East Sussex Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

Wednesday, 3rd August 2016

at 1115 am

in Uckfield Civic Centre

Chairman:	**David Clayton-Smith**
Chief Executive:	**Dr. Adrian Bull**

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 3rd August 2016, commencing at 11:15 in the Ashdown Room, Uckfield Civic Centre

	AGENDA			**Lead:**	**Time:**
1.	a) Chair's opening remarks b) Apologies for absence c) Monthly award winner(s)			Chair	
2.	Quality Walks			Chair	
3.	Declarations of interests			Chair	
4a.	Minutes of the Trust Board Meeting in public held on 8th June 2016		A	Chair	
4b.	Matters arising		B		
5.	Chief Executive's report		C	CEO	
6.	Board sub-committees: a) Audit Committee b) Finance & Investment Committee c) People and Organisational Development Committee d) Quality & Safety Committee	Assurance	D	Comm Chairs	
7.	Board Assurance Framework		E	DCA	

QUALITY, SAFETY AND PERFORMANCE

					Time:
8.	ESHT 2020 Improvement Programme	Assurance	F	CEO/DN	
9.	Integrated Performance Report Month 3 (June) 1. Performance 2. Finance 3. Workforce	Assurance	G	DN/MD COO HRD DF	
10.	Safe Nurse Staffing Levels report	Assurance	H	DN	
11.	Quality Report (Quarter 1)	Assurance	I	DN	

STRATEGY

					Time:
12.	Annual Business Plan Quarter 1	Approval	J	JR	

GOVERNANCE AND ASSURANCE

					Time:
13.	Nursing and Medical Revalidation Update	Assurance	K	DN/MD	
14.	Equality Delivery System	Assurance	L	DCA	
15.	a) Health & Safety Annual Report b) End of Year Workforce Report	Assurance	M	MD/DN /COO/ HRD	

ITEMS FOR INFORMATION

				Time:
16.	Questions from members of the public (15 minutes maximum)		Chair	
17.	Date of Next Meeting: Wednesday 12th October, Lecture Theatre, Conquest Hospital		Chair	

David Clayton-Smith

David Clayton-Smith
Chairman

6th July 2016

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DCIS	Director of Clinical Information & Strategy
DF	Director of Finance
DN	Director of Nursing
HRD	Director of Human Resources
MD	Medical Director
QID	Quality Improvement Director

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Wednesday, 8th June 2016 at 12:30 am in the St Mary's Boardroom, EDGH.

Present: Mr David Clayton-Smith, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Sue Bernhauser, Non-Executive Director
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Ms Miranda Kavanagh, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Dr Adrian Bull, Chief Executive
Dr David Hughes, Medical Director
Mr Philip Astell, Acting Director of Finance
Mrs Alice Webster, Director of Nursing

In attendance:
Mrs Pauline Butterworth, Acting Chief Operating Officer
Ms Monica Green, Director of Human Resources
Ms Sally Herne, Improvement Director
Dr Andrew Slater, Director of Clinical Information & Strategy
Mrs Lynette Wells, Director of Corporate Affairs
Ms Jan Humber, Joint Staff Side Chair
Mr Pete Palmer, Assistant Company Secretary (minutes)

039/2016 **Welcome and Apologies for Absence**

a) Chair's Opening Remarks

Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He explained that this was the first occasion on which the Board had met in private prior to the Board meeting, and provided a brief summary of the matters that had been discussed in private.

b) Apologies for Absence

Mr Clayton-Smith reported that apologies for absence had been received from:

Mr Mike Stevens, Non-Executive Director

c) Monthly Award Winners

Mr Clayton-Smith reported that the monthly award winners for April were Nutrition and Dietetics Administrators Linda Vince, Janet Tennant and Jackie Spencer. He explained that they had won the award for their tireless work during a change in clinic appointment systems to SystmOne within their department, and said that he would be visiting

them at the Conquest Hospital to present them with their award.

He reported that Staff Nurse, Kayleigh Beattie, and Healthcare Assistant, Danielle Baker, from Kipling Ward had won May's award for organising birthday celebrations for a young palliative care patient who was in hospital. They had arranged a collection, and bought presents and treats for the patient, and Mr Clayton-Smith explained that Mrs Webster would be visiting them in order to present them with their award.

d) Annual Staff Awards

Mr Clayton-Smith reported that some members of staff had been unable to attend the recent Annual Staff Awards to collect their awards. He commended these staff and presented awards to:

- Lorraine Gurr, who won the Working Behind the Scenes Award
- Mary Chantler, who was awarded for 52 years of NHS service
- David Wells, who was awarded for 41 years of NHS service

040/2016 **Feedback from Quality Walks**

Mrs Bernhauser reported that she had recently undertaken several quality walks, and had been given a wonderfully warm welcome on each occasion by staff who were very busy and very passionate about their work.

She said that she had visited Newington Ward, which had been very busy at the time of her visit, and had taken the opportunity to speak to staff, patients and relatives. She said that a daughter of a patient on the ward had told her that her mother had received fantastic care. She noted that there had been recent staffing issues during night duty, but that she had been told about the ward's proposals to resolve these problems.

Mrs Bernhauser reported that she had also visited the District Nursing team, who were embedding frailty nurses within their teams and had found that this was working well, with only minor issues reported which were being resolved. She said that the matron accompanied her team on community visits on a regular basis in order to gain assurance of good practice. She noted that staff were still reporting problems with using SystmOne within the community.

Mr Clayton-Smith reported that he had visited Theatres at EDGH and had been impressed by their stock control system which enabled the Trust to save money. He said that staff had reported that they had recently resolved their staffing issues, but had noted concerns about the amount of time it took for their scrubs to be returned from the laundry department.

He reported that he had also undertaken a walk with the Housekeeping team at EDGH and had met staff who provided patients with their meals,

finding them to be very knowledgeable and helpful. He said that he had arranged to meet with the maintenance team following his visit, as they had a number of ideas for Trust improvements that they wished to share with him.

Dr Bull reported that greater promotion of both the good work done throughout the Trust and the positive feedback that was regularly received from the public would be taking place, in order to foster a more positive atmosphere within the organisation and to celebrate all the good work that was being done.

Mr Clayton-Smith asked whether quality walks should be undertaken at night. Mrs Webster replied that carrying these out at night was a valuable exercise as the organisation felt very different at night and a number of visits had already been undertaken. She said that she would be happy to accompany Non-Executives on visits.

The Board noted the report on quality walks.

041/2016 **Declarations of Interest**

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

042/2016 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 13th April 2016 were considered. Amendments were noted to the minutes:

- page 6 – 029/2016 ii Paragraph 2 – changed from '62 day pathways' to '62 day cancer screening pathways'
- page 11 – 036/2016 a – changed from ‘'good levels of cleanliness' to 'levels of cleanliness'

They were otherwise agreed as an accurate account of the discussions held.

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

b) Matters Arising

032/2016 – Update on Mortality
Dr Hughes reported that the Trust's mortality summit had been extremely well attended, and that a number of helpful discussions had taken place.

035/2016 e) – Acorn House

Mrs Wells reported that Acorn House was not owned by ESHT and did not appear to be NHS property.

043/2016 **Chief Executive's Report**

Dr Bull reported that the Trust's issues with patient transport had headlined local news reports the previous night, and that they were due to be raised by Members of Parliament in the House of Commons. He explained that the issues were causing considerable inconvenience across the organisation and that patients were being put at risk. He said that the matter had been raised with HWLH CCG who had provided assurances that remedial action was in place, and noted that the Trust would be formally writing to the CCG. Dr Bull explained that the Trust was booking eligible patients directly onto alternate transport where possible, with the CCG covering the costs of this provision.

Dr Bull reported that a key issue identified within the Trust was the filling of vacancies at all levels of the organisation, and that there had recently been very successful recruitment of nurses to the Trust.

He advised that the CQC would be undertaking an inspection of the Trust in October 2016, and that mock inspections were planned in preparation, involving a large number of staff and external stakeholders.

Dr Bull noted that the Trust had reported a month one deficit of £5.2 million which was £500k worse than planned. He explained that this had been due to the loss of planned activity during both doctors' strikes and a period of high activity, and also related to a provision for fines and penalties.

044/2016 **Board Assurance Framework**

Mrs Wells highlighted that four areas within the Board Assurance Framework (BAF) had been rated as red.

- Reconfiguration of A&E departments
- Mortality indices
- The Trust's financial position
- Patient Transport

She explained that the risk relating to Board vacancies would be removed as these positions had now been filled, and noted that a risk relating to the Trust's lack of clinical strategy would be added to the BAF.

Mrs Churchward-Cardiff noted that items 4.1.1 and 4.1.2 were the same and Mrs Wells agreed to amend the BAF.

The Board confirmed that the main inherent/residual risks and gaps

in assurance or controls had been identified in the Board Assurance Framework and actions were appropriate to manage the risks.

The Board approved the removal of the risk relating to Board vacancies.

QUALITY, SAFETY AND PERFORMANCE

045/2016 **Quality Improvement Programme**

Mrs Webster presented a highlight report outlining progress made on the Trust's Quality Improvement Programme (QIP).. She reported that the monthly Improvement Subcommittee, chaired by Dr Bull, had recently met for the first time and noted that this reported to the Quality and Standards Committee. Dr Bull explained that the Improvement Subcommittee would sponsor organisational improvements when needed, with the support of the Trust's Executives and Project Management Office (PMO).

She advised that four red rated projects were reported within the QIP:

- Mortality and Morbidity Project
- Secure Premises and Facilities Project
- Evidence Based Care Project
- Patient Flow Project

She said that the PMO were providing support to QIP projects and were monitoring progress on a monthly basis. Mrs Webster said that the upcoming mock inspections would test whether ratings within the QIP were accurate. She explained that progress was being made across all areas of the QIP, but that until the Trust had evidence that progress was embedded within the organisation, ratings would remain red.

Mr Clayton-Smith noted that the new format of the report made it much simpler to understand the Trust's progress on the QIP.

In response to a question from Mrs Churchward-Cardiff, Mrs Webster explained that the ward improvement project would look at key metrics on how care was delivered in wards across the organisation. She said that the project would start by focussing on two wards on each site.

The Board noted the report updating the Trust's progress on the Quality Improvement Programme.

046/2016 **Draft Quality Account**

Mrs Webster explained that the draft Quality Account 2015/16 had been reviewed by the CCG, Healthwatch and HOSC and that comments from those organisations would be integrated into the report prior to the deadline for submission on 30th June. She said that the report had been presented at both the Audit and Quality and Standards Committees and

requested delegated authority for sign off by the Chairman.

The Board delegated authority to Mr Clayton-Smith to sign off the Quality Account 2015/16.

047/2016 **Integrated Performance Reports – February 2016 (Month 11)**

i) Patient Safety & Clinical Effectiveness

Mrs Webster reported that there had been a single Never Event within the Trust during April with no harm being caused to the patient, and that this was being fully investigated. She said that no incidents where severe harm had been caused to a patient had been reported during the month. She explained that the Trust had reported a small reduction in Venous Thromboembolism (VTE) assessments during March, and that a significant amount of work was being undertaken in order to reduce the number of falls within the Trust.

Ms Kavanagh asked whether the increase in incidents being reported was a cause for concern, and Dr Bull replied that a greater number of minor incidents being reported was a good sign, as it showed that the Trust was not hiding anything.

Ms Kavanagh asked about the Trust's progress with mortality, and Dr Hughes replied that the mortality trajectory was improving. He explained that two consultants were undertaking peer reviews of mortality reporting within the Trust to ensure that it was being carried out to an appropriate standard.

Mrs Churchward-Cardiff asked whether the Trust should be aiming to report no patients with pressure ulcers, and Mrs Webster replied that this would be an unrealistic target. She explained that patients may be admitted to hospital already having a pressure ulcer and that these incidents would still have to be reported and investigated. Dr Bull noted that Clinical Units had to ensure effective screening and monitoring of patients when they were admitted, as detecting existing pressure ulcers was as important as preventing them from occurring.

ii) Performance, Access and Responsiveness

Mrs Butterworth reported that A&E performance had improved during April to 83.9%. She explained that the Trust had not achieved its Referral to Treatment (RTT) pathway target during April, primarily due to industrial action and medical outliers in beds for elective patients. She reported that targets for diagnostic waiting times had not been achieved, as a result of issues with endoscopic capacity.

Mrs Butterworth reported that the Trust had achieved its 2 week wait and 31 day wait cancer standards for March, but that the 2 week wait standard for breast symptoms had been missed, mainly due to patient choice. She explained that the Trust was offering evening appointments

for patients to try to resolve this issue. She noted that 104 day waits had reduced significantly in March, and that the Trust was focussing on improving its performance against the 62 day target.

She explained that the Trust had seen a reduction in the number of delayed transfers of care as a result of collaborative work being undertaken with social services.

Mrs Butterworth reported that the Academic Health Science Network had finished its review of the Trust's A&E departments, and that feedback from this review was expected in July. An action plan would then be developed, to be owned by both the Trust and the CCG.

In response to a query from Mr Nealon, Mrs Butterworth explained that the number of patients awaiting discharge at the Conquest had been significantly reduced, while there were 60-70 patients at EDGH awaiting discharge from hospital. She said that meetings had been held with social services in order to resolve the issue which was exacerbated by attendances to A&E since March increasing by 1,000 a month compared to the previous year.

Mrs Churchward-Cardiff asked what plans were in place for managing the increasing number of referrals being received by the Trust. Mrs Butterworth replied that conversations had taken place with the CCGs and trajectories for referrals had been completed. She noted that the Trust had received a significant increase in cardiology referrals from primary care, and that there was an expectation that endoscopy referrals would continue to rise.

iii) Finance

Mr Astell reported that the Trust's deficit in April was £5.2million, £500k greater than planned. He explained that the overspend had mainly been due to non-pay costs associated with reduction of endoscopy waiting lists and RTT backlogs. He said that the Trust had made provision for £230k of fines and penalties as a result of missed targets.

Mr Clayton-Smith asked if the additional £500k overspend would be recoverable during the year, and Mr Astell replied that the position was potentially recoverable, but would be reliant on bed pressures easing during the year.

Dr Bull explained that elective activity should be ring fenced during periods of pressure to provide protection for the Trust's income. He explained that the Trust was exploring ways in which it could achieve best practice tariffs, and that the possibility of six day working was being reviewed in order to increase capacity.

iv) Workforce

Ms Green reported that during April recruitment of overseas nurses had continued. She advised that nursing would no longer be a funded

degree in 2017 with students being able to access loans in line with other degrees. In addition, education funds within the Trust were due to be reduced by 30%.

She explained that the Trust had encountered difficulties in recruiting staff in areas such as A&E, Histopathology and Community Geriatrics and had adopted a new approach, including the use of social media, discussions with staff about solutions and hiring head hunters in order to try to fill these positions. She reported that the Trust needed to recruit 15-20 more consultants within these areas, as well as further middle grade doctors, and that work was being undertaken with the CCG in order to make positions more attractive to potential employees.

Ms Green explained that the impact of the new contract for junior doctors would be felt from August, when 160 new junior doctors were due to join the Trust. She noted that they would start on the existing contract before transitioning to the new contract from August.

Mrs Churchward-Cardiff said that she felt that the Trust's website gave a poor impression of the organisation and needed to be updated. Dr Bull agreed and advised that a procurement process was commencing and that the website would be updated as soon as possible.

The Board noted the Performance, Workforce and Finance Reports for April 2016.

048/2016 **Safe Nurse & Midwifery Staffing Levels**

Mrs Webster presented a report detailing nursing and midwifery levels across the Trust, noting that work was being undertaken on staffing establishments within the district nursing teams and that this would be included in the report to the Board when completed. She explained that staffing levels throughout the Trust were monitored on a daily basis..

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

049/2016 **Patient Experience Report**

Mrs Webster presented the report and explained that the number of overdue complaints had been reduced, with the Trust maintaining its 100% response rate within 3 days to complaints. She noted that complaints had increased during April to their highest level in the last 7 months and explained that PALS contacts had also increased.

Mrs Webster reported that a summit about patient transport had been held with the CCG .Actions were being put in place to try to improve the level of Friend and Family Tests (FFT) being completed. She said that the Trust was aiming to increase the presence of volunteers stationed in the main entrances at the Conquest and EDGH as they were an incredibly valuable resource for the Trust.

Mrs Butterworth noted that the issue of patients not completing FFTs was being felt throughout the NHS and that a number of measures had been attempted in order to try to increase completion rates.

Mrs Webster reported that the CQC's inpatient survey had been published that day and that ESHT had shown an improved rating on 82% of the questions. She explained that a full analysis of these results would be presented to the Quality and Standards Committee.

The Board noted the Patient Experience Report

050/2016 **End of Life Care Strategy 2016-2019**

Dr Hughes explained that the strategy being presented cut across a number of different organisations and would be subject to approval from partner organisations before it could be finalised. He explained that the Trust had employed a full complement of End of Life Care (EOLC) practitioners and that the document reflected both national and local guidance. He noted that the Trust's six ambitions for EOLC were highlighted within the strategy.

He reported that issues raised by the CQC had been included within the strategy and that patients would need seven day access to EOLC to ensure adherence to best practice. He explained that the Trust had already implemented many of the measures within the strategy and that the EOLC service was improving as a result. He said that the Trust hoped to have appointed a clinical lead for EOLC by the end of June.

Dr Bull explained that the intention of the strategy was to enable patients to spend their last days where they wanted to. He noted that nurses would play a vital role in delivering EOLC within the Trust, and emphasised the importance of including them in discussions about the strategy.

Mrs Churchward-Cardiff said that the Trust needed to encourage people to talk about where they wished to die, and suggested that the Trust's mission statement could be changed to reflect the organisation's ambition to provide patients with a choice, which would be supported by the Trust.

The Board approved the draft End of Life Care Strategy noting that it would be discussed with stakeholders prior to being finalised.

051/2016 **ESHT 2020**

Dr Bull explained that an earlier version of the document had been presented to the Board during the Board Seminar in May. He advised that the document would shape the organisation and would be reviewed on an annual basis.

Dr Bull reported that staff had responded well to the draft plan, and that the values described within the document had been developed with staff and would be restated to the entire organisation. He said that the document had been translated into personal objectives for the Executives, and that it would allow all staff to know what was expected of them. He explained that the Trust would concentrate on doing less things to a very high standard, rather than trying to do everything at once and that the metrics for success in 5 key areas were set out within the plan. He noted the importance of all staff and stakeholders recognising and understanding clinical strategy metrics.

Dr Bull reported that governance structures had been reviewed, and the path of information through the Trust had been set out. He explained that the proposed governance structure would be ratified, that terms of reference and agendas for committees would be completed and Chairs would be appointed to the new groups. He noted that the Executives' meeting would sit below the main board sub committees within the structure in order to deal with the 'bread and butter' business within the Trust. He said that a central resource hub would be created to provide resources and training for staff in order to improve the Trust.

Dr Bull explained that the 2020 plan would be widely shared with staff in the Trust once it had been agreed by the Board, and asked for the endorsement of the plan from the Board, and a mandate to put the proposed governance structures in place.

Ms Kavanagh said that she approved of the plan, but raised concerns about the large number of subcommittees that were feeding into the Quality and Standards Committee. Dr Hughes explained that a large amount of quality work needed to be carried out within the organisation and that he hoped there would be scope for reducing the number of subcommittees in the future.

Ms Kavanagh asked for greater emphasis on clinical ownership of the 2020 plan to be included within the document, and Dr Bull agreed to include this information. She suggested that information about the actions the Trust was planning to take following the staff survey results should be included and asked for the metrics within the integrated performance report to be aligned to those in the ESHT 2020 plan.

Mrs Humber said that she felt that the document set a direction for the Trust that had not been in evidence for a long time, and explained that she was very enthusiastic about the plan.

The Board endorsed the ESHT 2020 plan and the Chairs of the main Committees agreed to support the proposed governance structure.

GOVERNANCE AND ASSURANCE

052/2016 **Staff Survey**

Ms Green explained that she was asking the Board to endorse three corporate priorities for actions linked to the Staff Survey. She noted that these had been agreed at the Board Seminar in May, but that it had been felt they should be discussed and formally agreed in public. She explained that the actions were already being undertaken within the Trust.

Ms Green reported that training was being given to managers in order to improve their communication skills, and noted that recruitment based around Trust Values was being introduced.

The Board noted the report on the Staff Survey results, and endorsed the three corporate priorities for actions linked to the Staff Survey.

053/2016 **Board Sub-Committee Reports**

a) Audit Committee (including Annual Report)

Mrs Bernhauser reported that the Audit Committee felt assured that there was now greater control of the clinical audit process within the Trust.

The Board noted the Audit Committee report, and formally received the Audit Committee's Annual Report.

b) Finance and Investment Committee

The Board noted the Finance and Investment Committee report.

c) Quality and Standards Committee

Mrs Bernhauser reported that the Quality and Standards Committee had met during the previous week and had discussed a new name, the Quality and Safety Committee. She explained that new Terms of Reference and revised membership had also been discussed, and said that she would circulate details of the proposed changes to the Board. **SB**

ITEMS FOR INFORMATION

054/2016 **Use of Trust Seal**

The Board noted that the Trust Seal had not been used since the previous meeting in April 2016.

055/2016 **Questions from Members of the Public**

Mr Clayton-Smith reported that Mr Campbell had emailed a number of questions to the Board prior to the meeting, and explained that a written reply would be sent to him.

a) Quality Walks

Mrs Walke asked whether the Trust kept a record of Quality Walks that had been undertaken and whether these were formally planned. Mrs Bernhauser replied that Non-Executive Directors could request to visit specific areas of the Trust, but were otherwise directed by the Trust to ensure that as many areas as possible were visited. She noted that a record of walks was maintained.

Mrs Walke explained that she thought that undertaking unannounced visits to areas was a very valuable exercise.

b) A&E

Mrs Walke said that she had visited the A&E department recently and had not found it clear where to get an FFT form from.

c) Thanks

Mrs Walke thanked Dr Bull and Mr Clayton-Smith for recent meetings with the Save the DGH group and explained that she had found the visits to be very helpful.

d) Third Party Expenditure

Mr Campbell asked what the £500k reported for third party expenditure had been spent on. Mr Astell replied that this figure included £200k on endoscopy services. Dr Bull explained that any third party expenditure had to be approved by the Executives following application via a business case.

e) 2020 Programme

Mr Campbell asked whether the governance structure set out in the ESHT 2020 document was too complicated to be effective. Dr Bull explained that the proposed system was much clearer than the one currently in place, explaining that it would evolve over time and would allow the Board clear sight of any safety issues that may arise.

f) Improvement Director

Mr Campbell asked if a summary of the work being undertaken by the Improvement Director could be presented to the public, and Dr Bull agreed that this would be presented, probably as part of his CEO update, at the Board Meeting in public in August. **AB**

g) Patient Experience Report

Mr Purkiss reported that the Trust had received the results of the Patient Experience Report, and that their rating had risen to four out of five stars for the first time.

056/2016 **Date of Next Meeting**

Wednesday, 3rd August 2016, at 1230 in the Uckfield Civic Centre.

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 8th June 2016 Trust Board Meeting

Agenda item	Action	Lead	Progress
053/2016 c)	Revised Terms of Reference and membership for Quality and Safety Committee to be approved by Board	Sue Bernhauser	On Agenda
055/2016	Summary of work undertaken by the Improvement Director to be provided	CEO	Information included within CEO's report

Chief Executive's Update

1. **Introduction**

CQC Mock inspections were held this month. The inspectors did not score the areas inspected but provided a qualitative assessment. Volunteer inspectors were drawn from members of staff, Healthwatch, patient representatives, and NHSI. Gill Hooper (from NHSI) conducted mock interviews with executive and non-executive directors and had held a number of group discussions with different groups of staff. The inspected areas were given individual feedback. The inspectors described several areas as of 'outstanding' quality. However several other areas had a number of flaws, some of which related to fundamental issues such as secure doors propped open or access to medicines. A specific list of issues has been drawn up to be addressed Trust-wide (such as disposal of redundant equipment). Work has commenced to take a structured approach to ensuring that standards are recognised and achieved consistently across the organisation. The feedback from the consultation groups was encouraging, including recognition that cultural and behavioural issues are being properly addressed and communication from the CEO and executive team has improved. A number of issues were raised including among others concerns about equipment and environment, staffing levels, and pressure of work. A further mock inspection will be carried out in the last week of July and the results of both exercises brought together for action.

Subject to formal approval, Board appointments have been made of Dr David Walker as Medical Director with effect from September 7th, and of Catherine Ashton as Director of Strategy, Innovation, and Planning.

Significant progress has been made on the analysis of patient flow and waiting time performance in all three areas of cancer, elective care, and urgent care. Plans to systematically address these issues have now been drawn up and will be implemented under the supervision of respective Clinical Boards.

Key points in specific areas are as follows:

2. Safety and Patient Experience

2.1 Quality and Safety

The End of Life Care Strategy for 2016-19 is now available on the intranet. There have been an abundance of recent national and local drivers supporting the end of life care agenda and the purpose of this strategy is to bring them together into one plan that will drive improvement in this area of care delivery.

As a Trust our overall Vitalpac performance is at its highest since implementation. This means 90% of our patients receive their observations on time, resulting in earlier identification and treatment the deteriorating patients. More work will need to be undertaken with the wards to improve the compliance. Vitalpac will be rolled out in the emergency department over the next 2 weeks, followed by the paediatric inpatients.

The centralisation of notes at Apex Way formally opened this week. Gynaecology records will be the first to roll out electronic records starting in November 2016.

2.2 Patient Experience

The 2015 patient survey has been published and demonstrates an overall 2% increase in positive patient experience against the previous year. Although this is a small increase we are assured by the auditors that this is a significant overall achievement. The result was supported by a healthy 40% response rate. Areas to continue to improve include noise at night, procedural explanation and mixed sex facilities. The next patient survey will be issued in October 2016.

3 People, leadership, culture

3.1 Operational HR

Staff sickness has reduced to the lowest rate for two years.
We are moving forward to implement the Junior Doctors Contract.
There are several significant workforce change programmes underway;

- Community Housekeeping TUPE as a result of transfer of properties to NHS property, and their outsourcing of facilities services to OCS
- Patient Booking Team
- Health records deployment to Apex Way

Workforce Development

An Education Business Manager has been appointed to support the move towards full integration of education, and the development of a more business focused approach to education funding and development.

We had a successful Project Search graduation with over half of the 15/16 interns in employment, two with ESHT, and one who received his job offer from a London hospital on graduation day.

We are working in partnership with Brighton and Sussex Universities NHS Trust, Western Sussex Hospitals NHS Foundation Trust, and the University of Brighton, to submit a bid to Health Education England to be part of the pilot for the first 1000 Nursing Associate roles which will commence training in 2017.

3.2 Staff Engagement & Wellbeing

We have launched nominations for our Unsung Heros awards aimed at celebrating the achievements of our Band 1-4 staff

The roll out of emotional resilience training to support the psychological wellbeing of our staff has started

4 Delivery and Access

Cancer standards continue to show sustained improvement with the recovery plan being driven through the clinically led Cancer Board. The Trust has achieved against the 2ww standard, breast screening and 31 day standards for the last quarter. The recovery plan continues for the 62 day standard currently delivering 82% against a standard of 85%.

The endoscopy recovery plan is now entering its next phase with a Vanguard unit to be on site at the Conquest Hospital to enable all patients waiting longer than 6 weeks for this service to be treated. This is an essential improvement which will allow the Trust to achieve its diagnostic standard by October.

The Urgent Care Programme Board will have its initial session in early August and will be responsible for following through on the recommendations made by the Academic Health Science team. This will focus on reducing A&E waiting times, improving patient

flow through our non-elective services and designing a medical model to support senior specialist assessments at the front end of the hospital

NHS Elect will be working with the Trust to support improvements in RTT, outpatients and Theatre Utilisation as part of a larger Elective care recovery plan.

A number of key appointments have been made in the operational teams including: Brenda Lynes-O'Meara as Interim General Manager for Women's and Children's, Abigail Turner as General Manager for Out of Hospital and Matt Hardwick as Hospital Director.

5 Finance and Contracting

The Trust has agreed a revised control target with NHSI in order to ensure access to the Transformation Fund held centrally. The Trust continues to have significant financial pressures and risks against its performance, although it is on track at the end of the first quarter. There is further detail in the main papers for the Board.

6 Strategy

ESHT is participating fully in the development of the East Sussex Better Together strategy, with commitment to producing an overview strategy for incorporation into the Sustainability and Transformation plan in the autumn. An Accountable Care Model is now being developed. Meetings with the Chair and Accountable Officer of High Weald Lewes and Havens CCG have confirmed our continued strategic commitment to community services in the west of the County.

7 Improvement Director

In response to a question from a member of the public, my summary view of the role of the Improvement Director (ID) from NHSI is that the role is making a significant contribution to the work of the organisation. The ID is a valuable link to NHSI and has enabled us to get access to financial resources and expert assistance in a number of areas. The ID has to strike a difficult balance between retaining an objective and independent view of the organisation, while working with the senior team on the Trust's agenda. The ID has provided workshop training and development in improvement methodologies for a number of members of staff and is supporting a programme of improvement projects. The ID supports the work of preparing for the monthly NHSI reviews, and the work in preparation for the CQC inspection in early October.

8 Recommendations

The Board is asked to note the contents of the report and receive the update.

Dr Adrian Bull
Chief Executive

East Sussex Healthcare NHS Trust

Audit Committee

1. Introduction

Since the Board last met an Audit Committee has been held on 20th July 2016. A summary of the items discussed at the meeting is set out below.

2. Minutes of Meeting Held on 5th May 2016

The minutes of the previous meeting of the Audit Committee were approved.

3. Board Assurance Framework and High Level Risk Register

The Director of Corporate Affairs presented the High Level Risk Register and the Board Assurance Framework and noted that the format of the Board Assurance Framework had been revised following the Board Seminar.

The Committee rejected the recommendation that the mortality gap in assurance move from red to amber. Whilst noting the considerable amount of work to strengthen controls in this area it was agreed further assurance was required before moving the risk ratings.

It was noted that a focussed project is in place to ensure consistency of description and rating of risks.

4. 2014/15 Reference Costs Audit

The Committee received a report on the audit undertaken by PWC on behalf of Monitor of the 2014-15 Reference Cost Collection submitted by **Error! No text of specified style in document.**. The Trust's 2014-15 Reference Cost Return preparation was not compliant with Monitor's Costing Guidance. The cumulative cost quantum affected by errors identified in the audit was 5.34% of the total quantum in the Trust's return. This was over the threshold identified for non-compliance, which is 5%.

The audit did not identify instances of misstatement of the overall quantum of costs contained within the return. Isolated areas were identified where allocation of cost or activity data resulted in misstated unit costs.

A comprehensive action plan has been developed and PWC assessed this as adequate to address the findings. This will be monitored by the Finance and Investment Committee

5. Trust IT Strategy Update

A comprehensive overview of the Trust's IT Strategy was provided by the Associate Director of IT. The Committee highlighted that its focus was principally on governance and assurance of IT systems and processes.

6. Clinical Audit Forward Plan 2016/17

It was noted that 295 clinical audits were current listed on the 2016/17 Clinical Audit Forward Plan.

The Trust remains unable to participate in the National Adult Diabetes Audit as the required specialist data collection software is currently unavailable for use across the organisation. Two software programmes have now been identified and discussions are taking place within the Cardio Vascular Clinical Unit to identify which would be the most suitable option for ESHT to purchase. A business case will then be developed. It was confirmed that the Trust's non-participation in this national audit was on the Risk Register. The Committee strongly supported the resolution of this matter

7. Internal Audit Progress Report and Recommendation Tracker

The Committee received an update on internal audit progress. Twelve final audit reports were issued – three gave "Reasonable" assurance, eight gave "Limited" assurance while one operational review did not carry an assurance rating. All 2015/16 work was complete.

Good progress was being made on the 2016/17 plan, with one first quarter review finalised, another at draft stage and five audits at fieldwork stage and progressing well.

The Audit Recommendations tracker was reviewed and progress in completed actions noted.

8. Local Counter Fraud Service

The Committee received the Counter Fraud annual report, annual staff survey results and progress report and noted actions being taken. There was one new referral since the last meeting.

Staff awareness survey results showed that Trust employees have a good awareness of fraud issues and are confident to report any suspicions. Fraud awareness roadshow events took place at every Community Hospital and in the two major Trust sites. Generalist training and more bespoke training was been delivered to staff groups across the Trust.

9. External Audit

The Annual Audit Letter summarising the key issues arising from the work carried out in respect of the year ended 31 March 2016 was considered. An unqualified true and fair opinion on the financial statements was issued and it was noted that detailed findings were reported to the Audit Committee on 1 June 2016.

A qualified assurance report was issued on the Quality Account on 30 June 2016. Auditors were unable to conclude that the indicator reporting the percentage of patient safety incidents resulting in severe harm or death met any of the six dimensions for data quality (accuracy, validity, reliability, timeliness, relevance or completeness). A management response was in the process of being developed and will be considered at the next meeting.

10. Information Governance

The Committee received the IG Annual Report for 2015/16. In respect of the Information Governance Toolkit (IGT) submission six of the requirements were submitted at Level 3, and 39 requirements were at Level 2 which gave the trust a score of 71% (higher than the target of 66%) with a 'green' or satisfactory rating. An update was provided on the 2016/17 IGT requirements.

During 2015/16 ESHT staff reported 80 IG incidents, 76 of these were scored against the Trust's incident scoring as either 'low' or 'none' for severity, the remaining 4 incidents were scored as 'moderate; indicating that the majority of incidents have no impact upon information security. The number of incidents reported had risen when compared with 2014/15, this increase was attributable to raised awareness of incident reporting requirements and information governance across the organisation. All incidents were investigated and actions implemented to prevent reoccurrence. The Trust had reported three incidents to the Information Commissioner's Office (ICO), all three incidents were closed by the ICO with no enforcement for the Trust. These were all declared as serious incidents by the Trust, robust investigations took place and actions, such as ensuring that only encrypted data sticks can be utilised with Trust computers, were implemented.

11. Annual Legal Services Report

An overview of claims, litigation and HM Coroner's Inquests was provided. The Trust is committed to learning from these with the aim of reducing both harm to patients and litigation costs. The report also provided an overview of the work undertaken by the Department and their co-ordinated approach to working with other departments. The Committee requested further analysis by area to understand themes and trends. The Director of Corporate Affairs advised that the NHSLA circulate this information and when the latest report is received she will share with the Committee.

12. Tenders and Waivers Report

The Committee received the Tenders and Waivers Report. There were no concerns highlighted.

13. Local Procurement of External Auditors

It was confirmed that a procurement process is in place and a panel has been convened for the procurement of external auditors.

Mike Stevens
Chair of Audit Committee

27 July 2016

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 1st June 2016 at 10.00am in the Committee Room, Conquest Hospital

Present: Mr Barry Nealon, Non-Executive Director (chair)
Mrs Sue Bernhauser, Non-Executive Director
Mr Mike Stevens, Non-Executive Director (via telephone)

In attendance Mr Phillip Astell, Acting Director of Finance
Dr Adrian Bull, Chief Executive
Dr David Hughes, Medical Director
Mr David Meikle, Interim Director of Finance
Mrs Lynette Wells, Director of Corporate Affairs
Ms Janine Combrinck, Director, BDO
Mr Jody Etherington, Audit Manager, BDO
Ms Sally Herne, Improvement Director
Mr Stephen Hoaen, Head of Financial Services
Mr Adrian Mills, Audit Manager, tiaa
Mr Mike Townsend, Regional Managing Director, tiaa
Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

028/16 Welcome and Apologies for Absence

Mr Nealon opened the meeting and explained that he would be Chairing the meeting as Mr Stevens was only able to attend the meeting via telephone. He noted that a quorum was present.

Apologies for absence had been received from:

Ms Miranda Kavanagh, Non-Executive Director
Mr Chris Lovegrove, Counter Fraud Manager, tiaa
Mrs Alice Webster, Director of Nursing

029/16 Minutes

i) The minutes of the meeting held on 23rd March 2016 were reviewed. An amendment was noted on page 10 of the minutes and they were otherwise agreed as a correct record.

ii) Matters Arising

It was noted that the meeting had been convened to review and sign off the accounts. Therefore, matters arising were deferred to the next Audit meeting scheduled for Wednesday 20th July 2016.

030/16 Quality Account 2015/16

Mrs Wells presented a paper on the Quality Account 2015/16 to the Committee, stating that the Trust had complied with mandatory guidance. She explained that the Quality Account was due to be submitted to the Secretary of State by 30th June 2016. Mr Etherington advised that BDO were currently auditing the Quality Account 2015/16 for accuracy.

The Committee noted that the Quality Account was compliant with statutory requirements and would be submitted by the 30th June deadline.

031/16 Annual Accounts & Report 2015/16

a) ISA260 BDO Annual Governance Report on the Annual Accounts 2015/16

Ms Combrinck noted that the version of the BDO Annual Governance Report circulated to the committee was substantially complete but that it would undergo further non-material updates prior to finalisation.

She presented the report and explained that the Annual Accounts were due to be submitted on Thursday 2nd June. She explained that in respect of the Trust's financial statements, no material misstatements had been identified and that they would be given an unqualified opinion.

Mr Etherington highlighted the following key risks to the Trust which had been identified within their report:

Management Override of Controls
No evidence of material misstatements as a result of management override of controls was identified.

Revenue Recognition
No significant control deficiencies were recognised in respect of revenue recognition.

Transfer of Community Services
A potential issue was identified regarding the Trust's accrual for work in progress at year end due to the transition from a cap/collar contract to payment by results in 2016/17. Mr Meikle explained that there was no risk of income loss to the Trust as a result of the transition, and that the auditors felt that the Trust was being too prudent. Mr Etherington agreed that there would be no material effect caused by the transition between the contracts.

Going Concern
Mr Etherington reported that the auditors were happy that the Trust would remain a going concern, and that they had received assurances from NHS Improvement that the cash requirements of the Trust would be met for the next 12 months.

Property, Plant and Equipment
Mr Etherington recommended that a review of processes around Property, Plant and Equipment (PPE) journals should take place at year end, as technical issues around classification had been reported.

Mr Hoaen explained that the finance department was upgrading to the Integra 2 system, and that the use of a fixed asset system as part of this upgrade was being reviewed which could resolve the technical issues.

Mr Etherington noted that a full revaluation of property assets and estate had been commissioned by the Trust during 2015/16, and that significant assumptions had been built into the final valuation. He noted that the valuation reduced the value of the Trust's land by £17.3 million.

Mr Etherington reported that the Trust had been issued with an adverse value for money conclusion, based on the cumulative deficit reported by the Trust for 2015/16, and the further deficit planned for 2016/17

The Audit Committee noted the external auditor's Annual Governance Report for 2015/16, the unqualified opinion on the financial accounts and the adverse conclusion on the use of resources.

b) Annual Report including Annual Governance Statement for 2015/16

Mr Etherington reported that significant changes to the mandated contents of annual reports had been made within the Manual for Accounts for 2015/16, and that some of these changes had been unclear which had caused issues with the original draft of the document. He explained that he would like to see a more detailed performance report produced for 2016/17, including greater detail and narrative.

Mrs Wells noted that a minor amendment had been made to the Annual Governance Statement since it had been circulated to the Board. She said that the Trust would meet with auditors early on in the planning process for the Annual Report 2016/17 in order to discuss any updates required by the Manual for Accounts.

Dr. Bull asked that the Trust's strategic objectives be updated within the Annual Report, as these had recently been refreshed, and Mrs

Wells agreed to amend these within the final version of the Report.

The Audit Committee approved the Annual Report and Annual Governance Statement for 2015/16 subject to the amendments to be carried out by the Company Secretary.

c) Annual Account & Associated Certificates & Summary Financial Statements 2015/16

Mr Etherington reported that an issue had been identified with a payroll verification process, where an existing check had not been undertaken. He noted that no issues had been found despite the lack of checks by the Trust, but explained that the process needed to be reinstated to ensure appropriate controls were in place. Mr Astell confirmed that the process had been unintentionally missed, and that it would be reinstated.

The Audit Committee approved the Annual Accounts and associated certificates for 2015/16 and noted that they would be signed by Dr Bull on behalf of the Trust.

d) Internal Audit Annual Report & Head of Internal Audit Opinion for 2015/16

Mr Townsend reported that he had provided a limited assurance opinion overall for the Trust in respect of the internal controls that had been reviewed during the year. He explained that the limited assurances had primarily been issued in individual audits to operational areas, rather than being due to financial issues.

He noted that during 2015/6, all audits had been completed within set budgets and had been compiled with internal audit budget standards.

He noted that the Internal Audit Annual Report provided a summary of the audits undertaken during the year and the assurance opinions provided. Individual reports were considered in detail at each Audit Committee.

Mr Stevens commented that a number of serious issues were highlighted within the Internal Audit Annual Report, and that he was particularly concerned by the issues highlighted around the Trust's IT issues. He asked about the processes auditors took to ensure that they received assurance that issues raised within the audits were resolved. Mr Townsend explained that management responses were required for all recommendations made within audits, and that these were recorded on a tracker which was presented at each meeting of the Audit Committee. Dr Bull asked for any issues that were not being completed appropriately to be raised at the regular meetings of the Executive team.

Mr Stevens asked that an update Executive responses to audit actions be provided to the Committee during July's meeting. **SH/MT**

The Committee noted the Internal Audit Annual Report and the Head of Internal Audit's Opinion of Limited Assurance for 2015/16

032/16 Audit Committee Annual Report 2015/16

Mrs Wells presented the Audit Committee Annual Report and explained that it was timetabled for consideration by the Board at its June meeting.

The Committee approved the Audit Committee Annual Report 2015/16 for submission to the Trust Board.

033/16 Internal Audit Plan 2016/17

Mr Townsend explained that the internal audit plan had been presented at the previous meeting of the Audit Committee, and that an updated version was being presented as it now included a planned audit of mandatory training within the Trust during 2016/17.

The Committee approved the Internal Audit Plan for 2016/17.

034/16 Date of Next Meeting

Wednesday, 20th July 2016, at 10:00am in the St Mary's Boardroom, EDGH.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 25th May 2016 at 9.30am – 11.30am, in the Committee Room, Conquest

Present
Mr Barry Nealon, Non-Executive Director (Chair)
Mr Mike Stevens, Non-Executive Director
Mrs Churchward-Cardiff, Non-Executive Director
Mr David Clayton-Smith, Chairman
Dr Adrian Bull, Chief Executive
Mr Philip Astell, Acting Director of Finance
Mrs Pauline Butterworth, Deputy Chief Operating Officer

In attendance
Mr David Meikle, Financial Consultant
Dr Sally Herne, Improvement Director
Mr Garry East, Associate Director for Delivery and Performance (for minute 022/16)
Mrs Michelle Clements, General Manager – Facilities Services (for minute 023/16)
Mrs Jo Brandt, Head of Performance & Planning (for minute 025/16)
Mr Ajay Channana, Head of Procurement (for minute 026/16)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

019/16	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee. Mr Meikle was thanked for his contribution, as it was his final Finance & Investment Committee meeting. Apologies were received from Dr David Hughes.	**Action**
020/16	**Minutes of Meeting of 27 April 2016** The minutes of the meeting held on 27 April 2016 were agreed as an accurate record.	
021/16	**Matters Arising** (i) Integrated Performance Report (Estates & Facilities CIP)	

	A detailed Estates & Facilities CIP update was provided under minute 023/16 below. (ii) Coding Review This item was discussed under minute 027/16 below. (iii) 5 year Strategic Capital Programme 2016/17 – 2020/21 This item was discussed under minute 024/16 below. (iv) Community Rebasing Project Update The draft terms of reference for the Community Rebasing Project were due to be presented to the Senior Leaders forum on 9 May 2016. However that meeting was cancelled and they will now be presented to the meeting on 13 June 2016. (v) Integrated Performance Report Dr Bull reported that the rationalised Governance Structures would be reviewed at the next Trust Board to cover the strategic objectives in order to try and avoid duplication. (vi) Business Plan 2016/17 The Committee had asked for reassurance that Consultants were not being paid above BMA guidelines. Mr Astell confirmed that there had not been any further requests but gave the Committee assurance that they would not be paid above the guidelines. (vii) Capital Programme Report for Year Ending 31 March 2016 This was discussed under minute 024/16 below. (viii) Urology – Progress Against Action Plan Dr Bull confirmed that discussions had taken place with Mr Garnett, Ms Bishop and himself. The Business case was being reprised and the figures were currently being validated. Dr Fiona McKinna, the Consultant Oncologist working with the Trust, was full of praise for the work the Urology team were doing in bringing back major cancer surgery across from Brighton to Eastbourne. Mrs Butterworth was reviewing a list of requirements passed to her by Mr Garnett with Mr Hardwicke. Dr Bull confirmed that Urology was on the agenda for the Surgical Review and Mr Garnett had expressed his appreciation for the re-focus on this item.	**PA** **AB**

	(ix) 2014/15 Education & Training Cost Collection Dr Hughes had undertaken to liaise with Mr Shuber & Mr Zaidi to assist to raise the profile of the Education & Training cost collection within the Trust. Dr Hughes was unable to attend today's meeting. ***Post meeting note*** Following the Committee meeting an email was received from Dr Hughes to confirm that there has been a drive to get the Consultants to fill in the cost collection exercise via their respective Clinical Units. A letter had been sent out to all clinical Units from Mr Shubber & Mr Zaidi to encourage a better response. The closing date was 20 May 2016 and a total of 27 Education & Training Cost Collection Questionnaires had been received from consultants. This was just over twice the amount received last year. However, it was noted that this was based on a 20% response rate. (x) Lord Carter Update It was noted that there would be a Lord Carter update at the June meeting. (xi) Tender & Service Development An update on the position of the accreditation for the Direct Access Hearing Services AQP was discussed under minute 029/16 below. (xii) Grip & Control update Mr Meikle gave assurance to the Committee that the Grip and Control measures that were established in the last six months were being maintained; in particular the daily review of the rolling 7 day agency commitment, the weekly health roster reviews of nurse agency reports and medial agency usage and a fortnightly meeting looking at temporary workforce. Mr Meikle confirmed that the Trust was planning to go live with the new bank programme from 14 June 2016. Dr Herne reported that she had circulated some information picked up on a mock inspection which were workforce issues but had a cost issue attached to them. One item related to the new model for Emergency Department middle grades launched in the East Midlands trying to create a new rotation for SAS doctors; this was being picked up by ops and HR; the other item referred to specialing where there was a bid in about how this might be rolled out nationally. This was a	**PA**

	financial pressure for a lot of Trusts. Dr Bull suggested that this item is picked up at the Executive Directors meeting.	**SH/AB**
022/16	**Integrated Performance Report – Month 1** Mrs Butterworth presented the Integrated Performance Report for Month 1 and the following key issues were highlighted: There were some key improvements this month: • Cancer performance; performance continued to improve in the Two Week Wait standard and the 31 Day Standard. • No Mixed Sex Accommodation breaches. Performance deteriorated in: • A Never Event was reported in Clinical Support and Theatres. • RTT incompletes did not meet the 92% standard with a final figure of 90.5%. • Diagnostic performance did not meet the < 1% target in March. • A&E performance remains challenged and under the target. Dr Bull queried the mixed sex areas that were exempt. Mrs Butterworth confirmed the exempt areas were CCU, Hyper Acute Stroke, ITU, (providing nobody is wardable), MAU/Urology Admission Unit based on clinical need. Dr Bull queried whether the area for patients waiting for planned catheterisation was included in the area defined as the CCU exempt area. Mrs Butterworth would check and confirm this. Mrs Butterworth explained that the mixed sex breach definition relates to overnight accommodation. Mr Astell presented the Finance Report at month 1. In the first month of the new financial year the Trust made a deficit of £5.2m, which was £0.5m worse than plan. While income and pay costs were broadly in line with plan, non-pay budgets were overspent by £0.5m. The main factor was third party support to deliver endoscopy backlog and RTT compliance. These costs were not budgeted and, although both will have delivered additional activity, this was not sufficient to generate an overall compensating income variance. The full year projection at this early point in the year is in line with the £48m planned deficit Dr Herne asked about being on PbR, what work was being done to look at where it's worth putting a bit of effort into being able to achieve the benefits in terms of improvement in margins at Clinical Unit level. Mr Meikle said that in the Business Plan process and in other discussions with the Clinical Units, they were being encouraged to look at this. He stated that it was not just about cost reduction, it was about contribution that can be achieved through additional income or additional tariffs. Mr Astell confirmed that this would be picked up at Integrated Performance Reviews and raising awareness of the	**PB**

	opportunities. Dr Bull suggested that we could come up with a short list of the most likely areas that would be amenable to them, then this could be discussed at the Monday Morning Clinical Unit Lead meeting. **Action** **The Committee noted Integrated Performance Report at month 1.**	**PA**
023/16	**Estates & Facilities 2015/16 CIP** Mrs Clements presented the Committee with an update on the position around year end budget and CIP status within Estates and Facilities. At the November 2015 meeting the Committee had raised concerns over the achievement of the CIP within Estates and Facilities. It was reported that there was a significant shortfall. A paper was presented to the December 2015 meeting which outlined the position. A further query was raised at the April 2016 meeting where further clarity was sought on the 2015/16 year end position. Mrs Clements reported that as at 29 April 2016, the CIP gap was £1,025K (red and amber) at year end as follows: Red £820k Amber £205k Green £560k Although there was a gap in performance of certain elements of the CIP, it was noted that Estates and Facilities position at the end of M12 was £567k overspent against a forecast of £640k. Therefore, it was argued that there was actual CIP delivery of £1,018k (CIP plan at £1,585k – M12 actual end of year deficit at £567k) through a combination of recurring/non-recurring methods, The Estates and Facilities team had worked hard to identify other recurring and non-recurring CIP opportunities throughout the year and therefore the year end position was better than the forecast. The Committee received a summary of other non-planned CIP opportunities that were released as “unplanned opportunities” savings within the current FY 2015/16. These “one-off “unplanned opportunities” have been taken into the current FY 2015/16 which actually reduced the formal CIP underspend. It was noted that the housekeeping modernisation plan CIP at £500k remains the single biggest challenge to FY 2016/17. A report had been presented to the March Finance and Investment Committee and also to the Business Development Group in May.	

	Mrs Clements reported that a further paper regarding the Housekeeping Modernisation financial plan was being developed for the Business Development Group. This report will provide assurance and support questions raised at the last Business Development Group meeting. It was noted that Mrs Clements was working closely with the Estates and Facilities Business partner to develop a financial analysis of spend over last three years and impact of increased activity and CQC requirements against original plan. This paper will also be shared with F & I as requested. Mrs Clements informed the group that, following a recommendation from Dr Sally Herne, they were investing in a Productive Cleaning Tool kit that was being used in other Trusts, This toolkit will provide support to the current modernisation plan and also determine whether there were any further opportunities to improve efficiency and productivity. CIPs for FY 2016/17 had been developed and the expenditure in the current financial year was being closely managed through the budget process and monitored at the Estates and Facilities monthly divisional meetings. The Committee queried what resource input was allocated to areas which may not achieve their National Standards of Cleanliness (NSC) scores. Mrs Clements advised that if an area does not achieve its NSC cleaning score a review would be undertaken to establish whether the failures were attributed to due to lack of resources, activity on the ward (eg. building works) staffing competencies, equipment and materials etc, and any failures would be rectified appropriately. **Action** **The Committee noted the Estates & Facilities update.**	
024/16	**5 year Capital Strategy 2016/17 – 2020/21** Mr Meikle circulated a paper, which was work in progress, showing the detail around the schemes in the Capital Programme for 2016/17 and the 5 year capital plan. This was produced following a discussion at the last Trust Board and will be discussed in further detail with the Chief Executive before it is presented to the Executive Directors meeting. It will then come back to the Finance & Investment Committee in June. The Committee noted the main items in the 2016/17 capital plan were: ***Estates & Maintenance Schemes*** • Emergency Department & Paediatric Development • Fracture Clinic Relocation	**DoF**

	• Front of House Concourse • Estates Backlog Maintenance – Engineering/Building risks • Ward Environment and NSC/PLACE – Estates remedial works ***IT Schemes*** • VitalPAC • Core IT • SAcP EDM Core IT schemes included Child Health Information Systems, Community Mobile device replacement, GS1 National Bar Code Standard and Clinical Correspondence. The Committee received the detailed 2016/17 IT plan split between the first six months, the final six months, and the rollout in the next four years. ***General*** • Pathology CLD • Brought forward Commitments/Other* • Other Project Management • Minor Capital Due to the demands on capital this year it was agreed that the Trust would look to lease medical equipment in 2016/17 up to a capital equivalent value of £2m. The Committee reviewed a summary of the draft medical 5 year plan. However, it was noted that there was still some work to do on this. Mrs Butterworth and Dr Forder were looking at reconstituting the Clinical Equipment and Product Group and were working with the Clinical Units to come back with their requirements for 2016/17. * Mr Meikle drew the attention of the Committee to a summary showing the brought forward Commitments which did include medical equipment. Mr Nealon queried how the £2m underspend that was identified at M10, in last year's capital programme, had been spent by March 2016. Mr Meikle said he would forward this information to Mr Nealon. This was included a report that was presented at the April Committee meeting. Dr Bull reported that he had agreed with Mr Meikle and Mr Astell to create a small fund for matrons and others to make a bid against for small works that might be transformational and would empower nurses to do things on the wards. This would be included in the next iteration. **Action**	**DM**

	The Committee noted the work in progress on the Capital Programme and the 5 year Capital Plan.	
025/16	**Reference Cost Board Approval of Process** Mrs Brandt presented an update on the arrangements for the 2014/15 Reference Cost submission. It was noted that the Director of Finance is responsible for the accurate completion of the reference cost return. The reference costs submission should be subjected to the same scrutiny and diligence as any other financial returns submitted by the Trust. The Finance & Investment Committee is required to confirm in advance of the reference costs submission that it is satisfied with the Trust's costing processes and systems, and that the trust will submit its reference cost return in accordance with guidance. Mrs Brandt explained that in providing this confirmation, the Finance & Investment Committee may wish to satisfy themselves that procedures are in place to ensure that the self-assessment quality checklist can be completed at the time of the reference cost submission. Trusts that are unable to provide this confirmation should provide details of non-compliance. Specifically, the Finance & Investment Committee are required to confirm the following statements: Specifically, Boards or their appropriate sub-committees are required to confirm that: a) the Board or its appropriate sub-committee has approved the costing process ahead of the collection; b) the Director of Finance has, on behalf of the board, approved the final reference cost return prior to submission; c) the reference cost return has been prepared in accordance with Monitor's Approved Costing Guidance, which includes the reference cost guidance d) information, data and systems underpinning the reference cost return are reliable and accurate; e) there are proper internal controls over the collection and reporting of the information included in the reference costs, and these controls are subject to review to confirm that they are working effectively in practice f) costing teams are appropriately resourced to complete the reference costs return, including the self-assessment quality	

	checklist and validations accurately within the timescales set out in the reference costs guidance. Workbooks were released in May with validation and open submission between 20 June and 26 July. It was agreed that the Finance and Investment Committee, reporting directly to the Board was considered the most appropriate Committee to carry out this review. The published 2014/15 Reference Costs index was presented to the Finance & Investment Committee on 16 December 2015. The Committee noted the reference cost index. Recommendations made in the PWC draft audit report for the 2014/15 reference costs audit were being addressed and either implemented or included in an action plan and responsibilities made clear. Mrs Brandt reported that the Trust will be meeting with NHSI & PWC on the 26 May 2016 to ensure that the action plan is acceptable. The Committee complimented Mrs Brandt and her team for this piece of work. **Action** **The Finance and Investment Committee confirmed that it was satisfied that the costing process, supported the 2015/16 reference costs submission and that the trust will submit its reference cost return in accordance with guidance.** **Minutes of this meeting will be taken to the Board and this will provide documentary evidence should the Trust be subject to external review.**	
026/16	**Procurement Update** Mr Channana presented a report highlighting the contribution made by the Procurement function in the delivery of the Trust's cost improvement programme and improving compliance levels through proactive engagement with cross-functional stakeholders. Mr Channana reported that Lord Carter's final report reiterated the key messages contained in his report and also emphasised upon the need to deliver savings by reducing variation in clinical supplies, collaborative working and implementing better controls. The report recommended developing a 'Procurement Transformation Plan' which will assist the Trust in delivering against five key criteria focussing on cost of inventory, catalogue compliance and contract management. The revised procurement strategy will be aligned with the	

	recommendations of the Lord Carter's final report and will support delivery of 'Procurement Transformation Plan' through implementation of revised SFI's and ' No Purchase Order, No Payment' policy. In the interim, procurement will continue to take all necessary steps to improve compliance levels and maximise 'value for money' by working collaboratively with other NHS Trusts and through reduction in Single Tender Waivers. The Procurement report provided by Mr Channana was part of an initiative to bring visibility to the work of the procurement team, highlight achievements to date and give assurance that procurement activity fully supports all the Department of Health initiatives including reduction in variation through supplier rationalisation and product substitution. An optimum balance of capacity and capability within the team will be vital to addressing the challenges emerging from Lord Carter's final report. The report recommended developing a 'Procurement Transformation Plan' which will assist the Trust in delivering against five key criteria focussing on cost of inventory, catalogue compliance and contract management. The Committee noted the progress to date against the CIP target and future work plan of the function. Mr Channana reported that during FY2015/16 the procurement team delivered cash release savings of £2.475m against 3 year CIP target of £6.5m. Delivery of higher than expected savings during FY 2015/16 has effectively reduced the cash savings target to £2m for both the current and next financial year. During the current financial year the Procurement team had so far delivered cash savings of £506k against a Q1 CIP target of £500k (as at 15 May 2016). In addition, the team was currently working on 12 projects which were expected to deliver substantial cash savings during current financial year. Mr Channana gave an overview of the following contracts awarded/ projects in process and summarised the key issues: • Contracts awarded – March and April 2016 • Projects in Process • Clinical Products and Consumable Projects – starting in Q1 and Q2 • Corporate Projects – starting in Q1 and Q2 • Implementation of Temporary Staffing caps – HCA's Mr Nealon asked for confirmation that all projects were going through the correct assurance process. Mr Channana assured the Committee that the correct process was being followed.	

	Dr Bull queried the amount of stock that the Trust holds, and what the trust was doing to try and minimise stock around the organisation. Also, in terms of lines of products, Dr Bull also queried whether there was a plan on rationalising the numbers of product lines the Trust was purchasing. Mr Channana confirmed that work was ongoing on both these items, and information would be provided at the next Procurement update. Mr Astell reported that the current inventory amounted to approximately £6.5m. Dr Bull said that the Trust should set a target to reducing the inventory to help release some of the cash. Mr Stevens asked if Procurement could compare stock levels with usage and, as part of the stock control, asked whether the Procurement team could visit all areas to check stock levels. The Committee noted that Procurement had successfully implemented the Department of Health capped rates in a short period of four weeks and all HCA staff were being recruited in a compliant manner with zero 'breaking glass' incidents reported since w/c 25 April 2016. The Procurement team were congratulated on this and their ongoing good work. Dr Herne asked for confirmation that the Quality Impact Assessment process has been followed for all the projects. It was agreed that Mr Channana would check and confirm this. **Action:** **The Committee noted the progress made against the target and the key metrics.**	**AC** **AC** **AC** **AC**
027/16	**Coding Review** It was noted that the Coding Review report had been delayed and was due to be received at the end of May. This would therefore be presented to the June Finance & Investment Committee. **Action** **The Committee noted position of the coding Review.**	**PA**
028/16	**IT Investment** Mr Nealon expressed his concerns over the IT plan and his low confidence levels and lack of information provided to the Finance & Investment Committee. He had requested an IT report to be presented to the Committee on two occasions and this has not yet happened. Mr Astell reported that there had recently been some significant developments in terms of improving the robustness of the IT	

	infrastructure and it was unfortunate that Mr Bissenden had not been able to attend a meeting to explain what had been done. It was agreed that Dr Andy Slater and Mr Andy Bissenden would be asked to attend the June meeting to give their view of the Clinical and related Information Strategy. **Action** **An update would be provided at the June Committee meeting.**	**PA**
029/16	**Tender & Service Developments** The Committee received a schedule providing up update on current tenders as at 20 April 2016. The schedule is monitored by the Business Development Group (BDG) on a fortnightly basis. The Committee noted the position of the following PQQ/tenders: • Direct Access Hearing Services AQP – confirmed in April that the Trust had been successful in the accreditation award. • Non-Invasive Ventilation Service – currently at clarification stage • Elective Service - AQP due for submission on 13 May 2016 Mrs Churchward-Cardiff expressed her concerns that the Trust had been waiting since February for information on the Non-Invasive Ventilation Service. Mr Astell confirmed that they had followed this up and would continue to do so. **Action** **The Committee noted the update on tenders.**	**PA**
030/16	**Business Cases for Review** There were no business cases for review this month.	
031/16	**2016/17 Work Programme** The Committee noted the 2016/17 work programme. It was agreed that Mr Nealon and Mr Astell would review the work programme outside the meeting due to the number of items on the work programme for June. **Action** **The Committee noted the work programme for 2016/17.**	**BN/PA**
032/16	**Date of Next Meeting** The next meeting will take place on Wednesday 29 June 2016 at 9.30am – 11.30am in St Mary's Board Room, Eastbourne DGH.	

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the People and Organisational Development Committee meeting held on Wednesday 1st June 2016 at 2.00pm in the PA Room, EDGH vc to Room 3, Education Centre, Conquest

Present: Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director (JCC)
Mrs Edel Cousins, Asst. Director of HR – Workforce Development (EC)
Ms Monica Green, Director of HR (MG)
Dr David Hughes, Medical Director (DH)
Mrs Pauline Butterworth, Acting Chief Operating Officer (PB)
Ms Kim Novis, Equality & Human Rights Lead (KN)
Mrs Moira Tenney, Deputy Director of HR (MT)
Mrs Lynette Wells, Company Secretary (LW)

In attendance: Mrs Karin Knowles, Ward Matron (KK) - Observer
Ms Tracey Okines, Voluntary Services (to) - Observer
Mrs Jacqui Ayres, PA to the Deputy Director of HR (JA) – Minutes

No.	Item	Action
1)	**Welcome, introductions and apologies for absence**	

The Chair welcomed all members to the meeting and introductions were made. The Chair welcomed Karin Knowles (Ward Matron) and Tracey Okines (Voluntary Services) who were in attendance as observers.

Apologies for absence were received from:

Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)
Mrs Alice Webster, Director of Nursing (AW)
Mrs Jan Humber, Staff Side Chair (JH)
Mrs Lorraine Mason, Head of Staff Engagement & Wellbeing (LM)
Miss Sarah Gilbert, PA to Director of HR (Minutes) (SG)

2) 2.1 Minutes of the last meeting held on 8 March 2016

The minutes were reviewed and agreed as an accurate reflection of the meeting.

The following actions were discussed and agreed:
Item 3. The Agenda item in relation to the Consultant Contract and Agenda for Change Terms and Conditions to be added to a meeting later in the year once further National information is received. **SG**

Item 4.1 Staff Survey action plan to be presented by LM at the next meeting. **LM**
Item 5.2 Following successful recruitment initiatives and the piece of work being undertaken on Regional Agency Control and NHSP to reduce agency usage and attract staff, it was agreed that the visit to Portsmouth would not take place at present.
Item 8.2 Communications message was drafted and circulated and received good response.

2.2 Agree updated Terms of Reference & Forward Plan

The Terms of Reference were reviewed, with the following amendments agreed: **SG**

- Section 1, Paragraph 3 - Spelling amendment
- Section 8, Changes agreed
- HR Senior Leaders Meeting to be added to the agenda for future meetings to provide an update regarding the work of sub committees.

The Forward Plan was agreed by the Committee.

3) ESHT 2020 Workforce Priorities

MG provided some background on the ESHT 2020 plan and the associated workforce priorities. The plan is based on five key areas:-

- Quality & Safety
- Leadership and Culture
- Clinical Strategy
- Access and operational delivery
- Financial Control and capital development.

The key workforce issues are:-

- That we have an Organisation Development Strategy to support ESHT 2020 and the Trust Strategy
- That we have staff with the right skills and development, with a succession plan in place
- Culture work is undertaken so staff feel able to speak up, are engaged, line managers take responsibility and undertake appraisals and fully involve staff in their areas of work.
- We have a recruitment and retention plan with the right staff in the right place.

An overview of the ESHT 2020 Plan has been provided to the Board, and will be discussed and agreed formally next week. Asked how this would be disseminated to staff, LW explained that as part of the Visions and Values, 200 Values Champions had been identified and a plan of engagement detailed to cascade values information and the ESHT 2020 priorities along with them.

4) Workforce Strategy & Plan

EC provided some context to the Strategy and explained that the Strategy would be presented to the Board in July this year as it was in 2015. The detailed workforce plan will not be presented at the same time, as there had been a time shift and there is a major change to the education commissioning landscape in terms of bursaries and funding from September 2017. The workforce return recently completed was requested for 1 year only, with a five year plan being submitted in September. The plan will therefore be presented in September.

Action: Workforce Strategy and Plan to be renamed Workforce Strategy **EC**

EC proposed that the following items are added and updates are made to the Strategy:

- Add ESHT 2020 workforce priorities
- Update demographic and establishments
- Business Planning to be aligned to ESHT 2020
- Capacity, Capability and Engagement to be refined and aligned to ESHT 2020

Individual committee members raised the following concerns:

- Target areas in relation to age profile in respect of the older demographic (JCC)
- Target areas in relation to younger age profile such as sixth formers (JCC)
- Keys on some graphics in yellow cannot be seen (JCC)
- More robust hospital at night – higher capability/support (JCC)
- WRES, EDS2 and Trust Equality Objectives to be included (KN)
- Specialling to be added into priorities (PB)
- Staff in Post table does not show establishment. (MK)
- Too many priorities (pages 11-13) (JCC). It was greed that some of these are actions and not priorities, and therefore these should be reviewed and amended, and defined into short, medium and long term priorities.

EC

Action: All items agreed to be added/amended as above and the Workforce Strategy to be reviewed at the next meeting.

Healthroster

JCC expressed the need to improve the attitude and use of Healthroster by improving the ability of people to use it and attention to more careful introduction. EC agreed that issues on technical skills and understanding were being addressed by the increase of the Roster Support Team; targeted training by visits to individual wards/areas. It was reflected that some of the inflexibility of the system was due to the initial set up, and these were being resolved individually.

KK expressed that she had been an early adopter of Healthroster and appreciated the system, but that it did take time to understand all aspects. Some colleagues currently still use a paper system. One issue is that Healthroster is not "live" and this caused delays with Temporary Workforce.

Following discussion on this subject, it was agreed by the Committee that a review should be undertaken on who the lead/responsible person should be for implementation and use, and that the responsible/accountable person should follow the model used for Vitalpak, and should be someone from within the business. A clear process also needs to be in place. **EC/PB**

Action: EC and PB to undertake review on responsibility and agree a clear process. Update to be provided at the next meeting.

Business Planning

JCC raised queries regarding the key workforce themes. EC confirmed that these had been taken from the Business Planning presentations of the CUs on 16th March. To JCC's query on whether these were funded or approved, PB advised that she did not see anything contentious and she was aware these had been approved.

JCC suggested that there should be a sanity check on these, as the plans for some CUs were not very good. **EC/PB**

Action: These plans to be triangulated and more information and expansion included, and a column added to give more information on funding/approval. EC and PB to work together to provide this.

5) Organisational Development Strategy Outline

MG provided background on the work undertaken by LM on the Strategy outline and the committee reviewed the paper. MG expressed that LM would welcome feedback on the paper, in particular relation to page 2 bullet points.

JCC suggested that bullet number 5 should include responsibility
MK stated that the document was very good overall, and was clearly articulated. Strategy to be clearly aligned with ESHT 2020 and Workforce Strategy.
EC asked if the OD Strategy would be the overarching document. This was confirmed with sub-documents being Leadership, Recruitment and Retention and Workforce Strategy and Plan, with no duplication and all referring back to the OD Strategy.

Action: Work to continue on this Strategy in preparation for presentation at the next meeting. **LM**

6) 6.1 Action and Feedback from Pulse Surveys

MG presented the feedback from the Pulse Survey undertaken from 18th March to 29th April. The overall Staff Engagement score was

3.46, 0.10 lower than the indicator score of the 2015 staff survey. The areas that have input a lot of work into staff engagement have increased or show a more positive score in their feedback. JCC expressed concern that the response rate was very low in most CUs, with 50% of the responses coming from 3 areas.

KK asked suggested that many staff remain suspicious about anonymity of electronic surveys, so don't complete them. Only Estates and facilities had paper surveys this time. KK also pointed out that the majority of clinical staff below band 6 do not have IT access.

MG explained that the Staff FFT surveys were out now, with the next Pulse Survey due July/August. EC advised that the current FFT output would not be available until September. PB and JCC urged that we continue to demonstrate that we are acting on feedback from surveys and that they are important. MG confirmed that feedback was provided by "You Said, We Did". MK agreed that we do need to promote this more.

Action: PB agreed to take this forward with the CUs **PB**

6.2 Medical Engagement Scale Results

DH provided a verbal update on the MES results, which were undertaken earlier this year. DH explained that we had received only a limited response, and this was not encouraging. A large amount of work has since been undertaken with consultation, visits and engagement, with Adrian (AB) setting a reviewed style of engagement and leadership including changes to performance review meetings from the top level down. A 1 day review of feedback received was undertaken at a Faculty Leadership Course.

JCC asked if there was a theme to the apparent disengagement. DH advised that anecdotally, feedback has been anything from not getting what they want, or not being happy or things are not happening. JCC agreed that people do not engage unless it is to their personal or political advantage, but we must lead them to action or they will continue to disengage.

MK asked if the change in leadership from AB was helping or having an effect. DH stated that he felt AB had a great opportunity and was doing all the right things, providing the energy and meeting the right people. MK felt that this was, or would eventually close the feedback loop. TO added that she felt that feedback must be provided in a timely manner, even if it was to inform that something had not been done or completed, then staff at least would continue to be engaged. The feeling of some staff was that nothing has happened since the last CQC inspection, nothing was changing and it was not worth completed a survey or raising a complaint. Staff need to engage with the values and get their "fight" back. JCC concurred that we needed very visible success. MK felt that further communication was needed on what had been done since the last CQC inspection if that

was the feeling of staff.

Action: MK has requested that an item on engagement with medical staff to be added to the September POD **SG**

7) Recruitment Hotspots: Plans and Retention

MT presented a paper regarding Recruitment Hotspots, and advised the committee that a Resourcing Manager was now in post with experience in Social Media and advertising, to improve recruitment and retention.

Medical Vacancies - MT outlined the priorities in Medical Vacancies with Consultants and Medical Grades, and that the number one priority at present was in Emergency Care. These posts had now been given to Head-hunters to fill, likely from overseas and potentially India, with the proviso that they must meet all our requirements including language tests, prior to interview. Other pieces of work being undertaken to improve recruitment were working with GP's to triage at the front end, or prevent inappropriate admissions.

JCC stated that this was a problem nationally, but some other Trusts do manage to recruit, and asked why we felt we had this issue. PB stated that middle grades to not want to work in Eastbourne, and Consultants are a challenge everywhere but the Trust was currently looking at Advanced Medical Practitioner roles. It was agreed that we need to promote our Trust and the area, and the positives should be the focus. LW advised that a video had been produced to assist recruitment.

Action: LW to share video/link. **LW**

JCC asked about the Trust's website. LW advised this was in hand and that funding had now been approved for its replacement, and was now at the procurement stage.

PB advised that in response to questions on why potential recruits do not want to come here, the response many times was that they had read the CQC report. DH advised that in terms of A&E, we need to offer rotations to other Trusts. Asked if the Emergency Medical Model would be better for here, PB confirmed this would be the case as the Emergency Medical Model works for DGHs in particular as opposed to Trauma units. We may also be able to offer rotations with the current work being undertaken with the STP.

The committee discussed improved communication about development plans and other changes taking place at the major sites.

Action: LW and LM to arrange for communications about project plans at the main sites, including the remodelling of the entrances of both acute hospitals, to include notice boards, updates on Twitter and making use of all available channels to reach staff. **LW / LM**

Nurse Vacancies - MT provided an overview of Nurse vacancies showing that in March, vacancies were reducing and leavers were also reduced however in April the establishment had been increased resulting in a higher level of vacancies. Risks were highlighted in where nurses will come from in the future and the introduction of Nurse Associate Posts into training from January 2017 was explained, together with the current issues with education commissions and training not being fully funded as it is now. JCC stated that we need to decide now what we need and if we want the Nurse Associate role and can recruit to it, we should have a structure and plan already in place once the way forward with commissioning is known. MT confirmed that in reality, this would be a transition from vacancies to these posts. PB agreed that we do need to put this in place, and that we should review with all CUs and agreed what we would do with these posts out of the vacancies we have. It was agreed that these discussions should take place with CUs and pick a couple of departments wand work through what we would need.

Action: EC to review with CUs and feed back to the next EC meeting.

TO asked if we currently go out to schools to promote recruitment. EC advised that we have been involved very successfully this year with the Big Futures Event; Bexhill Careers day and that a careers event for A level years is currently being planning for this Autumn.

AHP' Vacancies - MT advised that there was a more positive feeling regarding the position for AHP staffing for the Autumn, having had some very positive recruitment. This area was now less of a hotspot.

Retention – MT advised that we are now taking a more proactive approach to retention, and a piece of work was being undertaken with the JSC. As well as Exit interviews, "Stay" interviews are planned to be undertaken with staff we are aware may be thinking of leaving, and also with staff to ask "what keeps you here". With the ageing workforce, health and well-being needs also to be considered, with discussions for those nearing retirement to look at change in hours, jobs, roles and shifts.

8) Questions from staff attending as Observers

MK asked the observers for any questions or feedback having attended the meeting.

TO stated that she felt the Trust was working on the right lines, but that staff needed to see something happen and it was important to keep them informed. Staff should also be involved more in changes and engaged in all aspects. TO asked about the use of mentors. KN advised that the BME group would be offering that for shadowing shortly. MK advised that she had been involved in reverse mentoring where Junior staff are the mentors. The committee agreed that this could be valuable. TO raised some confidential issues that MG agreed to deal with outside the meeting.

KK said that she felt reassured by the meeting to see Board members in attendance and see that things were happening and plans were in place. She also felt it was good to see that the need for mentorship and support for overseas nurses was being addressed, and that issues were being acknowledged and acted upon.

MK thanked the observers for their attendance and input to the meeting.

9) Any other Business

9.1 HR Incident Report – LW stated that the increase in numbers of grievances could be a good thing or a need for concern, but felt that this needed further review and discussion.
Action: HR Incident Report to be added to the Agenda for the next meeting. **SG**

9.2 Workforce Report - MG asked that a review of all the indicators on the Workforce Report should be taken as "exception reporting" for the next meeting Agenda.
Action: Workforce Report Review to be added to the Agenda for the next meeting. **SG**

9.3 Minutes – MK asked that the minutes of the meeting be prepared and shared at the earliest. **JA**

10) The next meeting of the Committee will take place on Tuesday 6th September, 2016 from 2.30 – 4.30 pm. in St Mary's Room, EDGH video conferenced to Committee Room, Conquest

East Sussex Healthcare NHS Trust

Quality and Safety Committee

1. Introduction

The Quality and Safety Committee met on 20th July 2016 and a summary of the items discussed at the meeting are outlined below.

The meeting opened with a presentation from the family of a patient who had sadly passed away. They outlined their experience of care at the Trust. The Committee acknowledged the learning from the feedback, specifically the need to ensure those patients reaching the end of their life have a clear plan of care developed with the individual and their family.

2. Board Assurance Framework and High Level Risk Register

The Committee reviewed the Assurance Framework and noted the inclusion of a summary page on objectives and risks following the Board Seminar. It was agreed that the mortality gap in assurance should remain red. The other red flags were noted as patient transport, emergency department reconfiguration and finance.

In respect of patient transport it was updated that the Trust is working with the new provider to improve the service and the number of incidents has decreased. There will be continued monitoring of the situation.

It was noted that the risk register is being reviewed to support consistency in scoring and descriptions of risk.

3. Legal and Claims Annual Report

The Annual Legal and Claims Report was considered. For the year 2015/16 there were 66 new Clinical Negligence claims and 23 new Non-Clinical claims that were referred to and are being managed by the NHS LA. There were also 55 new Inquests. A review of systems and processes has been undertaken to ensure compliance with the NHS Litigation Authorities and HM Coroners reporting requirements. There is focus on shared learning and triangulation with incidents and complaints.

The NHSLA produce a more detailed report outlining themes and trends and this will be shared with the Committee when received.

4. Duty of Candour Audit

The Associate Director of Governance provided an overview of the most recent duty of candour audit. The Committee were pleased to note the improved compliance. However, there is still work to be done in embedding the process and ensuring findings of investigations are completed and embedded. Challenges remain in respect of Amber (internal investigations) Investigation Reports being robust in terms of clarity and strength of investigation. Actions are in place to address this.

5. External Visits Report

The report detailed the 15 visits and self-assessments that have taken place in Quarter 4, between 1st January and 31st March 2016. It was noted that the visits reported were only those from statutory bodies and those outlined in the Trust Policy i.e. for accreditation, rating or licensing. The Committee were advised an evaluation is currently underway to ensure that external reviews from all sources are captured and monitored and these will be included in future reports. This supports assurance of organisational memory and implementation of actions.

6. Quality Improvement Plan (plus ESHT 2020)

An update on progress in delivery of the Quality Improvement Plan was tabled. This encompassed achievement of the recommendations made by the Care Quality Commission (CQC) following their visits in September 2014 and March 2015. The report covered project summaries, highlights and milestones, risk and developments.

It was noted that the Medicines Management project had achieved all the objectives set out for the project; notably integrated pharmacy team in place, dedicated technicians to Clinical Units, gateway medicines reconciliation targets now met consistently, infrastructure designed to engage nursing teams, reconfigured medicines management groups so that they are aligned to the Trust wide Medicines Optimisation Strategy. The project was closed as continual improvement is embedded in the Pharmacy governance structure.

The single sex accommodation policy had been revised to ensure compliance with national requirements and good patient experience. Estates work has commenced to provide privacy and dignity improvements in Radiology and Paediatric assessment in A&E

Assurance was provided that actions have been developed in response to the mock inspection held in August.

7. Health and Safety Annual Report

The Annual Health and Safety Report was presented and it was noted that this will be considered at the August Board meeting. The Health and Safety Steering Group has a focus on the operational aspect of the programme. The Committee were assured that progress is being made and effective health and safety arrangements are in place.

8. Integrated Infection Prevention and Control Action Plan

The Committee were encouraged that a single action plan had been developed to support the IP&C Annual Programme of Work 16/17 and this will be monitored through the Trust Infection Prevention and Control Group. Clarity was sought on the RAG rating of the plan and this will be reviewed and addressed. The process for monitoring actions raised from other investigations, audits and Post Infection Reviews is being reviewed and agreed

9. Governance Quality Report

A considerable amount of work has been undertaken and is ongoing to support the delivery of good practice in clinical governance. The clinical governance meeting framework has been reviewed and a sub-committee to look at governance in greater detail, under the leadership of the Medical Director and Director of Nursing, has been established.

Work is still required to reduce the complaints backlog and ensure the final response is completed within the correct timescales of 30 days or 45 days. There is also a focus on reducing the number of older open Serious Incidents.

10. Capsticks Clinical Governance Report

The Capsticks Clinical Governance Report was reviewed. A number of actions are already underway and it was noted that an action place is being developed to address the recommendations. This will be considered at the next meeting.

11. Equality and Diversity EDS2 Report

The Committee reviewed the Annual Report and agreed the proposed grading for each area.

12. Hospital @ Night Report

The Medical Director outlined progress in the Hospital at Night programme of work. The H@N model is designed to redefine medical cover at night, ensuring effective safe clinical care, introduce multidisciplinary competency based teams who work together and also

minimise out of hours workload by changing current ways of working. The operational policy has been reviewed and revised and will be ratified in August.

13. Integrated Performance Report (Quality Element Only)

The quality element of the Integrated Performance Report was reviewed. It was noted that many of the areas had been covered in detail during the course of the meeting.

Approved minutes of the meeting held in April and June are attached for the Board's information.

Sue Bernhauser
Chair of Quality and Safety Committee

27 July 2016

East Sussex Healthcare NHS
NHS Trust

Quality and Standards Committee

Minutes of a meeting held on Thursday, 14th April 2016 at 2.30pm

In St Mary's Board Room, Eastbourne DGH

Present:
Mrs Sue Bernhauser, (Chair)
Mrs Jackie Churchward-Cardiff, Non-Executive Director designate
Dr Adrian Bull, Chief Executive Officer
Mrs Pauline Butterworth, Acting Chief Operating Officer
Mrs Janet Colvert, Ex-Officio Committee Member
Dr David Hughes, Medical Director
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary

In attendance:
Mr Ashley Parrott, Associate Director of Governance
Mrs Edel Cousins, Assistant Director of HR (Workforce Development)
Mrs Kim Novis, Equality & Human Rights Lead (for 4.7)
Mr Jonathan Palmer, Acting Chief Pharmacist (for 6.3)
Miss Leah Middleton, PA to Company Secretary & Improvement Director (minutes)
Mrs Karen Salt, PA to Director of Nursing (observer)

1.0 Welcome and Apologies for Absence

Mrs. Bernhauser welcomed participants to the Quality and Standards Committee meeting and confirmed that the meeting was quorate.

Mrs. Bernhauser noted apologies for absence had been received from:

Ms Sally Herne, Improvement Director
Mrs Moira Tenney, Deputy Director of Human Resources

Mrs Bernhauser expressed the Committee's appreciation to the outgoing Non-Executive Director (Chair) Mr Charles Ellis.

2.0 Patient Story

Mrs Webster explained to those attending that two ESHT colleagues (Jenny & Tracy) had participated in a video that told the story of their late father and their experience of care at the Trust.

The underlying theme in this case was poor communication leading to a lack of understanding for the family, and the impact this had on the patient and his family at the end of his life.

The full length version of Jenny & Tracy's story was shown (there was a shorter version available) and Mrs Webster explained that the DVD was being shown as part of the nurse induction programme and would be used in the next round of student nurse interviews. Work was ongoing with the Medical Education Department to formally include the DVD in the induction programme. This was a challenge due to the time pressures on the induction programme.

This was the second of a series of DVDs being used in teams, small groups, with students and on Dignity Day to understand how patients and their loved ones are affected by the care the Trust provides. The DVD was reported to have been very well received at Dignity Day. Mrs Webster noted that the learning from the DVD could be considerable leading to a better understanding of how to talk to patients and families. It reminded staff to explain situations carefully and ensure that the message had been received and understood.

It was noted that the DVD represented an impactful (and reusable) method of engagement.

Mrs Bernhauser asked that the Committee's thanks be passed to Jenny & Tracy for their participation in this important initiative.

3.0 Minutes and Matters Arising

3.1 Minutes of the Previous Meeting

The minutes of the meeting held on 12th January 2016 were considered and agreed as an accurate record.

3.2 Matters Arising

The action log was reviewed as follows:

Regulatory Compliance

Mrs. Wells advised that compliance with the statutory duty of candour had been added to the work-plan for consideration at the next meeting of the Committee.

RAG rating for Mandatory Training and Appraisal Compliance

Mrs Wells explained that there had been a discussion regarding the use of RAG rating (red, amber and green) and the Committee had indicated that Red and Green ratings would suffice. The HR team had indicated they wished the Amber rating to remain and this was noted.

Mrs Bernhauser noted that appraisals, and the quality of appraisers, had been discussed at Trust Board.

Terms of Reference
The Terms of Reference and work planner had been circulated. Mrs Wells, Mrs Bernhauser and Mrs Webster would meet to discuss and refine the documents, review the membership of the Committee to ensure appropriate representation.

Mrs Churchward-Cardiff sought clarification regarding the Patient Safety and Clinical Improvement Group and the reporting arrangements. It was noted that PSCIG had been disbanded and the governance structure was being reviewed and streamlined.

4.0 Compliance And Risk

4.1 Board Assurance Framework & High Level Risk Register

Mrs Wells tabled the Board Assurance Framework and high level risk register. It was noted that due to the change of date for the Quality and Standards meeting the Board Assurance Framework had already been presented to the Trust Board and Audit Committee. There were no additional comments on the document.

Focusing on the High Level Risk Register, Mrs Wells noted that Estates and Pharmacy had been asked to improve the descriptions and scorings of their risks to achieve consistency. The aim of the register was to highlight the high level risks to the organisation.

Following a discussion it was agreed that Mr Parrott would liaise with the Clinical Governance Team (Rae Joel) to look at delivering some training, across the organisation, to address inconsistencies in how risks were identified and recorded in the Register.

It was agreed that the High Level Risk Register should contain a document title for future meetings.

Mrs Churchward–Cardiff queried the fact that no progress appeared to have been made in over a year for some of the risks. Mr Parrott explained that all risks were now being discussed at Clinical Unit Assurance meetings

Discussion took place as to whether a trajectory arrow could be added to the risk register to show direction of the risk rating. Mrs Wells would look into the feasibility of this but it would be contingent on datix capability.

Action: Ashley Parrott to report back with recommendations once he had reviewed the register.

Action: To incorporate a trajectory arrow to indicate the direction a risk was taking and its' rating.

Mr Parrott highlighted concern around the plans in place for the 3rd item on the Risk Register, Legionella. Mrs Webster confirmed traces of Legionella had been found at the Conquest site and related to a single plant. A lengthy and complex piece of work was being undertaken to address this, which included the replacement of taps and levers. The Legionella risk was being monitored and worked through the estates and facilities unit with support from Public Health England and a water safety group was liaising with the Trust Infection Prevention and Control Team. Levels were reported as low, but it was still considered to be a risk for patients and patient safety.

The fluctuation in the grading was due to controls being put in place leading to reduced levels and then levels increasing again necessitating further controls.

4.2 **Quality Improvement Plan (QIP)**

Mrs Webster presented the update and advised that the QIP group met on a weekly basis and a report was considered at the Senior Leaders Forum which included Clinical Unit representation.

Mrs Webster summarised areas to be noted, focusing on the Trust's Governance Programme, PMO support, and the QIP.

Mrs Webster updated that the Improvement Sub-Committee was to start in May, chaired by Dr Adrian Bull, and would include other senior leaders from within the organisation, as well as patient representatives including Mrs Janet Colvert and Mrs Di Upton.

The aim of the new Sub-Committee would be to have oversight of the QIP and longer-term improvement plans. It was envisaged that the Sub-Committee would report in to the Quality and Standards Committee.

4.3 **Patient Safety & Quality Report**

Mr Parrott presented the report to the Committee noting an error in paragraph 2 relating to the harm rate (detail below). The report aimed to summarise the many areas of patient safety and quality for scrutiny by the Quality and Standards Committee. The report detailed patient safety, patient experience and clinical effectiveness. Mr Parrott invited the committee to review the report and its style

It was noted the ward / board dashboard would be aligned to this report.

Mr Parrott highlighted that the harm rate of 50% noted within the report should read 30%. The harm rate for January 2016 showed a rate of 66% unharmed with the national average being 71% unharmed. This indicated that more incidents were being reported with a lower harm rate.

In respect of complaints it was agreed that Ombudsman information should be contained within the report.

Mr. Parrot highlighted the Quality Account priorities for 2016/2017. A significant piece of work had been undertaken to develop the priorities, including aligning them with other programmes of work, staff input, surveys and a successful patient engagement event. The Committee was asked to approve the suggested priorities and to identify a lead, and secondary lead to help drive the programme.

The main focus was

- Sepsis pathway, and the Sepsis 6 standards;
- Reducing the transfer of patients for non-clinical reasons between 22.00 and 07.00;
- Improving medicines management and the administration of drugs;
- Improving the availability of outpatient appointments; and
- End of life care.

The Committee endorsed the proposed priorities.

4.4 **CQC Adult Inpatient 2015 Improvement Report**

Mr Parrott presented the report and highlighted the key areas where improvement was required:

- mixed sex accommodation;
- escalation and information before operation;
- information on discharge;

These were the main areas of low scoring - information on discharge and contact information had worsened since last year.

Areas of improvement included

- Sufficient nurses to care;
- Confidence in doctors;
- Pain control; and
- Respect and dignity.

It was also agreed that patient consent should be reviewed in light of the feedback in the report.

Action – Patient consent to be reviewed as part of the CQC inpatient actions (Ashley Parrott).

4.5 **Maternity Service Improvement Programme**

Mrs Webster presented the report advising more information regarding strategy would be available soon. One of the Trust's midwives had undertaken a piece of work to review models of care. This had involved talking to midwives and to 275 service users. In addition Catherine Ashton, Associate Director of Strategy, was working with the unit to help shape the strategy and develop a plan for a transformational change programme following a period of transition.

Mrs Webster further noted that a Leadership Development Programme was being offered to support Band 7s within the Clinical Unit.

There had been work undertaken around privacy and dignity and the management of information – all issues highlighted in the CQC report. Following, completion of building works the Unit had a handover room which supported patient privacy.

Mrs Bernhauser suggested that the Maternity Service should be invited back as a Clinical Unit, to present the vision and strategy.

Action – Maternity Services to present to the Committee/take part in a 'deep dive' at the July meeting

4.6 **Serious Incident Process and Complaints Process**

Mr Parrott proposed a new Patient Safety & Quality Group, to include doctors and consultants. The aim of the group would be to have oversight of Serious Incidents process and ensure the quality of reports, which would then be presented, to the Quality and Standards Committee for assurance.
The group would look at the trends and triangulation from incidents, complaints and claims. It would also review actions and how well learning was being shared across the organisation. Mr Parrott suggested that this group could feed into other working groups (sepsis, VTE etc.) to help with recovery programmes.

Dr Bull commended the current controls in place, but noted that there was a need to focus on the following three questions:

- How safe has the Trust been in the past?

- How safe are we today?

- How does the Trust know it is going to be safe next week?

It was agreed that Dr Bull, Mrs Bernhauser, Mr Parrott and Mrs Webster should discuss and work through this outside of Committee with a view to bringing it back to the Quality and Standards Committee.

Action: Meeting to be set up to look at the structures in relation to quality

Mr Parrott reported that the Clinical Governance Team was taking part in Root Cause Analysis training (delivered by an external facilitator) to aid their understanding of RCA as a process and to allow them to support Clinical Units with incident investigations. The Clinical Units would still own the investigation but the Governance Team would lead the investigation, write the report and support the Unit concerned.

The Committee noted and supported the proposal.

4.7 **Equality & Objectives & Interpreting**

Mrs Novis presented the report; highlighting that Interpreting services were currently being tendered. The process was in the final stage and following contract award a mobilisation plan would be rolled out.

Mrs Wells advised that this was positive for both staff and patients. The lack of awareness of equality and interpreting services had been an area of concern for the CQC.

Mrs Novis advised that under the Equality Act - Public Sector Equality duty, the Trust had a duty to find a minimum of one area that was not performing well and set a four year plan to improve. The Equality Objectives document submitted outlined four goals that had been identified.

In response to a question from Mrs Churchward-Cardiff regarding quality of interpreting services in the Trust; Mrs Novis confirmed that there were KPIs relating to the quality of interpreting services. All interpreting members of staff were required to be suitably qualified and appropriate checks were undertaken by the service providers.

Mrs Cousins suggested that page 15, objective 3 be amended to state that the Trust ‘aims’ to have BME for each panel, rather than ‘will’,

.

The need to improve the number of completed Equality Impact assessments

was noted.. The aim was 100% of all forms completed within four years with appropriate follow up and audit.

The Committee agreed the objectives and noted progress being made in Equality and Diversity.

5.0 Quality

5.1 External Visit Report

Mrs Wells presented the report noting the absence of forthcoming visits which were normally included.
Dr Bull added that the CQC had indicated the next inspection would be in the Autumn. Decisions around special measures would be made based on that inspection.

5.2 Annual Review of Risk Management

Mr Parrott presented the report, which had been updated from the original version with any changes highlighted in red. It was noted that regulation 17 should read 16.

5.3 Morbidity and Mortality

Mrs Bernhauser noted that the paper had been briefly discussed at the Trust Board meeting on the previous day and suggested that this area would be a useful topic for a deep dive discussion at a future Quality and Standards Committee meeting.

Dr Hughes confirmed that a successful Mortality Summit had taken place in early March 2016 and had included all the Clinical Units' management teams This had been teamed with a planning day, enabling some dissemination and a broader clinical engagement summit was planned for late May 2016. Following that summit Dr Hughes would bring a deep dive presentation to a future Quality and Standards Committee meeting.

Action – Mortality and Morbidity Deep Dive to be added to the workplan.

5.4 Infection Control Performance Report

Mrs Webster presented the report, which had been in draft at the time that papers were circulated.

The Trust ended the year with 42 cases of C-Diff. The Trust was in discussion with the CCG over whether the cases were attributable to lapses in

care.

MRSA cases numbered 4 and had been discussed at Trust Board the previous day

5.5 **Infection Control C. Diff Review**

Mrs Webster presented the report from the Trust Development Authority (TDA) who had been invited, along with the Maidstone and Tunbridge Wells (MTW) Head of Estates and Facilities; the Director of Infection and Prevention; and the Infection Control lead nurse from Surrey and Sussex Healthcare Trust (SASH); to review Infection Control at ESHT following a number of increases in cases at the Conquest site, specifically around surgery. The group also reviewed some of the medical wards. The TDA had made some recommendations following a previous visit and, noted that they had seen continued sustained improvement in the wards, but not in A&E or AAU. Mrs Webster reported that immediate action had been taken and the Trust continued to work with Estates and Facilities, and the CCG, to address issues.

6.0 **Sub Committee Minutes**

The Sub Committee minutes were noted with no actions arising.

6.1 **Minutes from the Trust Health and Safety Steering Group Meeting**

The Health and Safety Steering Group minutes were noted with no actions arising.

6.2 **Minutes of the Policy Group**

The Policy Group minutes were noted with no actions arising.

6.3 **Medicines Management Committee and Pharmacy Services**

The Medicines Management Committee and Pharmacy Services Group minutes were noted.

Following a low level of engagement with the Committee, James Wilkinson had taken over as Chair to provide medical leadership and input for this group.

Membership had been agreed through the Terms of Reference, work was being undertaken with the CCG to identify KPIs and challenging targets.

Underpinning this, the Medicines Management Committee had created a dashboard with KPIs, to demonstrate quality in medicines management and to provide assurance and support across the Trust.

There would also be Quarterly audits of medicines management from a pharmacy and nursing perspective It was agreed that Dr Bull, Mr Palmer, and Dr Wilkinson would have a separate meeting to consider, in more depth, the work Mr Palmer had done with a focus on medicines optimisation and using the link for more collaborative working.

8.0 **Deep Dive for next meeting: Mortality**

9.0 **Any other business**
There being no further business Mrs Bernhauser closed the meeting**.**

Date of the Next Meeting
Thursday 2nd June 2016
2.30pm – 4.30pm
Committee Room, Conquest Hospital

Quality and Standards Committee

Minutes of the Quality and Standards Committee Meeting

Thursday 2 June 2016
Committee Room, Conquest Hospital

Present: Mrs Sue Bernhauser, Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director designate
Mrs Pauline Butterworth, Acting Chief Operating Officer
Mrs Janet Colvert, Ex-Officio Committee Member
Dr David Hughes, Medical Director
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary

In attendance: Dr Adrian Bull, Chief Executive
Mrs Lesley Smith – for Item (Infection Control)
Mrs Angela Colosi – for Item (End of Life Care)
Mrs Edel Cousins, Assistant Director of HR
Mrs Karen Salt, PA to Director of Nursing (minutes)

1.0 Welcome and Apologies for Absence

Sue Bernhauser welcomed participants to the Quality and Standards Committee meeting and confirmed that the Committee was quorate.

Sue Bernhauser noted apologies for absence had been received from:

Ashley Parrott, Associate Director of Governance
Sally Herne, Improvement Director
James Wilkinson, Assistant Medical Director, Quality
Anne Wilson, Director of Infection Prevention and Control

2.0 Patient Story

Linking to the End of Life Care item on the agenda Alice Webster explained that she had received feedback on the new hospice at home service at St Michael's Hospice (Conquest) which operated 7 days per week, 8.00 am to 8.00 pm to facilitate discharge to home for those in the last few days, or few weeks of life, who otherwise would have to be admitted. A family had given permission for their family member's story to be told to the Committee. Following a referral from Acute Assessment Unit the patient had been expedited home and had passed away in the place of his choosing. Without this service it was unlikely that the patient would have been able to return home in the time he had. There were plans for a similar service linked to St Wilfred's (Eastbourne) but in the meantime a 24 hour telephone advice line had been introduced on the Eastbourne site.

Alice Webster then read a letter from the family of a patient who had spent time on the Irvine Unit at Bexhill, thanking the Unit for care received during the end of his life. The unit was described as 'an oasis of excellence'.

There was a discussion about how to celebrate such plaudits when this standard of care should be the norm, and many other teams were delivering to that standard.

Dr Simon Merritt was looking at how to use social media and short, snappy hashtags to do this without undermining the work of other hard working and committed teams.

3.0 **Minutes of the Previous Meeting**

Due to the late circulation of the minutes of the last meeting it was agreed that Lynette Wells would address issues of accuracy out of Committee and the minutes would be formally approved as a Chair's Action.

3.2 **Matters Arising and Action Log**

Action Log

QSC 1 (12 Jan 16) – Alice Webster reported that the investigation was still with the CCG and not yet closed. Action to remain open.

QSC 2 (12 Jan 16) - Deep Dive – It was agreed to invite Miranda Kavanagh for a deep dive later in the year (September meeting) once the People and Organisational Development Group was underway. Action to remain open.

QSC 3 (12 Jan 16) - Deep Dive – It was noted that policies had been identified as an issue by the CQC and it was agreed to schedule a Deep Dive on policies for the 20 Jul 16 meeting. Action to be closed.

QSC 4 (14 Apr 16) – Ashley Parrott not present, update held over to 20 July meeting.

QSC 5 (14 Apr 16) - The action for Item 4.4 of the 14 April 16 meeting – it was agreed that this action related to the High Level Risk Register, not the Board Assurance Framework and the action had been assigned to Ashley Parrott and not Lynette Wells. It was noted that the addition of a trajectory may not be possible with the programme that was in use but this was being investigated by Ashley Parrott.

QSC 6 (14 Apr 16) – Patient consent – this had been added. Action to be closed.

QSC 7 (14 Apr 16) - Maternity Deep Dive – timing to be agreed at 20 July meeting along with other Deep Dives.

QSC 8 (14 Apr 16) – Structures It was noted that the meeting had taken place and structures was on the agenda for the meeting. Action to be closed.

QSC 9 (14 Apr 16) – Mortality Deep Dive was on the agenda for the meeting. Action to be closed.

3.3 **Terms of Reference**

As a result of formation of the People and Organisational Development Committee revised Terms of Reference for the Quality and Standards Committee had been circulated.

It was felt that refreshed guidance was needed for those preparing and presenting papers. Cover sheets should give high level summaries and a clear indication of what the Committee was being asked to do. It was noted that presenters were expected to give only a brief overview which Committee members could then explore and challenge. The aim would be to make better use of the time of the Committee.

Comments on the Terms of Reference were invited and following a discussion it was noted that acronyms should be avoided. It was further agreed:

- To include 'Safety' in the section regarding the purpose of the Committee
- To change the title of the Committee to Quality and Safety Committee to better reflect its role. This would be in line with practice in other NHS organisations.

Action – 'Safety' to be added to the Purpose section of the Terms of Reference and circulated for comment (Lynette Wells)

Action – To propose to the Trust Board that the name of the Committee be amended to Quality and Safety Committee (Lynette Wells)

Action – Terms of Reference to be submitted for approval to the Trust Board (Lynette Wells)

4.1 **Board Assurance Framework and High Level Risk Register**

Lynette Wells presented the report noting that changes had been highlighted in red and some actions had been reviewed and refreshed.

Key points were:

- Patient Transport Services at red.
- Tenders had moved from green to amber due to a lack of workforce resource
- Vacant Chair/Chief Executive would be moved
- All items at red were ongoing and known about

Comments were received on the following:

Item 1.2.2 – The capital Programme had been restructured and there was no submission currently with the Integration Transformation Fund (ITF).

Item 1.2.4 – Adrian Bull suggested that this be more specific – for example noting colitis, COPD, sepsis.

Item 2.3 – Outcomes and Experience. – Clinical Units needed to demonstrate evidence by being more specific in reporting outcomes. This could then be incorporated into the ESHT 2020 document.

Action – Comments to be highlighted when presenting the Board Assurance Framework at the Trust Board meeting. (Lynette Wells)

There was a discussion about Objective 1 – Safe Care, and the global, over-arching vulnerability the Trust experienced in this area. While specific issues appeared on the risk register, there didn't appear to be a place for the over-arching group of risks, and they didn't appear on the Board Assurance Framework. The Committee felt it was, therefore, difficult to follow progress and demonstrate progress to auditors.

Clinical Unit risk registers were reviewed by senior leaders and performance reviews but this did not address the over-arching non-elective care pathway.

Action – An item relating to the over-arching non-elective care pathway to be added to the Board Assurance Framework (Lynette Wells and Pauline Butterworth)

High Level Risk Register

The risk register as a document needed to be improved and reduced in size.

There were a number of risks that had been added regarding estates, facilities and pharmacy. These needed to be worked through to ensure that they were on the register appropriately. There had been an issue around resource in the Governance Team to support the work but this was being addressed.

Ashley Parrott, on his return, would be working on addressing the training needs of those who added (and owned) risks on the register. The training would ensure that risks were added in a consistent way and with meaningful narrative.

Action – work to improve the quality of the risk register. (Ashley Parrott)

4.2 **Patient Transport Update**

Alice Webster presented the report outlining the background to the current issues. The Trust had put a number of measures in place to make sure that appropriate transport was in place, with the CCG supporting so that patients could be discharged. Elective work had been affected, particularly in April. The Trust's workforce was being impacted as they tried to manage the transport situation and fielding the increasing number of patient complaints.

The CCG had raised the issues as a level 2 investigation and was reviewing the contract detail and management with the assistance of TIAA. Coperforma had been tasked with responding to the Trust's patient complaints.

On 1 June Alice Webster had attended a Risk Seminar of CCGs and providers. Coperforma, the transport service provider, had been given a period of time to improve but the timeline for that had not been shared with the provider organisations.

There followed a discussion about the impact on the Trust. Alice Webster had asked for performance data to be split to reflect the impact on the Trust but had been told there was no resource to do so.

The issue presented a considerable risk to the organization and to patients.

It was agreed that as the CCG had agreed to refund transport costs there was value in using other, appropriate, forms of transport in the meantime. This would be relatively easy for discharge patients but less so for outpatient requirements.

The CCG would be notified that the Trust would follow this route for discharge patients and the Trust would retain documentary evidence for recharging. This involved a significant impact on workforce time, in particular for outpatient work.

Action – CCG to be notified of the Trust's plan to use other methods of transport and recharge.

Action – Alice Webster and Pauline Butterworth to confirm the operational ability to utilize alternative transport at a cost to the CCG.

Action – A formal letter to go from the Quality and Standards Committee Chair to the CCG Chair raising the Trust's concerns and seeking information on what mitigations were being put in place. The letter to be copied to Wendy Carberry, NHS Improvement, NHS England (Regional Director) and the Care Quality Commission

4.3 **Quality Improvement Programme (including ESHT 2020)**

Alice Webster presented the ESHT 2020 Improvement Programme update which had been developed from the Quality Improvement Plan. The ESHT 2020 Programme aimed to provide robust governance for all improvements linked to strategic objectives. The report contained highlights, milestones and Programme milestones with 4 rated as red.

Points to note were:

- The Evidence Based Care Project was red due to issues around audit compliance and would be investigated further.
- With regard to Secure Premises and Facilities Project, subsequent to the report being issued a provision had been made in the 17/18 Improvement Programme Budget to make some operational changes to address privacy and dignity.
- Strategic Priorities were due to be presented to the Trust Board.
- David Hughes would report on the Mortality Summit in the Deep Dive item.
- A Mock Inspection was scheduled for 22 and 23 June and work with staff was ongoing to prepare for this.

Significant Risks were noted as workforce and investment related.

The first meeting of the Improvement Sub-Committee had taken place and would

continue monthly, chaired by the Chief Executive. The aim was to ensure that there was focus on areas outside the Quality Improvement Plan and to support a tighter ESHT 2020 Programme Update. An improved version was expected to be available for the next meeting.

ESHT 2020 Strategic Priorities for Improvement

Adrian Bull presented this document which sought to set out a coherent framework for the organisation as a whole (including community services) and to provide a consistent set of Trust priorities. These priorities should then be reflected in the work of the Quality and Standards Committee, Senior Leadership Forum and in teams.

In 'Framing Our Work' (page 4) the Quality and Safety objective was the most relevant to the work of the Quality and Standards Committee.

The Committee was asked to consider the document, in particular the Quality and Safety objective, and identify what elements it would want to monitor through the year.

There would be a raft of metrics in the Clinical Unit Integrated Performance Review documentation and Ashley Parrott/Alice Webster were looking at identifying safety metrics.

The Quality Structure (page 20) outlined the governance structure. A number of the groups were looking at quality.

Action – Improvement Sub-Committee to be added to the structure and sent to Alison Prout for inclusion in the papers for Trust Board (Karen Salt).

Clinical Unit Integrated Performance Reviews (IPRs) were taking place monthly, chaired by the Chief Executive Officer and supported by the Executive Team. The reviews covered Safety, Finance, Operational Delivery and People. 7 groups fed into the Quality and Standards Committee but would also feed into the IPRs. Some areas had been combined but it had been agreed that the range of bodies was essential. The Clinical Outcomes Group would look at other elements in addition to Mortality. A new Patient Safety and Quality Group had been agreed to bring clinical governance together and develop/drive the safety strategy.

Risks –a number of key risks had been mapped and tied in with the Board Assurance Framework.

Recruitment had been highlighted as one of the most significant risks and a number of things were being done to address that. There was also a specific risk around children and young people with mental health issues

Capacity and Capability for Improvement outlined that improvement and transformation were essential to success. The Project Management Office and Improvement Sub-Committee would provide skills and techniques.

It was noted that there would need to be care over the naming of Quality and Safety Groups and Committees to avoid confusion.

Jackie Churchward-Cardiff reported that with reference to the statement regarding senior medical staff leading and observing (page 8 last column) the visibility of practitioners during the recent junior doctors' strike had resulted in excellent patient feedback.

Action – Quality Structure (page 20) to be amended to remove the word 'Steering'.(Karen Salt)

Action - 4th bullet point on page 14 to be reworded to say 'avoidable infections'. (Karen Salt to advise Alison Prout)

The Quality and Standards Committee **noted** the report and **agreed** that Quality and Safety agenda should be reflected in the work of the Committee going forward to demonstrate that improvements were being driven through.

4.4 **Patient Safety and Quality Report**

Alice Webster presented the report on behalf of Ashley Parrott, noting that in future it would be presented to the Patient Safety and Quality Group who would in turn report to the Quality and Standards Committee.

Key points were noted as follows:

- The Trust reported a high level of incidents that included severity 1 and 2. It was proposed to close severity 1s and 2s on the system as a batch.
- The Weekly Patient Safety Summit had, since November 2015, been looking at all severity 3, 4 and 5 incidents.
- A large number of incidents related to the patient transport issue.

National Safety Standards for Invasive Procedures (NatSSIPs). There was a discussion about clinical resource to conduct a piece of work relating to NatSSIP which had a deadline of September 2016. A radiologist had been identified who could to the work but clinical support would be needed as well. It was noted that anyone supporting the work would need to be backfilled.

Lynette Wells noted that the National Clinical Audit on diabetes was not normally completed by the Trust due to software issues. There was, however, concern that the Trust had not participated in the National Diabetes Pregnancy Audit due to resource issues. This represented non-compliance that was notifiable to commissioners and the CQC. It had not been raised at the Audit Committee.

Action – Alice Webster to check whether this was raised at the CQRG meeting.

The Friends and Family Test response rate, valued by the CQC as a measure, was noted to be low across the Trust, with inpatient rates generally higher than outpatient.

Patient groups had changed and other Trusts were struggling with response rates but it was agreed that there needed to be a push to get this right.

Other points noted were:

- District Nursing teams experienced even greater difficulty with response rates.
- The included criteria had changed for inpatients and appeared to reflect a large reduction in responses.
- The FFT had to be completed within a tight 12 hour window which was part of the issue.

It was agreed that it would be appropriate to aim for a more manageable 20% response rate and take that objective back to the ward teams.

4.5 **CREWS Reviews Update**

Alice Webster gave a verbal update on behalf of Hilary White, noting that the CREWS reviews had changed slightly. They were conducting specific reviews in multiple areas, for example a focus on specific issues such as medicines management. There were brief feedback reports identifying:

- mixed sex breaches in relation to toilets and signage.
- Medicines Management - IV fluids were all in lockable cupboards.
- Controlled Drugs books - 4 omissions in the previous 28 days.

The reviews would continue on a twice per month basis.

Projects were identified via staff reporting of incidents and the frequency of those incidents.

Action – Report to be circulated with the minutes of the meeting. (Karen Salt).

4.6 **Deep Dive – Mortality**

David Hughes presented the Mortality Reduction Project outlining that with the help of NHS Improvement there had been a move to refocus on what needed to be done to reduce preventable deaths, reduce harm. This would join up with End of Life work in the community.

There had been a Board Seminar, educational events with James Wilkinson, and then a clinical summit of 50 staff including the Chair and Chief Executive of the Trust. There had been a lot of enthusiasm at the summit relating to patient flow and getting patients to the right place quickly.

Specific Project Management Team support would be needed to get the project up and running.

It was agreed that the Mortality Group needed to focus on the co-ordination of mortality activities and report progress back to the Quality and Standards Committee. Standards of hospital safety at night and 7 day working sat more appropriately with the Clinical Effectiveness Group.

Action – progress report to come from Improvement Sub-Committee defining the Mortality Group responsibilities.

5.1 **Annual Complaints Report**

Alice Webster presented the report and highlighted that PALS enquiries were increasing (5668 to 8446) but with no increase in staffing. Conversion rates to complaints were low. Some complaints had not been resolved to the complainants' satisfaction.

Jackie Churchward-Cardiff noted that the themes were, in the main, the same as or similar to those reported in 2014/15.

There were no further comments.

5.2 **Duty of Candour Assurance Review**

Comments were invited on the initial Duty of Candour Assurance Review. There were issues with evidencing compliance and the use of correct templates. These were all being addressed through a programme of training to ensure that all those engaged in the process were aware of their obligations. A further audit was planned for April 2016 to June 2016 when improvements would be expected.

Action – Heads of Nursing, General Managers and Clinical Unit leads to be reminded of the process and Trust templates. (Ashley Parrott).

Action – Re-Audit to be presented at the 20 July meeting. (Ashley Parrott).

5.3 **Infection Control Report**

Lesley Smith presented the report noting highlights as follows:

- Appendix 1 summarised a findings of the Post Infection Reviews (PIRs) of 4 cases of MRSA diagnosed earlier in Quarters 1 & 2 at EDGH. All were considered to be avoidable.
- 1 case of MRSA was community acquired with no action for the Trust. .
- Dr Anne Wilson appointed new Director for Infection Prevention and Control.
- Legionella - a water safety meeting had taken place on 2 June and Public Health England specialists were reported to be satisfied with the remedial measures taken so far. They had offered suggestions for further remedial works.
- 3 Serious Incidents had been reported in Q4.

The Infection Control Team was commended for the improved report.

5.4 **Annual Quality Account**

Alice Webster presented the draft Quality Account noting that it was a standard document, with legislation dictating the content and format. The following elements had been received and were due to be added to the Quality Account:

- Statement from the Chief Executive
- Comments from the CCG

Photos would be added to the final version and it would be reformatted ready for uploading to the website. There would also be a summary document available for members of the public.

Positive comments and support for the chosen priorities had been received from the Health Overview and Scrutiny Committee (HOSC) and HealthWatch. Members of the Committee were asked to feedback comments to Emma Tate noting that there was a short window of opportunity for this

There was a comment about the section on page 15 **'What will success look like?'** and in particular the percentage (70%) of discharge letters that would be reviewed for accuracy by pharmacy. This suggested that 30% would not be reviewed.

Action – Alice Webster to check the percentages are accurate.

5.5 **End of Life Care Strategy**

Angela Colosi presented the report noting that this version 2 of the strategy was still in draft and would need further revision. The Strategy was out for consultation with stakeholders and positive feedback had been received. There was a considerable amount of work to do at pace in order to improve the Trust's CQC rating.

The Strategy included local information from the Joint Strategic Needs Analysis (JSNA) and other data.

The Strategy was underpinned by an extensive implementation plan.

Further activities were planned as follows:

- The draft End of Life Care plan would be sent out for consultation
- Drop in sessions to publicise the strategy
- First EOLC Steering Group meeting scheduled for 4 July 2016
- Further work to be done to engage external organisations
- Dr Mark Barnes and Dr Kay Muir to ascertain how frailty work streams could be woven in.

Jackie Chur ward-Cardiff that it would be helpful to have conversations with patients earlier, not at end of life and it was agreed that the Vulnerable Patient Scheme was one way of working towards that.

The Strategy was being presented to the Trust Board for approval and members were asked to submit comments to Angela Colosi as soon as possible. The Committee commended the work done so far.

Annual Review of Effectiveness and Draft Quality and Standards Committee Annual Review

5.6

The Committee noted the contents of the report without further comment.

6.1 **Sub-Committee Minutes – HSSG – 18 Mar 16**

A number of issues had been looked at including infection control management of legionella and waste management disposal. No questions arose from the minutes.

6.2 **Sub-Committee Minutes – TICG – 18 Mar 16**

It was noted that a new Director for Infection Prevention and Control (DIPC) had been appointed – Dr Anne Wilson – and thanks were extended to Dr David Hughes for taking on the role of DIPC in the interim.

It was further noted that the MRSA policy had been completed. No questions arose from the minutes.

7.0 **Any Other Business**

Adrian Bull suggested that for the next meeting it would be helpful to have a clearer statement of the work programme for the year for the Clinical Outcomes Group and Clinical Effectiveness Group. This would give assurance that the groups were addressing the work that the Committee wanted addressed.

Action – Clinical Outcomes Group and Clinical Effectiveness Group work programmes to be clearer.

There was no other business.

8.0 **Deep Dive Topic for next meeting.**

As noted in Item 3 on the agenda, Policies was agreed as the next topic for a deep dive.

9.0 **Date of the Next Meeting**

20 July 2016, EDGH - Apologies were noted from Alice Webster.

Quality and Safety Committee
Terms of Reference

1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Quality and Safety 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

Safe patient care is our highest priority and there is a commitment to provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients. The main duties of the Committee are to ensure, on behalf of the Board, that taking account of best practice

- there are effective structures and systems in place that support delivery of safe patient care and continuous improvement of quality services. as outlined in the ESHT 2020 strategy.

- that quality of decisions and effective decision making is based on information from robust systems and processes that are used effectively across the organisation in a culture that supports challenge, scrutiny and learning.

- that where risks and issues in respect of quality are identified these are being managed in a controlled and timely way.

- that staff are supported to speak up and be innovative and ideas focused to achieve excellent outcomes.

3. Responsibilities

Seek assurance that patients, staff and other key stakeholders are actively and effectively engaged in quality and safety issues and that the mechanisms for seeking and responding to feedback from staff and patients are robust and effective

Seek assurance that effective management processes are in place that ensure the Trust has taken appropriate action and shared learning in response to relevant national and local reports, guidance and reviews to improve the safety and quality of care

Review the risk register and BAF to identify relevant quality and safety risks and seek assurance that appropriate management action has been taken to

manage and mitigate these risks. Reporting any gaps in control or assurance to the Board

Seek assurance that the Trust's 2020 Quality Improvement Programme addresses key areas of concern and risk and is being delivered in a timely way and that there is an evidence base for the effectiveness of the plan and the delivery of the required quality improvements

Seek assurance that action is being taken to ensure compliance with regulatory and statutory standards and national best practice and guidance in respect to quality and safety. This will include scrutinising any concerns or adverse findings and monitoring actions taken by management to address these, for example mortality outlier alerts Identify gaps in control and assurance and report these to the Board.

Review themes and trends that occur in patient and staff feedback, findings from quality walks, patient safety and quality data, clinical audit, complaints, patient safety and serious incidents. Seek assurance that learning from incidents has been shared across the organisation and that actions required to deliver improvements are captured in the Quality Improvement plan and are delivered in a timely manner resulting in agreed and measurable improvements in quality and safety.

To support the work of the Trust's Audit Committee, receiving the outcomes of clinical audit.

Monitor the Trust's Quality Accounts and ensure effective consultation with stakeholders takes place and to monitor the delivery of the quality targets.

Review the Trust's quality performance metrics to seek assurance that areas of underperformance are identified and that appropriate quality improvements actions are taken to deliver the measurable improvements required

To monitor and review the systems and processes in place in the Trust in relation to Infection Control and to review progress against identified risks to reducing hospital acquired infections.

Receive reports and assurances (including those from internal and external audit) that the Trust's Quality Governance strategy is being effectively operated and agree any amendments to the strategy prior to recommending these to the Board for approval.

Monitor the programme of external visits and reviews and have oversight of the progress in implementing actions and shared learning. To receive a highlight report from groups that report into the Committee; the Improvement Sub Committee, Health and Safety, Medicines Optimisation, Infection Prevention and Control, Patient Safety and Quality, Clinical Effectiveness and Clinical Outcomes.

Membership and Attendance

The Committee and the Committee Chair will be appointed by the Chairman of the Trust Board. Members of the Committee shall be:

- Two Non-Executive Directors one of whom will be the Committee Chair
- Chief Operating Officer
- Medical Director
- Director of Nursing
- Chair of Clinical Governance Group
- Chair of Trust Infection Control Group
- Director of Corporate Affairs
- Associate Director of Governance
- HR Representation
- Assistant Medical Director - Quality
- Associate Director Knowledge Management
- Ex-Officio Members, numbers to be determined by the Committee and to include patient representation.

  Note: Ex-officio members of the Committee will have the same rights and privileges as do all other members, although this excludes the right to vote

Membership may be extended to support the Committee in the discharge of its duties this may include for example inviting Clinical Unit representatives or Associate Directors of Nursing to attend relevant meetings.

Members of the Trust Board not specified as members of the Committee shall have the right of attendance. The Secretary to the Committee shall circulate minutes of the meetings of the Committee to all members of the Trust Board.

4. Quorum

Quorum of the Committee shall be four members at least one of which must be a non-executive director. Fully briefed deputies should be sent in the absence of a core member and will count towards the quorum.

5. 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.

6. Authority

The Committee is authorised by the Trust Board to review any activity within its Terms of Reference. It is authorised to seek any information it requires

from any employee and all employers are directed to cooperate with any requests made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee may establish sub-committees or working groups if this would support it in achieving its objectives.

7. Reporting arrangements

Minutes of the Committee meetings shall be formally recorded by the Secretary to the Committee and submitted to the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

The Committee will report to the Board annually on its work in support of the statement on internal control and by exception as and when necessary.

The Committee shall undertake a self-assessment of its effectiveness annually. The Company Secretary will support the Committee to develop and implement an annual work programme

These Terms of Reference shall be reviewed by the Committee and proposed revisions considered by the Trust Board on at least an annual basis.

East Sussex Healthcare NHS Trust

Date of Meeting:	3 August 2016
Meeting:	Trust Board
Agenda item:	7
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

Purpose:

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

Introduction:

The Assurance Framework has been reviewed and updated since the last meeting of the Committee and following discussion at the Board Seminar on 6 July.

The BAF clearly demonstrates whether the gap in control or assurance remains unchanged, has increased or decreased since the last iteration. There are clear actions against identified gaps in control and assurance and these are individually RAG rated.

Updates are clearly shown in red text. The attached risk register provides an overview of the high level risks facing the organisation and mitigating actions.

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

The 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.

An additional gap in assurance has been added on page 6. 2.22 to highlight the greater focus required on developing clinical leadership.

There are 3 areas rated red:
Pg 4 – 2.12 Emergency department reconfiguration
Pg 5 – 2.14 Mortality (there was a proposal to move this to amber but the Committee's considered that it should remain red until there was greater assurance)
Pg 8 – 3.31 Patient transport
Pg 10 – 4.11 Finance

Benefits:

Identifying the principle strategic risks to the organisation allows the Committee to provide 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.

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

Consideration by other Committees
Audit Committee/Quality and Standards Committee 20 July 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 identified.

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

Assurance Framework - Key

RAG RATING:

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

Status:

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

Key:	
Chief Executive	CEO
Chief Operating Officer	COO
Director of Nursing	DN
Director of Finance	DF
Director of Human Resources	HRD
Director of Strategy	DS
Medical Director	MD

Committee:	
Finance and Investment Committee	F&I
Quality and Standards Committee	Q&S
Audit Committee	AC
Senior Leaders Forum	SLF

C indicated Gap in control
A indicates Gap in assurance

	Strategic Objectives:
1.	Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
2.	All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.
3.	We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.
4.	We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.
5.	We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.
	Risks:
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.
2.1	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.
2.2	There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.
3.1	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.
3.2	We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.
3.3	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
4.1	We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.
4.2	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.
4.3	We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.
4.4	We are unable to effectively recruit our workforce and to positively engage with staff at all levels.
5.1	If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.
5.2	

Board Assurance Framework - July 2016

Strategic Objective 1: Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients							
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 Effective processes in place to manage and monitor safe staffing levels PMO function supporting quality improvement programme iFIT introduced to track and monitor health records EDM implementation plan being developed Comprehensive quality improvement plan in place with forward trajectory of progress against actions.				
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 Deep dives into QIP areas such as staff engagement, mortality and medicines management				
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	March CQC inspection reports published Sept 15, trust in special measures. Quality Improvement plan developed Improvement Director working with the Trust. Mar-16 In depth review of all warning notice actions by exec team . QIP monitored by stakeholders, medicines management and incident deep dive took place Mar-16. May-16 2020 Quality Improvement Priorities agreed and key metrics developed to support compliance and monitoring. Commenced preparation for Autumn CQC inspection. Jul-16 Mock inspection took place end June, further mock planned end of July. Continued monitoring of QIP and preparation for CQC inspection.	end Oct-16	◄►	DN	Q&S SLF
1.1.2	C	In order to deliver an effective service, there is a requirement to improve controls in Health Records; to encompass systems and processes, storage capacity and quality of case note folders.	Oct-15 iFIT embedding with rolling improvement programme. Mitigating actions continue and extended to provide daily information re availability of notes. New escalation procedure for missing notes. Centralisation of Health Records and records management structure reviewed. Dec-15 Ongoing programme of work to support effective delivery of health records service monitored by SLF. Consultation taking place re health records structure. Mar 16 - Significant reduction in missing notes, positive feedback from clinicians.. Storage remains challenging but is being addressed through the development of an off-site facility. Repairs continue but ultimate solution is the EDM programme. May-16 Marked improvement in the availability of records. Progressing offsite record storage.	end Dec-16	◄►	COO	Q&S SLF

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.

Risk 2.1 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) processes and monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Cleaning controls in place and hand hygiene audited. Bare below the elbow policy in place Monthly audit of national cleaning standards Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure Cancer metric monitoring tool developed and trajectories for delivery identified, part of Trust Board performance report.
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.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls required to support the delivery of cancer metrics and ability to respond to demand and patient choice.	IST review to supplement work with KSS Cancer network on pathway management. Focused piece of work taking pace to initially cover 2ww performance position. Alterations to the set-up of the 2WW booking team and their processes are being implemented in order to improve performance. Mar-16 - Achieved 2WW breast symptomatic in Jan and both standards in Feb. In addition, TDA support provided 2 days per week to focus on sustainability and 62 day achievement. May-16 Ongoing review and strengthened processes supporting improved performance against cancer metrics. 2WW achieved Feb and Mar, breast symptomatic not achieved Mar, 62 days improving. Jul-16 Achieved 2 week wait and 31 day standard for last quarter. Clinically led Cancer Partnership Board commenced June . Cancer Action Plan providing continued improvements such as the reduction on 2 week wait triage delays. Number of actions in place to support progress in 62 day achievement.	end Oct-16	◄►	COO	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.1.2	C	Emergency departments require reconfiguration to support effective 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 for review to support expansion; outcome awaited, planning permission being sought in advance. Dec-15 Capital bid to be considered by ITFF at end of Feb. Mar-16 AHSN developing proposal to support the Trust with patient flow in A&E areas which will have a positive impact on privacy and dignity. Risk remains red as reconfiguration still required. May-16 Finance application being redeveloped for submission to ITFF to support capital plans. Jul-16 Trust prioritising reconfigurations from own capital programme to support effective patient pathways and address privacy and dignity issues. Finance application being redeveloped for ITFF.	end Dec-16	◄►	COO	SLF
2.1.3	A	Assurance is required that there are effective systems in place to minimise infection control incidents and share learning throughout the organisation.	Jun-Dec 15 Audit cleaning team strengthened. Infection control team being restructured, to increase management of audit / assurance process. Weekly walks round both sites with facilities and IC to review areas highlighted by the auditors as 'areas of risk'. NSC increased number of auditors and audits scrutinised at Accountability Reviews. Continued review and shared learning. Infection control deep dive at Jan Q&S committee. Mar-16 External assurance visits via CCG, TDA and External DIPC, Head of Estates and IC Lead. Awaiting report immediate action required in 2 out of 6 areas following one visit. Nothing further identified in remaining assurance visits form the CCG. Control dashboard being developed and planned to be part of the accountability review meetings. Single comprehensive action plan and annual programme of work being developed for April 2016. Assurance moved from Green to Amber. May-16 Bare below the elbows policy implemented in all clinical and ward areas. Increased compliance with national cleaning specification standards. Jul-16 Further work required to ensure BBE policy is embedded. Increased numbers of C Diff on EDGH site being closely monitored with support from CCG and NHS Imp. Talent work working with the Infection control team to manage the cultural change element of the embedding IC into practice	end Aug-16	◄►	DN	Q&S

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.							
Risk 2.1 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**
2.1.4	A	Mortality levels above expected range and assurance is required that there are robust mechanisms in place to understand the metrics and implement best practice.	Mar-16 Focussed action plan being developed. Identified top 10 drivers for elevated indices and reviewing pathways for cause in these groups. Internal mortality summit planned April 2016. Mortality Overview Group in place and additional governance review of deaths using data from the Bereavement Office. Peer review and support being accessed. May-16 Mortality meeting held with clinicians 20 May. Weekly review of deaths undertaken by consultant and senior coder. Work underway to understand further co-morbidity profile of our patients. A number of clinical pathway reviews in place to reduce risks eg colitis, deteriorating patient, gastroenterology. Jul-16 Mortality Improvement project expanded to incorporate AKI, Pneumonia, Sepsis. Project manager (full time) for mortality improvement project interviews being held in July.	end Jul-16	◄►	MD	Q&S
2.1.5	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 to Oct-15 Action plan implemented and waiting list backlog cleared. Patient Tracking List developed and activity being monitored. i Dec-15 Business Case (BC) and PTL considered Dec. Further updates to the BC and PTL will be reviewed at Jan meeting. Mar-16 CCG reviewed community paediatric business case, negotiations taking place. Following approval of business case substantive recruitment will take place to reduce the reliance on locums. Date moved to Sept to recognise recruitment timeframe. May-16 – Implementation timeframe of the recruitment plan is currently worked up. This will allow the service to build a recovery trajectory to reduce the waiting time and list size. Jul-16 Wait time to be seen reduced to 6 months for initial community paediatrician assessment. Active recruitment for CDC coordinator and 2 substantive consultant posts. 2 locum consultants start 4th July. Further part time locum consultant starting Aug.	end Sept-16	◄►	COO	SLF Q&S
2.1.6	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 CAMHS for ward nurses to ensure a competent and confident workforce. Mental health nurse requested via TWS to special the young people Reviewing options for cohorting mental health young people. Liaising with SPT and commissioners re purchasing adequate tier 4 beds. Oct-15-Mar 16 Creating amenity beds and liaising with SPT on a case by case basis for CAMHS patients. Joint working with SPT, CAMHS recruiting assessor to support appropriate pathway for these young people. Continued working with CAMHS and SPT to develop pathway. May-16 A& E Liaison Nurse appointed to Conquest, equivalent being recruited to DGH. HoN requested in-reach pathway from CAMHS for these pts and daily ward visit. HoN attending urgent help/crisis meeting care and attending CAMHS transformation board to raise profile of young people in crisis with commissioners and gain adequate investment for this cohort. Jul-16 Out of hours urgent help service increased weekend capacity from 2 to 4 staff. Business case submitted to CCG to increase workforce to meet the need of CYP in crisis. Awaiting decision. Meeting to be held 8th July to review the A& E Liaison Nurse at Conquest role.	end Jul-16	◄►	COO	SLF Q&S

Risk 2.2 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 SLF 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 Mandatory training passport and e-assessments to support competency based local training Additional mandatory sessions and bespoke training on request
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 Significant and sustained improvement in appraisal and mandatory training rates

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.2.1	A	Assurance is required that robust controls are in place in relation to mandatory training and appraisals are effective and evidenced by improved compliance in these two areas.	Mar 16 - Appraisal process and paperwork redesigned along with a development programme for Appraisers. New L&D manager started in Feb and key objectives to review mandatory training, develop competency work and identify further efficiencies. Rating moved from amber to green. May-16. Compliance trend for mandatory training and appraisals continues towards the 90% target. To support appraisal, Engaging for Development Masterclasses have been planned to run in June and July. Revised paperwork for Appraisal is currently will be launched in July 2016. Jul-16 Mandatory training and appraisal trend continues upwards - continued support of CUs and departments to maintain compliance. Development Masterclasses well attended. Reviewing best practice in other organisations to consider automated mandatory training booking. DNA levels for training being reviewed.		◄► Mar-16	HRD	POD SLF
2.2.2	A	The Trust needs to develop and support its clinical leadership to empower them to lead quality improvement in order to realise the ambition of becoming an outstanding organisation by 2020.	Jul-16 Reviewing medical leadership roles to ensure they are appropriately resourced. Faculty of Medical Leadership Programme in place. CEO leading regular meetings with consultant body. Medical education team continue to work with junior doctors to improve engagement and enhanced support. New Medical Director appointment (subject to central approval) Revision and reappointment of all key medical role job descriptions: CU Lead; Speciality Lead; Chairs of Clinical Boards (urgent care, elective, cancer); Chairs and ToR of key Medical Clinical Governance sub committees.	end Mar-17	NEW	MD	POD

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.	
Risk 3.1 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.	
Risk 3.2 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 effective relationships with commissioners and regulators Proactive engagement in STP and ESBT 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 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	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 East Sussex 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 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**
3.2.1	A	Assurance is required 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 developing clinical strategy. Dec-15 ESBT work continues. Board to Board meeting with Eastbourne, Hastings and Rother CCG took place Dec15. Mar-16 SPT footprint agreed. Trust to work with stakeholders to develop strategic plans. Board Seminar planned April 16. May-16 Trust fully engaged with SPT and East Sussex Better Together programmes. Trust strategy being developed and “stakes in the ground” identified. Priority specialities for clinical strategy development identified and specific work commenced Jul-16 Continuing to work closely with commissioners on aligning ESBT plans with the emerging clinical strategy. Multiple integrated strategic planning workstreams underway and recruiting to better support the planning process.	end Dec 16	◄►	DS	F&I SLF

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.	
Risk 3.3 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**
3.3.1	A	Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience.	Incidents logged, issues escalated to SECAMB /CCG. Service spec reviewed by commissioner; Trust engaging with process. Apr-15 Inpatients - Trust has access to additional vehicles via Elite. Issue remains with outpatients. . Oct-15 Tender for service to be awarded end Oct with April implementation date. Will work with CCG and new provider to support improvement. Mar-16 New provider in place, managed service contract. Working with provider to ensure effective transition from SECAMB. Effectiveness of service will be monitored. May-16 Following handover to new provider there have been significant service problems impacting on patient care and experience. In addition there has been an increase in DNA rates and loss of procedure time due to failure to collect patients and late arrivals. There is an operational group in place, monitoring of incidents and this has been escalated both internally and externally. All Trust in Sussex are experiencing the same issues and there is a CEO summit w/c 31.5.16 Jul-16 Some improvement on inward bound journeys but still subject to weekly monitoring across Sussex both at operational and strategic level. Independent review of procurement and transition underway by TIAA.	end Jul-16	◄► May-16	COO	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.2	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Shortage of staff in appointment and admissions booking teams 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 -Dec15 Close liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard. Reviewed processes to minimise short notice clinic cancellation and ensure appropriate clinical assessment of affected patients. New call management system introduced to address technical and resource issues in appointments centre/provide enhanced service Review of 700+ letter templates underway to improve patient communication. SOPs and specialty booking rules agreed and implemented. March 16 – 80% referrals registered within 48hrs of receipt, scanned on to e searcher to minimise paper referrals going missing. First specialty about to go live with e referral system, continued roll out through 16/17. Staff capacity/demand remains an issue and is being addressed through business planning. Planning to develop some self- service check in facilities in 16/17 May-16 Business Case for Clinic Manager and Self-Serve check in underway with PMO and IT. New structure with additional resources for OP booking to support retention of staff due for implementation by end of July 16. Informal staff engagement underway. Jul-16 Progressing with new structure but will require formal consultation to extend operational hours, improving access for patients, which is primary cause of complaints. Clinic Manager business case to be submitted to BDG in July.	end Aug-16	◄►	COO	SLF Q&S

Strategic Objective 4: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.	
Risk 4.1 We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.	
Key controls	Clinical strategy development informed by commissioning intentions, with involvement of CCGs and stakeholders QIPP delivery managed through Trust governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work Modelling of impact of service changes and consequences Monthly monitoring of income and expenditure Accountability reviews in place
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Written reports to SLF 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**
4.1.1	C	Require evidence to ensure achievement of the 2016/17 Financial Plan and prevent crystallisation of risks as follows: activity and income targets are not achieved; contractual fines and penalties are levied; activity, capacity and unplanned cost pressures arise; the CIP plan is not delivered;	PBR contract in place. Activity and delivery of CIPs regularly managed and monitored. Monthly accountability reviews in place and remedial action undertaken where necessary. Timely reporting of finance/activity/workforce performance in place. Regular reviews by BPSG, CLT, SLF, Finance & Investment Committee and Board. May-16 – Month 1 performance £0.5m adverse to plan. CIP plan for month achieved. Income broadly in line with plan; non-elective over performance offsetting elective shortfall arising from doctors' strike. Fines and penalties incurred – Trust will discuss with commissioners reinvestment of these. Pay costs in line with plan with a significant reduction in agency costs. Capacity cost pressures incurred – Trust will recover some of these through Tariff while premium cost of delivery to be discussed with commissioners. Integrated performance meetings in place, chaired by the CEO; continuing oversight by F&I Committee; Efficiency Improvement Group driving financial improvement, including opportunities from Lord Carter review. Jul-16 - Month 2 performance remains adverse to plan, although CIP plan for the month achieved and agency spend reducing. Income is slightly behind plan, but elective activity both behind plan and incurring 'send away' costs. Emergency activity ahead of plan, but associated costs also above plan. Recovery plan for elective and emergency activity under development for Improvement Board (Jul-16) and discussion with CCG. Fines and Penalties risk reduced due to agreement on S&F funding and refreshed control total, but increased CIP target. DoF refreshing CIP development and implementation process, and reviewing detail of temporary staffing spend plans. Risk will require consistent monitoring over remainder of financial year.	Commenced and on-going review and monitoring to end Mar-17	◄►	DF	F&I

Risk 4.2 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 Essential work prioritised within Estates, IT and medical equipment plans
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. Trust achieved its CRL in 2015/16

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.2.1	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.	May-16 – Capital programme has been submitted to NHSI as part of the 2016/17 business planning submission. The Trust Board will undertake a further review the capital programme with a view to ensuring that priorities for spend are correct within the limited funds available, including any urgent elements from the Estates Strategy. The Board will also look at medium term priorities to help shape a business case to the Department of Health for a capital loan to support requirements over and above 'core' capital funding. Jul-16 - 5 year capital plan agreed by FIC and reviewed in Board Seminar. Discussions opened with NHSI around submission of capital bid, with £5m initial amount included in refreshed submitted plan. DoF reviewing internal capacity to develop FBC for submission in Q£ for £35m, and interim bid, in partnership with DoN, in Q2. Finance and Estates teams reviewing alternative sources for finance for discussion in September 2016 FIC.	On-going review and monitoring to end Mar-17	◄►	DF	F&I

Strategic Objective 4: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.							
Risk 4.3: 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**
4.3.1	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. Dec-15 Estates strategy reviewed by Board, further engagement session planned. Mar-16 Estates strategy will be considered at May Board seminar. May-16 Producing clear statement of agreed capital programme for 16/17 and a forward five year plan for capital and estates development projects to support clinical strategy. This will be the basis of the bid for additional (PDC) funding. Jul-16 Capital programme reviewed at Board Seminar July 16.	end Sep-16	◄►	COO	F&I SLF

Risk 4.4 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
4.4.1	A	In order to retain and develop services the trust requires the capacity and capability to effectively respond to tenders. Specialist skills are required to support Any Qualified Provider and tendering exercises by commissioners.	Oct-15 Portfolio moved to DF and being reviewed. Dec 15 - additional external resource has been commissioned by the Trust for a limited period with a specific objective of knowledge transfer. Mar-16 as above Trust successful in Sexual Health Tender. May-16 Business planning team dispersed to support other projects, support required for tendering exercises will form part of portfolio of Director of Strategy. Assurance level moved from Green to Amber. Jul-16 - Trust recruiting for Business Development team, with specific focus on building support for tender planning and submission. DoF reviewing with DoS the forward Commercial Strategy for Trust, including alignment with Clinical Strategy development.	end Jun-16	◀ ▶ May-16	DF	SLF

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.	
Risk 5.1 We are unable to effectively recruit our workforce and to positively engage with staff at all levels.	
Key controls	Workforce strategy approved Jun-15 - aligns workforce plans with strategic direction and other delivery plans; - ensures a link between workforce planning and quality measures Recruitment and Retention Strategy approved Jun-15 with planned ongoing monitoring Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data (plans to include vacancies) Rolling recruitment programme Monthly vacancy report and weekly recruitment report to CLT Nursing establishment and skill mix review undertaken and monitored by Board TRAC recruitment tool in place
Positive assurances	Training and resources for staff development Workforce planning aligned to strategic development and support Workforce assurance quarterly meetings with CCGs Implementing Values Based Recruitment and supported training programme Success with some 'hard to recruit to' posts Well functioning Temporary Workforce Service. Full participation in HEKSS Education commissioning process.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
5.1.1	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.	May-16 Recruitment hotspots are Medical Consultants, A&E, Histopathology, Stroke, Gastroenterology, Other areas of focus are Dermatology, Obstetrics, Neurology, Haematology Paediatrics Middle Grades – A&E, Geriatrics, followed by Gastro and Orthodontics. Task and finish groups with CUs to develop a recruitment and retention strategy which includes skill mix review, international recruitment. Use of head hunters to identify suitable candidates. Registered Nurses – there has been an increase in establishment which has resulted in the vacancy rate increasing for registered nurses for this staff group. This will continue to be addressed through a combination of on-going international and overseas recruitment and newly qualified and UK recruitment. It is anticipated that a fill rate for Registered Nurses will be 93% by April 2017, and 97% by April 2018 Reviewing current recruitment marketing strategy and developing new literature and addition to the corporate website to promote ESHT as a place to work. Jul-16 Developing Trust competence and pay grade for junior doctors which will be an extension to the current specialty doctor posts.	end Dec-16	◄►	HRD	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
5.1.2	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.	May-16 Values Based recruitment has been introduced for all newly qualified Nursing Staff. As part of the Recruitment and Retention Strategy, Values and Behaviours based selection process is being developed and will be introduced for all posts Jul-16 Reviewing the impact of the change to funding of nurse training from Sept 17 where pre and post reg training will be funded through student loans.	end Mar-17	◄►	HRD	SLF
5.1.3	C	Assurance is required that the Trust has effective controls in place to maintain sufficient staffing levels in A&E; recruitment difficulties in consultant, middle grade and nursing. Deanery short falls in fill rate for junior positions.	Aug-15 Business continuity plans in place to cover short term difficulties. Overseas recruitment taking place. Longer term review of staff model planned. Dec-15 Discussion taking place with commissioners as part of East Sussex Better Together. Mar-16 Recruitment taking place however short falls in staffing remains. Mitigating actions such as use of long term locums Jul-16 Working with ESBT to develop GP triages in A&E. Post currently in recruitment process.	end Sep-16	◄►	COO	SLF

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

Risk 5.2 If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and being embedded Staff Engagement Plan developed OD Strategy and Workstreams in place
Positive assurances	Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Embedding organisation values across the organisation - Values & Behaviours Implementation Plan Staff Engagement Action Plan Leadership Conversations National Leadership programmes Surveys conducted - Staff Survey/Staff FFT/GMC Survey Staff events and forums - "Unsung Heroes"

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
5.2.1	A	The CQC staff surveys provide insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	May-16 Staff survey results – three priorities have been identified for improvement for 2016/17. Clinical units are working on action plans for their local issues . Cultural review has been commissioned and will commence April 2016 Number of local staff engagement initiatives are taking place across the trust . Pharmacy introduced suggestion boxes and are acting on feedback. Out of hospitals CU sharing work they have been doing to transform services Staff forums and listening conversations continue to take place with regular feedback on new initiatives. Trust annual awards took place with over 250 staff attending Most clinical units have completed action plans in response to staff survey International Nurses day conference celebrated achievements of all our nurses Take a Break campaign launched - all work areas given a basket of healthy snacks and advice and guidance on the importance of taking breaks and how to make the most of them. Chief executive has been visiting different staff groups as part of his induction Jul-16 Comprehensive programme of staff engagement continues. Supporting CUs to deliver local action plans. Pulse surveys taking place and responding to cultural review. Staff focus groups taken place to support quality improvement.	end Apr-17	◄►	HRD	POD SLF

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd August 2016
Meeting:	Trust Board
Agenda item:	8
Subject:	ESHT 2020 Improvement Programme
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 ESHT 2020 Improvement Programme initially developed from the recommendations made by the CQC in their reports published in March and September 2015 following the Chief Inspector of Hospitals visits in September 2014 and March 2015

Introduction:

CQC inspections of the Trust were undertaken in March and April 2015, with the report published in September 2015. The overall rating of the Trust was 'inadequate' and the Trust was placed in special measures in September 2015 following recommendation from the Chief Inspector of Hospitals. A detailed Quality Improvement Plan was developed to ensure that the Trust worked together to achieve the commitment of delivering safe, high quality care for all of our patients. This has now been transitioned into the ESHT 2020 Programme providing robust governance for all improvements linked to strategic objectives

The full Quality Improvement Plan and 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:

The purpose of this report is to update on progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visits in September 2014 and March 2015. The aim of the programme is to ensure the Trust is able to respond to the recommendations made in the reports and make any improvements required in order to ensure compliance is met with the Regulations (2014) of the Health and Social Care Act 2008. This report provides an update on the following aspects in relation to the progress of the improvement Plan:

1. **Highlights and Milestones**
   This section describes the outcomes of the Warning Notice deep dive exercise and how this has informed the future delivery of the programme

2. **Project Summary Dashboard**
   For each objective this shows the current delivery and sustainability RAG

status including KPIs where appropriate.

3. **Key activities and Significant Risks**
   Risks that potentially seriously threaten the progress of the Improvement Plan

4. **Improvements**
   Update of outcomes from the Improvement Programme that have already been met improving the quality and efficiency of our care.

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 and the Trust will be compliant with CQC regulations.

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

Assurance Provided:
Improvement Sub-Committee meetings attended by Executive Leads and Patient Experience Liaison Representatives take place monthly chaired by the Chief Executive, weekly meetings take place between the Senior Responsible Owner of the ESHT 2020 Programme, Alice Webster – Director of Nursing and the ESHT 2020 Programme Manager, Lesley Walton. Monthly meetings take place between the Project Executives the Project Manager and the Objective Leads.

Review by other Committees/Groups (please state name and date)**:**
Senior Leaders Forum July-16 Quality and Safety Committee July-16 Improvement Sub-Committee July 16

Proposals and/or Recommendations
The Committee is asked to review and note the progress in implementing the ESHT 2020 improvement plan.

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

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

East Sussex Healthcare NHS
NHS Trust

20th July 2016

ESHT TRUST BOARD REPORT

ESHT 2020 Improvement Programme Update

Introduction

The purpose of this report is to update on progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visits in September 2014 and March 2015. The aim of the ESHT 2020 Improvement programme is to ensure the Trust is able to respond to the recommendations made in the reports and make any improvements required in order to ensure compliance is met with the Regulations (2014) of the Health and Social Care Act 2008.

ESHT 2020 Improvement programme Status

This report provides an update on the following aspects from the last two months:

1. Highlights and Milestones
2. Project Summary Dashboard
3. Next key activities and Significant Risks
4. Improvements

Programme Highlights The main focus since the last report to the Committee has been the progression of the 11 projects that are currently delivering improvements. Key highlights are:

- ESHT 2020 Improvement Programme Sub-Committee chaired by Dr. Adrian Bull has met, and will continue to meet, monthly since July embedding the governance to ensure challenge to projects and continual improvement at ESHT.

- The Medicines Management project has achieved all the objectives set out for the project; integrated pharmacy team in place, dedicated technicians to Clinical Units, gateway medicines reconciliation targets now met consistently, infrastructure designed to engage nursing teams, reconfigured medicines management groups so that they are aligned to the Trust wide Medicines Optimisation Strategy. Chief Pharmacist started June. The committee agreed this project could close as continual improvement is embedded in Pharmacy governance structure.

I

- The Health Records project will be recommended to close based on the achievement of all the objectives. A new centralised Health Records facility formally opened this week. Other improvements such as state of repair of records, improved access for inpatient Health Records requests, security of records are now dependent on the Electronic Document management project which is due to go live in November starting with Gynaecology.

- ESHT 2020 Improvement Sub-Committee focused resources on detailed planning to ensure the Patient Flow project is seen as a priority to ensure clear route to improving RTT, diagnostic turnaround, Emergency and Day Surgery patient flow, delayed discharges, Theatre optimisation, Outpatient patient flow.

I

- New policy for single sex accommodation to ensure compliance being developed– this will set out what steps are expected to prevent breaches not just dealing with them when they happen

- Estates work commenced to provide privacy and dignity improvements in Radiology and Paediatric assessment in A&E

- Following Mock Inspection the following actions are in progress; dump the junk week 9-11th August, confidential waste collection increased to twice a week, cleanliness programme for communal areas, housekeeping refresher training for beverage service and waste removal.

I

- Bed modelling work completed – date to be set to implement in the summer. Real-Time Bed state business case in progress due for approval in October 2016.

- Maternity deep dive presented at QIP Monitoring Group in July.

- Maternity handover now using SBAR

- A Hospital at Night group has been formed and held fortnightly. The group is focussing on communication issues, clinical capacity and work being shunted onto night team which should be done during the day. New policy due for sign off in next few weeks

East Sussex Healthcare NHS
NHS Trust

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments
SRO - Alice Webster				
Vision	04-Apr-16	Alice Webster	C	
Set Up Programme Board	31-Mar-16	Lesley Walton	C	
Programme Governance, Assurance and Terms of Reference	09-May-16	Lesley Walton	C	
Programme Plan	30-Apr-16	Lesley Walton	C	
Communications and Engagement Strategy	30-Apr-16	Suzanne Gouch	C	
Benefits Management Strategy	30-Aug-16	Catherine Ashton	G	
Resource Management Strategy	31-May-16	Lesley Walton	C	
Risk Management and Issue Resolution Strategy	31-May-16	Lesley Walton	C	
Programme Gateway Assurance	30-Sep-16	HSCIC	G	
Programme Gateway Assurance	31-Jan-17	Internal/External (TBC)	G	
Programme Gateway Assurance	31-Jul-17	Internal/External (TBC)	G	
Delivering The Capabilities - PROJECT DOSSIER				
Programme Management Office Capability and Capacity for sustainable improvement framework	30-Jul-16	Johathan Reid	C	
Service Improvement Hub Established	31st Dec-2016	Catherine Ashton	G	Business Case in progress
Warning Notice Compliance	01-Sep-16	Alice Webster	A	Deep dive work identified processes complete but sustainability activities still in progress as part of improvement projectse.g Cleanliness
Mortality and Morbidity Project Complete	30-Nov-16	David Hughes	A	Scope agreed and work progressing on Sepsis and Mortality governance and processes
Cleanliness, Infection and Prevention Contro Project Complete	30-Nov-16	Alice Webster	A	Cleanliness still variable across the Trust as restructure and organistaion of cleaning services continue
Evidence Base Care Project Complete	30-Nov-16	David Hughes	A	Pain Management and Handover procedures require further planning
Medicines Management Project Complete	16th July 2015	David Hughes	C	
Workforce Capacity Capability & Engagement Project Complete	28-Feb-17	Monica Green	G	
Effective Relationships with External Stakeholders & the Public Project Complete	30-Nov-16	Lynette Wells	A	Project to be expanded to develop robust goverenance and feedback on relationships with the public.
Governance Project Complete	28-Feb-17	Alice Webster	G	
Health Records Project Complete	01-May-17	Liz Fellows	C	
Patient Flow Project Complete	30-Nov-16	Pauline Butterworth	A	Improvements in progress but scoping/agreement of new KPIs
Maternity Operations Project Complete	30-Nov-16	Pauline Butterworth	A	Senior resource issues within Clinical Unit impacting progress
Secure and Safe Premises and Faculties Complete	30-Nov-16	Alice Webster	G	
Ward Improvement project Complete	28-Feb-17	Alice Webster	U	Clinical Facilitator going out to advert. Immediate ward improvements ongoing e.g. safety huddles, improvement huddles
Mock Inspection	22-Jun-16	Lynette Wells	C	
Mock Inspection	27-Jul-16	Lynette Wells	G	
CQC Inspection	03-Oct-17	Lynette Wells	G	

East Sussex Healthcare NHS
NHS Trust

A	MORTALITY AND MORBIDITY PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Improve the Process and Governance of Mortality and Morbidity (IP 53)				
	Increase percentage of Mortality Cases reviewed within three months of death	30-Jun-16	95%	66%	
	Increase number of Mortality Meetings held per month to review deaths across the Trust	30-Jun-16	Monitoring	9	
	Audit compliance with VTE Guidance (IP 37)				
	Increase Rate of VTE Assessments undertaken within 24h of admission	30-Nov-17	95%	95%	
	Percentage of Fatal VTE Root Cause Analyses undertaken	30-Nov-17	90%	40%	n/a
	Percentage of Non-Fatal Post-Operative Pressure Ulcer Root Cause Analyses undertaken	30-Nov-17	90%	0%	n/a
	Audit compliance with National End of Life Care Guidance (IP 36c)				
	Complete End of Life Care Audits	31-Aug-16	n/a	10%	n/a
	Review and re-launch EoLC Policies	01-Oct-16	n/a	10%	n/a
	EoLC Strategy Approved	31-Jul-16	n/a	90%	n/a
	Increase EoLC Training for Clinical Staff	01-Oct-16	80%	10%	

Project Executive: David Hughes

Project scope confirmed as VTE, EOLC, Sepsis, AKI, Pneumonia and recently added COPD. Full time Project Manager due to start in September and full time Change Analyst will also support the project. Sepsis work stream already in progress with clear objectives to ensure consistent reliable recognition, reduce mortality rates, reduce ICU admissions and achieve 100% of the requirements for the 2016/17 National Sepsis CQUIN. Snapshot audit of 17 patients who had deceased in May 2016 diagnosed with Sepsis. Initial findings being reviewed by Nursing and Medical with immediate actions if required. Trust governance and processes for reviewing and learning from avoidable death will be the project focus this month with 'as is' mapping of governance and the development of a vision of what we want this to be. Detailed plans will be developed from the gap analysis.

A	EVIDENCE BASED CARE PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	MDT Working at Conquest Hospital - Morning Board Rounds (IP 3a)				
	Implement Morning Board Rounds at Conquest Hospital	30-Nov-17	n/a	50%	n/a
	Trust Consent Policy (IP 34)				
	Increase Percentage of Consent Forms being Confirmed by the Patient	30-Nov-17	90%	58%	*
	Increase Percentage of Consent Forms where Written Information has been provided to the Patient	30-Nov-17	90%	40%	n/a
	Increase use of Formal Capacity Assessment when using Form 4 of Mental Capacity Act	30-Nov-17	90%	71%	n/a
	Audit compliance with National Nil-By-Mouth Guidance (IP 36b)				
	Undertake Nil-By-Mouth Audit	30-Nov-17	n/a	0%	n/a
	Monitoring Pain Relief Effectiveness in the Emergency Department (IP 54a)				
	Monitor the effectiveness of Pain Relief in the Emergency Department	30-Nov-17			
	Pain Assessment Strategy for Dementia Patients (IP 54b)				
	Implement audit of Patients with Dementia to ensure Correct Pain Assessment Used	30-Nov-17	n/a	0%	n/a
	Pain Assessment Strategy for Learning Disability Patients (IP 54c)				
	Implement audit of Patients with Learning Disabilities to ensure Correct Pain Assessment Used	30-Nov-17	n/a	0%	n/a

Project Executive: David Hughes

Hospital at night group formed and held fortnightly. The group is focussing communication issues, clinical capacity and work being shunted onto night team which should be done during the day. New policy due for sign off in next few weeks. Nil By Mouth audit held in June and outcome to inform improvement objectives. Pain management objectives for Emergency patients still in early development. Pain Management audits for Learning Disability and Dementia patients to inform improvement objectives. Review of CQC issues to ensure all issues addressed and sustainable. TIAA audit and possible CREWS review to re-test handover on both sites.

A	ENVIRONMENTAL CLEANLINESS AND INFECTION PREVENTION AND CONTROL PROJECT	Due Date	Latest Metric	Six-Month Trend
	Sustained and documented compliance with the National Specifications for Cleanliness (IP 33a)			
	Increase Number of NSC Audits Undertaken	31-Jul-16	89%	
	Increase NSC Audit Score (Overall Trust)	31-Jul-16	96%	
	Increase NSC Audit Score (Nursing)	31-Jul-16	97%	
	Increase NSC Audit Score (Housekeeping)	31-Jul-16	98%	
	Increase NSC Audit Score (Estates / Maintenance)	30-Nov-16	86%	
	Consistent understanding and compliance with the Trust Hand Hygiene Policy (IP 33b)			
	Increase Percentage of Hand Hygiene Audits Completed	31-Jul-16	96%	
	Increase Hand Hygiene Audits Pass Rate	31-Jul-16	97%	
	Robust governance and performance processes related to Cleanliness and Infection Prevention and Control (IP 33c)			
	Establish monthly Patient Environment Audit Monitoring Group	31-Mar-16	100%	n/a
	Report Cleanliness to the Trust Infection Control Group (TICG)	31-Mar-16	100%	n/a

Project Executive: David Hughes

A monthly patient environment forum has been established. Further improvements need to be addressed at ward level which is variable across the Trust e.g. cleanliness of equipment. Housekeeping restructured to improve efficiency and flexibility and ward orderlies appointed to each ward. Trust will be using Nottingham's 'Productive Cleaning toolkit'. Audit compliance in some areas not achievable due to estates work required however £55,000 capital is allocated this year which will be used in the high risk areas.

A	GOVERNANCE PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Incident Management (IP 26)				
	Increase Rate of Incident Reporting	30-Sep-16	Monitoring	1299	
	Reduce number of Patient safety incidents 3,4,5	30-Sep-16	Monitoring	27	
	Reduce harm- high % no harm or near miss	30-Sep-16	71%	67%	
	Improve Timeliness of RCA Incident Reporting to CCG	30-Sep-16	90%	83%	
	Number of Serious Incidents Kept Open by the CCG	30-Sep-16	6	11	
	Shared Learning from Incidents (IP 28(27))				
	Staff reporting an incident receive feedback	01-Feb-17			
	SI investigations involve staff and patients	01-Feb-17			
	Complaint Management (IP 7)				
	Complaints Acknowledged within 3 days	30-Jun-16	100%	98%	
	Complaints Responded to within locally agreed guidelines	30-Sep-16	100%	46%	
	Reduce Complaints Re-opened per month	30-Sep-16	5	12	
	Reduce Number of Formal Complaints	30-Sep-16	20	54	
	Increase in satisfaction with complaints process	30-Sep-16	Monitoring		
	Ensure that the trust has a robust and effective governance process and structure in place (IP29)				
	Clinical governance organogram in place	31-May-16	n/a	20%	n/a
	Committee structure approved	31-May-16	n/a	20%	n/a
	Patient Experience (IP56)				
	Increase in total Trust FFT responses rate	31-Aug-16	Monitoring	1781	
	Total Trust FFT score	31-Aug-16	95%	93%	
	Duty of Candour (IP55)				
	Number of moderate and severe harm incidents v compliance with Duty of candour process:	31-Aug-16	100%		
	Follow up letter within 10 days to notify of investigation (for moderate and above incidents)	31-Aug-16	100%		
	Sharing investigation and discussion	31-Aug-16	100%		

Project Executive: Ashley Parrott

The weekly patient safety summit agenda now includes key highlights of shared learning fed back from the clinical units. Quality committee structure has been agreed, terms of reference are being finalised. Governance summary report piloted to Clinical Units to ensure clearer and easier identification of areas of concern that require action. Initial feedback is positive. Board to Ward dashboard has been finalised with first agreed set of metrics and is available for launch. Appointed Patient Experience Lead to develop more robust standard Friends and family feedback methods and actions as a result of themes.

G	SECURE PREMISES AND FACILITIES PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Privacy & Dignity in ED for people with mental health issues (IP 31)				
	Complete Estates Work in ED Conquest for people with Mental Health issues	31-Apr-17	n/a	0%	n/a
	Complete Estates Work in ED EDGH for people with Mental Health issues	31-Apr-17	n/a	0%	n/a
	Privacy and Dignity in Radiology and OPD (IP 32)				
	Complete Estates Work to Facilitate Privacy and Dignity in Radiology EDGH	31-Apr-17	n/a	25.0%	
	Complete Estates Work to Facilitate Privacy and Dignity in Radiology Conquest	31-Apr-18	n/a	12.5%	n/a
	Complete Estates work to ensure safety and security for paediatric assessment CQ 32c	31-Apr-19	n/a	12.5%	
	Complete estates work to facilitate privacy and dignity in Urology 32d	31-Apr-17	n/a	12.5%	n/a
	Secure Oxygen Cylinders (IP 40)				
	Secure All Oxygen Cyclinders	31-Mar-16	n/a	80%	n/a
	A&E department isolation in the event of lock down being required (IP 47)				
	Fit Electronic Lock to A&E Department Door at Conquest Hospital	31-Mar-16	n/a	100%	n/a
	Medical equipment checks (IP64)				
	Systems in place to ensure medical equipment and devices are checked and maintained	Aug-16			

Project Executive: Chris Hodgson

Capital investment allocated this year to reconfigure estate to improve privacy and dignity in Radiology at Eastbourne and Conquest, improve privacy and dignity in urology. Paediatric assessment unit in A&E at Conquest – temporary room made available until new facility available. Work commenced. A&E Lockdown at Eastbourne requires modernisation as relies on key locks – will require capital allocation. KPI's to be developed for equipment checks. Documentation for resus trolley checks being redesigned. Safety huddles will provide second check on equipment . Oxygen cylinders still not secure in some areas.

A	WORKFORCE CAPACITY, CAPABILITY AND ENGAGEMENT PROJECT	Due Date	Latest Metric	Six-Month Trend
	Staff Engagement and Satisfaction Levels (IP 1)			
	Improve Quarterly Staff Family and Friends Test Score	31-Dec-18		
	Improve Quarterly 'Pulse' Survey Response Rate?	31-Dec-18		
	Increase Overall Staff Engagement Score	31-Dec-18	3.54	
	Staff Health and Well-Being (IP 2)			
	Reduce Monthly Stress-related Absence	31-Dec-18		
	Reduce Staff Work Related Stress Levels (Annual)	31-Dec-18	40%	n/a
	Listening to Staff Feedback (IP 4)			
	Questions in the 'Pulse' Survey?	31-Dec-18		
	Increase Percentage of staff reporting Good Communication (KF6)	31-Dec-18	19%	n/a
	Harassment and Bullying of Staff (IP 6)			
	Reduce Quarterly number of Dignity at Work Cases	31-Dec-18		
	Decrease Percentage of Staff experiencing Harassessment, Bullying or abuse from Staff (KF26)	31-Dec-18	33%	n/a
	Staff Vacancies (IP 12)			
	Increase Overall Staff Fill Rate	31-Mar-17	94.20%	
	Increase Medical and Dental Fill Rate	31-Mar-17	88.68%	
	Increase Registered Nurses and Midwives Fill Rate	31-Mar-17	91.37%	
	Increase Scientific, Therapeutic and Technical Fill Rate	31-Mar-17	91.31%	
	Increase Additional Clinical Services Fill Rate (including HCAs)	31-Mar-17	105.36%	
	Increase Administrative and Clerical Fill Rate	31-Mar-17	95.67%	
	Increase Estates and Ancillary Fill Rate	31-Mar-17	96.44%	
	Decrease Time to Recruit	31-Mar-17		
	Staff Sickness Absence Levels (IP 13)			
	Reduce Staff Turnover Rate	31-Mar-17	10.62%	
	Reduce Staff Sickness Absence Levels (Annual)	31-Mar-17	4.53%	
	Reduce Staff Sickness Absence Levels (Monthly)	31-Mar-17	4.79%	
	Staff Training for staff working in Alternative Areas (IP 14)			
	Provide Policy for requesting staff in alternative areas	31-Mar-16	100%	n/a
	Mandatory Training Levels (IP 15)			
	Increase Staff Mandatory Training Levels	31-Dec-18	87.36%	
	Staff Appraisal Rates (IP 16)			
	Increase Staff Appraisal Rates	31-Mar-16	87.26%	
	Senior Management Team Review (IP 17)			
	Senior Management Team Review Complete	30-Jun-16	0	n/a
	Consultant Cover in the A&E Department (IP 48)			
	Increase Urgent Care (inc. A&E Department) Fill Rate	31-Mar-17	96.52%	
	Support for Newly Qualified staff (IP 50)			
	Number of Newly Qualified Staff in Preceptorship Programme	31-Mar-16	100%	n/a
	Monitoring Quality and Safety in relation to Staffing Levels (IP 51)			
	Reduce Number of Incidents Related to Low Staffing Levels	31-Mar-17		
	Pathology & Histopathology Vacancies (IP 52)			
	Increase Theatres and Support Services (inc.Pathology and HistoPathology Departments) Fill Rate	31-Mar-17	94.36%	
	Increase Scientific, Therapeutic and Technical Fill Rate	31-Mar-17	91.31%	

A WORKFORCE CAPACITY, CAPABILITY AND ENGAGEMENT PROJECT

Project Executive: Monica Green

Project progressing well with significant improvements made in reducing sickness rates, staff turnover, increasing mandatory training and appraisals rates. Overseas recruitment of nursing and technical support staff has been very successful. Medical and dental recruitment still proving difficult with often no suitable applicants for advertised posts. Objectives and KPIs being expanded. Talent Works staff engagement, bullying and Harassment and cultural review will inform further targeted improvements and KPIs. Go Engage (Wigan, Wrightington and Leigh FT) launching . Further proposal for extending clinical leadership development being worked up

C	HEALTH RECORDS AND DATA PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Availability of Health Records (IP 23)				
	Less than 1% of Medical Records not available for Patient Appointments	31-May-16	<1%	0.5%	
	Reduce number of Surgical Operations Cancelled due to non-availability of Notes	31-May-16	0	0	
	State of Repair of Health Records (IP 24)				
	Reduction in Number of DATIX Incidents Relating to Medical Record Quality	30-Nov-16			
	CHIS System Review (IP 41)				
	Review of CHIS System Complete	31-Mar-16	n/a	100%	n/a
	Children's Services KPIs Monitoring (IP 42)				
	Children's Services KPIs Available for Monitoring	31-Mar-16	n/a	100%	n/a

Project Executive: Liz Fellows

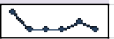
The Health Records project will be recommended to close based on the achievement of all the objectives. A new centralised Health Records facility formally opened this week. Other improvements such as state of repair of records, improved access for inpatient Health Records requests, security of records are mainly dependent on the Electronic Document management project which is due to go live in November starting with Gynaecology. Further interim improvements to security and state of repair will be addressed in the Patient Flow project.

A	PATIENT FLOW PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Outpatient Department Flow (IP 10a, 10b, 10c and 11)				
	Reduction in DNAs for New Appointments	30-Nov-16	8.0%	9.3%	
	Reduction in DNAs for Follow-Up Appointments	30-Nov-16	8.0%	8.7%	
	Reduce Outpatient Complaints received via PALS regarding patient experience during appointment	30-Nov-16	0	0	
	Reduce Formal Outpatient Complaints regarding patient experience during appointment	30-Nov-16	0	0	
	Percentage of GP letters completed within 5 working days	28-Feb-17	90.0%	56.0%	
	Percentage of outpatient clinic cancellations with less than 6 weeks notice	31-Dec-16	10.0%	32.0%	
	Number of New and Follow Up Appointments Cancelled as overall % of average outpatients bookings	31-Dec-16	10.0%	21.0%	
	Rates of Same Sex Breaches in Conquest CDU and A&E (IP 30a)				
	Reduce Number of Same Sex Accommodation Breaches	31-Mar-16	0	0	
	Privacy & Dignity in Radiology (IP 32b)				
	Reduction in complaints by patients in Radiology regarding privacy & dignity	30-Jun-16	1	0	n/a
	Improved response to FFT questions re privacy & dignity				
	Referral to Treat (RTT) Times (IP 35)				
	Meet Four Hour Standard	31-Mar-17	89.0%	85.1%	
	Consistently Achieve the Two-Week Wait Targets	30-Jun-16	93.0%	96.0%	
	Meet 62 day Cancer Target	31-Mar-17	85.0%	67.0%	
	Meet 92% RTT Target	31-Mar-17	92.0%	90.7%	
	Reduce Diagnostic Breaches to <1%	31-Mar-17	1.0%	2.7%	
	Ward Moves (IP 38)				
	Reduce Number of Ward Moves Out-of-Hours (2200-0600) for non-clinical reasons		0	114	
	Reduce Number of Ward Moves In-Hours (0600-2200) for non-clinical reasons				
	Discharge Process (IP 39)				
	Reduce Number of Complaints relating to quality and safety of the discharge process	30-Nov-16		9	
	Reduction in the number of Safeguarding alerts relating to quality and safety of discharges	30-Nov-16		1	
	Reduction in the number of incidents relating to the quality and safety of discharges	30-Nov-16		159	
	Surgical Assessment Unit Waiting Times (IP57)				
	Process in place to monitor the length of stay and outcomes for SAU patients	n/a	n/a	100%	n/a
	Waiting times for assessment				
	Urology Unit Patient Flow at EDGH (IP58)				
	Unit reconfigured to enable it to cope with the current service demand and address patient flow	n/a	n/a	100%	n/a
	Improved response to Q1 FFT (patient satisfaction)	30-Apr-16	90%	100%	
	Theatre Planning (IP59)				
	Increase in overall utilisation of theatres	30-Nov-16	85%	90%	
	Day Surgery Patient Flow at EDGH (IP60)				
	Improved response to Q1 FFT (patient satisfaction)	30-Jun-16	90%	99%	n/a
	Theatres Recovery Patient Flow at EDGH (IP61)				
	Reduction in percentage of patients waiting over an hour in PACU	30-Nov-16	5	10	n/a
	Availability of Health Records (IP 23)				
	Less than 1% of Health Records not available for Outpatient Appointments	31-May-16	<1%	0.5%	
	Reduce number of Surgical Operations Cancelled due to non-availability of Notes	31-May-16	0	1	
	Reduction in the number of temporary files produced Trust-wide	30-Nov-16	400	669	n/a
	State of Repair of Health Records (IP 24)				
	Reduction in Number of DATIX Incidents Relating to Medical Record Quality	30-Nov-16	1	0	n/a
	CHIS System Review (IP 41)				
	Review of CHIS System Complete	31-Mar-16	n/a	100%	n/a
	Children's Services KPIs Monitoring (IP 42)				
	Children's Services KPIs Available for Monitoring	31-Mar-16	n/a	100%	n/a

A PATIENT FLOW PROJECT

Project Executive: Pauline Butterworth

Detailed planning in progress to ensure clear route to improving RTT, diagnostic turnaround, Emergency and Day Surgery patient flow, delayed discharges, Theatre optimisation, Outpatient patient flow. Bed modelling work completed – date to be set to implement in the summer. Medical workshop to agree principles of new medical model e.g. senior specialty decision makers in reaching to ED – to be held on 21st July. NHS Elect are working on booking, productive outpatients and productive theatres. New policy for single sex accommodation to ensure compliance being developed– this will set out what steps are expected to prevent breaches not just dealing with them when they happen. Developing mechanism to easily capture ward moves for non-clinical reasons automatically. Business case in development for Real-Time Bed State

A	MATERNITY PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Low Risk Birth Facilities at Conquest Hospital (IP 18)				
	Complete Low Risk Birth Facilities at Conquest Hospital	30-Nov-16	n/a	100%	n/a
	Facilities to reduce Repeated Journeys between home and Hospital (IP 19)				
	Complete Facilities to Reduce Repeated Journeys	30-Sep-16	n/a	20%	n/a
	Develop and communicate a clear vision and strategy for maternity services across East Sussex (IP20)				
	Complete Maternity Services Vision	31-Mar-16	n/a	100%	n/a
	Complete Maternity Service strategic plan	01-Aug-16	n/a	50%	n/a
	Information to make an informed choice about Place of Birth available (IP 21)				
	Produce additional Information to Allow Informed Choice to be Made	30-Jul-16	n/a	100%	n/a
	Leadership and Culture of Maternity Services (IP 22)				
	Complete a review of the Maternity Services Leadership	31-Mar-16	n/a	100%	n/a
	Correct ratio of supervisiors 1:15	01-Jul-16	01:15		
	Follow Guidance for Syntocinon (IP 44)				
	Compliance with syntocinon guidelines	01-Jul-16	100%	80%	n/a
	Women being Contacted by Midwives etc. after suffering pregnancy loss (IP 49)				
	Reduce Inappropriate Communication Incidents to Zero	31-Mar-16	0	0	
	Audit compliance with National Pre-Eclampsia Guidance (IP 36a)				
	Compliance with pre-eclampsia guidelines	31-May-16	100%	80%	n/a
	Appropriate staffing in place (IP62)				
	Midwife staffing meets national standards 1:28 births	01-Aug-16	01:28		
	Mothers in labour to be given one-to-one Midwife support	01-Aug-16	100%		
	Enhance the number of hours dedicated to management and specialist roles	01-Aug-16	8%		

A MATERNITY PROJECT

Project Executive: Pauline Butterworth

This project has delivered some minor improvements. Low risk birthing unit implemented, web site pages and leaflets have been developed to inform women birth options, processes for inappropriate contact following a pregnancy loss have reduced significantly. The Maternity vision has been approved but the strategy still needs to be developed. Guidance in place for staff to reduce unnecessary journeys. Further scoping and KPI development required to address other areas requiring improvements e.g. midwife capacity. Strategic planning is developing with staff and commissioners. Business cases developed for further specialist posts, new ways of working to release time to care. Focus is now on review and improvement of the maternity dashboard, leadership and culture, integration with initiatives such as ESBT and STP.

A	EFFECTIVE RELATIONSHIPS WITH EXTERNAL STAKEHOLDERS AND THE PUBLIC	Due Date	Target	Latest Metric	Six-Month Trend
	Translation Service (IP 8)				
	New Translation Service Contract Awarded	30-Jun-16	n/a	100%	n/a
	Staff awareness of translation services	01-Sep-16			
	Number of incidents relating to translation services	01-Nov-16			
	Relationships with the Public and Other Key Stakeholders (IP 9)				
	Engagement and communication strategy and plan in place	01-Sep-16	n/a	10.00%	n/a
	Increase in positive feedback from stakeholders	01-Sep-16			

Project Executive: Lynette Wells

Improvements have been progressed by holding more events with the public and external stakeholders. Local groups have been contacted to offer opportunities for discussions with the Trust. Joint initiative with the 'save the DGH' group has resulted in the first joint press release. This project still requires further development KPI development to include the Communications and engagement Strategy, increase the number of engagement events and survey of external stakeholders. Objective owners reviewing additional KPIs. Communications Strategy ready for approval and launch to the Trust. External partners participated in the CQC Mock Inspection 22nd/23rd June. Meetings held with CCGs to discuss Sustainable Transformation Programme. Translation service contract awarded, programme of staff training to be rolled out.

Next Activities

- Continue to progress project improvements
- Ward Improvement Project initiated
- ESHT Vine launched – board to floor grapevine
- Run the Mock Inspection at the end of July
- Maternity dashboard re-launched
- Floor to Board dashboard launched.

Significant Risks:

- Risks to delays in improvements requiring estates work e.g. privacy and dignity, cleanliness targets impacted by estate environment issues, patient flow.

- Risks to improvement due to staff recruitment of key senior clinical roles within Medical and Dental

- Currently recruiting six additional Paediatric Nurses (three at Conquest Hospital and three at Eastbourne DGH), funded by the CCGs, to provide additional specialist support for children in our A&E departments.

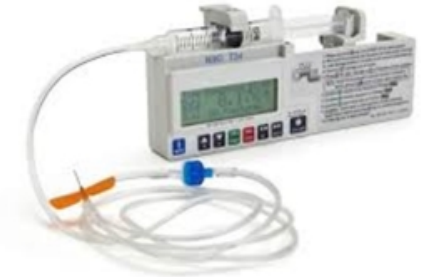
- Installed a total of 11 secure drugs cabinets with high tech fingerprint security in our wards and departments, so that medicines are securely stored, there is an audit trail of who has taken the medicine and which patient it is for and the Pharmacy Department can remotely monitor stock levels.

East Sussex Healthcare NHS
NHS Trust

- Safety Huddles are being introduced in all wards across the hospital. Staff gather at the same time each day for 5-7 minutes to identify risks and challenges in the day ahead.

- Piloting changes to the on-call rota for community midwives so that they are more consistently available to support home births, giving women more choice about where they have their baby.
- Maternity nominated for National Butterfly Award by a patient.

- Provided training for our staff to manage small syringe drivers, so there is no break in pain relief for patients nearing the end of their life between leaving hospital and being seen by community teams.



East Sussex Healthcare NHS Trust

Date of Meeting:	3rd August 2016
Meeting:	Trust Board
Agenda item:	9
Subject:	Integrated Performance Reports – June 2016 (Month 3)
Reporting Officers:	Director of Finance Director of Human Resources Chief Operating Officer

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 June 2016 (month 3).

Introduction:

The purpose of this paper is to inform the Trust Board of organisational compliance against national and local key performance metrics, of delivery of Trust targets and plans, and to provide detailed information on the financial position for review and scrutiny.

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

There were some key improvements this month:

- Cancer performance; all cancer targets with the exception of 62 days were achieved. 62 Days exceeded the trajectory but failed to meet the standard.

However, performance did not improve in four key areas:

- RTT incompletes did not meet the 92% standard
- Diagnostic performance did not meet the < 1% target in March.
- A&E performance remains challenged and under the target.
- Cancer 62 Day waits remains below the target

The Trust has a financial plan, agreed with NHSI, which delivers a £32m deficit – moving from the original plan of £48m through an increase in the efficiency challenge of £6m and additional funding from the Department of Health of £10m.

At Month 3, the Trust is reporting technical compliance with the financial plan, but the underlying position is £3m adverse to plan. As at month 2, this is driven by the additional costs of extra activity and the associated challenges of managing demand and capacity, as well as by continued increase in temporary staffing costs. Cost improvements are broadly on plan, but Clinical Units are forecasting very significant risks to delivery. The Executive Team have developed a plan to provide additional support across each of the key areas of risk to ensure a return to delivery of the operational financial plan.

Detailed recovery plans are in place for both emergency and elective care, and detailed work is underway to ensure that outsourced work is undertaken in the most effective way.

Cash remains broadly on plan, but a further weakening of the financial position will create challenges for the Trust in managing cashflow. Capital is behind plan, but steps are in place to accelerate expenditure to ensure delivery of key priorities.

Monthly sickness was 3.77%, a decrease of 0.17% from May. The annual sickness rate was 4.42%, a decrease of 0.04%.

Mandatory training rates have all increased, with the exception of Induction, Deprivation of Liberties and Safeguarding Children Level 2 which were slightly lower. The overall mandatory training rate was 87.92% an overall increase of 0.41%

Appraisal compliance decreased by 1.61% to 88.07%.

Benefits:

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

Risks and Implications

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

Assurance Provided:

This report includes all indicators contained within the Trust Development Authority's Accountability Framework for 2015/16 along with additional key, quality and performance information. The information contained within this report has been extracted from the Trust Data Warehouse in line with guidance supplied by the TDA. Please note the Framework for 2016/7 for NHS Improvement is currently out to consultation.

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

Executive Director Meeting, 5th July 2016
Finance and Investment Committee, 27th July 2016

Proposals and/or Recommendations

To review the report in full and note Trust Performance.

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

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

N/A

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

Name:	**Contact details:**
Sarah Goldsack - Associate Director of Knowledge Management	sarah.goldsack@nhs.net

East Sussex Healthcare NHS
NHS Trust

Month 03 - June 2016

Integrated Performance Report

Contents

1.0 Performance – JUNE 2016

Key Issues

- RTT incompletes did not meet the 92% standard
- Diagnostic performance did not meet the < 1% target in March.
- A&E performance remains challenged and under the target.
- Cancer 62 Day waits remains below the target

Key Risks

- Delivery against the agreed trajectories for improvement against the 4 key constitutional standards
- Delivery against the agreed financial plan

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

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

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

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

1.1 Safety & Quality – JUNE 2016

Indicator Description	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current Month Jun-16	Jun-15	Var	YTD Curr Yr	Last Yr	Var	Trend
Never events - incidence	0	0	0	0	0	3	1	0	0	0	1	0	0	0	0	1	0	1	
Serious Incidents rate (new Sis per 1000 beddays)	Monitoring	0.33	0.30	0.30	0.24	0.41	0.48	0.40	0.23	0.40	0.47	0.00	0.12	0.73	-83.0%	0.20	0.54	-63.0%	
Medication errors causing serious harm - incidence rate	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	0	0	
% of Patient safety incidentscausing severe harm/death	0.50%	0.0%	0.5%	0.1%	0.3%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	-0.4%	0.0%	0.52%	-0.5%	
Patient Safety Incident Rate (Incidents/1000 Beddays)	37	37	34	38	39	36	37	33	36	35	41	43	41	38	7.4%	42	37	13%	
Patient safety incidents resulting in death or severe harm	0	0	4	1	3	0	1	0	0	0	0	0	0	4	-100.0%	0	14	100.0%	

Commentary

There were no new never events in June.

There were 3 Serious Incidents in June, relating to a failure to act to test results in ophthalmology (Surgery), a fall (Medicine) and a GRE (Corporate).

The Patient Safety and Quality Group has been established and will meet in August.

1.2 Safety & Quality – JUNE 2016

Indicator Description	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current Month Jun-16	Jun-15	Var	YTD Curr Yr	Last Yr	Var	Trend
Clostridium Difficile - Variance from plan	4	2	7	6	3	5	3	4	3	5	2	7	7	5	2	16	10	6	
MRSA bactaraemias rate	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2	-2	
VTE Risk Assessment	95%	97.4%	96.4%	96.1%	95.9%	96.7%	96.7%	96.5%	95.8%	94.9%	95.2%	97.9%	98.0%	96.9%	1.1%	97.1%	96.4%	0.7%	
Number of Grade 3 or 4 Pressure Ulcers	Reducing	1	3	1	2	1	1	6	4	4	3	3	0	2	-2	6	6	0.0%	
Number of Falls: no harm/near miss	105 p/m (1260 OT)	96	104	107	109	98	123	119	122	118	101	99	100	107	-6.5%	300	310	-3.2%	
Number of Falls: Minor/Moderate	48 p/m (581 OT)	60	38	36	63	43	59	64	56	51	54	48	44	52	-15%	146	205	-29%	
Number of Falls: Major/Catastrophic	0	0	1	0	0	0	0	0	0	0	0	0	0	1	-1	0	3	-100.0%	

Commentary

There were 7 reported cases of C-Dificile in June. Of these, 5 were found to have a lapse in care but only 1 had a contributory lapse in care. This was due to non-essential antibiotics.

VTE risk assessment compliance remains significantly above target and achieved the highest level in the last 12 months.

Falls remain on a downward trajectory.

1.3 Safety & Quality – JUNE 2016

Indicator Description	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current Month Jun-16	Jun-15	Var	YTD Curr Yr	Last Yr	Var	Trend
Inpatient Scores from Friends and Family Test % positive	96.00%	97.3%	97.8%	97.5%	97.4%	98.8%	99.0%	97.9%	98.0%	97.8%	98.9%	99.1%	97.4%	97.5%	-0.1%	98.4%	97.5%	0.9%	
A&E Scores from Friends and Family Test % positive	88.00%	88.2%	90.8%	92.6%	89.3%	91.1%	90.7%	92.9%	91.0%	88.3%	93.5%	89.8%	88.3%	91.9%	-3.6%	90.5%	89.4%	1.1%	
Maternity Scores from Friends and Family Test % positive	96.00%	95.7%	96.0%	93.3%	95.1%	96.6%	95.5%	95.9%	90.4%	95.2%	92.1%	93.0%	94.4%	93.7%	0.8%	93.2%	94.1%	-0.9%	
Inpatients response rate from Friends and Family Test	45.00%	9.7%	15.4%	15.3%	15.5%	13.5%	12.9%	11.5%	13.1%	13.3%	14.0%	13.9%	17.0%	50.0%	-33.1%	15.0%	47.7%	-32.7%	
A&E response rate from Friends and Family Test	25.00%	9.3%	7.1%	8.9%	7.9%	6.8%	7.7%	8.2%	8.0%	6.5%	9.0%	9.9%	8.4%	16.9%	-8.5%	9.1%	15.6%	-6.5%	
Written Complaints - Rate	Monitoring	3.15	3.37	3.09	2.76	1.98	1.69	1.61	2.18	1.98	2.98	2.15	2.38	2.05	16.1%	2.51	2.31	8.7%	
Percentage of complaints acknowledged (within mandatory or agreed timescales)	95.00%	91.8%	96.6%	91.3%	82.7%	95.5%	90.9%	96.2%	93.1%	98.4%	100.0%	98.8%	100.0%	91.5%	9.2%	99.5%	91.8%	7.7%	
Mixed Sex Accommodation Breaches	0	0	0	14	23	16	3	27	29	0	0	0	0	0		0	18	100.0%	

Commentary

The Trust reported no sleeping mixed sex accommodation breaches during June.

Response rates for the family and friends tests remain low however those that have responded have generally responded positively. The A&E positive score recovered in May, in line with the improved performance against the 4 hour standard.

Substantial improvements are required to bring the response rates for inpatients and A&E up to the target levels.

The Trust's Patient Experience Steering group has begun a deep dive in to all FFT areas. This will review the data capture mechanism for FFT, from the perspective of the staff and patients, and ascertain the main factors causing low response rates.

The final report from this deep dive will be presented to the steering group in July.

1.4 Clinical Effectiveness – JUNE 2016

Indicator Description	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current Month Jun-16	Jun-15	Var	YTD Curr Yr	Last Yr	Var	Trend
Crude Mortality Rate	1.36%	1.49%	1.68%	1.46%	1.66%	1.94%	2.03%	2.09%	1.85%	2.31%	2.04%	1.74%	1.52%	1.51%	0.0%	1.76%	1.73%	0.0%	
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	Monitoring	7.68%	7.06%	6.96%	7.39%	6.58%	6.84%	7.30%	7.41%	8.07%	7.82%	11.44%	NO DATA	7.5%					

Commentary:

Crude mortality reduced for the month to its lowest level since September.

Due to systems failure, which impacted upon several database tables, the emergency re-admission figures for June are not yet available.

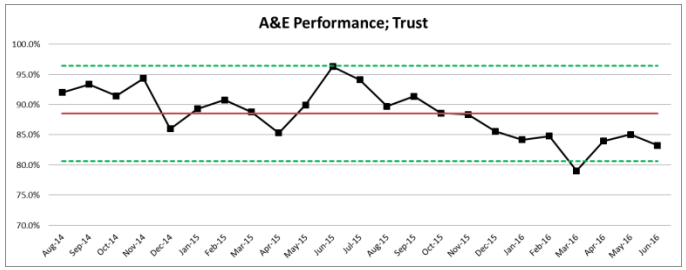
There were 137 deaths in June. The top causes of death were:

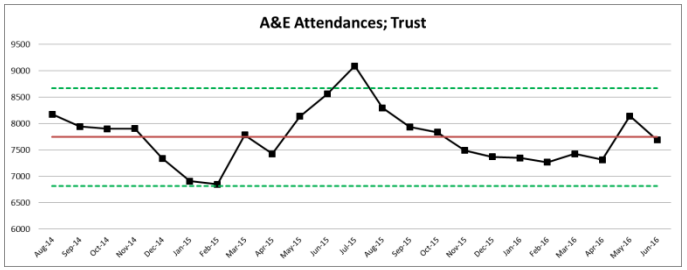
Bronchopneumonia	10
Congestive cardiac failure	6
Pneumonia	5
Multiple organ failure	5
Hypoxic brain injury	4
Aspiration Pneumonia	4
Hypercapnic respiratory failure	4
Acute Myocardial infarction	4

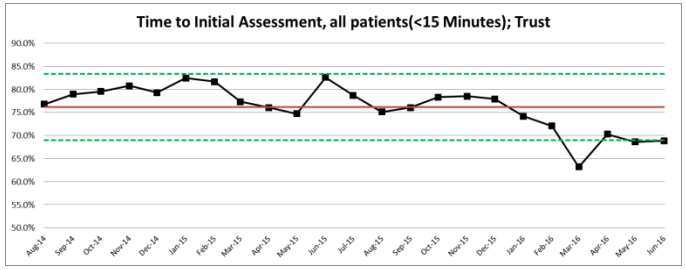
Deaths reviewed within 3 months	**Jan-16**	**Feb-16**	**Mar-16**
TRUST	**66%**	**57%**	**63%**

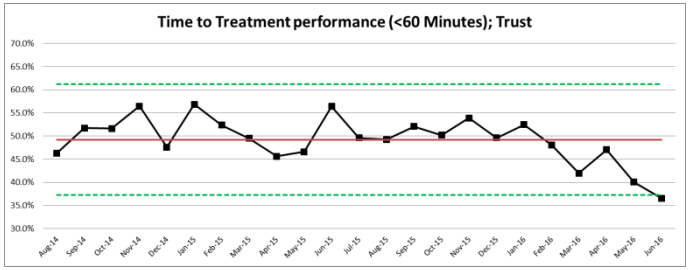
1.5 Access and Delivery – JUNE 2016

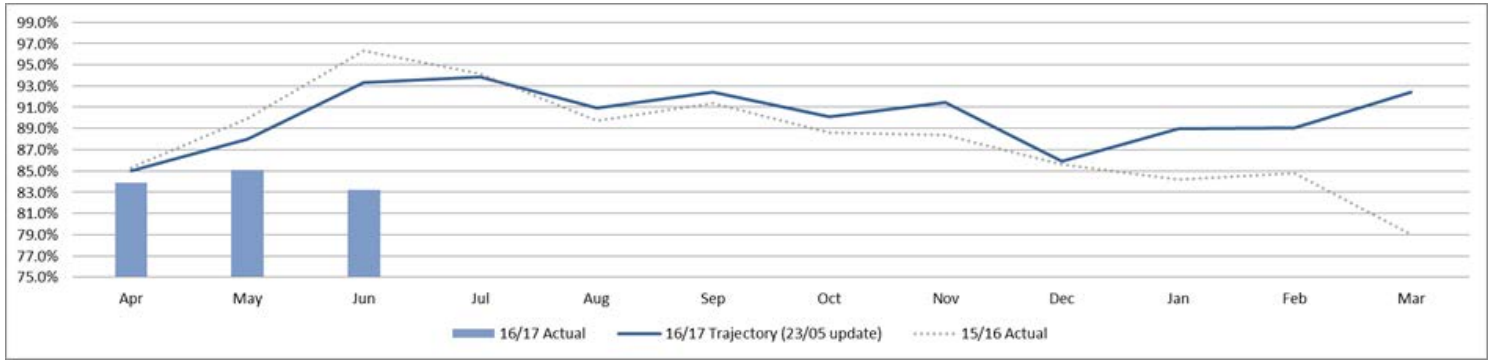
Indicator Description	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current Month Jun-16	Jun-15	Var	YTD Curr Yr	Last Yr	Var	Trend
A&E Monthly Performance (4Hr Wait)-Type 1 Only	95%	94.1%	89.7%	91.4%	88.6%	88.4%	85.6%	84.2%	84.8%	79.0%	83.9%	85.0%	83.2%	96.3%	-13.1%	84.1%	90.5%	-6.5%	
Emergency A&E >12hr to Admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	-1	







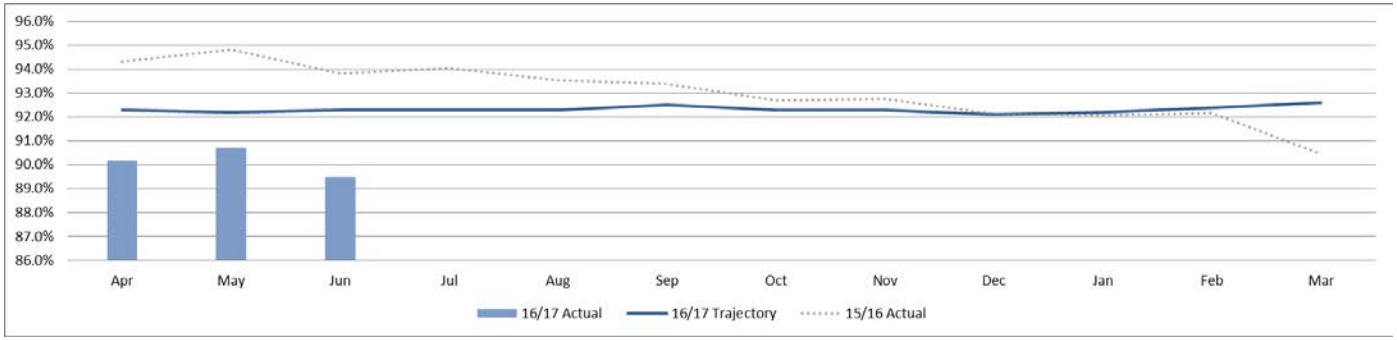




Commentary	Achievement remains below the trajectory target. A number of actions have been completed or are planned to ensure recovery of this position. These include: -Establishment of Emergency Care project Board in July 2016 to improve governance -Implementation of a new medical model, with specific reference to emergency flow, rules of engagement and frailty. This to be agreed on 21st July. -Implementation of Ambulatory Care model together with improvements to the ambulance handover process. -Introduction of Rapid Access & Treatment (RAT) in August 2016 -Improvements to discharge processes, with specific focus on Adult Social Care, Community beds and Assessment -Bed modelling to be undertaken to underpin reconfiguration that will meet real demand.

1.6 Access and Delivery – JUNE 2016

Indicator Description	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current Month Jun-16	Jun-15	Var	YTD Curr Yr	Last Yr	Var	Trend
Referral to Treatment Incomplete	92%	94.1%	93.5%	93.4%	92.7%	92.8%	92.1%	92.1%	92.16%	90.46%	90.17%	90.7%	89.5%	93.8%	-4.3%	90.1%	94.32%	-4.2%	
Referral to Treatment Incomplete 52+ Week Waiters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Diagnostic waiting times	1.0%	0.86%	0.92%	2.16%	1.94%	0.96%	1.98%	3.81%	2.44%	6.67%	2.93%	2.67%	2.57%	2.59%	0.0%	2.72%	2.31%	0.4%	



A review of the capacity and demand gap has been completed. Additional work, via in-house initiatives and independent providers has been identified. There is still a shortfall in capacity that would enable recovery to a sustainable 92%. Work is ongoing with the CCG to review and address any subsequent unmet demand.

Capacity sharing possibilities have been investigated across the STP to support regional RTT delivery.

Commentary

The Trust's access policy has been reviewed and updated in response to comments from the IST.

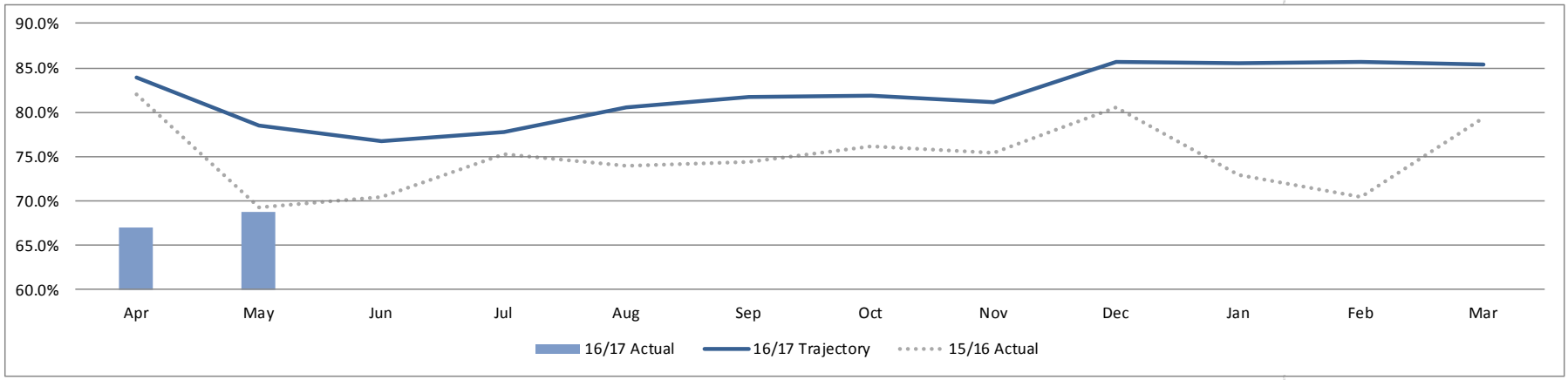
Diagnostic performance in June was 2.57% and remains above the ceiling limit. The Trust is committed to achieving the 1% standard by September 2016. Delivery of endoscopy remains the crucial factor for achievement.

A third Endoscopy room opens on 24th July. In addition there will be a Vanguard on site from 10th August. Locums have been secured to cover Endoscopy and 7 day working will be implemented by October 2016.

1.7 Access and Delivery – APRIL 2016 * Cancer data is always reported 1 month in arrears

Indicator Description	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Current Month May-16	May-15	Var	YTD Curr Yr	Last Yr	Var	Trend
Two Week Wait Standard	93.0%	93.1%	91.7%	85.9%	87.6%	91.3%	89.9%	91.9%	92.5%	94.9%	96.9%	96.0%	95.6%	93.72%	1.9%	92.1%	89.5%	2.6%	
Breast Symptom Two Week Wait Standard	93.00%	91.2%	84.1%	75.8%	81.3%	89.1%	88.5%	90.0%	99.1%	93.0%	90.0%	93.0%	98.5%	96.08%	2.5%	95.4%	88.0%	7.3%	
31 Day Standard	96.0%	95.1%	95.0%	96.9%	98.9%	100.0%	97.4%	98.3%	96.9%	98.8%	99.3%	98.5%	99.4%	98.16%	1.3%	98.0%	97.1%	0.9%	
31 Day Subsequent Drug Standard	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%	100.0%	100.0%	0.0%	
31 Day Subsequent Surgery Standard	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%	100.0%	100.0%	0.0%	
62 Day Standard	85.0%	70.3%	76.1%	73.5%	73.9%	75.2%	75.6%	80.9%	72.6%	69.8%	79.8%	67.0%	68.7%	69.52%	-0.8%	76.7%	83.0%	-6.3%	
62 Day Screening Standard	90.0%	80.0%	83.3%	75.0%	80.0%	83.3%	60.0%	50.0%	0.0%	100.0%	33.3%	100.0%	66.7%	87.50%	-20.8%	86.7%	84.6%	2.1%	
104 Day Waits	Monitoring	11.5	16.0	9.0	7.5	11.0	12.0	#N/A	8.0	12.0	8.0	14.5	3.5	7.5	-4.0				

Cancer 62 Day Standard



Commentary

The Trust has increased the number of 2WW booking clerks, which has ensured that the service is adequately supported. Standard Operation Procedures have been introduced, together with a new Cancer booking escalation policy.

A deep dive into Urology pathways will be undertaken in August, and in addition the Trust will be rolling out a Radiology PTL by September.

2 Nurse advisor roles to begin in August and September. These roles will support the challenges presented by patient choice and compliance with investigation and treatment pathways.

1.8 Access and Delivery – JUNE 2016

Indicator Description	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current Month Jun-16	Jun-15	Var	YTD Curr Yr	Last Yr	Var	Trend
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	0	1	1	1	2	1	0	0	0	0	0.0%	0	0		
Proportion of patients not treated within 28 days of last minute cancellation	0.0%	8.3%	2.9%	0.0%	6.1%	0.0%	0.0%	0.0%	5.7%	6.6%	0.0%	0.0%				79	56		
Delayed Transfers of Care	3.5%	6.7%	7.3%	5.3%	7.7%	7.9%	7.4%	7.5%	10.7%	9.4%	5.2%	5.7%	6.9%	7.3%	-0.4%	5.4%	6.5%	-1.1%	

Commentary

There were no urgent operations cancelled for a second time in June.

All last minute cancellations were rebooked within 28 days in June.

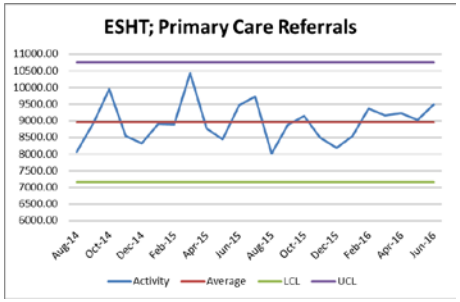
Delayed Transfers of Care, rose slightly in June. The greatest proportion of DTCs were due to patient or family choice or the requirement of further non-acute care.

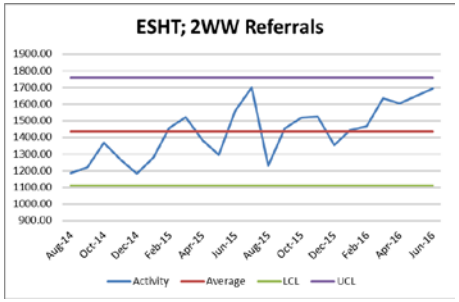
The Trust has begun an assertive discharge partnership with Adult Social Care to enable improvements to be made and DTC rates to improve to target levels.

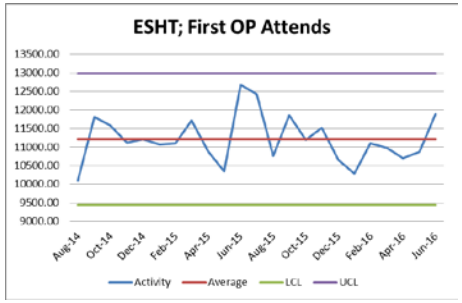
Frailty practitioner nurses have been appointed to support the reduction in LOS.

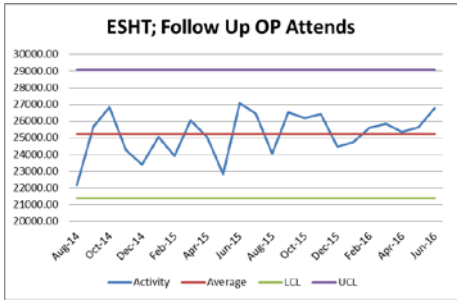
1.9 Activity/Effectiveness – JUNE 2016

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jun-15	Var	Curr Yr	Last Yr	Var	
Primary Referrals	Previous Yr	9,719	8,018	8,867	9,144	8,495	8,193	8,551	9,360	9,164	9,230	9,020	9,481	9,472	0.1%	27,731	26,680	3.9%	
Cons to Cons Referrals	Previous Yr	1,755	1,386	1,418	1,523	1,471	1,224	1,277	1,279	1,294	1,400	1,423	1,995	1,600	24.7%	4,818	4,704	2.4%	
First OP Activity	Previous Yr	12,433	10,763	11,861	11,194	11,523	10,656	10,294	11,107	10,990	10,702	10,872	11,886	12,673	-6.2%	33,460	33,901	-1.3%	
Subsequent OP Activity	Previous Yr	26,461	24,062	26,528	26,190	26,431	24,470	24,735	25,620	25,839	25,375	25,642	26,762	27,066	-1.1%	77,779	74,935	3.8%	









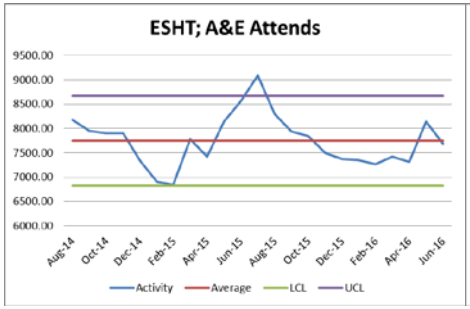
Commentary

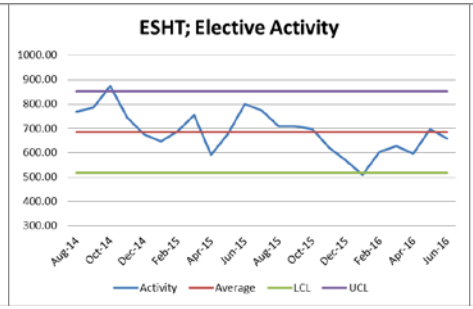
Whilst primary care referrals have remained fairly stable over the last several months, 2WW referrals are continuing to increase. In June 2WW referrals rose again and sit just below the upper control limit. This together with the fact there have been 5 consecutive months above the average, mean further scrutiny is required to determine the cause. This will look at local and national campaigns together with specific referral sources.

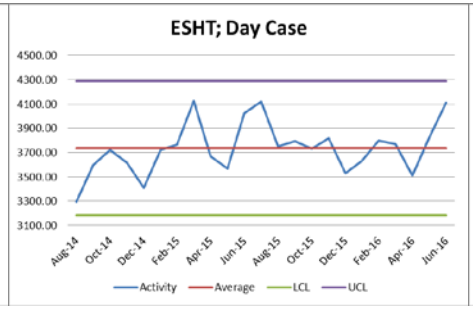
This increase will impact upon admitted and non-admitted pathways and will provide additional challenges to the achievement of 2WW and 62 day cancer standards.

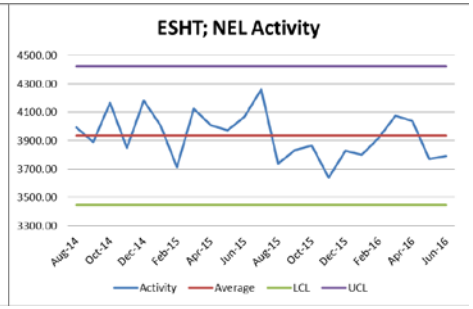
1.10 Activity/Effectiveness – JUNE 2016

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jun-15	Var	Curr Yr	Last Yr	Var	
Elective IP Activity	Previous Yr	773	710	710	696	621	567	511	603	627	596	696	658	799	-17.6%	1,950	2,068	-5.7%	
Elective DC Activity	Previous Yr	4,118	3,751	3,795	3,733	3,818	3,532	3,629	3,800	3,772	3,511	3,822	4,112	4,025	2.2%	11,445	11,259	1.7%	
Non-Elective Activity	Previous Yr	4,260	3,738	3,833	3,866	3,641	3,827	3,800	3,920	4,077	4,038	3,772	3,793	4,068	-6.8%	11,603	12,052	-3.7%	
A&E Attendances	Previous Yr	9,659	9,251	8,685	8,846	8,476	8,612	8,731	8,571	9,398	8,715	9,573	9,240	8,890	3.9%	27,528	26,647	3.3%	
Average LOS Elective	3.0	2.8	3.1	3.1	3.0	3.0	3.2	2.7	3.0	3.0	2.7	3.4	3.1	2.9	7.7%	3.2	3.0	5.4%	
Average LOS Non-Elective	4.6	5.5	5.1	5.7	5.5	5.7	6.2	5.7	5.9	6.0	6.1	5.8	5.7	5.1	12.7%	5.9	5.4	8.5%	









Commentary

Elective activity remains slightly below average and almost 6% lower than in 2015/16. Whilst day case activity appears to be increasing significantly in year and is almost 2% higher than last year. This will partially be due to a number of procedures being moved from elective to day case.

Non Elective activity also remains below average but is almost 4% down on 2015/16.

1.11 Community Services – JUNE 2016

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jun-15	Var	Curr Yr	Last Yr	Var	
Community Nursing Referrals	Monitoring	2,949	2,979	3,485	3,382	3,391	3,577	3,972	3,765	3,839	3,898	3,772	3,959	2,668	48.4%	11,629	7,133	63.0%	
Community Nursing Total Contacts	Monitoring	37,070	34,455	33,905	33,493	32,544	34,110	34,210	32,702	34,514	33,648	35,489	36,007	34,189	5.3%	105,144	101,152	3.9%	
Community Nursing Face to Face Contacts	Monitoring	21,663	19,743	18,923	18,836	18,468	19,112	18,850	18,388	19,532	19,121	20,054	19,503	20,104	-3.0%	58,678	59,800	-1.9%	
% Patient Facing Time	60.00%	58.44%	57.30%	55.81%	56.24%	56.75%	56.03%	55.1%	56.2%	56.6%	56.8%	56.5%	54.2%	58.80%	-7.9%	55.8%	59.12%	-5.6%	
Community Nursing ALOS	42.00	44.12	52.99	38.37	44.66	32.41	32.81	37.4	33.6	37.7	31.1	36.7	43.2	35.33	22.3%	37.5	47.74	-21.4%	

Commentary

Community nursing referrals remain stable following the upward trend from last summer.

Total contacts have continued to increase, whilst face to face contacts have reduced. This needs further scrutiny to ensure that only patient related activity is being included against all contacts. It would suggest that patients are receiving a greater proportion of indirect (non-face to face contact).

2.0 Financial Summary – June 2016

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 3.	R
Revised Plan	The Trust has agreed a new financial plan with NHS Improvement. This is based on a deficit plan 'control total' of £31.3m, replacing the original planned deficit of £48.0m. This is to be achieved by the Trust delivering further financial improvements of £6.3m and receiving a contribution from the national Strategic Transformation Fund (STF) of £10.4m. The revised plan sets an enhanced cost improvement target of £14.5m, compared to the original plan of £10.8m. The STF funding is contingent on meeting key financial and operational targets and the plan assumes these will be met in full.	R
Financial Summary	The Trust performance in month 3 was a run rate deficit of £2.4m with a favourable variance against plan of £1.5m. Sustainability and Transformation Funding (STF) of £10.4m has been agreed for 2016/17 and £2.6m of this has been factored into the month 3 position. Year to date the deficit now stands at £13.6m which is in line with plan.	R
Activity & Income	Total income received during June was £3.0m above planned levels of which £2.6m related to STF. The year to date variance is now £2.9m above plan. Tariff-Excluded Drugs and Devices (TEDDs) income over-performed by £0.2m in month, over-performance now stands at £0.5m YTD. There is however, a corresponding overspend of £0.5m on TEDDs expenditure so therefore, this has a zero effect on the bottom line.	G
Expenditure	Operating Pay costs are above plan by £0.6m in month and are cumulatively £0.5m above plan. Operating Non Pay costs are £1.1m above plan in month and are £2.6m above plan cumulatively. Total costs are now £2.8m overspent year to date	A
CIP plans	The CIP plan for 2016/17 has been increased to £14.5m. CIP achievement year to date was £0.9m which was marginally below the plan.	A
Forecast Outturn	The forecast outturn position is anticipated to be in line with the revised £31.3m deficit plan.	G
Balance Sheet	DH loans have increased by £16.2m in year as a result of the draw down of the revolving working capital facility.	G
Cash Flow	The cash position of the Trust remains extremely challenging as a result of the revenue financial deficit. This continues to result in increasing creditor values and poor performance against the Better Payments Practice Code.	A
Capital Programme	The charge against the Capital Resource Limit (CRL) is £1.6m year to date.	G

2.1 Income & Expenditure – June 2016

Headlines

• Total income in the month was £32.7m against a plan of £29.7m, a favourable variance of £3.0m. The YTD position is £2.9m above plan.

• Total costs in the month were £35.1m, this was £1.5m above plan. The YTD position is now £2.8m above plan.

• The £13.6m year to date deficit is in line with plan.

• Cost improvement plans of £14.5m have been developed for 2016/17 with a YTD achievement of £0.9m.

• Operating pay costs in the month, including ad hoc costs, were £0.6m above plan and are now £0.5m above plan YTD.

• Operating Non Pay costs, including third party costs, were £1.1m above plan in the month and are now £2.6m above plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	23,980	26,955	2,975	70,681	73,180	2,499	296,887
Tariff-Excluded Drugs & Devices	2,608	2,780	172	7,825	8,322	497	31,300
Private Patient/ ICR	243	188	-55	730	631	-99	2,919
Trading Income	483	413	-70	1,451	1,269	-182	3,631
Other Non Clinical Income	2,373	2,354	-19	7,117	7,263	146	29,148
Total Income	**29,687**	**32,690**	**3,003**	**87,804**	**90,665**	**2,861**	**363,885**
Pay Costs	-21,764	-22,334	-570	-65,658	-66,040	-382	-254,067
Ad hoc Costs	-35	-59	-24	-104	-195	-91	-450
Non Pay Costs	-7,659	-8,311	-652	-23,139	-24,581	-1,442	-91,076
Tariff-Excluded Drugs & Devices	-2,608	-2,780	-172	-7,825	-8,322	-497	-31,300
3rd Party Costs	-8	-337	-329	-24	-885	-861	0
Other	83	168	85	250	475	225	1,000
Total Operating Costs	**-31,991**	**-33,653**	**-1,662**	**-96,500**	**-99,548**	**-3,048**	**-375,893**
Surplus/- Deficit from Operations	**-2,304**	**-963**	**1,341**	**-8,696**	**-8,883**	**-187**	**-12,008**
P/L on Asset Disposal	0	0	0	0	0	0	0
Depreciation	-1,043	-1,042	1	-3,130	-3,121	9	-12,519
Impairment	0	0	0	0	0	0	0
PDC Dividend	-406	-479	-73	-1,217	-1,291	-74	-5,162
Interest	-177	98	275	-530	-251	279	-1,611
Total Non Operating Costs	**-1,626**	**-1,423**	**203**	**-4,877**	**-4,663**	**214**	**-19,292**
Total Costs	**-33,617**	**-35,076**	**-1,459**	**-101,377**	**-104,211**	**-2,834**	**-395,185**
Net Surplus/-Deficit	**-3,930**	**-2,386**	**1,544**	**-13,573**	**-13,546**	**27**	**-31,300**
Donated Asset/Impairment Adjustment	0	-23	-23	0	-21	-21	0
Adjusted Net Surplus/-Deficit	**-3,930**	**-2,409**	**1,521**	**-13,573**	**-13,567**	**6**	**-31,300**

2.2 Cash Flow – June 2016

Headlines

- The cash balance at the financial year end was £2.1m as required by the Department of Health.
- The Trust has in place a revolving working capital facility (RWCF) draw down of £31.3m against which £16.2m was drawn down at 30th June 2016.
- This new RWCF loan is repayable in April 2020.
- The cash flow now also reflects the revised trust planned deficit of £31.3m.
- It has been agreed that the Trust will receive a cash advance of £12m in July from the CCGs. This will be used to reduce trade creditors and is repayable in March 2017.
- Should the Trust be unable to deliver its planned deficit the level of trade & other payables would increase and that could risk non-delivery of goods and services.

Cash Flow Statement April 2016 to March 2017

£000s	Apr Actual	May Actual	Jun Actual	July Forecast	Aug Forecast	Sept Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast
Cash Flow from Operations												
Operating Surplus/(Deficit)	-4,616	-5,384	-2,004	-387	-2,096	-1,956	-2,287	-1,690	-1,769	-1,153	-1,230	45
Depreciation and Amortisation	1,039	1,040	1,042	1,043	1,043	1,043	1,043	1,043	1,043	1,044	1,044	1,051
Impairments	-3,577	-4,344	-962	656	-1,053	-913	-1,244	-647	-726	-109	-186	1,096
Interest Paid	-177	-176	96	-1	-267	-66	-1	-1	-1	-1	-269	-775
Dividend (Paid)/Refunded						-2,209						-2,581
(Increase)/Decrease in Inventories	-90	209	-182	0								63
(Increase)/Decrease in Trade and Other Receivables	-2,003	-1,684	-2,895	360	360	7,150	500	0	0	500	500	-3,220
Cash advance from CCGs				12,000								-12,000
Increase/(Decrease) in Trade and Other Payables	1,574	2,598	-2,164	-10,843	-569	-6,598	254	-327	-1,222	-499	1,177	18,169
Provisions Utilised	11	11	10	-40	-40	-40	-40	-40	-40	-40	-40	-184
Net Cash Inflow/(Outflow) from Operating Activities	**-4,262**	**-3,386**	**-6,097**	**2,132**	**-1,569**	**-2,676**	**-531**	**-1,015**	**-1,989**	**-149**	**1,182**	**568**
Cash Flows from Investing Activities:												
Interest Received	2	3	2	2	2	3	2	2	3	2	2	3
(Payments) for Property, Plant and Equipment	-978	-937	-1,069	-500	-500	-915	-2,000	-2,000	-2,000	-3,000	-2,000	-1,605
(Payments) for Intangible Assets	-35	-20	-1	-40	-40	-40	-40	-40	-40	-40	-40	-104
Net Cash Inflow/(Outflow) from Investing Activities	**-1,011**	**-954**	**-1,068**	**-538**	**-538**	**-952**	**-2,038**	**-2,038**	**-2,037**	**-3,038**	**-2,038**	**-1,706**
Net Cash Inflow/(Outflow) before Financing	**-5,273**	**-4,340**	**-7,165**	**1,594**	**-2,107**	**-3,628**	**-2,569**	**-3,053**	**-4,026**	**-3,187**	**-856**	**-1,138**
New Capital PDC	0	0	0	0	0	0	0	0	0	0	0	0
Revolving Working Capital Facility (RWCF)	7,290	4,982	3,930	4,163	2,648	1,725	1,725	1,725	1,725	1,387	0	0
Repayment of RWCF	0	0	0	0	0	0	0	0	0	0	0	0
New interim revenue support facility	0	0	0	0	0	0	0	0	0	0	0	0
New Capital Loan	0	0	0	0	0	0	5,000	0	0	0	0	0
Loans and Finance Lease repaid	0	0	0	0	0	-126	0	0	0	0	0	-426
Net Cash Inflow/(Outflow) from Financing Activities	7,290	4,982	3,930	4,163	2,648	1,599	6,725	1,725	1,725	1,387	0	-426
Net Increase/(Decrease) in Cash	2,017	642	-3,235	5,757	541	-2,029	4,156	-1,328	-2,301	-1,800	-856	-1,564
Opening balance	2,100	4,117	4,759	1,524	7,281	7,822	5,793	9,949	8,621	6,320	4,520	3,664
Closing balance	4,117	4,759	1,524	7,281	7,822	5,793	9,949	8,621	6,320	4,520	3,664	2,100

2.3 Balance Sheet – June 2016

Headlines

- The forecast increase in non current borrowings is in respect of the interim revolving working capital support facility (RWCF) required to finance the planned £31.3m revenue deficit.
- The reduction in the forecast retained earnings reserve is also a result of the planned deficit.

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Plan March 2017
Non Current Assets			
Property plant and equipment	231,172	229,743	244,661
Intangilble Assets	1,650	1,706	2,130
Trade and other Receivables	1,193	1,237	1,193
	234,015	**232,686**	**247,984**
Current Assets			
Inventories	6,472	6,535	6,341
Trade receivables	8,397	9,362	5,773
Other receivables	8,146	13,719	5,601
Other current assets	0	0	0
Cash and cash equivalents	2,100	1,524	2,100
	25,115	**31,140**	**19,815**
Current Liabilities			
Trade payables	-13,571	-22,453	-12,639
Other payables	-25,618	-18,743	-23,812
DH Capital Investment Loan	-427	-427	-427
DH Working Capital Loan	0	0	0
Other Financial Liabilities	0	0	0
Provisions	-253	-286	-552
	-39,869	**-41,909**	**-37,430**
Non Current Liabilities			
DH Capital Investment Loan	-3,767	-3,553	-7,876
Borrow ings - Revenue Support Facility	-35,004	-51,420	-66,518
DH Working Capital Loan	0	0	0
Other Financial Liabilities	0	0	0
Provisions	-2,709	-2,709	-2,902
	-41,480	**-57,682**	**-77,296**
Total Assets Employed	**177,781**	**164,235**	**153,073**
Financed by:			
Public Dividend Capital (PDC)	153,562	153,562	153,562
Revaluation Reserve	98,247	98,247	104,746
Retained Earnings Reserve	-74,028	-87,574	-105,235
Total Taxpayers' Equity	**177,781**	**164,235**	**153,073**

2.4 Receivables, Payables & Better Payments Practice Code Performance – June 2016

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, in month 35% 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%.
- The current Aged Debt KPI is 29% at 30th June 2016.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	NHS Debt Outstanding		Non-NHS Debt Outstanding	
	Current Month £000s	Previous Month £000s	Current Month £000s	Previous Month £000s
0 - 30 Days	4,180	2,186	688	776
31 - 60 Days	954	468	549	229
61 -90 Days	152	1,199	139	1,001
91 - 120 Days	817	111	913	63
> 120 Days	550	629	419	382
Total	6,653	4,593	2,708	2,451

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	7,633	6,572	8,533	7,133
31 - 60 Days	6,808	6,816	7,372	7,650
61 -90 Days	2,255	1,015	3,611	2,502
91 - 120 Days	493	726	1,071	1,148
> 120 Days	1,557	1,249	1,866	1,244
Total	18,746	16,378	22,453	19,677

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	27.73%	34.90%	35.84%	43.72%
NHS invoices paid within contract or 30 days of receipt	42.28%	91.52%	28.72%	86.05%

2.5 Key Performance Indicators – June 2016

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 in the plan, the bottom-line I&E assessment (1a) has an overriding effect on the overall Trust rating. As the Trust has set a deficit plan this rating is red and under the revised TDA criteria, the overall Trust rating is red.

Monitor Financial Sustainability Risk Ratings

• The Trust has a liquidity ratio rating of 1, a capital servicing capacity ratio of 1, an I&E margin of 1 and a variance in I&E margin of 4. This results in an overall rating of 1.

Better Payments Practice Code (BPPC)

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

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

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

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	44	95
BPPC – NHS Invoices by value (%)	86	95

2.6 Activity & Contract Income – June 2016

Headlines

- The Trust is on a PbR Contract with the 3 local CCGs for 2016/17. This is a change to the 'Cap & Collar' Risk share contract in 2015/16.
- The planned activity in the table on the right represents the TDA plan and not the activity contracted by CCGs & NHSE.
- NHS Patient Income at month 3 was £3.0m above the TDA plan.
- This is mainly linked to Non-Elective activity being £1m over plan (£811k Urgent Care – General Medicine & Geriatric Medicine), ESHT accessing 3 months of the STF funding and Elective activity £562k over plan (Cardiology Day Cases & T&O Elective). Partially offset by under performance in Audiology and maternity pathways (which is currently being investigated).
- A provision for Fines & Penalties has been made of £269k. This relates to MRSA & C Diff breaches.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,760	3,197	-563	10,767	9,371	-1,396
Elective Inpatients	686	685	-1	1,965	1,945	-20
Emergency Inpatients	3,547	3,342	-205	10,759	10,630	-129
Total Inpatients	**7,993**	**7,224**	**-769**	**23,491**	**21,946**	**-1,545**
Excess Bed Days	2,170	3,339	1,169	6,552	6,866	314
Total Excess Bed Days	**2,170**	**3,339**	**1,169**	**6,552**	**6,866**	**314**
Consultant First Attendances	8,277	8,586	309	23,703	23,528	-175
Consultant Follow Ups	12,935	13,657	722	37,039	38,043	1,004
OP Procedures	4,719	4,686	-33	13,513	13,200	-313
Other Outpatients inc WA & Nurse Led	12,702	14,222	1,520	36,372	38,606	2,234
Community Specialist	180	276	96	516	696	180
Total Outpatients	**38,813**	**41,427**	**2,614**	**111,143**	**114,073**	**2,930**
Chemotherapy Unbundled HRGs	646	517	-129	1,849	3,523	1,674
Antenatal Pathways	324	283	-41	930	830	-100
Post-natal Pathways	299	209	-90	856	722	-134
A&E Attendances (excluding type 2's)	9,171	9,475	304	27,817	28,101	284
ITU Bed Days	501	374	-127	1,519	1,441	-78
SCBU Bed Days	298	93	-205	906	757	-149
Cardiology - Direct Access	71	47	-24	203	192	-11
Radiology - Direct Access	5,346	5,673	327	15,308	17,049	1,741
Pathology - Direct Access	289,731	298,505	8,774	829,685	861,048	31,363
Therapies - Direct Access	2,662	4,060	1,398	7,622	8,473	851
Audiology	1,063	666	-397	3,042	2,116	-926
Midwifery	14	11	-3	39	31	-8

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,288	4,804	516	12,280	12,842	562
Inpatients - Emergency	6,107	6,496	389	18,523	19,579	1,056
Excess Bed Days	479	731	252	1,447	1,496	49
Outpatients	4,183	4,451	268	11,982	12,338	356
Other Acute based Activity	2,771	2,476	-295	8,277	7,894	-383
Direct Access	810	889	79	2,316	2,490	174
Block Contract	4,194	6,002	1,808	12,581	14,776	2,195
Fines & Penalties	0	505	505	0	-269	-269
Other	668	152	-516	1,835	475	-1,360
CQUIN	480	449	-31	1,440	1,559	119
Subtotal	23,980	26,955	2,975	70,681	73,180	2,499
Exclusions	2,608	2,780	172	7,825	8,322	497
GRAND TOTAL	**26,588**	**29,735**	**3,147**	**78,506**	**81,502**	**2,996**

2.7 Clinical Unit, Commercial & Corporate Performance (budgets) – June 2016

Headlines

Pay

Total Pay reported an overspend of £0.6m against plan in the month.

Total agency spend in June has increased by £0.2m compared to the previous month and reported at £2.1m spend in June. Continued use of escalation areas and medical agency covering vacancies in Urgent Care and Surgery.

Non pay

Total non pay recorded a £0.7m overspend in June and cumulatively £1.9m.

Surgery have outsourced activity to third party providers at a cost of £0.3m in June and Specialist Medicine have overspent £0.1m from use of Medinet.

Tariff Exclusions were £0.2m overspent in month and £0.5m to date, offset by over delivery on income.

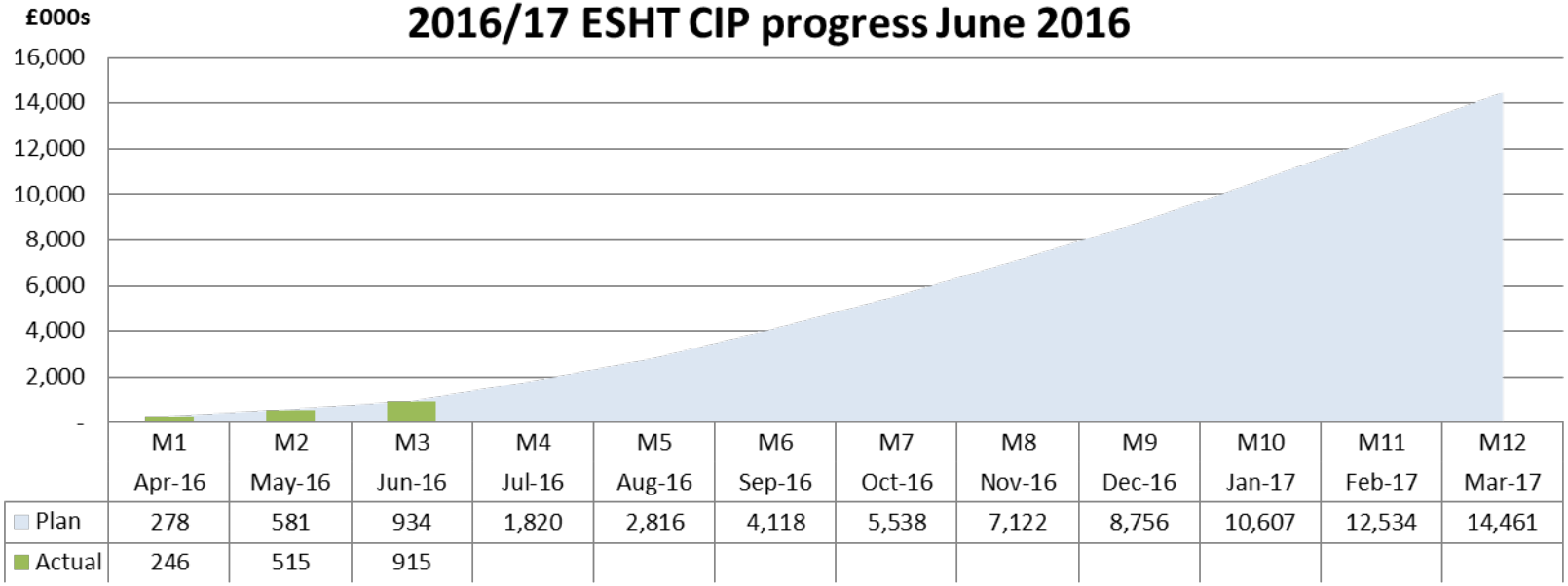
Income

Non-contract Income reported an adverse variance of £0.2m in month, private patient income is £0.1m below plan

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	-2,527	-2,726	-199	-7,408	-8,014	-606
Specialist Medicine	-1,933	-1,982	-49	-5,750	-5,956	-206
Cardiovascular	-1,430	-1,604	-174	-4,279	-4,617	-338
Surgery	-3,254	-3,955	-701	-9,866	-11,545	-1,679
Women & Children	-2,468	-2,525	-57	-7,497	-7,465	32
Out of Hospital Care	-2,421	-2,414	7	-7,302	-7,134	168
Clinical Support	-6,731	-7,005	-274	-20,170	-21,219	-1,049
Tariff-Excluded Drugs & Devices	-2,608	-2,780	-172	-7,825	-8,322	-497
COO Operations	-1,056	-1,100	-44	-3,188	-3,261	-73
Total Clinical Units	**-24,428**	**-26,091**	**-1,663**	**-73,285**	**-77,533**	**-4,248**
Estates & Facilities	-1,960	-2,201	-241	-5,927	-6,391	-464
Corporate Services	-2,449	-2,716	-267	-7,348	-7,915	-567
Central Items	-1,926	-1,298	628	-6,162	-3,830	2,332
Total Central Areas	**-6,335**	**-6,215**	**120**	**-19,437**	**-18,136**	**1,301**
Contract Income	26,588	29,735	3,147	78,506	81,502	2,996
Non-contract Income	245	185	-60	643	621	-22
Donated Asset/Impairment Adjustment	0	-23	-23	0	-21	-21
Adjusted Net Surplus/- Deficit	**-3,930**	**-2,409**	**1,521**	**-13,573**	**-13,567**	**6**

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
633	695	Urgent Care	-2,400	-2,572	-172	-7,047	-7,593	-546
480	467	Specialist Medicine	-1,787	-1,749	38	-5,323	-5,189	134
292	306	Cardiovascular	-1,150	-1,243	-93	-3,451	-3,601	-150
822	777	Surgery	-3,008	-3,301	-293	-9,167	-9,748	-581
617	555	Women & Children	-2,283	-2,311	-28	-6,944	-6,866	78
772	734	Out of Hospital Care	-2,250	-2,292	-42	-6,748	-6,708	40
1,109	1,110	Clinical Support	-4,343	-4,468	-125	-13,019	-13,441	-422
402	419	COO Operations	-992	-1,056	-64	-2,976	-3,097	-121
5,127	**5,064**	**Total Clinical Units**	**-18,213**	**-18,992**	**-779**	**-54,675**	**-56,243**	**-1,568**
705	744	Estates & Facilities	-1,450	-1,557	-107	-4,352	-4,564	-212
605	563	Corporate Services	-1,867	-1,831	36	-5,481	-5,390	91
1,310	**1,307**	**Total Non-Clinical Divisions**	**-3,317**	**-3,388**	**-71**	**-9,833**	**-9,954**	**-121**
0	**0**	Central Items	-269	-13	256	-1,254	-38	1,216
6,437	**6,371**	**Total Pay Analysis**	**-21,799**	**-22,393**	**-594**	**-65,762**	**-66,235**	**-473**

2.8 CIP Performance to date – June 2016



	M1 Apr-16	M2 May-16	M3 Jun-16	M4 Jul-16	M5 Aug-16	M6 Sep-16	M7 Oct-16	M8 Nov-16	M9 Dec-16	M10 Jan-17	M11 Feb-17	M12 Mar-17
Plan	278	581	934	1,820	2,816	4,118	5,538	7,122	8,756	10,607	12,534	14,461
Actual	246	515	915									

Theme	YTD Plan £000	YTD Actual £000	YTD Var £000
Clinical services productivity	121	141	-20
Corporate, administrative estates	237	140	97
Direct engagement	-	-	-
IM&T schemes	40	-	40
Income generation	69	76	-7
Lord Carter	-	-	-
Medicines Management	39	195	-156
Procurement	410	319	91
Redesign	18	44	-26
Streched target	-	-	-
Total	**934**	**915**	19

Clinical Unit	YTD Plan £000	YTD Actual £000	YTD Var £000
Cardiovascular	-	11	-11
Estates & Facilities	187	80	108
Operational COO	31	37	-6
Corporate	171	119	52
Specialist Medicine	22	22	-
Surgery	220	220	-0
Urgent	41	41	-
Women's & Children's	170	170	-0
Out of Hospital	21	13	8
Clinical Support	249	204	46
Trustwide	-178	-	-178
Total	**934**	**915**	19

2.9 Year on Year Comparisons – June 2016

Headlines

- Total Inpatient activity to date is 9.9% lower than last year's level.
- Total outpatients are 6.0% higher than last year.
- Total A&E attendances are 4.8% higher than last year.
- Total income is £2.2m (2.5%) up on the same period last year.
- Total expenditure is £5.5m (5.6%) up on the same period last year.

Activity	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	9,371	11,188	-1,817	-16.2%
Elective Inpatients	1,945	1956	-11	-0.6%
Emergency Inpatients	10,630	11,225	-595	-5.3%
Total Inpatients	**21,946**	**24,369**	**-2,423**	**-9.9%**
Elective Excess Bed Days	435	364	71	19.5%
Non elective Excess Bed Days	6,431	5,029	1,402	27.9%
Total Excess Bed Days	**6,866**	**5,393**	**1,473**	**27.3%**
Consultant First Attendances	23,528	22,857	671	2.9%
Consultant Follow Ups	38,043	35,853	2,190	6.1%
OP Procedures	13,200	12,217	983	8.0%
Other Outpatients (WA & Nurse Led)	38,606	36,269	2,337	6.4%
Community Specialist	696	415	281	67.7%
Total Outpatients	**114,073**	**107,611**	**6,462**	**6.0%**
Chemotherapy Unbundled HRGs	3,523	1,580	1,943	123.0%
Antenatal Pathways	830	874	-44	-5.0%
Post-natal Pathways	722	900	-178	-19.8%
A&E Attendances (excluding type 2's)	28,101	26,806	1,295	4.8%
ITU Bed Days	1,441	1,485	-44	-3.0%
SCBU Bed Days	757	1,051	-294	-28.0%
Cardiology - Direct Access	192	122	70	57.4%
Radiology - Direct Access	17,049	15,501	1,548	10.0%
Pathology - Direct Access	861,048	811,619	49,429	6.1%
Therapies - Direct Access	8,473	8,406	67	0.8%
Audiology	2,116	3,670	-1,554	-42.3%
Midwifery	31	38	-7	-18.4%

Income £000s	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	81,502	79,586	1,916	2.4%
Private Patient/ RTA	631	780	-149	-19.1%
Trading Income	1,269	1,475	-206	-14.0%
Other Non Clinical Income	7,263	6,605	658	10.0%
Total Income	**90,665**	**88,446**	**2,219**	**2.5%**
Pay Costs	-66,235	-63,426	-2,809	-4.4%
Non Pay Costs	-33,788	-30,203	-3,585	-11.9%
Other	475	375	100	
Total Direct Costs	-99,548	-93,254	-6,294	-6.7%
Surplus/-Deficit from Operations	**-8,883**	**-4,808**	**-4,075**	**-84.8%**
Profit/Loss on Asset Disposal	0	6	-6	
Depreciation	-3,121	-3,298	177	5.4%
Impairment	0	0	0	
PDC Dividend	-1,291	-1,941	650	33.5%
Interest	-251	-236	-15	-6.4%
Total Indirect Costs	-4,663	-5,469	806	14.7%
Total Costs	**-104,211**	**-98,723**	**-5,488**	**-5.6%**
Net Surplus/-Deficit	**-13,546**	**-10,277**	**-3,269**	**-31.8%**
Donated Asset / Other Adjustment	-21	84	-105	125.0%
Normalised Net Surplus/-Deficit	**-13,567**	**-10,193**	**-3,374**	**-33.1%**

2.10 Capital Programme – June 2016

Headlines

The Trust's capital programme continues to be planned on the following basis:-

- Routine capital replacement is planned within the limit of depreciation.
- Significant support from the Friends of the Hospitals.

In addition, the Trust included £5m request for a loan within its 2016/17 financial planning submission to the NHS Improvement (NHSI), representing the first year's spend on urgent estates strategy work for which a business case is being prepared. At this stage, this bid for additional resources has been excluded from the current year capital resource limit pending business case approval by NHSI.

The limited level of 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 the replacement of essential equipment and a consequent increase in maintenance expenditure.

Year To Date Performance:-
After three months, capital expenditure amounted to £1,589k, principally on brought forward commitments, minor capital schemes, pathology and donated purchases.

Following an accounting change required by NHSI, donated income can no longer be automatically credited against the Trust's capital resource limit (CRL). Donations can now only be included when the cash proceeds related to these receipts has been received. At month 3, donated income not yet received in respect of agreed donated purchases amounted to £96k.

Capital Investment Programme £000s	2016/17 Capital Programme	Expenditure at Month 3
Capital Resources		
Depreciation	11,519	
Interest Bearing Capital Loan Application. (Not currently approved by the NHSI.)	0	
League of Friends Support	1,000	
Cap Investment Loan Principal Repayment	-552	
Gross Capital Resource	11,967	
Less Donated Income	-1,000	
Capital Resource Limit (CRL)	**10,967**	-
Capital Investment		
Medical Equipment *	0	0
IT Systems	2,780	101
Electronic Document Management	1,112	99
Estates Strategy	2,500	1
Backlog Maintenance	2,258	106
Minor Capital Schemes	1,000	475
Pathology CLD	727	205
Vital Pac	338	144
Project Management	106	22
Brought Forward Commitments - Various	1,096	340
Sub Total	**11,917**	**1,493**
Donated Asset Purchases	1,000	255
Donated Asset Funding	-1,000	-159
Net Donated Assets	**0**	96
Sub Total Capital Schemes	**11,917**	**1,589**
Overplanning Margin (-) Underplanning (+)	-950	0
Net Capital Charge against the CRL	**10,967**	**1,589**

* Note: Medical equipment with a capital equivalent value of £2m is planned to be funded through revenue leasing in 2016/17.

2.11 Financial Sustainability Risk Ratings – June 2016

Headlines

Financial Sustainability Risk Ratings (FSRR):-

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

- Monitor assigns ratings between 1 and 4 to each component of the FSRR with 1 being the worst rating and 4 the best. The overall rating is the average of the four.
  - The liquidity ratio of -16 days, a rating of 1.
  - The capital servicing capacity ratio of -5.90 results in a rating of 1.
  - The I&E margin of -15.0% results in a rating of 1.
  - The variance in I&E margin is 0.5%, a rating of 4.
  - As a result the overall Trust rating is 1.

Liquidity Ratio (days) £000s	2015/16 Outturn	2016/17 YTD
Opening Current Assets	25,115	31,140
Opening Current Liabilities	-39,869	-41,909
Net Current Assets/Liabilities	-14,754	-10,769
Inventories	-6,472	-6,535
Adj Net Current Assets/Liabilities	**-21,226**	**-17,304**
Divided by:		
Total costs in year	383,768	99,548
Multiply by (days)	360	90
Liquidity Ratio	**-20**	**-16**

Capital Servicing Capacity (times) £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual
Net Surplus / Deficit (-) After Tax	-47,759	-13,573	-13,546
Less:			
Donated Asset Income Adjustment	-947	-250	-255
Interest Expense	846	537	257
Profit/Loss on Sale of Assets	-29	0	0
Depreciation & Amortisation	12,664	3,130	3,121
Impairments	-411	0	0
PDC Dividend	6,940	1,217	1,291
Revenue Available for Debt Service	**-28,696**	**-8,939**	**-9,132**
Interest Expense	846	537	257
PDC Dividend	6,940	1,217	1,291
Temporary PDC repayment			
Working capital loan repayment	31,842		
Capital loan repayment	335		
	39,963	1,754	1,548
Capital Serving Capacity	**-0.72**	**-5.10**	**-5.90**

Financial Efficiency £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual	2016/17 YTD Variance
Normalised Net surplus/ deficit	-47,759	-13,573	-13,546	
Less fixed asset impairments/disposals	-440	0	0	
	-48,199	-13,573	-13,546	
Divided by:				
Total Income (excl donated assets)	-355,205	-87,554	-90,410	
I&E Margin	**-13.6%**	**-15.5%**	**-15.0%**	**0.5%**

2.12 Financial Risks & Mitigating Actions – June 2016

Headlines

Financial Sustainability Risk Ratings (FSRR):-

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

- Monitor assigns ratings between 1 and 4 to each component of the FSRR with 1 being the worst rating and 4 the best. The overall rating is the average of the four.
  - The liquidity ratio of -16 days, a rating of 1.
  - The capital servicing capacity ratio of -5.90 results in a rating of 1.
  - The I&E margin of -15.0% results in a rating of 1.
  - The variance in I&E margin is 0.5%, a rating of 4.
  - As a result the overall Trust rating is 1.

Liquidity Ratio (days) £000s	2015/16 Outturn	2016/17 YTD
Opening Current Assets	25,115	31,140
Opening Current Liabilities	-39,869	-41,909
Net Current Assets/Liabilities	-14,754	-10,769
Inventories	-6,472	-6,535
Adj Net Current Assets/Liabilities	**-21,226**	**-17,304**
Divided by:		
Total costs in year	383,768	99,548
Multiply by (days)	360	90
Liquidity Ratio	**-20**	**-16**

Capital Servicing Capacity (times) £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual
Net Surplus / Deficit (-) After Tax	-47,759	-13,573	-13,546
Less:			
Donated Asset Income Adjustment	-947	-250	-255
Interest Expense	846	537	257
Profit/Loss on Sale of Assets	-29	0	0
Depreciation & Amortisation	12,664	3,130	3,121
Impairments	-411	0	0
PDC Dividend	6,940	1,217	1,291
Revenue Available for Debt Service	**-28,696**	**-8,939**	**-9,132**
Interest Expense	846	537	257
PDC Dividend	6,940	1,217	1,291
Temporary PDC repayment			
Working capital loan repayment	31,842		
Capital loan repayment	335		
	39,963	1,754	1,548
Capital Serving Capacity	**-0.72**	**-5.10**	**-5.90**

Financial Efficiency £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual	2016/17 YTD Variance
Normalised Net surplus/ deficit	-47,759	-13,573	-13,546	
Less fixed asset impairments/disposals	-440	0	0	
	-48,199	-13,573	-13,546	
Divided by:				
Total Income (excl donated assets)	-355,205	-87,554	-90,410	
I&E Margin	**-13.6%**	**-15.5%**	**-15.0%**	**0.5%**

3.0 Leadership & Culture; Executive Summary – Key Points – JUNE 2016

Headlines
• Actual workforce usage of staff in June was 6370.72 full time equivalents (ftes), 66.35 below budgeted establishment. • Temporary staff expenditure was £3,464K in June (15.47% of total pay expenditure). This comprises £1,360K bank expenditure, £2,061K agency expenditure and £43K overtime. This is an increase of £245K overall compared to May. • There were 611.23 fte vacancies (a vacancy factor of 9.77%). This was an increase of 31.78 fte vacancies though was due to an increase in the budgeted establishment of 55.84 ftes • Annual turnover was 10.03% which represents 535.28 fte leavers in the last year. This is a slight increase of 0.03% compared to last month. • Monthly sickness was 3.77%, a decrease of 0.17% from May. The annual sickness rate was 4.42%, a decrease of 0.04%. • Mandatory training rates have all increased, with the exception of Induction, Deprivation of Liberties and Safeguarding Children Level 2 which were slightly lower. The overall mandatory training rate was 87.92% an overall increase of 0.41% • Appraisal compliance decreased by 1.61% to 88.07%

3.1 Trust Overview – JUNE 2016

TRUST	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Trend line
WORKFORCE CAPACITY													
Budgeted fte	6233.56	6239.90	6244.41	6240.44	6028.97	6059.16	6057.38	6057.36	6057.39	6368.93	6381.23	6437.07	
Total fte usage	6216.76	6243.02	6237.90	6281.08	6236.91	6226.53	6282.89	6334.88	6492.33	6320.64	6340.02	6370.72	
Variance	16.8	-3.12	6.51	-40.64	-207.94	-167.37	-225.51	-277.52	-434.94	48.29	41.21	66.35	
Permanent vacancies	556.18	542.99	542.14	514.02	479.35	479.90	464.71	422.43	342.18	606.76	579.45	611.23	
Fill rate	90.84%	91.07%	91.09%	91.55%	91.83%	91.87%	92.12%	92.84%	94.20%	90.17%	90.66%	90.23%	
Bank fte usage (as % total fte usage)	6.15%	6.42%	6.34%	6.34%	6.75%	6.68%	6.27%	6.65%	6.58%	6.97%	6.23%	6.26%	
Agency fte usage (as % total fte usage)	5.64%	5.33%	5.08%	5.30%	6.94%	6.45%	7.35%	7.06%	8.09%	5.29%	5.37%	5.49%	
WORKFORCE EFFICIENCY													
Annual sickness rate	4.94%	4.91%	4.86%	4.77%	4.72%	4.61%	4.54%	4.53%	4.53%	4.50%	4.46%	4.42%	
Monthly sickness rate (%)	4.21%	4.26%	4.36%	4.51%	4.60%	4.48%	4.45%	5.10%	4.79%	4.18%	3.94%	3.77%	
Turnover rate	12.26%	12.20%	11.77%	12.24%	12.07%	11.97%	11.79%	11.28%	10.62%	10.25%	10.00%	10.03%	
TRAINING & APPRAISALS													
Appraisal rate	75.03%	73.69%	77.60%	77.93%	81.83%	81.85%	83.34%	85.29%	87.26%	88.47%	89.68%	88.07%	
Fire	83.78%	83.03%	82.90%	82.77%	84.49%	83.49%	83.96%	85.07%	85.31%	86.25%	87.01%	87.62%	
Moving & Handling	85.44%	84.21%	85.24%	85.02%	85.81%	85.76%	86.93%	88.09%	88.25%	89.43%	89.57%	89.91%	
Induction	94.62%	90.95%	92.53%	91.89%	93.66%	90.95%	91.97%	92.79%	93.83%	93.67%	94.69%	94.38%	
Infec Control	85.78%	84.58%	85.82%	85.81%	86.83%	86.53%	86.99%	87.86%	87.37%	87.92%	88.40%	89.24%	
Info Gov	82.57%	82.38%	82.25%	83.41%	87.40%	86.42%	86.81%	86.23%	85.49%	84.78%	84.48%	84.51%	
Health & Safety	74.80%	75.47%	78.16%	80.03%	82.88%	83.67%	84.42%	85.35%	85.94%	86.74%	87.42%	87.95%	
MCA	93.02%	92.80%	93.18%	92.84%	93.39%	93.36%	93.10%	93.40%	93.10%	93.92%	93.37%	94.13%	
DoLs	90.88%	90.82%	91.44%	91.31%	91.81%	92.29%	92.78%	93.29%	93.81%	94.06%	95.35%	95.04%	
Safeguarding Vulnerable Adults	75.08%	74.62%	76.05%	76.05%	77.64%	78.06%	78.28%	79.06%	79.71%	81.54%	81.37%	83.10%	
Safeguarding Children Level 2	80.13%	79.19%	80.59%	80.40%	81.42%	80.75%	81.45%	82.46%	82.12%	83.25%	83.35%	82.93%	

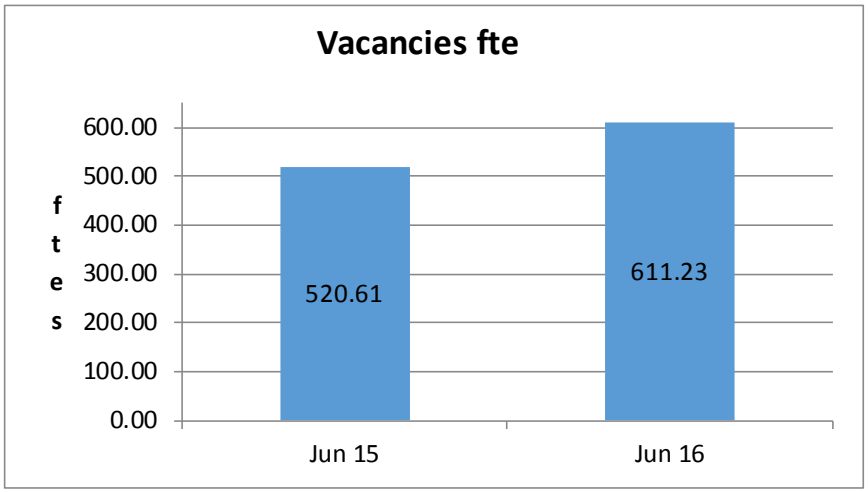
3.2 Trust Overview – Clinical Units – JUNE 2016

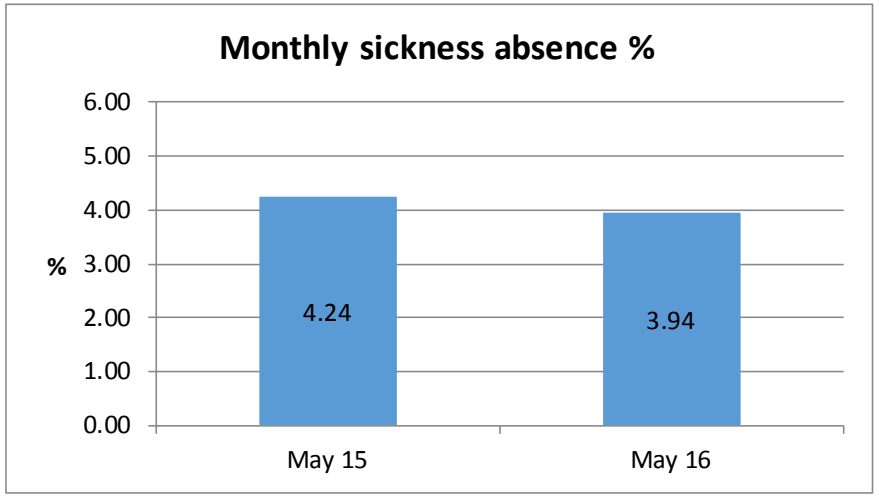
Jun-16	Budg estab fte	Actual worked fte	Vacancies fte	Vacancy trend since last month	Fill rate %	Monthly sickness %	Annual sickness %	Turnover	Temp staff expenditure	Appraised/ exempt in last yr	Appraisal trend since last month
Theatres & Clinical Support	1,109.49	1,110.41	51.52	↓	95.28%	3.10%	4.35%	8.00%	£586,502	90.95%	↓
Cardiovascular Medicine	292.49	305.54	26.68	↓	90.88%	2.86%	3.48%	4.82%	£224,640	90.25%	↓
Urgent Care	633.05	695.35	71.09	↓	88.77%	4.74%	5.13%	9.71%	£754,253	89.80%	↓
Specialist Medicine	479.78	467.22	48.57	↑	89.82%	3.63%	4.16%	8.19%	£261,157	89.25%	↓
Out of Hospital Care	771.76	733.68	70.31	↓	90.86%	4.86%	5.04%	14.70%	£245,732	91.63%	↓
Surgery	821.58	777.16	136.78	↑	83.14%	2.60%	3.58%	9.50%	£667,312	90.42%	↑
Womens & Childrens	616.77	555.47	61.99	↑	89.90%	4.09%	4.82%	11.02%	£167,290	77.01%	↓
COO Operations	402.04	418.98	31.85	↓	92.08%	4.02%	3.83%	9.45%	£145,745	74.68%	↓
Estates & Facilities	705.17	743.93	43.82	↑	93.22%	4.87%	5.84%	9.08%	£264,894	88.95%	↓
Corporate	524.47	483.09	68.62	↓	86.88%	3.31%	3.53%	11.08%	£146,708	90.61%	↓
TRUST	6437.07	6370.72	611.23	↑	90.23%	3.77%	4.42%	10.03%	£3,464,233	88.07%	↓

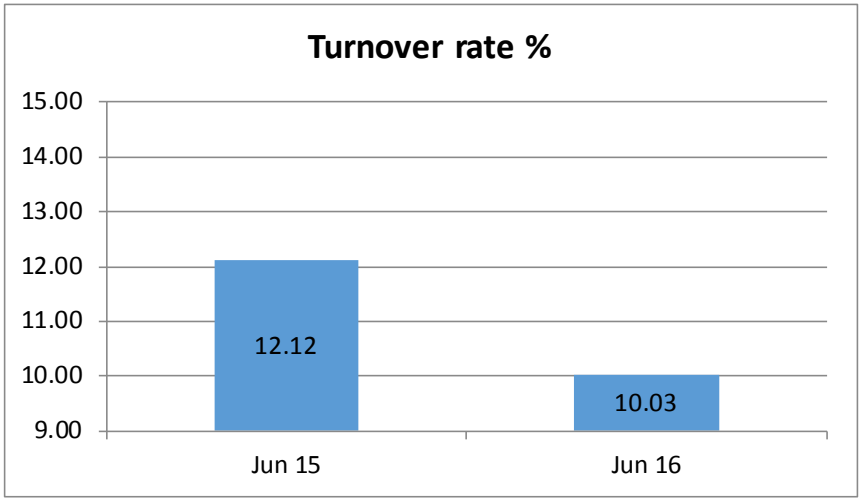
3.3 Trust Overview – Staff Groups – JUNE 2016

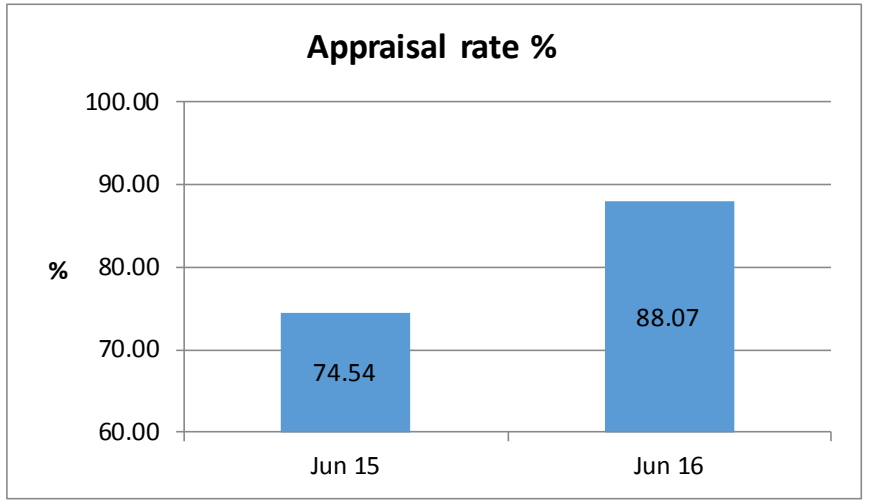
STAFF GROUPS	Budg estab fte	Actual worked fte	Vacancies fte	Fill rate %	Monthly pay budget (£000s)	Monthly pay expend. (£000s)	Monthly sickness %	Turnover %	Appraised/exempt in last yr
MEDICAL & DENTAL	603.67	572.35	87.17	84.73%	£5,005,398	£5,172,276	1.35%	10.91%	92.97%
NURSING & MIDWIFERY REGISTERED	2009.80	1885.49	183.95	90.70%	£7,061,626	£7,193,433	4.20%	8.49%	86.56%
SCIENTIFIC, THERAP & TECH	953.73	897.28	96.89	89.84%	£3,009,944	£3,104,370	2.43%	11.79%	91.03%
ADDITIONAL CLINICAL SERVICES	865.04	1025.85	79.33	90.58%	£1,838,123	£2,076,953	4.85%	11.55%	90.58%
ADMINISTRATIVE & CLERICAL	1262.36	1230.94	107.82	91.29%	£3,349,887	£3,320,657	3.39%	9.96%	83.94%
ESTATES & ANCILLARY	742.47	758.81	56.07	91.73%	£1,534,283	£1,525,828	5.11%	9.40%	89.83%
TRUST	6437.07	6370.72	611.23	90.23%	£21,799,261	£22,393,517	3.77%	10.03%	88.07%

3.4 12 Month Comparisons – JUNE 2016

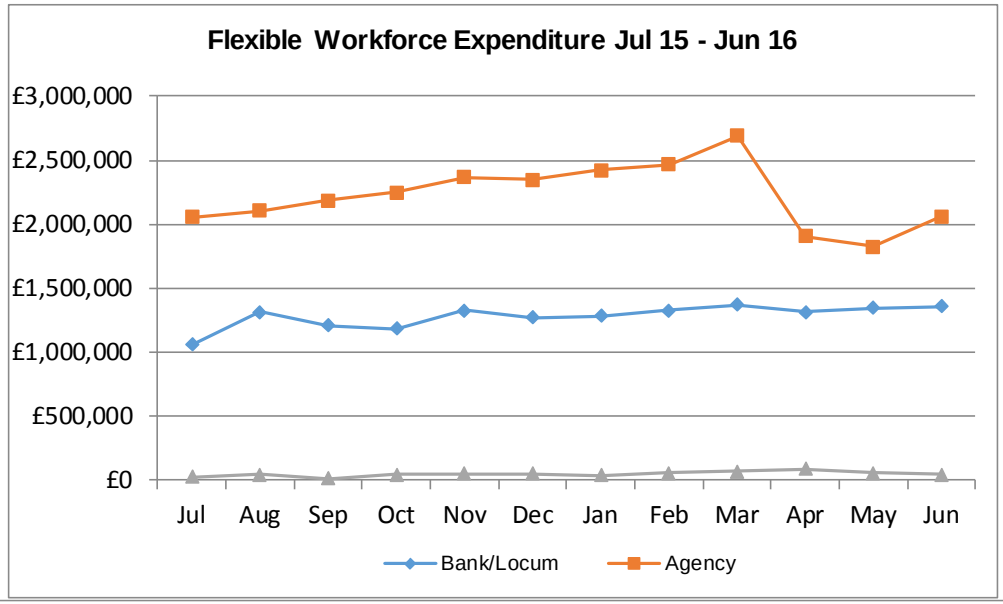


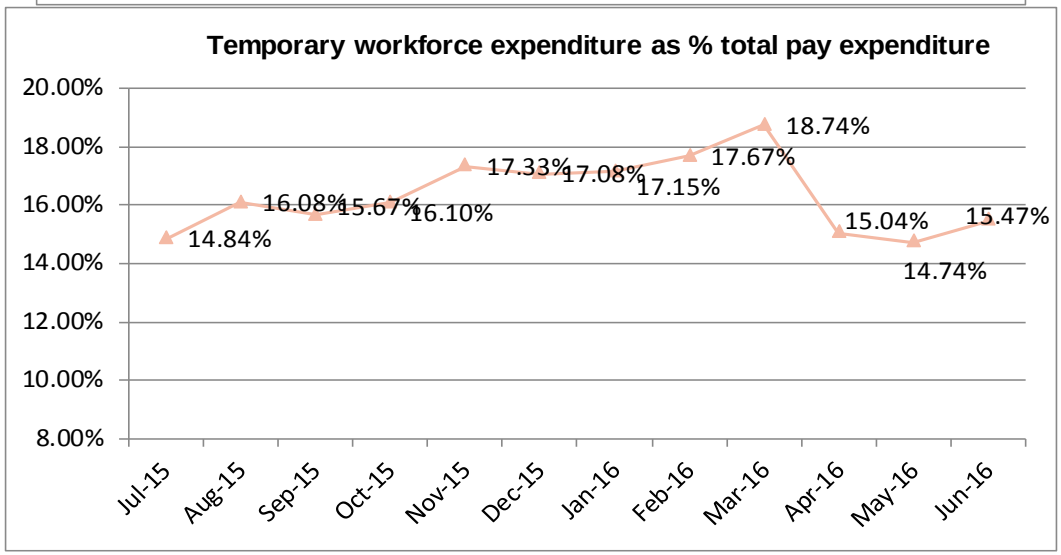


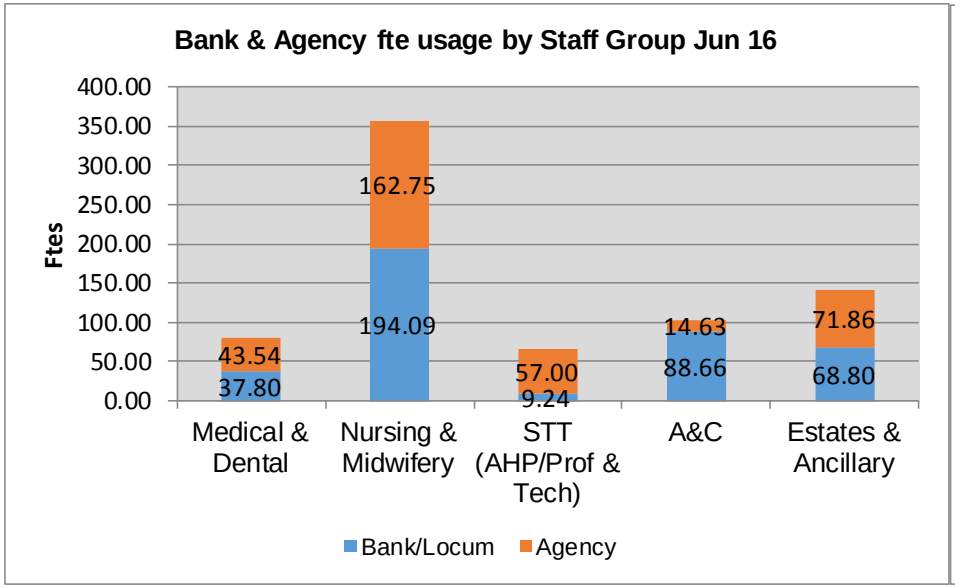


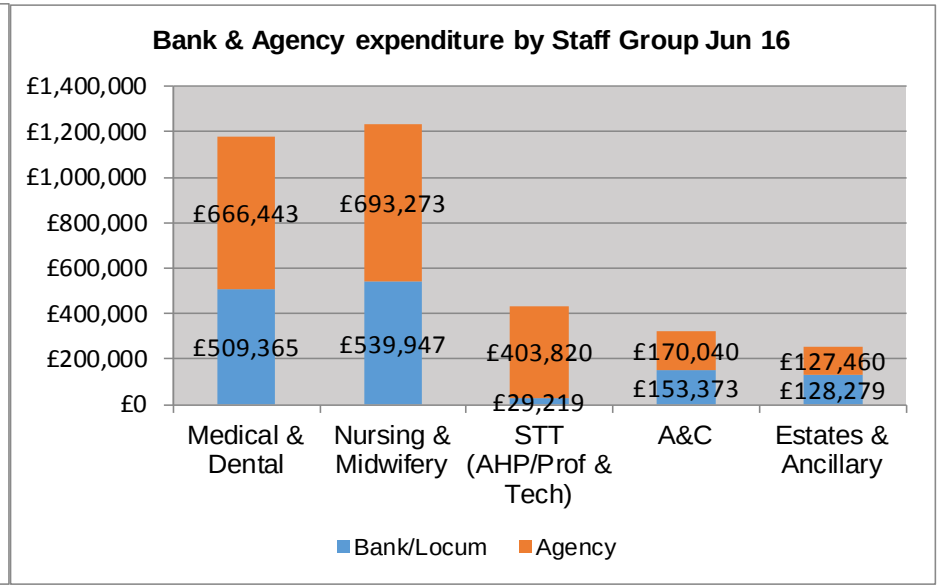


3.5 Workforce Usage – JUNE 2016









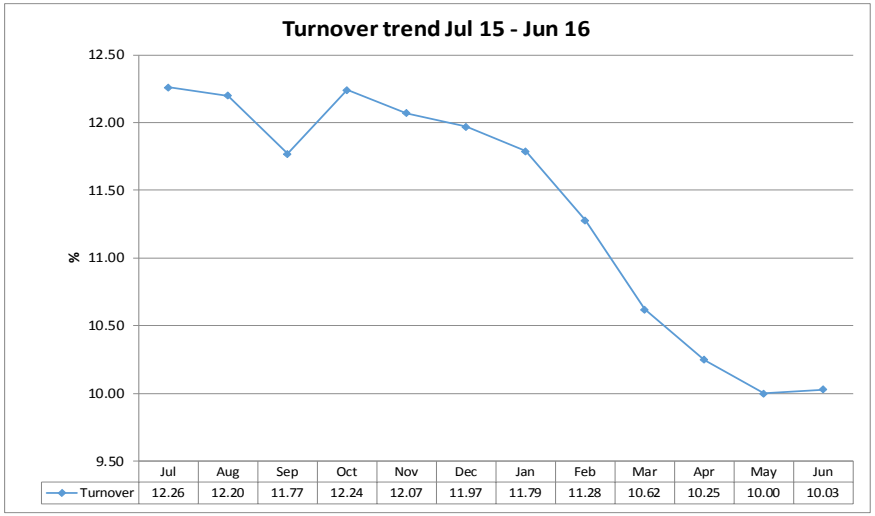
Pay expenditure has increased by £561K in June. This was partly due to some additional permanent staff that have been recruited in areas such as Health Visiting, District Nursing, Joint Community Rehabilitation, and for East Sussex Better Together posts. It does include, however, an additional £239K on agency expenditure which is back above £2m this month at £2061K.

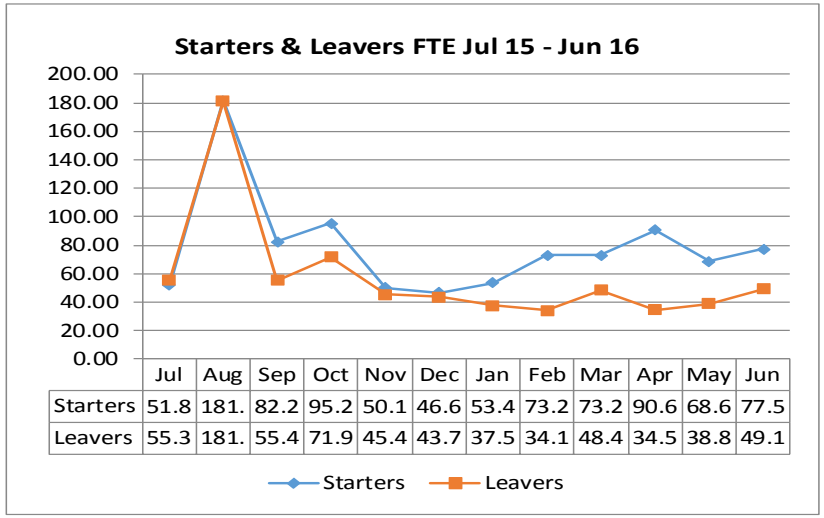
This increase is due to a variety of factors including, the reopening of EDGH Escalation (which was closed for part of May), staffing for additional beds at the Irvine Unit and adjustment to the Medical Oncology service level agreement (SLA) whereby the Trust is now paying for the agency consultant previously covered by Brighton & Sussex Universities Trust under the SLA.

There have been requirements this month for specialling on McDonald, Newington, Folkington and Berwick wards. There has also been agency cover for medical vacancies in Urology, Ophthalmology, on MAU and in Stroke and nursing agency vacancy cover on Berwick, CCU and Wellington amongst other areas. Similarly agency cover has been used for Audiology staff to cover sickness and because they have been unable to fill vacancies.

The Trust has also paid old invoices in June for a consultant in General Surgery and in Facilities, whilst machinery breakdowns in EHS necessitated additional hours to catch up on production.

3.6 Turnover & Vacancies – JUNE 2016





Starters & Leavers (not inc Employee Transfers)	Jul-15		Aug-15		Sep-15		Oct-15		Nov-15		Dec-15		Jan-16		Feb-16		Mar-16		Apr-16		May-16		Jun-16	
STAFF GROUP	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr
Add Prof Scientific and Technic	0.73	1.20	0.00	1.40	3.60	1.00	0.00	2.00	0.20	1.00	3.00	0.00	5.43	2.40	1.40	0.00	2.00	0.00	0.00	0.00	1.00	2.23	1.00	1.00
Additional Clinical Services	17.75	9.77	11.01	18.02	19.67	9.30	5.01	8.43	19.50	9.02	17.67	8.17	20.51	8.45	36.38	6.61	16.89	9.39	49.38	3.66	25.36	5.96	23.89	9.83
Administrative and Clerical	13.31	4.79	5.40	11.75	8.12	12.55	10.56	10.03	8.40	10.44	1.49	6.53	12.05	7.15	12.44	8.12	13.76	6.92	13.24	7.22	15.27	6.89	13.62	13.29
Allied Health Professionals	4.40	9.00	11.10	6.50	4.79	5.48	5.77	3.67	4.00	2.00	0.00	3.91	4.00	0.69	0.85	2.00	3.00	2.00	3.00	2.00	1.00	3.46	6.00	2.50
Estates & Ancillary	4.00	3.76	4.00	3.00	4.00	2.11	3.27	5.08	2.00	6.85	5.04	2.36	0.43	3.87	1.00	3.10	13.20	6.40	6.07	2.60	4.00	3.80	3.93	8.33
Healthcare Scientists	2.00	4.00	2.00	3.00	4.00	1.00	0.00	0.00	0.85	4.00	2.00	1.00	2.00	1.00	0.00	0.00	1.00	1.40	2.00	0.00	1.60	0.00	1.00	1.80
Medical and Dental	3.50	5.49	139.93	116.33	19.90	14.55	37.20	27.10	6.30	1.60	10.80	7.80	2.00	1.60	6.80	6.70	11.00	10.55	5.60	13.30	4.20	6.00	2.00	6.25
Nursing and Midwifery Registered	6.16	16.36	8.17	19.26	13.72	9.43	33.48	15.60	8.93	10.51	6.61	13.02	7.00	12.40	14.35	7.63	12.38	11.73	11.28	5.75	16.12	10.48	26.03	4.13
Students	0.00	1.00	0.00	2.00	4.50	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00
Grand Total	**51.85**	**55.37**	**181.61**	**181.26**	**82.29**	**55.42**	**95.29**	**71.91**	**50.19**	**45.42**	**46.61**	**43.79**	**53.42**	**37.56**	**73.22**	**34.16**	**73.23**	**48.39**	**90.57**	**34.54**	**68.55**	**38.82**	**77.47**	**49.13**

Trust fte vacancies increased by 31.78 ftes in June, a vacancy rate of 9.77%. This was due to an increase in the budgeted fte establishment of 55.84 ftes and the actual number of substantive staff in post did increase by 16.73 ftes. The additional budgeted establishment was mostly due to increases in the Health Visitor budget to the level agreed with East Sussex County Council and amendments to the unqualified nursing establishment in Surgery for rostering at night and an adjusted split between Band 2 & 3 posts.

The medical vacancy rate was 15.27% (87.17 fte vacancies), for registered nursing & midwives it was 9.30% (183.95 ftes) whilst for unqualified nurses it was 9.42% (79.33 ftes). There has been a shift between qualified and unqualified nurses to take account of the 49 overseas recruits who have joined and have been in unqualified posts pending receipt of their registration but have, in fact, been recruited to cover qualified vacancies.

The overseas nurse recruitment programme continues. A further 11 EU nurses have started or are due to start between 4 July and 8th August. The next cohort of 7 Philippine nurses starts on 5th September and there are a further 37 candidates in the pipeline. The Trust is reviewing existing recruitment companies, and is talking to a a further company (MSI) about supporting overseas recruitment if the existing companies cannot provide the additional numbers needed to the required timescales.

The selection and assessment process is under review to assist in identifying language gaps and to aid the overall retention of EU nurses. Going forward, the view is that it is better to focus recruitment on the Philippines as, though there is a higher initial cost, retention is better in the long term.

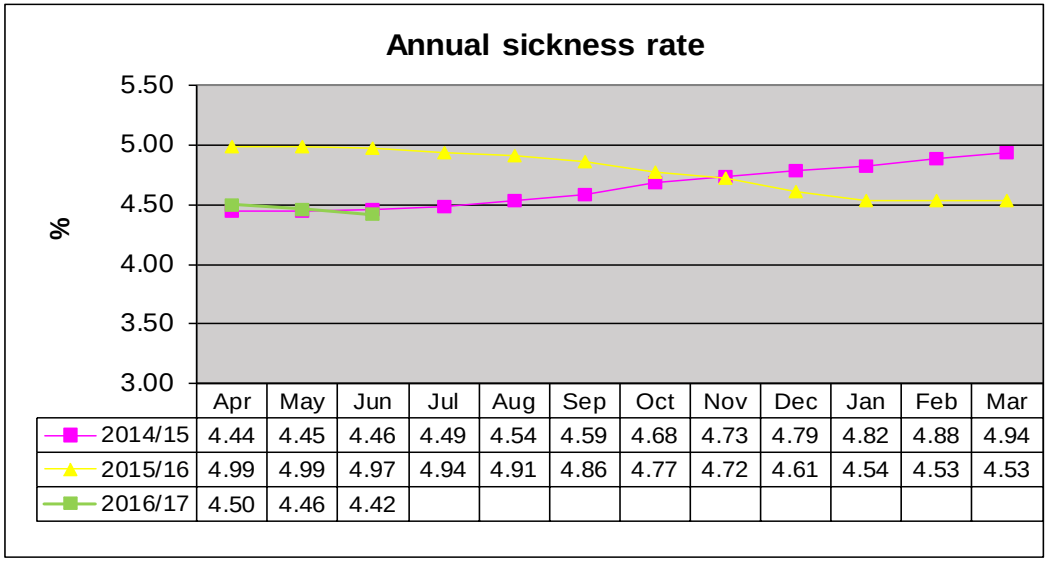
The key focus areas for medical recruitment remain Stroke, A&E, Gastroenterology, Histopathology and Haematology. The Trust has been working with recruitment “headhunting” companies and is starting to receive CVs for Consultant and Middle Grade doctors in Stroke and A&E. A Skype interview for a Histopathologist also took place on 14th July. Further meetings with recruitment companies are planned to discuss the approach for a consultant recruitment campaign.

A Specialty Doctor in Haematology started in June and there are interviews in place for a Consultant Immunologist, Locum Consultant Radiologist, Specialty Doctor in Paediatrics, Chief Registrar in Medicine and Senior Dental Officer. The Trust is shortlisting for a Consultant Cross Sectional Radiologist, Consultant Urologist and Locum Consultant Neurologist.

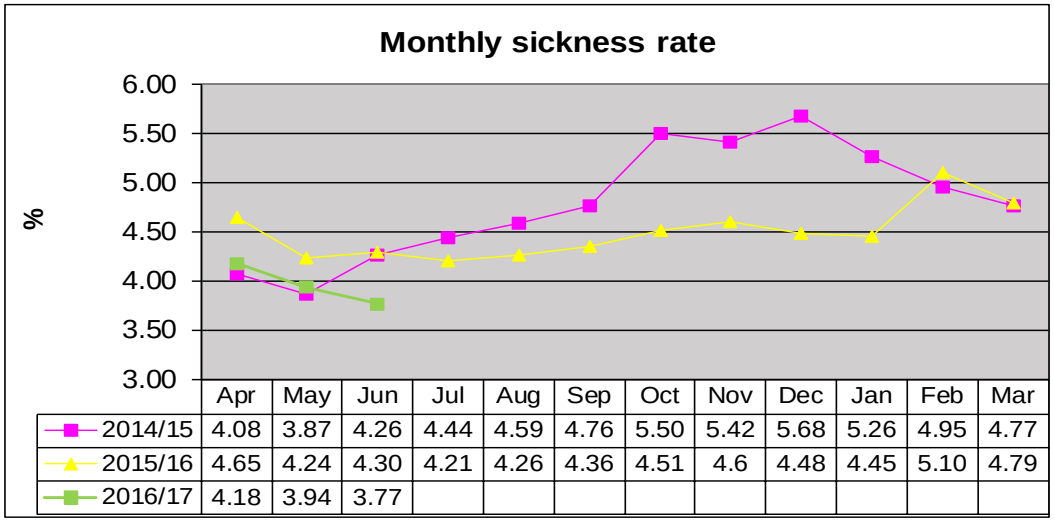
Open days are planned for further unqualified nurse recruitment going forward and to plan for winter pressures.

The Out of Hospital recruitment campaign for proactive care practitioners is ready to go live and will trial the new “Destination Sussex” recruitment materials. The Recruitment department have also met with the Audiology and Estates departments to discuss their future recruitment plans. Work also continues on social media, Twitter and Facebook recruitment pages

3.7 Sickness – JUNE 2016



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	4.44	4.45	4.46	4.49	4.54	4.59	4.68	4.73	4.79	4.82	4.88	4.94
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77	4.72	4.61	4.54	4.53	4.53
2016/17	4.50	4.46	4.42									



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	4.08	3.87	4.26	4.44	4.59	4.76	5.50	5.42	5.68	5.26	4.95	4.77
2015/16	4.65	4.24	4.30	4.21	4.26	4.36	4.51	4.6	4.48	4.45	5.10	4.79
2016/17	4.18	3.94	3.77									

Monthly sickness has reduced this month by 0.17% to 3.77%. The annual sickness rate is down by 0.04% to 4.42%, the lowest it has been since November 2012.

Sickness is highest amongst Estates & Ancillary staff at 5.11% though this represents a drop of 0.48% from May. The monthly rate for the next highest staff group, Additional Clinical Services staff (mostly unqualified nurses and therapy helpers), has also fallen by 0.51% to 4.85%.

The latest available comparative figures from the Health & Social Care Information Centre show the monthly sickness rates for NHS Trusts, in March 16, at 4.35%, at a time when our rate was 4.79%. The rate for large Acute Trusts was 4.44% and for Community Trusts it was 4.65**%**. Our monthly rate has fallen significantly since March.

HR staff have continued to work with managers on ensuring that absence reviews are undertaken. The focus will now be on specific staff groups; Nursing & Midwifery staff, including unqualified nurses, and Estates and Ancillary staff. With the appointment of the Health and Wellbeing Co-ordinator, there will also be an emphasis on engaging with staff proactively on wellbeing initiatives.

3.8 Training & Appraisals – JUNE 2016

Mandatory Training – Six Month Trend

Mandatory training course	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	6 month trend
Induction %	91.97	92.79	93.83	93.67	94.69	94.38	
Fire %	83.96	85.07	85.31	86.25	87.01	87.62	
Manual Handling %	86.93	88.09	88.25	89.43	89.57	89.91	
Infection Control %	86.99	87.86	87.37	87.92	88.40	89.24	
Info Gov %	86.81	86.23	85.49	84.78	84.48	84.51	
Health & Safety %	84.42	85.35	85.94	86.74	87.42	87.95	
Mental Capacity Act %	93.10	93.40	93.10	93.92	93.37	94.13	
Depriv of Liberties %	92.78	93.29	93.81	94.06	95.35	95.04	
Safeguard Vuln Adults	78.28	79.06	79.71	81.54	81.37	83.10	
Safeguard Child Level 2	81.45	82.46	82.12	83.25	83.35	82.93	

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	89.00%	90.53%	95.54%	89.09%	88.01%	89.81%	96.22%	97.12%	85.00%	86.06%	90.95%
Cardiovascular Medicine	88.58%	92.39%	95.35%	88.24%	86.16%	83.74%	93.33%	95.19%	80.00%	76.86%	90.25%
Urgent Care	78.28%	82.41%	89.78%	80.69%	71.38%	81.38%	88.09%	90.17%	77.32%	75.43%	89.80%
Specialist Medicine	92.31%	92.74%	98.72%	91.03%	84.40%	88.25%	93.78%	95.18%	85.65%	83.21%	89.25%
Out of Hospital Care	91.10%	93.23%	95.88%	94.24%	84.71%	88.22%	97.28%	98.73%	87.36%	83.42%	91.63%
Surgery	84.19%	88.56%	92.24%	85.22%	78.41%	89.33%	94.19%	94.44%	82.12%	79.65%	90.42%
Womens & Childrens	85.17%	88.80%	89.47%	86.75%	80.60%	85.33%	93.40%	91.77%	80.18%	90.54%	77.01%
COO Operations	87.14%	91.60%	95.45%	88.45%	94.75%	76.38%	n/a	n/a	n/a	n/a	74.68%
Estates & Facilities	86.17%	84.01%	98.00%	91.50%	86.31%	93.52%	100.00%	100.00%	100.00%	100.00%	88.95%
Corporate	95.03%	97.61%	98.48%	96.69%	94.11%	94.84%	97.37%	98.48%	92.00%	93.33%	90.61%
TRUST	**87.62%**	**89.91%**	**94.38%**	**89.24%**	**84.51%**	**87.95%**	**94.13%**	**95.04%**	**83.10%**	**82.93%**	**88.07%**

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

Overall, mandatory compliance rates are improving across the Trust. The Learning & Development team has been visiting wards with the Safeguarding and Information Governance workbooks to enable staff to easily update their learning and will continue to promote and focus on these subjects with the Clinical Unit (CU) leads, encouraging them to cascade the workbooks to their teams.

Non attenders are still an issue. In June there have been 171 instances where staff have failed to attend after booking training, the vast majority of which were either mandatory or role essential training. This will be highlighted to CU Leads to investigate within their teams.

The appraisal rate dropped this month, by 1.61%, the first decrease for ten months. This is due to appraisals not keeping pace with all those due for renewal. In July there are another 375 appraisals coming up for renewal.

3.9 Staff Engagement – JUNE 2016

Follow Up from the ESHT National staff survey 2015

Following the publication of our National staff survey results in February 2016 a number of actions have taken place to respond to staff feedback:

- Each of our Clinical Units are developing and implementing their own action plans to respond to particular issues raised in the staff survey. Many have asked their staff for feedback via questionnaires, suggestion boxes and listening conversations and made significant changes to improve engagement and involvement This includes regular staff forums, newsletters, the use of social media, and sharing good news stories.

- Listening conversations have also been taking place with staff, linked to small quality improvement projects, such as “Handover”, improving communication with the portering service and improving patient experience.

- The Medical Education team continue to work with junior doctors to improve engagement. Initiatives include, responding to a request to improve the Junior Doctors Mess, and a welcome event for new FY1s and existing FY1/FY2s, leading to good handover and ensuring trainees are comfortable at an early point when inducted to the Trust. There have also been dedicated 1:1s with trainees which have produce useful data and information which can be utilised to better inform specialities around issues experienced by our trainees.

- The launch of nominations for the Unsung Hero’s awards aimed at celebrating the achievements of our Band 1-4 staff.

- Matrons met at one of their regular workshops to discuss “What Does ‘Good’ Look Like?”. They also had the opportunity to have a question and answer session with the Chief Executive.

- The Out of Hospitals Clinical Unit commenced their Summer roadshows feeding back to their staff around the County on service developments and giving feedback based on the “You said, We did” initiative.

- The latest Pulse survey for staff has been issued asking staff for their feedback about communication between staff/managers and the way staff treat each other at work which is linked to the two corporate priorities for staff engagement.

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd August 2016
Meeting:	Trust Board
Agenda item:	10
Subject:	Safe Nurse & Midwifery Staffing Levels, May 2016
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

- To provide a report on 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 published NICE guidance, "Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals" (July 2014).

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

- Appropriate Nurse staffing levels are critical to patient safety.
- The Trust has systems in place to address and manage variations with support from senior nursing staff.
- Quality metrics and contributory factors are fully explored within the N&M Quality Review Group.
- Specific quality metrics are reviewed at steering groups i.e. Falls and Pressure Ulcers.

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/
- The quality figures cannot be considered as a measure of performance without significant validation and correlation with other dashboards and measures.
- This report does not negate the challenges of recruiting and maintaining a workforce that is robust and sustainable, without resorting to agency support and overseas recruitment.

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.

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

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

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

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

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. The guidance does not require escalation areas to be included however given the recent decision to retain an escalation area on each main site within ESHT they are included from February 2016.

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 potential for increased harm when there is less than 75% of the agreed Registered Nurse (RN) requirement on a shift.

3. Current Report – May 2016

3.1 The dashboards in Appendix 1 have been prepared to reflect the above requirements for May 2016.

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.

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

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

3.6 It is not possible to make a monthly comparison of the data due to changes in the report e.g. the community sites that transferred to Sussex Community Trust.

3.8 All these quality areas are monitored through respective steering groups, the safety thermometer and the trust nursing and midwifery reviews. The reviews utilises data from the nursing dashboard.

Conclusion/Recommendation

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

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

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

Alice Webster
Director of Nursing

Lucy Scragg
Assistant Director of Nursing (west)

Appendix 1

May-16	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	Variance for RSN<75%
Berwick Ward	Cardiovascular	118.30%	105.40%	90.30%	132.00%	2	4	44	
CCU - Eastbourne DGH	Cardiovascular	91.40%	100.00%	88.10%	89.50%		1	30	
James/CCU Ward	Cardiovascular	99.10%	109.30%	95.20%	158.10%		4	23	
Michelham	Cardiovascular	108.50%	121.20%	100.00%	112.90%	2	4	16	
Stroke Unit EDGH	Cardiovascular	93.90%	111.50%	115.60%	123.10%	2	6	9	
	Cardiovascular Clinical Unit Total					6	19	122	
Irvine Unit	Out of Hospital Care	91.90%	105.50%	96.80%	105.40%		7	7	
Rye Intermediate Care Beds	Out of Hospital Care	108.70%	96.90%	81.10%	93.50%		3	10	
	Out of Hospital Total					0	10	17	
Cuckmere Ward	Specialist Medicine (Loc)	125.20%	136.90%	91.70%	143.50%		5	22	
Folkington	Specialist Medicine (Loc)	105.70%	150.10%	90.50%	164.10%	1	5	9	
Jevington Ward	Specialist Medicine (Loc)	133.50%	100.40%	106.20%	95.30%		3	2	
Wellington Ward	Specialist Medicine (Loc)	97.80%	89.90%	100.00%	101.00%		3	30	

Pevensey Unit	Specialist Medicine (Loc)	95.60%	100.00%	100.00%	103.20%		1	16	
	Specialist Medicine Total					1	17	79	
Benson Trauma Ward	Surgery	91.50%	101.90%	99.90%	98.10%	3	4	4	
Cookson Devas Elective Ward	Surgery	89.5 %	91.70%	80.60%	96.80%		1	9	
De Cham	Surgery	94.10%	115.20%	102.20%	160.00%		2	3	
Egerton Trauma Ward	Surgery	81.20%	94.30%	90.30%	82.80%	2	8	1	
Gardner	Surgery	105.20%	99.90%	91.70%	103.70%		2	2	
Hailsham 3 Ward	Surgery	93.90%	103.10%	113.10%	103.20%	2	4	4	
Hailsham 4 - Urology Ward	Surgery	119.50%	100.10%	93.50%	104.10%	2	3	17	
Richard Ticehurst SAU	Surgery	99.10%	96.10%	91.80%	101.10%		3	8	
Seaford 2 Escalation	Surgery					1	3	1	
Seaford 4 - Mixed Surgery ward	Surgery	104.80%	95.80%	132.60%	102.10%	2	1	12	
	Surgery Total					12	31	61	

Cookson Attenborough Surgical short Stay	Theatres and Clinical Support	86.90%	93.90%	100.00%	100.00%			4	
ITU / HDU (Conq)	Theatres and Clinical Support	86.80%	80.80%	88.10%	96.80%		1	2	
ITU / HDU (EDGH)	Theatres and Clinical Support	98.70%	89.80%	82.30%	-			3	
	Theatres and Clinical Support Total					0	1	9	
Acute Admissions Unit (AAU) Conquest	Urgent Care	84.90%	97.50%	91.10%	102.10%				
Baird MAU Ward	Urgent Care	82.00%	108.70%	95.20%	116.00%	4	7	13	
Newington Ward	Urgent Care	90.90%	118.50%	95.90%	125.30%		9	13	
MacDonald Ward	Urgent Care	92.40%	131.70%	99.60%	188.10%	5	4	6	
Seaford 1 (Medical Assessment) Unit	Urgent Care	93.90%	118.10%	91.60%	102.10%		11	1	
	Urgent Care Total					9	33	34	
Eastbourne Midwifery Unit (EMU)	Women and Children	102.70%	100.00%	107.50%	80.60%			2	
Frank Shaw	Women and Children	95.40%	85.90%	93.60%	90.10%			6	

Kipling Ward	Women and Children	90.60%	100.50%	95.80%	96.90%			2	
Mirrlees	Women and Children	105.30%	94.00%	112.90%	99.90%				
Special Care Baby Unit (SCBU) Conquest	Women and Children	93.70%	100.00%	80.00%	100.00%			7	
	Women and Children Total					0	0	17	
	Grand Total					28	111	339	

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd August 2016
Meeting:	Trust Board
Agenda item:	11
Subject:	Quality Report – Q1
Reporting Officer:	Alice Webster

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

Purpose:

To provide a summary of all domains of quality during quarter 1 2016/17

Introduction:

This report is a summary of key issues and activity presented under the three domains of quality which are Patient Safety, Patient Experience and Clinical Effectiveness. Full details of each domain are reported to the Quality and Safety Committee.

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

- 10 serious incidents reported in Q1 2016, 5 relating to patient falls
- Backlog of open serious incidents is reducing
- Overdue complaints are gradually reducing however still a number overdue the final response timescale
- The number of plaudits has increased in May
- Progress made on FFT response with clear plan for improvement

Benefits:

Monitoring and responding to quality measures will improve patient safety, experience and responsiveness.

Risks and Implications

Failure to monitor quality effectively could impact on safe care.

Assurance Provided:

Systems in place to monitor safety and work in progress to improve governance processes and structure.

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

Quality and Safety Committee will review the full quality report. The new Patient Safety and Quality Group will review serious incident trends, learning along with complaints, claims and risks

Proposals and/or Recommendations

To note the report and actions underway to improve compliance and reduce backlog of complaints and serious incidents.

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: Ashley Parrott	**Contact details:** 07972244079

East Sussex Healthcare NHS Trust

Quality Report – Q1 2016

1. Introduction

1.1 This report is a summary of key issues and activity presented under the three domains of quality which are Patient Safety, Patient Experience and Clinical Effectiveness. Full details of each domain are reported to the Quality and Safety Committee.

1.2 A full clinical governance review has been completed by Capsticks with many recommendations already in progress. The report will be discussed in depth at the next Quality and Safety Committee. A number of actions have been underway to enhance the governance processes that need embedding in the system. Some of these are rolling out the new Ward to Board dashboard, further embedding the new Summary Governance Report for the Clinical Units, starting the new and revised groups under the Quality and Safety Reporting structure (terms of reference/duties produced) and clearing the serious incident and complaints backlog (in progress) whilst embedding new serious investigation process.

2. Patient Safety

2.1 Serious Incidents

During Q1 a total of 10 serious incidents were reported (7 in April and 3 in June):

- 5 were patient falls resulting in fracture hip (neck of femur)
- 1 Never Event – wrong route of administration (no harm caused)
- 1 GRE infection outbreak (7 patients effected)
- 1 failure to act on test results
- 1 unexpected admission to Neonatal Intensive Care Unit
- 1 VTE related incident

All the above incidents occurred in different wards or departments, with the highest reporting Clinical Unit being Specialist Medicine with 3 serious incidents (no theme). Patient falls continue to have similar themes however work is on-going through the Falls Prevention Group to manage these. The compliance to completing action plans for all serious incidents and triangulation between complaints and claims will be managed through the new Patient Safety and Quality Group. All individual Clinical Units discuss the incident reports and review the actions.

The serious incident process changed from the 1st April to improve the investigation cycle and ensure Duty of Candour is effectively applied and tracked (ensure evidence of compliance). This has been described at the Quality and Safety Committee and reflected within the Capsticks Governance Review. Part of the rationale for change was to speed up the investigation process and ensure the reports are more robust and have fewer returns from the CCG scrutiny Panel.

As of mid-July there are currently a total of 64 Serious Incidents in the system that are either under investigation, overdue, kept open following CCG scrutiny or requiring further work prior to final submission to the CCG following a first line triage. The change in system should reduce the number of returned incidents and early feedback from the CCG Scrutiny Panel suggests this is improving. The Governance Team are working to complete closure of all the 2015 serious incidents returned by the CCG by the end of August.

2.2 Incident reporting

Patient safety incident reporting numbers continue to increase with the number of these involving no harm/near miss. This demonstrates a good reporting culture.

3. Patient Experience

3.1 Complaints

The following complaints were reported during quarter 1:

- 67 in April
- 54 in May
- 60 in June

The highest complaint categories remain the overall standard of care, delays to access or treatment and lack of communication/information.

The average number of complaints reported per month over the last year is 63.
All but 1 of the complaints in Q1 were acknowledged within 3 working days. A total of 69 overdue complaints were reported in March, but this has decreased to 29 in June however long term sickness in the team may affect the continued downward trend for the next few months. This is being addressed to mitigate the risk where possible. The Complaints team has increased their face to face support with the Clinical Units to manage the responses but continue to face the challenge of receiving enough information to provide a robust response explaining the “what and the why”. Actions identified from the final report are now being recorded centrally on the Datix system. The next step is to track these to ensure completion as although the majority are the responsibility of the Clinical Units the Governance Team need to manage a central assurance process to document compliance.
There were 2 complaints referred to the Parliamentary and Health Service Ombudsman Enquiries (PHSO). One was partially and the other fully and partially upheld.

3.2 Inpatient Survey

The recently published inpatient survey results from 2015 were published with the following key findings:

Where we scored higher than average (sign of progress)

- Was your admission date changed by hospital?
- Did nurses talk in front of you as if you weren't there?
- Do you think staff did all they could to help control pain?
- Was your discharge delayed?
- Overall, were you treated with respect and dignity?
- During your time in hospital did you feel well looked after by hospital staff?

Where we scored lower than average (Improvement required)

- When admitted, was it a mixed-sex room or bay?
- After moving ward, was it to a mixed-sex room or bay?
- Did you ever share mixed-sex bathroom or shower areas?
- Before op, did staff explain the risks and benefits of the operation?
- Before op, did staff explain what would be done during the operation?
- Before op, were you told how might feel after the operation/procedure?
- Before op, did anaesthetist explain understandably how they would control any pain?

The full analysis and actions required will be presented to the Quality and Safety committee

3.3 Patient Advice Liaison Service (PALS)

There were a high number of PALS contacts made during the quarter due to enquiries about transport arrangements following the change in Patient Transport Service from the 1st April to Coperforma. These concerns have been followed up and the CCGs are working closely with the Trust to track incidents/concerns and work on improving the service.
A high number of people have raised concerns at being unable to contact a department. This may be a combination of getting through on the switchboard or accessing the booking centre.

3.4 Friends and Family Test (FFT) Data

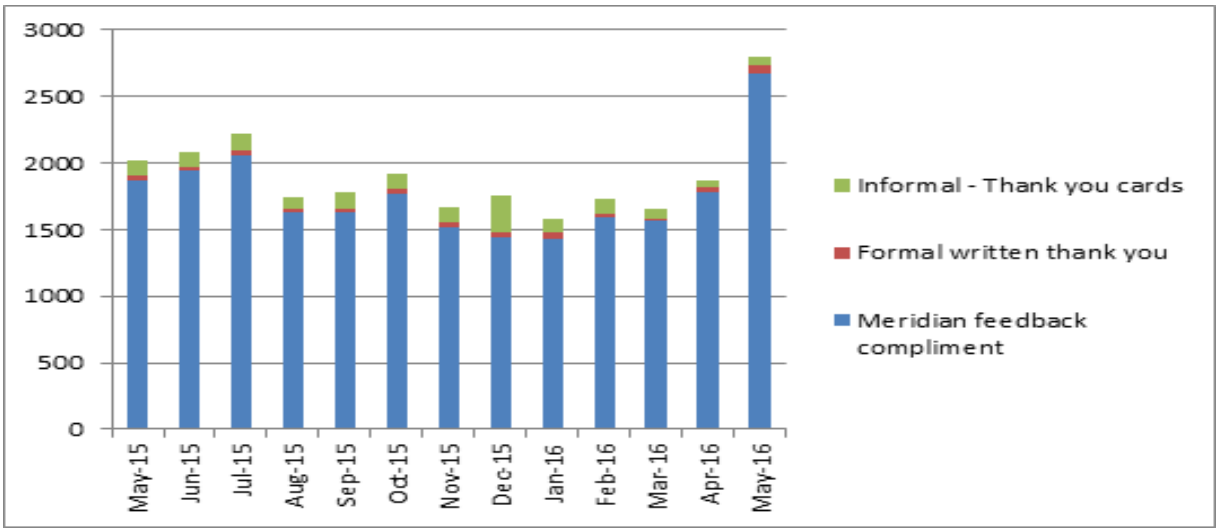
The Response and recommended rate for Q1 is as follows:

	Score	**A&E**	**Inpatient care**	**Maternity**
April	% Recommend % Response rate	91% 9%	98% 14%	90% 29%
May	% Recommend % Response rate	88% 10%	98% 14%	92% 31%
June	% Recommend % Response rate	87% 8%	97% 17%	93% 33%
Overall Themes		Waiting times and staff attitude.	Noise at night, staff shortages, waiting time for discharge and communication	More staff required, Improve communication on care plan

Friends and family responses remain low however a full analysis of this was completed and presented at the Patient Experience Steering Group in July. The plan is to adapt the old but successful token system in A&E to be a postcard with the main question, two other key questions the Trust would like to use and space for comments. This will be deposited in the recommend/not recommend boxes as used to happen with the token system. For the in-patient areas the questionnaire will be centrally printed by the Governance Team (sourcing cost) as currently some wards use old photocopied versions that look unprofessional giving a poor impression as to the importance of the survey. A league table will be in place to promote competition, champions will be identified and the lowest wards with response rates will be supported to improve.

3.5 Plaudits

As can be seen below the Trust has received a high number of plaudits in May. This provides a positive outlook on the excellent care that is also delivered across the organisation by caring and dedicated staff.



4. Clinical Effectiveness

Progress has been made on the Quality and Safety Committee structure with terms of reference for the new Patient Safety and Quality Group in place and clarity on the duties for the Clinical Effectiveness Group, and the recently named Clinical Outcomes Group. These will include sub groups reporting into them to ensure a clear escalation structure and to enable workstreams such as Sepsis, hospital at night, 7 day working, end of life care, VTE and quality account priorities can report progress and risks to improvements. These groups should start to take on the new roles from August.

A full report of audit progress was provided to the Audit Committee during July.

Ashley Parrott
Associate Director of Governance

21/7/16

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd August 2016
Meeting:	Trust Board
Agenda item:	12
Subject:	Annual Business Plan – Quarterly Update
Reporting Officer:	Jonathan Reid, Director of Finance

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

Purpose:

The Trust approved an annual business plan in private board during April 2016. The plan followed the national planning framework, and although it did not articulate specific objectives for the year, it did set out the key areas of focus for the 2016/17 financial year. Specific objectives for the Trust for 2016/17 and future years have now been articulated in the 2020 paper, which has subsequently been approved by the Board and the Board will receive regular updates on progress. This paper provides an overview of the key deliverables under the 2016/17 Business Plan.

Introduction:

The Trust produced an initial business plan for 2016/17 which was developed in partnership with the Clinical Units. The business plan was a useful starting point for the plans for the year, but has subsequently been supplemented and to a large degree superceded by the ESHT 2020 plan, which puts in place a strategic framework for the Trust, and sets out a series of measureable outcomes. The Trust's business plan remains in place and this paper sets out progress against the key priorities identified in the plan. Over the next quarter, the existing business plan will be aligned with the ESHT 2020 plans and cross-checked to ensure all key priorities are being addressed.

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

The 2016/17 Business Plan was approved by the Trust's Finance and Investment Committee in March 2016. It described a series of priority areas of focus and the actions the Trust would take to address key challenges and risks. These have been reviewed and a summary of action against each key issue is provided, covering the areas of quality and safety, activity and workforce and finance. The report does not capture all of the key areas of activity across the Trust, but provides assurance that the Trust is delivering on the commitments made in April 2016. For each of the key areas, a description of board scrutiny and assurance routes is provided, as are the actions in place to mitigate identified risks.

Benefits:

This paper has described progress against the initial business plan for 2016/17. During Q2, the business plan will be aligned with the in-year deliverables described in ESHT

2020, so that a more detailed update can be provided at Q2. However, the review provides evidence of good progress in a number of priory areas, and a continued need for focus by the Trust Board and Executive Directors on delivery.

Risks and Implications

The key risks identified in the review of business planning are threefold and echo the risks set out in the Board Assurance Framework:

- **Quality** – the Quality Improvement Plan is an ambitious document, setting out a number of high priority actions which require rapid implementation. The Trust has good arrangements in place to support delivery, but this needs continued focus and engagement, inside and outside the organisation;

- **Workforce** – the Trust has had considerable success in recruitment, but there remain a number of key areas of the workforce where there are shortfalls in available staff, and in consequence a heavy reliance on temporary resourcing. This has significant financial consequences and can create additional pressures for substantive staff. This remains a key area of focus for the Trust;

- **Finance** – the Trust has identified significant risk in the financial forecast for the year, and has put in place mitigating actions. This risk sits in the context of very significant financial challenges across the local and national NHS, which requires a continued daily focus on financial delivery.

Assurance Provided:

Process is planned and timescales achievable.

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

Audit Committee: 20th July 2016

Proposals and/or Recommendations

The Trust Board is requested to note this 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

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

Name: Jonathan Reid, Director of Finance and Estates	**Contact details: jonathan.reid@nhs.net**

1. Quality and Safety

Business Plan 2016/17	
Quality Improvement Plan *Central to the business plan for 2016/17 is the delivery of the Quality Improvement Plan, which articulates the key priorities stemming from both the CQC inspection and the need to drive up quality and safety standards across the organisation.*	
Progress	**Actions and Risks**
• The QIP is supported by robust programme and project management arrangements, and with a programme board which includes key external stakeholders. It is also scrutinised and supported by NHSI, NHSE and the local CCGs. • The QIP is delivering on all key workstreams – emerging risks are identified and managed through the programme board.	• The priorities of the QIP are aimed at supporting medium-to-long-term improvement across the Trust, but also at supporting readiness for the forthcoming CQC inspection. • Following the CQC inspection in October 2016, the Trust will be refreshing the QIP and ensuring emerging themes and issues are recognised. • Looking forward, past the QIP, the Trust is developing an Improvement function, supported by an improvement capacity within the organisation.
Patient Experience and Safety *The business plan set out the Trust's plans to improve, over and above the QIP, patient experience and safety – with a specific focus on complaints and learning through the reporting of incidents, and a wider exercise to strengthen clinical governance.*	
Progress	**Actions and Risks**
• The complaints process has been reviewed and a number of key improvements implemented. • The number of reported incidents has increased, and the number of serious incidents has decreased, and the processes for learning from incidents have been strengthened. • Work is in train to strengthen clinical governance across the organisation, and within Clinical Units, overseen by the Quality and Standards Committee.	• The key risk in respect of continued improvements to patient experience and safety is the capacity of clinical and operational staff to manage the level of demand that they face on a daily basis, whilst seeking to make significant improvements to processes and outcomes. However, staff across the Trust have prioritised this work and clinical governance continues to improve. Risks to delivery are reviewed by the Trust Board, with assurance through the Quality and Standards Committee. • The Trust also provides assurance to NHSI and CCGs on a monthly basis around key issues.

Clinical Effectiveness and Quality Impact Assessment

The business plan included a number of key actions around improving clinical effectiveness and outcomes for patients, including action on VTE, and a robust Quality Impact Assessment process (ensuring that efficiencies and significant service changes do not adversely impact on the quality of care provided).

Progress	Actions and Risks
• The arrangements for measuring and monitoring clinical effectiveness across the Trust are strengthening, and the Clinical Effectiveness group is now established. • The Trust has an established Quality Impact Assessment process, but following review by internal audit and by the Director of Finance, this is being refreshed to ensure that all key projects and programmes are included within the QIA review process.	• The strengthening of the arrangements to secure improved clinical effectiveness needs continued focus and support, and the allocation of resources. The Trust is continuing to develop appropriate metrics and measures, and this is being developed by the Business Intelligence team. • The QIA refresh may identify areas where current CIP or service change proposals create a risk to quality, and these will be addressed, with proposals either re-scoped or alternatives found. This review process is anticipated to be complete by the end August 2016 and will provide a greater level of assurance.

2. Activity and Finance

Business Plan 2016/17	
Delivering the Contract *The Trust signed a contract in April 2016 reflecting the key priorities identified in the Business Plan 2016/17 – a move to payment by results, implementation of demand and capacity planning, and joint delivery of East Sussex Better Together.*	
Progress	**Actions and Risks**
• Payment by results is bedding in, and the Trust has an improved understanding of the activity it is undertaking. • Coding and income recovery have improved, and are robust, and the Trust is in regular dialogue with the CCG around contract developments, noting the limited resources available within the local health economy. • The Trust is making good progress on delivering the ESBT schemes. The key area of risk is around delivery of the required capacity to meet national performance standards, and the financial impact of this additional work.	• The key risk for the Trust and the local health economy is around management of demand and capacity, to meet national standards around access and performance, and to do so in a way which is financially sustainable for both the Trust and the CCGs. The Trust has a detailed demand and capacity plan, which sets out the required capacity, and is jointly developing this with the CCGs to ensure agreed actions to secure optimal benefit for patients, the Trust and the local health economy. • The Trust is behind trajectory for both 18 weeks and A&E access standards, but has a robust recovery plan. This risk is significant and is reviewed at Finance and Investment Committee and at Trust Board.
Delivering on Carter *As one of the pilot sites for the national Carter programme, the Trust has been an advocate for the benefits to be secured. The 2016/17 plan set out the Trust's aspiration to turn the outputs from Carter into improved operational delivery and efficiencies.*	
Progress	**Actions and Risks**
• The Trust has a high level of engagement with the national Carter Team, and this engagement is distributed across the organisation with key managers and leaders supporting this work. • A small central team in finance undertakes detailed analytical work and supports 'deep dives' which are undertaken jointly with clinical teams. • The Carter work also informs future plans for service change, and has been shared with Clinical Commissioners.	• The Carter programme is proceeding well, but in August 2016, the programme management and support arrangements are being refreshed to ensure that the benefits identified through the key workstreams are more clearly articulated and are supported through to implementation. This means a greater focus on the in-year opportunities identified through Carter, and a delineation between strategic change plans and operational delivery – to ensure that the programme delivers immediate and significant improvements.

Delivering the Financial Plan
The Trust set a deficit budget of £48m for 2016/17, with cost improvements of £10.7m, agency reduction of £8.2m, and a capital plan of £12m. This plan is supported by a cash plan, which assumes drawdown of working capital support from the Department of Health of £31.3m.

Progress	Actions and Risks
• Cash and capital are delivering on plan – although adverse performance in the financial position will create pressure on cash flow. • The Trust is overspending against operational plans at Q1 by £3m, although has been able to deliver on the national financial plan, and a risk of £25m to the full year has been identified. • Progress on developing and implementing detailed cost improvement plans (CIPS) has been slower than planned, and agency reductions are proving challenging.	• A new Director of Finance joined the Trust in June 2016, and has agreed a series of recovery actions with the Executive Directors to support a reduction in the overall risk to the financial plan. Increased capacity is being secured across the organisation to support the development of more detailed and robust cost improvement plans for immediate in-year delivery, alongside the broader Carter plans, and a refreshed set of arrangements for managing temporary resource have been put in place. • The Director of Operations and the wider Operations/Finance teams are focusing on working jointly with CCGs to ensure appropriate management of demand and capacity. Progress and risks are reviewed on a monthly basis by the Finance Committee.

3. Workforce

Business Plan 2016/17	
Recruitment *The operating plan for 2016/17 assumed a 2.2% reduction in overall workforce, delivered by substantively recruiting to vacancies. Agency usage was planned to reduce by 57.7% and bank usage by 6.4%, with the Trust increasing the substantive workforce by 2.6%.*	
Progress	**Actions and Risks**
• The Trust is making good progress at Month 3 against the recruitment plans, with significant improvements in levels of substantive areas in a number of key areas. • Turnover has fallen to 1% and the substantive workforce is growing – although there are areas where levels of substantive staff are not as high as required. • Challenges remain in respect of reductions in the temporary workforce, particularly in respect of agency expenditure, which is adverse to plan. • The Trust has appointed a new Head of Recruitment who is working closely with HR and Operational colleagues to ensure delivery of the key priorities.	• There remain a number of significant challenges in delivering this business plan objective, given local and national workforce shortages. In the short term, this means that the Trust is not delivering on its plans for reduction in temporary expenditure. In the medium-term, the Trust needs to (and is actively doing so) explore new workforce models for care delivery in key specialities, in partnership with key stakeholders across the local health economy. This work is overseen through the Executive Directors, and workforce data is considered at the Quality and Standards Committee. • Further work is required on developing the workforce plan for the Trust, and this will continue in Q2 alongside the development of the long-term financial model for the organisation.
Staffing Shortages *Management of staffing shortages was identified as a key risk in the Business Plan for 2016/17, with the consequential risk of impact on delivery of care or key services*.	
Progress	**Actions and Risks**
• The Trust has a number of mitigations in place to support the management of staffing shortfalls, with staffing levels regularly reviewed during the year by the Trust Board, and by the Quality and Standards Committee. Crucially, the Trust has daily roster reviews and a robust escalation process, with clear processes for moving staff where appropriate.	• The Trust has processes in place to manage the delivery of services in the context of staffing shortages. However, there are two key risks which emerge – the sustainability of service delivery (stemming from the pressures on substantive teams) and the financial consequences of using additional temporary resource.

• Immediate shortfalls in staffing are managed through the recruitment of temporary resource and, as a consequence, although the Trust continues to provide safe care, the level of temporary staffing usage continues to increase.	• In July 2016, the Trust has agreed to a reshaping of the temporary resourcing team, with increased clinical leadership and a move to the Finance Directorate. This will support the development and management of the total temporary workforce across the Trust.

Staff Engagement and Wellbeing
The Business Plan set out how the Trust would develop a staff engagement team, with a detailed action plan, and would focus on significantly improving engagement with staff across the organisation – and wider stakeholders.

Progress	Actions and Risks
• The team is in place and working at pace to build engagement across the organisation. • Support, training and engagement events are in train, and at each Integrated Performance Review, staff engagement is discussed with Clinical Units to establish progress and any support required.	• Whilst there are considerable signs of improved staff and stakeholder engagement, this remains a key priority for the Trust's Board and leaders across the organisation. It is reflected on the Trust's Board Assurance Framework, and progress is considered by the Trust at the Quality and Standards Committee.

East Sussex Healthcare NHS Trust

Date of Meeting:	3 August 2016
Meeting:	Trust Board AGM
Agenda item:	13
Subject:	Revalidation – Medical and Nursing & Midwifery
Reporting Officer:	Dr David Hughes, Medical Director Alice Webster, Director of Nursing

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

Purpose:

The purpose of this report is to provide assurance to members of the Trust Board, colleagues, patients and the public that the doctors, nurses and midwives in ESHT are compliant with the relevant legislation and GMC/NMC requirements for revalidation.

The Chief Executive and/or the Chair of the Trust Board are asked to sign a statement of compliance (attached to the medical revalidation annual report), regarding medical revalidation, that will be submitted to NHS England before 31 August 2016.

Introduction:

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. This paper provides assurances about the processes, systems and achievements, for medical revalidation and medical appraisals in ESHT from 1st April 2015 to 31st March 2016.

In April 2016, the Nursing & Midwifery Council also introduced a three yearly revalidation process for nurses and midwives for similar reasons. The way that nursing and midwifery revalidation has been implemented means that some nurses have been required to submit their application for revalidation prior to April 2016 and so there are some minor data to include in this report. This paper describes the processes and systems being set up in ESHT to support our nurses and midwives and so provides this assurance to the Trust Board and members of the public.

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

-

a) Medical Revalidation key discussion points:

- Our achievement of a very high appraisal and revalidation compliance, particularly when benchmarked against other Acute Hospital Trusts in the NHS England South region. For the third year running, the medical appraisal compliance rate amongst our trained doctors is very high and this year is at almost 99%;

- The quality assurance processes of the outputs of appraisal and the appraisal process

itself; there is a heightened focus now, not just on the quantity of appraisals, but on the quality of the process and outputs and the benefits of appraisal for our patient care. There is an increased emphasis on the development of a personal development plan within each medical appraisal. Our doctors need to describe how what they learn will improve patient care year on year. Personal development plans that do not meet the required GMC standard are returned to doctors and their medical appraiser for revision with support provided by the medical revalidation team;

- The feedback provided by doctors who are being appraised about the skills, knowledge and experience of our team of medical appraisers; and

- Public and patient involvement in medical revalidation is now well embedded and there is a PPI representative who is a member of the Medical Revalidation Advisory Panel and who is also invited to participate in the recruitment, quality assurance and ongoing training of our highly valued medical appraisers.

b) Nursing Revalidation key discussion points:

- Nurses and midwives are very enthusiastic participants in the revalidation process and have been proactive in requesting support; this has been provided by the revalidation team in the form on advice in a 1-1 meeting, training sessions, roadshows, extranet guidance and fact sheets;

- NMC changes in requirements after the process had begun;

- Nurses and midwives engaged via the Temporary Workforce Service; and

- The risk and impact of lapsed registrations of nurses and midwives who fail to revalidate in time.

Benefits:

The benefit of achieving high medical and nursing revalidation and appraisal rates for our trained medical, nursing and midwifery staff is that it supports our aim to make safe patient care our highest priority and provides assurance to our patients and the public; it also assists in maintaining a skilled and motivated workforce. It additionally ensures that the Trust complies with current Responsible Officer Regulations and guidance issued by the General Medical Council (GMC) and the Nursing & Midwifery Council (NMC).

Risks and Implications

a) Key current risks for the medical revalidation system and processes:

1. There are a very small number of doctors who are not fully engaging with the annual medical revalidation and appraisal process which may mean that they are at risk of losing their licence to practise which will have a potential impact upon patient care and patient safety; and

2. The total number of medical appraisers has reduced in recent months due to retirement, their workload or because they have left the Trust. Medical appraisers are required to meet high standards of conduct in preparing, holding and writing up appraisals and there are some who, despite full support are not meeting this standard so they may not be asked to

renew their contract as medical appraisers.

New appraisers are being recruited and trained but the risk is that doctors may not receive quality assured medical appraisals with all the benefits they confer for their personal development in the meantime.

b) Key current risks for the nursing and midwifery revalidation system and processes:

1. Nurses and midwives who do not submit their revalidation applications in time will be removed from the nursing and midwifery register by the NMC; there is no Responsible Officer for nursing and midwifery revalidation. There are delays of up to 6-8 weeks of being reinstated on the register, during which time the nurse or midwife will not be able to work, other than in the capacity of a health care assistant. This will have an impact on the workforce and holds a risk of affecting patient safety and patient care;

2. Nurses who are engaged via the Temporary Workforce Service are required to have annual appraisals and to participate in the revalidation process; they do not have specific line managers and therefore require bespoke support from the organisation; and

3. Each nurse and midwife needs to have their supporting information 'confirmed' by an appropriate person and to have a reflective discussion about the contents of their supporting information by another NMC registrant. Increasing the awareness and understanding of the nursing and midwifery workforce of the responsibilities placed upon them in the different roles i.e. i) being appraised and/or revalidated ii) being a confirmer iii) being an appraiser and iv) being the provider of the reflective discussion, is challenging due to the complexities of communicating with different clinical areas and the sheer volume of nurses and midwives involved.

Assurance Provided:
Medical Revalidation and Nursing & Midwifery Revalidation

Review by other Committees/Groups (please state name and date)**:**
Medical Revalidation Advisory Panel 13.5.16 Senior Leaders' Forum 13.6.16

Proposals and/or Recommendations
The Trust Board are asked to accept this report as an assurance that systems and processes are in place for Medical and Nursing & Midwifery Revalidation

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

For further information or for any enquiries relating to this report please contact:	
Name: Dr Debbie McGreevy, Assistant Director – Revalidation	**Contact details:** (13) 6285 or 07554 439098

East Sussex Healthcare NHS
NHS Trust

MEDICAL REVALIDATION ANNUAL REPORT 2015-2016

1. Introduction

This report provides information about the medical appraisal and revalidation system and processes over the year 2015-2016, highlighting key issues and actions being taken to respond to them.

On 31st March 2016 there were 342 doctors in the Trust claiming a prescribed connection to the Responsible Officer, the Medical Director.

The Trust has for the third year running achieved a very high medical appraisal compliance status for 2015-2016 with almost 99% (338) of all doctors having their medical appraisal within the required timescales.

2. Background

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

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that the Trust Board of ESHT will oversee compliance by:

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

3. Governance and Quality Assurance

NHS England provides a Framework of Quality Assurance for Responsible Officers (FQA) and this has been published by the Department of Health. The framework details the combined approaches to achieving quality assurance so that the Responsible Officer has confidence that the doctors working in ESHT are up to date and fit to practise. It comprises of the following elements:

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

Core standards:

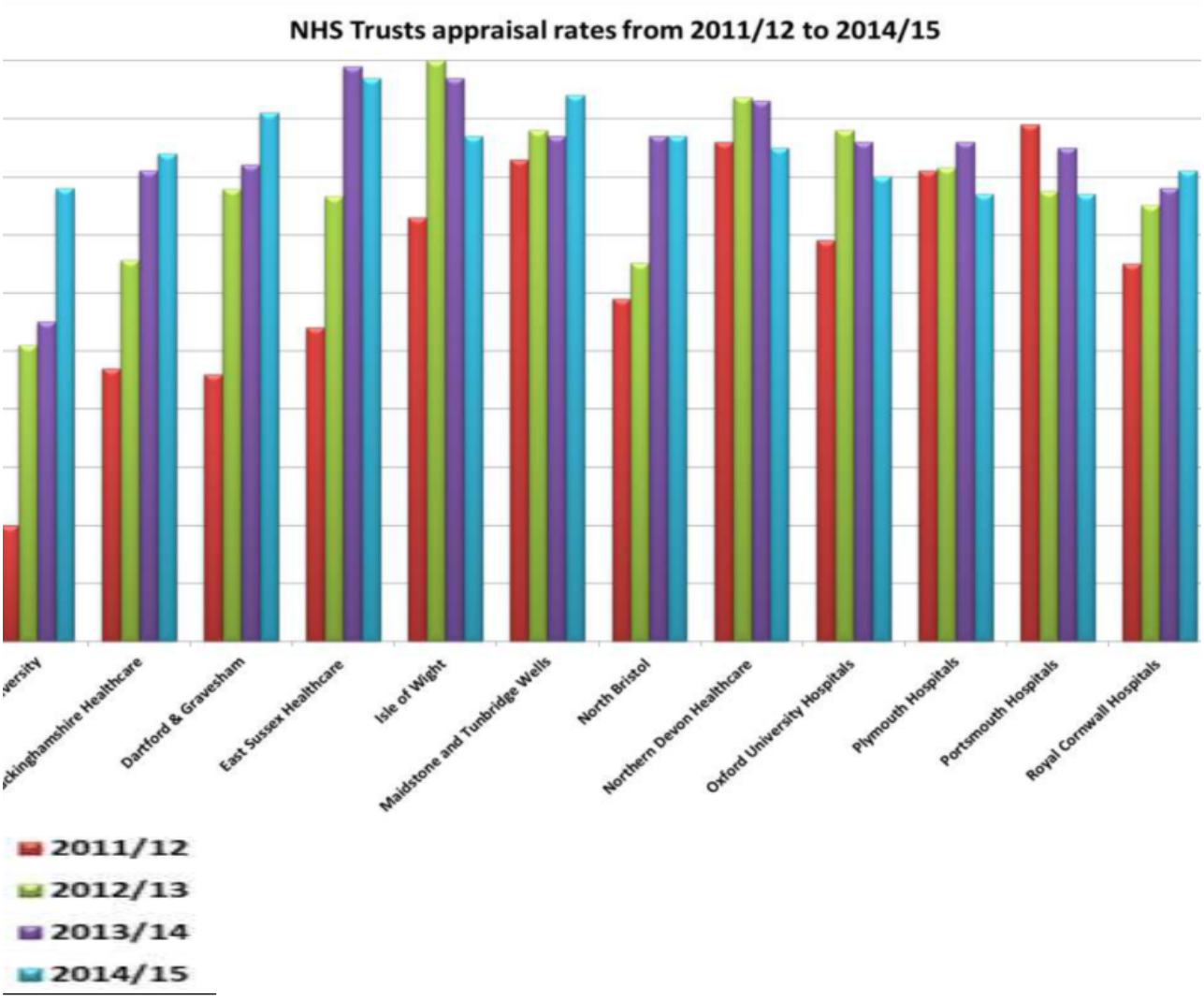
Core standards are a comprehensive overview of the requirements of the Responsible Officer regulations and associated mandatory guidance within a single document. ESHT is compliant with 77 of the 80 basic core standards; actions have been identified to address those relevant to ESHT, with which we are not yet fully compliant.

Quarterly information template:

This reporting process maintains quarterly communications between Responsible Officers at local level and their higher level Responsible Officers, to whom they are linked. This information provides ESHT appraisal rate data to be shared with NHS England regularly. A monthly performance report/dashboard with narrative is also provided to the Trust Board so that assurance is given that the medical appraisal compliance status is steadily increasing during the year.

Annual Organisational Audit (AOA):

The AOA is a mandatory audit that all Responsible Officers are required to complete. This is a standardised return to the higher level Responsible Officer and ultimately to Ministers and the public on the status of the implementation of revalidation across England. This information forms the benchmark across the NHS region and the chart below, provided by NHS England, shows that ESHT has consistently improved its medical appraisal rates, achieving the highest compliance in the region for an acute hospital trust over the previous two years. At the time of writing, the most recent data available for NHS Trusts appraisal rates are for 2014-2015.



Trust Board Annual Report:

Trust Boards are responsible for monitoring the organisation's progress in implementing the Responsible Officer regulations. The Trust Board annual report is one method of informing the Board of the achievements, challenges and compliance status in ESHT with regard to medical appraisals and medical revalidation

Statement of Compliance:

The Responsible Officer Regulations include the requirement of Designated Bodies such as ESHT to provide adequate support to the Responsible Officer. The Chair of the Trust Board or the Chief Executive is asked to sign a statement of the organisation's compliance with the RO Regulations. This is submitted to the higher level Responsible Officer. The statement of compliance accompanies this Trust Board annual report.

Independent Verification:

All Designated Bodies undergo a process to validate their system at least once in each 5 year revalidation cycle. An extensive audit is conducted of evidence that provides assurance to the higher level Responsible Officer. Although this did not occur within the last year, it is worth noting that an Independent Verification visit was made to ESHT in December 2014 by NHS England. The report declares that ESHT achieved a rating of 'EXCELLENT' for core standards relating to responsibilities of the Designated Body and Appraisals. The Trust scored 'COMPLIANT' for performance monitoring and HR processes.

Examples of good practice in ESHT, as identified by NHS England representatives, included: Trust Board engagement in medical revalidation by holding an informative seminar; collaborative working with local hospices and the Appraisal Lead's advice to them with regard to their relevant clinical governance processes; Medical Appraisers feeling valued and praising the support they receive from the Medical Revalidation team; the Trust extranet site for medical revalidation; the use of external case investigators when relevant. The Appraisal Lead for the Trust has since been invited to participate in, what is now called, the Framework of Quality Assurance – Higher Level Responsible Officer Quality Review (HLROQR) to review other organisations and has also presented at a recent RO network meeting in order to share learning across other Trusts.

4. Policy and Guidance

A Medical Revalidation & Medical Appraisal Policy and a Remediation Policy have both been ratified in ESHT. The Medical Revalidation & Medical Appraisal Policy is currently being revised to reflect recent changes required in process particularly in regard to the inclusion of job plans in the appraisal process and the method of addressing non-engagement. The policy will be ratified formally again once all revisions are completed.

5. Medical Revalidation and Medical Appraisals

Medical Revalidation

5.1 Appraisal and Revalidation Performance Data

The GMC provides web based access to ESHT revalidation data via GMC Connect. The revalidation status of all doctors who claim a prescribed connection to the Responsible Officer and ESHT as their Designated Body features on this site. The list of doctors with a prescribed connection is cross checked each month against a list provided by the Medical Recruitment team and when doctors leave or join the Trust.

5.2 Revalidation Recommendations in ESHT between 1 April 2015 – 31 March 2016

Table 1. Revalidation Recommendations in ESHT 1 April 2015 – 31 March 2015

Positive recommendations	108
Non engagement notifications	0
Recommendations completed on time	132
Recommendations completed not on time	0
Deferrals requests	24
Reasons for all missed or late recommendations	n/a

ESHT has not missed any of the deadlines for recommendation for revalidation.

Table 2. Reasons for medical revalidation deferrals 1 April 2015 – 31 March 2016

Number of doctors	Reason for deferral recommendation
5	Time allowed for completion of a '360' multi-source feedback report
9	New starters - to provide them with sufficient time to have their appraisals and to prepare supporting information for their medical revalidation recommendation
2	Long term sick leave and needed more time to prepare for their medical appraisal
1	Maternity leave and needed more time to prepare for their medical appraisal
1	The doctor was on reduced hours due to serious family health issues and needed more time to prepare for their medical appraisal
1	Appraisal was submitted too close to the revalidation recommendation date and so needed more time for a full review of all supporting information to take place
1	The doctor was taking a career break due to serious family health issues
4	Further supporting information required and needed more time to gather it

Medical Appraisals

5.3 Table 3. Medical Appraisals in ESHT between 1 April 2015 – 31 March 2016

	Total	Green	%	Amber	%	Red	%
Consultants	**221**	**219**	**99.1%**	**0**	**0.0%**	**2**	**0.9%**
SAS/Trust Grade	**88**	**86**	**97.7%**	**0**	**0.0%**	**2**	**2.3%**
LAS	**33**	**33**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**
Total Number of Doctors with Prescribed Connection	**342**	**338**	**98.8%**	**0**	**0.0%**	**4**	**1.2%**

KEY:

338	**98.8%**	**Doctors who HAVE forwarded evidence of an appraisal since April 2015 OR have been in the Trust for less than six months and are not due an appraisal before their contract ends OR until the next year's appraisal cycle OR are on long-term/maternity leave**
0	**0.0%**	**Doctors who have NOT had an appraisal since 1st April 2015 but who were expected to have an appraisal before the end of March 2016 if still with the Trust at that date**
4	**1.2%**	**Doctors who have NOT produced evidence of an appraisal for 2015 OR have provided a date for an appraisal OR requested an authorised postponement**

On 31st March 2016 there were 342 doctors in the Trust claiming a prescribed connection to the Responsible Officer, the Medical Director – Governance.

The Trust can boast a very high medical appraisal compliance status for 2015 – 2016 with almost 99% (338) of all doctors abiding by the Trust's medical appraisal compliance criteria.

5.4 Methods of reporting appraisal compliance

5.4.1 NHS England/GMC method of reporting:

There are two methods of reporting compliance with medical appraisals i.e. the method prescribed by NHS England/GMC and the other is the ESHT method, which has a smaller and stricter timescale than NHS England and the GMC to define compliance.

The method of reporting medical appraisal compliance is prescribed by NHS England/GMC as follows:

1a is a completed annual medical appraisal whereby the appraisal meeting has taken place between 9 and 15 months of the date of the last appraisal, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March.

1b is a completed annual medical appraisal whereby the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply:

- a period of time of less than 9 months or greater than 15 months from the last appraisal has elapsed;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting.

However, in the judgement of the responsible officer, the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

Where the organisational systems of the designated body do not permit the parameters of a '*Category 1a* completed annual medical appraisal' to be confirmed with confidence, the appraisal should be counted as a '*Category 1b'.* For example, new starters in the Trust have recently been confirmed as belonging to Category 1b, by NHS England.

5.4.2 ESHT method of reporting:

In ESHT, the medical appraisal cycle runs from April to December each year. If it is agreed by the Responsible Officer that, due to exceptional circumstances, an appraisal may take place between January and March, an additional appraisal must be undertaken by the end of December in the same year. Every doctor should have an appraisal in the anniversary month, or before, of their previous appraisal. Doctors who conform to this and/or have their appraisal within 365 days of their last appraisal are reported as being compliant.

ESHT's medical revalidation team contacts all doctors joining the Trust and provides them with supporting information including the expected month of appraisal; this is particularly significant in situations where their previous appraisal took place between January and March or if they have not had an appraisal within the twelve months before joining ESHT. Doctors are expected to have an appraisal within six months of joining ESHT if they have not had an appraisal within the previous 12 months. Training sessions are conducted at regular intervals to support doctors in developing their understanding of the expectations placed upon them for medical appraisals and medical revalidation. Help and support is also offered by the revalidation team on an ad hoc basis.

If doctors have had a medical appraisal within the last 12 months, and it was not conducted between January and March, the doctor will be expected to inform the Medical Revalidation team, who will then make every effort to provide a medical appraisal no later than their annual appraisal anniversary month. Therefore, doctors are reported as being compliant until they have been in the Trust for six months. After this time, if the doctor has not had an appraisal, they are reported as being non-compliant.

5.4.3. Summary of reporting methods:

The two methods of reporting compliance status with medical appraisals currently requires two different sets of data as supplied to the Trust Board and to NHS England.

NHS England has recently indicated that it is considering aligning its reporting criteria to those similar to ESHT and that the 15 month timescale, currently permitted by the GMC, may be reduced in the future.

ESHT will continue to expect doctors to have their medical appraisal on or before their appraisal anniversary month each year.

5.5 Appraisals completed between 1 April 2015 and 31 March 2016 by Clinical Unit

Table 4. Appraisals completed between 1 April 2015 and 31 March 2016 by Clinical Unit

Clinical Unit	**Number of doctors**	**Number of completed appraisals**	**Number of doctors who missed their 2015-16 appraisal**	**Number of doctors with an authorised deferred appraisal**	**Number of new starters not due an appraisal until next cycle***
Cardio Vascular	25	22	0	0	3
Clinical Support	37	35	0	0	2
Specialist Medicine	36	33	0	1	2
Surgery	99	88	3	2	6
Theatres	53	51	0	0	2
Urgent care	37	35	1	1	0
Women & Children	55	51	0	3	1
Totals	**342**	**315**	**4**	**7**	**16***

* These doctors are compliant with ESHT Medical Revalidation and Medical Appraisal Policy.

5.6 Missed appraisal audit

It is felt that one of the contributing factors in the high medical appraisal compliance status in ESHT is that doctors are reminded of their annual appraisal on at least two occasions. However, some doctors do miss their appraisals and an audit is conducted for all missed appraisals, whether approved or otherwise, and the reasons for these are provided here in Table 5.

A ‘missed’ appraisal is defined as one that has not taken place within fifteen months from the date of the last appraisal or one where the appraisal outputs are not signed off within 28 days from the date of the appraisal. A missed appraisal is defined as either approved or unapproved. Approved missed appraisals are where the Responsible Officer has authorised a postponed or deferred appraisal.

Table 5. Reasons for missed or incomplete appraisals 1 April 2015 – 31t March 2016

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window' (authorised)	4
Sickness absence during the majority of the 'appraisal due window' (authorised)	1
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window' (authorised)	1
New starter not due to have appraisal in current year but due within six months of joining (authorised)	16
Postponed due to incomplete portfolio/insufficient supporting information (authorised)	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	8
Lack of engagement of doctor (Unauthorised) One doctor has undertaken an appraisal before the 31st March 2016. Four doctors are non-compliant	5
Other doctor factors (describe) 1. Serious family health problems so an appraisal postponement authorised and the appraisal subsequently completed. 2. Serious family health problems so an appraisal postponement authorised and the appraisal subsequently completed. 3. New starter joined the Trust in November 2015 but last appraisal in previous trust dated March 2014. Appraisal completed in December 2015. 4. Serious family health problems so an appraisal deferral authorised to 2016-17	4
Appraiser factors	0
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors	0
Organisational factors	**0**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors	0

5.6 Public and Patient Involvement

Doctors are supported in obtaining patient and public feedback, an essential component of their supporting information in preparation for their medical revalidation recommendation to the GMC by the Responsible Officer. The Trust provides this support through the Allocate Software system in order for each doctor to gather patient feedback.

In the last year, 120 doctors received patient and colleague feedback in a report that was discussed during their appraisal with their medical appraiser. This is one of the most important elements of the appraisal and revalidation process as it provides assurances about many facets of individual character and performance and includes colleagues' and patients' views about the fitness to practise of each doctor. Occasionally, the report indicates that one or more areas of feedback warrant support to the doctor, in the form of further personal development or training. In this case, the medical appraiser and doctor being appraised are encouraged to add relevant actions to the doctor's Personal Development Plan. All 360 reports are read prior to submission of the Responsible Officer's recommendation to the GMC for medical revalidation.

A Public and Patient Involvement (PPI) representative is a full member of the Medical Revalidation Advisory Panel that provides oversight and scrutiny of medical revalidation processes. The representative is also involved in the recruitment and interview process for all medical appraisers and participates in the quality assurance audits of medical appraisal outputs.

Further work is in progress to increase the level of public and patient involvement in both medical and nursing revalidation processes; the Appraisal Lead (Assistant Director – Revalidation) and the PPI representative are participating in the Leading Together Programme.

5.7 Medical Appraisers

NHS England requires that the Responsible Officer ensures that the Designated Body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection. Doctors from a variety of backgrounds should be considered for the role of appraiser. This includes associate specialist doctors in secondary care settings. An appropriate specialty mix is important and it is not possible for every doctor to have an appraiser from the same specialty. The recommendation for the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. ESHT attempts to have approximately 37 trained medical appraisers available each year so that each appraiser has an average of 8 – 10 appraisals to conduct in that time scale. This offers a ratio of approximately 1:9 appraisers to doctors in ESHT, taking into account locum doctors and doctors who leave and join the organisation each year.

ESHT currently has 31 trained medical appraisers and 6 new appraisers are in the process of being trained. Medical appraisers are provided with regular update training at least twice per year, when appraisers also have the opportunity to calibrate their professional judgements for medical appraisals. This means that medical appraisers are able to compare their appraisal decisions and outputs with other medical appraisers and align them with the NHS England and GMC requirements. Two training sessions were conducted during the medical appraisal year 2015 – 2016. At least two group sessions of medical appraiser training is planned during 2016 for all medical appraisers.

As part of the training process for medical appraisers, training needs are identified by the following methods:

1. auditing of the appraisal outputs by the medical revalidation team, particularly for new medical appraisers who receive constructive feedback by the Medical Appraisal Lead on at least their first three appraisals and doctors who are due to be reviewed for revalidation;
2. Medical appraisers adding learning objectives about their medical appraiser role to their own Personal Development Plans (PDPs); and

3. An Appraiser Review Summary provides details of the self-identified learning needs of medical appraisers to the Medical Appraisal Lead; a thematic analysis of the learning needs is undertaken; this allows these learning needs to be formally incorporated into subsequent medical appraiser update training sessions.

   Medical appraisers also identify learning needs during update training sessions so that they can be addressed within the group setting. For example, during the most recent appraiser training, it was identified that doctors required more information on what is covered in the entire scope of practice and transfer of information. This was discussed in depth and doctors can obtain further assistance and information via the Medical Revalidation extranet site; there is a system in place which has been agreed by the revalidation team with all other local providers to support doctors in obtaining their 'Responsible Officer Transfer of Information' form. Many appraisers commented that the session on scope of practice was most helpful.

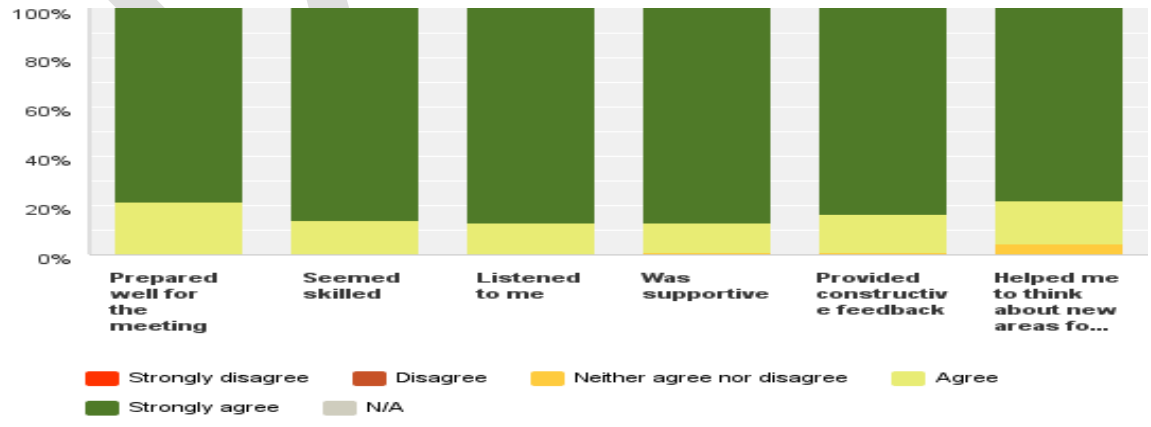
   The update sessions are also an opportunity to discuss any challenges that are posed by being a medical appraiser and these are addressed in an open forum when possible so that all appraisers can share their experiences and work together. Where certain issues are raised that can be addressed, such as appraisals being 'bunched together', the revalidation team can work with appraisers to ensure that appraisals are spaced out over the appraisal year. The medical appraisers and the medical revalidation team work well together in a spirit of co-operation and most issues are fully resolved with mutual respect and support.

   In recent sessions, medical appraisers requested another round of medical appraisal support sessions for new doctors is provided by the revalidation team. These sessions have now been implemented and will save the time of medical appraisers who are now more likely to receive the correct supporting information for their appraisal by new doctors.

   The revalidation team offers advice and support to medical appraisers and both the team and medical appraisers receive very positive feedback. Tables 5, 6 and 7 display a summary of this feedback for the year 2015-16 and some free form comments are also provided.

Table 5. Feedback on medical appraiser performance by 281 ESHT doctors 2015-16

Question 1 - My appraiser:



	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A	Total
Prepared well for the meeting	0.00% 0	0.00% 0	0.71% 2	20.64% 58	78.65% 221	0.00% 0	281
Seemed skilled	0.00% 0	0.00% 0	0.71% 2	13.17% 37	86.12% 242	0.00% 0	281
Listened to me	0.00% 0	0.00% 0	0.00% 0	13.17% 37	86.83% 244	0.00% 0	281
Was supportive	0.00% 0	0.36% 1	0.71% 2	11.74% 33	87.19% 245	0.00% 0	281
Provided constructive feedback	0.00% 0	0.00% 0	1.07% 3	15.30% 43	83.63% 235	0.00% 0	281
Helped me to think about new areas for development	0.00% 0	0.36% 1	4.27% 12	17.44% 49	77.94% 219	0.00% 0	281

In each feedback questionnaire there is an opportunity for doctors to write comments about their appraiser. Some of these comments are included here, demonstrating the participative nature of medical appraisals in ESHT, and the general view of doctors as appraisals being a positive and constructive dialogue which encourages reflective practice. Although there are several examples provided here, which would not normally be included in an annual report, it is important to recognise the valuable contribution that medical appraisers make to quality improvement in patient care and the professional development of our highly valued medical staff:

“My appraiser was thoroughly prepared and judged my needs extremely well. He is kind and thoughtful; he is extremely supportive and excellent at drawing out central areas of my practice, both in terms of achievements to date and where to develop in the future. The appraisal process was brilliant from start to finish.”

“I was amazed by my appraiser’s ability to understand a person he has never met before and being able to provide such meaningful feedback. He is truly insightful, gifted with all the qualities of a good appraiser.”

“My appraiser had digested the information I provided prior to our meeting and was very conversant with all the issues to discuss. He really put me at ease and was very supportive and helpful with suggestions about how to deal with issues at work and opened my eyes to new areas for my personal development and for helping improve some things in the department.”

“Very supportive appraiser. Knows well what she is doing. Gave me a role model how to be punctual. Understanding well my skills and limitations and able to guide me to improve myself.”

“Best appraisal I have ever had. Perfect balance of professional development, reflections and a focus on well-being.”

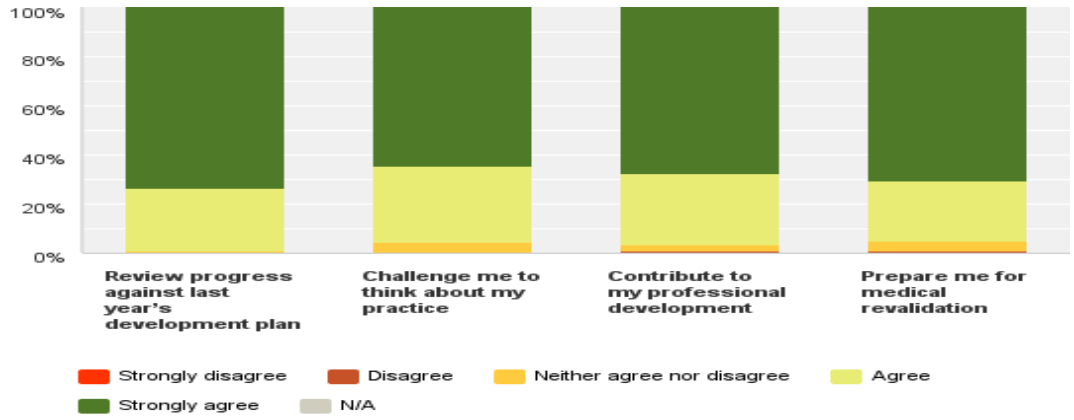
“I cannot speak highly enough about my appraiser’s appraisal skills. He makes the process highly constructive and has really helped me over the last 3 years' worth of appraisals. I am very grateful for his carefully thought out insight into my practice.”

“My appraiser prompted me to challenge myself and provided me with numerous ideas for personal and professional development. He introduced me to the idea of reflective practice and shared his experience with me. Overall this was a valuable experience.”

“My appraiser provided very constructive feedback and engaged in a discussion where he suggested some interesting areas for professional development which I welcome. He also suggested some areas where I could help provide some leadership which was helpful. He also did a helpful review of last year's development plan.”

Table 6. Feedback on medical appraiser performance by 281 ESHT doctors 2015-16

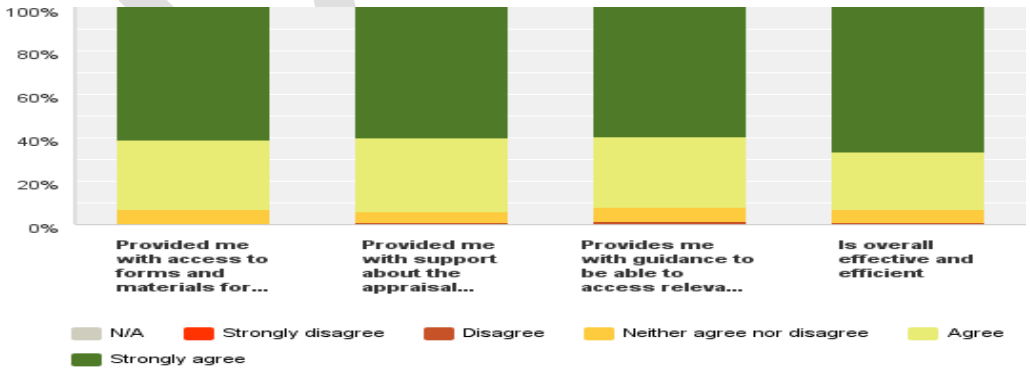
Question 1 - My appraiser was able to:



	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A	Total
Review progress against last year's development plan	**0.00%** 0	**0.38%** 1	**0.38%** 1	**25.94%** 69	**73.31%** 195	**0.00%** 0	266
Challenge me to think about my practice	**0.00%** 0	**0.00%** 0	**4.69%** 13	**30.69%** 85	**64.62%** 179	**0.00%** 0	277
Contribute to my professional development	**0.00%** 0	**1.08%** 3	**2.51%** 7	**29.03%** 81	**67.38%** 188	**0.00%** 0	279
Prepare me for medical revalidation	**0.00%** 0	**0.87%** 2	**3.91%** 9	**24.78%** 57	**70.43%** 162	**0.00%** 0	230

Medical appraisers receive regular training on core appraisal skills but also of any GMC updates and ESHT processes. This leads appraisers to become excellent sources of knowledge and champions for medical appraisals, one of the many reasons that the appraisal compliance in ESHT is so high, particularly compared with other Trusts. Our medical appraisers are highly valued.

Table 7. Feedback on medical revalidation team performance by doctors



	N/A	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Total
Provided me with access to forms and materials for appraisal	0.00% 0	0.36% 1	0.36% 1	6.41% 18	31.67% 89	61.21% 172	281
Provided me with support about the appraisal process	0.00% 0	0.36% 1	0.71% 2	4.98% 14	33.81% 95	60.14% 169	281
Provides me with guidance to be able to access relevant supporting information	0.00% 0	0.71% 2	0.71% 2	6.41% 18	32.74% 92	59.43% 167	281
Is overall effective and efficient	0.00% 0	0.00% 0	1.07% 3	6.05% 17	26.33% 74	66.55% 187	281

The medical revalidation team organise all the associated administration for medical appraisals and medical revalidation and deal directly with all enquiries from the medical staff. Table 6 indicates that all doctors are satisfied with the support received by the administration team with no negative comments received this year:

> "The medical revalidation team is doing an excellent and very important job with efficiency and they're always helpful and available to staff and our problems."
>
> "All relevant forms received in good time plus very supportive about rearranging appraisal date. Thanks."
>
> "They continue to work very hard and are an excellent team. The administrative process was good and effective. Many thanks for all the hard work and great efficiency."
>
> "With my very busy work schedule, it was easy to slip back on the process but for the active reminders and helpful suggestions."
>
> "Revalidation team was very helpful. They answered all my questions and replied to my emails swiftly.They were all positive, compassionate, supportive. A very good organised good team"
>
> "It was so nice to meet you this morning. So grateful for your assistance and friendliness. You solved that stressful situation for me in minutes. I promise that will be the last time that you will have problems with my appraisal in terms of being late and done properly."

5.7 Quality Assurance

The Medical Revalidation Advisory Panel regularly undertakes quality assurance exercises and 67 portfolios have been scrutinised by Panel Members over the appraisal year 2015-2016 to provide assurance regarding the following appraisal inputs:

- the pre-appraisal declarations and supporting information provided is available and appropriate - by whom and sign offs
- review of appraisal folders to provide assurance that the appraisal outputs, Personal Development Plan, summary and sign offs are complete and to an appropriate standard, by whom and sign offs
- review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal summary - by whom and sign offs

  During 2015-2016, only 9 of all Personal Development Plans (PDPs) that were audited were subsequently returned to the appraiser and to the doctor being appraised, with

advice on how to amend and improve this provided by the Appraisal Lead, thus ensuring that quality assurance standards are met and to provide learning for the future.

Continuous improvement of the quality of appraisal outputs is a common theme within all medical appraiser update training. The move away from 'tick box' appraisals is reinforced by the attention placed on the quality of the outputs and the consequent support of the individual doctor in their personal and professional development.

Even though the Trust has been praised for its high quality of appraisal outputs by NHS England, the revalidation team strive for continued excellence.

Within some local Acute Trusts, there is a formal panel who review 100% of appraisal outputs, rather than a randomised selection, or for those who are submitting their supporting information for review in preparation for their medical revalidation recommendation to the GMC. Capacity does not permit this in ESHT and this may become more of a challenge to the Trust in the future when seeking assurance of quality of appraisal outputs.

For the individual appraiser, quality assurance is achieved by holding a review of:

- the annual record of the appraiser's reflection on appropriate continuing professional development
- the annual record of the appraiser's participation in appraisal calibration events such as update training sessions
- 360 feedback from doctors for each individual appraiser; this is collected through 'Survey Monkey' and it is reviewed by the Medical Revalidation Panel on at least an annual basis. Findings are presented to the medical appraisers individually, where possible, and collectively in their update training sessions. Some Trusts have capacity to meet or discuss this feedback regularly on an individual basis. Capacity does not permit this in ESHT but medical appraisers are always welcome to request a confidential meeting if they wish.

  Feedback on medical appraisers is reviewed by the Trust's Appraisal Lead and individual support is provided to each medical appraiser, where appropriate and collectively all learning needs are addressed through the action learning update sessions
- Appraisal outputs and the quality of the Personal Development Plan and appraisal summary in particular.

5.8 Information Governance

There have been no breaches of information governance this year for medical appraisal documentation. Doctors are made fully aware through the medical revalidation and medical appraisal policy, and personal advice, that no patient identifiable data can be used in their portfolio of supporting information. Any appraisal governance report that identifies patients, and is used for the discussion within the appraisal for learning from complaints and incidents, is kept confidential. It is forbidden to forward any patient identifiable information outside the Trust. This applies also to the Transfer of Information forms that are requested by other employers for doctors who work in other organisations or who are leaving ESHT and must supply references that include their appraisal and revalidation status.

In the year 2015-2016, the medical revalidation team handled in excess of 25 requests for Transfer of Information forms for other Responsible Officers. This requires gathering information on the doctor's appraisal status and any involvement in incidents, complaints, investigations and undertakings.

One of the key challenges for the medical revalidation team is obtaining Transfer of Information forms for doctors who join the Trust. Some doctors join the Trust from other organisations or countries where Responsible Officers do not exist, or the doctor has not had appraisals previously. This is addressed by contacting all new doctors and supporting them through the appraisal and revalidation process as quickly as possible. All new doctors are expected to have an appraisal which includes the development of a personal development plan, within six months of joining ESHT.

Locum doctors, who might be new to the organisation, are always contacted and offered support with medical appraisals which enhances patient safety. Work is continuing to provide further information within an induction process and an enhanced policy for locum doctors. This work is being led by the Human Resources Department.

5.9 Clinical Governance

Every doctor is required to supply an Appraisal Governance Report to their medical appraiser at least two weeks ahead of their annual appraisal; this report is obtained through the revalidation team. An Appraisal Governance Report allows doctors a formal opportunity to review and reflect upon all incidents and complaints in which they were named or involved during the previous year.

In excess of 350 Appraisal Governance Reports were generated in the year 2015 - 16. These reports are also generated immediately prior to the medical revalidation recommendation to the GMC so that the Responsible Officer is able to make an informed recommendation of the doctor's fitness to practise.

6 Challenges and Next Steps

- Quality and service improvement initiatives are being further encouraged through the medical appraisal process and the development of professional objectives in the Personal Development Plan. Medical appraisers are asked to focus on this aspect during the medical appraisal and ways of disseminating good practice without breaking confidentiality are being investigated.

- Nursing revalidation was implemented in April 2016, and this offers many opportunities to the Trust. There is the potential of integrating certain aspects of medical and nursing appraiser/appraisal training such as shared learning, reflective practice, quality improvement and patient and public engagement; it is anticipated that the potential benefits are immense. Nurses and doctors have the additional benefit of learning from the others' knowledge, skills and experience. This activity will thoroughly support all the Trust Values.

7 Recommendations

1. The Trust Board is asked to approve this annual report, noting it will be shared, along with the annual audit, with the higher level Responsible Officer at NHS England.
2. The Trust Board is also asked to approve the 'statement of compliance' confirming that the organisation, as a designated body, is compliant with the regulations. The CEO and/or Chair of the Trust Board are asked to sign the statement.

Dr David Hughes
Medical Director – Governance
Responsible Officer – Medical Revalidation 12.5.15

East Sussex Healthcare NHS
NHS Trust

NURSING & MIDWIFERY REVALIDATION ANNUAL REPORT 2015 - 2016

1. Executive summary

1.1 This is the first annual report for nursing and midwifery revalidation in ESHT although this report needs to be read in the context of the launch by the Nursing & Midwifery Council's of nursing and midwifery revalidation in April 2016. This report provides information about the new revalidation process and how the Trust supports its nurses and midwives in ESHT, particularly those whose revalidation application preceded the formal implementation of the revalidation process.

1.2 This report additionally provides information about the number of nurses in the Trust and the number of completed revalidation submissions within the year 1st April 2015 and 31st March 2016. It also highlights challenges experienced by the organisation and our responses to them. For ease of reading, the report will mainly refer to nurses but the report also includes midwives within this category.

2. Background to revalidation

2.1 Nursing & Midwifery Revalidation was launched by the Nursing & Midwifery Council (NMC) on 1st April 2016 following the publication on 29 January 2015 of The Code which contains the professional standards that registered nurses and midwives must uphold. Although they do not align exactly, the Trust values also feed into the process of adhering to the Code.

2.2. Nursing revalidation is the process that allows a nurse and/or midwife to maintain their registration with the NMC by building upon existing renewal requirements. Nurses and midwives must demonstrate their continued ability to practise safely and effectively. Revalidation is a continuous process that all nurses and midwives need to engage with throughout the year and they must meet certain requirements in order to complete their revalidation and renewal of registration every three years with the NMC.

2.3 All nurses and midwives must develop a portfolio that provides supporting information such as: a record of sufficient practice hours; continuing professional development; practice related feedback; written reflective accounts; evidence that a reflective discussion has taken place with another NMC registrant; and they must make declarations to the NMC in regard to health, character, and professional indemnity arrangements. The supporting information must be confirmed by an appropriate colleague, normally a line manager, before revalidation can be applied for.

2.4 However, it should be noted that, unlike medical revalidation, nursing and midwifery revalidation is not an assessment of a nurse or midwife's fitness to practise. It is also not a new way of raising fitness to practise concerns as there are existing governance processes and systems to monitor the conduct and performance of nurses and midwives in ESHT and disciplinary policies and procedures are in place.

2.5 Although revalidation began formally in April, the NMC expects nurses to obtain confirmation during the final 12 months of their three year renewal period so as to make sure that the confirmation is recent. The nurse and/or midwife must submit their revalidation application through their online account with the NMC in the 60 days before the first of the month in which their revalidation is due. This means that there were some nurses in the Trust who needed to apply for revalidation prior to 1st April 2016. Thirty three nurses and one midwife completed their revalidation applications before 31 March 2016. There were no missed submissions in this time period.

2.6 There are currently 675 ESHT nurses and midwives due to revalidate in the year 1st April 2016 to 31st March 2017, of whom 107 are due to submit their revalidation applications between 1st April and 30th June 2016. This number remains flexible due to workforce movements.

3. Governance Arrangements

3.1 Director of Nursing

The Director of Nursing is the senior nursing and midwifery professional within the organisation and has, amongst her accountabilities, those of ensuring that all nursing and midwifery staff are appraised annually and participate in the revalidation process.

3.2 Heads of Nursing and Governance

Heads of Nursing and Governance are responsible for monitoring the appraisal compliance of nurse and midwives within their Clinical Unit and ensuring that they have all undertaken an appraisal within 12 months of their previous appraisal. It should be noted that the appraisal year has recently been shortened and nurses and midwives should have their appraisals between April and December to align with medical staff and to avoid appraisals taking place during the months where 'winter pressures' are most likely to occur.

3.3 The revalidation team

The revalidation team has the role of monitoring the nursing and midwifery revalidation process within ESHT by maintaining an appraisal and revalidation tracker with information and data provided by our workforce information team; team members also organise and deliver the ongoing support for all nurses and midwives including nurse and midwifery appraisers, confirmers and line managers. This support is particularly important for nurses and midwives who are engaged via the Temporary Workforce Service register who might otherwise find it challenging to be provided with an annual appraisal or other assistance with the revalidation process.

3.4 Nurses and Midwives

The responsibility for participating in the revalidation process lies with the nurse and midwife who are obliged to revalidate to maintain their registration. Failure to revalidate by the appointed date provided by the NMC has the consequence of being removed from the Register, meaning that it is illegal to continue to work as a Registered Nurse or Registered Midwife. It also puts the nurse or midwife at risk of being moved to a Healthcare Assistant role temporarily and of disciplinary action. Nurses and midwives who have genuine reasons for delaying their revalidation submission are asked to contact the NMC directly who considers each case on its merits.

4. Policy, Guidance & Training

4.1 ESHT Nursing and Midwifery Revalidation and Appraisal Policy

On 12 January 2016 the ESHT Nursing and Midwifery Revalidation and Appraisal Policy was ratified by the Trust Patient Documentation and Policies Ratification Group, having firstly been extensively reviewed and amended by various clinical and managerial colleagues.

This policy document provides an outline of the requirements and arrangements for conducting nursing and midwifery appraisals in ESHT but needs to be understood in the context of the revised Performance Development Review (PDR) Policy which provides guidance on the generic process for annual appraisals. The new PDR process (also sometimes called 'the appraisal process') provides the baseline appraisal process but nurses and midwives need also to provide supporting information to demonstrate progress towards their three yearly revalidation application to the NMC.

4.2 Support for ESHT nurses and midwives and those engaged via the Temporary Workforce Service

4.2.1. There were approximately 1934 nurses and midwives in the Trust at 31 March 2016 excluding those who were engaged via the Trust's Temporary Workforce Service (TWS) (n=127). Of these, 1601 had an appraisal during the year 2015 – 2016. It is now Trust Policy that the principles and requirements of revalidation apply to all nurses and midwives licensed by the NMC and therefore those who are registered on the TWS will now be supported to have their annual appraisal and revalidation confirmation provided by specialist nurse teams. Support was also specifically targeted at those nurses and midwives who have a revalidation date between April and June 2016.

4.2.2. The revalidation team has provided up to 31 March 2016:

- 14 workshops for 70 nurses
- 15 roadshows for 60 nurses
- 46 visits to clinical areas (ward rounds)
- 62 individual meetings for nurses

4.2.3. Workshops

Two main styles of workshop session have been developed to cover all areas of revalidation:

- NMC Revalidation Workshops provide a general overview of revalidation and how to meet the NMC requirements.

- NMC Revalidation Workshops 'The role of the confirmer' are specifically targeted to those who are providing confirmation; the session also covers each requirement of revalidation and what they are required to do as a confirmer.

4.2.4. Roadshows

The roadshows visited the majority of Trust sites to provide an introduction to revalidation. The sessions were held over the lunchtime periods to attract as many nurses and midwives as possible.

4.2.5. Ward Rounds

The revalidation team, with the support of the workforce education team, has visited the majority of the wards at the Conquest and EDGH sites. An audit was carried out to capture how revalidation was bedding into the ward/unit, to provide support to the Matrons and Sisters and give them an opportunity to make any comments or requests. A revalidation pack was devised and left on the ward for all nurses and midwives to access.

4.2.6 Individual Sessions

The initial individual 1:1 sessions supported nurses who were due to revalidate in the first few months of 2016; they provided bespoke guidance to ensure the nurse or midwife met the requirements on time.

The sessions have been developed to provide all the required information and guidance needed to approach revalidation, and to help alleviate the anxiety surrounding revalidation. During the sessions, examples are given of how to complete some of the requirements and advice provided about their scope of practice. Resource materials have been created to assist with the sessions including presentations, guidance sheets, workbooks, and completed examples. The revalidation team has been requesting feedback from the sessions and responding to comments and suggestions. All resource materials are available on the Trust's revalidation extranet page.

4.2.7 Extranet site

An extranet site has been developed so that nurses can view details of any training and support sessions, roadshows, workshops, library sessions (such as training on reflective writing), templates for revalidation portfolios and the most up to date guidance.

4.3 Reminder Emails

The revalidation team has been sending out reminder emails to all nurses and midwives who are due to revalidate. Where an email address is not located, correspondence has been sent to either the Matron or their home address. The reminders are sent to them approximately 10-12 weeks prior to their revalidation date and then again approximately 4 weeks ahead of their revalidation due date.

The reminder emails provide an opportunity for the nurse or midwives to contact the revalidation team if they have any concerns about revalidation, as well advertising the revalidation team support sessions.

4.4 Portfolio Examples

Nurses and midwives have shown great enthusiasm for revalidation, and the team has received sample portfolios, reflective writing guidance and, in some areas, the Matrons or Practice Educators have created revalidation portfolio folders for each team members to use. Nurses have shown great passion for their practice and career and the revalidation process enables them to demonstrate this.

5. Quality Assurance

5.1 Randomised internal audit

The revalidation outputs of confirmers, and the nurses' and midwives revalidation portfolios, will be quality assured by randomised auditing during the year. The findings of these audits will be reported to the Heads of Nursing and Governance, the Assistant Directors of Nursing and the Director of Nursing through the Trust Nursing & Midwifery Action Group for any action deemed necessary. Any learning will also be applied to training and support sessions provided by the revalidation team. The audit findings, and the application of any learning, can be included in future annual Trust Board reports on nursing and midwifery revalidation.

5.2 External verification

5.2.1. The NMC has advised us that they will be contacting a sample of nurses and midwives for verification. The nurse or midwife will be contacted once they have submitted their revalidation application and paid their renewal fee. The NMC will request the nurse or midwife completes an additional online form which asks for further information relating to their revalidation portfolio.

5.2.2. The NMC will also contact the reflective partner and the confirmer as part of the verification process. The additional information needs to be returned within six weeks of the NMC requesting it, and the verification process will be completed within three months of the nurse's or midwife's renewal date. The registration will not be affected during this process, and it will be renewed once the verification process has been successfully completed.

5.2.3. Once the revalidation application has been submitted, the confirmer, as entered onto the nurse's or midwives revalidation application form, may be sent an email by the NMC to verify the confirmation took place.

5.3. Feedback on the organisational support provided by the revalidation team

5.3.1 In order to quality assure the revalidation and appraisal process, a Nursing & Midwifery Appraisal Colleague Feedback form has been included in the Nursing & Midwifery Revalidation and Appraisal Policy. This form can be retained by the confirmer and/or appraiser for use as colleague feedback for their own portfolio.

5.3.2 This form will also be requested on a randomised basis by the Revalidation team; this will assist the Revalidation team and the Learning & Development team to assess the standard of appraisal and revalidation support offered to nurses and midwives with specific reference to the development of their portfolio and the revalidation and appraisal processes. If the standards are not in accordance with the Trust PDR or Nursing & Midwifery Revalidation and Appraisal Policy requirements, the confirmer and/or appraiser would be required to attend further training.

Fifty three survey forms have so far been returned by nurse and midwives attending training or accessing the ESHT extranet site for nursing revalidation. Tables 1 and 2 show the feedback provided so far regarding information and support provided by the revalidation team.

Table 1. Feedback on information provided by the revalidation team

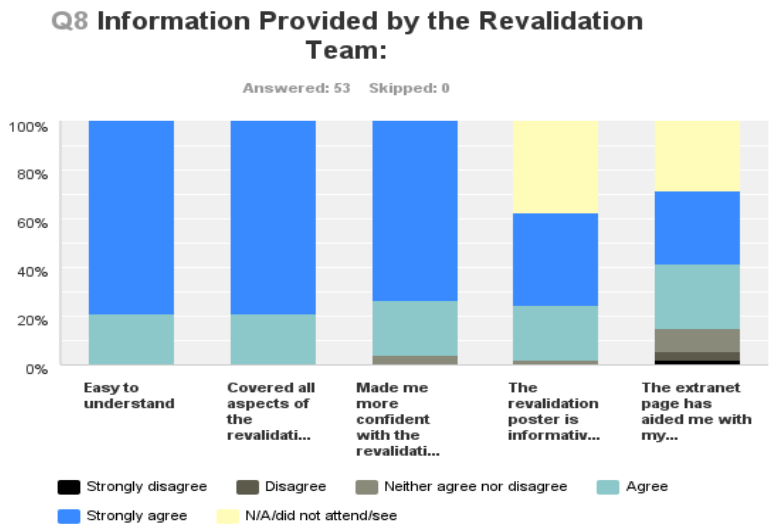
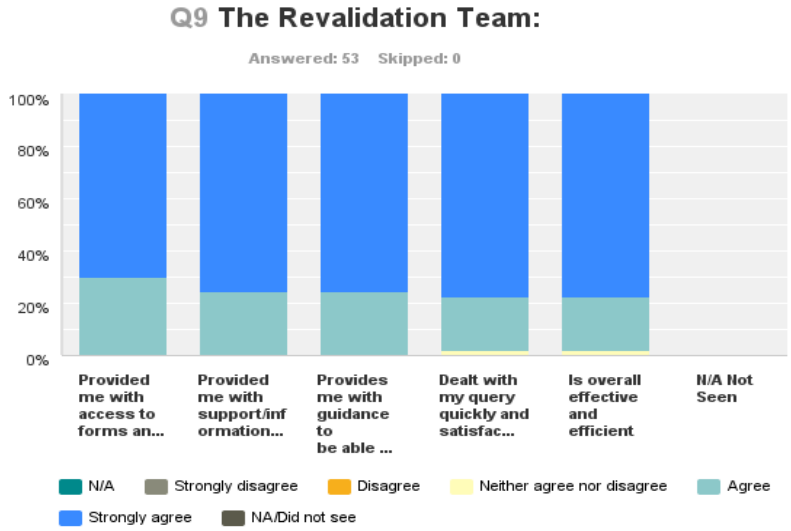


Table 2: Feedback on the support provided by the revalidation team



"It was very helpful to have a 1:1 or small group to go through queries and questions that came to mind. Having details explained re-enforces any previous understanding and helps ensure comprehension!"

"I feel able to help & support staff going through revalidation. You gave me the confidence to do this. To do my own and help others."

"Very helpful and informative session. Explained everything in an easy to understand way and really took the unease about the process away. Now feel much happier and more confident about this."

"Thank you, the session was great, it dispelled a lot of myths and I am now able to cascade to the team!"

6. Clinical Governance

6.1 One of the most important elements of any appraisal is the opportunity of reflection on what has gone well and also on what has been learned. The revalidation team now supplies every nurse and midwife with an appraisal governance report for their annual appraisal. This report contains information spanning over the previous 12 months and includes information about any complaints or incidents in which the nurse and midwife has been directly or indirectly involved. This means that the nurse can reflect upon what they have learned, how they have shared their learning and applied it to their clinical practice. It is this reflection and learning that promotes continuous improvement in the quality of our patient care.

7. Challenges and Next Steps

7.1 As with all new systems and processes there have been several key challenges. Here are some of the key challenges the revalidation team and the organisation have faced in the implementation of revalidation for nurses and midwives since October 2015 when the revalidation team formally took on the role of supporting the organisation with this task:

7.2 The NMC changes in their requirements.

An example of the NMC change in their requirements is the requirement for evidence of 40 Continuing Professional Development hours which was reduced to 35 hours after the preliminary information had already been shared with the nursing and midwifery workforce. This meant that the revalidation team needed to contact all nurses and midwives again to inform them of the new requirements.

7.3 Communicating with nurses and midwives who do not have ready access to emails.

Increasing the awareness and understanding of the nursing and midwifery workforce of the responsibilities placed upon them in the different roles i.e. i) being appraised and/or revalidated ii) being a confirmer iii) being an appraiser and iv) being the provider of the reflective discussion, is challenging due to the complexities of communicating with different clinical areas and the sheer volume of nurses and midwives involved.

There are approximately 350 nurses without an active Trust email account. This creates further administration to make contact. The team are providing revalidation reminders and guidance, Line Managers are contacted to request the information is passed on, and a Trust email is set up. Appraisal governance reports are also sent via email. Due to the sensitive nature of the information included within the appraisal governance reports, they must be sent to a secure location and personal email addresses cannot be used. Where an email address is missing, the reports are sent to the home address.

7.4 Ensuring data is timely and accurate for record keeping purposes – access to ESR

The team now has access to ESR which has enabled the team to access up to date data as and when required. This reduces the need to rely on other teams for the information. Previously, the team relied on monthly updates which became rapidly outdated and contained insufficient information. One of the benefits of direct access to ESR is that the revalidation team and HR now have direct access to the NMC's caller code system. The NMC has a direct link to the ESR system which updates every night. The caller code system can be used for checking individual Pin numbers.

The revalidation team maintains a tracker which stores the registration and revalidation dates and these are updated on a monthly basis or when required.

7.5 Correcting inaccurate messages spread by rumour by offering training

The revalidation team are providing weekly support sessions open to all nurses, and those providing confirmation. The sessions cover all aspects of the revalidation process, and a workbook is provided for each attendee to keep and use as a basis to their revalidation portfolio. During the confirmer sessions, which line managers attend, they are asked to cascade the information down to their team, and ask they help support each other through the process. The extranet site for nursing and midwifery revalidation also details each requirement of the process.

7.6 Nurses engaged via the Temporary Workforce Services

Support sessions have been arranged by the Clinical Education team, initially on a weekly basis. The team have also been providing confirmation to those due. A lack of Trust emails has made it difficult to contact those due to revalidate, and the revalidation team has relied on the TWS team to support this. There are further processes to be implemented for those who are new to the Temporary Workforce Service, and who have revalidated already to check that a revalidation portfolio has been developed to satisfy the NMC's requirements. If a nurse is engaged via an external agency, this agency must ensure the nurse or midwife has an active registration with the NMC.

7.7 Embedding the NMC requirements into the Trust's appraisal process – appraisal policy

The NMC strongly recommends that the revalidation process sits within the appraisal process. This requires all nurses and midwives to have an appraisal every year, between April and December. The appraisal allows the line manager to have a discussion about revalidation, and to check evidence is being collected to meet the NMC requirements. The confirmation can be completed 12 months ahead of their revalidation due date allowing the appraisal closest to the nurse's revalidation date to include the confirmation.

The Nursing & Midwifery Revalidation & Appraisal policy was ratified in January 2016 and the Performance Development Review policy is in the process of being ratified. The policies are being highlighted within the revalidation sessions. Nurses who do not have an appraisal will be reported via the Nursing and Midwifery Dashboard report which will be submitted to the Director of Nursing on a monthly basis, beginning in June 2016 (when reports for both April and May 2016 will be provided).

7.8 Lack of engagement and the risk of lapsed registrations

Nurses and midwives who do not submit their revalidation applications in time will be removed from the nursing and midwifery register by the NMC; there is no Responsible Officer for nursing and midwifery revalidation. There are delays of up to 6-8 weeks of being reinstated on the register, during which time the nurse or midwife will not be able to work, other than in the capacity of a health care assistant. This will have an impact on the workforce and holds a risk of affecting patient safety and patient care.

Where registrants fail to renew their registration, disciplinary action could be taken and the lapsed registrations will also be reported to the Director of Nursing and to the Trust's Nursing and Midwifery Action Group (TNMAG).

During the ward rounds, revalidation sessions, and direct contact with nurses and

midwives, some areas were identified as having nurses who were not (at the time) fully engaging with the implementation of the revalidation process. Where this has been highlighted, the revalidation team and the clinical education team have provided bespoke sessions to the teams or areas to overcome some of the resistance and to alleviate the pressure of nurses leaving the ward and creating a temporary staff shortage. The revalidation team has also provided a list of revalidation dates to each of the wards to assist with their own forward planning.

7.9 Harnessing the enthusiasm of nurses and midwives in an effective way

The Revalidation team is aware of numerous examples of portfolios and guidance on the different areas of revalidation that have been developed by our nurses and midwives. Whilst this is highly encouraged, it is essential that any examples to be shared with others are reviewed to ensure they conform to the NMC's revalidation requirements. The revalidation team is seeking advice from TNMAG on how these documents can be reviewed, signed off, and potentially promoted via the extranet revalidation pages.

8.0 Recommendations

The Trust Board is asked to approve this annual report.

Alice Webster, Director of Nursing 31.5.16

East Sussex Healthcare NHS Trust

Date of Meeting:	4th August 2016
Meeting:	Trust Board
Agenda item:	14
Subject:	Equality Delivery System
Reporting Officer:	Kim Novis

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

Purpose:

To provide assurance to the Board that the Trust is fulfilling its duties as a healthcare provider and employer and complying with the Public Sector Equality Duty (Equality Act 2010).

Introduction:

The refreshed Equality Delivery System (EDS2) is a reporting framework provided by NHS England and is included in the NHS Standard Contract. EDS2 is ESHT's annual report providing equalities data on service, patients and staff. It seeks to highlight areas across the Trust of good practice and areas requiring development. EDS2 is designed to be accessible to the general public, without complex data and narrative; to give an insight into how well protected groups fare when compared to people overall.

The RAG rating is a rating of how well protected groups fare and not how the service performs overall.

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

The points for discussion and key issues are data collection methods

Benefits:

ESD2 provides a good starting point to highlighting areas requiring development, which enables the Trust to identify areas which are relevant locally but not necessarily identified nationally. It also provides the Trust the opportunity to publicise the good practices that often go unseen.

There has been an excellent uptake of the new Equality analysis (EHRA) for procedural documents with all ratification groups adopting the process of 'procedural documents must contain an EHRA' in order to be ratified. This has provided a 'green rating' as EHRA ensures all protected groups are considered to ensure equality of opportunity.

Staff supporting patients with Learning Disabilities continue to develop innovative ways to ensure barriers are removed to enable equal access to Healthcare to this group who often require reasonable adjustments.

PROJECT Search continues to be a great benefit to the interns and the Trust.

Risks and Implications
Complaints data continues to be RAG rated 'Red' due to absent data. The Equal pay audit commenced this year. In order to comply with the standard, it requires further analysis to be carried out on an annual basis. A&E data requires improvement to ensure ethnicity data is collected at admission.

Assurance Provided:
There is always more work to be done to eliminate discrimination and advance equality as an employer and healthcare provider. EDS2 2015/16 seeks to provide assurance that the Trust is fulfilling its legal obligations and continually working towards being an organisation that constantly seeks to improve access to those who might otherwise find it difficult or impossible, whether an employee or service user.

Proposals and/or Recommendations
EDS2/WRES group to meet quarterly with full members in attendance to ensure future leads for EDS2 and WRES are fully informed to ensure risks are identified and addressed early.

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:	**Contact details:**
Kim Novis	Kim.novis@nhs.net

The Equality Delivery System (EDS2)

Final Grading and Equalities Analysis Report 2015/16

Contents

Summary

1. **Introduction**
   This report seeks to provide assurance for patients, carers, the public and to staff that the Trust is inclusive of the needs of all people. Whether people are accessing services, visiting or working for the Trust, no matter where they live within the organisation's geographical reach, they can be confident that the Trust is continually seeking to improve the services it offers as a healthcare provider and employer.

   2015/16 has been another year of building on existing good work, implementing revised equality objectives and once again rising to new challenges. The report uses the EDS2 outcomes to guide the Trust in highlighting the progress in delivering good practice and identifying areas for further development.

2. **Achievements**
   The Trust has devised many initiatives throughout the organisation to ensure patients, carers, visitors, service users and staff have equal access to services.

   The Trust Annual Staff Awards again provided the opportunity to recognise the great work ESHT staff do. Awards were given out to staff for a variety of achievements such as exemplary leadership, commitment and dedication to improving access to healthcare for those who may otherwise find it difficult.

   ESHT welcomed a further cohort of interns on Project Search, a programme that supports young adults with learning difficulties and enables them to widen their employment opportunities.

   The New Pevensey unit opened in Nov 2015 with a separate day unit which has a spacious waiting area, reception, 3 treatment areas a procedure room, shared staff room and quiet room for patients and relatives to discuss care and treatment pathways.

   The new Pevensey ward provides single sex bays, young teenage adult room and separate kitchen area. The new unit has significantly improved the privacy and dignity for all patients and improved facilities for young teenage adults with the provision of a purpose built room.

3. **Areas of Focus from 2014/15 report:**
   A baseline for EDS2 was established in the 2014/15 report and recognised there was a need to increase engagement throughout the organisation to support development of equality and diversity; identify areas of improvement, raise awareness and share learning of some of the good practices that already exist. Through the development of the Equality Steering Group and Black Asian and Minority Ethnic (BAME)

Staff Groups, managers were able to commence identifying, discussing and implementing ways to make improvements

It was also recognised that robust data collection and analysis needed further development to improve assurance of the organisation's compliance against the standards and to identify areas requiring further development. Through the Equality Steering Group managers were able to receive guidance and discuss ways of improving data collection.

4. Areas of focus for 2016/17:

Increasing communication with the organisations service users is planned during 2016/17 which will continue to reach the Trust's target of achieving an 'Outstanding' rating by 2020. Through the development of patient engagement groups and staff networks the Trust aims to provide an open and transparent approach to present topics that cause concern, listen to peoples' views and act on innovation wherever possible.

Implementing the new Accessible Information Standard across the Trust to ensure patients, service users and carers have access to healthcare information in a format that is suitable to them. The Standards aims to identify, record, highlight, share information and support the communication needs of all those that require communication support due to a disability, sensory or cognitive impairment.

5. EDS2 Outcomes and Grading 2015/16

Goal 1: Better health outcomes		
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	**ACHIEVING:**
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	**ACHIEVING:**
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	**DEVELOPING:**
1.4	When people use 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:**
Goal 2: Improved patient access and experience		
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	**DEVELOPING:**
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	**DEVELOPING:**
2.3	People report positive experiences of the NHS	**DEVELOPING:**
2.4	People's complaints about services are handled respectfully and efficiently	**UNDEVELOPED**
Goal 3: 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**
Goal 4: 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	**ACHIEVING**

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 is to help 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.

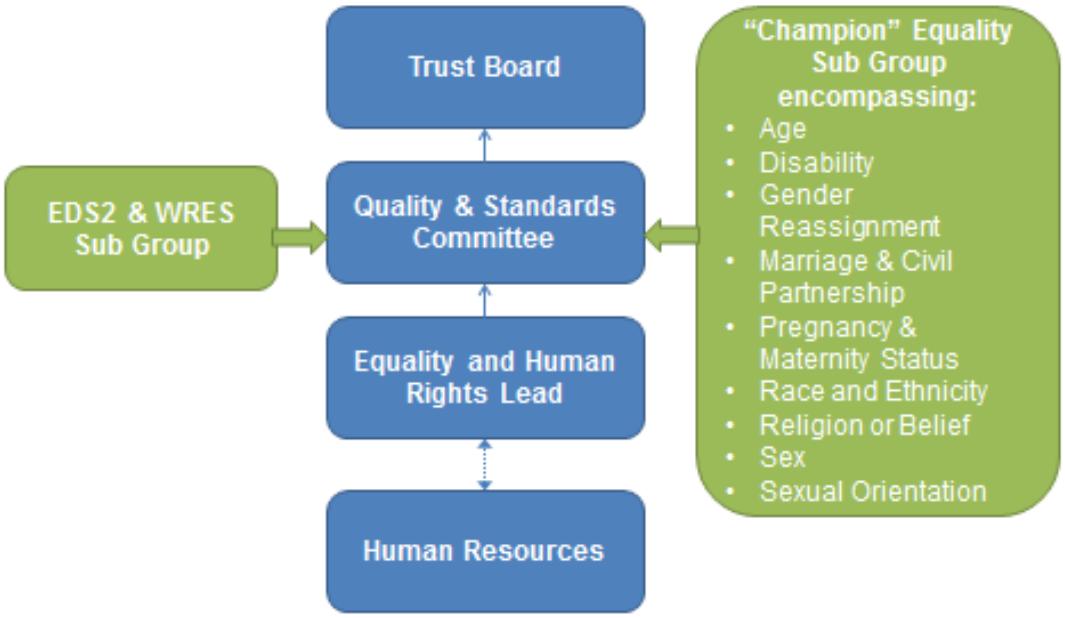
East Sussex NHS Healthcare Trust has embedded the EDS2 into everyday practice which assists the Trust to deliver a report that is understandable and transparent. Complying with EDS2 assists East Sussex Healthcare Trust in:

- Ensuring staff and service users are free from unlawful discrimination
- Identifying barriers to healthcare enabling the Trust to improve access to services
- ensuring staff and service users are provided with equality of opportunity and are fostering good relations
- Improving patient experiences of the organisation which will deliver better health outcomes
- Deliver a well-led, supported workforce that is representative of the communities it serves.

Equality sits with the highest level of leadership at ESHT with a robust governance framework to support monitoring and delivery. There are 2 sub-groups that feed into the Quality and Safety Committee; The EDS2/WRES group is made up of 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 that ensures objectives are being met and progress reported.

The second subgroup, chaired by the Equality and Human Rights Lead, will link with other patient groups, staff groups and networks. The aim is to discuss and address concerns and capture innovative ideas that will assist the Trust in becoming the Healthcare provider of choice for local people and an employer where staff are happy and proud of their membership.

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**

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:

ESHT 2020 is a major programme of work planned to ensure the Trust consistently deliver high levels of responsive, effective and compassionate care .ESHT aim to provide safe and high quality healthcare for the people of East Sussex and to achieve a CQC rating of 'Good' by 2017 and 'Outstanding' by 2020. The 2020 programme will be published in May 2016.

To support the Trust's compliance with current equality legislation and ensure it meets the needs of all its users, the EDHR Lead continues to be a panel member for relevant tendering processes alongside dedicated procurement leads when out-sourcing its services.

ESHT was successful in retaining the contract to continue providing integrated Sexual Health, HIV treatment and care services in East Sussex. Specialist sexual health services in East Sussex are provided from two main bases; Station Plaza, Hastings and Avenue House, Eastbourne. Sexual Health Friends and Family test results are consistently above 95%.

Language and communication
Language and communication needs were supplied under the East Sussex County Council's SUSTI framework which translates foreign community languages, through telephone, face to face, written, audio, braille and sensory interpreters. It was recognised through the Care Quality Commission's report that the current system for accessing interpreters was not as simple as it could be and that staff often found it challenging and time consuming to obtain 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. In order to improve this service a scoping exercise commenced with internal stakeholders and service users to identify where and how this service could be improved. Potential suppliers from an existing framework provided by NHS Commercial Solutions were invited to submit a bid for a sole contract for interpreting services at ESHT. A successful bidder was identified and mobilisation of a new and improved service will be rolled out across the Trust early summer 2016. The new supplier will also assist the Trust in implementing the Accessible Information Standard which supports patients with communication needs arising from a disability or impairment.

Grade:	ACHIEVING

Evidence for grading:
- Quality Accounts
- CQC Report

- Healthwatch
- FFT
- Tender processes / contracts
- Internal scoping exercises

Areas of focus from 2014/15 Report for 2015/16

- 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 further 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.

The EDHR Lead, along with stakeholders conducted a mini-competition and evaluated bids for interpreting services at ESHT. A Service Level Agreement (SLA) with robust Key performance indicators was awarded.

The EDHR Lead participated in the successful bidding process for Sexual Health Services to remain at ESHT.

Areas of focus for 2016/17

- Develop a full action plan to successfully implement the Accessible Information Standard across the Trust.
- Identify innovative ways to meet the communication needs of all service users with Learning Disabilities, sensory and cognitive impairments and other disabilities.
- Ensure a robust SLA for Interpreting Services meets the needs of all service users who do not communicate using spoken English.

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 (LD)
The Trust has increased the use of the 'This is Me Care Passport' and Disability Distress Assessment Tool (DISDAT) across the trust when patients are admitted to any of the Trust hospitals. This was supported by the formulation of 'Guidance for inpatient care: assessment and provision of reasonable adjustments'. These then remain on the patient's record through a flagging system, highlighting any additional needs. This now includes children and young people.

Enhanced pre-op assessments (undertaken in pre-op assessment clinics) which identify complex needs associated with the presence of LD, enables identification of reasonable adjustments, which were required to facilitate admission. This includes a wide range of staff engagement, individual planning meetings and production of individualised care plans. This is resource intensive but without this there are many patients who would not be able to access hospital services. Other areas of improvements include:

- Enhanced training to a range of staff including 2nd year Doctors and external providers. Utilising clinical guidelines for the care of the surgical patient (adult and child) with LD
- 76 – 78% of wards and clinics have an identified LD champion.
- Delivery of awareness training on annual health checks to 2 GP CCGs
- Building on existing effective joint working with the community LD ASC and Health teams
- Staff can access useful tools / pathways / documents via internet link
- Exploring ways to create a link for public access to information on LD nurse's and documents such as passport and DisDAT toolkits.

Equality & Human Rights Analysis (EHRA)
In 2015 a refreshed Equality & Human Rights Analysis (EHRA) form was introduced along with training and support for staff developing policies, strategies and other procedural documents. Embedding the form into relevant documents has become a Trust Equality Objective thus ensuring any inequalities are identified and removed wherever possible. Any inequalities identified through the EHRA that cannot be removed are subject to strict monitoring processes through the Equality steering group. The aim is to ensure 100% of all relevant Trust documents are appropriately assessed by 2019.

Healthwatch engagement and feedback
The Trust is working with Healthwatch in delivering the Trust Quality Improvement Plan (QIP). 2016 will see Healthwatch cover a 24 hour period in the A&E Department and will report on its findings soon after.

Healthwatch have also been involved in ESHT Maternity departments to support the Trust in improving the areas highlighted in the Trust CQC report. Healthwatch will publish their findings from Maternity in 2016.

Language and communication

Language and communication needs continue to be assessed and met in a variety of ways. Face to face interpreters, telephone interpreters, and bilingual advocates are provided for patients who do not have spoken English as their first language, to enable health needs to be assessed and met in appropriate and effective ways.

Grade:	**DEVELOPING**

Evidence for grading:

- Healthwatch
- Patient Experience Surveys
- Language and Communication policy
- Interpreter data
- LD initiatives
- CQC Report

Areas of focus from 2014/15 Report 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.
- Identify Champions for each of the protected characteristics

The new SLA for interpreting services will be rolled out over the summer with results of surveys reported in 2016/17 EDS2 report..

Recruitment of staff and patient champions will commence in July 2016 with regular patient engagement groups offered.

Areas of focus for 2016/17

- Link in with patient engagement groups and identify champions for protected characteristics.
- Collect, record and analyse feedback from bilingual patient FFT and devise action plans from the outcomes.
- Build on existing effective joint working with the community LD ASC and Health teams
- Explore ways to create a link for public access to information on LD nurse's and documents such as passport and DisDAT toolkits.

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
As an integrated health provider, the Trust continues to work closely with commissioners and partner organisations, including other trusts, GPs and adult social care to support an effective transition of people on care pathways.

Building effective relationships with external stakeholders and the public is a key priority for the Trust. An effective engagement strategy is now in place to improve relationships with all stakeholders.

Waiting Times
Referral To Treatment Times (RTT) vary according to speciality. Average waiting times are broken down by speciality in the 2015/16 Equalities Analysis to Support EDS2. 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.

Those over 65 years waited the least amount of time 9.5 weeks overall with those aged 31 – 45 years having to wait longest at 10.9 weeks.

Those over 65 years waited the least amount of time 12.9 weeks for appointments that did not require being admitted and under 16's waited the longest, 17.1 weeks

Grade:	DEVELOPING

Evidence for grading:
- Equality & Human Rights Analysis
- FFT
- RTT waiting times

Areas of focus from 2014/15 Report 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.

Collecting Interpreter data by speciality was not possible using current data collection methods. The new supplier will assist the Trust in collecting data by speciality.

Analysis of delayed transfers for people aged 85 years and over will be conducted over the summer 2016

Areas of focus for 2016/17

- Meetings with local CCG's will provide a deeper insight into causation of delayed transfers of patients over the age of 85 years. This information will be used to support ESHT in planning to reduce delayed transfers in this group.
- Continue to use the engagement strategy to rebuild effective relationships with external stakeholders

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:

There is an extensive system for reviewing and reporting on patient experience, clinical effectiveness and patient safety. At clinical quality review meetings pressure ulcers, falls and medication incidents are reviewed and actions and learning continue to be agreed. Indicators such as infection control, incidents and safeguarding are monitored at the Quality and Safety Committee. This process also identifies themes and trends, along with actions and learning.

Serious Incidents
Serious Incidents are subject to root cause analysis and are 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 meetings. Again 2015/16 had no SI reports in relation to equalities issues during the reporting period. However, the Trust continues to recognise that a large number of serious incidents relate to falls and pressure ulcers which are prevalent in older people. Falls and Pressure Ulcer breakdown by gender highlighted there were no discrepancies between gender. A review of the provision of equalities data collection for SI's will commence in August 2016.

Equality & Human Rights Analysis (EHRA)
EHRA's are mandatory for all new procedural documents/policies/plans. Successful implementation of the new EHRA provides patients and staff with confidence that potential equalities related mistakes, incidents and risks are identified, managed, mitigated or eliminated wherever possible.

Grade:	ACHIEVING

Evidence for grading:

- Privacy and Dignity policy
- Equality & Human Rights Analysis for policy and strategic developments
- SI Reporting and analysis

Areas of focus from 2014/15 Report 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.

This action is ongoing and will continue to be monitored

Areas of focus for 2016/17

- Establish and implement a standardised method for collecting equalities data for Serious Incident reporting.
- Continue to deliver EHRA training to ensure equalities related mistakes, incidents and risks are identified, managed, mitigated and eliminated wherever possible.

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:

Health Promotion
Health Promotion is led by Public Health with commissioners supporting NHS Trusts. In 2014 Hastings and Rother Clinical Commissioning Group (CCG) launched an action plan to tackle poor health in the Hastings and Rother area due to many people having worse health outcomes there compared to the rest of England. Funding was agreed to pilot a project called 'Making Every Contact Count' (MECC). MECC is a project that provides training for Conquest staff to identify, when in contact with patients, opportunities to talk about their patients' wellbeing and to empower those individuals to make healthier lifestyle choices. The emphasis is on prevention of problems and early intervention by providing information and signposting to other services. 100 staff had received training up to 31st March 16. In April 16 further funding was awarded to implement the project in Eastbourne.

Sexual Health
Retaining Sexual Health Services at ESHT was a key priority to ensure local people, continued to have access to the service. ESHT successfully retained this service and continues to offer innovative services to all people.

The Sexual Health teams continue to nurture working relationships with LGBT patient groups. Further training for staff has been developed on Gender and Identity, Chem Sex and LGBT groups including referral pathways.

ESHT continues to offer fast track referral services from Terrance Higgins Trust (THT) via Health Adviser Services for Men who have Sex with Men (MSM) and Black and Minority Ethnic groups (BME) who may benefit from high risk rapid HIV testing. Early detection of HIV can prevent people from dying prematurely. GRINDER is a shared social networking initiative between the Trust HIV service and THT, delivering home sampling HIV testing along with supporting testing on World AIDS day.

Just fewer than 78% of those accessing sexual health services were female. 17.9% of people reported being gay or bi-sexual. However 96% of those were male. Further analysis is required to determine a reason for this.

Eastbourne and Hastings Sexual Health Services have maintained "Your Welcome" Status supporting Young People. There is on-going Safeguarding group supervision and all staff are trained in Child Sexual Exploitation.

Grade:	ACHIEVING

Evidence for grading:

- Sexual health data
- Service accessibility (online)
- Sexual Health Tender Results

- Reducing Health Inequalities in Hastings & Rother CCG Area Report (2014)
- MECC Project Plans

Areas of focus from 2014/15 Report 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.

ESHT continue to engage and work with partner organisations on many projects as highlighted above.

Areas of focus for 2016/17

- MECC will continue across Hastings and also Eastbourne.
- Continue identifying innovative ways to deliver Sexual Health services.

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
The Trust has adopted a 'you said, we did' approach to encourage feedback from patients, carers, partner organisations and the local community with plans to erect visible screens displaying 'You said we did' feedback around ESHT sites.

Learning Disabilities
The learning disabilities liaison team (LDLT) have continued to provide a range of tools to assist patients with learning disabilities (LD) and ensure they have the same access to treatment and care as those without LD.

Enhanced pre-op assessments are used to identify complex needs associated with LD. Many LD patients require reasonable adjustments to ensure equal access to hospital services. Planning meetings and individualised care plans are put together for all patients with LD.

Accessibility
The Trust is committed to ensuring access to all services across all ESHT sites is available to all who require it. Many provisions already exist including lifts, ramps, induction loops, disabled toilets and free of charge disabled parking. Equality and Human Rights Analysis (EHRA) and local access audits are carried out on all service changes, ensuring due regard is given and reasonable adjustments are made. Annual departmental audits will be reviewed to include accessible information. An external company will be commissioned to carry out the Trust's 5 yearly accessibility audit during 2016/17.

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 has provided 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)

A review of the provision of all interpreting services was undertaken; it was recognised that this service required improvement and as a result, was included in the Trust's Quality Improvement Programme (QIP). Engagement with stakeholders identified the need to have one access point for staff to access all interpretation services to ensure people with language or other communication needs are supported and their health needs are met.

The most requested language in 2015/16 was Mandarin followed by Polish and BSL. Further details of the languages requested are found in 2015/16 Equalities Analysis to Support the EDS2.

Accident and Emergency Waiting times

The national target for A&E waiting times in acute hospitals remains at 4 hours. Using early analysis it is identified that those aged over 85 years who were admitted to A&E suffered delays in admittance or discharge and therefore waited longer in A&E. These cohorts 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. Further analysis and engagement with external stakeholders is required to identify causes and develop action plans.

The Trust's A&E departments have only one dedicated paediatric assessment area due to this, children with minor injuries continue to be assessed quickly to support discharge; those requiring further investigations are transferred to the ambulatory ward which is a more suitable environment

Analysis of A&E data by ethnicity highlighted inconsistencies in collection during the admission process and therefore further analysis and investigation is required to produce data.

Grade:	**DEVELOPING**

Evidence for grading:

- Equality & Human Rights Analysis
- SUSTI usage data
- A&E metrics
- Interpreter procurement documentation

Areas of focus from 2014/15 Report for 2015/16

- Enter into a Service Level Agreement for interpretation services ensuring; easy access to interpreters and translation materials, robust data, staff training.
- 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

During 2015/16, the provision of interpreting services was procured with a successful company awarded a service level agreement. This contract will also aim to increase BSL interpreter availability. This contract is planned to commence in June 2016. It was not possible to link data of interpreter requests to patient discharge therefore an audit of delays to services due to interpreter availability was not carried out.

Areas of focus for 2016/17

- Commission an external company to carry out an access audit on Conquest, Eastbourne and Bexhill Hospital sites.
- Ensure ethnicity data collection in A&E is consistent to provide clear data for reporting.
- Review annual departmental Access Audits to include Accessible Information.

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
Through engagement with Healthwatch and the CQC reports, the Trust has good evidence and insight into potential areas of concern. Further engagement with Healthwatch through 2016/17 will enable the Trust to address any further areas of concern. During 2015/16 Healthwatch independently reviewed the complaints process and maternity services at both acute sites.

Complaints - An independent review of 60 complaints were scrutinised for the process that ESHT complaints team followed.

Maternity - 'From Special Measures to Special Moments' is a report on the experiences of 50 women accessing ESHT maternity services.

Both reports will be published during 2016.

Support
The Trust is committed to ensuring patients, as well as their families and carers, are involved, informed and consulted on all decisions about their care and treatment. All patients continue to have a personalised care plan which is developed with them

The Trust has in place the following policies aimed at supporting patients
Consent Policy

- Privacy & Dignity Policy
- Equality & Human Rights Policy
- Guidance for Staff on the Implementation of the Mental Capacity Act (MCA)
- Policy for the use of the Mental Health Act 1983

An EHRA is completed for each policy to ensure due regard and reasonable adjustments are applied accordingly.

A patient leaflet group was formed to provide guidance to staff developing patient leaflets to ensure information relating to treatments and procedures is available to each patient. All patient leaflets are made available, upon request, in alternative formats and languages.

The trust Patient Advice and Liaison Service (PALS) support patients in accessing support and signposting should they require help. If people report that they do not feel informed after speaking to PALS then this is investigated as a concern and/or 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

The Learning Disabilities Liaison Team (LDLT) ensure reasonable adjustments are continually made with information provided in alternative formats. LD patients have the same access to, and information about, their treatment and care as those without LD. This ensures LD patients 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), continue to be carried out and remain on the patient's record through an electronic flagging system which highlights any additional needs the patient may have.

Grade:	**DEVELOPING**

Evidence for grading:

- Language & Communication Policy
- Revised consent policy and process
- Individualised care plans
- In house systems
- Communication & Engagement Strategy
- CQC Report

Areas of focus from 2014/15 Report 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.

A Communications and Engagement Strategy was developed to re-position and 're-establish' ESHT in the hearts and minds of all our audiences. The strategy can be viewed on the Trust website www.esht.nhs.uk

Areas of focus for 2016/17

- To implement and use the Communication & Engagement Strategy to deliver the Trust principles so people feel confident that are involved in decisions about their care.

EDS2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.3
Outcome: People report positive experience of the NHS	

Summary of Activity:

Friends & Family Test (FFT)
A breakdown of equalities information for 2016 FFT will be published in January along with action plans. 90.6% of people accessing Trust services would recommend the Trust. Results of the FFT can be viewed on the Trust website (http://www.esht.nhs.uk/EasysiteWeb/getresource.axd?AssetID=503618&type=full&servicetype=Inline)

NHS choices website also enables service users to post comments of their experiences of the Trust. This system does not collect any equalities information.

Grade:	Developing

Evidence for grading:
- Friends and Family Test
- NHS Choices

Areas of focus from 2014/15 Report for 2015/16
- 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

As part of the communications & Engagement plan, the Trust website will be reviewed to include a patient engagement page with a ‘you said, we did’ approach. Results to surveys and feedback will also be available. Bilingual FFT is being developed as part of the new Interpreter services contract.

The Trust Dignity Day was again a success with staff, visitors and service user taking part.

Areas of focus for 2016/17
- Continue to develop the new improved Trust website to provide a place for people to report their experiences of the Trust
- Ensure people who use the Trust services, and do not use spoken English as their first language, are included in the FFT.
- Publish equalities breakdown of FFT for 2016

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 patient experience. The Trust recognises that at times some peoples' experience of the Trust and its services may not reach individual expectations. Complaints and concerns provide the Trust with an invaluable opportunity to make sustained and continuous improvements to patient care, safety and experience. 'Communication', 'standards of care' and the 'patient pathway' were the top three categories of complaints reported in 2015/16 and will require specific attention in the year ahead. Improvements will be tracked via the 2016/17 Complaints Work Plan. Additional focus will be placed on improving responses to the Friends and Family Test, which remain low. This is included in the 2016/17 Quality Account as an ongoing quality improvement priority.

The CQC report highlighted much work needed to done to improve this area. As part of the on-going Improvement Plan at ESHT, Healthwatch undertook an independent review of ESHT complaints process. 60 complaints were scrutinised and recommendations were made. This report is due to be published in 2016 and will be available on the Healthwatch website.

Complaints by Subject (primary) - Top (5)

	2015/16	2014/15	2013/14
Communication	**197** ↑	154	115
Standard of Care	**190** ↓	233	173
Patient Pathway	**153** ↑	120	87
Attitude	**53** ↓	79	73
Provision of Services	**42** ↓	85	89
Total	**635** ↓	**671**	**537**

Data is not always available to identify the protected characteristics of complainants. However, any equality and diversity concerns identified in the complaints process are highlighted to the Trust Equality & Human Rights Lead

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.

Initiatives
The Trust second Dignity Day was held in February. This year encompassed patients, carers and relatives positive and negative experiences of the Trust. There were exercises that simulated sight and hearing impairments to raise awareness of some of the difficulties hearing and or sight impaired people encounter and how this impacts on communication and can lead to complaints.

Grade:	UNDEVELOPED

Evidence for grading:

- Complaints Report 2015/16
- Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C)
- Dignity Day 2016
- Complaints Process

Areas of focus from 2014/15 Report 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.

All staff in the complaints team undertook additional training and continue to develop their skills when processing complaints. Healthwatch have supported the Trust in making improvements with an independent review of the complaints process. A post complaints survey continues to be developed and anticipate roll out to commence towards the end of summer 2016

Areas of focus for 2016/17

- Use the recommendations of the Healthwatch review to implement changes to improve the complaints process
- Continue to develop a post complaints survey that captures equalities data.

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:

The Director of Human Resources continues to oversee the operational delivery of recruitment and selection to support the Trust's strategic aims

Recruitment
The Trust has a Recruitment and Selection Policy which adheres to the mandate for employment checks in the NHS (in England). The policy requires managers to complete recruitment and selection training prior to becoming involved in recruitment processes ensuring all staff, involved in recruitment and selection, understand their roles and their responsibilities and to ensure that they recruit the best possible candidate into a post. Staff are encouraged to consider the Workforce Race Equality Standard and advertise using BME networks when senior positions are being recruited for. Data of ESHT workforce and recruitment are found in the analysis to support EDS2 2015/16.

The Recruitment and Selection Policy provides a framework for managing recruitment and selection in an efficient, effective and fair manner. The Trust aims 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 continued to review policies governing recruitment and selection to ensure compliance with best practice. There is a dedicated recruitment team, based within HR, providing, guidance, advice, support and administration throughout the recruitment process. Recruiting mangers are also supported through an online training portal and ad-hoc face to face training sessions

All activity is monitored to ensure consistency and compliance with the recruitment standards. To support this, the Trust is now moving into year 2 using 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 2015/16 Equalities Analysis to Support EDS2 for workforce recruitment: shortlisting to appointment figures.

Engagement
The Trust continues to engage with Job Centre+ to promote vacancies and has participated in development sessions with local Job Centre+ representatives in order to gain an informed understanding of each organisation's role.

In March 2016 the Trust again successfully retained the two ticks symbol which demonstrates the Trust's on-going commitment to employing disabled people. Job Centre+ continue to be responsible for the annual monitoring of the Trust's continued adherence to, and compliance with, the 2 ticks standards.

Focus work has taken place in a number of areas:

- Supported Project Search initiative, delivering training and support in developing skills when applying for jobs and interview skills for young people aged 18-24 with learning disabilities.
- Attendance at job fairs set up by Job Centre+ the most recent for people aged over 50 years
- Attending Apprenticeship Fair at Bexhill with Job Centre+
- Attending the “Big Futures Event” – organised with East Sussex County Council in May aimed at years 9-11 career planning
- Continued introduction of Apprentice posts across the Trust

Grade:	ACHIEVING

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
- Retention of two ticks symbol status
- Project Search

Areas of focus from 2014/15 Report 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 represented groups for all levels will be monitored and action taken accordingly

The areas of focus from 2015/16 report have been high on the Human Resources agenda throughout the year and will continue to be focused on through 2016/17. Implementation of the new recruitment system (TRAC) has greatly improved the monitoring processes for data collection of shortlisting to appointment. Data can be found in the workforce analysis at the end of this report.

Areas of focus for 2016/17

- 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.
- Continue to roll out Recruitment System training for managers and recruiters
- Underrepresented 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.

Equal Pay Audit 2016
In order to identify discrepancies of pay between male and female employees the Trust commenced an equal pay audit. The figures highlighted a varying degree of salary and earnings differences. The largest difference between male and female salary was male Junior Doctors receiving on average 21% higher salary compared to their female colleagues, reducing only slightly to 18.86%, when considering total earnings. Male Medical Career Grades salary was an average of 8.93% more than female Medical Career Grades which increased to 18.2% when considering their total earnings. Male Consultants salary was 5.98% higher than female consultant's salary and earned 14.82% more with total earnings than female consultants. .

Band 3 and 4 were the only grades where females' salary was higher than their male equivalent. These were 0.59% and 1.49% higher. However, the total earnings gap changed to males earning 1.82% and 4.32% more than females. Further details can be found in the Equal Pay Audit analysis in the analysis to support EDS2 2015/16.

Further exploration is required to gain a deeper understanding of why this difference exists across pay scales.

Grade:	UNDEVELOPED

Evidence for grading:
- Established national guidance and local policies – Open and transparent processes.
- ESHT Equal Pay Audit 2016

Areas of focus from 2014/15 Report for 2015/16
- Conduct full equal pay audit using audit tool

Equal pay audit was successfully commenced.

Areas of focus for 2016/17
- Conduct further analysis of pay differences
- Conduct Annual Equal Pay Audit

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:

Commissioned and funded training courses are evaluated through Higher Education Institutes; this information is then 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.

NHS Staff Survey

85% of White respondents believed they were provided with equal opportunities for career progression or promotion. 64% of BME respondents believed they were provided with equal opportunities for career progression or promotion which is significantly lower than those who identified as White. This figure is also lower than 2014 results which demonstrated 70% of BME staff believed they were provided with equal opportunities for career progression or promotion. The overall average for the Trust in 2015 was 82% and the median for all national scores for combined acute and community trusts was 87%.

Ethnicity	2015	2014	Average (median) for combined & community Trusts
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion			
White	85%	85%	89%
BME	64%	70%	74%

NHS Staff Survey KF21. % of staff believing the organisation provides equal opportunities for career progression / promotion									
Gender		Disability		Ethnic Background		Age			
Male	Female	Yes	No	White	BME	16-30	31-40	41-50	51+
77	84	72	85	85	64	92	83	82	80

Staff engagement and improving membership experience of the workforce is a key priority of ESHT Trust Board and Managers. Pulse surveys are being carried out to gain an insight into where improvements can be made to ensure staff are supported and provided with opportunities to progress and reach their full potential.

Project SEARCH

Project SEARCH is a collaborative approach to a supported internship programme for young people with learning difficulties/ disabilities, run from the Eastbourne DGH site. The number of departments that are involved has increased from 20 to 27, and the number is set to rise. The programme has continued to grow and attract positive media attention, with Project SEARCH being nominated and shortlisted for the KSS Leadership Recognition Award for Outstanding Collaborative Leadership in November last 2015. The benefits to the interns include increased confidence, self-esteem and aspirations, giving them an opportunity to acquire new skills, receive tailored support in situ and apply for employment. In addition, their internship has created a social network with their work colleagues.

Grade:	**DEVELOPING**

Evidence for grading:

- Established policies and processes.
- Staff training records
- Trust's Learning Funding Panel
- Staff Survey
- Project SEARCH

Areas of focus from 2014/15 Report 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.
-

The areas of focus for 2015/16 will continue to be developed during 2016/17

Areas of focus for 2016/17

- 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.
- Address career progression through the BAME Staff Network meetings.

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

It is accepted that the Trust needs to do more to ensure staff are free from abuse, harassment, bullying and violence from any source and that if this does occur; they are supported to speak up. Senior Managers have implemented many Harassment & Bullying (H&B) initiatives across the Trust encouraging staff to speak out if they feel they are experiencing H&B of any kind. The appointment of the 'Speak up Guardian' aims to support this. The NHS Staff Survey highlighted staff continue to feel reluctant to speak out, however, the staff survey was carried out prior to many initiatives commencing and it is hoped that the upcoming staff survey will demonstrate improvements are happening in this area. Senior managers are 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 or violence.

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 were organised, including a Black, Asian & Minority Ethnic (BAME) group which aimed to engage and support staff. The Trust has a Staff Health and Well-being Board, whose membership includes the Equality & Human Rights Lead.

NHS Staff Survey Feedback

Ethnicity	2015	2014	Average (median) for combined & community Trusts
KF25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months			
White	32%	31%	28%
BME	34%	26%	26%
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months			
White	32%	26%	24%
BME	34%	25%	26%
Q17b In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?			
White	8%	7%	5%
BME	11%	12%	13%

Harassment & Bullying Initiatives

Medical Education continues to ensure junior doctors do not experience bullying and undermining behaviour at ESHT through facilitated support sessions.

.

Google feedback tool (developed by Anaesthetics) was rolled out to all clinical departments in June 2015. This provides an anonymous mechanism for trainees to feedback on their supervisors.

Grade:	**DEVELOPING**

Evidence for grading:

- Dignity at work policy. Raising Concerns policy, Independent Board member
- Staff survey Results
- CQC Inspection Report
- Local security management service which investigates reports of violence against staff by patients or other employees
- Reports to Quality and Standards committee
- NHS Staff Survey 2015

Areas of focus from 2014/15 Report 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

All areas of focus from 2014/15 report were implemented and will continue through 2016/17.

Areas of focus for 2016/17

- Continue to implement H&B initiatives and empower staff to speak out.
- EDHR training to continue providing H&B - channels for 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 the benefits of offering flexible working opportunities, attracting skilled potential employees that may otherwise struggle to seek employment, in particular those with parental or caring responsibilities. The Trust supports staff to remain in employment and retain skills within the Trust exploring suitable flexible working opportunities with employees. 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 Trust continued to have a dedicated Child and Family Care Manager who offers drop-in sessions for all staff returning from maternity or adoption leave. 4.51% of Staff took maternity, paternity or adoption leave during 2015/16. Flexible working options are reviewed annually as part of each member of staff's Personal Development Review. 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. Flexible working requests are often agreed locally and may not result in a change to working hours. For example a nurse on a ward may still do the same number of overall hours but may change to fixed days/nights each week due to caring needs or something similar. Equally a member of staff may agree a 9 day fortnight with their manager but still doing full-time hours. The E-rostering system allows for an element of self rostering. Setting up a system centrally to capture all of this is very resource intensive therefore this will be explored at a future Equality steering group with a view to identifying potential solutions.

47% of respondents to the NHS Staff Survey felt they were 'satisfied with the opportunities for flexible working patterns'. The median for national scores for combined acute and community trusts was 50%.

Grade:	DEVELOPING

Evidence for grading:

- Flexible Working Policy
- Recruitment and Retention Strategy
- Organisational Change Policy
- Special Leave Policy
- Attendance Management Policy
- Work-Life Balance Policy

Areas of focus from 2014/15 Report for 2015/16

- Review the effectiveness of policies and through workforce planning process, identify whether further actions or engagement is required.

Identifying further actions or engagement will continue through 2016/17.

Areas of focus for 2016/17

- Explore options to increase flexible working monitoring.

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 assisting staff to feel motivated and engaged an increased number of staff will feel able to recommend the Trust as a place to work. Following the CQC Report it was identified that this was not always the case and that the 2014 and 2015 NHS Staff Survey's corroborated this, although 2015 reported staff experience in some areas had improved. Many initiatives were implemented to improve engagement and tackle the Bullying and Harassment environment that staff had reported.

Staff Feedback

The Trust instructed an external company to conduct a review of organisational culture at ESHT, called 'Taking the Temperature 2016'. This review aimed to help the Trust understand the underlying issues to ensure success of the Improvement Plan. 186 people across all bands were invited to participate, in 17 focus groups and 14 one-to-one interviews. The facilitators used the Trust's 4 values as a structure for the review. Each conversation explored the difference between the aspirational statements contained in the values and the everyday experience of those working within the Trust. They were asked to investigate factors contributing to some key areas of concern arising from the 2015 staff survey, recommendations for actions based on the findings were:

- Improving communication and engagement
- Enhancing operational effectiveness
- Achieving a sustainable cultural shift

The review reported equality and diversity were generally seen as within acceptable boundaries albeit with scope for development. Whilst there were reports of low-level discriminatory language in some areas, there were also positive stories of support for minority groups, especially LGBT staff and patients.

Project Search

Once again this year's cohort of interns reported a positive experience of working within the Trust. Feedback has been very positive from all interns.

"The best bit of Project SEARCH is meeting new people, learning new skills and gaining more confidence"

Intern

"Project SEARCH is great to be a part of, it helps you get new skills for a job"

Intern

"Proof you can get a job no matter who you are."

Intern

Grade:	DEVELOPING

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
- PROJECT Search feedback
- 'Taking the Temperature 2016' Report

Areas of focus from 2014/15 Report 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

A Staff Engagement plan was developed and communicated with staff. LiA groups continued through the year with a 'You said, we did' theme. A review of the organisational culture was conducted to gain a deeper insight into reasons why staff felt they were unlikely to recommend the Trust.

A LGBT Staff Network will commence at the end of summer 2016, led by the Chairman, along with a BAME Staff Network led by the Chief Executive.

Areas of focus for 2016/17

- Invite GIRES, an organisation that supports trans and gender non-conforming individuals, to deliver training, e-learning and information to staff and support the Trust in forming a successful, well led LGBT Staff Network.
- Identify training opportunities to support BAME Staff through the BAME Staff Network

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
ESHT has undergone many changes at senior level through the year which saw other senior managers step up and provide a great level of leadership to the organisation.

Chairman – David Clayton-Smith
ESHT welcomes a new Chairman to the organisation in January 2016
"I am delighted to have been appointed to this important position with the Trust. It is a tremendous honour to be given the opportunity to lead the Trust and I am looking forward to working with the team as we tackle the significant healthcare challenges ahead of us. Everything we do must be focused on the patient experience and the quality of their care and treatment. The people of East Sussex rightly expect us to be able to deliver services to the highest standard within the NHS. I very much look forward to meeting with our staff, local people and civic leaders over the coming months to help build a better future together."

David Clayton-Smith

David Clayton-Smith will chair the LGBT Staff Network

Chief Executive – Dr Adrian Bull
ESHT welcomes a new Chief Executive to the organisation in April 2016.
"I am delighted to have been appointed as Chief Executive of East Sussex Healthcare NHS Trust. I very much look forward to joining the organisation on 11th April. I'm excited about the opportunity this role presents to make a positive difference, both to patient care and for the staff who do so much to deliver that care. The Trust has been through a difficult time and is currently facing some major challenges. People working in it have continued to show care and compassion in looking after their patients. I am looking forward to working with staff, patients, local health and care partners and the public to ensure that we provide safe and effective healthcare services in which the people of East Sussex can be fully confident."

Dr Adrian Bull

Dr Adrian Bull will chair the BAME Staff Network

Finance Director – Jonathan Reid
ESHT welcomes a new Finance Director to the organisation in June 2016
"I am delighted to join East Sussex Healthcare NHS Trust. I look forward to working hard with colleagues to achieve our aim of delivering safe, compassionate, high quality care that is clinically and financially sustainable for the people of East Sussex. I've already met many caring and committed colleagues in East Sussex across the Trust and it's truly a privilege to join this team."

Jonathan Reid

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. The refreshed Equality Delivery System (EDS2) was welcomed by many members of the public and staff with positive feedback received for 2014/15 reports.

Grade:	DEVELOPING

Evidence for grading:

- Quality and Standard Committee terms of reference
- EDHR SG minutes
- Equality Action plans
- Statements from new Trust Board Members

Areas of focus from 2014/15 Report 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

Monthly conversations with staff took place across all sites and an engagement strategy was developed to further improve engagement with staff. Regular quality walks were conducted and many initiatives supported such as encouraging staff to 'take a break'.

Areas of focus for 2016/17

- The Chairman will provide leadership to the LGBT Staff Network
- The Chief Executive will provide leadership to the BAME Staff Network
- The Trust Board will engage regularly with the EDHR Lead to ensure equality remains at the most senior level of the organisation.

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 (EHRA), 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. A summary of the Trust Equality Objectives can be found at the end of this report.

One to one and group training sessions were held throughout the year to support managers in conducting Equality & Human Rights Analysis. The uptake of training was high and all ratification groups have ensured they embedded the EHRA into their ratification process.

The Trust has an established Equality, Diversity and Human Rights (EDHR) Lead who is line managed by the Director of Corporate Affairs. The EDHR Lead meets regularly with the Chairman, Chief Executive, Director of Nursing and other Medical and Non-Medical Executives. The Equality Steering Group is linked with Patient Experience and the People & Organisational Development Group.

Completion of EHRA's is embedded in the Equality, Diversity & Human Rights Policy and the Policy & Procedure for the Development and Management of Procedural Documents.

Grade:	**ACHIEVING**

Evidence for grading:

- Trust Quality Objectives 2015- 2019
- EHRA Database
- EHRA training sessions
- Equality, Diversity & Human Rights Policy
- Policy & Procedure for the Development and Management of Procedural Documents

Areas of focus from 2014/15 Report 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.

Successful implementation of the Equality & Human Rights Policy and training on EHRA's was carried out.

Areas of focus for 2016/17

- Establish the LGBT Staff Network
- Establish the BAME Staff Network
- EDHR Department will oversee implementation of the new interpreting services

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 continue to 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.

Mentoring
Mentoring opportunities are available to staff who wish to gain skills and knowledge from other managers.

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. These are offered on a one to one basis and group sessions.

Additional Equality, Diversity & Human Rights face to face training sessions were rolled out for all staff. At the time of reporting compliance was 78.16%. An increase of 16.47% from 2014/15. The Trust will continue facilitating additional sessions to raise awareness and increase compliance rate to 85% through 2016/17.

Further training packages were developed to equip managers with the skills to tackle prejudice arising from communication needs. Sessions will be rolled out across the Trust in 2016.

Staff Feedback

The 2015 NHS Staff Survey reported that staff felt support from immediate managers had increased from 2014. The number of staff reporting receiving an appraisal within the last 12 months had increased from 77% in 2014 to 82% in 2015. This is a positive step with much work still to be done.

Grade:	DEVELOPING

Evidence for grading:

- Equality & Human Rights Policy
- Equality and diversity training evaluations
- NHS Staff Survey results

Areas of focus from 2014/15 Report for 2015/16

- Mentoring schemes will equip managers with the skills to promote positive cultural change

Uptake of mentoring opportunities will be analysed and reported in the next EDS2 report.

Areas of focus for 2016/17

- Mangers will be offered developmental master classes to ensure they are equipped to support their teams.

Patient Equalities Analysis to Support EDS2 Report 2015/16

Interpreters provided for Sensory Support 2015/16

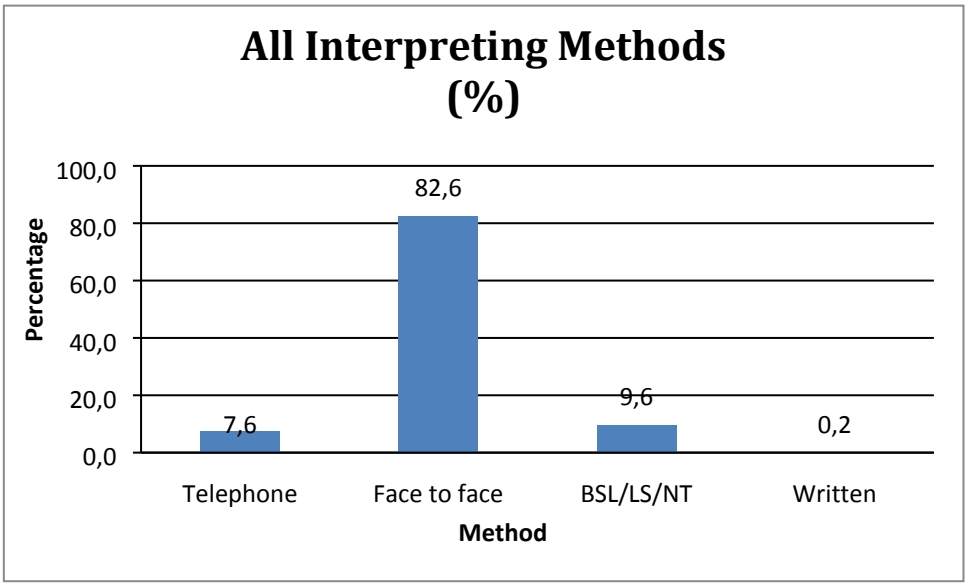
Language Requested	Total	St Leonards	Eastbourne	Surrounding
BSL	139	77	47	15
Lipspeaker	6	0	6	0
Note Taker	1	0	1	0
Total	**146**	**77**	**54**	**15**

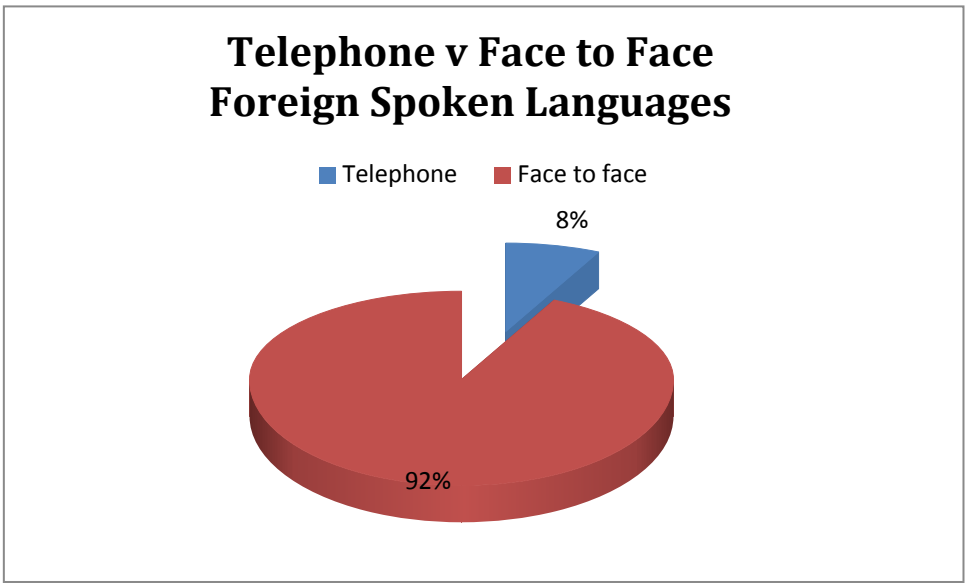
All interpreters supplied to patients, service users or carers during 2015/16 in order of most requested

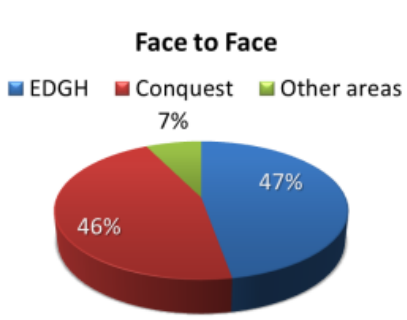
Language Requested	Total	St Leonards	Eastbourne	Surrounding
Mandarin	256	161	76	19
Polish	236	57	164	15
BSL	139	77	47	15
Portuguese	112	13	96	3
Arabic	97	60	34	3
Russian	76	27	49	0
Cantonese	69	38	15	16
Czech	67	58	7	2
Albanian	58	40	18	0
Bengali	54	22	23	9
Hungarian	44	38	6	0
Farsi	39	5	34	0
Bulgarian	36	14	21	1
Turkish	35	15	16	4
Romanian	28	14	13	1
Spanish	26	5	18	3
Sorani	23	17	5	1
Italian	18	5	13	0
French	10	3	7	0
Kurdish	9	8	1	0
Punjabi	9	9	0	0
Slovak	8	7	1	0
Tamil	8	3	5	0
Vietnamese	8	6	0	2
Lipspeaking	6	0	6	0
Lithuanian	6	2	4	0
German	5	4	1	0
Tigrinya	5	5	0	0
Kurdish Sorani	4	2	2	0
Sylheti	4	3	1	0
Amharic	2	2	0	0
Greek	2	1	1	0

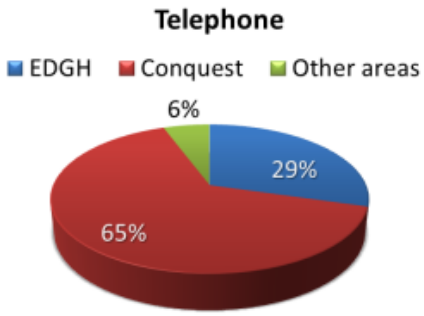
Gujarati	2	1	1	0
Latvian	2	1	1	0
Thai	2	2	0	0
Urdu	2	1	1	0
Benei	1	0	0	1
Czech/Slovak	1	0	1	0
Hindu	1	0	1	0
Nepalese	1	0	1	0
Notetaking	1	0	1	0
Pashtu	1	1	0	0
Sorani/Kurmanji	1	1	0	0
Swahili	1	1	0	0
Tagalog	1	0	1	0
Total	**1516**	**729**	**692**	**95**

ESHT Interpreting Methods (%) 2015/16









Referral to Treatment Times (RTT)
September 2015 – March 2016

Average Referral To Treatment (RTT) Time in Weeks			
Speciality	**Admitted**	**Non-Admitted**	**Avg combined Wait**
Orthodontic	NA	19.4	19.4
Respiratory Physiology	NA	14.3	14.3
Endocrinology	NA	14.2	14.2
Paediatric Surgery	18.8	12.7	13.2
Trauma And Orthopaedics	17.3	11.0	13.1
Rheumatology	4.9	13.1	13.1
Pain Management	13.8	12.2	12.2
General Surgery	15.2	10.9	12.0
Neurology	24.9	11.8	11.8
General Medicine	NA	10.9	10.9
Ear, Nose And Throat	17.4	10.0	10.9
Urology	11.6	10.2	10.5
Diabetic Medicine	NA	10.4	10.4
Ophthalmology	14.1	9.1	10.3
Maxillo-Facial Surgery	13.2	9.1	10.2
Paediatric Epilepsy	NA	10.1	10.1
Paediatric Medicine	1.1	10.0	10.0
Gynaecology	13.9	9.0	9.9
Gastroenterology	7.7	9.7	9.6
Vascular Surgery	9.3	8.7	8.7
Thoracic Medicine	4.8	8.5	8.5
Radiology	7.6	9.0	7.9
Medicine For The Elderly	NA	7.4	7.4
Cardiology	9.9	7.0	7.4
Haematology	0.6	6.6	6.6
Dermatology	8.0	4.1	4.9
Breast Surgery	6.6	4.3	4.7
Palliative Medicine	NA	3.5	3.5
Clinical Oncology	1.4	3.5	3.4
Anaesthetics	NA	2.1	2.1
Transient Ischaemic Attack	NA	1.2	1.2
Overall Average Wait	**13.9**	**9.3**	**10.1**

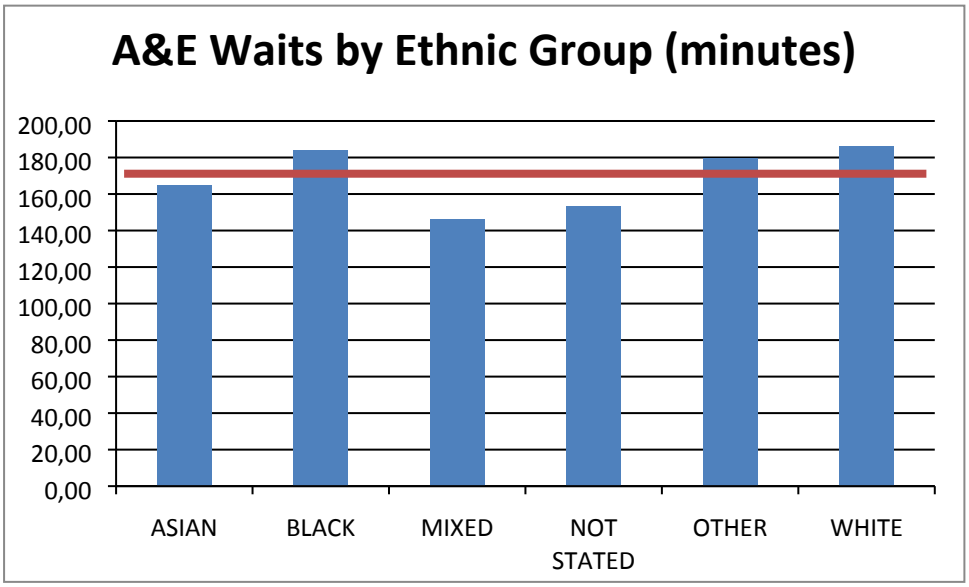
Table of Average RTT time broken down by Age

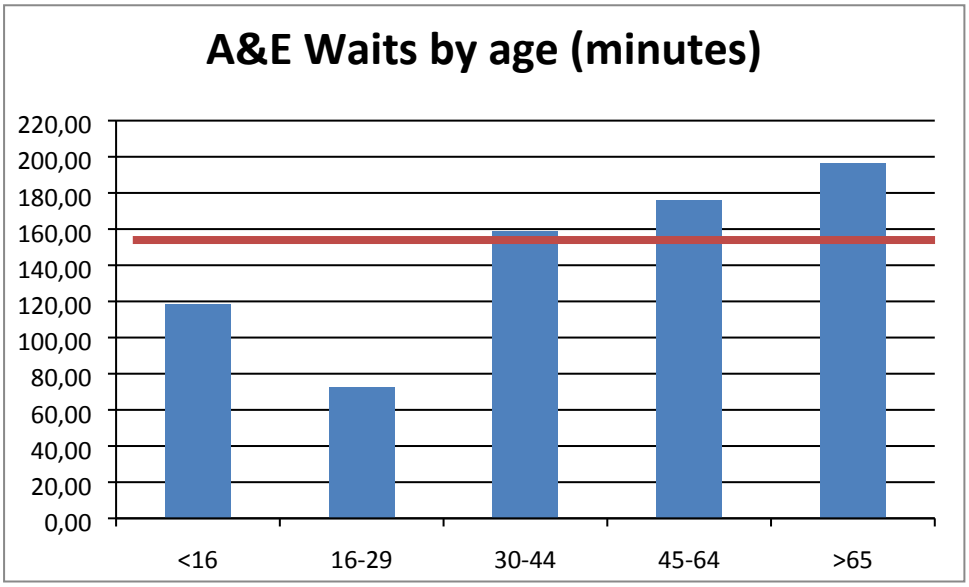
Average Referral to Treatment Time (RTT) in Weeks by Age Group			
Age Group	**Admitted**	**Non-Admitted**	**Overall Wait**
<16	17.1	10.3	10.8
16-30	15.3	10.0	10.8
31-45	15.6	10.0	10.9
46-64	14.2	9.3	10.2
65+	12.9	8.6	9.5
Grand Total	**13.9**	**9.3**	**10.1**

Table of Average RTT time broken down by Ethnicity

Average Referral to Treatment Time (RTT) in Weeks by Ethnicity			
Ethnicity	**Admitted**	**Non-Admitted**	**Overall Wait**
White	13.8	9.2	10.2
Mixed/Multiple ethnic groups	16.8	9.8	10.9
Asian/Asian British	15.6	10.1	10.8
Black/African/ Caribbean/Black British	16.1	9.9	10.8
Other ethnic group	18.0	9.7	11.1
Unknown	14.0	9.3	9.8
Grand Total	**13.9**	**9.3**	**10.1**

Accident & Emergency waiting times 2015/16





Cancer Equalities Data 2015/16

Cancer Survival rates for 1 and 5 years broken down by age

Survival Rate at 1 year	
Age Range (years)	**Survival rate (%)**
2013/2014	74.36%
< 25	0.36%
25 - 39	1.30%
40 - 49	3.52%
50 - 59	9.35%
60 - 69	19.45%
70 - 79	20.72%
80 - 89	16.06%
> 89	3.62%
2014/2015	75.32%
< 25	0.46%
25 - 39	1.54%
40 - 49	3.43%
50 - 59	9.50%
60 - 69	19.79%
70 - 79	21.36%
80 - 89	15.18%
> 89	4.07%
Grand Total	74.82%

Survival Rate at 5 years	
Age Range (years)	**Survival rate (%)**
2009/2010	52.13%
< 25	0.59%
25 - 39	1.56%
40 - 49	3.23%
50 - 59	7.79%
60 - 69	14.42%
70 - 79	15.20%
80 - 89	8.34%
> 89	1.00%
2010/2011	51.73%
< 25	0.69%
25 - 39	1.66%
40 - 49	3.57%
50 - 59	6.48%
60 - 69	16.62%
70 - 79	13.95%
80 - 89	7.83%
> 89	0.93%
Grand Total	51.92%

Cancer Survival rates for 1 and 5 years broken down by Gender

Survival Rate at 1 year	
Gender	**Survival rate (%)**
2013/2014	74.36%
Female	35.41%
Male	38.96%
2014/2015	75.32%
Female	35.61%
Male	39.71%
Grand Total	74.82%

Survival Rate at 5 years	
Gender	**Survival rate (%)**
2009/2010	52.13%
Female	26.77%
Male	25.36%
2010/2011	51.73%
Female	24.20%
Male	27.53%
Grand Total	51.92%

ESHT Risk Adjusted Mortality 2015 (RAMI) April 2015 to March 2016 35 Years and Over by Age Band

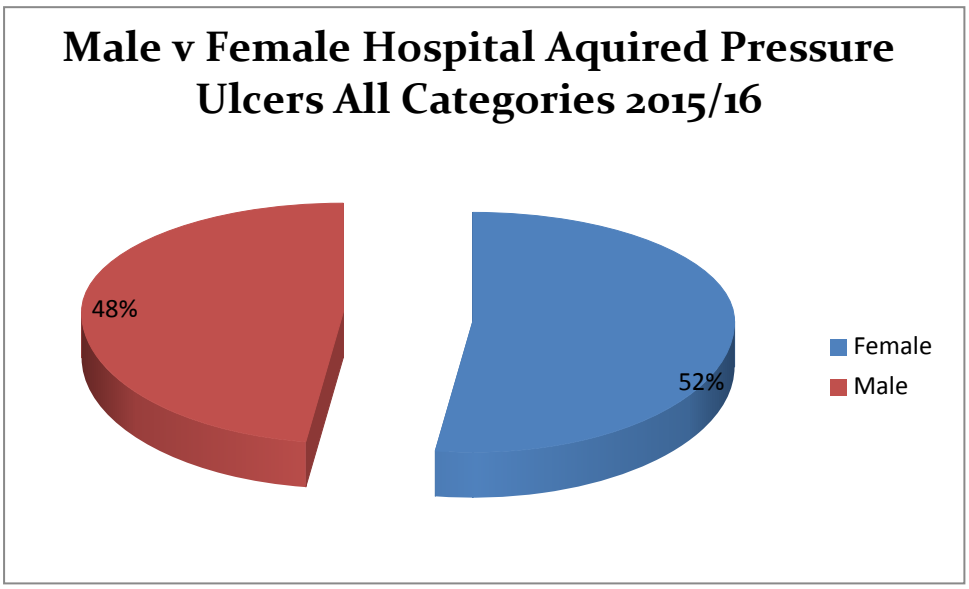
	Male		Female		Total	
Age band	**deaths**	**RAMI Index**	**deaths**	**RAMI Index**	**deaths**	**RAMI Index**
35-39	3	115	1	52	4	88
40-44	4	71	3	73	7	72
45-49	13	129	12	144	25	136
50-54	18	112	11	84	29	100
55-59	29	121	10	76	39	105
60-64	29	105	19	122	48	111
65-69	60	93	47	99	107	96
70-74	62	94	48	98	110	96
75-79	90	92	72	85	162	88
80-84	133	101	119	110	252	105
85-89	187	105	143	71	330	87
90+	170	118	221	112	391	115

Access to Sexual Health by Age, Gender and Sexual Orientation

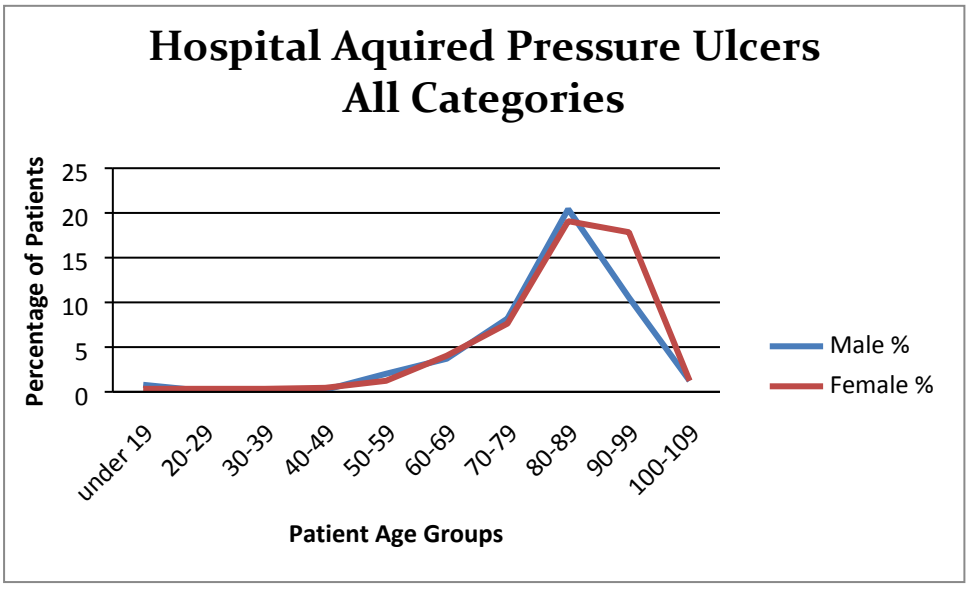
Category	Male (%)	Female (%)	Total (%)
Sexual Orientation			
Straight	17.94	76.33	**94.27**
Gay	3.33	0.19	**3.52**
Bi-Sexual	0.48	0.36	**0.85**
Indeterminate	0.46	0.90	**1.36**
Age			
<16	0.26	2.58	**2.84**
16-19	2.41	18.17	**20.58**
20-29	9.36	34.59	**43.96**
30-39	4.59	12.25	**16.84**
40-49	2.87	7.72	**10.59**
50-59	1.69	2.04	**3.73**
60-69	0.79	0.37	**1.16**
70+	0.24	0.05	**0.29**
Total	**22.22**	**77.78**	**100**

Serious Incidents – 2015/16

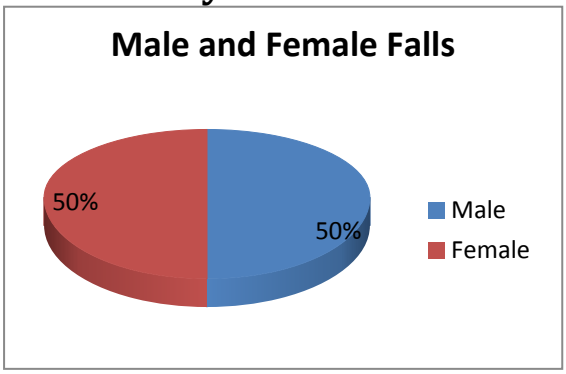
Pressure Ulcers by Gender



Pressure Ulcers by Age



All Falls by Gender across All Sites



Workforce Profile broken down by protected characteristics

East Sussex Healthcare NHS Trust employed 6519 people as of 31st March 2016.

Workforce breakdown by protected characteristics.

Ethnic Origin	Percentage of Employees (%)
White	79.61%
BME	12.33%
Unknown	8.05%

Age Group	Percentage of Employees (%)
<=29 yrs old	12.78%
30-44	34.13%
45-59	43.38%
60-78	9.71%

Sexual Orientation	Percentage of Employees (%)
Bisexual	0.35%
Gay	0.40%
Heterosexual	56.25%
Lesbian	0.26%
Unknown	42.74%

Religion	Percentage of Employees (%)
Atheism	9.53%
Buddhism	0.49%
Christianity	36.26%
Hinduism	1.29%
Islam	1.23%
Other	5.63%
Unknown	45.57%

Disability	Percentage of Employees (%)
Yes	2.72%
No	40.13%
Unknown	57.16%

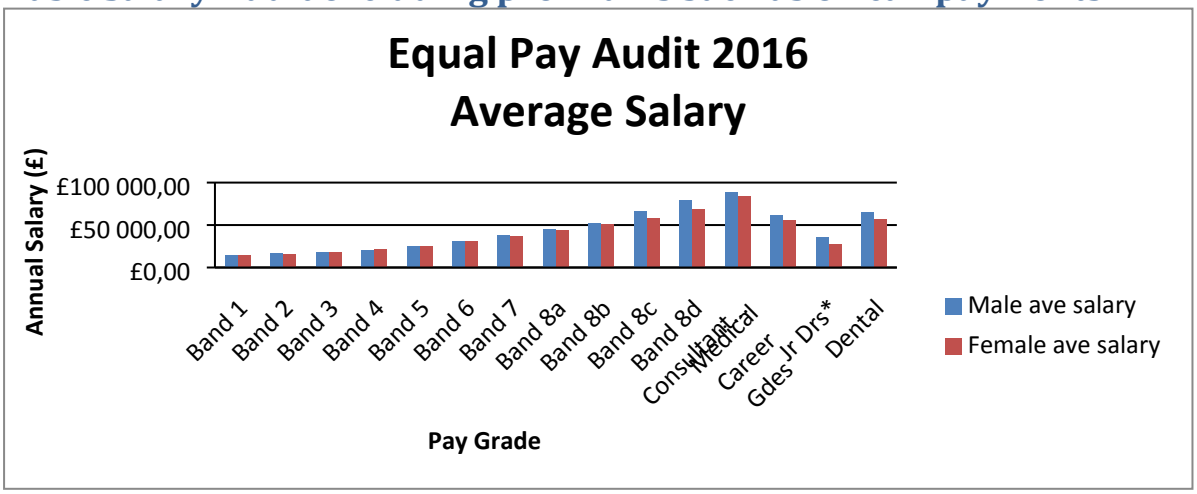
Gender	Percentage of Employees (%)
Female	77.48%
Male	22.52%

2015/16 Recruitment Annual Monitoring

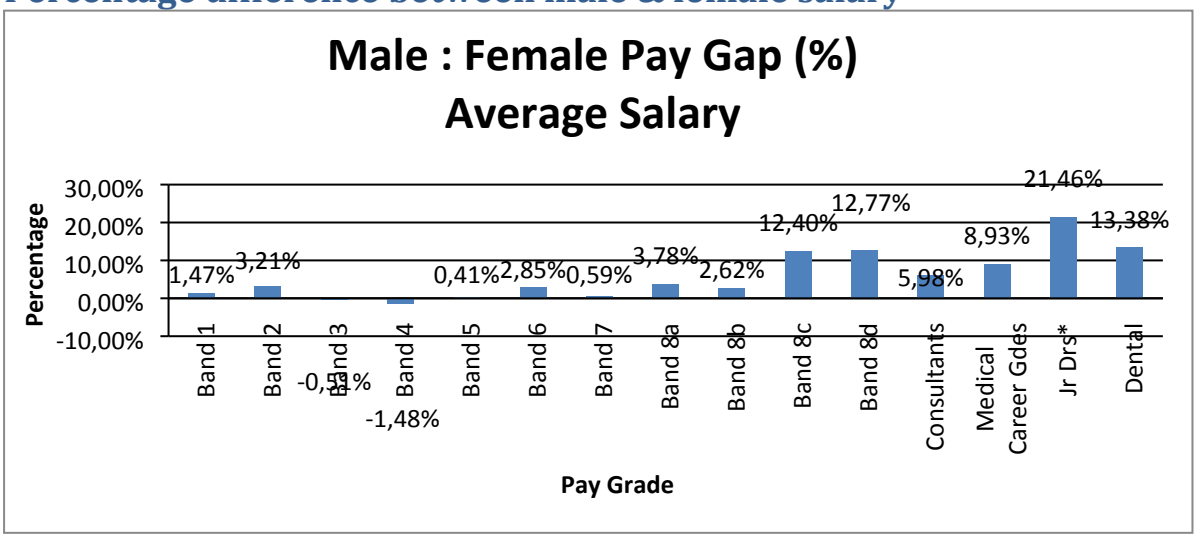
Percentage of application, shortlisting and appointment across the protected characteristics:

Characteristic	Applied	Shortlisted	Appointed
Gender			
Male	28.60%	29.10%	26.50%
Female	71.20%	70.70%	73.40%
Not stated	0.20%	0.20%	0.20%
Ethnicity			
White	73.70%	77%	69.90%
BME	23.40%	21.70%	12%
Undisclosed	2.80%	1.30%	18.10%
Disability			
No	93.10%	94.60%	77.80%
Yes	4.30%	4%	3.70%
Not stated	2.60%	1.10%	18.50%

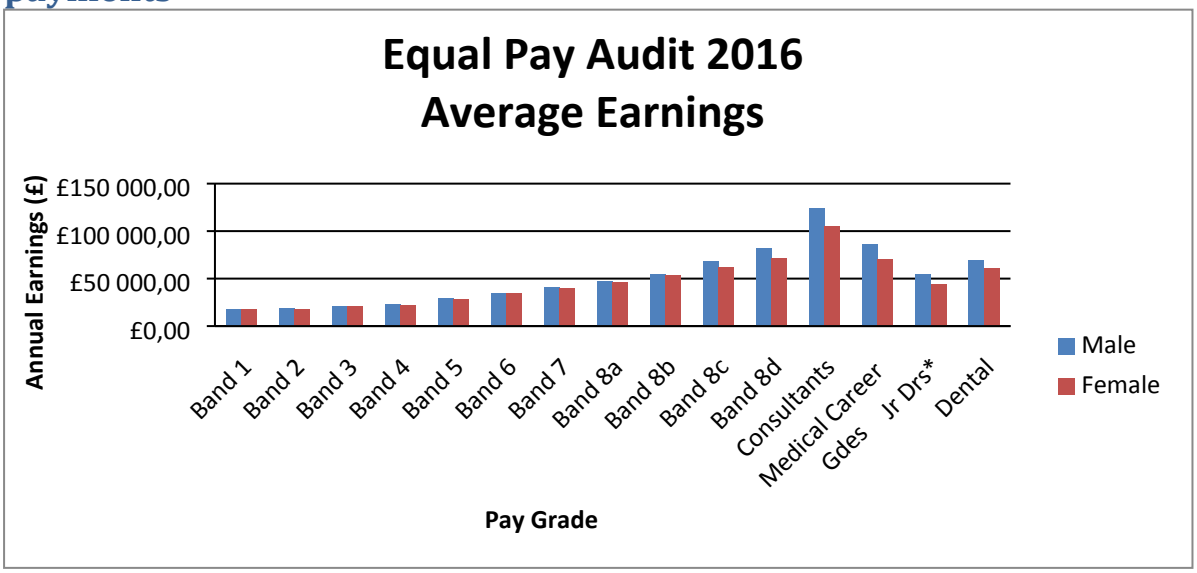
Basic Salary Audit excluding premiums such as on call payments



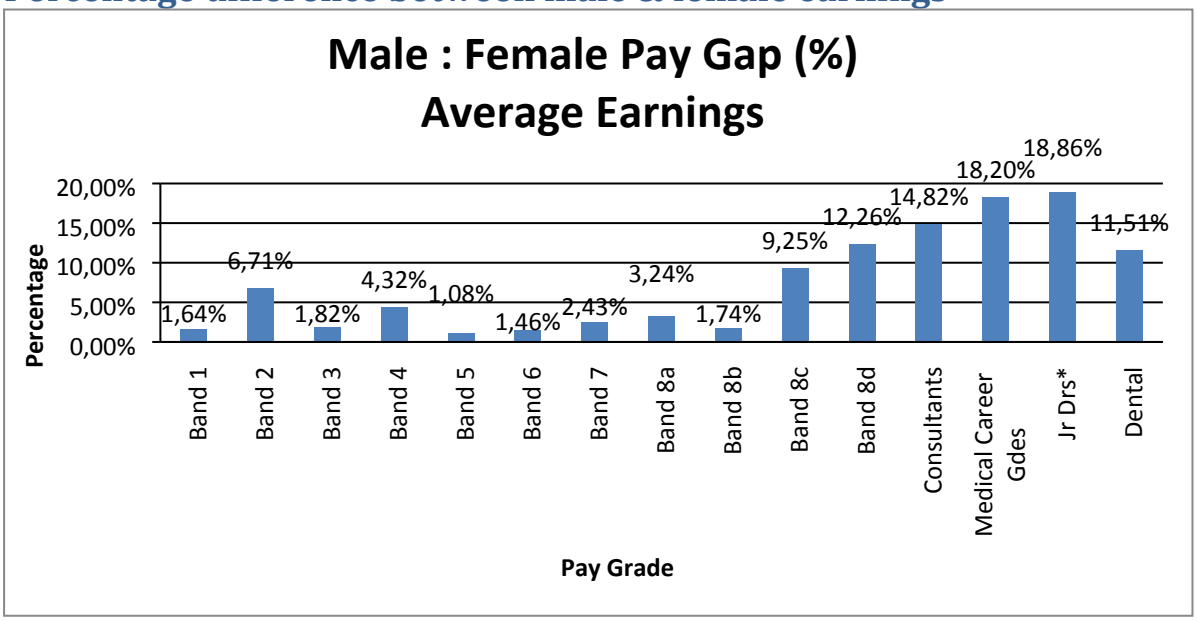
Percentage difference between male & female salary



Total earnings audit including premiums such as on-call payments



Percentage difference between male & female earnings



ESHT 2015 – 2019 Equality Objectives

EDS2 Goal	EDS2 Goal	Method	Actions	EDS2 Outcome	EDS2 Outcome	Lead	Monitored / Reviewed
1	Better Health Outcomes	Review SI action points	Review learning from incidents to ensure we are not treating anyone less favourably and implement actions appropriately	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	1.4	Director of Nursing/ Patient Safety Lead	TNMAG EDS2/WRES SG
2	Improved Patient Access and Experience	Evaluate arrangements and awareness of existing interpreting and translation services	Enter a Service Level Agreement to implement a robust streamlined system providing easy access to interpreters. A post interpretation survey will be conducted by the interpreter. Raise staff awareness of access to interpreting service	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds People are informed and supported to be involved as they wish to be in decisions about their care People report positive experiences of the NHS	2.1 2.2 2.3	Company Secretary / EDHR Lead	EDS2/WRES SG
3	A Representative and Supported Workforce	Analyse percentage of BME staff at all levels of the organisation and ensure that the recruitment process is reflective of best practice.	Conduct analysis of BME staff at all levels and develop actions such as encouraging BME staff to participate in training and development opportunities Band 8+ recruitment panel will consist of a BME member or the EDHR Lead.	Fair NHS recruitment and selection process lead to a more representative workforce at all levels	3.1 WRES metric 1 & 2	Director of HR / Assistant Director Workforce Development	EDS2/WRES SG
4	Inclusive Leadership	Strategies, business plans and annual reports will require EHRA.	Approval of all strategies, business plans and annual reports that come before the Board, will be subject to completion of Due Regard, Equality & Human Rights Analysis, which includes how inequalities will be managed.	Papers that come before the board and other major committees identify equality –related impacts including risks, and say how these risks will be managed.	4.2	EDHR Lead / Assistant Director of Nursing (Safeguarding)	EDS2/WRES SG

Further breakdowns of data contained in this report are available upon request by contacting the Equality & Human Rights department.

This document is available, upon request, in alternative languages and formats, such as large print, Braille, Audio and electronic. Please contact the Equality and Human Rights Department for further information on: 01424 755255 ext 8828

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd August 2016
Meeting:	Trust Board
Agenda item:	15
Subject:	Health & Safety Annual Report 2015/16
Reporting Officer:	Alice Webster

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

Assurance	√	**Approval**	√	**Decision**	

Purpose:

The Health and Safety Annual report 2015/16 demonstrates that the H&S department (H&S team, Moving & Handling Team and Medical Device Educators) continue to ensure the organisation has robust systems, processes and the ability to embed the learning in practice which supports all staff and patients.
It also highlights what has been achieved and future developments for the Trust H&S department will be taking forward through the course of the year of 2016/17.

Introduction:

East Sussex Healthcare NHS Trust (ESHT) recognises that the effective management of health, safety and welfare supports the Trust in meeting its vision of being 'the healthcare provider of first choice for the peoples of East Sussex' and the main values of the Trust are:

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

The health and safety team focusses on what really matters and what action will deliver meaningful health and safety outcomes – not only in relation to process or bureaucracy. The team preventative efforts reflect our broad risk profile and this will be reflected in the various sections within this annual report. This report will have three distinct areas of health and safety, moving and handling and medical device educators. Over time the annual report will reflect a more integrated approach.

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

Staff incidents (see graph 8.3.2 page 14) Indicates a month on month trend compared with the previous year. The average monthly incident figure for 2013/ 14 were 78.92 which have increased for 2014/15 to 81.42 and again in 2015/ 16 to 86.42.
In the scope of the current fiscal year the most significant increase was in December 2015 followed by August and July.

Patient Health and Safety related incidents (see graph 8.3.4 page 15) have consistently reduced since 2013/ 14 as the table below indicates. The decline in patient incidents resulting in falls has accounted for this.

Of the remaining 195 incidents in 2015/ 16;

- 8 Moving and Handling incidents; inadequate or lack of available equipment
- 5 sharps incident. 4 found proximate to patients however a further incident was medical devices issue where the tip of a needle broke
- 29 incidents involving security/ violence or aggression including illegal substances found
- 153 incidents were categorised as health and safety. Of concern were 67 cuts or lacerations including skin tears although in many instances the cause was unknown. There were 15 scalds or burns to patient as the result of hot food or drinks spilled.

See graph 8.3.6 Incidents by Prevalence & CU/Directorate - Violence and aggression to staff are an ongoing concern in the community and domiciliary environment and Out of Hospital clinical unit reported the highest number with 11 of those incidents being intentional physical or verbal abuse and discrimination; please see the following section for further analysis (see graph 8.3.6 page 17)

Benefits:

In the last five years, significant amount of progress has been made by the Trust with the completion of health and safety risk assessments; the development and work by the moving and handling team to ensure that services have the right equipment for the right job and training to an appropriate level and standard; medical device educators moved to the H&S department October 2015 having previously been in the EME department managing the equipment library and training staff. They are now able to concentrate on the training / education and safety/competencies for staff.

Risks and Implications

ESHT has specific responsibilities as an employer under various sections of the Health & Safety at Work etc. Act 1974:

- Section 2 – duties of employers to employees;
- Section 3 – duties to protect people who are not its employees from being exposed to the risks of its activities, e.g. patients, members of the public;
- Section 4 – duties as a landlord by being in control of premises.

The Management of Health and Safety at Work Regulations 1999 extends the provisions of the Health and Safety at Work etc Act 1974 and in particular the requirement to undertake suitable and sufficient risk assessments and provide adequate training and supervision.

Assurance Provided:

This annual report is presented to show the progress made over the year 2015/16. It is well recognised that health and safety is central in the delivery of safer services for staff, patients, carers and visitors.

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)**:**

Sent to Executive Lead; Health and Safety Steering Group July 2016; reviewed by Quality & Standards Committee July 2016

Proposals and/or Recommendations

The key achievements and future develops by the H&S department is succinctly captured on pages 8-9 of the annual 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:	**Contact details:**
Nicky Creasey	Ext. 6545 (14)

East Sussex Healthcare NHS
NHS Trust

Health and Safety Services

Annual Report

1st April 2015 – 31st March 2016

Complied by and completed by:

Nicky Creasey, Trust Lead Health & Safety; Jennifer Newbury, Deputy Trust Lead Health & Safety

Susanna Marsden, Specialist Practitioner Lead Advisor Moving & Handling;

Wayne Parsons, Medical Device Educators; Bernadette Monaghan, Medical Device Educator

Executive Summary

This annual report is presented to show the progress made over the year 2015/16. It is well recognised that health and safety is central in the delivery of safer services for staff, patients, carers and visitors.

The Trust Health and Safety Steering Group (HSSG) have been established to plan, organise and monitor organisational compliance with its statutory health and safety obligations and duties. The role of the HSSG is to ensure compliance with external body requirements such as the Health and Safety Executive, NHSLA, Department of Health, CQC etc. This annual report reflects that work over the period 2015 /16.

The nature of our activities means that a wide range of risks exist, but through the implementation of related policies, directors, managers and workers continue to ensure that all significant risks to health are reduced so as far as is reasonable and practicable.

This report demonstrates the progress made, acknowledges areas of development and this report is intended to assure the Board that suitable and sufficient health and safety arrangements are in place and that health and safety is being effectively managed across the organisation.

Director of Nursing and Governance – Trust Executive Lead for Health and Safety

Contents

1. Introduction

The Trust knows the value of a positive safety culture and continues to place a great importance on health and safety and welfare of our patients, staff, visitors and contractors.
The Health and Safety team have strived to embed the Trust values in all of the work we undertake, the values are:

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

The health and safety team focusses on what really matters and what action will deliver meaningful health and safety outcomes – not only in relation to process or bureaucracy. The team preventative efforts reflect our broad risk profile and this will be reflected in the various sections within this annual report. This report will have three distinct areas of health and safety, moving and handling and medical devices. Over time the annual report will reflect a more integrated approach.
This annual report highlights the breadth and depth of work underway, successes and our future developments through 2016/17 for the all of the team that sit within the line management of Health & Safety. The team members all provide a proportionate approach to health and safety management and are visible from a leadership, advisor and facilitator role.
The health and safety department as stated in the Overarching Trust Health and Safety at Work Policy will:

- Conduct all of our undertakings so as to avoid, or control to an acceptable level, risks to the health and / or safety of all of our employees, all users of our services, all members of the general public who are exposed to our activities and all other people who work on, or visit, our premises;
- Create and maintain a positive health and safety culture within all areas of our organisation, so that there is a continuous, improvement in our health and safety performance;
- These aims will be pursued regardless of whether the particular services which form part of the organisations' undertakings are performed by our employees, or by outside contractors acting on our behalf;
- These aims will be borne in mind in all policy and operational decisions made by the organisation, especially in relation to the adequate provision of resources. It is recognised that managers could render themselves liable under criminal health and safety law should they place requirements upon staff that are contrary to this policy.

2. Working Together with Trade Union

Staff-side is made up from members of East-Sussex HealthCare NHS Trust Staff (ESHT) who are members of a Trade Union or Society, recognised by the Trust. The Staff-side members have been elected and / or appointed into their role of Health & Safety Representatives, through their Trust recognised organisations.

These staff members undergo training by their own organisations in Health & Safety, and also may have undertaken further training via the Trade Union Confederation (TUC) which runs more in-depth courses which are College/University accredited. They also attend seminars & workshops in Health & Safety subjects, such as; stress, COSHH (Controls of Substances Hazardous to Health,) and RSI (Repetitive Strain Injury.)

- Staff-side Health & Safety representatives are governed by "The Safety Representatives and Safety Committees Regulations 1977".
- Staff-Side Health & Safety representatives are part of the consultation process into Health & Safety policies written by the management side of the Trust.
- Staff-side Health & Safety representatives support & represent staff, patients & visitors to the Trust.
- Staff Side Health & Safety Representatives, are involved in Investigations, and may be consulted by the Health & Safety Executive(HSE,) during Site Inspections, and when necessary they also have the legal duty to consult with the Health & Safety Executive(HSE).

The union members hold their own staff-side Health & Safety Committee, to which The Chair & Deputy are elected yearly into the role. They attend the main Trust Health & Safety Steering Group (HSSG) and report hazards and findings to the management side. These meetings are every other month and minutes are taken during meetings and agreed correct at the next meeting date.

The staff side chair also completes a report to the Staff-side Forum/Joint Staff Committee (JSC), so that Union & Society members elected into the role of workplace stewards are made aware of any issues which have arisen from meetings. Policies approved by staff side Health & Safety representatives are forwarded to the staff side forum/Joint Staff Committee (JSC) pre meet for information and when necessary for sign off 'approval'.

3. Context

As at 31/3/16, permanent headcount was 6519 staff. The average across the year, the headcount on 1st April 2015 was 6566 (the Trust had various transfers out of services, most significantly, the High Wealds staff). ESHT (source: ESHT Workforce Department) ; operating over approximately over 120 sites and covers 770 square miles.

The Trust Health and Safety Steering Group (HSSG) (see appendix 1 for reporting structure) was chaired by the Director of Nursing & Governance (DoN) who is the executive named but mid-year of 2015 the Associate Director for Estates and Facilities took over as chair of the group and the DoN took over as deputy chair. The Group receives reports from Trust wide services, for example, Clinical Units, Fire, Security, Waste and so forth, see Appendix 1 for the H&S reporting structure within the Trust.

4. Staffing within Health and Safety Department

See Appendix 2 for the team structure

5. Legal Background

The Trust legal department have identified that the numbers are quite low and that there is nothing in relation to trending to show except to say that slips/trips/falls remains the category for the largest number of the Trust's non-clinical claims (additional report available on request).

The key pieces of legislation and guidance are:

The Health and Safety at Work etc Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.

In particular it requires organisations to:

- Provide a health and safety policy
- Provide safe and secure working environment
- Provide safe suitable work equipment
- Provide information, instruction, training and supervision
- Provide adequate welfare facilities.

Management of Health and Safety at Work Regulations 1999 which extends the provisions of the Health and safety at Work etc Act 1974 in particular the requirement to undertake suitable and sufficient risk assessments.

Management for health and safety (HSG65) 2013 guidance explains the Plan, Do, Check, Act approach and shows how it can help an organisation to achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

Leading health and safety at work (INDG 417) guidance sets out an agenda for the effective leadership of health and safety; it is designed for use by all directors, governors, trustees, officers and their equivalents in the private, public and third sectors. It applies to organisations of all sizes. Protecting the health and safety of employees or members of the public who may be affected by an organisations activity is an essential part of risk management and must be led by the board. Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership. Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety. By following this guidance, it would help the organisation find the best ways to lead and promote health and safety, and therefore meet its legal obligations.

Memorandum of Understanding (MOU) between Health and Safety Executive (HSE) and the Care Quality Commission CQC) came into effect on the 1st April 2015, to reflect the new enforcement powers granted to the CQC by the Regulated Activities Regulation 2014. It reflects the 2012 Liaison Agreement between the CQC and HSE that applied solely to healthcare,

The purpose of the MOU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public visiting these premises. It is one of the measures taken by Government to close the 'regulatory gap' identified by the Francis Report into failings at Mid Staffordshire NHS Foundation Trust.

It outlines the respective responsibilities of CQC, HSE and Local Authorities (LAs) when dealing with health and safety incidents in the health and Social Care sectors, and the principles that will be applied where specific exceptions to general arrangements may be justified. It also describes the principles for effective liaison and for sharing information more generally.

6. Key achievement and Future development

Health and Safety Department service continue to achieve in delivering high standard training, the development and monitoring of policies and procedures to ensure safe working practices, this is reflected in the various sections within this annual report.

- Health and safety team will be reviewing the service 'gap analysis' that was completed for this current three year programme of work that had commenced April 2014. The refreshed annual action plan is available on request.
- The health and safety team continue to undertake a multitude of tasks and projects including the provision of specialist advice, undertake audits etc.

- Moving and handling team realised that effective Manual Handling training enables a reduction of Musculoskeletal (MSDs), which are the most common cause of workplace injuries in the workplace. In 2014/15 an estimated 2 million people were suffering from an illness they believed was caused or made worse by their current or past work, over half a million were relating to MSDs in the UK (HSE October 2015).
  In the next 12 months the Manual Handling Team will aim to:

- Achieve training compliance of 90%
- Proactively engage with staff and patients to respond to the needs of the Trust
- Develop team roles and responsibilities in line with Trust needs, including further education
- Target and support clinically high risk areas e.g. Radiology, A&E , ITU, Orthopaedics and Dental practices
- Plan and continue to develop effective training, to include a training needs analysis
- Deliver evidenced and competency based training (clinical and work towards non-clinical for 2016/7)
- Trial new equipment for clinical and non-clinical staff , as needed
- Roll out a phased Moving and Handling Link Trainer programme
- Establish clear and workable processes for the management of Moving and Handling equipment, including accessibility
- Work closer with procurement to ensure that products purchased are best practice, fit for purpose and financially sound
- Improve support for desk workers, to include access of sit to stand desks as required, and self-help e.g. Deskercises
- Review and update documentation ,which should be readable, usable and reflect current guidance and practices
- Respond to Datixweb incidents and support managers in a timely fashion to assist in reducing potential hazards and risks
- Promote Back Care Awareness Week (October 16), focussing on Low Level working (clinical and non-clinical staff)
- Engage fully with the Sussex Back Exchange (and other agencies) and provide opportunity for local engagement
- Develop improved and smarter working relationships with key stakeholders
- Continue to increase team visibility within the Trust
- Be accessible by all staff.

- Medical Device Educators realise that they need to further develop the service, to ensure that the Trust meet the CQC essential standards. The service will be reviewing current methodology of medical device training. This will allow the team to look at what are the current goals for staff compliance are and how do these figures compare to the national average. In turn this will allow the team to ensure we are implementing the correct level of training to the appropriate staff groups and will assist in the revalidation process for clinical staff. As part of the review process the team will be looking at:

- Clinical risk categories for medical devices

- Implementation of medical device link trainers (ward based)

- Review of ESR/SHE (Assure) systems in relation to recording medical device competencies
- Review of current competency paperwork and compliance time frame
- Ensuring that training material/sessions are mirrored on all sites of ESHC to ensure a uniformed approach to training
- Development of the medical device web page on the intranet.
- Processes for monitoring quantitative data are established

7. Health and Safety Team Annual Incident Report and Audit Findings

7.1.0 Summary

This annual review highlights trends and key areas of risk in terms of health and safety through the identification of risks, reporting of incidents and audit results. Key risks were identified;

1. Failure to achieve KPI's set for Occupational Health and Safety Managements Systems (OHSMS) audits
2. Work Related Dermatitis
3. Training records of Temporary Workforce services

7.2.0 Introduction

This section gives the number of health and safety related incidents and also describes the nature of Health and Safety related incidents that occurred in East Sussex Healthcare NHS Trust between 1st April 2015 and March 31st 2016 to staff and others. Full reports are given by departments responsible for leading on the implementation of their subject matter; Moving and Handling, Occupational Health, Security, Waste, Infection Control (Sharps incidents) and Fire.

Patient Safety incidents are reported to the Patient Safety and Clinical Improvement Group (now Quality and Standards Committee) however, where patient incidents are defined as reportable to the Health and Safety Executive within the context of RIDDOR; these are reported to this Steering Group as well. Patient related RIDDOR's are identified in section 3. In addition, patient falls are reported to the Falls Steering Group.

From 1st April 2015, the quarterly reports for the Health and Safety Steering Group included health and safety related incidents affecting patients including a summary of patient falls.

2013/14 was the first year where full information was able to be extracted from Datix enabling a benchmark to be set due to the implementation of Datix web part way through the financial year 2012/13 and this year enables full comparisons to be made against that benchmark. An exercise enabling benchmarking of comparable Trust data external to the organisation has also been undertaken on RIDDOR events.

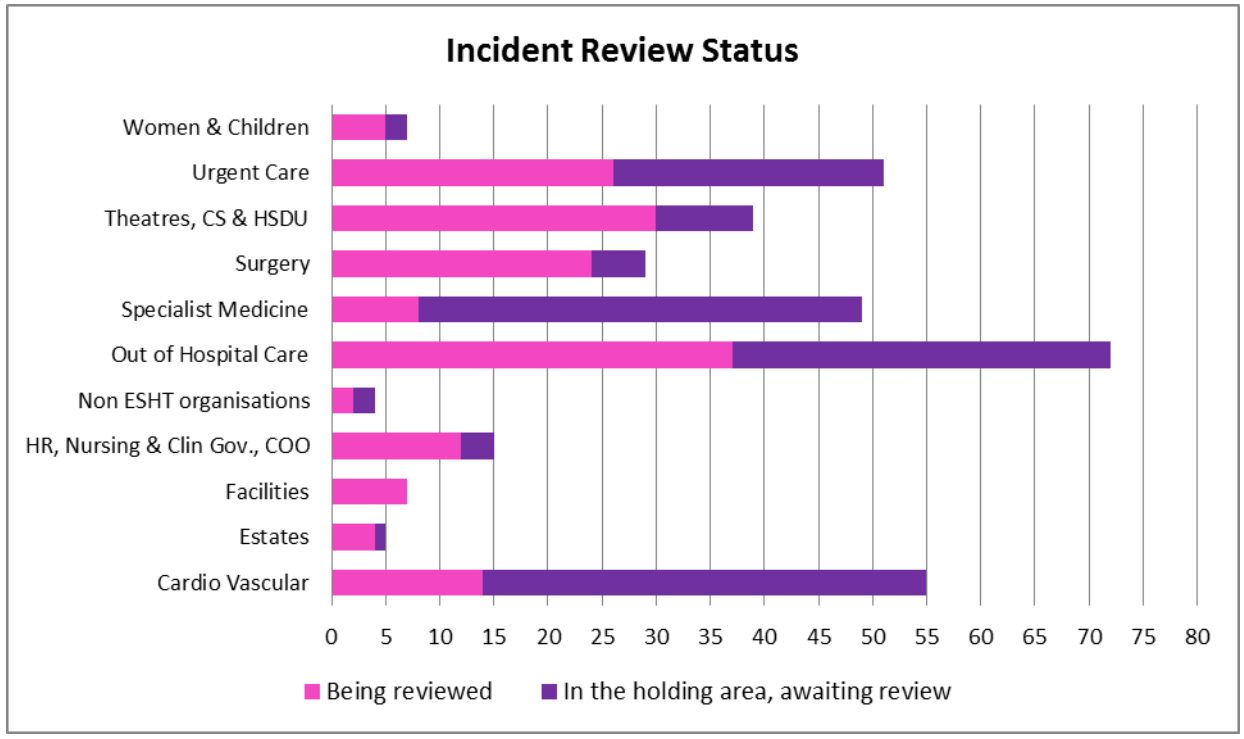
7.3.0 Incidents

Information for the purposes of this area was extracted from Datixweb on 1st June 2016 and is based on the date of incident to enable trends analysis.

7.3.1 Incident Review and Closure

The framework for using Datixweb efficiently includes the requirement to review incidents within a specified timeframe, in line with training received and then assign or undertake investigations according to the level of incident.

There are a total of 164 (16 staff) incidents yet to be reviewed by the handler and 169 (18 staff) incidents are still in the process of being reviewed. In comparison 2014/ 15 indicated there were still 50 staff incidents that had not been reviewed and 52 under review.



The graph represents the cumulative incidents that are still outstanding for the previous year the results of which will affect the accuracy of this report in terms of grading and categorisation. Therefore whilst every effort has been made to ensure the accuracy of the data presented in the following report, the information presented is as accurate as that which is taken from Datix at the time and relies on both timely reporting and review of the incident, the accuracy and interpretation of the trained handler.

The benefits of moving to an online reporting system are clear, including:

- Greater ownership of incidents in real time by local managers Feedback can be sent to reporters of an incident

- Instant notification to be sent to specialists enabling effective triage and response to the incident where required
- Reinforcement of a strong incident reporting culture
- Full audit history on every incident and subsequent investigation
- Increased ‘real time’ reporting

7.3.2 Classification of Severity and Categories

This report includes the following categories of incident as reported;
Health and Safety

- Animal bites
- Burns and Scalds – dry or wet
- Cuts and Lacerations. This category includes incidents such as skin tears and lacerations other than needles stick or sharp devices
- Trapped by the collapse or an overturn of an object
- Impact with static object – walking in to/ standing up
- Impact with moving, falling or flying object
- Road traffic collision
- Exposure to Hazardous Substances or clinical waste – biological, dust, chemicals, spores
- Environment - Infestation, noise, temperature, ventilation, surfaces and walkways

Slips, Trips and Falls
Moving and Handling
Needlestick and other Sharps
Security, Violence and Aggression -. Theft and loss has been excluded for the purposes of this report.

In accordance with the National Patient Safety Agency (NPSA) matrix an extract of which is below; and in line with the requirements of the National Reporting and Learning System (NRLS), the report identifies those incidents according to the initial severity. It is essential that the matrix is used consistently within the organisation for both the reporting and grading of incidents and risk. Whilst there have been difficulties reported with staff using the NPSA risk matrix, the difficulty is identified as a training issue rather than the matrix itself.

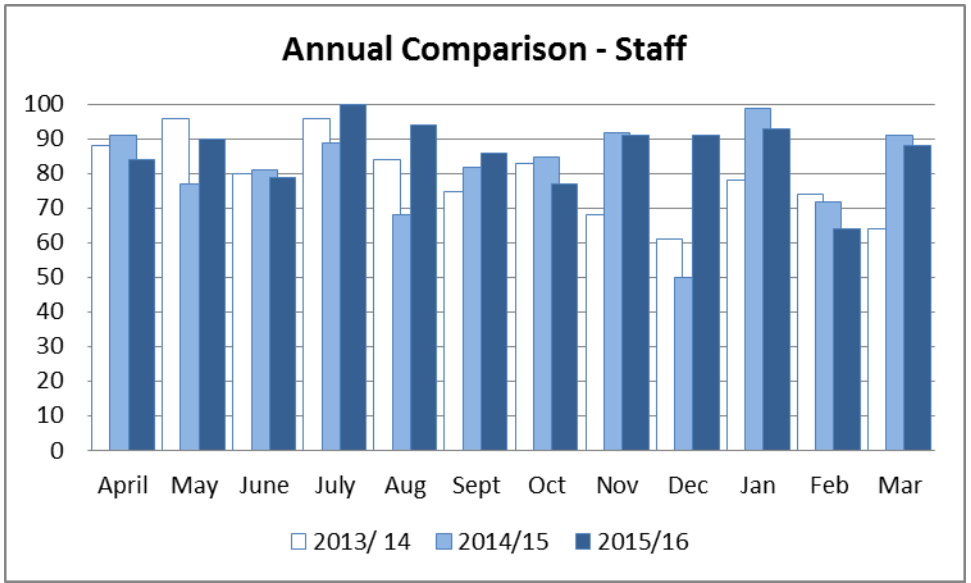
Source; www.npsa.nhs.uk

NPSA matrix	**Consequence score (severity levels) and examples of descriptors**				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects

8.3.3 Incidents reported

8.3.1 Annual Comparison

The graph represents the incidents reported by month for the full calendar year. There has been a 3.7% increase in incidents reported over the last year and the NHS Staff Survey indicates the same percentage of staff witnessing potentially harmful errors, near misses or incidents as in 2013 which is 29%. The actual figure of staff reporting incidents or errors within the last month (key finding 13) is stated to have decreased marginally and may affect the reliability of some of the figures in the report. The survey is sent to staff in September 2014 and the results published in February 2015

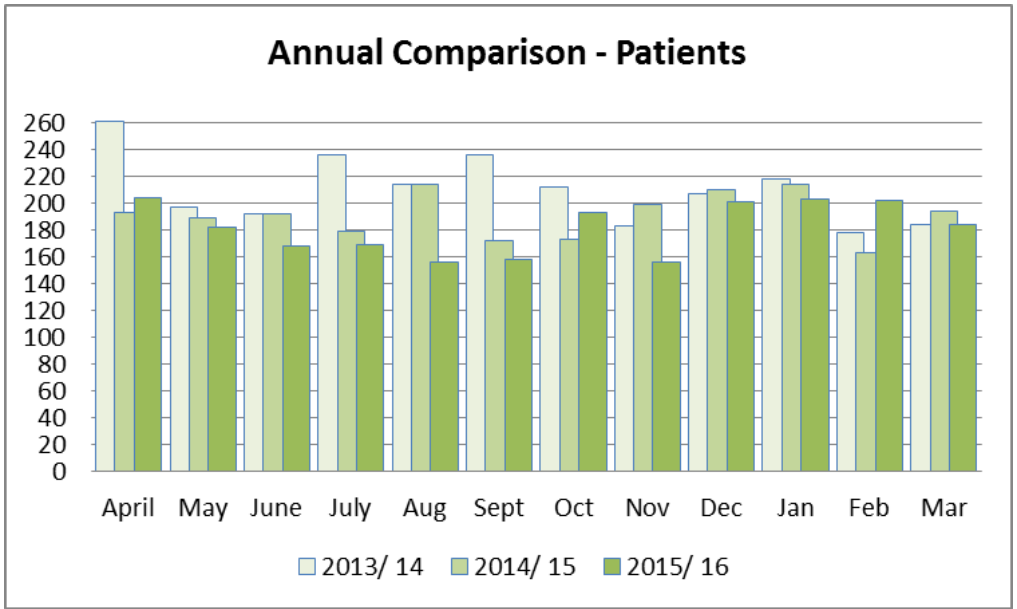


8.3.2 Staff Incidents

The graph to the left indicates a month on month trend compared with the previous year. The average monthly incident figure for 2013/ 14 were 78.92 which has increased for 2014/15 to 81.42 and again in 2015/ 16 to 86.42.
In the scope of the current fiscal year the most significant increase was in December 2015 followed by August and July.

Further analysis is offered in 3.3.7; Incident trends by quarter.

Staff Incidents	2013/ 14	2014/ 15	2015/ 16
Totals	947	977	1037
Monthly Average	78.92	81.42	86.42
% Increase/ Decrease		3.17	6.14



8.3.4 Patient Incidents

Patient Health and Safety related incidents have consistently reduced since 2013/ 14 as the table below indicates. The

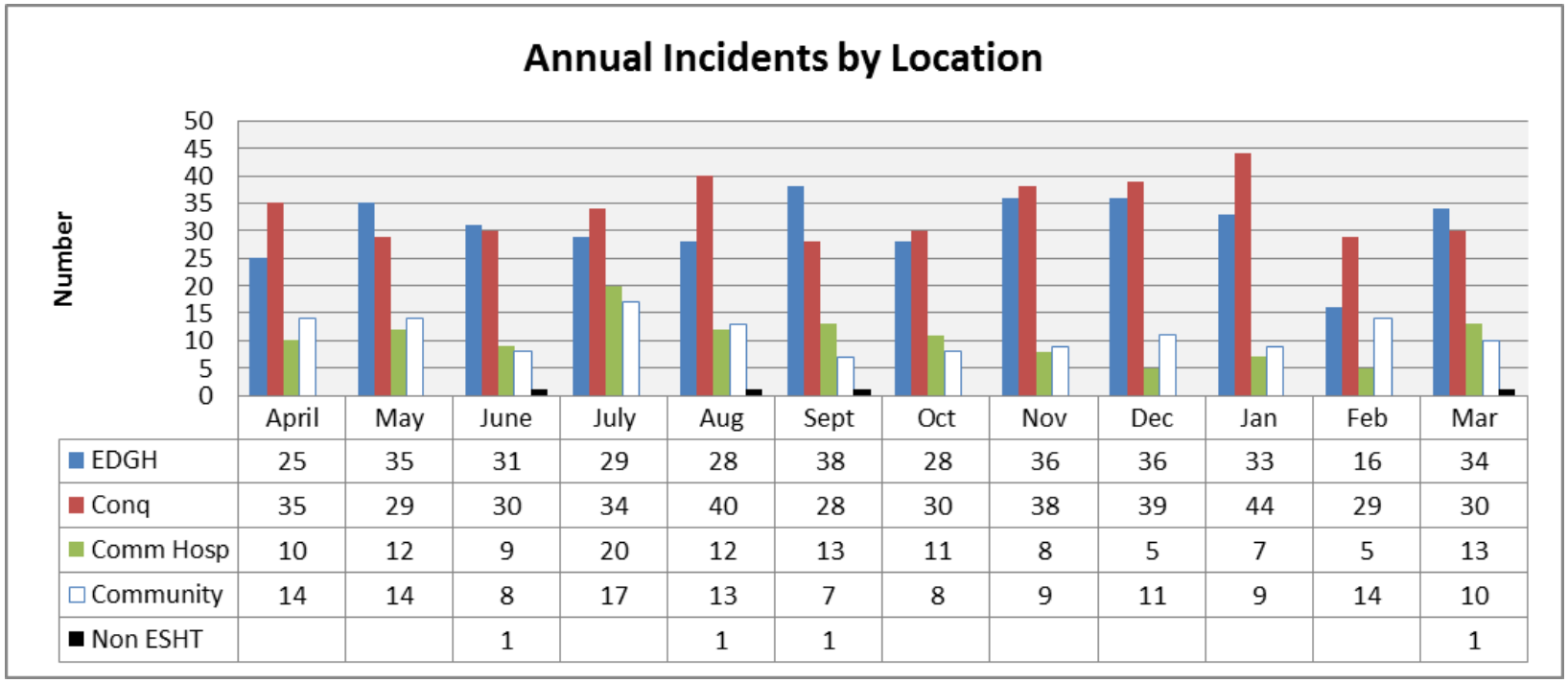
decline in patient incidents resulting in falls has accounted for this.

Of the remaining 195 incidents in 2015/ 16;

- 8 Moving and Handling incidents; inadequate or lack of available equipment
- 5 sharps incident. 4 found proximate to patients however a further incident was medical devices issue where the tip of a needle broke
- 29 incidents involving security/ violence or aggression including illegal substances found
- 153 incidents were categorised as health and safety. Of concern were 67 cuts or lacerations including skin tears although in many instances the cause was unknown. There were 15 scalds or burns to patient as the result of hot food or drinks spilled.

Patient Incidents	2013/ 14	2014/ 15	2015/ 16
Totals	2518	2292	2176
Monthly Average	209.83	191.00	181.33
% Increase/ Decrease		- 8.97%	-5.06%
Falls	2445	2101	1981

8.3.5 Incidents by Location



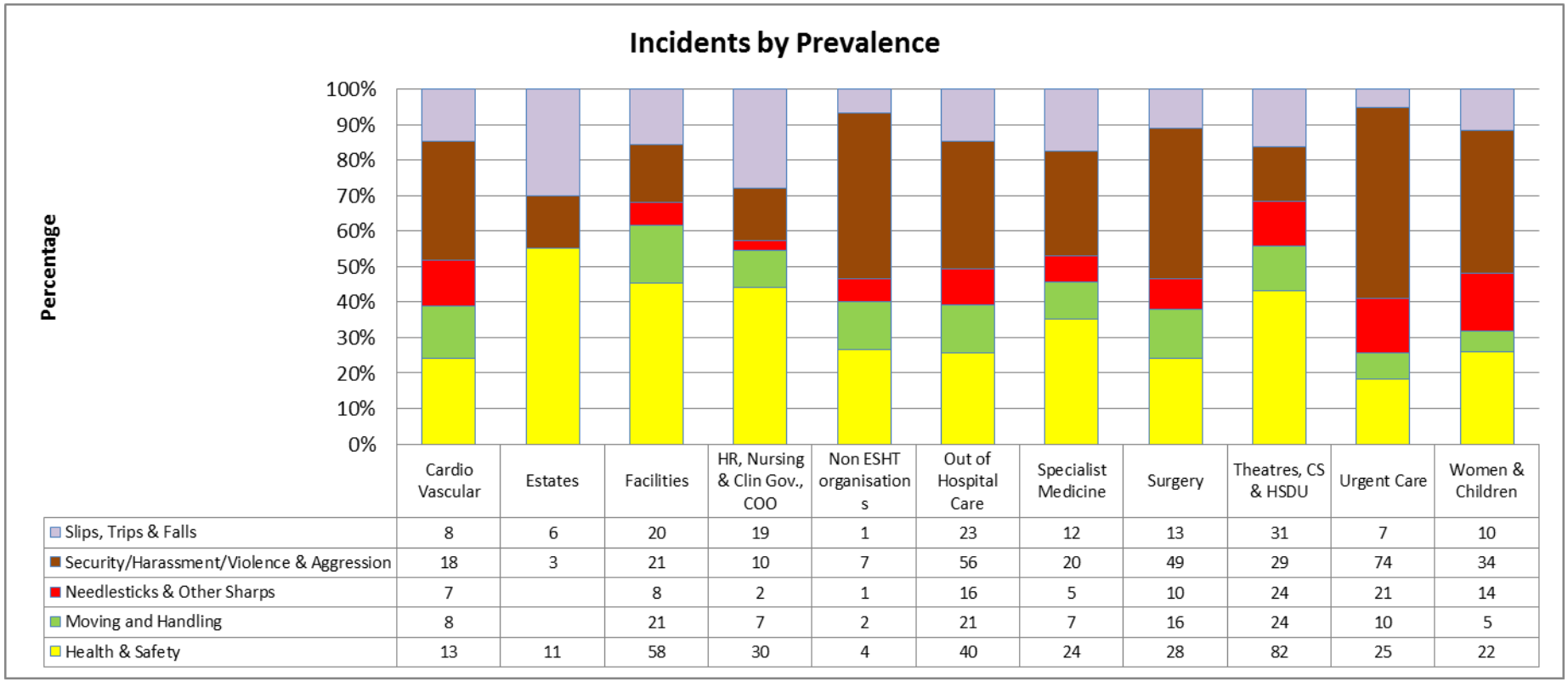
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
EDGH	25	35	31	29	28	38	28	36	36	33	16	34
Conq	35	29	30	34	40	28	30	38	39	44	29	30
Comm Hosp	10	12	9	20	12	13	11	8	5	7	5	13
Community	14	14	8	17	13	7	8	9	11	9	14	10
Non ESHT			1		1	1						1

Incidents by location have been included in the annual report to enable potential identification of trends across sites and areas where services are to be located to enable preventative measures to be put in place. The previous years have consistently indicated that incidents that occur in community and domiciliary tend to be higher coinciding with school term dates whereas community hospitals tend to be lower during this period. However, this trend has not been identified for 2015/ 16 despite further analysis. In addition with the movement of High Weald, Havens and Lewes and School Nurses to Kent and Medway Trust there was a smaller than expected decrease in incidents.

Both acute sites reported high levels of incidents during November and December 2015. Peaks at Conquest site in August were identified as Violence and Aggression; 15 including 5 cases of intentional physical assault and in January there were 17 cases of violence and aggression including 10 intentional physical assault. EDGH peaked in September although all categories increased.

8.3.6 Incidents by Prevalence and Clinical Unit/ Division

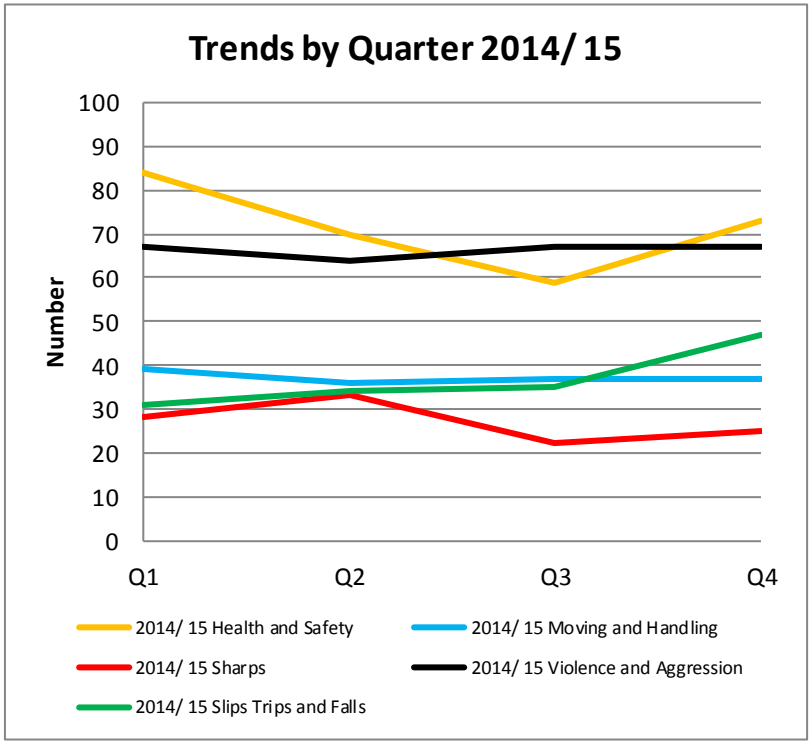
The graph below summarises all incidents to staff by severity for the full year. Each Clinical Unit and Directorate reports on those incidents quarterly to the Health and Safety Steering Group.

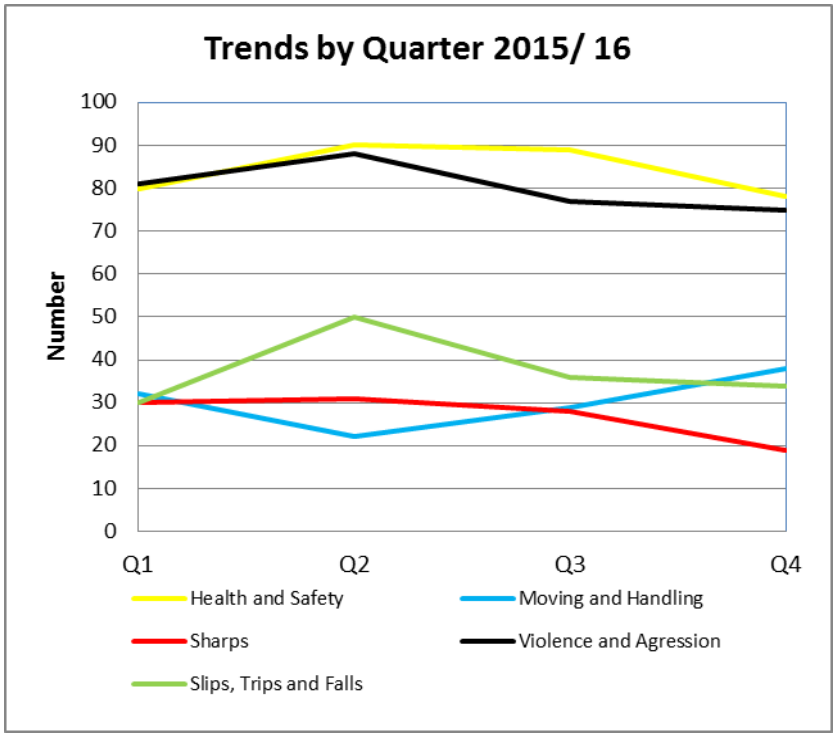


	Cardio Vascular	Estates	Facilities	HR, Nursing & Clin Gov., COO	Non ESHT organisations	Out of Hospital Care	Specialist Medicine	Surgery	Theatres, CS & HSDU	Urgent Care	Women & Children
Slips, Trips & Falls	8	6	20	19	1	23	12	13	31	7	10
Security/Harassment/Violence & Aggression	18	3	21	10	7	56	20	49	29	74	34
Needlesticks & Other Sharps	7		8	2	1	16	5	10	24	21	14
Moving and Handling	8		21	7	2	21	7	16	24	10	5
Health & Safety	13	11	58	30	4	40	24	28	82	25	22

Violence and aggression to staff are an ongoing concern in the community and domiciliary environment and Out of Hospital clinical unit reported the highest number with 11 of those incidents being intentional physical or verbal abuse and discrimination; please see the following section for further analysis

8.3.7 Incident trends by Quarter



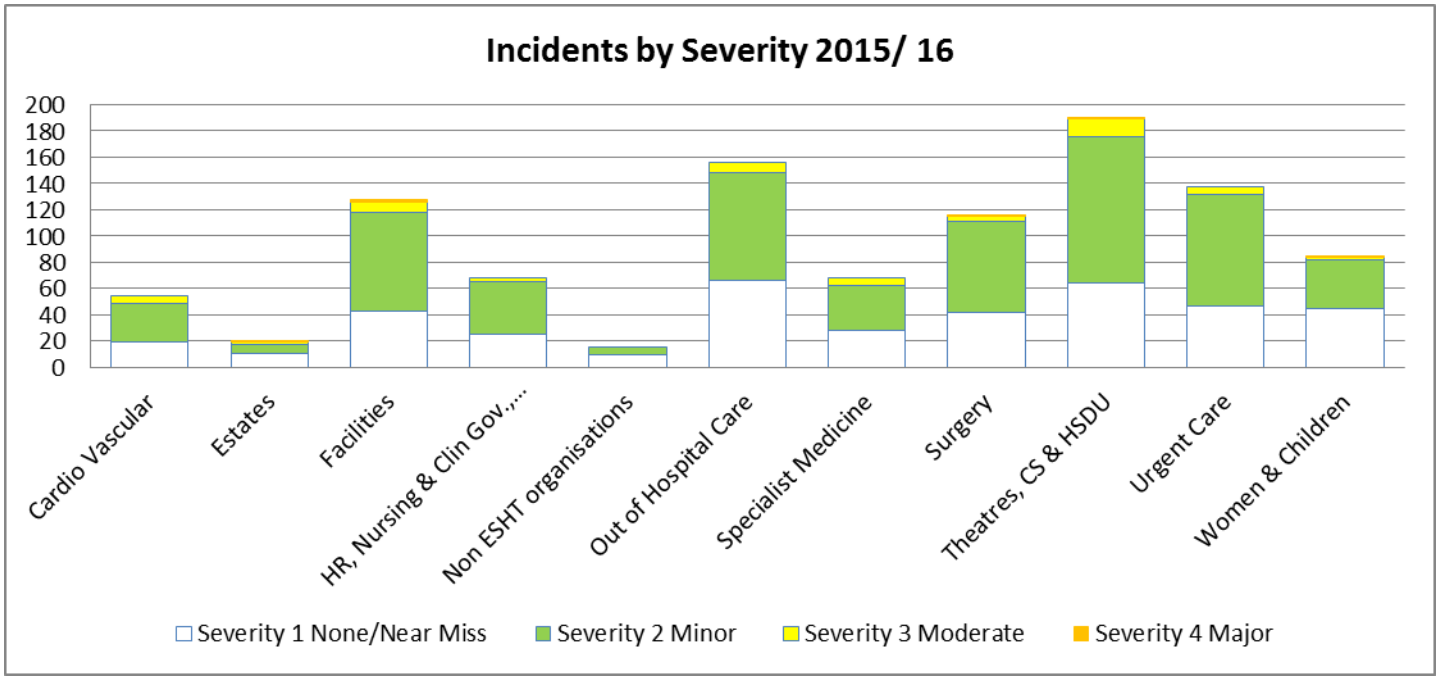


Of 108 needlestick and sharps incidents, 8 occurred in Facilities; 7 were as the result of poor clinical waste procedures followed at source.

Theatres and clinical support; decontamination services reported 24 needlestick and sharps injuries 11 of which were categorised as ‘dirty’, in all case Occupational Health were contacted and Trust process followed. Trust wide, reports of incidents have indicated problems with catches on safety needles however a trend was not identified this year and an overall downward trend is indicated from last year which reported 186.

50 slips, trips and falls were reported in quarter 2 alone; and increase of 30% from 2014/ 15; 37 of these were staff including 7 falls due to existing health or environmental conditions. 15 incidents highlighted poor storage in areas and cable management. 3 reports highlighted the fact that inappropriate castors have been fitted to chairs in areas with hard floors causing the chair to move away from the member of staff. 13 carers and members of the public expereinced falls and faints which were not foreseeable and due to circumstances beyond the control of the Trust.

8.3.8 Incidents by Severity



9. RIDDOR events

The Reporting of Incidents Disease and Dangerous Occurrences Regulations (as amended) 2013 requires the Trust to report certain categories of incidents to the Health and Safety Executive (HSE). The update to the Regulations amended the requirement for incidents involving an absence of 3 days or more to 7 days or more however, the Regulations stipulate that those incidents falling into the category of 'over 3 days' must be formally recorded by all organisations.

Across the full year, a total of a total of 45 incidents defined within the RIDDOR Regulations were reported to the Health and Safety Executive: staff and others (44) patients (1). The patient was visiting a community hospital where it is believed the doors caused a trip. This incident resulted in a fractured neck of femur and subsequently a claim.

	Health and Safety	Moving and Handling	Sharps	Violence/ Aggression	Slips Trips and Falls	Total
Over 7 day	3	25		4	8	40
Specified Injury		1			2	3
Fatality						
Dangerous Occurrence			2			2
Disease						

Incident rates over the previous 3 years are indicated in the table below

The HSE uses accident rates to compare organisations. The most useful are workplace deaths and the number of RIDDOR reportable injuries per 100,000 employees. The HSE publish data for the health sector and for all industries. Data is based on total employee numbers for rather than whole time equivalents and is collated by Labour Force Survey (LFS)

	RIDDOR No	Staff Count	Incident rate per 100000 employees	**HSE and LFS comparisons
2013/14	65	6693	971.16	***Not available
2014/15	52	6566	791.75	2350
2015/16	45	6542	687.86	Not yet published

*** Not available due to the extensive legislative changes were introduced to simplify the reporting of workplace injuries. One key change was the introduction of 'specified injuries', which replaced the previous 'major injury' category. This change occurred half-way through the 2013/14 reporting year.
The HSE states that use of the LFS RIDDOR data needs to be interpreted with care because it is known that non-fatal injuries are substantially under-reported and indicated a very poor reliability. The Trust places great emphasis on the reporting of incidents and the triage process of incidents ensures that almost all incidents defined as a RIDDOR are reported however it is known that retrospective reporting still occurs in the Trust and therefore the incident rate may vary within a tolerance of 6%.

9.1 Over 7 day Incidents

Health and Safety
2 road traffic collisions in Community , 3 involving the transfer of goods and equipment (Moving and Handling) and a further caused by a burn
Moving and handling incidents reported 24 including 12 patient moving activities; 2 of which were working alone with non-compliant patients

Security; 2 intentional and 2 non-intentional physical assaults
Causes of trips were not always identifiable; in 4 cases there was no direct cause observed or reported and it is observed that these may have been the result of a pre-existing health condition. 2 incidents occurred in car parks, trailing wires resulting in falls on floors, down steps or stairways. There was 1 slip on a wet floor.

9.2 Specified Injuries

There was one Moving and Handling incident which resulted in a dislocation and torn rotator cuff resulting from a member of staff moving a damaged drum with integral handle that was stated to have been potentially faulty. I member of staff tripped in a Theatres reception area resulting in a fracture although the cause of this was not identifiable.

There was 1 patient related RIDDOR events believed to be as the result of door causing a patient to fall

9.3 Fatalities

There have been no fatalities reported to the HSE in 2015/ 16

9.4 Dangerous Occurrences

There have been 2 incidences of high risk sharps injury. One occurred when a member of staff tried to assist a patient with their own insulin pen and a further during venepuncture. Although both were categorised as dangerous occurrences due to the inherent risk neither member of staff was individually assessed as required post exposure prophylaxis.

9.5 Disease

There have been no confirmed cases of Occupational Disease

10. Policies

Health and Safety Policies continue to be reviewed and during review a summary sheet is now embedded within the policy which will enable staff to briefly note and recognise the objectives, purpose and outline contents of the policy. The summary sheet will not absolve managers and staff of the need to read the policy in full where required.

10.1 Health and Safety Links

The directory of health and safety link persons continues to build and those staff registered on the database having had suitable training receive information directly from the health and safety department to ensure that there is no miscommunication or delay of information and that information is disseminated at an operational level quickly. A Health and Safety Open Day was held at EDGH in November 2015 to support the links in fulfilling their role which was very successful and will be repeated during 2015/ 16 on Conquest Hospital site.

10.2 Health and Safety Intranet

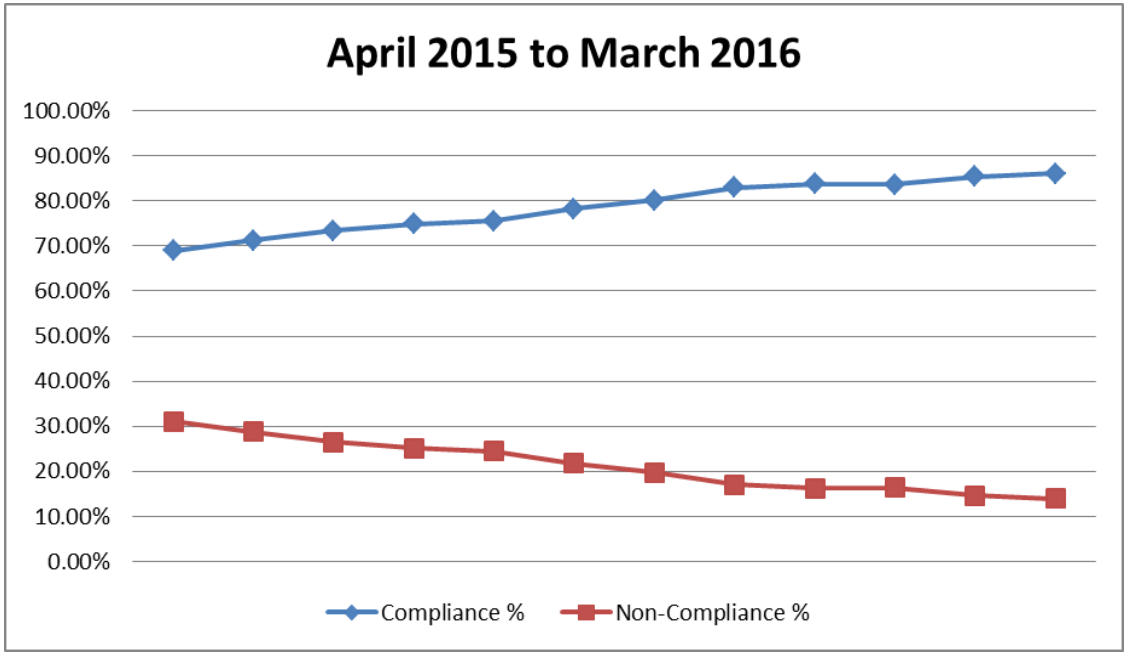
The intranet is continually updated with all aspects of health and safety information including links and newsletters from associated departments and regulatory bodies including the Medicines and Healthcare Regulatory Agency (MHRA). Plans identified in 2013/14 to ensure that a Trust wide database of commonly used substances exists as well as the associated COSHH assessments and up to date safety data sheets progressed throughout 2015/ 16 and includes Trust wide common substances particularly those used by Facilities staff on wards. All departments that have responsibility for trialling and approving substances for use Trust wide also have a responsibility for ensuring a COSHH assessment is completed. Access to the public folders via the intranet will avoid duplication of work however all department must adapt these to their department.

11. Training

There are 4 levels of Health and Safety training all of which require refresher training at 3 yearly intervals.

- IOSH for Senior Executives
- Level 3 - IOSH Managing Safely for Healthcare Professionals for
- Level 2 - Full day Health and Safety training for team leaders, supervisors and managers
- Level 1 - E-Learning or Class based training for staff who do not have supervisory or management responsibilities

11.1 Health & Safety Training Compliance



Cascade training was temporarily implemented throughout the Trust during 2014/ 15 to enable IOSH trained staff to deliver training within their departments and improve compliance throughout the Trust. This was initially successful in improving figures and a further 158 courses were provided during 2015/ 16 to address the shortfall in compliance of 68.92%

At the end of the fiscal year the Trust could demonstrate 86.02% compliance for substantive staff and it is anticipated that this will continue through 2016/ 17 with the provision of the following in addition to e-learning.

Level 1	1610 places
Level 2	373 places
Level 3	54 places

Workforce Development provides a monthly report that identifies training compliance by clinical unit. This information is collated and used to populate the scorecard that is sent to senior managers on a monthly basis.
Levels of health and safety training compliance for the substantive workforce are reported to Board however this report does not currently include the figures for Temporary Workforce Services bank staff. Therefore there is a potential that staff may not be compliant with mandated training when requested to work in departments and wards.

Work has been undertaken by both the Health and Safety department and Learning and Development to ensure that courses are aligned with the National Passport System which the Trust has signed up to. E learning continues to be revised to ensure that it provides the most relevant training for Trust staff.

12. Health and Safety Executive

1. There have been no formal interventions in this Trust by the Health and Safety Executive (HSE).

2. Maidstone Tunbridge Wells NHS Trust made both local and national news when the Trust was prosecuted following a patient burn in 2012. There was a total cost to the Trust of £256,200 including Fees For Intervention, fines and costs

3. Fees for Intervention; The cost recovery regime implemented by the HSE from 1st October 2012, have increased from £124.00 per hour to £129.00 per hour

13. Audits

13.1 Process

Elements of the OHSMS relevant to the service are objectively scored against compliance criteria – legislation and Trust policy. Evidence is required at the time of audit to support any statements;

1. Visible evidence obtained by the auditor e.g. presence of legal notices and posters, storage of PPE
2. Questions of both staff and managers
3. Records e.g. training records, risk assessments, minutes of meetings, fire inspection records

All areas audited are subject to a further audit the frequency of which is currently dependent on risk rating of the preceding audit as indicated below.

% Compliance	RISK RATING	Re audit
0-50	Very High	0 – 6 months
51-70	High	6 – 12 months
71-90	Medium	12 - 24 months
91-100	Low	24 - 36 months

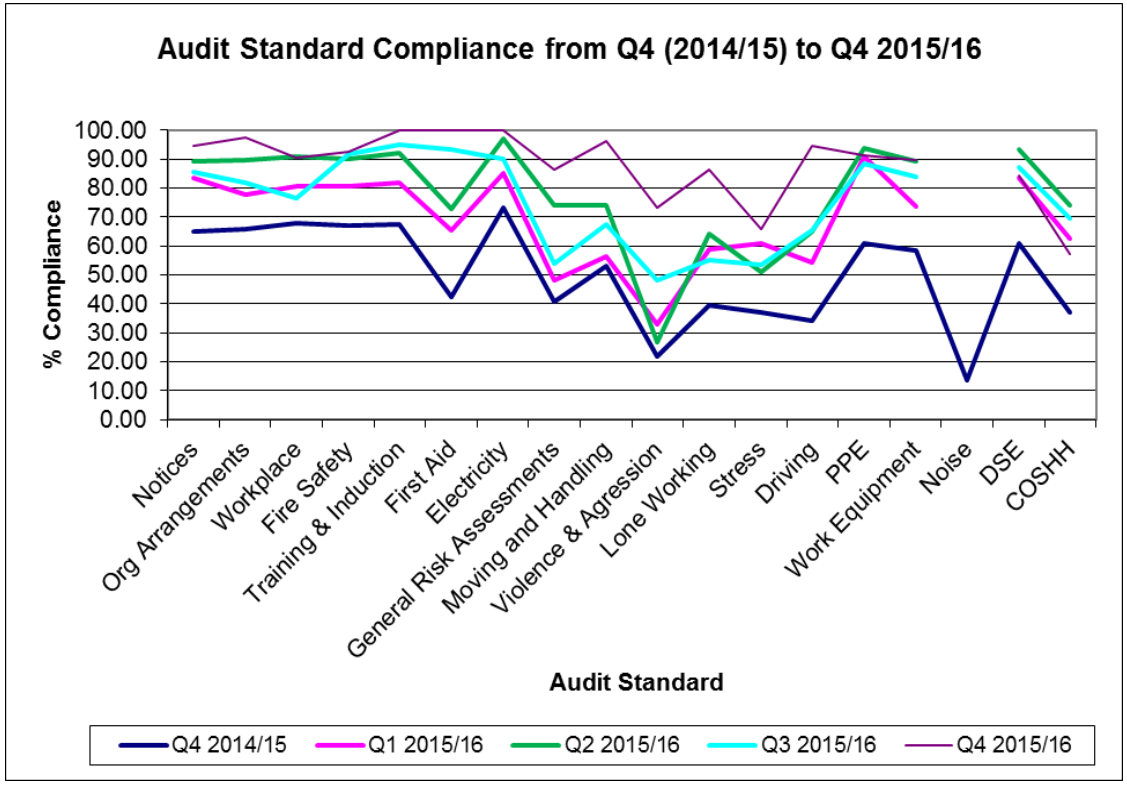
The Trust HSSG approved amendment of the audit frequency to a maximum of 3 years for low risk areas and a greater intervention in those departments. This was to allow departments where audit compliance was high risk improving specific audit standards. There were a total of 67 audits completed during the fiscal year.

13.2 Quarterly Standards

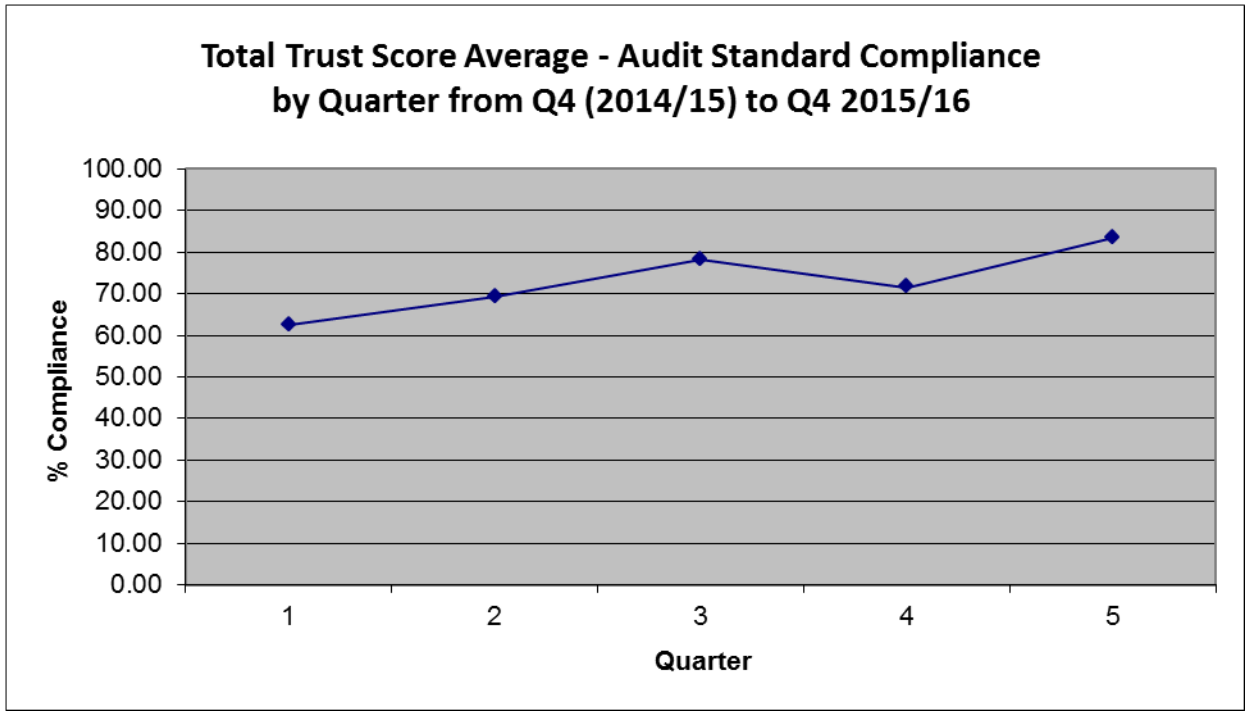
Audits for Occupational Health and Safety Management Systems (OHSMS) began in June 2012, quarter 2 and have been conducted since in order to both benchmark the systems in place to support health and safety and measure improvements made. The audit tool comprises 18 standards which are designed to examine;

- Structure and Roles/ Responsibilities
- Consultation, Communication and Reporting
- Hazard Identification, Risk Assessment and Control of Risks
- Hazardous Substances, Infectious Materials and control of waste.

Initial results indicated there was a poor interpretation of the regulatory requirements for risk assessment stating general policy as a control measure rather than extracting the specific actions; these did not meet the need for a 'suitable and sufficient' risk assessment. There was also a low level of awareness for the process of escalating risk and communication and actions resulting from that escalation including feedback.



13.3



This graph indicates average results of audit across 5 quarters. Although an upward trend of improvement is indicated, this appears to be driven by improvements made in specific standards as indicated in 13.2.

For an improvement to be sustained, systems must be fully understood and embedded in all departments regardless of the nature of service and the frequency of audit. Therefore improvement targets will continue to be set and interventions including training undertaken.

Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Lowest audit score	32.16	Lowest audit score	41.12	Lowest audit score	57.08	Lowest audit score	45.63
Highest audit score	100.00	Highest audit score	100.00	Highest audit score	100.00	Highest audit score	99.92

13.3 Improvement Targets

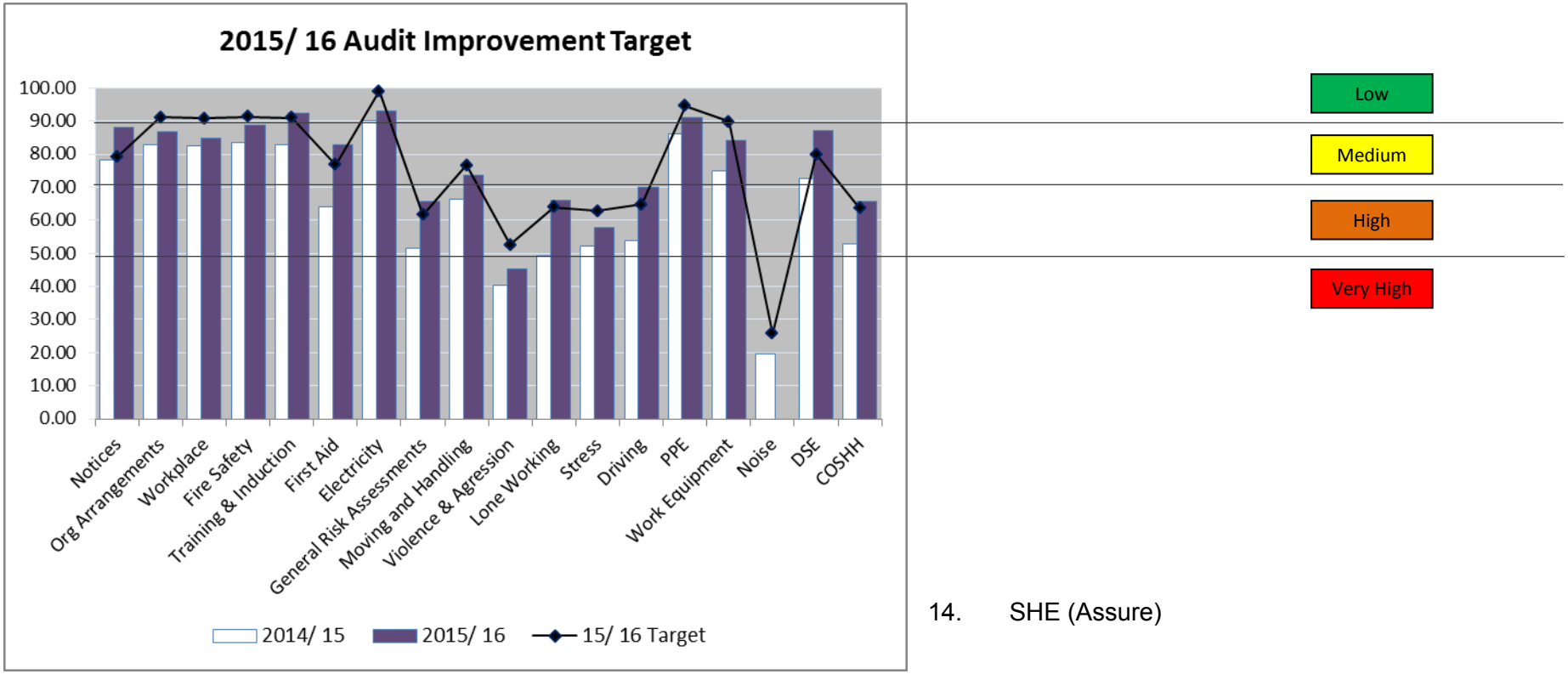
Based on the principle that some resources could be better targeted to areas in need of clear direction audit improvement targets were set for 2015/ 16 with the greatest improvements needed for Violence and Aggression, Lone Working and risk mitigation for Driving although some improvements were still needed for Stress.

Improvement targets set for 2015/ 16 were;

30% improvement for Very High risk
20% High risk and
10% Medium risk

Whilst the results of the improvement intervention are not able to be fully measured until mid-2016/ 17; initial results are indicated in the below graph for each specific standard. At present, COSHH is lowest compliance score with 57.14%, then Stress (65.67%) and then V&A (73.33%) however these indicate results on a quarterly basis.

The graph below indicates the collated average for each audit standard over the fiscal year clearly indicating the improvements made in each standard and those where further interventions across the Trust are needed.
Notices, Training, First Aid, Risk Assessments, Lone Working, Driving for Work, DSE and COSHH all achieved or exceeded improvement targets set.
Those clearly needing further improvement are;
Violence and Aggression; this is not being adequately scoped in departments which a lack of workplace security assessment and measures to mitigate the risk from violence and aggression. There is an absence of a proactive team based stress risk assessments or where they are in place, a copy has either not been sent to Occupational Health or the assessment is out of date. A single department was audited where noise was indicated to be a risk factor and this had an inadequate assessment and control measures



14. SHE (Assure)

The Trust purchased a system for the recording of health and safety risk assessments and audits at the end of August 2015. Initially a ‘staging’ site to determine the extent of the configuration required and to fully scope the flexibility and accessibility of the system.

By the end of December a significant number of ESHT risk assessments had been transferred onto the system and configured, and a top-level organisational structure had been ported to the system. Extensive configuration of the system was then undertaken to ensure it fully reflected the needs of the Trust for assurance and regulatory purposes. A training framework with subsections and outcomes was also produced, and broken down into a number of separate stages for implementation. Stakeholders and interested parties for the system were identified at an early stage, and meetings have taken place as configuration of the system has progressed.

The implementation of the programme is currently focusing primarily on Urgent Care Clinical Unit, although other areas, such as Trauma and Orthopaedics, and Urology have also been targeted. It is essential that the early stages of delivery are controlled in order to identify and resolve any problems prior to opening the system via fast find navigation Staff response to the system has been very positive overall, and a number of areas have come forward to request that they receive the system without prompting or previous contact.

Completed works are available as a separate report.

14.1 Current Project Issues

The SHE (Assure) Project Issue Log contains full details of resolved and ongoing challenges However, a brief summary of the main issues can be found below:

COSHH Module usability; a full rewrite of the COSHH module by the developers, with a scheduled completion date of July/August 2016
Reporting Configuration; integration of reports required to reflect the governance needs of the Trust
IT and system stability; current difficulties and access now restricted due to IE8 compatibility with software
Confidential permissions pathway; permissions are required to be split so that any member of staff completing a record marked as confidential does not automatically have the right to view a confidential record within the remit of the structured permissions.

14.2 Benefits Realisation

In the last five years, significant amount of progress has been made by the Trust with the completion of health and safety risk assessments , however, this does not provide sufficient assurance to Governance leads that all required risk assessments within the Trust are being created, reviewed and actioned. By implementing the online system, the following significant benefits will be realised for the Trust in regards to Health and Safety risk assessments

Accessibility for all staff via ‘Portal’ or as a licensed user of the system

Completed and approved risk assessments from all areas of the Trust will also be published to the Portal, for anyone to view.
Greatly improved feedback mechanism for management and staff
Automatic notifications via the system including reminders for reviews, actions
Ability to embed current policy or standard operating procedure for the assessment
Audit Trail & Audit Module
Reporting Dashboard and Detailed Data for In-Depth Reporting
Detailed organisation structure

14.3 Conclusion

As indicated in 12.2, the benefits for the Trust in moving to the online system are great although the configuration required for the system was more extensive than initially anticipated due to the changes that were made in the software and this is not able to be circumvented at this stage. Therefore a controlled introduction of general workplace risk assessments is currently underway with the anticipation that the COSHH module will be available by August 2016 in order that implementation is not further hindered.

15. Moving and Handling Team

15.1 Introduction

Clinical Matrons, managers and supervisors / team leaders hold responsibility for ensuring staff are compliant in completing Moving and Handling mandatory training and for highlighting and requesting additional training, as needed, to support their teams appropriately. Responsibility is also held for purchase of suitable equipment, maintenance and the planning of training with the relevant training team.

15.2 Staffing

The Moving and Handling Team was newly formed in March 2015, following staff retirement and relocation, with 2 team members seconded into post, being swiftly made permanent. The team is made up of x1 Band 7 Specialist Practitioner Lead Advisor (RGN), x1 Band 6 Specialist Practitioner Advisor/Trainer (paramedic) and x1 Band 5 Associate Practitioner/ Trainer.

15.3 Professional Development

The team will need to develop with essential further education to specialise in Back Care and Ergonomics, as recommended by external bodies to support fully with Trust needs. During 2015/6 the team have taken full advantage of internal training throughout the year, and have been supported to attend the following key events:

- X2 Staff IOSH Managing Safely for Healthcare Professionals (x5 days)
- X1 ROSPA Safer people handling train the trainer course (x4 days)
- X2 NAIDEX NEC Birmingham (Equipment free CPD event)
- X1 Back Care Exchange conference (x3 days) and Sussex based meetings

15.4 Moving and Handling - Training and Education

The Moving and Handling Team deliver training and advice across the Trust (acute and community environments). The team are open to change and innovation and provide a comprehensive training programme for all Trust staff and volunteers in the acute and community, this includes:

- Mandatory training on Induction for all Clinical, Non-Clinical staff, and volunteers
- eLearning (mandatory on joining the Trust)
- Annual refresher training for clinical staff and targeted non-clinical staff teams
- 3 yearly refresher training for non-clinical staff
- Skill station drop in sessions (a refresh on targeted equipment, mass inductions or mandatory training)
- Locally delivered sessions e.g. Crowborough, Lewes and Uckfield
- Supporting other multi-disciplinary training events e.g. H&S open days, Tissue Viability (SSKIN),OT Hoist prescription workshop

15.5 Review of training

In order to develop strong foundations and identify fresher ways of delivering training a review of training evaluation forms in Q3 from 2013 to 2015 was undertaken. Broadly put, the evaluations indicated that the trainers from Q1 2015 were seen as being excellent in the delivery of training however the content did not fulfil their needs; this in part was due a range of skill mix in the classroom, not all needs can be meet in 2 hours. During Q4, work commenced on the development of a fresh approach to content and delivery of training, based on ESHT Datixweb incidents for launch in April 16. The benefit will be evidenced and competency based training being delivered .ESHT will be the first Trust in England, that we are aware of have taken this route for training.

15.6 Training group capacity

External bodies recommend that clinical training group sizes for Manual Handling should be between 8 to 10 persons.

In 2015/16 group sizes for clinical staff for 2015/6 were agreed to be a maximum of 12 persons for induction per cohort and 18 persons for clinical refresher per cohort (due to a high DNA rate in Q1 and 2) In Q3 clinical refresher cohort size was reduced to 16 in agreement with Learning and Development. In Q1 2016 will be 14 persons (with an expectation of a 2 staff per cohort DNA rate). These changes benefit the staff and trainer.

The Medical Education team provided the opportunity to deliver practical training to FY1s. Post training evaluation review indicated that longer sessions are needed. This has already been factored into the 2016/7 training programme.

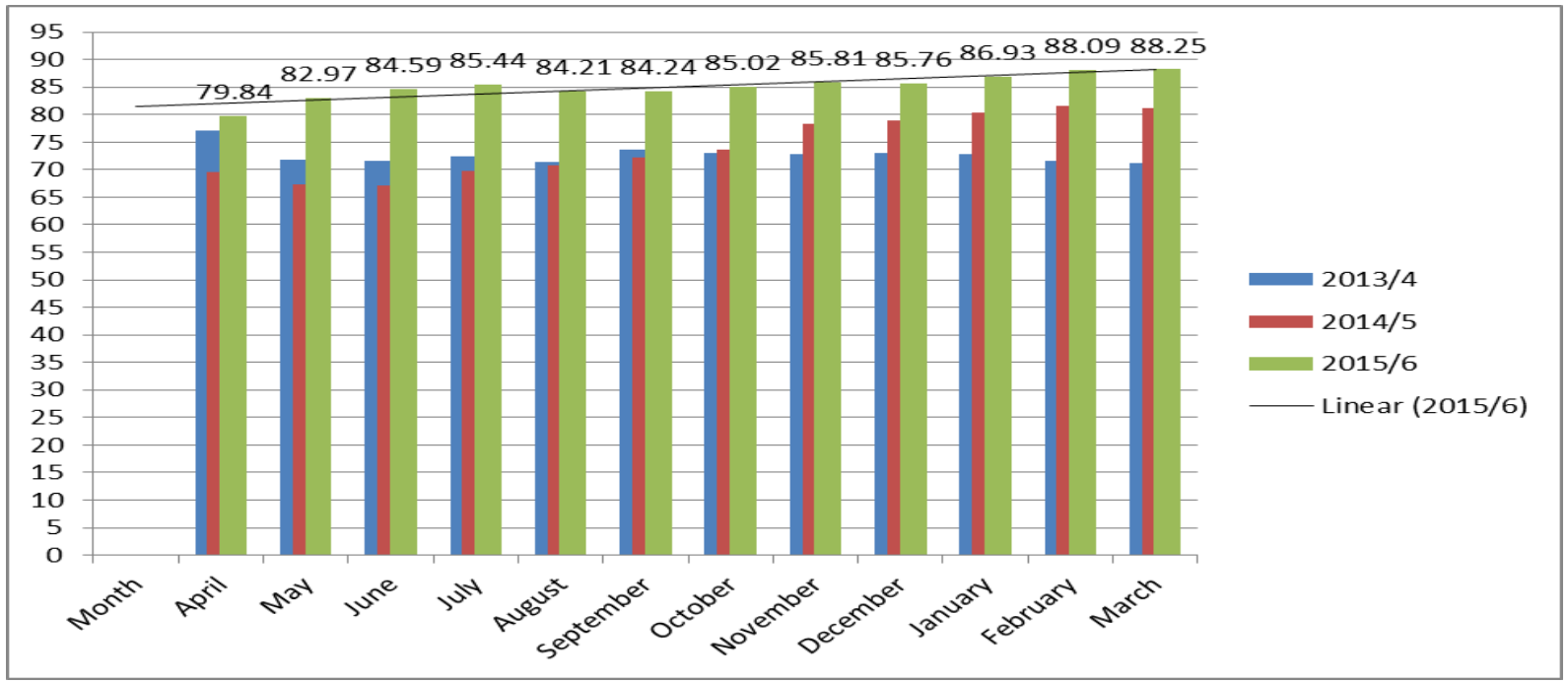
15.7 Training efficiencies

A review of training schedules, training locations and equipment was completed in Q1. Areas identified for immediate action included gaining ownership of the DGH training room, which removed the need to book our training room. A refurbishment of the Conquest Moving and Handling training room 9 in the Education centre, which included removal of wall units, redundant sink unit increased floor space. Amendments to the HCA Induction week planning saved 22 training hours, with no impact on other teams. A trial of new skill station drops in session and mass inductions have additionally provided the opportunity for closer team working.

15.8 Training Compliance

The annual report for 2014/15 stated that the Moving and Handling Team would achieve an end of year compliance rate of **85%**. It is very pleasing to be able to report that this target was exceeded for 2015/16 with an end of year compliance figure of **88.25%.** This can be attributed to a well-planned training programme delivery by Learning and Development, with an additional 68 targeted sessions being planned and delivered by this team.

Fig 15.8 Moving and Handling mandatory training % year on year comparison 2013 to 2015



16. Equipment

16.1 Equipment overview

In order to gain a clear overview of the equipment held within the Trust the Moving and Handling Team introduced DISCovery walkrounds. These enabled the gathering of required data and to enable a good working relationship between the team and staff in the workplace. A unique uniform was sought for approval, which shows a professional image when supporting clinical areas.

DISCovery walkrounds highlighted a number of issues, which included:

- Multiple brands of the same product, with varying performance in use (Glide sheets, Single Patient Use slide sheets)

- Equipment procured pre 2010 ,having not been maintained (Hover Jacks and HoverMatt) will need replacement
- Washable slings located in clinical areas were not being used, non-compliant with LOLER checks and were delayed in transit on return from laundering between each patient use
- No equipment held for weighing patients on admission
- No training, insufficient equipment and processes to support the care of patients requiring bariatric equipment

16.2 Equipment Actions

- Communications with staff, procurement and suppliers has enabled the required equipment to be purchased from a single supplier. This provides assurance should there be a product failure / recall. Cost savings have also been made.g. ordering from the manufacturer, not a 3rd party supplier. Order levels of certain equipment is monitored by amount and location to ensure availability of products for staff
- A washable sling recall was completed in the acute setting for clinical areas (exclusions paediatrics and therapies) on safety grounds, long-term there will be a cost saving and provide a consistency of product use across the Trust. Slings held varied in sizing and colour, which could contribute to user error
- A “Weight and Tea” day provided a planned opportunity for clinical and non-clinical staff to attend the education centre to view a wide range of weighing equipment
- A Plus Size/ Bariatric working group was formed to look at the patient journey from home to discharge and detail priorities. Suppliers of hired bariatric equipment have responsibility for training equipment hired in for ESHT patient needs. A dedicated training room has been allocated from Q3 2016 at the Conquest Education centre, which will enable the acquisition of suitable and sufficient equipment. A review by the Design team to reconfigure x2 training rooms could not be taken forward due to structural concerns
- Due procurement process is being followed to enable purchase of required HoverJack and Matts.

16.3 Equipment Compliance

In quarter 3 (2015) the Medicines and Healthcare Regulatory Agency (MHRA) issued a safety alert relating to Hoist and Sling use nationwide. In response an action plan was agreed, measures put in place included:

- Suitable effective communications across the Trust
- Improve collaborative working. A new formed Manual Handling Advisory Group has been formed made up of ESHT Physiotherapists, Occupational Therapists and the Moving and Handling Team. If supported by all areas, this group is key for collaborative working and standardisation of equipment

- Set up Quarterly Review Meetings (QRMs) with Estates, Health and Safety, and with Procurement
- Plan for dedicated competency assessed hoist and sling workshop delivery in 2016/7 (acute and community focussed).

17. Equipment trials

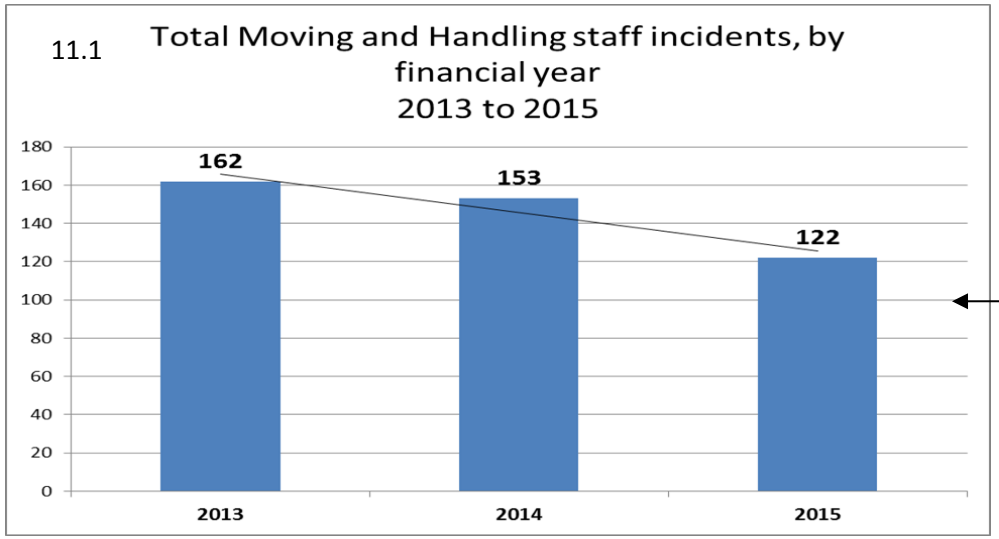
17.1 Sit to stand desk

Varidesk trial: A single sit to stand desk trial escalated into a 6 month trust wide trial due to an overwhelming positive response from Trust staff. Height adjustable sit to stand desks enable an easy transition for workers between sitting and standing. Units can be used by multiple users and can be moved easily i.e. are not permanent fixtures. 35 staff trialled a selection of units for between 1 to 2 weeks. Post use evaluations received showed that during the trial staff gained improved postural awareness, a reduction in back pain and felt more energised and alert at work. All participants stated they would recommend the product with 80% benefitting from the trial. ESHT have purchased a few units which are in use by staff where a clear need has been identified.

17.2 Single Carer Handling device

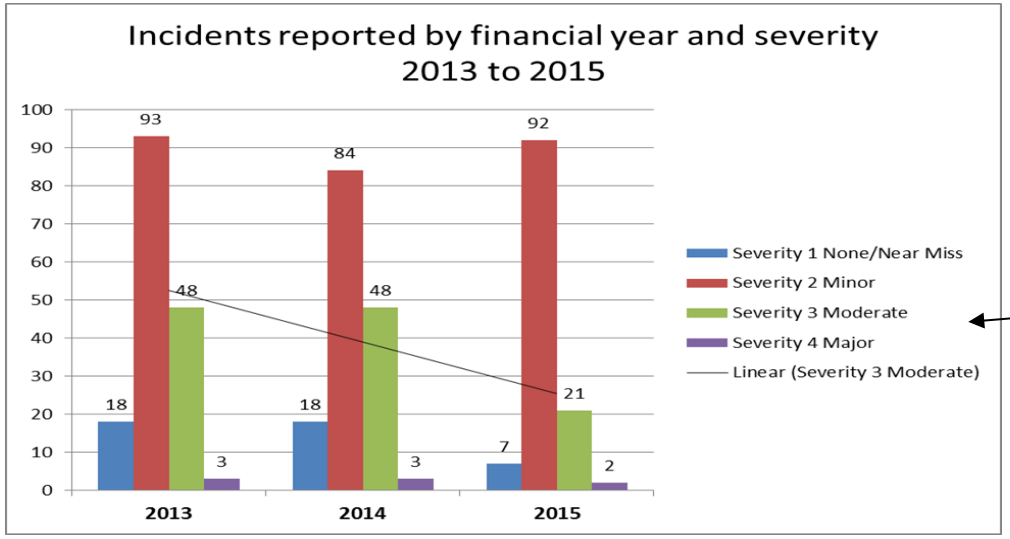
Supine to Seated Edge of Bed Solution (Seba ©). A product promoted to improve single carer ergonomic efficiency, reduce lift load by 80% and encourage patient involvement was identified for trial. The Seba © was shared with ESHT Subject Matter Experts (SME) only. The product was within drawn by the manufacturer due to safety concerns.

18. **Moving and Handling Staff Incident reporting (by report date)**



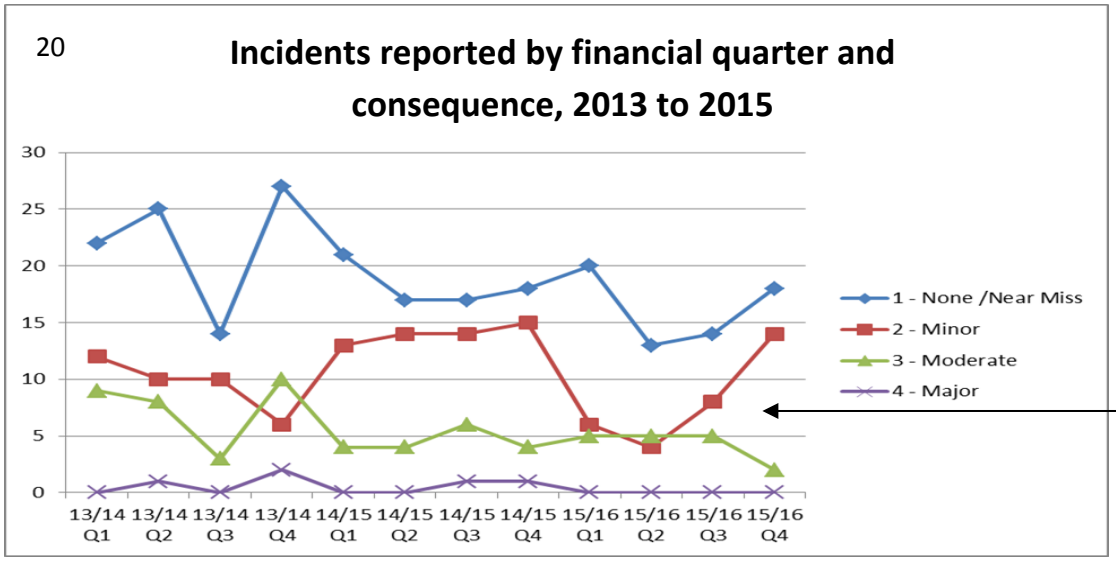
18.1 Total Moving and Handling staff incidents, by financial year, 2013 to 2015.

Year on year there has been a positive reduction in the total number of staff incidents. A 20% decrease can be seen in the number of incidents reported, from 153 to 122, in the last 12 months.



19. Incidents reported by financial year and severity 2013 to 2015.

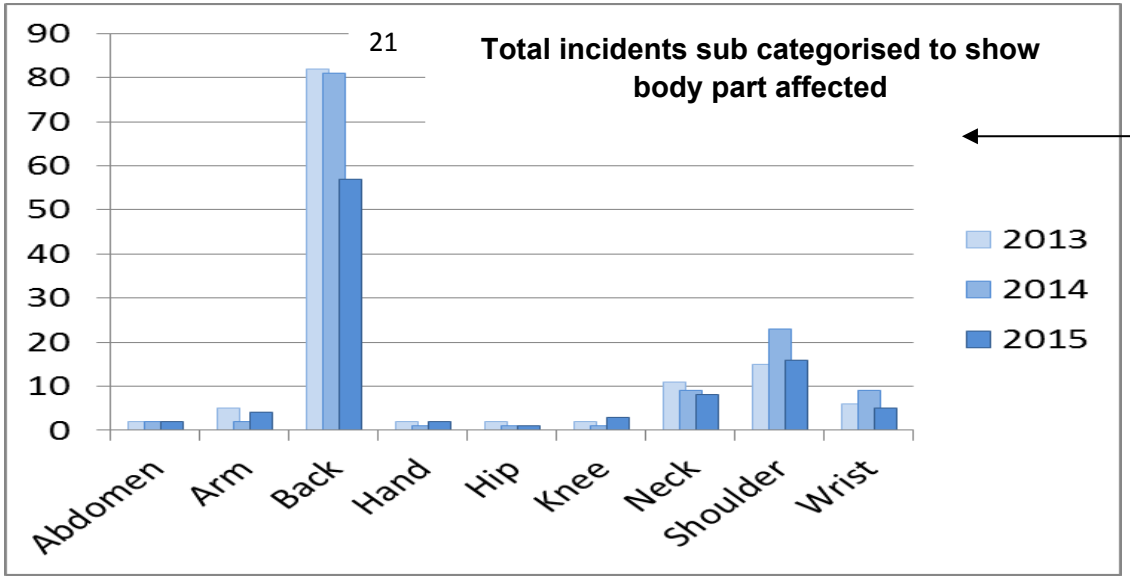
Year on year a positive decrease of incidents listed as being Severity 3 and 4 incidents can be seen. An increase of incidents reported as Severity 1/Near miss incidents is needed to reduce risks and injuries. See Fig 20.



20. Incidents reported by financial quarter by consequence 2013 to 2015.

This chart shows the severity/ consequence by financial quarter. The Trust requires a downward trend for Minor to Major incidents and a significant increase for Severity 1 (No injury/ Near miss)

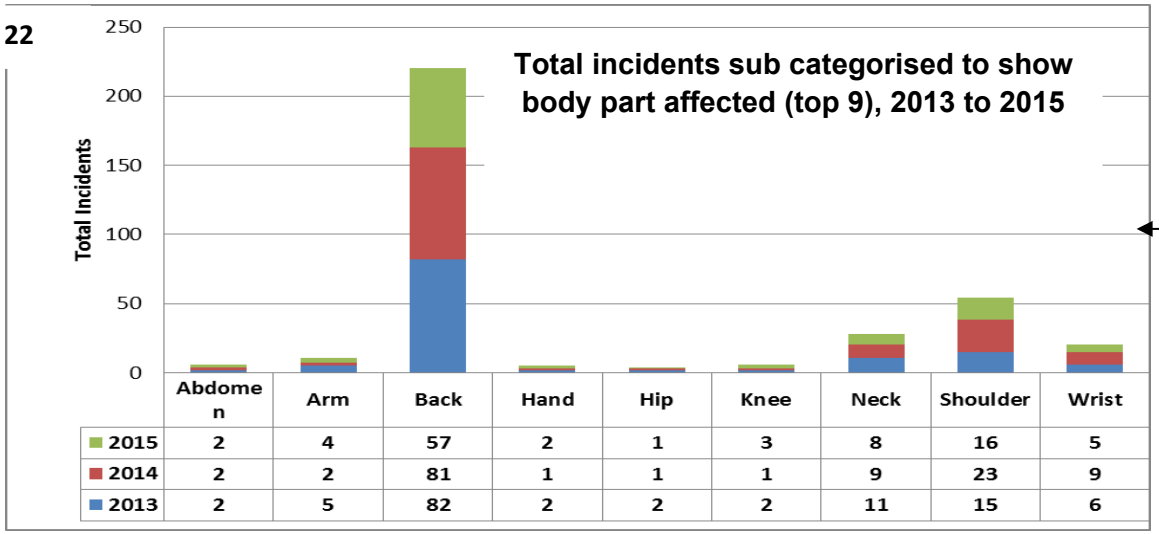
The review of all incidents shows that staff are able to identify the risks before activities occur, yet continue to carry out those tasks particularly in reference to Severity 2 / Minor incidents, where a marked increase can be seen. Supportive and educational needs have been identified to start to reverse this trend. A lessening of incidents may also be seen with further financial support in regards to powered mechanical devices and profiling beds.



21. Total incidents sub categorised by financial year, to show body part affected 2013 to 2015 (top 9)

This chart shows a reduction of 30% for back injuries from 82 to 57 between 2013 and 2015. Taking into account the 20% reduction in overall reporting the statistics are encouraging.

22

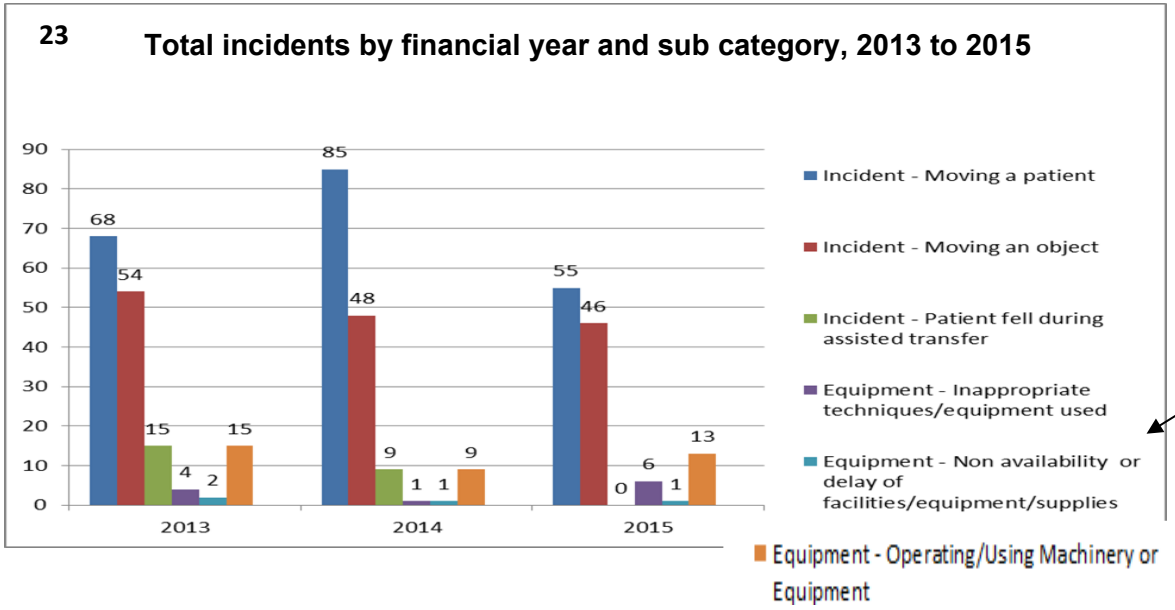


	Abdomen	Arm	Back	Hand	Hip	Knee	Neck	Shoulder	Wrist
2015	2	4	57	2	1	3	8	16	5
2014	2	2	81	1	1	1	9	23	9
2013	2	5	82	2	2	2	11	15	6

22. Total incidents sub categorised to show body part affected (top 9) 2013 to 2015

This chart shows the breakdown of staff injuries (top 9 categories) by body part year on year. Minimal increase in arm and knee incidents can be seen, which relates to accumulative damage rather than specific injuries.

23



23. Total incidents by sub category

2013 to 2015

Attention does need to be drawn to an increase within category Equipment – operating/ using equipment. These incidents refer to equipment that was not fit for purpose (i.e. cages, buffering equipment, and bariatric equipment). A positive balance between financial viability and the promotion of replacing equipment that is not fit for purpose would reduce these incidents significantly. (Please note that patient falls in 2015 are reported by the ESHT Falls group).

24. Medical Device Educators

The role of the Medical Device Educators team is to provide essential training and support to front line clinical staff in the safe use of medical equipment. To ensure that staff are competent to use equipment and investigate and monitor areas of risk. The team work closely with EME, finance and procurement to ensure that equipment is fit for purpose and meets relevant clinical specifications.

Currently the medical device training team consists of 2 WTE medical device educators. 1 WTE based at EDGH and 1 at Conquest. This allows for cross cover due to annual leave, sickness etc.

The MDE team is in a transition stage at the moment due to staff changes.

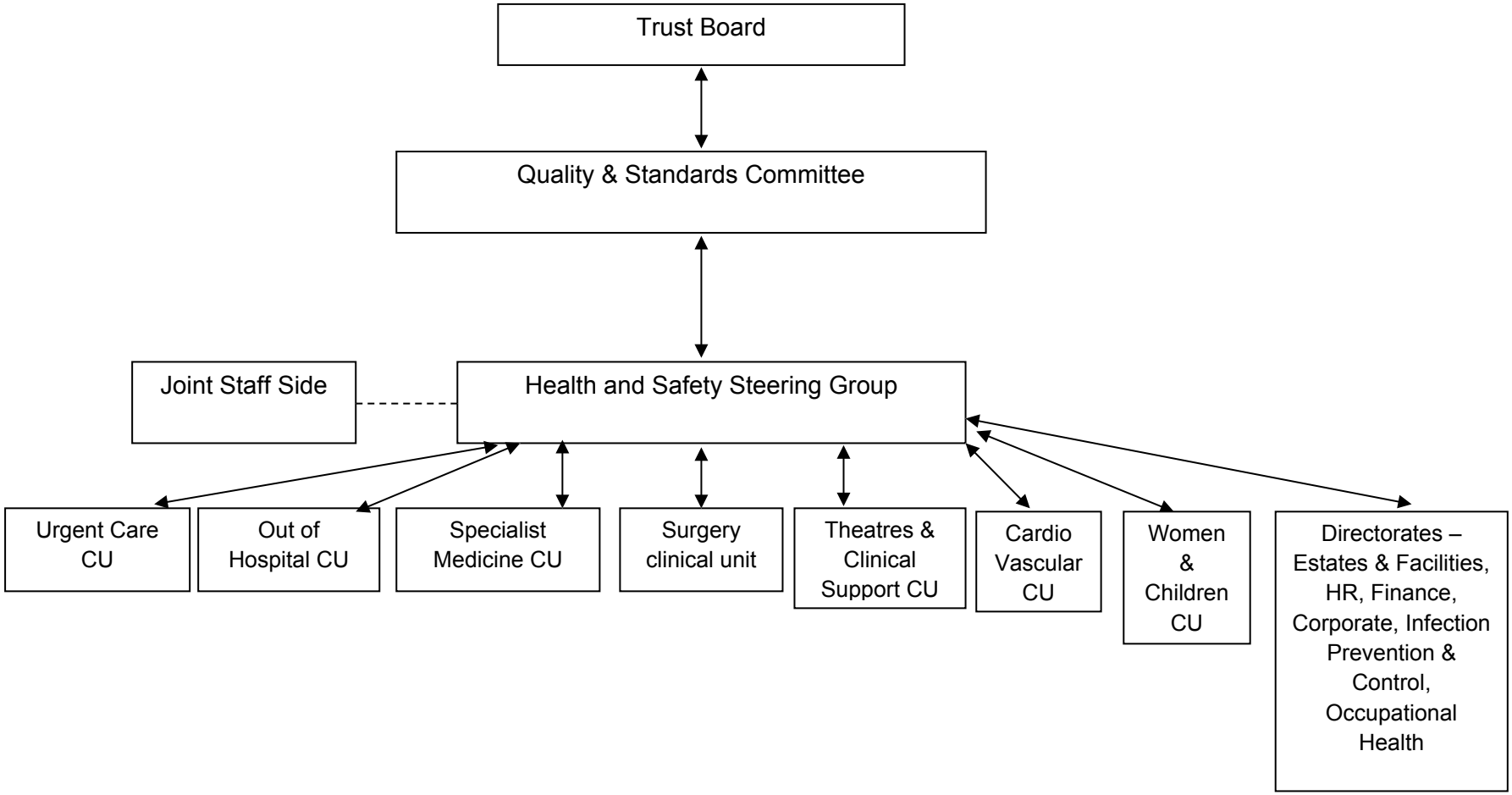
- The MDE covering EDGH retired in March 2016 after 10 years in the role. The replacement MDE started in May 2016.
- The MDE covering the Conquest site will be reducing their hours to 3 days (0.6 WTE) to help with work life balance as of September 2016 (TBC). Discussions will take place to ensure there is a plan in place to cover the remaining 0.4 WTE

As a team we have a well-defined annual programme of work available on request. This lays out our training plan for 2016/17. This gives us clear objectives and essential KPI’s to work towards and the team report on progress to the Trust Medical Devices group and HSSG.

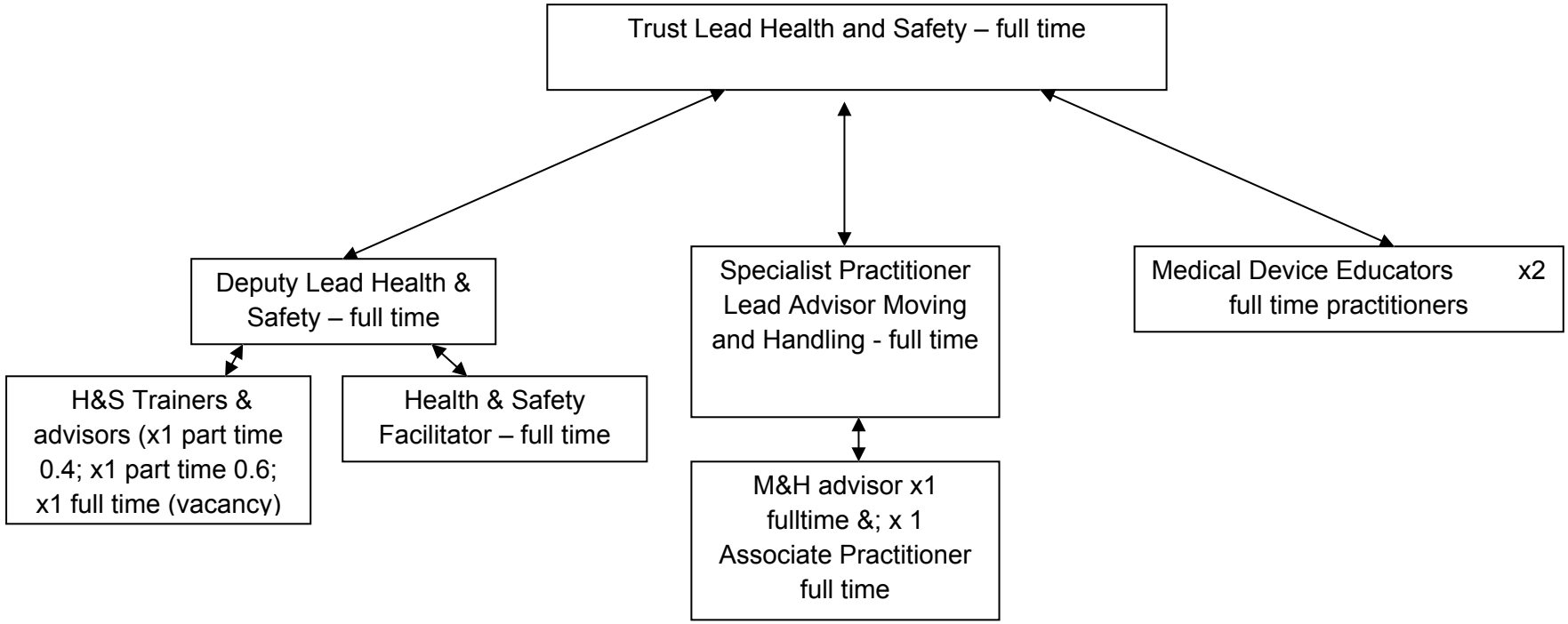
Currently we have an on-going mandatory training programme established for infusion devices which is well subscribed too. Staff who complete this course are deemed to be competent in the use of the devices and this competency is added to the ESR system.

The training of other types of medical devices is done on an ad hoc basis and /or bespoke training as required by the services.

Appendix 1 Health and Safety reporting structure



Appendix 2 Health and Safety Department



East Sussex Healthcare NHS Trust

Date of Meeting:	3rd August 2016
Meeting:	Trust Board
Agenda item:	15b
Subject:	Workforce Strategy 2016/2017
Reporting Officer:	Monica Green

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

Assurance	x	**Approval**		**Decision**	

Purpose:

To gain Trust Board approval of the refresh of the Workforce Strategy for 2016/2017.

Introduction:

The workforce strategy document summarises key workforce outputs and achievements during 2015/2016, and outlines our key areas of focus during 2016/2017.

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

The strategy includes:

- A reflection on our staffing demographics and how they have developed during 2016/2017;
- A summary of Clinical Unit workforce areas of focus from the 2016/2017 Business Planning process;
- An outline of key achievements during 2015/2016 and key areas of focus for 2016/2017;
- A summary of main workforce risks and challenges;
- A reflection on how this strategy will align with wider organisational and regional strategy development;
- A summary of workforce measures.

Benefits:

The workforce strategy draws together the key workforce elements of the Trust's business and strategic development processes.

Risks and Implications
As detailed in the strategy.
Assurance Provided:
That a workforce strategy is developed to reflect and align with ESHT and Regional developments

Review by other Committees/Groups (please state name and date)**:**	
Draft reviewed by People & OD Committee – 1st June 2016 Circulated to Senior Leaders Forum members – July 2016	
Proposals and/or Recommendations	
That the Board receives assurance of a strategic approach to workforce development that will be continually refreshed as wider strategic developments in our local health economy are taken forward.	
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: Edel Cousins	**Contact details:** Edel.cousins@nhs.net

East Sussex Healthcare NHS
NHS Trust

WORKFORCE STRATEGY

2016/2017

WHAT MATTERS TO YOU MATTERS TO US ALL

Contents

1. Summary

This Workforce Strategy document summarises key workforce outputs and achievements during 2015/2016, and outlines our key areas of focus during 2016/2017.

The document also includes a reflection on our staffing demographics and how they have developed/changed during 2015/2016. We have successfully recruited to 100% of our Healthcare Support Worker establishment and have made significant progress with recruiting qualified nurses, particularly from overseas, however this area remains a challenge. We also still have a number of challenges in relation to medical staffing, particularly in Urgent Care and our recruitment team are working closely with Urgent Care leads to address the shortfalls.

During 2015/2016 there was also a greater focus on supporting managers to deal with sickness absence, and we are now seeing a downward trend in relation to our annual sickness rate.

We are now placing greater focus on staff engagement and leadership development as both of these are areas of development for ESHT. This work will gather pace during 2016/2017 but we also recognise that this is a medium to long term area for development and progress will be incremental over the next few years.

Our annual refresh of the Workforce Strategy aims to reflect strategic developments both at ESHT and within the wider health economy. We are currently refreshing and further developing our own clinical strategy and vision (ESHT 2020) as well as working in partnership with East Sussex CCGs via East Sussex Better Together (ESBT), and partners in Sussex and East Surrey via the Sustainable Transformation Plan (STP). Through ESBT there have been developments in Out of Hospital care including the introduction of Frailty Nurses, Pro-active Care Nurses, and Crisis Response teams. These teams are currently being established with the aim of providing more robust and responsive clinically led out of hospital care to support admission avoidance. All of the above areas of strategic focus are still developing plans and this Workforce Strategy will be further refreshed once the workforce aspects of those plans are developed.

2. Introduction

The vision for East Sussex Healthcare is to provide compassionate, high quality and safe care to improve the health and wellbeing of all local people.

This Workforce Strategy details how we will manage our workforce to enable the organisation to move forward and be able to react and adapt to the changing environment of the NHS, both nationally and locally. A highly skilled, motivated, and engaged workforce is essential to ensuring this can be achieved.

The workforce strategy is written at Organisational level and reflects key themes and issues across the organisation. The workforce strategy details how we will manage our workforce during 2016/2017 and address key challenges.

3. Background and Context

East Sussex Healthcare NHS Trust provides acute hospital and community health services for people living in East Sussex and some areas of the adjacent counties. We also provide an essential emergency service to the many seasonal visitors to the county every year.

Our services are mainly provided from two district general hospitals, Conquest Hospital and Eastbourne District General Hospital, both of which have Emergency Departments and provide care 24 hours a day. They offer a comprehensive range of surgical, medical and maternity services supported by a full range of diagnostic and therapy services.

At Bexhill Hospital we provide outpatients, day surgery, rehabilitation and intermediate care services. Outpatient services and inpatient intermediate care services are provided at Rye, Winchelsea and District Memorial Hospital.

In addition to the above, the Trust jointly provides with Adult Social Care inpatient intermediate care services at Firwood House in Eastbourne.

Our staff also provide care in patients' homes and from a number of clinics and health centres, GP surgeries and schools. We work in close partnership with colleagues in acute, primary and social care, together with education services and the voluntary sector.

The workforce strategy and plan reflect the current and planned strategic developments at ESHT in line with:

- East Sussex Better Together (ESBT) – Transforming Community Services;
- Sustainable Transformation Plans (Sussex and East Surrey) (STP)
- ESHT Quality Improvement Plans.
- ESHT 2020

Our strategic objectives are:

- Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
- All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.
- We will work with Commissioners, Local Authority, and other partners to plan and deliver services that meet the needs of our local population in conjunction with other care services.
- We will operate efficiently and effectively, diagnosing and treating patients in a timely fashion and expediting their return to health.
- We will use our resources efficiently and effectively, diagnosing and treating patients in a timely fashion and expediting their return to health.

We will adopt the following principles as the basis for our work:

We are ambitious and aspire to excellence
We work closely with Commissioners and Social Services in planning and delivering health and care.
We state clearly what we do and achieve high standards in delivering it.
Services are provided seamlessly across hospital and community settings.
We have robust operational and financial systems.

Improved efficiency and quality in our services needs to be delivered against a background of financial challenge and the drive for increased productivity and improved quality of care. We are seeing a year on year increase in demand for health services, without the same levels of investment that we have received over the past 10 years. Nationally we are already experiencing shortages in key professions, and we therefore need to seek new ways of working and ways of adapting existing skills to meet future needs.

At ESHT we have recently developed a set of values and behaviours which are important to staff, place the focus on patients and will help the organisation to achieve its strategic aims and objectives. Our values will be at the heart of how we behave and act as we plan for the future to provide high quality, safe care to patients in the right place and at the right time.

Our values are:

4. ESHT Strategic Development

There are a number of key areas of strategic development at ESHT currently:

ESHT 2020

This strategy outlines our key aims between now and 2020, in the following areas:

- Quality & Safety
- Clinical Strategy
- Leadership & Culture
- Access & Delivery

Sustainable Transformation Plan (STP) / East Sussex Better Together (ESBT)

The STP for Sussex and East Surrey is being led by the CEO of SaSH. A submission of the plan will be made on 30th June 2016 which is viewed as a first milestone on progress. We are actively involved in this process and we are working closely with our CCG colleagues in East Sussex to demonstrate that our East Sussex Better Together (ESBT) programme which focuses on developing an integrated service model alongside provider efficiencies, and reducing the cost base of the Acute Hospitals, will be the key principles on which we will focus our combined efforts to deliver financial sustainability.

Accountable Care Organisation (ACO)

The CCGs and Local Authority are working through how an ACO might be the model that best supports system wide planning and delivery. The ACO model might provide a significant opportunity for the Trust and it will align with our own ambition to deliver end to end integrated care.

ESHT Clinical Strategy

It is envisaged that each clinical unit will develop speciality level clinical strategies that will articulate a five year ambition which will then become a five year delivery plan that will be refreshed each year as part of the annual planning cycle.

Workforce

As plans emerge from the work described above, ESHT will refine its workforce strategy and plans to meet the deliverables outlined. This work will be taken forward in conjunction with partners through the following mechanisms:

- ESBT Strategic Workforce Planning Group – This is a CCG led group with representation from Providers and Local Authorities in East Sussex;

- STP Workforce Group – Yet to be formed.

- Community Education Provider Network – This is currently being established by the CCGs and will follow the same footprint of the ESBT Strategic Workforce Planning Group. This network will address the education and learning needs of our future workforce and will include representatives from local Higher Education Institutes.

5. Current Workforce Demographics (as at 31st March 2016)

5.1 Staff in Post (as at 31st March 2016)

	31-Mar-15	30-Sep-15	31-Mar-16
Add Prof Scientific and Technic	160.06	153.18	152.80
Additional Clinical Services	952.36	980.51	1004.71
Administrative and Clerical	1064.67	1089.14	1123.36
Allied Health Professionals	359.15	354.36	336.36
Estates and Ancillary	597.34	590.07	592.07
Healthcare Scientists	126.77	126.70	126.15
Medical and Dental	549.19	543.39	557.96
Nursing and Midwifery Registered	1800.84	1767.95	1727.39
Students	50.29	45.79	46.10
TRUST	5660.69	5651.09	5666.91

We have made significant progress in relation to the recruitment of Healthcare Support Workers and are at just under 100% of establishment in June 2016. Decreases in the Nursing and AHP workforce reflect the national shortages in these areas. We have recently been successful with overseas recruitment and should be able to fill a larger number of our establishment vacancies during 16/17. Similarly we have recruitment challenges in a number of medical areas but we have been successful in recruiting to some posts and will review our approach to medical recruitment during 16/17.

At 1st April 2016 establishment was increased based on establishment reviews across all area. Nursing establishments have been increased to align with changing dependency and acuity. The increases in Admin & Clerical reflect and increase to our Clinical Admin area which has been under-resourced, and increases to Estates & Ancillary to ensure adequate focus on infection control.

Increase to Establishment at 1st April 2016

	Substantive Budget estab. Mar 16 (ftes)	Substantive Budget estab. Apr 16 (ftes)	Difference	% Difference
Medical & Dental	567.70	567.56	-0.14	-0.02%
Qualified Nurse & Midwifery	1897.14	1961.33	64.19	3.38%
Unqualified Nurse	727.27	808.43	81.16	11.16%
Allied Health Profs	435.69	432.35	-3.34	-0.77%
Other STT	502.59	506.20	3.61	0.72%
Admin & Clerical	1140.99	1214.47	73.48	6.44%
Estates & Ancillary	626.32	679.75	53.43	8.53%
TRUST	**5897.70**	**6170.09**	**272.39**	**4.62%**

5.2 Age Profile (as at 31st March 2016)

Age Group	**Number of Employees**	**Percentage of Employees (%)**
<=29 yrs old	833	12.78%
30-44	2225	34.13%
45-59	2828	43.38%
60-78	633	9.71%
TOTAL	6519	100.00%

We know that the average age of our workforce is higher than the national average age and this is reflected in the above table with the majority of our workforce being over the age of 45.

We want to further investigate recruitment and retention issues in the younger age bands. During 16/17 we will also significantly increase our apprenticeship offering and whilst

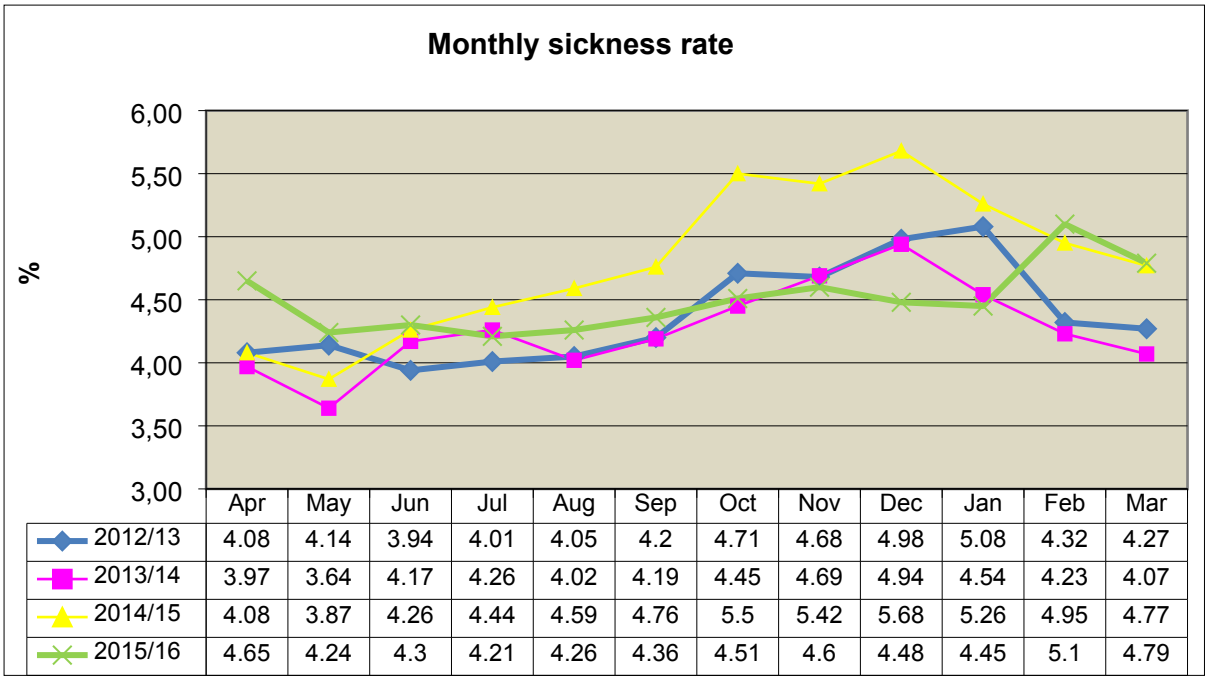
apprenticeships are open to all ages, we will do some targeted work with schools and colleges in the Autumn to promote our range of opportunities and the apprenticeship training that will be provided alongside.

5.3 Vacancy Rate (as at 31st March 2016)

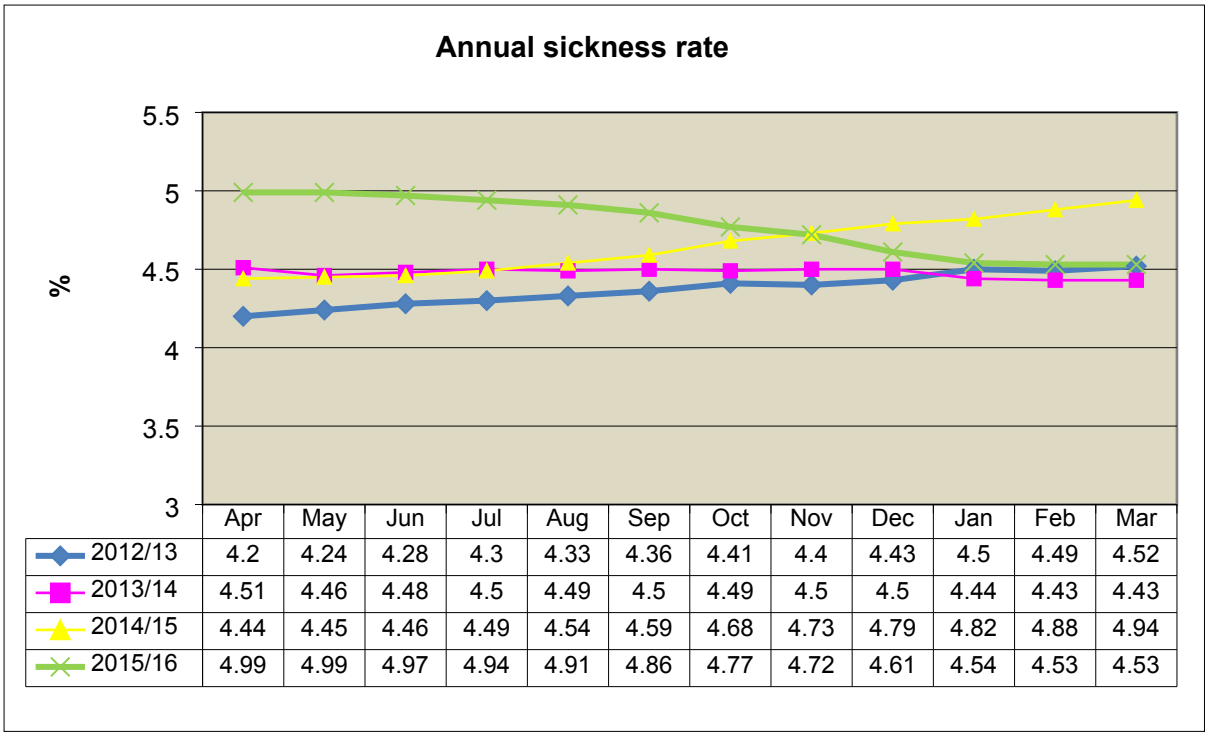
STAFF GROUPS	Vacancies fte	Vacancy rate %	Fill rate %
MEDICAL & DENTAL	64.28	11.32%	88.68%
NURSING & MIDWIFERY REGISTERED	163.65	8.63%	91.37%
SCIENTIFIC, THERAP & TECH	81.58	8.69%	91.31%
ADDITIONAL CLINICAL SERVICES	-39.01	-5.36%	105.36%
ADMINISTRATIVE & CLERICAL	49.41	4.33%	95.67%
ESTATES & ANCILLARY	22.27	3.56%	96.44%
TRUST	**342.18**	**5.80%**	**94.20%**

We ended 2015/2016 with an overall vacancy rate of less than 10%. However, we continue to experience challenges with medical and nursing recruitment, and some areas within the Scientific and Allied Health professions. We have, however, managed to recruit to establishment with Healthcare Support Workers which will help to significantly reduce agency spend in this area.

5.4 Absence Rate (as at 31st March 2016)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.08	4.14	3.94	4.01	4.05	4.2	4.71	4.68	4.98	5.08	4.32	4.27
2013/14	3.97	3.64	4.17	4.26	4.02	4.19	4.45	4.69	4.94	4.54	4.23	4.07
2014/15	4.08	3.87	4.26	4.44	4.59	4.76	5.5	5.42	5.68	5.26	4.95	4.77
2015/16	4.65	4.24	4.3	4.21	4.26	4.36	4.51	4.6	4.48	4.45	5.1	4.79



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.2	4.24	4.28	4.3	4.33	4.36	4.41	4.4	4.43	4.5	4.49	4.52
2013/14	4.51	4.46	4.48	4.5	4.49	4.5	4.49	4.5	4.5	4.44	4.43	4.43
2014/15	4.44	4.45	4.46	4.49	4.54	4.59	4.68	4.73	4.79	4.82	4.88	4.94
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77	4.72	4.61	4.54	4.53	4.53

Our sickness absence trend is gradually reducing compared to one year ago. During 15/16 we revised and relaunched the Sickness Absence policy. In the new policy the points at which sickness reviews are triggered have changed and this has given Managers clearer guidance on when formal reviews need to be instigated. In addition greater HR focus has also been given to ensuring that sickness absence reviews are conducted and support has been given to managers to conduct formal absence meetings under the policy.

5.5 Bank/Agency Use (as at 31st March 2016)

	BANK			AGENCY		
	Bank ftes used	Bank expenditure	% total pay expenditure	Agency ftes used	Agency expenditure	% total pay expenditure
Dec-14	375.73	£1,079,982	5.31%	177.93	£1,009,445	4.96%
Dec-15	415.84	£1,269,629	5.91%	401.89	£2,348,346	10.94%
Mar-16	427.06	£1,370,387	6.22%	524.93	£2,690,422	12.21%

We experienced a significant uplift in temporary workforce spend during 2015/2016. A significant portion of this increased spend reflects the shortages we are experiencing with medical and nursing recruitment. The agency caps that have been imposed since April 2016 will assist with reducing this spend as will a greater focus on recruiting to areas of need and/or developing new roles to address gaps.

Another area of focus has been on Bank rates of pay. Bank rates for pay for Nursing and Healthcare Support workers were increased in autumn 2015. This did result in an increase in candidates applying to join the Trust Bank. In addition feedback from staff during 2015/2016 suggested that one barrier to working on ESHT Trust Bank was the move away from weekly Bank pay to monthly Bank pay. Work is currently being undertaken by

Finance to look at how we could reintroduce weekly Bank pay and there is a proposal to reinstate this from July/August 2016.

Through the STP work consideration will also be given as to how Providers across Sussex could link their temporary workforce services to enable staff to work on other Banks at short notice.

6. ESHT Annual Business Planning 2016/2017

Shaping our Future' written in 2011 was the five year clinical strategy for the organisation which outlined a number of key initiatives and work streams in eight primary access points. The majority of these initiatives were undertaken through service redesign but three services required major reconfiguration and warranted public consultation. This was undertaken in 2012/13 and the conclusion of this was the single siting of emergency orthopaedics and emergency surgery at the Conquest Hospital and stroke services at EDGH.

Since then, and again after public consultation, obstetric care and in patient paediatrics have also been single sited at Hastings with a midwife led unit at EDGH.

The table below outlines the key workforce themes that emerged from each Clinical Unit and Corporate area business plans for 2016/2017.

Clinical Unit / Department	Key Workforce Elements from Business Plan
Urgent Care	Improve Staff Engagement (Appraisals, Training) Review Clinical Site Management team Development of workforce - Advanced/Emergency Nurse Practitioners - AHP roles Review Temporary Workforce Services Development of new roles/models of care to address shortage areas.
Women and Children	Increase compliance with mandatory training and appraisals Recruit to vacant posts
Out of Hospitals	Increase/Maintain compliance with mandatory training and appraisals. Reduce turnover and absence. Take forward ESBT developments
Surgery	Address shortage of junior and middle grades Maintain improved compliance with mandatory training and appraisals. Reduce agency use

Specialist Medicine	Maintain/improve compliance with mandatory training and appraisal Reduce turnover and recruit to vacant posts Success planning/career development
Cardiovascular	Review banding of staff in Cath labs Increased therapy support for 7 day working in Stroke, particularly SALT and OT. Development of roles in Cardiac Physiology – Grow our own?
Clinical Support	Increase/maintain compliance with mandatory training and appraisal. Increase use of B1 Clinical Orderlies Trainees in Pathology Inability to recruit Histopathology Consultants Possible area for Apprenticeships
Clinical Administration	Continue to work with staff re service improvement. Customer Service Training Additional staff recruitment over summer Compliance with mandatory training and appraisal Develop adaptable workforce Reduce turnover
Estates & Facilities	Back Office space rationalisation Possible area for apprenticeships
Corporate	Systems Development Reduce absence/turnover Recruitment strategy Succession planning Back Office rationalisation?

The key elements above are incorporated into our key priorities as detailed below.

7. Workforce Development 2016/2017

7.1 Workforce Capacity – Key Achievements 15/16

- TRAC – Implementation of the new TRAC system which allows the recruitment team and recruiting managers to have full transparency of the recruitment process and allows real time monitoring of the recruitment process. We are able to produce reports on recruitment activity and these have demonstrated that we have been able to reduce time to recruit from 57 days to 37 days.

- Overseas Recruitment – To support shortage and hard to recruit to areas we have undertaken overseas recruitment. To date we have appointed 86 nurses from these campaigns and are planning to undertake further overseas recruitment in 2016/2017. In addition to nursing we have also recently recruited 20 Radiographers from The Philippines to support an increase to 7 day working in this area.
- Values Based Recruitment – This has been implemented for newly qualified nurses and HCAs, and some Therapy areas. A generic suite of questions has been developed that can be adapted for any staff group.
- The Trust vacancy factor has reduced from 9.16% (June 2015) to 7.16% (February 2016), and turnover has reduced from 12.42% (April 2015) to 11.28% (February 2016).
- During 2015/2016 we have also successfully recruited to 100% establishment for HCAs.
- The recruitment team has managed the recruitment for 805 new starters since April 2015.

7.2 Workforce Capacity – Key Priorities 16/17

- Developing recruitment and workforce planning action plans for each Clinical Unit and key Operational area;
- Ensuring our recruitment and workforce plans are aligned with the objectives of East Sussex Better Together and the Sustainable Transformation Plan;
- Identifying areas where new roles may be feasible, examples of new roles that have already been taken forward, or are proposed include:
  - Clinical Orderlies
  - Doctors Assistants (to support Junior Doctors)
  - Physician Associates (first cohort for HEKSS start training in Sept 2016)
  - Further development of Band 4 roles
- Significant expansion of our Apprenticeship programme to meet the government target of 2.3% of our workforce as Apprentices;
- Targeted events for school/college leavers to engage with a younger workforce and potentially grow our own;
- Further overseas recruitment where appropriate
- Consideration of incentives and 'unique selling points' to attract new recruits to our area.

7.3 Workforce Capability – Key Achievements 15/16

- Achieved 87% compliance with mandatory training at 31st March 2016;
- Achieved 87.26% compliance with appraisal at 31st March 2016;
- Full use of our education contracts with local Universities to support staff to develop key skills and continuing professional development;
- Significant expansion of the Clinical Education team to support staff on the wards and ensure that new staff and newly qualified staff are mentored appropriately;
- Supported a range of staff to access national leadership development programmes.
- Supported staff at middle and junior levels with internal programmes such as First Line Manager, and focused management development training such as HR Conversations, Absence Management, and Recruitment.
- Expansion of the Healthroster support team to support rostering on wards to drive up efficiency and reduce temporary workforce costs.

7.4 Workforce Capability – Key Priorities 16/17

- Development of a multi-disciplinary leadership development programme specifically aimed at middle level managers;
- Preparing for the changes to nurse training from September 2017 and assessing the impact this will have on ESHT;
- Focus on skills development for Bands 1 – 4 through the apprenticeship route;
- Focus on appraisal quality through 'Engaging for Development' masterclasses;
- Developing of a Leadership and Talent Management strategy;
- Embedding talent management in appraisal from April 2017 through the use of 'Maximising Potential Conversations'

7.5 Workforce Engagement – Key Achievements 15/16

- Increased focus on engagement activity based on staff feedback and external reports;
- Continued development of Leadership Conversations;
- Bespoke programme for Out of Hospitals Clinical Unit supporting and valuing managers who will lead transformation in this area;
- Developed process for 'pre-engagement' of staff facing service change;
- Ran a number of Listening Conversations with staff areas where they would like to make improvements, e.g. Incident Reporting, Health & Well-being, Mentorship;
- Regular staff forums with the Chief Executive;
- Developed a scheme where staff can bid for small amounts of money to make improvements in their area;
- Introduction of Schwartz Rounds and Emotional Resilience training;

7.6 Workforce Engagement – Key Priorities 16/17

- Addressing bullying and harassment issues through a programme focusing on the 'professionalism' of our workforce;
- Promoting the physical and emotional health and well-being of staff;
- Responding to the output of the cultural review;
- Developing a programme to embed staff engagement at line management level;
- Increased use of short focused surveys to highlight areas that need greater support;
- One off interventions such as 'Take a Break' week to raise staff awareness and support health and wellbeing;
- Develop and implement a framework for celebrating success.

8. Workforce Risks and Challenges

Our key areas of risk continue to be the following:

Area of Risk	Mitigation
Recruitment Difficulties – Shortages in some professions.	Overseas recruitment Use of locum/agency staff Active review of agency usage
Staffing shortages due to sickness, leave etc.	Daily roster reviews Escalation process Moving staff where appropriate
Poor staff morale Staff engagement issues	Newly established Staff Engagement team Staff Engagement Action Plan Significant development of staff engagement initiatives

In addition to the above the Trust will also need to manage the following workforce challenges going forward:

- Culture and Organisational Development (openness and transparency)
- Leadership Development, Capability and Accountability
- Staff Engagement and Involvement
- Workforce Supply
- Operational focus vs. need for Strategic Development
- Funding
- IT Infrastructure
- Learning and Improvement – Ensuring this is embedded
- Responding to ESBT and Sustainable Transformation Plan (STP)

9. Workforce Measurement

The HR Department has agreed the following targets to April 2018:

By April 2017:

Reduce turnover to 11.5%

Reduce annual sickness absence to 4.4%

Reduce monthly vacancy rate to 5.8%

Increase staff appraisal and mandatory training rates to 90%

By April 2018:

To move all staff survey scores to national average

Increase overall staff engagement scores from 3.46 to 4.5

KF11 - % staff suffering work related stress reduced to 33%

KF19 - % staff experiencing harassment, bullying or abuse from staff reduced to 24%

KF21 - % reporting good communication between senior management and staff increased to 30%

Move all MES meta scales to at least middle tier performance

Edel Cousins
June 2016