, consider re-scheduling	Deputy COO ADs/ ADN's/GMs		
		Weekend staffing cover required for forward planning, report back within an agreed timeframe	HONs to CSM's both sites		
		Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe	HONs to CSM's both sites		
	Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E>6 hours	Re-deploy medical staff to the frontend	GMs		
		Medical study leave/ training sessions to be reviewed& stopped as necessary	GMs/Clinical Leads		
		Audit half days to be cancelled	Clinical Lead		
		Consider use of agency staff	GMs		
	Patient Flow, Ward Rounds, Discharges	**Patient Flow, Ward Rounds, Discharges**			
	Less than 5 discharges identified per Site	Limited discharges – escalate to all GMs & HONs	CSM's/ HONs/GM's		
		Identify early discharges, expedite confirmed discharges using the Discharge lounge	CSM's both Sites		
		Potential discharges-clarify plan, and action as necessary	CSM's/ Ward Teams		
		Instigate Grand Rounds	Clinical Lead/GMs		
		Deliver Discharge proforma &reinforce benchmark, info to be available by12pm,reinforce discharge benchmark	CSM's both sites		
		Cancel all TCI's	COO/Deputy COO/ GMs		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERP LEVEL 4 – POTENTIAL SERVICE FAILURE	**Patient Flow**	**Patient Flow-Bed Capacity**		POTENTIAL SERVICE FAILURE WHICH WILL AFFECT PERFORMANCE AND PATIENT CARE	REPORT BACK TO CROSSSITE CONFERENCE CALL
	No beds available on MAU or SAU across the Site	Early discharges, utilize discharge lounge in order to create capacity in gateway areas	CSM's/ Ward Teams		
	Morethan10 beds closed per Site	Review rationale for closed beds and report at cross site conference call	CSM's both Sites		
	More than 20 additional beds open per the Site	Review rationale for additional open beds and report at cross site conference call	CSM's both Sites		
	TCI's cancelled on the day	Review plan going forward for TCI's except urgent and cancer stream	CSM's both Sites		
	Elective cancellations 24 hours previously				
	Patient Flow- A&E	**Patient Flow-A&E**			
	A&E performance is below 98%	Monitor flow at front end, liaise with A&E leads for hourly Sit Rep	CSM's both sites		
	Over 20 breaches across the site in the previous 6 hours, all extra capacity beds open	Highlight all potential breaches at2.45hours that do not have a plan	A&E Leads to CSM's both Sites		
		Contact CCGs (GP's),South East Healthcare: current operational status, request alternative pathways/ admission avoidance	CSM's both Sites		
		Highlight all potential breaches at 3.15hours that do not have a plan	CSM's Both sites to HoN/GM		
	More than 6 Ambulances unable to off load within 30 minutes within a defined 8 hour period (0.00Hrs-08.00Hrs, 08.00Hrs-16.00Hrs, 16.00Hrs-00.00Hrs)	Escalate all ambulance queuing issues to HON/GM urgent Care and Deputy COO if wait times exceed 30mins	CSM's Both sites to HoN/GM		
		Report >3 ambulances waiting to off load at any given time to HoN Acute medicine and patient Flow Manager.	CSM's Both sites to HoN		
		Liaise with SECamb regarding operational status, consider Divert	Chief Operating Officer/Deputy COO		
		Escalate all un-resolvable site issues to Deputy COO	GMs/HONs		
	Critical Care Beds	**Critical Care Beds**			
	No Level 3 critical care beds per site	Confirm plan for Patients who are suitable to move from critical care areas ITU/HDU	CSM's both sites liaise with ITU Consultants		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERP LEVEL 4	**Infection Control**	**Infection Control**		POTENTIAL SERVICE FAILURE	REPORT BACK TO CROSS SITE CONFERENCE CALL
	Infection Control Issues impacting on bed capacity	ICN review of side room provision (Monday & Wednesday)	ICN both sites to CSM's		
		ICN review of specific infection control issues	ICN both sites to CSM's		
	Whole Systems	**Whole Systems**			
	DTC's across Site >30	Daily Operational Conference Call	GM Out of Hospital		
		Board Rounds-Mon AM/Wed PM-add in Friday	HoNs		
		Daily Whole Systems Task Group	Chief Operating Officer/Deputy		

Notes:

1. Additional attendees at Bed Meetings-COO/Deputy COO, ADNs /Director of Nursing
2. Facilities representation
3. Representation from A&E Leads
4. In Hours– COO/Deputy COO (AD UCD if COOs not available) **Out of Hours, Exec Director on call.**
5. Out of Hours-GM to attend bed meeting and either Hospital Site as required. Must remain on site until 10pm at least.
6. Out of Hours-Exec on Call to chair bed meetings and attend either Hospital Site as required
7. For additional actions please refer to Trust Business Continuity Plan

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board Meeting
Agenda item:	12
Subject:	NHS Constitution Update
Reporting Officer:	Lynette Wells Company Secretary

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

Purpose:

To provide an update on the revised NHS Constitution and Handbook to the NHS Constitution which have been updated to reflect current policy and legislation and to make the Constitution a more practical document. A copy of the revised document is attached.

Introduction:

In his inquiry into the failings at Mid-Staffordshire, Sir Robert Francis QC recommended amendments to the NHS Constitution based on:

- prioritising patients
- protecting patients from avoidable harm
- providing assistance that patients need
- staff compliance with guidance

Each of these recommendations has been fully accepted and implemented within the new NHS Constitution.

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

Standards of care

The NHS Constitution now reflects a series of fundamental standards, below which standards of care must never fall. In April 2015, the way hospitals are inspected was changed with the Care Quality Commission becoming regulators of fundamental standards. Failure to meet these standards, and an inability to meet the high standards patients expect and deserve, will result in decisive action to protect patients.

Physical and mental health

To close the gap between physical and mental health, the NHS Constitution makes it clear each are equally important. This is an important part of the NHS Principles that guide the NHS in all that it does.

Armed forces

The role of the armed forces is recognised by enshrining the Armed Forces Covenant in the Constitution to ensure equal access to services.

Duty of candour
The Department of Health has also introduced a new duty of candour into the NHS Constitution, to promote a culture of openness within the NHS. The inclusion of a patient right to candour helps to achieve this.

The Handbook to the NHS Constitution provides further information on the Constitution, including detail on important policies, such as whistleblowing.

Benefits:
The aim of the Constitution is to safeguard the enduring principles and values of the NHS. The Constitution also sets out clear expectations about the behaviours of both staff and patients. It is intended to empower the public, patients and staff by setting out existing legal rights and pledges in one place and in clear and simple language. By knowing and exercising their rights the public, patients (their carers and families) and staff can help the NHS improve the care it provides.

Risks and Implications
Non-compliance with the Constitution can lead to regulatory and legal action.

Assurance Provided:
The Trust has mapped compliance against the fundamental standards of care and is raising awareness of this and the duty of candour across the organisation.

Proposals and/or Recommendations
The Trust Board is asked to review and note the revised NHS Constitution

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. The Constitution advances equality and outlines a right "not to be unlawfully discriminated against in the provision of NHS services, including on the grounds of gender, race, religion or belief, sexual orientation, disability including learning disability or mental illness or age."

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

THE NHS CONSTITUTION

the NHS belongs to us all

for England
27 July 2015

The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health.
It touches our lives at times of basic human need, when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

This Constitution establishes the **principles** and **values** of the NHS in England. It sets out **rights** to which patients, public and staff are entitled, and **pledges** which the NHS is committed to achieve, together with **responsibilities**, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities. Where there are differences of detail these are explained in the Handbook to the Constitution.

The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff. It is accompanied by the Handbook to the NHS Constitution, to be renewed at least every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal are legally binding. They guarantee that the principles and values which underpin the NHS are subject to regular review and recommitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.

1. Principles that guide the NHS

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. These values are set out in the next section of this document.

1. The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. Access to NHS services is based on clinical need, not an individual's ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. The NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

4. The patient will be at the heart of everything the NHS does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. As part of this, the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces, reservists, their families and veterans are not disadvantaged

in accessing health services in the area they reside. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. The NHS is accountable to the public, communities and patients that it serves. The NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

2. NHS values

Patients, public and staff have helped develop this expression of values that inspire passion in the NHS and that should underpin everything it does. Individual organisations will develop and build upon these values, tailoring them to their local needs. The NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.

Working together for patients. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

Respect and dignity. We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

Commitment to quality of care. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

Compassion. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

Improving lives. We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Everyone counts. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

3a. Patients and the public – your rights and NHS pledges to you

Everyone who uses the NHS should understand what legal rights they have. For this reason, important legal rights are summarised in this Constitution and explained in more detail in the Handbook to the NHS Constitution, which also explains what you can do if you think you have not received what is rightfully yours. This summary does not alter your legal rights.

The Constitution also contains pledges that the NHS is committed to achieve. Pledges go above and beyond legal rights. This means that pledges are not legally binding but represent a commitment by the NHS to provide comprehensive high quality services.

Access to health services:

You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

You have the right to access NHS services. You will not be refused access on unreasonable grounds.

You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.

You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.

You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.

You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.

The NHS also commits:

- to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution (pledge);
- to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered (pledge); and
- to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them (pledge).

Quality of care and environment:

You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.

You have the right to be cared for in a clean, safe, secure and suitable environment.

You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.

You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.

The NHS also commits:

- to identify and share best practice in quality of care and treatments (pledge).

Nationally approved treatments, drugs and programmes:

You have the right to drugs and treatments that have been recommended by NICE[1] for use in the NHS, if your doctor says they are clinically appropriate for you.

You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.

You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.

1 NICE (the National Institute for Health and Care Excellence) is an independent organisation producing guidance on drugs and treatments. 'Recommended for use by NICE' refers to a type of NICE recommendation set out in legislation. The relevant health body is obliged to fund specified NICE recommendations from a date no longer than three months from the publication of the recommendation unless, in certain limited circumstances, a longer period is specified.

The NHS also commits:

- to provide screening programmes as recommended by the UK National Screening Committee (pledge).

Respect, consent and confidentiality:

You have the right to be treated with dignity and respect, in accordance with your human rights.

You have the right to be protected from abuse and neglect, and care and treatment that is degrading.

You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests.[2]

You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.

You have the right of access to your own health records and to have any factual inaccuracies corrected.

You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.

You have the right to be informed about how your information is used.

You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.

The NHS also commits:

- to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively (pledge);
- that if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution (pledge);
- to anonymise the information collected during the course of your treatment and use it to support research and improve care for others (pledge);
- where identifiable information has to be used, to give you the chance to object wherever possible (pledge);
- to inform you of research studies in which you may be eligible to participate (pledge); and

2 If you are detained in hospital or on supervised community treatment under the Mental Health Act 1983 different rules may apply to treatment for your mental disorder. These rules will be explained to you at the time. They may mean that you can be given treatment for your mental disorder even though you do not consent.

- to share with you any correspondence sent between clinicians about your care (pledge).

Informed choice:

You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.

You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.

You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally.

You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution.

The NHS also commits:

- to inform you about the healthcare services available to you, locally and nationally (pledge); and
- to offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the range and quality of clinical services where there is robust and accurate information available (pledge).

Involvement in your healthcare and in the NHS:

You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.

You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.

You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

The NHS also commits:

- to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services (pledge);
- to work in partnership with you, your family, carers and representatives (pledge);
- to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one (pledge); and
- to encourage and welcome feedback on your health and care experiences and use this to improve services (pledge).

Complaint and redress:

You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.

You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.

You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.

You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.

You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.

You have the right to compensation where you have been harmed by negligent treatment.

The NHS also commits:

- to ensure that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely affect your future treatment (pledge);
- to ensure that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again (pledge); and
- to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services (pledge).

3b. Patients and the public – your responsibilities

The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly.

Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.

Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.

Please treat NHS staff and other patients with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.

Please provide accurate information about your health, condition and status.

Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.

Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.

Please participate in important public health programmes such as vaccination.

Please ensure that those closest to you are aware of your wishes about organ donation.

Please give feedback – both positive and negative – about your experiences and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

4a. Staff – your rights and NHS pledges to you

It is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really make the difference. High-quality care requires high-quality workplaces, with commissioners and providers aiming to be employers of choice.

All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress. Care professionals should be supported to maximise the time they spend directly contributing to the care of patients.

The Constitution applies to all staff, doing clinical or non-clinical NHS work – including public health – and their employers. It covers staff wherever they are working, whether in public, private or voluntary sector organisations.

Staff have extensive **legal rights**, embodied in general employment and discrimination law. These are summarised in the Handbook to the NHS Constitution. In addition, individual contracts of employment contain terms and conditions giving staff further rights.

The rights are there to help ensure that staff:

- have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives;
- have a fair pay and contract framework;
- can be involved and represented in the workplace;
- have healthy and safe working conditions and an environment free from harassment, bullying or violence;
- are treated fairly, equally and free from discrimination;
- can in certain circumstances take a complaint about their employer to an Employment Tribunal; and
- can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.

In addition to these legal rights, there are a number of **pledges**, which the NHS is committed to achieve. Pledges go above and beyond your legal rights. This means that they are not

legally binding but represent a commitment by the NHS to provide high-quality working environments for staff.

The NHS commits:

- to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability (pledge);
- to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities (pledge);
- to provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential (pledge);
- to provide support and opportunities for staff to maintain their health, wellbeing and safety (pledge);
- to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge);
- to have a process for staff to raise an internal grievance (pledge); and
- to encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996 (pledge).

4b. Staff – your responsibilities

All staff have responsibilities to the public, their patients and colleagues.

Important legal duties are summarised below.

You have a duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.

You have a duty to take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.

You have a duty to act in accordance with the express and implied terms of your contract of employment.

You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

You have a duty to protect the confidentiality of personal information that you hold.

You have a duty to be honest and truthful in applying for a job and in carrying out that job.

The Constitution also includes **expectations** that reflect how staff should play their part in ensuring the success of the NHS and delivering high-quality care.

You should aim:

- to provide all patients with safe care, and to do all you can to protect patients from avoidable harm;
- to follow all guidance, standards and codes relevant to your role, subject to any more specific requirements of your employers;
- to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole;
- to find alternative sources of care or assistance for patients, when you are unable to provide this

(including for those patients who are not receiving basic care to meet their needs);

- to take up training and development opportunities provided over and above those legally required of your post;
- to play your part in sustainably improving services by working in partnership with patients, the public and communities;
- to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff[3] or the organisation itself, at the earliest reasonable opportunity;
- to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis, and their individual care and treatment;
- to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation;
- to contribute to a climate where the truth can be heard, the reporting of, and learning from, errors is encouraged and colleagues are supported where errors are made;
- to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care;
- to take every appropriate opportunity to encourage and support patients and colleagues to improve their health and wellbeing;
- to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care;
- to inform patients about the use of their confidential information and to record their objections, consent or dissent; and
- to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

3 The term 'staff' is used to include employees, workers, and, for the purposes of the Employment Rights Act 1996 (the ERA) (as amended by the Public Interest Disclosure Act), agency workers, general practitioners (e.g. those performing general medical services under General Medical Services Contracts), student nurses and student midwives, who meet the wider ERA definition of being a 'worker'. Whilst volunteers are not covered by the provisions of the ERA, guidance to employers makes clear that it is good practice to include volunteers within the scope of organisations' local whistleblowing policies.

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East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	13
Subject:	Capital Programme Mid-Year Review
Reporting Officer:	Vanessa Harris – Director of Finance

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

Purpose:

To update the Trust Board on the mid-year review of the capital programme.

Introduction:

This report is being brought to the Trust Board for information, decision and approval.

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

The capital pressures the Trust is facing are very significant with backlog pressures on maintenance, medical equipment and IT at a time when it is also continues to be under pressure on its revenue performance.

The attached mid-year review paper updates the Trust Board on:-

- The current performance of the capital programme.
- The current capital plan which has been revised by the Capital Approvals Group (CAG) in order to manage the capital plan within the capital resource limit (CRL) and in order to meet the changing capital requirements of the Trust.

Benefits:

The Trust Board has assurance on the development, management and control of the capital programme.

Risks and Implications

The capital budget will remain under its current pressure.

Assurance Provided:

The Trust Board has assurance on the development, management and control of the capital programme.

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

The mid-year review was conducted by the CAG at its meeting in August.

Proposals and/or Recommendations

The Trust Board is asked to:-

i) Note the current performance of the capital programme

ii) Approve the revised capital plan in order that the Trust does not breach its capital resource limit (CRL) at 31st March 2016

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

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

East Sussex Healthcare NHS Trust

Capital Programme Mid-Year Review

1. Introduction

This report provides a mid-year review of the 2015/16 capital programme including recommendations made by the Capital Approvals Group (CAG).

2. Summary

The 2015/16 capital programme was planned on the assumption that the Trust would have available to it two main sources of funding:-

- Planned clinical strategy exceptional public dividend (PDC) capital £17.4m which is subject to approval by the Trust Development Authority (TDA)
- Internally generated capital funding planned within the limit of depreciation, £11.8m.
- Total capital resource £29.2m.

However, it should be noted that the full clinical strategy business case has yet to be considered by the TDA.

The Trust has also been notified by the TDA that the delegated limit for capital expenditure in 2015/16 for East Sussex Healthcare NHS Trust is £1m in accordance with the TDA Capital & Cash guidelines and as a consequence of the trust's planned deficit. All outline business cases (OBC) and full business cases (FBC) for proposals over this limit will need to be provided to the TDA and agreement to proceed is at the discretion of the TDA Director of Development and Delivery (South).

3. Capital Programme Position at Month 5 – 31st August 2015.

At the end of month 5 the year to date capital expenditure amounts to £5.0m. This is marginally behind the planned expenditure of £5.1m at this stage in the financial year.

Commitments entered into amount to £7.2m, and the programme is currently planned with an over commitment margin of £0.2m at the mid-year stage compared to the Trust's currently approved capital resource limit (CRL) of £11.8m, excluding unapproved clinical strategy funding.

The CAG reviewed the capital programme at its August meeting and this level of over commitment is considered acceptable at this stage of the financial year.

The CAG will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital and to ensure the Trust does not exceed its CRL at 31st March 2016.

4. Current Capital Programme

The CAG has reviewed and adjusted the provisional capital plan, approved by the Trust Board at its June meeting, to take into account revised resource assumptions, re-prioritisation of capital demands and planned timing changes in order to meet the changing capital requirements of the Trust. The revised capital programme is set out below:-

2015/16 Capital Programme	2015/16 Capital Programme Approved June 15 £000s	2015/16 Revised Capital Programme August 15 £000s	Expenditure Month 5 £000s
Capital Resources			
Depreciation	12,130	11,820	
League of Friends Support	1,541	1,255	
Clinical Strategy Exceptional Additional PDC	17,400	17,400	
Additional Capital Loan – Health Records Storage	441	441	
Gross Capital Resource	31,512	30,916	
Interest Bearing Capital Loan Repayment	-427	-427	
Less Donated Income	-1,541	-1,255	
Total NHS Capital Financing (Capital Resource Limit)	**29,544**	**29,234**	
Planned Capital Expenditure			
Clinical Strategy Reconfiguration	17,400	17,400	
Medical Equipment	1,764	1,405	913
Information Systems	1,777	1,028	403
Electronic Document Management	1,010	835	205
Child Health Information System	510	673	127
PAS Upgrade	523	523	68
Backlog Maintenance	2,100	1,241	100
Infrastructure Improvements – Modernisation of Inpatient Environment & Facilities	700	700	19
Minor capital	1,500	1,500	625
Pevensey Ward	2,200	2,055	1,603
Health Records	441	441	441
Other Various	1,047	1,657	502
Sub Total	**30,972**	**29,458**	**5,006**
Donated Asset Purchases	1,541	1,255	272
Donated Asset Funding	-1,541	-1,255	-272
Net Donated Assets		**0**	**0**
Sub Total Capital Schemes	**30,972**	**29,458**	**5,006**
Over Planning Margin	-1,428	-224	
Total Capital Expenditure	**29,544**	**29,234**	**5,006**

The principle revisions to the provisional capital programme are:-

- The provisionally estimated level of depreciation and the support available from the Friends of the Hospitals has been reassessed at a slightly lower level in the revised capital programme.

- The over planning margin has been reduced in view of the proposed content of the capital programme and in order to ensure the Trust does not exceed its capital resource limit budget (CRL) at 31st March 2016. This has been managed through a combination of recognising timing changes to schemes which means some costs will move into next financial year as well as reductions to planned capital expenditure across a range of headings including medical equipment, information systems and backlog maintenance.

5. Capital Pressures & Risks

Although the 2015/16 capital programme has been revised with an acceptable over commitment the programme is under severe pressure and demands for capital expenditure continue to far outstrip available resources.

In order to achieve a balanced position demands for medical equipment have had to be restricted to available resources and the impact on service delivery and quality will need to be carefully managed.

The capital programme does not have any allowance for any unplanned urgent and equipment replacement occurring in the remainder of the financial year and any demand will require current plans to be revisited in year.

6. Long Term Pressures

The limited capital funds available to the Trust in recent years has constrained spending on backlog maintenance, medical equipment and IT infrastructure. This has resulted in delays in replacement of essential equipment and a consequent increase in maintenance expenditure.

7. Recommendations

The Trust Board is asked to:-

i) Note the current performance of the capital programme.

ii) Approve the revised capital plan in order that the Trust does not breach its capital resource limit (CRL) at 31st March 2016.

Vanessa Harris
Director of Finance

16th September 2015

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	14a
Subject:	Annual Report for Infection Prevention & Control 2014-15 and key priorities for Programme of Work for 2015-16
Reporting Officer:	Tina Lloyd, ADIPC / Dr Barry Phillips, DIPC

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

Purpose:

This paper sets out the key activities, incidents & achievements of the Trust relating to infection prevention and control during 2014-15 and the key priorities for the programme of work for 2015-16.

Introduction:

This Annual Report has been developed in collaboration with key stakeholders in delivery of the IP&C Annual Programme of Work including Clinical Specialities and Estates & Facilities. It highlights the key activities, incidents and achievements in relation to infection prevention and control during 2014-15 and provides an account of performance to prioritise activities and managing risks going forward into 2015-16.

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

East Sussex Healthcare Trust has shown a significant reduction in both MRSA bacteraemia and *Clostridium difficile* infections over five years reducing MRSA by 95% and CDI infections by 78% up until April 2014. During 2014/15 the number of cases reported increased to 2 cases of MRSA bacteraemia compared to 1 in the previous year and 49 cases of CDI compared to 41 in the previous year.

In recognition of the often sporadic nature of CDI the Department of Health revised the objectives for reduction of CDI for Trusts in 2014/15 so that where no lapses in care are identified for cases of CDI Trusts may appeal to their local commissioners for such cases not to count towards annual objectives. East Sussex Healthcare Trust worked with East Sussex Commissioners and agreed a process and criteria for review of all cases. Of the 49 cases 27 were judged as no lapse in care and would not count against the trajectory. Of the remaining 22 cases 3 were considered lapses in care that may have contributed to the patient developing CDI and 19 were lapses in care that were unlikely to have contributed to the patient developing CDI.

Although the total number of cases of CDI reported have increased, the number of cases related to transmission has reduced from 6 the previous year to 1 in 2014/15.

Benefits:

Provides a formal account of the activities and achievements in 2014-15 in relation to infection prevention and control and outlines key priorities for 2015-16

Risks and Implications

Failure to improve upon measures to prevent cross infection and comply with Regulation 12 “Cleanliness and Infection Control” will lead to a risk of harm to patients, inability to demonstrate compliance and increase the likelihood of adverse outcomes for the Trust.

Significant investment is required to deliver a programme of improvement of the Estates and environment.

Operational activity and bed capacity restricts capability for planned programmes of refurbishment and delivery of a structure decant deep clean programme.

Assurance Provided:

The Trust has demonstrated effective systems are in place to rapidly identify and manage outbreaks of infection in line with local and national guidelines. The number of outbreaks of CDI has reduced from the previous year to one single episode of transmission.

Risks identified during 2014-15 in relation to lessons learnt from outbreaks of CDI and assessment against Regulation 12 were reviewed by the Trust Infection Control Group and areas for further improvement will be included in plans going forward into 2015-16.

The Trust is seeking support from the Trust Development Authority (TDA South) in addressing the key priorities for 2015-16 and responding to findings of Care Quality Commission investigations.

Review by other committees / groups

Approved by the Trust Infection Control Group 21st August 2015
Presented to Quality & Standards Committee 1st September 2015
Presented to Commissioning Clinical Quality Review Group 2nd September 2015

Proposals and/or Recommendations
Priorities for 2015/16 (i) Completion of the housekeeping modernisation plan approved by the Trust Board. (ii) A full review of the Trust Estates strategy including provision of isolation facilities (iii) Programme of improvement to demonstrate assurance of compliance by all staff with infection control policies (iv) Reduction of healthcare associated infections (v) Delivery of the local Antimicrobial Resistance Strategy (vi) Meet mandatory reporting and surveillance requirements related to HCAI (vii) Implementation of the new software to support the delivery of the National Specification of Cleanliness programme of audit (viii) Robust procedures to identify and respond where a need for improvement is identified. (ix) Formal review of the Infection Prevention & Control service and the activities delivered by the team. (x) Review and maintain all Infection Prevention & Control policies to meet latest guidance and recommendations

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: Tina Lloyd, Assistant Director of Infection Prevention & Control	**Contact details:** Tina.lloyd@nhs.net

East Sussex Healthcare NHS
NHS Trust

INFECTION PREVENTION & CONTROL ANNUAL REPORT 2014/15

□pproved by the Trust □nfection □ontrol □roup □1st □ugust □□1□

CONTENTS

Executive Summary

This report outlines the activities of the Trust relating to infection prevention and control for the financial year 2014/15 including key achievements. It is presented to explain the Trust arrangements to allow early identification of patients with infections and measures taken to reduce the spread of infections to others. It also reviews the accountability arrangements relating to infection control, audit, surveillance and education.

Tackling infections is a key priority for the NHS and all NHS healthcare providers. Prevention and control of healthcare associated infections (HCAIs) has always been taken seriously by East Sussex Healthcare Trust which has developed programmes of activities to embrace national initiatives and reduce infection rates. Whilst the Trust employs a team of specialist nurses and support staff to advise and coordinate activities to prevent and control infection it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area.

The Trust reports performance and activities related to infection prevention and control regularly throughout the year to the local commissioning groups (CCGs).

The Infection Prevention & Control team works closely with other stakeholders in relation to strategies for prevention of infection including Public Health England and Regional Specialist Laboratories and experts.

Each NHS provider organisation is set annual objectives for the reduction of both MRSA bacteraemia and CDI. East Sussex Healthcare Trust has shown a significant reduction in both infections over five years reducing MRSA bacteraemias by 95% and CDI infections by 78% up until April 2014. During 2014/15 the number of cases reported increased to 2 cases of MRSA bacteraemia compared to 1 in the previous year and 49 cases of CDI compared to 41 in the previous year.

In recognition of the often sporadic nature of CDI the Department of Health revised the objectives for reduction of CDI for Trusts in 2014/15 so that where no lapses in care are identified for cases of CDI Trusts may appeal to their local commissioners for such cases not to count towards annual objectives. East Sussex Healthcare Trust worked with East Sussex Commissioners and agreed a process and criteria for review of all cases. Of the 49 cases 27 were judged as no lapse in care and would not count against the trajectory. Of the remaining 22 cases 3 were considered lapses in care that may have contributed to the patient developing CDI and 19 were lapses in care that were unlikely to have contributed to the patient developing CDI

Although the total number of cases of CDI reported have increased, the number of cases related to transmission has reduced from 6 the previous year to 1 in 2014/15.

The Infection Prevention & Control team has continued to coordinate the programme of activity related to infection prevention and control within the organisation, providing education and training, clinical advice and exploring new ways of engaging with clinical staff within the diverse organisation to reduce the risk of infection to patients in our care both in and out of hospital.

Tina Lloyd
Assistant Director of Infection Prevention & Control

1 Structure

The □irector of □ursing is the □xecutive □ead for □nfection □revention & □ontrol within the Trust and sits on the Trust □oard.

□r □arry □hillips (□ritical □are □onsultant) holds the position of Trust □irector of □nfection □revention & □ontrol (DIPC) reporting to the □hief □xecutive □fficer (CEO) and is supported by Tina □loyd, □ssistant □irector of □nfection □revention & □ontrol (ADIPC) who reports to the □irector of □ursing.

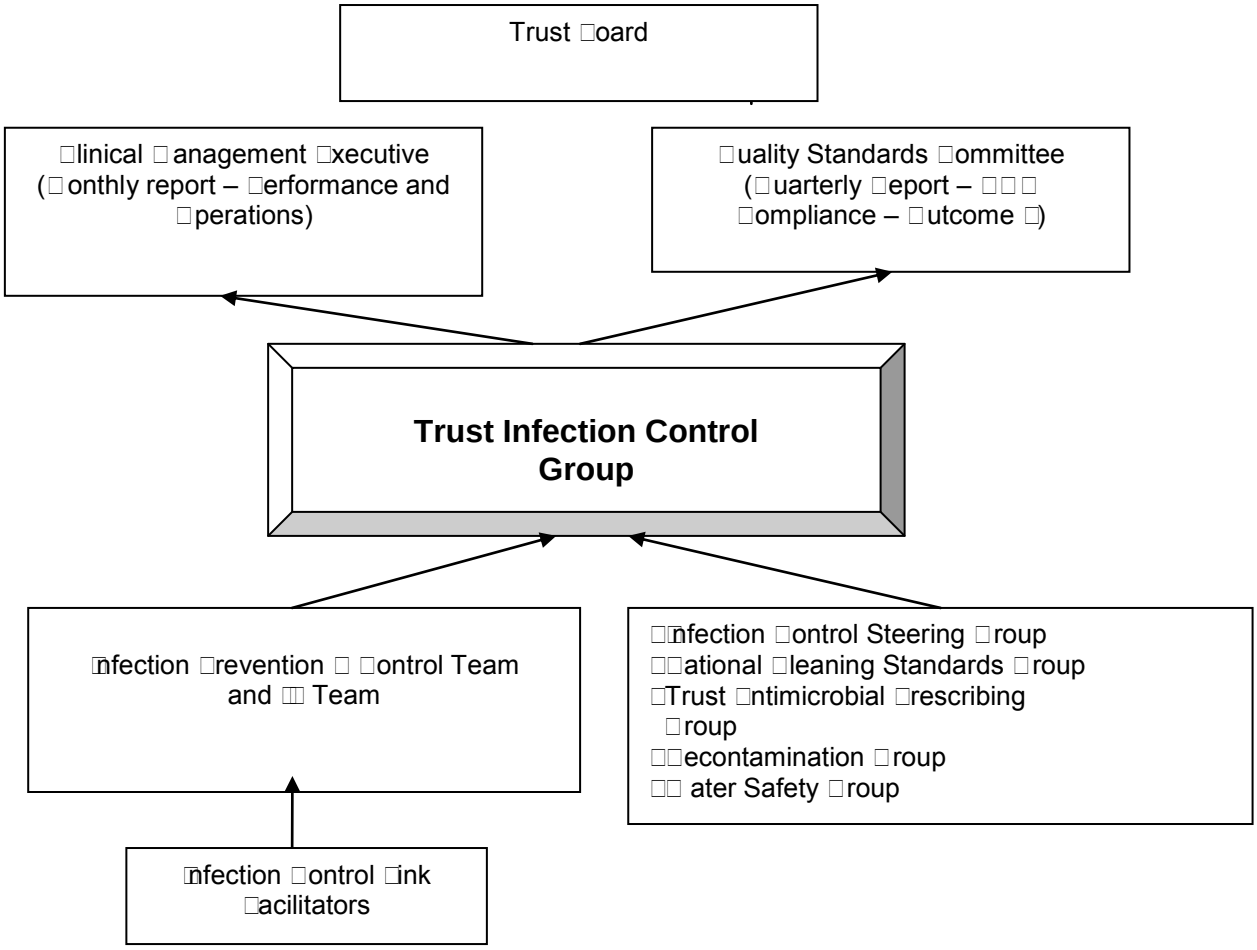
□uring the second half of 2014/15 the three clinical divisions were dissolved leaving seven clinical units (CU s), each with a □linical □ead, an □ssociate □eneral □anager and a □ead of □ursing reporting to the □hief □perating □fficer. □ach of the CU s report directly to the Trust □nfection □ontrol □roup (TICG) reporting on compliance with regulatory standards for □nfection □revention & □ontrol.

The Trust □nfection □ontrol □roup is chaired by the □irector or the □ssistant □irector of □nfection □revention & □ontrol. The □roup meets monthly and has wide representation from throughout the Trust including from clinical units, occupational health, pharmacy, commercial division and also external membership from the local department of □ublic □ealth □ngland (PHE). □uring 2013-14 the Trust □nfection □ontrol □roup reported to the Trust □oard via the □linical □anagement □xecutive. □rom 1st □pril 2014 the Trust □nfection □ontrol □roup will continue to report monthly to CME regarding performance and operational issues and will also report quarterly to the □uality & Standards □roup regarding compliance against Outcome 8 Regulation 12 “Cleanliness and Infection Control” Health & Social Care Act 2008. (See reporting structure in 1.1)

The Terms of □eference for the Trust □nfection □ontrol □roup were revised and approved in □ovember 2014 to reflect the new reporting arrangements outlined above.

□linical □atrons and □linical □anagers have the responsibility for the prevention and control of infection in their local area in line with national and local policies and guidelines. □ach clinical department has appointed an □nfection □ontrol □ink □acilitator who with educational support and guidance from the □nfection □revention & □ontrol Team is responsible for cascading and monitoring compliance with infection prevention and control practices at local level.

1.1 Infection Prevention & Control internal reporting arrangements



1.2 Infection Prevention & Control external reporting arrangements

□xternally, the □ssistant □□□□ also reports directly on performance to the □linical □uality □eview □roup (□□□□) held by three local clinical commissioning groups (□□□s);

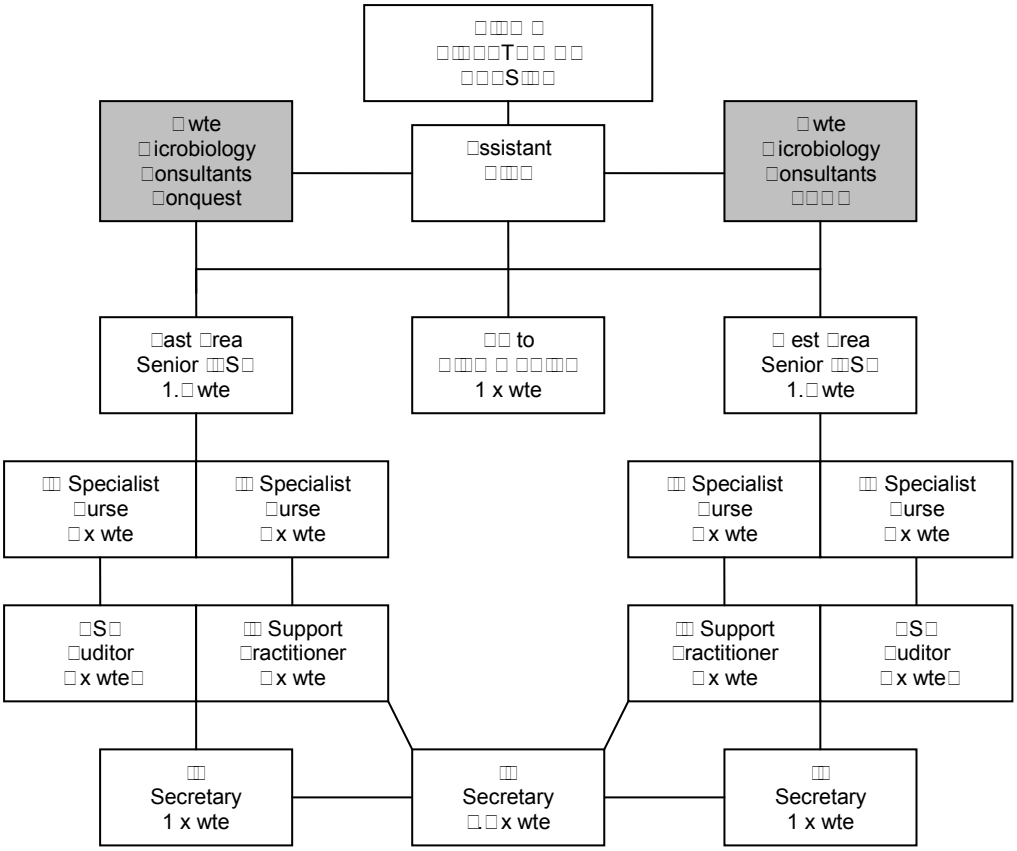
- □ □astings □ □other □□□
- □ □astbourne □ailsham and Seaford □□□
- □ □igh □ eald, □avens and □ewes □□□

1.3 Infection Prevention & Control structure

The □nfection □revention □ □ontrol team comprises of specialist infection control nurses, specialist intravenous (□□) therapy nurses, □□ support practitioners and administrative staff and for the first time, during □□1□□1□ also incorporated the environmental audit team previously managed within the □acilities □epartment.

□n interim structure has been in place during □□1□□1□ whereby two area teams (□ast and □ est) based in each of the acute hospital sites provide infection control support to all □S□T services in their local area (acute, community, inpatient and domiciliary).

Interim IP&C team structure



□*prior to March 2015 1 x wte in each area*

□n addition to the team, the Trust also funds □ x wte □onsultant □icrobiologist posts (□ on each acute site) based within □linical Support □□ who work closely with the team, one of whom holds the □ead □nfection □ontrol □octor responsibility.

1 x wte □rthopaedic Surgical Site □nfection Surveillance □urse is appointed within the Surgery □□ and 1 x wte □ntimicrobial □rescribing □ead post is appointed within □harmacy□linical Support □□.

1.4 Vacancies

□uring □□1□□1□ the team was unable to recruit experienced and fully qualified □□ □urse Specialists and has therefore recruited □ x wte trainee nurses who are currently being supported in their development into this specialist role.

□t the end of □arch □□1□ two posts remain vacant;

- □ Specialist □urse with plans to recruit
- □ □urse under consideration as part of service review

The environmental audit service transferred from □acilities was reviewed during quarter □ of □□1□□1□ and funding agreed for an increased establishment to □ x wte posts in □□1□□1□ to meet service demand.

1.5 Infection Control Link Facilitators

□t any one time there are between 80 – 100 □ink □acilitators across the Trust. □nfection □ontrol □ink □acilitators, with educational support and guidance from the □nfection □revention & □ontrol Team, are responsible for cascading and monitoring compliance with infection prevention and control practices at local level. Those in high risk areas attend monthly meetings held by the □nfection □ontrol Team.

The ICLF s are provided with education and training from the specialist IP&C team and other relevant specialists. In addition the Trust also encourages and supports ICLF s to undertake further training to support them in their role. A number of ICLF s have completed a □evel 6 module at Brighton University "Principles and Practice of Infection Prevention & Control".

The ICLF s are responsible for the completion of monthly hand hygiene audits, other Trustwide audits, cascade training and implementation of new policies and paperwork etc. under the guidance of the □nfection □revention & □ontrol Team.

The results of the monthly hand hygiene compliance audits are readily available on the Trust electronic information system (□eridian). □ ard □atrons are required to report regularly to the □irector of □ursing to provide evidence of action to improve if indicated. □f repeated non□compliance by an individual member of staff is reported this is escalated to their line manager to performance manage.

1.6 Joint working across the local health economy

The Trust □nfection □revention & □ontrol Team has worked closely with □linical □ommissioning □roup (CCG) □nfection □ontrol □urse and □ublic □ealth □ngland (PHE) colleagues towards □oint strategies for the reduction of healthcare associated infections which can lead to hospital admission. The □ssistant DIPC reports monthly to the CCG □uality □erformance □eview □roup (QPRG) and quarterly to the □ast Sussex HCAI □ orking □roup.

The infection control specialist nurses are members of the □nfection □revention Specialists □egional □etwork □eeting who share and discuss local initiatives, innovations and work towards common goals across Sussex.

The □nfection □revention & □ontrol team in collaboration with PHE , □ast Sussex □ounty □ouncil and the □etwork □roup are focussing efforts on the reduction of catheter associated urinary tract infections. □ducational events were held in 2014/15 to implement a catheter passport for patients with indwelling urinary catheters to promote best practice and reduce the risk of infection.

2. Compliance with Outcome 8 Regulation 12 “Cleanliness and Infection Control” Health & Social Care Act 2008

The Trust is required to undertake self-assessment against Care Quality Commission (CQC) standards and regulations, develop action plans for improvement if required and provide evidence of compliance, including against Outcome 8 which specifically relates to cleanliness and infection control.

The Trust Infection Control Group reviews generic self-assessment against Outcome 8 and receives reports from Clinical Units as evidence of local compliance and assurance which is then reported quarterly to the Trust Quality & Standards Committee.

One of the greatest challenges to the Trust in demonstrating compliance against Outcome 8 is in the provision of isolation facilities to meet the increasing demand due to emerging threats and diseases and for those at most risk. During 2014/15 the funding was approved to commence a major refurbishment project of the haematology and oncology unit at the Eastbourne DGH site with works planned to start in May 2015. The refurbishment will provide much needed bespoke isolation facilities to meet the needs of this vulnerable group of patients as well as dedicated day care facilities separated from the ward.

The CQC undertook an inspection in East Sussex Healthcare Trust between the 9th & 11th September 2014. The findings of the investigation report were published late in March 2015 and included recommendations regarding improving compliance in some areas, for example environmental cleanliness, hand hygiene and ‘Bare Below the Elbows” dress code. These will be included in the priorities for action in the programme of work for 2015/16.

Immediately following the publication of the September 2014 report the CQC undertook a subsequent unannounced inspection of the Trust in March and April 2015. The findings and the report are expected to be published in September 2015.

3. Mandatory Surveillance

Some infections and micro□organisms are reported by the Trust to the □epartment of □ealth as part of a national mandatory surveillance programme. The infections under greatest scrutiny are bloodstream infections due to □eticillin resistant *staphylococcus aureus* (MR SA bacteraemia) and diarrhoea due to *Clostridium difficile* infection (CD □).

□ach NH S provider organisation is set annual ob□ectives for the reduction of both MR SA bacteraemia and CDI □ast Sussex □ealthcare Trust has shown a significant reduction in both infections over the five years reducing MR SA bacteraemias by 95% and CDI infections by 78% up until □pril 2014. □uring 2014/□5 the number of cases reported increased to 2 cases of MR SA bacteraemia compared to 1 in the previous year and 49 cases of CDI compared to 41 in the previous year.

□t is recognised that not all cases of HCAI are avoidable hence the focus for infection prevention and control is on preventing avoidable harm. □ll cases of MR SA bacteraemia and CDI diagnosed and apportioned to the Trust are investigated by a root cause analysis (RCA) by a multi□disciplinary team to ensure any potential lessons learnt are acted upon and shared across the organisation.

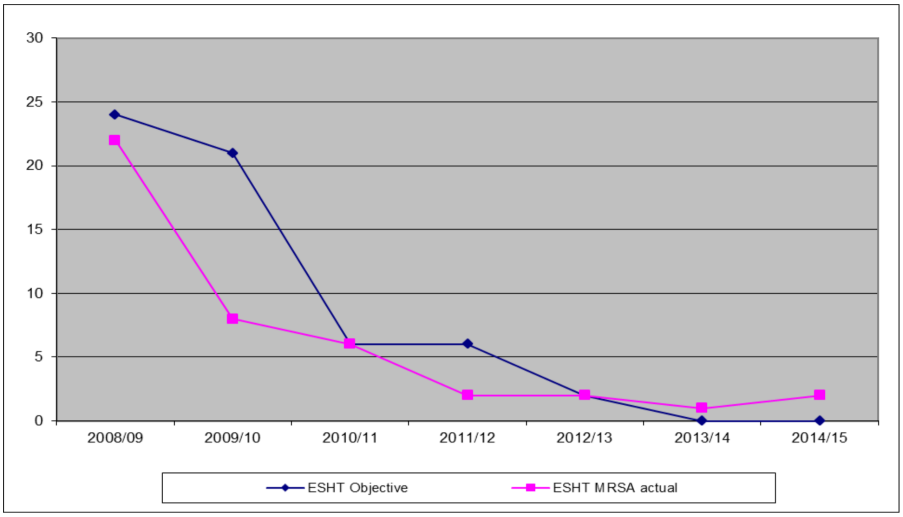
Since 2011, bloodstream infections due to meticillin sensitive *Staphylococcus aureus* (□SS□) and *Escherichia coli* have been added to the national mandatory surveillance. □owever, these infections are more often community acquired and at the moment no hospital or Trust ob□ectives for reduction have been set.

3.1 MRSA bacteraemia

A □ero tolerance approach was given to cases of MR SA bacteraemia which could potentially be avoidable. □ast Sussex □ealthcare Trust reported two cases of MR SA bacteraemia in 2014/□5 compared to one in 2013/□4. □ne of the cases was not thought to be clinically significant; no harm was caused to the patient who was discharged home without treatment (it is likely that the blood culture sample was contaminated at the time of collection from the patient's skin). The second case was related to post□operative complications and resulted in infection.

The table below shows the number of cases of MRSA bacteraemia reported since 2008. It should be noted that prior to 2011 the data reported was for the previous acute organisation (East Sussex Hospitals NHS Trust) only.

Reduction of MRSA cases reported between 2008/09 and 2014/15



Now that the number of MRSA infections is very small the challenge for Trusts is to prevent patients with MRSA colonisation of the skin developing subsequent infection when they have severe underlying conditions, poor skin or require the insertion of intravenous lines and other devices as part of their treatment. Regimes to screen all admissions and give topical antiseptics to the skin are in place for those patients with known MRSA colonisation. In 2014/15 revised Department of Health guidance was published that recommends a move away from routine screening of all admissions for MRSA towards a risk based screening strategy whereby only those at high risk of MRSA would be screened. The Trust is currently continuing to screen all admissions and is reviewing the guidance and seeking further evidence before any reduction in current control measures.

3.2 Clostridium difficile infection (CDI)

The number of *C.difficile* infections reported annually within the Trust is shown in the chart below. As with MRSA, the Trust has objectives for reduction in CDI In 2014/15 the Trust reported 49 cases of CDI against a challenging objective of no more than 44. This represents an increase in 6 cases on the previous year.

As with MRSA bacteraemia, cases of CDI are reviewed in detail. During the year, the majority of infections were sporadic. That is, there was no obvious connection between them to suggest that they were the result of transmission of CDI from one patient to another. Instead, they are more likely to have been brought into hospital at the time of admission.

In recognition of the often sporadic nature of CDI the Department of Health revised the objectives for reduction of CDI for Trusts in 2014/15 so that where no lapses in care are identified for cases of CDI Trusts may appeal to their local commissioners for such cases not to count towards annual objectives. East Sussex Healthcare Trust worked with East Sussex Commissioners and agreed a process and criteria for review of all cases. Of the 49 cases 27 were judged as no lapse in care and would not count against the trajectory. Of the remaining 22 cases 3 were considered lapses in care that may

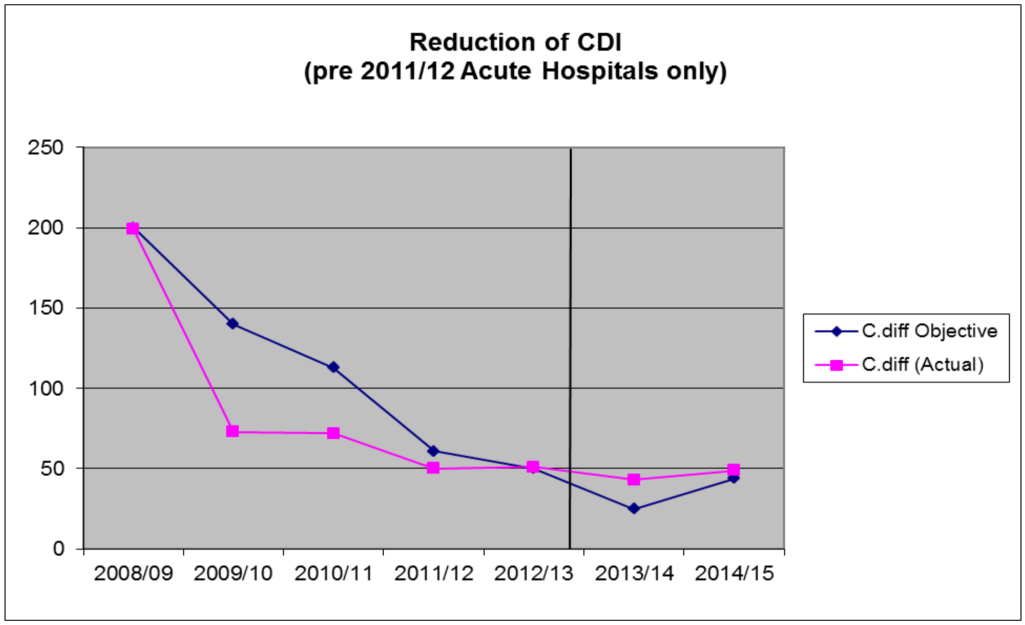
have contributed to the patient developing CDI and 19 were lapses in care that were unlikely to have contributed to the patient developing CDI

In line with national guidelines, where 2 or more cases were identified on the same ward within 28 days of each other these were investigated as periods of increased incidence (IIIs). Further tests were performed at a specialist reference laboratory to compare the cases and cross infection was identified in 1 case in August 2014 compared to 6 cases last year. The case was reported as a serious incident and investigated and the most likely cause was thought to be a breach in infection control practice due to delay in isolation of a patient symptomatic of diarrhoea prior to diagnosis of CDI

As a result of the investigation recommendations were made regarding improvements and upgrade of the inpatient environment on the surgical wards at the Conquest Hospital which has been agreed in the capital funding for 2015/16.

Of the 19 cases considered lapses in care that were unlikely to have contributed to the patient developing CDI the most common area for improvement was related to National Specification of Cleanliness audit scores not reaching the expected level. The Infection Control Steering Group chaired monthly by the Deputy Chief Executive Officer reviews progress against actions and recommendations made following the root cause analysis investigation of each case of CDI

Reduction of CDI cases reported between 2008/09 – 2014/15



Please note that prior to 2011/12 the number of cases reported are related to acute inpatients only. From 2012/13 onwards the number of cases also includes cases reported from the additional community inpatient beds following integration.

3.3 Surgical Site Surveillance

□ast Sussex □ealthcare Trust (□S□T) upholds its requirement to the □epartment of □ealth (□□□) by undertaking continuous orthopaedic surgical site infection (SS□) surveillance at the □astbourne □istrict □eneral □ospital (□□□□) and The □onquest □ospital □astings (□□□). Since □□□□ all □□S Trusts undertaking orthopaedic surgery are required to complete the mandatory surveillance study program devised by the Surgical Site □nfection Surveillance Service (SS□SS) □ublic □ealth □ngland (□□□) for a minimum of three consecutive months per year. □urrently over □□□ of participants submit continuous surveillance and since □anuary □□1□, □S□T have maintained this recommended gold standard and practiced a continuous study to establish any patterns or trends over time. □ standardised set of demographic and operation□related details were submitted for every patient undergoing □ip and □nee □rosthetic □eplacement Surgery including re□surfacing and revision (excluding 1st stage revision where spacer implant is used) and the study covered surgical procedure, inpatient stay, post discharge reports and complete relevant data of any case readmitted with a SS□during the first post□operative year.

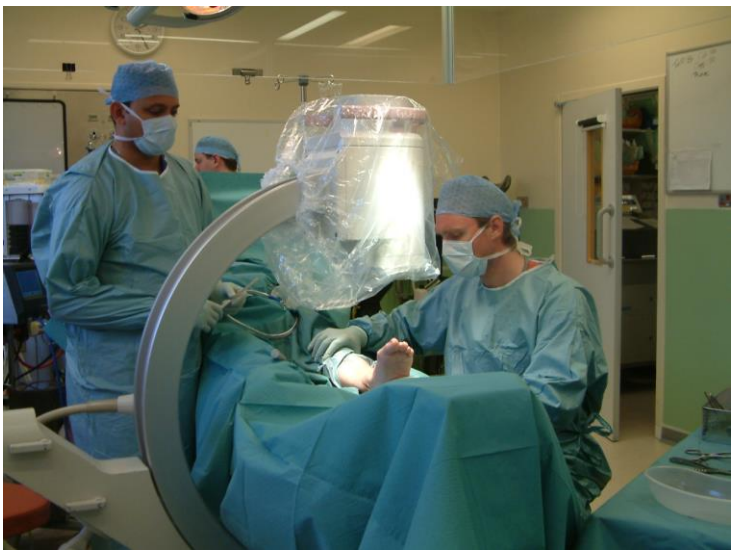
□lease note□□□□ SS□SS studies need to be undertaken prospectively and submitted quarterly but results are published 1□ months retrospectively as infection rates are influenced by performance and readmissions within the audit population over each 1□ month surveillance period.

□inalised results are therefore only available up until end □arch □□1□ although data from □pril □□1□ onwards is within the surveillance system and continues to be analysed and officially reported by the □□□ at the end of the following year.

Core data 1st April 2013 – 31st March 2014

□ategory of surgery	□umber of procedures	□umber of infections	□nfection rate	□ean infection rate for all participating Trusts
Total hip replacement	□□□	□	□.□□	□.□□
Total knee replacement	□□□	1	□.□□	□.□□

Surgical site infection rates for both hip and knee replacement surgery were lower than the national mean according to the most recent □□□ SS□SS □nnual □eport.



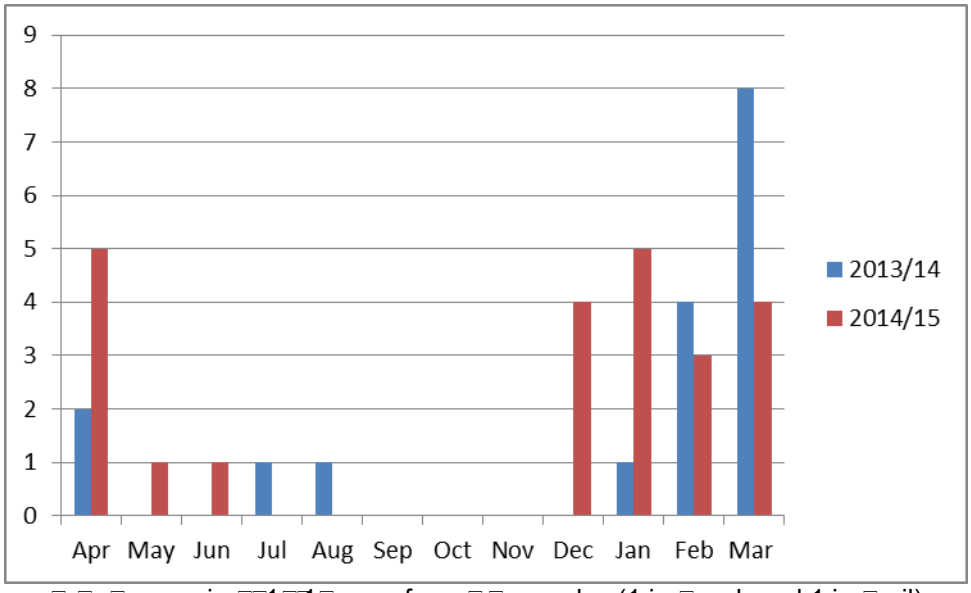
3.4 Influenza

□ hilst there was no national surveillance programme for influen□a all acute provider trusts were required to report on a weekly basis during the influen□a season the number of cases of influen□a requiring admission to intensive care to determine the burden on critical care units nationally.

□ ithin □S□T a total of 1□□ patients were tested for influen□a during □□1□□1□ (both □□ and inpatient samples), 1□□ resulted negative and □□ resulted positive, all inpatients (1□.□1□). □f the positive cases 1□ required admission to the □ntensive □are □nit (□□□) compared to □ out of 1□ in the previous year.

The chart below shows the number of cases by month compared to the previous year.

□S□T □ositive □nfluen□a Test □esults □□1□□1□ – □□1□□1□



□.□. □cases in □□1□□1□were from □□ samples (1 in □arch and 1 in □pril)

4 Incidents related to infection

4.1 Incidents managed by the Infection Prevention & Control Team

The Trust reports outbreaks of infection as serious incidents to the local □linical □ommissioning □roups (□□□s). These include incidents where there has been a significant impact on the running of the Trust's services (ward closures for example), or where there has been a severe impact on patient outcome.

□n □□1□□1□ the Trust reported □ serious incidents that were investigated and managed by the □nfection □revention □ □ontrol Team. The root cause analysis investigations and subsequent recommendations and completion of actions are monitored by the Trust □nfection □ontrol □roup.

The table below provides a brief outline of these incidents.

Month	SI No	Incident
pril	2014/ 1042	utbreak of orovirus affecting 4 wards at the onquest ospital, astings
ay	2014/ 4883	utbreak of 2 cases of a sub type of 014 strain lostridium difficile at onquest ospital, astings *Period of increased incidence of CDI was investigated in February and March 2014 and subsequent results indicated probable cross infection from a patient with a community acquired infection to a hospital inpatient*
uly	2014/24775	utbreak of 2 cases of lebsiella pneumonia MDM metallo-carbopenemase gene positive at onquest ospital, astings
ugust	2014/27630	utbreak of 2 cases of 002 strain lostridium difficile at onquest ospital, astings
ugust	2014/296 15	utbreak of 2 cases of anton- alentine eukocidin eticillin esistant Staphylococcus aureus (PVL-MR SA) at astbourne istrict eneral ospital (EDGH)
ctober	2014/31996	robable outbreak of Scabies involving 3 individuals at the onquest ospital, astings
ctober	2014/39 102	utbreak of colonisation of lycopeptide esistant nterococci (GRE) at astbourne istrict eneral ospital

4.2 CDI mortality incidents managed by Clinical Units

The Trust routinely reports any deaths where CDI is recorded on art 1 of the death certificate as a serious incident. This does not necessarily mean that the death was a serious incident. t does however reflect how seriously the Trust takes the prevention, management and control of CDI The purpose of the S s is to determine whether the patient's diagnosis and treatment have been managed appropriately in line with Trust and national guidance. Some of the cases are admitted to the Trust with known CDI or are diagnosed within 72 hrs of admission and are therefore not attributable to S T. The Trust, however, works closely with the CCG s to ensure best practice across the local health economy for CDI 4 cases were recorded and ointly investigated during 2014/ 5.

5 Emerging threats and operational preparedness

5.1 Ebola

bola virus disease (EVD) is a rare but severe infection caused by bola virus. Since arch 2014 there has been a large outbreak of bola virus in est frica with widespread and intense transmission in uinea, iberia and Sierra eone. t is the largest ever known outbreak of disease and prompted the orld ealth rganisation (WHO) to declare a public health emergency of international concern in ugust 2014.

In July 2014 the Chief Medical Officer (CMO) issued an alert to the NHS about the possibility of a patient presenting at GP surgeries and emergency departments, so that they could act promptly in the event of a suspected case presenting in the UK.

In response the Trust established an Ebola Preparedness Group to respond to regular updates and information regarding provision of facilities and resources to enable the safe admission and treatment of any suspected cases returning from the affected areas.

A dedicated isolation facility and staff were identified on the Eastbourne District General Hospital site and stringent processes and procedures agreed to triage patients at risk following guidance by the Advisory Committee on Dangerous Pathogens (ACDP).

To date this facility has been used once for a healthcare worker who had recently returned to the UK and who had been in direct contact with patients with Ebola. The patient fitted the high risk category and presented with symptoms of Ebola, however was subsequently found not to be infected.

Nationally 3 healthcare workers with Ebola have been returned to the UK and received treatment in a high level NHS isolation unit so far. The risk of Ebola to the general public in the UK remains very low however NHS Trusts continue to be prepared to receive potential cases.

5.2 Operational preparedness

The operational preparedness group established initially in response to the threat of Ebola continues to function within the organisation to ensure ongoing plans are in place for potential Ebola cases and other emerging threats and diseases including Pandemic Influenza and Carbapenemase Producing Enterobacteriaceae (CPE).

6 Infection Prevention Activities and Innovation

6.1 Hand Hygiene Promotion

The Trust Infection Prevention & Control Team coordinates an annual programme to promote effective hand hygiene throughout the organisation including;

- Monitoring of compliance by clinical staff with monthly audits; these audits were integrated during 2014/15 onto the Trust Meridian system which is used for other quality measures on a live reporting system.
- Monthly hand hygiene promotional posters
- Series of focussed hand hygiene promotion events for staff and patients including participation in the International World Hand Hygiene Day on 8th May 2014. The key message for the World Health Organisation (WHO) led event for 2014 was "Clean Hands, Save Lives"
- Pirle pre-assessment unit at EDGH, the Minor Injuries Unit at Crowborough and Kipling paediatric ward were successful winners in a Trust competition amongst staff to promote hand hygiene.
- Training of ICLFs to facilitate cascade training at local level of practical hand hygiene technique.
- Providing training of all staff on induction (joining the organisation) and at regular mandatory updates.
- Ad-hoc training when indicated for focussed improvement.

- □ollowing feedback from a patient survey, actively promoted provision of hand wipes and hand hygiene by patients before meals, whilst in hospital.

6.2 Audit activity

The Trust IP&C team co□ordinates a number of planned and unplanned audits throughout each year to monitor compliance with core infection prevention and control standards and any areas of risk or concern which may arise as a result of incidents.

The planned programme of audits outlined for 2014/□5 was reviewed during the year to ensure the highest priority audits were completed which were:

- □onthly staff hand hygiene audits
- □ational Specification of □leanliness audits reported and monitored monthly
- □d□hoc audits e.g. hand hygiene, environmental, cleanliness, equipment cleanliness and *Clostridium difficile* controls in response to local risk assessments
- Safer Sharps audit
- □niversal □recautions audit

The remaining planned audits unable to be completed in 2014/□5 due to reduced resources within the specialist team will be scheduled in future programming.

6.3 Training and Education

The IP&C specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required. □or example;

- □andatory training on induction for all staff and volunteers
- □nnual updates for clinical staff, patient facing staff, food handlers and other high risk groups
- 3□yearly updates for non□clinical, non patient facing staff
- □egular training sessions to monthly ICLF meetings for cascade
- □d□hoc training where identified due to service need or clinical incidents (serious incidents for example)

- □nduction training programme for new ICLF s
- Support other multi□disciplinary training events e.g. urinary catheter, intravenous therapy training days and other local health economy events involving independent care providers.
- Train the trainer sessions in □and □ygiene and □it Testing of FFP3 masks (cascaded by ICLF s)

□ompliance with attendance at mandatory induction and update sessions is monitored by the Trust along with other mandatory components of the Trust mandatory training programme.

6.4 Professional Development

□ll specialist nurses within the team maintain professional competence and attend relevant study and training. □etworking with other clinical specialists is supported through attendance at regional meetings.

□ne member of the team attended a 3□day annual conference held by the □nfection □revention Society in □dinburgh in September 2014.

A member of the administration team has been supported to undertake a □ity & □uilds □evel 3 □iploma in □usiness and □dministration.

□ne of the □nfection & □ontrol □urse Specialists attended the in□house □irst □ine Manager's course to support their personal and professional development.

The □ssistant □irector of IP&C was supported in undertaking a Master's □egree, received external coaching and attended training to undertake the role of □irector on-call to support the Trust leadership team.

A trainee □nfection □ontrol □urse Specialist was supported to attend □righton □niversity to undertake a module in the □rinciples and □ractice of the □revention and □ontrol of □nfection.

□linical supervision was utilised by a senior member of the team in developing their leadership skills and another attended the □ursing & □idwifery □eadership □evelopment □rogramme run by the NHS □eadership □cademy.

□s well as utilising the in□house □earning & □evelopment training programme team members have been supported in attending other essential specialist training and conferences required to maintain their professional practice to enable them to provide education and training to others in the organisation including:-

- □nfection □revention Society, □ondon South □ranch development days
- □and □ygiene □onference
- □on□medical prescribing update
- □isiting other Trusts to learn from others experiences in implementing programmes of improvement (□ital□□□ and IV devices)

6.5 Launch of "My Urinary Catheter Passport"

Indwelling urinary catheters are recognised as one of the most common sources of healthcare associated infections which can lead to hospital admission. Patients with long term catheters, or those requiring intervention, are at greatest risk. The NHS has identified the reduction of catheter associated urinary tract infections as a priority to improve quality of patient care.

Specialist Nurses from the Infection Prevention & Control Team and Urology participated in a Sussex wide working group to develop a patient held document to support individuals in the management and care of urinary catheters in their own home and when being admitted to hospital. The purpose of the document is to improve communication for all involved in the patient's care, standardise best practice and reduce the risk of infection.

Launch events were held during 2014 including training for Trust staff, local nursing, care home and agency staff to implement this useful document.

Assistant Director of Infection Prevention & Control and Urology Nurse Specialist during the launch of "My Urinary Catheter Passport"

7 Intravenous Therapy Team Activities and Innovation

The IV team works as part of the infection control team. Management and service development is led by a Senior Infection Control Nurse Specialist. The team has recently been consists of two lead nurses (Band 7) and two specialist practitioners (band 6) and four support staff (band 3) working at Conquest and EDGH . Funding to increase staffing establishment was approved in the last year and a further two band 6 specialist practitioners have been recruited to support long line insertion and patient pathways. These new posts plus recruitment to a vacant post has resulted in recruitment of three new members of staff who will join the team in May and June 2015. The team provides a 7 day service including bank holidays from 08:00 – 19:00 to the acute hospitals. Long line placements are usually undertaken Mondays – Fridays.

The team support clinical staff by inserting catheters for venous access, troubleshooting problems with lines, cannulation and blood taking, dressing changes and advice on best practice in □□ therapy to in□patients at □S□T and also supports community based staff as requested.

7.1 Clinical Practice

The □□ team undertook nearly 1□,□□□ recorded procedures □clinical contacts during □□1□□1□ to enable essential intravenous therapy for inpatients and to facilitate patients being discharged home to receive medium to long term treatment in the community, see details in the table below.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Monthly Average
□lood cultures taken	1□□	□□	1□□	□□	□□	□□	□□	□□	□□	□□	□□	□□	□□□	□□.□□
□annulations done	□□□	□□□	□1□	□1□	□□□	□□□	□□□	□1□	□□□	□1□	□□□	□1□	□□□1	□□1.□□
□lood tests taken	□□□	□□□	□□□	□□□	□□□	□□□	□□□	□□□	□□□	□□□	□□□	□□□	□□1□	□□□.□□
□hange of dressings done	□□	111	1□□	□□	1□1	□□	□□	□□	□□	□□	□1	1□□	11□□	□□.□□
□ong line insertions done	□□	□□	□□	□□	□□	1□	□□	11	□□	□□	□□	□□	□□□	□□.□□
□ong lines□□entral lines reviewed	□□	□□	□1	□□	□1	□1	□□	□□	□□	□□	□□	□□	□□□	□□.□□
□ailed □ttempts (bloods and cannula)	1□	□	1□	1□	1□	□	1□	□□	□□	1□	□□	1□	1□1	1□.□□
Total													1□,□□1	
□long term staff sickness														

□n addition the team has also provided clinical supervision to clinical staff gaining competence in □□ skills and assisted with insertion and troubleshooting of portacaths (a device inserted into patient's chest which provides a portal for long term infusions).

□annulation (the insertion of peripheral □□ devices) is the highest demand to the service which is required by many inpatients for essential treatment. The specialist skills of the team are best utilised with patients who have difficulty with cannulation. □annulation training is also provided by the □□ specialist practitioners to multi□disciplinary staff within the Trust. □fter initial training staff are required to demonstrate competency in practice before going on to practice cannulation independently. The □□ team is working on strategies to ensure staff gain opportunities to complete their competency assessments.

□eneral blood sampling (non blood cultures) are undertaken by other clinically trained staff and the Trust phlebotomy service. The IV team's expertise is used for more specialist tests like blood cultures. □lood culture samples require expert skill in aseptic non touch technique when collecting the sample to avoid contamination and spurious results. The □□ team not only undertake blood culture collection as a routine part of the service, they also train and assess other staff competency in this procedure

The number of long line insertions varied depending on staffing within the team. The service at the □onquest site was affected by sickness absence and a vacancy. □s an interim measure the interventional □onsultant □adiologist at □onquest has supported service delivery with placing □□□□ lines when the □□ specialist service was restricted. The numbers of lines inserted by interventional radiology is not shown in this report.

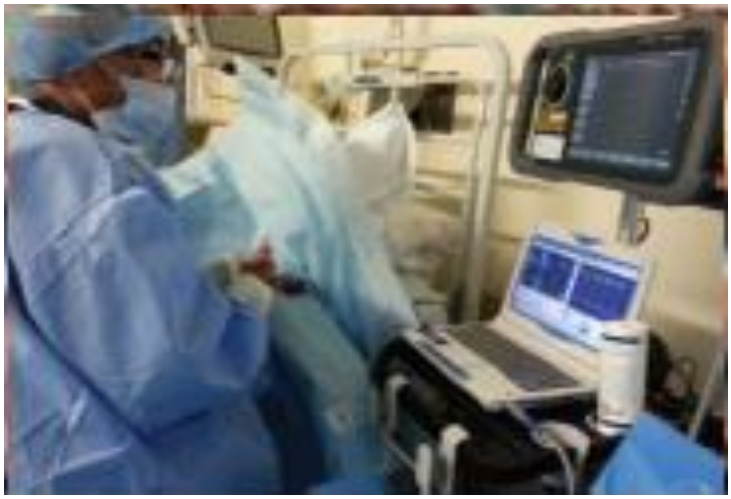
□aily routine checking of venous access documentation (□□□) is undertaken on the ward for patients with □□□□s, □idline and □eader□lex devices. The □□ Team changes

the dressing and assesses the line within the first □□hrs post insertion and every seven days thereafter

7.2 Training and Education of clinical staff

The □□ therapy service provides a comprehensive training and education programme for Trust clinical staff related to □□ insertion, line care and blood culture collection including;

- □ onthly □ene□cannulation training
- □lood cultures for □th year medical students (six times a year on both acute sites)
- □ormative □S□□ for blood culture annually
- □lood culture and cannulation with □□1 and □□□ doctors as part of their induction
- □lood culture assessment for doctors and nurses
- □ entoring new doctors and nurses with vene□cannulation technique
- □dvocating best practice with highlighting □septic □on□Touch Technique (□□TT) principles and adherence to infection prevention and control practices, to all healthcare workers
- □romoting vessel health preservation
- Training on vascular access devices monthly to update staff on best clinical practice
- □□ additives training for acute and community Trust staff now established and incorporated within the Trust □earning □ □evelopment □rogramme excluding the need for external training to be provided.
- Simulation training for accessing □□□□s and portacaths introduced following the purchase of a training mannequin.



IV Team Lead EDGH using the Nautilus machine

7.3 Review of products for quality and costs saving

The team has changed its choice of □□□□ line to provide a non□valve product that has associated cost savings, standardised practice and is used by all departments that place □□□□s.

The team has introduced insertion packs that improve ability to undertake surgical □□TT and work is in progress to introduce a trust wide □□□□ maintenance pack to promote best practice for every patient with a □□□□ line in hospital and in their own home.

7.4 Audit and surveillance

The team monitors blood culture contaminants (false positive blood culture results caused by potentially poor technique by blood sampler) and investigates each one to identify contributing factors and take action to improve individual's practice, including repeat competency assessment. The Trust blood culture contaminant rate remains below the nationally accepted level of 3% .

□oot cause analysis investigations are undertaken on IV line related infections that result in bacteraemia (micro□organisms isolated from blood culture which indicates sepsis) which include recommendations and actions to improve.

7.5 Professional Development

□ll specialist nurses within the team maintain professional competence and attend relevant study and training. □etworking with other clinical specialists is supported through attendance at regional meetings. A member of the team attended an annual □□TT conference in □ondon and a national □utpatient □arenteral □ntimicrobial Therapy (OPA T) □onference. Training has been arranged for early 2015/ 6 for the newly appointed IV practitioners in PICC insertion and new training is planned on the use of the □autilus guided PICC placement and best practice PICC procedures.

□ll of the IV therapy support workers attended an IV study day at □ast □ent □ospitals □niversity NH S □oundation Trust.

7.6 Service Development

□eaderflex and midline insertion is now embedded in practice at both acute sites. This allows greater flexibility and choice for intravenous access to meet individual patient needs whilst being cost effective for patients who require intravenous access for six weeks or less.

Two □autilus machines were purchased for the team by the □eague of □riends at both the □onquest and EDGH . The □autilus enables the IV team to quickly locate the tip of the PICC line to confirm that the PICC is safe and ready for use without the need for □adiology investigation (x□ray).

□n recognition of the success of this piece of work which was supported by the Trust □istening into □ction (L¡A) programme the IV team were shortlisted as finalists in the □nnual Trust □wards in the category of □uality □mprovement. □n addition to this the team were chosen to represent the Trust at the □ent Surrey & Sussex □cademic □ealth Sciences □etwork □xpo □wards to present their pro□ect.

A new service has been established for patients with PICC lines in the □astings & □other area to attend a PICC maintenance clinic held twice weekly at the □exhill □ospital site. The clinic offers assessment, weekly dressing change, maintaining line patency and blood sample collection, and if required disconnection of infusion pumps (for chemotherapy for example). The clinics support ambulatory patients being treated nearer to home and without the need to access acute emergency services in the general hospitals or the community nursing service.

8 Housekeeping Services

The □ousekeeping services for □S□T are provided by an in house team within □acilities □ivision of the □states and □acilities □irectorate. □n partnership with a □epartment of □ealth representative, the housekeeping service has undergone a full review and standardised working practices to meet the ob□ective of achieving a more productive, efficient and cost effective cleaning service which meets the clinical service demands and patient care. □s a result of this service review a modernisation plan was created to be considered by the Trust □oard for approval. Subsequently the plan has been given full approval and the management team will now progress the changes to implement the plan by □an/□eb 2016.

8.1 Deep clean programme

□n important part of housekeeping services is to support the reduction of infections and meeting CQC regulation 12 “Cleanliness and infection Control”. □ue to continuous patient pressures housekeeping has been unable to undertake a structured deep clean plan of patient areas as per recommendations within NHS □leanliness Standards documentation in 2014/15 through lack of decant areas (vacant ward to allow emptying of wards that require a deep clean). The housekeeping team works in close partnership with IP&C and has worked on alternative ways of ensuring cleanliness standards are maintained by introducing weekly quality meetings to discuss standards in partnership with IP&C , □aintenance, and clinical partners and actions are drawn up to address low standards if needed in any areas until a structured deep clean plan can be established.

8.2 Activity

□ousekeeping continued to receive demands from all areas for cleaning support from the □apid □esponse Team including single rooms, bed space cleans, and others this averages at about 200+ calls per month per acute site. To meet this demand calls for cleans are prioritised and communication and support is structured from IP&C and clinical site leads and clear plans are in place at all levels to ensure patient disruption is minimised

8.3 Service development

The □ousekeeping department continues to use HPV □ydrogen □eroxide □aporisation units to support the reduction of infections by destroying organisms, this process is undertaken by the rapid response team who are on site 24hrs and can be deployed to any site if called upon this will be sustained in the modernisation plan. The □apid □esponse Team are trialling a new process as part of the HPV process when cleaning decontaminated isolation areas by trialling a clean air unit this if works will release patient beds for occupation in a shorter time frame

The housekeeping management team have worked in partnership with IP&C and reviewed all clinical areas on the acute sites using the “PAS 5748 Specification for the planning, application, measurement and review of cleanliness in hospitals” and have remapped and risk weighted every area as part of developing and reviewing cleaning services.

The housekeeping team has introduced a new cleaning trolley system across the Trust, called “Magic System”. The trolleys are designed to take all cleaning buckets and mops and are lockable for safety, so that the trolley can be secured if left unmanned. The

new mops are colour coded for easy identification and are micro□fibre which supports better cleaning of floors.

These are being introduced in con□unction with new updated task sheets which are being specifically designed to each area to ensure that every room is listed and visited by the cleaning staff responsible.

A member of the housekeeping team with one of the new "Magic System" cleaning trolleys

9 Antimicrobial Stewardship Activities and Innovation

The Trust has an established □ntimicrobial Stewardship □roup (□S□) which has a core membership of an antimicrobial pharmacist, consultant microbiologist, medical consultant, □linical □harmacy □anager and a □□□ representative. The purpose of the □S□ is to support the prudent prescribing of antimicrobials to reduce antimicrobial resistance rates. □t does this by□

- □eveloping and maintaining evidence based on antimicrobial policies and guidelines for use in secondary and primary care
- □nsuring safe and cost effective use of antimicrobials taking local, national and international bacterial resistance rates into account.
- □onitoring antimicrobial usage (reviewing daily divided doses, antimicrobial expenditure data and compliance to policy using a point prevalence audit) and addressing any issues that may arise.
- □roviding advice to other specialist groups□committees on use of antimicrobials
- □roviding education to staff on all matters relating to prescribing and administration of antimicrobials.
- □ducating patients and members of the public on antimicrobial stewardship.

The Trust □ntimicrobial Strategy will be revised to address and include the updated Public Health England "Start Smart Then Focus" guidance expected in 2015.

□uring the last financial year the activities of the □S□ were as follows□

9.1 Antimicrobial Prescribing Policy

The □ntimicrobial □rescribing □olicy for □dults and □hildren which contains the antimicrobial formulary of drugs is in the process of being updated. The policy contains peer□reviewed, evidence based guidelines on common infections and a large number of specialist consultants are involved. □dditional chapters such as Treatment of Sepsis

and Treatment of □aediatric □nfections are included. The □ntimicrobial □rescribing □olicy is available on the staff □xtranet for easy access by staff in areas where patient related activities take place. □n addition, the □ntimicrobial □rescribing □olicy is summarised and printed onto pocket si□ed summary cards which are distributed to all training grade doctors for easy access to the policy at point of care (e.g. at patient's bedside).

9.2 Multi-disciplinary Ward Rounds

The antimicrobial pharmacists and consultant microbiologist participate in daily □ntensive □are ward rounds and weekly *Clostridium difficile* □nfection ward rounds at both acute sites. This is in order to provide specialist input into the highest risk□most critical patients in the hospitals.

9.3 Medication Prescribing Chart

The □S□ was also heavily involved in the design of a new medication prescribing chart for the trust. This was to reduce inappropriate prescribing of antimicrobials which drives patient safety, low bacterial resistance rates, reduction in □□□rates and complies with national standards. □ dedicated section on the chart was also designed for □ancomycin and □entamicin which are two antibiotics that are toxic to the kidneys and require blood levels taken regularly.

□ollowing introduction of the new prescribing chart, the risk group has not been made aware of any clinical incidents involving inappropriate dosing□use of intravenous □entamicin or □ancomycin during □□1□□1□.

9.4 Training

The □S□ has reviewed the e□learning module on antimicrobial prescribing which is an internet based programme on antimicrobial prescribing, with an assessment that all new doctors have to pass at induction and all trust doctors have to undertake every three years. The Trust □harmacist antibiotic training pack has been introduced and is being used to help support the development of rotational pharmacists in relation to antimicrobial prescribing in line with □oyal □harmaceutical Society antimicrobial training guidance.

9.5 Admission Avoidance Pathways / OPAT service

□n con□unction with □ommissioners and □rimary □are, □S□ developed □dmission □voidance □athways and is piloting an □□□T service. Treatment pathways are processes developed to keep patients out of acute care or reduce length of hospital stay.

9.6 Smartphone App

□unding to create a smartphone app of the antimicrobial policy so that prescribers can download it onto their smartphone and use as required instead of carrying disposable cards has been approved. This innovative approach has been taken up by a number of trusts nationally and will improve access and help with policy update.

9.7 European Antibiotics Awareness Day

The lead antimicrobial pharmacist spearheaded a campaign on □ovember 1□th which was called □uropean □ntibiotics □wareness □ay. This day was marked to educate patients and the general public on antibiotics. □ctivities undertaken were posters in common areas, articles in local bulletins□paper, on the intranet and handing out of leaflets.

9.8 Antibiotic prescriptions / algorithms

The lead antimicrobial pharmacist has also created algorithms for clinical pharmacists to follow when presented with antimicrobial prescriptions on their wards. These are meant to aid pharmacists query prescriptions, appropriately switch from intravenous to oral antibiotics and how to dose toxic antibiotics. This helps reduce inappropriate prescribing, switching early to oral antibiotics and reduces risk to patients from side effects, multi□resistant bacteria, hospital acquired infections and has proved a useful tool to aid pharmacists in the clinical screening of prescriptions.

9.9 Audits

The lead antimicrobial pharmacist also conducts monthly snapshot audits to monitor the quality of antimicrobial prescribing within the trust. This is done at ward level by clinical pharmacists and helps ascertain any issues with prescribing that is then dealt with by the ward pharmacist.

9.10 Incident reports

The lead antimicrobial pharmacist is also involved in reviewing of incident reports involving antimicrobials and also participates in root cause analysis of patients who have come to harm where antimicrobials may have directly or indirectly been involved such as □□□s of *Clostridium difficile* cases.

10 Annual Programme of Work / Priorities for 2015/16

Taking into account the performance delivered by the Trust in 2014/15, the lessons learnt from the root cause analysis investigations of MRSA bacteraemia, *Clostridium difficile* infections and the findings of the CQC investigation reports, the Trust is working with the Head of Infection Prevention & Control for the Trust Development Authority (South) to review the work priorities for 2015/16 to include:

(i) Completion of the housekeeping modernisation plan approved by the Trust Board.

(ii) A full review of the Trust estates strategy including provision of isolation facilities

(iii) Programme of improvement to demonstrate assurance of compliance by all staff with infection control policies

(iv) Reduction of healthcare associated infections

(v) Delivery of the local Antimicrobial Resistance Strategy

(vi) Meet mandatory reporting and surveillance requirements related to HCAI

(vii) Implementation of the new software to support the delivery of the National Specification of Cleanliness programme of audit

(viii) Robust procedures to identify and respond where a need for improvement is identified.

(ix) Formal review of the Infection Prevention & Control service and the activities delivered by the team.

(x) Review and maintain all Infection Prevention & Control policies to meet latest guidance and recommendations.

East Sussex Healthcare NHS Trust

Date of Meeting:	30 September 2015
Meeting:	Trust Board
Agenda item:	14b
Subject:	Equality Delivery System Annual Report
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

This document provides an overview of the Trust's work to build on existing good practice to eliminate discrimination and reduce inequalities in care. It provides analysis of how the Trust is working to meet the 18 Equality Delivery System 2 outcomes.

Introduction:

The main purpose of the EDS2 is to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

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

The Trust is developing in most areas, achieving in four areas and undeveloped in one. In respect of the undeveloped area, complaints, quality improvements have been made which should move the rating in the current year.

The report identifies a number of areas of success but recognises that we need to increase engagement, awareness and data collection and analysis. There are a number of initiatives in place to support improvement.

Benefits:

It is important that those peoples using our services have the right to be treated fairly and not to be discriminated against, regardless of their 'protected characteristics' The EDS2 supports the Trust to meet this.

Risks and Implications

Non-compliance could constitute a breach of the Equality Act 2010 and NHS Constitution.

Assurance Provided:

The Trust is developing well against the majority of the metrics.

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	X
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	X
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.	x

Review by other Committees/Groups (please state name and date)**:**
Board Seminar presentation on WRES/EDS2 in September. Quality and Standards Committee will review progress.

Proposals and/or Recommendations
The Board is asked to review and note the data, progress made and plans to further develop.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
There is one area rated red and this is being addressed.

For further information or for any enquiries relating to this report please contact:	
Name: Kim Novis, E&D Lead	**Contact details:** Kim.novis@nhs.net

The Equality Delivery System (EDS2)

Final Grading and Equalities Analysis Report 2014/15

Contents

Summary

1. **Introduction**

   This report seeks to provide assurance for patients, carers, the public and staff, that the Trust is inclusive of the needs of all types of people whatever the service they are accessing and wherever they live within the organisation's geographical reach.

   This has been a year of building on our existing good work, reviewing our equality objectives and rising to new challenges, including a refreshed Equality Delivery System (EDS2). The report has been drafted around the standards outlined in the EDS2 and highlights the progress in delivering good practice and identifying areas for further development.

2. **Achievements**

   The Trust has many initiatives to ensure patients, carers, visitors, service users and staff have equal access to services and will actively seek to minimise disadvantage. The Learning Disabilities Liaison Team (LDLT) are always seeking to ensure patients with Learning Disabilities (LD) have the same access to services as those without LD, including treating LD patients in their home environments.

   The Trust has worked with Stonewall, an organisation that addresses issues that lesbian, gay, bi-sexual and transgender (LGBT) communities can sometimes face. Stonewall Healthcare Equality Index measures organisations on how friendly and accessible they are for LGBT communities, the Trust moved up 6 places from 23rd in 2014 to 17th in 2015 in the Stonewall in 2015.

   The Trust Annual Staff Awards provided the opportunity to recognise the great work of staff. Awards were given out to staff for a variety of achievements such as exemplary leadership.

   ESHT was proud to be a pilot site for Project Search, a programme that supports young adults with learning difficulties and enables them to widen their employment opportunities. The majority of this year's cohort are already reaping the rewards of the programme with offers of employment.

3. **Areas of Focus for 2015/16:**

   A baseline has now been established for EDS2 and it important that there is increased engagement throughout the organisation to support development of equality and diversity, identify areas of improvement and raise awareness and share learning of some of the good practices that already exist. As outlined in this report there are a number of initiatives in place that will support this, such as developing the Equality and Delivery Steering Group.

It is also imperative that data collection and analysis is developed to improve assurance of our compliance against the standards and to identify areas requiring further development.

4. EDS2 Outcomes and Grading

EDS2 Goal:	Grade:

Better health outcomes:		
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	**DEVELOPING:**
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 the NHS their safety is prioritised and they are free from mistakes, mistreatment and abuse	**ACHIEVING:**
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	**ACHIEVING:**

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	**ACHIEVING:**
2.3	People report positive experiences of the NHS	**DEVELOPING:**
2.4	People's complaints about services are handled respectfully and efficiently	**UNDEVELOPED:**

EDS2 Goal:	Grade:

A representative and supported workforce		
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**ACHIEVING:**
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	**DEVELOPING:**
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	**DEVELOPING:**
3.6	Staff report positive experiences of their membership of the workforce	**DEVELOPING:**
Inclusive leadership:		
4.1	Boards and other 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:**

1. Introduction to the refreshed Equality Delivery System (EDS2)

The Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a toolkit that assists NHS organisations in improving their services, both as service providers to their local communities, and also as employers. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

Based on this evaluation and subsequent engagement with the NHS and key stakeholders, a refreshed EDS – known as EDS2 – was made available in November 2013.

The main purpose of the EDS2 was, and remains, to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

East Sussex NHS Healthcare Trust aims to comply with the Equality Delivery System and to deliver a report that is understandable and transparent. The benefits to ESHT of complying with EDS2 are:

- ensuring staff and service users are free from unlawful discrimination
- ensuring staff and service users are provided with equality of opportunity and are fostering good relations
- patients can expect improved access and experiences of the organisation which will deliver better health outcomes delivered by a well-led, supported workforce that is representative of the communities it serves.

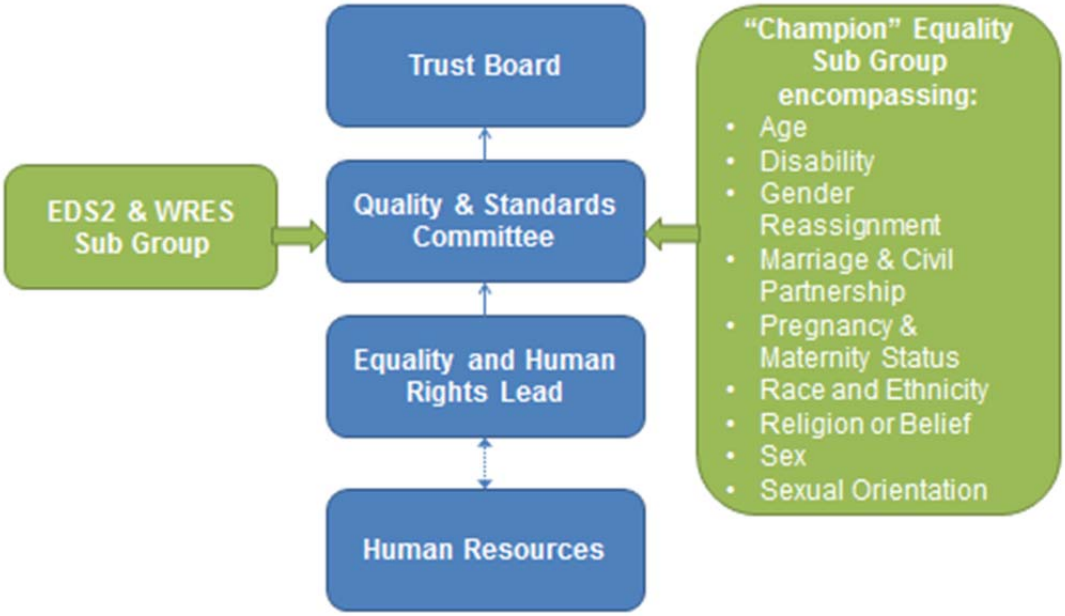
Equality sits at the highest level of leadership at ESHT with a robust governance framework currently being developed to support implementation and monitoring. There are 2 sub-groups that feed into the Quality and Standards Committee; 1 group is made up of staff and patient champions representing each protected characteristic and the other group is for directors, managers, EDS2 and Workforce Race Equality Standard (WRES) leads. The aim of the EDS2/WRES steering group is to ensure that there are robust reporting mechanisms and to constantly review data to ensure our objectives are being met and reported in subsequent reports. EDS2 can only work if there is a high level of engagement from stakeholders and therefore input from any internal and external stakeholders will be welcomed.

External equality stakeholders consist of

- Patients and Service Users
- Volunteers
- Voluntary organisations
- Hastings Rainbow Rother Alliance Group

- Healthwatch East Sussex
- Clinical Commissioning Groups
- East Sussex County Council
- Stonewall
- NHS BME Network

1.1 Equality & Human Rights Governance Structure



1.2 The four Goals that lead to the 18 outcomes:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

1.3 EDS2 Grading

For each EDS2 outcome, there are four grades, and a RAG "plus" rating, to choose from:

Excelling – **Purple**
Achieving - **Green**
Developing – **Amber**
Undeveloped – **Red**

Essentially, there is just one factor for NHS organisations to focus on with the grading process. For most outcomes the key question is: how well do people from protected groups fare compared to people overall?

Each grade is dependent on evidence of the protected characteristics including; gender, race and ethnicity, age, disability, religion or belief, sexual orientation, pregnancy/maternity/adoption and paternity, transgender and marital status.

Undeveloped 	**Developing** 	**Achieving** 	**Excelling** 
People from all protected groups fare poorly compared with people overall OR evidence is not available	**People from only some protected groups fare as well as people overall**	**People from most protected groups fare as well as people overall**	**People from all protected groups fare as well as people overall**

3. Trust Performance

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.1
Outcome: Services are commissioned, procured, designed and delivered to meet the health needs of local communities	

Summary of Activity:
Extensive work to enhance the quality of life for people with long term conditions, such as dementia, diabetes and coronary heart disease is on-going across the Trust.

Cancer
Data analysis on those with cancer surviving or dying within 1 year of diagnosis revealed the highest rate of survival was amongst Females aged between 60-74. When comparing survival rates between genders 27.45% of Men survived one year post diagnosis and 43.71% of Females survived one year post diagnosis.

The highest prevalence of cancer was found amongst patients in the 60-74 and 75-89 age ranges. Of the patients diagnosed in 2014/15 within these age ranges, 43.67% of were men, and 56.33% were women.

“The majority of people who develop bowel cancer are over 50…” (Macmillan Colorectal Clinical Nurse Specialist) and therefore the Trust encourages eligible people aged 60 to 69 to take part in the national bowel cancer screening programme. Further analysis will be carried out to monitor participation from at risk groups in the screening programme and to identify if any trends exist for 5-year diagnosis and survival rates. Further analysis of those affected is contained in the appendix 2014/15 Equalities Analysis to Support EDS2.

Engagement
The Trust received a ranking of 17 in the Stonewall Healthcare Equality Index 2015, 6 places higher than 2014. Stonewall assess healthcare organisations on how well it delivers services to LGBT communities in East Sussex. ESHT strives to provide a comprehensive service accessible to all irrespective of age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief and sexual orientation.

ESHT provides sexual health services to local communities. This is predominately done using drop in clinics, but bookable appointments are available.

The Trust is often required to out-source some of its services, and to support the Trust’s compliance with current equality legislation and ensure it meets the needs of all its users the EDHR Lead is a panel member for tendering processes alongside dedicated procurement leads.

Language and communication
Language and communication needs are supplied under the East Sussex County Council’s SUSTI framework which translates broad foreign community languages, through telephone, face to face, written, audio, braille and sensory interpreters,

ESHT strives to ensure that the health needs for all patients who do not use spoken English as their first language are being met.

Grade:	**Developing** Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Quality Accounts
- Healthwatch
- FFT
- Tender processes / contracts
- Equality & Human Rights Analysis
- Stonewall Healthcare Equality Index

Plans for 2015 - 2016

- EDHR Lead to participate in evaluation panels to ensure new contracts provide robust evidence of commitment to equality when services are commissioned by the Trust.

- To improve the interpretation services ESHT plans to enter into a service level agreement to provide easy access to interpreters and a service that meets the needs of the service user.

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.2
Outcome: Individual people's health needs are assessed and met in appropriate and effective ways	

Summary of Activity:

Learning Disabilities
The learning disabilities liaison team (LDLT) have provided a range of tools to assist in ensuring that patients with learning disabilities (LD) have the same access to treatment and care as those without LD. 'This is Me Care Passport' or Disability Distress Assessment Tool (DISDAT) are carried out and remain on the patient's record through a flagging system, highlighting any additional needs.

Many patients with LD required surgery and or treatments during 2014/15. To ensure equal access to treatments, reasonable adjustments were made. This included supporting patients in their own home environment prior to admission to hospital.

Equality & Human Rights Analysis (EHRA)
A new Equality & Human Rights Analysis (EHRA) form has been implemented across ESHT to ensure any inequalities are identified within our service delivery, service change, policies, strategies and procedural documents. Any inequalities identified through the EHRA are addressed and removed wherever possible. Monitoring processes are required for any inequalities that cannot be removed at the time of completing the EHRA analysis, therefore ensuring fair access to treatment and care.

Healthwatch engagement and feedback
Healthwatch East Sussex (HWES) attended, at the invitation of the CQC, two "Listening Events" in Eastbourne and Hastings prior to the CQC inspection of ESHT, to gather feedback and consumer experiences. Some of the concerns HWES identified were:

- Long waiting times for health services
- Concerns about access to care in a crisis and not knowing where to go for help
- Access to the right information at the right time

This feedback has been captured in the Trust Quality Improvement Plan and the Trust is working with Healthwatch to develop plans for improved community engagement.

Wider community engagement
Enhancing the quality of life for people with long-term conditions is a priority, with on-going initiatives such as dementia care improvements, HIV World AIDS Day, diabetes, asthma and epilepsy in children.

Epilepsy, diabetes and asthma in under 19 year olds
The Trust has a dedicated epilepsy nurse specialist, who provides on-going support for children and their families. A combined analysis of epilepsy, diabetes and asthma

in patients under 19 years old is contained in the 2014/15 Equalities Analysis to support EDS2.

National Clinical Audits
The Trust participated in all applicable national clinical audits, with the exception of the National Diabetes Audit due to software availability. These audits support improved patient care and shared learning.

Language and communication
Language and communication needs were assessed and met in a variety of ways. Where additional support was required, this was provided through the use of face to face interpreters, telephone interpreters, advocates and bilingual advocates. Bespoke training was provided across the Trust regularly.

The most requested language was Polish followed by Mandarin. Further details of the languages requested are found in 2014/15 Equalities Analysis to Support EDS2.

Grade:	**Developing** Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Healthwatch listening events
- Patient Experience Surveys
- Equality & Human Rights Analysis
- Language and Communication policy
- Interpreter data

Plans for 2015-16

- ESHT will work closely with Healthwatch with projects to address concerns raised at the listening events.
- Conduct a patient experience questionnaire following appointments where an interpreter was used, this is planned to commence April 2016
- Identify Champions for each of the protected characteristics

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.3
Outcome: Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	

Summary of Activity:

Engagement
The Trust works closely with commissioners and partner organisations, including other trusts, GPs and adult social care to support an effective transition of people on care pathways. This is facilitated further by the Trust's status as an integrated provider, as many people transition to one of the organisation's community sites or utilise community services. When developing new or revised pathways of care, a dedicated pathways coordinator is assigned to that pathway. Equality and Human Rights Analysis must be completed to ensure that the transition does not affect any of the protected groups less favourably.

Waiting Times
Referral To Treatment (RTT) times vary according to speciality. Average waiting times are broken down by speciality in the 2014/15 Equalities Analysis to Support EDS2. However caution must be used when forming judgments about the data based on Age and Ethnicity as the prevalence of certain conditions are likely to be higher/lower within these groups which could also lead to differential waiting times.

Patient Feedback
The FFT suggests that those who identify as BME are more likely to report 'unlikely' to recommend the Trust.

The CQC Inpatient Survey 2014 asked questions relating to information about your condition/illness. In A&E the question was 'were you given all the necessary information regarding your condition/ illness' which scored 7.7/10, a slight drop of 0.7 compared to 2013. A similar question was asked about waiting lists and planned admissions, 'were you given all the necessary information regarding you condition/illness from the referring person'; scoring 8.5/10, this is a slight decrease of 0.8 compared to 2013.

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:
- Equality & Human Rights Analysis
- FFT
- CQC Inpatient Survey 2014

Plans for 2015-16

- Use existing data collection methods to ensure equalities data is robust and reported on in the next annual equality report (EDS2)
- Ensure data is collected on interpreter usage for each speciality to ensure all patients who do not have spoken English as their first language are well informed and supported.
- Continue to build relationships with external stakeholders to engage in improving pathway transitions, ensuring all service users are well informed
- Collect and report equalities data on delayed transfers
- Further analysis will be undertaken such as reviewing complaints and delayed transfers of care to identify whether there is inequity amongst the protected groups.

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.4
Outcome: When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	

Summary of Activity:

Engagement
There is an extensive system for reviewing and reporting on patient experience, clinical effectiveness and patient safety. At clinical quality review meetings, triangulation of information relating to complaints, incidents, staffing, skill mix and key areas of harm (e.g. pressure ulcers, falls and medication incidents) is reviewed and actions and learning agreed. Indicators such as infection control, incidents and safeguarding are monitored at the Quality and Standards Committee. This process also identifies themes and trends, along with actions and learning.

National and local CQUINs are agreed with commissioners to improve quality and safety through innovative practice.

Serious Incidents
Serious Incidents are subject to root cause analysis and discussed and reviewed by the Serious Incident Review Group (SIRG) prior to being submitted to commissioners for closure. Any issues regarding equality are highlighted at the meeting; there have been no SI reports in relation to equalities issues during the reporting period. However, the Trust recognises that a large number of serious incidents relate to falls and pressure ulcers which are prevalent in older people. A number of actions are in place with the aim of reducing these incidents.

Infection control
There were 47 cases of Clostridium Difficile (CDiff) infection and 1 case of MRSA infection during the reporting period. Analysis of CDiff, where ethnicity was declared, identified all cases as either 'White British' or 'White Other'. 46.81% identified as male and 53.19% were female. All cases were over the age of 55 years with 36.17% of cases aged 55-79 years and 63.83% of cases aged 80-99. The highest prevalence of CDiff was 23.4% in the 90-94 year olds and the lowest prevalence was in 70-74 years with just over 2%.

Deprivation of Liberty safeguards (DoLs)
Guidelines on the Mental Capacity Act and Deprivation of Liberty are available for staff on the Trust's extranet. The Trust also provide a DoLs leaflet to all staff which is given out at their induction to the Trust, as well as at mandatory DoLs update training. On the back of the DoLs leaflet there is a flowchart showing the DoLs process. This is also available on the extranet to enable staff to make quick reference to the process when needed.

DoLs training is on-going and is delivered together with the MCA mandatory training.

Patient Feedback
Question 19 on the QCQ Inpatient Survey 2014 asks patients whether they felt threatened by other patients or visitors during their stay. The answer was fairly static compared to the previous year at 9.6/10, whilst the 2013 outcome was 9.7/10. This

demonstrated that the majority of patients surveyed did not feel threatened by other patients or visitors.

The Trust scored 8.6/10 for room or ward cleanliness and 8.0/10 for bathroom cleanliness in questions 17 and 18 of the QCQ Inpatient Survey 2014

The Trust scored 8.5/10 for the question “Did you have confidence in the doctor treating you?”, 0.1 lower than in 2013. For the question “Did you have confidence in the nurse treating you?” the Trust scored 8.6/10, again 0.1 lower than in 2013.

8.1/10 was achieved for staff giving information to patients about who they should contact if they had any worries about their condition or treatment after leaving hospital. This was an increase of 0.3 from 2013.

Grade:	**Achieving** – People from most protected group fair as well as most people overall

Evidence for grading:

- Privacy and Dignity policy
- Dignity at work policy
- Updated safeguarding training
- Deprivation of Liberty Safeguards
- Equality & Human Rights Analysis for policy and strategic developments
- SI Reporting and analysis
- CQC Inpatient Survey 2014
- Infection control data
-

Plans for 2015-16

- Continue to monitor data related to incidents and infection control cases to ensure that no person with protected characteristic is affected less favourable than any other person. Ensure that appropriate actions are implemented if any discrimination is identified

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.5
Outcome: Screening, vaccination and other health promotion services reach and benefit all local communities	

Summary of Activity:

Engagement
Health promotion is led by Public Health with commissioner support and focuses on targeted communities where there are particular health issues which have been jointly identified with partner agencies. The immunisation programme is commissioned by NHS England and school nursing is provided by Kent Community Health Trust.

Contracting is undertaken with specific requirements on how providers will offer their services to the designated population with emphasis on ensuring that this includes hard to reach groups.

Examples of innovative practice through engagement
Terrence Higgins Trust directly refer any Men who have Sex with Men (MSM) and Black and Minority Ethnic groups (BME) who may benefit from high risk rapid HIV testing to the Trust. Patients who are considered high risk are fast tracked to health advisors. Rapid testing is offered for asymptomatic people who present as MSM, BME or other known high risks. Weekly clinics for MSM are held in Hastings. Early detection of HIV can prevent people from dying prematurely. Over the past year there has been an increase in MSM attending clinics compared with 2013/14.

In March 2015 the Trust commenced a pilot in Eastbourne led by a Sexual Health Clinical Nurse Specialist to provide an asymptomatic pathway service; 55 men accessed this. This service initiative was developed in response to meeting a KPI within our contract of delivering a 10% increase in male attendances within the sexual health service. The service model is now being rolled out to Station Plaza. Sexual Health Services based in the East of the county.

Healthwatch East Sussex (HWES) worked with the Terrence Higgins Trust to deliver pilot training sessions to staff at ESHT and other partner organisations. These sessions were specifically aimed at recognising the importance of overcoming prejudice, encouraging testing and confidentiality regarding a person's HIV status.

Grade:	**Achieving –** There is good evidence / data that suggest all groups fare as well as people overall

Evidence for grading:

- Sexual health data
- Service accessibility (online)

Plans for 2015-16

- Continue to monitor the uptake of key projects to reach a 10% increase in male attendances within the sexual health service
- Continue to work with partner organisations to develop and implement public health initiatives.

EDS2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.1
Outcome: People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	

Summary of Activity:

Engagement

There is a Patient and Pubic Engagement Forum which has been established to enable two-way communication between patients, carers, partner organisations and the local community. The Forum supports the Trust in making sure that experiences and feedback from patients and the public informs service developments and improvements. The Trust encourages feedback from patients about concerns relating to their care to enable the Trust to take actions and share learning. The Director of Nursing along with dedicated Patient Experience leads ensure engagement activities are accessible to all who wish to be involved through the use of EHRA's and access audits.

Accessibility

The Trust is committed to providing accessible services across all ESHT sites. Examples of accessible provisions include lifts, ramps, induction loops, disabled toilets and free of charge disabled parking. Equality and Human Rights Analysis and local access audits are carried out on all service changes following changes to a service ensuring due regard is given and reasonable adjustments are made. An external company is commissioned to carry out an accessibility audit every 5 years.

Language and communication

The Trust provides a wide range of interpretation services for patients, carers and service users through the use of a framework provided by East Sussex County Council, East Sussex Translation & Interpretation (SUSTI). The framework provides a choice of interpretation companies for different types of interpreting:

- Face to face
- Telephone
- Sensory losses (BSL, Lip Speakers, Deaf-blind manual)
- Advocacy & Bilingual Advocacy
- Written & Audio Translation (inc Braille)

Interpreter access during 2014/15

A total of 814 people accessed interpretation services. The top 3 spoken languages accessed between both sites were Polish, Mandarin and Portuguese.

A detailed breakdown of requested interpretation is contained in the 2014/15 Equalities Analysis to Support EDS2

Accident and Emergency Waiting times

The national target for A&E waiting times in acute hospitals is 4 hours. During 2014/15 the average wait was just over 2.5 hours. Those aged over 65 years waited

on average 3.25 hours. This cohort of patients are usually seen quickly but due to co-morbidities may require specialist input which can lead to an extended period in A&E. Those under 16 years waited less time (under 2 hours). The Trust's A&E department has only one dedicated paediatric assessment area and therefore children with minor injuries are seen quickly to support discharge; those requiring further investigations are transferred to the ambulatory ward which is a more suitable environment.

An analysis of this data by ethnicity indicates that there were no disparities amongst ethnic groups.

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Complaints policy and reports
- Heathwatch meeting notes
- Equality & Human Rights Analysis
- SI Reporting
- SUSTI usage data
- A&E metric
-

Plans for 2015-16

- Enter into a Service Level Agreement for interpretation services ensuring; easy access to interpreters and translation materials, robust data, staff training.
- Work with providing interpretation company to design an action plan with targets to reduce time spent waiting for BSL interpreter availability
- Conduct a local audit to ascertain whether access to services is delayed due to time spent waiting for interpreters.
- Continue to monitor A&E metrics

ESD2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.2
Outcome: People are informed and supported to be as involved as they wish to be in decisions about their care	

Summary of Activity:

Engagement

Healthwatch surveys such as 'No Barriers to Health' provide the Trust with good evidence and insight into what the wider communities and other NHS Trusts and organisations are doing to support local and wider communities with communication. It has also helped the Trust identify areas that may be potential barriers to effective communication. Further engagement with Healthwatch through 2015/16 will enable the Trust to address any areas of concern.

Support

The Trust is committed to ensuring patients, as well as their families and carers, are involved in and consulted on all decisions about their care and treatment. For example, all patients have a personalised care plan which is developed with them in order to fully support their involvement in decisions about their care.

The Trust has a robust consent policy in place which has been reviewed to promote good practice in the way patients are asked to give their consent to examination or treatment. An EHRA form has been completed and the policy clarifies how all patients can access all elements of the policy and procedure for consent.

The trust provides a PALS service and supports patients in accessing this service should they require help and will signpost them to the appropriate place. If people report that they do not feel informed after speaking to PALS then this is investigated as a concern and/or they are advised about the formal complaint procedure.

Interpreters and advocates are provided for patients, carers and service users to ensure that those who do not have spoken English as their first language are supported in making decisions about their care. By providing trained interpreters ESHT ensures patients are fully informed and involved in their own care.

The Learning Disabilities Liaison Team (LDLT) have provided many additional tools to assist patients with learning disabilities (LD). These ensure that these patients have the same access to treatment and care as those without LD, that they are involved in decisions about their care and that their wishes are taken into account. 'This is Me Care Passport' or Disability Distress Assessment Tool (DISDAT) are carried out and remain on the patient's record through a flagging system, highlighting any additional needs.

Many patients with LD required surgery and/or treatments during 2014/15. To ensure equal access to treatments, many reasonable adjustments were made. This included supporting patients in their own home environment prior to admission to hospital.

Patient Feedback

In the CQC Inpatient Survey 2014 8.3/10 Patients reported having confidence in the decisions about their condition or treatment but only 7.2/10 reported that they were as involved as they wanted to be in decisions made about their condition or treatment.

Grade:	**DEVELOPING** – Most protected groups fare as well as people overall. Robust data is not available for all groups

Evidence for grading:

- Language & Communication Policy
- Revised consent policy and process
- Individualised care plans
- Those with L&D requirements flagged on in house system
- Patient feedback

Plans for 2015-16

- The Trust is developing a Communications and Engagement Strategy which identifies the organisations commitment to improving communication with patients and the public and to continuously seek patient feedback and experiences.

EDS2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.3
Outcome: People report positive experience of the NHS	

Summary of Activity:

The Trust's information systems are not currently set up to collect information on all protected groups so there is a lack of evidence available in order to draw comparisons

Engagement & Patient Feedback

The CQC national children's inpatient and day case survey was carried out for the first time in 2014. This survey focused on young people who were admitted to hospital as inpatients or for treatment as day case patients. One hundred and thirty seven acute and specialist NHS Trusts across England participated. Nationally nearly 19,000 surveys were returned about the care of young patients, a response rate of 27%. The response rate for ESHT was 31% (125) and therefore higher than the national response rate. Young patients were eligible to take part in the survey if they were:

- Aged between 0-15years
- Not staying in hospital at the time patients were sampled
- Not "well babies" i.e. new born babies where the mother is the primary patient
- Were admitted to hospital in August 2014 (some trusts also sampled patients who were admitted in July or September 2014)

The report shows how a trust scored for each evaluative question in the survey compared with other trusts. It utilises an analysis technique called the "expected range" to determine if the trust is performing "about the same", "better" or "worse" compared with other trusts.

The results of the report are presented for two main groups of respondents: children and young people, and their parents or carers. Each of these groups used different questionnaires, although both are focused on the care provided to the young patient. The report presented feedback from the following groups:

- Children and young people aged 8-15 years
- Parents and carers of patients aged 0-15 years
- Parents and carers of patients aged 0-7 years (where questions were only asked of this group)

There are nine different sections within the survey. The responses for ESHT were 'about the same' as other Trusts for eight of the sections. The section which identified ESHT was amongst the "worst performing trusts" was "being prepared to leave hospital".

This report also captured gender and ethnic characteristics. ESHT response rate was higher than the national average (by 4%). The completion of the survey by "white"

people was higher than the national average (ESHT 87%, nationally 79%) however “multiple ethnic group”, “Asian or Asian British”, “Black or Black British”, “Arab or other ethnic group” were all lower than the national average. Given our diverse population across the Trust, further work needs to be completed in order to find out if these ethnic groups are able to access hospital care appropriately.

Friends and Family Test (FFT) does collect information regarding age, sex, ethnic group and disability. 2,312 under 16 year olds attended Accident and Emergency during 2014/15. 87% of under 16 year olds said they would recommend the Trust to friends and family, however 11% said they were “neither likely or unlikely” or “don’t know” if they would recommend the organisation to their family and friends. The data available through FFT is quantitative and it is not possible to analyse it into categories of what certain groups of under 16 year olds said about the Trust (i.e. gender, ethnicity or disability). A further breakdown of the FFT is contained in the 2014/15 Equalities Analysis to Support EDS2.

The FFT analysis of Inpatient adults suggests that females who identified as BME were 3.8% less likely to report a positive experience when compared to female patients who identified as ‘white’ and compared to the total figure overall. This figure was slightly lower at approximately 2.5% when looking at under 16 year olds. Further analysis is available in the 2014/15 Equalities Analysis to Support EDS2.

NHS choices is a website where service users can post comments about their experiences of using NHS services. It does not collect any information regarding the characteristics of those posting comments which the Trust is able to access.

Leadership

Leadership is provided by dedicated patient experience leads, champions, advisors and monitoring through bi-monthly Patient Experience Steering Groups.

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Friends and Family Test
- NHS Choices
- CQC surveys

Plans for 2015-15

- Patient engagement page of Trust website to be developed to include themes and trends from complaints, FFT, 'you said we did', links to survey reports, links to NHS choices and Healthwatch.
- Host a 'Patient Engagement Event' in quarter 2 of 2015/16 to develop quality indicator(s) for compassionate care
- Customer care training is being developed
- All staff groups to be involved in the Dignity Day (Doctors, Nurses, Administrators, Allied Health Professionals)
- Those who use interpreters will be able to complete an FFT questionnaire in their preferred language

EDS2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.4
Outcome: People's complaints about services are handled respectfully and efficiently	

Summary of Activity:

The Trust is committed to continuously improving the outcomes for patients and achieving excellence in patient care and the patient experience.

Complaints are viewed positively and as a valuable form of feedback, playing an important role in the Trust's Governance and Quality Improvement processes, by maintaining and improving the quality of services provided. It is therefore important that there is a consistent and effective process for receiving and handling feedback and making positive use of the information gained to avoid similar occurrences by identifying lessons learned, sharing that learning and generally improving services. The Trust has adopted the 4C approach, consisting of complaints, compliments, comments and concerns, in order to manage patient experience.

Engagement & Support

If it is appropriate, complainants are made aware of Support, Empower, Advocate, Promote (SEAP). This is an independent service which helps service users to pursue complaints within the NHS at the point of acknowledging the complaint. Advocacy caseworkers support complainants in drafting letters, representing them or attending meetings with them. The level of support varies according to the complainant's personal needs. Healthwatch East Sussex (HWES) supported 256 people with complaints via "Support, Empower, Advocate, Promote."

Complaint responses are tailored to the complainant's needs in the form of a letter, meetings, through an advocate or family member (if consent is provided).

The table below shows the number of received, closed and reopened complaints for the years of 2013/15 and 2014/15.

Year	Complaints received	Closed complaints	Reopened complaints
2013/14	632	629	87 (14%)
2014/15	734	698	103 (15%)

Reopened complaints have increased by 1% compared from 2013/14 to 2014/15. In these cases initial findings show that the original complaint response did not answer all the questions within the original complaint. The Trust has initiated a robust quality assurance process which ensures all questions are answered in a language the complainant can understand. The number of reopened complaints has decreased in the first quarter of 2015.

Data is not always available to identify the protected characteristics of complainants. However, if any equality and diversity concerns are identified from a review of the complaint these are highlighted to the Trust EDHR lead and service.

Initiatives

A Dignity Day was held in February 2015 which included looking at areas where patients, carers and relatives had both positive and negative experiences. Following evaluations given at the end of the Dignity Day, all staff groups will be invited to attend further Dignity Days as speeches by service users proved to be very powerful and thought provoking about the way in which we communicate with our patients.

Grade:	**Undeveloped** - Data is not currently collected to identify protected groups within complaints

Evidence for grading:

- Complaints data for 2013/14 and 2014/15
- Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C)
- Dignity Day
- Escalation of any E&D issues to relevant staff
-

Plans for 2015-16

- A post complaint survey is due to be implemented in October 2015. This will be sent to all complainants for completion and they will be invited to attend a complaints service user group. This survey will include monitoring protected characteristics.
- A complaints training package is to be developed and delivered to all staff, this training will include customer care and the complaints handling process (October 2015).
- Datix will be reviewing and updating our system to ensure we are capturing and able to report on the appropriate information to ensure all complaints are handled in a culturally competent way.

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.1
Outcome: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	

Summary of Activity:

Leadership

The Director of Human Resources oversees the operational delivery of recruitment and selection to support the Trust's strategic aims. Trust managers are required to undertake recruitment and selection training prior to becoming involved in the recruitment process. The Trust engages with local community groups – e.g. schools for careers fairs and employers for job fairs to promote the organisation as a local employer.

The Trust has a Recruitment and Selection Policy, to ensure all staff involved in recruitment and selection understand their roles and their responsibilities in ensuring that they recruit the best possible candidate into a post, regardless of any negative forms of discrimination. Staff are also encouraged to look at under representative groups and advertise using BME networks when senior positions are being recruited for. See the 2014/15 Equalities Analysis to Support EDS2 for details of ESHT workforce.

The mandate for employment checks in the NHS (in England) was issued by the Department of Health under Health Circular HSC2002/008 in May 2002. This includes standards which outline the legal and mandated employment checks that NHS organisations must carry out to meet the Department of Health's core standards outlined within the Standards for Better Health. The Trust's recruitment and selection policy adheres to these standards.

The policy provides a framework for managing recruitment and selection in an efficient, effective and fair manner, ensuring selection of the best possible candidate for a vacancy. It seeks to ensure that no unlawful discrimination occurs during the recruitment and selection process, that equality of opportunity is an integral part of the procedure and that all relevant pre-employment checks are undertaken for all staff.

The Trust has an online training portal for managers, accessible at any time, and runs ad hoc face to face training sessions for those who do not have IT access or the skills to use the technology.

There is a dedicated recruitment team, based within HR, who give help, advice and support throughout the recruitment process, as well as providing administration for the process. All activity is monitored to ensure consistency and compliance with the recruitment standards. To support this, the Trust has recently started to use a new recruitment system that delivers end-to-end tracking of the process, visible both to the recruiting manager and the recruitment team. This supports monitoring compliance with recruitment standards. See the 2014/15 Equalities Analysis to Support EDS2 for workforce recruitment: shortlisting to appointment figures

Engagement

The Trust engages with Job Centre+ to promote vacancies and has participated in a development session with local Job Centre+ representatives in order to gain an informed understanding of each other's role, to deliver better working together.

The Trust is committed to employing disabled people as identified by the 2 ticks symbol. Job Centre+ are responsible for the annual monitoring of the Trust's continued adherence to, and compliance with, the 2 ticks standards and the on-going permission to continue to use the symbol. The last successful review took place in March 2015. See appendix B detailing requirements for two ticks status.

Focussed work has taken place in a number of areas. For example

- Supported initiatives such as Project Search, delivering training and support in developing skills when applying for jobs and interview skills.
- Supported interview skills development for the charity 'ambitious about autism' which helps 16 – 24 year olds with autism to gain the right skills to apply for jobs.
- Attendance at job fairs set up by Job Centre+, the most recent for the over 50 age group.

Grade:	**Achieving –** There is good evidence / data that suggest all groups fare as well as people overall

Evidence for grading:

- Trust policy and training on recruitment and selection
- Support for recruitment and training for some disadvantaged groups
- Raising awareness of opportunities to disadvantage groups
- Two ticks symbol status continuing

Plans for 2015-16

- Policy review to ensure all policies governing recruitment and selection continue to comply with best practice
- Improve monitoring of staff recruitment and selection training to demonstrate compliance
- Under representative groups for all levels will be monitored and action taken accordingly

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.2
Outcome: The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil legal obligations	

Summary of Activity:

The Trust follows national established pay scales for all staff:
Agenda for Change – All non-medical staff
Medical & Dental Pay Scales
VSM Pay Scales – For very senior staff where AfC is not applicable.

The process that is followed on appointment or promotion is detailed in the organisation's recruitment policies. There is a process in place to consider increasing credit on appointment to the Trust by taking into consideration relevant experience gained outside of the NHS. The correct grading for a role is established through the job evaluation process or the medical job planning process. Established policies are in place for when someone is acting down (Acting Down policy), and guidance for temporarily acting up. A Pay Protection policy is in place for when staff may be redeployed to a lower graded post either for personal reasons or through organisational change.

Engagement
Policy development or changes to existing policies and processes are negotiated via the Policy Group (includes staff side representation), and ratified at the Joint Staff Committee (JSC), and Clinical Management Executive (CME).

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Established national guidance and local policies – Open and transparent processes.

Plans for 2015-16

- Conduct full equal pay audit using audit tool

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.3
Outcome: Training and development opportunities are taken up and positively evaluated by all staff	

Summary of Activity:

Leadership & Engagement
The Trust has an Integrated Education Steering Group, which is multidisciplinary and includes director representation. The Trust has a large education remit for all staff. Education and training opportunities are provided through:

- Mandatory Training (e-learning and classroom based – applicable to all staff)
- Medical Education manages the Foundation Programme, Core Medical and Surgical and GP Vocational Training schemes for medical doctors and also dental doctors in training. This includes a centralised Induction Programme for all incoming doctors in training followed by a Local Induction in their clinical placements.
- Learning & Development Department (Manage mandatory training, essential skills training, role specific training, general training, e.g. Soft skills, and Medical study leave for Doctors)
- Learning Funding Panel – Meets monthly and authorises applications for education that require funding (mainly with our established Higher Education Institutes (HEIs). The panel comprises representatives from across the Trust and includes staff side learning reps.
- Clinical Practice Team – Manages the commissioning of professional education (all non-medical), manages placements, supports newly qualified staff and develops staff in bands 1-4.
- National Programmes – e.g. National Leadership Academy programmes.

The above are supported by polices which outline processes for applying for funding.

Training and Education opportunities are evaluated in a number of ways:
Commissioned and funded training courses are evaluated via the HEIs and this information is fed back to the organisation.

Internal Trust courses are evaluated by participants at the end of each course. Poor evaluations are fed back to the lead trainers for action. In addition, internal 'Train the Trainer' courses take place regularly and specialist trainers are encouraged to attend these.

Staff feedback
83% of ESHT staff believed they were provided with equal opportunities for career progression or promotion. This is a decrease of 1% compared to the previous year. The national average for acute Trusts in 2014 was 87% with the best score of 96%

- 85% White respondents believed they were provided with equal opportunities for career progression or promotion.

- 70% BME respondents believed they were provided with equal opportunities for career progression or promotion.

Available figures demonstrate BME staff were 1.13 times more likely to access non-mandatory training compared to white staff.

Collection of data on those accessing non-mandatory training is incomplete due to how this data is captured. Line managers often block book places on conferences and university workshops, the booking forms require a line manager's name plus the number of attendees and not necessarily individual names. Therefore identifying members of staff who have attended these non-mandatory training events has proved challenging. Where staff have been identified this has been reported.

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Established policies and processes in place. Records show training is accessed by staff across the Trust and at all levels. The Trust's Learning Funding Panel is multi-disciplinary and has representation from across the Trust. Staff Survey questions

Plans for 2015-16

- Embed more active diversity monitoring of funding applications and take up of education commissions.
- Improve monitoring and data collection of all staff accessing non-mandatory training.

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.4
Outcome: When at work, staff are free from abuse, harassment, bullying and violence from any source	

Summary of Activity:

Engagement

The Trust is committed to ensuring that the culture of the organisation empowers staff to speak up and work in an environment which is free from harassment, bullying, and victimisation. However, the staff survey and CQC inspection feedback showed that the Trust needs to do more to ensure staff are free from abuse, harassment, bullying and violence from any source and that when this does happen they are supported to speak up.

The Listening into Action (LiA) Group was set up to establish and review issues and develop an action plan to address issues and promote a culture of speaking up. A number of Listening into Action events have been organised to engage and support staff. The Trust has a Staff Health and Well-being Board, whose membership includes the EDHR lead.

Staff Feedback

Results from the staff survey revealed 31% of ESHT staff reported they had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, an increase of 2% from the previous year. The national average for acute Trusts in 2014 was 29% and the best score was 20%. 31% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. 26% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

27% of ESHT staff indicated on the survey they had experienced harassment, bullying or abuse from staff in last 12 months. This was an increase of 1% from the previous year. Only 31% indicated that this was reported. The national average for acute Trusts in 2014 was 23% and the best score was 17%. 26% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. 25% BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months.

8% of respondents felt they had experienced discrimination at work from their manager or team leader. The national average was 8%.

4% reported they had experienced discrimination at work from their manager or team leader on the grounds of ‘ethnicity’. The national average was also 4%.

2% reported ‘gender’ discrimination, 1% ‘disability’ related discrimination, 2% felt they were discriminated because of their ‘age’ and 4% reported ‘other’.

Harassment & Bullying Initiatives

Medical Education has accomplished the following during the past year with reference to bullying and undermining behaviour as they impact doctors in training:

- Dealing with Undermining & Bullying Behaviours Workshop (half-day) with external facilitators. There were 20 in attendance. Invitees included Medical Director, College Tutors/LFG Leads, Clinical Unit Leads, Medical Education Executive, General Managers, HR Managers, L&D Managers and Chair of Trust Education Steering Group.
- Statement from Medical Director produced and given to all new incoming trainee doctors from August 2015 onwards. MD and other Senior Managers emphasising "zero tolerance" approach and support at doctors' Induction.
- Independent person (external to Trust) appointed in May 2015 for Foundation doctors to go to so that they can raise any concerns in a safe and non-judgemental environment.
- Supervisors' workshops ran from January – July 2015 (five in total) with 74 Educational Supervisors attending. One of the areas covered was how to give appropriate/constructive feedback to doctors in training.
- Charter of Trainer & Trainee Responsibilities and Educator Standards documents sent to all Supervisors. The former has to be signed off by trainer and trainee at their first meeting with a copy returned to Medical Education.
- Google feedback tool (developed by Anaesthetics) made generic and rolled out to all clinical departments in June 2015. This provides an anonymous mechanism for trainees to feedback on their supervisors.
- GMC "Mock" Survey done in December 2014 (76 respondents) to gauge Harassment and Bullying within the Trust and other issues with reference to doctors in training.
- GMC Building a Supportive Environment document distributed to all College Tutors.

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Dignity at work policy. Raising Concerns policy, Independent Board member
- Staff survey Results – 2014 23% of staff reported harassment & bullying.
- CQC Inspection
- Local security management service which investigates reports of violence against staff by patients or other employees
- Reports to Quality and Standards committee
- Statement from the Medical Director demonstrating continued commitment to tackle H&B in the workplace

Plans for 2015-16

- Appointment of Speak Up Guardian.
- Implementation of Harassment & Bullying (H&B) action plan to include implementation of Harassment and Bullying Champions, communications plan, development programme for managers
- H&B - channels for reporting to be communicated via EDHR mandatory training
- Implement an EDHR Policy explicitly highlighting H&B is a disciplinary offence and will not be tolerated
- EDHR Training will reiterate the Trusts commitment to tackling H&B and encourage reporting

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.5
Outcome: Flexible working options are available to all staff consistent with the needs of the service and the way that people lead their lives	

Summary of Activity:

Implementation of policies and any revisions are overseen by the Deputy Director of HR. The Trust recognises that offering flexible working opportunities increases the potential workforce and supports staff to remain in employment and retain skills within the Trust. This approach also supports the Health and Well-Being agenda, as supporting staff in maintaining a good work-life balance reduces stress amongst the workforce.

The Child and Family Care Manager undertakes drop-in sessions for staff, maternity returners, and carers events. 121 sessions were held for staff as part of the process of organisational change. Flexible working options are reviewed annually as part of each member of staff's Personal Development Review. The E-rostering system allows for an element of self rostering.

Any member of staff can request flexible working and wherever their service permits, managers will always endeavour to accommodate such requests. Many staff request temporary flexible working arrangement, such as during school holidays when childcare can become difficult. However, data on this is not collected as arrangements are generally agreed locally amongst teams and therefore not recorded within HR.

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Flexible Working Policy
- Recruitment and Retention Strategy
- Organisational Change Policy
- Special Leave Policy
- Attendance Management Policy
-

Plans for 2015-16

- Review the effectiveness of policies and through workforce planning process, identify if further actions or engagement is required.

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.6
Outcome: Staff report positive experiences of their membership of the workforce	

Summary of Activity:

The Trust has a number of policies such as 'Health and Well Being' in place to support staff in feeling motivated and engaged. It is hoped that by doing this, an increased number of staff will feel able to recommend the Trust as a place to work, or a place in which to receive treatment.

The Annual Awards Ceremony was held in May 2015 at the De La Warr Pavilion in Bexhill. It celebrated the amazing work that Trust staff do on a daily basis and recognised their achievements. Over 200 nominations were received for the eight categories and winners and finalists were chosen by panels of independent judges. The event was supported by local businesses and by the Leagues of Friends.

Project Search

Eleven young adults with learning difficulties or disabilities graduated in July 2015 from a pilot scheme called Project Search, which was run as a joint partnership. The project is designed to give young adults with learning difficulties or disabilities, an under-represented group in the workplace, the skills to gain competitive paid employment.

Feedback from the interns, Sussex Downs College and East Sussex County Council, along with supported employment service ChoicES, has been very positive. The interns felt that they were able to try lots of different job roles which increased both their self-confidence and their self-esteem.

Staff Feedback

The staff survey highlighted that a high proportion of staff would not recommend the Trust as place to work.

- 64.29% of Gay staff and 66.67% of Lesbian staff unlikely or extremely unlikely to recommend the Trust as a place to work.
- 52.48% of staff who identified as being disabled were unlikely or extremely unlikely to recommend the Trust as a place to work.
- 62.50% who recorded as being of Islam religion were the highest group likely or extremely likely to recommend the Trust as a place to work, 0.00% Islam religion were unlikely or extremely unlikely to recommend the Trust as a place to work.

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Staff Health & Well-Being Policy
- Staff feedback
- Staff Health & Well-Being Steering Group
- Staff Engagement Group and Engagement Action Plan
- Staff Conversations

Plans for 2015-16

- Delivery of Staff Engagement Action Plan and Quality Improvement Plan
- LiA Groups to establish reasons why staff were unlikely to recommend the Trust
- Black, Asian & Ethnic Minority Listening Groups to commence
- Establish LGBT Listening Groups

EDS2 Goal 4: Inclusive leadership	**EDS2 Reference Number: 4.1**
Outcome: Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	

Summary of Activity:

Leadership & Engagement
The Quality and Standards Committee, chaired by a Non-Executive Director, monitored the effectiveness of the Trust's equality delivery systems and reported to the Trust Board.

Medical Director
The Medical Director released a statement of 'Our commitment to address the issue of bullying and undermining of doctors in training'. The statement is one of many steps the Trust Board and the Medical Director are taking to address the issue and to communicate a "zero tolerance" approach. The Director of Medical Education and Human Resources have been working with Health Education Kent, Surrey & Sussex (HE KSS) and Health Education South London (HESL) to develop approaches, strategies and interventions that the Trust will employ to tackle the issues.

Finance Director
The Director of Finance chaired the Age and Healthcare Steering Group. Membership comprised representatives from seniors groups across East Sussex, ESCC Adult Social Care as well as the Trust's Head of Equality & Human Rights and clinicians from within the Trust.

The Group reflected on national and local issues from an older person's point of view and tried to ensure that local services delivered by ESHT 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 our meetings to their membership. During the year the Group completed its Age Equality Action Plan which it has 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

Staff Feedback:
The Staff FFT suggests that large proportions of protected groups were unlikely to recommend the Trust as place to work. Staff engagement and action plans to address these concerns are being developed

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- Quality and Standard Committee terms of reference
- EDHR SG minutes
- Equality Action plans

Plans for 2015-16

- Board members to engage in equality initiatives
- Directors and Senior Managers to promote equality when conducting quality walks
- Directors and Senior Managers to hold monthly conversations open to all staff
- Action plans to address these concerns will be established

EDS2 Goal 4: Inclusive leadership	**Reference Number: 4.2**
Outcome: 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	

Summary of Activity:

The Trust Equality Objectives 2015 – 2019 include: "all strategies, business plans and annual reports that come before the Board or other major committees will include the Trust's standard Due Regard, Equality & Human Rights Analysis, including how any inequalities will be managed". This form is an integral part of the policy writing template and therefore no strategy, business plan or annual report will be considered by the Board or other major committee without this information being completed.

The Trust has an established Equality, Diversity and Human Rights (EDHR) Lead who is line managed by the Company Secretary. The EDHR Lead meets regularly with the Chief Executive, Director of Nursing and other Medical and Non-Medical Executives. The Equality Steering Groups are linked with Patient Experience and one group is made up of champions, patients, volunteers as well as the EDHR and PE Leads. This group feeds into the EDHRSG and PESG. Equality & Diversity is held at the most senior level to ensure there equality is considered in all decision making processes. The EDHRSG will monitor the quality of the EHRA forms submitted.

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- There was no robust way of monitoring all documents that came before the Board and other committees in 2014/15. A new analysis was designed and is part of the policy writing template, require all procedural documents, strategies and reports to Equality and were examined to ascertain equality-related impacts and risks and how these risks would be managed in relation to the general duty of the public sector Equality Duty.

- 13 papers were examined containing EHRA. The analysis identified some potential risks and had given due regard and made reasonable adjustments where appropriate. With the new mandatory process in place all protected characteristics will be considered during local and Trust wide decision making processes.

Plans for 2015-16

- Policy writers will undergo further training and have support when considering equality during decision making processes
- All strategies, business plans and annual reports that come before the Board or major committees will include the Trust's standard Due Regard, Equality & Human Rights Analysis
- An overarching Equality & Human Rights Policy will be published.
- Translation & Interpreting services will be led and managed by the EDHR Lead.

EDS2 Goal 4: Inclusive leadership	EDS2 Reference Number: 4.3
Outcome: Middle managers and other line mangers support their staff to work in culturally competent ways within a work environment free from discrimination	

Summary of Activity:

Staff Annual Awards

Many members of staff consistently go above and beyond their everyday roles to ensure that patients and staff feel supported. The Annual Staff Awards are an opportunity for the Trust to recognise such Leadership. This year the Leadership award was given to a Head of Nursing for her "focused, inspirational, dynamic leadership style … always displaying a passion for quality, safety and a positive patient experience and instils this in all her staff".

Training

All staff are required to undertake mandatory Equality and Diversity training, either face to face or via E-learning as part of their Trust induction. Line managers are offered additional training on completing Equality & Human Rights analysis when delivering their policies, procedural documents, guidance, strategies etc.

Equality, Diversity & Human Rights mandatory training compliance was 61.69% at the time of reporting. The Trust aims to increase the compliance rate to 85% with additional sessions through 2015/16.

Staff Feedback

The staff survey results showed that 76% of respondents 'felt 'satisfied or 'very satisfied' with the support they received from their colleagues with 7% responding as 'dissatisfied' or 'very dissatisfied'. The percentage of staff feeling they were supported by their immediate manager was lower at 58% with 22% saying they were 'dissatisfied' or 'very dissatisfied'. 86% responded that their manager supported them with receiving training / learning & development.

Grade:	**Developing** - Evidence suggests that people from only some groups fare as well as people overall as data is not available for all protected groups

Evidence for grading:

- E&D Policy
- Equality and diversity training evaluations
- Staff Feedback

Plans for 2015-16

- Mentoring schemes will equip managers with the skills to promote positive cultural change

Appendix

Equalities Analysis to Support EDS2 Report 2014/15

Spoken community Language interpreters supplied to patients, service users or carers during 2014/15

Language Requested	Total	St Leonards	Eastbourne	Surrounding Areas
Polish	159	52	106	1
Mandarin	155	107	41	7
Portuguese	96	10	86	
Cantonese	66	22	27	17
Arabic	51	22	28	1
Czech/Slovak	46	43	2	1
Russian	32	15	17	
Farsi	30	8	15	7
Bengali / Bengla	24	11	13	
Spanish	23	6	17	
Turkish	23	8	15	
Sorani	19	18	1	
Tamil	13	3	10	
Bulgarian	11	4	7	
Hungarian	10	2	8	
Thai	8	1	7	
Romanian	7	5	2	
Latvian	6	2	4	
Lithuanian	6	4	2	
French	5	5	0	
Italian	5	0	5	
Kurdish/sorani	4	3	1	
Slovakian	4	4		
Albanian	3	2	1	
Vietnamese	2	2	0	
Dari	1	1	0	
German	1	1	0	
Greek	1	0	1	
Hindi	1	0	1	
Mauritian	1	0	1	
Urdu	1	1	0	
Total	**814**	**362**	**418**	**34**

Adult inpatient FFT Responses by ethnicity and gender (percentage of inpatients how likely inpatients would recommend ESHT)

Inpatients	Likely or Extremely Likely (%)	Unlikely or Extremely Unlikely (%)	Don't know or neither likely nor unlikely (%)
All inpatients	94.91	1.41	3.68
Female	94.94	1.40	3.86
BME Female	91.11	2.22	6.66
White Female	95.11	1.37	3.52
Male	95.30	1.27	3.43
BME Male	95.24	0	4.76
White Male	95.46	1.31	3.23
BME All	91.97	2.01	6.02
White All	95.20	1.37	3.44
BME includes all who identified as any 'Black African', 'Black Caribbean', and 'Any Other Ethnic groups', Asian, and 'Mixed Ethnic Group'. White includes all who identified as 'White British', 'White Irish' and 'White Other' 3.22% did not disclose their age or gender 2.93% did not disclose age, gender or ethnicity			

Breakdown by Age (16 and less), Ethnic Group and Disability

	Likely or Extremely Likely (%)	Unlikely or Extremely Unlikely (%)	Don't know or neither likely nor unlikely (%)	Total
All under 16yrs	85.21	3.59	11.2	2312
Female	84.5	3.6	11.91	890
Male	86.61	3.71	9.68	1105
Prefer not to say (Gender)	82.33	3.15	15.46	317
No Disability Identified	87.29	3.1	9.61	645
Disability identified	84.85	4.55	10.61	660
Prefer not to say (Ethnicity)	79.46	3.7	16.84	297
BME All	83.77	5.84	10.39	154
White All	86.24	3.39	10.37	1861
Due to the risk of patient confidentiality, for this report 'Disability' includes, 'communication', '(d)Deafness', '(b)Blindness', 'Learning Disabilities', 'mobility' and 'other disability'.				

Primary Diagnosis on Admission of Asthma, Diabetes or Epilepsy age <19 years - where admission was not elective for the last 3 years

Age at Discharge	2012/2013	2013/2014	2014/2015	Total
0-4 years	148	110	92	**350**
5-9 years	82	70	65	**217**
10-15 years	75	70	103	**248**
16-18 years	38	17	48	**103**
Total	**343**	**267**	**308**	**918**

Sex	2012/2013	2013/2014	2014/2015	Total
Female	132	121	144	**397**
Male	211	146	164	**521**
T o t a l	**343**	**267**	**308**	**918**

Ethnic Group	2012/2013	2013/2014	2014/2015	Total
ABME	33	28	33	**94**
Not recorded / stated	43	41	42	**126**
White	267	198	233	**698**
T o t a l	**343**	**267**	**308**	**918**

Table to show average Referral to Treatment Time in weeks during 2014/15

Speciality	Average RTT	Admitted Average RTT	Non Admitted Average RTT	Overall Total Proportion of Service Users (%)
General Surgery	10.3	11.8	9.8	7.90%
Urology	7.5	9.1	6.8	6.16%
Breast Surgery	3.9	4.6	3.7	3.26%
Vascular Surgery	10.3	7.5	10.7	0.84%
Trauma And Orthopaedics	11.6	15.3	9.4	12.17%
Ear, Nose And Throat	7.7	11.6	7.0	8.12%
Ophthalmology	9.0	12.7	7.7	14.38%
Maxillo-Facial Surgery	11.4	14.1	10.0	7.65%
Paediatric Surgery	7.7	6.4	7.8	0.06%
Anaesthetics	2.1		2.1	0.52%
Pain Management	6.3	13.3		0.92%
Paediatric Epilepsy	6.1		6.1	0.08%
General Medicine	5.8	1.7	8.0	0.23%
Gastroenterology	13.6	5.2	14.2	4.00%
Endocrinology	7.1	3.0	7.2	0.98%
Haematology	6.1	1.2	6.3	0.92%
Diabetic Medicine	7.0		7	0.52%
Palliative Medicine	1.5		1.5	0.09%
Cardiology	6.0	8.1	5.6	6.16%
Transient Ischaemic Attack	1.2		1.2	0.28%
Dermatology	5.6	7.0	5.4	4.10%
Thoracic Medicine	7.1	2.4	7.3	2.19%
Respiratory Physiology	6.9		6.9	0.36%
Neurology	10.8	7.2	10.8	2.70%
Rheumatology	21.5	1.8	21.8	2.31%
Paediatric Medicine	6.7	5.8	6.7	3.84%
Medicine For The Elderly	5.6	1.0	5.6	0.95%
Gynaecology	8.3	10.8	7.6	7.03%
Clinical Oncology	2.7	1.3	2.8	1.24%
Paediatric Diabetes	5.0		5	0.01%
Radiology	2.1	2.7	0.8	0.03%
Total Ave RTT (weeks)	**9**	**11.9**	**8.2**	**100**

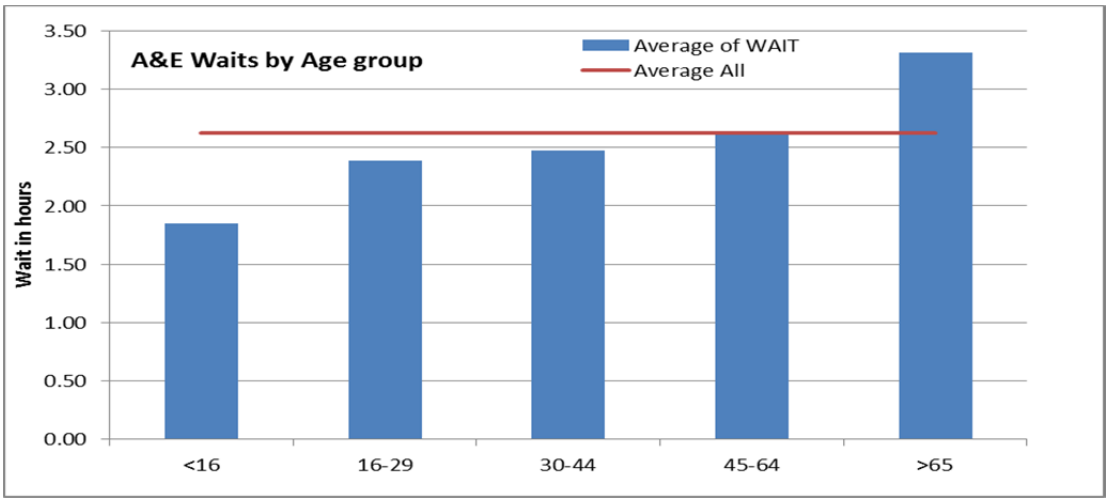
Table of Average RTT time broken down by Ethnicity

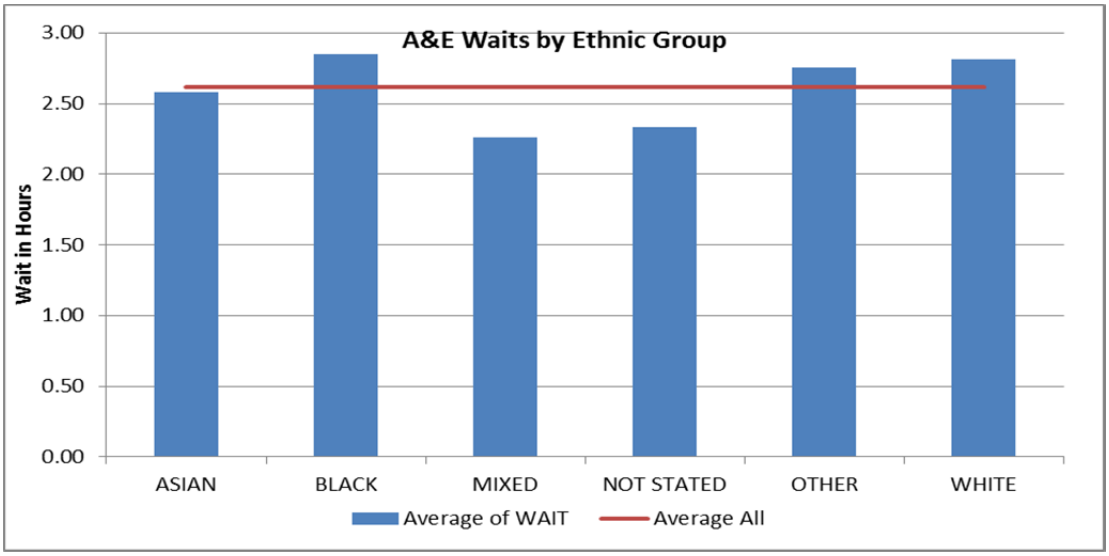
Ethnicity	Total Service Users (%)	Overall	Admitted	Non-Admitted
White	68.42	9.1	11.9	8.2
Mixed/Multiple ethnic	0.4	9.1	13.4	8.0
Asian/Asian British	0.72	9.1	11.7	8.4
Black/	0.33	9.9	11.7	9.4
Other ethnic group	0.53	9.4	12.6	8.5
Unknown	29.6	8.7	12.3	8.3
Grand Total	**100**	**9.0**	**11.9**	**8.2**

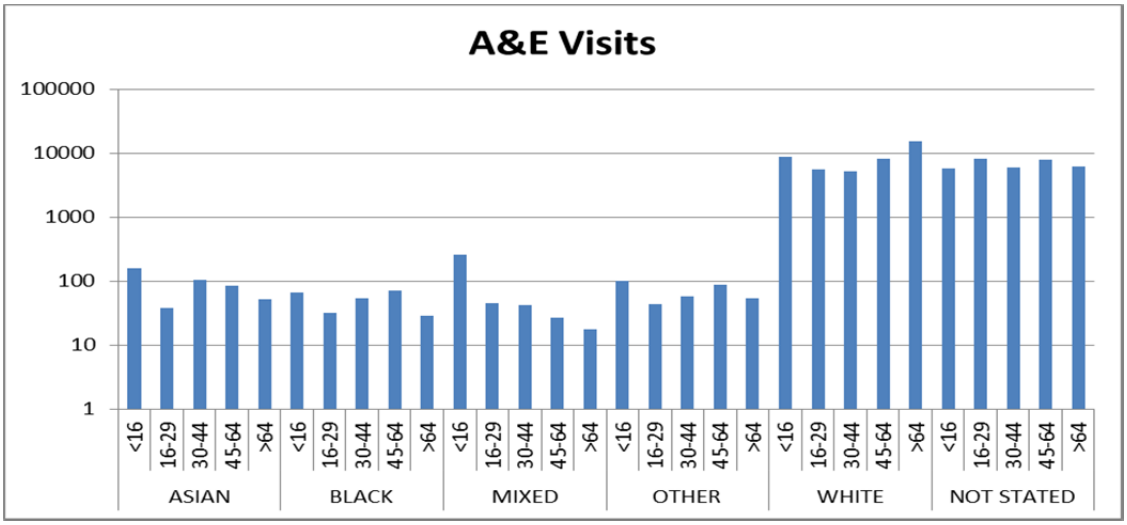
Table of Average RTT time broken down by Age

Age	Total Users (%)	Ave (weeks)	Admitted	Non-Admitted
<16	8.89	7.9	13	7.4
16-30	9.6	10.1	13.8	9.3
31-45	12.85	10.0	13.5	9.2
46-64	26.0	9.5	12.2	8.8
65+	42.66	8.4	11.0	7.6
Grand Total	**100**	**9.0**	**11.9**	**8.2**

Average A&E Waiting time in hours 2014/15







ESHT Risk Adjusted Mortality 2014 (RAMI) April 2014 to March 2015 35 Years and Over by Age Band

Column1	Male	Column2	Female	Column3	Total	Column4
Age band	deaths	RAMI Index	deaths	RAMI Index	deaths	RAMI Index
35-39	2	117	1	72	3	97
40-44	6	169	5	107	11	134
45-49	7	130	8	151	15	140
50-54	12	105	9	82	21	94
55-59	22	93	15	85	37	89
60-64	36	117	10	69	46	102
65-69	56	109	33	96	89	104
70-74	63	119	48	106	111	113
75-79	112	105	80	90	192	98
80-84	149	118	153	111	302	115
85-89	163	97	186	90	349	93
90+	148	115	252	117	400	116

Workforce Profile broken down by protected characteristics

East Sussex Healthcare NHS Trust employed 6566 as of 31st March 2015. Below is a summary breakdown.

Ethnicity

Ethnicity	Number of workforce	Percentage of Workforce (%)
White / White other	5357	81.59
Black, Asian and Ethnic minorities	772	11.75
Undefined, not stated, unknown	437	6.66

Age

Age Group	Number of Employees	Percentage of Employees (%)
<=29 yrs old	824	12.55
30-44	2226	33.90
45-59	2899	44.15
60-77	617	9.40

Gender

Gender	Number of Employees	Percentage of Employees (%)
Female	5142	78.31
Male	1424	21.69

Religion

Religion	Number of Employees	Percentage of Employees (%)
Atheism	594	9.05
Buddhism	28	0.43
Christianity	2362	35.97
Hinduism	74	1.13
Islam	77	1.17
Judaism	6	0.09
Other	294	4.48
Sikhism	8	1.12
Undisclosed / not stated	3123	47.56

Sexual Orientation

Sexual Orientation	Number of Employees	Percentage of Employees (%)
Bisexual	19	0.29
Gay	26	0.40
Heterosexual	3521	53.62
Lesbian	20	0.30
Undisclosed / not stated	2980	45.39

Recruitment

2014 – 15 Annual monitoring of application, shortlisting and appointment across the protected characteristics:

Figures % of total applicants for each stage

GENDER	Applied	Shortlisted	Appointed
Male	35.50%	27%	21%
Female	64%	72%	77.50%
Undisclosed	0.50%	0.60%	1.50%

DISABILITY	Applied	Shortlisted	Appointed
Yes	3.70%	4.40%	4.40%
No	94.80%	94.10%	94.50%
Undisclosed	1.50%	1.50%	1.10%

ETHNICITY	Applied	Shortlisted	Appointed
White	72%	78%	85%
BME	26%	20%	11.50%
Undisclosed	2%	2%	3.50%

Staff Friends and Family Test
(percentage of staff; how likely they would recommend ESHT as a place to work)

Category	Likely/Extremely Likely (%)	Unlikely/Extremely unlikely (%)	Neither likely nor unlikely/don't know (%)
All Staff	**764**	**691**	**363**
Male	40.48	41.27	18.25
Female	42.43	37.15	20.42
Heterosexual	45.75	34.34	19.91
Gay	28.57	64.29	7.14
Lesbian	33.33	66.67	0.00
Not	36.07	43.52	20.42
Disabled	29.70	52.48	17.82
Not Disabled	47.63	33.67	18.71
Not	39.43	39.53	21.04
Christian	47.57	34.47	17.96
Islam	62.50	0.00	37.50
Hindu	47.37	26.32	26.32
Atheism	40.96	36.70	22.34
Not	34.96	43.70	21.35
Other	44.44	35.80	19.75

Workforce Race Equality Standard Metrics 2014/15

Workforce metrics For each of these four workforce indicators, the Standard compares the metrics for white and BME staff.	
1.	**Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce**
	At the time of reporting, ESHT employs 6566 members of staff. ❖ 11.8 % Identified as BME ❖ 81.6% Identified as White British or White Other ❖ 6.7% Unknown 6.7% of the workforce were employed in positions 8 – 9 and VSM. ❖ 17.1% of Bands 8 - 9 and VSM identified as BME compared to 11.8% BME in the overall workforce. ❖ 78.4% in Bands 8 - 9 and VSM identified as White British or White Other. ❖ 4.6% of staff in Bands 8 - 9 and VSM, ethnicity was unknown
2.	**Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.**
	4584 applicants were shortlisted. . ❖ 3576 applicants identified as White British or White Other ❖ 916 applicants identified as BME ❖ 92 applicants ethnic origin was unknown 730 applicants were appointed ❖ 620 appointees identified as White British or White Other ❖ 84 appointees identified as BME ❖ 26 appointees ethnic origin was unknown The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 1.88 times greater.
3.	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year**
	Staff identified as White British or White Other were 2.2 times more likely to enter the formal disciplinary process compared to staff identified as BME. These figures for reporting of staff entering into the disciplinary process over a 2 year period were extremely small. Only a relative likelihood figure is included due to the risk of breaching staff confidentiality. This is unlikely to change in 2015-16.

4.	**Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff**
	Available figures demonstrate BME staff were 1.13 times more likely to access non-mandatory training compared to white staff. Note: Collection of data on those accessing non-mandatory training is incomplete due to how this data is captured. Line managers often block book places on conferences and university workshops, the booking forms require a line manager's name plus the number of attendees and not necessarily individual names. Therefore identifying members of staff who have attended these non-mandatory training events has proved challenging. Where staff have been identified this has been reported.
National NHS Staff Survey findings For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for white and BME staff	
5.	**KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**
	31% of ESHT staff said they had experienced harassment, bullying or abuse from patients, relatives or the public in last 12 month. This is an increase of 2% from the previous year. The national average for acute Trusts in 2014 was 29% and the best score was 20%. ❖ 31% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. ❖ 26% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6.	**KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**
	27% of ESHT staff said they had experienced harassment, bullying or abuse from staff in last 12 months. This was an increase of 1% from the previous year. The national average for acute Trusts in 2014 was 23% and the best score was 17%. ❖ 26% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. ❖ 25% BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months.
7.	**KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion**
	83% of ESHT staff believed they were provided with equal opportunities for career progression or promotion. This is a decrease of 1% compared to the previous year. The national average for acute Trusts in 2014 was 87% with the best score of 96% ❖ 85% White respondents believed they were provided with equal opportunities for career progression or promotion. ❖ 70% BME respondents believed they were provided with equal opportunities for career progression or promotion.
8.	**Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**
	8% of respondents felt they had experienced discrimination at work from their manager or team leader. The national average was 8% ❖ 4% reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. The national average was 4%.

Boards Does the Board meet the requirement on Board membership in 9?	
9.	**Boards are expected to be broadly representative of the population they serve**
	ESHT Board is broadly representative of the population it serves. Although no members identify as BME they do identify with other protected characteristics which also have a high prevalence in East Sussex. Advertisement of current Board vacancies include BME networks/forums and other wider advertising such as The Telegraph.

Cancer Equalities Data 2014/15

1 year Survival and Death Rates by gender

Cancer 1yr Survival rate	Breast, Lung, Colorectal	Other Cancer	Total
Female	563	386	**949**
Male	177	419	**596**
Total	**740**	**805**	**1545**

Cancer 1yr Death rate	Breast, Lung, Colorectal	Other Cancer	Total
Female	116	158	274
Male	138	214	352
Total	**254**	**372**	**626**

Percentage of all who survived 1 year from diagnosis

Cancer 1yr Survival rate (%)	Breast, Lung, Colorectal	Other Cancer	Total
Female	25.93%	17.78%	**43.71%**
Male	8.15%	19.30%	**27.45%**
Total	**34.09%**	**37.08%**	**71.17%**

Percentage of all who died within 1 year of diagnosis

Cancer 1yr Death rate (%)	Breast, Lung, Colorectal	Other Cancer	Total
Female	5.34%	7.28%	**12.62%**
Male	6.36%	9.86%	**16.21%**
Total	**11.70%**	**17.13%**	**28.83%**

Comparison of Female & Male Survival Rates

Cancer 1yr Survival rate (%)	Breast, Lung, Colorectal	Other Cancer	Total
Female	36.44%	24.98%	**61.42%**
Male	11.46%	27.12%	**38.58%**
Total	**47.90%**	**52.10%**	**100.00%**

Comparison of Female & Male Death rates

Cancer 1yr Death rate (%)	Breast, Lung, Colorectal	Other Cancer	Total
Female	18.53%	25.24%	**43.77%**
Male	22.04%	34.19%	**56.23%**
Total	**40.58%**	**59.42%**	**100.00 %**

1 year Survival and Death Rates by age and gender

Age (years)	Breast Lung & Colorectal Cancer					Other Cancer					All Cancer Total
	Cancer 1yr Death rate		Cancer 1yr Survival rate		Total	Cancer 1yr Death rate		Cancer 1yr Survival rate		Total	
	Female	Male	Female	Male		Female	Male	Female	Male		
0-14	0	0	0	0	**0**	1	0	1	1	**3**	3
15-29	0	0	3	1	**4**	0	1	6	8	**15**	19
30-44	2	2	19	3	**26**	2	2	20	16	**40**	66
45-59	9	1	135	17	**162**	8	22	76	83	**189**	351
60-74	39	55	236	85	**415**	50	77	160	156	**443**	858
75-89	51	70	148	70	**339**	75	101	106	151	**433**	772
90+	15	10	22	1	**48**	22	11	17	4	**54**	102
Total	**116**	**138**	**563**	**177**	**994**	**158**	**214**	**386**	**419**	**1177**	**2171**

1 year Survival and Death percentage Rates by age and gender

Age (years)	Breast Lung & Colorectal Cancer					Other Cancer					All Cancer Total
	Cancer 1yr Death rate (%)		Cancer 1yr Survival rate (%)		Total	Cancer 1yr Death rate (%)		Cancer 1yr Survival rate (%)		Total	
	Female	Male	Female	Male		Female	Male	Female	Male		
0-14	0.00%	0.00%	0.00%	0.00%	**0.00%**	0.05%	0.00%	0.05%	0.05%	**0.14%**	0.14%
15-29	0.00%	0.00%	0.14%	0.05%	**0.18%**	0.00%	0.05%	0.28%	0.37%	**0.69%**	0.88%
30-44	0.09%	0.09%	0.88%	0.14%	**1.20%**	0.09%	0.09%	0.92%	0.74%	**1.84%**	3.04%
45-59	0.41%	0.05%	6.22%	0.78%	**7.46%**	0.37%	1.01%	3.50%	3.82%	**8.71%**	16.17%
60-74	1.80%	2.53%	10.87%	3.92%	**19.12%**	2.30%	3.55%	7.37%	7.19%	**20.41%**	39.52%
75-89	2.35%	3.22%	6.82%	3.22%	**15.61%**	3.45%	4.65%	4.88%	6.96%	**19.94%**	35.56%
90+	0.69%	0.46%	1.01%	0.05%	**2.21%**	1.01%	0.51%	0.78%	0.18%	**2.49%**	4.70%
Total	**5.34%**	**6.36%**	**25.93%**	**8.15%**	**45.79%**	**7.28%**	**9.86%**	**17.78%**	**19.30%**	**54.21%**	**100.00%**

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	14c
Subject:	Safeguarding Annual Report for Safeguarding Adults and Children
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

To provide Trust Board of an annual overview of Adult and Child Safeguarding activity, with proposed actions for 2015/2016.

Introduction:

Detail is presented to provide both context of safeguarding and a summary of the activity of the work accomplished through 2014/2015 and a resume of the planned activities for 2015/2016.

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

Review of 2014/2015 key actions for Safeguarding adults and children.
Update of current National reports.
Local plan for 2015/2016.

Benefits:

To advise the Trust 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 and Children Strategic Group
Safeguarding Adults Operational Group
Safeguarding Children's Operational Group

Proposals and/or Recommendations

The Trust Board are asked to note the contents of this paper and to receive assurance around processes in place to protect adults 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, Safeguarding.	**Contact details:** 07900680616

East Sussex Healthcare NHS Trust

SAFEGUARDING ANNUAL REPORT FOR SAFEGUARDING ADULTS AND CHILDREN

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 2014/15 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 (2015) 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 is a revision of Working together to safeguard children (2013). A 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 2015 Working Together remain the same as the 2013 guidance, but the guidance is presented succinctly with a focus on early intervention (Revisions to Working Together to Safeguard Children, (March 2015).

Following consultation the government has updated and replaced the current statutory guidance Working Together to Safeguard Children 2013. The revisions include changes to:

1) The referral of allegations against those who work with children
2) Notifiable incidents involving the care of a child; and
3) The definition of serious harm for the purposes of serious case reviews

The guidance continues 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 judgment 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:

1) Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and a child-centered approach: for services to be effective they should be based on a clear understanding of the needs and views of children.
2) Early intervention and relationship-based practice is used to engage families and effect a positive impact on the child.

The Intercollegiate Document (2014, RCPCH)

This document describes six levels of competences provides model role descriptions for named and designated professionals and sets down competency levels for all healthcare staff. To protect children and young people from harm, all healthcare staff must have the competencies to recognise child maltreatment and to take effective action as appropriate to their role. It is the duty of employers to ensure that those working for them clearly understand their contractual obligations within the employing organisation, and it is the responsibility of employers to facilitate access to training and education which enable the organisation to fulfil its aims, objectives and statutory duties effectively and safely. ESHT safeguarding training at levels 1, 2 and 3 is designed to meet these competencies. All community staff complete competencies with the support of the community safeguarding team. The Child Safeguarding Supervision Policy includes the competency assessment and the need for staff to ensure they fulfil these requirements.

2.1.2 Children Act 1989 Children Act 2004 (Children's Services) Regulations 2005

We continue to work within the boundaries of The Children Act 1989 which 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, in response to the governments "**Better Together" agenda (2015).** East Sussex County Council (ESCC) and ESHT are working with commissioners to design the integrated Children Centre Keyworkers/health visiting team service due to be rolled out in April 2016.

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 provides 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 reviewed policy and process accordingly.

2.1.4 Independent Enquiry into Child Sexual Exploitation, Rotherham, (2014)

The main criticisms of Rotherham were regarding the local authorities were

Leadership & Management:

- Safeguarding Board not fulfilling its scrutiny and challenge function
- No clear leadership and no consistent approach to addressing CSE and many professionals were not aware of the procedures
- Poor Performance Management and Quality Assurance
- No systems in place for agencies to learn lessons from serious CSE cases in which children had been failed
- Recruitment/retention of staff
- Insufficient budget and resources; specifically cutbacks in the Youth Service; resource priority given to protection of younger children
- Denial of the existence of sexual exploitation by Senior Officers and Elected Members
- Restructure of social work services impacting on frontline practitioners focus and diverting attention from core function of child protection
- Patriarchal, macho and bullying environment and culture

Lessons learnt

Attempts to raise the concerns described above with senior personnel were met with defensiveness and hostility.

"Accessibility is one of the key elements in reaching out to children who are sexually exploited or being groomed, and this needs to be done in ways that young people will engage with and trust. Every effort should be made to increase this capacity" (Independent Inquiry into Child Sexual Exploitation in Rotherham, Alexis Jay OBE)

Frontline Practice Issues

- Weaknesses in risk assessment and risk management.
- Lack of priority for children sexually exploited by both Police and social care.
- Details of discussion at sexual exploitation forum was not recorded on individual children's files
- Information and planning for children in care affected by CSE was poor and was dealt with via 'case review' processes
- Police were not prioritising the precepts of identifying and prosecuting perpetrators of sexual exploitation
- Children exploited were routinely moved out-of-area as a solution
- Awareness of CSE and interest in it were not widespread. Effective interventions were lacking
- Attitudes of professionals towards victims was to describe them as 'undesirable', 'deviant' or 'promiscuous' and not worthy of protection
- Parents were not informed when professionals had concerns about their children

ESHT response to Rotherham

- LSCB sub-groups at Gold, Silver and Bronze level have been set up to manage CSE at strategic and operational level, ESHT are represented at all levels.. WISE and MACSE (Multiagency child sexual exploitation meeting) At the Bronze operational the MACSE meeting shares information to identify vulnerable young people within our community and designs multiagency plans to reduce risk/minimize harm to children and young people.

- Kent School Nursing and the ESHT Looked After Children Team are represented at these meetings. Named Nurses receive the minutes from the meetings. Information is shared as appropriate.

- ESHT safeguarding training and the ESHT Child Protection Policy includes raising CSE awareness within community and acute healthcare settings. There is a clear referral pathway for staff to follow.

- The Local Safeguarding Children Board has specialist CSE training for staff in order to raise awareness.

- Staff working closely with vulnerable groups are encouraged to attend the specialist training provided by the LSCB

Multiagency Partnership Working

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.

The Section 11 Audit is completed bi-annually through self-assessment. ESHT identified itself as being compliant in all areas apart from the delivery of statutory child safeguarding supervision in the 2012/13 audit.

ESHT response

- The Child Safeguarding Supervision Policy was re-written in 2015.
- Regulated supervision is now set up across the community and acute service
- NSPCC supervision training was completed by all ESHT Safeguarding Children Team staff providing child protection supervision in July 2013. It was extended to all team members through in - house training in 2014.
- All areas are now receiving regulated child protection supervision in line with the section 11 recommendations and the ESHT Child Safeguarding Supervision Policy.
- The internet policy was updated

2.3 Changes to Commissioning of Services

- Kent Primary Community Health Services Trust is now the provider for The School Health Service (previously the ESHT School Nursing Service). The provision of child protection supervision and level 3 Safeguarding training remains with the ESHT Community Safeguarding Children Team.
- The commissioning of the Health Visiting Service will be transfer over to the local authority in October 2015.

2.4 Staffing

The Community Safeguarding Children Team has one full-time Named Nurse 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.

ESHT has a Named Doctor who predominantly oversees safeguarding within the East and West of the Trust at present. (There is a second Named Doctor who is due to return to her post in September and will take over the West of the trust). There will be six PA's to cover this role

The Designated Nurse and Doctor activity now sits within the CCG's.

3.0 Annual Activity **Annual activity - Child Protection**

June, 2015

Area reviewed	Number of cases
LAC	LAC 549
Lac & CP Plan	15
CP Plan	463 plus 14 unborn
CIN allocated to a social worker	2314

4.0 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 2015	100%	78.12%	87.42%
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 87.42%.
- Staff evaluation of the training has been positive.
- A focussed approach to ensure all areas of poor compliance for level 2 training was targeted with training by and should see a significant improvement by September 2015.
- 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 training are available to relevant ESHT staff and THRIVE workforce development training is still available to those staff working in multiagency early help settings.

4.1 Domestic Abuse/ Training

- Mandatory domestic violence training for community and acute staff is on-going.
- The East Sussex Safer Communities Partnership Domestic Abuse Strategy, 2014-2019 consultation has taken place.
- The Named Nurse Community sits on the 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.

5.0 Serious Case Reviews (SCR)/Multiagency Reviews (MAR)

2 LSCB serious case review reports were published during 2013/2014.

The SCR for child K has recently been published, June 2015.

Reports are publically available on the LSCB website. ESHT has a number of completed action plans relating to the SCR's and MAR's, all are available for scrutiny upon request.

5.1 Progress of action plans relating to SCRs/MARs

Outstanding actions from community – Audits of New ESHT Safeguarding Supervision Policy Due July, 2015 (This was delayed to enable roll-out of the Supervision Policy prior to audit).

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.

"Better Together" 2015, will bring further integrated working between Health and Social Care. Changes to the ISH process will follow as a result of the "Better Together" agenda and planned re-structuring within ESCC. The Named Nurse Community sits on the Integrated Working "Better Together" Project Board.

5.3 Child Sexual Exploitation (CSE)

CSE is covered within Level 2 and 3 ESHT Child Protection training. Staff working intensively with children are 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 health visiting and safeguarding services. This will then be rolled out to the Family Nurse Partnership.

There are some initial difficulties with implementation which are being addressed via an operational and strategic level working group.

Online records will support improved Child Safeguarding information-sharing.

CP-IS will enable ESHT safeguarding staff to access information regarding children at risk at level 4 and will replace the Children's Index. ESHT and the local authority are at the implementation stage.

"Better Together" also aims to enable improved data-sharing between ESCC and ESHT staff.

6.0 Improving Quality within Child Safeguarding/Audits

ESHT continue to improve quality of care within safeguarding, the audit programme supports this process:

Audit Programme 2014/15

Community

Referrals to Duty and Assessment Team, due for completion July 2015; An audit to assess the quality of referrals into DAT from Health Visitor, Midwifery, Acute and Family Nurse Partnership Staff.

Supervision Audit, due for completion August 2015: An audit to assess the quality of child protection supervision and appropriate use of documentation.

Named Nurse Community sits on **Multi Agency Risk Conference (MARAC) Quality and Audit Group** which reviews selected cases bi-monthly and makes recommendations for learning/ improving practice.

Multi Agency Risk Conference (MARAC) Quality and Audit Group recommendation, due to commence July 2015: Named Nurse Community to complete a dip check of how cases are 'flagged and tagged' within ESHT service areas.

Acute

CAMHs Pathway Audit (re-audit), due for completion September, 2015.

Main areas of focus for improving quality of care within ESHT for Child Safeguarding are:

- Communication and information sharing
- Partnership working
- Domestic abuse
- CSE/Trafficking/Missing Children
- FGM
- PREVENT (counter-terrorism agenda)
- Disability/SEN and transitional work
- Public health to include school nursing service
- Changes to community services as a result of new commissioning strategy.

7.0 Safeguarding Adults

The Care Act
The Care Act was passed through Parliament to gain Royal ascent in May 2014. With regard 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 people's 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 provides sets of regulations and new statutory guidance and regulation, published in October 2014. The new legal framework came into effect on 1 April 2015.

The Care Act and it's supporting guidance place a series of new duties and responsibilities on local authorities about care and support for adults.
Chapter 14 of the Care and Support Statutory Guidance provides guidance on sections 42 – 46 of The Care Act 2014. This guidance replaces the "No secrets guidance"

Adult Safeguarding what it is and why it matters

Safeguarding means protecting an adults right to live in safety, free from abuse and neglect, while at the same time making sure the adults wellbeing is promoted including, where appropriate having regard to their views, wishes, feelings and beliefs in deciding on any action.
Organisations should always promote the adults wellbeing in their safeguarding arrangements.
Professionals and other staff should not be advocating "safety" measures that do not take account of individual well-being, as defined in **Section 1 of the Care Act**.

The Care Act requires that each local authority **must**:

- Make enquiries, or cause others to do so, if an adult is experiencing, or is at risk of abuse or neglect – the enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so by whom
- Set up a safeguarding adults Board
- Arrange where appropriate for independent advocate representation
- Co-operate with each of its relevant partners (**section 6 of the care Act**)

The aims of adult safeguarding are to:

- Stop abuse or neglect wherever possible
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Safeguard adults in a way that supports them in making choices and having control about how they want to live
- Promote an approach that concentrates on improving life for the adult concerned
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect

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
- Psychological abuse
- Financial or Material abuse
- Neglect and acts of omission
- Domestic Violence
- Self-neglect
- Modern Slavery
- Organisational abuse

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

These principles are a key feature of the Care Act 2014

7.2 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.

7.3 Review of Whistle Blowing in the NHS

On 11 February 2015, Sir Robert Francis QC published his final report following the Freedom to Speak Up review which looked at the raising concerns culture in the NHS. The report makes a number of key recommendations under five overarching themes with actions for NHS organisations and professional and system regulators to help foster a culture of safety and learning in which all staff feel safe to raise a concern.

7.4 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.

7.5 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.
In April 2015, implementation of the Care Act took place within ESHT, this involved updating all related policies and joint process across health and Social Care.

7.6 Training

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.

Overall Trust % Trained	**Level 2 Safeguarding Adults** ***All clinical staff***	**Mental Capacity Act**	**Deprivation of Liberty safeguards**
March 2015	85.98%	92.36%	89.09%
March 2014	77.07%	84.86%	76.19%
March 2013	76.27%	80.56%	72.60%
March 2012	59.43%	69.78%	50.18%

Overview of Substantiated alerts comparative data

Alerts against ESHT	**2012/13**	**2013/14**	**2014/15**
Total Number of alerts	156	146	56
Total Number of substantiated alerts	53	27	22

Data evidences a reduction of overall substantiated adult safeguarding alerts. Overall actions are captured within the table below.

Analysis of safeguarding alerts

ESHT Adult Safeguarding team hold a database of all action taken based on alerts raised, outcome and related action taken. Action taken during 14/15 includes that as described below. This action links to other risk identified within ESHT including Incidents and Serious Incidents reported. The Trust has begun work on Integrated Patient Documentation (IPD 5) which will include a section on discharge planning. A trial has commenced on wards at EDGH and Conquest using a new discharge checklist which is aimed to improve patient experience of discharge, ensuring appropriate referrals are made. The use of the SBAR (Situation, background, assessment and treatment) handover tool, aids communication between wards/departments when transferring patients.

All Trust Wide Action taken for 2014/15

Areas Involved	Concern	Action taken	Date completed	Link to SI Y/N
473,512,503	Communication and discharge	Updated patient Admission, Transfer & Discharge policy ratified and cascaded Use of SBAR tool Electronic discharge letters to GP	09/14	Y
554	Discharge planning	Review of Integrated patient documentation (IPD) is being undertaken, a trial of a discharge checklist is ongoing at EDGH	ongoing	Y
Community	Communication	The implementation of System One Electronic documentation	ongoing	Y
472 (13/14)	Assessment and care of patients with mental health issues	Mental Health Triage Tool agreed for A&E	11/14	Y
#545	Examination of vulnerable patients	Chaperone policy reviewed and updated	April 2015	Y
OPAR	Safeguarding patient property and valuables	Patient monies and property reviewed, external auditors, pilot of revised property disclaimer for IPDv5	ongoing	Y

Analysis of Data 2014/15

CQC/SEC visits

SEC – Last visit November 2012 – Compliant against audit with significant assurance

Ofsted visit May 2014 – Good

The latest CQC report published in April 2015 stated:

Safeguarding

- Staff knew how to report safeguarding issues.
- The process of safeguarding was both understood and followed.

The CQC report fits with evidence obtained through monitoring mandatory training and reviewing all safeguards which are raised against the Trust. There has been a continuing decline in substantiated alerts between 2012 and 2015, with effective action planning and delivery, including prevention planning for the future. Actions are identified and training packages implemented in order to mitigate against issues raised, ensuring lessons are learned preventing repeated similar safeguards.

Response to actions for Safeguarding Adults and Children 2013/2014

Action Identified	ESHT action taken during 14/15
Audit the effectiveness of Child Safeguarding supervision process within the Trust	This 6 month audit is currently underway, results will be available during November 2015
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 safeguarding team currently work closely with the Trusts Dementia lead. Recent activity include updated care planning tools which can be used for people who lack capacity for making specific decisions, which includes people with Dementia and people with a learning disability. The Butterfly scheme will be implemented in September 2015.
The Trust to ensure that action is taken in line with the Supreme Court ruling in relation to the Mental Capacity Act	Significant training and Education has taken place throughout the year in relation to the 'Cheshire West' ruling, this has resulted in significant increase in the number of Deprivation of Liberty Safeguards (Urgent and Standard applications)
The Trust to implement all policy in line with the Care Act	Completed in May 2015. Brief overview training provided as an introduction to The Care Act with all training, policy and protocols updated.

Actions identified for 15/16

Concern Identified	Action	Outcome date
Correct implementation of the MCA 2005	Ad hoc 'Lite Bites' sessions. Consent Audit	Ongoing April 2016
White Ribbon Campaign	ESHT to Apply	November 2015
Putting PREVENT Duty on a Statutory Footing	Targeted, extended discrete training sessions to commence September 2015 as part of the safeguarding 'Safety Day'	Review April 2016
Development/Implementation of Integrated 'Better Together' working between Health Visitor and Children's Centre Keyworkers.	Named Nurse Community sits on 'Better Together Project Group'.	Project design to be completed by Oct 2015 and roll-out in April 2016.
Development of Multiagency Child Sexual Exploitation (MACSE) Health Sub-Group to review and develop CSE management/practice within ESHT.	First meeting set for 18th August 2015. Chair Debbie Barnes Designated Nurse Safeguarding Children. ESHT Safeguarding Leads including Named Professionals to attend. CSE Champions to be developed.	First meeting 18th August. Terms of Reference and actions with outcome dates to be developed.
To ensure Systmone online records system is working efficiently and usage is embedded into practice.	Systmone user group in progress and actions identified for improvements.	In progress for regular review via user's group.

7.7 Mental Capacity Act/ Deprivation of Liberty Safeguards (DoLS)

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?

This is now widely applied across ESHT. Please see an overview table of DoLS applications, Urgent and Standard, throughout 2014/2015. Please note that when an Urgent authorization is raised by ESHT, it is routine to make a standard application, however many people recover prior to requiring a standard authorization, hence the low number of standard granted. The Assistant Director of Nursing attends quarterly DoLs strategic meeting, where it is noted that all applications made during 14/15 for DoLS applications were appropriate.

Quarter 2014/15	Urgent Authorisations/ standard Requests	Granted Standard Requests
1	13	6
2	17	4
3	29	11
4	15	3
Total	**74**	**24**

7.8 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

7.9 Deprivation of Liberty Safeguards

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 Standard DOLS applications are reported quarterly to the CQC. At ward level specific care plans exist for patients who lack or have fluctuating capacity for specific decisions.

8.0 Duty of Candour

ESHT have in place a Being Open policy. This policy is used where ESHT undertake a safeguarding concern. Currently all Safeguarding concerns are initiated through a planning meeting, ESHT agree with ASC, who will ensure clear communication with the adult affected during the process, this includes a follow up letter outlining all issues and action discussed.

8.1 Governance

The updated Pan Sussex Adult Safeguarding policy is available in a downloadable format at website:
http://pansussexadultsafeguarding.proceduresonline.com/chapters/contents.html

The 2014 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.

CCG 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 1/4/2013

ESHT continue to work in partnership with the Multi Agency Professionals of East Sussex to safeguard vulnerable adults.

Adult Social Care (ASC) is the lead organisation for Adult Safeguarding. They are accountable to and responsible for coordinating all Adult Safeguarding Enquiries.

ESHT has jointly agreed and signed up to the East Sussex Multi Agency Policy for Adults at Risk, this policy sets out the process for safeguarding adults.

ESHT updated its internal Trust policy for safeguarding adults at risk in May 2015 in line with agreed procedures and protocol following implementation of The care Act.

The Director of Nursing is the Executive representative for ESHT at the Multi Agency Safeguarding Adults Board (SAAB). The Assistant Director of Nursing for Safeguarding Adults & Children, deputises as required.

The Safeguarding Adults Team within ESHT is led by the Assistant Director of Nursing for Safeguarding and two nurses deliver safeguarding operational function including Mental Capacity Act and the Deprivation of Liberty Safeguards. One of these nurses delivers the DASM function.

An ESHT Safeguarding Strategic Group meets quarterly which reviews jointly Adults and Children safeguarding, this is chaired by the Director of Nursing.

The ESHT Safeguarding Adults Operational meeting meets Bi-monthly to discuss all operational issues.

ASC is a permanent invitee to both meetings.

8.2 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.

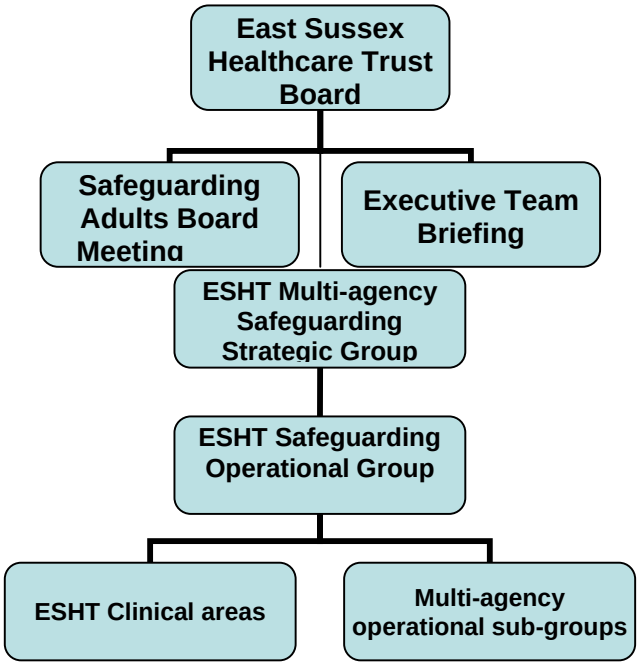
DoLS process is part of ESHT's safeguarding process, where a patient lacks capacity the use of the Mental Capacity Act (MCA) care planning tools are used. DOLS training is available for relevant staff. Statutory notification of all DOLS applications and outcomes are reported quarterly to the CQC.

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 on-going activity are provided to: CME, CQRG, Trust Board. These reports outline on-going activity and relevant actions taken to mitigate risk within ESHT.

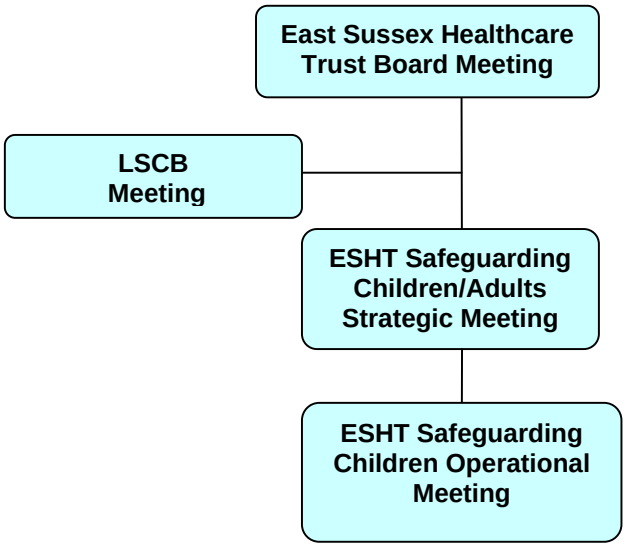
8.3 Safeguarding Adults Meeting structure:



8.4 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.

8.5 ESHT safeguarding Meeting structure:



CONCLUSION

ESHT continue to provide a robust Adult safeguarding service throughout all areas, with on-going awareness raising to staff of Adult Safeguarding process, in line with the Care Act 2014. The latest CQC report published in April 2015 stated:

Safeguarding

- Staff knew how to report safeguarding issues.
- The process of safeguarding was both understood and followed.

The CQC report fits with evidence obtained through monitoring mandatory training and reviewing all safeguards which are raised against the Trust. There has been a continuing decline in substantiated alerts between 2012 and 2015, with effective action planning and delivery, including prevention planning for the future. Actions are identified and training packages implemented in order to mitigate against issues raised, ensuring lessons are learned preventing repeated similar safeguards.

Name of Author: Brenda Lynes-O'Meara

Title of Author:
Assistant Director of Nursing for Professional Practice and Standards

Date 12/8/15

APPENDIX 1

East Sussex Healthcare NHS Trust

Sussex Partnership NHS Foundation Trust

EAST SUSSEX HEALTHCARE TRUST
MENTAL HEALTH ACT ACTIVITY - 1st April 2014 to 31st March 2015

Use of section 5 – short term holding powers

Section 5(2) MHA 1983 is the doctors holding power used to hold a patient for up to 72 hours to enable a MHA Assessment to be safely arranged.

Section 5(2) was used on 11 occasions during the reporting period, compared with 14 the previous year. Three patients had their detentions under section 5(2) discharged, four were 'regraded' to section 2 and one section 5(2) was permitted to lapse. On three occasions, detentions under section 5(2) were found to be invalid.

Seven detentions were made at the Conquest Hospital and four at Eastbourne DGH. The wards on which detentions under section 5(2) were applied are as follows:

The Conquest Hospital		**Eastbourne DGH**	
AAU	2	Cuckmere Ward	1
Baird Ward	1	Medical Assessment Unit	2
High Dependency Unit	1	Seaford 4	1
MacDonald Ward	1		
Wellington Ward	2		

Section 2

Section 2 MHA 1983 allows admission for assessment. The patient may be admitted for up to 28 days.

There were 21 detentions under section 2 in 2014-15, up from 18 in 2013-14. Of these, four section 2 detentions were of patients already admitted informally on wards at East Sussex Hospitals Trust, three patients were already detained under a section 5(2) holding power and the remaining 14 patients were admitted to hospital whilst detained under section 2.

Of these patients, 12 were transferred to more specialist care: 10 at Sussex Partnership and two at private providers. Eight had their section 2 discharged and remained in acute hospital informally and one patient's section was found to be invalid.

Those detained patients who transferred from BSUHT to Sussex Partnership moved within the following timescales:

Same day	1
Next day	5
2-3 days	3
4-7 days	3

Nine detentions under section 2 were applied at the Conquest Hospital and 12 at Eastbourne DGH. The wards on which the patients were detained were as follows:

The Conquest Hospital	AAU	4
	Baird Ward	1
	MAU	1
	Newington Ward	1
	Tressell Ward	1
	Wellington Ward	1
Eastbourne DGH	Berwick Ward	1
	CDU	1
	Cuckmere Ward	1
	ITU	1
	MAU	7
	Seaford 4	1

Section 3

Section 3 MHA 1983 allows admission for treatment. The patient may be admitted for up to 6 months and the section can be renewed thereafter. There were no detentions under section 3 at East Sussex Hospitals Trust during this reporting period.

Equality Data

Age

	Section 5(2)	Section 2	Section 3
20 and under	1	1	-
21-30	3	3	-
31-40	2	1	-
41-50	-	2	-
51-60	2	5	-
61-70	1	2	-
71+	2	7	-

Gender

	Section 5(2)	Section 2	Section 3
Male	3	8	-
Female	8	13	-

Ethnicity

	Section 5(2)	Section 2	Section 3
White British	9	19	-
White Irish	-	-	-
Any other White	1	1	-
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	-	-	-
Any other Black Background	-	-	-
Arab	-	-	-
Any other Ethnic group	-	-	-
Not stated/known/undefined	1	1	-

Religion / Belief

	Section 5(2)	Section 2	Section 3
Agnostic	-	-	-
Atheist	1	1	-
Baha'i	-	-	-
Buddhist	-	-	-
Christian	5	7	-
Hindu	-	-	-
Humanist	-	-	-
Jewish	-	-	-
Muslim	-	-	-
Pagan	-	-	-
Rastafarian	-	-	-
Any other	-	1	-
Not disclosed	5	12	-

Relationship Status

	Section 5(2)	Section 2	Section 3
Married / Civil Partnership	-	5	-
Co-habiting	-	-	-
Single	7	10	-
Separated	1	-	-
Divorced/Dissolved Civil Partnership	1	3	-
Widowed/Surviving Civil Partner	1	2	-
Not disclosed	1	1	-

Sexual Orientation

	Section 5(2)	Section 2	Section 3
Heterosexual	3	6	-
Lesbian/gay	-	-	-
Prefer not to say	-	-	-
Undefined/not disclosed	8	15	-

Disability

	Section 5(2)	Section 2	Section 3
Undefined/not disclosed	8	15	-
Mental health	1	1	-
'None' stated	3	6	-

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	14d
Subject:	Annual Fire Safety Report
Reporting Officer:	Richard Sunley

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

Purpose:

The report seeks to provide assurance of implementation of fire safety policy and procedures, fire safety risk assessment and fire safety mandatory training compliance that contribute to effective fire safety management.

Effective fire safety management is a legal required under Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum (HTM) 05-01. The report meets the requirements of the Regulatory Reform Order (Fire Safety) Order 2005 to present an annual statement of the fire conditions and standards within its premises.

The purpose of this report is to provide the Trust Board with an overview of fire safety management for the period 1st April 2014 and 31st March 2015.

Introduction:

The Trust is required to present an annual statement of the fire conditions and standards within its premises in accordance with the requirements of the Regulatory Reform Order (Fire Safety) Order 2005 and the guidance within Health Technical Memoranda as amended in 2005.
The report provides evidence of the efforts of the Fire Advisory team to comply with all relevant guidance. The overall objective being to ensure that all relevant persons are safe from fire.
The dynamic nature of the Trust's estate means a continual improvement programme of fire precautionary works funded year on year, increasing as the estate increases or relevant legislation changes.

An important part of this report is also to provide the Fire Safety Manager and Trust Board with a summary of the Risks carried in relation to Fire Safety, in order that informed decisions regarding the allocation of capital funding to remedy shortfalls can be made.

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

1. **Fire Training**

Now at 86% of Staff trained as of 31st March 2015.

2. Fire Risk Assessments

100% of the departments / services at the 2 Acute Hospital sites have now had risk assessments completed during the past 12 months.

100% of the Community sites transferred to ESHT from the PCTs have now had risk assessments completed during the past 12 months.

41% of the "undocumented" properties occupied by ESHT in the community have been risk assessed and a strategy is required to ensure full completion.

100% of all properties owned by NHS Property Company Ltd in East Sussex, covered by the current service level agreement, have a current fire risk assessment

3. Main Risks (Capital)

The investment in fire safety standards continues to demonstrate that the Trust has a responsible and proactive approach to dealing with fire safety issues and risks.

3.1 Fire Compartmentation at the EDGH

A comprehensive compartmentation report has been received from the Fire Protection Association; subsequently a full intrusive survey of the EDGH has been carried out by Staff.
Every recommended hour compartment line and hour fire door has been examined and placed on a project record list. All breaches in the penetrations through the EDGH flooring have been identified and intumescent collars purchased ready to install.
The remedial works have commenced with 375K spent on new hour compartment fire doors in Phase 2 areas.

3.2 Emergency Lighting at the Conquest.

Maternity delivery, SCBU, Maternity Theatre and Frank Shaw ward at the Conquest are not currently compliant to the Emergency Lighting British Standard (BS5266 Part1) and not covered by the current central emergency lighting battery system.

As the current central battery system is now unsupported and on failure of any part of the system parts are unlikely to be able to be sourced

The replacement system will need to be phased over a period of 4-5 years due to as logistical constraints.

Benefits:

Continued support in terms of fire safety management provide the following :

Preservation of life and Business continuity restricting the spread of fire, heat and smoke.
Compliance with the Regulatory Reform (Fire Safety) Order 2005.
Compliance with CQC Outcome 10 – 'Safety and Suitability of Premises'

Risks and Implications

Details of the identified risks are contained within the report. Implications of non-compliance with statute. Our premises are regularly audited by East Susses Fire and Rescue Service who are aware of our risks. Currently they are content with our action plan. Failure to adhere to our plans may result in improvement notices being served.

Assurance Provided:

The Trusts support has led to significant improvements in fire safety standards, based upon the findings of the risk assessments. This has improved our compliance with current standards demanded by the Enforcing Authority. The Board provides the appropriate level of funds, managed correctly by the designated responsible managers within Project and Property Management department. This assists in achieving and maintain the regulatory defined standard. Demonstrable evidence includes :

Completed Risk Assessments.
High compliance level for Fire Safety Training.
Progress against physical issues through the continued support through capital funding.

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

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

Health & Safety Steering Group, 17th July 2015

Proposals and/or Recommendations

It is recommended that the Board accept the report and continue to fund the essential works necessary to enable the risks to be reduced.
Also that the Trust continue to fund essential works arising from the changing nature of legislation regarding the Trust's estate, the takeover of new buildings and the impact of the change of use of rooms and buildings within the Trusts estate.
The Trust looks to support the revenue impact of changing legislation in terms of on-going maintenance..

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: Chris Hodgson	**Contact details: (13) 3655 or (14) 8818**

East Sussex Healthcare NHS
NHS Trust

Annual Fire Safety Report

1st April 2014 – 31st March 2015

V1.0 July 2015

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 2015

Annual Fire Safety Report

April 1st 2014 – 31st March 2015

CONTENTS

Annual Fire Safety Report

April 1st 2014 – 31st March 2015

EXECUTIVE SUMMARY

The Annual Fire Safety Report (AFSR) has been prepared by the Trust Senior Fire Safety Advisor to provide assurance to the Trust Board and report risks with subsequent recommendations relating to Trust Fire Safety Management arrangements.

The Trust is currently carrying a **High - Extreme risk** in relation patient and staff safety, Statutory Duty (enforcement) and service interruption, because of the historic disinvestment in the Estate (summary and details of these risks are contained in Appendix A and B) which requires a significant amount of funding over the next 5 – 10 years. £1.2 million has been invested in a new fire alarm system at The Conquest Hospital over the past 4 years, £250,000 has been invested in upgrading the fire compartmentation at Eastbourne in 2014 and a further £250,000 agreed for 2015/16 for the fire compartmentation at Eastbourne..

The 2013 **Fire Policy** ratified in 2014 reflects the new national guidelines included in Hospital Technical Memorandum (HTM) 05-01 2013 Second edition. The Policy will be reviewed in June 2016.

Fire **Safety Protocols** are being developed for all aspects of Fire Safety Management identified in HTM 05-01. It is the intention to complete the remaining documentation by the 31st December 2015.

Mandatory Fire Training is at **86%** (March 2015 data) of Trust Staff trained, which has increased from 62% (February 2012).
608 Staff have participated in **Fire Drills.**
93 **Fire Wardens and Fire Team members** have been trained.

The Regulatory Reform (Fire Safety) Order 2005 (RRO) focuses on the requirement for all premises to have a suitable and sufficient current **Fire Safety Risk Assessment**.

100% of the 164 **Acute** Hospital areas have been subject to risk assessments in the past 12 months.

100% of **Community sites** have been subject to risk assessments in the past 12 months.

Annual Fire Safety Report

April 1st 2014 – 31st March 2015

1.0 PURPOSE

The purpose of this report is to confirm assurance and report risks with subsequent recommendations relating to Trust Fire Safety Management arrangements.

1.1 Context

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 on 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 on-going 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.

Annual Fire Safety Report

April 1st 2014 – 31st March 2015

2.0 FIRE SAFETY POLICY & PROTOCOLS

2.1 Fire Policy

The 2013 Fire Policy ratified in 2014 reflects the new national guidelines included in Hospital Technical Memorandum (HTM) 05-01 2013 Second edition. The Policy is due to be reviewed in June 2016.

.

2.2 Fire Safety Protocols

As identified in the Fire Safety Policy, new Fire Safety Protocols are being developed for all aspects of Fire Safety management identified in HTM 05-01.

Personal Emergency Evacuation Plan (PEEP)	Ratified
Risk Assessments	Ratified
Fire Safety Training	Ratified
Normal Operating Procedures	Ratified
Emergency Action Plans	Ratified
Fire Prevention	Ratified
Fire Extinguishers	Ratified
Normal Operating & Emergency Procedures	Ratified

It is the intention to complete the remaining documentation by the 31st December 2015.

Fire Strategies
Construction and refurbishment
False Alarms and unwanted fire signals
Fire Extinguishers
Security
Arson
Hot Works
Maintenance of Fire Equipment.

Annual Fire Safety Report

April 1st 2014 – 31st March 2015

3.0 FIRE TRAINING

The current level of mandatory Fire Training is at 86% (March 2015 data), which has increased from 62% (February 2012).

Spaces have been allocated to accommodate 110% of Trust Staff for 2015/16 to maintain and improve on this level of compliance.

The annual training needs analysis has been completed and the training presentation content amended accordingly.

The training figures for the past three years are shown below for comparison.

Year	2012/13	2013/14	2014/15
Number of ESHT Staff	6808	6727	6285
Number of ESHT Staff in date	5116	5415	5342
Percentage	75.15%	80.50%	86%
Non ESHT Staff trained Volunteers, Sussex University and Doctors Surgery Staff)	No records	564	701

3.1 Fire Warden Training and Fire Team Training

Training is being carried out by the Fire Advisor / Fire Trainer and 93 Fire wardens have been trained.

3.2 Practical Evacuation Exercises and Fire Drills

Fire Drills are organised and carried out by Fire Advisors and the Fire Trainer at the Trust premises with 608 Staff trained.

4.0 INCIDENT REPORTS

4.1 False Alarm Activations

Fire Alarm activations are now available to be recorded on the Datix Web Report system.

Alarm activations are within National guide Lines.

4.2 Fires

There were two fires during 2014/15 with no injuries reported.

EDGH Fleming House – Cooking – Accidental.

Conquest Theatre Kitchen - Microwave Fire

A table and analysis of Fire Calls is attached at **Appendix C.**

5.0 RISK

5.1 Risk Assessment

The Regulatory Reform (Fire Safety) Order 2005 (RRO) focuses on the requirement for all premises to have a suitable and sufficient current Fire Safety Risk Assessment. The suitability being assessed against a series of guidance notes specific to the accommodation type.

5.1.1 100% of the 164 Acute Hospital areas have been subject to risk assessments in the past 12 months.

100% of the Community sites have been subject to risk assessments in the past 12 months.

36% 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 2016.

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.

5.1.2 Infrastructure Risks

The Trust is currently carrying a **High - Extreme risk** in relation patient and staff safety, Statutory Duty (enforcement) and service interruption, because of the historic disinvestment in the Estate (summary and details of these risks are contained in Appendix A and B) which required a significant amount of funding over the next 5 – 10 years.

A list of infrastructure risks has been identified from the outcome of Fire Risk Assessment findings and the requirements of the local enforcing authority. A summary is provided in **Appendix A** and Details in **Appendix B.**

Continued investment to resolve those risks will demonstrate that the Trust has a responsible and proactive approach to dealing with fire safety issues and compliance requirements.

The risks identified have yet to be considered for funding with the exception of EDGH Compartmentation Project.

5.1.3 Operational Maintenance

Operational maintenance includes the day to day maintenance of the both active and passive fire related equipment; including fire alarms, fire dampers, fire extinguishers, fire doors and emergency lighting systems.

Planned preventative maintenance of that fire related equipment is increasing in nature as systems expand and national guidance is changed. Annual inspections are now required to fire dampers (Conquest has approximately 500 and EDGH 700). The replacement of Conquest's fire alarm increased the number of devices from 1500 to

approximately 5000, all of which require testing. Modern systems often assist the maintenance function making testing less onerous, but their increasing scope providing enhanced cover, more than negates any savings made by technology.

Revenue budgets should be increased to meet these requirements:

Conquest Fire Damper maintenance	£25,000 per year
EDGH Fire Damper maintenance	£20,000 per year
Conquest Fire Alarm, System Maintenance	£16,000 per year

A business case is being prepared for these items.

6.0 AUDIT AND REVIEW

7.1 An Audit of Trust Fire Safety Management systems will be undertaken by an Authorised Engineer.

7.2 Compliance against Legal and Trust requirements will be reviewed each Month by the Estates Department to provide Independent assurance and advice.

7.0 LEGISLATION UPDATES SINCE THE PREVIOUS REPORT

8.1 The HTM Managing Healthcare Fire Safety 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.

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8.0 INSPECTIONS BY EAST SUSSEX FIRE AND RESCUE SERVICE AUTHORITY.

EDGH Visits: 24th of June 2014
Conquest Visits: 25th of April 2014

N Ingram
Senior Fire Safety Advisor
15th July 2015

Appendix A – Infrastructure Risk Summary

ITEM	Reference Number	RISK ASSESSMENT					ACTION Required to further* MITIGATE Risk Insert actions required to reduce/eliminate risk		COST Year					RR Following investment			COMMENTS
		Domain	C	L	RR	Risk Phrase	Description	In place	2014/15	2015/16	2016/17	2017/18	2018/19	S	L	RR	
Compartmentation EDGH	**906**	Safety	4	4	**16**	Extreme	Funding required to upgrade compartment walls and doors. Replace ceilings and lighting.		250K	250K	250K	250K	250K	4	1	**4**	**ESFRS requirement.** Year 1 Completed.
		Statutory Duty / Inspections	4	4	**16**	Extreme								-	-	**-**	
		Service Interruption	4	4	**16**	Extreme								-	-	**-**	
Emergency Lighting Conquest	**907**	Safety	3	5	**15**	Extreme	**Year 1** Commission the design of a replacement emergency lighting system, identifying and listing the works required to achieve compliance with BS5266 Part1. **Year 2** Replace three of the five system loops, batteries and controllers. **Year 3** Replace the remaining two system loops, batteries and controllers.		-	-	25K	450K	275K	3	1	**3**	**ESFRS requirement.**
		Statutory Duty / Inspections	3	5	**15**	Extreme								-	-	**-**	
		Service Interruption	3	5	**15**	Extreme								-	-	**-**	
Compartmentation Conquest	**907**	Safety	3	3	**9**	High	**Year 1** Identify and list the works required to achieve the required fire resistance in the existing compartments. **Year 2** Carry out works to upgrade breaches in the existing fire Compartmentation.		-	-	25K	175K		3	1	**3**	**ESFRS requirement.**
		Statutory Duty / Inspections	3	3	**9**	High								-	-	**-**	
		Service Interruption	4	3	**12**	High								-	-	**-**	
Fire Dampers EDGH	**TBC**	Safety	4	4	**16**	Extreme	Carry out sample testing. Update building ventilation plans. Test all fire dampers and maintain records of those tests. Carry out remedial works. Annual year on year cost.		-	-	25K	25K	25K	4	1	**4**	**Estates and Facilities requirement.** Sample report completed.
		Statutory Duty / Inspections	3	4	**12**	High								-	-	**-**	
		Service Interruption	4	4	**16**	Extreme								-	-	**-**	
Fire Dampers Conquest	**907**	Safety	4	3	**12**	High	Update building ventilation plans. Increase frequency of testing to annually. Maintain records of those tests. Annual year on year cost.		-	-	25K	25K	25K	4	1	**4**	**Estates and Facilities requirement.**
		Statutory Duty / Inspections	3	3	**9**	High								-	-	**-**	
		Service Interruption	4	4	**16**	Extreme								-	-	**-**	
Escape from Plant Rooms Crowborough	**908**	Safety	4	4	**16**	Extreme	Design new escape ladders and hatches. Install and commission the equipment. Train Staff in their use.		-	-	50k			4	1	**4**	**ESFRS requirement**
		Statutory Duty / Inspections	5	3	**15**	Extreme								-	-	**-**	
		Service Interruption	2	4	**8**	High								-	-	**-**	

***Action are in place to mitigate risks which include automatic Fire Alarm Systems, Maintenance, regular inspections, local risk assessment and staff training.**

Appendix B Infrastructure Risk details

A1.0 Fire Damper Testing and Maintenance

A1.1 EDGH:

The recent sample testing of Fire Dampers at EDGH has identified deficiencies in Damper Maintenance.

A programme of Maintenance and testing should be introduced and supported through revenue.

A1.2 Conquest:

Fire dampers are tested every 3 years, however the legal requirements is now annually and would require additional revenue support.

A1.3 Bexhill and the Irvine Unit:

Fire Damper testing at Bexhill and the Irvine Unit, is being carried out funded from the ventilation budget.

A1.4 Lewes Community Hospital:

Fire Damper testing is being carried out by Sussex Community NHS Trust with the remedial report being sent to the ESHT Operational Property Manager.

A1.5 Crowborough War Memorial Hospital:

Fire Damper testing is being carried out by Sussex Community NHS Trust with the remedial report being sent to the ESHT Operational Property Manager.

Annual Fire Safety Report

April 1st 2014 – 31st March 2015

A1.6 Uckfield Community Hospital:

Fire Damper testing has been carried out by Sussex Community NHS Trust with the remedial report sent to the ESHT Operational Property Manager for action.

A2.0 Fire Compartmentation EDGH:

Parts of the EDGH were built with “crown immunity” and not covered by the Fire Precautions Act 1971. Sixty minute Fire Compartments were not properly established also alterations over time have caused breaches in the 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. The original 4 year programme of remedial works identified may well extend to 7 years

East Sussex Fire and Rescue Service are in agreement with the Trusts commitment of £250k per year to resolve the issue. Regular meetings are scheduled in order to maintain relationships and update progress of the Project.

Year 1 (2014/2015)

Progress with the upgrade to the buildings Phase 2 fire 60 minute fire resisting doors:

- 250K Committed
- Orders issued for 74 single and double 60 minute door sets
- Accredited installers instructed to supply and install door sets.
- Installation of hour door sets on a rolling programme from October 2014 to 31st March 2015.
- Each door set will receive a certificate of conformity.

Year 2 (2015/2016)

- 250k Committed
- During installation unexpected issues have occurred regarding the structure.
- Suspended ceilings will have to be replaced after their removal as will general emergency lighting.

A3.0 Fire Compartmentation Conquest:

When the Conquest Hospital was built Building and Firecode regulations applied however, alterations to the building have occurred causing breaches in 60 minute fire boundaries. The breaches are not assessed 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, identifying existing boundaries.

Funding has not been made available.

A4.0 Emergency Lighting Conquest:

The Building currently does not comply with British Standard for emergency lighting.

The Building consists of five separate central systems linked together by a central controller.

Due to the age of the system replacement parts cannot be sourced either new or second hand. No other maintenance support is available, system test reports cannot be accessed and there is a risk of whole or part failure of the system at any time.

Annual Fire Safety Report

April 1st 2014 – 31st March 2015

East Sussex Fire and Rescue Service have instructed the Trust to have a suitable replacement plan in place by April 2015.

A5.0 Means of Escape Crowborough WM Hospital Roof Spaces/Plant Rooms-

The means of escape from the Crowborough WM Hospital Roof Spaces/Plant Rooms is not satisfactory.

East Sussex Fire and Rescue Service have instructed the Trust to have a suitable plan to rectify the situation in place by June 2015.

This risk was identified prior to the building transferring from the PCTY to ESHT in 2012.

The Risk was transferred to the Estates Risk Register schedule under 908.

Annual Fire Safety Report

April 1st 2014 – 31st March 2015

Appendix C Analysis of Fire Calls

Call Type	SPT*	Conquest	EDGH	EDGH Residencies	Crowborough	Uckfield	Lewes	Bexhill& ABC
Fires.	0	1**	0	1***	0	0	0	0
False Alarms –Fire Service called.	13	6	9	0	0	0	8	8
False Alarms –Fire Service not required.	8	30	20	50	0	0	0	0
False Alarms – Malicious (Break Glass broken by patient).	27	3	0	0	0	0	0	0

***Sussex Partnership Trust in ESHT Buildings.**

**** Microwave Fire**

***** Cooking Fire**

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Monday 3rd August 2015 at 10.00am in the Committee Room, Conquest Hospital

Present: Mr Mike Stevens, Non-Executive Director (Chair)
Mrs Sue Bernhauser, Non-Executive Director
Mr Barry Nealon, Non-Executive Director

In attendance Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Medical Director (Clinical Governance)
Mrs Lynette Wells, Company Secretary
Miss Imelda Donnellan, Clinical Unit Lead, Surgery (for item 4)
Mrs Michele Elphick, General Manager, Theatres & Clinical Support (for item 4)
Mr Robert Grant, BDO
Mr Matt Hardwick, General Manager, Surgery (for item 4)
Mr Stephen Hoaen, Head of Financial Services
Mr John Harmer, Security Advisor (for item 11)
Mr Tim Leakey, Governance Manager (for item 4)
Mr Mike Townsend, Regional Managing Director, TIAA
Mr John Butler, Counter Fraud Manager, TIAA
Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

1. Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions were made.

Apologies for absence were received from:

Mr Charles Ellis, Non-Executive Director
Dr Amanda Harrison, Director of Strategic Development and Assurance
Mr John Kirk, Facilities Manager
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Mrs Alice Webster, Director of Nursing
Mr Steffan Wilkinson, Counter Fraud Manager, TIAA

2. Minutes of the meeting held on 3rd June 2015

i) The minutes of the meeting were reviewed and agreed as an accurate record.

ii) Matters Arising

The updates on the matters arising log were noted.

The following verbal updates were provided:

Audit Committee Annual Report

Mr Stevens noted that he was due to meet with Dr Hughes and Dr Wilkinson in order to discuss an increased focus on Clinical Audit for the Audit Committee for 2015/16, and that this meeting had not yet taken place. **MS**

Internal Audit Plan

Mr Townsend noted that due to the recent serious Information Governance breach within the Trust, a further audit on information governance had been arranged which would encompass progress on actions taken against audit recommendations from the previous audit on Data Security Measures and Data Loss in 2011/12.

Mrs Harris reported that work was being carried out to try to ensure that a recurrence of the data breach would not be possible, including the preventing the download of data to any portable device.

3. Board Assurance Framework and High Level Risk Register

Mrs Wells presented the Board Assurance Framework (BAF) and high level Risk Register.

Mrs Wells explained that the BAF had been updated following the recent Trust Board Seminar and that changes to the document were highlighted in red.

Mr Stevens asked for a schedule of out of date Trust policies to be presented to the next Audit Committee Meeting alongside the BAF in order for the Committee to review the issue. **LW**

Mr Nealon queried why the current issues with staffing in A&E did not appear on the high level Risk Register. It was noted that it was on the register but had only recently escalated to become a high risk.

Mrs Bernhauser asked if risk 1294 on the high level Risk Register was associated with the backlog in endoscopy surveillance, and Mrs Wells explained that she was unsure but would report back to the next Audit Committee meeting about this. **LW**

The Committee reviewed and noted the revised High Level Risk Register and Board Assurance Framework and were of the view that the main inherent/residual risks had been identified and

that actions were appropriate to manage the risks.

4. Clinical Unit Clinical Audit and Risk Register Reviews

i) Surgery

Risk Register

Mr Hardwick and Miss Donnellan reported on the following risks for the Surgery Clinical Unit:

- Premises at Sturton Place
- Lack of Clinical Admin Space in Urology Department
- Orthoptic Led Vision Screening Programme
- Outstanding Ophthalmology Follow Up Appointments

Clinical Audits

Mr Leakey reported that the Surgery Clinical Unit had 2 outstanding audits from their 2013/14 plan, and 21 outstanding from their 2014/15 plan. Mr Stevens asked why audits were still outstanding from these periods, and Miss Donnellan replied that it was usually due to trainee doctors leaving the Trust prior to completion of audits that they had started. Mr Leakey reported that all the outstanding audits had been followed up, and Mr Hardwick said that he would make it a priority to ensure that they were all completed as soon as possible.

Dr Hughes suggested it would be prudent to make permanent members of staff, such as consultants, accountable for clinical audits to ensure that audits would be completed even if trainee doctors left the Trust. Mrs Harris noted that completing audits and then ensuring that any learning from them was shared, was a vital process for improving quality and safety within the Trust. She explained the importance of ensuring that evidence that these processes had been undertaken was recorded.

Mr Hardwick said that he planned to improve his Clinical Unit's audit performance by ensuring that audits were appropriately closed, actions were taken from the audits and that lessons learned and changes made were correctly documented.

The Committee noted the Surgery Clinical Unit's risk register and clinical audit reports.

ii) Theatres & Clinical Support

Risk Register

Mrs Elphick reported that the Theatres & Clinical Support Clinical Unit had 23 risks that were rated “inadequate” and 1 risk that was rated “uncontrolled”.

- Risk to Pathology Accreditation with CPA and UKAS ISO15189

Clinical Audits

Mrs Elphick reported that the Clinical Unit still had one audit that was outstanding from 2012/13, and that Mr Leakey would ensure that this was closed as soon as possible. Mrs Bernhauser commented that a lot of the outstanding audits were marked as ‘awaiting updates’ and asked how these were chased up. Mr Leakey replied that all outstanding audits would be followed up after the meeting, and an update on progress would be provided for the next Audit Committee meeting.

The Committee noted the Theatres & Clinical Support Clinical Unit’s risk register and clinical audit reports.

5. Clinical Audit Forward Plan 2015/16

Mrs Wells noted that the author of the report, Emma Moore, was currently on maternity leave and plans were being put in place in order to provide cover for her absence.

The Committee noted the Clinical Audit Forward Plan 2015/16.

6. Internal Audit

a) Progress Report

Mr Townsend reported that four final audit reports had been produced, one with a limited and three with reasonable assurances. He said that the audit report into e-rostering was at its draft stage. He reported that all work due for Quarter 1 had already been started, along with the audit report into mandatory training which was due in Quarter 2.

Mr Townsend explained that a protocol had been set up in conjunction with East Sussex County Council for joint working to ensure that outcomes of audits were shared between the organisations, and that work was not duplicated.

The Committee noted the Internal Audit Progress Report.

b) Audit Recommendations Tracker

Ms Wells presented the Tracker and explained that the paper highlighted recommendations for audits, and tracked whether these recommendations were being implemented. She explained that many of the updates to the Tracker had been received after circulation to the Committee. Processes required strengthening to ensure all audit recommendations were captured on the Tracker and Mrs Wells would meet with Mr Townsend to discuss further. **LW/MT**

Mr Nealon asked about progress on Interventional Radiology Recording, Audit number ESH121319, and Mr Hoaen noted that the recommended work had now been completed, and that it would be removed from the Tracker when it was updated.

The Committee noted the report.

7. Local Counter Fraud Service

a) Progress Report and 2015/16 Work plan

Mr Butler explained that Trust staff who were involved in recruitment were being given training in conjunction with the UK Border Agency in order to help them to identify counterfeit ID documents. He said that the Trust now had access to an ID scanning service which enabled the authentication of original ID documents, and that the Trust was considering utilising this service at induction sessions in order to provide a comprehensive check of ID documents for new starters. Mr Butler noted that both the NMC and the BMA carried out their own checks on international recruits, and that the Trust relied on the accuracy of these checks alongside their own checks on documents.

Mrs Harris explained that the Trust planned to carry out recruitment for nursing staff in the Philippines in conjunction with a recruitment agency. She said that the agency would carry out checks on candidates, followed by further checks carried out by the NMC. Candidates would then undergo an adaptation course before they could start working for the Trust. Mr Butler said that he felt that interviewing staff in person was a key aspect in controlling the risk of ID Fraud.

An update on counter fraud activity was considered by the Committee.

The Committee noted the Local Counter Fraud Service report and 2015/16 Work plan

b) Investigations Update

The Committee noted the Local Counter Fraud Service Investigations Update.

8. External Audit

a) Annual Audit Letter

Mr Grant explained that the Annual Audit Letter would be posted onto the Trust's website on 30th September, to coincide with the Trust's AGM meeting. He advised that the letter gave an unqualified opinion on the Trust's financial statements, and that any weaknesses highlighted were being already addressed by the Trust. He explained that the Trust had been issued with a qualified opinion on Value for Money, due to the deficit plan that was in place. Mr Grant noted that the Trust's reports from the CQC were highlighted within the Annual Audit Letter.

The Committee noted the Annual Audit Letter.

b) Quality Account Review

Mr Grant noted that for 2014/15 a separate audit report was being produced highlighting outcomes that had previously been covered under the Audit Commission. He explained that BDO had looked at two areas, deep vein thrombosis and the Friends and Family Test, in detail in order to ensure that they complied with guidelines and regulations, and that they used suitable performance indicators. Mr Grant reported that the Trust had been given a qualified audit report, which contained recommendations on improving data quality and evidence within the Trust.

Mrs Harris explained that the Full Final Audit Report for 2014/15 had been included in the papers for the Committee's information. Mrs Wells noted that the recommendations from the audit report would be included on the Audit Recommendations Tracker.

The Committee noted the Quality Account Review and the Full Final Audit Report for 2014/15.

9. Information Governance

a) Annual Report 2014/15

Mrs Wells explained that last year had been a positive year for Information Governance within the Trust, but that there had been two recent referrals to the Information Commissioner's Office (ICO) due to recent data breaches. Full investigations were taking place into both incidents and some immediate actions such as controlling port

access and ordering additional encrypted data sticks had already taken place.

b) Information Governance Toolkit 2015/16 Update

Mrs Wells explained that some criteria had changed within the Information Governance (IG) Toolkit for 2015/16, which would make it very hard for the Trust to achieve Level 3. She reported that the first submission to the Toolkit had already been made and the Trust had achieved a percentage score of 26% which was equivalent to ratings received for the same period in previous years.

The Committee noted the Annual Report and the Information Governance Toolkit 2015/16 Update.

10. Tenders and Waivers

Mrs Harris explained that the internal audit service had been due for re-tender on 31st March 2014. However because of tapering residual liability arrangements, a waiver on the basis of value for money was made in the previous financial year allowing the service to continue for 2014/15. She proposed that a further waiver on the same basis be put in place for 2015/16.

The Committee approved that a further waiver be put in place for 2015/16 for the internal audit service.

Mrs Harris presented the Tenders & Waivers report to the Committee and noted that it covered all of the Trust's tenders, and recorded when waivers had been used. She explained that a waiver had been put in place for consumables used within Pathology services in June 2015 because it had taken longer than anticipated to move to a managed service, and that the waiver would be removed once a decision on the managed service had been finalised.

Mr Stevens proposed that the process for approving waivers be reviewed in order to ensure there was appropriate scrutiny by the Audit Committee prior to approval, particular for those that were novel or of high value. Mrs Harris would consider amending the waiver form in the future to ensure that, under certain circumstances, appropriate Audit Committee approval was received in advance.

The Committee noted the current position on Tenders and Waivers.

11. Annual Security Report

Mr Harmer noted that the report had been approved by Richard Sunley prior to being presented to the Audit Committee. He reported that the non-availability of a psychological team within A&E at EDGH

was causing security issues, and that a trial was underway to attach a nurse to police patrols in order to provide psychological support to patients who would benefit from it.

Mr Harmer explained that actions highlighted within the Trust's CQC reports following the inspection in September 2014 were being reviewed and resolved.

Mr Harmer explained that the Annual Work Plan included within the report was very flexible and aspirational, and that he did not think it would be possible to undertake everything included on it.

The Committee noted the report on Annual Security Report.

12. Date of Next Meeting

The meeting scheduled for 2nd September was cancelled due to its proximity to this meeting. The next meeting of the Audit Committee would instead be held on:

Wednesday, 4th November 2015, at 10.00 am in the Bob Webster Seminar Room, EDGH.

Signed: ……..

Date: …….

East Sussex Health Care NHS Trust

Audit Committee Annual Report 2014/15

1. Introduction

The Audit Committee is established under Board delegation with approved terms of reference that are aligned with the *Audit Committee Handbook*, published by the HFMA and Department of Health.

The Handbook outlines that the remit of the Committee should not be limited to the traditional focus on review of financial issues. It states that "The Audit Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. At the corporate level these will include a risk management system and a performance management system underpinned by an Assurance Framework."

2. Meetings of the Committee

The Committee is chaired by a non-executive with a financial background and membership comprises himself and 3 non-executive directors; thus reflecting and meeting the need for independence and objectivity. The Committee convened on six occasions throughout the financial year and all meetings were quorate. Meetings were also held with auditors in private session.

3. Principal review areas

This annual report reflects compliance with the key duties of the Committee as set out in the terms of reference [attached as Appendix A]

2.1 Governance, risk management and internal control

The Committee reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit opinion, external audit opinion and other appropriate independent assurances and considers that the Annual Governance Statement was consistent with the Committee's view on the Trust's system of internal control. Accordingly the Committee supported Board approval of the Annual Governance Statement.

The Committee reviewed the Board Assurance Framework (BAF) and were supportive of the revised format introduced during the year. The BAF is in line with Department of Health expectations and has been reviewed by internal audit to give additional assurance that this opinion is well founded.

The Committee has oversight of the completeness of the risk management system. Divisional and Corporate representatives attended the Committee on a rotational basis to present their clinical

audit plans and risk registers, outlining mitigating actions and demonstrating that risk is becoming increasingly embedded throughout the organisation

The Committee received the Annual Research Governance Report and were assured that reorganisation of Research and Development had put in place a system for managing the research activity and performance to deliver effective governance processes.

Progress against achieving compliance with the Information Governance Toolkit was monitored throughout the year. The Trust successfully achieved level 2 and this was verified by internal audit.

The Committee reviewed the Trust's Annual Quality Account and noted compliance with statutory requirements.

2.2 Internal audit

The internal audit service is provided by TIAA Limited. Throughout the year the Committee worked effectively with internal audit to strengthen the Trust's internal control processes. It approved the detailed programme of work and considered the major findings of internal audit and that the Head of Internal Audit opinion and Annual Governance Statement reflected any major control weaknesses.

The Committee noted sustained improvement in responding to Internal Audit recommendations and were assured that appropriate controls are in place.

2.3 External audit

The Committee approved the External Audit Plan at the start of the financial year and received regular updates on the progress of work. In addition, the Committee received reports and briefings (as appropriate) from the external auditors in accordance with the national requirements. These included; the Annual Audit Letter, Final Accounts Memorandum and report on the audit of financial statements, in addition to briefings on specific issues.

Updates were provided on the implementation of recommended actions arising from audit reviews.

2.4 Counter Fraud Services

Counter fraud services were provided by TIAA Limited who took over from Mazars Public Sector Internal Audit Limited on 1st April 2014. The Trust remains committed to ensuring fraud, bribery and corruption does not proliferate within in the organisation. To support this TIAA are developing a presence within the organisation and raising awareness of counter fraud. The Trust is fully compliant with the directions issued by the Secretary of State in 1999, the NHS Standard Contract (2012) and the NHS Counter Fraud and Corruption Manual.

The Committee approved and monitored the counter fraud workplan for 2014/15. A counter fraud representative attends each meeting and updates on actions being taken in respect of investigations.

2.5. Clinical Audit

At each meeting the Committee received a report on progress against implementing the Clinical Audit Forward Plan 2014/15. The Chair of the Clinical Audit Steering Group or a nominated representative attended Audit Committee meetings where possible. The Committee were concerned about the lack of progress against three national audit and actions were monitored during the year. At the year end the Trust had not participated in the National Diabetes Audit due to software issues and the Committee were supportive of this being resolved. The Committee continued to emphasise the need to move to a position of reporting on the learning from audits.

2.6 Management

The Committee continually challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process included calling managers to account when considered necessary to obtain relevant assurance.

The Committee also works closely with the executive directors to ensure that the assurance mechanism within the Trust are fully effective and that a robust process is in place to ensure that actions falling out of external reviews are implemented and monitored by the Committee. This included review of tenders and waivers, losses and special payments, declaration of interests, gifts and hospitality, sponsorship and ex gratia payments.

Members of the Committee are also members of other Board sub-committees including Quality and Standards and Finance and Investment and this provides additional assurance and triangulation of information.

2.7 Financial reporting

The Committee reviewed the annual financial statements before submission to the Board and considered them to be accurate.

4. Review of the effectiveness and impact of the Audit Committee

4.1 The Committee performed its duties during the year as delegated by the Trust Board and mandated through governance requirements, ensuring compliance with and further developing good practice through:-

- continuous self assessment and review of its effectiveness; and

- assessing itself against the checklist in the Audit Committee Handbook.

4.2 In the forthcoming year the Committee will continue with its programme of work and will provide further scrutiny of clinical audit.

5. Conclusion

The Committee is of the opinion that this annual report is consistent with the draft Annual Governance Statement and external audit reviews and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Mike Stevens
Audit Committee Chair

July 2015

Appendix A

Audit Committee Terms of Reference

1. Constitution

The Board has resolved to establish a committee of the Board to be known as the Audit 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 Audit Committee will support the Board by critically reviewing governance and assurance processes on which the Board places reliance. It will seek assurance that financial reporting and internal control principles are applied, and maintain an appropriate relationship with the organisation's auditors, both internal and external. This includes the power to review other committee's work, including in relation to quality, and to provide assurance to the board with regard to the reliability and robustness of internal controls.

The Committee will agree and work to an annual programme that takes into account the need to contribute to the timely sign-off of statutory requirements such as the annual accounts. This programme will be reviewed by the Board. The Committee may be commissioned by the Board to undertake particular studies or investigations, or to focus attention on any matters relating to finance and investment as the Trust Board thinks fit.

3. Membership

The Committee shall be appointed by the Chairman of the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members.

One of the members will be appointed Chair of the Committee by the Trust Board Chairman. One member should also be a member of the Quality and Standards Committee and one member a member of the Finance and Investment Committee.

At least one member of the Committee should have recent and relevant financial experience.

The Chairman of the Trust shall not be a member or act as substitute for a member of the Committee.

Other non-executive directors of the Trust, including any designate non-executive directors, may substitute for members of the Audit Committee in their absence and will form part of the quorum.

4. Attendance

Members of the Committee are expected to attend all meetings; if this is not possible then another non-executive director may substitute as outlined in the preceding paragraph.

The Director of Finance and appropriate Internal and External Audit representatives shall normally attend the meetings.

At least once a year the Committee should meet privately with the internal and external auditors.

The Chief Executive and other executive directors shall be invited to attend particularly when the Committee is discussing areas that are the responsibility of that Director.

The Chief Executive shall be invited to attend, at least annually, to discuss with the Committee the process of assurance that supports the Annual Governance Statement.

The Company Secretary shall attend the meetings to provide appropriate support and advice to the Chairman and committee members.

5. Quorum

A meeting of the Committee shall be quorate if at least two members are present, one of whom shall be the Chairman of the Committee. Other non-executive directors of the Trust, including any associate non-executive directors who are substituted for members, may form part of 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. The external auditor or head of internal audit may request a meeting if they consider that one is necessary.

7. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and in line with the Committees prime purpose of providing assurance to the Board.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. Duties

8.1 Governance, Risk Management and Internal control

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

In particular, the Committee will review the adequacy and effectiveness of:

- the board assurance framework, risk management system, Annual Governance Statement together with an accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible
- the clinical governance system of the Trust, including the clinical audit programme
- the information governance system, including requirements under the NHS Information Governance Toolkit
- the research governance system relating to any research activity the Trust may be engaged with
- the rigour of the processes for producing the quality accounts, in particular whether the information included in the quality account is reported accurately and whether the quality account is representative in its reporting of the services provided and the issues of concern to its stakeholders.
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the Annual Governance Statement
- the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related

reporting and self certification

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service

- Standing Financial Instructions (SFIs) and Standing Orders (SOs) on an annual basis.

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

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions.

It will also seek reports and assurances from officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

8.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

- Review of the major findings of Internal Audit work, management's response and the implementation of management action

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- An annual review of the effectiveness of internal audit.

8.3 External audit

The Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor as far as the rules governing the appointment permit.

- discussion and agreement with the External Auditor, before the audit commences on the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate with other external and internal auditors in the local health economy.

- discussion with the External Auditors of the local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- review of all external audit reports including agreement of the annual audit letter before submission to the Board for any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

8.4 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of Counter Fraud work.

8.5 Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include but will not be limited to reviews by:

- Department of Health
- Care Quality Commission
- NHS Litigation Authority
- Other regulators and inspectors
- Professional bodies with responsibility for performance of staff or functions including Royal Colleges and accreditation bodies
- The Trust's internal assurance function

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work; in particular this will include the Quality and Standards Committee and the Finance and Investment Committee. In reviewing the work of the Quality and Standards Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself that appropriate assurance that can be gained from the clinical audit function and to take the advice of the Quality and Standards Committee on how this function should best be utilised.

8.6 Hosted arrangements

The Committee will review and provide assurance to the Board in respect of any hosted arrangements or services, both those services hosted by the Trust and also those services hosted elsewhere but to which the Trust is a party.

8.8 Management

The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example clinical audit) as they may be relevant to the overall arrangements.

8.9 Financial reporting

The Committee shall monitor the integrity of the financial systems of the Trust and systems of financial control.

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- changes in and compliance with accounting policies and practices.
- unadjusted mis-statements in the financial statements.
- significant judgments in preparation of the financial statements.
- significant adjustments resulting from the audit.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review

as to completeness and accuracy of the information provided to the Board.

9. Reporting arrangements

Minutes of the Committee meetings shall be formally recorded by the Company Secretary, or her nominee, and submitted to the 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 Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and compliance with CQC registration standards.

The Committee shall undertake a self assessment of its effectiveness on at least an annual basis and this will be timetabled into the schedule of audit committee business.

This assessment will follow best practice as outlined in the NHS Audit Committee Handbook and may be facilitated by independent advisors if the Committee considers this appropriate or necessary. A copy of the self-assessment and any proposed actions will be reviewed by the Trust Board.

These Terms of Reference shall be reviewed by the Committee and Trust Board at least annually.

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 24 June 2015 at 9.30am – 11.30am in St Mary's Board Room Eastbourne DGH

Present

Mr Barry Nealon, Non-Executive Director/Chair
Mr Vanessa Harris, Director of Finance
Mr Philip Astell, Deputy Director of Finance
Dr David Hughes, Medical Director
Mr Darren Grayson, Chief Executive
Mr Richard Sunley, Deputy Chief Executive/COO

In attendance

Mr Matt Hardwick, General Manager, Surgery Clinical Unit (for item 6)
Ms Imelda Donnellan, Clinical Lead, Surgery Clinical Unit (for item 6)
Miss Sarah Goldsack, Associate Director of Knowledge Mrs Management (for item7)
Mrs Lesley Walton, Programme Manager (for item 7)
Mr Andy Horne, Programme Director (for item 10)
Mr Chris Hodgson, Associate Director of Estates & Facilities for items 10 and 12)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the meeting. Apologies were received from Professor Jon Cohen and Mr Michael Stevens.	**Action**
2.	**Minutes of Meeting of 20 May 2015** The minutes of 20 May 2015 were agreed as an accurate record.	
3.	**Matters Arising** (i) Performance Report M11 Mr Sunley provided an update on how the Trust was performing against the trajectories under item 4. (ii) Market Testing It was noted that there would be a Board strategic discussion on options for nursery services.	

The Laundry Business Case was discussed under item 12(ii).

(iii) Performance Report – Month 12

Mr Nealon had some queries over waiting times for Podiatry and MSK which were discussed under item 4.

(iv) Transformation Update

Mr Grayson reported that he had asked for the escalation policy to be circulated. It was noted that this had been approved by the Board. He explained that the definition of 'black' was 'whole system failure'.

(v) Transformation Update

Mrs Harris confirmed that she had sent a copy of the bridge chart discussed at the last meeting to Mr Stevens.

(vi) PMO Projects Update

An update on the Acute Oasis PAS upgrade was discussed under item 7.

An update on the Health Records Storage Rationalisation will be given at the meeting on 29 July 2015.

(vii) Job Planning

A detailed update on job planning was discussed under item 9.

(viii) Making Better Use of Government Resource Services Procurement & Service Delivery Platforms and the Lord Carter Review – Update Report

Mr Astell confirmed that a review of NHS Professionals was due to be undertaken shortly. In addition the outline business for outsourcing some back office functions was discussed under item 12(i).

(ix) Pathology Reconfiguration and Re-equipping under a Managed Service Contract

Mr Astell confirmed that he had followed up the VAT issue. In terms of the accounting treatment of assets, he felt that this was very clear and was querying with the TDA what clarification they required. It was noted that Pathology Business Case had been submitted to the TDA on 23 June 2015.

(x) Energy Performance Contract:

	A verbal update was given under item 12(iii) <u>(xi) Work Programme</u> It was confirmed that the work programme had been updated.	
4(i)	**Performance Report – Month 1** The Committee received the month 1 Performance Report which detailed the Trust's in month performance against key trust metrics as well as activity and workforce indicators. The report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15. Mr Sunley gave an update on the how the Trust was performing against the trajectory. The Overall Performance was Score: 4 (from a possible 5) Responsiveness Domain: 2 8 out of the 17 indicators for this domain were achieved this month. The Trust remains below the higher scores predominately as a result of not achieving the RTT admitted standard of 90%. This indicator has a high weighting within the domain. The other indicators which were not achieved this month were: • RTT Non Admitted • Diagnostic waiting times • A&E performance • Cancer Two Week Wait Standard • Cancer 62 Day Standard • Cancer 62 Day Standard for Screening • Delayed Transfers of Care Effectiveness Domain: 5 The domain remained at a 5, achieving in all indicators. Safe Domain: 3 The Safe domain has reduced from 5, primarily due to a reported case of MRSA, which has a high weighting within the domain. Caring Domain: 4 The Caring domain achieved a score of 4 due to A&E Friends and Family scores remaining below the required standard. Well Led Domain: 3 The score for the Well Led domain remains at a 3 with achievement of 4 of the 9 indicators. A&E response rates, turnover, sickness, temporary costs and appraisal rates remain below the required standard, keeping the domain score to 3.	

	Action **The Committee noted the Performance Report for month 1 and noted the Trust Performance against each domain and the Workforce update.**	
4(ii)	**Finance Update – Month 2** Mrs Harris gave an update on the financial position as at Month 2. It was noted that the Trust performance in month 2 was a run rate deficit of £3.1m with an adverse variance against plan of £0.3m. Year to date the run rate deficit stands at £6.0m which is £0.2m above plan. CIP delivery was slightly under plan. It was noted that where CIPs were at risk alternative schemes would need to go into place. The Committee received information on the downside case at M2. Mrs Harris reported that the Trust had received feedback on the plan from the TDA and this would be discussed at the Business Planning Steering Group. **Action** **The Committee noted the financial position as at Month 2.**	
5.	**EBITDA – Quarterly Report – Q4** The Committee received the 2014-2015 Q4 EBITDA statement, the 2014-2015 quarterly EBITDA comparison statement and the Patient Cost Benchmarking EBITDA statement to the Finance & Investment Committee. It was noted that the income received by the Trust for winter & RTT funding had been included within the Q4 EBITDA statement. The income disputes & WIP accrual adjustments had also factored into the EBITDA statement for Q4. The Committee noted: The 2014-2015 Q4 EBITDA deficit position for the clinical units The number of service lines that had negative EBITDAs The 2014-2015 quarterly EBITDA variances. **Action** **The Committee noted the EBITDA statement position and recommended that the Committee continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews, and to return at a subsequent meeting to update on their progress.**	

6.	**EBITDA deep dive – Breast Surgery** Miss Donnellan gave an overview of the Trust Breast Surgery service. It was noted the Breast Surgery review was initiated following the positive response to similar service reviews in Gynaecology & Trauma & Orthopaedics. Breast Surgery was chosen because it had an adverse Qtr 4 2014-2015 EBITDA variance. Breast Surgery has been asked to present the findings from the planned 'deep dive' into their business. It was noted that the adverse position related to predominantly to elective inpatient work. One HRG was a high volume and high loss HRG, therefore the decision was made to review. An analysis of cost types, length of stay, theatre minutes, site, age demographics and re-admissions information identified areas requiring further understanding/investigation. The patient cost benchmarking system was used to enhance the findings. The chosen benchmarking peer was a neighbouring Foundation Trust, but it was agreed that the Breast Surgery team would ask Mrs Brandt to obtain data from a third Trust. The General Manager, Service Manager and Breast Consultants for Breast Surgery had worked alongside the Planning & Performance team and were committed to the work plan which ensured that all action points are progressed. It was agreed that Breast Surgery would follow the next steps highlighted in the Breast Surgery Service Review paper and would be invited back to present the actions taken since their presentation. It was noted that the deep dive proved to be a very useful exercise and Urology would be asked to go through the same exercise. This would be scheduled into a future Finance & Investment Committee meeting. **Action:** **The Committee noted the Breast Surgery EBITDA statement position. It was agreed that Breast Surgery would follow the next steps highlighted in the Breast Surgery Service Review paper. The Committee would invite Breast Surgery back to present the actions taken since their presentation. The Committee recommended that individual clinical specialties would be invited to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews.**	**VH**

7.	**Oasis PAS Upgrade – Project Update** Miss Goldsack and Mrs Walton updated the Committee on the progress of the Oasis V16 PAS upgrade. It was noted that the Oasis V16 PAS Upgrade project had been making excellent progress over the last 3 months following the delays in 2014. The main elements taken forward were the approval of the RTT pathway processes on Oasis, the design of standard outcome forms across the Trust, the successful testing of migrating the data from the existing RTT Patient Tracking System to Oasis V16, the securing of additional funds to progress the upgrade following the delays and the progression of training with nominated Super Users and the progression of the technical infrastructure upgrade. It was noted that the project was on track to go live during September. This revised date was agreed following the review of the project plan from the suppliers. The Committee reviewed the risks and noted the mitigation in place to minimise the risk. The Committee received a highlight report which outlined the current position of the project. **Action** **The Committee noted the progress on the Oasis PAS Upgrade.**	
8(i)	**Tender & Service Development Schedule** The Committee received a schedule which provided an update on current tenders and service developments as at 16 June 2015. It was noted that the tender and service development schedule was updated on a weekly basis and monitored by the Business Planning Steering Group (BPSG) at its weekly meetings. The Committee noted the position of the following PQQ/tenders in the pipeline: • High Weald Lewes and Havens community services – the CCG announced that the contract was awarded to Sussex Community Trust on 10.06.15. The General Manager for the Out of Hospital Clinical Unit is leading the process for decommissioning the service from the Trust. • Community Diabetes Service for Brighton & Hove and High Weald Lewes & Havens CCGs – the Trust passed the PQQ stage. The issue of the ITT documentation has been delayed but the Trust	

	had entered into a strategic partnership with Sussex Community Trust . • Fracture Liaison Service – the CCG has decided not to proceed further in the procurement process. Instead the service will be embedded within fracture clinics and procured through variation to local acute contracts The Committee also noted some of the service developments that had been considered by the Business Planning Group. **Action** **The Committee noted the update on tenders and service developments.**	
8(ii)	**HWLH Community Tender: Transfer of Lewes, Victoria, Uckfield and Crowborough Hospitals** Mrs Harris updated the Committee on the transfer of Lewes Victoria, Uckfield and Crowborough hospitals in 2015/16. The High Weald Lewes Havens CCG had announced that the Sussex Community NHST has been successful in the CCG's recent community services procurement. The Department of Health had written to East Sussex Healthcare NHS Trust on 10 June 2015 requesting transfer of the following freehold properties from East Sussex Healthcare NHST to NHS Property Services (NHSPS) Ltd as the nominee of the SofS: · Lewes Victoria Hospital, · Uckfield Community Hospital, and · Crowborough War Memorial Hospital. In addition to the formal notification the DH has sent due diligence forms to be completed and returned directly to NHS Property Services. This represents a significant amount of work for the Trust particularly for Estates and HR. It was noted that the transfer will be effected on 1 November 2015. It was noted that the net book value of the assets was £30m at 31 March 2015 **Action** **The Committee noted that the process for asset transfer has started. It was requested that a summary transition update should be made at future Committee meetings.**	**VH**
9.	**Job Planning – Quarterly update** Dr Hughes provided the Committee with an update on consultant job planning.	

	It was noted that since the last update provided to the Finance & Investment Committee in February of this year, the CU leads and General Managers had been progressing with job planning in their clinical areas. Individual meetings were taking place with each specialty at which their planned activity and requirement for medical staffing was compared to their capacity to meet this demand. Adjustments were then made to job plans as a result of this. The organisation had embedded its new clinical management and leadership structure and the new CU Leads were implementing and managing a more rigorous approach to job planning to ensure expenditure remains within budget whilst the quality of services continues to improve. Monthly scrutiny meetings have been undertaken with each CU from August 2014 through to March 2015 to ensure progress continues to be made and the job plans reflect the workload and activity the Trust needs to undertake. It is recommended that this work continues. The Committee reviewed the trajectories for completion of all consultant job plans provided by each Clinical Unit. It was agreed that a further update would be provided for the September Finance & Investment Committee. **Action** **The Committee noted progress and asked for an update at the September meeting.**	**DH**
10(i)	**Market Testing** **Occupational Health Post Procurement Business Case** Mr Horne presented the Committee with the Occupational Health Post Procurement business case for consideration. Committee discussions on this matter are considered to be commercially confidential and have therefore been removed from the publically available minutes.	
10(ii)	**Soft FM (Housekeeping / Cleaning) Modernisation Plan** Mr Hodgson presented the Committee with a report to provide assurance that all processes and considerations relating to the implementation of the Housekeeping/Cleaning Modernisation plan had been accounted for.	

	The Modernisation plan clearly identified all key objectives, tasks, dependencies, responsibilities and timescales for completion to improve service performance, quality, sustainability, infection prevention and patient experience. It identified efficiencies to be achieved through better management and increased productivity and provided assurance that the declared financial savings had been accurately forecasted. The report related specifically to Housekeeping / Cleaning services but it was the intention that the methodology was applied to all Soft FM services during 2015/16. On the 2 June 2015 the Trust Board agreed to the recommendations that market testing for Soft FM services be suspended for a minimum of two years to allow the in house teams to progress with on going Service Modernisation plans. The local Soft FM team had been working closely with the DH to compare local service and cost with the private sector. The outcome of this had been the development of Modernisation plans following private sector principals and these are supported by the DH Representative. The Cleaning / Housekeeping Modernisation plan is one of a number of schemes being designed to increase productivity and realise further efficiencies. It was noted that the declared Soft FM CIP initiatives excluding the Housekeeping project realisation for 2015/16 were set to achieve efficiencies in the region of £470,000. YTD these were achieving. **Action** **The Committee acknowledged the work undertaken thus far in modernising the Cleaning and Housekeeping services within the Trust:** - **To support the full implementation of this modernisation plan throughout the Trust** - **To recognise the base line service provision included within this report, delivering £500,000 savings and plan for additional resource that will need to be funded to reflect any ad hoc/winder demand** - **Commit the resource requirement (£30,000) to support the implementation of the modernisation plan** - **Secure on-going support and adoption of governance and reporting mechanisms by Trust Board including a full QIA review to ensure that there is full understanding of the services being provided and to maintain momentum required to deliver the full potential of the changes.**	

11.	**Making Better Use of Government Resource Services Procurement & Service Delivery Platforms and the Lord Carter Review – Update Report** Mrs Harris gave an update on progress with the DH (Department of Health) invitation to take part in 1) a review of Government support services and delivery platforms and 2) the Lord Carter review of efficiency and productivity metrics. Work under Project 1- a provisional business case to consider outsourcing financial services, payroll and operational procurement was discussed and considered under agenda item 12(i) below. Work under Project 2 – the Lord Carter review, was also progressing and there had been some recent media interest in some of the high level outcomes. A meeting between Lord Carter and the Trust (CEO, Chairman, and Deputy Finance Director) had taken place on 10 June 2015 and the Committee received feedback from that meeting. It was noted that submissions were still being made to contribute to the development of the draft metrics. **Action** **The Committee noted the progress on these two projects to date.**	
12(i)	**Outline Business Case (OBC) Outsourcing Back Office Functions** Mr Astell presented an Outline Business Case (OBC) to consider whether to outsource certain 'back office' functions. The Trust had been carrying a significant underlying financial deficit for a number of years and was facing substantial financial pressures that will further worsen the underlying position. There was a need to ensure and demonstrate that its services and functions were as efficient and productive as possible and that value for money was achieved in the use of public funds. One theme that was being explored was whether certain 'back office' functions could be delivered more cost-effectively if they were outsourced to an external service provider. This business case examined potential efficiencies within the following functions ('the relevant services'):- • Finance and accounting services • Employment services • Transactional procurement The report examined a proposal to outsource certain functions, as above, and compared this with a number of alternative options. The case concluded that, while there were a number of benefits to outsourcing, it was not financially beneficial to do so at the present time and there were no major quality concerns that would act as an	

	overriding driving force to replace the existing in-house services. The case identified the need to address issues of resilience, notably within financial systems, and proposed alternative means of achieving this within a 'do minimum' scenario. The business case provided a full option appraisal detailing the relative benefits, risks and risk mitigations of each of the available options. The recommended option was shown to be the most financially beneficial option that also addressed the key risks of systems and workforce resilience. It was recommended that option 2 was approved. This was the 'do minimum' option, which means keeping the services in house and investing separately to address key areas of risk around systems and workforce resilience. **Action** **The Committee approved option 2.**	
12(ii)	**DRAFT Laundry Services Outline Business Case** Mr Hodgson presented the draft Outline Business case for Laundry and Linen services at EDGH for information only. He summarised the number of options which had been explored, and provided information for discussion on potential preferred options for consideration. Committee discussions on this matter are considered to be commercially confidential and have therefore been removed from the publically available minutes. The refined business case would need to go through the Capital Approvals Group, Business Planning Steering Group and Clinical Management Executive before returning to the Finance and investment Committee. **Action** **The Committee noted the outline business case which need to be strengthened before passing through the Trust decision process.**	
12(iii)	**Schneider Business Case** It was reported that, as Mr Hodgson was new in post, he would be reviewing the Schneider Project. **Action** **The Committee noted that the Schneider Project was being reviewed.**	

13.	**2015 Work Programme** The updated work programme was noted. A job planning update would be presented in September and a deep dive for Urology should be scheduled into the work programme. **Action** **The Committee noted the revised work programme.**	
14.	**Date of Next Meeting** The next meeting will take place on Wednesday 29 July 2015. It was noted that the meeting would be moved to Eastbourne DGH with a slightly earlier start time of 9am.	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 29 July 2015 at 9am – 11am, Princess Alice Room, Eastbourne DGH

Present

Mr Barry Nealon, Non-Executive Director/Chair
Professor Jon Cohen, Non-Executive Director
Mrs Vanessa Harris, Director of Finance
Mr Philip Astell, Deputy Director of Finance
Mr Stuart Welling, Chairman
Mrs Pauline Butterworth, Deputy Chief Operating Officer
- deputising for Mr Richard Sunley (for item 4)

In attendance

Mr Garry East, Assistant Director of Delivery & Performance (for item 4)
Mr Dave Wells, Deputy Head of Financial Services (for items 5 & 6)
Mr Steve Hoaen, Head of Financial Services (for item 7)
Mrs Liz Fellows, Assistant Director of Operational Planning/Business Management (for item 8)
Ms Michele Small, General Manager, Out of Hospital and Therapies Clinical Unit (for item 9)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee meeting. Apologies were received from Mr Mike Stevens, Dr David Hughes and Mr Richard Sunley.	**Action**
2.	**Minutes of Meeting of 24 June 2015** The minutes of the meeting held on 24 June 2015 were agreed as an accurate record subject to an amendment on page 5, which should say: “It was noted that the deep dive....”	
3.	**Matters Arising** <u>(i) Abridged minutes of meeting of 20 May 2015</u> The abridged minutes of the meeting of 20 May 2015 were noted. <u>(ii) Abridged minutes of meeting of 24 June 2015</u>	

	The abridged minutes of the meeting of 24 June 2015 were noted. (iii) EBITDA deep dive The Urology deep dive had been scheduled for November 2015. (iv) HWLH Community Tender An update on the HWLH Community transition was given under item 9 below. (v) Job Planning Job Planning had been added to the work programme for the September meeting.	
4(i)	**Performance Report – Month 2** Mrs Butterworth presented the month 2 Performance Report which detailed the Trust's in month performance against key trust metrics as well as activity and workforce indicators. The report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15. Overall Performance Score: 4 (from a possible 5) Responsiveness Domain: 3 10 out of the 17 indicators for this domain were achieved this month. The Trust remains below the higher scores predominately as a result of not achieving the RTT admitted standard of 90%. This indicator has a high weighting within the domain. The other indicators which were not achieved this month were: • RTT Non Admitted • Diagnostic waiting times • A&E performance • Cancer 62 Day Standard • Cancer 62 Day Standard for Screening • Delayed Transfers of Care It was noted that admitted and non admitted targets would no longer be reported on from October 2015, however the Trust would continue to monitor this information internally. Effectiveness Domain: 5 The domain remained at a 5, achieving in all indicators. Safe Domain: 4 Due to there being one case of MRSA (high weighting within the domain) the Safe domain has remained at a score of 4.	

	Caring Domain: 4 The Caring domain achieved a score of 4 due to A&E Friends and Family scores remaining below the required standard. Well Led Domain: 3 The score for the Well Led domain remains at a 3 with achievement of 4 of the 9 indicators. A&E response rates, turnover, sickness, temporary costs and appraisal rates remain below the required standard, keeping the domain score to 3. Mr East gave a brief summary on the month 3 performance data which had yet to be finalised. It was noted that compliance with the 62 day cancer standards was still a challenge. It was agreed that Mr East would update the Committee on specific diagnostic issues at its next meeting. **Action** **The Committee noted the Performance Report for month 2 and noted the Trust Performance against each domain and the Workforce update.**	**GE**
4(ii)	**Finance Update – Month 3** Mrs Harris gave an update on the Month 3 financial position. It was noted that the Trust performance in month 3 was a run rate deficit of £4.2m with an adverse variance against plan of £0.5m. Year to date the run rate deficit stood at £10.2m which was £0.7m above plan. The forecast outturn remains as per plan - £37m deficit. Mr Astell gave an update on the Financial headlines at quarter 1. The Committee was concerned that pay costs are over budget and this needs to be addressed. It was noted that an internal group has been formed to review agency usage and manage cost reduction in that area. The Committee reviewed the 2015/16 downside case at M3. It asked to see further information and analysis of cost pressures at the next meeting. Mrs Harris circulated a letter received from the TDA on the financial position, and discussion took place on the response which was required by 31 July 2015. **Action** **The Committee noted the financial position as at Month 3.**	**VH**

5.	**Review of Capital Programme Outcome** Mr Wells provided the Committee with an update on the capital business cases considered by the Capital Approvals Group (CAG) and the Finance & Investment Committee during 2014/15 and the current financial year to date. These included: • Conquest Clinical Decisions Unit • Anaesthetic machines replacement • Conquest Operating Tables • Conquest X Ray Room 7 • Conquest Fluoroscopy Room 9 • Electronic Expense Claims • Electronic Document Management • Oasis PAS Upgrade, including clinic manager implementation • Health Records - Introduction of a bar coding identification system & improved physical storage. • Infrastructure Improvements – Modernisation of inpatient environment and facilities • Pevensey Development • Windows 7 Office 2010 Migration It was agreed that where these had been completed, they should come off this schedule. **Action** **The Committee noted the current position on capital business cases approved during 2014/15 and the current financial year.**	
6.	**Capital Programme Report** Mr Wells updated the Committee on the performance of the capital programme after three months of the financial year. At the end of month 3 the year to date capital expenditure amounted to £3.6m and the capital programme had an over planning margin of £81k which was considered acceptable at this stage of the financial year. The Capital Approvals Group (CAG) has had to reduce the provisional capital programme over planning margin in view of the uncertainty around the clinical strategy funding. It was noted that the CAG would continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital. **Action:**	

	The Committee noted the current performance of the capital programme and noted the risks associate with limited capital.	
7.	**Quarterly Review of Aged Debts** Mr Hoaen presented the Committee with a report showing the current level of aged debt at the end of June 2015, split between NHS and non NHS and segmented into operational categories. It was noted that overall levels of debt over 90 days old have continued to reduce, from £2.912m at the end of February to £2.778m at the end of June. The percentage of over 90 day debt to the total was 37%. This was an increase against the last reported position due to a change in process. Contract income was now invoiced on the first day of the month; previously it had been invoiced earlier which had the effect of reducing the percentage of aged debt to that of the total. The target remains 5%, so although progress continues to be made, the Trust was not yet in compliance with this KPI. Mr Hoaen assured the Committee that his team were aligned to hitting 5% at the end of month 6. A further update would be provided at the October meeting. **Action** **The Committee noted the current aged debt position.**	
8.	**Health Records Storage Rationalisation – Project Update** Ms Fellows updated the Committee on the investment in Health Records. The Committee noted that there were known and increasing risks regarding the condition, storage and availability of health records within ESHT. Whilst electronic document management was the long term solution, two initiatives are underway to address the known risks – iFIT Health Records tracking and improvement in storage facilities. • The iFIT Health Records tracking project, which was scheduled to 'go live' on 12th August 2015 would provide software and support systems to address a number of the risks that impact on safe, effective care and patient experience. From 'go live' there would be a 6 month implementation period although some shorter benefits will be made. • The reprovision/single siting of the Health Records library is being reviewed subject to the iFIT project and development costs to ensure that the initial proposals meet the medium term requirements	

	It was noted that the projects would address the majority of high risk issues relating to Health Records including: • Effective tracking and the ability to provide an audit trail • More flexible and effective storage of records • More efficient ways of working • Reduced staffing costs associated with the management of notes. • Improved compliance with Information Governance (IG) legislation. • Medium term 'future proofing' of service The projects would stabilise and significantly improve the Health Records service, allowing for medium term sustainability. It was highlighted that the project costs could exceed the estimated costs by £295k, however it is possible that the storage requirements may reduce as a result of the preparatory work for iFIT and the implementation of the project. **Action** **The Committee supported the projects.**	
9(i)	**Tender & Service Development Schedule** The Committee received a schedule which provided an update on current tenders and service developments as at 17 July 2015. It was noted that the tender and service development schedule was updated on a weekly basis and monitored by the Business Planning Steering Group (BPSG) at its weekly meetings. The Committee noted the position of the following PQQ/tenders in the pipeline: • Community Diabetes Service for Brighton & Hove and High Weald Lewes & Havens CCGs • H&R Cancer Quality Improvement Service • Integrated Sexual Health and HIV Service • Laundry and Linen Crown Commercial The Committee also noted some of the service developments that had been considered by the Business Planning Group. **Action** **The Committee noted the update on tenders and service developments.**	

9(ii)	**HWLH Community Transition: Update** Ms Small gave an update on the High Weald, Lewes and Havens' Community Services transfer to the new provider, Sussex Community Health NHS Trust, with effect from 1 November 2015. It was noted that a comprehensive project plan had been developed incorporating key risk and issues. The project plan was updated on a regular basis and progress was being reported at the ESHT Project Team which meets fortnightly. The Project Manager also attends a fortnightly CCG/SCT mobilisation/exit project team meeting which includes a wide range of representatives from HWLH CCG and SCT. Ms Small presented a highlight report which provided some of the key issues and described the transition process in more detail. These issues included: • Tender process – a lessons learnt paper was in preparation highlighting key themes. • Consultation process and staffing – all staff to TUPE across to Sussex Community Health NHS Trust with effect from 1st November 2015 have been written to individually. • A series of Inform and Consult meetings had been arranged for the three Community sites (Uckfield, Lewes and Crowborough). • Financial impact –stranded costs. • Freehold properties transfer. • Information Governance and Technology – it was noted that there would be some loss of project benefits going forwards as those benefits associated with HWLH staff would no longer count. • Review of existing services. • General enquiries and issues. **Action** **The Committee noted the governance process for the transfer of HWLH community services to the new provider, and the issues and risks associated with this transition.**	
10.	**Making Better Use of Government Resource Services Procurement & Service Delivery Platforms and the Lord Carter Review – Update Report** Mrs Harris gave an update on progress with the DH (Department of Health) invitation to take part in 1) a review of Government support services and delivery platforms and 2) the Lord Carter review of efficiency and productivity metrics.	

	Action **The Committee noted the progress on these two projects to date.**	
11.	**Notification of Delegated Capital Expenditure Limit** The Committee received an update on the delegated capital expenditure limit for 2015/16. It was noted that the TDA had recently written to clarify the delegated limit for capital expenditure in 2015/16 for ESHT. The Committee received a copy of the TDA letter dated 3 July 2015. **Action** **The Committee noted the letter and process for 2015/16.**	
12.	**Business Case** There were no business cases for review. **Action** **The Committee noted that there were no business cases for review.**	
13.	**2015 Work Programme** The updated work programme was noted. It was agreed that an update on East Sussex Better Together would be presented at the August Committee meeting. **Action** **The Committee noted the revised work programme.**	**CA**
14.	**Date of Next Meeting** The next meeting will take place on Wednesday 26 August 2015 at 9.30am – 11.30 am in St Mary's Board Room at Eastbourne DGH.	

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	15b
Subject:	Finance & Investment Committee Annual Review of Committee Effectiveness
Reporting Officer:	Vanessa Harris

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

Purpose:

To note that the Finance & Investment Committee has recently undertaken an annual review reviewed of effectiveness.

Introduction:

It is considered good practice for every committee of the Trust to conduct an annual self-assessment review. The attached report sets out the outcome of this review which was conducted via a questionnaire to all Committee members in July 2015.

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

Members agreed that the number of Committee meetings held had been sufficient and agendas appropriately structured to support the effective discharge of responsibilities.

Matters considered and decisions made by the Committee were taken on an informed basis and members agreed these decisions were understood, owned and properly recorded and would bear scrutiny; subsequent implementation of decisions and progress had been reported back to the Committee as required. Overall the Committee was considered to be well organised, well chaired and effective.

Some minor changes to current Terms of Reference are suggested, some of these are to ensure alignment with the revised Business Planning Framework and the revised Terms of Reference are attached.

Benefits:

The review has identified some minor improvements to the operation of the Committee.

Risks and Implications
None identified

Assurance Provided:
That the Committee has reviewed its effectiveness

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

Proposals and/or Recommendations
The Board to: • note that the F&I Committee had reviewed its effectiveness • note the revised Terms of Reference (minor changes only)

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

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

East Sussex Healthcare NHS Trust

Finance and Investment Committee - Terms of Reference

1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Finance and Investment Committee (the Committee). The Committee is a 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 Board of directors. On authorisation as an NHS Foundation Trust, the Board of directors shall adopt terms of reference which have been prepared in advance and which reflect the statutory requirements that apply with respect to NHS Foundation Trusts.

2. Purpose

The Finance and Investment Committee should provide recommendations and assurance to the Board relating to:

- Understanding the future financial challenges and opportunities for the Trust
- The future financial risks of the organisation
- The integrity of the Trust's financial structure
- The effectiveness and robustness of financial planning
- The effectiveness and robustness of investment management
- The robustness of the Trust's cash investment approach
- The investment and market environment the Trust is operating in, and the process for agreeing or dismissing investment decisions
- The risk appetite that is appropriate for the organisation
- The process for business case assessments and scrutiny
- Review and approve business cases including tracking of delivery against plan and benefits realisation
- Monitoring the capital investment programme
- Undertake substantial reviews of issues and areas of concern.

3. Membership and attendance

The Committee and the Committee Chairman shall be appointed by the Chairman of the Board of directors. The membership of the Committee shall be as follows:

- At least three non-executive directors
- Chief Executive
- Director of Finance & Performance
- Medical Director
- Chief Operating Officer
- Director of Strategic Development and Assurance (optional)

4. Quorum

Quorum of the Committee shall be three members, one of whom shall be a non-executive director.

5. Frequency

Meetings shall be held at least four times a year and at such other times as the Chairman of the Committee shall require.

6. Duties

The Committee shall review and monitor the longer-term financial health of the Trust.

In particular its duties include:

- Reviewing the financial environment the Trust is operating within, and supporting the Board to ensure that its focus on financial and business issues continually improves
- Supporting the Board to understand and secure the financial and fiscal performance data and reporting it needs in order to discharge its duties
- Understanding the market and business environment that the Trust is operating within and keeping the capacity and capability of the Trust to respond to the demands of the market under review
- Understanding the business risk environment that the organisation is operating within, and helping the Board to agree an appropriate risk appetite for the Trust
- Supporting the Board to agree an investment and business development strategy and process
- Supporting the Board to agree an integrated business plan
- Approval for business cases with a value between £250k-£500k and recommendation of business cases over £500k to the Board

The Board may from time to time delegate to the Committee the authority to agree specific investment decisions over and above the annual financial plan provided that the amended plans:

- Do not compromise the Standing Orders and Standing Financial Instructions
- Do not adversely affect the strategic risk facing the Trust
- Do not adversely affect the organisation’s ability to delivery its operational plans

7. Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the PA to the Finance Director and submitted to the 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 actions.

The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. The Trust Secretary will support the Committee to develop and implement an annual work programme

These terms of reference shall be reviewed by the Board of directors at least annually.

26 August 2015

East Sussex Healthcare NHS Trust

QUALITY AND STANDARDS COMMITTEE

1. Introduction

1.1 Since the last Board meeting a Quality and Standards Committee meeting has been held on 1 September 2015. A summary of the issues discussed at the meeting is provided below.

1.2 The minutes of the meeting held on 6 July 2015 are included at Appendix 1.

2. Issues discussed at 1 September 2015 meeting

2.1 Patient Story

It was confirmed that the filming of patient stories had commenced and these would be shared with staff at induction and general staff development sessions. It was noted that the Committee valued listening to service users' experiences and welcomed their continued attendance at meetings.

2.2 Mandatory Training and Appraisal Compliance

The Committee noted that mandatory training compliance percentages had increased but specific work to address areas of low compliance was needed. The Assistant Director of Workforce described the specialist support available which included the delivery of bespoke mandatory sessions. The Surgical clinical unit was highlighted as a good example of where this had occurred, with some audit days given over to mandatory training; this had ensured the participation of large numbers staff. It was noted that a full review of the appraisal process was underway which included quality and consistency checks.

The General Manager from the Specialist and Planned Medicine clinical unit attended the meeting and provided an update on the current position of appraisal and mandatory training compliance for the Cardiovascular clinical unit. This had been noted as an area of concern by the Committee. The Assistant Director of Workforce highlighted a proposed blended approach to ward based training that would involve an assessment with a practical element.

2.3 Board Assurance Framework and High Level Risk Register

The Committee was provided with an update around the Trust Board Assurance Framework (BAF) and High Level Risk Register. Three areas of concern were discussed and noted; health records, the configuration of emergency departments and mandatory training and appraisals compliance. The committee asked that it be kept regularly updated about progress in these three areas with specific focus on health records.

2.4 **Self Assessment of Compliance against Regulation 12 'Cleanliness and Infection Control' – Quarter 1, 2015-16**

The Assistant Director of Infection Prevention and Control presented the report which had been compiled in collaboration with key stakeholders. The report provided a comprehensive and accurate assessment of the Trust compliance against Regulation 12. Discussion took place around recruitment to the National Specification of Cleanliness (NSC) audit team which would support full compliance with the NSC schedule and the implementation of the new electronic audit tool. The Committee was updated on the recruitment to the ward orderly posts and assurance provided that evaluation, effectiveness and improved compliance with cleanliness of nursing and patient equipment would be undertaken.

2.5 **Annual Report for Infection Prevention and Control 2014-15 and key priorities for Programme of Work 2015-16**

The Assistant Director of Infection Prevention and Control described the key activities, incidents and achievements related to infection prevention and control in 2014-15 and highlighted the key priorities for the programme of work for 2015-16. It was noted that operational activity and bed capacity restricted capability for planned programmes of refurbishment and delivery of a structured decant deep clean programme. The Committee were assured the Trust had demonstrated effective systems were in place to rapidly identify and manage outbreaks of infection.

2.6 **Quality Improvement Plan (CQC Recommendations)**

The Interim Head of Governance updated the Committee on the progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visit in September 2014. The report explained that the organisation worked within the themes identified in the CQC's overarching Trust report and an action plan ensured that all the 'must do' recommendations were being addressed. It was noted that following review by the Project Improvement Working Group there were 116 actions of which 5% were overdue, 33% were on track and 62% had been completed. It was acknowledged that following a clear understanding of the regulators requirements, the Board approved recovery plan should be communicated to staff and guidance given on its delivery.

3 Conclusion

3.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meeting held on 1 September 2015 and the minutes of the meeting held on 6 July 2015.

Charles Ellis
Quality and Standards Committee
1 September 2015

Appendix 1

East Sussex Healthcare NHS Trust (ESHT)

Quality and Standards Committee

Minutes of the Quality and Standards Committee Meeting

Monday, 6 July 2015
Committee Room, Conquest Hospital

Present: Mrs Janet Colvert, Ex-Officio Committee Member
Mr Charles Ellis, Non-Executive Director (Chair)
Dr David Hughes, Medical Director
Miss Lindsey Morgan, Deputy Director of Nursing
Mrs Alice Webster, Director of Nursing
Mr Stuart Welling, Chairman
Mrs Lynette Wells, Company Secretary

In attendance: Mrs Pauline Butterworth, Deputy Chief Operating Officer obo Mr Sunley
Mrs Edel Cousins, Assistant Director of HR (Workforce Development) obo Mrs Tenney.

Mrs Susan Cambell, PA to Director of Nursing (minutes)

1.0 Welcome and Apologies for Absence

Mr Ellis welcomed participants to the Quality and Standards Committee meeting and confirmed that the Committee was quorate.

Mr Ellis noted that apologies for absence had been received from;

Mrs Sue Bernhauser, Non-Executive Director
Professor Jon Cohen, Non-Executive Director
Ms Tina Lloyd, Assistant Director of Nursing Infection Prevention and Control
Mr Richard Sunley, Chief Operating Officer
Ms Emma Tate, Head of Clinical Improvement
Mrs Moira Tenney, Deputy Director of Human Resources
Dr James Wilkinson, Assistant Medical Director, Quality
Dr Jamal Zaidi, Assistant Medical Director, Workforce

2.0 Patient Story

A presentation was made by a service user on behalf of a family member. The case highlighted the need for further learning around communication and empathy. The service user had agreed to be filmed so that their experiences could be shared with staff at induction and general staff development sessions. The service user and carer had also met with the Learning and Development Manager to influence future staff training programmes. Mrs Webster agreed to provide an update to ensure that learning and development had been taken forward. **AW**

3.0 Minutes and Matters Arising

3.1 Minutes of the Previous Meeting

Minutes of the Quality and Standards Committee meeting held on 5 May 2015 were considered. Discussion was had regarding item 4.1, Update on Compliance Against Outcome 8 Regulation 12, 'Cleanliness and Infection Control' Quarter 3, 2014-15, which had been identified as a concern by the Committee. It was agreed that this would be presented at the next meeting, due to staff sickness and annual leave from the presenters. **TL**

3.2 Matters Arising

The action log was reviewed and updated.

4.1 Mandatory Training and Appraisal Compliance.

Mrs Cousins was welcomed to the meeting and informed the Committee that as at 31 May 2015, mandatory training compliance percentages had improved in most areas. Mrs Butterworth confirmed that a compliance target of 90% for each clinical unit had been agreed for Information and Governance training. Mrs Butterworth requested the inclusion of adult and children safeguarding training statistics in future reports. **MT/EC**
Mr Welling queried the RAG rating for training compliance and Mrs Cousins agreed that in future, only 90% plus compliance would achieve a green rating and this could be stretched to 95% if this was required. **MT/EC**
Mrs Webster suggested simplifying the data with the removal of the amber rating to show red, not complaint, green compliant. **MT/EC**
Mrs Cousins agreed Health and Safety training compliance would be demonstrated in a more meaningful way. Mr Welling requested that a quarterly report showing trends and analysis be provided to the Committee. **MT/EC**

Mrs Cousins reported that appraisal compliance had registered a marginal fall of 0.34%, with specific work being undertaken with the Chief Operating Officer (COO) Operations clinical unit, due to low compliance. Mrs Cousins confirmed that this related primarily to clinical administration staff.

The Committee requested that representatives from the Cardiovascular Unit attend the next Quality and Standards Committee meeting to provide an update on staff appraisal and mandatory training compliance. **Nik Patel /Sandra Field**

4.2 Board Assurance Framework and High Level Risk Register

The updated organisational Board Assurance Framework (BAF) and High Level Risk Register were presented by Mrs Wells. The Committee considered and noted the areas of concern which related to health records, mandatory training and appraisals. Mrs Wells informed the Committee that the gap control around the inability to use web based applications due to the internet gateway running at capacity between 11am and 3pm daily had been removed, as this had been resolved nationally. Mrs Wells confirmed that the BAF would be looked at in depth at the next Trust Board Seminar meeting.

Mr Welling sought assurance around BAF item 1.2.6 which related to the risk assessment of the plain film reporting backlog pre 2010. Mrs Butterworth reported that the NHS Emergency Care Intensive Support Team (ECIST) currently provided

the Trust with an external mechanism for risk stratification related to this group of patients and a report outlining what had been done would be presented to the Clinical Leadership Team (CLT). Dr Hughes confirmed that the Clinical Commissioning Groups (CCGs) would be informed of this information via the Clinical Quality Review Group (CQRG) forum.

Mrs Webster sought clarity around the risk entry relating to a further outbreak of Glycopeptide Resistant Enterococcus (GRE) infection on Pevensey Ward which she stated was not current. Mrs Butterworth agreed to highlight this to the General Manager. **PB**

4.3 **External Visits Report**

Mrs Wells provided the summary of external agency, inspections and accreditation visits that had taken place between 1 January and 31 March 2015. The Committee noted the Health and Safety Executive visit in response to an incident that had occurred in the laundry and Mrs Wells confirmed this continued to be monitored. Mrs Butterworth stated that feedback had been positive following the Trauma Peer Review by the Sussex Trauma Network. Mrs Wells agreed to seek an update to the outstanding actions concerning the Audit of Pharmacy Aseptic Unit, Conquest Hospital. **LW/HW**

4.4 **Legal and Claims Annual Report**

Mrs Wells provided the Committee with the Trust Legal Services annual report 2014/15. Mrs Wells explained that the data provided was fedback to the organisation to ensure lessons were learnt and any actions taken. Mrs Wells highlighted the quarterly feedback being developed which would incorporate any emerging trends identified and support the sharing of lessons from claims, litigation and inquests.

Mr Wells stated that a lack of feedback following the reporting of incidents on DatixWeb was a recurring theme when meeting with staff. Miss Morgan highlighted the recent Serious Incidents Listening into Action (LiA) events that had sought ideas from staff on how this could be improved. Mrs Butterworth raised concerns around medical staff and the non- reporting of incidents on DatixWeb. Dr Hughes confirmed that both he and Mr Sunley planned to meet with medical staff to raise this issue.

Mrs Webster assured the Committee that, with Adult Social Care (ASC) involvement, Duty of Candour awareness training would be implemented to front line clinical staff. Mrs Butterworth highlighted the need for competency checks for assurance purposes. Discussion took place to clarify if this training should be mandatory. Mrs Webster agreed that this would be discussed at a Clinical Management Executive (CME) meeting and a report presented to the Committee at the next meeting. **AW**

4.5 **Changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Fundamental Standards of Care**

Mrs Webster described important changes to the health and social care standards which were regulated by the Care Quality Commission. The Committee noted that the 12 Fundamental Standards of Care represented one of the key ways in which the Government had responded to the Francis Inquiry and these replaced the previous 16 Essential Standards of Quality and Safety. Mrs Webster highlighted the guidance for staff which helped them relate to the standards in their day to day roles and had been widely communicated and made available on the extranet.

5.1 **Annual Complaints Report 2014/15**

Miss Morgan informed the Committee of the key highlights raised by the report. Miss Morgan confirmed that interviews had been scheduled for the Patient Experience Lead role and a new Complaints Manager would commence in post imminently.

Miss Morgan reported a 24% increase in the number of formal complaints received in comparison to the previous year, and explained that issues around patient appointments had impacted significantly on this. Mrs Webster requested that the total number of complaints received be interrogated to provide detailed analysis of the issues raised and year on year comparison information be included. Mr Welling requested inclusion of further information regarding the external review and the processes and changes made. Miss Morgan agreed to provide narrative around the Parliamentary and Health Service Ombudsman (PHSO) referrals. Mrs Welling asked that Mrs Bernhauser, whose portfolio included complaints, had sight of the report prior to it being presented at Trust Board. Mrs Webster confirmed that complaint letters were routinely quality checked by Mrs Bernhauser. Mrs Colvert highlighted the need for information to be comprehensible by service users. **LM** **LM** **LM**

5.2 **Quality Improvement Plan (CQC Recommendations)**

Mrs Webster provided the Committee with an update of the quality improvement plan which included actions from the September 2015 Care Quality Commission (CQC) inspection. Mrs Webster confirmed that the Project Improvement Working Group met fortnightly and oversaw progress of the delivery of the plan. Mrs Webster highlighted those actions rated as red, which indicated a deadline missed, and explained that these would remain until assurance had been provided that actions had been fully completed. Mr Welling sought clarity around the Trust's overarching Quality Improvement Plan and the action plan implemented following the CQC visit. It was noted that these were currently separate but acknowledged that the terminology was confusing. Mrs Cousins explained that a series of LiA events to engage staff with the Speaking Up/Harassment and Bullying Plan was underway.

6.1 **Deep Dive into Health Records Service.**

Mrs Butterworth provided an update and overview of the progress and actions within the Health Records Service which addressed known significant risks and concerns. The primary risks for the organisation were described as the impact on clinical care and not being able to robustly demonstrate compliance with Department of Health Code of Practice for Records Retention and Disposal Scheme. The iFIT Health Records tracking implementation, which had successfully revolutionised the service in other NHS Trusts, was highlighted. Mr Welling noted that training for this had been delayed.

Mr Welling sought assurance around rebuilding staff confidence and morale in both the Clinical Administration and Medical Records teams where practice had been adversely affected. Mr Welling requested this was fed back Mrs Fellows, Assistant Director of Operations. Mrs Cousins reported that a member of Medical Records team had joined the Staff Engagement Group which included Executive and Non-Executive Director participation. **PB/LF**

Mrs Webster sought clarity around the target of 80 temporary file notes produced shown on the dashboard and Mrs Butterworth agreed to highlight this to Mrs Fellows. **PB/LF**

Mrs Butterworth confirmed that in future, Clinical Administration and Medical Records

would attend accountability reviews on a monthly basis where Key Performance Indicators (KPIs) would be monitored.

7.0 **Sub Committee Minutes**

The following items were noted by the Committee;

7.1 Minutes from the Trust Health and Safety Steering Group meeting held on 20 May 2015.

7.2 Minutes from the Patient Safety and Clinical Improvement /Essential Compliance Group meeting held on 27 April 2015.

8.0 **Any Other Business**

8.1 None noted.

9.0 **For Information**

9.1 Clinical Effectiveness Overview Group – Mrs Wells agreed to feedback to the Chair comments regarding the Terms of Reference (ToRs) for this group. **LW**

10.0 **Date of the Next Meeting**

Tuesday, 1 September 2015
2.30pm – 4.30pm
St Mary's Room, Eastbourne District General Hospital

East Sussex Healthcare NHS Trust

Date of Meeting:	30th September 2015
Meeting:	Trust Board
Agenda item:	16
Subject:	Chairman's Briefing
Reporting Officer:	Stuart Welling, Chairman

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

Purpose:

To keep the Board informed of the activities undertaken by the Chairman since the last Board meeting.

Introduction:

The purpose of this paper is to provide an overview of activities undertaken and relevant correspondence received or sent by the Chairman since the last Board meeting.

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

Key external meetings attended in April and May:

• 4th September	Amber Rudd – Opening of Data Centre, Conquest
• 7th September	Professor Andrew Lloyd – Dean of College Life, Health and Physical Science
• 18th September	Quality Summit
• Various	Meetings with CQC
• Various	Meetings with the TDA

Use of Trust Seal

No documents have been sealed since the last Board meeting:

Proposals and/or Recommendations

The Board is asked to note the activities undertaken by the Chairman since the last Board meeting.

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

Name:	**Contact details:**
Stuart Welling, Chairman	s.welling@nhs.net